Bundle Trust Board Public 6 March 2025

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates
January SOX of the month – Adam Parsons, Operational Performance Management and Christopher Mansfield, Cardiology and Stroke Operational Manager
January Patient Centred SOX – Amalia O'Neill, Leigh Eldridge and the Phlebotomy Department
February SOX of the month –
February Patient Centred SOX –

1.2 10:10 - Patient Story

1.3 10:30 - Welcome and Apologies
Apologies received from Duncan Murray

1.4 Declaration of Interests, Fit & Proper / Good Character

1.5 10:35 - Minutes of the previous meeting held on 9 January and 6 February 2025
For approval
1.5a Draft Public Board mins 9 January 2025
1.5b Draft Public Board mins 6 February 2025

1.6 Matters Arising and Action Log
1.6 Action Log

1.7 Register of Attendance
1.7 Register of Attendance - Public Board 2024-25

1.8 10:40 - Chair's Business
Presented by Ian Green
For information

1.9 10:45 - Chief Executive/Managing Director Report
Presented by Cara Charles Barks/Lisa Thomas
For information
1.9 Chief Executive Report March 2025

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 10:55 - Integrated Performance Report to include exception reports
Presented by Judy Dyos
For assurance
2.1a IPR Cover Sheet - Trust Board 2025-03
2.1b Integrated Performance Report - March 2025 FINAL

2.2 11:25 - Finance and Performance – 28 January and 25 February
Presented by Debbie Beaven
For assurance
2.2 Finance and Performance Escalation Report Jan 2025
2.2 Finance and Performance Escalation Report Feb 2025

2.3 11:30 - Clinical Governance Committee – 28 January and 25 February
Presented by Anne Stebbing
For assurance
2.3 CGC report Feb 2025

2.4 11:35 - Trust Management Committee – 22 January and 26 February (to include Green Plan update)
Presented by Lisa Thomas
For assurance
2.4 TMC 22 January escalation report March Board
2.4 TMC 26 February escalation report March Board

2.5 11:40 - People and Culture Committee – 30 January and 27 February
Presented by Eiri Jones
For assurance
2.5a PCC Escalation Report to Trust Board from January 2025 PCC to March 2025 Trust Board
2.5b PCC Escalation Report to Trust Board from February 2025 PCC to March 2025 Trust

Board

3 QUALITY AND RISK

3.1 11:45 - Women and Newborn Divisional Governance Report
Presented by Hannah Boyd/Abi Kingston/Vicki Marston
For assurance
- 3.1a TB WNB Div Gov Report Jan 25
- 3.1b Appendix to Divisional Governance Report to CGC on 28.01.25

3.2 11:50 - Maternity Quality and Safety Report Quarter 3
Presented by Vicki Marston
For assurance
- 3.2a Front sheet Q and S report Q3 24 25
- 3.2b Maternity and Neonatal Safety Report Q3 Oct-Dec 24
- 3.2c APPENDIX 1 - PMRT Report Q3 Oct-Dec 24
- 3.2d APPENDIX 2 - Training Report Q3 Oct-Dec 24
- 3.2e APPENDIX 3 - Patient and Staff Experience Report Q3 Oct-Dec 24
- 3.2f APPENDIX 4 - Saving Babies Lives Report Q3 Oct-Dec 24
- 3.2g APPENDIX 5 - Workforce Report Q3 Oct-Dec 24
- 3.2h APPENDIX 6 - ATAIN TC Report Q3 Oct-Dec 24

3.3 11:55 - Perinatal Quality Surveillance Report January (December data)
Presented by Vicki Marston
For assurance
- 3.3a Front sheet Perinatal Quality Surveillance Report - January (December data)
- 3.3b Perinatal Quality Surveillance Jan 2025 Slides (Dec data)

3.4 12:00 - Perinatal Quality Surveillance Report February (January data)
Presented by Vicki Marston
For assurance
- 3.4a Front sheet Perinatal Quality Surveillance Report -February (January data)
- 3.4b Perinatal Quality Surveillance Feb 2025 Slides (Jan data)

3.5 12:05 - Annual Maternity Survey 2024
Presented by Vicki Marston
For assurance
- 3.5a Front sheet for National Maternity Survey Results
- 3.5b RNZ Salisbury NHS Foundation Trust (full report)
- 3.5c National Maternity Patient Experience survey - action plan for 2024.final
- 3.5d Appendix 1 - MAT24 Headline Report RNZ Salisbury NHS FT (005)
- 3.5e Appendix 2 - MAT24 FrequencyTables and patient comments RNZ Salisbury NHS FT (002)

3.6 12:10 - Salisbury NHS Foundation Trust Maternity Self Certification Board Assurance Report for Clinical Negligence Scheme for Trusts, Maternity Incentive Scheme Year 6 January 2025
Presented by Vicki Marston
For assurance
- 3.6 Front Sheet CNST Board Report year 6
- 3.6b CNST MIS Year 6 Board self certification report January 2025

3.7 12:15 - CQC Maternity Report
Presented by Judy Dyos
For assurance
Links in report can be provided on request
- 3.7 Front sheet CQC Inspection Report February 2025

3.7.1 12:20 - BREAK 30 MINUTES

3.7.2 QUALITY AND RISK - CONTINUED

3.8 12:50 - Patient Experience Report Q3
Presented by Judy Dyos
For assurance
- 3.8 Patient Experience - Patient Feedback Report Q3 24-25 v1.0

3.9 13:00 - Learning from Deaths Q3

Presented by Stuart Henderson
for assurance

3.9a Cover Sheet - Feb 25 LfD CGC
3.9b Learning from Death Report -Q3v1.4

4 GOVERNANCE

4.1 13:10 - Emergency Preparedness, Resilience and Response Annual Assurance Statement and Compliance – deferred from December
Presented by Niall Prosser
For assurance

4.1a EPRR Annual report 2024
4.1b EPRR Annual Report 2024 Version 1.0

4.2 Register of Seals - seal has not been used since last report

4.3 13:20 - Board Meeting Schedule Proposal
Presented by Fiona McNeight
For approval

4.3 Board Meeting Schedule Proposal

4.4 13:30 - Group Chair Role
Presented by Fiona McNeight
For approval

4.4a Cover Sheet and report Group Joint Chair Role March 2025 Public Board
4.4b Appendix 1 Guide to the appointment of Joint Chair Nov-24 Draft V1.0
4.4c Appendix 2 Joint Chair and Local Lead NED Tasks and Assumptions V1.0

5 PEOPLE AND CULTURE

5.1 13:40 - Gender Pay Gap
Presented by Melanie Whitfield
For approval

5.1a 20250227-Gender Pay Gap Report 2024-25 Cover Sheet
5.1b 20250227- Gender Pay Gap Annual Report and Action Plan 2024-25

6 STRATEGY AND DEVELOPMENT

6.1 13:50 - Estates Strategy
Presented by Mark Ellis
For approval

6.1a FS Estates Strategy Jan 25
6.1b MASTER Salisbury Estate Strategy - Executive Summary - V2.3 - 20.08.24

6.2 14:00 - Service Strategy Responses
Presented by Alex Talbott
For assurance

6.2a 2025-03-06_SSRs_Cover-Sheet
6.2b 2025_SFT-SSRs-Compendium_FINAL

6.3 14:10 - Strategic Planning Framework Update
Presented by Alex Talbott
For approval

6.3a 2025-03-06_SCPN_SPF-Refresh-Cover-Sheet
6.3b 2025-03-06_BoardSlides-SPF-Refresh

6.4 14:15 - Strategy Horizon Extension - 2028
Presented by Alex Talbott
For approval

6.4a 2025-03-06_Strategy-Horizon-Extension_Cover-Sheet
6.4b 2025-03-06_Strategy-Horizon-Extension

7 CLOSING BUSINESS

7.1 14:20 - Any Other Business

7.2 Agreement of Principal Actions and Items for Escalation

7.3 14:25 - Public Questions

8 Resolution

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

Salisbury NHS Foundation Trust

Draft

Minutes of the Public Trust Board meeting held at 10am on Thursday 9th January 2025, Boardroom/MS Teams Salisbury NHS Foundation Trust Boardroom

Board Members:

Ian Green (IG)	Chair
Eiri Jones (EJ)	Non-Executive Director
Debbie Beaven (DB)	Non-Executive Director
Richard Holmes (RH)	Non-Executive Director
Rakhee Aggarwal (RA)	Non-Executive Director (via Teams)
Mark Ellis (ME)	Interim Chief Finance Officer
Duncan Murray (DM)	Chief Medical Officer
Lisa Thomas (LT)	Managing Director
Niall Prosser (NP)	Interim Chief Operating Officer
Melanie Whitfield (MW)	Chief People Officer
Anne Stebbing (AS)	Non-Executive Director
Paul Cain (PC)	Non-Executive Director

In Attendance:

Fiona McNeight (FMc)	Director of Integrated Governance
Alex Talbott (AT)	Director of Improvement
Sasha Godfrey (SG)	Board Support Officer (minutes)
Tapiwa Songore (TS)	Head of Corporate Governance
Vicki Marston (VM)	Director of Midwifery (items 5.5, 5.6, 5.7 and 5.8)
Thalina Wijetung (TW)	Visiting fellow
Jayne Sheppard (JS)	Lead Governor (observer)
Jane Podkolinski (JP)	Governor (observer)
Francis Owen (FO)	Governor (observer via Teams)
Gillian Rennison (GS)	CQC
Helen Rynne (HR)	Patient Engagement Lead (for agenda item 1.2)
Luke Curtis (LC)	Lead Cancer Nurse (for agenda item 1.2)
Sarah Garratt (SG)	MacMillan Lead Cancer AHP (for agenda item 1.2)
Ken Buckett (KB)	Patient (for agenda item 1.2)

ACTION

TB1 9/1/1 **OPENING BUSINESS**

IG referred to the Improving Together Program and noted the Trust is using the approach and methodologies to bring about improvement, IG asked members and attendees to ask appropriate questions as part of the process of seeking assurance and to be present in the room, reminding them to highlight if they needed to step out during the meeting.

IG welcomed Tapiwa Songore (TS) to his first meeting while covering for the Head of Corporate Governance.

TB1 9/1/1.2 **Patient Story**

LT introduced the Patient Story.

HR introduced Ken Buckett (KB) a cancer patient and asked him to share his story.

KB referred to his experience and thanked the staff on Pembroke Ward. KB noted he could not find fault with the care he had received and really appreciated the staff particularly the cleaners who were happy to take time to speak to him when he was on his own. KB noted the importance of face-to-face appointments and noted it was often easier to receive bad news face to face rather than by a phone call.

LC shared a presentation and noted the following achievements:

- Patient and public groups established in August 2023 to seek views of our population.
- Decorated Pembroke Ward.
- Developed web site for cancer.
- Patient leaflet developed in an easy to understand format.
- Business cards with contact details introduced.
- Introduced information pack for cancer patients.
- Macmillan hub now a central point for information.

LC noted next steps were to arrange an engagement event to generate new ideas.

Discussion:

DB referred to the lack of ongoing information after treatment and asked if this was something that engagement events would cover. LC noted patients would be given information throughout their pathway. SG noted the new way of working needed to be embedded but patients needed as much information as possible. KB noted if information is not provided patients will resort to google which was not helpful.

EJ thanked KB for sharing his story and noted there was more to do regarding providing information to improve patient experiences. IG referred to the Boards strategic responsibility and noted the Patient Story was worth thinking over and would encourage future Board discussion.

AS noted plans to make efficiencies through more digital contact and referred to the benefits of formal and informal face to face contact.

IG reflected on the very powerful Patient Story and noted the importance of giving difficult news to people clearly and in a caring, consistent way.

KB, HR, SG and LC left meeting.

DM joined the meeting.

TB1 9/1/1.2 **Presentation of SOX Certificates**

IG presented the SOX nominations:

- December SOX of the month – Tina Simpson, Housekeeping and Lilly Harman, Midwife
- December Patient Centred SOX – Radiology and Switchboard and Downton Ward, ED, Bereavement and Chaplains

IG reflected it was a privilege to hear the positive feedback from both internal and external sources and noted it was an opportunity to recognise good practice in the workplace and important to meet staff to present the awards and to recognise them publicly.

TB1 9/1/1.3 **Welcome and Apologies**

IG welcomed everyone to the meeting and noted that apologies had been received from:

- Jon Burwell, Senior Information Officer
- Cara Charles Barks, Chief Executive
- Kirsty Matthews, Non-Executive Director
- Judy Dyos, Chief Nursing Officer

TB1 9/1/1.4 **Declarations of Conflicts of Interest, Fit and Proper/Good Character**

There were no declarations of conflict of interest pertaining to the agenda.

TB1 9/1/1.5 **Minutes of the Part 1 (Public) Trust Board meeting held on 5th December 2024**

IG presented the public minutes from the meeting held on 5th December 2024.

Decision:

The Board approved the minutes as a correct record of the meeting.

TB1 9/1/1.6 **Matters Arising and Action Log**

FMc presented the action log and noted the first three items had been closed at the December Board meeting. FMc noted the following updates:

TB1 3/10/5.2 Estates Technical Service Update – on agenda – ME noted full assurance would be provided following the Finance and Performance Committee in January, item should remain open.

TB1 3/10/6.1 Health and Safety Quarter One Report – Tugs – Update provided in January report – Completed.

TB1 3/10/7.1 Research Annual Report – Completed, update provided at December meeting.

TB1 5/12/5.5 Perinatal Culture and Leadership Report – Update received action can now be closed.

The Board noted the updates.

TB1 9/1/1.7 **Chair's Business**

IG referred to the pressure the Trust had faced over the last couple of weeks and noted staff had gone way above and beyond to continue to provide safe

and effective services to our population. IG noted Non-Executives were aware and wanted to pass on their thanks to the Executive Team.

The update was noted.

TB1 9/1/1.8 **Chief Executive's Report**

LT provided an update noting the following key points:

- Planning guidance available on 16th January.
- Group development – Group Boards to meet on 28th January.
- Work with governors was ongoing.
- Thanks to Communications Team and Stars Appeal for the events over the Christmas period which had lifted spirits at a busy time of year.
- Currently 10% of beds were occupied by flu patients but teams were coping very well in circumstances.
- All excess capacity in hospital now open and flu numbers were stabilising.
- Learning as a system to understand if there was more that could be done in the community to avoid patients coming to ED with respiratory illness.
- Ambulance Service had declared a critical incident but were now reporting a better position.

Discussion:

IG referred to the impact on the financial position, ME noted the forecast had assumed an element of pressure related to Winter and anticipated an increase in spend on staff.

MW noted an increase in staff calling in unwell and noted the staff who were still working were going above and beyond to cover.

EJ asked if the Christmas period had a worse than expected impact on elective work. NP referred to the Winter Plan and noted the downstairs area of Day Surgery had been protected.

EJ noted demand for the flu vaccine had increased and asked if the Trust was still able to provide vaccines. LT noted the uptake of vaccines had not been as good as last year but people were still able to access vaccines if they wished.

The update was noted.

TB1 9/1/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 9/1/2.1 **Integrated Performance Report (IPR) (M5)**

DM presented the Integrated Performance Report which provided a summary of Month 8 (November 2024). DM noted the purpose of the report and highlighted the following key points:

- Organisation was operating under significant operational and financial pressure, operationally this was most evident for staff and patients on Emergency Care pathways.
- Improvements reported in performance from Diagnostics and Cancer.
- Rise in ED demand sustained with another increase in attendance from November to December evident in the December data.
- In response to the challenges ED footprint had been reconfigured to free up assessment space for clinical staff to assess and treat patients.
- Improvement in the time to first outpatient appointment and progress with reducing waiting lists in Colorectal Surgery, Urology and Oral and Maxillofacial Surgery.
- Continued improvement in recognising patient deterioration and assurance from low levels of ICU admissions and cardiac arrests.
- Concerning rise in pressure injuries.
- No cause for concern in Infection Prevention and Control and mortality metrics.
- Continued improvement in reducing turnover and vacancies.
- Financial position becoming increasingly challenging.

Discussion:

DM reflected on the distress of patients and their families who were behind the data and were waiting in ED corridors and in escalation areas or for inpatient beds and packages of care but also the more positive news that patients were having shorter wait times for MRI and CT scans and getting cancers diagnosed quicker and finally receiving treatment. DM noted staff were providing the best care in difficult circumstances.

IG reflected on the impact of the overall Trust performance on patients and staff. IG referred to the reconfiguration of ED and asked if it had a positive effect. IG referred to concerns in Paediatrics and asked if there was anything else required. DM noted the reconfiguration of ED had freed up more assessment space and had helped to address some concerns regarding violence towards staff. DM noted the concerns in Paediatrics had been addressed although there was still concern regarding the relative isolation of paediatric area.

DB referred to the Elective Recovery Finding (ERF) income shortfall and noted a deep dive had been presented at Finance and Performance Committee into interventions and asked if the operational pressures were having a negative impact. NP noted the Trust was on track and forecasting to meet if not slightly exceed the agreed recovery in ERF.

DB asked if there was more that could be done to utilise theatres. NP noted theatres ran well but some lists had been cancelled recently due to sickness. On the day cancellations were the next top contributor to productivity and work was ongoing to increase the number of pre-assessed patients before being booked for surgery. ME noted activity had been expected to drop in

December due to the Christmas period but activity in theatres was up by 20% compared to the previous year.

EJ noted there were lots of positives despite challenging times and referred to the stroke SSNAP process and asked if there was more that could be done to improve outcomes in this area. DM noted work to maximise the limited therapy resource available. LT referred to the challenging geography and suggested a future deep dive at Clinical Governance Committee. AS noted this was a national issue and suggested a deep dive into stroke and heart attacks to seek assurance that the Trust was doing everything possible internally. **ACTION**: **AS and DM** to discuss presenting a deep dive into stroke and heart attacks at a future Clinical Governance Committee meeting. **AS/ DM**

AS referred to the number of acronyms in the Board papers and asked if it would be possible to explain the abbreviations in future reports. AS referred to text on page 9 and asked for more clarity on the meaning and asked if there was a reason for the dramatic change in mixed sex accommodation breaches in November. NP explained the abbreviations, gave more detail and assurance that future reports would be made clearer. DM noted the mixed sex breach was due to the need to isolate patients to prevent the spread of seasonal infections.

RH referred to the No Criteria to Reside (NCTR) sprint and asked for some feedback. NP noted the focus was on making the process as efficient as possible including digitalising the referral form and including more information to help with assessing care. NP noted numbers of NCTR patients were reducing slowly and would reduce further once new processes were introduced.

AS asked for assurance that the Trust was doing everything possible to ensure the utilisation of theatres translated into income received. ME considered it was and noted the Trust was over performing from an NHSE perspective. ME referred to challenges in the coding team due to the paper-based system.

IG referred to Mortality coding and asked if there was more to do to improve coding generally across the Trust. ME referred to an action plan and mitigations including training, use of agency staff and a remote company.

AT referred to improvements and noted it was clear from the discussion that despite the pressure the Trust was under, it was still aspiring to deliver outstanding care.

IG thanked DM for his approach to presenting the IPR report. The Board noted the report.

TB1 9/1/2.2 **Audit Committee – 12th December**

RH presented the report from the Audit Committee and asked for the Board to take it as read, noting the following key points:

- Received an update from the Chief Pharmacist regarding a process issue with stocktaking.
- Internal audit report received with partial assurance and improvements required.
- Positive feedback from Counter Fraud auditors.
- Audit Plan was received in December, congratulations to ME and his team and the auditors for achieving this.

The Board noted the report.

TB1 9/1/2.3 **Finance and Performance Committee – 17th December**

DB presented the report which provided a summary of escalation points from the meeting held on 17th December. The report was taken as read and DB highlighted the following points:

- Financial performance remains very challenging and there was a significant risk to delivering the forecast.
- Deep dive into drug spend and the Committee were assured there were good controls in place and a proactive approach to finding the best drugs for patient care.
- The Committee had received a paper regarding the restricted capital fund next year and had agreed on an approach.

Discussion:

IG asked for more details on the level of scrutiny undertaken by the Finance and Performance Committee to reduce the financial deficit. DB reflected the Committee had challenged well, presented deep dives and had robust conversations. DB referred to the balance of challenging sufficiently and being supportive. IG referred to the difficult financial position and noted the importance of discussing the risks in a public setting and the positive steps to improving performance reported in the IPR.

DB noted the Committee had considered short term actions, but they came with mid-term consequences. DB referred to the leadership team and department heads and noted their continued perseverance to drive improvements, efficiencies and progress.

ME referred to the model hospital and noted the Trust benchmarked positively in terms of performance.

AS referred to interaction and transparency between the sub committees and noted financial challenges and consequences had been shared.

IG noted the Capital Plan would be received by the Board when the allocation was known.

The Board noted the report.

TB1 9/1/2.4 **Clinical Governance Committee – 17th December**

AS presented the report which provided a summary of escalation points from the meeting held on 17th December. The report was taken as read.

AS noted the papers discussed at the meeting were also on the Trust Board agenda.

EJ reflected if there was a way to improve the Board's learning and considered the improving together process may help. IG noted self-reflection was important and noted the Board had a culture of reflection and learning.

The Board noted the report.

TB1 9/1/2.5 **Trust Management Committee – 18th December**

LT presented the report which provided a summary of escalation points from the meeting held on 18th December. The report was taken as read.

IG considered the key issues in the IPR report had been reflected in conversations taking place at committee level which provided assurance that the committees were aware of the current pressures and risks in the organisation.

The Board noted the report.

TB1 9/1/3 **STRATEGY AND DEVELOPMENT**

TB1 9/1/3.1 **External Well Led Review – 6 monthly update on progress –** ***deferred from December 2024***

FMc presented the report which was an update on progress 18 months after the external review and noted the following key points:

- Making good progress, feeding into existing workstreams.
- Ongoing work with talent management and succession planning.
- Governance arrangements regarding group model.
- Focus on health inequalities and cyber security.
- Changes to the Risk Appetite and how to take forward.
- Building on patient engagement.
- Future reports to be biannually with an external review every three to five years.

Discussion:

IG thanked FMc for the helpful overview and considered the group planning had tested the Trust's governance arrangements and the relationship between the Board and Governors. IG suggested the Well Led Report was presented at a future Council of Governors for information. **ACTION FMc** **FMc**

DB suggesting using the CQC inspection Key Lines of Enquiry (KLOEs) as a point of reference when discussing the group structure.

PC referred to the gap between external reviews and asked how new improvements were added into the KLOEs. IG noted there needed to be an appropriate structure in place in the three independent trusts to ensure governance was aligned to the aspiration of the group. FMc noted the governance arrangements needed more thought. IG referred to governors in

all three trusts and noted the extra support they required. IG added the KLOEs needed to be continually reviewed and updated.

EJ referred to children and young people and suggested the Board could do more for them as they were a large part of the population. IG noted he was the Chair of the Trust's Children's Board which reported to the Clinical Governance Committee.

FMc suggested the next report could focus on a more holistic view of the current position and will include the work underway in the system.

The report was noted.

TB1 9/1/3.2 **Quarterly Strategy Update**

LT asked the Board to read the report in the context of trying to improve the longer-term strategic initiatives.

Discussion:

DB referred to the Community Services contract and asked if it should be included in the strategy. LT noted at the moment HCRG were focusing on mobilisation, but the Trust was keen to work in partnership. LT referred to meetings that had taken place with HCRG and noted the challenge required some reflection.

AS referred to improving healthy life years and asked what the Trust should be focusing on. LT noted the Trust was part of a group with the Integrated Care Alliance and Wiltshire Council and work was ongoing to try to agree how to work together.

PC referred to the impact of the financial challenge and asked if it had been considered as part of the Trust's ability to meet our strategy. LT noted the Strategy focused on the population, patients and staff but added finances would have an impact on what can be delivered. DB noted the strategic ambitions needed to be articulated within the financial parameters.

NP referred to community based care and noted early community based care helped to reduce the demand for urgent care and referrals.

LT noted the next quarterly Strategy report would reflect the Board's feedback.

The Board noted the report.

TB1 9/1/3.3 **Improving Together Update Report**

AT presented the report, reflected on the years achievements and highlighted the following points:

- 1st Catalysis Academy cohort had completed their coaching, 2nd cohort to follow.
- 1st Coach House rotational roles completed, and strong applications received for 2nd cohort.

- The Trust had continued the programme successfully without support from KPMG.
- Divisional and specialty triumvirates trained resulting in increased awareness in the rest of the organisation.
- More work to do with patient involvement and engagement with improvements.
- Group SPF work was a challenge.
- Reputation of organisation and its use of Improving Together had increased.

Discussion:

IG considered the change in Executive Lead for Improving Together programme had gone well and reflected on consultant interviews where candidates had recently referred to Improving Together.

EJ referred to two recent visits she had made to departments and noted it was clear the principles had been embedded. EJ asked what the Non-Executive Directors could contribute to support Improving Together.

RA reflected on the lessons learned and the evaluation of improvements to contribute to learning.

DB referred to the numbers of leaders trained and asked if there was any correlation between staff survey results and leadership behaviours. DB referred to the maturity assessment and asked if there were plans to mature the Executive roles. AT noted it was a self-assessment and added there were plans to develop some critical challenge. LT noted the Executive team had developed personal A3s on their leadership development.

DB referred to the benefits and noted the importance of demonstrating the positive progress made both financially and from a quality perspective.

AS referred to freedom to speak up data and asked if there was evidence that staff were not speaking up anymore. MW referred to People and Culture committee and noted the increase in the number of staff speaking up and staff feeling more confident in talking to their line mangers, indicating freedom to speak was being used well and appropriately.

PC referred to ‘Becoming the Change’ and noted the book referred to Board huddles and asked if this may be a next step for the Board. IG referred to Development days and noted there was a regular Improving Together item. IG suggested the Board reflect on next steps at the next Development Day.

TB1 9/1/4 PEOPLE AND CULTURE

TB1 9/1/4.3 Health and Safety Quarterly Report

MW took the report as read and highlighted the following points:

- Small upturn in number of injuries but overall decreasing.

- Increase in number of incidences of violence and aggression towards staff due to increased awareness and training.
- Sexual Safety Charter signed, national documentation received and training to be launched at beginning of February.
- Reduction in flow of tugs using inside corridors.
- Work with Estates to prioritise the maintenance list.

Discussion:

DB referred to the lack of Uninterruptible Power Supply (UPS) and storage in theatres and asked if there was any assurance to mitigate the fire risk. MW referred to reports from an independent assessor and Wiltshire Fire Service which both flagged concern and noted equipment remained in corridors due to lack of space, but it was well organised and staff were well trained. MW added a working group had been set up to find space within the limited footprint available. IG referred to limited storge space across the Trust and asked what approaches were in place to mitigate storage in public areas. LT referred to regular walks around the site with safety and fire officers where equipment stored in escape routes were reviewed.

PC asked if there was any feedback to show that staff felt more supported after the extra training on violence and aggression, MW referred to positive feedback received after each training course and to quicker responses when incidents happen.

DB referred to the rise in exposure to sharps and biological, radiation, electrical and chemical exposure incidences and asked if the long term impact of these were assessed. MW considered there would be a RIDDOR report if someone had been injured and also there would be sickness records. EJ noted staff in Radiology wore a tag which monitored their exposure to radiation.

IG noted the report was clear regarding issues with reporting to the police.

AS referred to the high numbers of incidences compared to days lost. MW noted incidences may be severe and result in more days lost.

Post meeting note received from Health and Safety Officer:

The time lost in Q2 (73 days) and YTD (94 days) was from 1 staff member within the post and mail team. He aggravated a preexisting injury, was on reduced hours, then unfit post surgery / initial recovery and then returned to work on reduced hours for a further period of time. The staff member has since returned to work on full hours and has made a complete recovery. A number of ways to reduce the risk of injury was explored with the team just prior to the workers surgery and have implemented a number of changes and we continue to explore other options to make work less physically demanding for what is an aging group of workers.

RH asked from a patient perspective what the consequence of a red card was. NP noted red and yellow cards were common practice in the NHS and added an act of violence would result in a warning and then if behaviour is repeated a yellow card is issued which served as written warning, a red card

would mean all but lifesaving treatment is withdrawn. RH asked if the red card would mean treatment would also be denied at other hospitals. NP noted the cards were hospital specific and acted as a deterrent to patients to act in different ways. IG noted violence and aggression towards staff would not be tolerated, but the Trust would not withdraw treatment lightly and it had to be a balance against protection of staff.

Post meeting note from Health and Safety Officer:

We do not currently share red cards with other trusts. This week was given the details for the ICB's Integrated Care Record Programme Lead to see if / how we can. This would also help with alerting lone workers in the community to potential risks from community / other trusts patients.

The Board noted the recommendations in the report.

TB1 9/1/5 QUALITY AND RISK

TB1 9/1/5.1 Board Assurance Framework and Corporate Risk Register (aligned with Corporate Priorities)

FMc presented the report and noted it had been presented at Clinical Governance Committee and Finance and Performance Committee in December. FMc highlighted the following points:

- Improving processes had led to new risks and escalation through different routes.
- Risk appetite had shifted from Open to Cautious resulting in 25 risks out of tolerance.
- Board committees had received the BAF and Risk Appetite and not been overly concerned with the shift.

Discussion:

IG referred to the Risk Appetite, acknowledged the work involved, and that with the change to cautious as risks are assessed there will be more out of tolerance.

IG asked the Board if they were comfortable with the risks out of tolerance and the mitigations in place to bring them back into tolerance. PC noted there was little to differentiate between the risks out of tolerance which could have an impact on the Trusts ability to target resources at the most important risks. EJ referred to national and system pressures and considered the Risk Appetite had been discussed by the Board several times and the narrative clearly explained the more cautious approach. RH referred to the difference between the definition of the risk appetite and the analysis of the risks themselves. DB suggested risks should be evaluated to make sure they aligned with the BAF. RH noted he and FMc were working on the presentation of the report.

FMc referred to a risk appetite framework which set out the Trust's approach and included a risk appetite statement, this report would be presented at Trust Management Committee, then Board Committees and Board.

IG summarised the discussion and noted the Board were comfortable in the shift in the risk appetite which would be reviewed on a regular basis. The risks would be managed and mitigated against the more cautious risk appetite. RH noted the internal auditors were very comfortable and supportive of the approach.

MW noted the risk to our reputational risk was open. IG noted the Board were prepared to accept the possibility of some reputational risk as long as there was potential for improved outcomes.

NP referred to the performance risk which had been broken down into component parts to make it easier to understand.

The Board noted the report and endorsed the more cautious approach to the Risk Appetite.

TB1 9/1/5.2 **Quarter 2 Learning from Deaths Report**

DM presented the quarterly report and highlighted the following points:

- SHIMI index continues to be favourable due to the quality of coding.
- HSMR process to be remodelled which could mean the Trust would become an outlier with mortality higher than expected.
- Clinical teams engaged with electronic mortality reporting tool which helped with learning from this process and shared learning.
- Performance data from the Catheterisation Laboratory suggests a very low death rate when compared to the national average.

Discussion:

IG referred to the significant improvements and suggested the Trust Board report back to the regional team regarding intervention and the Trust's present situation. DM agreed to report the Trust's continued improvement in mortality indices to the regional team and officially close the visit.
Action: DM **DM**

The Board noted the report.

TB1 9/1/5.3 **Director of Infection Prevention Control Report**

IG noted in the absence of JDy the Board would take the report as read and feedback any issues to JDy.

Discussion:

EJ referred to compliance and noted the Trust had performed well. AS noted the report had also been presented at Clinical Governance Committee and the committee had asked for evidence of compliance in future reports.

The Board received the report.

TB1 9/1/5.4 **Incident Reporting and Risk Report – deferred from December**

IG noted in the absence of JDy the report should be taken as read and asked if the Board had any issues.

Discussion:

EJ expressed concern regarding compliance with Duty of Candour. DM referred to the Patient Safety meetings which provided weekly oversight. IG asked if there were barriers to complying with the Duty of Candour. DM considered if staff had missed the opportunity to report incidences straight away the exercise became more difficult and added less value. AS noted the report had been presented at Clinical Governance Committee and added the Trust was in a transition period and suggested the Board pick up again in the next quarter report. IG noted the regular focus of Duty of Candour at the weekly Patient Safety meetings and suggested an update regarding Duty of Candour responsibility and improvements in the next quarterly report. **Action: JDy** **JDy**

RH referred to the total incidences graph and noted moderate incidences had doubled. RH asked if there needed to be more focus to encourage a reduction in moderate incidences. DM noted all incidences recorded as moderate or above were reviewed on a weekly basis and new incidences discussed and investigated. DM considered the increase could be as a result of the organisation being busier and under greater pressure. RH expressed concern regarding the review of pressure ulcers. AS referred to a discussion in Clinical Governance Committee and noted the process of grading pressure ulcers had changed and had resulted in them being categorised differently, this was expected to plateau. IG noted the assurance from the Clinical Governance Committee.

The Board noted the report.

TB1 9/1/5.5 **Perinatal Quality and Surveillance Report December (November data)**

This item was taken after agenda item 7.1.

VM joined the meeting.

VM presented the report which demonstrated assurance on maternity and neonatal quality and safety issues as required by the Maternity Incentive Scheme. VM highlighted the following points:

- Improvement in midwife to birth ratio, the Department was now fully recruited but there had been sickness and maternity leave which meant the recommended ratio had not been achieved. This had not impacted on care.
- 1:1 care in labour ward had been achieved 100% of time.
- Supernumerary status of labour ward maintained 100% of time.
- Six incidences reported as moderate.
- Working towards completing Ockenden actions - 17 amber actions, no red actions.
- Increased focus on health inequalities with a listening event for young families and teenagers.
- Purchase of translation devices for out of hours.

The Board noted the report.

TB1 9/1/5.6 **Maternity Incentive Scheme – Safety Action 4**

VM noted that the report gave evidence and assurance that the Trust was complaint with the Clinical Negligence Scheme for Trusts (CNST) Safety Action 4. VM highlighted the following points:

- Action referred to workforce planning in obstetric, anaesthetic, neonatal medical and neonatal nursing staffing.
- Compliance to - short term locum usage, long term locum guidance, consultant attendance for the clinical situations listed in the RCOG workforce document, availability of Obstetric anaesthetic cover.
- The Trust was non-compliant with the remaining two actions however there was an action plan in place.

The report recommended the Board agree the workforce action plan and evidence of progress against the workforce action plan included in the report.

Discussion:

IG noted the assurance that the business plan process was being considered and the detailed evidence of compliance noted in the report cover sheet and appendices.

EJ noted the standards were difficult to achieve for small units but the Trust was able to demonstrate that it was maintaining safety.

EJ referred to her Board Safety Champion role and escalated the following points:

- Paediatrics had flagged difficulty accessing community children's nursing service which had resulted in children returning or staying longer.
- Praise for all staff involved in an incident in the Neonatal unit regarding the electrics.

AS referred to advanced neonatal practitioners and asked if they were medical or nursing staff. VM noted the advanced neonatal practitioners were nurses and the position was widely used by other Trusts.

PC endorsed the report and asked if the Trust would be compliant if it followed the process and there was still residual risk. IG noted there were resource requirements to achieve compliance and referred to the business case and noted the Board would make a decision based on the resources available.

VM noted there was an opportunity for the Trust to feedback, and the requirements may change next year.

The Board noted the report and agreed with the recommendation.

TB1 9/1/7.1 **Maternity Incentive Scheme – Safety Action 10**

VM presented the report and noted the Board were required to have oversight and agree with the evidence presented in the report. VM noted the two specifications for Safety Action 10:

- Trust Board have seen evidence that the families have received information on the role of Maternity and Newborn Safety Investigations (MNSI) and NHS Resolution's Early Notification (EN) Scheme.
- Trust Board have seen evidence of compliance with Statutory Duty of Candour.

VM noted during the specified time frame the one family to whom this applies received information on the role of MNSI and EN by letter which was signed for. VM also confirmed compliance with statutory Duty of Candour for this case.

Discussion:

EJ referred to her role as Executive Safety Champion and noted a planned external review and internal process to go through the CNST evidence, EJ added this would be presented as a report at the Trust Board Development in February.

The Board noted the report and the assurance provided.

TB1 9/1/5.8 **CQC Maternity Report (if published)**

VM noted the CQC Maternity Report had not been received.

TB1 9/1/6 **GOVERNANCE**

TB1 1/9/6.1 **Emergency Preparedness, Resilience and Response Annual Assurance Statement and Compliance**

This item taken after agenda item 5.4.

The Board noted this item had been deferred to next meeting.

TB1 9/1/6.2 **Register of Seals**

FMc presented the report which asked the Board to note the entries to the Trust's Register of Seals which, while not formally authorised by resolution of the Trust Board, have been authorised through powers delegated by the Trust Board. FMc noted there were no conflicts of interest with any of the entries.

The Board noted the report.

TB1 9/1/7 **FINANCIAL AND OPERATIONAL PERFORMANCE**

TB1 9/1/7.1 **Estates Technical Service Update**

ME presented the report and referred to an internal audit that had suggested performance against the KPIs should be included in future update reports. ME noted the report had been presented at Finance and Performance Committee.

Discussion:

AS expressed concern regarding the number of red tasks in the report. ME referred to the performance of Estates and noted previously the Board had received monthly reports due to the significant number of risks but now after a lot of work the Department had considerably improved.

MW reflected some of the risks were also being worked on by the Health and Safety team. DB referred to duplication and noted it provided more assurance.

DB referred to the Estates team and noted they were a high risk team that had to work in reactive mode which meant sometimes that planned work could be considered less of a priority.

IG asked if there was appropriate leadership in the Estates teams. ME noted locally there was a Head of Estates who reported directly to ME.

The Board noted the report.

TB1 9/1/8 CLOSING BUSINESS

TB1 9/1/8.1 Any Other Business

RH referred to Emergency Preparedness, Resilience and Response and asked if there was a plan in response to bad winter weather. NP referred to the Trust's detailed snow plan and noted there were two 4x4 on site and local volunteers were also asked to help in extreme weather. NP noted ongoing work with the Council on gritting roads and bus routes. NP suggested RH arrange a Go and See to meet the team.

TB1 9/1/8.2 Agreement of Principle Actions and Meeting Reflection

IG noted the principal actions from the meeting would be captured in the action log.

IG asked the Board for their reflections on the meeting.

RH noted it was a good sign that people were able to say they didn't know the answer, it was ok not to know.

EJ referred to AT's summary and reflected the Board had been curious, EJ added DM's summary of the IPR had been very helpful. EJ added the reports had been more strategic which was positive.

IG noted the reports had been more manageable.

JS referred to a course she had attended with other acute nurses and had been proud to share the Trust's progress with Improving Together.

JP considered the attendees had challenged each other in respectful way, with curiosity and good humour.

FO noted the meeting was a very useful opportunity for governors to keep up with things broadly and strategically and valued everybody's input to the meeting.

TB1 9/1/8.3 **Public Questions**

There were no public questions.

TB1 9/1/8.4 **Date of Next Public Meeting**

The next Public Trust Board meeting will be held on 6th March 2025.

TB1 9/1/9 **RESOLUTION**

TB1 9/1/9.1 Resolution to exclude Representatives of the Media and Members of the Public from the Remainder of the Meeting (due to the confidential nature of the business to be transacted).

Salisbury NHS Foundation Trust

Draft

Minutes of the Public Trust Board meeting held at 10am on Thursday 6th February 2025, Boardroom/MS Teams Salisbury NHS Foundation Trust Boardroom

Board Members:

Ian Green (IG)	Chair
Eiri Jones (EJ)	Non-Executive Director
Debbie Beaven (DB)	Non-Executive Director
Richard Holmes (RH)	Non-Executive Director
Rakhee Aggarwal (RA)	Non-Executive Director (via Teams)
Mark Ellis (ME)	Interim Chief Finance Officer
Duncan Murray (DM)	Chief Medical Officer
Lisa Thomas (LT)	Managing Director
Niall Prosser (NP)	Interim Chief Operating Officer
Melanie Whitfield (MW)	Chief People Officer
Anne Stebbing (AS)	Non-Executive Director
Paul Cain (PC)	Non-Executive Director

In Attendance:

Fiona McNeight (FMc)	Director of Integrated Governance
Alex Talbott (AT)	Director of Improvement
Sasha Godfrey (SG)	Board Support Officer (minutes)
Vicki Marston (VM)	Director of Midwifery
Abi Kingston (AK)	Chief Medical Officer
Hannah Boyd (HB)	Divisional Director of Operations for Women

ACTION

TB1 9/1/1 OPENING BUSINESS

TB1 9/1/1.3 Welcome and Apologies

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

TB1 9/1/1.4 Declarations of Conflicts of Interest, Fit and Proper/Good Character

There were no declarations of conflict of interest pertaining to the agenda.

TB1 9/1/1.5 CNST Full Report

IG welcomed Vicki Marston (VM), Abi Kingston (AK) and Hannah Boyd (HB) to the meeting and noted the report and supporting documents had been circulated to the Board to provide assurance.

JDy noted the hard work to gather the evidence and referred to a meeting with the ICB where the evidence had been examined to provide more assurance to the Board.

VM presented the report which demonstrated assurance on maternity and neonatal quality and safety issues as required by the Maternity Incentive Scheme. VM took the report as read and highlighted the following points:

- The Trust was fully compliant with all 10 safety actions.
- Chief Nursing Officer for SFT, Non-Executive Safety Champion, Chief Nursing Officer for Integrated Care Board (ICB) and Local Maternity and Neonatal System (LMNS) Lead Midwife had all reviewed the detailed evidence in full and agreed that it met the requirements for the standards to declare compliance to all 10 Safety actions.
- All evidence is included alongside the Board report.
- Safety Action four, Clinical Workforce, had previously been discussed at Clinical Governance Committee as the Trust was not compliant with the British Association of Perinatal Medicine (BaPM). The Trust had achieved CNST compliance by having an action plan in place. The action plan was included in the report.

Discussion:

EJ referred to the meeting with the ICB and LMNS and assured Board colleagues that the data had been looked at in detail. EJ noted the Clinical Workforce BaPM standards were a challenge for small trusts to achieve and thanked AK, HB and VM for their leadership and the whole team for their work over the last four years.

IG asked that the Board's appreciation was fed back to the team and noted the Board had been assured by the clear sense of ambition to address the areas of non-compliance in a systematic and appropriate way.

AS referred to the national maternity ambition to reduce the number of still births, neonatal and maternal deaths and brain injuries by 50% by the end of 2025 and asked if the Trust was on track to deliver that level of improvement. VM noted the Trust was currently below the national average.

AS referred to the action plan for Safety Action four and asked if it was achievable. JDy referred to the financial implications to achieve the standards and noted a business case had been developed to try to meet them. LT noted the Trust had the best intentions to meet the standards. EJ noted the action plan was realistic and was expected to be achieved. EJ added if the Trust could not deliver on the action plan it would then be compliant in nine out of ten standards next year but there would be rationale to explain why.

RH referred to Safety Action six and asked if there was written confirmation from the ICB to confirm compliance. VM noted the ICB had confirmed this in a letter and added changes to data collection should make audits easier in the future.

PC referred to compensatory rest and asked if discussions were being documented. HB noted there was a clear Standard Operating Procedure, but compensatory rest was not measured in the report. HB added assurance could be proved if required.

AS referred to the Draft CQC report and asked for assurance that the report did not contain any contradictory information which would prevent sign off of the CNST report. VM confirmed there was no contradictory information.

IG referred to the recommendations in the report. The Board approved the recommendations.

The Board noted the report would be formally noted at the next Public Board meeting taking place on the 6th March.

TB1 9/1/1.6 **CLOSING BUSINESS**

TB1 9/1/1.7 **Date of Next Public Meeting**

The next Public Trust Board meeting will be held on 6th March 2025.

TB1 9/1/1.8 **RESOLUTION**

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

Master Action Log

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

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

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Godfrey	TB1 3/10/5.2 Estates Technical Service Update	~~09/01/2025~~ 6/3/2025	Mark Ellis (ME) John O'Keefe (JoK)	Focus of the report should provide assurance of mitigation of BAF risk. ACTION: ME/JoK to work this through. The F&P committee will receive an updated report and decide what should be escalated to the Board.	**Full assurance to be provided at 28 January F&P, action to remain open**	N	2
Trust Board Public	Sasha Godfrey	TB1 5/12/5.5 Perinatal Culture and Leadership Report	TBC	Vicki Marston	Further feedback on actions taken and outcomes on support for the Maternity quadrumviarte	**At present no further suport required from Trust Board. A Perinatal Quadrumvirate update section has been added to the perinatal Quality slides and the team will use this to share progress but also to highlight and escalate concerns, Trust Board will have oversight of this when slides are presented monthly.**	Y	3
Trust Board Public	Sasha Godfrey	TB1 9/1/2.1 Integrated Performance Report M5	06/03/2025	Anne Stebbing (AS) Duncan Murray (DM)	Discuss a deep dive into stroke and heart attacks to take place at a future Clinical Governance Committee meeting.	**Deep dive to come to CGC in April**	Y	3
Trust Board Public	Sasha Godfrey	TB1 9/1/3.1 External Well Led Review - 6 monthly update on progress	24/02/2025	Fiona McNeight (FMc)	Well Led Report to be presented at a future Council of Governors meeting for information.	**to be presented at the next CoG meeting**	Y	3
Trust Board Public	Sasha Godfrey	TB1 9/1/5.2 Quarter 2 Learning from Deaths Report	06/03/2025	Duncan Murray, (DM)	DM to report the Trust's continued improvement in mortality indices to the regional team and officially close the visit.	**LT wrote to Michael Marsh to close visit**	Y	3
Trust Board Public	Sasha Godfrey	TB1 9/1/5.4 Incident Reporting and Risk Repor	01/05/2025	Judy Dyos (JDy)	Update on Duty of Candour responsibility and improvements to be included in the next quarterly report.		N	4

Register of Attendance – Public Board 2024/25

	2 May	4 July	22 July	5 September	3 October	5 December	9 January	6 March	attendance rate
Tania Baker	✓								1/1
Michael von Bertele	✓	✓	✓	✓	✓				5/5
Lisa Thomas	✓	✓	✓	✓	✓	✓	✓		7/7
Judy Dyos	✓	✓	✓	✓	✓	✓	x		6/7
Melanie Whitfield	✓	✓	✓	✓	✓	✓	✓		7/7
Eiri Jones	✓	✓	✓	✓	✓	✓	✓		7/7
Rakhee Aggarwal	✓	✓	✓	✓	✓	✓	✓		7/7
David Buckle	✓	✓	✓	✓	✓				5/5
Peter Collins	✓	✓	✓	✓	✓				5/5
Mark Ellis	✓	✓	✓	✓	✓	✓	✓		7/7
Debbie Beaven	✓	✓	✓	✓	✓	✓	✓		7/7
Richard Holmes	✓	✓	x	✓	✓	✓	✓		6/7
Ian Green	✓	✓	✓	✓	✓	✓	✓		7/7
Kirsty Mathews		✓	✓	✓	✓	✓	x		5/6
Paul Cain		✓	✓	✓	x	✓	✓		5/6
Anne Stebbing		✓	✓	✓	✓	✓	✓		6/6
Duncan Murray				✓	✓	✓	✓		4/4
Niall Prosser	✓	✓	✓	✓	✓	✓	✓		7/7
Cara Charles Barks						✓	x		1/2

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

Attended - ✓

Apologies – X

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	1.9
Date of meeting:	6th March 2025		

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

Recommendation:

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

Executive Summary:

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

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

National/System

Amanada Pritchard, Chief Executive NHS England, announced her decision to step down from her position at the end of the financial year. Sir James (Jim) Mackey will be the Transition CEO of NHS England, working closely with Amanda for the next month before taking up post formally on the first of April. Sir Jim Mackey will step in on a secondment basis, with a remit to radically reshape how NHS England and Department of Health and Social Care (DHSC) work together.

NHS Staff Survey results

The 2024 NHS Staff Survey results will be published at 9.30am on Thursday 13 March on the Staff Survey Coordination Centre website. Further to receiving local data, each organisation will receive its local benchmark report under embargo provisionally at the end of February.

Group Development:

January and February have seen the foundations start to form, putting us in a good place to significantly move forward over the next 12 months.

Board to Board Development:

We had our first of our Board-to-Board development day in January, providing us time for Board members from GWH, RUH and SFT to meet, continuing to develop relationships, and to reflect on the collective challenges and opportunities we have ahead.

We explored our national and BSW context, our Group strategic response and planned areas of focus. The day was supported by a session on Group Governance Development, led by Browne Jacobson, a legal firm which is supporting us with some of this work currently. The remainder of the day saw teams reflecting on opportunities, values, behaviours, and the culture we aim to foster.

Leadership Team: Managing Directors. The recruitment process for our three Managing Directors is well-underway. We had planned to hold interviews in February; in collaboration with the three Chairs across the Group we decided to allow more time in the recruitment process and now aim to interview in March/early April.

Resources and Transitional Support: We have received funding from the NHSE South West Region for transitional support for our Group development, and a tender exercise is underway to identify a partner. We expect the selected partner to start with the Group in March. Early focus will be on planning our Group Design Phase – including work on our operating model and organisational design.

Partnership Agreement and Joint Committee Establishment: A task and finish group of executives and non-executives met in late January. Supported by Browne Jacobson colleagues, the legal and policy context for provider Groups were set out, followed by a series of examples of how other groups around the NHS have established themselves. There is no off-the-shelf model for our BSW Hospitals circumstances. The working party met again in February to consider the potential Joint Committee role in scenarios related to likely priorities in BSW – strategy and group mobilisation, financial sustainability and successful EPR implementation and benefits realisation. We are aiming to confirm Terms of Reference for the Joint Committee in March.

System working engagement series with Councils of Governors: In January, supported by colleagues from our Legal Advisors Browne Jacobson, we held a series of local Governor discussion sessions focused on system working and group leadership and development. A further development session for all three Governor teams is planned for March.

Operating model/structures: Work to establish our new operating model will begin in earnest in March, supported by the transitional team. We will establish Improving Together, Organisational Design,

Organisational Development and change management as essential complementary components for successful development of BSW Hospitals Group. We plan to finalise our operating model by September.

Corporate service collaboration will be an important part of our operating model, identifying opportunities to work at scale and align processes. Executive colleagues are planning our approach in readiness for arrival of transitional support to help with more detailed design and implementation. We are aiming to agree our corporate services model by September.

Governance & Accountability Framework. In parallel, our Trust governance leads and company secretaries have begun meeting weekly to identify opportunities for collaboration, alignment and avoidance of duplication.

Shared Electronic Patient Record (EPR): We are now in the 'Engage' stage which runs through to March 2026. This includes the build, testing and training for EPR. Our EPR Joint Committee met on 29 January. Our implementation team is well established.

Managing Director update

The hospital has been busy in February with operational pressures across urgent care being significant. Whilst respiratory illness levels reduced compared to December and January the number of patients requiring admission has increased overall, this has placed significant pressure on beds and hospital flow, particularly as staffing levels have been more challenged within an increase in short term sickness absence. Despite the pressures performance has remained strong, ambulance handovers remain prioritised and the number of escalation beds has reduced. Further information is outlined in the IPR.

We have been celebrating this month the fantastic maternity department who formally received a CQC rating of Good following an unannounced inspection back in September. This reflects the quality of the maternity provision here at SFT and the staff who have worked tirelessly to improve services. The Trust exited the national maternity safety improvement programme implementing many improvements to services, governance and oversight.

Our staff networks have been busy with LGBTQ+ history month, the pride flag was flying high and the Pride Community has relaunched aiming to continue supporting SFT to be an inclusive place to work, where everyone is welcome.

The Trust has been looking for some months at the best organisation leadership structure to enable and support staff to be able to continue to deliver services to patients in the best way possible. The Divisional Management Team, with the Executive, considered a number of options before concluding that three divisions, (Medicine, Surgery and Family and Specialist Services) will best support the delivery of our Trust vision, delivery against the emerging themes in the NHS 10-year plan and the long-term shift to supporting more patients in the community. The reorganisation aims to balance the services in each division, build on the success we have had, and enable some essential areas to have additional focus. This is planned to be in place for the new financial year.

The national planning guidance for 2025/26 was published on the 30th of January. The 2025/26 NHS Planning Guidance sets out clear priorities to: (1) continue to reduce elective care waiting times, with 65 per cent of patients waiting less than 18 weeks; (2) improve ambulance response and A&E waiting times, with a minimum of 78 per cent of patients seen within four hours, (3) improve patients' access to general practice (GP) and urgent

dental care access, including 700,000 additional urgent dental appointments; and (4) accelerate patient flow in mental health crisis and outpatient care pathways.

The most significant implication is the financial settlement, the Trust's financial position (alongside the BSW system) remains incredibly difficult and the plan for next year looks stretching. Whilst SFT has had a successful year increasing productivity by c8%, the ask for 2025/26 is significant, all the Divisional teams have been working together to understand how we can change services and become even more productivity to improve value for the patient in 2025/26. These conversations are replicated at group and system level. More details will follow to Board in the next month.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board	Agenda item:	2.1
Date of meeting:	06th March 2025		

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

Recommendation:

The Trust Board are asked to note the Trust's operational performance for Month 10 (January 2025).

Executive Summary:

Breakthrough Objectives

- *Time to First OP Appointment* increased slightly from 131 to 132 days also impacted by reduced capacity although remains in an improving trend overall.
- *Managing Patient Deterioration* increased from 46.5% to 47% and continued its incremental improvement against the target of 60%.
- *Staff Turnover* increased slightly from 16.7% to 16.8% although sustains the improving trend against the target of 15%.
- *Productivity* increased slightly from -13.6% to -14.1% although maintains improving trend overall and is 3.9% total improvement against the adoption baseline of -18% in April 2024.

Deteriorating Performance

- Flow into the hospital remains challenged with *Bed Occupancy* levels at an average of 97% across the month, and the number and proportion of patients spending *More than 12 hours in the Emergency Department* alerting above upper control limits at 349.
- Diagnostics *DM01 Standard* reduced slightly further from 79.5% to 78.5% as demand challenged high volume modalities of Ultrasound, Audiology and Endoscopy still recovering from the Christmas reduction in capacity.
- *Staff Sickness Absence* reached its highest point in 2 years at 4.7% with cough / cold / flu the main cause.

- *Income* is below plan year-to-date driven by underperformance in Elective activity impacting on the ERF income, partially offset by overperformance on Day Cases, Non-Elective and Outpatient activity.

Alerting Metrics

- *No Criteria to Reside (NCTR)* remains stubbornly high, increasing slightly from 82 to 84 against the original plan of 22 and H2 plan of 64.
- *Mixed Sex Accommodation* breaches rose significantly from 25 to 53 as evidence of challenged flow.
- The Emergency Department (ED) saw improved performance overall supported by attendances:
  - *Attendances* reduced from 7,314 to 6,545 overall and for the first time equal to previous year in the last 12 months, however Type 1 specific remained 3% higher.
  - *4-hour Performance* improved sharply from 67.7% to 73.2% although remains under trajectory of 78%. The Trust is the 4th best performing ED within the South-West.
  - *Ambulance Handover* time reduced from 28 to 23 minutes average.
  - *Ambulance Handovers >60 minutes* reduced sharply from 114 to 68.
- Cancer continued as the shining light of performance in the Trust:
  - *28-day Faster Diagnosis Standard (FDS)* increased again from 82.7% to 85.8% and above the target of 78% for the third month in a row. This places the Trust in the top 5% nationally.
  - *62-day Standard* remained fairly static from 76.8% to 76.7% and sustained position above the target of 70% for the third month in a row.
  - Patients waiting *More than 62 days* for Cancer treatment increased from 55 to 66 although is within tolerance as only 6.8% of total waiting list.
    Note: Cancer performance reports one month behind, December in this IPR.
- *Referral to Treatment (RTT)* waiting list metrics continued overall improvement:
  - Patients waiting *>65 weeks* reduced from 10 to 8 against the ongoing target of zero.
  - Patients waiting *>52 weeks* reduced from 749 to 674 with progress to reduce ongoing.
  - Total *RTT Waiting List* increased from 28,394 to 29,337 as recovery from seasonal reduction in capacity continued.
- New RTT targets were outlined through NHSE guidance published on 30/01/2025 as follows:
  - ≥65% of waiting list receiving treatment within 18 weeks - Currently 60.4%.
  - ≤1% of waiting list waiting more than 52 weeks - Currently 2.6%.

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

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

March 2025

(January 2025 data)

Our Strategy 2022-26
IMPROVING together

Summary

Salisbury NHS Foundation Trust

January saw strong performance across the Trust continue despite challenges associated with winter. The continued level of high attendances to the Emergency Department (ED) reduced to 6,545 and the first time in 12 months to a similar level to the previous year, although Type 1 attendances remain 3% higher. Following the implementation of the new ED layout and the introduction of ED mid-shift (as part of the winter plan) the *4-hour Standard* improved sharply to 73.2% and the *Ambulance Handover* time reduced to 23 minutes average, with the number of patients waiting *More than 60 minutes for Handover* also reducing significantly to 68. The *Temporary Use of Escalation Beds and ED Corridor Care* also improved, reducing the number of patients to 164 and 9 respectively. Patients with *No Criteria to Reside (NCTR)* remained above plan at 84 average and adult bed occupancy levels at an average of 97% across the month.

Diagnostics *DM01 Standard* reduced slightly further to 78.5% as key modalities of Ultrasound, Audiology and Endoscopy were challenged with demand as recovery from seasonal reduction in capacity continued. The new Stroke Care measure of *Motor Minutes per Patient per Day* remained static at 38 minutes average but remains below the 180 minutes target.

Cancer performance continues to be a regional and national high performer, as both the *28-day Faster Diagnosis Standard (FDS)* and *62-day Standard* improved again to 85.8% (placing the Trust in the top 5% within the country) and 76.7% respectively, with both remaining above operational plan targets. The number of patients waiting *More than 62 days* for Cancer treatment increased slightly to 66 although this is within tolerance as only 6.8% of total waiting list. *Note: Cancer data is one month behind, reporting December in this IPR.*

The breakthrough objective of *Wait Time to 1st Appointment* increased slightly to 132 days however continues the overall improving trend and is a better position than the previous year. The number of patients waiting longer than 65 weeks for elective treatment reduced to 8 against the now ongoing target of zero, however this sustains good performance when comparing regionally. New waiting list national targets were detailed in NHSE guidance released at the end of January, advising expectations of at least 65% of patients receiving treatment within 18 weeks of referral and only 1% of total Referral to Treatment (RTT) waiting list waiting more than 52 weeks by the end of March 2026. The Trust is currently 60.4% and 2.6% respectively.

The workforce related breakthrough objective of *Staff Turnover* remained static at 16.8% and extended the improving trend. *Staff Sickness Absence* increased again to 4.7% and although expected during winter, is now the highest point in almost 2 years against the 3% target. Contrary to this, *Staff Vacancies* reduced again to 0.6% and is now the lowest point in 2 years, far below the 5% target.

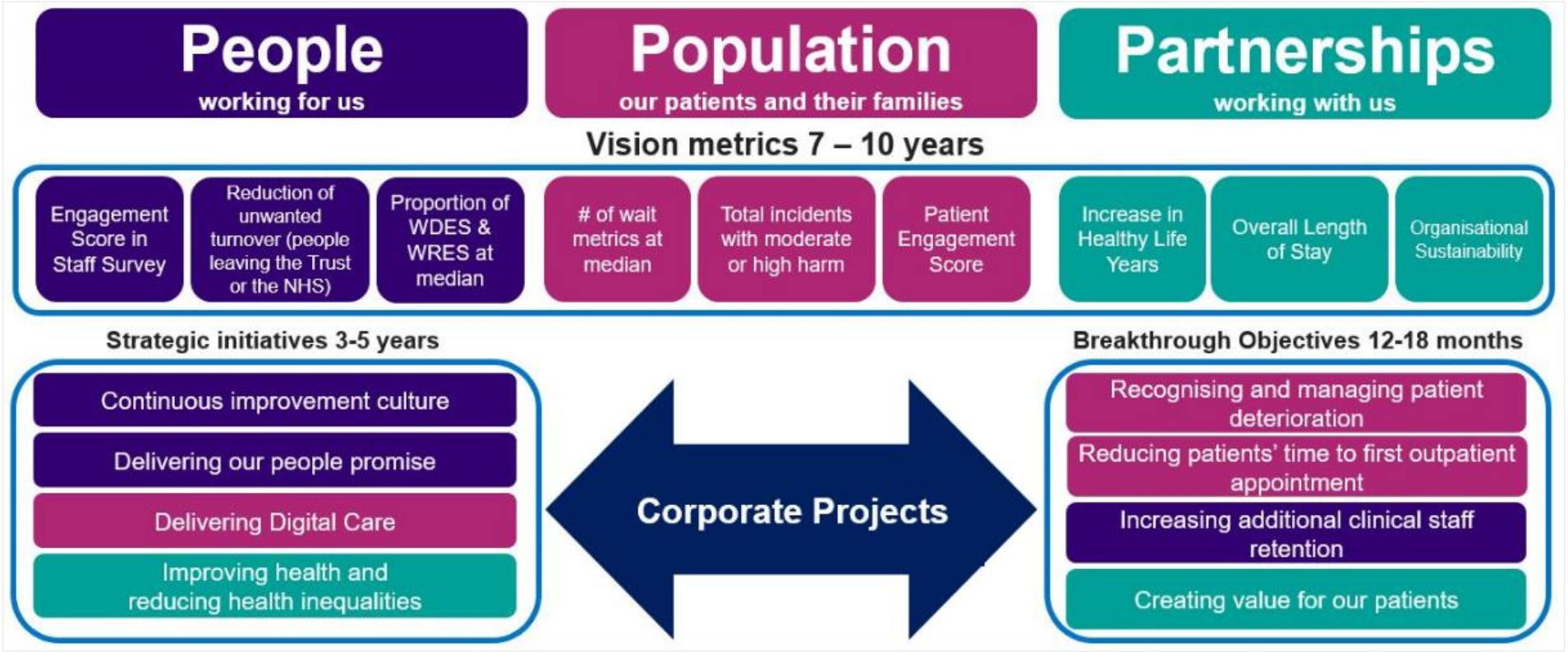
The quality related breakthrough objective of *Managing Patient Deterioration* continued the incremental improvement to 47%, whilst *Time to Escalate* increased to 333 minutes average. Wider quality metrics were impacted by the high levels of staff sickness and beds occupied, as *Care Hours per Patient per Day* reduced to 7.7 hours and the number of *Mixed Sex Accommodation Breaches* increased sharply to 53. *Pressure Ulcers (PUs)* measuring the total number of Hospital acquired PUs increased to 37 and the number of *Incidents* resulting in high harm increased to 3.9%. Positively, the *Infection Control* metrics remained static despite these challenges.

The Finance breakthrough objective of creating value for our patients measured through *Productivity* increased slightly to -14.1% although maintains improving trend overall and demonstrates a 4.1% improvement overall since adoption in April 2024. The Trust recorded an in-month control total deficit of £3.1m against an original deficit target of £1.2m, an adverse variance of £1.9m. This is adjusted for £1.2m income which is the in-month impact of the £17m. The year-to-date *Elective Recovery Fund (ERF)* performance is currently at 115% against a H2 plan of 115%.

Strategic Priorities

NHS Salisbury NHS Foundation Trust

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



What is an Integrated Performance Report (IPR)

NHS Salisbury NHS Foundation Trust

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

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

Part 1: Quality of Care, Access and Outcomes

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

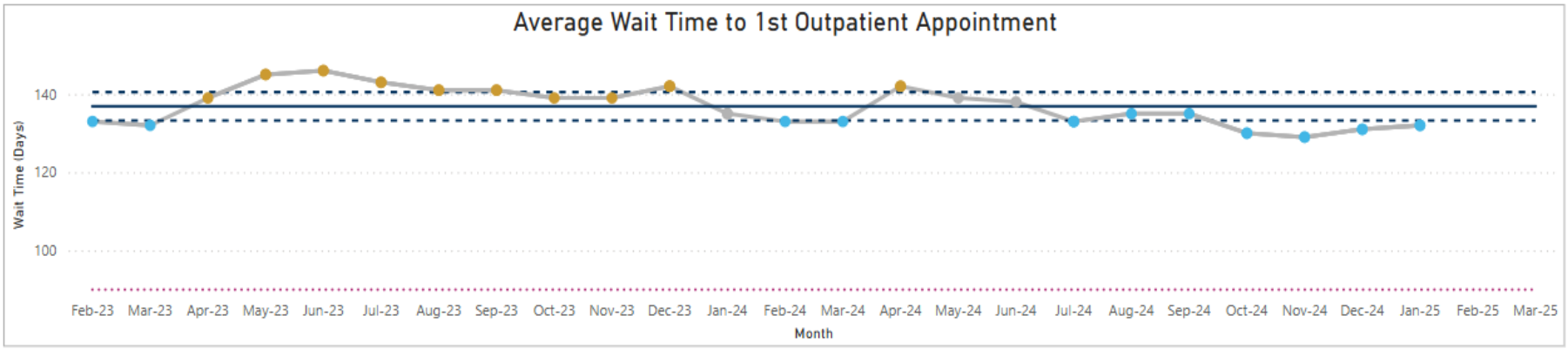
Reducing Patients' Time to First Outpatient Appointment

NHS Salisbury NHS Foundation Trust

Breakthrough Objective

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

Target: ≤90 days Performance: 132 days Position: Special Cause Improvement



Understanding the Performance

Time to first outpatient increased slightly over December and January and currently sits at 132 days. This slight deterioration may be due to the impact of less working days during December and winter pressures heading into the new year.

The three focus areas continue to show improvements. Since April, Colorectal has improved by 25.5%, Urology by 26.5% and Oral Surgery by 23.5%.

For high PTL specialties, the longest average TT1OPA waits are Dermatology at 265 days, Plastic Surgery at 175 days and General Surgery at 173. The 2nd – 5th highest waits are for specialties with low numbers of patients on these pathways.

Countermeasure Actions	Due Date
• To establish the required leadership structure to support the TT1OPA work going into the 2025/26 period. This will include an Outpatient Operational Manager and Clinical Lead.	30/04/25
• Develop an Outpatient Programme to support the delivery of the national Elective Reform targets. This will involve agreeing a strategy and programme of work for addressing TT1OPA waits across the Trust	30/04/25
• Investigate how Robotic Process Automation could help with PIFU utilisation full process compliance, to increase capacity for New appt slots.	31/03/25

Risks and Mitigations

- Dependency on already stretched clinical and booking teams to drive improvement.
- Data quality issues may impact interpretation of and decisions around TT1OPA data.
- Risk that overall TT1OPA improvements may not be realised due to declining performance in other specialties.
- Risk to project delivery if the required Operational, Clinical and Transformational resource is not in place.

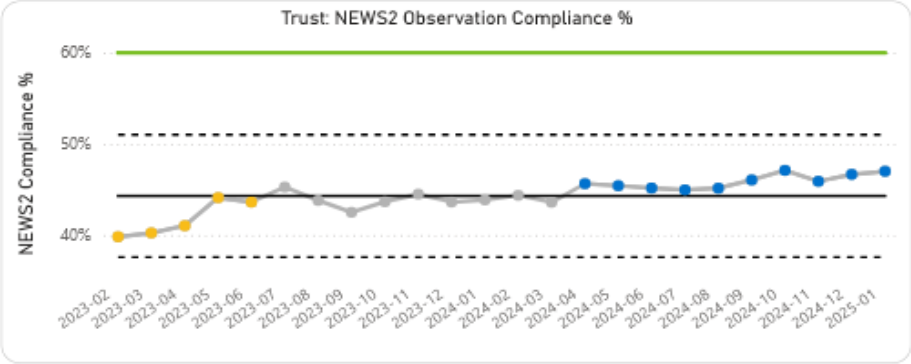
Recognising and Managing Patient Deterioration

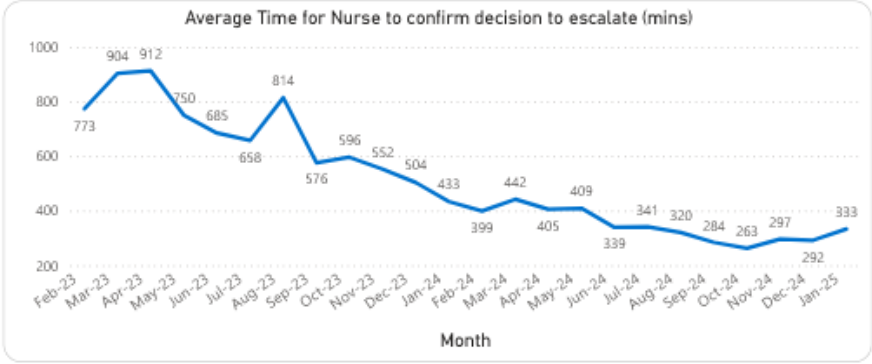
Salisbury NHS Foundation Trust

Breakthrough Objective

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

Target: ≥60% Performance: 47.0% Position: Special Cause Improvement





Understanding the Performance

Frequency of clinical observations is a nationally set standard which is determined by the automatic calculation of the NEWS2 score. The *"NEWS2 Observation Compliance"* graph is for scores of 3-6 which in January 2025 represented 15% of the total observations completed. The data for this sub section is 47%. Work around improving compliance is being led by the divisional teams. Work continues around bedside handovers and band 7 oversight of frequency. Compliance across all observation's averages between 64-67%.

The average time for the RN to electronically document decision to escalate has decreased this month to 333 minutes. The measure does not consider verbal escalation by the ward team.

Countermeasure Actions	Due Date
• RECORD: Analyse the audit data in relation to patient risk and determine acceptable benchmarking standards.	March 25
• Evaluation of patient outcome for those identified at outcomes at the daily huddle	April 25
• RESPOND: Carry out a PDSA cycle around the documentation of escalation responses on a surgical ward.	May 25
• Matron for Quality and Safety to work collaboratively with AMU, Imber, Spire and Laverstock ward,	Feb 25

Risks and Mitigations

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

Positive

- Overall mortality rates remain low.
- Cardiac arrest rates remain low.

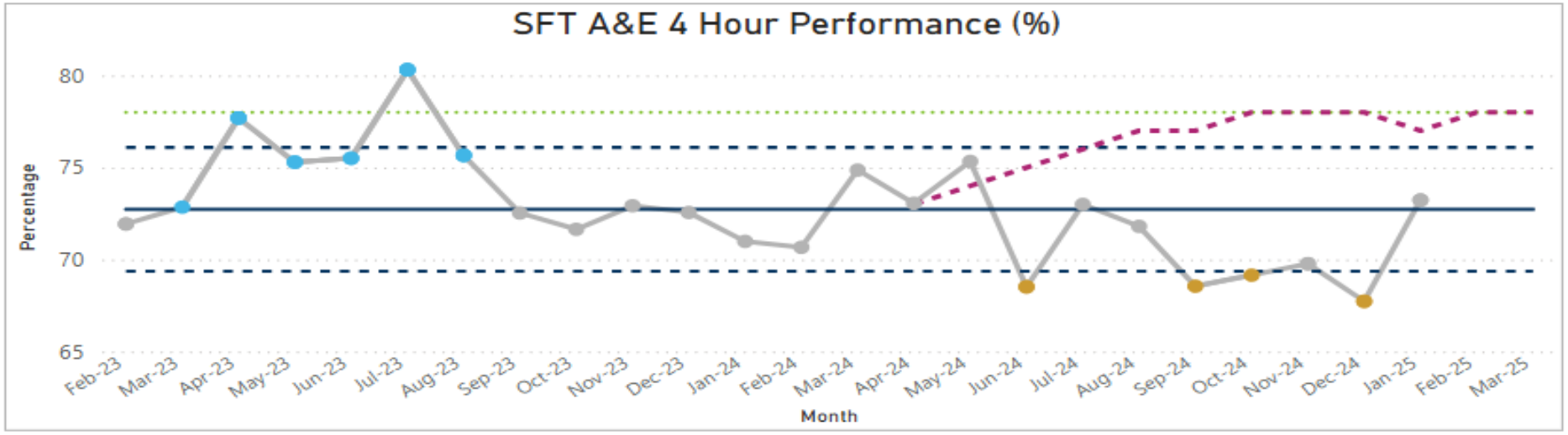
Monitor

- Medical emergency Team calls are decreasing.
- Unplanned admissions to ITU from the ward are increasing due predominantly to an increased cases of Influenza A.

Emergency Access 4-hour Standard

Salisbury NHS Foundation Trust

Target: ≥78% Performance: 73.2% Position: Common Cause

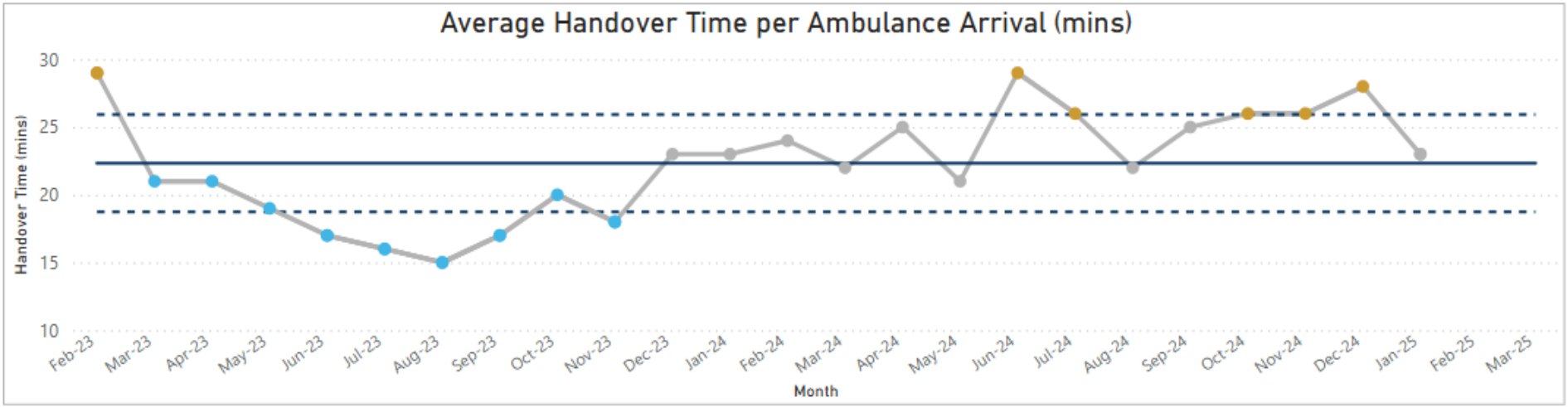


Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Availability of clinicians within Rapid Assessment Treatment and Triage (RATT), increased assessment space, and lower Type 1 attendances in January have led to increased performance in the 4-hour standard. Throughout the month there has been a mid-shift senior decision maker rostered consistently which has enabled medical RATT on most days. This has made a significant difference to the time to first clinician (within 60mins), rising from average of 35% in December to 50% in January, and contributing to the increase in 4-hour performance. Parallel to the 4-hour target, per attendance, the average time in the department fell to 4.8hrs compared to 5hrs in December. Flow and bed capacity across the Trust was severely constrained throughout the month with overcrowding in the department at times. However, balanced with the reduction in attendances and medical ratting, allowed for a strong overall position, the highest in 5 months.	• A3's continue with Overcrowding, Front Door and Minors now complete. The Paediatrics A3 remains in development, with Resus and SSEU A3's yet to commence. • Agreement for funding of the mid-shift registrar has allowed for medical RATT consistently.	Ongoing Feb 2025	• Staffing gaps have been mitigated with the cancellation of meetings, study days and supernumerary time. • Corridor care is often supported by staff from staff across the Trust which poses increased risk with not knowing the area, however, is mitigated with initiation processes and support from the NIC.

Ambulance Handover Delays

NHS Salisbury NHS Foundation Trust

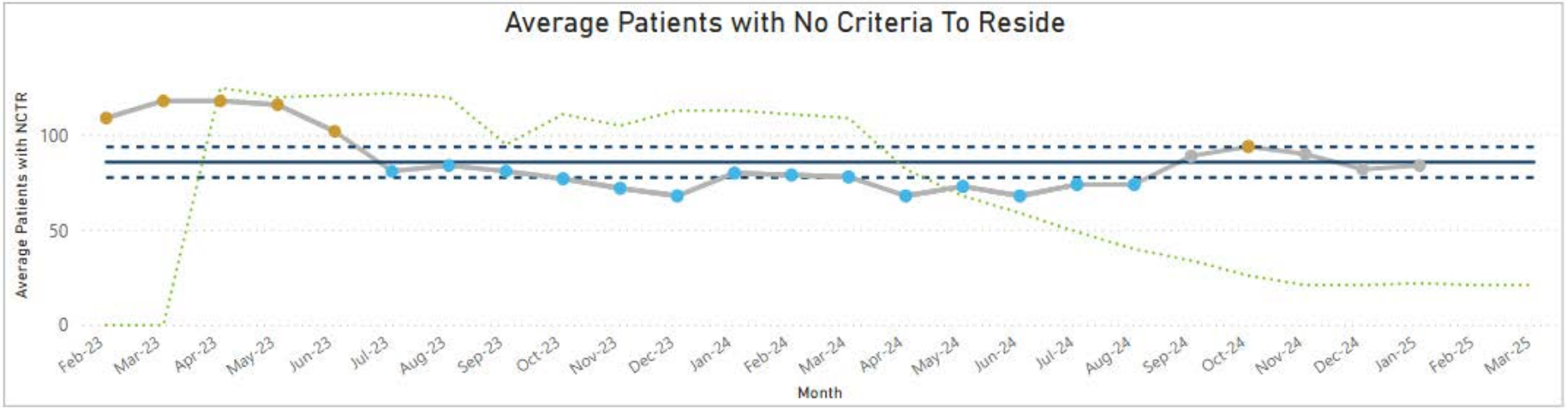
Target: ≤15 mins Performance: 23 mins Position: Common Cause



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Following the Interdepartmental move and the introduction of the Timely Handover Process (THP) SOP, across all 3 performance targets (<15m, <30m, <60m) there has been lower standard variation demonstrated throughout January. THP has driven change in response to queueing ambulances which is driving performance. The increased availability of space has led to the opportunity for the ED2 Doctor to base themselves within the vicinity of Rapid Assessment Treatment and Triage (RATT) earlier in the day. Enabling them to monitor the flow of ambulances, stop admin tasks (predominant role of ED2), assess a patient in RATT and return to admin, with as little disruption as possible. The mid shift registrar then takes over this role of medical RATT. This practice alongside lower attendances has contributed to increased performance.	• THP v2.1 has been released and includes less clinical restrictions on which patients meet the criteria for offload and crew withdrawal. • The consultant team plan to review and address any inconsistencies within the role of ED2 to ensure the role of Medical RATT is covered as consistently as possible.	Feb 2025 Feb 2025	• Risks have been identified as planning continues to move towards extended hours for THP. • A QIA has been submitted to identify these risks. • Staffing (Medical, Nursing and Operational) are required, either in increased template, uplifting for skills and/or agreement of different ways of working to safely manage the extension of this THP policy. All of which are in discussion and planning.

Optimising Beds

Target: ≤25 (5%) Performance: 84 Position: Common Cause

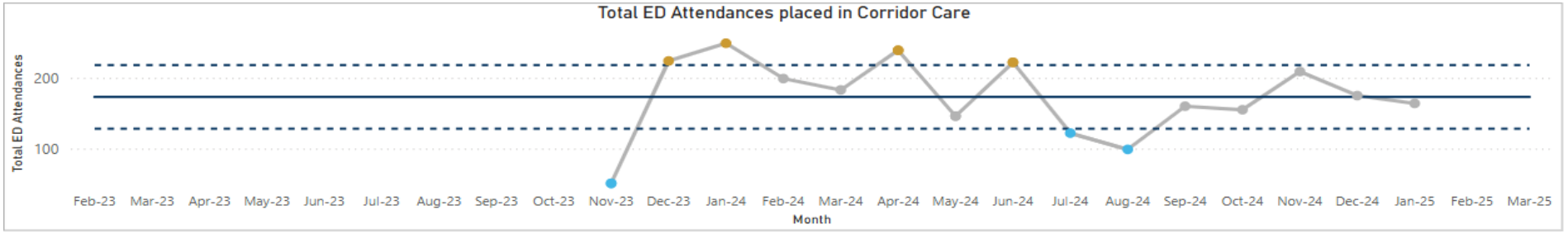


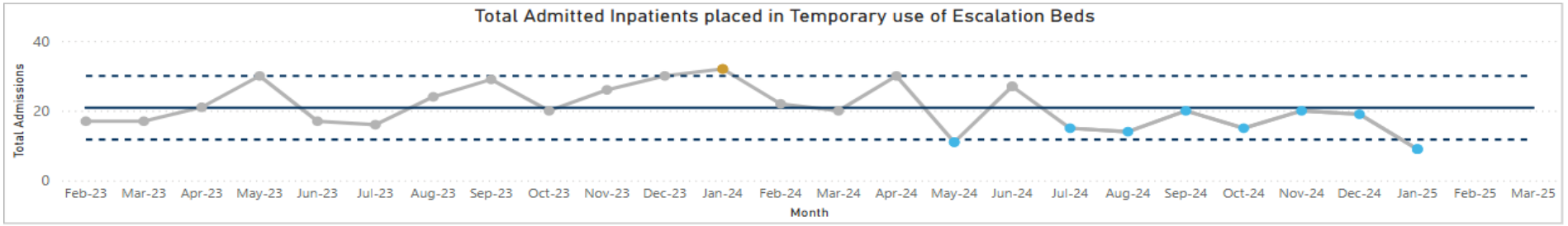
Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
The average number of patients with No Criteria to Reside (NCTR) has risen slightly, this is being driven by the wait for P3 beds (see below) month. The internal referral time for patients with NCTR was an average of 1.1 days from 1.6 days in July. The average Length of Stay (LoS) to patients being NCTR shows no statistical change from December. Average bed day delays by pathway: • P0 – 3 days • P1 – 6.77 days • P2 – 7.95 days • P3 – 20.86 days Note: ED attendances continue to remain high with no decline in conversion rate, hence the number of patients being admitted is also higher.	• Ongoing work to reduce time from NCTR to pathway allocation – Sprint Improvement. • Digitisation of Decision to Admit (D2A), awaiting confirmation from provider. • Greater use of Hospital at Home (H@H). Agreement for model of care to be ACP lead with consultant oversight. • Breamore ward team working to reduce Length of Stay (LoS) and prevent deterioration of patients waiting packages of care. • Detailed codes providing details on reasons for delays in discharge. • Ward flow work that standardises process to link into NCTR group • System working to reduce time for NCTR patients to be allocated beds.	April 25 April 25 May 25 April 25 Ongoing Ongoing Ongoing	• External conflicts such as reduction in capacity in local authority social care teams and financial constraints. • Changes to community model. • Clinical capacity and demand conflicts. • Clinical engagement. • Operational pressures.

Use of Temporary Escalation Beds & ED Corridor Care

Salisbury NHS Foundation Trust

Target: 0 Performance: 164 Position: Common Cause





Understanding the Performance

Patients placed in the Emergency Department corridor fell slightly in January, despite lower attendances and increased 4h performance. The number of patients placed in the corridor, evidences the strained bed state and overcrowded reality created by the bottle-neck felt within the Emergency Department as flow out to inpatient beds remained constrained. A temporary reduction from 6 to 3 patients in the corridor was put in place due to low temperatures and unsuitable places to hold patients which may have led to a slight reduction in the numbers overall in month.

The number of patients placed within temporary escalation beds saw a decline in January. This is linked to the fluctuation in ED attendances throughout January. The beds were still in use due to the number of medical patients requiring admission increasing the outlying patients within the surgical footprint and a high number of escalation beds in use within the normal bedded template.

Countermeasure Actions	Due Date
• Ongoing work to push for earlier discharges.	Ongoing
• NCTR working group linked with system partners to increase pull of patients into community services.	Ongoing
• Accurately reporting and monitoring of escalation spaces through divisional teams to ensure quality of patient care and reflection of an accurate bed state.	Ongoing

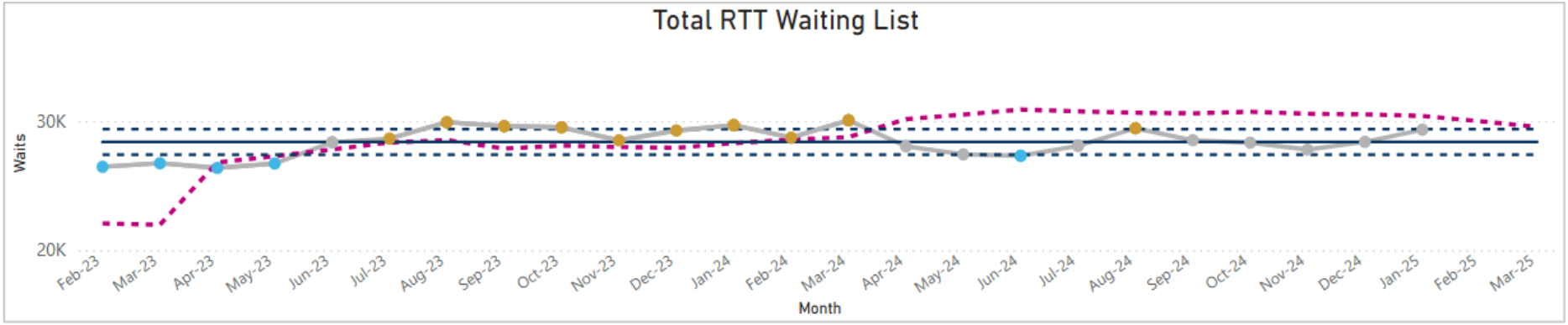
Risks and Mitigations

- Patients placed in the Emergency department corridor were often subjected to fluctuating temperatures, being so close to the main ambulance doors. This has been mitigated through the installation of a further set of internal doors and portable radiators which reduces the variation in temperature, allowing for a total of patients to now be placed there with maximum of 6 in extremis.
- Note: beds classed as Temporary Escalation Beds (TES) are areas that are above the normal bedded footprint of an area and do not contain bedhead services. This report does not include escalation into bedded areas that would usually be used for a different purpose - e.g. Day Surgery, SDEC etc.

Total Elective Waiting List (Referral to Treatment)

Salisbury NHS Foundation Trust

Target: ≤30,398 Performance: 29,337 Position: Common Cause



Balancing Metric	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Longest waiting patient	139	110	94	72	68	73	74	78	83	73	74	78	71	74

Understanding the Performance

The total Referral to Treatment (RTT) waiting list increased in month to 29,337 patients although remains below the trajectory target and follows pattern of previous years, with growth after Christmas reduction in capacity.

Long waits reduction continues, with patients waiting more than 65 weeks reducing to 8 in month and the expectation is to move below this wait time as standard, before targeting 52 weeks.

Highlight specialties with waiting list change in month (patients):

- Oral Surgery (-246)
- Dermatology (-166)
- Ophthalmology (+420)
- Gastroenterology (+116)

Countermeasure Actions	Due Date
• Work underway to validate all patients currently assigned with non-RTT status in elective waiting list.	28/02/2025
• Continue weekly access meeting to focus on reducing long waits of patients in line with new national targets - NHSE planning guidance received 30/01/2025 - of 65% of patients waiting no more than 18 weeks for treatment and only 1% of overall waiting list waiting more than 52 weeks by March 2026.	Ongoing
• Work with Trust CCS software to improve waiting list management by enhancing reports (Pre-Op status, Access plan creation date, Duplicate access plans, non-RTT patients) and utilise the system to improve efficiency.	Ongoing

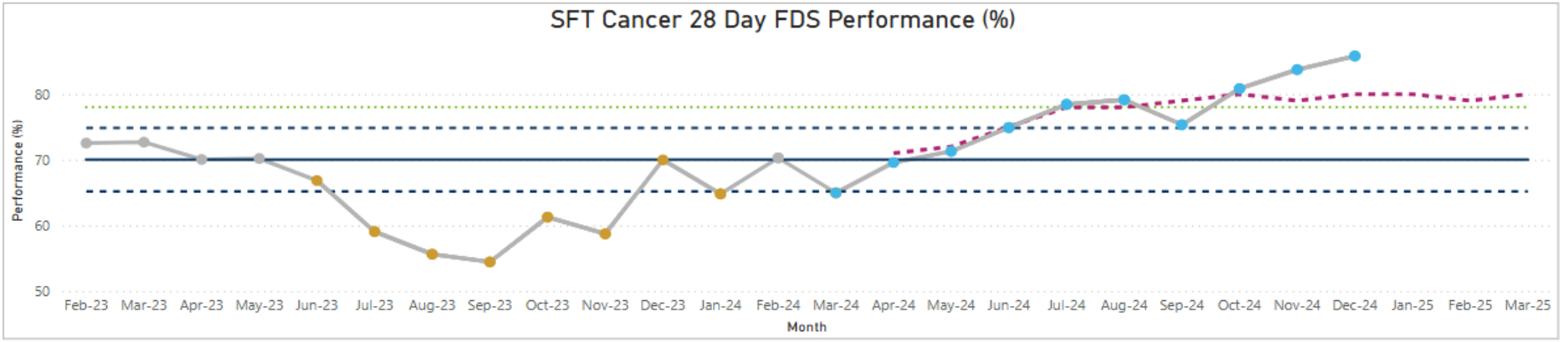
Risks and Mitigations

- Risk of long wait patients having incorrect status (particularly non-RTT) now being addressed through validation. Sustainable management linked to action reference developing Trust CCS software.
- Capacity constraints in some specialties are a risk to reducing overall waiting list and particularly challenging with regards to national reduction targets - being mitigated through additional capacity arrangements where necessary.
- Weekly Access Meeting continuing with aim of reducing risk of long waiting patients and drive towards national reduction targets.

Cancer 28 Day Faster Diagnosis Standard

Salisbury NHS Foundation Trust

Target: ≥78% Performance: 85.8% Position: H Special Cause Improvement:



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

Understanding the Performance

28-day performance standard achieved in M9, with month-end position of 85.8% which places the Trust in the top 5% nationally. Performance is above trajectory of 79.92%. Specialties which remain most challenged in delivering the standard include:

- Lower GI: 49.8% (deterioration from 63.8%).
- Haematology: 37.5% (deterioration from 55.6%).
- Urology: 56.6% (improvement from 53.5%).
- Non-site specific: 50% (deterioration from 79.2%).

Lower GI performance continues to be challenged, predominantly due to complex diagnostic pathways and patient comorbidities, as well as endoscopy capacity constraints within the Bowel Cancer Screening pathway.

Countermeasure Actions	Due Date
• Maintain regular site-specific 'Faster Diagnosis touch-point' meetings.	Ongoing
• Maintain sufficient breast and skin capacity for first appointments to support overall delivery of FDS.	Weekly via CIG
• Impact of BSW-wide Bowel Cancer Screening pathway alongside 'local' Lower GI FDS remains ongoing.	Q4 2024/25
• Review / deep dive of non site specific pathway delays to identify root cause and improvement action.	Q4 2024/25

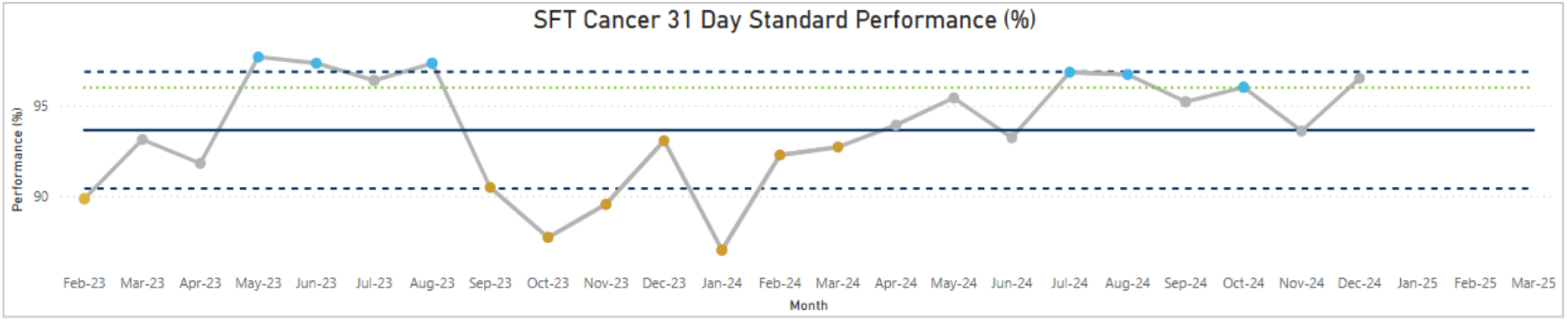
Risks and Mitigations

- Skin pathways remain reliant on insourcing or locum support to achieve required capacity to maintain average wait for first appointment under 14 days. This is monitored weekly via Cancer Improvement Group. 'Super clinics' established from Q4 to support increased capacity on a more sustainable basis. Involvement in SWAG-driven tele-dermatology roll-out across BSW.
- Expansion of Bowel Cancer Screening criteria likely to impact Lower GI performance due to increased demand from March '25; impact to be monitored via Cancer Improvement Group.
- Long-term resource within MDT cancer services team remains challenging in terms of capacity. Assistant MDT Co-ordinator posts recruited to on a fixed-term basis; impact to be monitored.
- Cancer escalation policy routinely in use across all tumour sites.

Cancer 31 Day Standard

Salisbury NHS Foundation Trust

Target: ≥96% Performance: 96.5% Position: Special Cause Improvement



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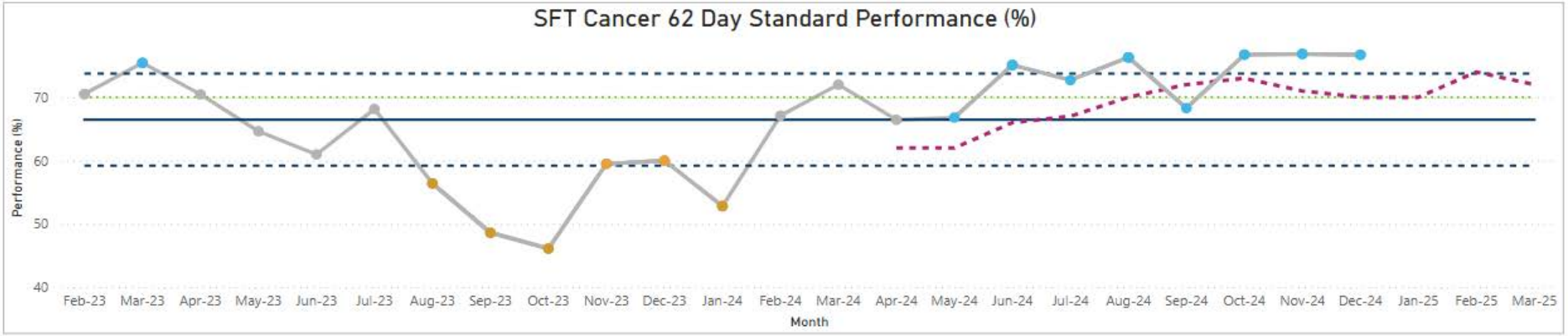
Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
31-day performance standard achieved in M9, with month-end post submission position of 97.9%. This represented 4 breaches of a total of 191 patients treated. Revised position to be reflected in quarterly submission. All specialties achieved the standard, with the exception of: • Lower GI: 94.4% (1 breach of 19 patients treated).	• Maintain routine use of Cancer Escalation policy, ensuring early escalation where a patient is booked to breach. • Increased visibility of 31-day breach dates within weekly PTL meetings established, with further consideration of awareness and visibility of breach dates within booking teams.	Ongoing Ongoing	• Theatre capacity across all tumour sites remains vulnerable to demand and capacity issues. Escalation to Divisional Director-level for increased scrutiny. • Long-term resource within MDT cancer services team remains challenging in terms of capacity. Assistant MDT Co-ordinator posts recruited to on a fixed-term basis; impact to be monitored. Job plans within MDT office under development to ensure time is routinely allocated to 'tracking' and escalation.

Cancer 62 Day Standard

NHS Salisbury NHS Foundation Trust

Target: ≥70% Performance: 76.7% Position: Special Cause Improvement:



Patients waiting over 62 days for treatment	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	87	158	145	117	91	73	76	65	61	69	78	68	55	84

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

Understanding the Performance

Sustained delivery of 62-day performance, with M9 post-submission position of 81.1%. Performance is above trajectory of 70.13%.
N.B. Data is subject to change upon receipt of post-op histology and confirmed cancer diagnosis treatments recorded after the quarterly submission. Data will be updated within quarterly submission.

143 patients were treated in total against the 62-day standard in M9, with 27 patients not meeting the standard. Notable specialty performance as below:

- Lung: 40% (3 breaches/5 patients treated)
- Upper GI: 64.3% (5 breaches/14 patients treated)

Breach reasons predominantly related to pathway complexity and patient engagement.

Countermeasure Actions	Due Date
• Sustain robust patient tracking list meetings, with improved resilience and standardisation across all tumour sites	Ongoing
• Amendment of Cancer Escalation policy complete to support timely escalation of patients booked to breach at Divisional Director-level.	Ongoing

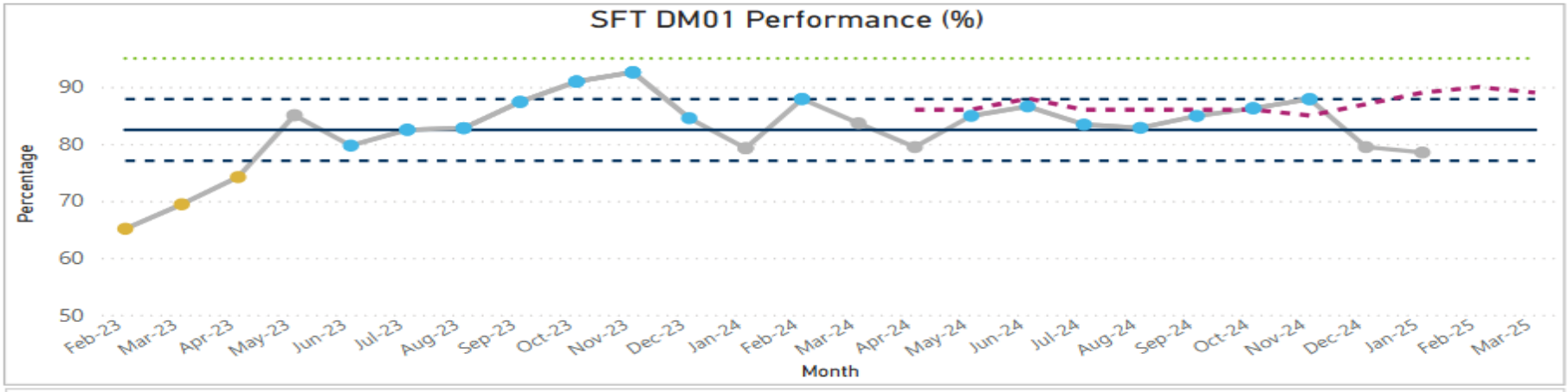
Risks and Mitigations

- Whilst there remains focus on reducing 62-day backlog, 62 day compliance will be impacted. Aiming for <6% of PTL size for patients >62 days in their pathway.
- Risk to M10/11 performance identified in light of tertiary centre prostate surgery backlog. Ongoing liaison and escalation as required.
- Noted resource within MDT cancer services team remains challenging in terms of long-term capacity.
- Risk of Oncology capacity assoscaited with Aseptics and associated outsourcing, alongside Consultant (UHS) and nursing capacity.
- Cancer escalation policy routinely in use across all tumour sites.

Diagnostic Waiting Times

NHS Salisbury NHS Foundation Trust

Target: ≥95% Performance: 78.5% Position: Common Cause



	%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks
MRI	81.7%	147	Dexa	100%	0	Colonoscopy	43.1%	293	Urodynamics	42.6%	54
CT	92.0%	57	Neurophysiology	100%	0	Gastroscopy	71.7%	63	Cystoscopy	98.5%	1
Ultrasound	85.8%	314	Echo	87.7%	31	Flexi Sigmoid	47.4%	100	Audiology	59.4%	267

Understanding the Performance

Diagnostic performance deteriorated slightly in M10 compared to M9, reducing to 78.51% from 79.46%. 1,327 patients were impacted by a breach of wait time, compared to 1,184 in M9. The waiting list has also increased from 5,763 to 6,174.

MRI, CT, USS, Cardiology Echo and Audiology remained relatively stable in month with only small changes to their performance.

The largest contributor to the increased breaches in month was Endoscopy, increasing from 317 patients impacted in M9 to 456 patients impacted in M10.

M11 performance is predicted to improve with recovery back to mid 80% planned for end of year.

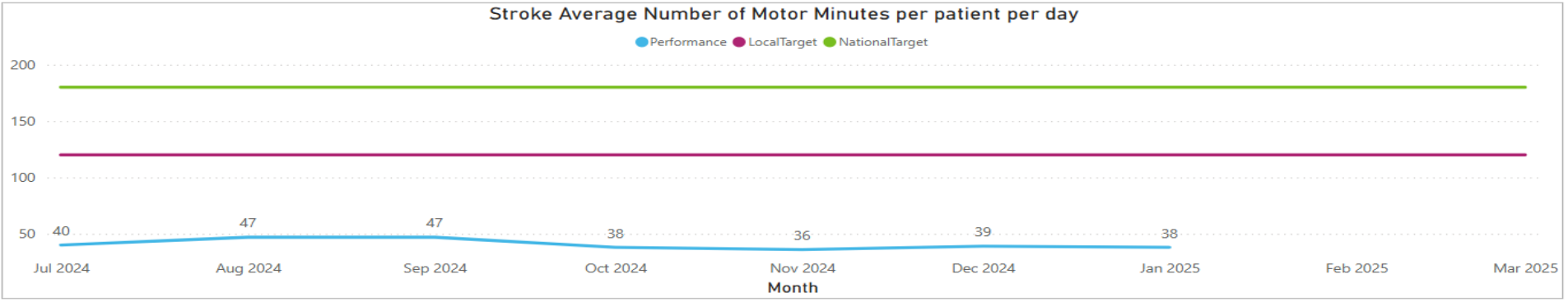
Countermeasure Actions	Due Date
• Endoscopy insourcing arrangement to be online from M11.	M11
• Continued maximisation of CDC USS and Echo capacity to a) achieve CDC activity plan and b) recover DM01 position for USS.	M11 & M12
• Locum support in Audiology continuing to support reduction of paediatric waiting list.	M11 & M12
• CT1 replacement to be commissioned from late M11 giving opportunity for cardiac CT capacity increase (CTCA is the remaining small part of CT backlog, circa 60 patients).	M12 onwards

Risks and Mitigations

- Capacity remains reliant on either insourcing or in house overtime to meet demand.
- Audit of validation to be undertaken in M11, with re-education of access policy with teams to ensure waiting lists are being managed appropriately and patients have the lowest waiting time possible.

Stroke Care

Target: ≥180 mins Performance: 38 mins Position: N/A



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

Understanding the Performance

January demonstrated an average 38 minutes. This is consistent from previous month and is within expected variation given pressures on the bed state during the month, although below targets.

Key Themes from the data:

- Staffing vacancies has impacted the ability of staff to deliver therapy minutes. With staff recruited and trained through January and February, improvement is expected.
- Group sessions are a key driver for our therapy minutes. These sessions started towards the end of January, which contributed to being able to mitigate continuing bed pressures impacting therapy minutes.
- Minutes completed by Nursing staff inconsistently logged, which is felt to be due to a lack of understanding of the new targets.

Countermeasure Actions	Due Date
• Increased use of Group Therapy Sessions: Using the Wessex Rehab Centre, as well as volunteers and students, there is a focus on increasing the number of group sessions versus individual sessions, which will increase therapy minutes for all patients.	Feb 25
• Training for nursing staff on gathering therapy minutes: As therapy minutes is a MDT metric, an increased focus is on ensuring that motor minutes are being captured by the nursing staff. This is aimed at increasing therapy minutes by better recording work by staff.	Feb 25
• Ongoing Recruitment: Recruitment is ongoing for therapist posts, with a view for new staff to be starting in the new year.	Feb 25
• New Sessions Group Sessions to be included in programme of activities: A new group is being trialled for February, which should improve minutes.	March 25

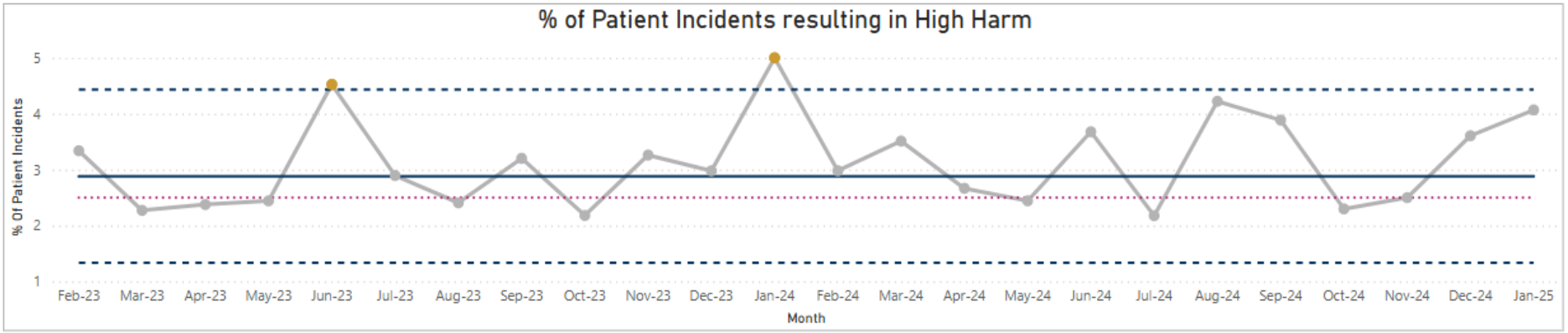
Risks and Mitigations

Bed Flow / Length of Stay (LoS): the Stroke Unit LoS impacts on therapy performance. With more complex discharges, therapy minutes are reduced. Driver metrics for the unit are before midday discharges, with a view to improving bed flow. A key driver for performance has been identified as EDS timing. Doctors have been invited to the huddle to identify areas in the process where EDS's have been delayed.

Staffing Numbers: Current staffing numbers for therapy are below recommended levels. Recruitment is ongoing.

Incidents

Target: ≤2.5% Performance: 4.1% Position: Common Cause

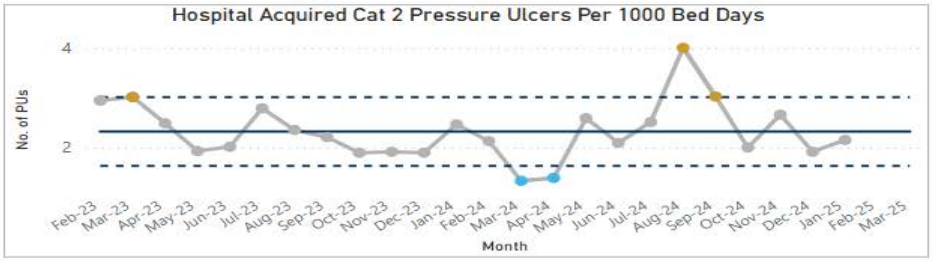


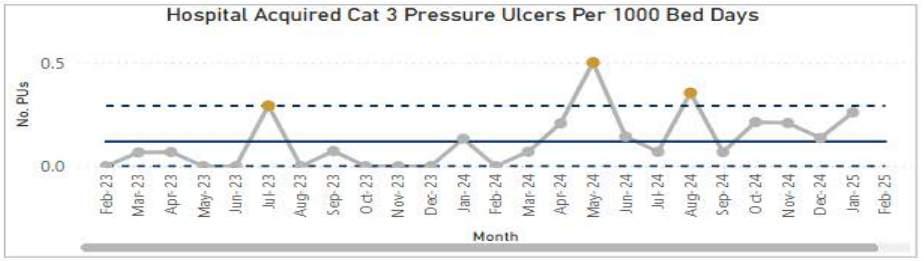
Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
There were 893 total incidents reported in January compared to 856 in December. Of those 893 incidents, 867 occurred within the month of January. In January: Of those 867 incidents, 723 were incidents relating to patient safety, 25 reported moderate harm (decrease of 2 from previous month), 2 reported major harm (no change from previous month) and 2 reported catastrophic harm (a decrease of 1 from previous month). The morning incident huddle, where the previous 24hrs incidents are reviewed and discussed continues to occur with excellent engagement from across the Divisions. A patient safety review (PSR) is undertaken for all patient incidents where moderate harm is reported to have potentially occurred.	• Daily morning huddle across all divisions to discuss previous 24 hours incidents and any immediate actions required. • Weekly Patient Safety Summit (PSS) where all moderate, major and catastrophic graded incidents are discussed. • Patient Safety Reviews (PSR) are undertaken for all cases where moderate or above harm has occurred to patients. • Consider if information from the PSR immediately identifies an unexpected level of risk or emergent issue/trend and a patient safety incident investigation (PSII) is indicated. • Divisional learning from incidents forum. • Trust Learning from incidents forum	Daily Weekly Ongoing Ongoing Monthly Quarterly	Learning: No PSIIs commenced in January. • The importance of checking INR if on warfarin and antibiotics are commenced. • Patient education - falls prevention. • Awareness and use of 4AT (delirium assessment). • Review of Enhanced therapeutic supervision risk assessment tool (currently leads to variability of application). • Post fall management - C-spine in line immobilisation. • Access to debrief post Resuscitation attempt. Note: *There may be a slight fluctuation in the actual % of reported incidents with harm from previous months, due to data validation and conclusions of reviews which occur retrospectively).*

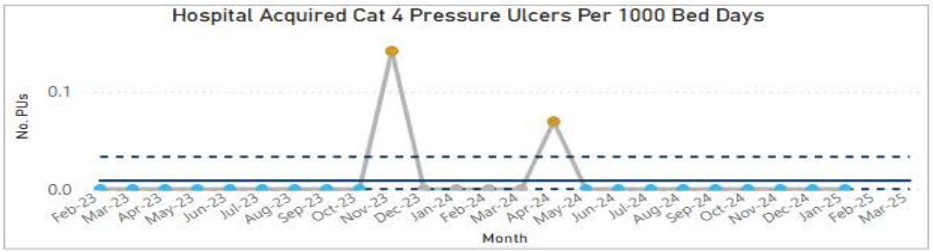
Pressure Ulcers

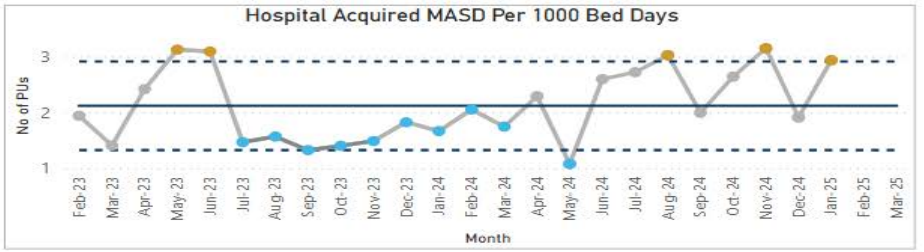
NHS Salisbury NHS Foundation Trust

Target: N/A Performance: 2.2 Position: Common Cause









Understanding the Performance

The number of Pressure Ulcers (PUs) across the Trust has increased from 30 in December to 37 in January.

Categorisation breakdown as follows:
- Increase from 28 to 33 Category 2 PUs.
- Increase from 2 to 4 Category 3 PUs.
- No hospital acquired category 4 PUs.

The number of medical device related pressure ulcers was the same as last month at 4.

The total number of PUs identified on admission was 67.

MASD (Moisture Associated Skin Damage) hospital incidence increased from 32 to 45 and MASD identified on admission was 51, an increase from the 36 in December.

Countermeasure Actions	Due Date
• Continue to review data for PU and MASD monthly.	Ongoing
• Tissue Viability (TV) continue to provide monthly information and updates to the ward Link nurses.	Ongoing
• Ward leaders to ensure TV Link Workers attend the TV study days.	03/03/2025
• Wards to utilise TV link workers to support with wound care management and prevention of skin tissue injury.	03/03/2025
• New VAC training dates have been added to MLE.	Ongoing
• Trial and evaluation of Octenilin wound irrigation being discussed with pharmacy and procurement teams.	Ongoing

Risks and Mitigations

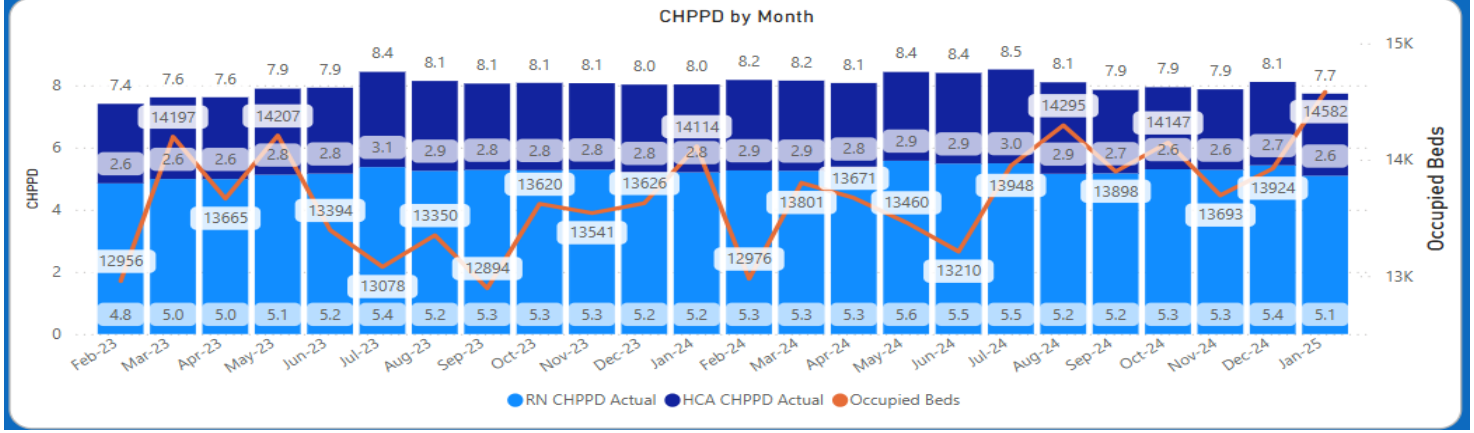
- Wards to utilise Link workers to support with wound care management and prevention of skin tissue injury.
- MASD incident numbers have increased.
- Pressure ulcer incident numbers have increased.
- Extraordinary meeting arranged for senior divisional nurses has been delayed due to reduced TV service.

Care Hours per Patient per Day (CHPPD)

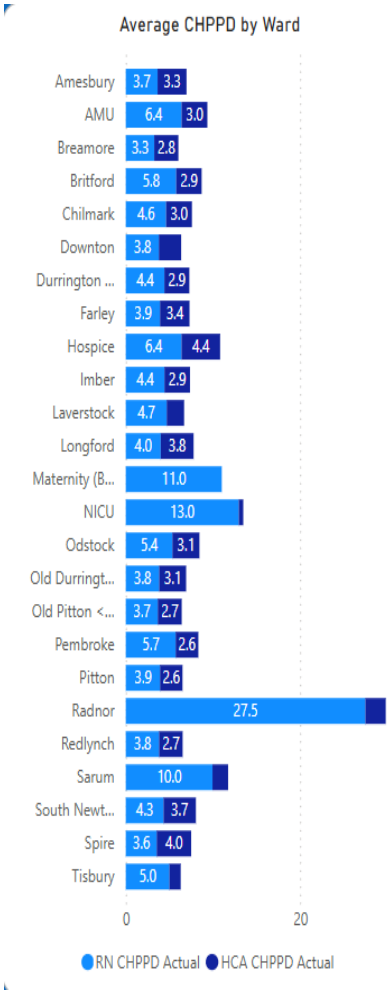
NHS Salisbury NHS Foundation Trust

Target: N/A Performance: 7.7 Position: N/A

Latest Month CHPPD	Average CHPPD	Latest Month RN CHPPD	Average RN CHPPD	Latest Month HCA CHPPD	Average HCA CHPPD
7.7	8.0	5.1	5.2	2.6	2.8



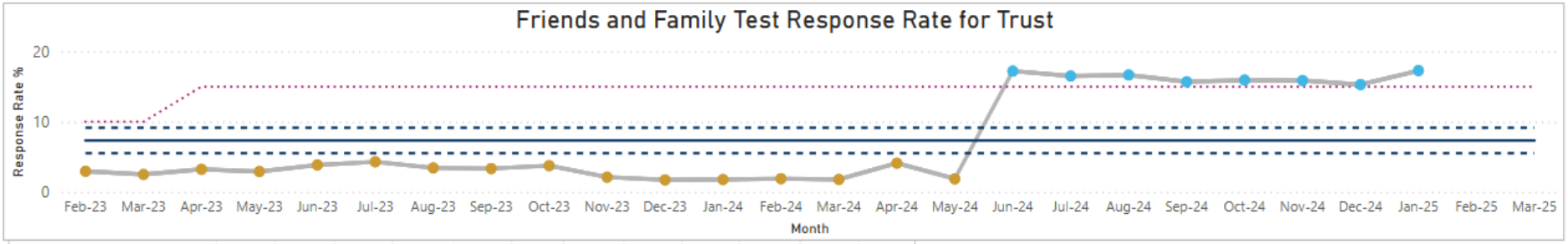
Definition: CHPPD measures the total hours worked by RNs and HCAs divided by the average number of patients at midnight and is nationally reported. Note: There is no national target as is a benchmark to review wards.



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
CHPPD 7.7 in month and 7.1 when excluding critical care, maternity and NICU. This is a decrease of 0.4 compared to previous month. This is reflective of high sickness absence in January and escalation beds being open in ward areas ie boarding and SDEC/SAU spaces. Is the lowest rate CHPPD has flagged since May 2023. Fill rate is relatively stable with a small increase for HCAs which is reflective of incentives running in January. Temporary staffing spend is relatively flat in month.	• Daily and weekly staffing meetings ensuring effective use of resource • Allocation on arrival incentive for Jan and Feb to mitigate patient safety for increase in escalation beds	Ongoing Ongoing	• Requirement to reduce headcount / temporary staffing spend (risk). • On-going demand for RMNs to support patients at risk. • On-going high short-term sickness driving temporary staffing spend in light of low vacancy (risk). • Winter escalation beds being open (risk). • HCA turnover – reducing but still higher than Trust target (risk). • SW agency collaborative holding agency at capped rates (mitigation).

Friends and Family Test Response Rate

Target: ≥15% Performance: 17.3% Position: Special Cause Improvement



Response Rate by Area	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
FFT Response Rate - A&E	0.5%	0.5%	0.7%	0.6%	20.6%	20.4%	22.0%	20.7%	21.6%	20.6%	21.7%	21.8%
FFT Response Rate - Day Case	3.2%	3.3%	2.1%	2.9%	3.4%	10.8%	11.2%	6.3%	10.3%	8.7%	10.1%	12.3%
FFT Response Rate - Inpatient	19.7%	17.2%	22.3%	18.5%	10.4%	26.3%	31.8%	21.4%	26.0%	24.8%	27.2%	30.2%
FFT Response Rate - Maternity	0.0%	3.0%	0.5%	0.0%	13.7%	9.7%	10.1%	10.3%	9.5%	10.2%	10.4%	10.3%
FFT Response Rate - Outpatient	1.0%	0.8%	1.0%	0.9%	18.3%	16.4%	16.0%	15.8%	15.6%	15.8%	14.5%	16.8%

Understanding the Performance

Our response rate in January showed the highest maintained improvement since the new digital dashboard and SMS message service went live in June 24. Our response rate was 18% with a satisfaction rate of 94% therefore we met our response rate target but slightly fell short of our satisfaction rate target of 95%.
We don't have full insight on the dissatisfaction at this stage, but we are looking to provide this with future narratives.

Countermeasure Actions	Due Date
• SMS messages are sent to all eligible patients attending our maternity services, Outpatients and ED This has demonstrated a significant improvement to the Trust's response rate. The new online forms have now also gone live and work is underway to advertise these changes through a new poster.	Ongoing
• The installation of the new FFT boards currently in the inpatient areas is currently taking place, with a second phase rollout planned for outpatient areas	Apr 25
• The patient experience team will be working with individual clinics and services not included in the new hierarchy data structure, to consider alternative data collection methods for informing service Improvements.	Apr 25

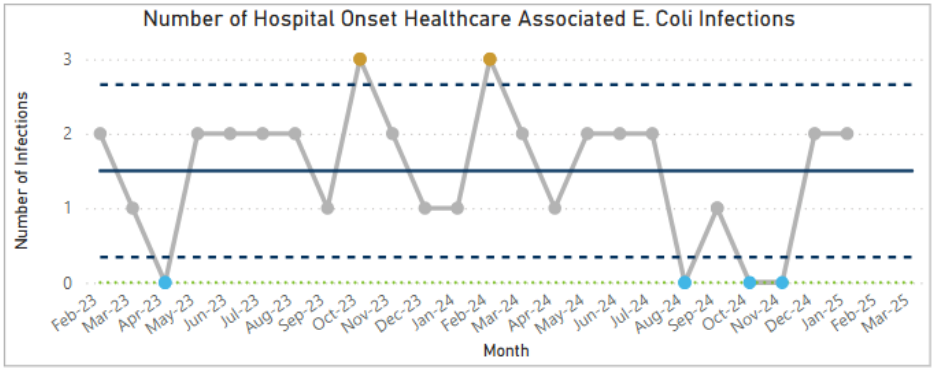
Risks and Mitigations

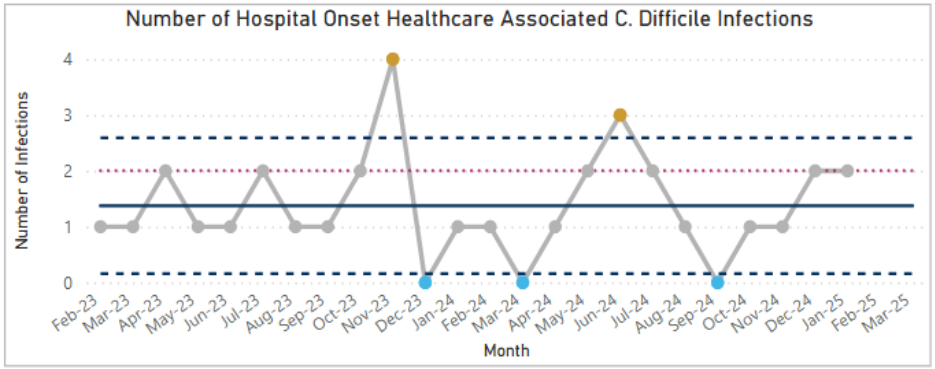
- The new dashboard continues to enable better themes and insight analysis of comments. Going forward we will be able to offer more robust analysis and insights from the feedback received. Implementation of the new system has already demonstrated a successful drive towards the Trust's 15% improving together response rate target set for 2024/25.

Infection Control

Position: Common Cause

Position: Common Cause





Year	2022-2023	2023-2024	2024-2025
MRSA Bacteraemia Infections: Hospital Onset	0	0	0
MSSA Bacteraemia Infections: Hospital Onset	10	10	9

Understanding the Performance

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

There has been one HOHA reportable *MSSA* bacteraemia infection, the same as last month.

For HOHA reportable *C.difficile* cases, there have been two cases the same as last month. *(As previously reported, the period of increased incidence (PII) of C.difficile declared on 7th January 2025 for Redlynch Ward during December 2024 continues).*

An outbreak of Influenza A for inpatients was declared for Tisbury Ward and included Whiteparish Ward. Spire Ward continues to cohort nurse Influenza A positive patients within identified bays (as per Trust respiratory illness escalation plan).

An increasing level of diarrhoeal activity has continued across inpatient areas.

Countermeasure Actions

Countermeasure Actions	Due Date
• Completion of required case investigations by clinical areas/teams to identify good practice and any new learning continues with identified timeframes.	Monthly
• From reviews completed for *C.difficile,* lapses in care have been identified including poor assessment and documentation and delay in isolation nursing. The divisions continue to monitor those areas that have produced action plans and provide updates to the Infection Prevention & Control working Group (IPCWG).	Monthly
• The IPC nursing team undertake targeted ward visits and use educational opportunities with different staff groups.	Ongoing
• Installation of new soap and gel dispensers (wall and bed mounted).	Ongoing

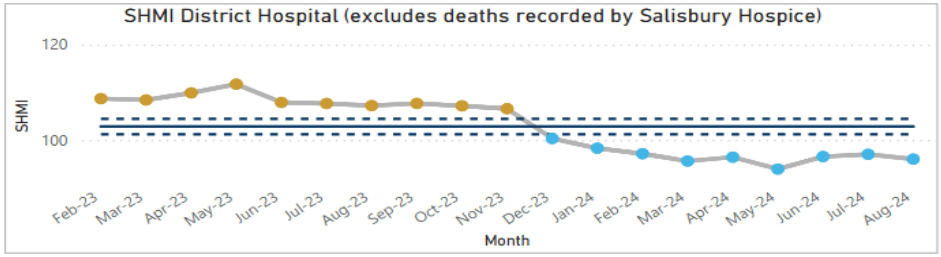
Risks and Mitigations

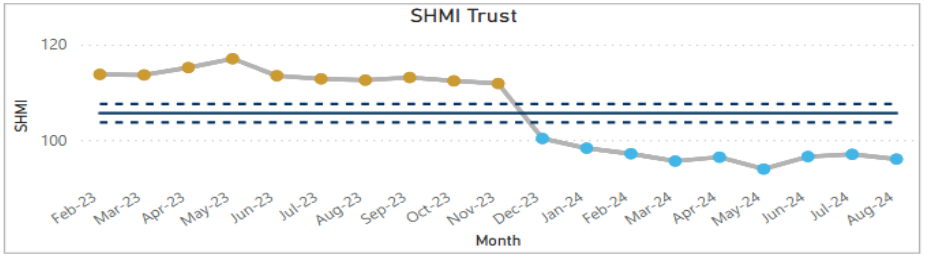
- Increased clinical workload for IPC nursing team has impacted on ability to progress other prevention work.
- A potential increase in incidence of reportable HCAIs with poor patient outcomes. As of 1st April 2024, the admission date definition for reporting HCAIs has changed, which **may** lead to an increase in cases classified as HOHA.
- NHS Standard Contract 2024/25: Minimising *C.difficile* and GNBSIs received, outlining the threshold levels set by NHSE. For reportable *C.difficile*, the threshold is set at 21 cases. From 1st April to 31st January, there have been 25 cases (15 HOHA and 10 COHA).
- For one of the reportable *Gram negative bacteraemias,* the Trust has exceeded the threshold for cases of *Pseudomonas aeruginosa.* The threshold is set at 7 cases, and the Trust has reported 11 cases to date.

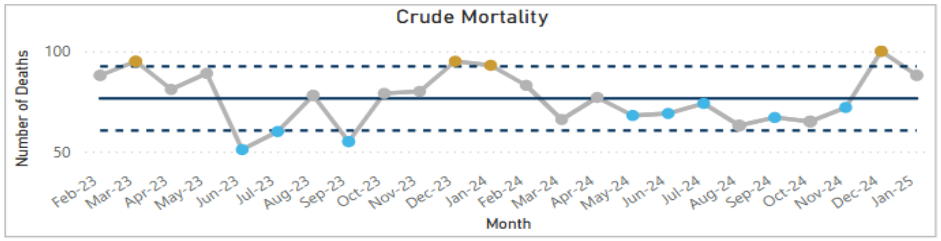
Mortality

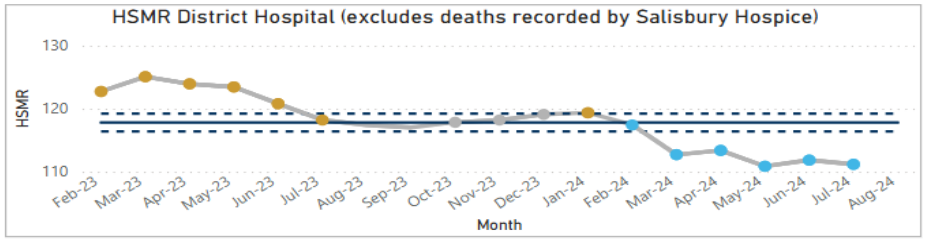
Salisbury NHS Foundation Trust

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









Understanding the Performance

The Summary Hospital-level Mortality Indicator (SHMI) for the 12-month rolling period ending in September 2024 remains at **0.96** and is statistically within the expected range.

The Hospital Standardised Mortality Ratio (HSMR) for the 12-month rolling period ending in August 2024 for Salisbury District Hospital is **109** and is statistically higher than expected*

A national revision to the methodology for calculating the SHMI came into effect as per the rolling 12-months of Dec'23 onwards. *We have recently seen the introduction of the newly anticipated remodelled HSMR (HSMR+). The Trust has seen an upward shift in the data (also applied to retrospective data) as a result, but the overall trajectory remains a downward one.

Countermeasure Actions	Due Date
• Telstra Health UK (our data intelligence provider) have provided a detailed summary report to the Trust's upcoming Mortality Surveillance Group (MSG) outlining the changes to the HSMR and the driving factors.	Ongoing / Bi-Monthly
• The number of primary mortality reviews (SJRs) being undertaken across the Trust is increasing and the Trust's online mortality system is capturing thematic learning and actions.	Ongoing / Bi-Monthly
• The online mortality system to support learning from deaths was launched in March last year. Activity has been centred on improving reporting outputs from the mortality reviews. A new training guide for staff and a supporting video have recently been produced and disseminated.	Ongoing / Bi-Monthly

Risks and Mitigations

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

Watch Metrics: Alerting

NHS Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Ambulance Handovers 60+ mins	80	114	68		0		Common Cause Variation	✗	48
Beds Occupied %	92.3%	90.7%	96.9%	96.0%	92%		Special Cause Improving - Run Below Mean	✗	1
Complaints Closed within agreed timescale %	42.0%	53.0%	60.0%	85.0%			Special Cause Improving - Above Upper Control Limit	✗	48
ED 12 Hour Breaches (Arrival to Departure)	381	344	349		0		Special Cause Concerning - Above Upper Control Limit	✗	48
Inpatients Undergoing VTE Risk Assessment within 24hrs %	35.5%	26.1%	28.2%		95%		Common Cause Variation	✗	48
Mixed Sex Accommodation Breaches	36	25	53	0	0		Special Cause Concerning - Above Upper Control Limit	✗	48
Number of High Harm Falls in Hospital	3	2	2	0	0		Common Cause Variation	✗	8
Pressure Ulcers Hospital Acquired Cat 2 - Device Related	5	4	3	0				✗	10
Pressure Ulcers Hospital Acquired Cat 3 - Device Related	1	0	1	0				✗	1
Proportion of patients spending more than 12 hours in an emergency department	8.0%	7.1%	7.8%				Special Cause Concerning - Above Upper Control Limit		
RTT Incomplete Pathways: Total 52 week waits	936	749	674	260	0		Special Cause Improving - Below Lower Control Limit	✗	48
RTT Incomplete Pathways: Total 65 week waits	38	10	8	0	0		Special Cause Improving - Below Lower Control Limit	✗	17

Watch Metrics: Alerting

NHS Salisbury

Quality of Care, Access and Outcomes

Understanding the Performance

A range of metrics in relation to the front door continue to alert – with the number and proportion of patients spending longer than 12 hours in the Emergency Department above the upper control limits indicating no statistical confidence in the position improving currently. Bed occupancy levels remained high at an average of 97% for Adult General and Acute beds in January, a level that impacts upon flow from the Emergency Department into the hospital. Despite the ongoing flow challenges the number of patients arriving by Ambulance that waited over an hour to be handed over decreased to 68. The average handover time reduced from 28 to 23 minutes underlining the commitment from the Emergency Department to remain focused on continuing to improve this important measure.

Continued progress can be seen in the Elective standards, with the number of patients waiting longer than 65 weeks for treatment now just 8, and the second month of sizeable reductions to the 52 week wait group.

Also alerting positively is the percentage of complaints closed within agreed timescales, rising from 42% in November to 60% in January.

Countermeasure Actions

- A3's approach in the Emergency Department with Overcrowding, Front Door and Minors now complete, and coutner measures in development. The Paediatrics A3 remains in development, with Resus and SSEU A3's yet to commence.
- Funding of the mid-shift registrar to be agreed which will allow for medical RATT consistently, improving ambulance handover and average wait to be seen times in the Emergency Department.
- Continued focus on reducing longest waiting elective patients, with Plastics, Oral Surgery and Dermatology identified as biggest contributors. Demand and capacity reviews in progress to determine required capacity to reduce longest waits.

Risk and Mitigations

- Ongoing high levels of attendances in the Emergency Department put pressure on the staffing levels and ability to manage workload. Ongoing work to review staffing model, additional mid-shift registrar proved productive, approval to continue to be secured.
- Peaks in demand from seasonal respiratory illness, ongoing strict adherence to infection prevention measures around isolation.

Watch Metrics: Non-Alerting

NHS Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Diagnostics Activity	8017	7633	8424	0			Special Cause Improving - Run Above Mean	✓	0
ED Attendances	6772	7314	6545				Common Cause Variation		
Patients referred on a suspected cancer pathway and seen within 2 weeks (%)	81.0%	75.4%	90.3%				Special Cause Improving - Above Upper Control Limit		
Pressure Ulcers Hospital Acquired Cat 4 - Device Related	0	0	0	0				✓	0
RTT Incomplete Pathways: Total 78 week waits	1	0	0	0	0		Special Cause Improving - Below Lower Control Limit	✓	0
Stroke patients receiving a CT scan within one hour of arrival	72.0%	48.0%	65.0%		50%		Common Cause Variation	✓	0
Total Incidents (All Grading) per 1000 Bed Days	65	55	57				Common Cause Variation		
Total Number of Complaints Received	19	22	17				Common Cause Variation		
Total Number of Compliments Received	61	140	43				Common Cause Variation		
Total Patient Falls per 1000 Bed Days	6.19	6.53	6.73	7			Common Cause Variation	✓	0
Trust 30 day Emergency Readmission Rate	11.8%	11.8%	10.3%				Common Cause Variation		

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

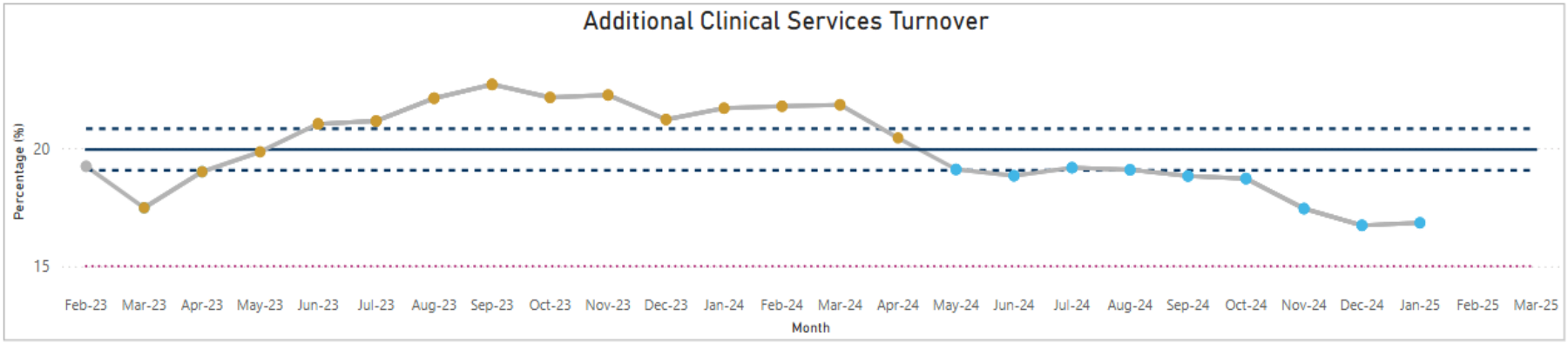
Partnerships

Increasing Additional Clinical Staff Retention

Breakthrough Objective

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

Target: ≤15% Performance: 16.8% Position: Special Cause Improvement



Understanding the Performance

ACS turnover slightly up 16.84% from M9 low of 16.73%, the breakthrough target (15%). This remains the highest turnover staff group but equates to 9.5 WTE leavers in month.

- 6.1 WTE had less than 2 years' service.
- 3.6 WTE were u-25 years old.

Leavers reasons:

- 3.0 WTE Undertake further education/training.
- 2.73 WTE Other/not known.
- 1.0 WTE Dismissal – conduct.
- 1.0 WTE Dismissal – SOSR.
- 1.0 WTE Health.
- 0.8 WTE Flexi retirement.

SFT turnover is down to 12.26%, the lowest recorded level on the BI dashboard

Countermeasure Actions	Due Date
• HCA team to meet with new starters along with ward leads within 1st 2 weeks supernumerary to ensure preceptor is allocated.	Feb 25
• R&R retention leads delivering exit interviews to improve leavers data.	Ongoing
• Quarterly HCA learning and celebratory events. (HCA Retention lead). Next event 14 February.	Mar 25
• Review of current recruitment processes. Slight delay due to resourcing issues.	Q4 25

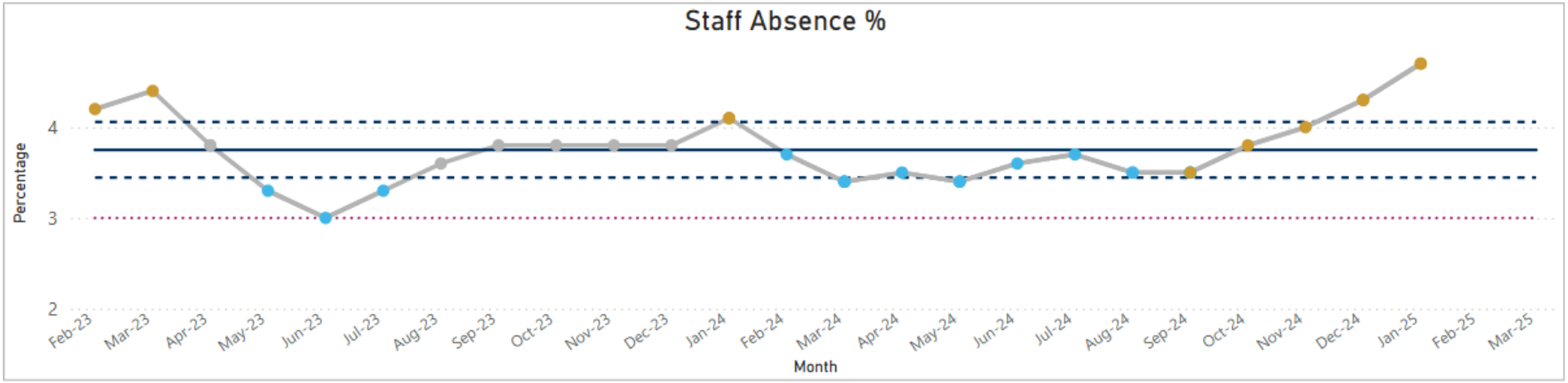
Risks and Mitigations

- New to care staff identified on appointment and provided additional support.
- Care certificate completion rates up to 99%.
- Insufficient leavers data to plan actions. HCA R&R team working to develop this.
- HCA role not sufficiently understood by applicants. Educational/informative HCA Vlogs now part of attraction/recruitment process.
- High attrition of staff in first 12 months of appointment.
- HCA opportunities not well understood by line managers and staff.

Sickness Absence

NHS Salisbury NHS Foundation Trust

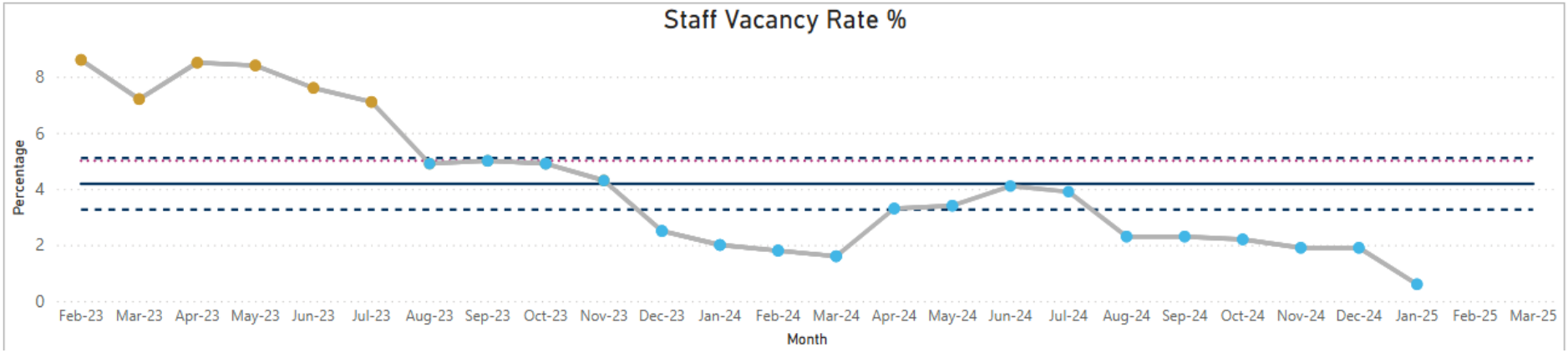
Target: ≤3% Performance: 4.7% Position: Special Cause Concern



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
An increase in sickness absence rate for January, with the rate at 4.74%, from 4.24% M9. Impact of cold / cough / flu - links to higher patient admissions for these reasons. This has now become the highest absence rate in month remains, overtaking Anxiety/Stress/ Depression, accounting for c25% of all absence. W&NB and Surgery remain the highest contributors at 6.6% and 5.52% respectively. All divisions above 3%. Additional clinical services remain the highest contributing staff group at 6.21% (6.65% in M9) and Nursing and Midwifery 5.96% (4.82% in M9). Sickness accounted for 6,023 FTE days lost (5,405 in M9), with a broad 70/30 split of short-term v long-term sickness highlighting the proportionate increase in short term sickness.	• Line Manager (LM) training on Absence Management policy and actions seeking to deliver training opportunities for all by year end. Sessions programmed through the year, with additional support through breakfast clubs. (Hd ER and Policy). • Reduction of violence and aggression on wards and in ED / AMU, seeking to prevent physical injury and reduce cases of workplace stress and anxiety. 'No excuse for abuse' campaign and training interventions planned each month. • Deep dive of EFM absence causation to generate mitigation actions. Main volume / % absence is within Housekeeping. Newly appointed HRA for Corporate will begin deep dive into Top 50 absentees.	Ongoing Mar 25 Feb 25	• Availability of instructors and advisers to support training interventions and workplace support to LM. Staff are being trained and recruited to fill vacancies in current team. • Availability of LM to attend training. • The ER team has filled all HRA roles as of January but this currently remains a risk until new starters are established in post. There are still significant vacancies in other HR roles.

Vacancies

Target: ≤5% Performance: 1.9% Position: Special Cause Improvement



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
M10 showed exceptional high performance in Recruitment means Trust vacancies remains at 0.59% M10 (1.93% for M9), well below the 5% target. The highest contributing staff group is infrastructure staff, where there are a total of 104 WTE vacancies (126 WTE M9). The highest vacancy rates amongst clinical divisions sit within Surgery - Theatres, specifically ODP 24.37 WTE (68.69%) & HCAs 19.07 WTE (32.69%). Payroll 9.06 WTE (46.34%) & (GWH) Procurement 8.8 WTE (20.28%) are the highest in Corporate. HCA vacancies down to 72.46 WTE (78 WTE M9), with 15.11 WTE in Elderly Medicine (Breamore, Durrington, Imber, Pitton & Spire). Work is being undertaken across the divisions to confirm where these are and track against any potential high turnover areas. M9 vacancy information as reported to ICS, which includes subsidiaries and hosted services show a total of 139 FTE in (154 M8), a vacancy rate of 3.2%.	• Targeted support to the identified hard to recruit roles, seeking to support attraction campaigns to fill these post which generate high agency back fill costs. • Confirmation that vacancies identified as greater than 10% align accurately to team structures in order to ensure that attraction campaigns are focussed on the areas of most need. Further work required to prioritise these areas in line with patient safety/service delivery and to support Trust headcount management. • Development of campaigns to attract ACS and Admin and Clerical staff, both groups subject to high levels of turnover. This is being worked on for completion in Q4	Ongoing Jan 25 / Ongoing Q4	• DMT and HRBPs working to design and develop attraction packages for hard to recruit roles. • Understanding of future resourcing and staff requirements. Workforce trajectory forecasting, seeking to support Divisions and Line Managers with targeted attraction and recruitment campaigns, specifically for hard to fill high value niche posts is a key focus of the recruitment team. • Loss of potential staff through ineffective recruitment and on-boarding processes Implementation of PWC 'overhauling recruitment' programme phase 2 recommendations. This includes ED&I monitoring, Recruiting manager training and development of job personas.

Watch Metrics: Alerting

NHS Salisbury NHS Foundation Trust

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Mandatory Training Rate %	85.5%	85.5%	%	90.0%	85%		Common Cause Variation	X	48
Medical Appraisal Rate %	85.1%	85.6%	89.0%	90.0%			Common Cause Variation	X	6
Non-Medical Appraisal Rate %	69.8%	68.2%	69.3%		90%		Common Cause Variation	X	48

Watch Metrics: Alerting Narrative

Salisbury NHS Foundation Trust

People

Understanding the Performance

Due to Information Systems failiure between Kalidus and Power BI there is no M10 updated Mandatory training data at the time of producing this report. Mandatory training remained at M9 below target at 85% completion rate across the Trust. The best performing area was Facilities with 95% completion. The lowest contributors are Corporate at 81% and Medicine at 85%. The 90% target has not been met for since January 2023. The application of significant oversight from management teams remains the most effective action to increase compliance.

Medical appraisals improved in month, the third month running and is 89% (M9 85.6%). The number of 'out of date' appraisals has decreased from 97 to 85, with the number out of date by >3months decreasing from 55 to 42 (compared to the previous month).

Non-medical appraisals rates have improved slightly to 69.3% (68.2% Jan 2024). This is >10% worse than the previous February. This equates to over 1000 appraisals being 'out of date'. The main contributors to poor appraisal rates across the Trust are Corporate at 53.3% (M9 56%) and Medicine at 68.5% (M9 66%). No clinical division is above 75%.

Countermeasure Actions

- Medical appraisals: Clinical directors to maintain positive oversight of appraisals for medical staff, with a focus on appraisals more than 3 months out of date.
- Non-Medical Appraisals: Monthly reconciliation of appraisals with line managers by business partners will continue, with a focus on those staff who have not had an appraisal for more than 15 months. A working group is established to review and improve the process to enable higher completion rates.
- The review/project to overhaul non-medical appraisals is also looking to link to talent management, and CPD required for colleagues across SFT. This is part of the OD&L steering group for monthly review and update.

Risk and Mitigations

• Loss of Trust in the accuracy and useability of the MLE system may deter staff from completing mandatory training. Work is ongoing to improve accuracy and design course content which is easy to understand and use.

• Inability to release staff to enable MLE completion is frequently cited as the main blocker to success.

• Completion of appraisals remains patchy, and susceptible to interpretation from staff and line managers, leading to incomplete appraisals and lack of effective recording. Having delivered a new, more succinct form, which improved the rate from Sep 23, further work is now being planned to improve training and oversight of appraisals for line managers.

• Management time to enable appraisal completion is frequently cited as the main blocker to success.

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

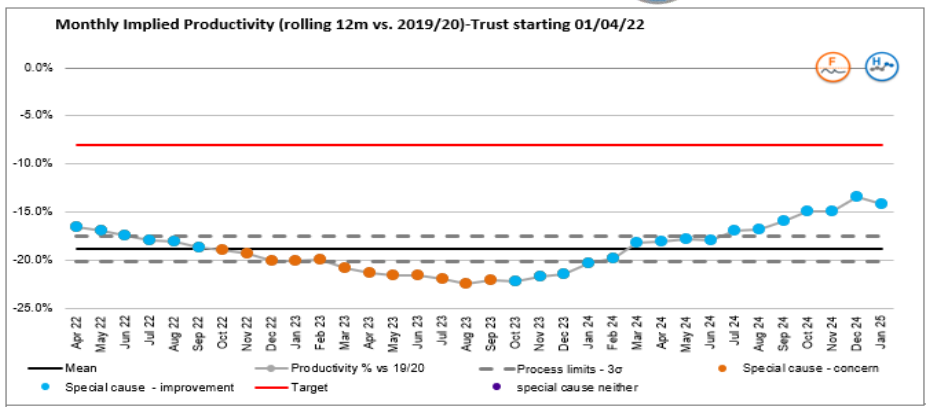
Creating Value for Our Patients

Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because… **Baseline: -18% (April 2024)**	Productivity is closely linked to the vision metric of financial sustainability. Since 2019/20 SFT's activity per unit cost has deteriorated leading to challenges of financial sustainability and constraining SFT's ability to invest in service developments and quality initiatives. Through Productivity all front line, clinical support areas and back-office services have the opportunity to affect positive change, either through driving additional activity through a given resource base or through the release or redistribution of excess resource. Divisional proposals for key driver metrics have been agreed and are being measured.

Target: ≤-8% Performance: -14.1% Position: Special Cause Improvement



Understanding the Performance
In Month 10 higher non-pay costs, driven by accelerated depreciation, aseptic stock write off and seasonal utilities costs, have been partially mitigated by activity, with a 0.7% deterioration in the rolling 12-month delivery. There has been an improvement of 4.1% delivery since March with cost increases mitigated by Non-Elective, Day cases and Outpatient activity increases. The calculation is generated by adjusting Pay and Non-Pay costs for cumulative inflation since 2019/20 and activity valued at a standard rate to provide a monthly Implied Productivity % as a comparator to 2019/20.

Countermeasure Actions	Due Date
• FRG task and finish group operating on alternate fortnight basis to review headcount above March 23 levels.	Ongoing
• Modernisation and consistency of admin processes.	Ongoing
• ERF performance, key metrics and coding opportunities to be shared for review and discussion at next FRG.	February
• Temporary staffing controls.	February

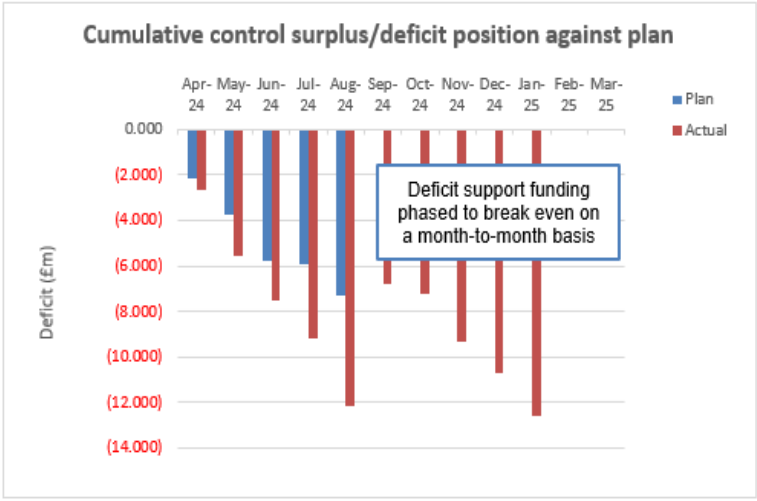
Risks and Mitigations
• The Finance Recovery Group and ERF / Delivery groups support the savings programme and ERF points of delivery.

Income and Expenditure

Salisbury NHS Foundation Trust

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

	January '25 In Month			January '25 YTD			24-25
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	26,923	27,397	474	267,730	262,992	(4,738)	319,525
Other Clinical Income	894	1,282	388	9,022	11,673	2,651	10,795
Other Income (excl Donations)	3,267	3,622	355	32,770	32,762	(8)	39,359
Total income	**31,084**	**32,301**	**1,217**	**309,522**	**307,427**	**(2,094)**	**369,679**
Operating Expenditure							
Pay	(20,585)	(20,703)	(118)	(205,909)	(210,695)	(4,786)	(246,855)
Non Pay	(9,768)	(11,731)	(1,963)	(98,032)	(104,482)	(6,450)	(117,175)
Total Expenditure	**(30,353)**	**(32,434)**	**(2,081)**	**(303,941)**	**(315,177)**	**(11,236)**	**(364,030)**
EBITDA	**731**	**(133)**	**(864)**	**5,581**	**(7,750)**	**(13,331)**	**5,649**
Financing Costs (incl Depreciation)	(1,888)	(2,918)	(1,030)	(18,876)	(18,126)	750	(22,654)
NHSI Control Total	**(1,157)**	**(3,050)**	**(1,893)**	**(13,295)**	**(25,876)**	**(12,581)**	**(17,005)**
Deficit Support Funding	1,157	1,157		13,295	13,295		17,005
Reported Position		**(1,893)**	**(1,893)**		**(12,581)**	**(12,581)**	



Understanding the Performance

The financial plan submitted to NHS England on 12 June shows a £17m deficit position for the year and includes an efficiency requirement of £21.1m. £17m non recurrent deficit support has been funded from October.

The Trust recorded an in-month control total deficit of £3.1m against an original deficit target of £1.2m, an adverse variance of £1.9m. This is adjusted for £1.2m income which is the in-month impact of the £17m.

The deficit position year to date is driven by pay and non-pay pressures due to non-elective activity volumes and pathways resulting in an increased bed base, backfill requirements and medical agency costs plus drugs and clinical supplies costs. In month accelerated depreciation, aseptic stock write off and seasonal utilities costs have driven the position.

Countermeasure Actions

- Financial recovery group (FRG) was established in April 23, as a sub-committee of the Finance and Performance committee, to provide monthly scrutiny and support to the savings programme. The workforce FRG was established in July 24 to provide additional scrutiny on the deployed workforce.

Due Date

Ongoing

Risks and Mitigations

- Pressure on emergency care pathways, particularly in relation to continued levels of patients with no clinical right to reside, as the efficiency plan assumes significant length of stay reductions which will not be realised in full without effective system working.
- Delivery of productivity increases which are contingent on both length of stay reductions, staff availability and recruitment.
- The Trust's £21.1m efficiency savings plan includes more than 40% non-recurrent delivery and signals a risk into 25/26.

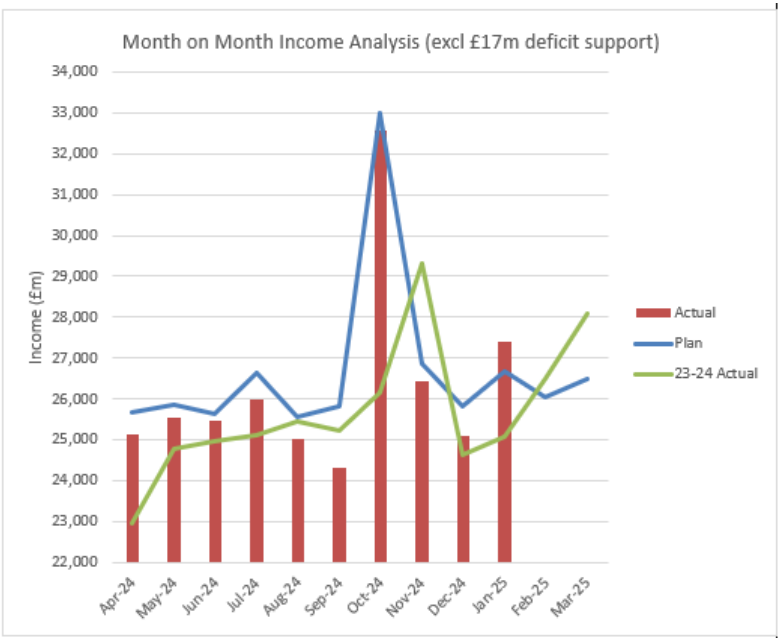
Income and Activity Delivered by Point of Delivery

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

Income by Point of Delivery (PoD) for all commissioners	January Year to Date (YTD)		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	10,299	11,007	708
Day Case	22,273	22,563	290
Elective inpatients	18,353	14,237	(4,116)
Excluded Drugs & Devices (inc Lucentis)	23,205	24,738	1,533
Non Elective inpatients	69,479	70,191	712
Other	85,876	81,025	(4,851)
Outpatients	38,245	39,231	986
TOTAL	267,730	262,992	(4,738)

SLA Income Performance of Trusts main NHS commissioners	Contract		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	158,902	158,041	(861)
Dorset ICB	26,492	25,803	(689)
Hampshire, Southampton & IOW ICB	23,580	22,571	(1,009)
Specialist Services	36,180	39,524	3,344
Other	22,576	17,053	(5,523)
TOTAL	267,730	262,992	(4,738)

	Activity YTD			Activity Last Year Actuals	Variance last year
	Plan	Actuals	Variance		
A&E	55,591	59,774	4,183	55,650	4,124
Day case	21,167	20,591	(576)	17,849	2,742
Elective	3,527	2,768	(759)	2,407	361
Non Elective	21,499	23,251	1,752	21,143	2,108
Outpatients	222,471	224,715	2,244	204,956	19,759



Understanding the Performance

The Trust level under performance is driven by lower Elective Inpatients and Outpatient First attendances impacting on the ERF income partially offset by overperformance on Day case income and Outpatient Procedures, underperformance on Community diagnostics activity, prior year funding which will not be received and overperformance above the block high-cost drugs and devices and diagnostics plan for BSW.

Activity across Day cases, Elective Inpatients and Outpatients was higher in January than in December with A&E and SWIC attendances and Elective Inpatients lower.

All of the main commissioners are under performing except specialised commissioning due to ERF and high-cost drugs and devices over performance.

Countermeasure Actions

- The ICB contract is progressing to signature with responses awaited from commissioners on contract values, following the pay award uplifts, and Indicative Activity Plans.

Due Date

February

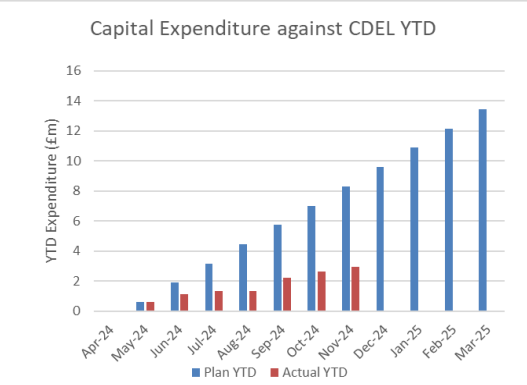
Risks and Mitigations

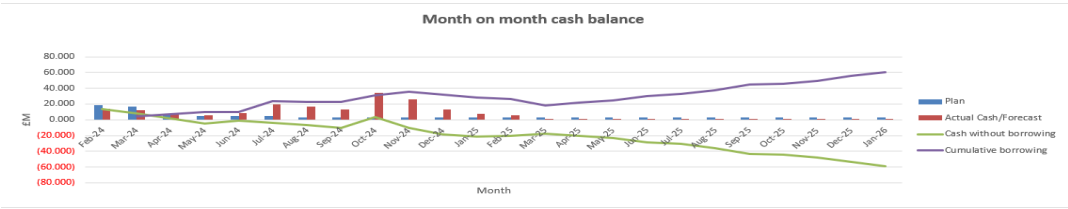
- The NHS England Specialised commissioning ERF outturn has now been agreed for 24/25 including Cardiac monitoring and long stay Spinal patients.
- Issues remain on the NHS England Specialised position which is lower than the Trust reported position. This is being reviewed with NHS England SW region analytics teams and escalated to NHS England Specialised commissioning via Contract review meetings.
- The Trust is maximising activity recording opportunities, Advice and Guidance and productivity improvements.

Cash Position and Capital Programme

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

	Closing Balance March 2024 £000s	Current Month Balance £000s	Actual In Year Movement £000s
Inventories (Stock)	7,954	7,874	(80)
Debtors	24,999	26,140	1,141
Cash	28,891	10,780	(18,111)
TOTAL CURRENT ASSETS	**61,844**	**44,794**	**(17,050)**
Creditors	(58,026)	(37,185)	20,841
Borrowings	(641)	(21,368)	(20,727)
Provisions	(474)	(365)	109
TOTAL CURRENT LIABILITIES	**(59,141)**	**(58,918)**	**223**
TOTAL WORKING CAPITAL	**2,703**	**(14,124)**	**(16,827)**





Schemes	Annual Plan £000s	January '25 YTD Plan £000s	Actual £000s	Variance £000s
CDEL Schemes				
Building schemes CIR	3,609	2,901	4,478	1,577
Building projects	2,682	2,236	4,165	1,929
Fire schemes	500	406	106	(300)
IM&T	6,264	5,022	1,629	(3,393)
Medical Equipment	393	308	186	(122)
Total CDEL schemes	**13,448**	**10,873**	**10,564**	**(309)**
National Funding				
Shared EPR - national element	2,231	1,784	943	(841)
Digital Pathology & LIMS	837	679	247	(432)
Community Diagnostic Centre	1,306	1,046	526	(520)
CIR Funding	761			
PDC Regional re-allocation	525			
Total National Funding	**5,660**	**3,509**	**1,716**	**(1,793)**
IFRS 16 Leases				
Medical Equipment	1,800	900	634	(266)
Vehicles and transport	850	426	360	(66)
All other leases including property	350	174	167	(7)
Total IFRS 16 Leases	**3,000**	**1,500**	**1,161**	**(339)**
GRAND TOTAL	**22,108**	**15,882**	**13,441**	**(2,441)**

Understanding the Performance

Capital expenditure on both CDEL and nationally funded projects totals £13.4m driven by the South Newton site purchase, Breamore refurbishments, Imber ward, lifts and CT scanner installation costs.

The cash balance at the end of Month 10 was £10.8m, £7.7m above the planned level of £3.1m. The improvement is due to payments relating to the non recurrent deficit support, CDC, ERF and Pay award in advance.

Countermeasure Actions

- 25/26 cash support guidance sought from NHS England.

Due Date

March 25

Risks and Mitigations

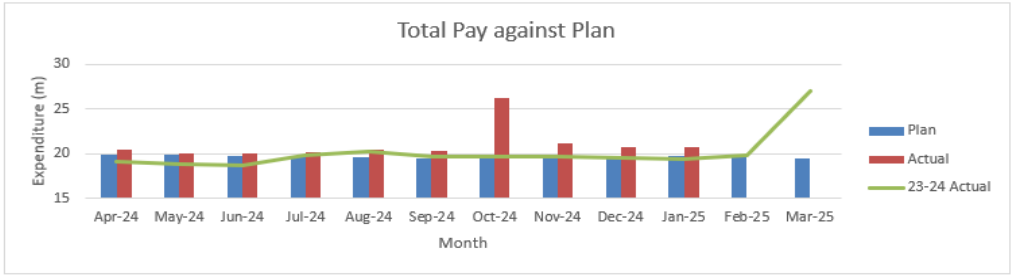
- The Capital cash support application has been confirmed at £8.9m and will be paid in February 25.
- BSW ICB cash support will be required during March and April until the revenue support process has been confirmed.
- The aging estate, medical equipment and digital modernisation means that the Trust's capital requirements are in excess of resources.
- The Trust seeks to mitigate the constraint of available system capital by proactively budding for national funds.
- The cash support framework and monitoring draws on finance and procurement resources to ensure that payments are made on a timely basis in line with limited cash balances.

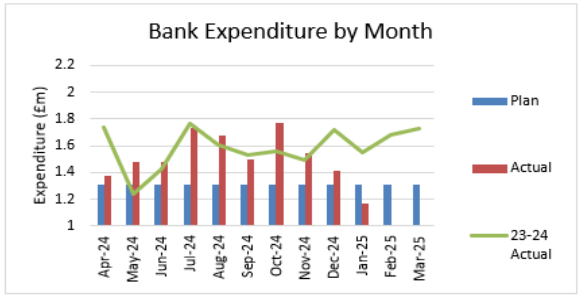
Workforce and Agency Spend

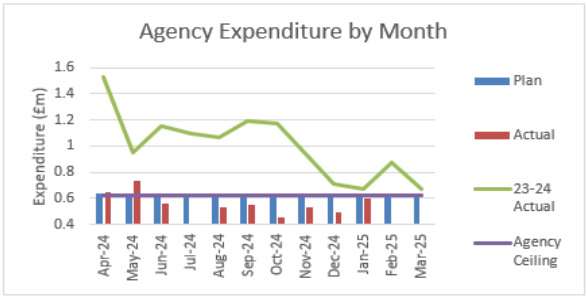
Target: N/A Performance: N/A Position: N/A

	January '25 YTD Plan £000s	Actual £000s	Variance £000s
Pay - In Post	185,517	189,279	(3,763)
Pay - Bank	13,495	15,142	(1,647)
Pay - Agency	6,296	5,430	866
Other (eg apprenticeship levy	601	844	(243)
TOTAL	**205,909**	**210,695**	**(4,786)**
Medical Staff	52,740	59,804	(7,064)
Nursing	56,357	55,263	1,094
Support to Nursing	19,963	17,175	2,787
Other Clinical Staff	27,871	27,990	(119)
Infrastructure staff	48,661	49,619	(958)
Other (eg apprenticeship levy	317	844	(526)
TOTAL	**205,909**	**210,695**	**(4,786)**

	January '25 YTD Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	537.1	560.76	23.7
Nursing	1,201.3	1,306.71	105.4
Support to Nursing	433.7	553.61	119.9
Other Clinical Staff	816.8	659.67	(157.1)
Infrastructure staff	1,344.1	1,463.31	119.2
TOTAL	**4,333.0**	**4,544.1**	**211.0**







Understanding the Performance

Pay costs in month were £0.1m above plan with the in-month position driven by reductions across Substantive and Bank, and Agency increases. Agency costs increased by £0.1m due to Medical staff within Surgery and CSFS linked to ERF delivery.

Unavailability reduced by 92 WTE from December with unavailability due to sickness at its highest level of 243 WTE.
The pay savings target was £10.7m against which achieved pay savings were £6.5m - an adverse variance of £4.2m, with £2.4m recurrent delivery.

There is an over-establishment of 211 WTE against the 4,333 WTE Workforce trajectory (4,309 WTE at March 25) with the over-establishment across all Pay categories with the exception of Other Clinical Staff.

Countermeasure Actions	Due Date
• Trust-wide and Division workforce control panels in place since November 23.	Ongoing
• Finance recovery groups to review workforce actions (detailed under Creating Value for our Patients).	Ongoing

Risks and Mitigations

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

Appendix

Business rules and Statistical Process Control (SPC) chart guidance

Our Priorities

People

Population

Partnerships

Appendix

Business Rules – Driver Metrics

NHS Salisbury NHS Foundation Trust

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

Appendix

Business Rules – Watch Metrics

Salisbury NHS Foundation Trust

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

Appendix

NHS Salisbury NHS Foundation Trust

Business Rules – Statutory/Mandatory Metrics

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

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

Appendix

Reading a Statistical Process Control (SPC) Chart

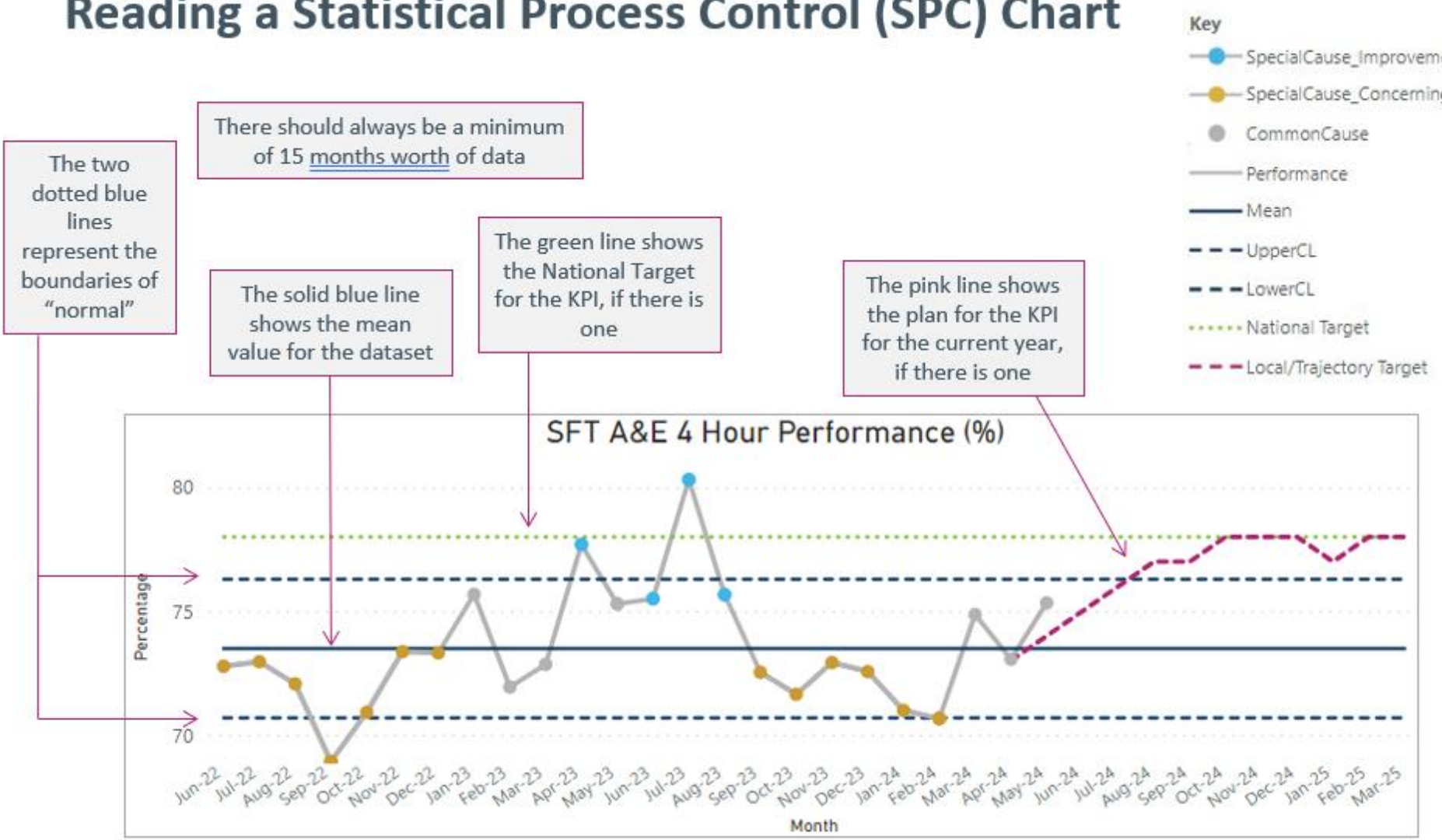
There should always be a minimum of 15 months worth of data

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

The solid blue line shows the mean value for the dataset

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

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



NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.2
	6 March 2025		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	28 January 2025
Status:	Information	Discussion	Assurance	Approval
	x		x	
Prepared by:	Debbie Beaven – Chair of Finance & Performance Committee			
Non-Executive Presenting:	Debbie Beaven			
Appendices (if necessary)	none			

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

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

- Demand – it is important to emphasise that our ability to manage and stem demand is limited and we continue to see growth of c10%, which beyond this year's plan, for example ED type 1 attendances are 14% higher than the previous year. There is nothing to indicate that this will fall, and the fear is that these levels will continue and be beyond the national guidelines for demand planning for 25/26 – see planning below.
- NCTR – was 82 in December and on 27th January 74, so there is some progress, and the "sprint" continues, but the numbers are still a long way from the plan assumption of 21. Interventions are starting to take effect as we drive to an H2 forecast position of 64.
- Financial Performance – The deficit gap has worsened again in December and is now £10.7m behind plan with a forecast deficit at year end of £12.7m. The exit run rate will have a knock-on impact into 25/26 financial planning challenges.
- SOF4 risk – despite our own assessment that there are no significant gaps in our key areas of learning, compared to others, there is a significant risk that the Trust and wider system will be moved into SOF4. The impacts have been clearly laid out for us with insights from other Trusts' experience.
- Community Services Contract – continues to present financial challenges around the funding of the hospice.

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

- Emerging risk arising from workforce controls
  - Examples of where requests have been declined by system impacting everyday safety processes
  - Potential impact on backfilling for roles in ERP
- Planning 25/26 challenges and risks
  - Current bottom-up and top-down gap significant and current model is potentially £19m off what is acceptable from a system perspective
  - ERP cap next year, limiting our ability to improve income through increased elective activity

  - UEC growth could be constrained to 2%, despite SFT experiencing 10% year on year rolling growth.
  - Level of CIPs next year could be >£25m to deliver an acceptable plan
  - Unpalatable and difficult choices being evaluated
  - Lack of time and sequencing of Committee and Board meetings not ideal
- Risk Management Framework – tabled and accepted as a good piece of work in bring everything together. We anticipate a review of the appetites as we move into 25/26.
- Coding – ERP improved in December to 127% as a result of the coding catch up with cardiology, however with the loss of another coder and the challenges of recruitment and training we need to ensure that coding does not fall behind.

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

- Pathology – deep dive. We received an update on the pathology network and the choices for the future operating model. There is a national driver for further amalgamation is further improve efficiency and value for money. However not all parties in the network are aligned on the best way forward. A business plan is being developed to show benefits and risks of options, which will come to all Trusts when complete, although it is not clear when that will be.
- Cancer – continues to improve with signs that December continues that trend. We are best performing trust in the Southwest for Cancer, which is testimony to the work of all those supporting cancer patients in the Trust.
- ERP – is on track and at 115%, which is expected to be sustained until the year end.
- RTT – there are some challenges around specialisms, however we have seen at improvement of approx. 4.5% and 5% further improvement next year. However, to get to 92% from the current 58% we would need to improve by 8% pa. Exploration of what that looks like is taking place, with a particular focus on outpatient transformation.
- Productivity – continues to improve and SFT are in the top quartile nationally, indicating that the interventions and improvements have a lasting impact, despite being negated by the demand challenges.

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

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NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.2
	6th March 2025		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	25 February 2025
Status:	Information	Discussion	Assurance	Approval
	x		x	
Prepared by:	Debbie Beaven – Chair of Finance & Performance Committee			
Non-Executive Presenting:	Debbie Beaven			
Appendices (if necessary)	none			

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

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

- Financial Performance – The another deficit month the cumulative deficit is now £12.8m and expectation of ending the year closer to £15.7m (acknowledged by the ICB). The pressure continues in urgent and emergency care pathways (NCTR and demand as reported in previous escalations).
- NCTR – averaged 84 (H2 plan 64) remaining the area of biggest pressure and impact on flow and levels of care. The cost impact is 150 WTEs over plan (direct and indirect) at a cost of c£7m FYE. The sprint concludes with an improvement in tactical relationships, detailed process mapping, care diaries and, in April, ewhiteboards and the development of digital notes to provide more rounded/complete info on transfer out of hospital. However, the transformational change in community care (left shift) will take longer and there is no real indication of when we can expect to see a significant shift.
- Planning 25/26 challenges and risks
  - The draft submission shows a residual £15m deficit after £15m of identified CIP opportunity. (6% of all CIPs must be cash releasing), and no apparent "hocky stick" in the current draft. Transition plans from "now to next" are in development. It was helpful to see the "extremis" list of cost saving actions in the reading room, some of which have been taken through into the plan. The Executive made clear that this current plan already has a high level of risk. The Committee needs a better level of assurance around the plan, pace and value of the CIPs – with more detail and clarity on what of the extremis list is in the plan - expected in the next update,
  - The plan relies on Outpatient transformation. National productivity benchmarking highlighted a significant opportunity in outpatient and there needs to be emphasis on a 5-year roadmap to achieve RTT targets; currently 141 days and drive to get to 91 days, through a more coordinated approach and engagement with clinical teams, reviewing the booking processes, and using Improving together. A key next step is the recruitment of an Outpatient Operational Manager, however with the current enhanced workforce controls doubt was expressed about getting this role approved. It is, therefore, key that speciality clinicians are supported to improve processes and to use the new governance model effectively.
  - Headcount reductions for a compliant plan will be significant, these will come from reduction in bank and agency and a reversal of growth - approximately 200 roles.

- Planning timetable – The next submission is 19th March, by which time F&P and Board will need to have seen and endorsed (approved) the next version. Extraordinary teams sessions will be set up.
- Cash flow 25/26 – if we don't submit a "balanced" plan (breakeven), then there is a risk that we will not get cash support for the deficit. Mark will provide more information on what this scenario could look like in the next update.
- I&I4 risk – investigate and interrogate – BSW has a huge CIPs target of £150m, and still a residual deficit that needs addressing in the plan, or there is a risk of intervention. There is a new Recovery Director starting with the ICB soon, so there may be some useful support, guidance or insight to come.

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

- Subsidiary – STL – with the loss of another major contract due to price the mid/long term commercial viability of the subsidiary is in question and strategic choices are being considered.
- Estates backlog maintenance – the estimated cost is now £80m with inflationary increases. Critical infrastructure backlog is £14m, with bids submitted for £5.8m (awaiting outcome) and potential routes to more funding and elimination of risk (e.g. DSU funding) and priority allocation through CDEL.

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

- Performance improvement – Lots of good results:
  - Productivity – continues to improve and SFT are in the top quartile nationally, indicating that the interventions and improvements have a lasting impact, despite being negated by the demand challenges.
  - Ambulance handovers - >60 mins reduced by 40%, time improved by 5 mins average.
  - 4 hour performance up to 73.2 (from 67.7%) – impact of winter plan, RATT and ED layout.
  - Productivity – overall 4.1% improvement against baseline of -18% in April 2024.
  - Cancer – regional and national high performer. FDS (faster diagnosis) up at 85.8% - SFT in top 5% nationally.
  - ERP remains on track at 115%.
- Estates – CAFM now approved and in progress. Coming to the next committee - outcome of geothermal feasibility and overview of the Imber build (budget, time, quality).
- South Newton & Campus update – Salutum partnership extended (no cost impact), vital for negotiations on car park. Procurement of architects progressing with shortlist coming to next F&P.
- Subsidiary – OML and SSL – both are operating effectively. OML Commercial framework looks strong, with just the absence of an "exit plan" for completeness.

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

- Pathology – after the deep dive in the last committee we considered the proposal to continue with the current network arrangements (with some enhancement), rather than a full amalgamation. This recommendation came following sharing of the Winchester experience, expectation that there would be no significant saving in resources – given critical mass and on site needs, potential delivery challenges (given geography) and the lack of a clearly defined integrated model. The Committee supported this position for recommendation to the Board, acknowledging that the National drive is to an amalgamated model, so we should consider if and how a transition could happen over time.
- Annual Review of Committee effectiveness and Terms of Reference – both were supported with some challenge on the need for all members to answer some standard questions (terms and quorate) and more clarification needed around the "objectives" question.

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Report to:	Trust Board (Public)	Agenda item:	2.3
Date of meeting:	March 2025		

Report from (Committee Name):	Clinical Governance Committee		Committee Meeting Date:	25 February 2025
Status:	Information	Discussion	Assurance	Approval
	X			
Prepared by:	Anne Stebbing, Chair, Clinical Governance Committee			
Non-Executive Presenting:	Anne Stebbing, Chair, Clinical Governance Committee			
Appendices (if necessary)				

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

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

- None

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

- CGC received the quarterly reports for adult and children's safeguarding. It was noted that a key member of the adult team is leaving the Trust at the end of March and this is a potential risk. The CNO stressed that the need for re-appointment to this role would be prioritised in workforce discussions. Both teams still have concerns regarding the accuracy of training compliance figures, while noting that work continues between MLE and the departments. It was agreed that the Managing Director would follow this up to provide greater assurance, and that this would be referred to People and Culture committee for further attention.
- CGC recognised the good results in the most recent national dementia audit, (audit of patients under SFT care in August 2023, report published December 2024) and agreed this provided assurance about standards of care at that time point. It was noted that there is still room for improvement in some areas, (including assessment of pain), and that delivering our Dementia Strategy needs everyone in the Trust to be engaged with our approach. Key to this is education of staff which is delivered by a small team. CGC requested that the next Dementia Strategy report needs to include evidence of progress with our strategy, and this will need some departmental audits this year, especially as the next National Dementia Audit is not due until 2026.
- In discussion of metrics in the IPR and following discussion at Board, CGC requested a deep dive into Stroke care, to include performance metrics collated nationally and how the trust benchmarks, what plans the team have to improve any areas that are not meeting targets, and the risk around delivery of these plans.
- Continued assurance was noted regarding the Learning from Deaths process. CGC has requested future reports provide greater details on what has been learnt and changes proposed following this.
- Received the Divisional report from Surgery and noted improvements within the division. CGC agreed a more structured template for divisional reports to CGC would be helpful. The executives will propose a new format and share with NEDs.
- CGC was pleased to note that many of the open actions from previous incident investigations have now been closed (raised at Dec 2024 CGC), and that the remining open actions are mostly related to developing / approval of SOPS and guidelines. These are due for completion by April 2025.

- CGC noted a rise in complaints in the last quarter and that this has occurred previously at this time of the year. The number of early resolutions has increased, but slow progress continues regarding timeliness of response. CGC has asked how FFT responses at SFT benchmarked with RUH and GWH, and noted that the other two Trusts have increased digital process to more areas (with a higher spend), to achieve SFT 15-17%, RUH 21.5% and GWH 27%.
- CGC also noted that the financial constraints of the following year may lead to an increase in complaints and the Trust needs to consider how we might mitigate this risk.

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

- CGC noted the overall rating of Good for maternity services from the CQC, following an unannounced inspection in September 2024. CGC noted that strong leadership from the maternity leadership team had been crucial to achieving this result, and congratulated the Director of Midwifery.
- CGC received and noted the quarterly Maternity and neonatal Quality and Safety Report, and the February Perinatal Quality Surveillance Report (January data). Much of this was already familiar to the committee given the recent review of evidence for CNST. Key performance metrics were maintained.
- Received and discussed the annual Human Tissue Act (HTA) report, which provided assurance following inspections pertinent to both Trust licences, and confirmed actions required had been completed.
- The Trust's two Patient Safety Partners (PSPs), attended the meeting and discussed their role and the potential benefits they can bring to the Trust. CGC noted how active these individuals had been in developing their role and attending national meetings. CGC also noted that two further PSPs are being recruited, bringing the total to four. It was agreed it would be beneficial for them to attend 1-2 CGC meetings / year, to help ensure we consider the patient voice.

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

- CGC is content with the approach suggested for Committee Effectiveness Review, noting that some minor changes to the template had been suggested by FPC and CGC.
- CGC noted the approval of the introduction of Badgernet system for maternity, which had gone live on the day of CGC

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.4
Date of meeting:	6th March 2025		

Report from (Committee Name):	Trust management committee TMC		Committee Meeting Date:	22/01/2025
Status:	Information	Discussion	Assurance	Approval
	x			
Prepared by:	Interim Managing Director, Lisa Thomas			
Non-Executive Presenting:	Interim Managing Director, Lisa Thomas			
Appendices (if necessary)	N/A			

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

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

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

- Financial position was discussed in full considering the pressures from demand impacting on bed capacity this was highlighted as a significant risk for 2025/26 financial plan.

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

- Risk Appetite framework was presented and shared for adoption.
- Estates strategy was presented following a lengthy engagement piece of work.
- The EPRR steering group annual report was shared showing strong compliance.
- The Green plan annual progress was shared which demonstrated significant progress.

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

- Risk management policy was approved
- No purchase order/no pay policy was approved

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

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Report to:	Trust Board (Public)	Agenda item:	2.4
Date of meeting:	6th March 2025		

Report from (Committee Name):	Trust management committee TMC		Committee Meeting Date:	26/02/2025
Status:	Information	Discussion	Assurance	Approval
	x			
Prepared by:	Interim Managing Director, Lisa Thomas			
Non-Executive Presenting:	Interim Managing Director, Lisa Thomas			
Appendices (if necessary)	N/A			

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

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

- Workforce controls process is generating some risks in individual departments, the Committee discussed a need to review the overall risk process for overseeing the collective risks associated with the gaps in workforce – this process review is now in action.

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

- Estates escalated the concern that system VCP process has rejected several estates roles which have implications for accommodation, and compliance.
- The financial challenges were discussed in full both recognising the in year financial position but similarly the financial challenges posed in the draft plan for 2025/26.

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

- The Committee received the final recommendations following the lengthy car parking engagement which were approved. The paper was approved which outlined a number of changes proposed and a communication plan to implement.
- The committee had a presentation on work undertaken in Medicine on the medical staffing model required for both ED and Acute medicine to work to 7 day working and manage predicted patient demand. This was supported to be worked into a business case for consideration.
- The committee had an update on the staff survey results which would be published in March.
- Performance across targets was positive in month with sustained improvement in cancer in particular.

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

- Approval of E-rostering investment to expedite the roll out of e-rostering across medical staffing.

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.5
Date of meeting:	6th March 2025		

Report from (Committee Name):	People and Culture Committee		Committee Meeting Date:	30th Jan 2025
Status:	Information	Discussion	Assurance	Approval
	√		√	
Prepared by:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Non-Executive Presenting:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Appendices (if necessary)				

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

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

- Impact of workforce reduction target on ability to deliver both strategic and operational intentions and the quadrangulation required across people, finance, quality and performance. Discussed as part of the risk appetite discussion
- Delay in medical e-roster implementation – actions to address through FRG discussion

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

- The following items were presented and discussed at this month's meeting:
  - Risk appetite framework. Health and Safety reporting was discussed with agreement that whilst TMC has oversight it should report for assurance through PCC.
  - Committee Terms of Reference. These were discussed with a plan to finalise at next month's meeting
  - People Promise updates noting positive improvements for staff survey and good progress in terms of recruitment and turnover. Gaps identified included a lack of wellbeing lead for the Trust and the risk due to an Associate Director post not being approved for recruitment. Clear plans in place for the launch of the Sexual Safety Charter noting the challenge of having enough trained investigators.
  - Workforce plan and winter planning update
  - The IPR report – noting sickness absence increasing with flu/coughs/colds being highest reason for absence this month and as previously noted the reduction in mandatory training compliance and non medical apprasials
  - Freedom to Speak Up report
  - Guardian of Safe Working report
  - Gender Pay Gap report – noting some prioritisation of actions required to be undertaken which will come back to February meeting
  - OD&P Management Board escalation report – noting improvement to annual leave calculations process to support line managers and reduce errors

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

- The meeting was quorate with good discussions taking place
- Good performance across most key metrics (exceptions noted above under IPR)
- Assurance was received in relation to Freedom to Speak Up and Guardian of Safe Working activity

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
Board to receive Freedom to Speak Up and Guardian of Safe Working reports

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.5
Date of meeting:	6th March 2025		

Report from (Committee Name):	People and Culture Committee		Committee Meeting Date:	27th Feb 2025
Status:	Information	Discussion	Assurance	Approval
	√		√	
Prepared by:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Non-Executive Presenting:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Appendices (if necessary)				

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

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

- Ongoing concern re the challenge of reducing workforce with increasing demand, financial challenges and maintaining quality whilst meeting national initiatives
- Demand on a depleted workforce and OD team – the CPO was asked to identify the impact of this
- Masks for PPE – lack of availability and change in type of mask increasing the risk for some staff
- Physio gap in occupational health

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

- The following items were presented and discussed at this month's meeting:
  - Annual Review of Workplan – this was approved, noting that there will likely be changes through the year to reflect Group and National developments
  - Committee Effectiveness review template – this was approved with minor changes
  - Terms of Reference – these were approved
  - Job evaluation nursing and midwives job profiles – this national workstream was noted with the potential financial risk to be flagged to F&PC
  - OD&P SLA and KPIs - noting that only 5 of 54 metrics were off track
  - Strategic workforce systems steering group update – noting support from FRG and TMC to support resources for implementation of medical e-roster alerting last month and MLE downtime
  - Audit and Fraud Report action plans update – noting good progress on actions with all projected to meet due dates
  - Workforce operational plan – first submission submitted
  - Strategic Workforce plan – noting the challenging ask in the operational plan therefore pause to this workstream. The committee felt a Board discussion was relevant to this
  - The IPR report – noting flu/cough/colds sickness absence and the non-medical appraisals rate. It was confirmed that appraisals will be a breakthrough objective for next year
  - Improving Working Lives of Doctors in Training – noting good assurance received though flagging the pause of the digital passport in the region
  - Gender Pay Gap – noting the focussed plan for 2025-6 based on the 4 areas of highest concern

o Organisational Development and People (OD&P) management Board escalation report o Safe Staffing Escalation Report (6 month snapshot) – noting the Trust performs above the national average and sits mostly in the top 2 quartiles
ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.
• The meeting was quorate • Good practice noted in KPIs, audit actions, Working Lives of Doctors in Training, launch of Sexual Safety Charter preparation, safe staffing workforce oversight report

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
• Gender Pay Gap Report and Action Plan to be presented at Board

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

Report to:	Trust Board (Public)	Agenda item:	3.1
Date of meeting:	6th March 2025		

Report title:	Women & Newborn Divisional Governance Report			
Status:	Information	Discussion	Assurance	Approval
	Yes		yes	
Approval Process: (where has this paper been reviewed and approved):	Women & Newborn Divisional Governance 17th January 2025 CGC 28th January 2025			
Prepared by:	Abigail Kingston, Clinical director for WNB			
Executive Sponsor: (presenting)	Judy Dyos			

Recommendation:

Assurance to the Board of the Women and Newborn Governance processes

Executive Summary:

To provide assurance that quality care and patient safety is effectively monitored and shared within the Women and Newborn Division, to understand the challenges, improve practice and maintain standards. This is being achieved by providing Divisional teams (MDT) with information required to promote changes in practice and learning from incidents at monthly Divisional Governance meetings.

These monthly meetings have a clear agenda to ensure that feedback and Patient Experience, Patient Safety and Clinical Effectiveness is shared divisionally, and to ensure escalation of concerns to the Divisional Management Team (DMT). Each service within the division is required to provide an escalation report to include information from within the specialist area, highlighting any areas of concern. This includes updates on guidelines, top risks and serious incidents, workforce and national workstreams.

The divisional behaviour charter and final sense check both form integral parts of our meeting.

June – all services represented

BAPM compliance for neonatal nursing staff noted and business case noted as in train.
Gynaecology surgery working to 65 week wait with steady progress.
Cancer 28 day and 62 day performance A3s discussed.
Significant improvement noted in risk compliance tracker.
Fertility services to use assure:alert:advise template.
Triangulation using quarterly litigation report discussion – “failure to diagnose” risk discussed.
Trust policy & guideline summit – on track for good response.

July – all services represented

Coil clinics to start to address GP reluctance to fit in community.
Maternity progress in 60 day breaches for investigations commended.
Screening review undertaken and discussion.
Fertility staff shortages discussed and addressed.
Clinical audit plan update with Julie Higgins and discussion & learning for teams.

August – not all services present (no fertility)

ROP screening discussion in NNU due to no cover with ophthalmologist. Cross-divisional meeting arranged.
Good progress with guidelines noted.
Clinical coding in gynaecology discussed and plans for coders to attend department agreed.
Huge improvement in 28-day faster diagnosis with 79% compliance.
On course to achieve 65-week performance target in gynaecology.
Review of 60-day investigation targets shows consistent improvement.
Midwifery vacancy predicted to be zero from October.
Fertility staffing challenges continued, and mitigations discussed.
HFEA inspection due, no support needed.
MNVP update – feedback discussed showing improvement plans for sharing information around induction of labour and translating patient information.
Helen Rynne attended for update on patient experience with excellent F&F responses and good complaint response noted.
Communication noted as complaint theme, Patient panels discussed and divisional patient engagement driver discussed.
Compliance with updating guidelines commended.
MSSP exit report discussed and commended.

September – all services represented.

NICU discussion re Badgernet use rather than millennium, BSW discussions awaited.
ATAIN issues escalated with discussion and action to address obstetric attendance.
GP prescribing for maternity outpatients discussed and agreed to escalate through DPR.
Gynaecology matron added to compliance action tracker distribution.
Mitigation for staffing in fertility discussed and noted.
Radiology support to fertility escalated and action for WCP taken.
Quarterly mitigation report discussed with Judith Leach. Triangulation using quarterly litigation report discussion Themes reviewed and written consent for instrumental deliveries discussed.
For MNVP feedback on prepopulated consent forms.
NHSR visit scheduled for December to discuss scorecard.

October – all services represented.

BAPM medical and nursing staff business case position reviewed, and assurance given re progression.
Backlog of ATAIN reviews discussed and plan outlined for catch up.
NICU ventilator delay to be escalated through DPR.
Gynecology 28 day target noted at 76.7% (target 78%), ongoing A3 work reviewed.
Datix backlog in maternity discussed and action plan suggested.
Discussed first PSII report in maternity and escalation of concerns.
Screening update; structure commended, KPIs reviewed and reassuring.
HFEA report for fertility with three areas of action, plan to address with no additional support required.
Staffing discussed and alerting – for escalation to DPR.
Clinical audit update with Jaime Richards-Smart.
Deep dive risk register review feedback, no issues.
DPR pack reviewed and drivers for division discussed.
Freedom to speak up update – nothing to report.

November – all services represented

NLS and PROMPT compliance 90%
ATAIN backlog reviewed, extraordinary meeting arranged to catch up.
RCPCH (Royal col paed) calculator for ophthalmology screening tool in use for monitoring ROP screening delays.
“golden drops” project for colostrum use.
Badgernet roll out staffing impact discussed an action for team agreed.
Excellent cancer performance noted for gynaecology.

Outpatient prescribing by GPs being discussed at executive level and with Paul Russell no current issues.
Reduction in overdue DATIX's noted.
HFEA action plan received and noted and license agreed for 2 years.

MNVP update – working party for antenatal education, birth centre criteria discussed as a theme in feedback, review of criteria underway.
PALs update with Helen Rynne, Sophie Rolfe and Jenny Smith. Open visiting regulation discussed.
Thematic review of 3rd and 4th degree tears discussed, no themes noted.
IG review and staffing compliance actions discussed.
MSSP exit confirmed

Key successes / improvements;

- MSSP exit
- Golden drops breastfeeding project
- Patient feedback and engagement
- Cancer performance improvement

Next steps

- Confirm ATAIN backlog completed.
- CNST submission Jan 25
- Working towards 52 week pathways in Gynaecology.
- Badgernet rollout Feb 25

Version: 1.0

Appendix 1 (sent under separate cover)

Extract from DPR Governance Slides for December data (DPR Meeting 15th January 2025

NHS
Salisbury
NHS Foundation Trust

Divisional Governance Pack M9 (December 2024 data)

Incidents (1)

Salisbury NHS
NHS Foundation Trust

QUARTER 24/25	September	October	November	December
Category 1 –	Medication error during the prescription process 6	Labour Delivery – Other 11	Injury or poor outcome for the mother 7	Labour or delivery – Other 8
Category 2 –	Post-partum haemorrhage > 1,000ml 6	Connected with the management of operations/treatments 4	Administration or supply of a medicine from a clinical area 6	Injury or poor outcome for the mother 5
Category 3 –	Admission 4	Communication between staff, teams or departments 4	Labour or delivery - other 5	Admission 5
Number of PSII's and PSR's (presented / commissioned in month)	7 PSR's	5 PSR's	7 PSR's	7 PSR's

Incidents analysis (2)
November & December 2024 data

Salisbury NHS Foundation Trust

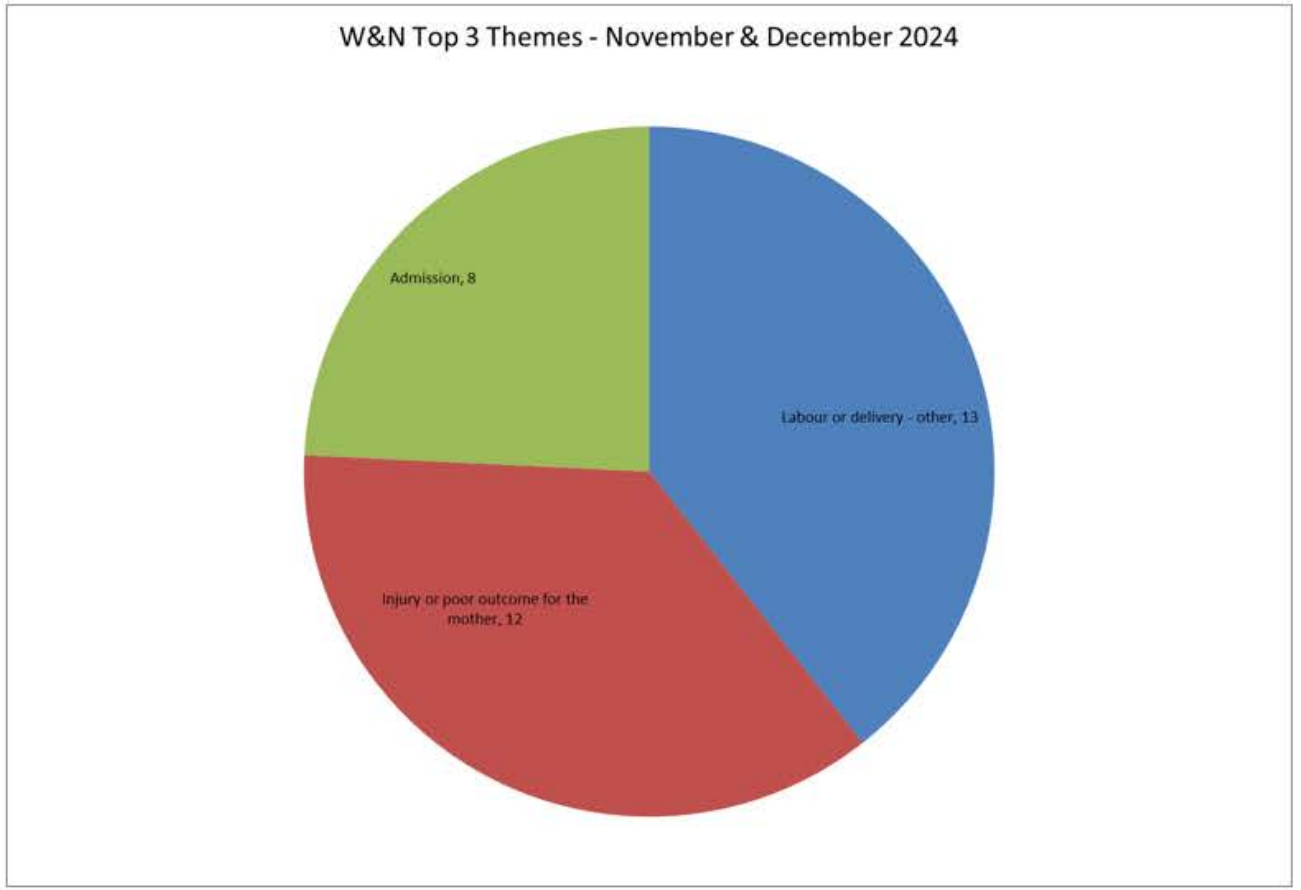
Top 3 themes

- **13 Datix relating to labour or delivery**
- **12 Datix relating to injury or poor outcome for the mother**
- **8 Datix relating to Admission**

Actions:

- **Labour and delivery**: Thematic reviews continue as per Trust PSIRP and rolling audits.
- **Injury or poor outcome for the mother:** As above
- **Admission:** As above

PSII - 0 commissioned



Open PSR's and PSII's

Salisbury NHS
NHS Foundation Trust

Ongoing Patient Safety Reviews with Division						
ID	Date incident Pulled	Directorate / Ward / Dept	PSR part 1 PSS	PSR part 2	Comments	
170537		Gynaecology Outpatients			PSR2 to be updated	expected from 06/12
170783	24/09/2024	Gynaecology Outpatients	12/11/2024		Awaiting PSR 2	17/12 Luke for more info, bring back
171165	19/11/2024	Labour ward	26/11/2024		Awaiting PSR 2	

Divisional Risk Register

Salisbury NHS
NHS Foundation Trust

ID	Title	Location (exact)	Specialty	Rating	Review date	Who else do you want to notify?	Risk Subtype
8049	Maternity Information syastem back and forward copying issue	Beatrice 4	Maternity Services	2	31/10/2024	Informatics, Information Governance Manager	Digital Steering Group
7758	Failure to submit invasive cancer patient details to the national audit leading to missed learning	Gynaecology Outpatients	Gynaecology	3	31/12/2024		Clinical Governance Committee
7999	No dedicated 24/7 obstetric anaesthetist cover.	Labour ward	Maternity Services	4	01/11/2024	Anaesthetics	Transformation Board
7109	There is a theorectical risk of infection to women and babies as the Labour Ward birthing pools are over recommended manufactu	Labour ward	Maternity Services	5	01/01/2026	Estates	Directorate Management Team Meeting
7623	Neonatal ROP	Neonatal Unit	Neonatal Intensive Care Unit	5	30/03/2026		Maternity Risk Group
7827	Inadequate QMS in Salisbury Fertility Centre	Fertility Centre	Fertility Centre	6	30/05/2025		Departmental Team meeting
7996	Unpaid storage invoices	Fertility Centre	Fertility Centre	6	31/01/2025		Directorate Management Team Meeting
8244	BIRR flask CE marking coming to an end	Fertility Centre	Fertility Centre	6	27/01/2025		Departmental Team meeting
8259	Floor lifting on labour Ward	Labour ward	Maternity Services	8	03/03/2025		Departmental Team meeting
8180	Witnessing Risk in Embryology lab	Fertility Centre	Fertility Centre	8	30/04/2025		Departmental Team meeting
7221	There is a risk of cases with harm not being investigated and escalated due to the large backlog of Datix	Maternity Administration	Maternity Services	8	03/03/2025		Directorate Management Team Meeting
8279	Air Handling Unit not fit for purpose	Fertility Centre	Fertility Centre	8	30/09/2025	Estates	Departmental Team meeting
8278	Water ingress in laboratory	Fertility Centre	Fertility Centre	9	30/09/2025	Estates	Departmental Team meeting
6412	Harm to women and babies through lack of dedicated 2nd obstetric theatre	Labour ward	Maternity Services	9	03/03/2025		Maternity Risk Group
8013	No robust system for checking results on review	Gynaecology Outpatients	Gynaecology	9	31/12/2024		Departmental Team meeting
7659	Poor uterine vision during a hysteroscopy due to aged flexiscopes	Gynaecology Outpatients	Gynaecology	10	31/01/2025		Clinical Governance Committee
7923	Neonatal unit heating	Neonatal Unit	Neonatal Intensive Care Unit	10	28/03/2025		Estates Assurance Meeting
7995	Embryology Staffing number	Fertility Centre	Fertility Centre	12	30/04/2025		Directorate Management Team Meeting
7694	Lack of space in the Fertility Centre	Fertility Centre	Fertility Centre	12	31/05/2025		Directorate Management Team Meeting
8239	VIN patients are not having the correct FU in VSC due to long FU waiting lists causing delays in recurrent cancer diagnosis	Gynaecology Outpatients	Gynaecology	12	05/12/2024		Departmental Team meeting

Top 3 Risks

Salisbury NHS
NHS Foundation Trust

Risk Score	Risk No	Title
12	7694	Lack of space in the Fertility Centre
12	7995	Embryology Staffing number
12	8239	VIN patients not having correct FU in VSC due to long FU waiting lists causing delays in recurrent cancer diagnosis

None awaiting closure

Risks being added post Fertility PRM (09.01.25)

- Out of date governance documents in the fertility service
- Intensive support to fertility
- Storage backlog within fertility

Complaints & Concerns

Salisbury NHS
NHS Foundation Trust

	November & December 24
Number of complaints and concerns opened	13
Number of complaints and concerns being investigated	13
Number of overdue complaints and concerns (>60 days)	0
Number of complaints and concerns closed	3

Policy & Guideline Update

Salisbury NHS
NHS Foundation Trust

Maternity and Neonatal Guidelines/Policies and SOPs position*

Out of date	5	2%
In date total	220	98%
Total G/P/S	225	

Gynae – 1 x NICE guideline due for review post update

Fertility – See next slide – Department currently on reduced activity and extensive DMT support to complete these documents

*position as of 09/01/2024

Compliance to National Guidance (1) – Ockenden 2022

Salisbury NHS
NHS Foundation Trust

OCKENDEN 2022		Immediate and Essential Action	Number of actions under each heading rated			
			RED	AMBER	AWAITING CLOSURE	GREEN
Dec-24	1	Workforce Planning and Sustainability	0	2	0	5
	2	Safe Staffing	0	0	0	10
	3	Escalation and Accountability	0	0	0	5
	4	Clinical Governance - Leadership	0	1	0	7
	5	Clinical Governance - Incident Investigation and Complaints	0	0	0	7
	6	Learning from Maternal Deaths	0	0	0	2
	7	Multidisciplinary Learning	0	0	0	7
	8	Complex Antenatal Care	0	3	0	2
	9	Preterm Birth	0	2	0	2
	10	Labour and Birth	0	1	0	5
	11	Obstetric Anaesthesia	0	1	0	6
	12	Postnatal Care	0	1	0	3
	13	Bereavement Care	0	2	0	2
	14	Neonatal Care	0	1	0	5
	15	Supporting Families	0	0	0	3
			0	14	0	71

Ockenden 2022

Key Achievements

1 action closed in November. No meeting in December.

Next steps for progression

- Work progressing well, the remaining actions are more complex so it is taking longer to see formal closure.
- Target date for closure for remaining actions set, with an aim for closure by end of Q4

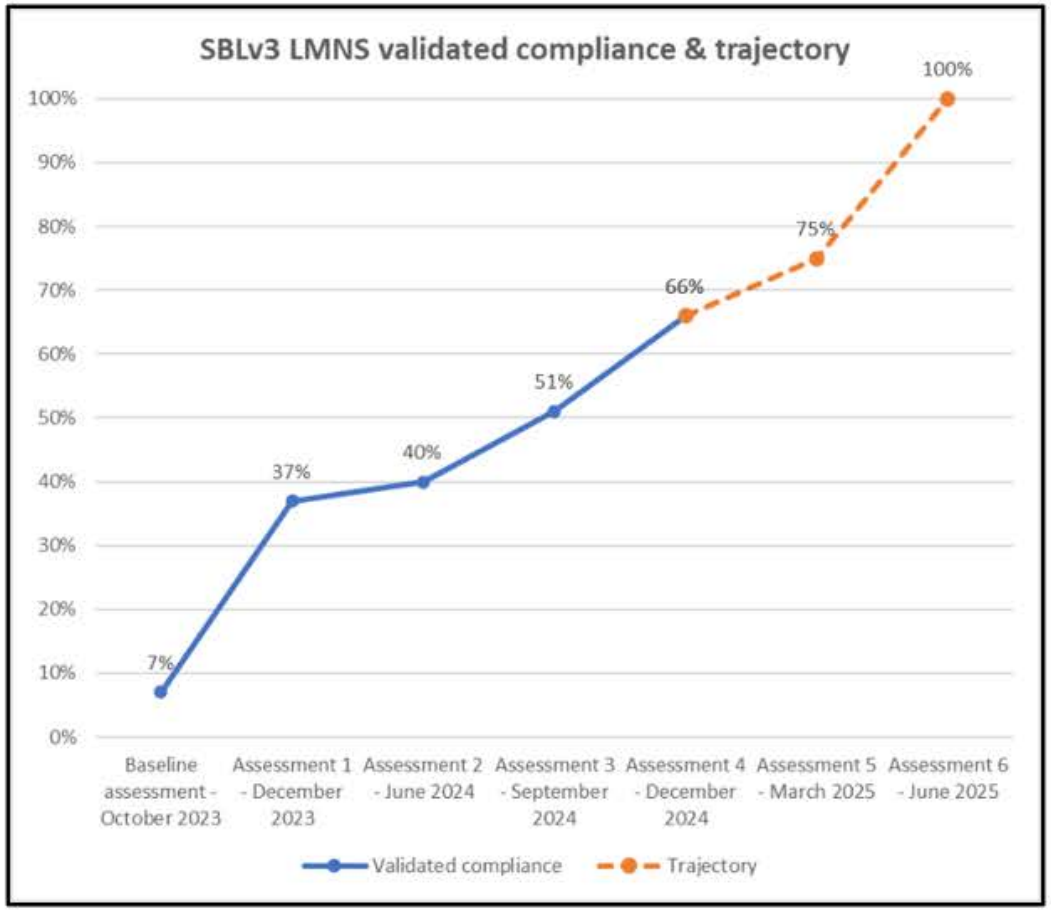
Compliance to National Guidance (2) – Saving Babies Lives v3 (SBLv3)

Salisbury NHS Foundation Trust

Implementation progress

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4
Review Quarter	Initial				
Assurance Review Date	25.10.2023	23.12.2023	24 06 2024	13.09.2024	02.12.2024
Element 1	10%	29%	20%	40%	60%
Element 2	5%	50%	50%	70%	70%
Element 3	0%	100%	50%	50%	100%
Element 4	0%	0%	20%	40%	60%
Element 5	11%	37%	48%	52%	63%
Element 6	7%	33%	17%	17%	67%
TOTAL	7%	37%	40%	51%	66%

% of Interventions Fully Implemented (LMNS Validated)



Saving Babies Lives (SBL) Care Bundle Version 3

Key Achievements

- There has been steady progress with implementation with SFT being 7% compliant last year to 66% compliant with the interventions and the most recent submission to the LMNS

Next steps for progression

- Work continues with leads for each element.

Compliance to National Guidance

- NHSR Maternity Incentive Scheme (CNST)

Salisbury NHS Foundation Trust

NHSR Maternity Incentive Scheme- Year 5 Submission by 1st February 2024				
	Description	Yr 5 Submission	Comment	Current Assessment
Are we well led?	1 **Perinatal Mortality Review Tool** using to required standard for all perinatal deaths	Compliant	All Standards Met	
	2 **Maternity Services Data Set** submission to required standard	Compliant	All Standards Met	
	3 **Transitional Care Data Set** minimise separation to mothers and babies	Compliant	All Standards Met	
	4 **Clinical Workforce Planning** effective system	Compliant	All Standards Met	
	5 **Midwifery Workforce Planning**	Compliant	All Standards Met	
	6 **Saving Babies Lives Care Bundle V3** compliance with all elements	Non Compliant	New bundle published 31/5/23- Extra element for women with pre pregnancy diabetes. Work in progress. Several barriers to achieving compliance. Compliance is achievable.	
	7 **Service User Involvement and co-Production**	Compliant	All Standards Met	
	8 **Multidisciplinary Training**	Compliant	All Standards Met	
	9 **Board Assurance** Board to Ward to Board	Compliant	All Standards Met	
	10 **HSIB and EN Reporting**	Compliant	All Standards Met	
Person Centred & Safe	Professional	Responsive	Friendly	Progressive

Key Achievements:

- Evidence has been initially reviewed within the CNST working group, confident with compliance for 9 of 10 safety actions
- SBL continues to make good progress, awaiting final outcome of November's submission which will determine compliance of SA6

Next steps for progression:

- Evidence to be reviewed in January in line with NHSR guidance and compliance to be presented to Trust board in February

Overview of SLT meetings

Salisbury NHS Foundation Trust

Specialty	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Fertility												
Gynae												
Mat/Neo	PRM due to start May 2024											

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.2
Date of meeting:	6th March 2025		

Report tile:	Maternity & Neonatal Quality and Safety Report for Quarter 3 2024/25.			
Status:	Information	Discussion	Assurance	Approval
	X	x	X	
Approval Process: (where has this paper been reviewed and approved):	DMT approval e-mail 13.02.2025 Divisional Governance 21.02.2025 Clinical Governance Committee - 25th February 2025			
Prepared by:	Vicki Marston- Director of Midwifery and Neonatal Services.			
Executive Sponsor: (presenting)	Judy Dyos – Chief Nursing Officer			

Recommendation:

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

CNST requirement for board minutes to note the following:

1. PMRT review to be noted in board minutes.
2. Compliance with labour ward coordinator being supernumerary and women receiving 1:1 care =100%
3. Feedback from ward to board and board to ward evidenced by Safety Champion meetings and attendance by Executive and Non-executive safety champions.

Executive Summary:

The Maternity and Neonatal Quality and Safety Report for Q3 demonstrates current position against local and nationally agreed measures to monitor maternity and neonatal safety. The purpose of this report is to inform the Salisbury Foundation Trust Board of present and emerging safety concerns within Maternity and Neonatal Services.

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

This report reflects data from **Quarter 3 24/25** with detail highlighted below:

- Midwifery and Neonatal staffing-
  - Non-complaint for BAPM (British Association for Perinatal Medicine) for Neonatal Nurses
  - Non-Compliant for BAPM for Medical cover– action plan in progress and due for presentation to Trust Board in December.

- 3 Stillbirths (Excluding Medical Termination of Pregnancy)
  - Overall rate for last 12 months for SFT is 2.12 per 1000. (National rate 3.9/1000 National ambition 2.5 per 1000)

- 0 reportable Neonatal Deaths.
  - This makes a total of 1 NND > 24 week in the last 12 months which equates to 0.55 per 1000 live births. The national neonatal death rate is 1.65 per 1000 live births.

- 2 reportable cases referred to Maternity and Newborn Safety Investigations **(**MNSI). One case met eligibility for investigation but not referral to ENS (not eligible), the other case was rejected by MNSI.

- 0 new Maternity PSII commissioned in Q3.

- Training compliance achieved of 90% in December 2024 for training included in CNST Maternity Incentive Scheme.

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

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

- 66% compliant November 2024

- 1:1 labour care and supernumerary status of labour ward coordinator maintained 100% of the time in Q3.

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

- Significant progress made with the Maternity Safety Support Programme. Exit meeting with National team held in Q3, and formal exit from the programme confirmed.

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

Maternity and Neonatal Services Quality and Safety Report Q3 2024/25

Women and Newborn Division

SALISBURY NHS FOUNDATION TRUST MATERNITY OVERVIEW DATA MEASURES: PERINATAL QUALITY SURVEILLANCE TOOL

Trust: **Salisbury NHS Foundation Trust Hospital**

CQC Maternity Inspection Ratings 2021	OVERALL	SAFE	EFFECTIVE	CARING	WELL-LED	RESPONSIVE
	Select Rating:	*Select Rating:*	*Select Rating:*	*Select Rating:*	*Select Rating:*	*Select Rating:*
	Requires Improvement	**Requires Improvement**	**Inspected but not rated**		**Inadequate**	

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

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

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

Contents

1. Report Overview

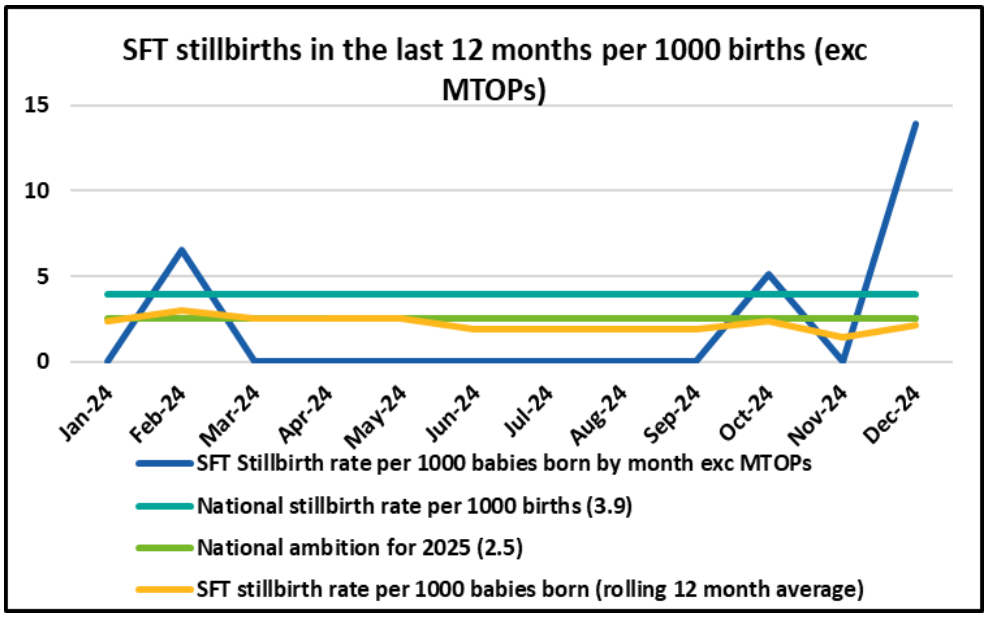
This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model*' (December 2020). The purpose of the report is to inform the Trust Board and LMNS Board of present or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

2. Perinatal Mortality Rate

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

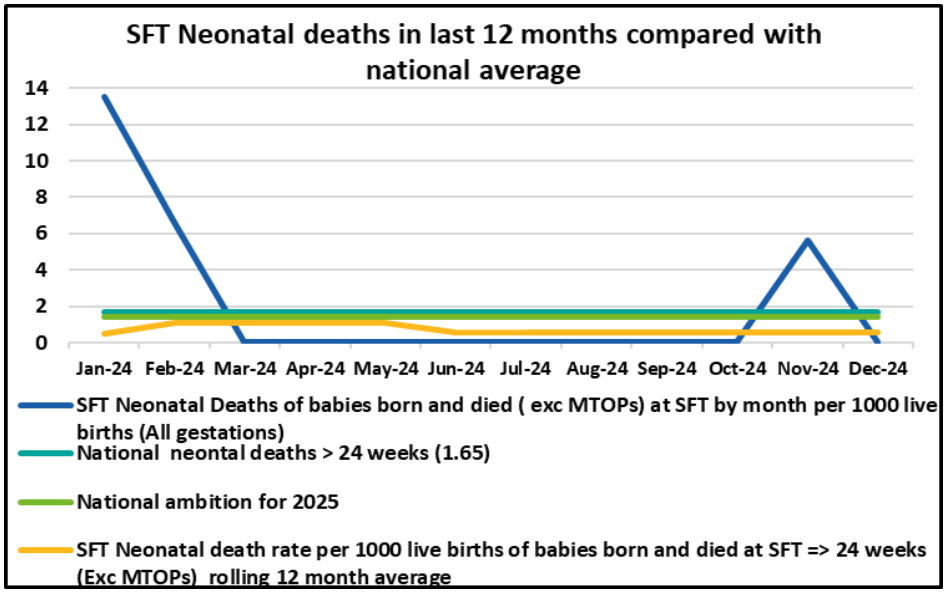
The graphs below demonstrate how Salisbury NHS Foundation Trust is performing against the national ambition.

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



In the last completed quarter (Q3), SFT had 3 stillbirths (Excluding MTOP's). This is a total of 4 in the last 12 months, which equates to 2.12 per 1000 births in the last 12 months and is below the national rate is 3.9 per 1000 births and national ambition of 2.5 per 1000 births.

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



In the last quarter (Q3), SFT had 0 neonatal deaths >24 weeks. This is a total of 1 neonatal death >24 weeks in the last 12 months which equates to 0.55 per 1000 live births and is below the national neonatal death rate of 1.65 per 1000 live births.

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

2.1 Perinatal Mortality Summary for the Quarter (Q3 Oct-Dec 2024)

Figure 3. Perinatal Mortality summary

PMRT ID	Cause of Death	Issues/ Actions / learning
There were no PMRT cases to review in Q3.		

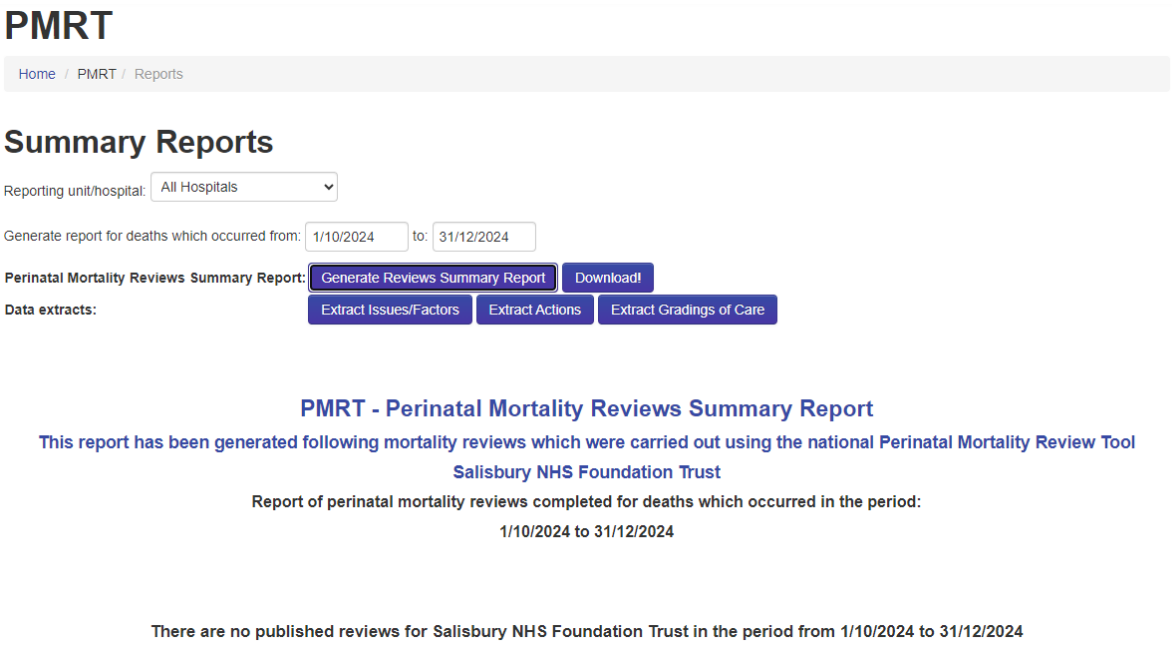
2.2 PMRT real time data monitoring tool

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

It is not possible to embed a copy of the Q3 2024/25 PMRT board report of the perinatal

losses reviewed at SFT. This is because it is not possible to generate a report for quarter 3 as there were no perinatal losses reviewed within that timeframe (as per previous graphs and screenshot of the MBRRACE reporting tool below).

Figure 4. PMRT Report screenshot showing that there were no published reviews in Q3.



2.3 Learning from PMRT reviews

There were 0 cases reviewed under PMRT in Q3. Learning and progress against previous actions are detailed in the full report in the appendices.

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

3.1 Background

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

MNSI undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), taken from Each Baby Counts and MBRRACE-UK. In accordance with these defined criteria, eligible babies include all term

babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

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

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

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

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

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

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

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

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

During Q3, two cases were referred to MNSI. One case met eligibility for investigation but not referral to ENS (not eligible), the other case was rejected by MNSI (see figure 5 below).

Figure 5. Summary of MNSI and ENS cases for safety action 10 compliance in Q3.

Cases referred to MNSI	Case accepted as eligible for investigation by MNSI	Families have received DOC 2 letter containing information explaining the role of MNSI and ENS	Duty of Candour (DoC) compliance	Case referred to ENS	Claims reporting wizard completed (families informed of NHSR involvement)
MI-039159	Rejected	N/A	N/A	N/A	N/A
MI-039163	Accepted	Yes REDACTED DOC 2 letter to parents re M REDACTED MNSI signature of receipt	Compliant with DoC 1 & 2	No – does not meet criteria	N/A

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

3.3 Investigation progress update (MNSI and PSII cases) for the last Quarter (Q3)

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

During this quarter, all cases under the previous incident investigation model (CCR's and SI's) have seen steady progress. At the beginning of Q3, there were 7 investigations in breach of the 60-day investigation target to CRG. At the end of Q3, there is one Commissioned Clinical Review (CCR) in breach of the 60-day target from the previous model. In addition, there is one MNSI case with an action plan in draft and a PSII. Current ongoing investigations are summarised below.

Figure 6. Investigation progress update

Investigation Type and Ref	MNSI Ref	Summary of Incident	Date Investigation Commissioned	External Notifications and Other Investigations	Current Investigation Progress
CR 613* *(*previous incident investigation model)*	N/A	Eclampsia	28.11.23		Awaiting exit meeting date for case presentation.
PSII-001	N/A	Cooled baby - preterm	6.2.24		Awaiting report.
MNSI Investigation: STEIS 2024/3982	MI-036889	Cooled baby	5.3.24	MNSI and NHSR Early Notification Scheme	Final report received and tripartite meeting completed. Actions in progress.

3.4 Coroner Reg 28 made directly to Trust

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

3.5 Maternity Patient Safety Incident Investigation (PSII) during Q3

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

Figure 7. Commissioned Maternity PSII's

DATIX	Incident Summary	Immediate learning identified
N/A	Nil PSII's commissioned or MNSI cases in Q1.	

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

4. Midwifery Continuity of Care (MCOC)

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

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

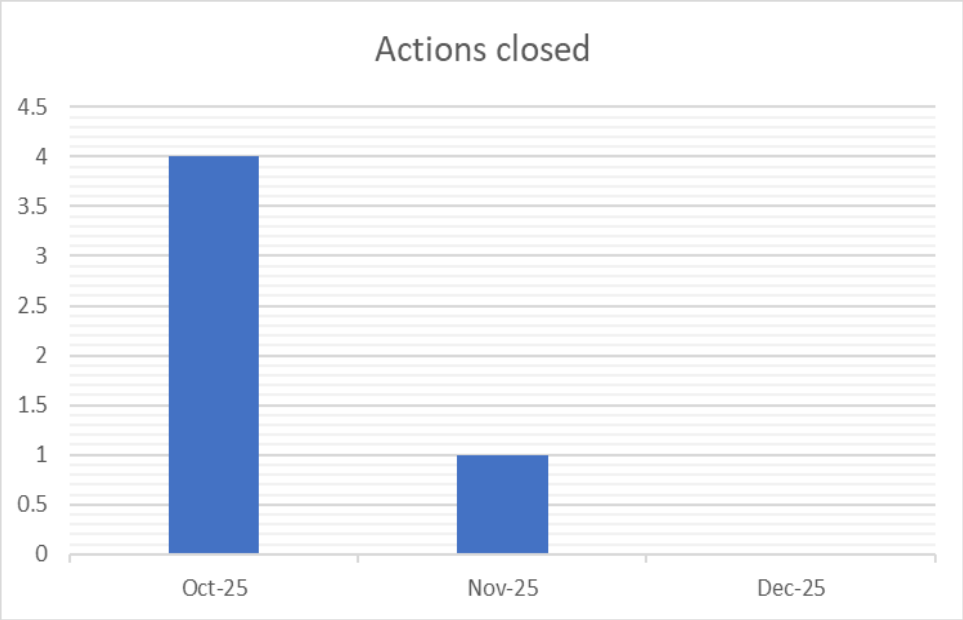
5. Ockenden updates

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

Figure 8. Current progress with Ockenden 2022 IEAs.

OCKENDEN 2022		Immediate and Essential Action	Number of actions under each heading rated			
			RED	AMBER	AWAITING CLOSURE	GREEN
Dec-24	1	Workforce Planning and Sustainability	0	2	0	5
	2	Safe Staffing	0	0	0	10
	3	Escalation and Accountability	0	0	0	5
	4	Clinical Governance - Leadership	0	1	0	7
	5	Clinical Governance - Incident Investigation and Complaints	0	0	0	7
	6	Learning from Maternal Deaths	0	0	0	2
	7	Multidisciplinary Learning	0	0	0	7
	8	Complex Antenatal Care	0	3	0	2
	9	Preterm Birth	0	2	0	2
	10	Labour and Birth	0	1	0	5
	11	Obstetric Anaesthesia	0	1	0	6
	12	Postnatal Care	0	1	0	3
	13	Bereavement Care	0	2	0	2
	14	Neonatal Care	0	1	0	5
	15	Supporting Families	0	0	0	3
			0	14	0	↑71

Figure 9. Numbers of actions closed per month in Q3.



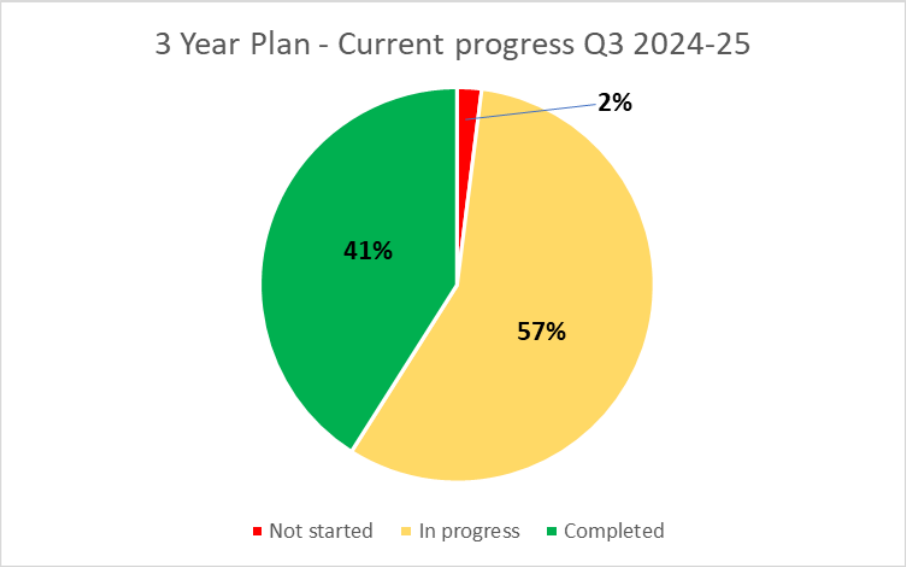
The key achievements and next steps to progress the closure of Ockenden 2022 IEAs are highlighted below:

- **Key achievements:** Compliance achieved in areas of bereavement care services availability daily, MDT working and training being job planned, risk assessments in labour, induction of labour pathways and expert fetal monitoring advice.
- **Next steps for progression:** Ongoing work continues around having specialist antenatal clinics for complex care (multifetal, diabetes, preterm birth), consultant reviews of all postnatal readmissions, labour ward coordinator leadership education, succession planning gap analysis and leadership development training, maternity self-assessment, centralised CTG monitoring and anaesthetic documentation and bereavement care – this action was agreed at the November Maternity Improvement Group meeting to be split so that services within Women and Newborn Division are covered by the Bereavement Midwife. There is now a separate action held at Trust level for providing the same level of care within services outside of this remit, e.g., ED.

6. Three Year Delivery Plan

Ongoing work continues around the 3 year delivery plan, with update meetings held in January 25 between the Quality Assurance Midwife and the Head of Maternity and Neonatal services (HoM) to review each action's progress.
Currently, only one action has not started – provide administrative support to free up pressured clinical time - the action holder is the HoM and this is being reviewed.
A further meeting has been held between the QA and Inclusion Midwives for updated progress.
With 18 of the 27 actions now complete we are progressing at pace.
This is demonstrated in the chart below.

Figure 10. Three Year Delivery Plan Q3 progress



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

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

Safety Action 8 of the Maternity Incentive Scheme (MIS) requires all maternity units to implement all six core training modules of the Core Competency Framework (CCF) (version 2). This safety action aims to address known variation in training and competency assessment across England and address areas of significant harm. A three-year training plan was developed for maternity and neonatal services (2021-24) and agreed with the quadrumvirate and signed off by the Trust Board and LMNS/ICB. There are six core modules of the CCF:

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

The MIS year 6 requirement was for 90% attendance for each relevant staff group at fetal monitoring training, multi-professional maternity emergencies training and neonatal life support by 30th November 2024. The other core modules were not measured within the MIS requirements. Training compliance ≥90% for relevant staff groups within the MIS training requirements were fully met on the deadline in Quarter 3.

For 2025, a plan is being created across all professions to ensure consistent attendance at

PROMPT, fetal monitoring and NLS throughout the year, as this year saw large numbers attending towards November as the deadline approached, which negatively influenced learners feedback on the study days and made training challenging to deliver.

Figure 11. PROMPT Training Day Compliance

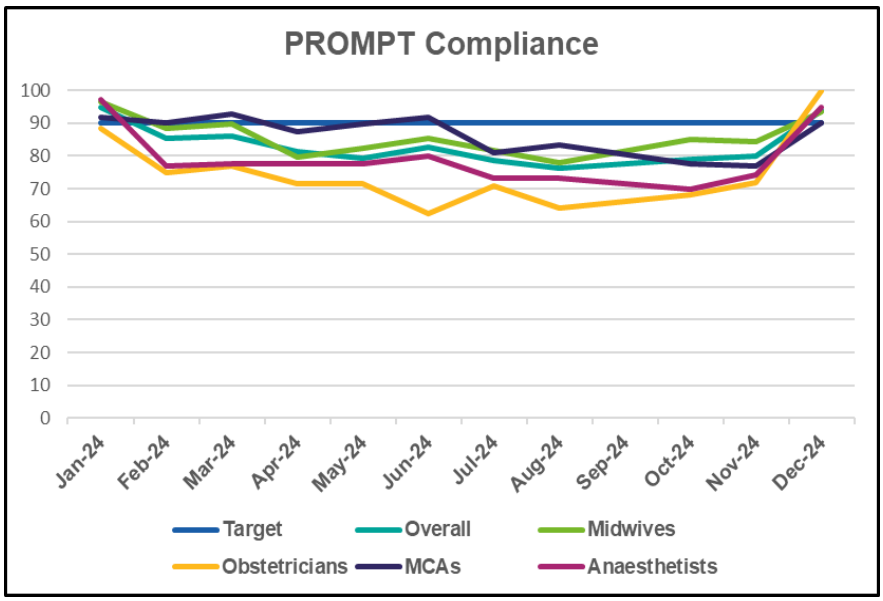


Figure 12. Fetal Monitoring Training Compliance

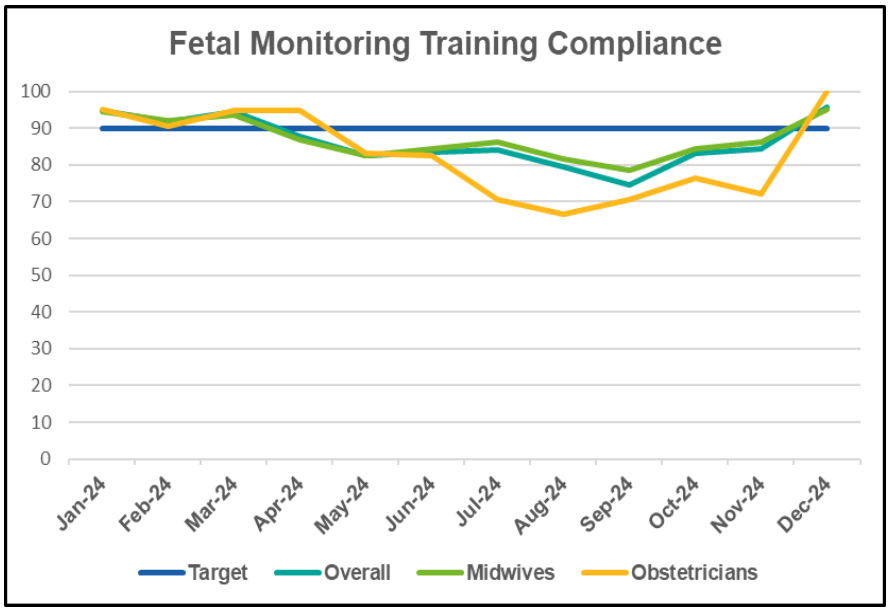
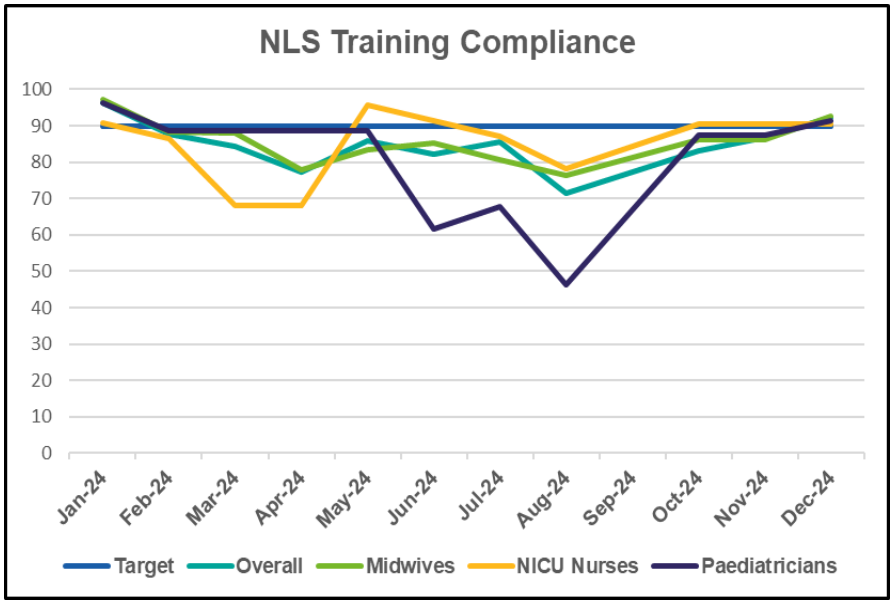


Figure 13. NLS Compliance Training



8. Maternity & Neonatal Safety Champions meetings

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

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

MATERNITY SAFETY CHAMPIONS ToR APF

8.1 Maternity and Neonatal Safety Champions meeting attendance by role for Q3

Figure 14. Maternity and Neonatal Safety Champions attendance by role in Q3.

Staff groups	October	November	December
Trust Executives	Non-Executive Director	Chief Nursing Officer Non-Executive Director	Chief Nursing Officer Non-Executive Director
Obstetric	Consultant Obstetrician	Consultant Obstetrician	Consultant Obstetrician
Midwifery	Director of Midwifery Band 6 Midwife Representative Family Experience & Inclusion Midwife	Director of Midwifery Band 6 Midwife Representative Family Experience & Inclusion Midwife	Head of Midwifery Family Experience & Inclusion Midwife Quality & Safety Matron Operational Manager

	Head of Midwifery Operational Manager	Operational Manager Community Midwife Preceptee Lead Midwife Bereavement Lead Midwife Quality & Safety Matron	
MSW		Lead MCA	
Neonatal	Neonatal Matron	Neonatal Matron Consultant Paediatrician	Neonatal Matron
MNVP	MNVP Representative	MNVP Representatives	MNVP Representatives
Secretarial support	Quality & Safety Administrator	Quality & Safety Administrator	Quality & Safety Administrator

8.2 Positive points recognised

Over the course of the Q3 period, the following positive points were highlighted:

- Maternity welcomed a new Preceptee Lead Midwife to help support preceptee induction and training.
- Great feedback from engagement sessions with both military and younger families, held in collaboration with the Patient Experience Midwife and MNVP.
- Positive steps in procuring a solution for women and families where English is not their first language, to help with translation and understanding in clinic, community, and inpatient environments.
- Separation Time Improvement project continued to go well across Q3, with a notable improvement already being seen. Current average time was 10 hours, with an aim to reduce by 20% to 8 hours within a year.
- Successful recruitment of a new ANNP within Neonatal services, progressing staffing requirements to become BAPM compliant.

8.3 Concerns raised in Q3

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

Concerns raised	Action and progress
A dedicated meal trolley is required for NICU, currently it is shared between NICU and Maternity Ward.	Neonatal Matron is working closely with the catering and facilities team to rectify this. It was also escalated by the non-executive at the next board meeting to support progression of this.
Delays to scan reviews on the Day Assessment Unit (DAU).	Scan review times has now become an Improvement Project being led by the DAU and Antenatal teams, and reported through the Maternity & Neonatal Performance Review meetings, with oversight by the Perinatal Quad and Divisional team for support including a review of doctors' job plans.
Long term Registrar sickness within the Neonatal team, increasing the likelihood of the Consultant needing to act down.	Recruitment progressing through the CSFS Division for a short mid-term Locum. Continuing to progress the workforce action plan in line with CNST safety action, as the unit continues to be BAPM non-compliant.

Understanding around process for sharpening of episiotomy scissors.	This was picked up with the Director of Midwifery outside of the meeting and process confirmed and current stock checked.
Lack of Community Children's nurse service in Fordingbridge and Alderholt area.	This has previously been escalated via the ICB and the Executive and Non-executive safety champions took an action to escalate again.
Issue around GP's and prescribing for outpatients.	Clinical Director and Divisional Director of Operations liaising with GP Liaison Manager to find a solution.
Reports of essential equipment being difficult to source.	Executive safety champion to take a "go and see" with procurement to understand the process and to report back at next meeting.

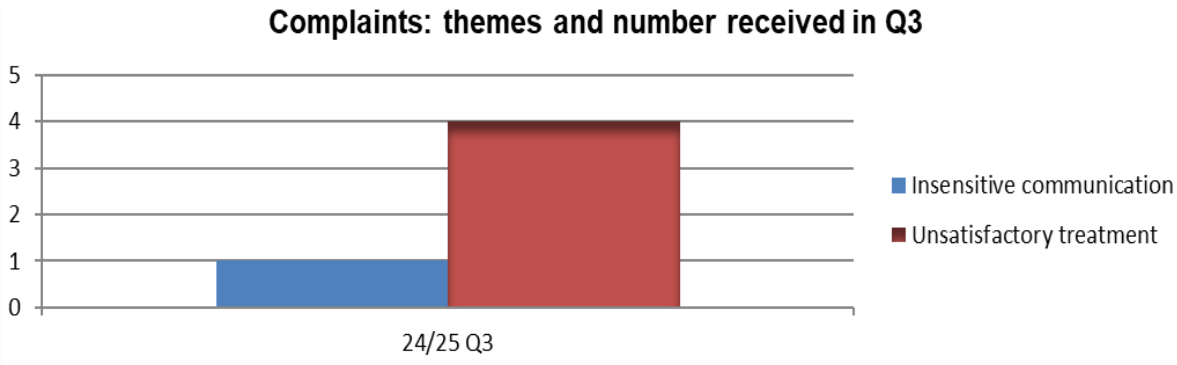
**The detail above informs the 'You said, we did' information displayed on the Maternity Safety Champions boards.*

8.4 Concerns raised by service users

There have been 5 formal complaints and 1 concern logged in Q3 24/25.

There has been an increase in formal complaints in Q3, with 'unsatisfactory treatment' being the top theme.

Figure 16. Summary of complaints in Q3



In Q3, there were 4 complaints closed, 1 within closed within target time, offering a 25% compliance rate.

Please see the document below for a summary of the complaints received and learning and actions from closed complaints in Q3.

Q3 Matneo complaints and con

8.5 Additional safety champions intelligence

Both executive and non-executive safety champions conduct regular walk-arounds to seek intelligence regarding safety concerns. The following findings were reported in Q3:

Figure 17. Walk around findings

Area/date visited	Discussion points	Concerns raised	Actions
Executive Safety Champion visit - 5/11/2024 - Open forum with community midwives.	Open forum with Community Midwife Team. Concerns raised about milage payments. Through discussion there was clear variation in the amount of home visits being provided, equipment and processes.	No safety concerns raised.	Team session to review the standard leader work for home visiting, equipment, and processes.
Executive Safety Champion visit with Managing Director - 20/12/2024 - Labour ward and Day Assessment Unit.	Staffing was good in all areas no patient safety concerns raised any of the three areas.	Concerns re. staff safety discussed, due to beds being moved from areas up a steep ramp and MSK injury risk.	This has been raised and reviewed before with no easy answer as the bed hoppers need specialist training and take time to attach, which is not ideal in the case of a crash caesarean section. To investigate whether there are any other options with Estates Team - staffing much better which should facilitate more staff being available for the bed moves.

8.6 Culture/SCORE survey findings

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

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

The initial results have been shared with the wider leadership team and the Perinatal Quad will be working with the workforce to drive some of the changes suggested, so they can be shaped by the staff.

The Perinatal Quad have also tried to improve visibility and understanding of the Quad and the work that is progressing with some targeted activity at the end of Q3, following feedback around visibility of the leadership team.

9. Saving Babies Lives V3

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

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

9.1 Update

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

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

10. NHS Resolution Maternity Incentive Scheme

MIS Year 6 requirements were published on 2nd April 2024 and SFT is required to be compliant by 30th November 2024. Progress with CNST Maternity Incentive Scheme Year 6 2024/25 has been steady. SFT are declaring compliance with all 10 safety actions. The evidence has been shared with NHSR and the LMNS and are due to be presented at board in February 2025.

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

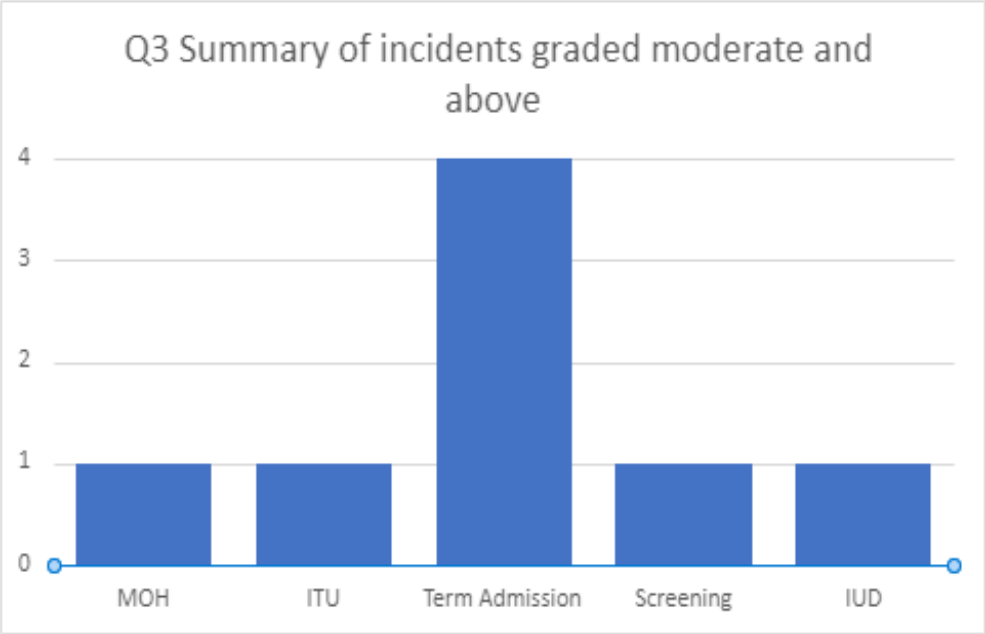
		Description	Yr 5 Submission	Comment	Current Assessment
Are we well led?	1	**Perinatal Mortality Review Tool** using to required standard for all perinatal deaths	Compliant	All Standards Met	
	2	**Maternity Services Data Set** submission to required standard	Compliant	All Standards Met	
	3	**Transitional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

11. The number of incidents in Q3 and actions being taken

A summary of 'Moderate' or above incidents in Q3 are provided below. These numbers were extracted from our reporting system DATIX and a search created using the following data:

Date: 01/10/2024:31/12/2024
Severity: Moderate and above
Directorate: Women and Newborn Division

Figure 19. Summary of Moderate or above incidents



Unexpected term admission to NICU throughout Q3, has remained consistent and is below national and local targets. Through Q3, the admission rate was 4.8%. However, it is important to note that 2 cases are still awaiting review. This may lead to a reclassification of harm, following the completion of an MDT review meeting and Patient Safety Review (PSR) presentation at the weekly corporate Patient Safety Summit (PSS) meeting.

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

Figure 20. Description of 'Moderate' or above incidents reported in Q3.

DATIX Number	Incident Category	Outcome/Learning/Actions
170694	ITU	Unusual presentation of pre-eclampsia with hyperkalaemia requiring stabilisation, cardiac monitoring and subsequent emergency delivery at 31+3/40. Transfer to AMU occurred for monitoring and patient observations recorded onto POET with missed opportunity to escalate and medicate elevated BP. This was an incidental finding which raised the question of pregnant people having observations on POET. Action: look at a possible workstream to prevent POET generating an obs chart by detecting the 'patient pregnant alert' from Lorenzo.
170736	System	Datix system was not working for 5 days.

169941	Screening	Baby born and during the NIPE examination a cleft palate was identified. Immediate escalation to the Paediatric and Cleft teams occurred with same day reviews. Scan images reviewed with no indication/visualisation of cleft palate.
171321	Term Admission to NICU	Baby born 90 minutes following maternal opiate administration. Naloxone given and later admitted to NICU.
172472	Term Admission to NICU	Concealed pregnancy with unknown gestational age.
172214	Term Admission to NICU	Elective Caesarean Section performed @ 37+4/40, steroids declined by mother. Case currently awaiting review with potential for reclassification.
172412	Term Admission to NICU	PSR part 1 completed due to low APGARs at birth and possible escalation issues.

12. Safe Maternity Staffing

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

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

12.1 Midwifery Staffing

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

Figure 21. Percentage shift fill rates for the inpatient areas by month in Q3.

Month	RM Day %	RM Night %
October 2024	93.9	96.5
November 2024	99.4	96.7
December 2024	93.7	96.9

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

- Elective workload prioritised to maximise available staffing.

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

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

12.2 Obstetric staffing

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

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

Figure 22. Table showing compliance of consultant attendance meeting above criteria.

Date	Clinical Situation(s)	Comments
02/10/24	Caesarean birth for women with BMI >50.	Consultant present.
06/10/24	High acuity, second theatre opened.	Consultant present.
16/10/24	4th Degree perineal tear repair.	Consultant present.
27/10/24	Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary.	Consultant present.
30/10/24	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant not present
19/11/24	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.
23/12/24	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.

The table above shows that for Q3 (1st October 2024 – 31st December 2024) there were 7 cases meeting the criteria above. The audit demonstrates 87.5% compliance to the standard.

The case where the Consultant was not present was discussed with the Consultant on-call and the case was reviewed in line with the trust PSR process. There was no harm caused by Consultant non-attendance and the case was appropriately managed.

The medical teams are aware of the expectation of consultant attendance for future cases and continued audits for this Safety Action will be completed monthly by the Maternity Service.

12.3 Short Term Locum usage

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

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

An audit of compliance with our Medical HR colleagues was completed for the time period 1st October 2024 – 30th December 2024. The audit demonstrated that during this period, 19 (short term) middle grade locum shifts were required. 4 Doctors completed these shifts, 2 of these Doctors were employed by Salisbury NHS Foundation Trust and 2 Doctors were locums, not employed at Salisbury NHS Foundation Trust at the time of undertaking the shifts. However, both Doctors were working in their local unit (within the Wessex area) on their Tier 2 or 3 rota and held a certificate of eligibility (CEL) to undertake short-term locum shifts, therefore the trust is 100% compliant with the criteria described above.

12.4 Long term locum usage

During the time period 1st October 2024 – 30th December 2024, the trust has utilised 2 long term middle grade locum doctors. Both Doctors had been working in the trust prior to Q3 and therefore standards 1-6 are not applicable during this time period.

For all standards that were applicable, the trust was 100% compliant. The compliance can be seen below.

Figure 23. Long term locum usage compliance

Standard	Compliance % for Locum 1 (in post prior to Q3)	Compliance % for Locum 2 (in post prior to Q3)
Standard 1 Locum doctor CV reviewed by consultant lead prior to appointment	N/A	N/A
Standard 2 Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment	N/A	N/A

Standard 3 Departmental induction by consultant on commencement date	N/A	N/A
Standard 4 Access to all IT systems and guidelines and training completed on commencement date	N/A	N/A
Standard 5 Named consultant supervisor to support locum	N/A	N/A
Standard 6 Supernumerary clinical duties undertaken with appropriate direct supervision	N/A	N/A
Standard 7 Review of suitability for post and OOH working based on MDT feedback	100%	100%
Standard 8 Feedback to locum doctor and agency on performance	100%	N/A (remains in post)

12.5 Anaesthetic staffing

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

The following table demonstrates compliance with this standard by month.

Figure 24. Anaesthetic staffing compliance

Month	October 2024	November 2024	December 2024
% compliance	100	100	100

The service will continue to audit this standard on a monthly basis.

12.6 Neonatal Services Staffing

Neonatal medical staffing

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

Neonatal nursing staffing

To meet safety action 4 of the Maternity Incentive Scheme the Neonatal Unit needs to demonstrate that it meets the service specification for neonatal nursing standards and the Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For

units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies.

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

1.92 WTE are now on maternity leave, and we have had 0 leavers. Planning is currently in process to move 3 WTE band 5 registered nurses from the Maternity Service to support the 4.98WTE vacancy.

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

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

- The response rate to the Friends and Family Test (FFT) in Q3 is consistent with the previous quarter. There has been an increase in positive feedback and a reduction in negative comments. Analysis of the feedback is discussed at Maternity Governance and the quarterly Triangulation meetings.
- There has been an increase in complaints this quarter, with the top theme being ‘unsatisfactory treatment’.
- Work continues to embed the Triangulation meeting into the Divisional Governance structure.
- In this quarter, the CQC Maternity Survey 2024 results were released. The subsequent action plan was co-produced with the local Maternity and Neonatal Voices Partnership (MNVP).
- The Neonatal Parent Survey (June -Dec 24) results are included within this report in section 7.0. The results were reassuring; with a 9.5/10 positive (satisfaction) rating score. The development of the action plan is to be considered and reported in the next quarter’s Quality and Safety Report.
- To fully understand the diversity within the local population, work is ongoing to create a Health Inequalities clinical dashboard, with the focus on birth outcomes related to ethnicity and social deprivation.
- A listening event was held in November with several Family Nurse Practitioner’s (FNP) clients. The feedback from this event will be shared at the next Triangulation meeting, scheduled in February 2025.
- The referral process to the Birth Reflection Service was reviewed in this quarter. The expansion of the referral criteria to include self-referrals has been agreed. Work continues to ensure service users can access the service directly via our maternity website.

- The Birth Trauma Inquiry Report was published in May 2024. Work commenced in Q3 on an assurance report in response to the Inquiry's 13 recommendations.

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

- To undertake listening events with hard-to-reach groups, to prioritise the voices from women (birthing people) from communities with the poorer maternity outcomes.
- To support the implementation and monitoring of the 'Pocketalk' translation device.
- Review themes from the feedback obtained via FFT, with the focus on increasing patient engagement with the survey.
- Working with the LMNS Inclusion Lead to align the service with the national agenda relating to reducing health inequalities.
- Development of a local Health inequalities dashboard.
- The implementation of the 2024 National Patient Experience Maternity Survey action plan.
- Progress the actions detailed in the Three-Year Delivery Plan and support the work currently ongoing to promote personalisation of care with both patients and staff.
- Ensure women can make a referral to the Birth Reflection Service, via the maternity website.
- Ensure the completion of the benchmarking exercise and action plan in relation to the Birth Trauma Inquiry.

14. Quality Improvement projects/ progress

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

Projects which have been rolled out and are continuing include:

- Development of flexible working agreements.
- New National Maternity Early Warning Score (MEWS) to replace MEOWS.
- New Neonatal Early Warning Score (NEWT2) to replace NEWS.
- Fluid balance compliance.
- RCOG clinical escalation toolkit planned launched on 1st October.

Projects planned in the next quarter (Q4):

- Ultrasound scan review process.
- Exit interviews.

15. Implementation of the A EQUIP model

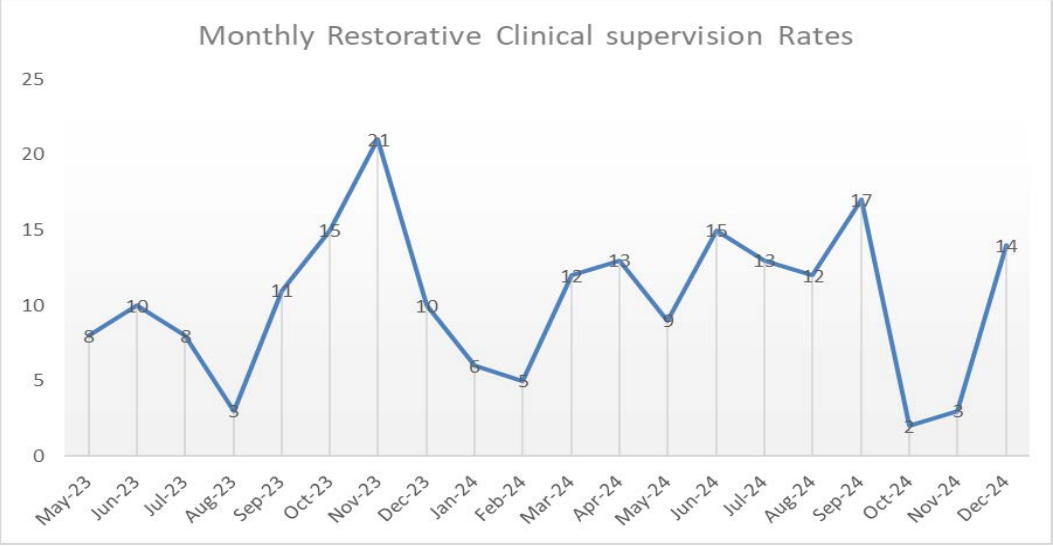
The Professional Midwifery Advocate (PMA) Team are responsible for implementing and deploying the A-EQUIP model (Advocating for Education and Quality Improvement), which supports a continuous improvement process that aims to build personal and professional

resilience, enhance quality of care and support preparedness for appraisal and professional revalidation.

15.1 PMA Update

- Restorative Clinical Supervision (RCS): In Q3, RCS was not provided for all the new starters or Midwives returning from long term sickness. All preceptees received at least 1 RCS session – achieved by running a group session at a Preceptee study day. During Q3, a total of 19 RCS sessions were carried out (incorporating wellbeing and Career conversations). This is a decrease on the 42 sessions held in Q2.
- RCS support: the PMA team aim for all NQMW continue to receive RCS as part of a retention initiative. The current cohort consists of 8 preceptees, who started in September and a further 2 in November. As per the Preceptee plan, they receive quarterly teaching to help support them to thrive during their transition from student to qualified Midwife and they each receive quarterly 1:1 restorative supervision from a PMA. This is a team priority for the PMA team operating on a sessional model.
- Anonymous data is kept on themes and numbers of RCS sessions. These are shared with Director of Midwifery for awareness and via appropriate channels to support action and improvement.

Figure 25. Restorative Clinical Supervision Rate (p/m)



15.2 Plans and Actions

The structure of the PMA Service changed at the end of October 2024, as it moved back to a sessional model. There is a team of 8 trained PMA's that are being given protected time from their substantive hours each month. This is to carry out restorative supervision, teaching activities and other PMA activity. The ambition is to offer 16 half day PMA sessions every 4 weeks.

The focus and priority over the next quarter continues to be around upskilling and supporting sessional PMA's, and ensuring the support offered to Preceptees and Midwives returning from either long-term sickness or maternity leave is sustained.

16. Avoidable Admission into the Neonatal Unit (ATAIN)

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

16.1 The National Ambition

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

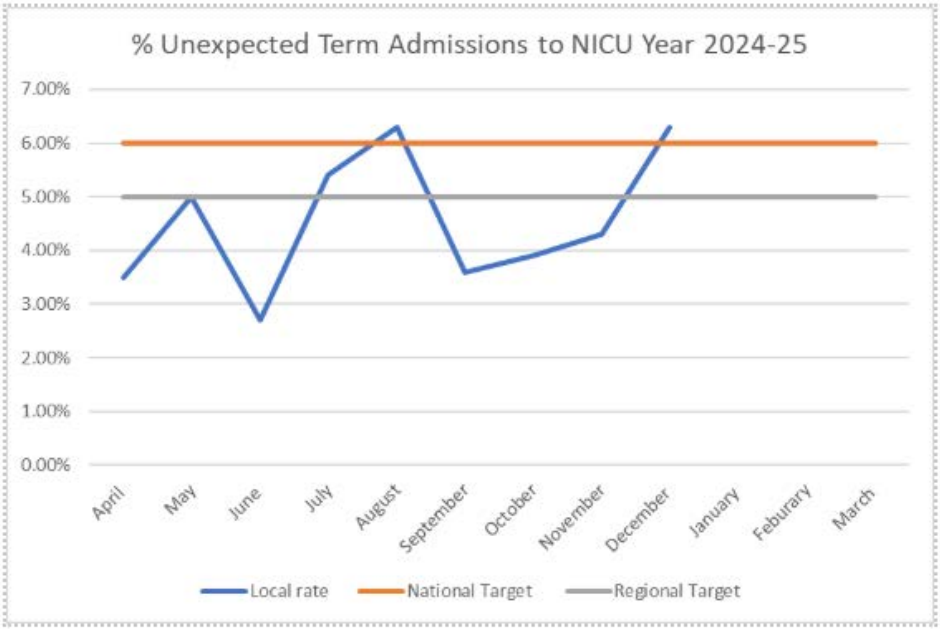
This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme with a key focus on:

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

16.2 Why is it important?

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

Figure 26. Monthly ATAIN rates 2024 for Salisbury NHSFT Trust



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

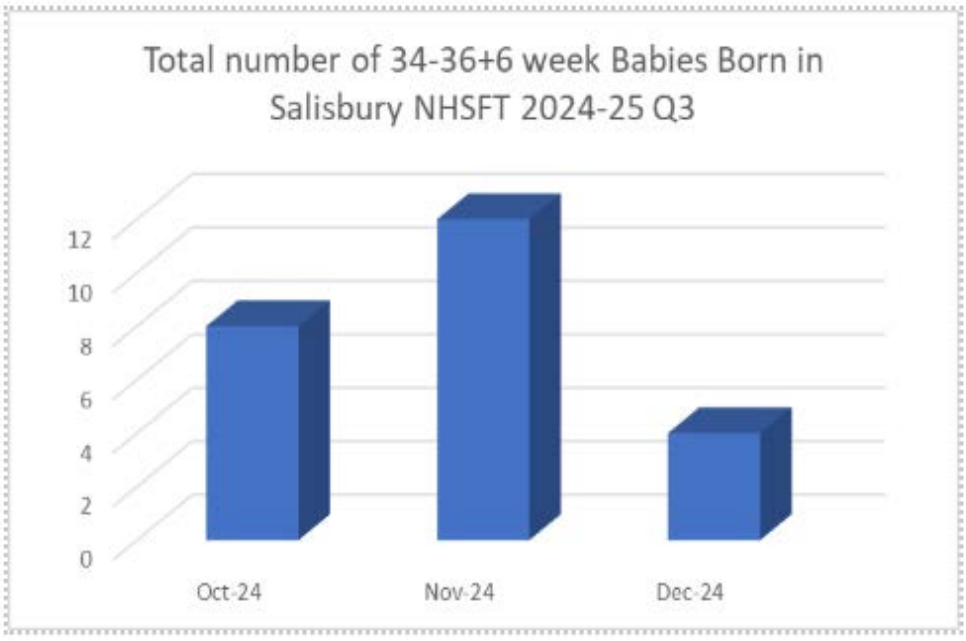
Figure 27. ATAIN reviews during Q3 (babies equal or >37 weeks gestation)

	October 2024	November 2024	December 2024
Total number of admissions in month	7	7	9
Number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU due to capacity or staffing issues.	0	0	0
Number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding but could have been cared for on TC if nasogastric feeding was supported there.	0	0	0
	October 2024	**November 2024**	**December 2024**
Total number of case reviews undertaken in month	7	12	6
Total number of case reviews with both maternity and neonatal staff present	7	12	6

16.3 SFT Trust transitional care rates

The number of late pre-term babies (34-36+6 weeks gestation) born that met transitional care criteria in the last quarter are shown below for Q3. Further detail is contained within the appendices.

Figure 28. Total number of 34-36+6 babies born each month since beginning of Q3.



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

17. Staff Survey

The most recent annual NHS Staff survey was published in March 2024 (Q4 23/24), with data having been collected in October and November 2023. The questions in the NHS Staff Survey are aligned to the People Promise as well as two themes, staff engagement and morale.

The data below reflects the whole Women and Newborn division, which includes nurses working in both the Gynaecology and Fertility departments, as well as nurses and midwives in Maternity and the Neonatal unit.

Figure 29. Proportion of nurses and midwives working in the Women and Newborn Division responding with 'Agree' or 'Strongly Agree', regarding recommending Trust as place to work and for care/treatment.

Description	Picker survey national average	Salisbury Foundation Trust average	Women and Newborn
Would recommend organisation as place to work	60.4%	60.3%	**69.6%**
If friend/relative needed treatment would be happy with standard of care provided by organisation	62.6%	63.4%	**72.2%**

There are significantly higher percentages in the Women and Newborn division compared to both the national and main Trust average which is very positive.

Figure 30. Proportion of specialty trainees responding with 'excellent' or 'good', regarding how they would rate the quality of clinical supervision out of hours.

Response	Salisbury Foundation Trust trainee %	National average %
Very good (excellent)	0%	26%
Good	75%	47%
Neither good nor poor	25%	18%

The percentages relate to a small number of trainees and reflect a positive experience for the trainees.

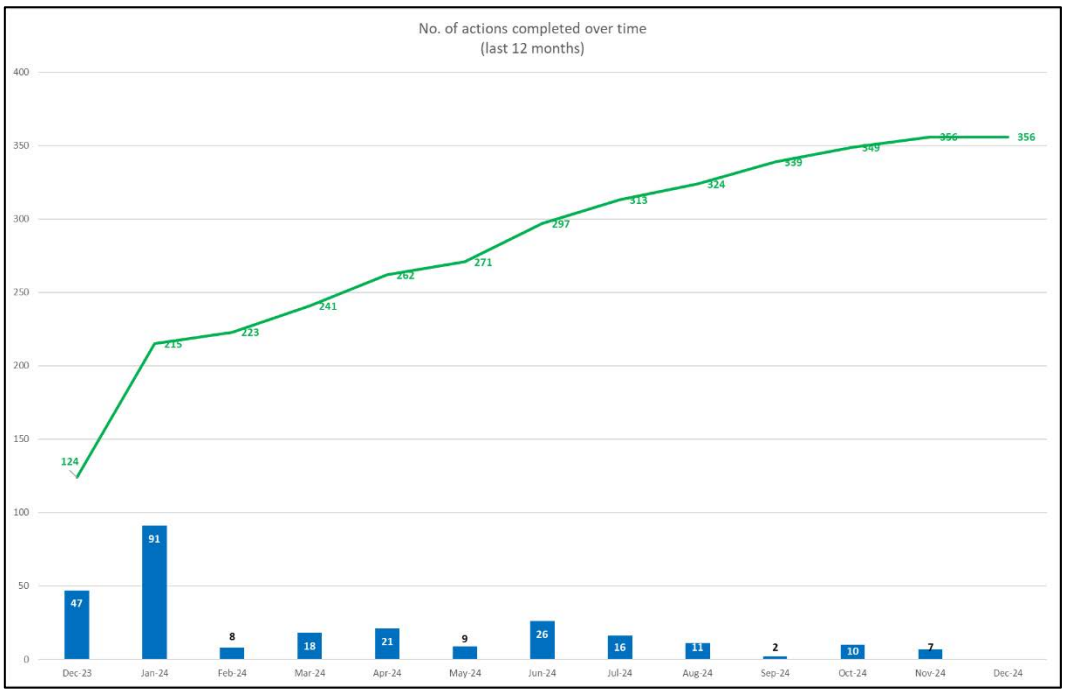
18. Safety Improvement plan

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

18.1 Progress made over the last quarter

In Q3, progress continued with closing actions on the Maternity Improvement Plan, with the highest impact within the governance workstream. More of an 'inch-wide mile-deep' approach is being taken towards the end of Q3, due to the complexity of the actions being tackled, hence a reduced quantity of actions completed in that period. A number of actions within the digital workstream have a dependency on the implementation of the BadgerNet maternity EPR system which is planned to go-live in February 2025.

Figure 31. Progress with Maternity Improvement Plan actions Q3



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

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

19. Risk Register highlights

The Divisional risk register is reviewed bi-monthly with leads being encouraged to review and update any risks ahead of this. On 27th January 2025, the current risks on the risk register are noted below.

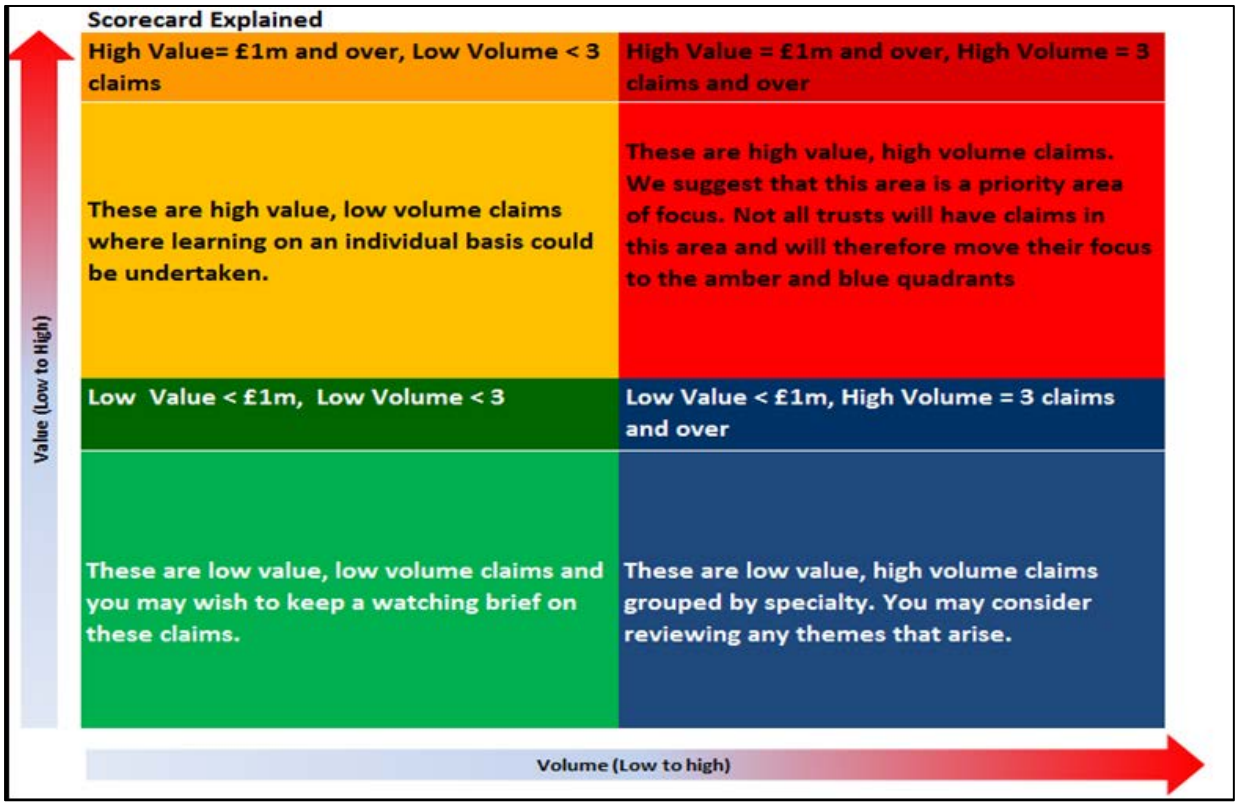
Figure 32. Current Risk Register items for Maternity and Neonatal services

ID	Title	Location (exact)	Specialty	Rating (current)
8049	Maternity Information syastem back and forward copying issue	Beatrice 4	Maternity Services	2
7221	There is a risk of cases with harm not being investigated and escalated due to the large backlog of Datix	Maternity Administration	Maternity Services	4
7999	No dedicated 24/7 obstetric anaesthetist cover.	Labour ward	Maternity Services	4
7109	There is a theorectical risk of infection to women and babies as the Labour Ward birthing pools are over recommended manufactu	Labour ward	Maternity Services	5
7623	Neonatal ROP	Neonatal Unit	Neonatal Intensive Care Unit	5
8259	Floor lifting on labour Ward	Labour ward	Maternity Services	8
6412	Harm to women and babies through lack of dedicated 2nd obstetric theatre	Labour ward	Maternity Services	9
7923	Neonatal unit heating	Neonatal Unit	Neonatal Intensive Care Unit	10

20. Litigation Scorecard and Triangulation of Incidents and Complaints

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

Figure 33. NHSR litigation scorecard explained in terms of value and volume of claims

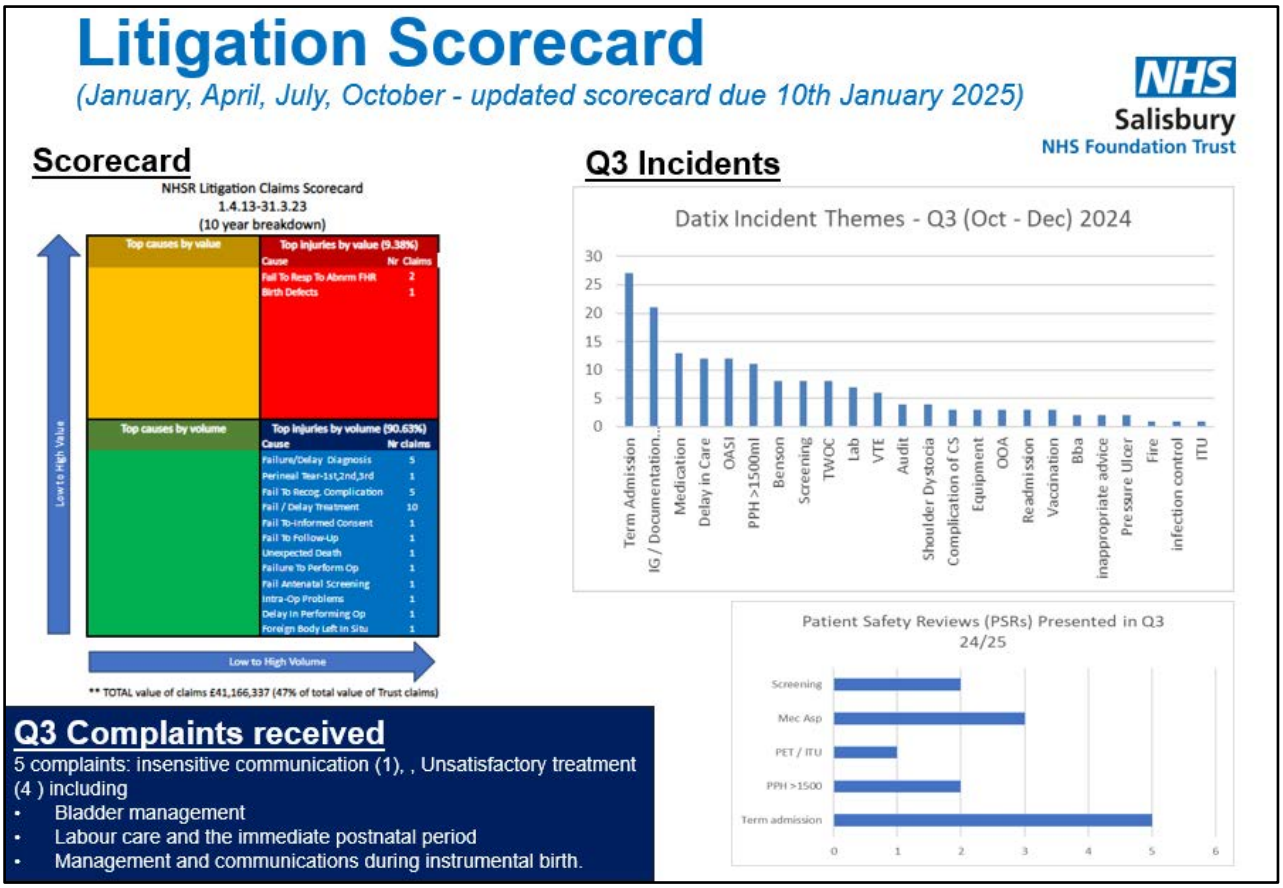


The themes from incidences, claims and complaints are reviewed at the quarterly triangulation meeting and Maternity Governance meeting.

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

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

Figure 34. Litigation scorecard - triangulation of complaints, incidents and legal claims in Maternity and Neonatal services



21. Recommendation

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

Report prepared by

Name: Danielle Freemantle & Hollie McKellar

Title: Quality and Safety Matron for Maternity & Neonatal Services and Maternity Quality & Safety Administrator

Date: 03/02/2025

Perinatal Mortality & Morbidity Review Group
Perinatal Mortality Review Tool (PMRT) Quarterly Report
Maternity and Neonatal Services
(Quarter 3 2024/25)

1. Introduction

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

1.1 Definitions

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

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

MIS Year 6 requirements to notify:

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

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

2. Standards

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

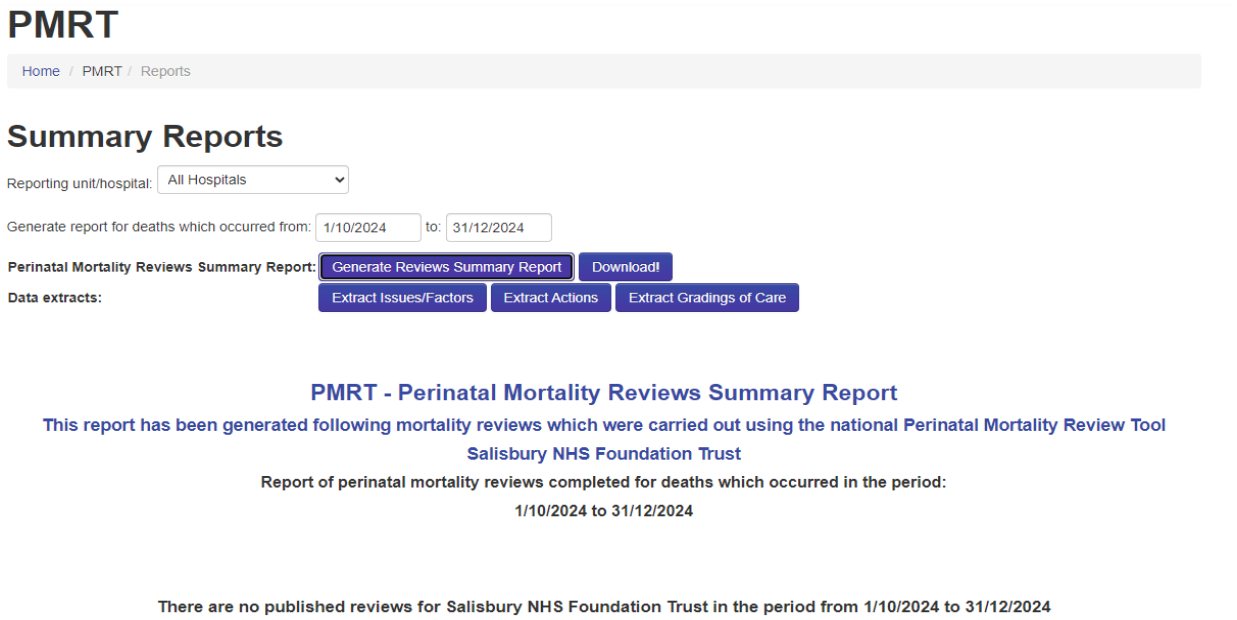
The MIS Year 6 scheme was released in April 2024 and will apply to babies who die between 8th December 2023 until 30th November 2024.

Figure 1. MBRRACE-UK/PMRT standards

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	Standard
a) Notify all deaths: All eligible perinatal deaths should be notified to MBRRACEUK within seven working days.	**100%**
b) Seek parents' views of care: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.	**95%**
c) Review the death and complete the review: For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023 • 95% of reviews should be started within two months of the death, • minimum of 60% of multi-disciplinary reviews should be completed and published within six months.	 **95%** **60%**
d) Report to the Trust Executive: Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.	**100%**

It is not possible to generate a report for quarter 3 as there were no (zero) perinatal losses within that timeframe (as per screenshot of the MBRRACE reporting tool below).

Figure 2. PMRT Report screenshot showing that there were no published reviews in Q3.



3. Recommendations

3.1 Eligible Incidents in 2024-2025 (appendix A)

There has been a total of 5 incidents reported to MBRRACE-UK in Quarter 3.

- One medical termination of pregnancy at 24 weeks which is legally registerable as a stillbirth due to gestation and notified to MBRRACE. This case does not require surveillance and review under PMRT arrangements.
- One antenatal stillbirth at 25 weeks. This was notified to MBRRACE, surveillance was completed and a PMRT review of the case will be undertaken in Q4.
- One antenatal stillbirth at 26 weeks. This was notified to MBRRACE, surveillance was completed and a PMRT review of the case will be undertaken in Q4.
- One intrapartum stillbirth at 40 weeks. This was notified to MBRRACE, and surveillance was completed. This case was referred to the MNSI. A PMRT review will be completed following the final MNSI report and the MNSI team will be invited as external reviewers.
- One neonatal death at 21+6 weeks. This was notified to MBRRACE, surveillance was completed. This case does not meet the criteria for PMRT review.

1 PMRT case has met the threshold for referral to the Maternity and Newborn Safety Investigations programme (MNSI).

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

3.2 Summary of all incidents closed in Quarter 3 (appendix B)

There have been 0 incidents closed in Q3.

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

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

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

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

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

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

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

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

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

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

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

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

Where actions have been identified, appropriate deadlines have been put in place and can be found in appendix 3.

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

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

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

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

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

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

There were 3 stillbirths (excluding MTOP's) in Q3. This makes a total of 4 stillbirths in the last 12 months, which equates to 2.12 per 1000 births in the last 12 months. The national rate per 1000 births is 3.9 per 1000 with a national ambition to reduce to 2.5 per 1000 births.

There were 0 neonatal deaths > 24 weeks in Q3. This makes a total of 1 NND >24 weeks in the last 12 months which equates to 0.55 per 1000 live births in the last 12 months. The national neonatal death rate is 1.65 per 1000 live births.

Appendix A - Summary of all Eligible Incidents Reported in Q3 2024/25

	PMRT ID	Reason for entry to MBRRACE/ PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking / Primary Antenatal Care	Location of Delivery	Location of Death (reporting hospital)	MNSI Case	CIIR /SI	Notify MBRRACE within 7 days	Seek parent's views of care	Start review <2 months	Complete and publish review <6 months	Report to Trust Executive
Q3	95782	Medical termination of pregnancy	24+4	24.10.24	22.10.24	NA MTOP	SFT	SFT	SFT	NA	NA	Yes	Not required MTOP	Not required MTOP	Not required MTOP	Yes
Q3	**95895**	Antenatal stillbirth	25	31.10.24	28.10.24	330	SFT	SFT	SFT	NA	NA	Yes	Yes	Yes	Yes	Yes
Q3	**96142**	Neonatal death	21+6	18.11.24	18.11.24	435	SFT	SFT	SFT	NA	NA	Yes	Yes via MEO as NND	NA	NA	NA
Q3	**96493**	Antenatal stillbirth	26+3	16.12.24	13.11.24	1460	SFT	SFT	SFT	NA	NA	Yes	Yes	Yes	Planned Feb 2025	Yes
Q3	**96580**	Intrapartum stillbirth	40	19.12.24	19.12.24	4651	SFT	SFT	SFT	Yes	NA	Yes	MNSI	Yes	Does not meet criteria as under MNSI	Yes

Appendix B - Summary of all incidents closed in Q3 2024/25

Case	Cause of Death	Grading of Care	Issues Identified	Actions	Responsible/Date	Update
There were no reviews closed in Q3						

Appendix C - Summary of CNST Compliance as per MIS Year 6 Standards

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	% Target	From 8 Dec Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	To 30 Nov Q3 24/25	Total
Notification of all perinatal deaths eligible to be notified to MBRRACE-UK to take place within 7 working days	100	2 (1 MTOP)	4 (2<22wk)	1 (MTOP)	1 (MTOP)	3 (1 MTOP, 1<22 wks.)	11
		100%	100%	100%	100%	100%	100%
Seek parents' views of care: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.	95	1	2	0	0	1	4
		100%	100%	NA	NA	100%	100%
A PMRT review must be commenced within two months following the death of a baby.	95	1	2	0	0	1	4
		100%	100%	NA	NA	100%	100%
Minimum of 60% of multi-disciplinary reviews should be completed and published within six months.	60	1	2	0	0	NA- out of timeframe	3
		100%	100%	NA	NA	NA	100%
Report to the Trust Executive: Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.	100	2	4	1	1	3	11
		100%	100%	100%	100%	100%	100%

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

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

Appendix E - Perinatal mortality rate

Stillbirths

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

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

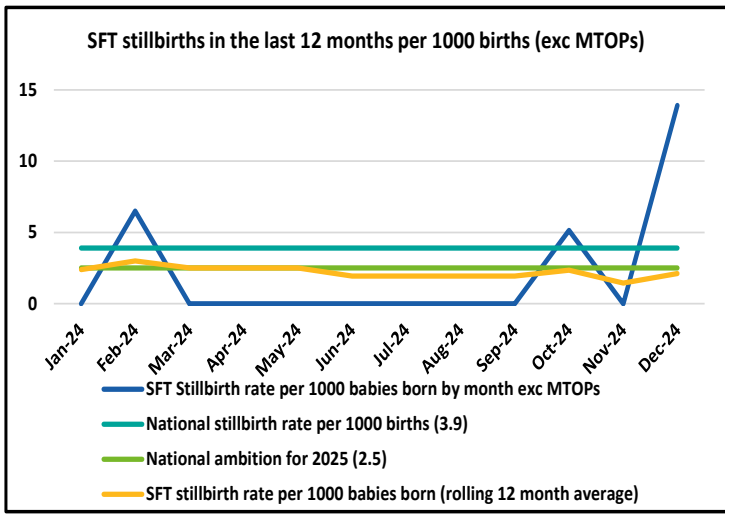
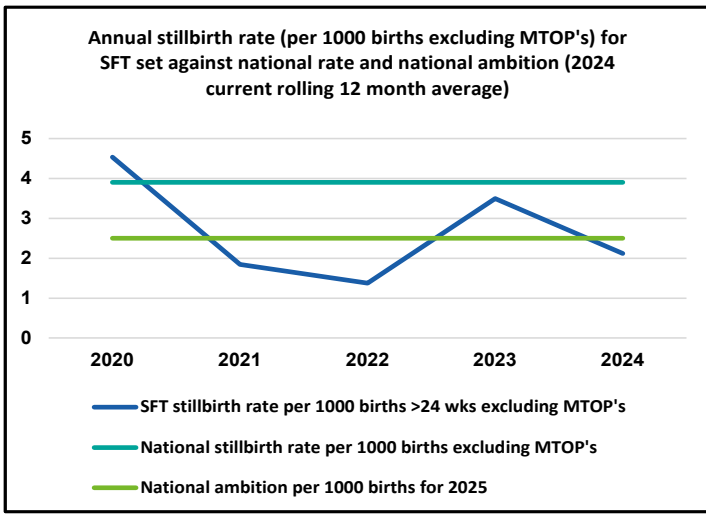


Figure 2. Annual Stillbirth rate (per 1000 births excluding MTOP's) for SFT set against national rate and national ambition (2024 current rolling 12 month average).



Neonatal Deaths

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

Figure 3. Monthly Neonatal death rate >24 weeks per 1000 live births for SFT over the last 12 months set against national rate and ambition

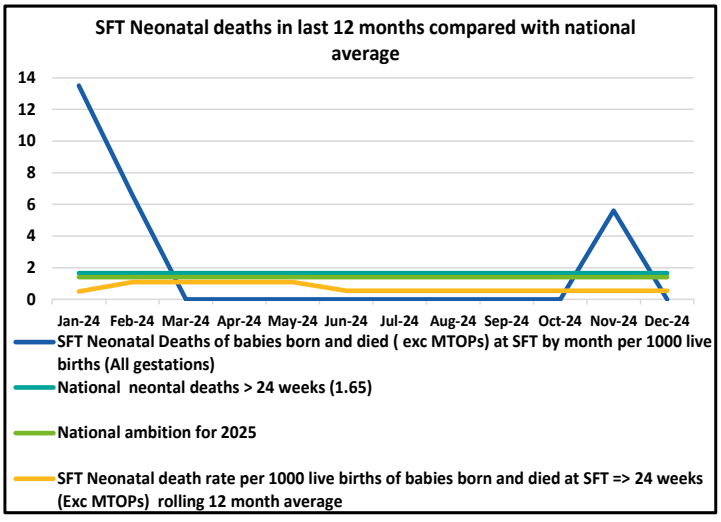
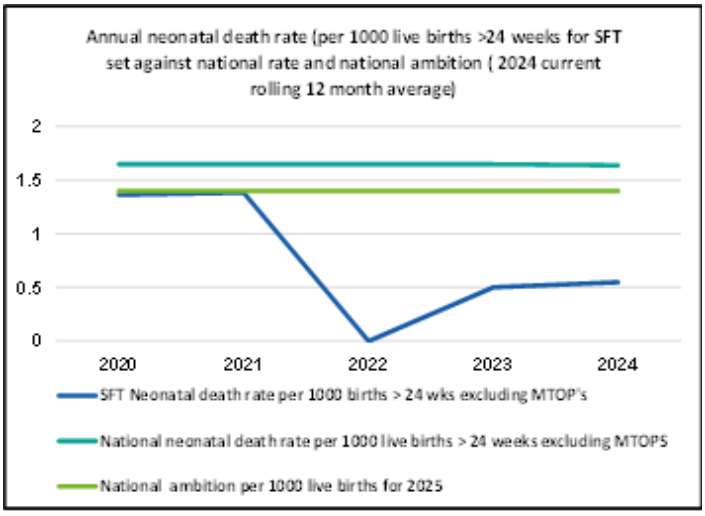


Figure 4. Annual Neonatal death rate per 1000 live births >24 weeks for SFT set against national rate and national ambition (2024 current rolling 12 month average)



Maternity and Neonatal Training Report
Maternity and Neonatal Services
(Quarter 3 2024-25)

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

A training plan for the 3-year period of the Core Competency Framework (2021-2024) was submitted on 21/11/23, covering January 2022 – December 2024, as per the CCFv2. This included all training requirements for the multi-disciplinary team within maternity and neonatal services. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. The TNA has been reviewed this quarter, in line with the CCFv2, to start a new 3-year programme for all maternity-specific training. This will be submitted to the Trust Board and LMNS next quarter to be agreed.

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

The report aligns to the Maternity Training and Development Policy.

Contents

Compliance

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

Saving Babies Lives Care Bundle (SBLCB) version 3 minimum compliance with each of the 6 elements is 90% attendance – annual for each element (eLearning is appropriate for some elements on eLearning for Health). There is also an ambition to achieve the stretch target of ≥95% attendance.

On the 30th November 2024, training compliance of ≥90% for all staff groups at PROMPT, fetal monitoring and newborn life support was required to meet the requirements of safety action 8 in the Maternity Incentive Scheme. This was achieved locally, with all staff groups of ≥90% attendance at their mandatory maternity-specific training with additional study days created in October and November.

Unfortunately, ≥90% attendance for all relevant staff groups was also required by 30th November 2024 for all elements of the Saving Babies' Lives care bundle. This was a new requirement for 2024 as per MIS year 6, and it was unable to be achieved locally due to sickness and clinical escalations affecting attendance at the required study day. An action plan has been created, in collaboration with the LMNS to meet this compliance requirement by March 2025.

1. Saving Babies Lives Care Bundle

The CCF version 2 introduced training requirements for each element of the Saving Babies' Lives Care Bundle in 2023. However, each element is not currently required for all staff groups. The compliance graphs in the next sections of the report demonstrate which staff groups are required for each element of training.

1.1 Smoking in Pregnancy

Minimum standard:

- All multidisciplinary staff trained to deliver Very Brief Advice to women and their partners (NCSCT eLearning).
- Local opt-out pathways/protocols, advice to give women and actions to be taken.
- CO monitoring and discussion of result.
- Individuals delivering tobacco dependence treatment should be fully trained to NCSCT standards.

For 2024, this training is provided via eLearning for Health (eLfH) online, as part of the national Saving Babies' Lives eLearning package. Compliance is held once certificates of completion are evidenced to the maternity education team.

Midwives are now being provided with rostered time to complete the eLearning required for SBL Care Bundle, introduced in January 2024, which is aiding compliance in multiple training elements. This element is currently non-compliant (see figure below) as the training was only introduced in January, with midwives having rostered time to complete the eLearning in their maternity study week. There are 10 study weeks throughout the year, therefore it is not expected to meet compliance until November 2024.

In Q3, when reviewing the SBL training compliance, it was recognised that MSWs require training in Element 1 of SBL alongside midwives and obstetricians as they will provide CO monitoring/observations within their role. This requirement was added to their study leave in September hence compliance below. MSW's are now being rostered to complete the eLearning.

Also in Q3, face-to-face training for reducing smoking in pregnancy was provided to obstetricians as there has been a lack of engagement with completing eLearning. Feedback was positive and for Q4, to meet the required 90%, additional face-to-face sessions will be provided. Starting in 2025, Element 1 will also be provided face-to-face for midwives.

Figure 1. Compliance progress with SBL Element 1 eLearning in Quarter 3

	October 2024	November 2024	December 2024
Midwives	**60.9%**	**63.9%**	**84.4%**
Obstetricians	**22.7%**	**36%**	**54.2%**

MSWs	**25%**	**33.3%**	**37.5%**

1.2 Fetal Growth Restriction (FGR)

Minimum standard:

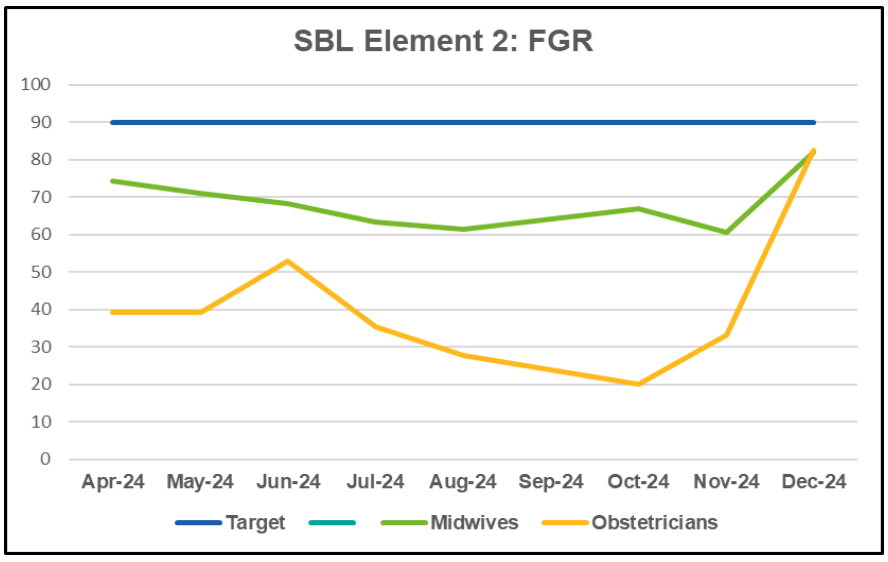
- Local referral pathways, identification of risk factors and actions to be taken.
- Evidence of learning from local Trust detection rates and actions implemented.
- Symphysis fundal height measuring, plotting, and interpreting results practical training and assessment, and case reviews from examples of missed cases locally.

From January, FGR detection and surveillance is accessible via the eLfH eLearning website and data of compliance is kept within our Divisional Performance Review on PowerBI and is reported to Trust quarterly. The following table demonstrates overall compliance for the last quarter.

The staff groups required to complete FGR training changed in April 2024, now only required for midwives and obstetricians as per the CCF and SBL Care Bundle. Midwives are now required to complete this during their maternity study week, which has supported an overall increase in their compliance. However, 90% was not achieved for midwives due to sickness during their study week and clinical requirements taking priority. A plan has been created to reach required compliance by March 2025.

Obstetric compliance is challenging due to the constant rotations of junior doctors. An obstetric training passport was created in Q2 to give to all rotating junior doctors prior to their inductions, which has aided them to complete the training. Also in Q3, face-to-face training for element 2 was provided to obstetricians as there has been a lack of engagement with completing eLearning. Feedback was positive and for Q4, to meet the required 90%, additional face-to-face sessions will be provided. Starting in 2025, Element 2 will also be provided face-to-face for midwives.

Figure 2. FGR compliance (Q3 Oct-Dec)



1.3 Reduced Fetal Movements

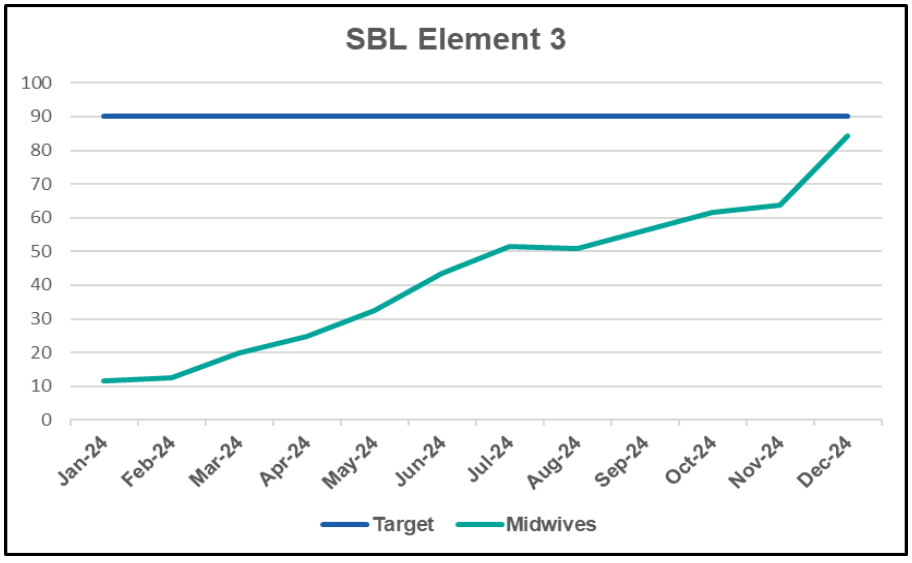
Minimum standard:

- Local pathways/protocols, and advice to give to women and actions to be taken.
- Evidence of learning from case histories, service user feedback, complaints and local audits.

This training element was introduced for the first time in January 2024 as part of Saving Babies' Lives version 3, it was previously being covered as part of the maternity update days. This element is now being taught on the Fetal Monitoring study day as well as the eLearning on eLfH. Compliance for the eLfH module is presented below and fetal monitoring compliance presented within element 4.

Training for this element was introduced in January 2024. Midwives are now required to complete this during their maternity study week, which has supported an overall increase in their compliance. However, 90% was not achieved for midwives due to sickness during their study week and clinical requirements taking priority. A plan has been created to reach required compliance by March 2025.

Figure 3. SBL training compliance (Q3 Oct-Dec)



1.4 Fetal Monitoring

Minimum standard:

- 90% attendance.
- Annual update.
- All staff will have to pass an annual competency assessment that has been agreed by the local commissioner (ICB) based on the advice of the clinical network.

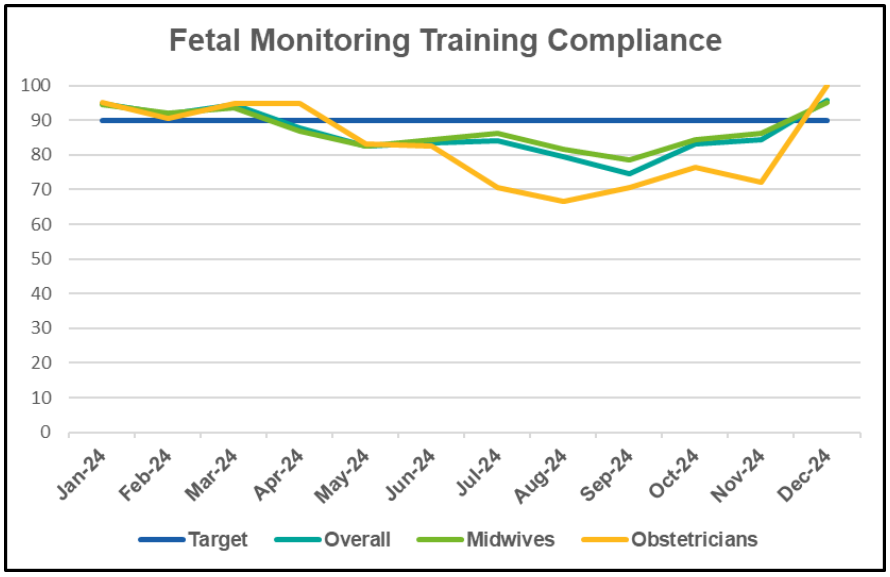
Training assurance report

- One full day's training in addition to the local emergencies training day.
- Fetal monitoring lead trainers must attend annual specialist training updates outside of their unit.

For MIS Year 6, the requirement for attendance at fetal monitoring training now excludes GP trainees and Foundation Year doctors, as they will not be interpreting CTGs and fetal wellbeing without supervision.

The following graph demonstrates overall compliance for fetal monitoring over the past 12 months and evidence of meeting the required compliance on 30th November 2024 (data collected 1st of the month):

Figure 4. Fetal Monitoring training compliance (Q3 Oct-Dec)



The below data is specific to attendance on the fetal monitoring study day.

Figure 5. Fetal Monitoring Training compliance

Attendance & overall compliance	Midwives	Obstetricians
October attendance (2 sessions)	23	5
1st October % compliance	84.3% ↑	76.5% ↑
November attendance	15	5
1st November % compliance	86.1% ↑	72.2% ↓
December attendance	No training session held	No training session held
1st December % compliance	95.1% ↑	100% ↑

1.5 Preterm birth

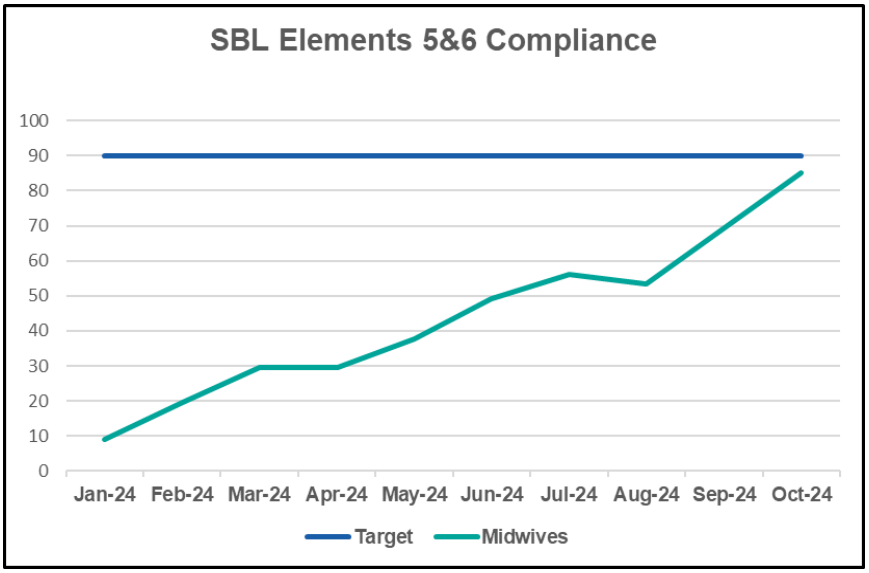
Minimum standard:

- Identification of risk factors and local referral pathways.
- All elements in alignment with the BAPM/MatNeoSIP optimisation and stabilisation of the preterm infant pathway of care.
- A team-based, shared approach to implementation as per local unit policy.
- Risk assessment and management in multiple pregnancy.

To provide face-to-face teaching on elements 5&6 of the SBL Care Bundle, a new study day was introduced in 2024, which includes face-to-face teaching and time for midwives to complete required eLearning for other elements. This study day is currently only mandatory for midwives to attend and therefore also incorporated other local learning requirements such as blood transfusion.

The below graph demonstrates midwifery compliance with Preterm Birth and Diabetes in Pregnancy. Midwives are now required to complete these elements during their maternity study week, which has supported an overall increase in their compliance. However, 90% was not achieved for midwives due to sickness during their study week and clinical requirements taking priority. A plan has been created to reach required compliance by March 2025.

Figure 6. SBL Elements 5&6 compliance (Q3 Oct-Dec)



1.6 Diabetes in Pregnancy

Minimum standard:

- Identification of risk factors and actions to be taken.
- Referral through local multidisciplinary pathways including Maternal Medicine Networks and escalation to endocrinology teams.

Training assurance report

- Intensified focus on glucose management in line with the NHS Long Term Plan and NICE guidance, including continuous glucose monitoring.
- Care of the diabetic woman in labour.

This training element was introduced for the first time in January 2024 as part of Saving Babies' Lives, it was previously being covered as part of the maternity update days. Please see above training compliance within Element 5 (Preterm Birth).

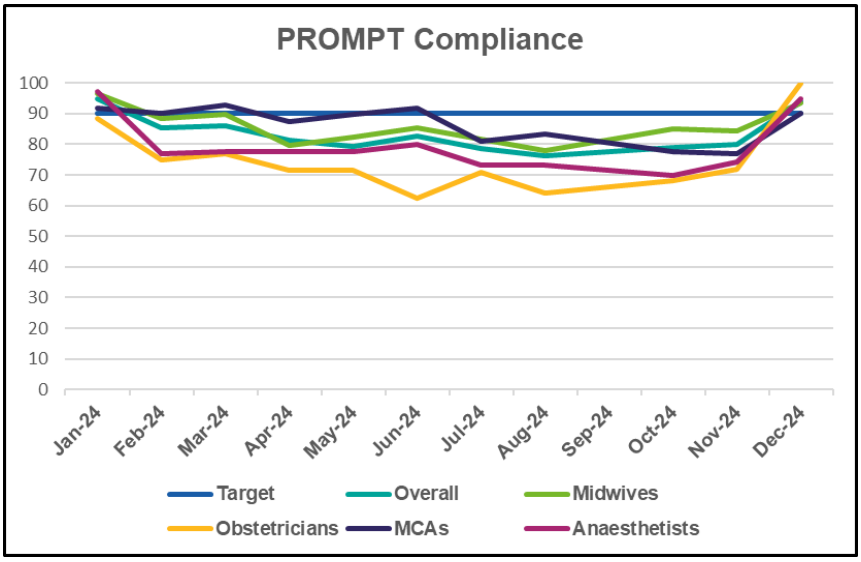
2. Maternity Emergencies and Multi-Professional Training Day (PROMPT)

CNST MIS year 6 minimum standards:

- 90% of each relevant maternity unit staff group has attended an 'in-house' MDT training day which includes a minimum of four maternity emergencies with all scenarios covered over a three-year period and priorities based on locally identified training needs:
  - Antepartum and postpartum haemorrhage
  - Shoulder dystocia
  - Cord prolapse
  - Maternal collapse, escalation, and resuscitation
  - Pre-eclampsia/eclampsia and severe hypertension
  - Impacted fetal head
  - Uterine rupture
  - Vaginal breech birth
  - Care of the critically ill patient
- Annual update.
- Training should be face-to-face (unless in exceptional circumstances such as the covid pandemic).

The following graph demonstrates compliance for the specific staff groups over the past 12 months:

Figure 7. PROMPT training day compliance (Q3 Oct-Dec)



The MIS deadline for training compliance was for year 5 was in December 2023. Since then, there have been multiple challenges in achieving consistent MDT attendance at the study day. PROMPT attendance has been affected by junior doctor industrial action and conflict of workload for anaesthetists.

PROMPT had 10 planned study days throughout 2024 to enable opportunities for attendance, with 2 extra dates being added in October and November 2024 in anticipation for junior doctor rotations, newly qualified midwives being recruited and to overcome challenges of meeting compliance requirements. Training compliance of ≥90% for midwives, obstetricians, anaesthetists and MCAs were met on 30th November 2024.

For 2025, a plan is being created across all professions to ensure more consistent attendance at PROMPT throughout the year, as this year saw large numbers attending towards November as the deadline approached, which negatively influenced learners' feedback on the study day and made training challenging to deliver.

The below data is specific to attendance on the PROMPT study day (compliance % taken 1st of the month).

Figure 8. PROMPT study day attendance

Attendance & overall compliance	Midwives	Obstetricians	Anaesthetists	MCAs
October attendance (2 sessions held)	26	2	11	6
1st October % compliance	85.2% ↑	68.2% ↑	69.8% ↓	77.5% ↓
November attendance (2 sessions held)	18	7	6	9
1st November % compliance	84.4% ↑	72.0% ↓	74.4% ↑	76.9% ↑
December attendance (No session held)				
1st December % compliance	93.4% ↑	100% ↑	95% ↑	90% ↑

3. Neonatal Basic Life Support

Minimum standard:

- 90% compliance at a neonatal basic life support annual update, either as an in-house neonatal basic life support training or newborn life support (NLS).
- Only registered Resuscitation Council (RC) trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates.

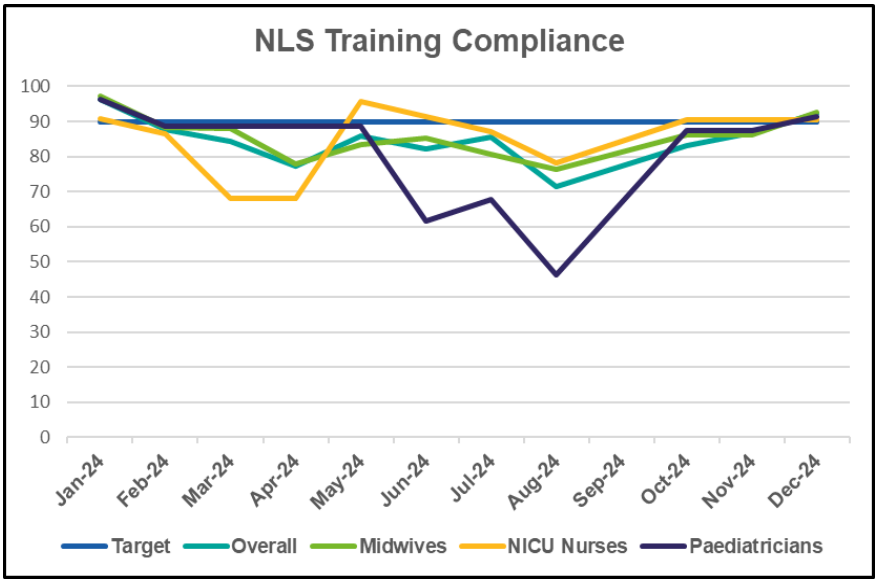
Training assurance report

Within Maternity and Neonatal services, there are 5 RC-trained instructors, with a further 3 midwives that have been invited to become instructors in the future. This has enabled the delivery of in-house updates with RC-trained instructors for all staff groups since 2023.

Although training compliance requirements were met on 30th November 2024, paediatricians and NICU nurses found monitoring their team's compliance difficult as it is currently held within the Maternity Education Team. It has been agreed that in 2025, paediatrics and NICU will hold their own training compliance data to ensure oversight into the requirements of their staff.

The following graph demonstrates compliance for the specific staff groups in the past 12 months.

Figure 9. NLS training compliance (Q3 Oct-Dec)



**NB: This data includes staff that have completed an Resus Council NLS course.*

4. Maternity Update Day

The maternity update day is an annual day for midwives, nurses working in maternity and MCAs and includes training in modules 4 & 5 of the CCFv2 (Equality, equity and personalised care and care during labour and immediate postnatal period). This study day also includes content required locally, such as an epidural care update and learning from patient feedback. A trajectory for 2024 ensures by November 2024 all Midwives, MCA and maternity nurses will have attended and be compliant.

Minimum standard:

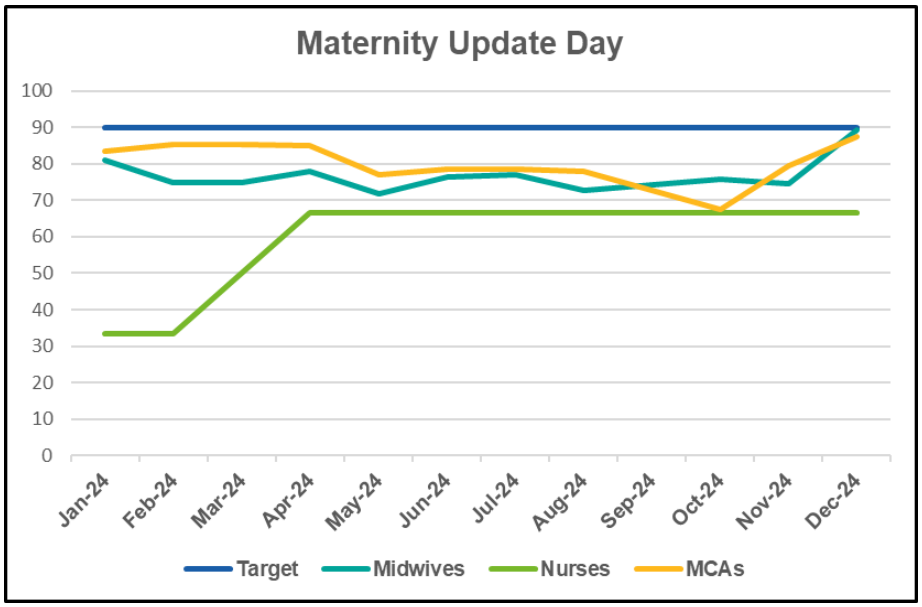
- 90% attendance (three yearly programme of all topics)
- Training should cover local pathways and key contacts when supporting women and families.

- Training must include learning from incidents, service user feedback, local learning, local guidance, audit reviews, referral procedures and 'red flags.
- Learning from themes identified in national investigations e.g., MNSI.
- Include national training resources within local training e.g., OASI Care Bundle, RoBUST.
- Be tailored to specific staff groups depending on their work location and role e.g., homebirth or birth centre teams/maternity support worker (MSW).

The CCF and MIS do not currently require submission of this training compliance, but the aim is still to achieve ≥90% attendance for staff development and safety.

The following graph outlines attendance data since January 2024:

Figure 10. Maternity Update Day attendance (Q3 Oct-Dec)



5. Level 3 Safeguarding Children

In line with the recommendations from the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: Intercollegiate document: All midwives, obstetricians and doctors in training who have posts in these level 3-affiliated specialties, are required to complete level 3 children's safeguarding training.

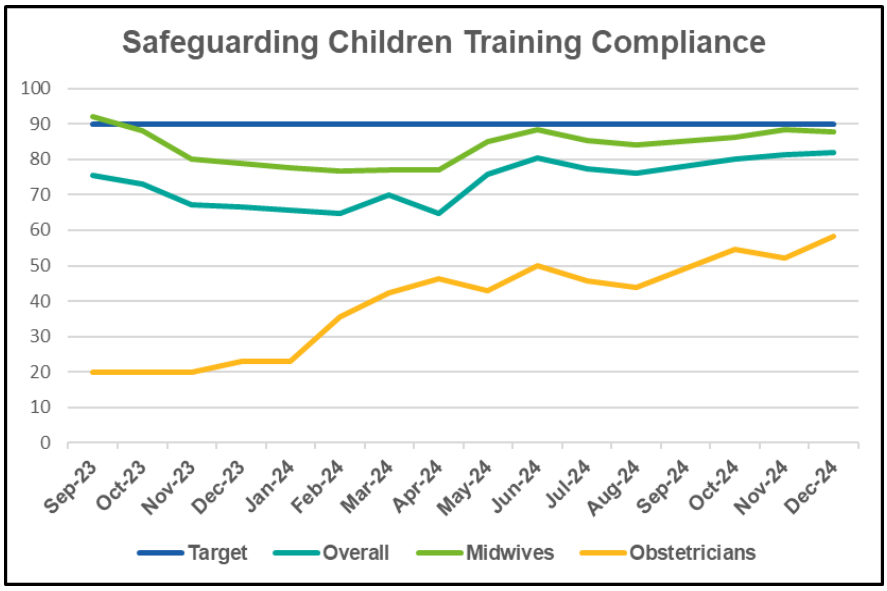
Initial training: Professionals will complete the equivalent of a minimum of 8 hours education, training and learning related to safeguarding/child protection. Those requiring role specific additional knowledge, skill and competencies should complete a minimum of 16 hours.

Refresher training: Over a three-year period, professionals should be able to demonstrate refresher education, training and learning equivalent to a minimum of eight hours for those

requiring Level 3 core knowledge, skills and competencies a minimum of 12-16 hours for those requiring role specific additional knowledge, skills and competencies.

The level 3 training is currently delivered by the named nurse for safeguarding and is mandated for all staff across the Trust who are required to complete this level of training. Currently there is 1 training day (7.5 hours) running each month and there is a waiting list. There have been vacancies within the Trust safeguarding team which has been a challenge to support teaching on the safeguarding Level 3 study day. Recently eLearning for health online training has been introduced for experienced maternity staff who are non-compliant, this was due to the reduced compliance levels within maternity. The overall vision is for all staff to receive this training face to face. Another extra maternity session was supported in Q3 to target newly recruited midwives and rotating junior doctors and aided an overall increase in training compliance.

Figure 11. Safeguarding children training compliance (Q3 Oct-Dec)



6. BSOTs Training

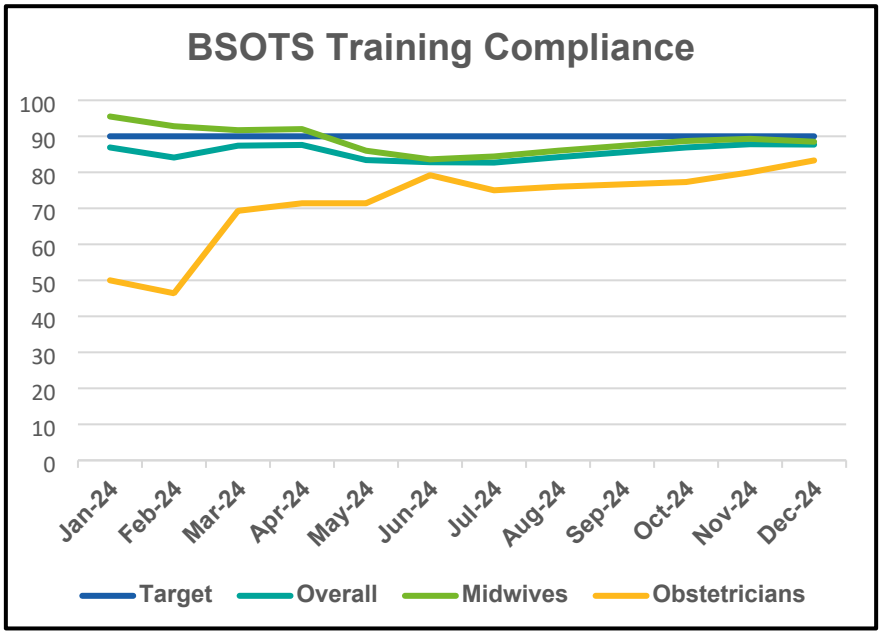
Birmingham Symptom Specific Obstetric Triage System (BSOTs) is a triaging system used within maternity day assessment unit and labour ward for all unplanned admissions. The aim of using BSOTs is to ensure that patients receive the level and quality of care appropriate to their clinical needs by prioritising the order in which they receive care following triage. This system was introduced in Salisbury in 2020 but requires ongoing training for all new and existing staff for it to be utilised successfully.

This year, BSOTs training was provided for all new midwives and obstetricians during their induction period by the DAU lead midwife or maternity education team, which saw an improvement in our training compliance. Locally, the aim is to have refresher updates at least every 3 years to maintain competence and update on changes within BSOTs. It has been challenging to train all obstetric staff due to the frequent rotations of resident doctors

but by providing BSOTs training during inductions, this has seen a steady increase of obstetric compliance in 2024.

In 2025, BSOTs training will be included within the Saving Babies' Lives study days for midwives and continue during induction for rotating obstetric staff. The DAU lead midwife is also providing ad-hoc updates on DAU for staff to maintain compliance and clinical competency.

Figure 12. BSOTs training compliance (Q3 Oct-Dec)



7. Newborn and Infant Physical Examination (NIPE)

The Nursing and Midwifery Council's Standards of Proficiency for Midwives has included all newly qualified midwives to be able to perform full systemic physical examinations of the newborn (NIPE). This was introduced by the NMC in 2019, increasing the numbers of midwives who are now qualified at SFT to complete NIPEs. In addition, CPD funding is utilised to support midwives to gain this qualification as a post-graduation module, in collaboration with Bournemouth University.

Within the midwifery workforce, there are 45 midwives qualified to perform NIPE. To ensure their knowledge and skills are up to date, it is a requirement for them to complete the NHS NIPE Programme eLearning annually. The current compliance for this eLearning is at 88.8%, with 5 midwives expired. Their NIPE Smart accounts are suspended if they are expired until evidence of eLearning has been sent to the NIPE screening lead midwife. The NIPE lead has contacted all expired midwives and reiterated the importance of this eLearning in the NIPE forums. Due to the small numbers of those qualified, compliance should quickly increase following these contacts. SFT have 9 Midwives awaiting final sign off for their qualification from the university, all were submitted in December.

8. Adult Basic Life Support

Adult Basic Life Support (BLS) training is provided by the Trust's Resuscitation Department. All staff, including non-clinical, require BLS training but at different levels depending on their role.

Midwives are required to attend Level 3 Adult BLS, which is a 3.5-hour training session, every year. Nurses and MCAs are required to annual attend Level 2 Adult BLS, which is a 2.5-hour session.

It has been a challenge to collect the data on BLS compliance for staff groups as LEARN (Trust eLearning platform) does not appear to collect accurate staffing details within the Women and Newborn Division.

During Q3, some BLS dates were cancelled by the resuscitation department due to staffing/sickness, therefore staff had to delay their training. There are currently limited dates available for BLS for staff to book, with 3-5 options per month which midwives have to attend around their clinical shifts/commitments.

The following table outlines RAG rated compliance with Adult Basic Life Support training:

Figure 13. Adult Basic Life Support training compliance (data collected from LEARN 01/01/2025)

Obstetricians	Midwives	Maternity Nurses	MCAs & MAs
63.1% (19)	78.2% (101)	33% (3)	55.6% (27)

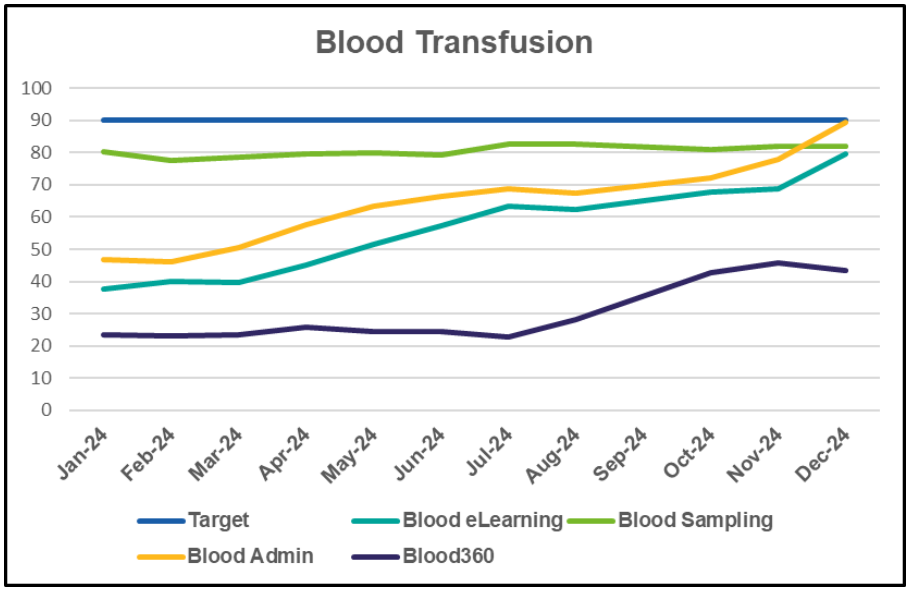
All staff out of date for Adult BLS have been contacted and advised to book via the Trust's LEARN platform.

9. Blood Transfusion Training

The following graph outlines compliance with blood transfusion competency training for midwives. The Trust requires several elements in relation to blood transfusion for registered midwives, including 2 eLearning modules (essential transfusion practice and Anti-D), a blood sampling assessment, blood administration training (1.5 hours) and blood collection (Blood360).

From January, blood transfusion link nurses provided training on the SBL study day and includes time to complete the eLearning. This has shown an improvement in training compliance, meeting target compliance for blood administration training and a vast improvement in the eLearning. In 2025, the Maternity Education Team will continue working with the blood transfusion link nurses to improve training compliance.

Figure 14. Blood transfusion training compliance (Q3 Oct-Dec)



10. Simulation Training

During Q3, due to the induction of new members to the Education Team and supporting the clinical teams, the Maternity Education Team were unable to support any ad-hoc in-situ simulation training. However, simulation training continued in PROMPT and community PROMPT, including pool evacuation, maternal sepsis, and newborn life support. The plan for Q4 would be to run more ad-hoc clinical simulations for staff during shifts if it is safe and appropriate to do so. This would require more simulation-trained faculty to support, in which additional training is being arranged.

The plan is to continue providing ad-hoc simulations within the clinical area throughout the whole year, with technical and equipment support when required from the Trust Simulation Team.

Figure 15. Simulation training in Q2

	Scenario details	Attendance	Findings	Actions Taken
October	Nil sessions			
November	Nil sessions			
December	Nil sessions			

11. Education Dashboard

All maternity-specific training is collated and monitored via the Education Dashboard, held by the Maternity Education Team. This includes the CNST training requirements, CCFv2

training, SBL study days and any local requirements for training e.g. BSOTs training. Data is collected following all study days and updated on the dashboard. The dashboard is presented at Maternity Risk and Governance meetings every month and presented via the Perinatal Quality Surveillance report. All training data within this appendix has been pulled from the maternity education dashboard.

All Trust mandatory training data is held on the eLearning platform LEARN. Reports for maternity's training compliance for mandatory training is requested from our MLE team quarterly to monitor, however, the quality of this report can make analysing the data challenging as staff numbers appear inaccurate.

12. CNST Maternity Incentive Scheme (MIS)

Safety action 8 of the Maternity Incentive scheme compliance is dependent upon an agreed local training plan which demonstrates implementation of Version 2 of the Core Competency Framework. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB on 17/09/24.

Between 30th November 2023- 30th November 2024, safety action 8 of the MIS requirements were all met. All relevant staff groups met compliance for NLS, PROMPT and fetal monitoring training.

The Maternity Education Team have developed an action plan which in outlined below. This plan will be reviewed and updated quarterly, and any concerns will be escalated to the Senior Management Team at Quality and Safety meetings.

13. Plans for next quarter

The objectives for the team in the next quarter are:

- Finalise new Training Needs Analysis for the delivery of the CCFv2 over the next 3 years. This will then need sign off from Trust Board via the quarterly report and the LMNS.
- Commence new 2025 programme for maternity update day and saving babies' lives study days.
- Follow Maternity Training and Development pathway for those who were unable to attend training during Q1-3 due to sickness – rebook as soon as possible in Q4.
- Liaise with anaesthetic and obstetric rota co-ordinators to ensure for 2025 there is evenly spread attendance at maternity-specific training to receive effective learning.

14. Appendix A

The following action plan includes actions taken to maintain or improve training compliance and any other actions in relation to training and education.

Figure 15. Action plan

Actions to maintain or improve training compliance				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Contact all rotating doctors prior to start date with all training expectations and requirements (obstetric training passport created).	Shelley King and Hannah Rickard	August for SHOs October for SPRs	Emails sent to SHOs in June by HR UHS sent data of PROMPT and FM compliance for incoming SPRs in July to HR.	Email sent by HR to all new junior doctors in June 2024.
Ensure all obstetricians are booked to attend all required study days before MIS deadline in December.	Scarlett Leahy Helen O'Shea Yazmin Faiza	July	Complete	MIS deadline for Safety Action 8 met on 30/11/2024
Contact all bank-only staff to ensure attendance at all required study days for 2024.	Scarlett Leahy Justine Wren	August 2024	Bank-only midwives contacted in July by SL.	All bank-only midwives and MCAs contacted by SL in July and booked onto maternity training for 2024.
Offer more PROMPT dates before MIS deadline of 30th November 2024	Scarlett Leahy	October 2024	2 additional PROMPT dates created – one in October and one in November	Dates created and MDT staff allocated to attend
Improve annual update compliance for NIPE qualified practitioners.	Donna Crayden	September 2024	Individual emails sent to those out of date. NIPE Smart accounts suspended until eLearning completed.	Increase from 77% to 88% since previous quarter.

Actions from simulation training				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Disseminate education around performing external manoeuvres before internal manoeuvres in the management of shoulder dystocia to reduce the risk of brachial plexus injury and OASI.	Maternity Education Team	December 2024	To be introduced on PROMPT from September 2024. Scenario on community PROMPT May – July 2024.	New SD in birth pool scenario introduced onto PROMPT in September – including learning as highlighted.
Increase simulation faculty within maternity to allow more in-situ simulations to be run.	Scarlett Leahy SFT Simulation Team	July 2025	New preceptorship lead booked to attend Simulation course March 2025	Changes to the Maternity Education Team expected 2025, to ensure ongoing development to run clinical simulations.
Further Actions				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Create new PROMPT programme to run Sept 2024-25.	Maternity Education Team Yazmin Faiza Q&S Midwife Julia Bowditch/ Juliet Barker	August 2024	New content being created and MDT meeting planned for August 2024.	PROMPT programme created with MDT support and introduced September 2024. Content noted at Maternity Risk and Governance September 2024.
Create new Training Needs Analysis to deliver the requirements of the CCFv2 locally over the next 3 years (2025-2027)	Scarlett Leahy	June 2025	New programmes for maternity update day and SBL study days created for 2025	Need to complete training plans for 2026 and 2027 and submit to LMNS and Trust Board in Q4

Patient and Staff Experience Report
Maternity and Neonatal Services
(Quarter 3 2024/25)

1.	Purpose of the Report
	The purpose of this report is to provide a quarterly overview of patient and staff experience within the maternity and neonatal service. Any trends and themes are identified and shared not only with those directly involved but the whole team to ensure there is learning and continual improvement of the service. The report also outlines work and co-production with the MNVP. Escalation of feedback is shared monthly at the Safety Champions meeting, Maternity Risk and Governance meeting, and via the Perinatal Quality Surveillance slides. Themes from patient are discussed quarterly at the Triangulation meeting. Staff feedback is captured by the annual staff survey and work undertaken by the Perinatal Quadrumvirate which is shared at the Safety Champions meetings and via the Perinatal Quality Surveillance slides.
2.	**Executive Summary**
	• The response rate to the Friends and Family Test (FFT) in Q3 is consistent with Q2. There is an increase in positive feedback and a reduction in negative comments. Analysis is discussed at Maternity governance and quarterly Triangulation meetings. • There has been an increase in complaints this quarter, with the top theme being 'unsatisfactory treatment'. • Work continues to embed the Triangulation meeting into the Divisional Governance structure. • In this quarter the CQC Maternity Survey 2024 results were released. The subsequent action plan was coproduced with the local Maternity and Neonatal Voices Partnership (MNVP). • The Neonatal Parent Survey (June -Dec 24) results are included within this report in section 7.0. The results were reassuring; with a 9.5/10 positive (satisfaction) rating score. The development of the action plan is to be considered and reported in the next quarter's Quality and Safety report. • Work is ongoing to create a Health Inequalities clinical dashboard, with the focus on birth outcomes related to ethnicity and social deprivation. This will assist in developing an understanding of local health inequalities. • A listening event was held in November with several Family Nurse Practitioner's (FNP) clients. The feedback from this event will be shared at the next Triangulation meeting, scheduled in February 2025. • The referral process to the Birth Reflection service was reviewed in this quarter. The expansion of the referral criteria to include self-referrals has been agreed. Work continues to ensure service users can access the service directly via our maternity website. • The Birth Trauma Inquiry Report was published in May 2024. Work commenced in Q3 on an assurance report in response to the Inquiry's 13 recommendations.

	Key priorities for patient experience and inclusion, next quarter includes: • To undertake listening events with hard-to-reach groups to prioritise the voices of women (birthing people) from communities with the poorer maternity outcomes. • To support the implementation and monitoring of the Pocketalk© translation device. • Review themes from the feedback obtained via FFT, with the focus on increasing patient engagement with the survey. • Working with the LMNS Inclusion Lead to align the service with the national agenda relating to reducing health inequalities • Development of a local Health inequalities dashboard. • The Implementation of the 2024 National Patient Experience Maternity Survey action plan. • Progress the actions detailed in the Three-year delivery plan and support the work currently ongoing to promote personalisation of care with both patients and staff. • Ensure women can make a referral to the Birth Reflection service, via our Maternity website. • Ensure the completion of the benchmarking exercise and action plan in relation to the Birth trauma Inquiry.
3.	**Patient Story**
	No patient story presented this quarter. A patient has come forward who is wishing to share their story through a short film in Q3 and for use in local training. Due to the current demands placed upon the Communications team, they are unable to support the patient stories at the present time. The Maternity department is working with PALS to look at alternative means of capturing this valuable insight into service users experience of their pregnancy journey with us.
4.	**Patient Surveys – National and Local (including CQC national maternity survey)**
	The National Maternity Survey is a requirement by the CQC for all NHS Trusts providing maternity services. Women receiving maternity services in January and February 2024 were selected for the survey. • Our top five scores compared nationally were around the areas of partners being able to stay, induction of labour information and Mental health support. • Our bottom five scores were around care at home after birth and support with feeding.

5.	**Maternity and Neonatal Voices Partnership (MNVP), Staff and Patient Experience - Triangulation**
	In Q1, a new Triangulation meeting was introduced with the aim of triangulating insights and feedback from: staff via DATIX risks, legal claims, local and national patient feedback surveys, the Birth Reflections Service and through the intelligence obtained by the Maternity and Neonatal Voice Partnership (MNVP). These themes inform and drive the priorities of service development and quality improvement. Themes from the last Triangulation meeting included: • Waiting times in ANC and DAU for USS reviews. It was discussed that an A3 service improvement initiative is currently in progress to map out the service, with the aim of improving the flow through the ANC and reducing unnecessary waiting times for service users. There is an emerging theme around service users feeling that they are not being listened to, or a perceived lack of acknowledgement by staff that they are in labour. This will be picked up in the analysis and subsequent action plan, following the review of the National Maternity Patient Experience Survey 2024 and feedback from Birth Reflections Service. This will be discussed at the next Triangulation meeting.

Figure 1. Update from the MNVP regarding planned and completed engagement events

6. Friends and Family Test (FFT)

Friends and Family Test: October - December 2024

Prior to Q1, the Maternity department experienced challenges with FFT response rates, despite a relaunch of the FFT in January 24. Maternity services were chosen to be part of the initial role out of the digital SMS messaging service across the Trust, with the touch points including:

- Maternity Antenatal (at 20 weeks)
- Maternity Birth (at 7 days)
- Maternity Postnatal (at 14 days)
- Maternity Community (at 28 days)

	FFT Q3 2024/25 Data: In Q3, it was identified that 3012 women were eligible to receive the FFT survey request with a total of 308 responses, offering a 10.1% compliance rate, consistent with the previous quarter. A priority in Q2 was to consider ways of increasing patient engagement with the FTT survey. Actions implemented in this quarter included providing service users with the opportunity to complete the survey before discharge from Beatrice Maternity Ward. We can see from the postnatal figures that this has made a significant improvement in response rates for December 2024. **FFT Priorities for Q3:** The FFT data will be presented at the next Triangulation meeting and used to inform any learning opportunities or service improvements.
7.	**Feedback from Neonatal and Bereaved Families**
	Neonatal feedback The analysis of the Neonatal Parent Survey was undertaken in Q3. 86 Families responded to the survey. Overwhelmingly, the response was positive with parents rating the service provided as 9.5/10. **What the families say...** • Admission to the unit was smooth, they all felt welcomed. • The families surveyed felt they received regular updates and most families felt they could ask questions and receive the answers in a language they could understand. • Most families felt they received enough privacy, and those signed posted to the Padlet found this to be useful. • Most families felt prepared for their baby's discharge.

	What the families want... • Accessibility and visibility of pediatricians on the Neonatal Unit. • More information about the NNU prior to admission. A robust action plan is currently under consideration and in consultation with the Paediatric service. **Feedback from Bereaved Families** Women (birthing person) who have experienced the unexpected loss of a baby from 22 weeks gestation, are asked as part of the Perinatal Mortality Review Tool (PMRT) to share their feedback with either the Bereavement Lead or the Family Experience Midwife. The aim of the PMRT is to support the standardised perinatal mortality reviews across NHS maternity and neonatal services in England, Scotland, and Wales. The tool supports the multidisciplinary, high-quality review of the circumstances and care leading up to and surrounding the deaths of babies who die in the postnatal period. Active communication with parents is encouraged, therefore, parents are asked prior to the PMRT meeting if they have any questions they would like addressed by the panel. The outcome of the multidisciplinary review, together with the family's questions, are shared with the family during the (post PMRT meeting) follow up with their named consultant obstetrician. If there are concerns raised by the family which cannot be addressed by the panel, these are then taken forward an investigated through the complaint procedure. Three thank you cards were received from bereaved parents, and one piece of negative feedback (from a previously bereaved family) was received relating to the communication of a sonographer during a 12-week scan appointment, during their current pregnancy.
8.	**Feedback from Black, Asian and Minority Ethnic Backgrounds and Families Living in Areas with High Levels of Deprivation**
	An Inclusion Midwife has been successfully recruited to support the development of this workstream and started in post at the beginning of Q2.

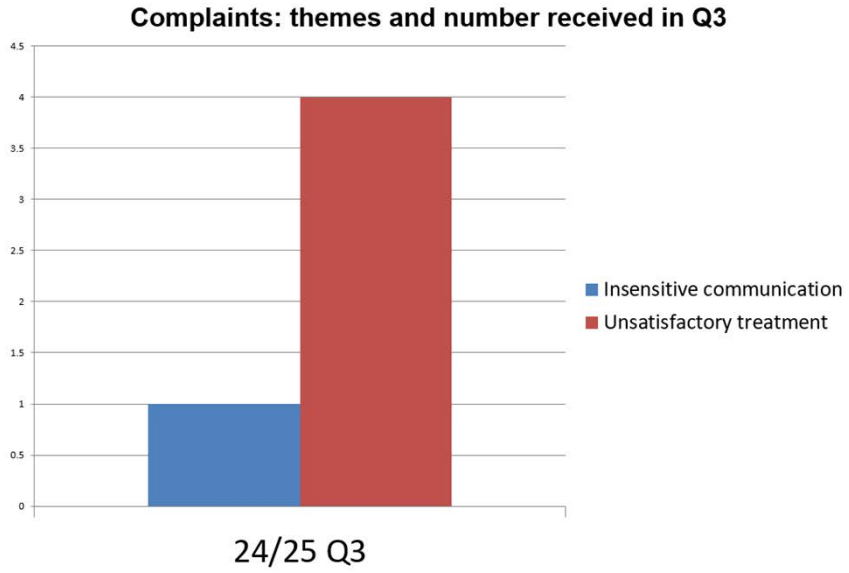
	A deliverable objective of the 3 Year Delivery Plan is that Trusts collect and disaggregate local data and feedback by population groups, to monitor differences in outcomes and experiences for women and babies from different backgrounds and improve care. This data should be used to make changes to services and pathways to address any inequity or inequalities identified. In the previous quarter, analysis of birth outcome data in relation to the ethnicity and social deprivation for the local population commenced. This continues as a priority across the LMNS. **Continued priorities for Q3:** • Collaborative working with the Communications Team and IT to ensure our Trust website has a translation function. There has been a delay in the implementation of this due to the project lead's repatriation back to the Transformation Team, following the end of their secondment to the Division. • To develop strong links with Wessex Health Innovation to continue the ongoing work to secure funding for a new 'at the point of contact' translation device. Work is ongoing to complete the Clinical Safety Case and Hazard Report, however, the funding has been secured. Together with Health innovation Wessex, discussions are being had with the provider to map out the implementation and evaluation of the device in practice. • To undertake listening events with hard-to-reach groups to prioritise the voices of women (birthing people) from communities with poorer maternity outcomes, with the focus on our Afghanistan community of refugees. • Development of a Health Inequalities Dashboard.
9.	**Compliments**
	Thank you cards are collected from both inpatient and outpatient areas throughout the year and are now added to DATIX by the PALS team. **Actions** • Themes of compliments together with examples of service user's gratitude is shared with the workforce on a quarterly basis.

- If a compliment is sent via the PALS department, this is then shared with the individual staff member and a SOX nomination completed.

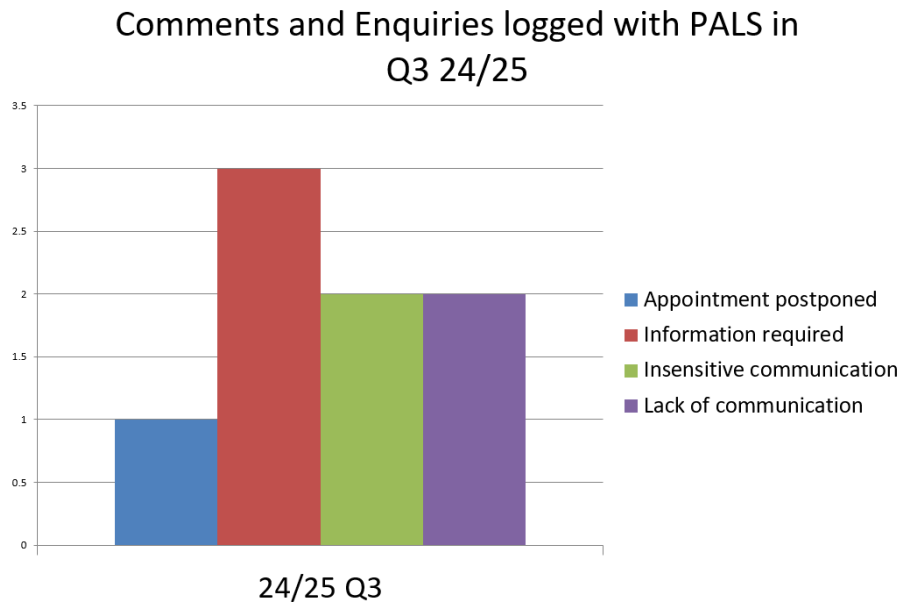
In Q3 2024/25, Maternity and Neonatal Services received 45 compliments. The top 3 themes reported were 'gratitude', 'support' and 'exceptional'.

10. Complaints/PALS Contacts

There have been 5 formal complaints and 1 concern logged in Q3 24/25.



There has been an increase in formal complaints in Q3, with ‘unsatisfactory treatment’ being the top theme.



In Q3, there were 4 complaints closed, 1 within closed within target time, offering a 25% compliance rate.

	Birth Reflections Service The Birth Reflections Service aims to provide women and their families with an opportunity to discuss and reflect on their birth experience with a view to nurturing psychological wellbeing in preparation for parenting, and future pregnancies. Birth Reflections sessions can also provide valuable feedback for the maternity service, facilitating change and improvements in the care that is provided. The Birth Reflection Service offers a confidential, one to one midwifery-led listening service for women who have given birth in Salisbury Foundation Trust. It has been agreed that SFT will expand the referral criteria to include self-referrals. A priority in Q3 was to continue the work to enable women to self-refer to the service via the maternity website. This requires updating the SOP, developing a new patient information leaflet, and updating the website. **The Birth Trauma Inquiry Report (May 2024)** *Birth Trauma Inquiry Report: A Call for Comprehensive Reform in Maternity Services.* This report calls for substantial reforms in the UK's maternity services. By implementing 13 key recommendations, Maternity services can ensure a safer, more respectful, and supportive environment for mothers and their families, ultimately improving outcomes and reducing the long-term impacts of birth trauma. Work is ongoing to benchmark our maternity services with the national recommendations, as well as the development of an action plan where aeras for improvement have been identified.
11.	**Matron/ Ward Manager Audits**
	During Q3, antenatal services undertook a service review in response to feedback from service users regarding waiting times in Antenatal Clinic (ANC) and the Day Assessment Unit (DAU) for obstetric review. As part of the Improving Together Strategy, an audit was completed in Q3 to understand waiting times in ANC and the number of women requiring obstetric reviews, following scans on the afternoon that the ANC is not in operation. The audits demonstrated that the waiting times in Antenatal Clinic were not as long as anticipated, however, the waiting times in the DAU for obstetric review following an ultrasound scan were at times two to three hours and therefore of concern. The latter has now become the focus of one of the speciality drivers for Improving Together. Please also see section 5 above regarding triangulation related to this.

12.	**Internal/ External Visits (relating to patient or staff experience)**
	In Q3 the planned listening event was undertaken in co-production with the MNVP and the Family Nurse Practitioners (FNP). • Visit to Stonehenge Community Hub to hear the voices of the women from our Afghan refugee community.
13.	**Staff Survey Results**
	The National Annual Staff Survey was not published in Q3.
14.	**Staff Experience/ Wellbeing**
	Restorative Supervision has been offered and received by all staff returning from sick leave and maternity leave, as well as all new starters. Quarterly 1:1 RCS has been achieved for all preceptee midwives. There has been one significant potentially traumatising event and a hot debrief was facilitated for all staff involved, with all staff being offered a TRiM intervention.
15.	**Key Activities in place for both Staff and Patient Experience**
	Themes from complaints and concerns, patient experience surveys and FFT are discussed at the Triangulation meeting and shared with the workforce during the annual maternity study days.
16.	**Sharing of Best Practice**
	Patient and staff experiences are shared as follows: • Friends and Family Test (FFT) feedback is shared via email and posters in ward areas. • SOX can be seen in inpatient and ward areas.

- MNVP feedback is shared via email, in team meetings, and through Maternity Governance and Safety Champion meetings.
- Compliments
- Learning from incidents
- New guidelines
- Maternity and Neonatal Services Newsletter

The department has implemented numerous service improvements in response to service users' feedback. It is hoped that these changes are making a positive impact on the care provided to women (birthing person) and their families.

To celebrate these achievements, over the past year a patient experience advent calendar was shared with the workforce.

17. Update on Actions Outlined in the Previous Report

The main priorities were previously identified in the last Quality and Safety report with updates:

- To undertake listening events with hard-to-reach groups, to prioritise the voices from women (birthing people) from communities with the poorer maternity outcomes. There are two listening events planned in Q3 RE Family Nurse Practitioner (FNP) and the 'entitled people' (refugees entitled to be residing in the UK) .
  Update: The FNP listening event was undertaken in November 2024.
  Afghanistan refugee listening event was planned in Q3 but has been rescheduled to Q4 due to service demands.

- To continue to work with Health Innovation Wessex, to secure funding for a new 'at the point of contact' translation device.
  Update: An implementation working party has been set up to support the roll out of this translation device, in the spring.

- Increase patient engagement and review themes from FFT.
  Update: As noted in section 6, there has been an increase in responses and themes from feedback are monitored through our governance systems.

	• Working with the LMNS Inclusion Lead to align the service with the national agenda relating to reducing health inequalities. **Update: This work is ongoing and a local Dashboard is being developed.** • Review of the data from 2024 National Patient Experience Maternity Survey and coproduce an action plan with the MNVP. **Update: Data analysis complete and action plan developed. Implementation monitored through the Local and LMNS governance group.** • The Three-year delivery plan requires personalisation of care. There is an action to disseminate the 'My Maternity Choices' booklets developed across the LMNS in Q3. **Update: Staff training provided, and 'My Maternity Choices' are now being provided to all women at booking.** **A personalisation audit is undertaken monthly as part of the Improving Together Strategy 22/26.**
18.	**Next Steps/ Looking Forward**
	Key priorities for patient experience and inclusion in the next quarter includes: • To undertake listening events with hard-to-reach groups to prioritise the voices of women (birthing people) from communities with the poorer maternity outcomes. • To support the implementation and monitoring of the 'Pocketalk' translation device. • Review themes from the feedback obtained via FFT, with the focus on increasing patient engagement with the survey. • Working with the LMNS Inclusion Lead to align the service with the national agenda relating to reducing health inequalities. • Development of a local Health Inequalities Dashboard. • The Implementation of the 2024 National Patient Experience Maternity Survey action plan. • Progress the actions detailed in the Three-Year Delivery Plan and support the work currently ongoing to promote personalisation of care with both patients and staff. • Ensure women can make a referral to the Birth Reflection Service via our Maternity website. • Ensure the completion of the benchmarking exercise and action plan in relation to the Birth Trauma Inquiry.

Saving Babies Lives Quarterly Report
Maternity and Neonatal Services
(Quarter 3 2024/25)

1. Background

The Saving Babies' Lives Care Bundle (SBLCB) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. The Three-Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three. SBLCBv3, in line with MIS Year 6, maintains an approach of continuous improvement and comprehensive evaluation of organisational processes and pathways as part of developing an understanding of where improvements can be made.

A national implementation tool was launched in 2023 to help maternity services to track and evidence improvement and, compliance as set out in Version Three. This has been continued for use with MIS Year 6 requirements. The national implementation tool contains a 'Board Report & Progress' and 'LMNS review' sections for monitoring progress on actions. This is part of the quarterly assessment of evidence collated by providers which is reviewed by the LMNS and validated accordingly. This is shared with the Trust Board quarterly via this report as part of MIS Year 6 requirements and with the ICB.

2. Introduction

This report provides a quarterly update on the implementation, monitoring and training of all six elements of the Saving Babies Lives care bundle v3.

Saving Babies Lives audits for quarters 1 and 2 2024/25 have been completed to provide assurance to the Trust and LMNS that all six elements have been implemented. Maternity services are working towards a consistent high level of compliance to improve care for women and their families, which in turn will assist in reducing the still birth and neonatal death rates. Due to the process of submission to LMNS and dates associated with this Q3 data is currently being collected to submit the LMNS on 21st February and will be reported in Q4 report.

Each organisation is expected to look at their performance against the outcome measures for each element using the new national implementation tool, with a view to understand where improvement may be required. Previously, the Year 5 MIS requirements required providers to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. The current MIS Year 6 requirements mandate that providers should fully implement Saving Babies Lives Version 3 by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours and sufficient progress have been made towards full implementation, in line with the locally agreed improvement trajectory.

3. Progress and LMNS Review Record

Figure 1. Percentage of interventions fully implemented following each LMNS validation.

% of Interventions Fully Implemented (LMNS Validated)	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4
Review Quarter	**Initial**				
Assurance Review Date	**25.10.2023**	**23.12.2023**	**24 06 2024**	**13.09.2024**	**02.12.2024**
Element 1	10%	29%	20%	40%	60%
Element 2	5%	50%	50%	70%	70%
Element 3	0%	100%	50%	50%	100%
Element 4	0%	0%	20%	40%	60%
Element 5	11%	37%	48%	52%	63%
Element 6	7%	33%	17%	17%	67%
TOTAL	7%	37%	40%	51%	66%

4. Implementation Progress

SFT has made steady progress and has several actions in place to move towards full implementation.

Figure 2. Implementation progress for Q2 2024-2025 with self-assessment of 66% and LMNS validated of 66%.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	**Partially implemented**	90%	**Partially implemented**	60%	CNST Met
Element 2	Fetal growth restriction	**Partially implemented**	55%	**Partially implemented**	70%	CNST Met
Element 3	Reduced fetal movements	**Fully implemented**	100%	**Fully implemented**	100%	CNST Met
Element 4	Fetal monitoring in labour	**Partially implemented**	20%	**Partially implemented**	60%	CNST Met
Element 5	Preterm birth	**Partially implemented**	70%	**Partially implemented**	63%	CNST Met
Element 6	Diabetes	**Partially implemented**	67%	**Partially implemented**	67%	CNST Met

The graphs below show the breakdown for each element of interventions partially or not yet implemented which have been validated by the LMNS and those which have been fully implemented as validated by the LMNS. This shows that the LMNS agree, for the most part, with SFT's self-assessments.

Figure 3. Self-assessment vs LMNS assessment Q2 2024 (51%) and Q3 2024 (66%)

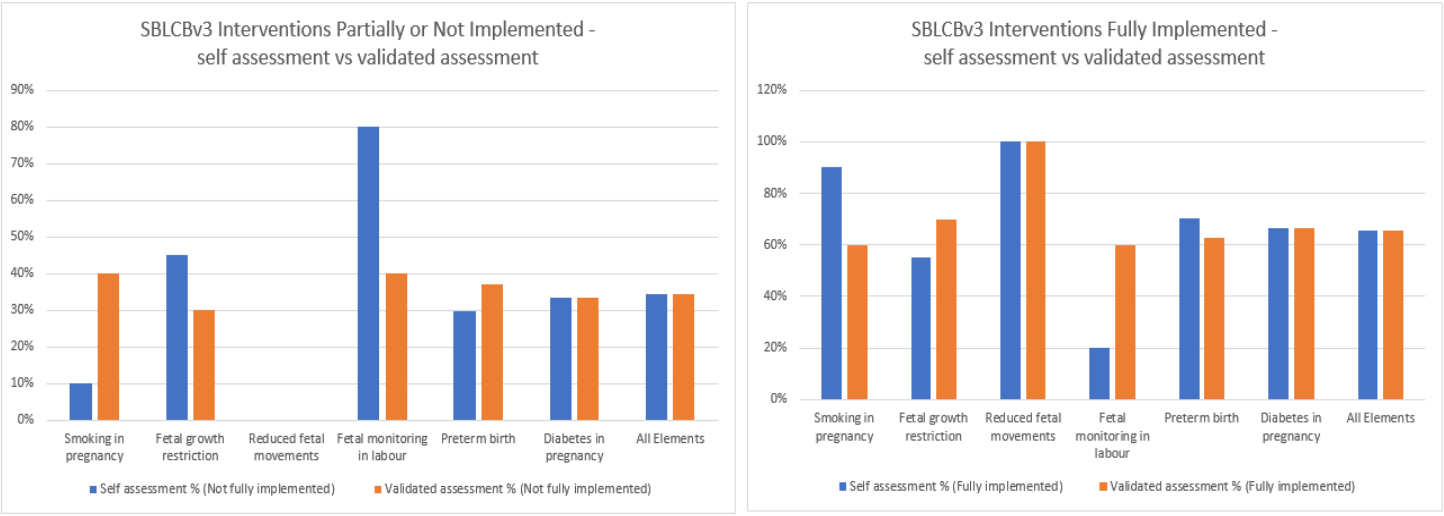
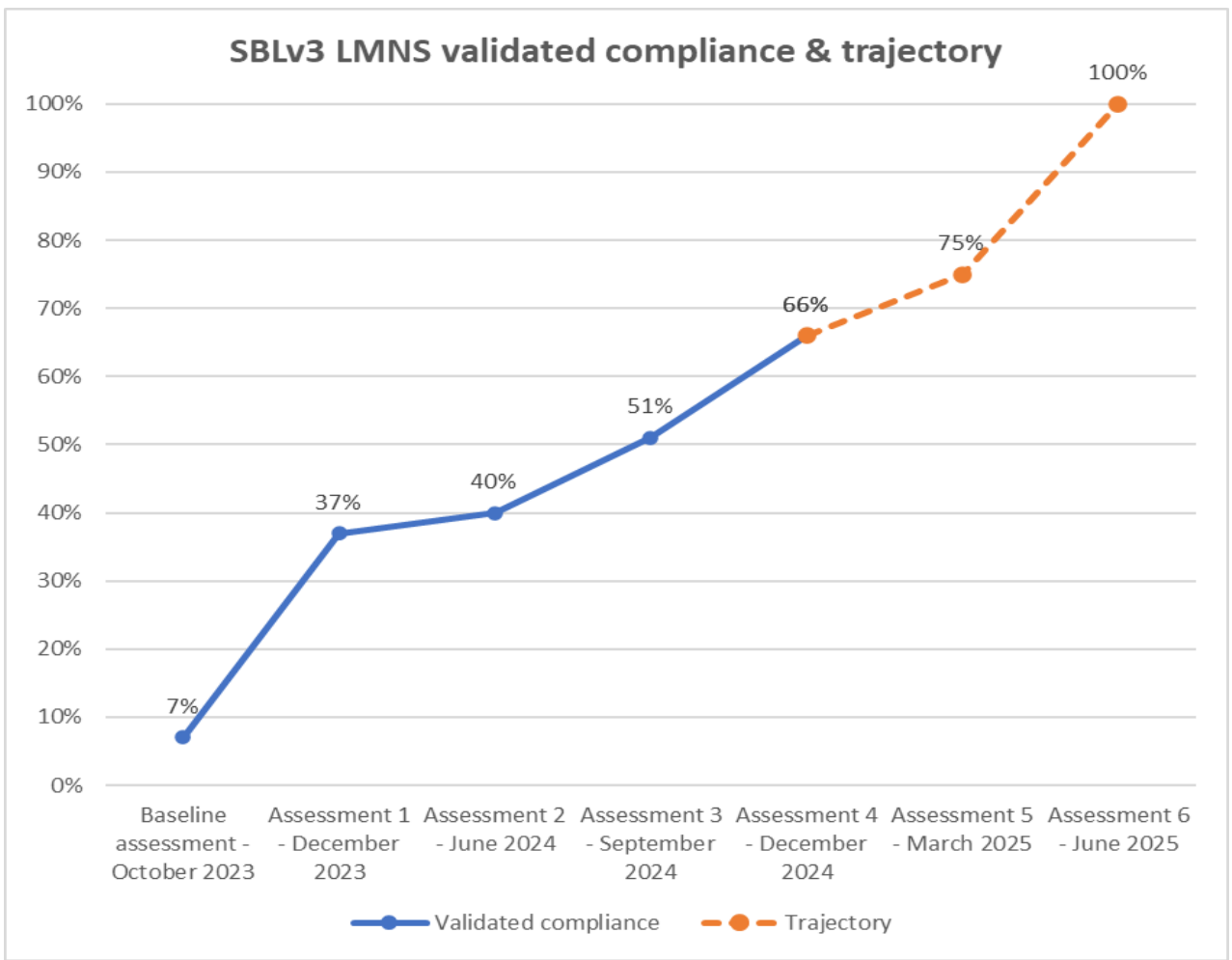


Figure 4. LMNS validated compliance and SFT trajectory Oct 23 – June 25



5. Care Bundle Elements

An audit and training plan has been developed to continually monitor and identify areas to improve the service and outcomes relating to the care bundles elements:

- **Element 1: Reducing Smoking in Pregnancy**
- **Element 2: Fetal Growth: Risk assessment, surveillance, and management**
- **Element 3: Raising awareness for reduced fetal movements**
- **Element 4: Effective fetal monitoring during labour**
- **Element 5: Reducing pre-term birth and optimising perinatal care**
- **Element 6**: **Management of Pre-existing Diabetes in Pregnancy**

Element 1: Reducing Smoking in pregnancy

Reducing smoking in pregnancy by identifying smokers with the assistance of carbon monoxide (CO) testing and ensuring in-house treatment from a trained tobacco dependence adviser is offered to all pregnant women who smoke, using an opt-out referral process.

Compliance%	Actions taken and progress made
60%	• Meeting with LMNS held to provide mutual feedback on current progress and to help identify areas for improvement and any barriers. Complete. • 1:1 meetings arranged with action holders, leads and stakeholders for Element 1. Complete. • 24/25 Q2 audit data collated and submitted. Complete. • Maternity Services Dataset (MSDS) Data Quality rating passed and the most up to date data to be submitted as evidence for next submission. Complete. • Audit numerators and denominators to continue until final submission with ongoing support provided. Complete. • Audit plan for Element 1 created by action holder to amalgamate recording of audits in one place for ease of reporting, and to ensure that multiple staff members can complete the audits to safeguard against single point of failure. Complete. • Ongoing audit plan for Element 1 created by action holder to amalgamate recording of audits in one place for ease of reporting, and to ensure that multiple staff members can complete the audits to safeguard against single point of failure. Complete. • SFT stop smoking strategy and Wiltshire stop smoking service specification now submitted as evidence. Complete. • Acknowledgment of current non-compliance with training actions regarding carbon monoxide (CO) screening and 'very brief advice' (VBA) for Obstetricians, Midwives and Maternity Care Assistants (MCAs). SMART action plan created with a clear goal to achieve compliance with targeted study days. Ongoing. • 'Smoking in pregnancy' guideline has been subject to minor amendments to make it clearer that the guideline and SOP are to be used in conjunction with the Wessex Pathway for smoking in pregnancy. It has also been amended to correctly reflect the amount of support women can expect to receive throughout their pregnancy. Complete. **Looking Forward** • Assist in the review of action plans to monitor compliance trajectory. Complete. • Utilising non-clinical bank hours to ensure backlog of audit data has been captured. Complete.

	Update • Plan to provide training for new Band 4 PIMS/HiP practitioners for there to be a rolling audit plan for the collation of data. Ongoing. • Poster reminders for smoking status disseminated to Antenatal Clinic and Community Midwives to increase compliance around recording of status. Complete.

Element 2: Risk assessment and surveillance for fetal growth restriction

Risk assessment and management of babies at risk of or with fetal growth restriction (FGR).

Quarter audit %	Actions taken and progress made
	• 1:1 meetings arranged with action holders, leads and stakeholders for Element 2. Complete. • 23/24 Q3 and 23/24 Q4 data not included in previous submissions, now completed and submitted as evidence. Complete. • 24/25 Q1 and Q2 audit data collated and submitted. Complete. • Feedback received from LMNS meeting to advise that guideline evidencing Aspirin recommendation was not included in evidence folder. The correct guideline has been located to be included in the next submission. Complete. • As above but for recommendation of vitamin D-the 'routine booking' guideline has been subject to minor amendments to make the recommendation of Vitamin D supplementation in pregnancy clearer. Complete. • Work ongoing with Outpatient Matron to procure and implement the use of digital blood pressure machines validated for use in pregnancy. Only a limited number of machines are validated for use in pregnancy and then also for women with pre-eclampsia. Upon checking the NHS Supply Chain catalogue, one validated BP machine is available, however, this is only validated for use in pregnancy, not pre-eclampsia. Another has been discontinued and another is not available through the NHS Supply Chain website. Work is ongoing to reach out to other Trusts within the LMNS to identify the monitors they use and understand their procurement processes. Complete. • Meeting with Trust Medical Devices Team to identify possible alternative BP machines, which are still compliant. Conclusion of this meeting highlighted that procurement is a national issue. Discussed with Head of Midwifery who will feed this back in a regional forum for escalation to the national SBL team. Ongoing. **Looking Forward:** • Continue to liaise with Outpatient Matron and other Trusts to procure BP monitors validated for use in pregnancy and for women with pre-eclampsia. Procurement plan to be submitted as evidence. Complete. • Trust Medical Devices Lead to continue to liaise with national Medical Devices teams to try to identify compliant machines. Complete. **Update:** • Confirmation received from MSDS Lead, that manufacturer of the VS-900 Dinamaps has advised that those already in circulation in the acute areas are compliant for pregnancy and PET related BP monitoring - no need to procure extra Dinamaps but exploring procurement of community - based BP machines. Awaiting funding process information from LMNS. Complete.

	• Funding process to procure digital blood pressure machines confirmed with LMNS. Outpatient Matron to invoice LMNS who will release the funds. Complete. • Outpatient Matron has liaised with other BSW Trusts who are sending details of the BP machines that they use. Ongoing. • Outpatient Matron acquiring quotes for BP machines. Ongoing.

Element 3: raising awareness for reduced fetal movements

Raising awareness amongst pregnant women of the importance of reporting reduced fetal movements (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM.

Quarter audit %	Actions taken and progress made
	• Identified discrepancy between RCOG Green Top Guidance (suggested within SBL technical guidance) which states: 'if ultrasound scan assessment is deemed necessary, it should be performed when the service is next available - preferably within 24 hours.' The reduced fetal movements and fetal surveillance guidelines do not have a fixed timeframe as mentioned above. The Wessex pathway advises to 'arrange ultrasound scan' but with no specific timeframe, and the same can be said for the BSOTS triage pathway for women presenting with reduce fetal movements. For women categorised as an 'orange' risk category within BSOTS, the pathway advises 'USS for estimated fetal weight, liquor volume and uterine artery dopplers as per local policy and guidance' however SFT local policy and guideline around timings of ultrasound are ambiguous. LMNS feedback suggested liaising with sonography lead to enquire as to whether there would be capacity and staff availability to provide this, and then to update guidance in collaboration with sonography, stakeholders, and authors of the current guideline. Email communication sent to Lead Sonographer and awaiting their reply. Complete. • Updated 24/25 report submitted for evidence by Bereavement Lead detailing no cases of stillbirths with issues associated with management of reduced fetal movements. Complete. **Looking Forward:** • Awaiting further Q4 audit data. Complete. • To liaise with Digital Lead Midwife to enquire as to whether there are any further reports that can be built into E3 to make data capture more streamlined. Complete. **Update:** • Ongoing plan now in place for monthly data collation. Complete.

Element 4: Effective fetal monitoring during labour

Quarter audit %	Actions taken and progress made
	• Feedback received from LMNS in relation to training compliance around intermittent auscultation and how this is evidenced during fetal monitoring study days. Assurance provided that intermittent auscultation case study and post-study day assessment are still utilised, and snapshot of assessment shown and will be provided as evidence for next submission to provide further assurance. Complete. • Element 4 interventions audit data has been submitted for Q1 & Q2 2024-2025. Complete. • Minor amendment to intermittent auscultation guideline to reflect the importance of a buddy system when conducting intermittent auscultation and completing the 'Intermittent Auscultation Wellbeing Proforma'. Complete. • Discussions held around the job descriptions relating to the Fetal Surveillance co-leads. Feedback received from LMNS to advise that the job descriptions were un-dated and now x2 job descriptions are to be submitted to reflect the two individuals fulfilling the role. To discuss with the co-leads re: dating job descriptions and WTE contracted hours. Complete. • To obtain evidence of PA time for Obstetrician with responsibility for fetal surveillance as currently insufficient evidence submitted. Complete. • **Update:** • Meeting held between LMNS, Fetal Surveillance Lead and SBL Lead to provide clarification around certain elements of the required actions. Complete.

Element 5: Reducing preterm birth and optimising perinatal care

Reducing the number of preterm births and optimising perinatal care when preterm birth cannot be prevented.

Quarter audit %	Actions taken and progress made
	• Feedback received that job descriptions received in relation to point 5.1: 'lead for preterm perinatal optimisation' were not detailed enough to be used as evidence. Discussed with LMNS and Neonatal Matron, and the LMNS willing to accept email confirmation that both the Neonatal Consultant and Neonatal Matron have enough time in their job plans to devote to neonatal optimisation. The same was fed back for the Quality Assurance Midwife role. Request sent to neonatal leads via email to enquire as to whether they are happy that they can fulfil this part of their job description, and a request that they are able to provide their evidence-currently awaiting this. Complete. • Discussion with Neonatal Matron around new ventilators. Procurement ongoing and as soon as they are acquired, a new SOP will be created and implemented. Ongoing. **Update** • Most guidelines are now compliant and awaiting further audit data for next submission. Ongoing. • Liaised with neonatal consultant lead for SBL and neonatal nursing lead. Job description confirmation received. Complete. • Liaised with neonatal consultant re: x1 outstanding audit-awaiting response. Complete. • Ventilators now arrived. Complete. • SOP is in progress. Ongoing.

Element 6: Management of Pre-existing Diabetes in Pregnancy

Women with Type 1 and Type 2 diabetes have persistently high perinatal mortality with no improvement over the past 5 years. The recent Ockenden report has highlighted the need for continuity of experienced staff within Diabetes in Pregnancy teams to reduce poor outcomes in women with diabetes. Providing multidisciplinary care in a joined-up way for women with type 1 and type 2 diabetes during pregnancy and harnessing technology (e.g. continuous glucose monitoring) to reduce maternal complications of diabetes, including perinatal morbidity and mortality.

Quarter audit %	Actions taken and progress made
	• In discussion with Antenatal Clinic Lead Midwife. Plan: make minor amendments to guideline as current guidance advises incorrectly that women with Type 1 diabetes are currently not being offered continuous glucose monitoring. Ongoing. • Feedback received from LMNS advising that main Trust-wide guideline does not include any guidance or policy on management diabetic ketoacidosis (DKA) specifically in pregnancy. ANC Lead Midwife to liaise with authors of this guideline to collaboratively write a passage/appendix for management of DKA in pregnancy. Ongoing. • Exploration of the possibility of a specialist diabetic midwife post at SFT. Reached out to Clinic Matron at Great Western Hospital to ask for guidance on how they managed their specialist education requirements and the clinic in general. Discussion with Director of Midwifery and Outpatient Matron where it was identified that a draft job role description already exists, and the Maternity Education Team have secured funding for relevant specialist training for 2 staff members. Meeting to discuss next steps planned for before August submission date. Complete. • Evidence for referral pathway to regional maternal medicine network for women with complex diabetes previously not included in evidence folder-now collated and ready for next submission date. Complete.

Midwifery, Maternity and Neonatal Staffing Report
Maternity and Neonatal Services
(Quarter 3 2024/25)

1. Background

It is a requirement that NHS providers continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

Previously midwifery staffing data has been included in the nurse staffing paper, however, to provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, a separate paper is now provided which also includes staffing data on other key groups, obstetricians, and anaesthetics.

2. Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents. It also gives a summary of key workforce measures for obstetricians and anaesthetics to provide evidence for the current maternity incentive scheme year 6.

3. Birthrate Plus Workforce Planning

A formal Birth Rate Plus assessment was completed in 2024, which reviewed the acuity of women who used maternity services at Salisbury NHS Foundation Trust. This review recommended a birth to midwife ratio of 1:24 across the Trust.

NICE (2017) recommend that an assessment is carried out every three years. The 2024 formal Birth rate Plus assessment indicated that an increase of 3.27 WTE was required to the establishment and the midwifery staffing budget has been augmented to reflect this and agreed by the Trust board.

4. Planned Versus Actual Midwifery Staffing Levels

The following table outlines percentage fill rates for the inpatient areas by month.

Figure 1. Percentage fill rates for inpatient areas by month

Month	Day qualified %	Night qualified %
October 2024	93.9	96.5
November 2024	99.4	96.7
December 2024	93.7	96.9

Fill rates are gradually improving month on month due to the increase in available workforce, following both successful recruitment and staff returning from maternity leave. SFT do however continue to have 4.82 WTE on maternity leave and some long-term sickness. Staffing is monitored daily, and staff redeployed based on the acuity. There have been more new starters, a cohort of preceptee Band 5 midwives, in quarter 3 which has further improved our position.

When staffing is less than optimum, the following measures are taken in line with the escalation policy:

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

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

5. Birth to Midwife Ratio

The birth to midwife ratio is calculated monthly using Birth Rate Plus methodology and the actual monthly delivery rate. Birthrate Plus has calculated an individualised midwife to birth ratio for Salisbury, recommending a rate of 1:24. Following review of individualised data, this considers anticipated levels of risk and safeguarding which both affect the amount of time and care required for women and their families. This has now been added to the maternity dashboard, so that it can be monitored alongside clinical data. The table outlines the real time monthly birth to midwife ratio.

Figure 2. Birth to Midwife ratio

Month	October	November	December
Birth to midwife ratio	1:30	1:27	1:22

6. Specialist Midwives

Birth Rate Plus recommends a percentage of the total establishment is not included in the clinical numbers. This percentage is tailored to units considering size, acuity and whether units are multi-centred. These roles include management positions and specialist midwives. These roles include Named Midwife for Safeguarding Children, Antenatal and Postnatal Screening Leads, Perinatal Mental Health Lead Midwife, Birth Environment Lead, Practice Educator, Fetal Surveillance Lead and Midwifery Matrons amongst others.

Following the birthrate plus review in February 2024 the current percentage for Salisbury is calculated to be 13%.

7. Birth Rate Plus Live Acuity Tool

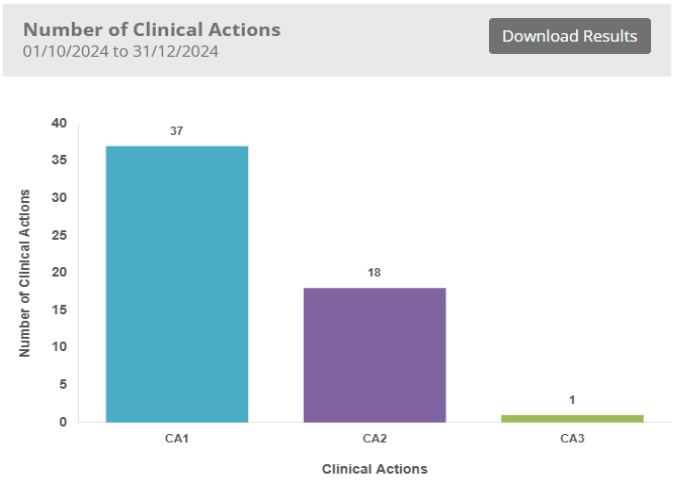
The Birth Rate Plus Live Acuity Tool was introduced in the intrapartum areas on 1st December 2014 and has since gone live in the other inpatient areas. It is a tool for midwives to assess their 'real time' workload arising from the number of women needing care, and their condition on admission and during the processes of labour, delivery and postnatally. It is a measure of 'acuity', and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system Birth Rate Plus.

The Birth Rate Plus classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four-hourly by the labour ward co-ordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one-to-one care in labour for all women and increased ratios of midwife time for women in the higher need categories. This provides an assessment on admission of where a woman fits within the identified Birth Rate Plus categories, and alerts midwives when events during labour move her into a higher category and increased need of midwife support.

This safe staffing tool kit supports most of the components in the NICE Guidance (and is endorsed by NICE) on safe midwifery staffing for maternity settings necessary for the determination of maternity staffing requirements for establishment settings. It provides evidence of what actions are taken at times of higher acuity and use of the escalation policy when required.

The following provides evidence of actions taken (both clinical and management) to mitigate any shortfalls in staffing or for periods of high acuity.

Figure 3. Number and percentage of clinical actions taken

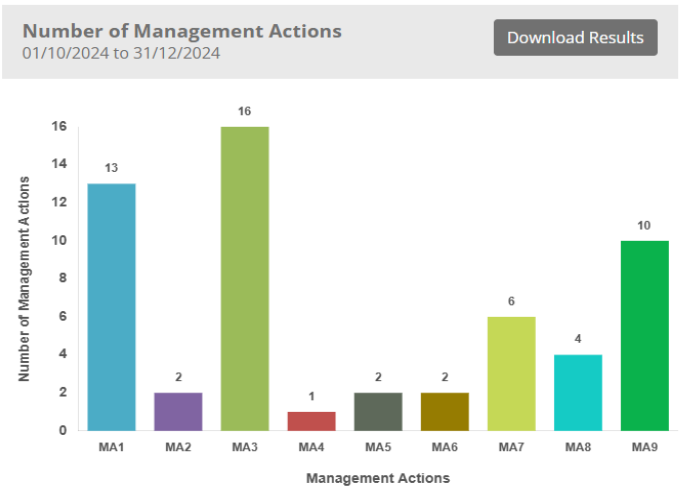


Number of Clinical Actions
01/10/2024 to 31/12/2024 — Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Delay commencing IOL	37	66%
CA2	Delay on-going IOL	18	32%
CA3	Delay/cancel Elective LSCS	1	2%
TOTAL		56	

*The % is rounded to nearest whole number

Figure 4. Number and percentage of management actions taken



Number of Management Actions
01/10/2024 to 31/12/2024 — Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff from ward	13	23%
MA2	Redeploy staff from community	2	4%
MA3	Staff unable to take breaks	16	29%
MA4	Staff working beyond rostered hours	1	2%
MA5	Staff sourced from Midwifery Bank	2	4%
MA6	Matron/Midwifery Managers working clinically	2	4%
MA7	Specialist Midwives to work clinically	6	11%
MA8	Initiate the escalation policy	4	7%
MA9	Contact on-call duty Manager	10	18%
TOTAL		56	

*The % is rounded to nearest whole number

The data above indicates that there is a low incidence of occasions where clinical or management actions are taken to mitigate for high acuity and when needed the escalation process is followed for support. The management of induction of labour (IOL) without any delay is an issue with which all maternity units struggle due to its complex process pathways and unpredictable nature of its management.

Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward. SFT have ensured that rostering reflects this requirement. The Birthrate Plus acuity tool monitors this every 4 hours.

The following table outlines the supernumerary status compliance by month:

Figure 5. Supernumerary status of Labour Ward Co-ordinators by month

	Number of days per month	Number of shifts per month	Compliance
October	31	62	100%
November	30	60	100%
December	31	62	100%

8. One to One in Established Labour

Women in established labour are required to have one to one care and support from an assigned midwife. Care will not necessarily be given by the same midwife for the whole labour, but it is expected that the midwife caring for a woman in established labour will not have any other cases allocated to her.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical or management actions taken.

The following table outlines compliance with provision of 1:1 care by Month.

Figure 6. 1:1 care in labour compliance by month

	October	November	December
Birth Centre	100%	100%	100%
Labour Ward	100%	100%	100%

9. Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool.

The following tables demonstrate red flag events for the 3-month period from 1st October 2024 to 31st December 2024. Out of 546 data admissions (confidence factor of 85%

recorded), there were red flags entered onto the system with the reasons detailed below:

Figure 7. Number and percentage of red flags recorded during Q3

Number of Red Flags recorded
01/10/2024 to 31/12/2024

Download Results

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	1	100%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay of more than 30 minutes in providing pain relief	0	0%
RF5	Delay of 30 minutes or more between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay of 2 hours or more between admission for induction and beginning of process	0	0%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Supernumerary status of labour ward coordinator not achieved	0	0%
TOTAL		1	

*The % is rounded to nearest whole number

Each red flag is recorded on the acuity tool and reported via DATIX, this ensures timely review and action planning to reduce repeat incidents and maintain safety.

10. Obstetric staffing

10.1 Consultant Attendance

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

Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG *'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'* (updated 2022) document. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as the LMNS.

Clinical situations listed in the RCOG document when a consultant is required to attend in person:

- In the event of high levels of activity e.g., a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input.
- Any return to theatre for obstetrics or gynaecology
- Team debrief requested if requested to do so.
- Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary.
- Caesarean birth for major placenta praevia/ abnormally invasive placenta
- Caesarean birth for women with a BMI >50
- Caesarean birth <28/40
- Premature twins <30/40
- 4th Degree perineal tear repair
- Unexpected intrapartum stillbirth
- Eclampsia
- Maternal Collapse e.g., septic shock, massive abruption
- PPH 2L where the hemorrhage is continuing, and Massive Obstetric Haemorrhage protocol has been instigated.

For Q3 (1st October 2024 – 30th December 2024) there were 7 cases meeting the criteria above. The audit demonstrates 87.5% compliance to the standard.

Figure 8. Consultant attendance audit for Q3

Date	Clinical Situation(s)	Comments
02/10/24	Caesarean birth for women with BMI >50.	Consultant present.
06/10/24	High acuity, second theatre opened.	Consultant present.
16/10/24	4th Degree perineal tear repair.	Consultant present.
27/10/24	Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary.	Consultant present.
30/10/24	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant not present
19/11/24	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.

23/12/24	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present.

10.2 Short Term Locum usage

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

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

An audit of compliance with our Medical HR colleagues was completed for the time period 1st October 2024 – 30th December 2024). The audit demonstrated that during this period, 19 (short term) middle grade locum shifts were required. 4 Doctors completed these shifts, 2 of these Doctors were employed by Salisbury NHS Foundation Trust and 2 Doctors were locums, not employed at Salisbury NHS Foundation Trust at the time of undertaking the shifts. However, both Doctors were working in their local unit (within the Wessex area) on their Tier 2 or 3 rota and held a certificate of eligibility (CEL) to undertake short-term locum shifts, therefore the trust is 100% compliant with the criteria described above.

10.3 Long term locum usage

During the time period 1st October 2024 – 30th December 2024, the trust has utilised 2 long term middle grade locum doctors. Both Doctors had been working in the trust prior to Q3 and therefore standards 1-6 are not applicable during this time period.

For all standards that were applicable, the trust was 100% compliant. The compliance can be seen in the table below.

Figure 9. Long term locum usage compliance

Standard	Compliance % for Locum 1 (in post prior to Q2 VP)	Compliance % for Locum 2 (in post prior to Q2 RM)
Standard 1 Locum doctor CV reviewed by consultant lead prior to appointment	N/A	N/A
Standard 2 Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment	N/A	N/A
Standard 3 Departmental induction by consultant on commencement date	N/A	N/A

Standard 4 Access to all IT systems and guidelines and training completed on commencement date	N/A	N/A
Standard 5 Named consultant supervisor to support locum	N/A	N/A
Standard 6 Supernumerary clinical duties undertaken with appropriate direct supervision	N/A	N/A
Standard 7 Review of suitability for post and OOH working based on MDT feedback	100%	100%
Standard 8 Feedback to locum doctor and agency on performance	100%	N/A (remains in post)

11. Anaesthetic staffing

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

The following table demonstrates compliance with this standard by month.

Figure 10. Anaesthetic staffing compliance by month

Month	October 2024	November 2024	December 2024
% compliance	100	100	100

The service will continue to audit this standard on a monthly basis.

12. Neonatal medical staffing

To meet safety action 4 of the Maternity Incentive Scheme, the Neonatal Unit needs to demonstrate that it meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in previous years, there should be an action plan with progress against any previously developed action plans. Salisbury Neonatal Unit is designated a Local Neonatal Unit (LNU) and there are no current plans for this to change.

Compliance has never been met for medical staffing against BAPM criteria. A trainee ANNP has started their training which is a first step towards increasing medical staffing numbers and in turn compliance with BAPM.

Figure 11. Action plan for medical staffing against BAPM criteria

Action	Owner	Deadline	Rating
Report submitted through Maternity and Neonatal Safety champions meeting	Mary Pedley-Duncalfe	Awaiting response from Trust board. Next safety champions meeting 20th February	
Business case submitted to Divisional Director of Operations for review and submission to financial services	Mary Pedley-Duncalfe	March 2025	

The above action plan serves to put in motion a plan to achieve BAPM compliance. Both the LMNS and Neonatal ODN are aware of non-compliance to BAPM and of the above action plan.

13. Neonatal nursing staffing

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

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

1.92WTE are now on Maternity leave and we have had 0 leavers. Planning is currently in process to move 3 WTE band 5 registered nurses from the maternity service to support the 4.98WTE vacancy.

Figure 12. Compliance with BAPM standards for Neonatal Nurses with respect to QIS

	Funded December 2024	In post December 2024	BAPM calculated requirement *(from ODN tool, based on NNU activity)*	Variance *(BAPM less funded)*
Total direct care nurses	24.08	19.95	24.55	-0.47
of which QIS	13.64	13.27	15.16	-1.52
Total Non-QIS	9.64	4.66	6.50	3.14
Total Non-Reg	0.80	2.02	2.89	-2.09
% Registered Nurses QIS Qualified		67%	70%	

14. Recommendations

It is recommended for the Board to note the contents of the report and formally record to the Trust Board minutes agreement to the action plan, in place due to non-compliance with BAPM standards for both neonatal nurse staffing and neonatal medical workforce.

Avoidable Term Admissions into Neonatal Units (ATAIN) and Transitional Care Report
(Quarter 3 2024-25)

1. Report Overview

ATAIN is an acronym for Avoiding Term Admissions into Neonatal units. It is a national programme of work initiated under patient safety to identify harm leading to term neonatal admissions. The current focus is on reducing harm and avoiding unnecessary separation of mothers and babies.

This report outlines the term admission rates at 5%, findings from audits of the pathway/ policy, findings from the ATAIN reviews both term and late pre-term babies and provides assurance of actions being taken and progress being made.

2. The National Ambition

In August 2017, NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030. This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme, with a key focus on:

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

2.1 Why is it important?

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals. Collaboration between neonatal and maternity staff at Salisbury NHSFT has seen several positive changes, with a real focus around improving maternity and neonatal care. Several projects have been identified to support the reduction in the unnecessary separation of the mothers and babies that use maternity and neonatal services.

Using the 'Improving Together' methodology, SFT are embarking on a Separation Improvement Times (SIT) project. This project aims to produce a culture change in maternity and neonatal services that will support mothers to have where possible, immediate access for to their infants admitted to the neonatal service. With multidisciplinary working across all stake holders, women should feel empowered and have a seamless experience when their infant requires unexpected admission to the neonatal unit (>37 weeks' gestation).

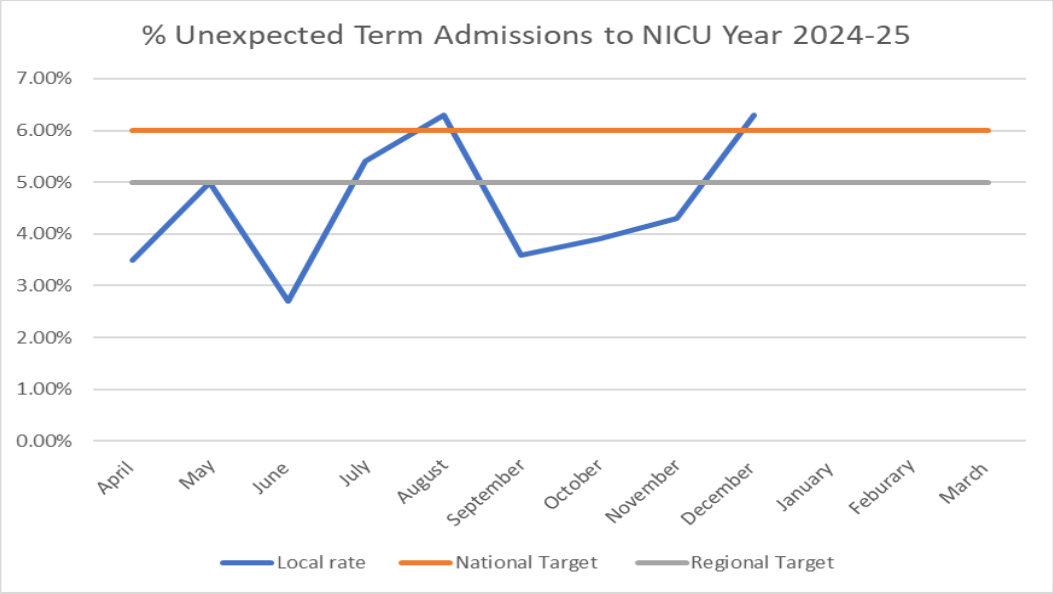
In addition to the SIT project, the ‘Think 45’ project was introduced in 2024. This project has been running across the TV&W ODN and was adopted in Salisbury to reduce the amount of term respiratory admissions admitted to the unit.

The national aim for term admissions to the neonatal unit is less than 6% of all term babies, however Trusts should strive for this rate to be as low as possible. This is covered in the next section of the report.

3. ATAIN rates

The following graph outlines the rolling calendar year ATAIN rates for Salisbury NHSFT Trust.

Figure 2. Monthly ATAIN rates since April 2024 for Salisbury NHSFT Trust



Updates and progress from the last report is included in the action plan below.

Figure 3. ATAIN reviews (babies equal or >37 weeks' gestation)

	October 2024	November 2024	December 2024
Total number of admissions in month	**7**	**7**	**9**
Number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU due to capacity or staffing issues.	**0**	**0**	**0**
Number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding but could have been cared for on TC if nasogastric feeding was supported there.	**0**	**0**	**0**
	October 2024	**November 2024**	**December 2024**
Total number of case reviews undertaken in month	**7**	**12**	**6**
Total number of case reviews with both maternity and neonatal staff present	**7**	**12**	**6**

During Q3, significant progress has been made to ensure completion of the backlog of ATAIN reviews.

4. Findings and learning from the ATAIN review meetings

4.1 Neonatal

During Q2, SFT identified discrepancies in the amount of time that PEEP had been delivered to babies, as it was not always 45mins. It was apparent that it is not always possible to achieve the full recommended time due to the hospital environment of a District General Hospital being smaller and having less staff capacity to support. Paediatrics had thus requested that PEEP to be delivered for 30-45 minutes. This has noted an improvement during Q3 and will continue to be monitored over Q4. If practice is embedded, then audit into results of the 'Think 45' project will be completed.

4.2 Maternity

During Q2, a theme had been identified during ATAIN case reviews around delays in 'decision to delivery' timeframes for category 1 & 2 emergency caesareans as recommended by NICE. NICE guidance recommends that category 1 births occur within 30 minutes (decision to birth) and, that category 2 births occur within 75 minutes.

A change in practice was implemented whereby all category 1 & 2 caesareans are communicated to the team using a '2222' call. This has resulted in a significant improvement and continues to be audited monthly:

August:

- category 1 (≤ 30 mins) birth achieved in 67% of cases
- category 2 (≤ 75 mins) birth achieved in 60% of cases

November:

- category 1 (≤ 30 mins) birth achieved in 100% of cases
- category 2 (≤ 75 mins) birth achieved in 94% of cases.

4.3 Learning

In Q3, (in addition to the above themes) the following shared learning is planned:

- Maternity to focus on the Golden Hour during the month of February 2025, to include education board, tea trolley teaching and email information. Themes to include keeping babies warm and optimum positioning during skin to skin.
- To support staff to facilitate mothers to be with their babies immediately following birth if clinically appropriate.

5. Transitional Care Service (TC)

SFT's TC policy was updated in 2023 and includes a clear staffing model for TC. It is recognised that SFT's neonatal services are not always BAPM compliant with the additional TC work, and there is ongoing work for a business case to increase NICU staffing to 4/shift to offer more standardised care.

6. TC Audit

6.1 How many TC babies did SFT have and how long did they stay for?

The graphs below demonstrate the numbers of babies born each month that fit within the TC gestational criteria and the length of stay.

Figure 4. Total number of 34-36+6 babies born each month since beginning of Q3.

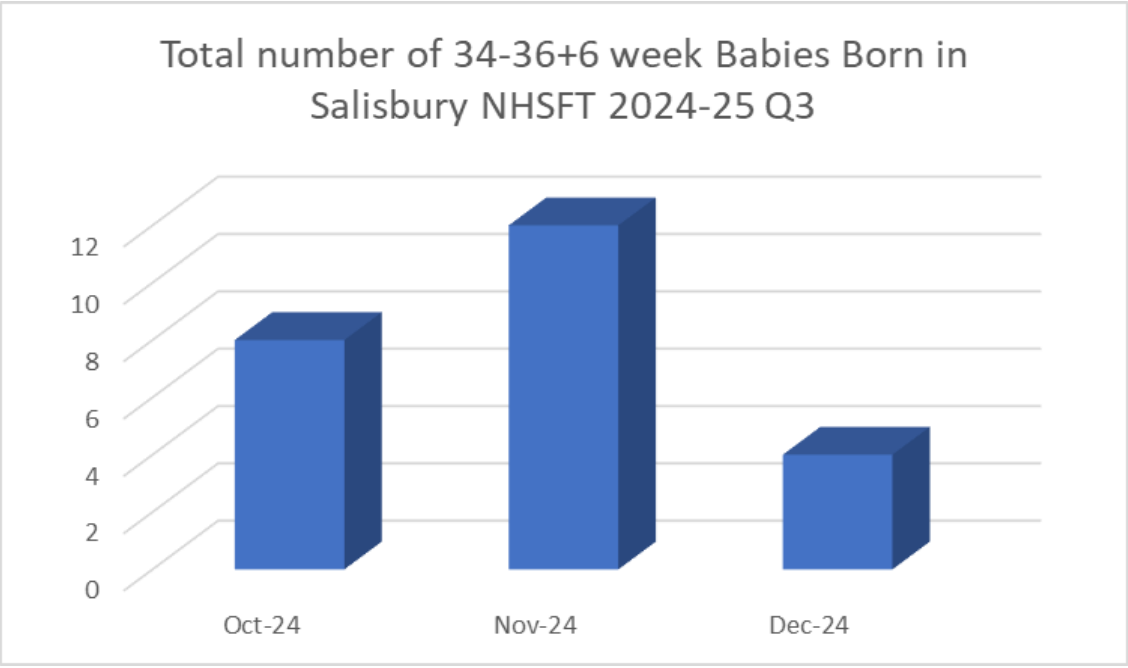
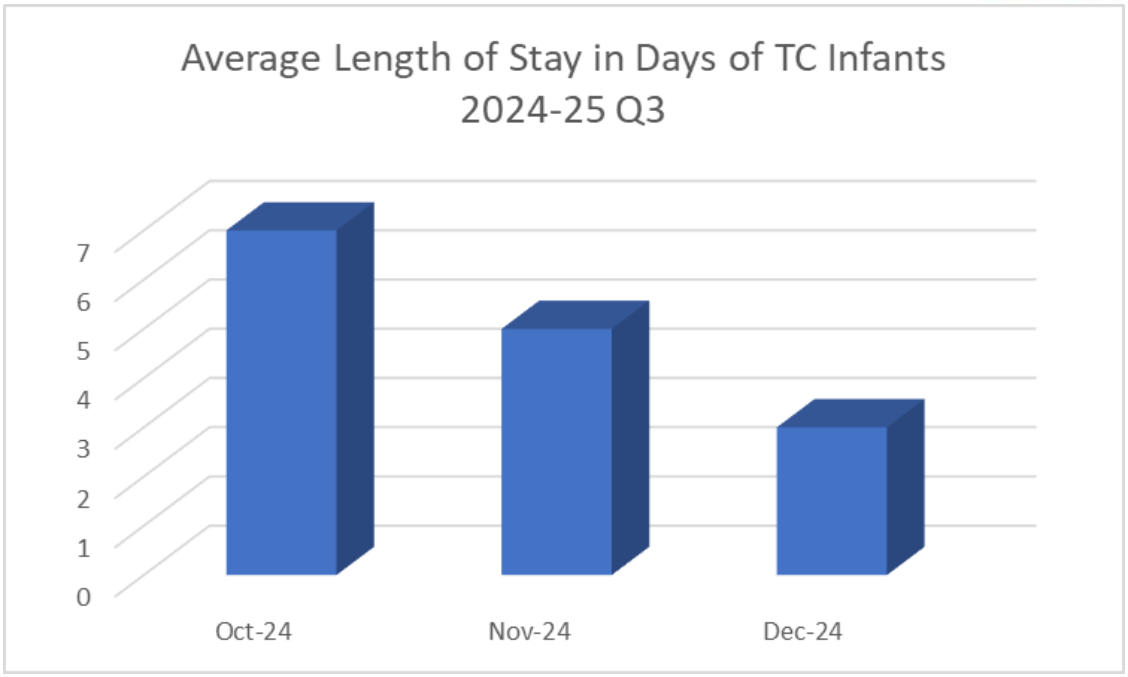


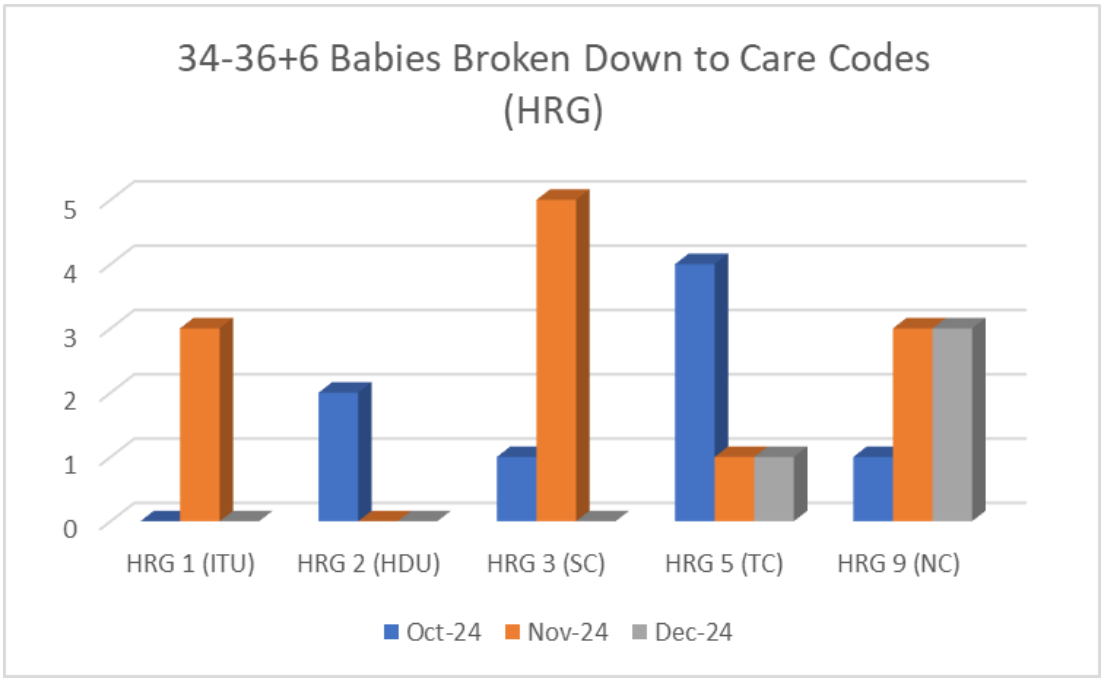
Figure 5. Average length of stay in days for TC infants.



6.2 Did SFT admit the correct babies to TC and SCBU?

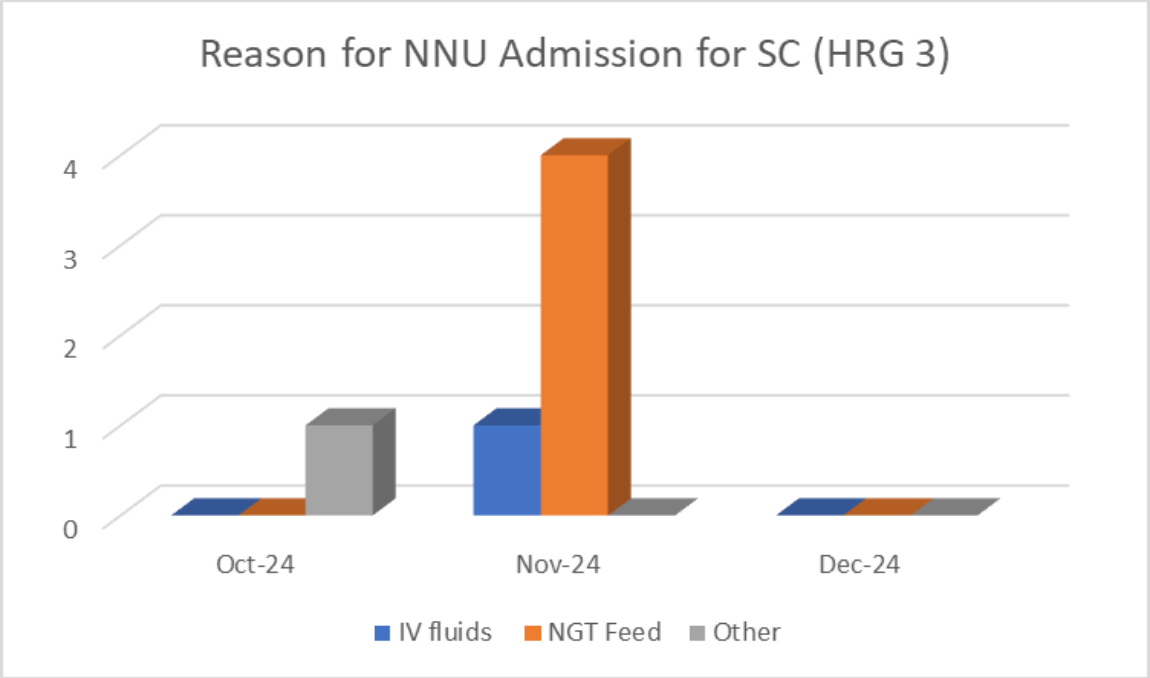
This graph below shows that SFT are further interrogating care codes for infants that fall within the Transitional Care gestation. This helps to understand if these are correct for each baby.

Figure 6. TC babies identified by care codes each month 2024-25 Q3.



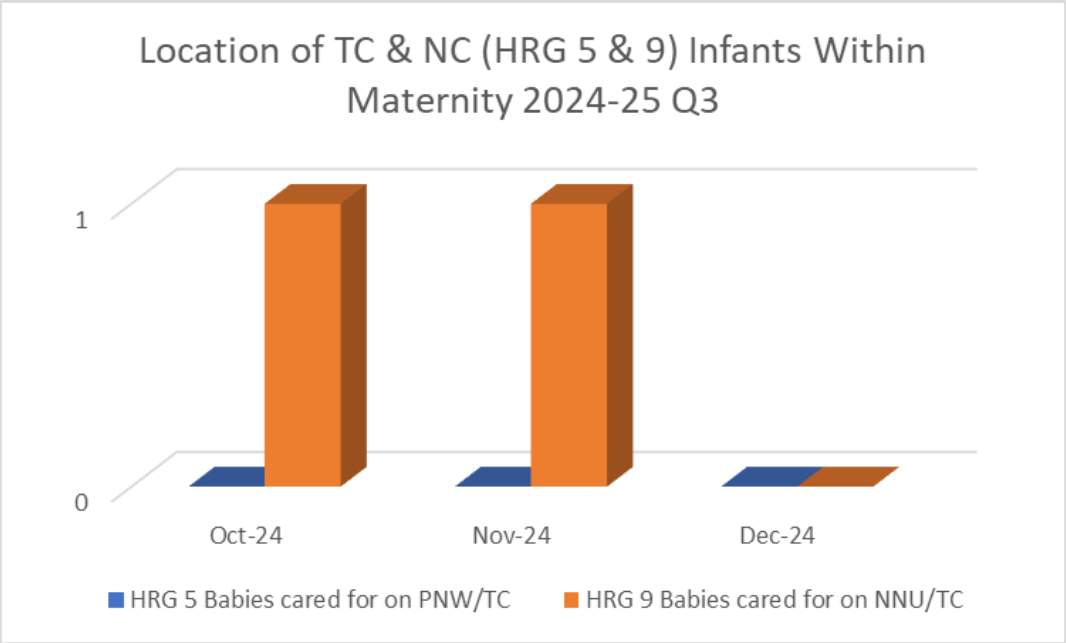
It is then possible to drill down further on special care infants (HRG 3) to ascertain if these infants could in-fact be coded as TC infants. The graph below shows that in Q3 there has been 0 infants that could have been coded as TC, from the SC cohort.

Figure 7. Reason for NNU admission



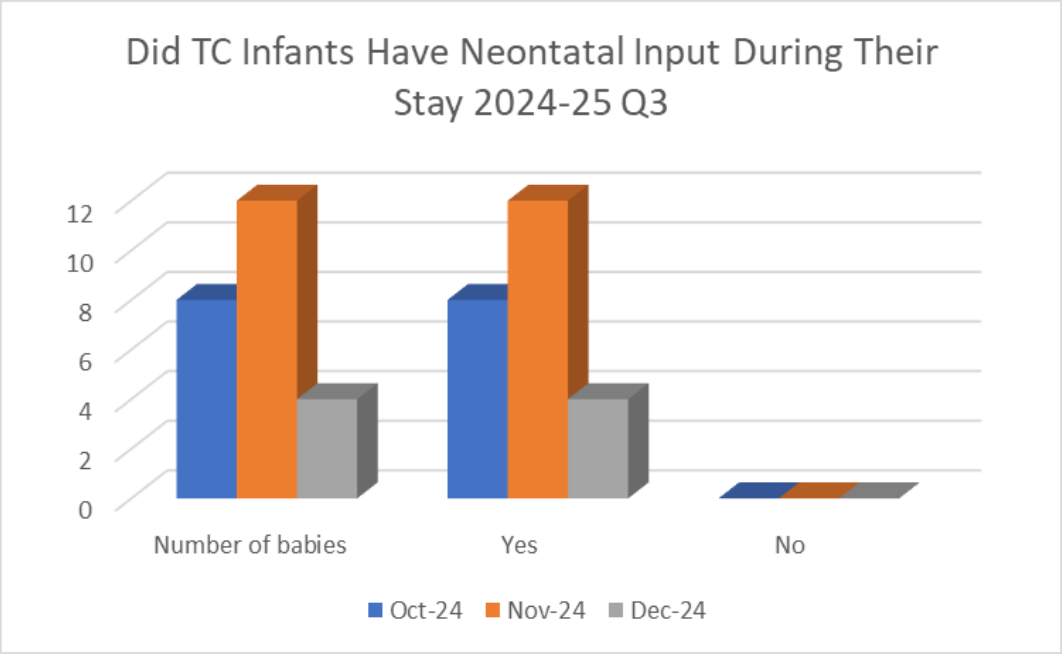
The graph below shows that SFT have cared for babies in the correct setting (BMW/LNU - TC), but during most months, have had 1 normal care (HRG 9) infant on the neonatal unit. These numbers are monitored monthly via CNST audit. These are very low and can be anything from 'place of safety', a twin that does not require specialist neonatal care but a sibling does, lack of space on BMW/TC, etc. Due to this monitoring, it will be easy to recognise and act on changes to this number.

Figure 8. Location of care setting



6.3 Did all TC infants have Neonatal involvement?

Figure 9. Babies receiving neonatal input during their stay.



Neonatal input can be any input from neonatal nursing team or medical staff. These results are taken from National Neonatal Audit Programme (NNAP) data, showing if they have been seen by a senior medical member of staff. There has been a sustained improvement in this over Q3 as all infants have had neonatal input.

7. Pre-term babies (34 – 36+6 weeks gestation)

Figure 10. Table showing number of admissions each month during Q3.

	October 2024	November 2024	December 2024
Total number of admissions	8	12	4

The TC pathway is now fully integrated and familiar to staff and has become the norm.

The action plan below provides updates and progress from the last report.

8. Action Plan

The following combined action plan outlines actions being taken in response to audits of compliance with the pathway/ policy and actions being taken in response to ATAIN reviews for both term and late pre-term babies.

The plan includes progress since the last report.

Figure 11. ATAIN and TCU action plan

Actions from TC pathway /policy audits	

Action	Responsible person	Deadline	Progress made	Rag rating
Education on the MW study day continues but still struggling for sustained engagement from MW cohort. Plan to look at increasing number of maternity nurses as part of an options appraisal, and subsequently rotate these nurses to the neonatal unit to build up skills. They can then care for TC infants on LW until mother & baby can come to NICU TC together for ongoing care.	GD/SC-O/BR & SL	30/11/24	Ongoing midwifery education continues and is now in a sustaining phase. Maternity nurses have completed a period of supernumerary. Ongoing discussion with DMT regarding staffing model.	
Actions from ATAIN reviews for babies >37 weeks				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Missing Q1 reviews from last report.	ATAIN group	Q2	All Q1 reviews complete. There was 1 avoidable admission. Action: Present case and learning to perinatal meeting	
Lack of ATAIN reviews for Q2.	ATAIN group	Q3	Exceptional dates agreed.	
CAT 2 C-section timing audit.	BR/SM-G	Q3	Update required (on-going audit). Significant improvement now in a sustained period to ensure continued compliance.	
Update ATAIN meeting TOR as >3yeas old.	ATAIN Group & JB	November 2024	TOR with JB for completion end of November.	Remains amber
Actions from TC pathway for late pre-term babies (34 weeks – 36+6 weeks)				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Discussion of splitting of twins if one requires NICU treatment – keeping mother with infant that only requires TC care.	GD/BR/JB/ SM-G	November 2024	To be discussed in November TC meeting.	Remains in progress

9. Recommendations

The Trust Board are asked to note the contents of the report and agree to sign off the action plan.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.3
Date of meeting:	6th March 2025		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services –**January 2025 (December 2024 data)**			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Divisional Governance 17.01.25 Clinical Governance Committee 28th January 2025			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 6 – Safety Action 9.

As per CNST Maternity Incentive Scheme requirements this will be a monthly report to Trust Board and will require noting in minutes.

Executive Summary:

The Maternity Incentive Scheme (safety action 9) states an expectation that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance take place at Board level monthly. The perinatal Quality Surveillance Models sets out a model to report this and the information required is shared in the Perinatal Quality Surveillance report for SFT for December 2024.

The report comprises of a slide pack which has been designed collaboratively across the LMNS, ensuring that Trust Board at SFT, RUH and GWH are receiving the same metrics for review in each provider across BSW

Summary:

Staffing:

- Midwife to birth ratio 1:22– SFT recommended ratio 1:24. Activity and births reduced in December contributing to low ratio.
- 1:1 care in labour achieved 100% of time

- Supernumerary status of labour ward maintained 100% time.
- Business case being written to propose increase in Neonatal Nurses to achieve BAPM compliance

PMRT

- 2 x stillbirth in December–
  - 1@26 weeks – known anomaly in pregnancy
  - 1 @ term – intrapartum, referred and accepted by MNSI as met referral criteria.

- No PMRT cases for review in December

Incidences reported as moderate.

- 5 Incidences reported as moderate or above.
  - 4 x Term admission to Neonatal Unit. All in process of review at present.
  - 1x Stillbirth

Training

- Compliance for PROMPT, CTG and NLS training as of 90% for November 30th, 2024.

Service user and staff feedback

- Feedback received from varying sources including MNVP, safety champions, friends, and family survey and PALS
- Safety Champions meeting well attended and escalation taken for action by Exec and Non-exec safety champions, You said/We did boards updated monthly on wards.

National Guidance

- CNST compliance 9 out of 10 for 2023. MIS year 6 published in April 2024.
  - ESCALTION: Concerns remain around compliance with Saving Babies Lives. Work ongoing around Saving babies lives Vs 3.

Perinatal Culture and Leadership Programme:

- Work in place following score survey and more recent cultural survey for SFT perinatal quadrumvirate Action plan to progress improvements and report to Board to ensure Executive and Non-executive team have oversight of the programme and needs of the quad

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

NHS
Salisbury
NHS Foundation Trust

Perinatal Quality Surveillance

January 2025 (December Data)

Maternity and Neonatal Unit

Salisbury Foundation Hospital

Safe: Maternity & Neonatal Workforce

	Target	Threshold		Sept '24	Oct '24	Nov '24	Dec '24	Comment
		Green	Red					
Midwife to birth ratio	1:24	1:24	>1:24	1:30	1.30	1:27	1:22	Ratio decreased this month due to decrease in expected births and acuity.
Compliance with supernumerary Status of LW Coordinator %	0	0	>1	100%	100%	100%	100%	
1:1 care not provided	0	0	>1	0	0	0	0	
Confidence factor in Birthrate+ recording	60%	>60%	<50%	83.3%	83.8%	85.5%	84.4%	Percentage of possible episodes for which data was recorded.
Consultant presence on LW (hours/week)	40	60		40	40	40	60.5	Consultant presence on Labour ward recently amended to align with Ockenden requirements
Neonatal shifts staffed to BAPM standards	100%	>90	<90	-	-	80%	84%	Recruitment plan in place to support BAPM standards compliance
Daily multidisciplinary team ward round	90%	>90%	<80%	100%	100%	100%	100%	
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0	>1	0	0	0	0	

Is the standard of care being delivered?

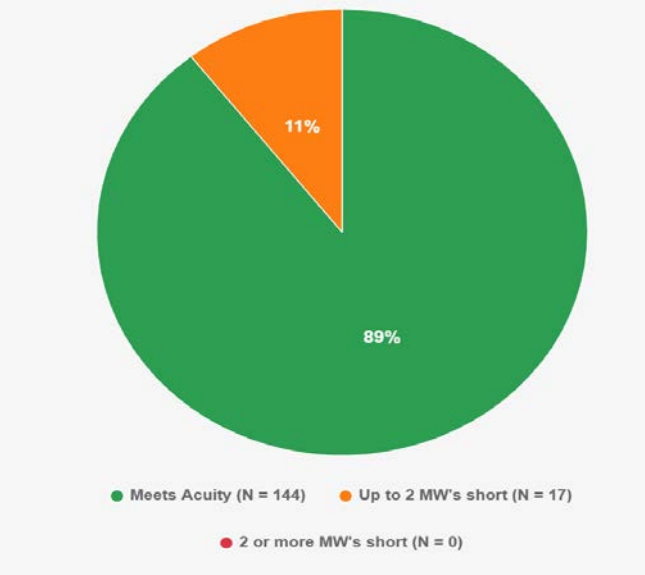
- Supernumerary Labour Ward coordinator status achieved 100% time
- 1:1 care in labour achieved 100% of time

What are the top contributors for under/over-achievement?

- The Midwife to Birth ratio decreased this month due to a decrease in expected births and acuity.
- A recruitment plan is in place to support an increase in NNU workforce to support BAPM standards.

Salisbury NHS Foundation Trust

Graph 1. Acuity by RAG vs staffing data:

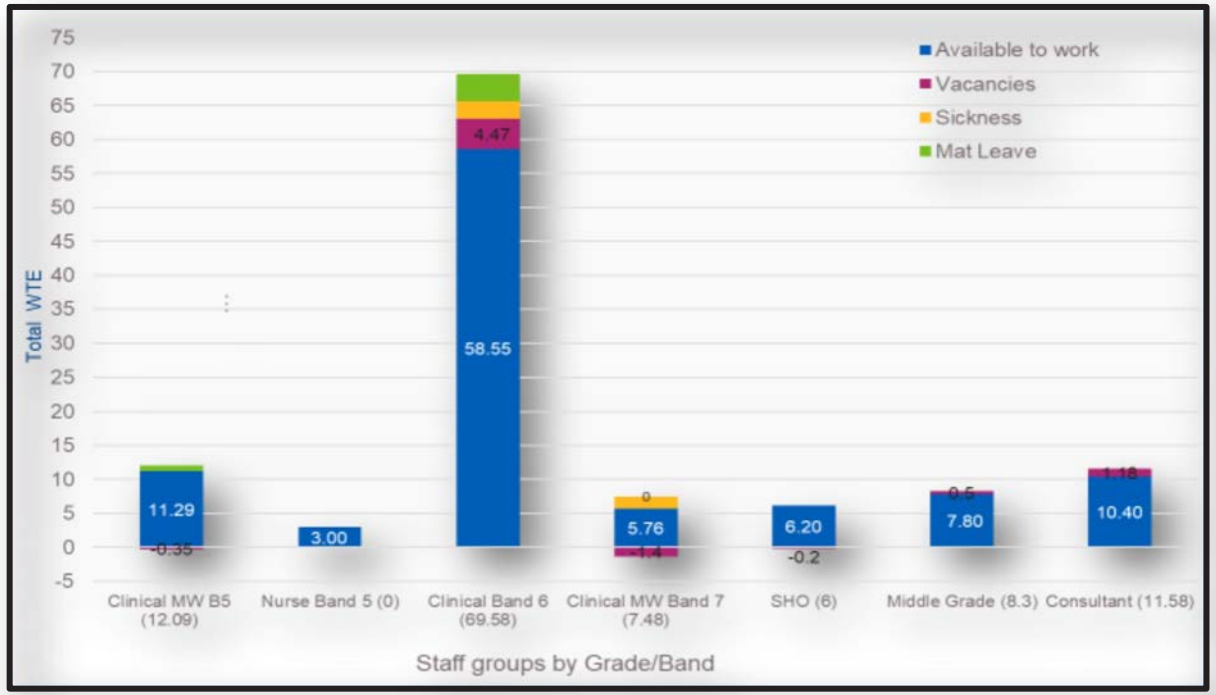


Countermeasures / Action (completed last month)	Owner
NNU Nurse Band 6 recruitment	NNU Matron

Countermeasures / Action (planned this month)	Owner
NNU Nurse Band 5 recruitment	NNU Matron

Safe: Maternity & Neonatal Workforce (cont)

Table 1. Total WTE vacancy and availability to work - by role



Is the standard of care being delivered?

- Our staffing vs acuity ratio was very positive this month showing 89% of the time there were required staffing numbers for acuity

What are the top contributors for under/over-achievement?

- Available workforce numbers this month show an increase due to additional recruitment in month. High levels of short and longterm sickness continue.
- MCA fill rates have been affected by vacancy rate – successful recruitment undertaken in month to improve this.

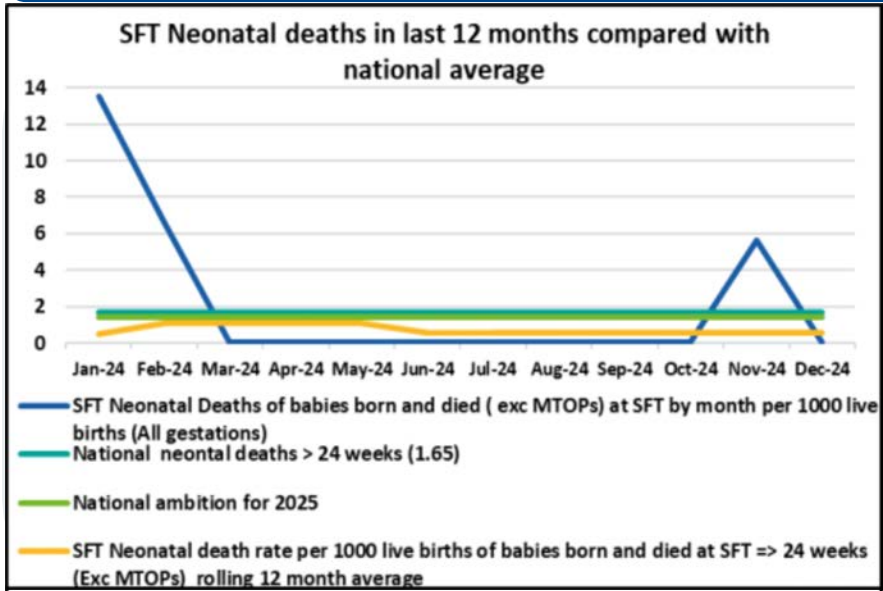
Table 2. Average midwife/MCA/Neonatal nurse shift fill rates

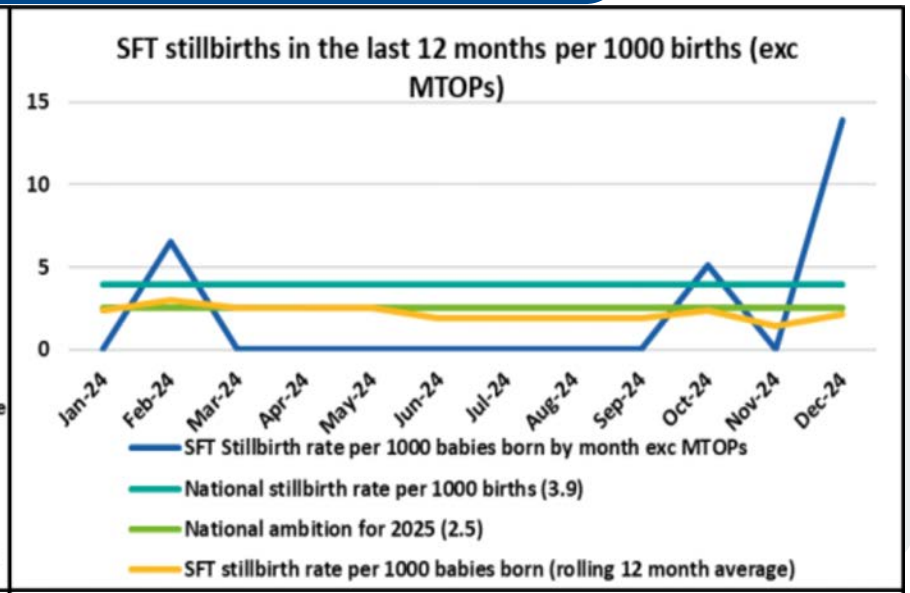
		Sept '24	Oct '24	Nov '24	Dec' 24
Midwives	Day	97.6%	93.95%	99.42%	93.7%
	Night	96.8%	96.50%	96.77%	96.9%
MCA/MSWs	Day	92.8%	92.61%	85.37%	80.8%
	Night	88.7%	91.84%	93%	89.6%
NNU Nurses	Day	-	-	97.04	90.8%
NNU Nurses	Night	-	-	99.7%	93.8%

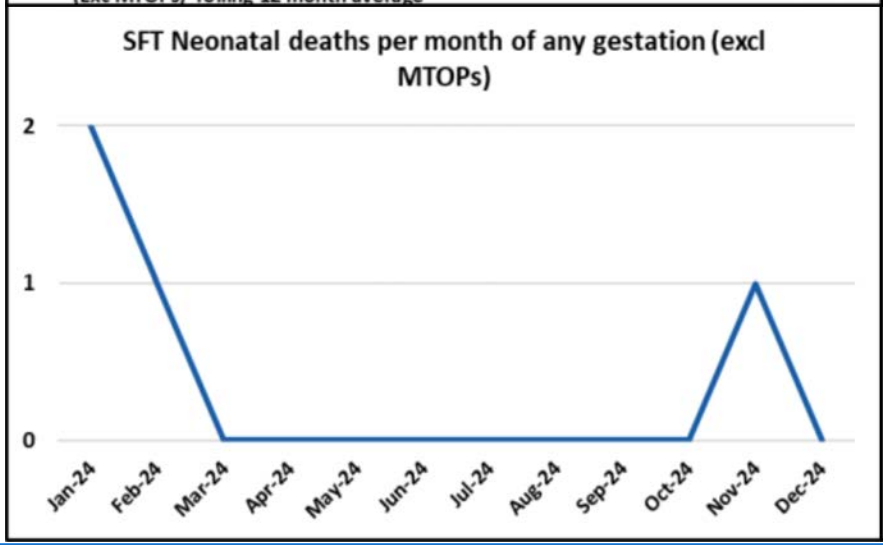
Countermeasures / Action (completed last month)	Owner
MCA recruitment	Workforce lead/HOM
NNU Band 6 recruitment	NNU Matron

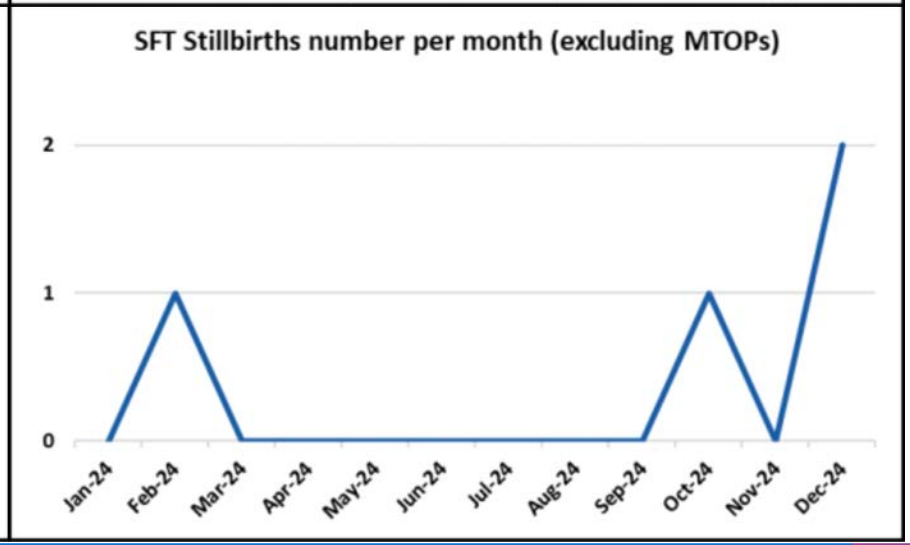
Countermeasures / Action (planned this month)	Owner
Review of sickness absence management compliance	HOM

Safe: Perinatal Mortality Review Tool (PMRT)









NHS Salisbury NHS Foundation Trust

- All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT). PMRT reporting is mandated by MIS Safety Action 1 for year 6. A quarterly update paper is shared with the board.
- Neonatal deaths of any gestation are a registerable birth and have been included in these numbers unless stated as excluded.
- Stillbirth rate is presented per 1000 births for national benchmarking, therefore the number presented on the graphs will not automatically correlate to direct numbers per month.
- There were 5 perinatal losses in December > 12 weeks-
- 1 MTOP <22 weeks for medical reasons
- 2 miscarriage < 22 weeks
- 1 stillbirth at 26+3 weeks
- 1 stillbirth at 40 weeks

PMRT Action Plans for Salisbury Foundation Trust – December 2024 review

PMRT case ID	Issue text	Action plan text	Person responsible	Target date
	There were no cases to review under PMRT in December.			

PMRT grading of care – Key

NHS Salisbury NHS Foundation Trust

A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Case Ref	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI? Reference
				The were no cases ready for PMRT review in December		

INCIDENTS: Moderate Incidents and PSRs

NHS Salisbury NHS Foundation Trust

DATIX Incidents classified as moderate harm and above at month end

Case Ref (DATIX no)	Date of incident	Category	Incident Summary	Comments	Commissioned Y / N	MNSI ref no.?	PSII ref no.?
172105	14/12/24	Moderate	Unexpected Term Admission to NNU	Case referred to MNSI with potential for rejection	**N**	**MI 039159**	
172214	18/12/24	Moderate	Unexpected Term Admission to NNU	Case currently being reviewed with potential for reclassification	**N**		
172231	19/12/24	Catastophic	Intrapartum Stillbirth	Referred to MNSI and awaiting notes for full review	**N**	**MI 039163**	
172412	24/12/24	Moderate	Unexpected Term Admission to NNU	Case currently awaiting notes and review with potential reclassification and addition to rolling audit	**N**		
172480	26/12/24	Moderate	Unexpected Term Admission to NNU	Case currently awaiting notes and review with potential reclassification and addition to rolling audit	**N**		

INCIDENTS: Investigation update

NHS Salisbury NHS Foundation Trust

Ongoing Maternity & Neonatal Reviews

Case Ref (DATIX)	Date	Category	Incident	Outcome/Learning/Actions
CCR 613	19/11/2023	Moderate	Eclampsia	Amendments received from readership group. **Next steps**: Amended report sent to risk for review 31/12/24. Action plan to be drafted and sent to DMT, CRG and Exit (for approval).
PSII 162915	29/01/2024	Moderate	Preterm baby transferred to tertiary unit for cooling	Draft report received and awaiting final.
MNSI 163944	04/03/2024	Moderate	Baby transferred to tertiary unit for cooling	Final report received and met with family. **Next steps:** Action plan to be drafted and sent to DMT, CRG readership panel and exit (for approval).

Responsive – Patient Experience

NHS Salisbury NHS Foundation Trust

MNVP Service User feedback (December 2024)

Key achievements and feedback:

Positive Themes:
- Parents feel well supported & listened to

Areas for Improvement:
- More support needed on postnatal ward, especially with early baby care & infant feeding

Safety Champions/ Staff Feedback

Items for escalation:

- GP prescribing: It was recognised that this was an ongoing issue across the LMNS. This concerns has been discussed at previous Safety Champions meetings and at the recent Divisional Governance meeting.
- Availability of children's nursing services in Fordingbridge – The Chief Nursing Officer will liaise with the ICB once in receipt of the full details
- There has been reports of service essential equipment being difficult to get hold of, particularly amino hooks and delivery packs. It was noted that there are often difficulties with the supply chain around Christmas time and there is often an inconsistency around delivery dates. The Chief Nursing officer has taken this as a 'go and see' action with procurement re. process for when supplies are running low.

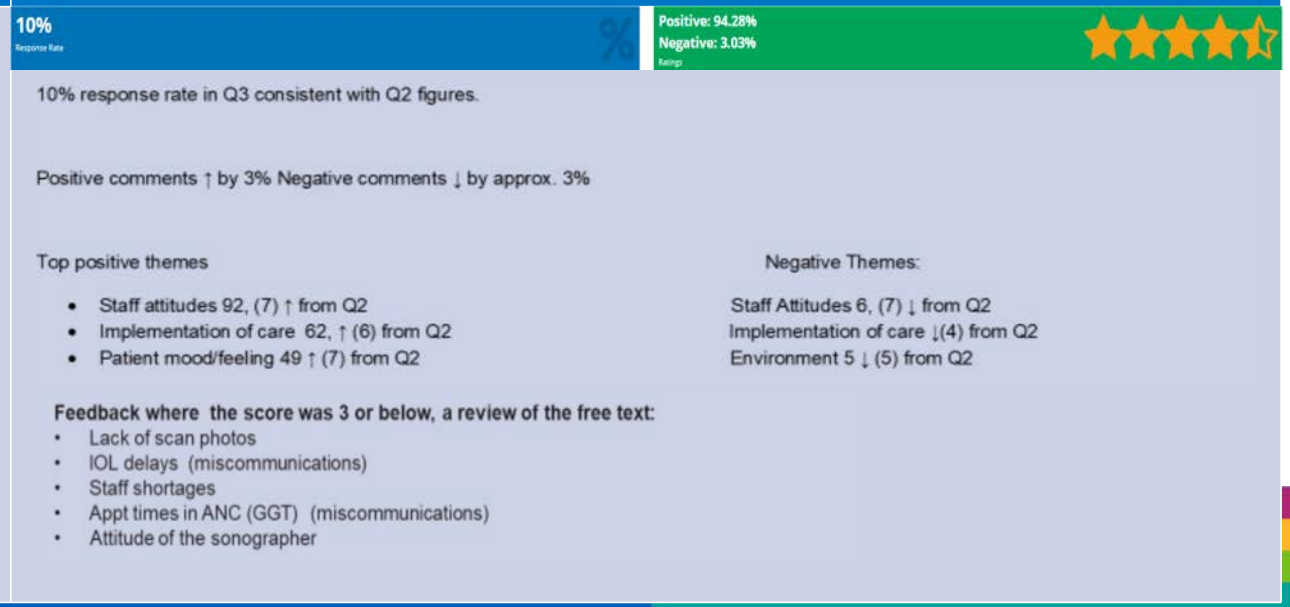
Compliments and Complaints

- **3 complaints and 1 concern logged in December 2024.**
- **19 compliments logged.**
- **15 SOX:**

"Michelle not only worked extremely hard, recognising what tasks needed to be completed within the team seamlessly. On what was a busy day with minimal staffing, to ensure the women in our care received safe postnatal care. More importantly, she recognised a critically ill baby, acting without hesitation to raise the alarm getting help. She then went on to support the family whilst a resuscitation took place, giving full emotional support to the family.

Michelle is a valuable part of the maternity team who is quick to recognise where she can be of help. She is wonderful with the families, offering both practical and emotional support whilst escalating concerns without hesitation".

Friends and Family Test - Q3 summary



Health Inequalities Priorities

Salisbury NHS Foundation Trust

Listening events: No listening events were planned for December 2024.

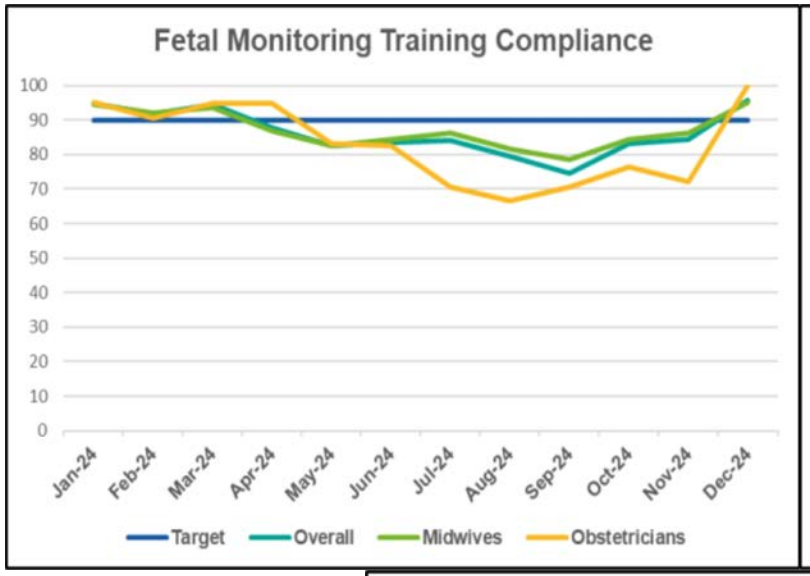
Ongoing Projects: A working party has been appointed to explore the possibility of offering women face to face parent education classes. Work is ongoing to establish a pathway to enable all Hubs to offer in person education classes.

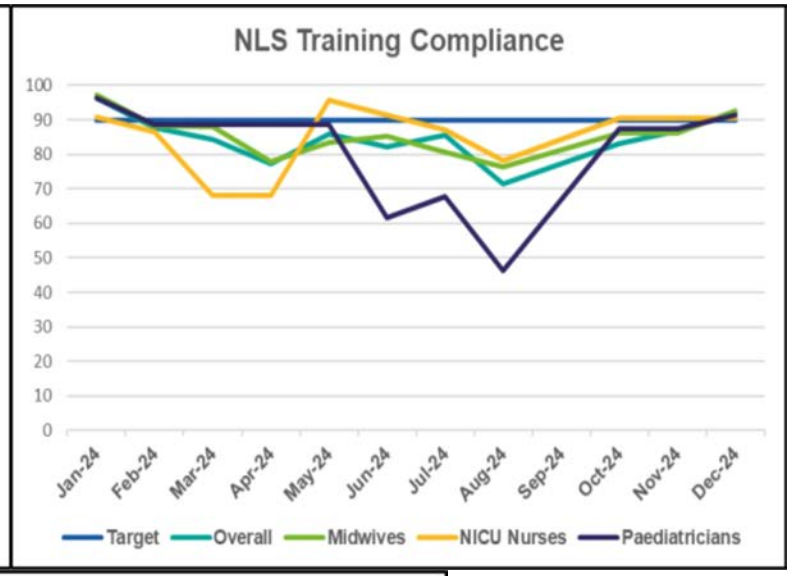
Equality Data: Locally we are starting to interrogate our local data around birth outcomes for women from the global majority groups, and ethnicity data from maternity services such as Bereavement, mental health, PSR/ PSIR, and pelvic health.

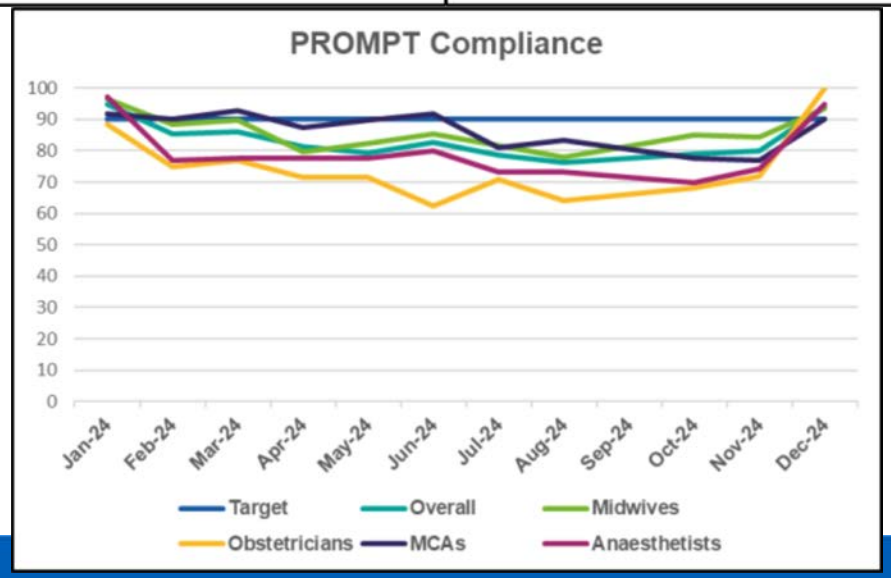
Translation service: As a Trust we are working towards the implementation of a translation tool bar to the Trust's website.

We continue to explore 'at the point of contact' translation services. We hope to purchase 10 'Pocketalk' translation devices (following positive feedback from trials undertaken in Nottingham and Southampton primary care). We are in discussion with Health Innovation Wessex and Scale Innovations in regard to the implementation and evaluation of the device.

Well-led Training







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Training

Updated training plan to commences in 2025 to meet the Core Competency Framework Version 2 requirements, including training requirements for Saving Babies' Lives Care Bundle version 3.

Countermeasures/action:

- 90% training compliance requirements for CNST met for all 3 training elements in all staff groups (30/11/23 - 30/11/24).
- Midwives and MSWs to attend "training week" to cover all maternity-specific requirements.
- Anaesthetics planning to send staff on every PROMPT date evenly throughout 2025 (to maintain compliance rather than see drop-off over summer as in 2024).

Risks:

- Plan needs to be created with obstetrics to meet the SBL training requirements in 2025.

Compliance to National Guidance

Salisbury NHS Foundation Trust

Table 1. CNST Maternity Incentive Scheme – Year 6

	NHSR Maternity Incentive Scheme- Year 5 Submission by 1st February 2024			
	Description	Yr 5 Submission	Comment	Current Assessment
Are we well led?	1 **Perinatal Mortality Review Tool** using to required standard for all perinatal deaths	Compliant	All Standards Met	
	2 **Maternity Services Data Set** submission to required standard	Compliant	All Standards Met	
	3 **Transitional Care Data Set** minimise separation to mothers and babies	Compliant	All Standards Met	
	4 **Clinical Workforce Planning** effective system	Compliant	All Standards Met	
	5 **Midwifery Workforce Planning**	Compliant	All Standards Met	
	6 **Saving Babies Lives Care Bundle V3** compliance with all elements	Non Compliant	New bundle published 31/5/23- Extra element for women with pre pregnancy diabetes. Work in progress. Several barriers to achieving compliance. Compliance is achievable.	
	7 **Service User Involvement and co-Production**	Compliant	All Standards Met	
	8 **Multidisciplinary Training**	Compliant	All Standards Met	
	9 **Board Assurance** Board to Ward to Board	Compliant	All Standards Met	
	10 **HSIB and EN Reporting**	Compliant	All Standards Met	
Person Centred & Safe	Professional	Responsive	Friendly	Progressive

Table 2. Ockenden 2022

OCKENDEN 2022		Immediate and Essential Action	Number of actions under each heading rated			
			RED	AMBER	AWAITING CLOSURE	GREEN
Dec-24	1	Workforce Planning and Sustainability	0	2	0	5
	2	Safe Staffing	0	0	0	10
	3	Escalation and Accountability	0	0	0	5
	4	Clinical Governance - Leadership	0	1	0	7
	5	Clinical Governance - Incident Investigation and Complaints	0	0	0	7
	6	Learning from Maternal Deaths	0	0	0	2
	7	Multidisciplinary Learning	0	0	0	7
	8	Complex Antenatal Care	0	3	0	2
	9	Preterm Birth	0	2	0	2
	10	Labour and Birth	0	1	0	5
	11	Obstetric Anaesthesia	0	1	0	6
	12	Postnatal Care	0	1	0	3
	13	Bereavement Care	0	2	0	2
	14	Neonatal Care	0	1	0	5
	15	Supporting Families	0	0	0	3
			0	14	0	71

Maternity Incentive Scheme (CNST)

Key Achievements:

- Evidence has been initially reviewed within the CNST working group, confident with compliance for 9 of 10 safety actions
- SBL continues to make good progress, awaiting final outcome of November's submission which will determine compliance of SA6

Next steps for progression:

- Evidence to be reviewed in January in line with NHSR guidance and compliance to be presented to Trust board in February

Ockenden 2022

Next steps for progression:

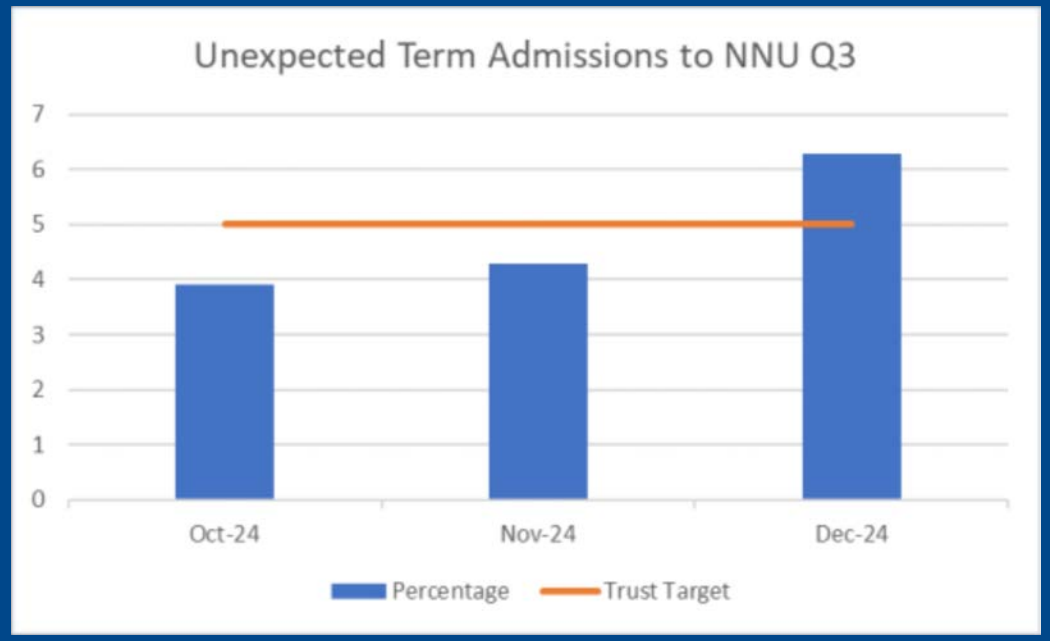
- Work progressing well, the remaining actions are more complex so it is taking longer to see formal closure.
- Target date for closure for remaining actions set, with an aim for closure by end of Q4

Themes

Including PSIRF 'continuous audits' & DATIX

Salisbury NHS Foundation Trust

Unexpected Term Admission to NICU



Q3 Average = 4.8%

Learning and Actions:

- Absence of a 'Golden Hour' has been identified as a theme in several cases where babies have been hypothermic and or experienced low blood sugars.
- There is ongoing work to establish an action plan to improve this for women and babies, including 'Golden Hour' month in February.
- The temperature in Obstetric Theatre is also being audited by the team and results will be fed through the Labour Ward Forum.
- Our term admission rate remains within national targets.

Perinatal Culture & Leadership Programme

NHS Salisbury NHS Foundation Trust

Aims of the programme:

- To support Perinatal leadership teams to develop the conditions for a positive culture of safety and continuous improvement.
- To drive change with a better understanding of the relationship between leadership, safety improvement and safety culture.

Current position:

Since the updated staff questionnaire which was circulated in September and October 2024, the following progress has commenced:

- The results of the Culture & Leadership staff survey has been shared with the wider leadership team
- The Perinatal Quad are currently working through an action plan for each of the themes identified across the SCORE Survey, with an aim of some of this work to be driven and shaped by the workforce
- Some of the feedback from the survey has been around visibility of the leadership team, in response to this members of the Perinatal Quad and wider leadership team have focussed on visibility with staff in the weeks leading up to Christmas, to talk about the work of the Quad and hear thoughts of staff.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.4
Date of meeting:	6th March 2025		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services – **February 2025 (January 2025 data)**			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Divisional Governance 21.02.2025 CGC 25th February 2025			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 6 – Safety Action 9.

As per CNST Maternity Incentive Scheme requirements this will be a monthly report to Trust Board and will require noting in minutes.

Executive Summary:

The Maternity Incentive Scheme (safety action 9) states an expectation that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance take place at Board level monthly. The perinatal Quality Surveillance Models sets out a model to report this and the information required is shared in the Perinatal Quality Surveillance report for SFT for January 2025.

The report comprises of a slide pack which has been designed collaboratively across the LMNS, ensuring that Trust Board at SFT, RUH and GWH are receiving the same metrics for review in each provider across BSW

Summary:

Staffing:

- Midwife to birth ratio 1:25– SFT recommended ratio 1:24. Increased acuity and sickness in January contributing to ratio.
- 1:1 care in labour achieved 100% of time

- Supernumerary status of labour ward maintained 100% time.
- Business case being written to propose increase in Neonatal Nurses and Medical staffing to achieve BAPM compliance

PMRT

- 0 stillbirth in January
- 0 Neonatal death in January

- 1 PMRT cases for review in January -Graded A and B
    - **A** - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
    - **B** - The review group identified care issues which they considered would have made no difference to the outcome for the mother

Incidences reported as moderate.

- 1 Incidences reported as moderate or above.
    - 1x OASI

Service user and staff feedback

- Feedback received from varying sources including MNVP, safety champions, friends, and family survey and PALS
- Safety Champions meeting well attended and escalation taken for action by Exec and Non-exec safety champions, You said/We did boards updated monthly on wards.

Health Inequalities

- Work to enable parent education to be offered in person
- Listening events planned for Afghan refugee community in Tidworth
- Continued work to purchase translation tools – 'pocket talk'

Themes

- Maternity Early warning Score and Newborn Early warning Track and Trigger introduced in Q3.
    - Actions in place to address NEWTT2 audit compliance.

Perinatal Culture and Leadership

- Staff event in the spring, with a focus on OD&L, Wellbeing and celebrating Maternity & Neonatal services.
- The "team of the shift" model continues to be used, to have a team check-in and support each other on shift.

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

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Perinatal Quality Surveillance

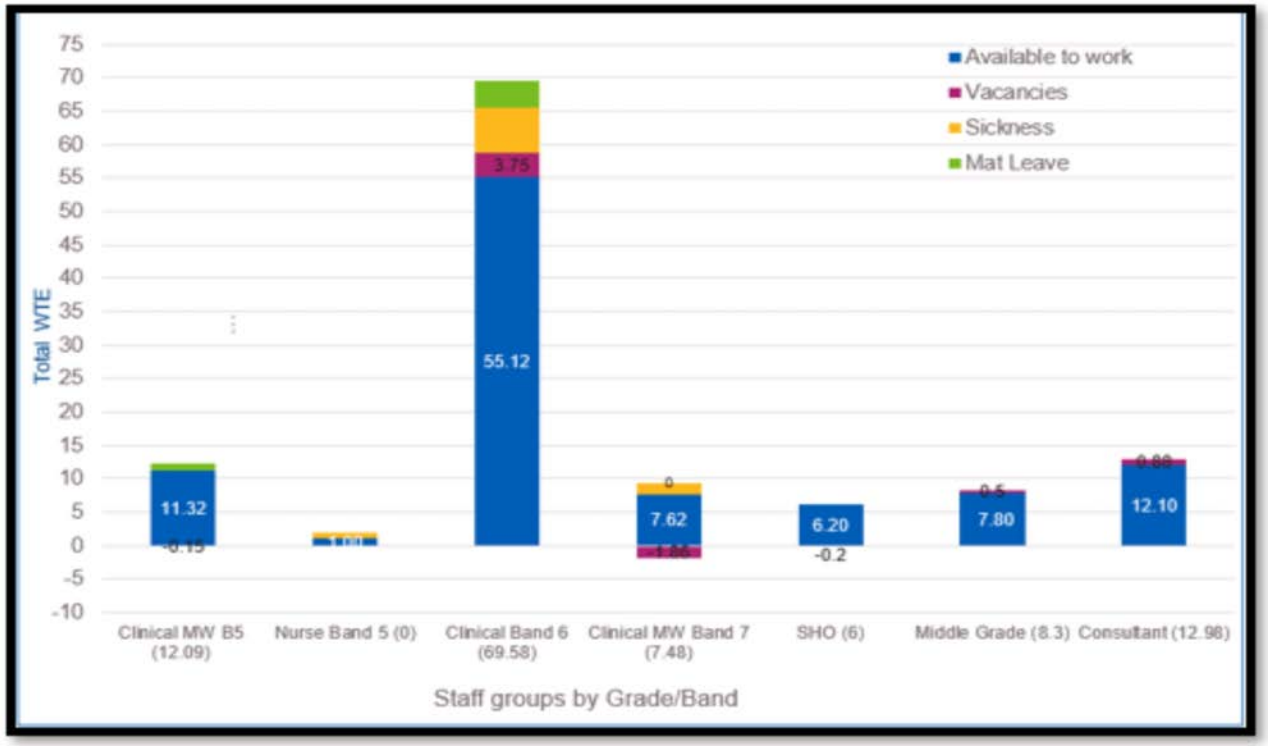
February 2025 (January Data)

Maternity and Neonatal Unit

Salisbury Foundation Hospital

Safe: Maternity & Neonatal Workforce

Table 1. Total WTE vacancy and availability to work - by role



Is the standard of care being delivered?

- Staffing vs acuity ratio was very positive this month showing 95% of the time there were required staffing numbers for acuity.

What are the top contributors for under/over-achievement?

- Available workforce numbers this month show a decrease due to increased levels of short and long-term sickness.
- MCA fill rates have been affected by vacancy rate – successful recruitment undertaken in month to improve this with new starters due in February.

Table 2. Average midwife/MCA/Neonatal nurse shift fill rates

		Oct '24	Nov '24	Dec '24	Jan '25
Midwives	Day	93.95%	99.42%	93.7%	98.3%
	Night	96.50%	96.77%	96.9%	97.5%
MCA/MSWs	Day	92.61%	85.37%	80.8%	86.5%
	Night	91.84	93%	89.6%	94.4%
NNU Nurses	Day	-	97.04%	90.8%	88.70%
NNU Nurses	Night	-	99.7%	93.8%	95.8%

Countermeasures / Action (completed last month)	Owner
MCA recruitment	Workforce lead/HOM
NNU Band 6 recruitment	NNU Matron

Countermeasures / Action (planned this month)	Owner
Review of sickness absence management compliance.	HOM

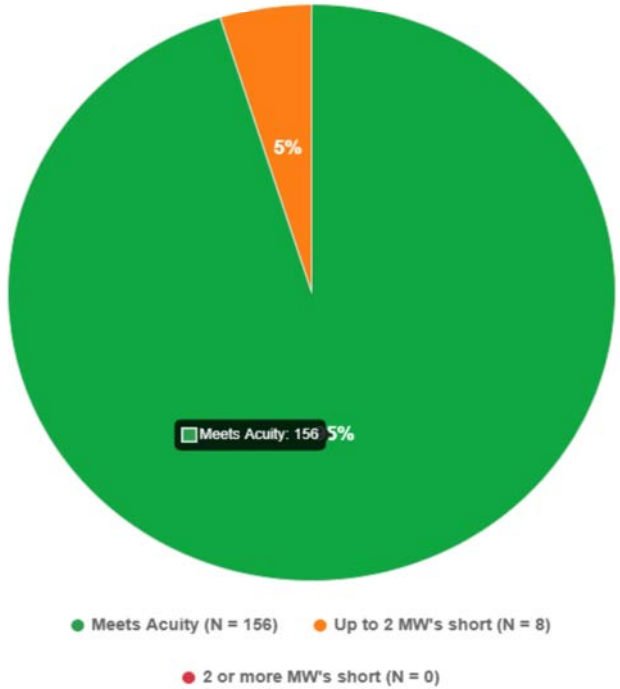
Safe: Maternity & Neonatal Workforce (cont)

	Target	Threshold		Oct '24	Nov '24	Dec '24	Jan '25	Comment
		Green	Red					
Midwife to birth ratio	1:24	1:24	>1:24	1:30	1.27	1:22	1:25	Ratio slightly increased this month due to expected births and acuity resuming to normal monthly activity.
Compliance with supernumerary Status of LW Coordinator %	0	0	>1	100%	100%	100%	100%	
1:1 care not provided	0	0	>1	0	0	0	0	
Confidence factor in Birthrate+ recording	60%	>60%	<50%	83.8%	85.5%	84.4%	86.02 %	Percentage of possible episodes for which data was recorded.
Consultant presence on LW (hours/week)	40	60		40	40	60	60	Consultant presence on Labour ward recently amended to align with Ockenden requirements.
Neonatal shifts staffed to BAPM standards	100%	>90	<90	-	80%	84%	95.16 %	Recruitment plan in place to support BAPM standards compliance.
Daily multidisciplinary team ward round	90%	>90%	<80%	100%	100%	100%	100%	
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0	>1	0	0	0	0	

Is the standard of care being delivered?
- Supernumerary Labour Ward coordinator status achieved 100% time.
- 1:1 care in labour achieved 100% of time.

What are the top contributors for under/over-achievement?
- The Midwife to Birth ratio increased this month due to resumption of expected birth numbers.

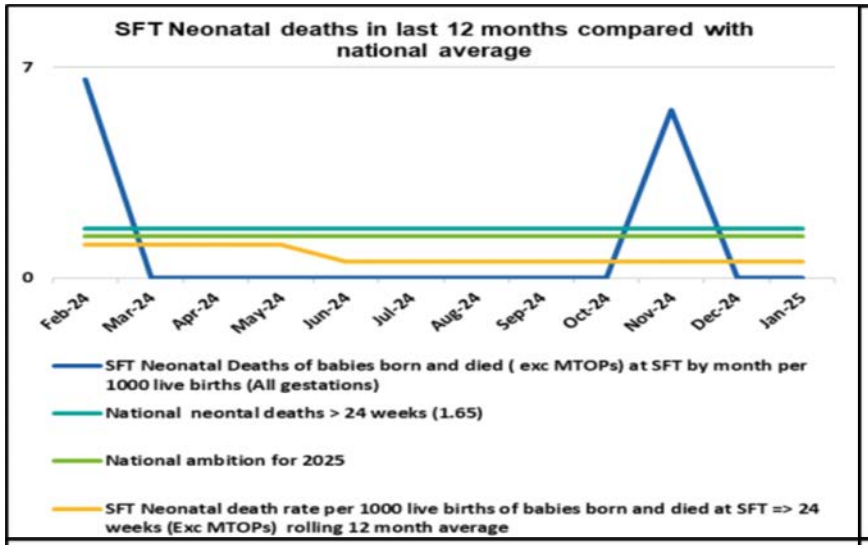
Graph 1. Acuity by RAG vs staffing data:

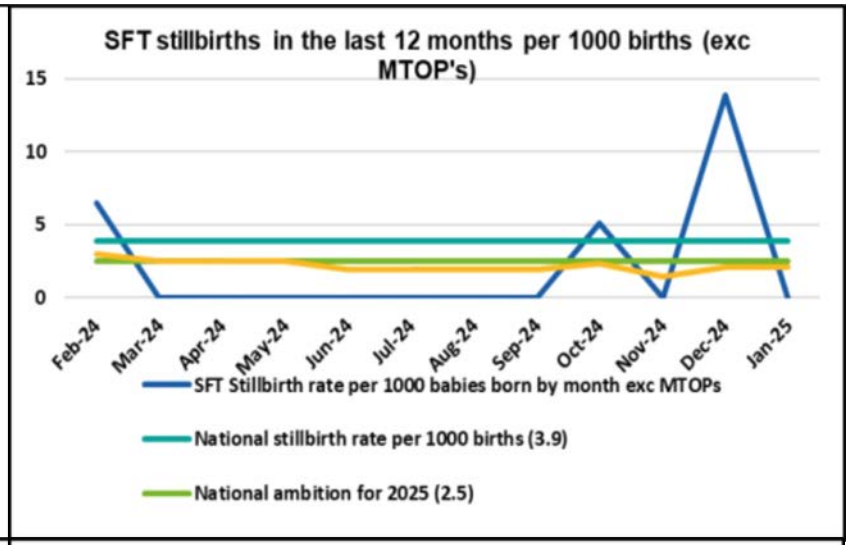


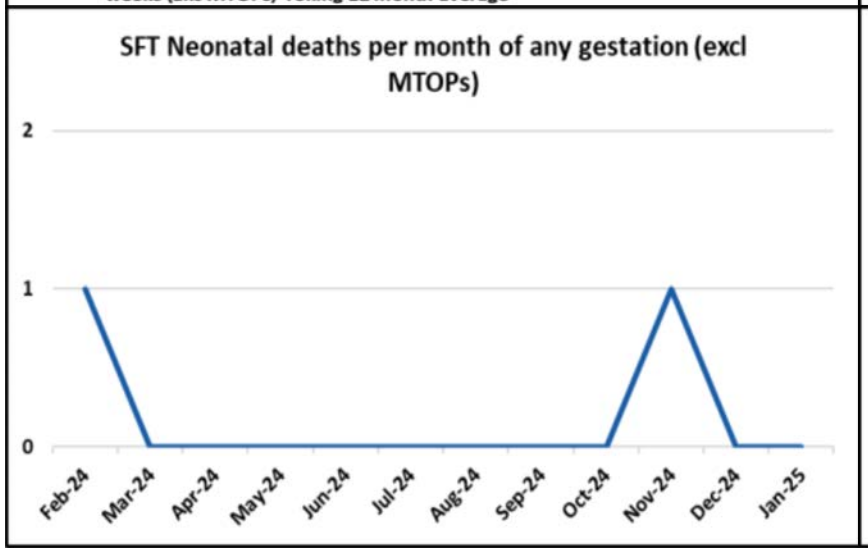
Countermeasures / Action (completed last month)	Owner
NNU Nurse Band 6 recruitment	NNU Matron

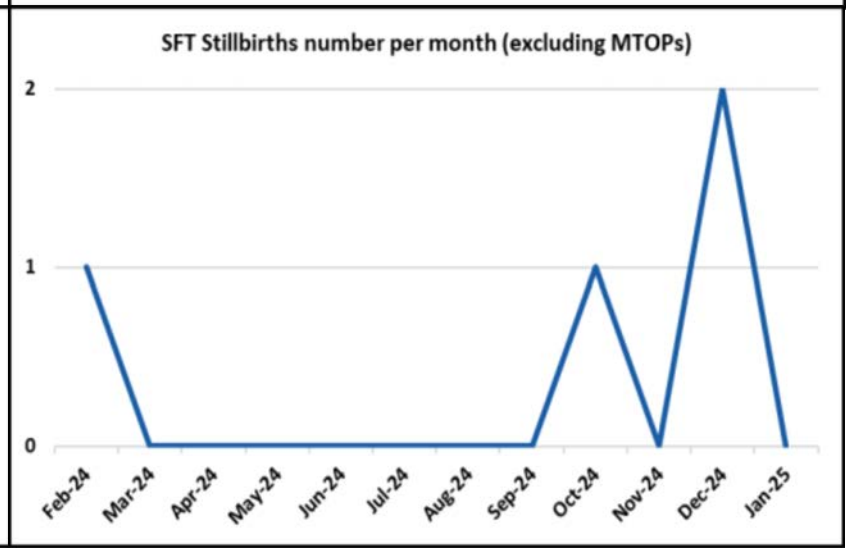
Countermeasures / Action (planned this month)	Owner
NNU Nurse Band 5 recruitment	NNU Matron

Safe: Perinatal Mortality Review Tool (PMRT)









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- All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT). PMRT reporting is mandated by MIS Safety Action 1 for year 6. A quarterly update paper is shared with the board.
- Neonatal deaths of any gestation are a registerable birth and have been included in these numbers unless stated as excluded.
- Stillbirth rate is presented per 1000 births for national benchmarking, therefore the number presented on the graphs will not automatically correlate to direct numbers per month.
- There was 1 perinatal loss in January >12 weeks.
- 17+2 weeks miscarriage.

PMRT Action Plans for Salisbury Foundation Trust – January 2025 review

PMRT case ID	Issue text	Action plan text	Person responsible	Target date
95895/1	Stillbirth 25 weeks	Share learning with GP surgeries re preconception care. Education and update days – use of partogram. Bloods to chase and review.	S. Thompson and CLA	31/3/25

PMRT grading of care – Key

NHS Salisbury NHS Foundation Trust

A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Case Ref	Date	Category	Incident	Outcome/Learning/Actions	MNSI Reference	SI? Reference
Case: 95895/1	3/1/25	A B	Stillbirth 25/40	History pf severe pre-eclampsia – share learning with GP surgeries re preconception care. Partogram not used in labour – to discuss on education and update days. A couple of bloods initially not taken – to chase and review.	N/A	N/A

INCIDENTS: Moderate Incidents and PSRs

NHS Salisbury NHS Foundation Trust

DATIX Incidents classified as moderate harm and above at month end

Case Ref (DATIX)	Date of incident	Category	Incident Summary	Comments	Commissioned Y / N	MNSI ref no.?	PSII ref no.?
173444	31/01/25	Moderate	OASI	Case currently being reviewed	**N**		

PSRs Presented in the last month

Datix	Date Presented to PSS	Incident Summary	Actions	Part 2/ PSII?
172412 Part 1	7/1/25	Unexpected poor outcome. Escalation issues apparent in initial review	• Conversation with team involved to understand thought process. • To share this case example as part of the clinical escalation toolkit work with LWC, Obstetricians and midwives regarding CTG escalation concerns.	Part 2 in draft
172480 Part 1	7/1/25	EMCS followed by NICU Admission. Influenza A Positive	• Positive learning of effective escalation of patient deterioration and CTG deterioration. • To share learning via clinical escalation update.	No
171165 Part 2	14/1/25	PPH 1.5L and decision making	• Reminder of all staff to ensure PPH Proforma is completed contemporaneously during emergency scribing – added to the shift change daily safety bulletin. • Sensitive reflective conversations with staff involved to help improve documentation.	No
171321 Part 1	14/1/25	NLS and use of Naloxone without NICU admission	• Immediate teaching has been provided within the Paediatric Team to ensure any baby receiving Naloxone is admitted to NICU. • Ongoing investigation into the use of Naloxone during NLS.	Part 2 in draft
172231 Part 1	14/1/25	Intrapartum Stillbirth	• This case has been referred to MNSI. • Immediate learning has been identified with the GP referral processes, use of translation services and community follow up processes.	Part 2 in draft

INCIDENTS: Investigation update

Salisbury NHS Foundation Trust

Ongoing Maternity & Neonatal Reviews

Case Ref (DATIX)	Date	Category	Incident	Outcome/Learning/Actions
CCR 613	19/11/2023	Moderate	Eclampsia	Final signed report received. **Next steps**: Report share tba. Actions to be added to the action tracker.
PSII 162915	29/01/2024	Moderate	Preterm baby transferred to tertiary unit for cooling	Feedback provided on draft report. Awaiting final report.
MNSI 163944	04/03/2024	Moderate	Baby transferred to tertiary unit for cooling	Final report received and met with family. **Next steps:** Action plan drafted, for review by DMT and to PSOG group (for approval).

Responsive – Patient Experience

Salisbury NHS Foundation Trust

MNVP Service User Feedback

Positive Themes:

- Parents feel well supported & listened to.
- Good Scan appointments.
- Flexibility of ANC appointments.
- Reassuring consultant.

Areas for improvement:

- More support needed on postnatal ward, especially with early baby care & infant feeding.
- No pelvic health support.

Complaints and Concerns

Complaints received	Summary / themes
2	Poor care and communication received in antenatal clinic.
	Unhappy with postnatal advice given.

Concerns received	Summary / themes
0	N/A

Service User Compliments

- **5 compliments reported on Datix in January**

Compliments top themes	Numbers received
Gratitude	4
Exceptional care	1

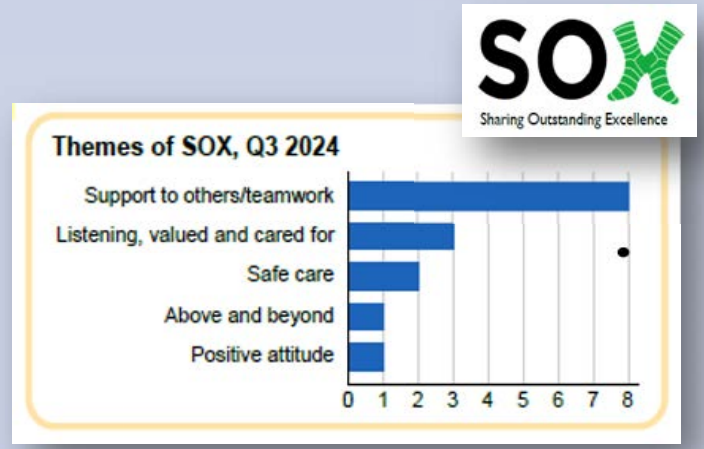
Friends and Family Test

Response rate	% Positive	% Negative
10%	92.2%	4.4%

Top 3 themes

Positive	Negative
• Staff attitudes (30) • Patient mood/feeling (20) • Implementation of care (18)	• Staff attitude (4) • Clinical Treatment (2) • Communication (2)

Sharing Outstanding Excellence (SOX)



Safety Champions

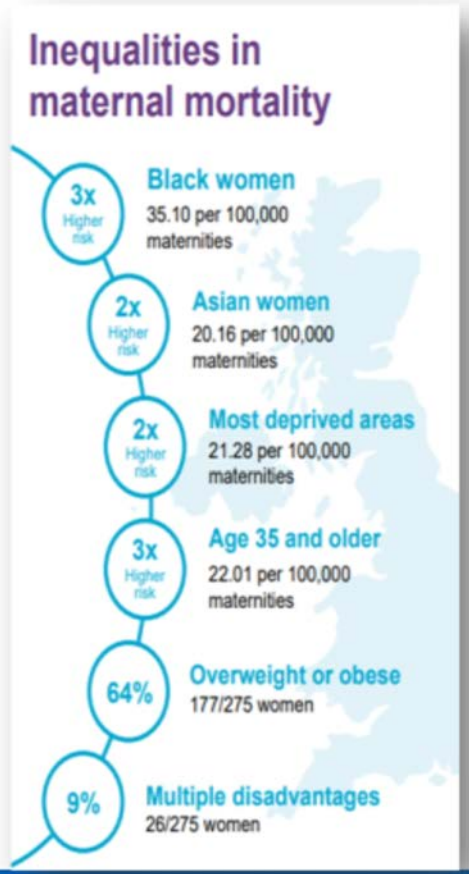
Concerns from staff	Action
Delays to obstetric medical reviews on Beatrice Maternity Ward.	Audit being undertaken to understand the incidence and action plan to be made.

You said, we did...

'Episiotomy scissors are blunt.'

'Programme for sharpening scissors has been provided by sterile services and reminder to staff re process for this outside of these times.'

Health Inequalities - Priorities



Listening events: to take place in February targeting hearing the voices of women from the 'Entitled people'/ Afghan refugee community.

Ongoing Projects: work is ongoing to establish a pathway to enable all Community Hubs to offer in-person parent education classes.

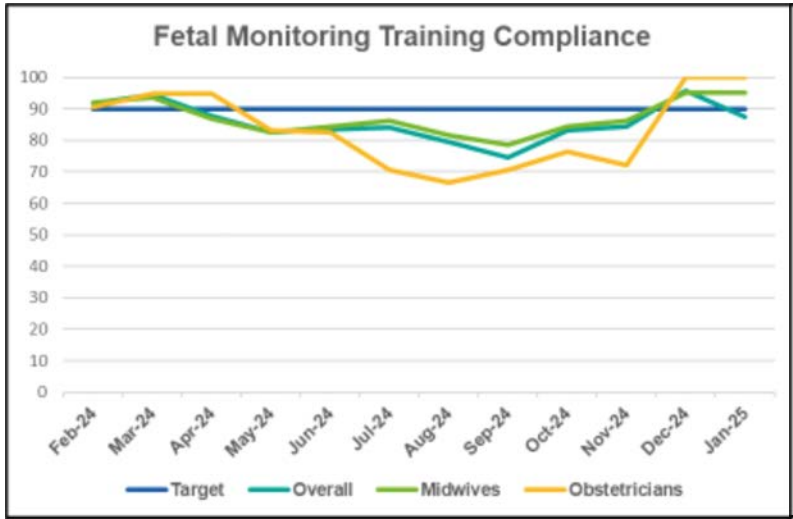
Equality Data: work is ongoing to identify local clinical outcome data. A local health inequalities database is planned for summer 2025. This will support targeted activities and bench-marking against national MBRRACE data .

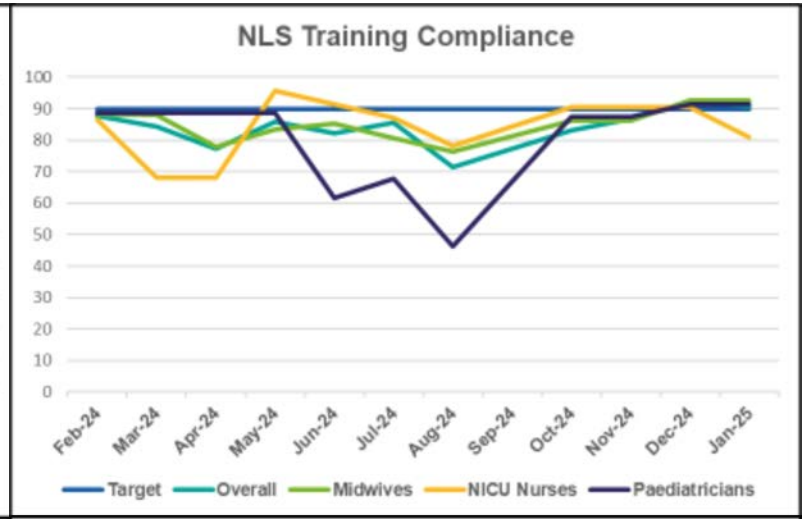
Translation service: translation tool bar functionality to be implemented on the Trust's website.

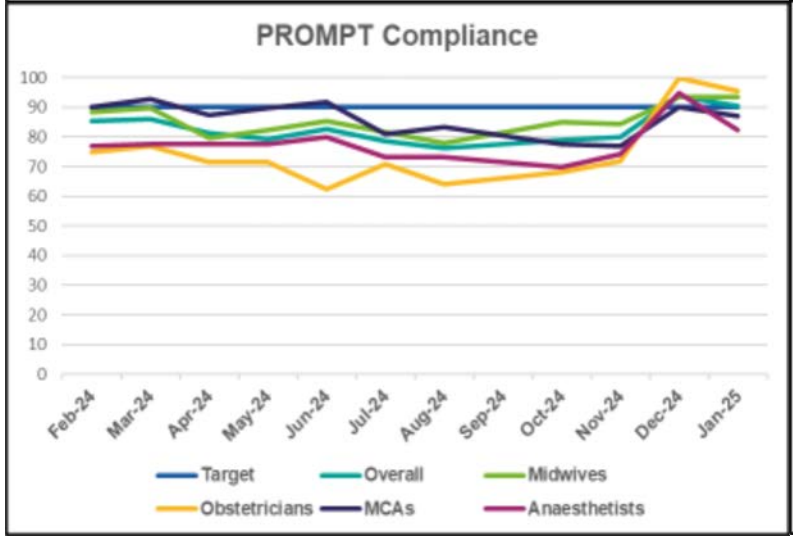
We continue to explore 'at the point of contact' translation services. We hope to purchase 10 'Pocketalk' translation devices (following positive feedback from trials undertaken in Nottingham and Southampton primary care). Steady progress has been made, and it is hoped we will roll out the device in March/ April 2025

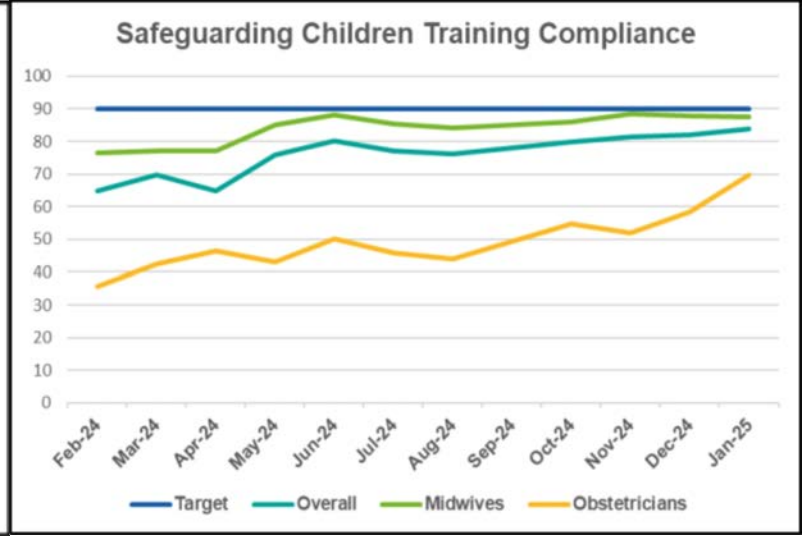
Well-led Training

Salisbury NHS Foundation Trust









Training

Updated training plan to commences in 2025 to meet the Core Competency Framework Version 2 requirements, including training requirements for Saving Babies' Lives Care Bundle version 3.

Countermeasures/action:

- Anaesthetics planning to send staff on every PROMPT date evenly throughout 2025 (to maintain compliance rather than see drop-off over summer as in 2024) - this was achieved in January.
- Additional SG Children sessions being planned within maternity to maintain compliance in 2025 (limited dates available with Trust SG team).

Risks:

- MDT attendance (obstetric) at all PROMPT and fetal monitoring training is a challenge and not meeting CCFv2 requirements.
- Obstetric engagement with eLearning requirements of SBL is a challenge and has been escalated.

Compliance to National Guidance (1)

CNST Maternity Incentive Scheme (Year 6)

	NHSR Maternity Incentive Scheme- Year 5 Submission by 1st February 2024			
		Description	Yr 5 Submission	Comment	Current Assessment
Are we well led?	1	**Perinatal Mortality Review Tool** using to required standard for all perinatal deaths	Compliant	All Standards Met	
	2	**Maternity Services Data Set** submission to required standard	Compliant	All Standards Met	
	3	**Transitional Care Data Set** minimise separation to mothers and babies	Compliant	All Standards Met	
	4	**Clinical Workforce Planning** effective system	Compliant	All Standards Met	
	5	**Midwifery Workforce Planning**	Compliant	All Standards Met	
	6	**Saving Babies Lives Care Bundle V3** compliance with all elements	Compliant	Met best endeavours of improvement	
	7	**Service User Involvement and co-Production**	Compliant	All Standards Met	
	8	**Multidisciplinary Training**	Compliant	All Standards Met	
	9	**Board Assurance** Board to Ward to Board	Compliant	All Standards Met	
	10	**HSIB and EN Reporting**	Compliant	All Standards Met	

Maternity Incentive Scheme (CNST)

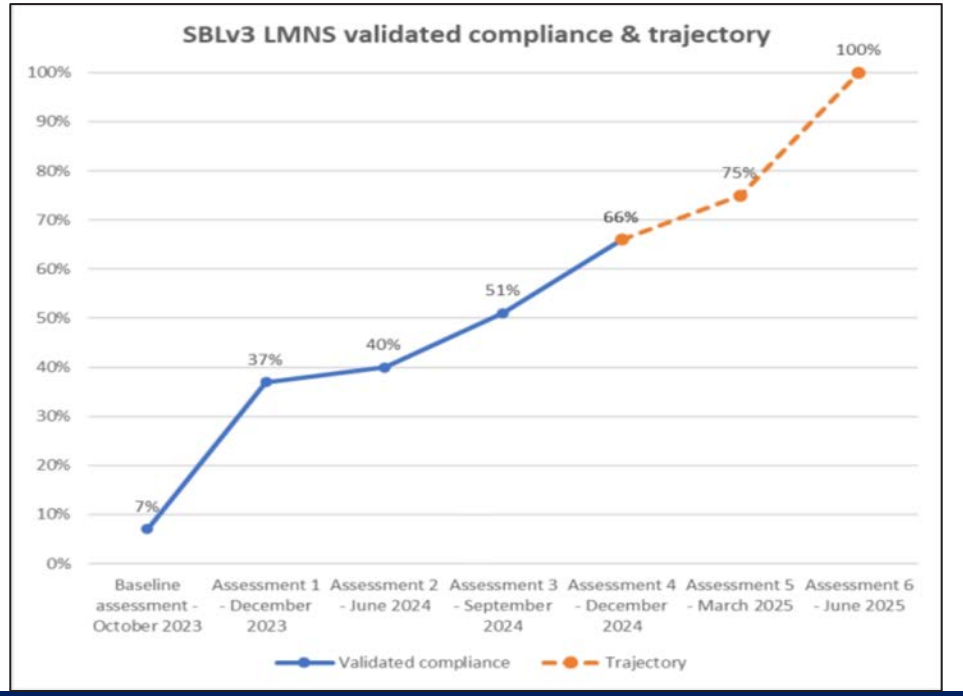
Key Achievements:

- Evidence and report have been submitted to Trust Board for presenting in February, declaring 10 out of 10 compliance.
- SBL SA 6 met best endeavours of progression and local trajectory for compliance has been signed off and agreed.

Next steps for progression:

- Continue to focus on completion of SBL and await guidance for MIS Year 7.

Saving Babies Lives v3



Saving Babies Lives v3

Key Achievements:

- SFT have achieved 66% compliance from the recent November 2024 submission. This has been agreed with the LMNS as best endeavours which makes SFT compliant for CNST MIS.

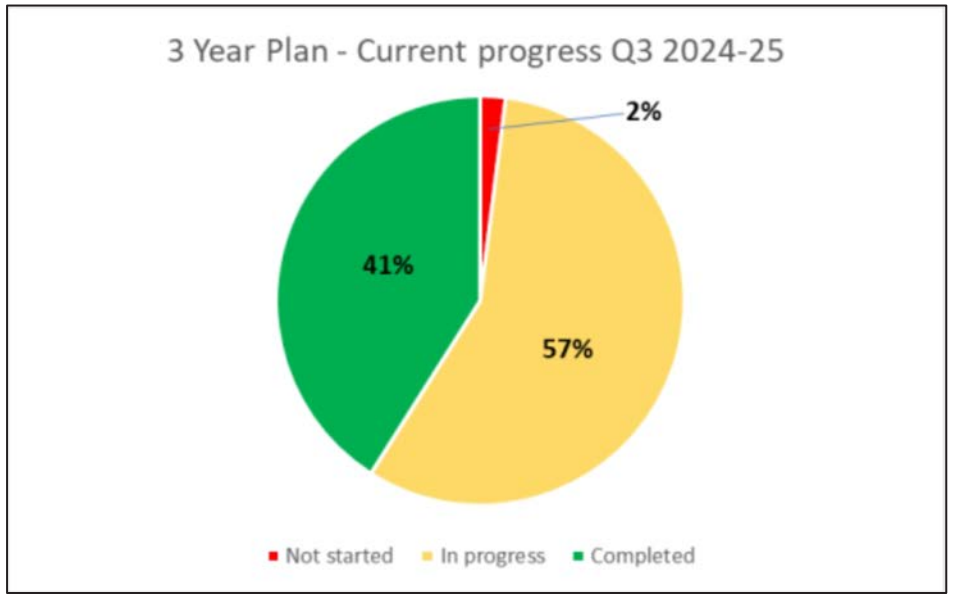
Next steps for progression:

- Next submission is February 2025 (for Quarter 3 2024-25 data).

Compliance to National Guidance (2)

NHS Salisbury NHS Foundation Trust

3 Year Delivery Plan



Ockenden 2022

OCKENDEN 2022		Immediate and Essential Action	Number of actions under each heading rated			
			RED	AMBER	AWAITING CLOSURE	GREEN
Jan-25	1	Workforce Planning and Sustainability	0	2	0	5
	2	Safe Staffing	0	0	0	10
	3	Escalation and Accountability	0	0	0	5
	4	Clinical Governance - Leadership	0	1	0	7
	5	Clinical Governance - Incident Investigation and Complaints	0	0	0	7
	6	Learning from Maternal Deaths	0	0	0	2
	7	Multidisciplinary Learning	0	0	0	7
	8	Complex Antenatal Care	0	2	1	2
	9	Preterm Birth	0	2	0	2
	10	Labour and Birth	0	0	1	5
	11	Obstetric Anaesthesia	0	1	0	6
	12	Postnatal Care	0	1	0	3
	13	Bereavement Care	0	1	1	2
	14	Neonatal Care	0	1	0	5
	15	Supporting Families	0	0	0	3
			0	11	3	↑71

3-Year Delivery Plan

Key Achievements:

- 15 actions have been completed with a further 25 in progress and no concerns identified.

Next steps for progression:

- Only 1 action not started yet – Provide admin support to free up pressured clinical time – HoM is the action holder and aware.

Ockenden 2022

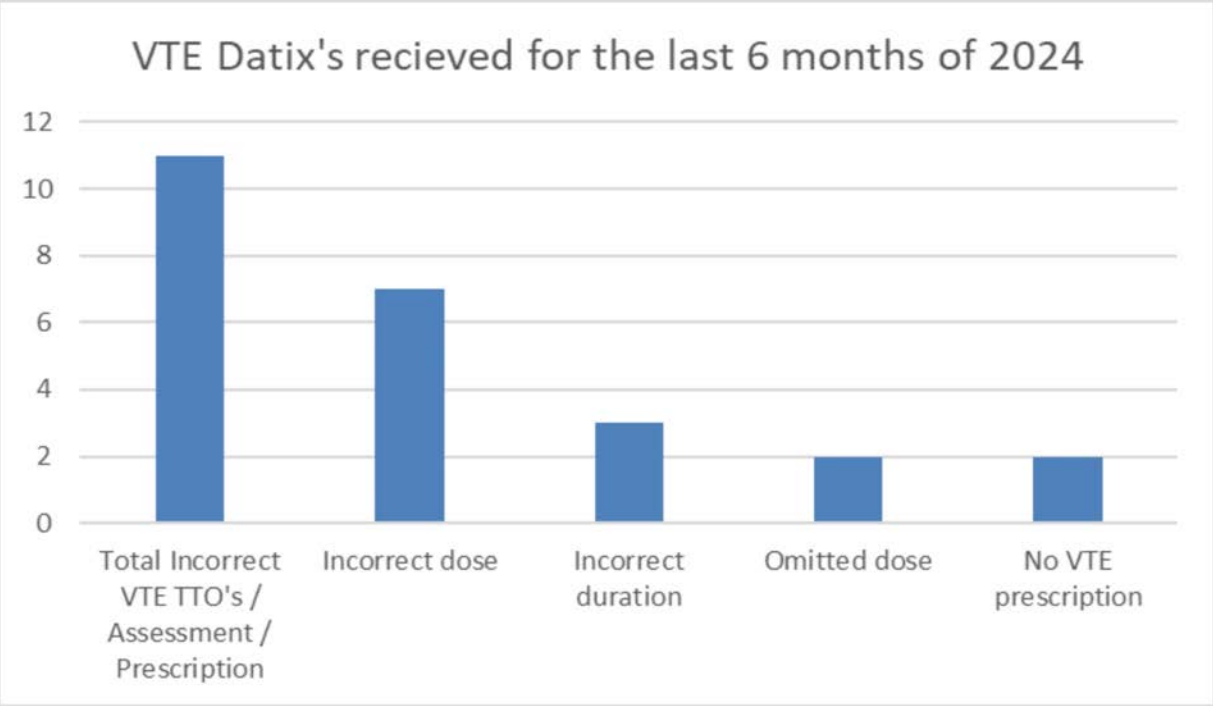
- **Key achievements:** Compliance achieved in areas of bereavement care services availability daily, MDT working and training being job planned, risk assessments in labour, induction of labour pathways and expert fetal monitoring advice.
- **Next steps for progression:** Ongoing work continues around having specialist antenatal clinics for complex care, consultant reviews of all postnatal readmissions, labour ward coordinator leadership education, succession planning gap analysis and leadership development training, maternity self-assessment, centralised CTG monitoring and anaesthetic documentation.

Themes

Including PSIRF 'continuous audits' & DATIX

Salisbury NHS Foundation Trust

VTE Assessment and Prescription Errors



VTE Assessment and Prescription errors

Results

- Theme with one particular healthcare professional – have been provided with feedback and additional training.
- Discharge summaries on Lorenzo also being reviewed re prescribing TTO's like LMWH.

Actions

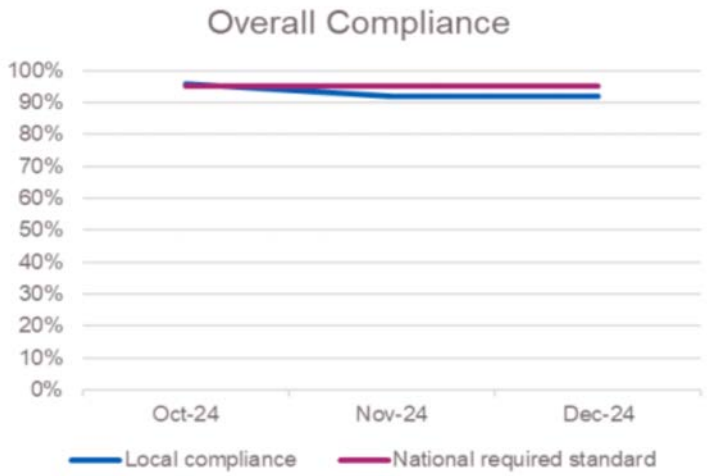
All Datix submissions were provided by the Pharmacy team and not identified by the Midwifery team. Therefore, the follow actions have been drafted:

- Focus group set up – met in January with plan to await BadgerNet rollout due February. VTE risk assessment is an automatic process here.
- Safety notice – VTE risk assessment must be the responsibility of the midwife at birth to ensure correct assessment and prescription request.
- Thematic review planned.

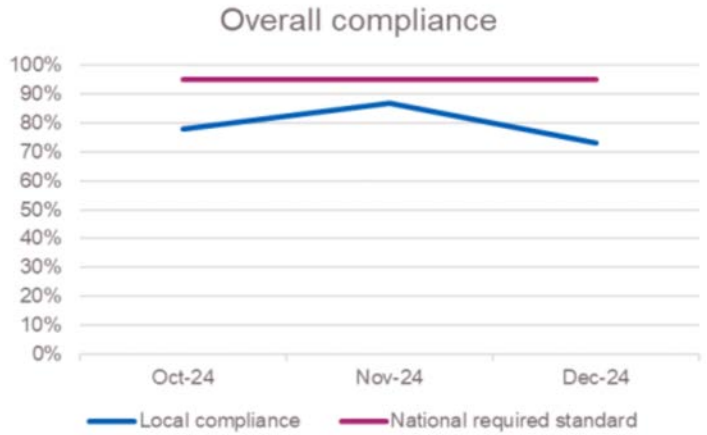
Themes (cont)
Clinical Deterioration (Q3 data)

Salisbury NHS Foundation Trust

Modified Early Warning Score (MEWS)



Newborn Early Warning Track & Trigger (NEWTT 2)



Modified Early Warning Score (MEWS)

- Introduced new national MEWS charts within maternity and across the Trust on 18th November 2024.
- Audits have evidenced that there has been no decrease in compliance since the introduction.

Newborn Early Warning Track & Trigger (NEWTT 2)

- Introduced the new national NEWTT charts within maternity and for all transitional care babies in NNU on 18th November 2024.
- Slight deduction in compliance which is being addressed through cascade emails, safety briefing and spot checks by the audit lead.

Perinatal Culture & Leadership Programme

NHS Salisbury NHS Foundation Trust

Aims of the programme:

- To support Perinatal leadership teams to develop the conditions for a positive culture of safety and continuous improvement.
- To drive change with a better understanding of the relationship between leadership, safety improvement and safety culture.

Current position:

- The Perinatal Quad continue to use the action plan produced following the SCORE Survey, to prioritise their workstreams
- The Quad are aiming to organise a staff event in the spring, with a focus on OD&L, Wellbeing and celebrating Maternity & Neonatal services, following the feedback from the staff survey completed at the end of 2024 – look out for an invite!

Actions in progress:

- Following the culture and leadership work, the Neonatal nurses now attend the huddle on Sarum to ensure all clinical areas are aware of which Neonatal medical staff are on duty – helping with communication and collaboration across teams
- The "team of the shift" model continues to be used, to have a team check-in and support each other on shift.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.5
Date of meeting:	6th March 2025		

Report tile:	CQC Maternity Survey 2024 and associated SFT Action plan			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	x
Approval Process: (where has this paper been reviewed and approved):	Divisional Governance 17.01.25 Clinical Governance Committee 28th January 2025			
Prepared by:	Vicki Marston - Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

Recommendation:

The Trust Board are asked to review the CQC Maternity Survey 2024 and SFT action plan, for discussion, assurance and final approval.

Executive Summary:

The National Maternity Survey is a requirement of, and carried out by, the CQC annually for all NHS Trusts providing Maternity services.

Women accessing maternity services at SFT in January and February 2024 were selected for the survey by CQC and provided responses anonnymously to them.

289 women were included in the survey and 162 responded (56.4%). The Patient Perspective average response rate for all 30 Trusts surveyed was 45%.

The average Mean Rating Score was 81.1%, 1.5% higher than in 2023.

SFT maternity department scored in the top 20% of Trusts on 10 questions and bottom 20% of Trusts on 12 questions out of 63 questions.

4 questions showed at least 10% improvement on the 2023 score, and for 0 questions the score was worse by 10% or more.

- Our top five scores compared nationally were around the areas of
  - Partners being able to stay
  - Induction information
  - Mental health support.

- Our bottom five scores were around
  - Care at home after birth
  - Support with Infant feeding.

An action plan to focus on areas to improve on has been coproduced with the Maternity and Neonatal Voices partnership (MNVP) to ensure service user oversight and input into improvements.

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

NHS Maternity Services Survey 2024 Benchmark Report

Salisbury NHS Foundation Trust

NHS

Care Quality Commission

Survey Coordination Centre

Contents

This work was carried out in accordance with the requirements of the international standard for organisations conducting social research (accreditation to ISO27001:2013; certificate number GB10/80275).

Background and methodology

This section includes:

- an explanation of the NHS Patient Survey Programme
- information on the 2024 Maternity Survey
- a description of key terms used in this report
- navigating the report

NHS

Care Quality Commission

Survey Coordination Centre

Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Maternity Survey was first carried out in 2007. The 2024 Maternity Survey will be the eleventh caried out to date. CQC use results from the survey to build an understanding of the risk and quality of services and those who organise care across an area.

To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

The 2024 Maternity Survey

The survey was administered by the Survey Coordination Centre (SCC) at Picker.

A total of 46,687 maternity service users were invited to participate in the survey across 120 NHS trusts.

Completed responses were received from 18,951 maternity service users, an adjusted response rate of 41.2%.

Service users were eligible to participate in the survey if they were aged 16 years or over at the time of delivery and had a live birth at an NHS Trust between 1 February and 29 February 2024. If there were fewer than 300 people within an NHS trust who gave birth in February 2024, then births from January were included. Full sampling criteria can be found in the sampling instructions.

Fieldwork took place between May and August 2024.

Trend data

In 2021, the Maternity Survey transitioned from a solely paper-based methodology to both paper and online. This dual approach was continued in 2022, 2023 and 2024.

Analysis conducted prior to the 2021 survey, concluded that this change in methodology did not have a detrimental impact on trend data. Therefore, data from the 2013 survey and subsequent years are comparable with previous years, unless a question has changed or there are other reasons for lack of comparability such as changes in organisational structure of a trust.

Where results are comparable with previous years, a section on historical trends has been included. Where there are insufficient data points for historical trends, significance testing has been carried out against 2023 data.

Further information about the survey

- For published results and for more information on the Maternity Survey, please visit the Maternity Survey page on the NHS Surveys website.
- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the NHS Patient Surveys website.
- To learn more about CQC's survey programme, please visit the CQC website.

Background and Methodology (continued)

Antenatal and Postnatal data

The Maternity Survey is split into four sections that ask questions about:

- Antenatal care
- Labour and birth
- Postnatal care
- Complaints

It is possible that some maternity service users may have experienced the first three stages of care in different trusts. This may be for many reasons such as moving home, or having to travel for more specialist care, or due to variation in service provision across the country. For the purpose of benchmarking, it is important that we understand which trust the respondent is referring to when they are completing each section of the survey.

When answering survey questions about labour and birth we can be confident that in all cases respondents are referring to the trust from which they were sampled. It is therefore possible to compare results for labour and birth across all 120 NHS trusts that took part in the survey.

Trusts were asked to carry out an "attribution exercise", where each trust identifies the individuals in their sample that are likely to have also received their antenatal and postnatal care from the trust. This is done using either electronic records or residential postcode information. This attribution exercise was first carried out in the 2013 survey. In 2024, all of the 120 trusts that took part in the survey completed this exercise.

The survey results contained in this report include only those respondents who were identified as receiving care at this trust.

Limitations of this approach

Data is provided voluntarily. In 2024, all trusts provided this data. The antenatal and postnatal care sections of this report are therefore benchmarked against all trusts that provided the required information.

Some trusts do not keep electronic records of antenatal and postnatal care. Where this is the case, location of antenatal and postnatal care is based on residential location of respondents. This is not a perfect measure of whether antenatal and postnatal care was received at the trust. For example, respondents requiring specialist antenatal or postnatal care may have received this from another trust. This may mean that some respondents are included in the data despite having received care from another trust.

Key terms used in this report

The ‘expected range’ technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement. More information can be found in the Comparison to Other Trusts section.

Standardisation

Demographic characteristics, such as age, can influence care experiences and how they are reported. Since trusts have differing profiles of maternity service users, this could make fair trust comparisons difficult. To account for this, we ‘standardise’ the results, which means we apply a weight to individual service user responses to account for differences in demographic profile between trusts.

For each trust, results have been standardised by parity (whether or not a service user has given birth previously) and age of respondents to reflect the ‘national’ age distribution (based on all respondents to the survey). This helps ensure that no trust will appear better or worse than another because of its profile of maternity users and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results.

Scoring

For selected questions in the survey, the individual (standardised) responses are converted into scores, typically 0, 5, or 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. Only evaluative questions in the questionnaire are scored. Some questions are descriptive (for example A2), and others are ‘routing questions’, which are designed to filter out respondents to whom subsequent questions do not apply (for example C23). These questions are not scored. Please refer to the scored questionnaire for further details. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied. More information can be found in the ‘An example of scoring’ slide.

National average

The ‘national average’ mentioned in this report is the arithmetic mean of all trusts’ scores after weighting is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to).

Further information about the methods

For further information about the statistical methods used in this report, please refer to the survey technical document which is on the 'Analysis and Reporting' section of the 2024 Maternity Survey webpage on the NHS surveys website.

Using the survey results

Navigating this report

This report is split into five sections:

- **Background and methodology** – provides information about the survey programme, how the survey is run, and how to interpret the data.
- **Headline results** – includes key trust-level findings relating to the maternity service users who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.
- **Benchmarking** – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the 'expected range' analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve. Only trusts that provide data on antenatal and/or postnatal care and have sufficient respondent numbers are also provided with survey results for antenatal and postnatal care within this report.
- **Change over time** – includes your trust's mean score for each evaluative question in the survey shown in a significance test table, comparing it to your 2023 mean score. This allows you to see if your trust has made statistically significant improvements between survey years.
- **Comparison to Other Trusts** – includes additional data for your trust.

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey.

The two chart types used in the section 'Benchmarking' use the 'expected range' technique to show results. For information on how to interpret these graphs, please refer to the 'How to interpret benchmarking in this report' slides.

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results; technical document: https://www.cqc.org.uk/publications/surveys/maternity-survey
- National and trust-level data for all trusts who took part in the 2024 Maternity Survey https://nhssurveys.org/surveys/survey/04-maternity/year/2024/. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys
- Information about how CQC monitors hospitals: https://www.cqc.org.uk/what-we-do/how-we-use-information/using-data-monitor-services

Headline results

This section includes:

- information about your trust population
- an overview of benchmarking for your trust
- the best and worst scores for your trust

NHS

Care Quality Commission

Survey Coordination Centre

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of maternity service users who took part in the survey.

289 invited to take part

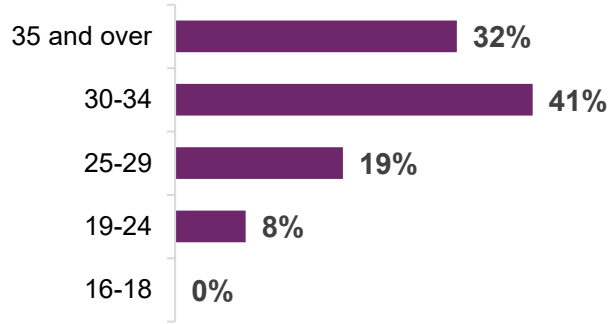
162 completed

56% response rate

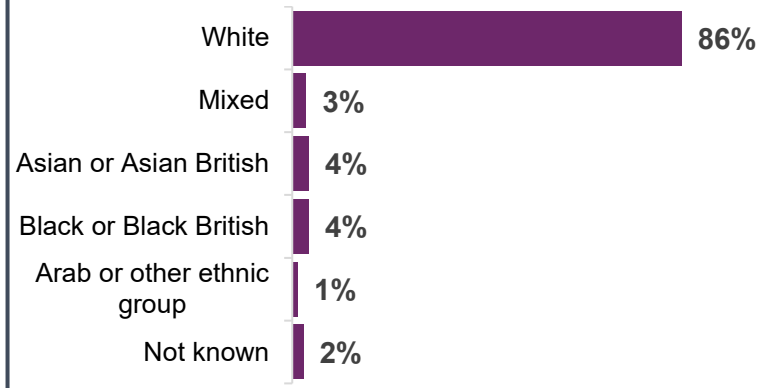
41% average response rate for all trusts

59% response rate for your trust in 2023

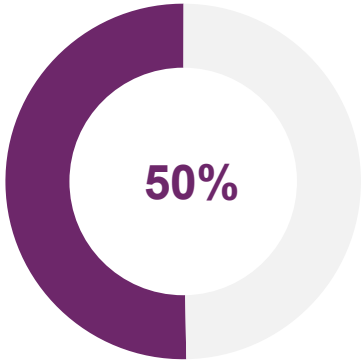
Age



Ethnicity



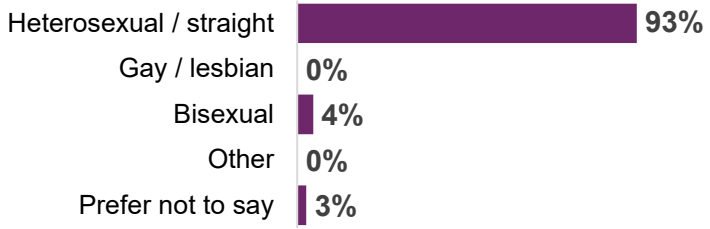
Parity



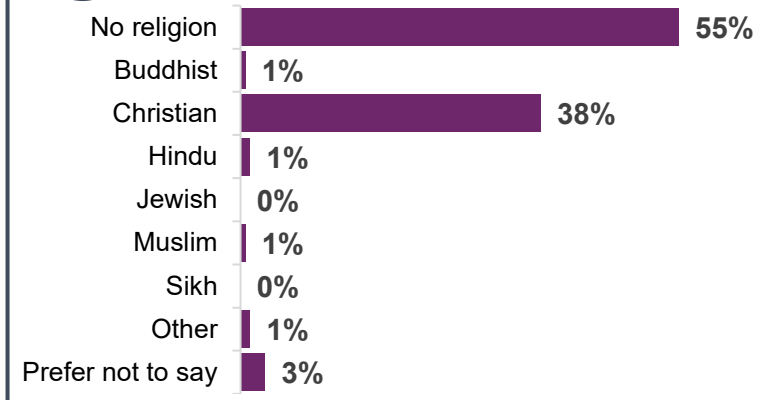
of respondents gave birth to **their first baby**.

Sexuality

Which of the following best describes your sexual orientation?



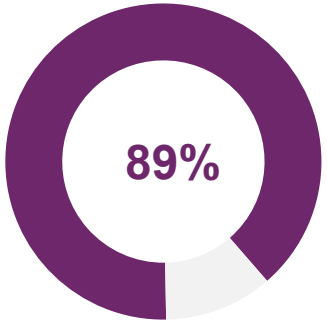
Religion



Who took part in the survey? (continued)

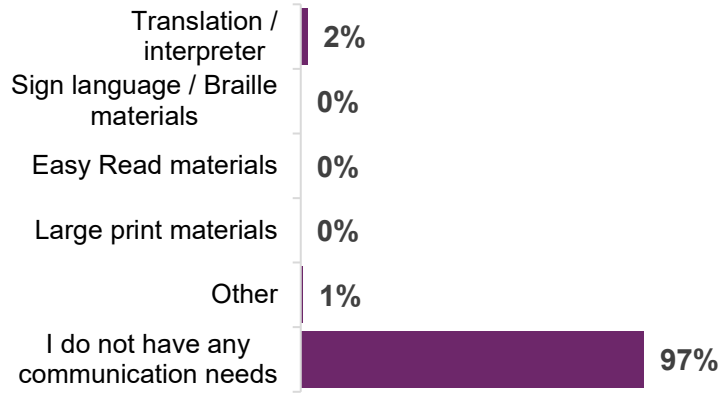
This slide is included to help you interpret responses and to provide information about the population of maternity service users who took part in the survey.

English as main language

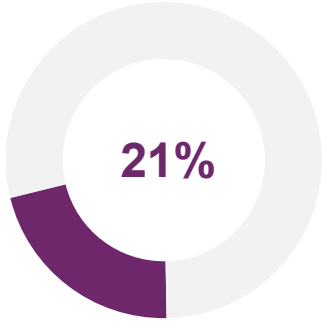


of maternity service users have **English as their main language.**

Types of communication needs

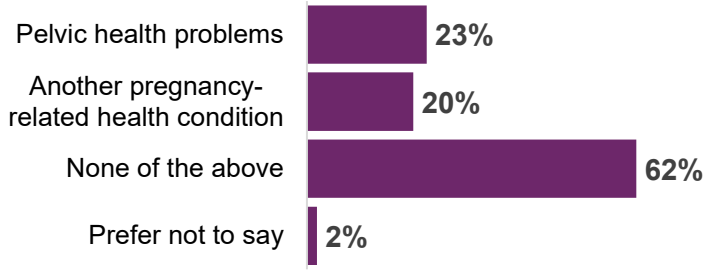


Long-term conditions

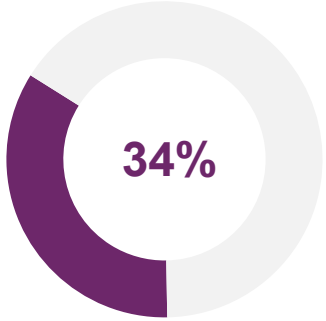


of maternity service users have a **physical or mental health condition or illness** that has lasted or is expected to last for 12 months or more.

Pregnancy-related health conditions



Baby received neonatal care

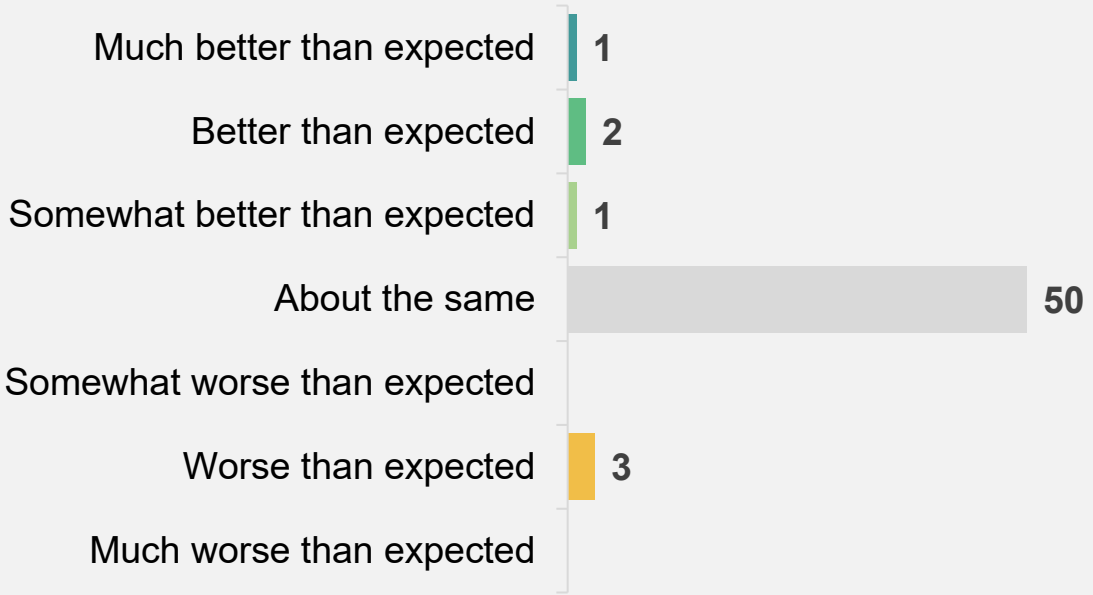


of respondents reported that their baby received **neonatal care**.

Summary of findings for your trust

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2024 vs 2023.

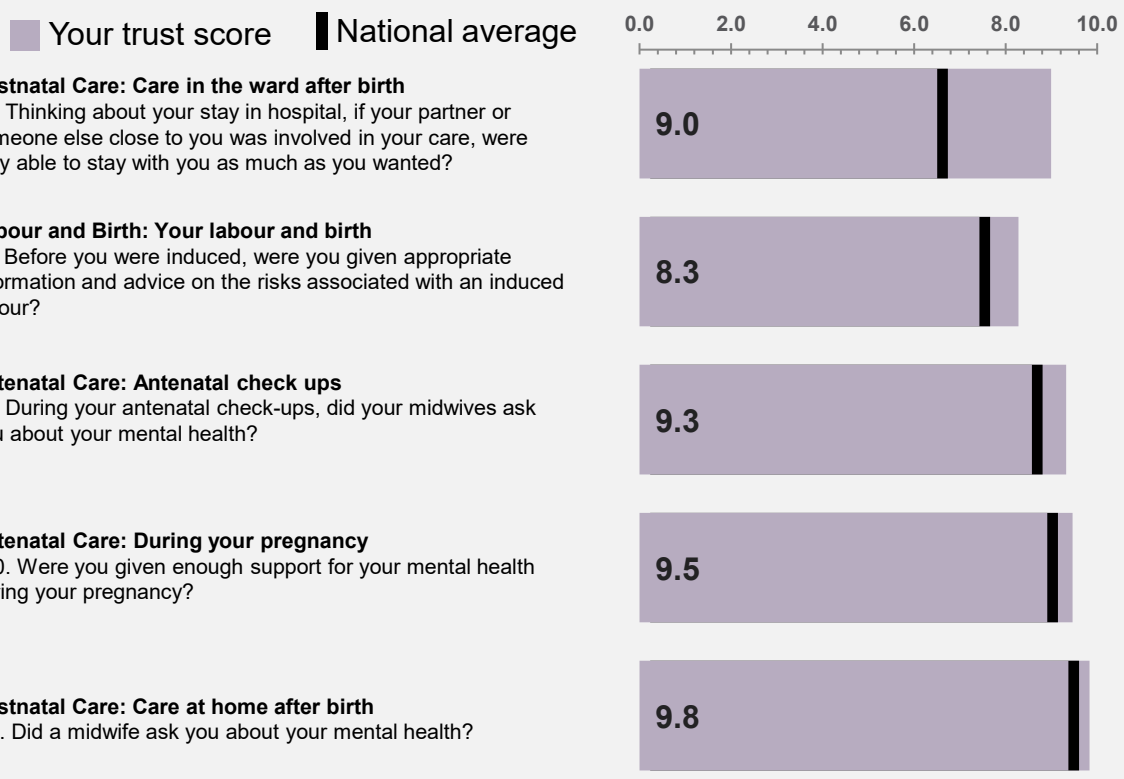
For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the section "Comparison to Other Trusts".

Best and worst performance relative to the national average

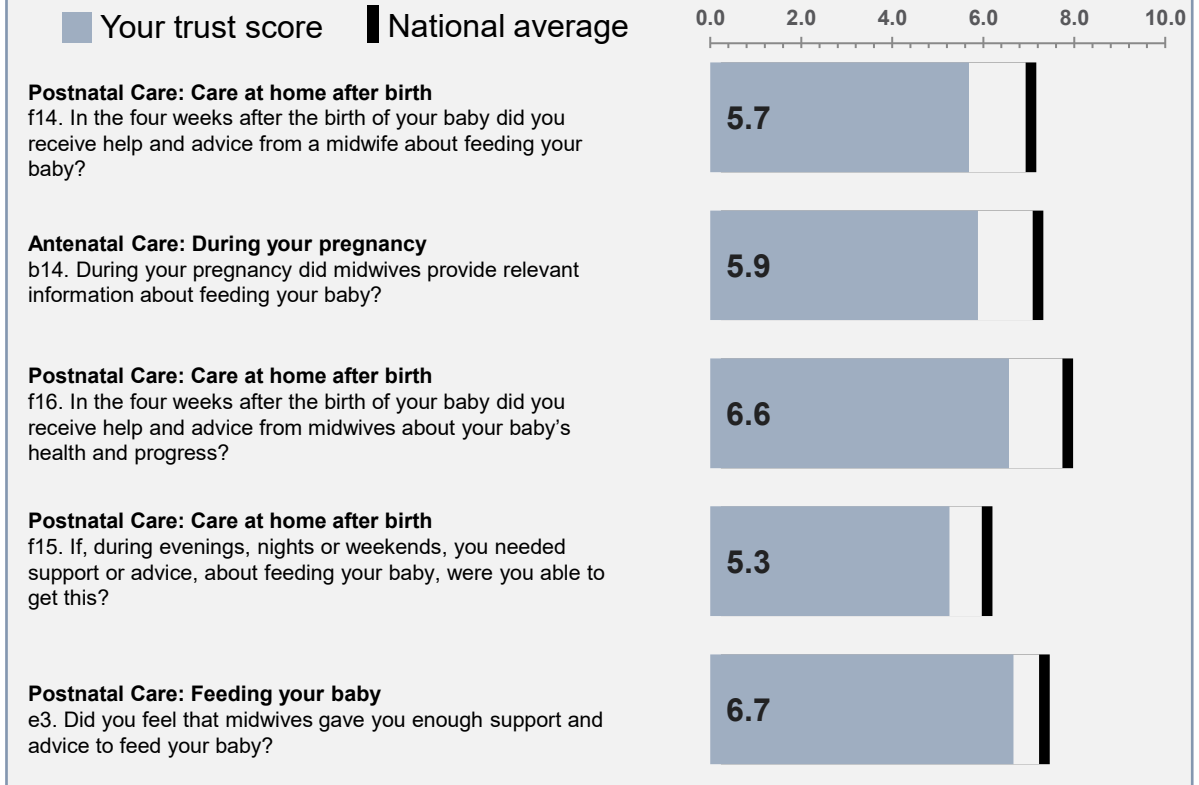
These five questions are calculated by comparing your trust's results to the the average trust score across England.

- **Top five scores**: These are the five results for your trust that are highest compared with the national average. If none of the results for your trust are above the national average, then the results that are closest to the national average have been chosen, meaning a trust's best performance may be worse than the national average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the national average. If none of the results for your trust are below the national average, then the results that are closest to the national average have been chosen, meaning a trust's worst performance may be better than the national average.

Top five scores (compared with national average)



Bottom five scores (compared with national average)



2024 Maternity Survey

Results for Salisbury NHS Foundation Trust

Where service user experience is best

- ✓ **Postnatal Care: Care in the ward after birth:** Partner or someone else close to service user was able to stay as much as the service user wanted
- ✓ **Labour and Birth: Your labour and birth:** Service users given appropriate information and advice on the associated risks with induction
- ✓ **Antenatal care: Antenatal check ups:** Being asked about mental health by midwives
- ✓ **Antenatal care: During your pregnancy:** Service users given enough support for their mental health
- ✓ **Care after birth:** Being asked about mental health by midwife

Where service user experience could improve

- o **Care after birth:** Receiving help and advice from a midwife about feeding baby in the 4 weeks after birth
- o **Antenatal care: During your pregnancy:** Relevant information provided from midwives to service users about feeding their baby
- o **Care after birth:** Receiving help and advice from a midwife about baby's health and progress in the 4 weeks after birth
- o **Care after birth:** Being able to get support or advice about feeding baby during evenings, nights or weekends
- o **Feeding your baby:** Midwives giving enough support and advice to feed their baby

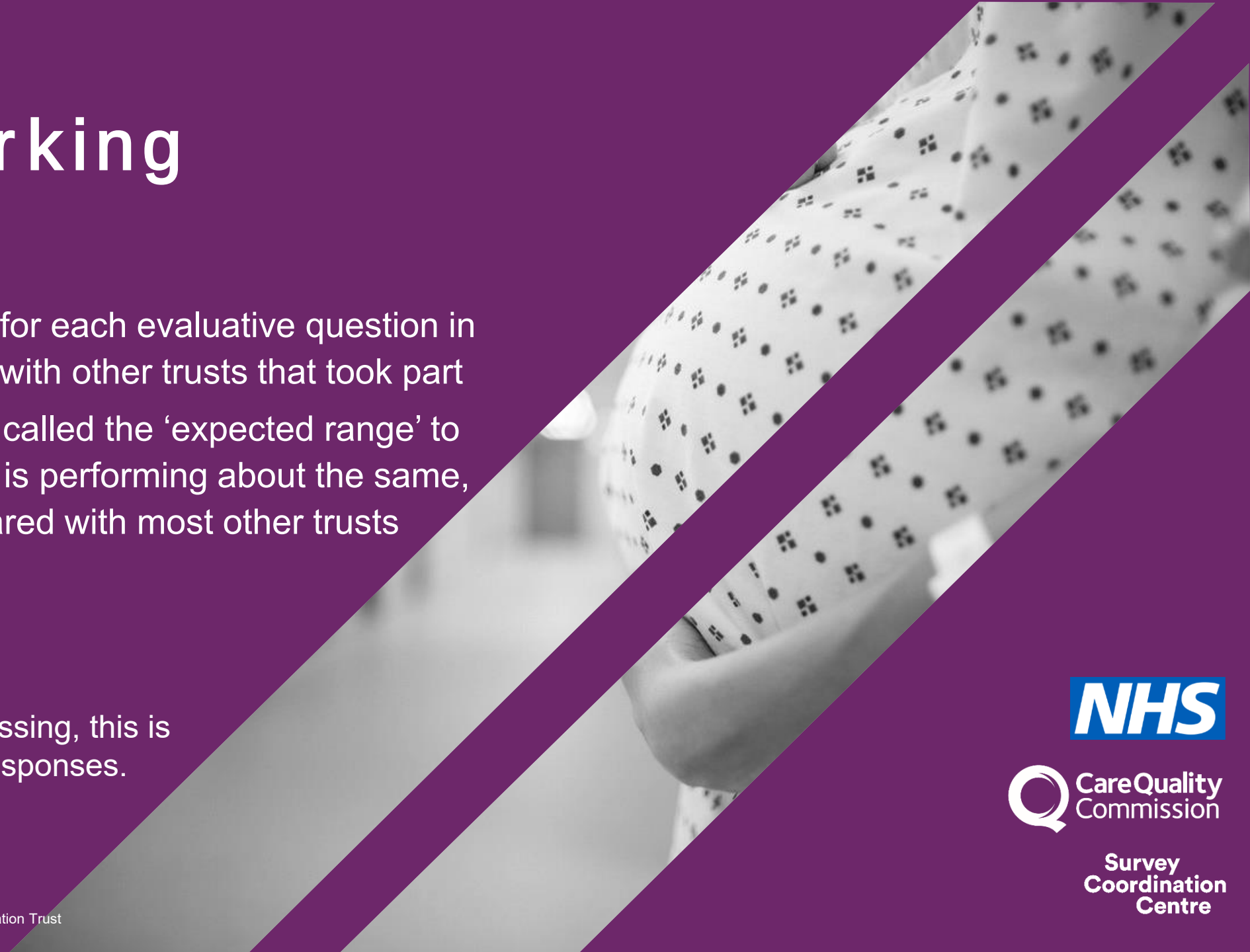
These questions are calculated by comparing your trust's results to the national average. "Where service user experience is best": These are the five results for your trust that are highest compared with the national average. "Where service user experience could improve": These are the five results for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

This survey looked at the experiences of service users who gave birth at the trust in January and/or February 2024. Between May and August 2024, a questionnaire was sent to 289 recent service users who gave birth at Salisbury NHS Foundation Trust. Responses were received from 162 service users at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

Benchmarking

This section includes:

- how your trust scored for each evaluative question in the survey, compared with other trusts that took part
- an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts



Please note: If data is missing, this is due to a low number of responses.

NHS

Care Quality Commission

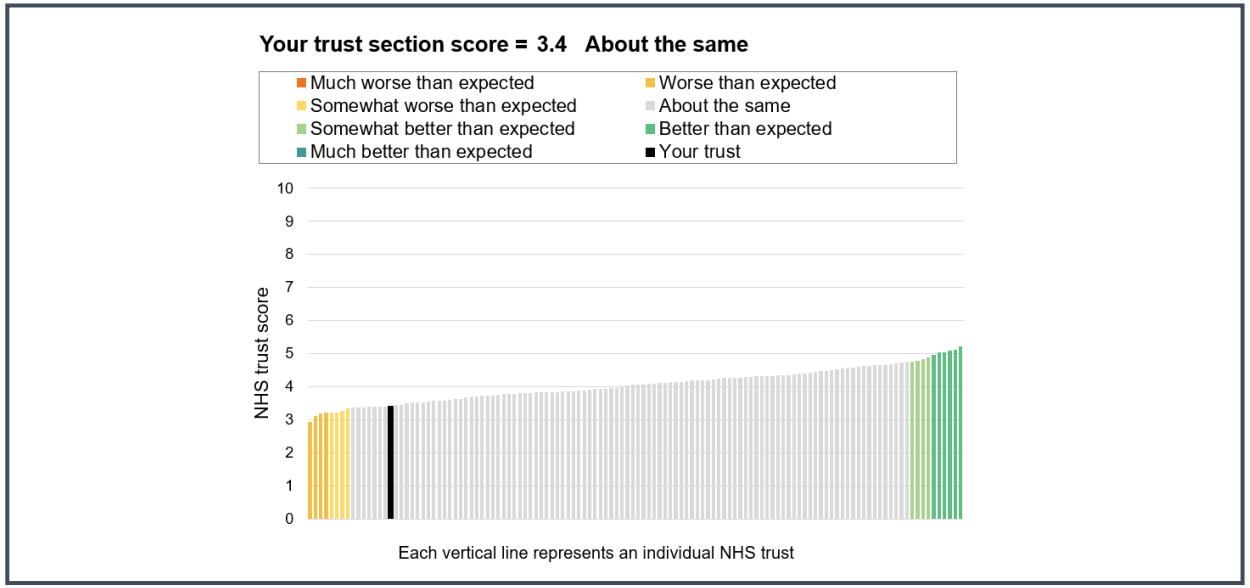
Survey Coordination Centre

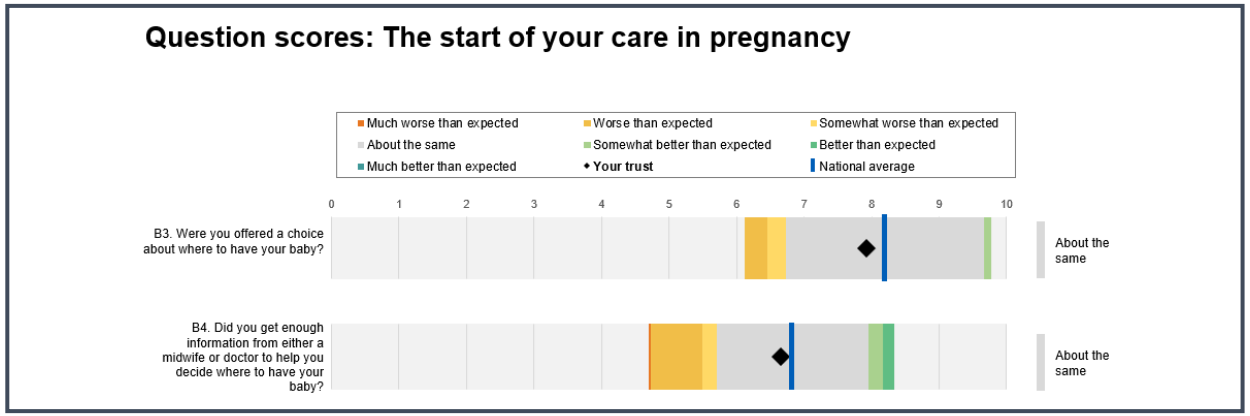
How to interpret benchmarking in this report

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange** section of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange section** of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.





How to interpret benchmarking in this report (continued)

The ‘much better than expected’, ‘better than expected’, ‘somewhat better than expected’, ‘about the same’, ‘somewhat worse than expected’, ‘worse than expected’, and ‘much worse than expected’ categories are based on an analysis technique called the ‘expected range’. Expected range determines the range within which a trust’s score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust’s performance is ‘about the same’ as other trusts. Where a trust is identified as performing ‘better’ or ‘worse’ than the majority of other trusts, the result is unlikely to have occurred by chance.

The question score charts show the trust scores compared to the minimum and maximum scores achieved by any trust. In some cases, this minimum or maximum limit will mean that one or more of the bands are not visible – because the range of other bands is broad enough to include the highest or lowest score achieved by a trust this year. This could be because there were few respondents, meaning the confidence intervals around your data are slightly larger, or because there was limited variation between trusts for this question this year.

In some cases, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust. This occurs as the bandings are calculated through standard error rather than standard deviation. Standard error takes into account the number of responses achieved by a trust, and therefore the banding may differ for a trust with a low numbers of responses.

Additional information on the ‘expected range’ analysis technique can be found in the survey technical report on the NHS Surveys website.

An example of scoring

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the maternity service user's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive maternity service user experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of maternity service user experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question B11 "During your pregnancy, if you contacted a midwifery team, were you given the help you needed?":

- The answer code "Yes, always" would be given a score of 10, as this refers to the most positive maternity service user experience possible.
- The answer code "Yes, sometimes" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer codes "No" and "No, as I was not able to contact a midwifery team" would be given a score of 0, as these responses reflect considerable scope for improvement.
- The answer code "I did not contact a midwifery team" would not be scored, as they do not have a clear bearing on the trust's performance in terms of maternity service user experience.

Calculating the trust score for each question

The weighted mean score for each trust, for each question, is calculated by dividing the sum of the weighted scores for a question by the weighted sum of all eligible respondents to the question for each trust. An example of this is provided in the survey technical document.

Calculating the section score

An arithmetic mean of each trust's question scores is taken to provide a score for each section.

Benchmarking

Section 1: Antenatal Care

NHS

Care Quality Commission

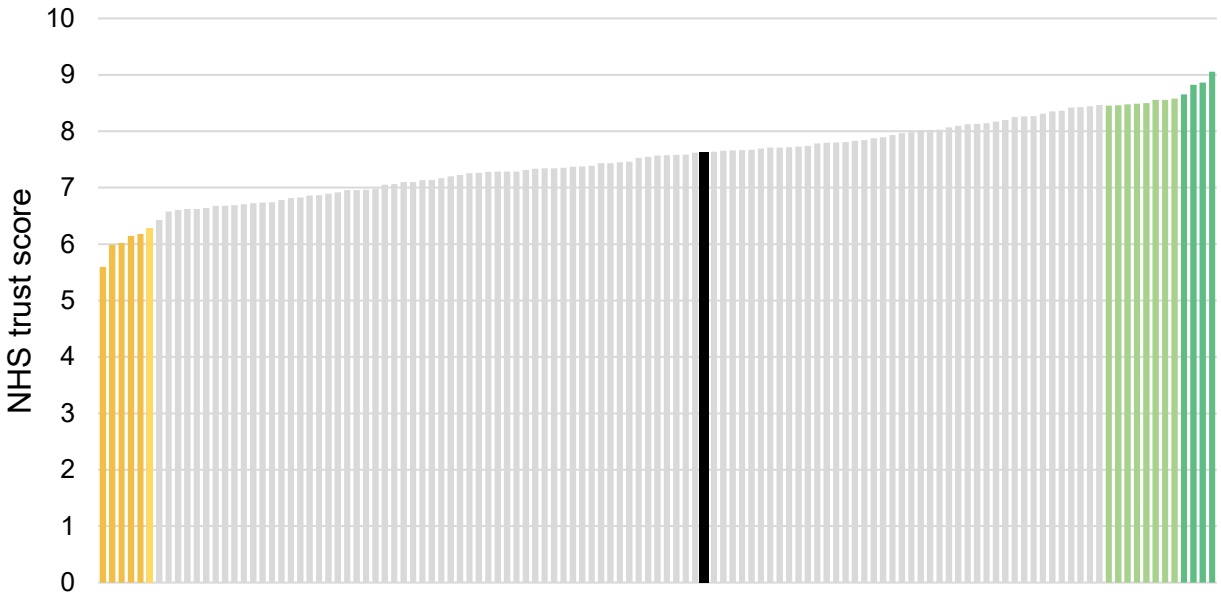
Survey Coordination Centre

The start of your care during pregnancy

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'the start of your care during pregnancy' is calculated from questions B3 and B4. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.6 **About the same**

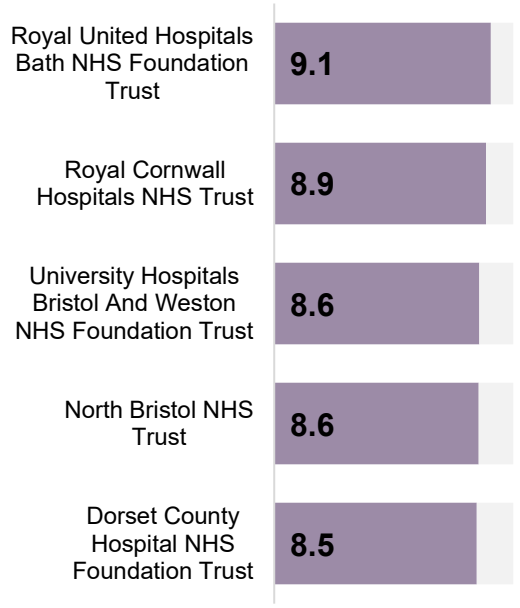
- Much worse than expected
- Somewhat worse than expected
- Somewhat better than expected
- Much better than expected
- Worse than expected
- About the same
- Better than expected
- Your trust



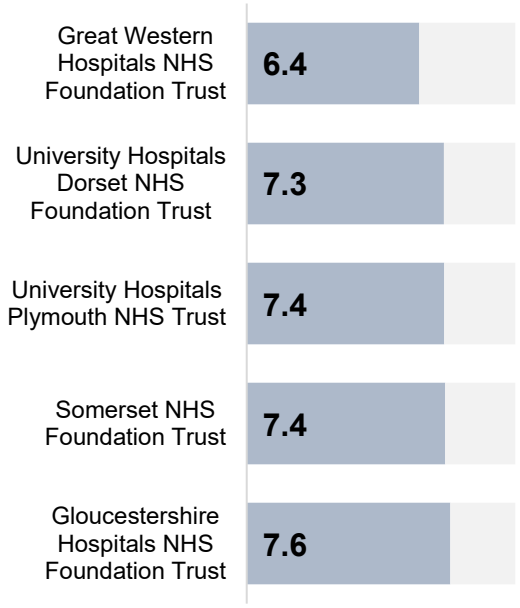
Each vertical line represents an individual NHS trust
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores

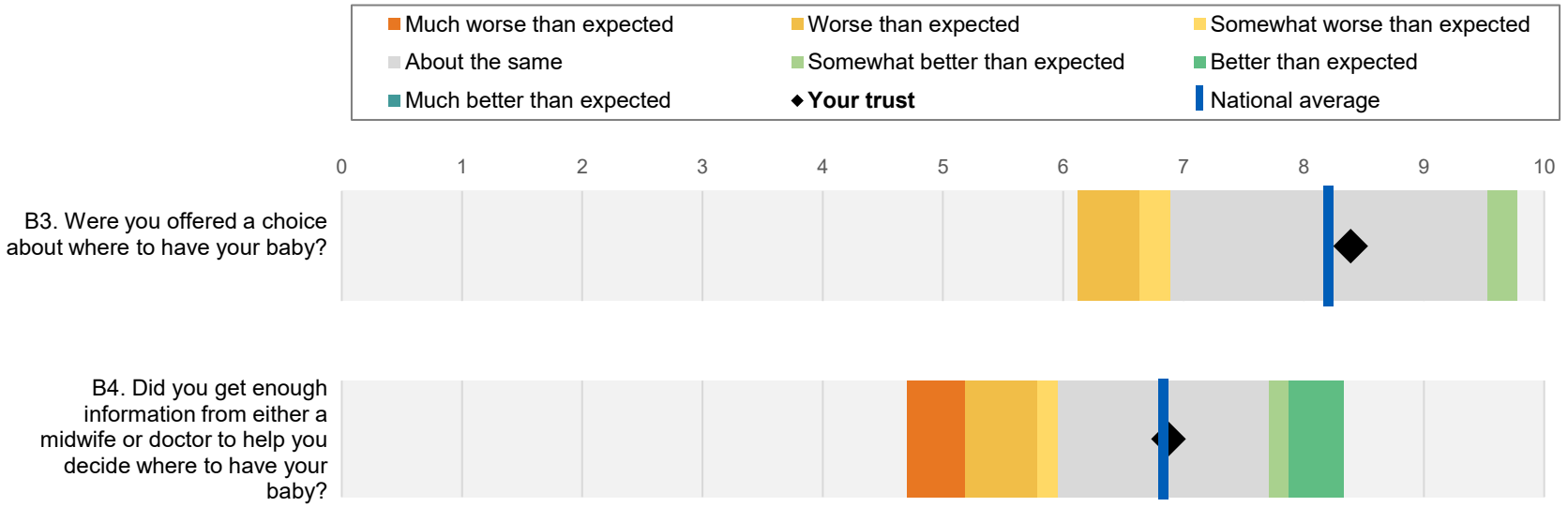


Trusts with the lowest scores



Section 1. Antenatal Care

Question scores: The start of your care in pregnancy

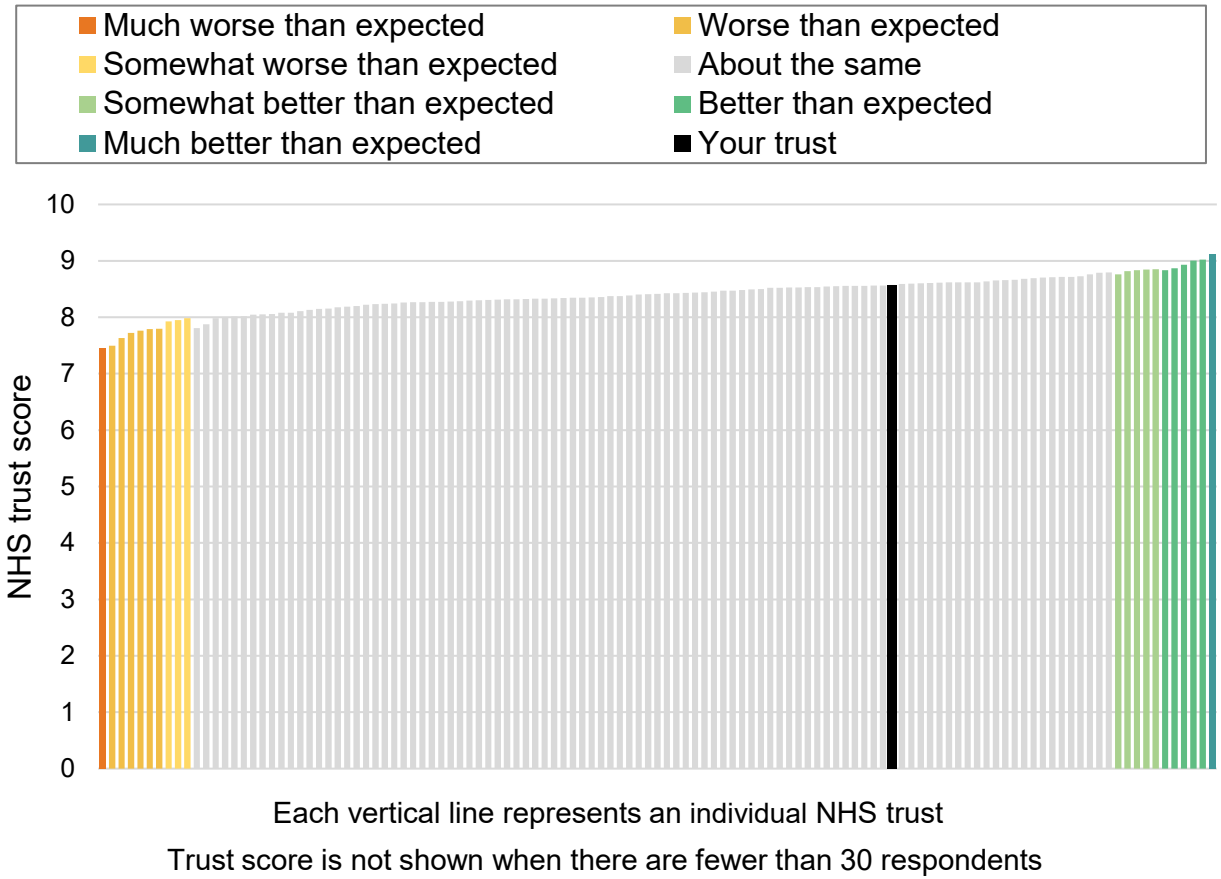


			All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score	
B3. Were you offered a choice about where to have your baby?	124	8.4	8.2	6.1	9.8	About the same
B4. Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	147	6.9	6.8	4.7	8.3	About the same

Antenatal check-ups

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'antenatal check-ups' is calculated from questions B6 to B9. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

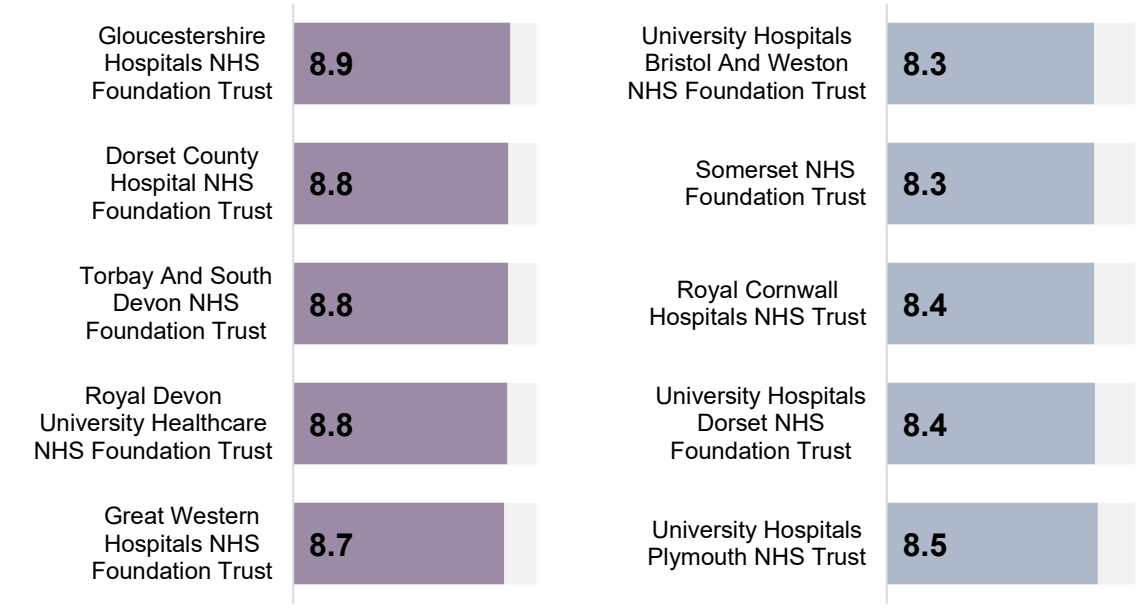
Your trust section score = 8.6 **About the same**



Each vertical line represents an individual NHS trust

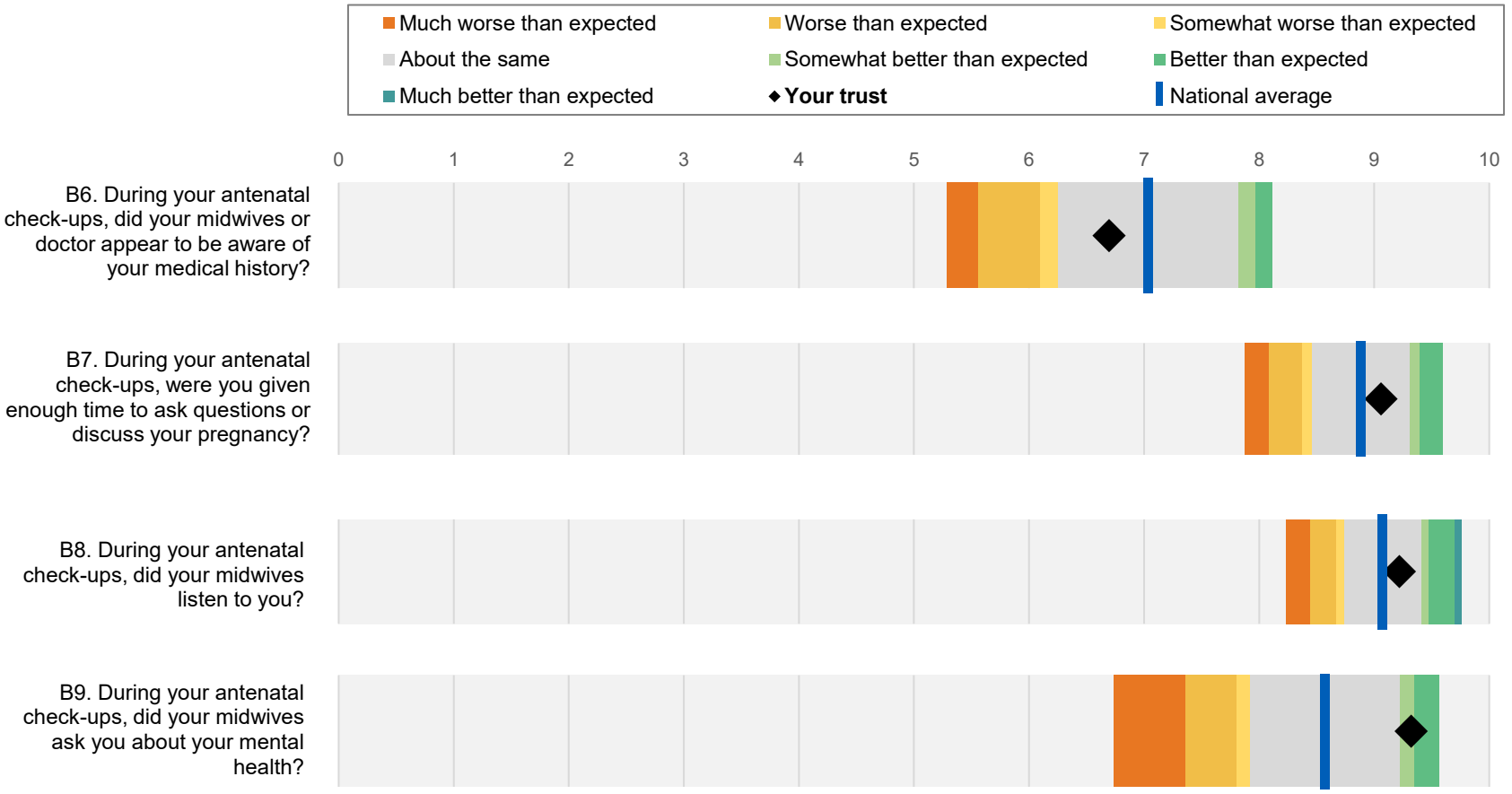
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region



Section 1. Antenatal Care

Question scores: Antenatal check-ups

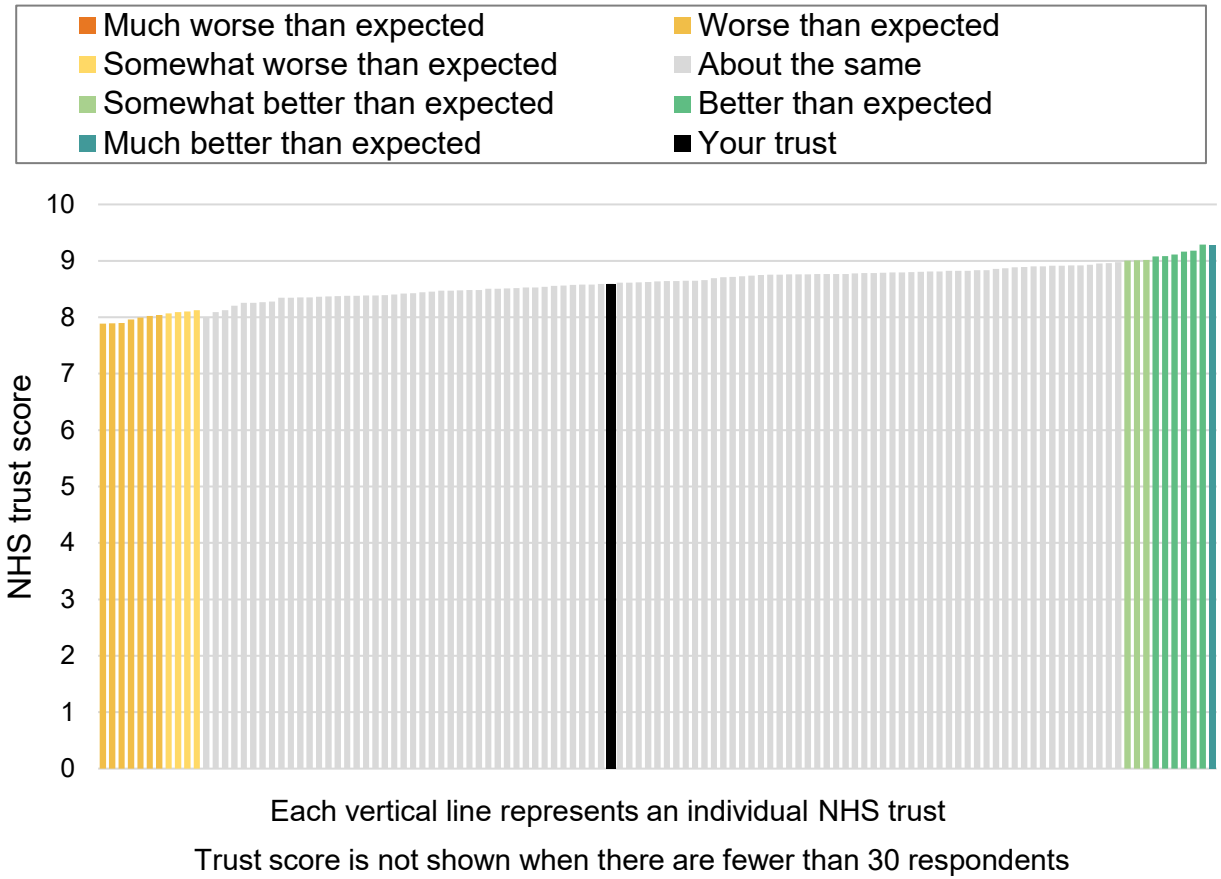


		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	149	6.7	7.0	5.3	8.1
About the same	150	9.1	8.9	7.9	9.6
About the same	150	9.2	9.1	8.2	9.8
Somewhat better than expected	150	9.3	8.6	6.7	9.6

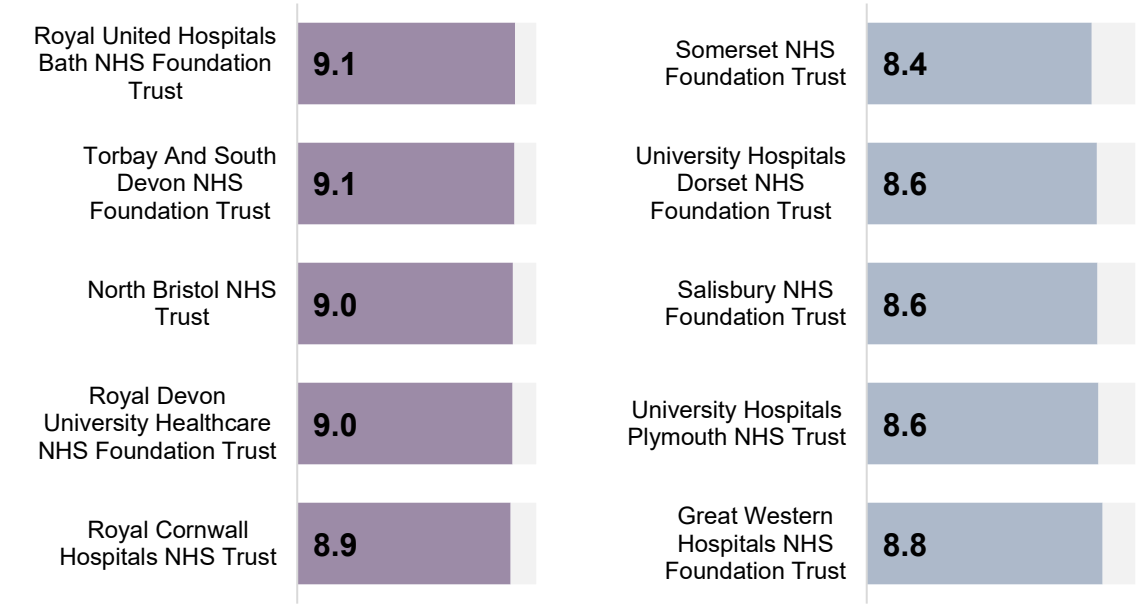
During your pregnancy

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'during your pregnancy' is calculated from questions B10 to B18. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.6 **About the same**



Comparison with other trusts within your region



Section 1. Antenatal Care

Question scores: During your pregnancy

		All trusts in England		
Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
91	9.5	8.9	7.2	9.8
133	8.5	8.3	6.9	9.3
150	9.4	9.4	8.7	9.7

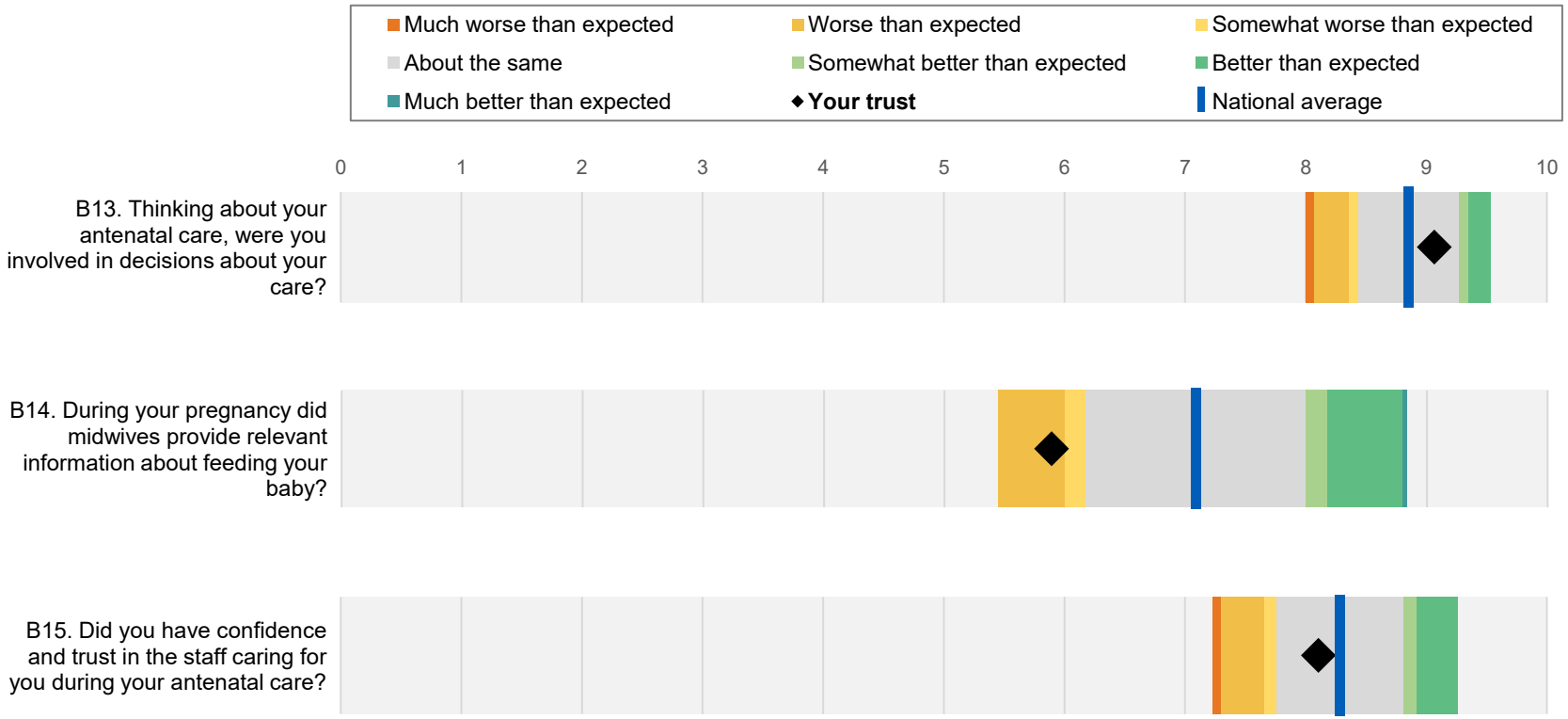
About the same

About the same

About the same

Section 1. Antenatal Care (continued)

Question scores: During your pregnancy



		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	150	9.1	8.9	8.0	9.5
Worse than expected	147	5.9	7.1	5.4	8.8
About the same	150	8.1	8.3	7.2	9.3

Section 1. Antenatal Care (continued)

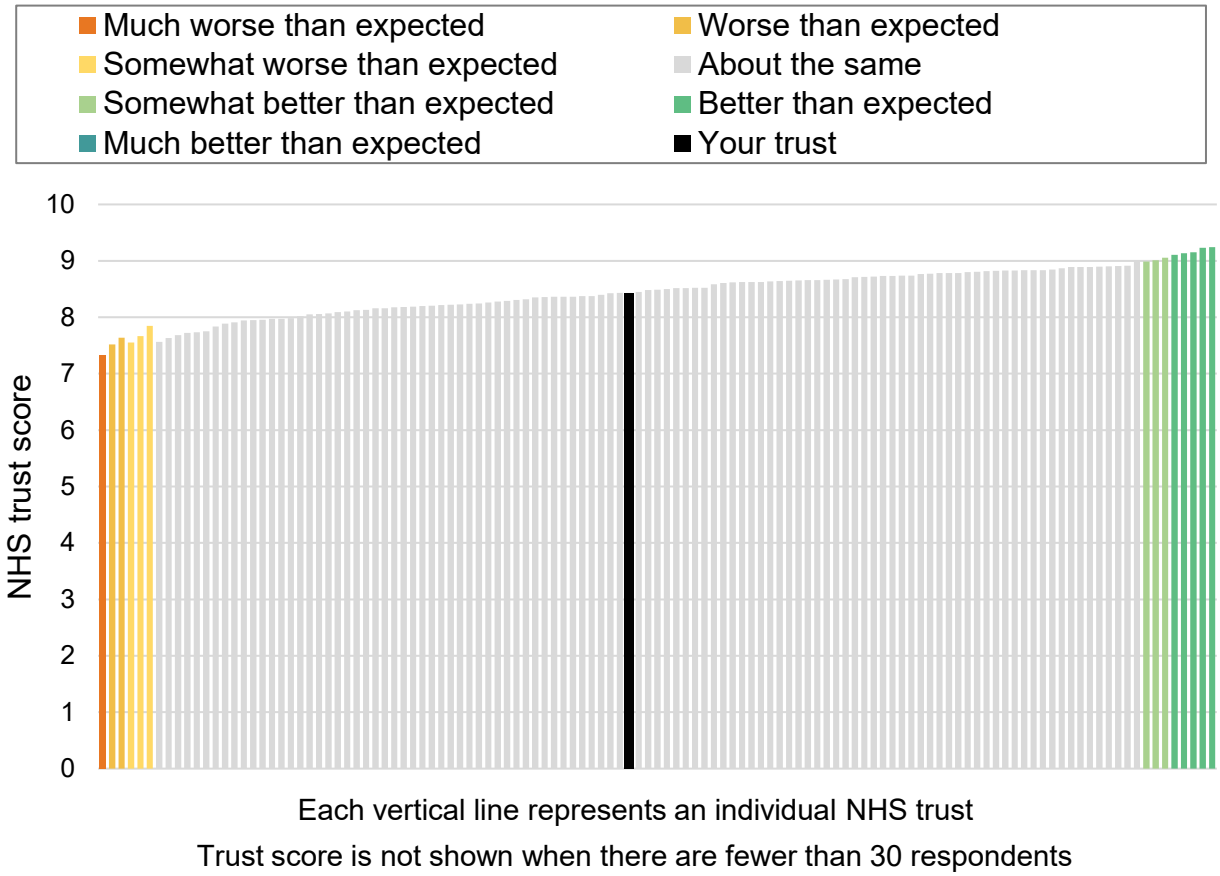
Question scores: During your pregnancy

		All trusts in England				
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score	
B16. Thinking about your antenatal care, were you treated with respect and dignity?	150	9.3	9.3	8.6	9.8	About the same
B17. If you raised a concern during your antenatal care, did you feel that it was taken seriously?	110	8.9	8.8	7.4	9.8	About the same
B18. Thinking about your antenatal care, were you given information about any warning signs to look out for during your pregnancy?	149	8.7	8.6	7.5	9.4	About the same

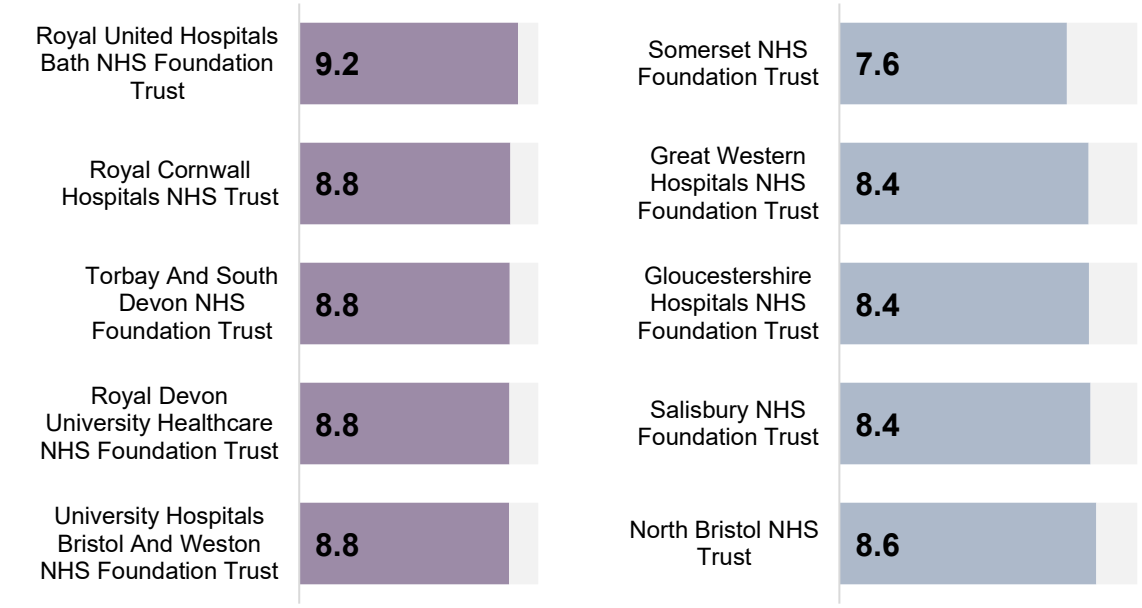
Triage: Assessment and Evaluation

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'triage: assessment and evaluation' is calculated from question B20. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.4 **About the same**

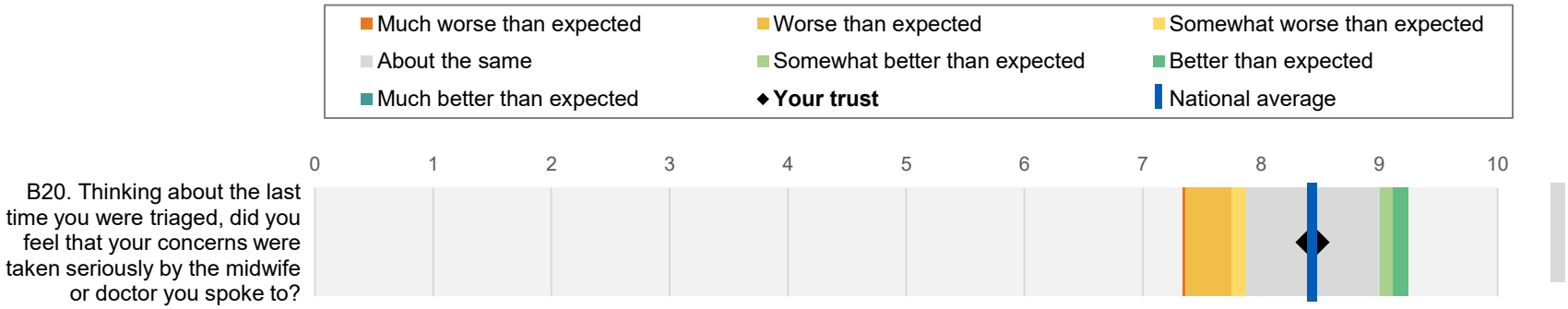


Comparison with other trusts within your region



Section 1. Antenatal Care

Question scores: Triage: Assessment and evaluation



	All trusts in England			
Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
119	8.4	8.4	7.3	9.2

Benchmarking

Section 2: Labour and Birth

NHS

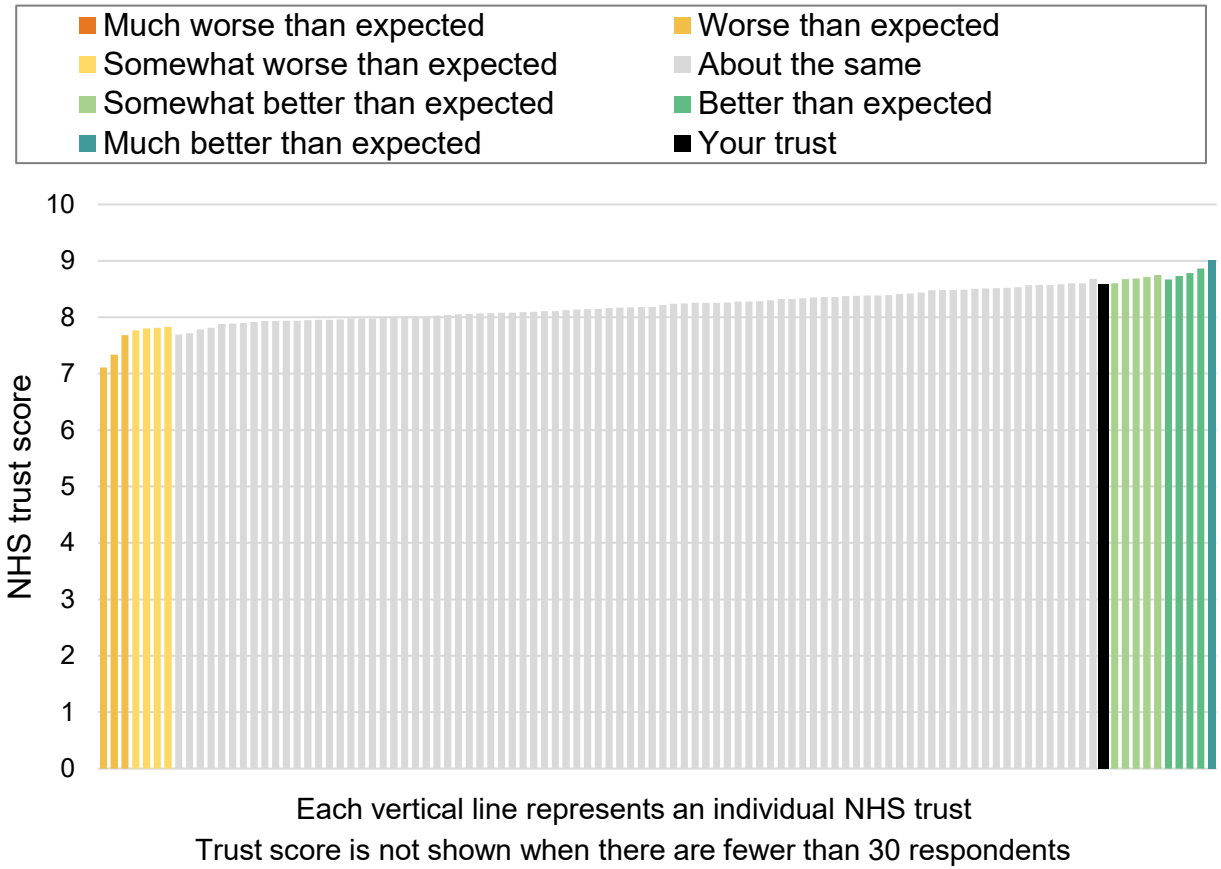
Care Quality Commission

Survey Coordination Centre

Your labour and birth

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'your labour and birth' is calculated from questions C4 to C9. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

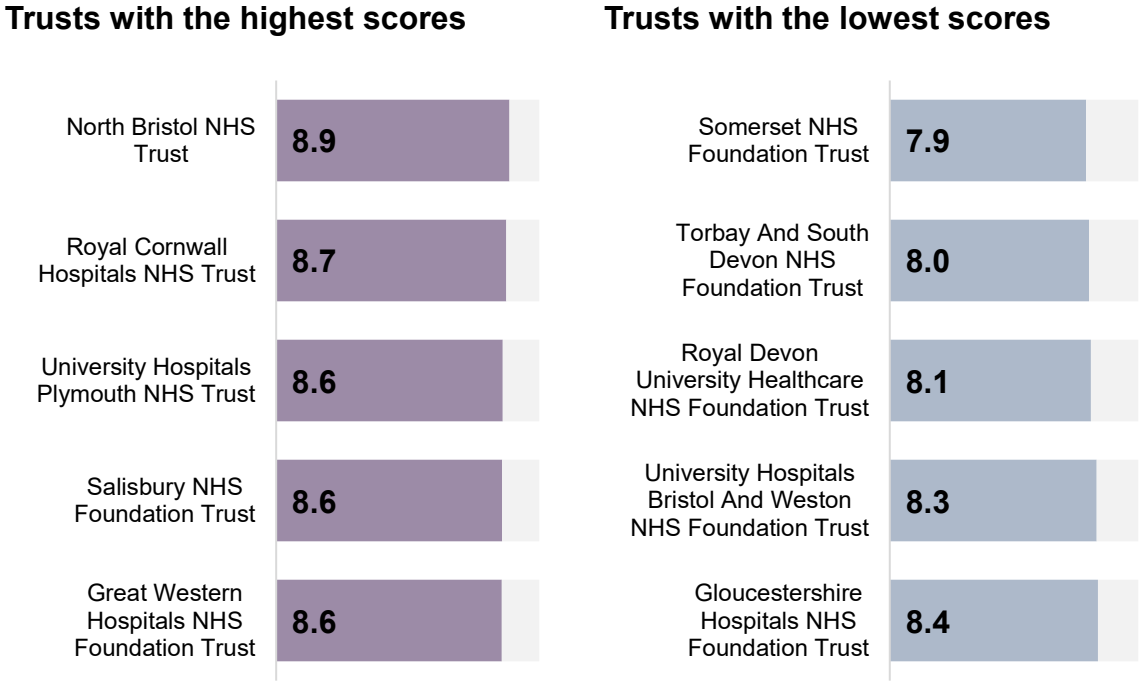
Your trust section score = 8.6 **Somewhat better than expected**



Each vertical line represents an individual NHS trust

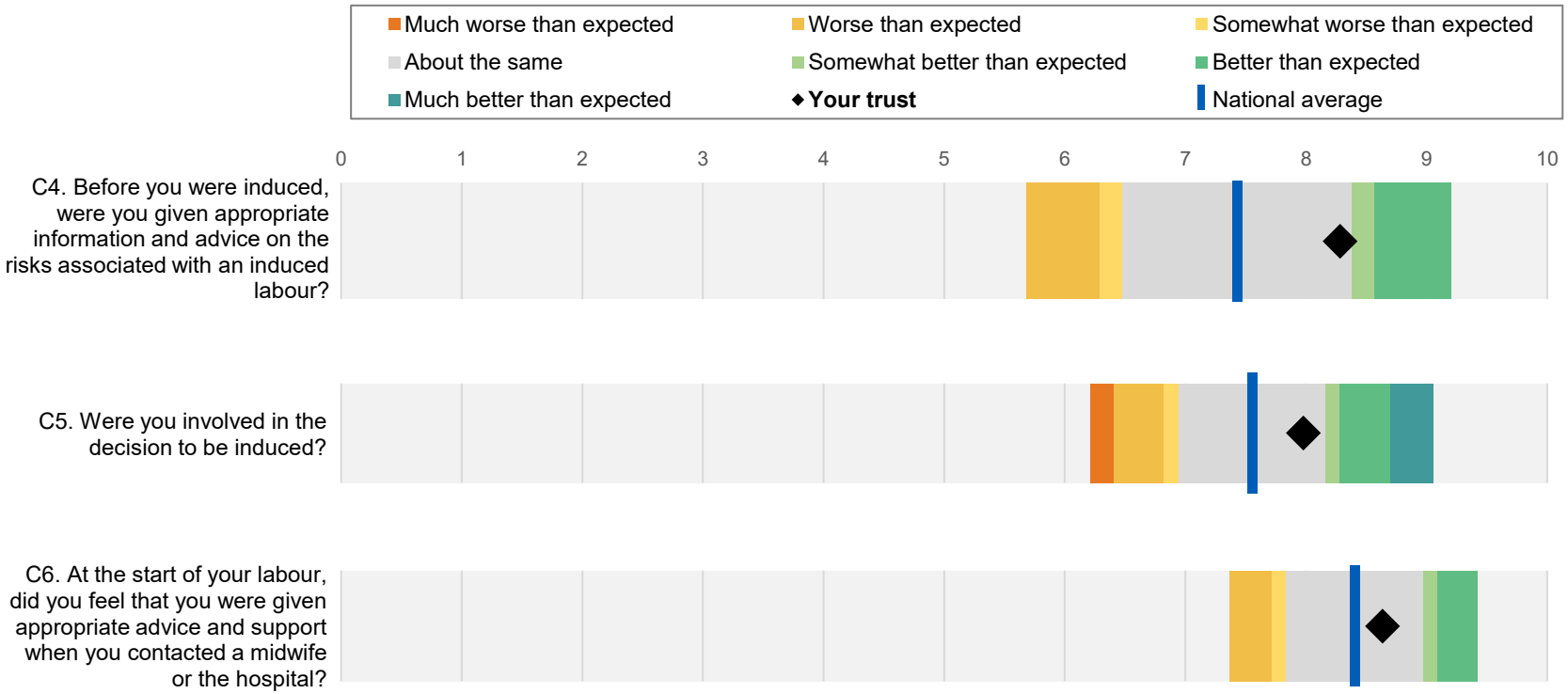
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region



Section 2. Labour and Birth

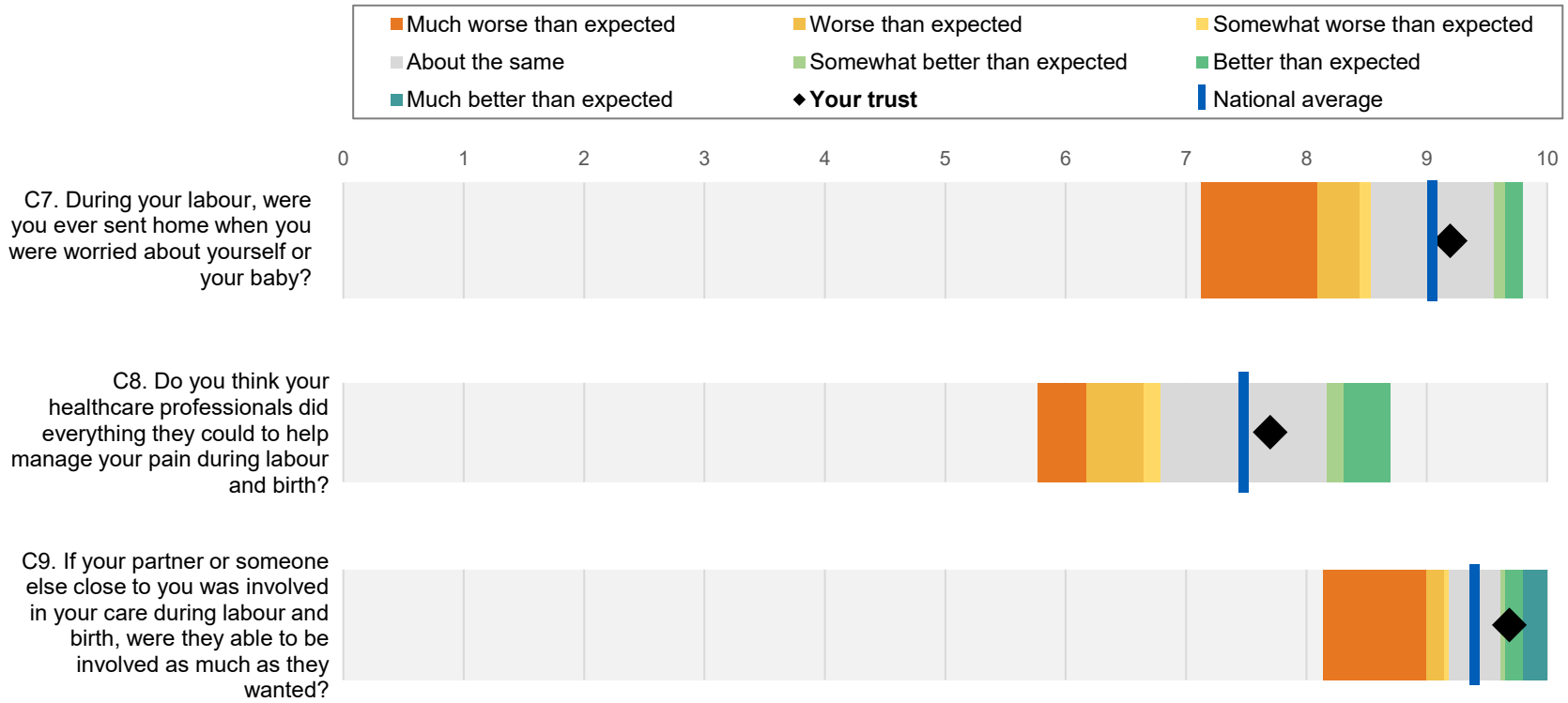
Question scores: Your labour and birth



	All trusts in England				
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	57	8.3	7.4	5.7	9.2
About the same	59	8.0	7.6	6.2	9.1
About the same	113	8.6	8.4	7.4	9.4

Section 2. Labour and Birth (continued)

Question scores: Your labour and birth



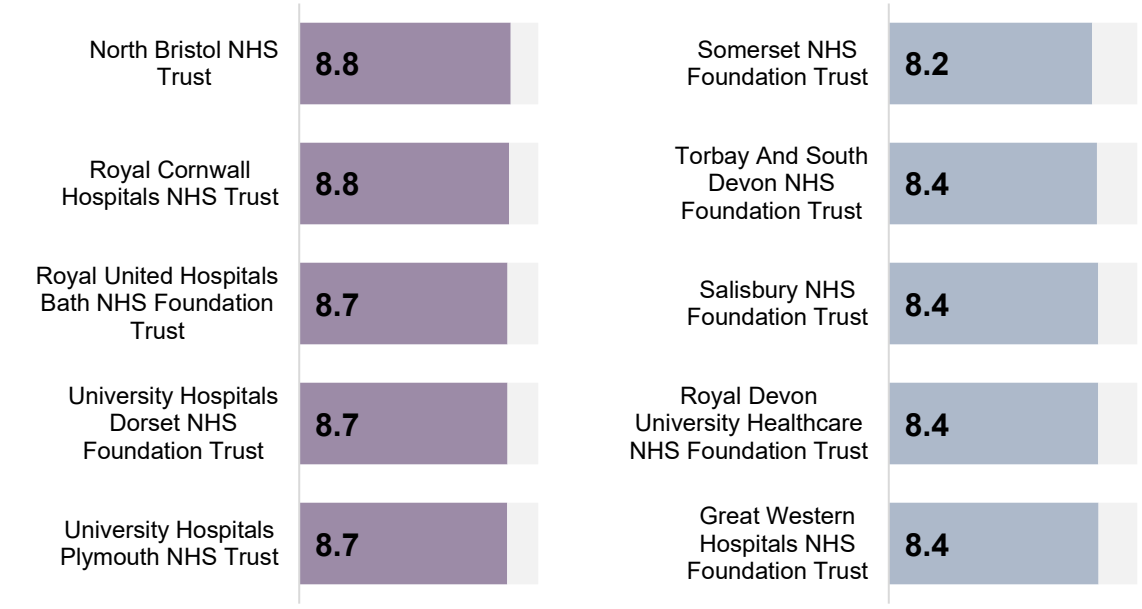
		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	132	9.2	9.0	7.1	9.8
About the same	122	7.7	7.5	5.8	8.7
Better than expected	156	9.7	9.4	8.1	10.0

Staff caring for you

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'staff caring for you' is calculated from questions C10 to C21. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

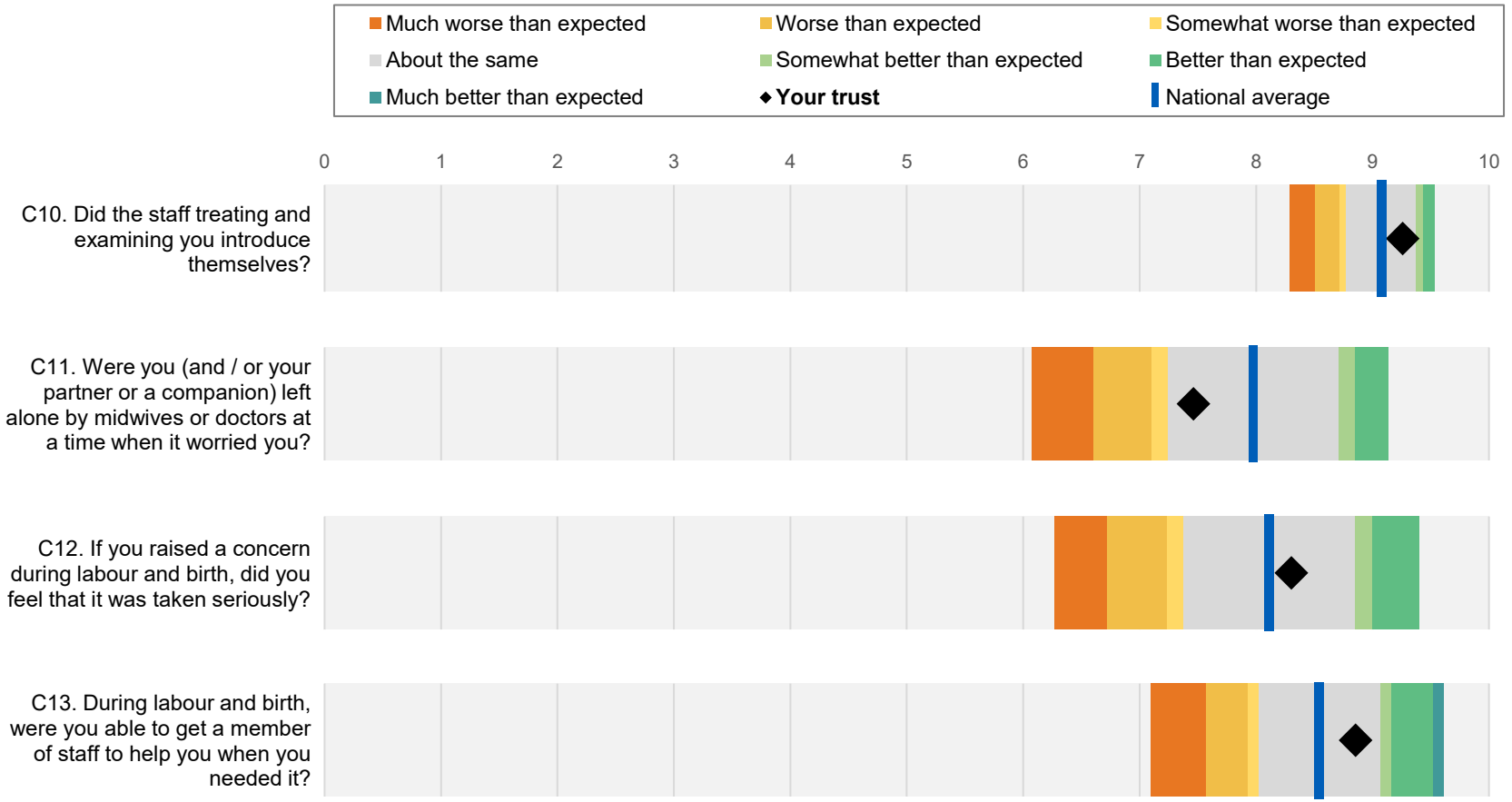
Your trust section score = 8.4 About the same

Comparison with other trusts within your region



Section 2. Labour and Birth

Question scores: Staff caring for you



		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	160	9.3	9.1	8.3	9.5
About the same	155	7.5	8.0	6.1	9.1
About the same	106	8.3	8.1	6.3	9.4
About the same	156	8.9	8.5	7.1	9.6

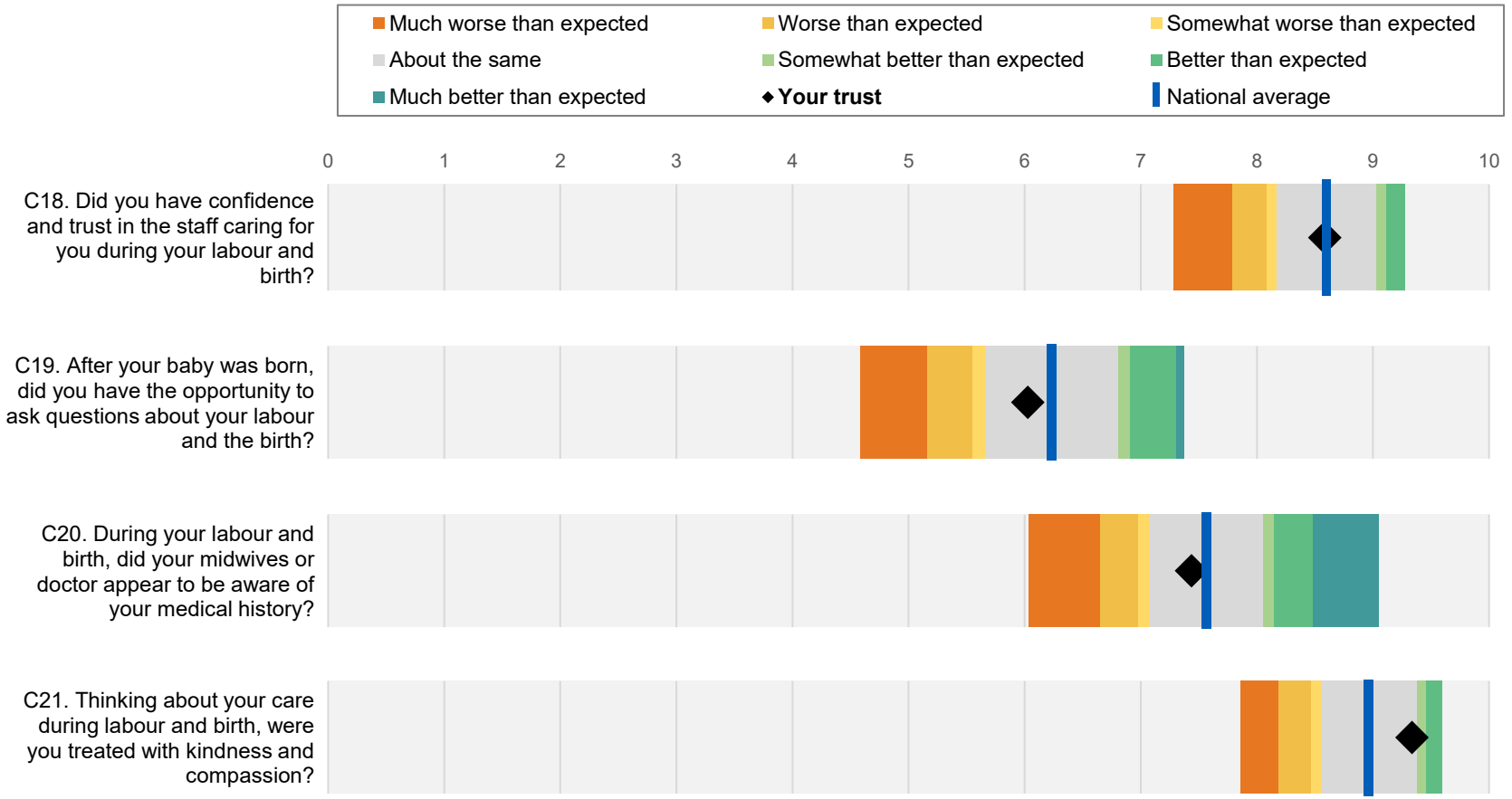
Section 2. Labour and Birth (continued)

Question scores: Staff caring for you

		All trusts in England				
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score	
C14. Thinking about your care during labour and birth, did you feel that the midwives and / or doctors looking after you worked well together?	158	8.5	8.4	7.2	9.3	About the same
C15. Thinking about your care during labour and birth, were you spoken to in a way you could understand?	161	9.3	9.2	8.4	9.7	About the same
C16. Thinking about your care during labour and birth, were you involved in decisions about your care?	155	8.7	8.5	7.7	9.3	About the same
C17. Thinking about your care during labour and birth, were you treated with respect and dignity?	160	9.3	9.1	7.9	9.7	About the same

Section 2. Labour and Birth (continued)

Question scores: Staff caring for you



		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	161	8.6	8.6	7.3	9.3
About the same	137	6.0	6.2	4.6	7.4
About the same	149	7.4	7.6	6.0	9.0
About the same	161	9.3	9.0	7.9	9.6

Benchmarking

Section 3: Postnatal Care

NHS

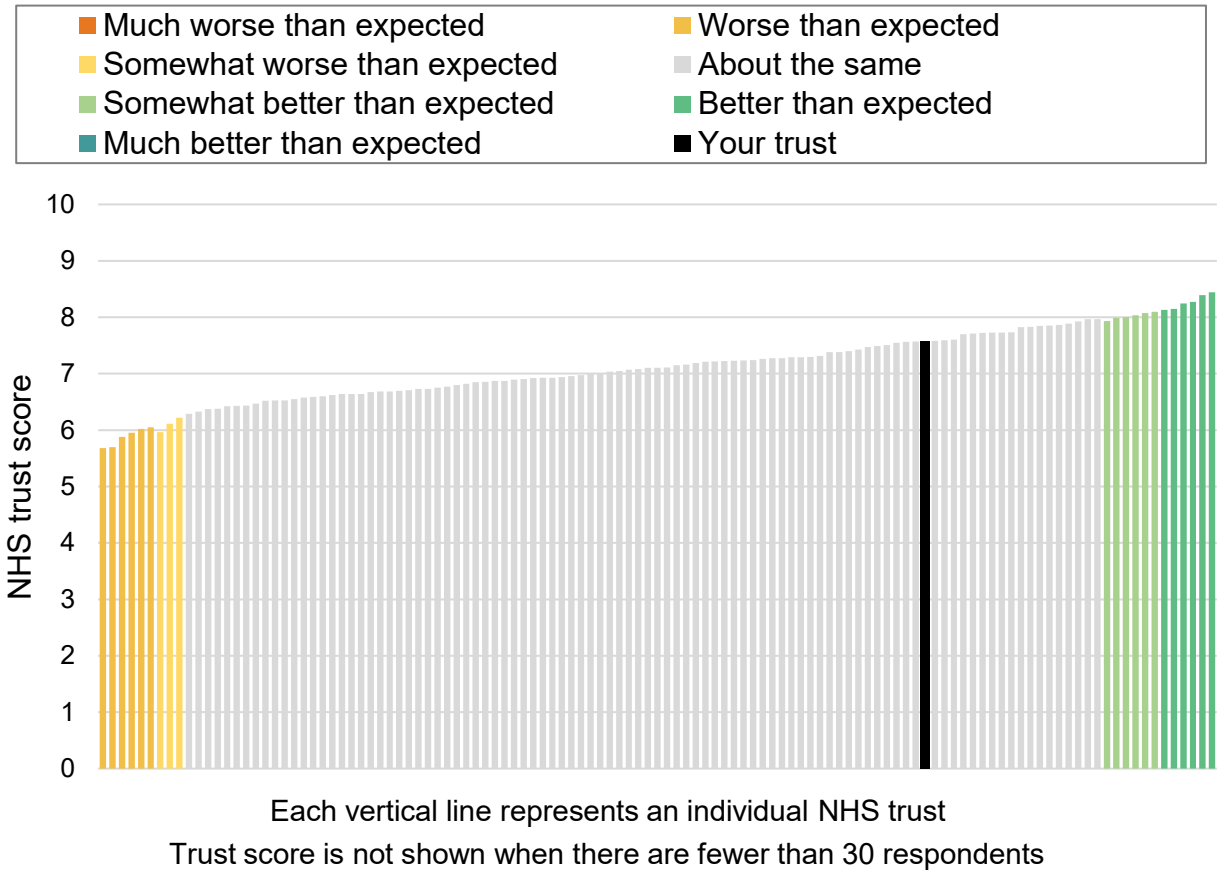
Care Quality Commission

Survey Coordination Centre

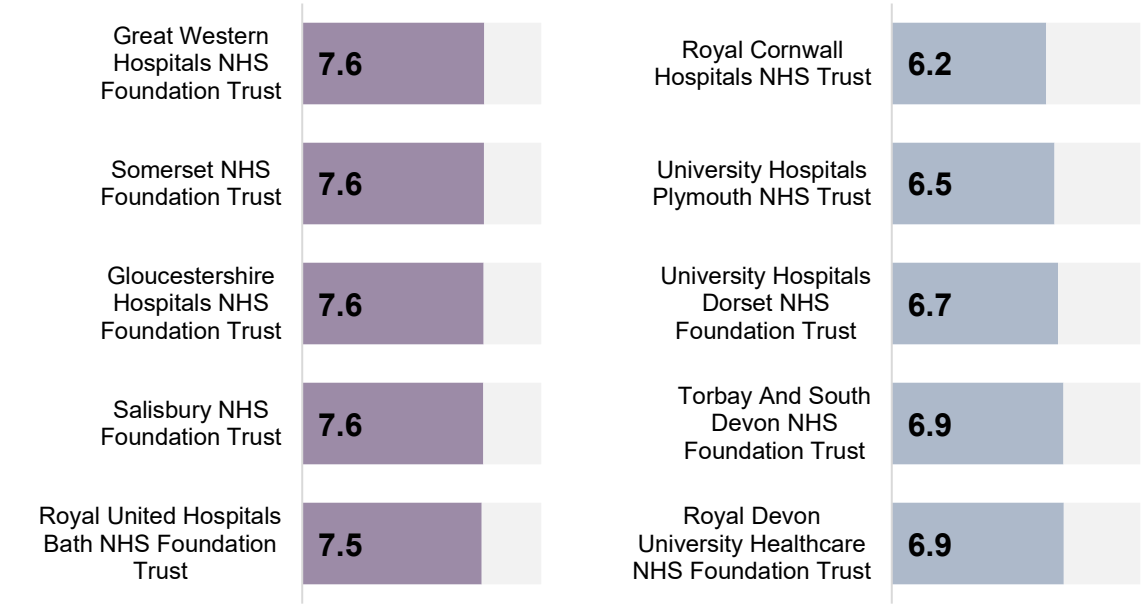
Care in the ward after birth

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care in the ward after birth' is calculated from questions D2 to D7. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.6 About the same

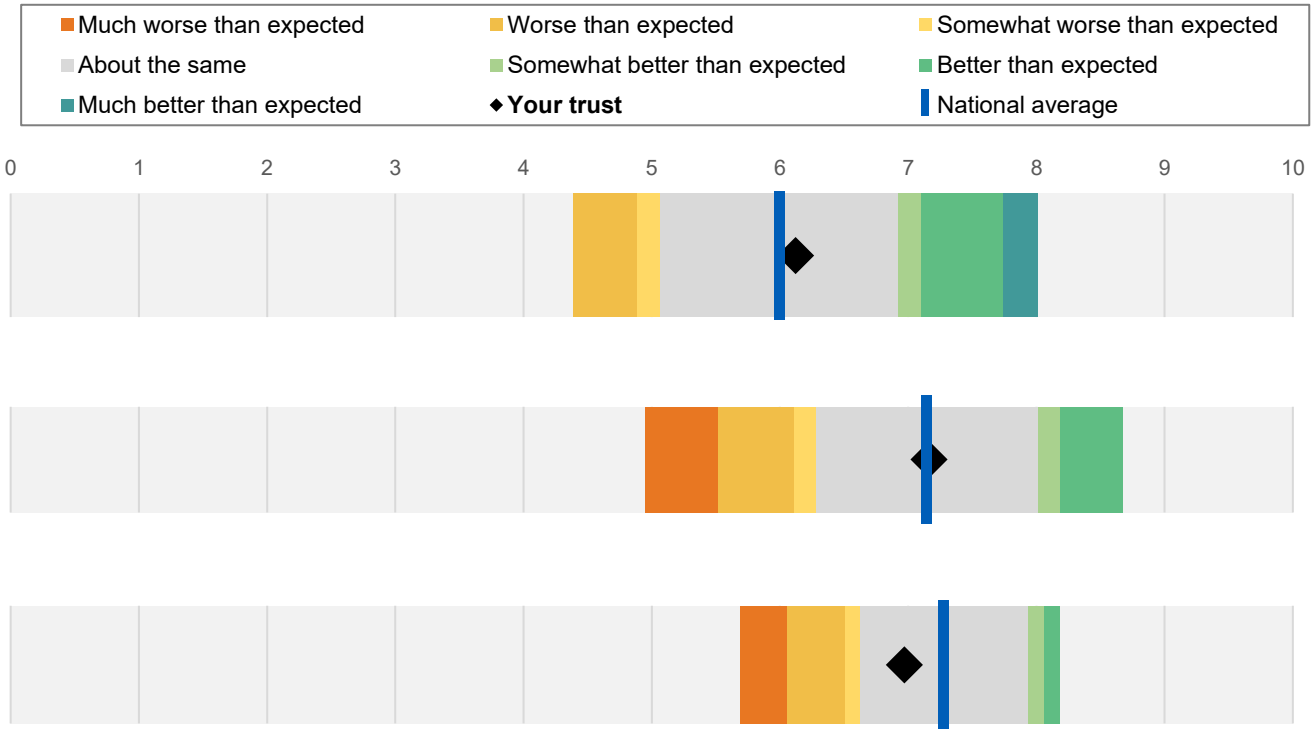


Comparison with other trusts within your region



Section 3. Postnatal Care

Question scores: Care in the ward after birth



		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
D2. On the day you left hospital, was your discharge delayed for any reason?	145	6.1	6.0	4.4	8.0
D3. If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?	132	7.2	7.1	5.0	8.7
D4. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	144	7.0	7.3	5.7	8.2

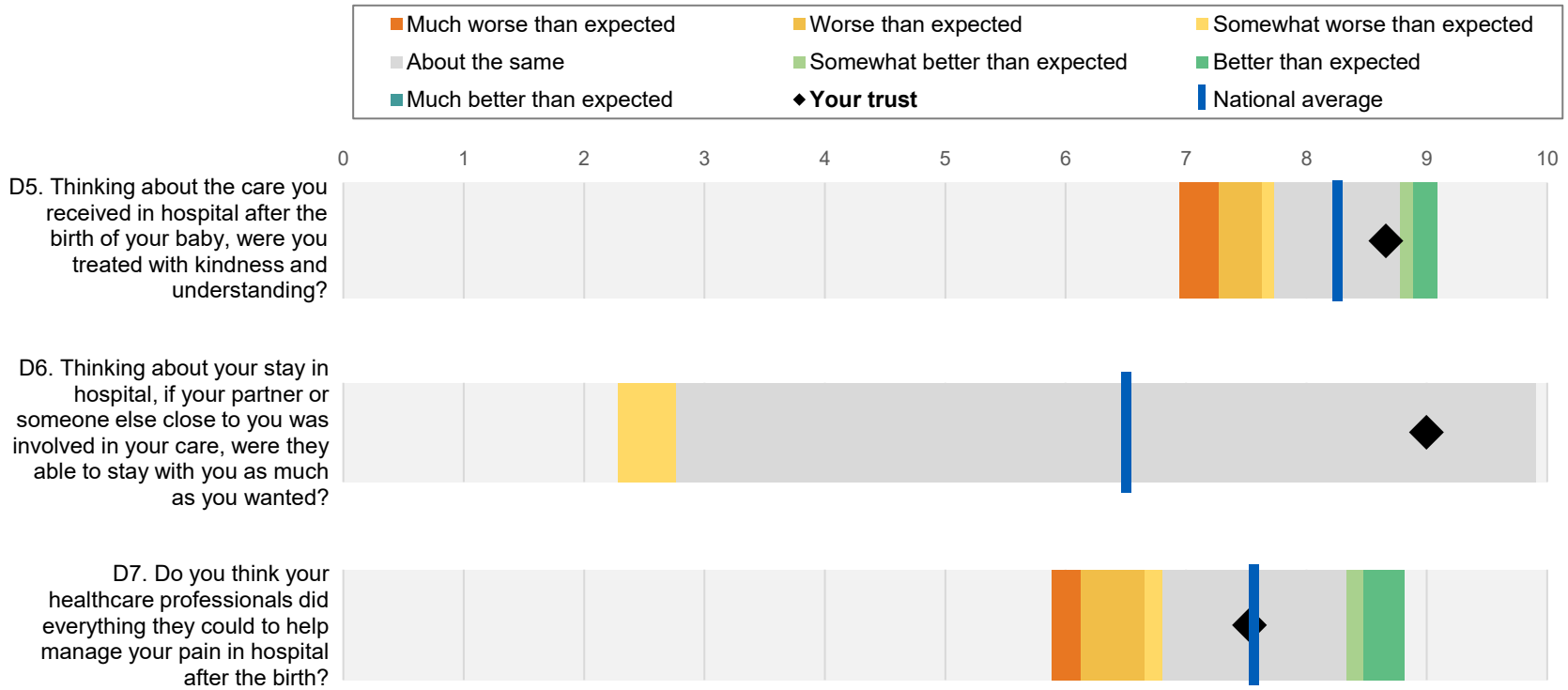
About the same

About the same

About the same

Section 3. Postnatal Care (continued)

Question scores: Care in the ward after birth

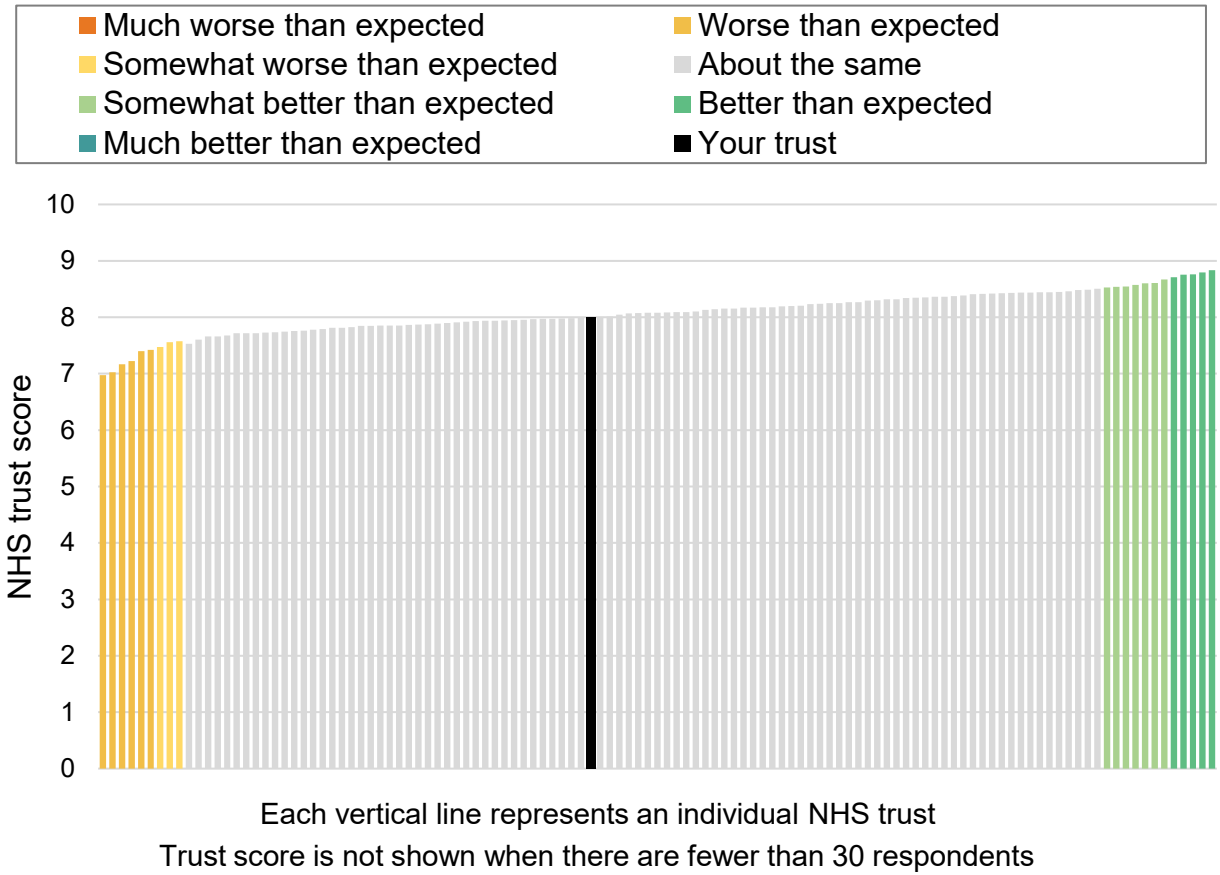


		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	145	8.7	8.3	6.9	9.1
About the same	137	9.0	6.5	2.3	9.9
About the same	135	7.5	7.6	5.9	8.8

Feeding your baby

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'feeding your baby' is calculated from questions E2 and E3. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

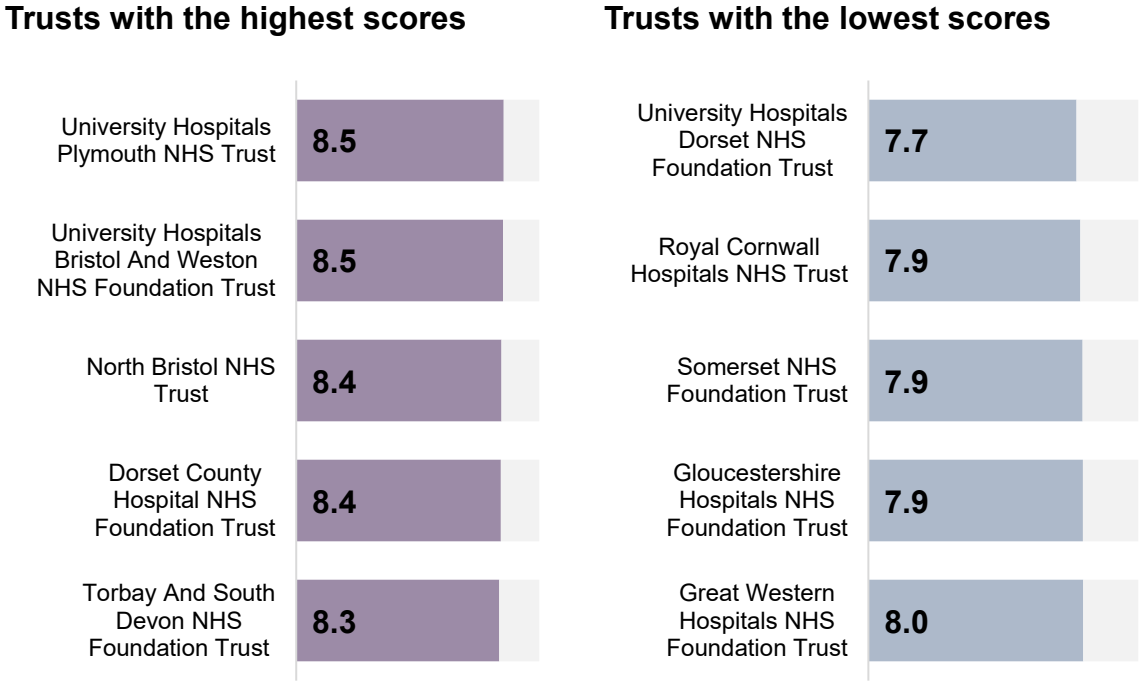
Your trust section score = 8.0 **About the same**



Each vertical line represents an individual NHS trust

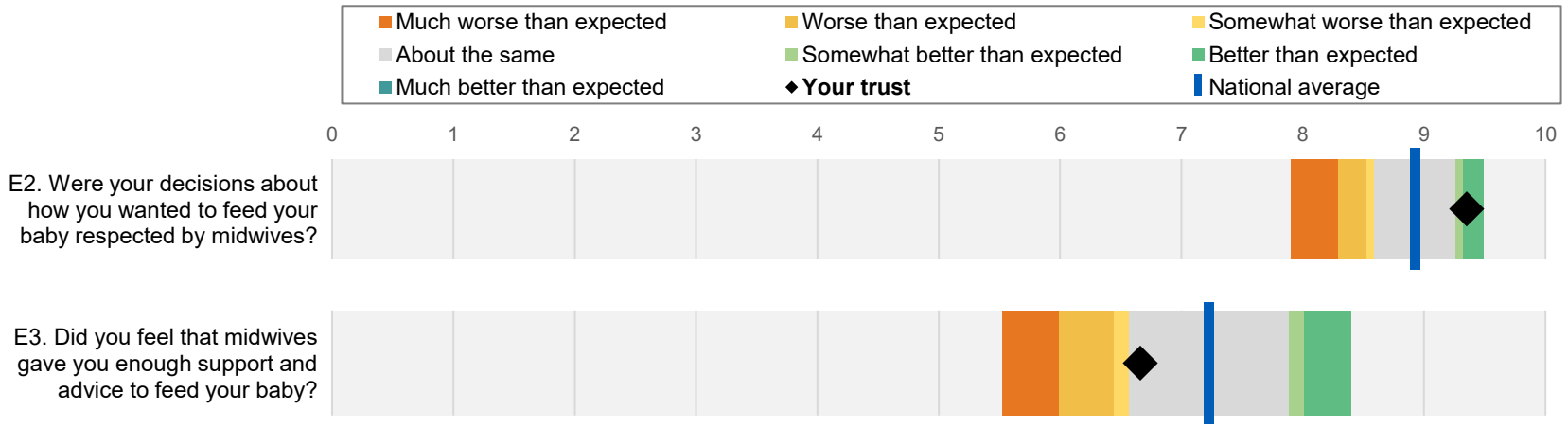
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region



Section 3. Postnatal Care (continued)

Question scores: Feeding your baby



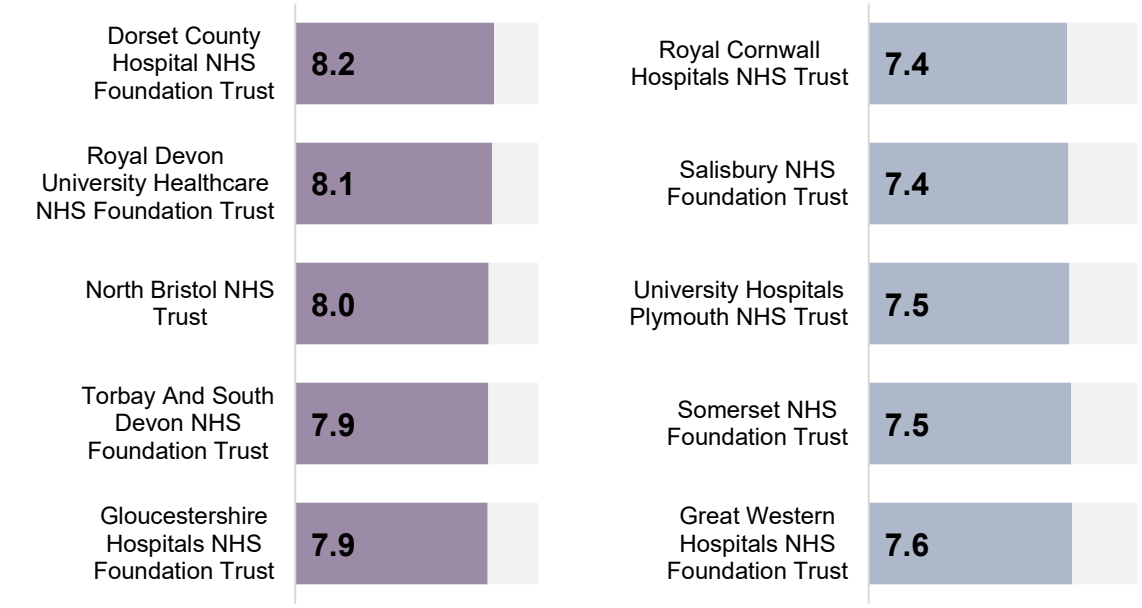
		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
Better than expected	149	9.3	8.9	7.9	9.5
About the same	134	6.7	7.2	5.5	8.4

Care at home after birth

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care at home after birth' is calculated from questions F1 and F2, F4 to F8, and F10 to F16. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

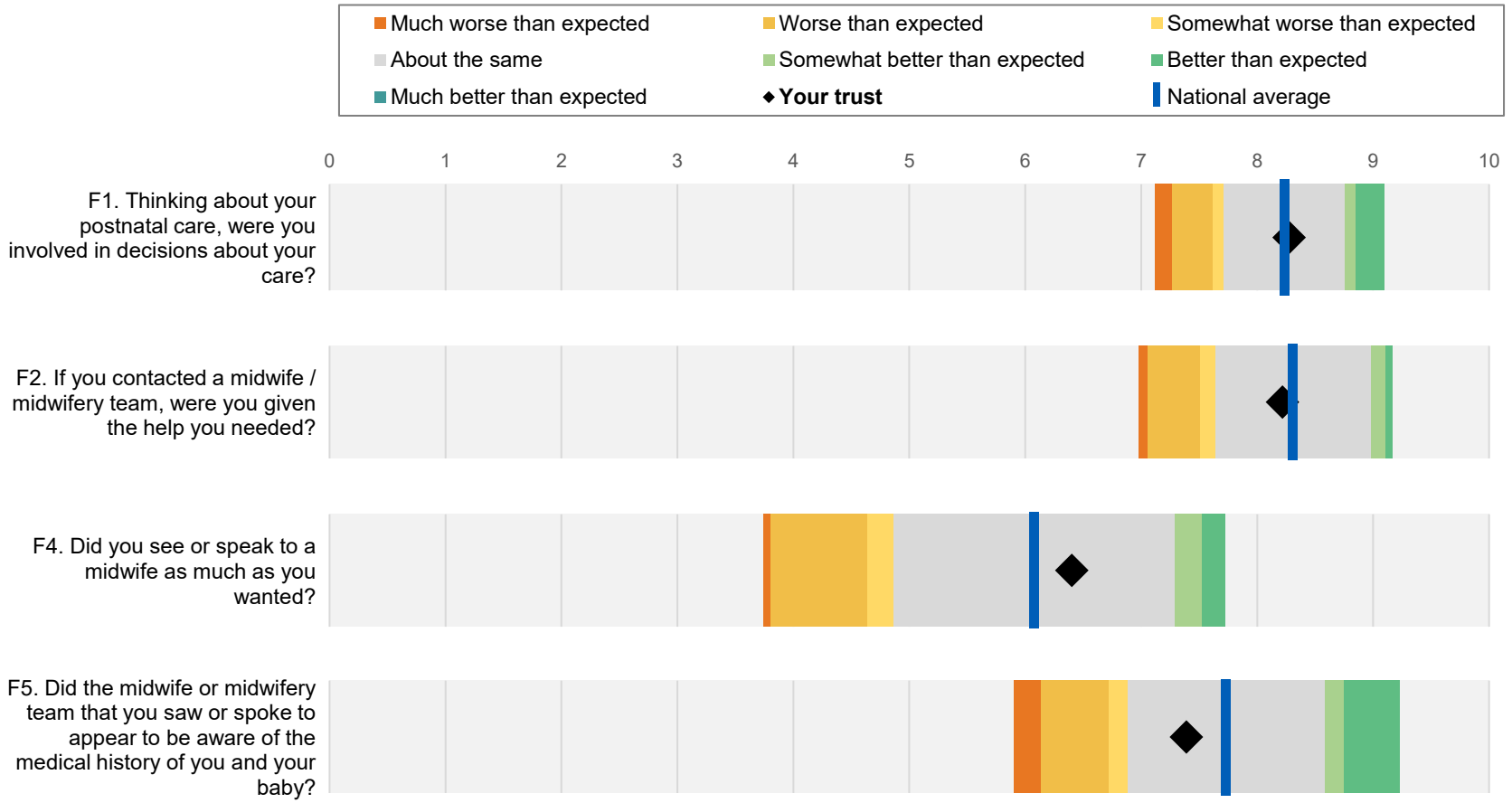
Your trust section score = 7.4 **About the same**

Comparison with other trusts within your region



Section 3. Postnatal Care

Question scores: Care at home after birth



		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	144	8.3	8.2	7.1	9.1
About the same	121	8.2	8.3	7.0	9.2
About the same	149	6.4	6.1	3.7	7.7
About the same	137	7.4	7.7	5.9	9.2

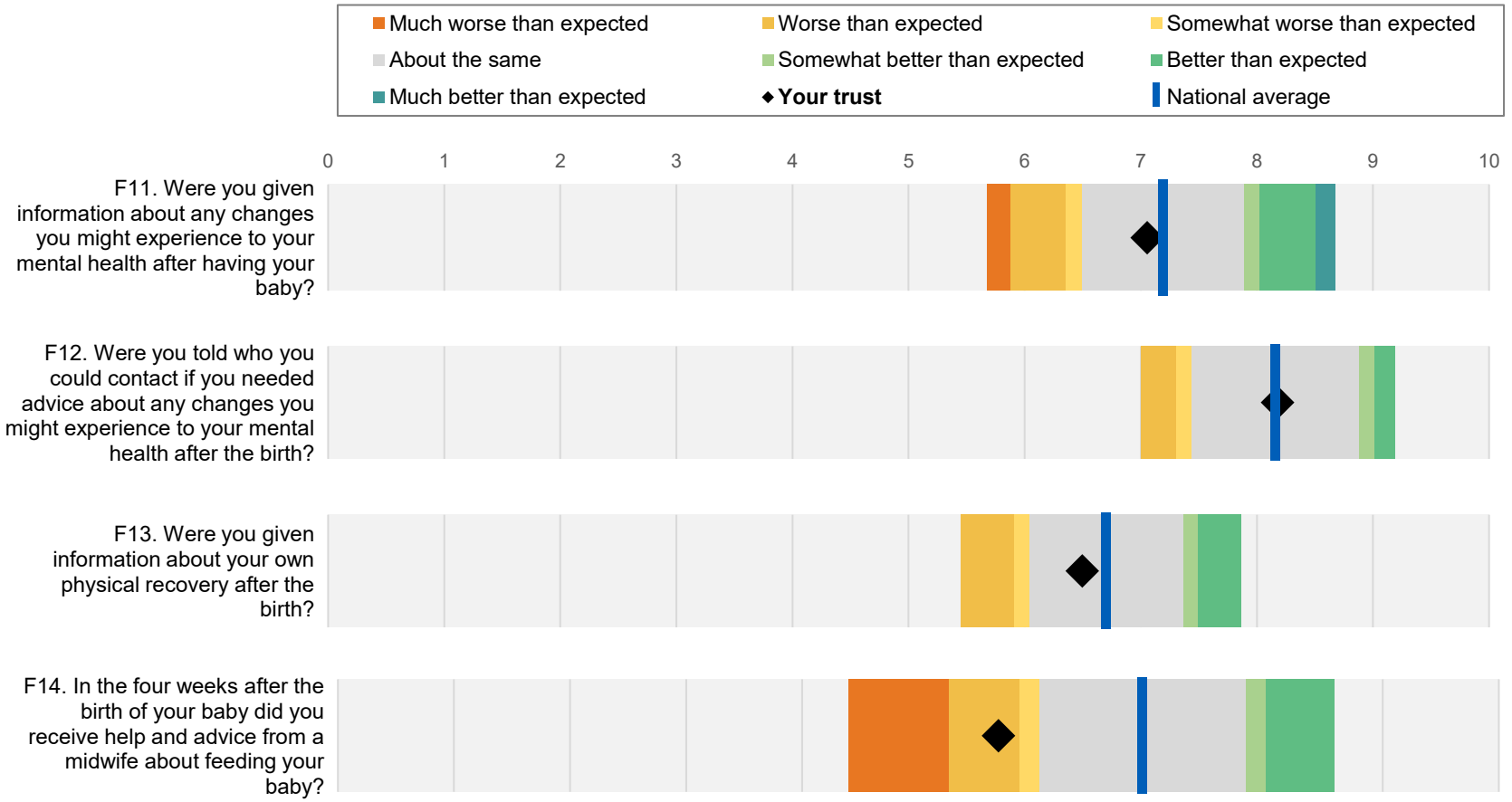
Section 3. Postnatal Care (continued)

Question scores: Care at home after birth

		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	147	8.6	8.6	7.7	9.3
About the same	138	8.2	8.3	7.2	9.3
About the same	148	8.0	8.2	7.1	9.3
Much better than expected	143	9.8	9.4	8.6	10.0

Section 3. Postnatal Care (continued)

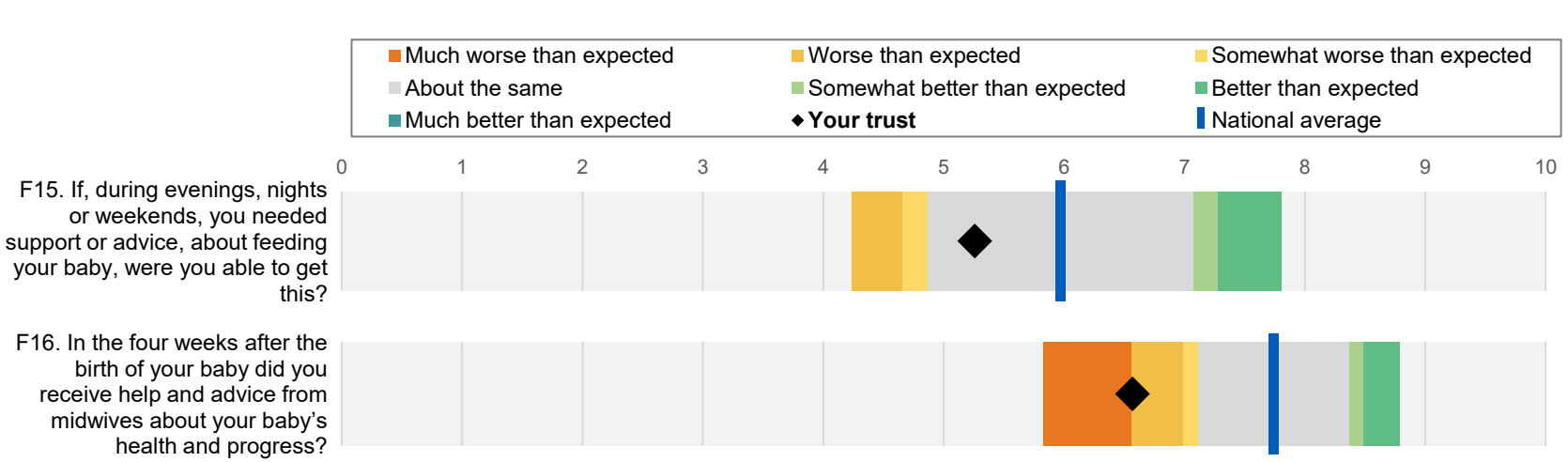
Question scores: Care at home after birth



		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	142	7.1	7.2	5.7	8.7
About the same	125	8.2	8.2	7.0	9.2
About the same	147	6.5	6.7	5.5	7.9
Worse than expected	113	5.7	6.9	4.4	8.6

Section 3. Postnatal Care (continued)

Question scores: Care at home after birth



		All trusts in England		
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	55	5.3	6.0	4.2	7.8
Worse than expected	126	6.6	7.7	5.8	8.8

Benchmarking

Section 4: Complaints

NHS

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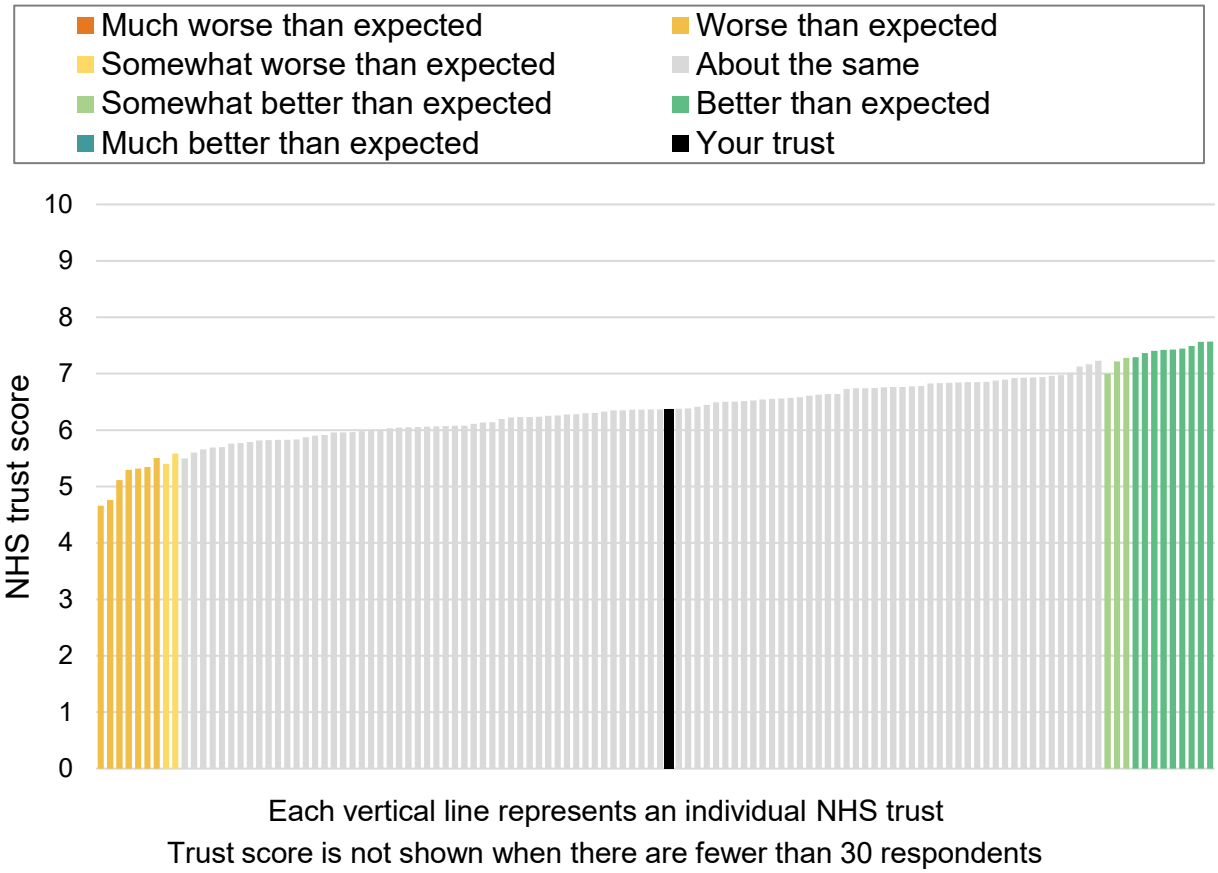
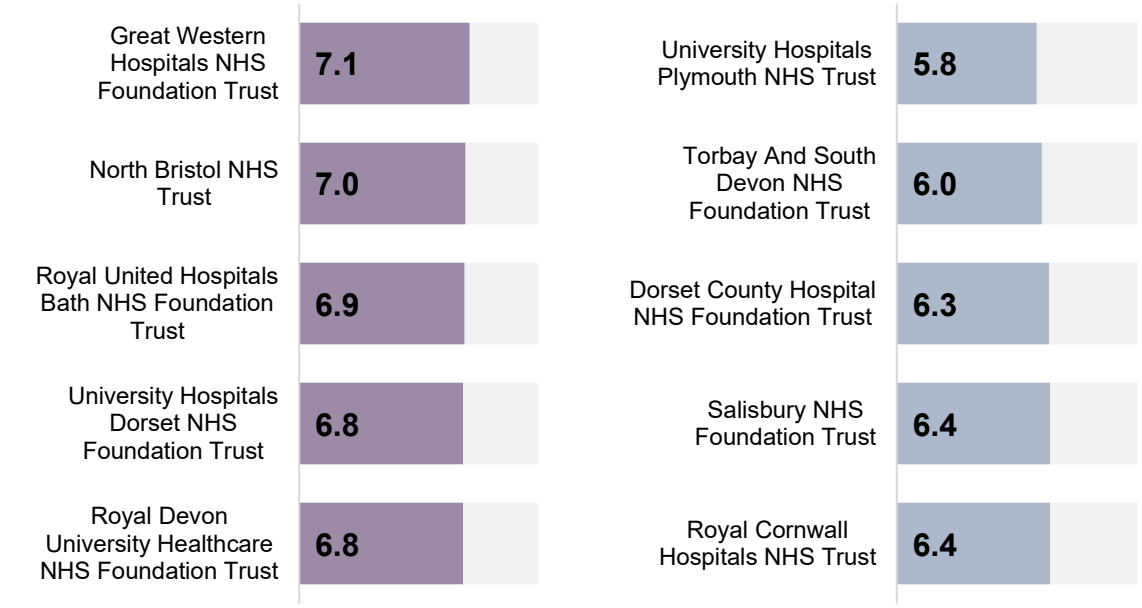
Complaints

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'complaints' is calculated from question F19. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 6.4 About the same



Comparison with other trusts within your region



Section 4. Complaints

Question scores

F19. At any point during your maternity care journey, did you consider making a complaint about the care you received?

About the same

	All trusts in England			
Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
160	6.4	6.4	4.7	7.6

Change over time

This section includes:

- your mean trust score for each evaluative question in the survey
- where comparable data is available, statistical significance testing using a two-sample t-test has been carried out against the 2023 and 2024 survey results for each relevant question. Where a change in results is shown as ‘significant’, this indicates that this change is not due to random chance, but is likely due to some particular factor at your trust

Please note:

- If data is missing for a survey year, this is due to a low number of responses, or because the trust data was not included in the survey that year, due to sampling errors or ineligibility.
- The following questions were new or changed for 2024 and therefore are not included in this section: B3, B18, B20, C5, C7, C14, E3, F2, F10, F14, F16, G12.

NHS

Care Quality Commission

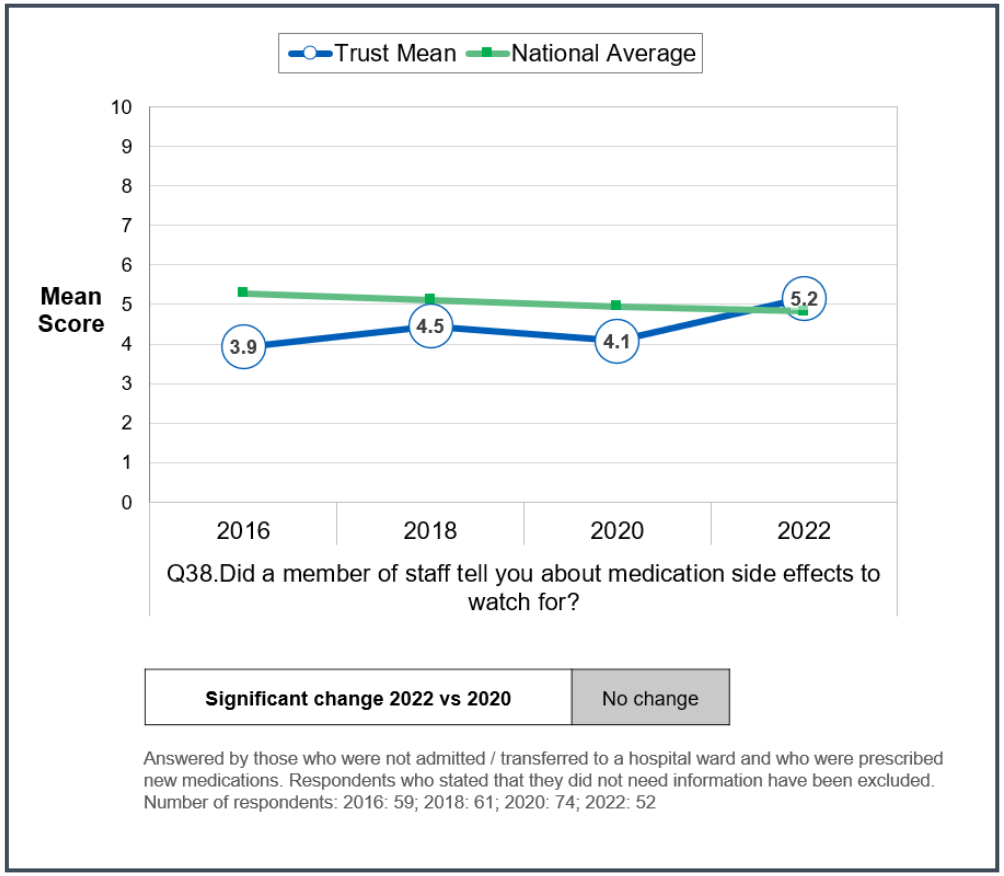
Survey Coordination Centre

How to interpret change over time in this report

The charts in the 'change over time' section show how your trust scored in each Maternity survey iteration. Where available, trend data from 2013 to 2024 is shown. If a question only has one data point, this question is not shown. Questions that are not historically comparable are also not shown.

Each question is displayed in a line chart. These charts show your trust mean score for each survey year (blue line). The national average is also shown across survey years, this is the average score for that question across all NHS trusts with a maternity department in England (green line). This enables you to see how your trust compares to the national average. If there is data missing for a survey year, this may be due to either a low number of responses, because the trust was not included in the survey that year, sampling errors or ineligibility.

Statistically significant changes are also displayed in tables underneath the charts, showing significant differences between this year (2024) and the previous year (2023). Z-tests set to 95% significance were used to compare data between the two years (2024 vs 2023). A statistically significant difference means it is unlikely we would have obtained this result if there was no real difference.

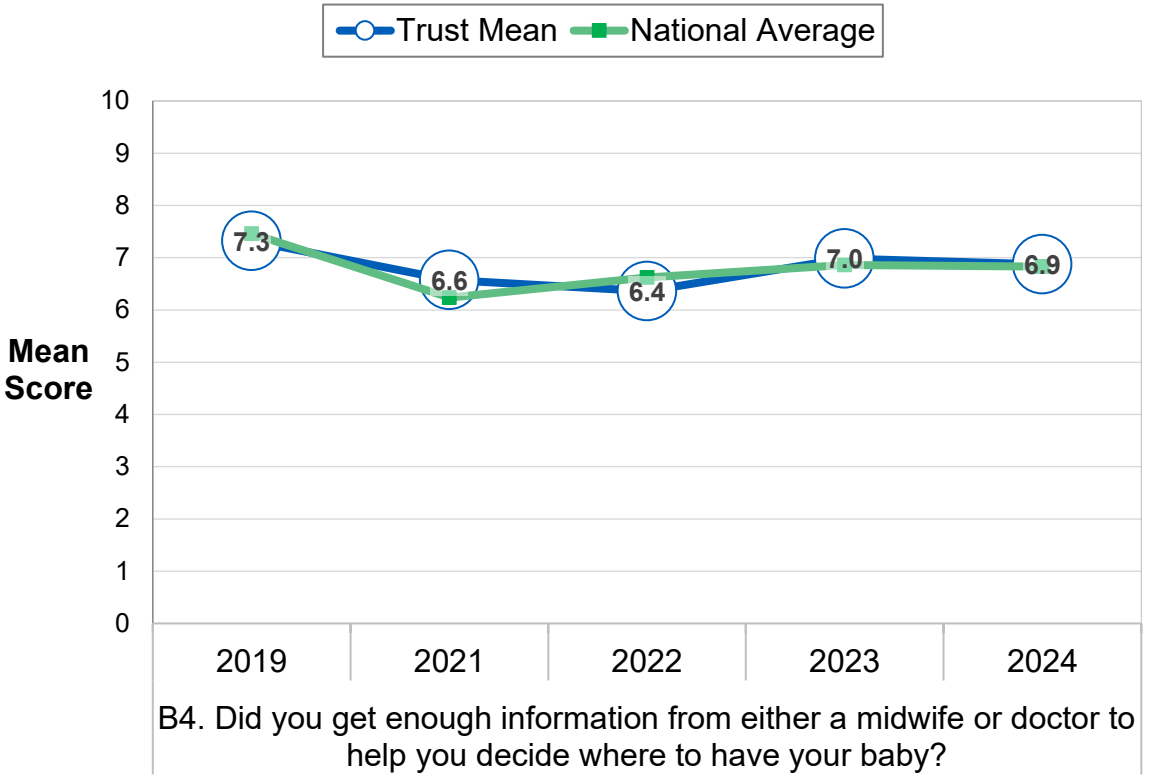


Change over time

Section 1: Antenatal Care

Section 1. Antenatal Care

The start of your care during pregnancy

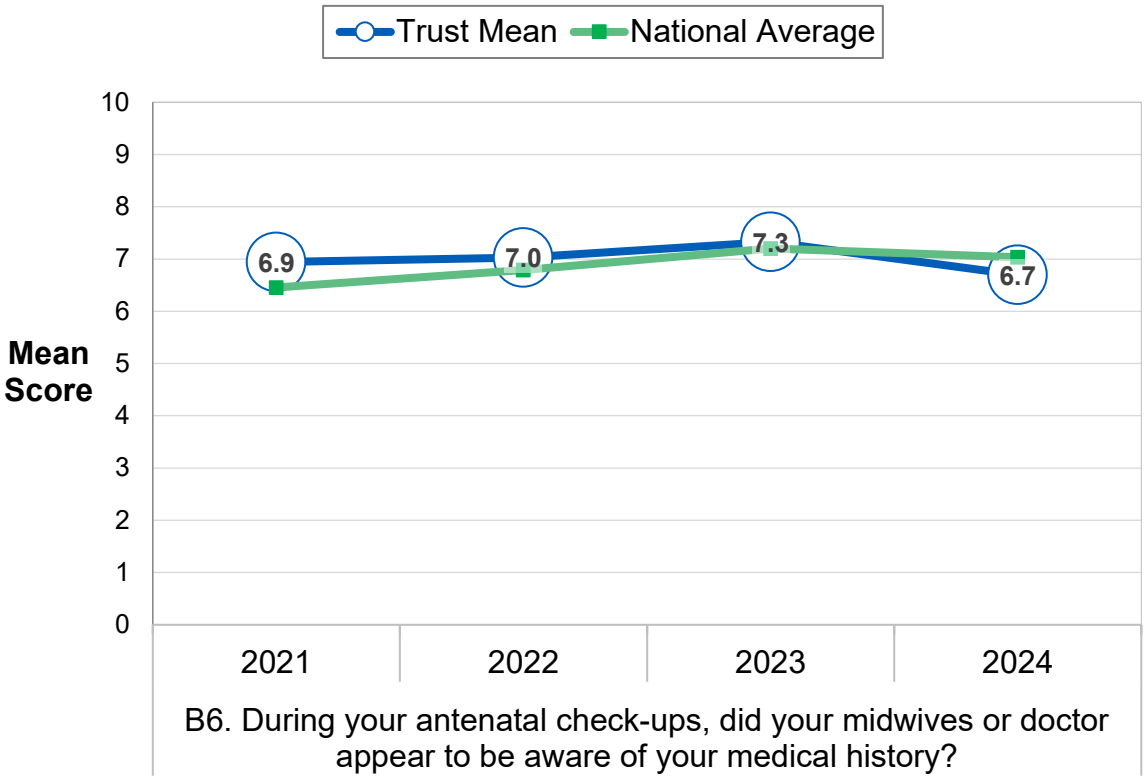


Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2019: 150; 2021: 154; 2022: 158; 2023: 149; 2024: 147

Section 1. Antenatal Care

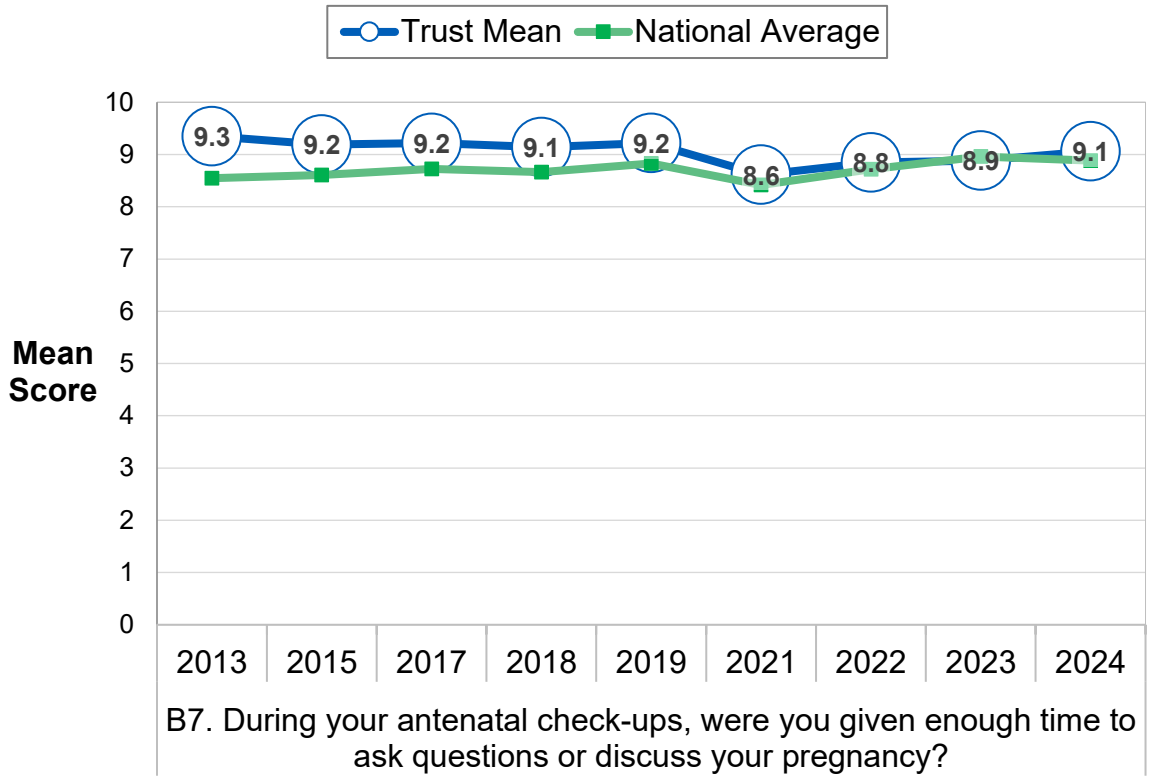
Antenatal check ups



B6. During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2021: 154; 2022: 157; 2023: 155; 2024: 149



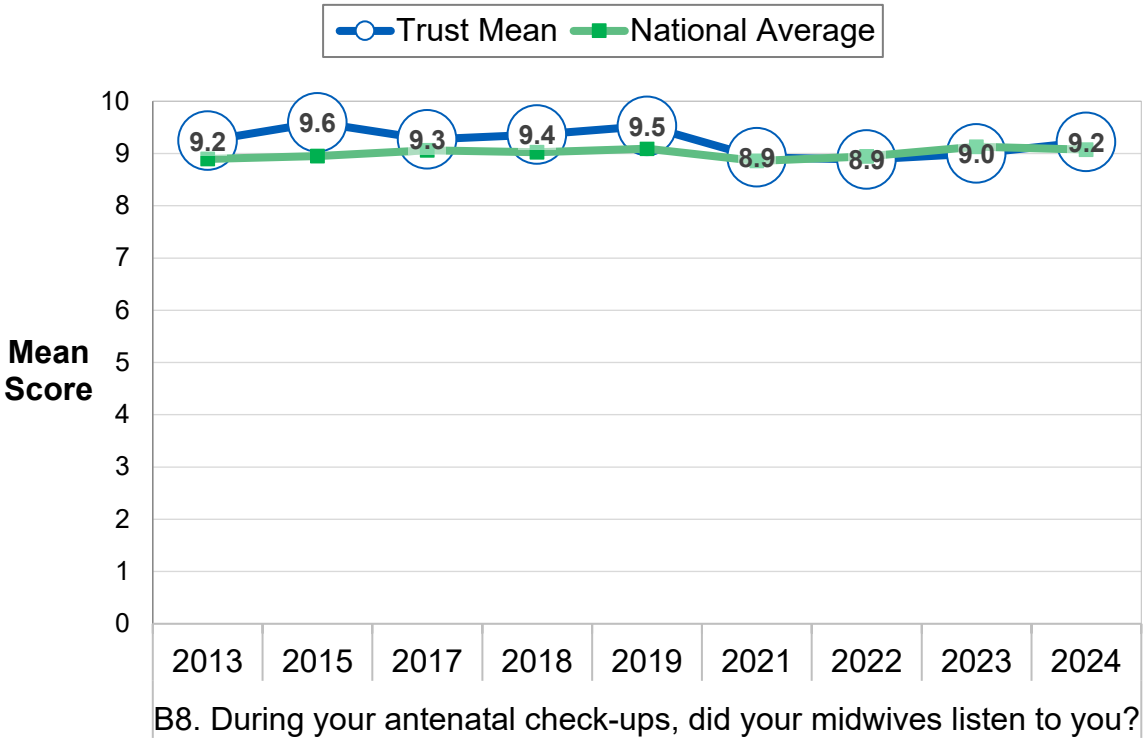
B7. During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2013: 168; 2015: 149; 2017: 149; 2018: 154; 2019: 154; 2021: 159; 2022: 161; 2023: 156; 2024: 150

Section 1. Antenatal Care

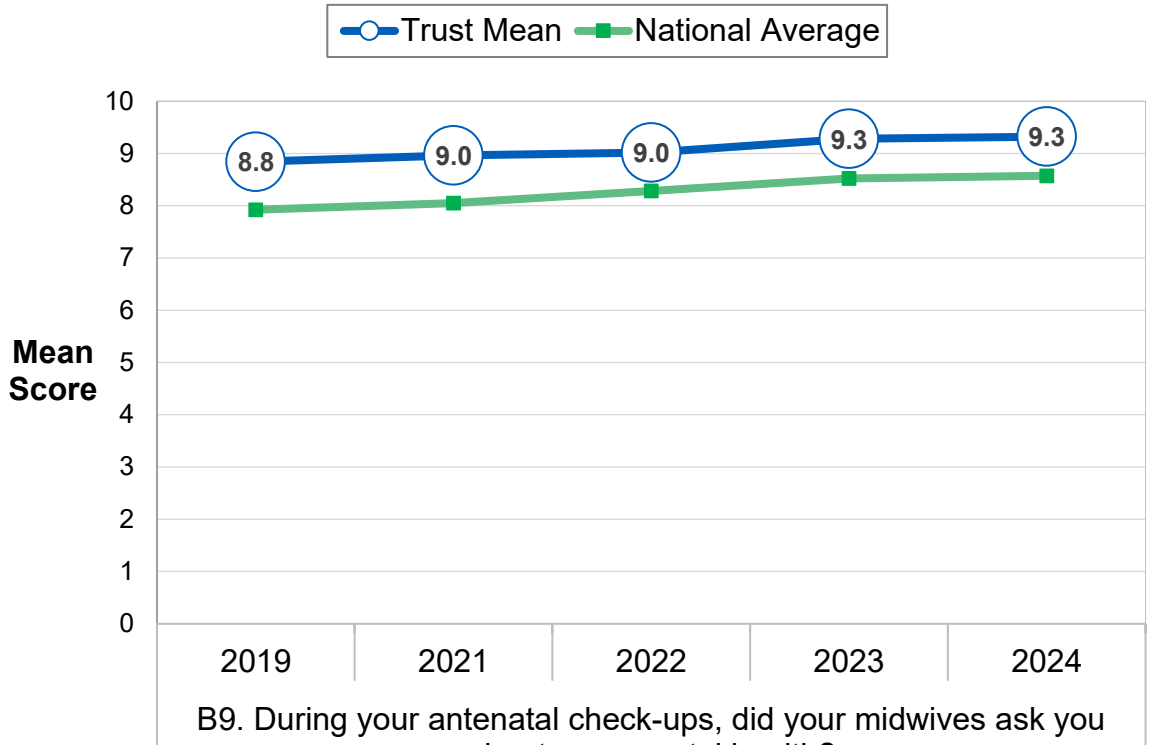
Antenatal check ups



B8. During your antenatal check-ups, did your midwives listen to you?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2013: 168; 2015: 149; 2017: 150; 2018: 154; 2019: 153; 2021: 159; 2022: 162; 2023: 156; 2024: 150



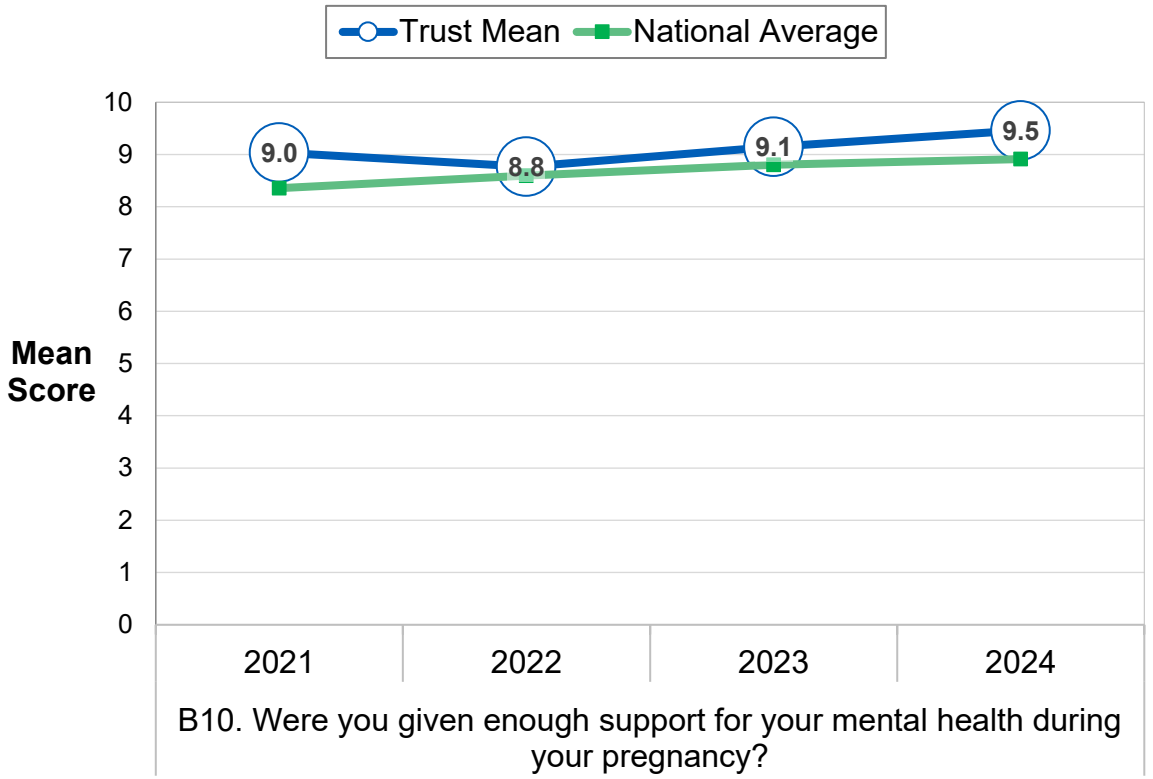
B9. During your antenatal check-ups, did your midwives ask you about your mental health?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2019: 151; 2021: 158; 2022: 162; 2023: 156; 2024: 150

Section 1. Antenatal Care

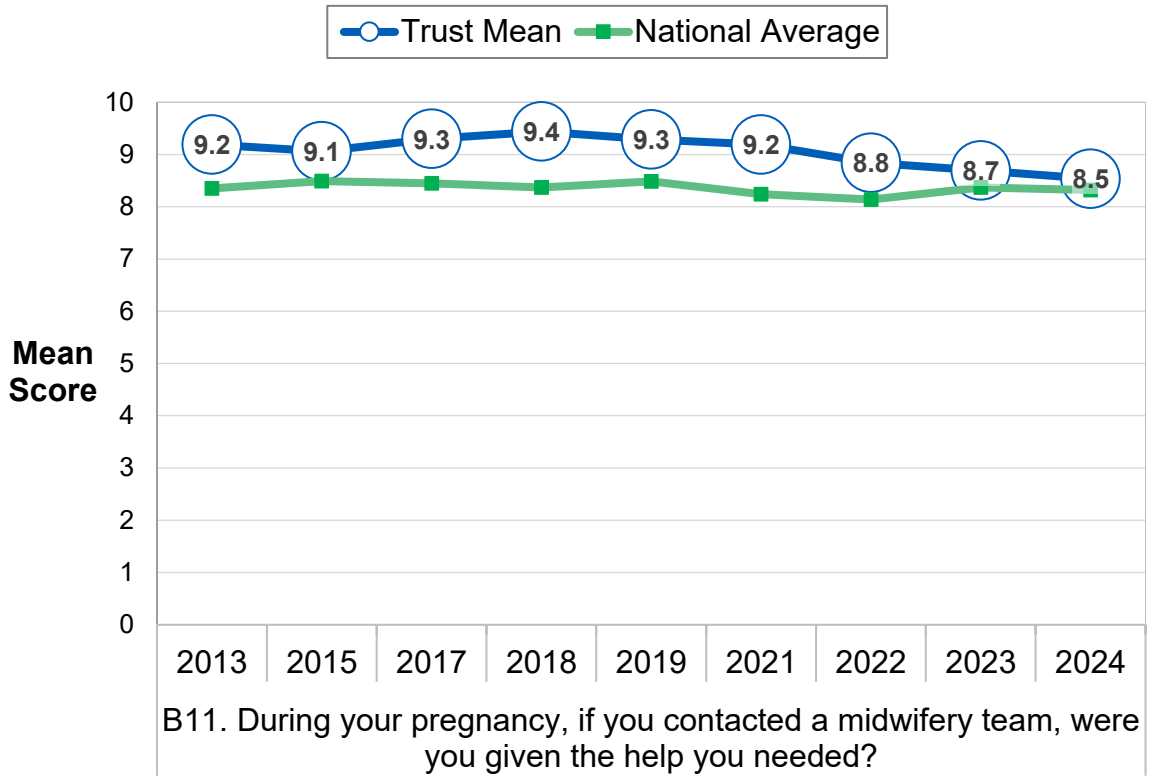
During your pregnancy



B10. Were you given enough support for your mental health during your pregnancy?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or did not want / need support have been excluded.
Number of respondents: 2021: 111; 2022: 112; 2023: 107; 2024: 91



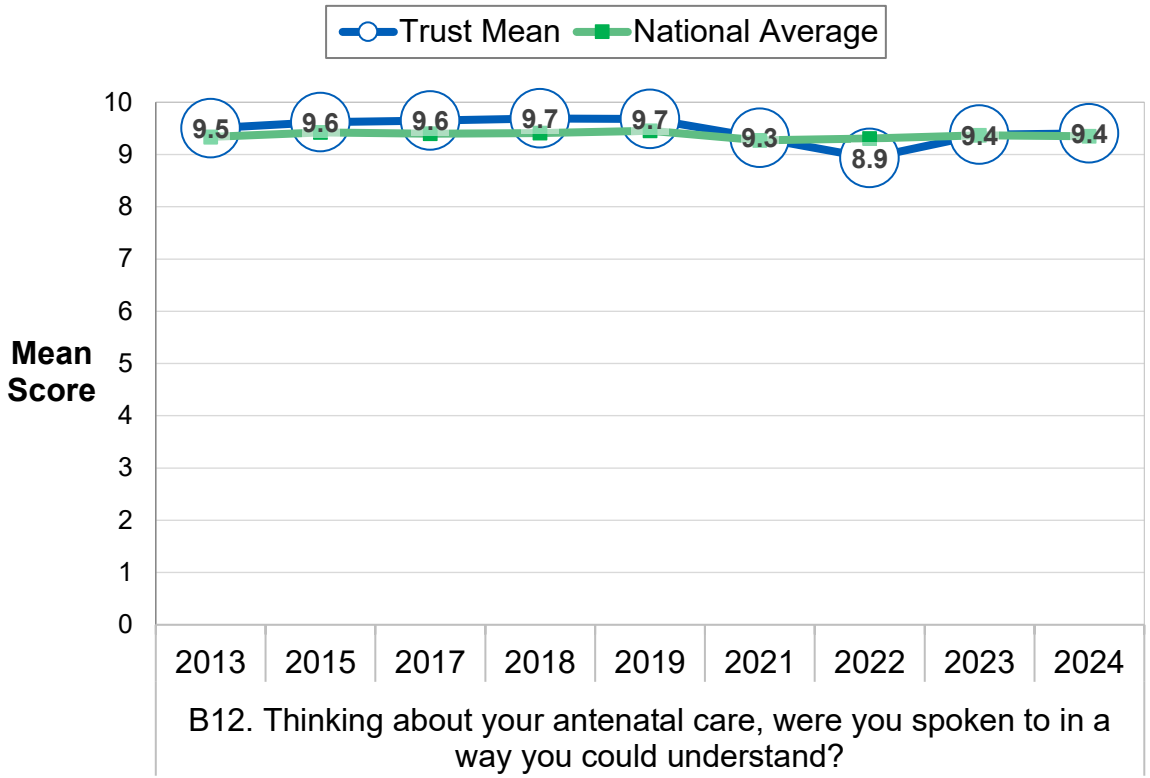
B11. During your pregnancy, if you contacted a midwifery team, were you given the help you needed?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they did not contact a midwifery team have been excluded.
Number of respondents: 2013: 150; 2015: 125; 2017: 126; 2018: 127; 2019: 131; 2021: 150; 2022: 151; 2023: 149; 2024: 133

Section 1. Antenatal Care

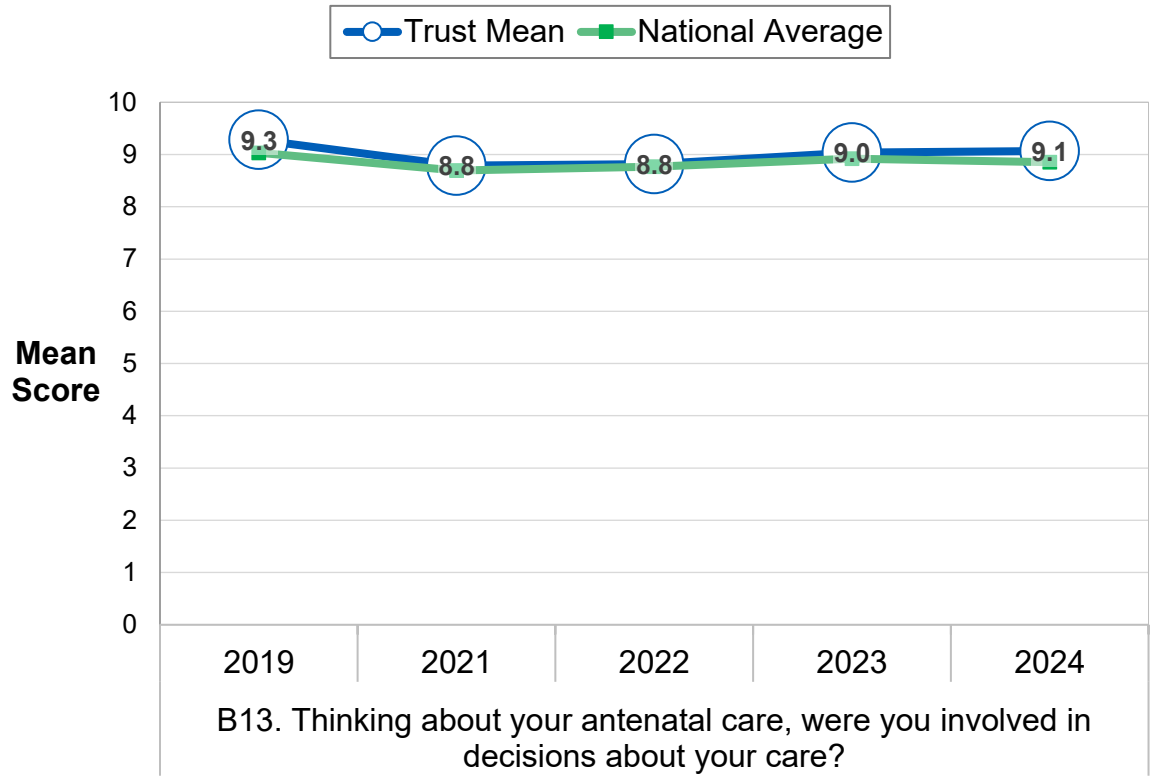
During your pregnancy



B12. Thinking about your antenatal care, were you spoken to in a way you could understand?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 167; 2015: 148; 2017: 150; 2018: 155; 2019: 153; 2021: 159; 2022: 161; 2023: 156; 2024: 150



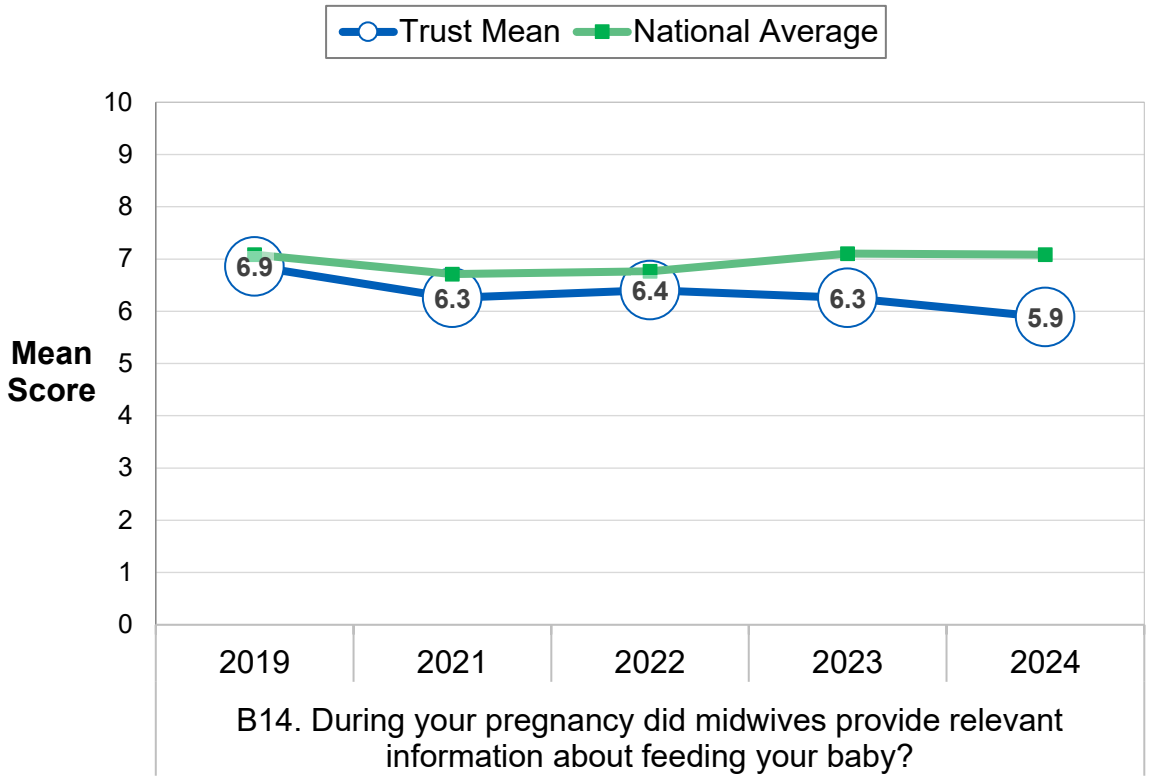
B13. Thinking about your antenatal care, were you involved in decisions about your care?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember or did not want / need to be involved have been excluded.
Number of respondents: 2019: 152; 2021: 153; 2022: 159; 2023: 153; 2024: 150

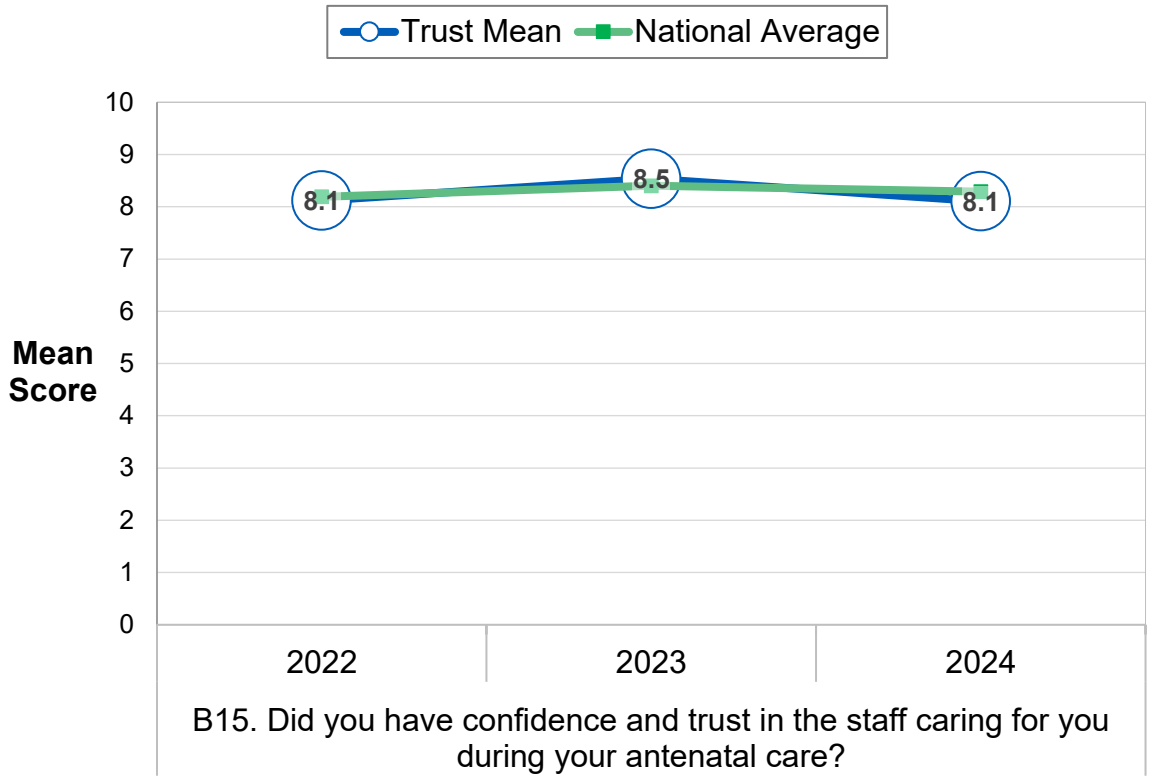
Section 1. Antenatal Care

During your pregnancy



Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2019: 149; 2021: 153; 2022: 156; 2023: 151; 2024: 147

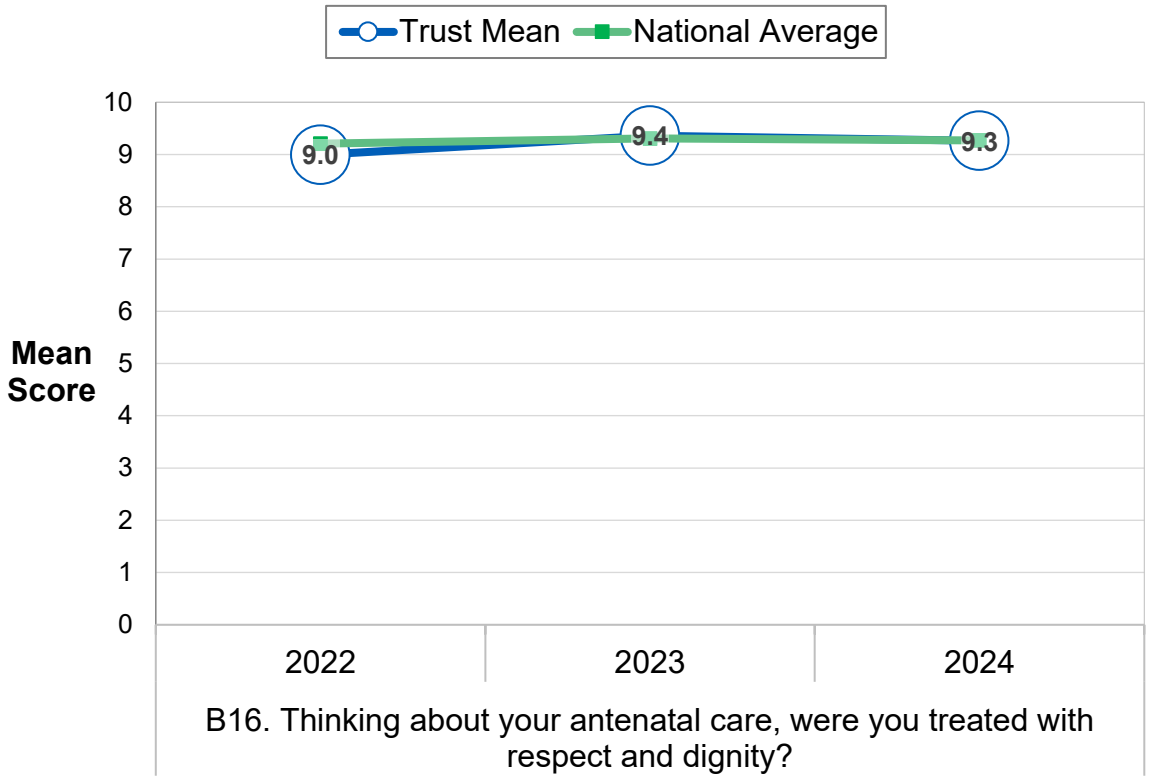


Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2022: 162; 2023: 156; 2024: 150

Section 1. Antenatal Care

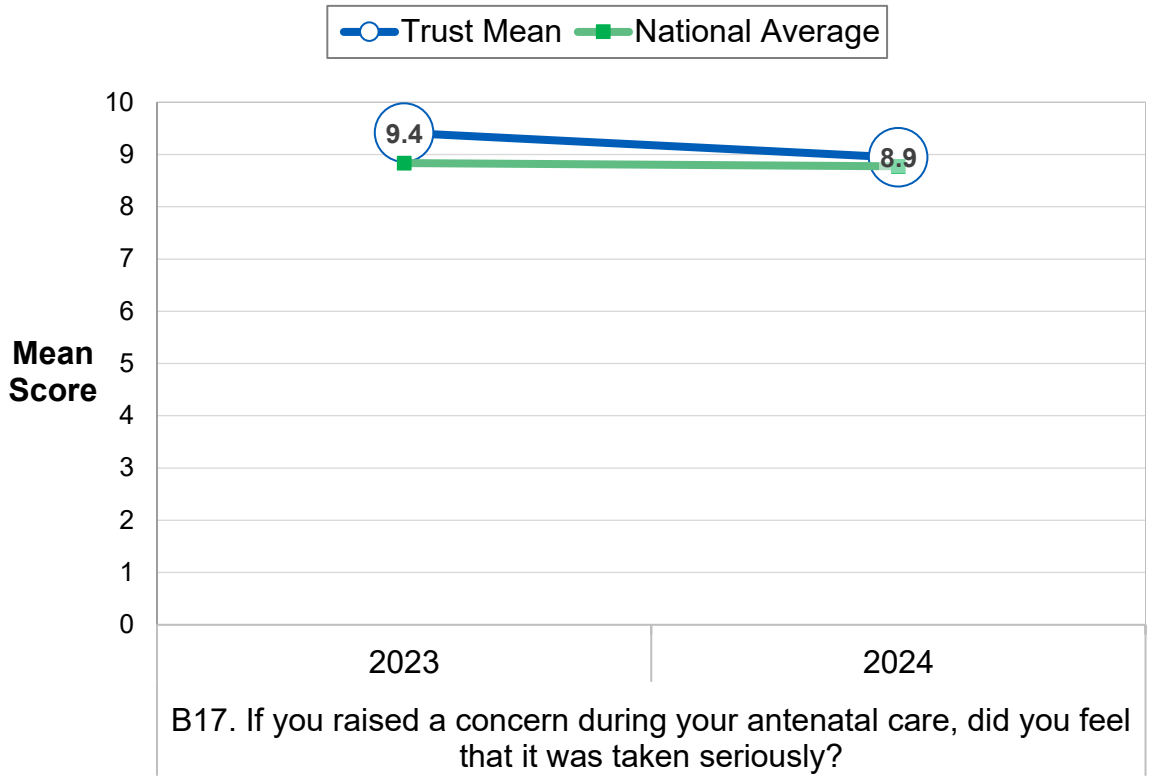
During your pregnancy



B16. Thinking about your antenatal care, were you treated with respect and dignity?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2022: 161; 2023: 156; 2024: 150



B17. If you raised a concern during your antenatal care, did you feel that it was taken seriously?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2023: 106; 2024: 110

Change over time

Section 2: Labour and Birth

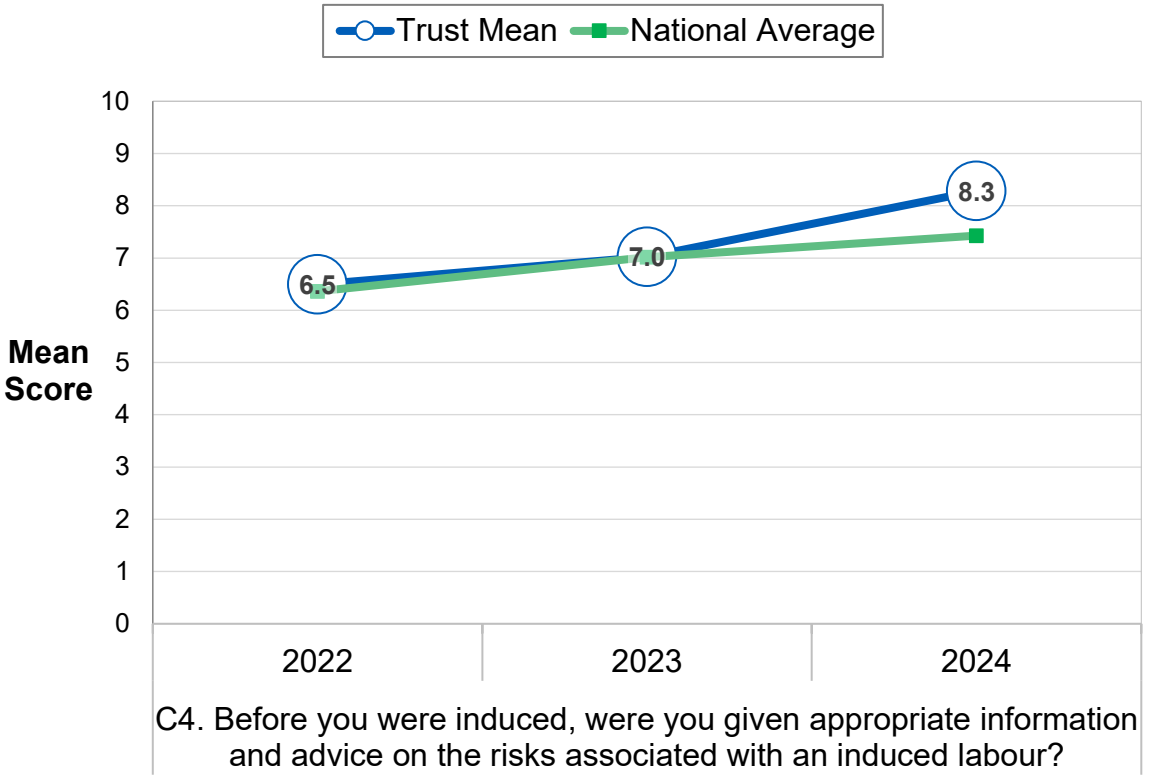
NHS

Care Quality Commission

Survey Coordination Centre

Section 2. Labour and Birth

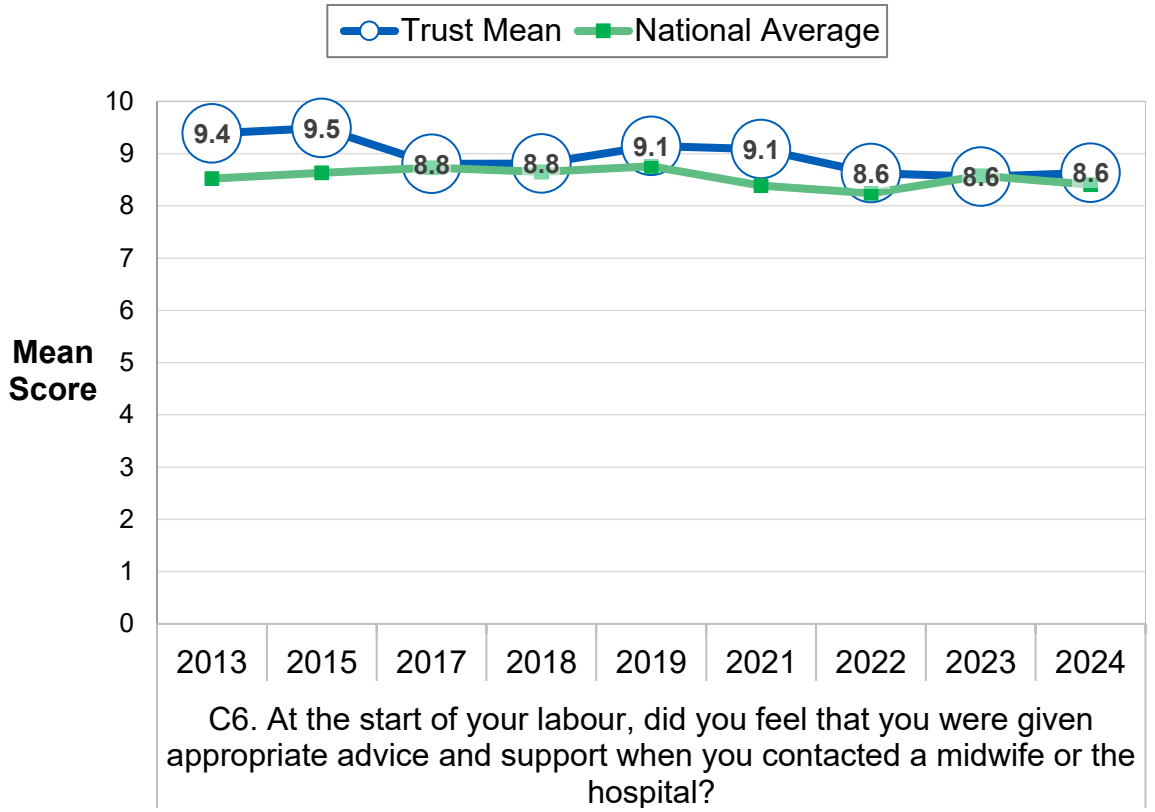
Your labour and birth



C4. Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?

Significant change 2024 vs 2023	No change

Answered by those who were induced. Respondents who stated that they didn't know or couldn't remember have been excluded. Note of caution when interpreting the trend data: The 2023 preceding question asking about information and advice on the benefits of an induced labour was removed.
Number of respondents: 2022: 57; 2023: 60; 2024: 57



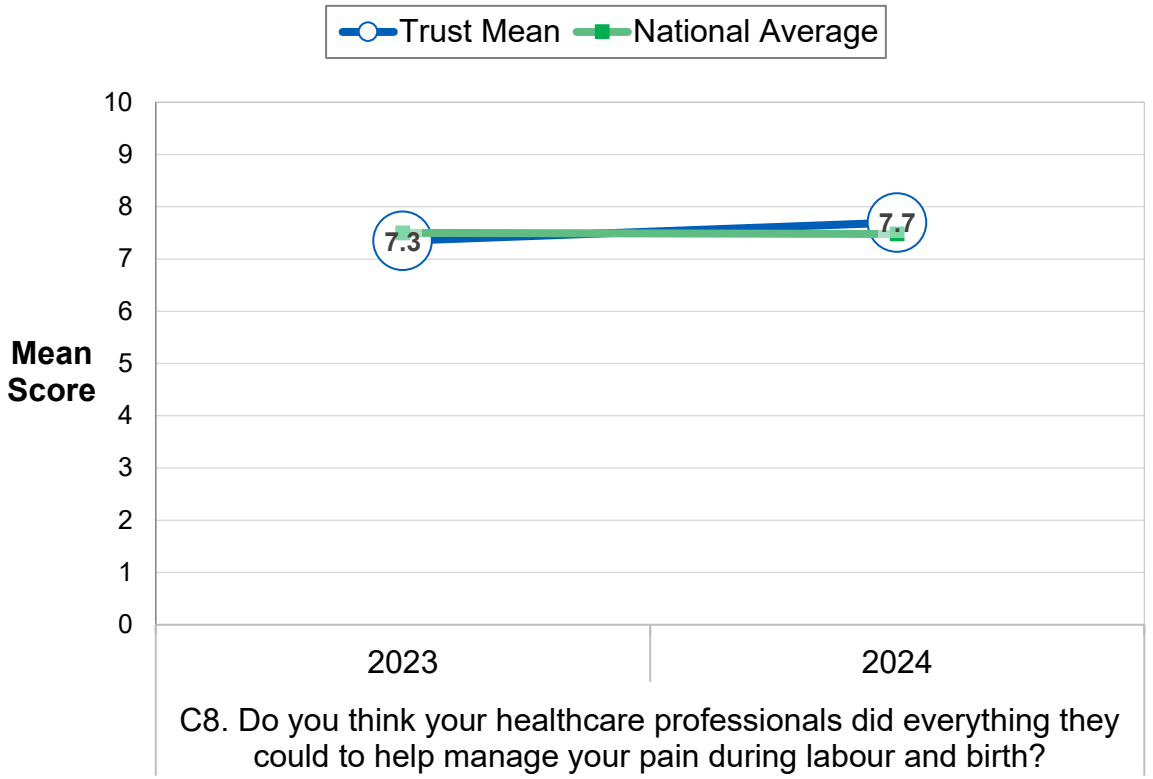
C6. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?

Significant change 2024 vs 2023	No change

Answered by those who went into labour. Respondents who stated that they did not contact a midwife / the hospital have been excluded.
Number of respondents: 2013: 153; 2015: 129; 2017: 130; 2018: 134; 2019: 125; 2021: 135; 2022: 124; 2023: 112; 2024: 113

Section 2. Labour and Birth

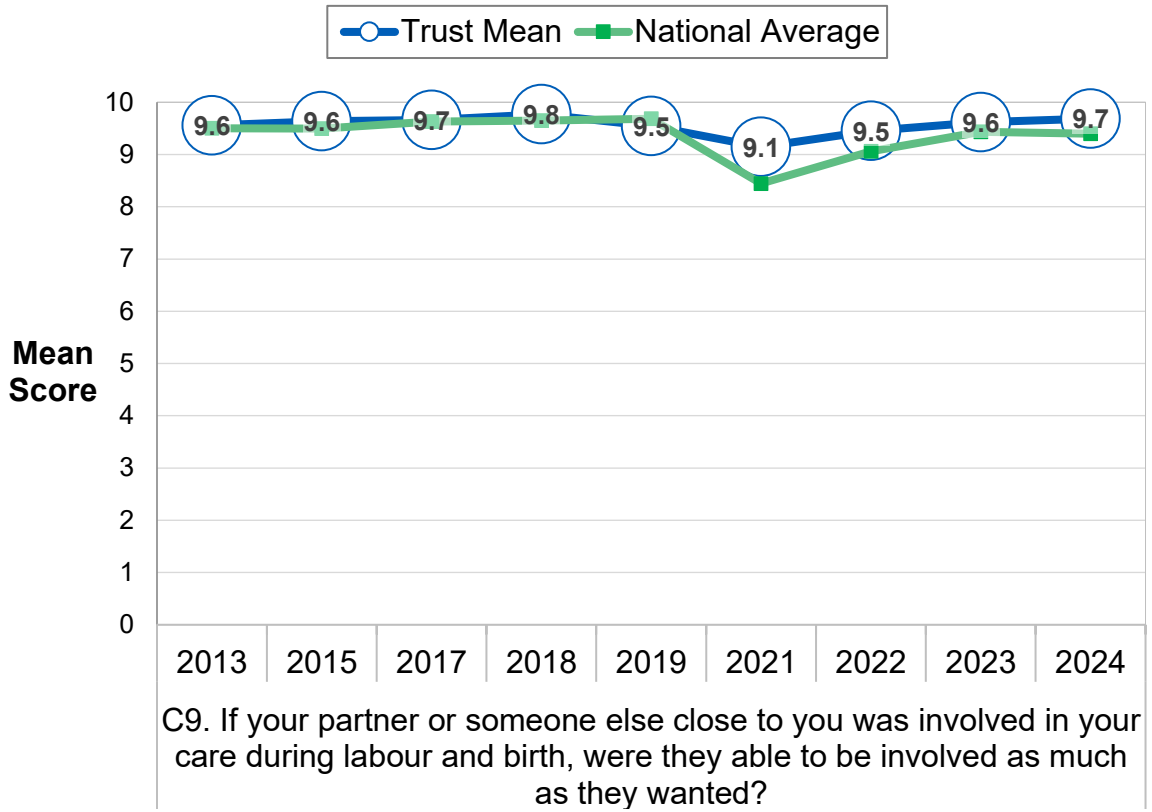
Your labour and birth



C8. Do you think your healthcare professionals did everything they could to help manage your pain during labour and birth?

Significant change 2024 vs 2023	No change

Answered by those who had a labour. Respondents who stated that they didn't know or couldn't remember or did not need any help with pain relief have been excluded.
Number of respondents: 2023: 133; 2024: 122



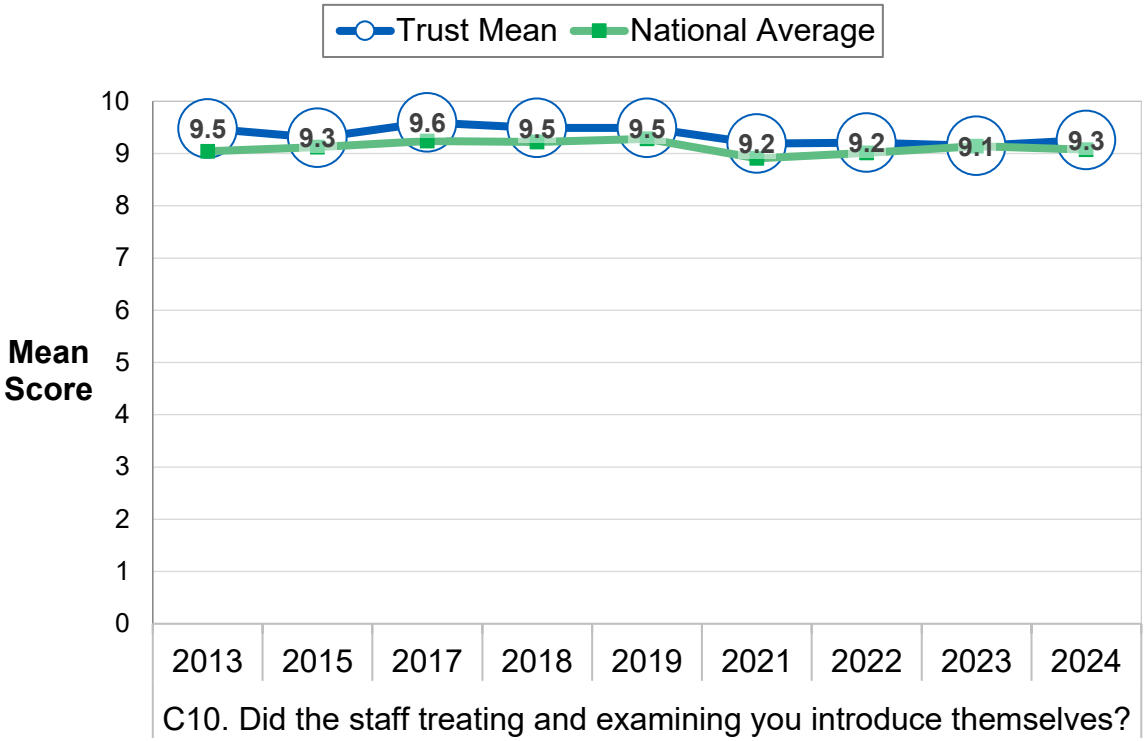
C9. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they did not have a partner / companion with them, did not want their partner / companion to be involved, or that their partner / companion did not want to / could not be involved have been excluded.
Number of respondents: 2013: 178; 2015: 166; 2017: 159; 2018: 170; 2019: 157; 2021: 172; 2022: 175; 2023: 163; 2024: 156

Section 2. Labour and Birth

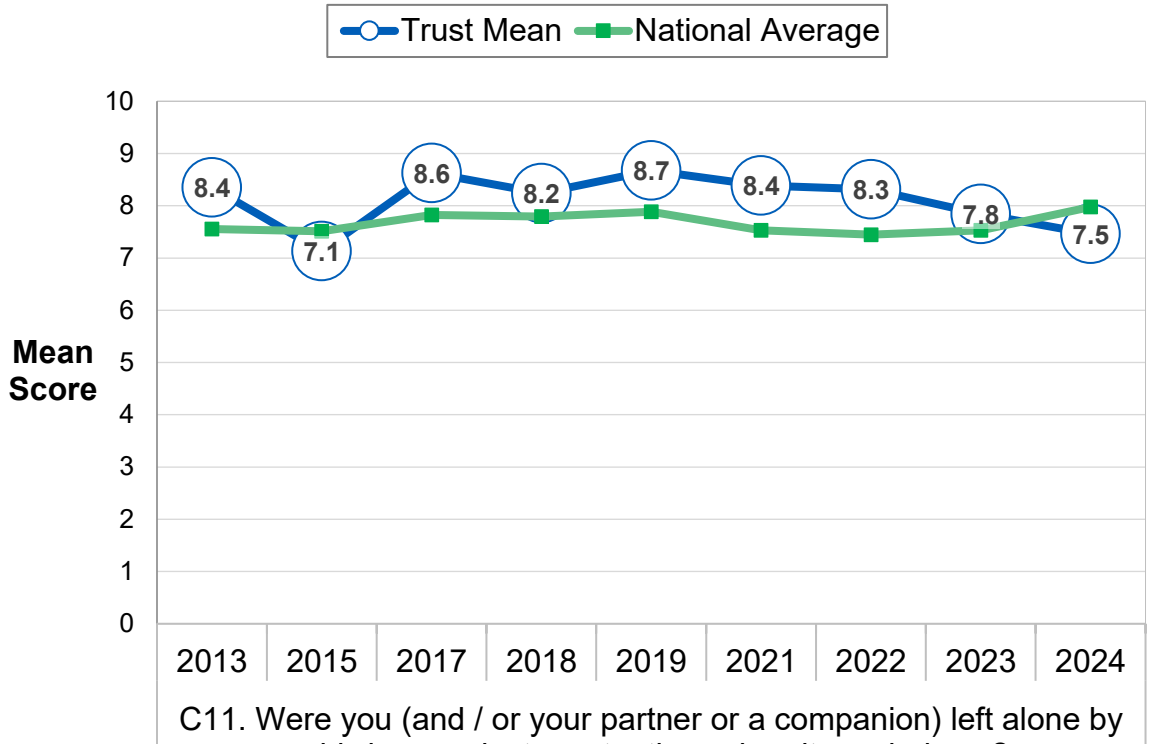
Staff caring for you



C10. Did the staff treating and examining you introduce themselves?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 178; 2015: 165; 2017: 159; 2018: 174; 2019: 163; 2021: 175; 2022: 176; 2023: 164; 2024: 160



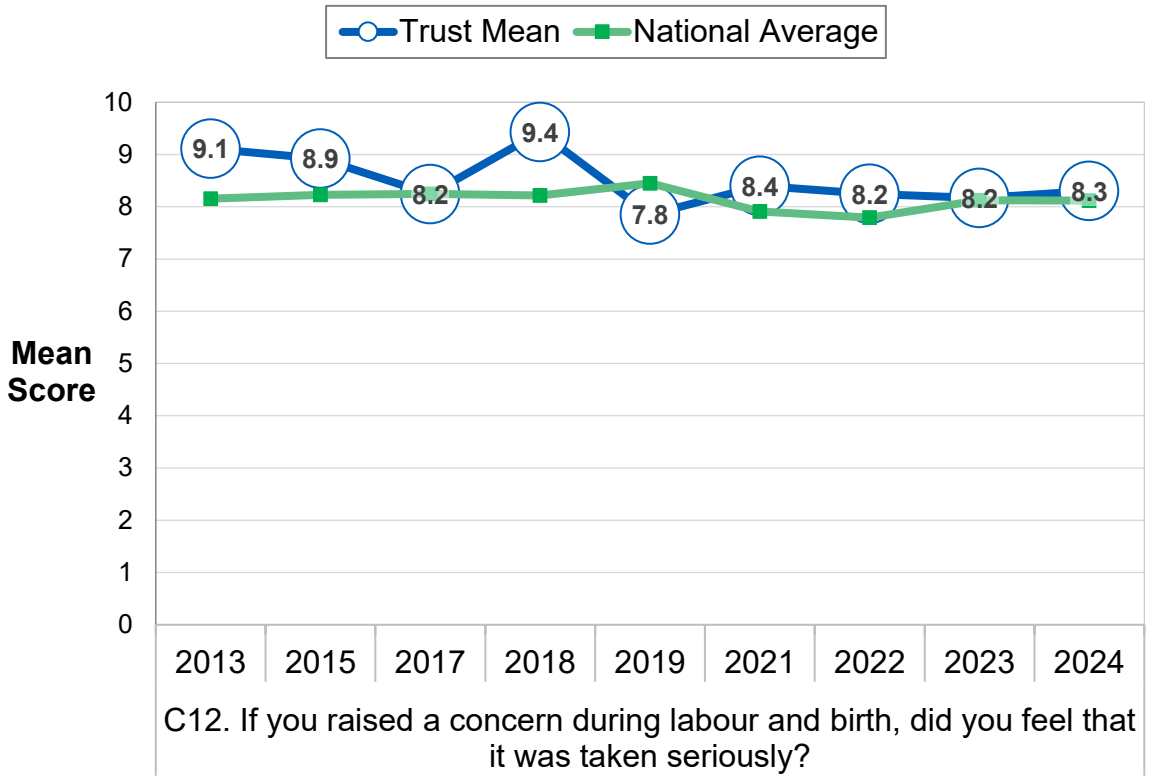
C11. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?

Significant change 2024 vs 2023	No change

Answered by all. Multiple response question: percentages may sum to more than 100.
Number of respondents: 2013: 178; 2015: 168; 2017: 157; 2018: 176; 2019: 164; 2021: 179; 2022: 179; 2023: 168; 2024: 155

Section 2. Labour and Birth

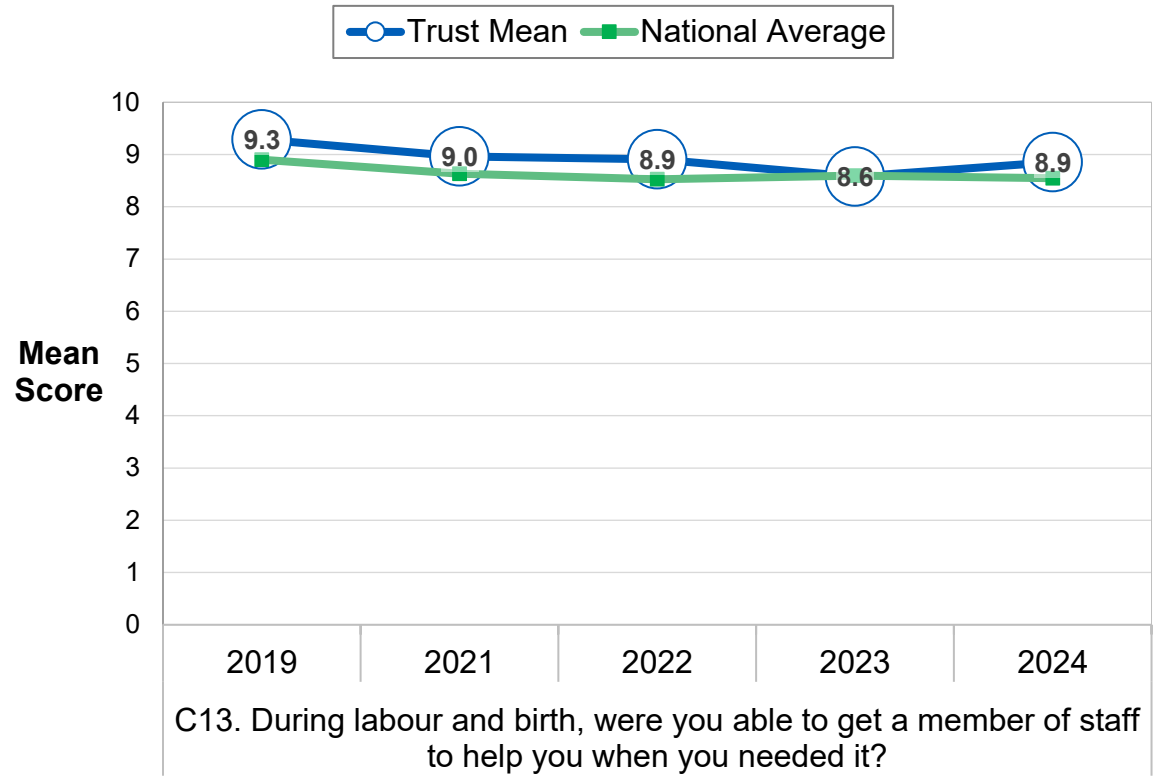
Staff caring for you



C12. If you raised a concern during labour and birth, did you feel that it was taken seriously?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they did not raise any concerns have been excluded.
Number of respondents: 2013: 106; 2015: 105; 2017: 108; 2018: 96; 2019: 98; 2021: 103; 2022: 96; 2023: 102; 2024: 106



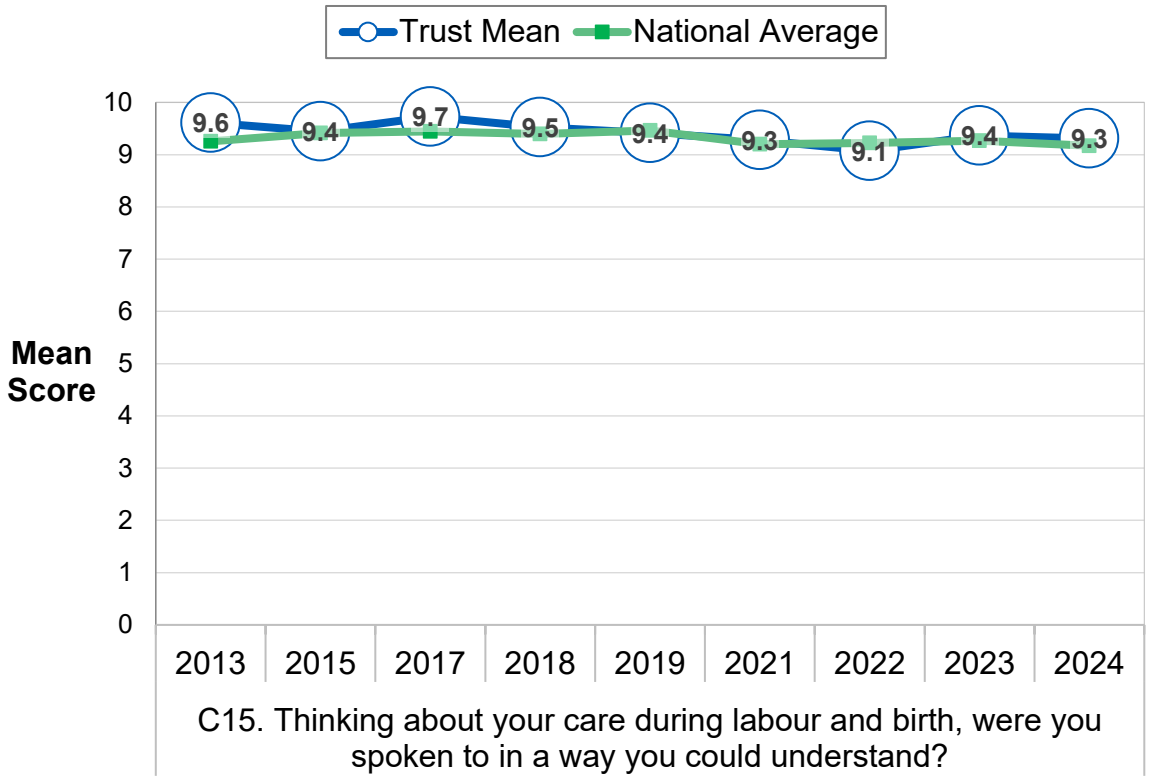
C13. During labour and birth, were you able to get a member of staff to help you when you needed it?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or did not want / need this have been excluded.
Number of respondents: 2019: 151; 2021: 171; 2022: 172; 2023: 165; 2024: 156

Section 2. Labour and Birth

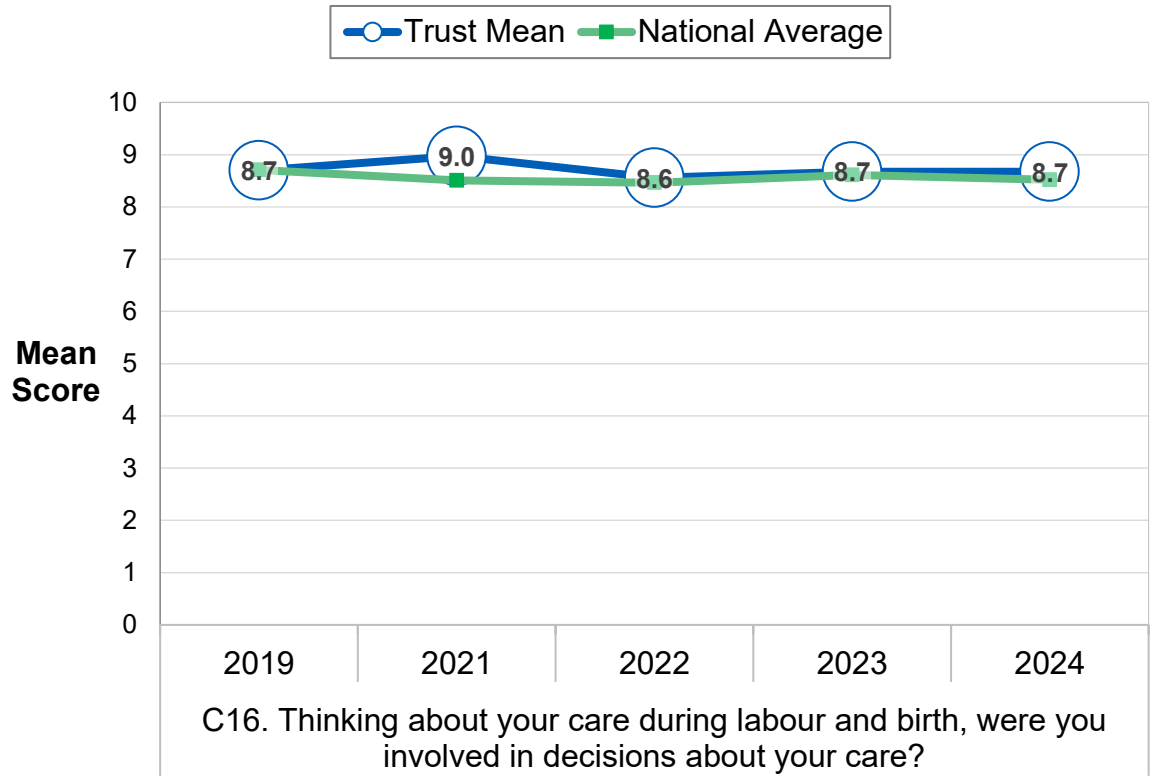
Staff caring for you



C15. Thinking about your care during labour and birth, were you spoken to in a way you could understand?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 181; 2015: 167; 2017: 155; 2018: 173; 2019: 163; 2021: 178; 2022: 179; 2023: 168; 2024: 161



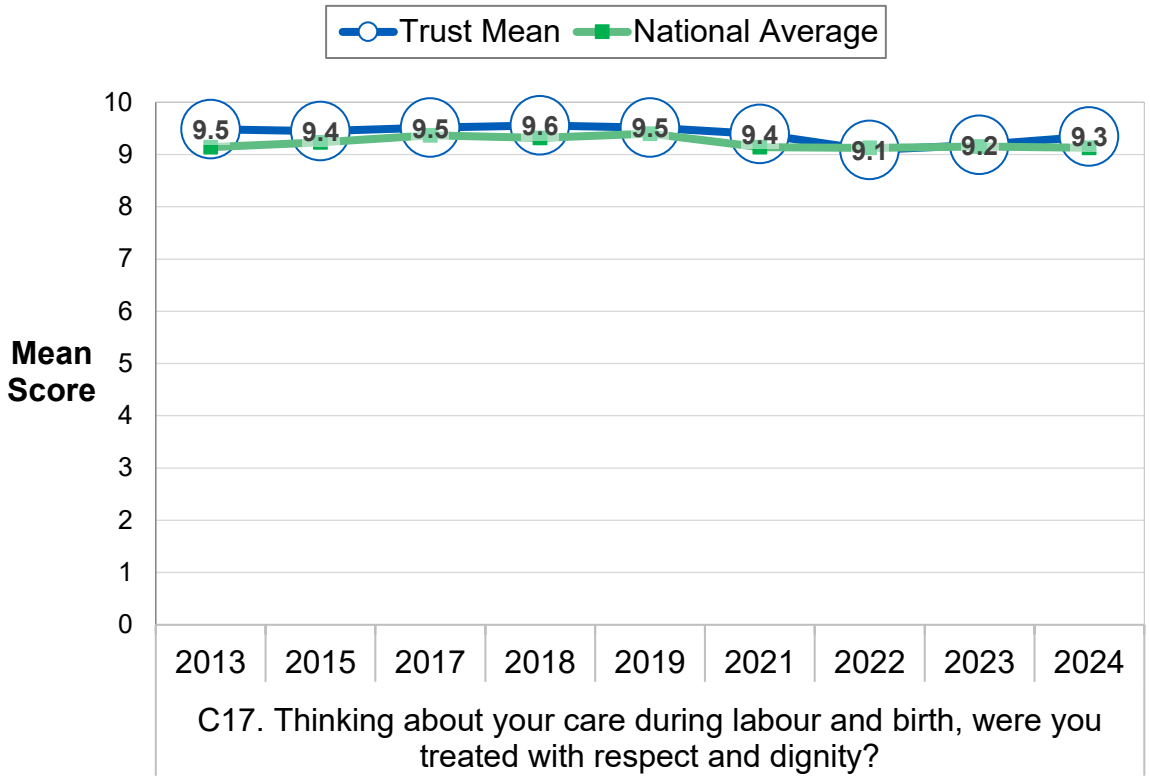
C16. Thinking about your care during labour and birth, were you involved in decisions about your care?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or did not want / need to be involved have been excluded.
Number of respondents: 2019: 165; 2021: 174; 2022: 174; 2023: 168; 2024: 155

Section 2. Labour and Birth

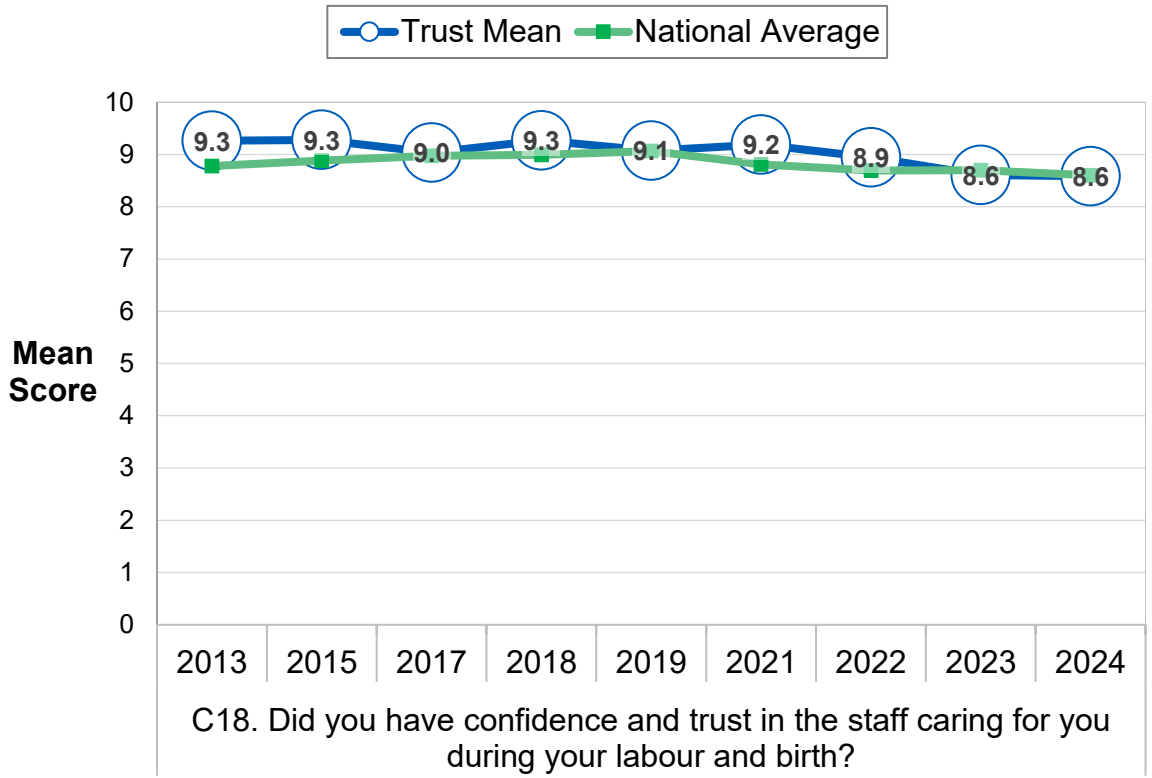
Staff caring for you



C17. Thinking about your care during labour and birth, were you treated with respect and dignity?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 181; 2015: 168; 2017: 156; 2018: 176; 2019: 164; 2021: 179; 2022: 179; 2023: 168; 2024: 160



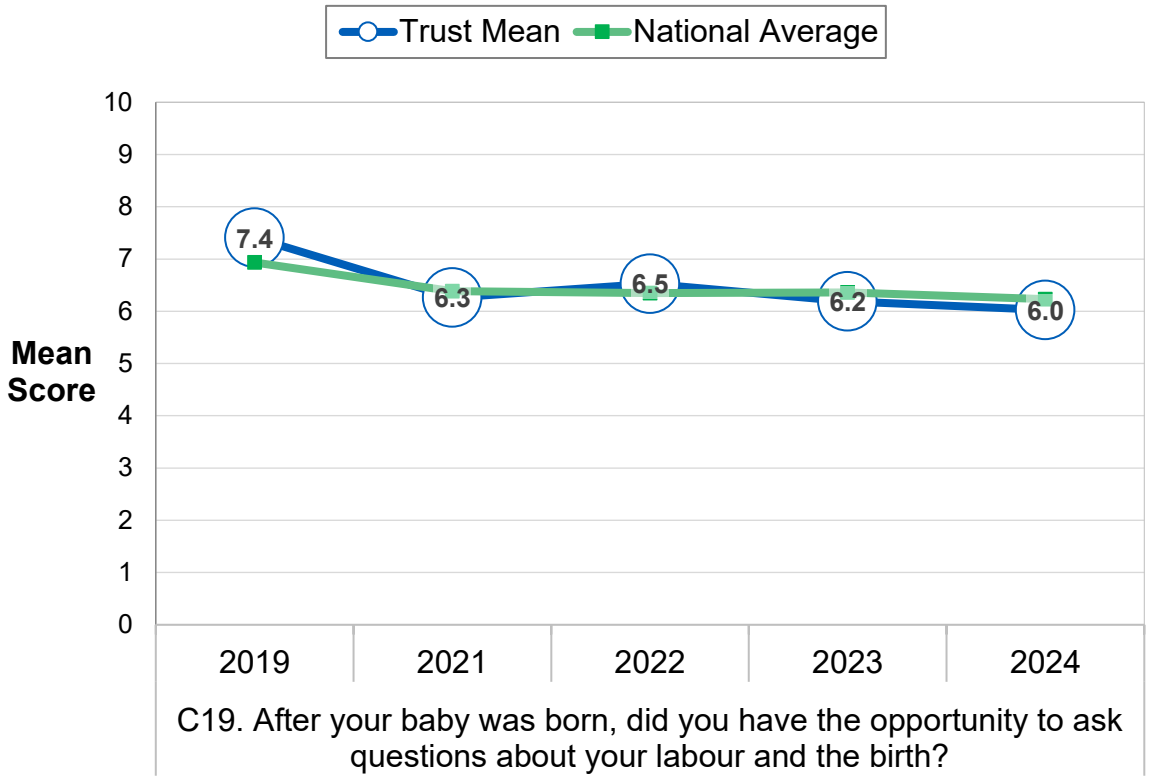
C18. Did you have confidence and trust in the staff caring for you during your labour and birth?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 179; 2015: 168; 2017: 156; 2018: 175; 2019: 164; 2021: 179; 2022: 179; 2023: 167; 2024: 161

Section 2. Labour and Birth

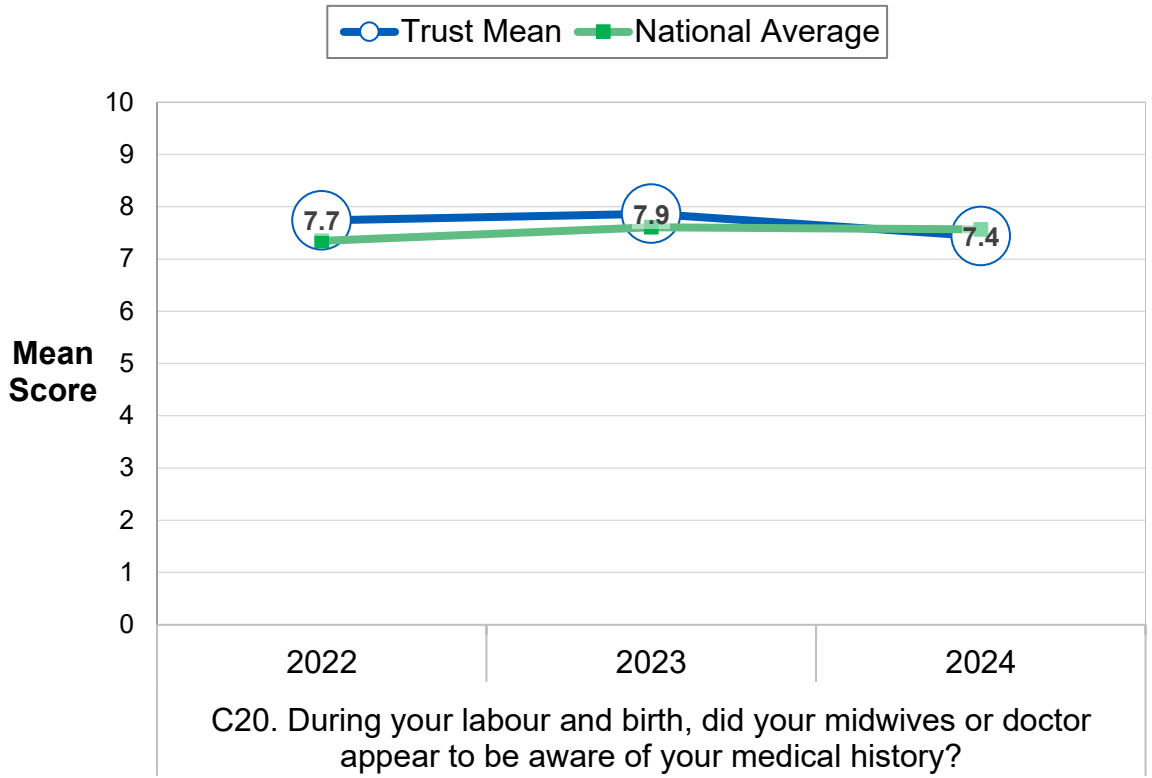
Staff caring for you



C19. After your baby was born, did you have the opportunity to ask questions about your labour and the birth?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or that they did not want / need this have been excluded.
Number of respondents: 2019: 146; 2021: 153; 2022: 166; 2023: 143; 2024: 137



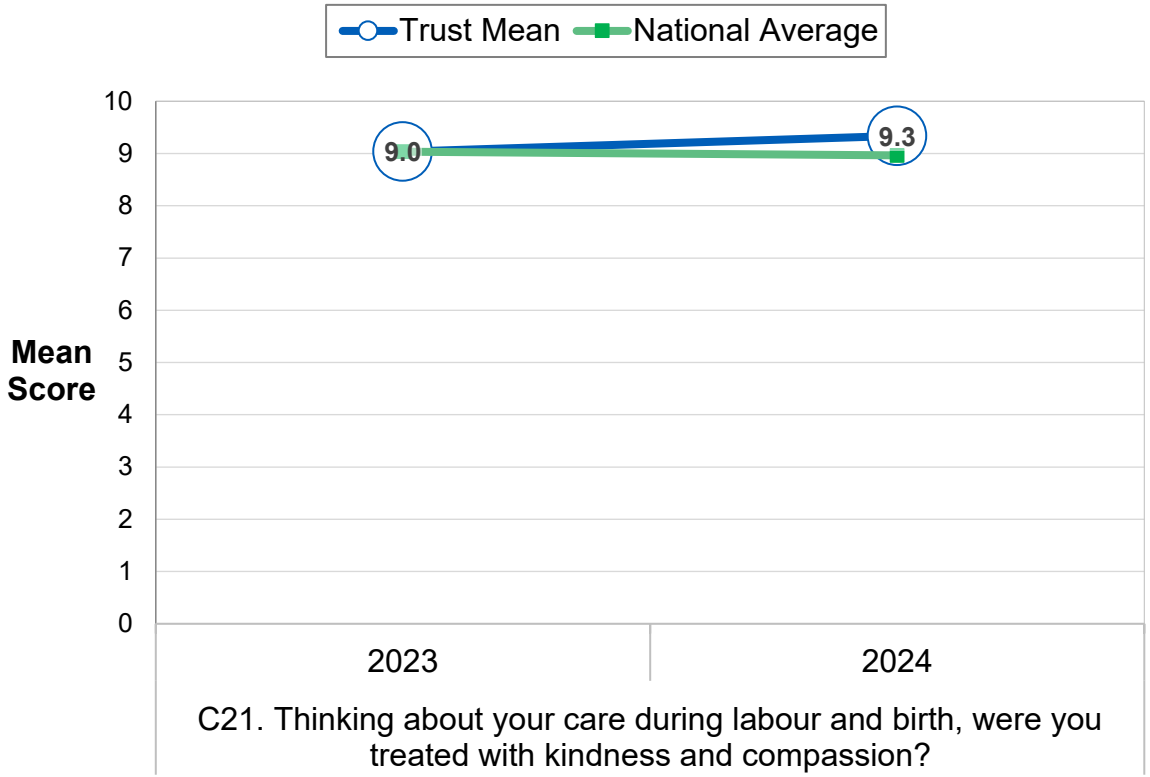
C20. During your labour and birth, did your midwives or doctor appear to be aware of your medical history?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2022: 159; 2023: 150; 2024: 149

Section 2. Labour and Birth

Staff caring for you



Significant change 2024 vs 2023	No change

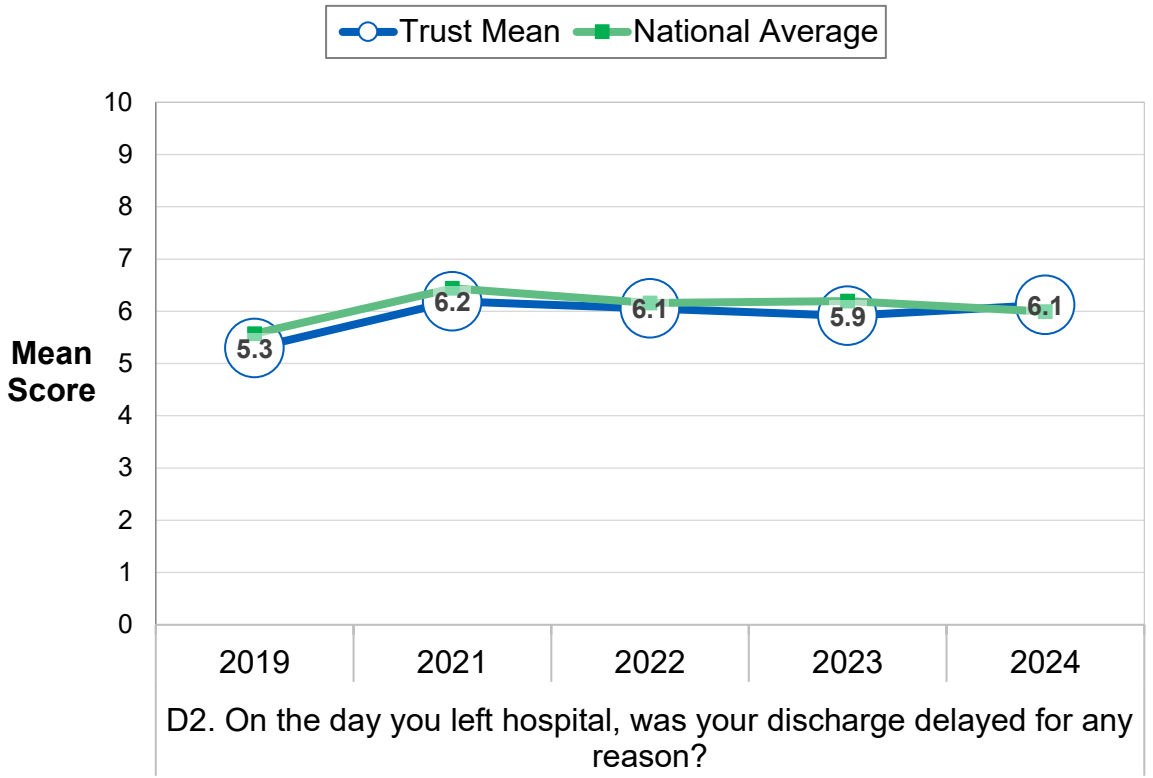
Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2023: 168; 2024: 161

Change over time

Section 3: Postnatal Care

Section 3. Postnatal Care

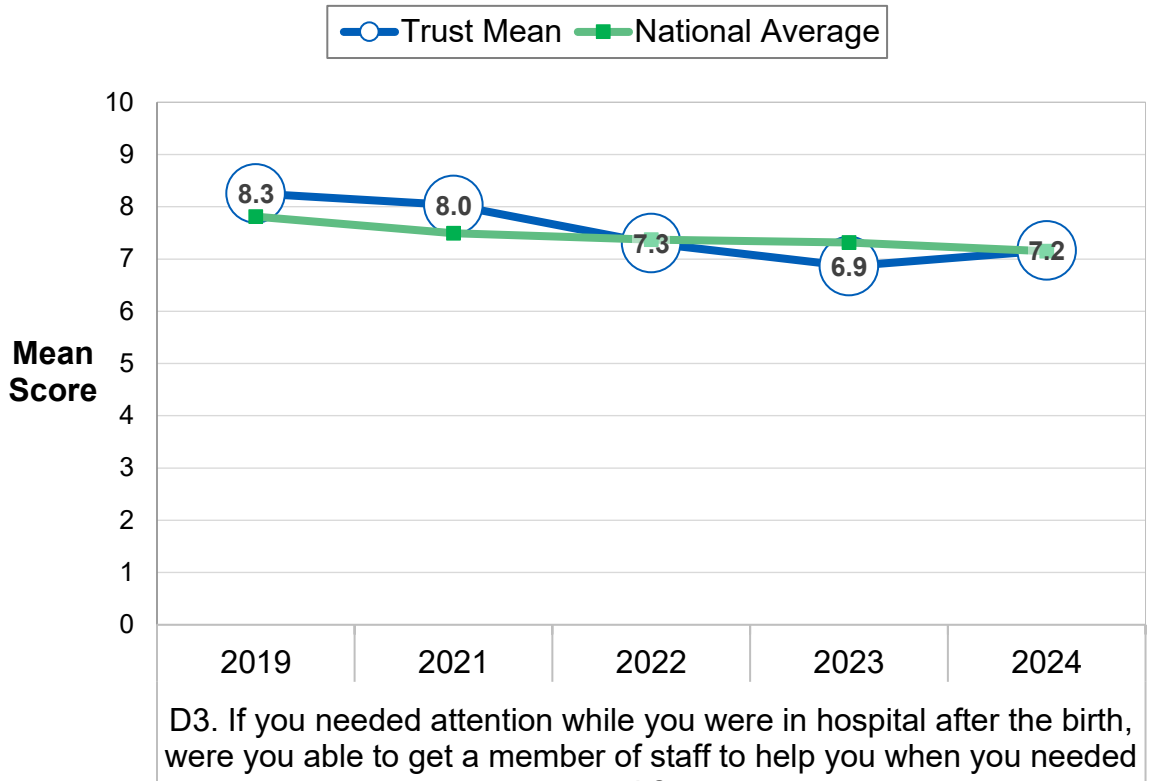
Care in the ward after birth



D2. On the day you left hospital, was your discharge delayed for any reason?

Significant change 2024 vs 2023	No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth.
Number of respondents: 2019: 157; 2021: 170; 2022: 175; 2023: 162; 2024: 145



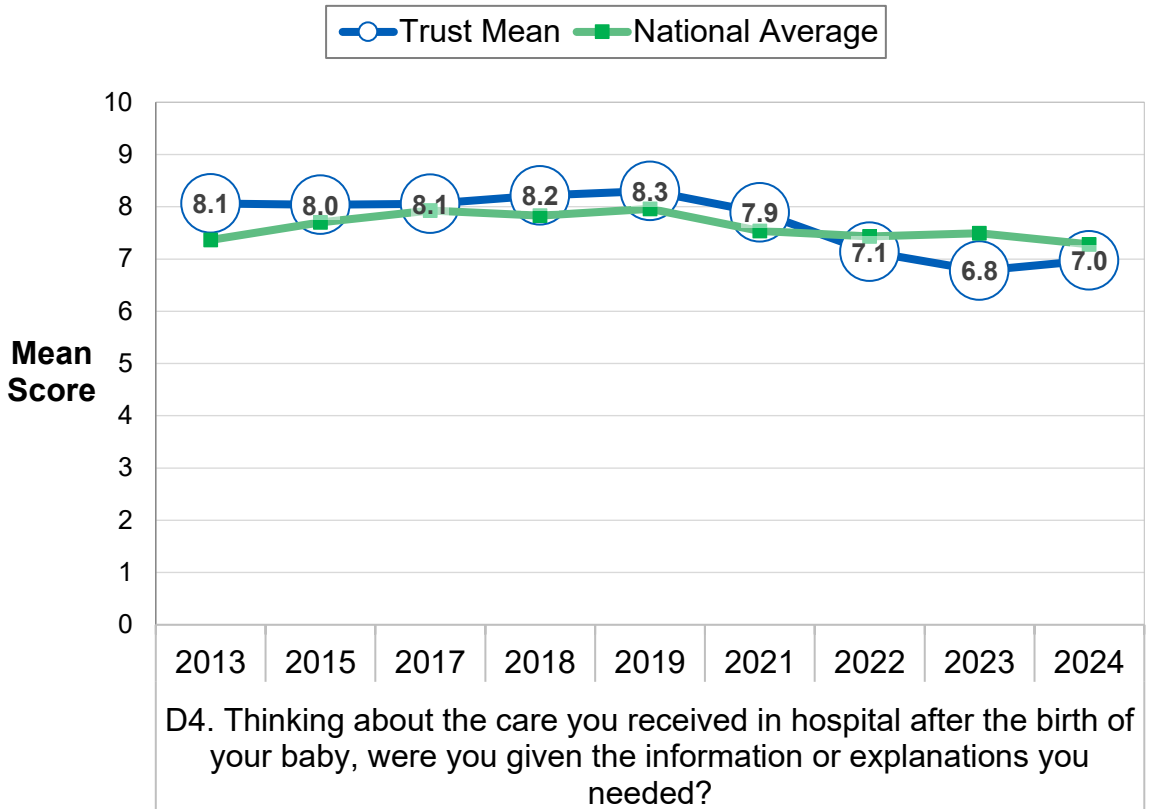
D3. If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?

Significant change 2024 vs 2023	No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth.
Respondents who stated that they didn't know / couldn't remember or did not want / need this have been excluded.
Number of respondents: 2019: 146; 2021: 156; 2022: 167; 2023: 148; 2024: 132

Section 3. Postnatal Care

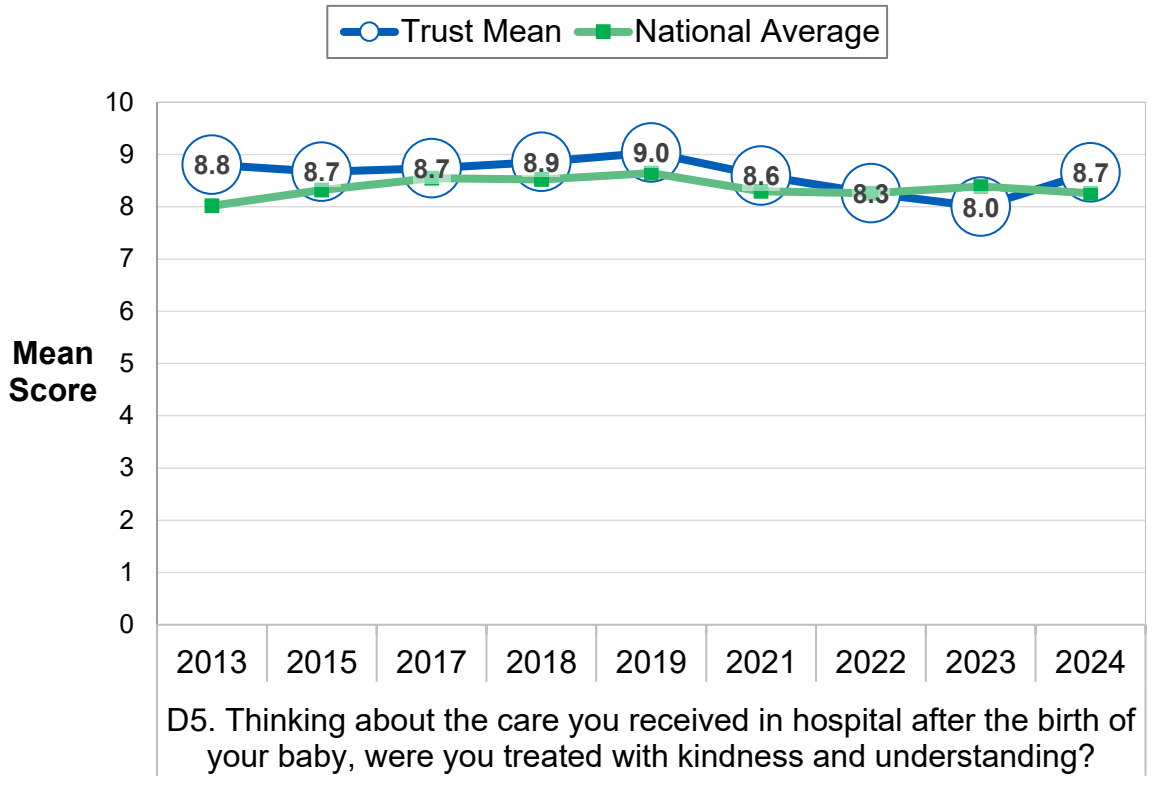
Care in the ward after birth



D4. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?

Significant change 2024 vs 2023	No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2013: 175; 2015: 164; 2017: 156; 2018: 162; 2019: 155; 2021: 169; 2022: 174; 2023: 161; 2024: 144



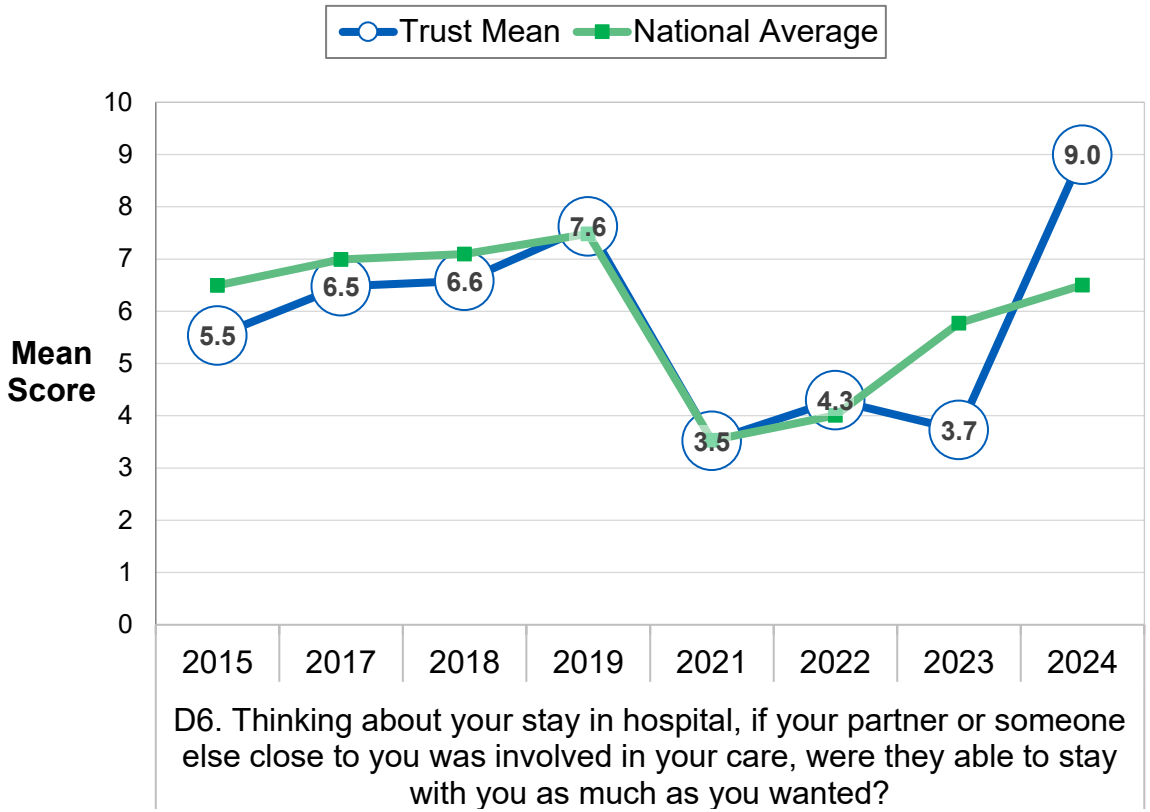
D5. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

Significant change 2024 vs 2023	No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 176; 2015: 165; 2017: 156; 2018: 165; 2019: 157; 2021: 170; 2022: 175; 2023: 162; 2024: 145

Section 3. Postnatal Care

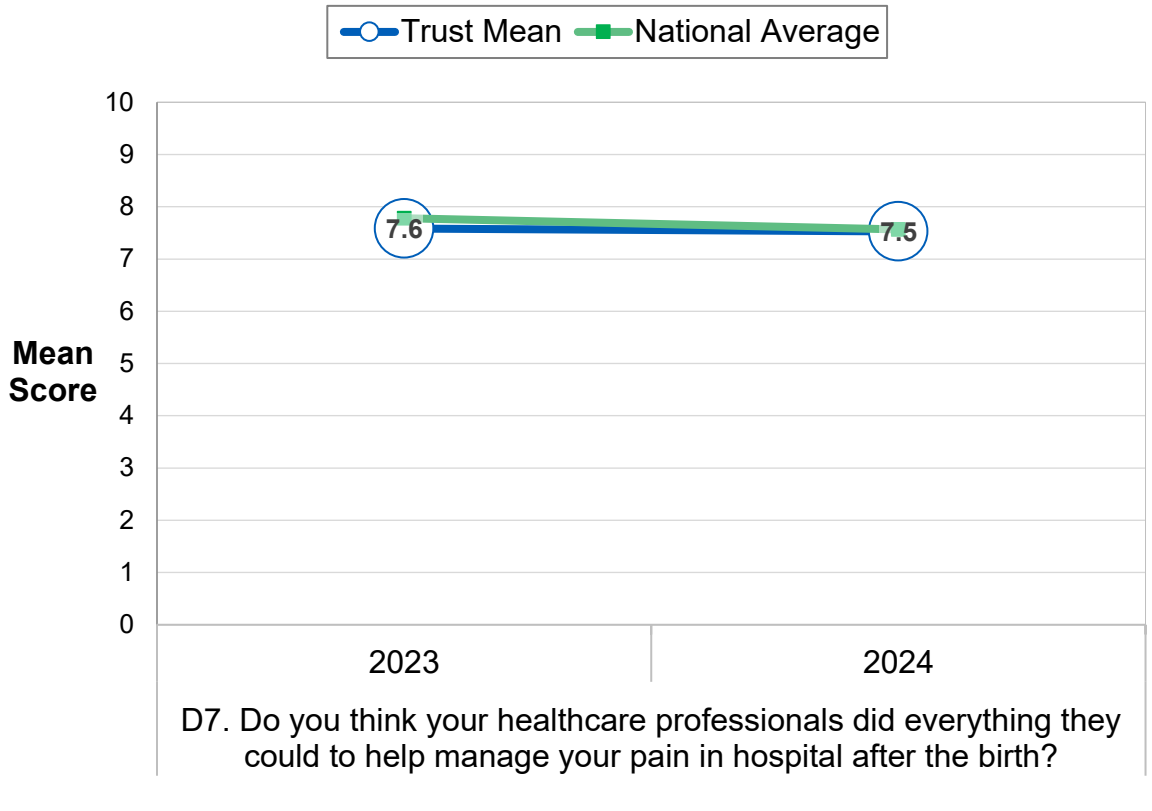
Care in the ward after birth



D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?

Significant change 2024 vs 2023	Increase

Answered by those who stayed in hospital after the birth or required hospital care after a home birth. Respondents who stated that their partner / companion was not able to stay for another reason or that they did not have a partner / companion with them have been excluded.
Number of respondents: 2015: 159; 2017: 148; 2018: 160; 2019: 154; 2021: 130; 2022: 154; 2023: 155; 2024: 137



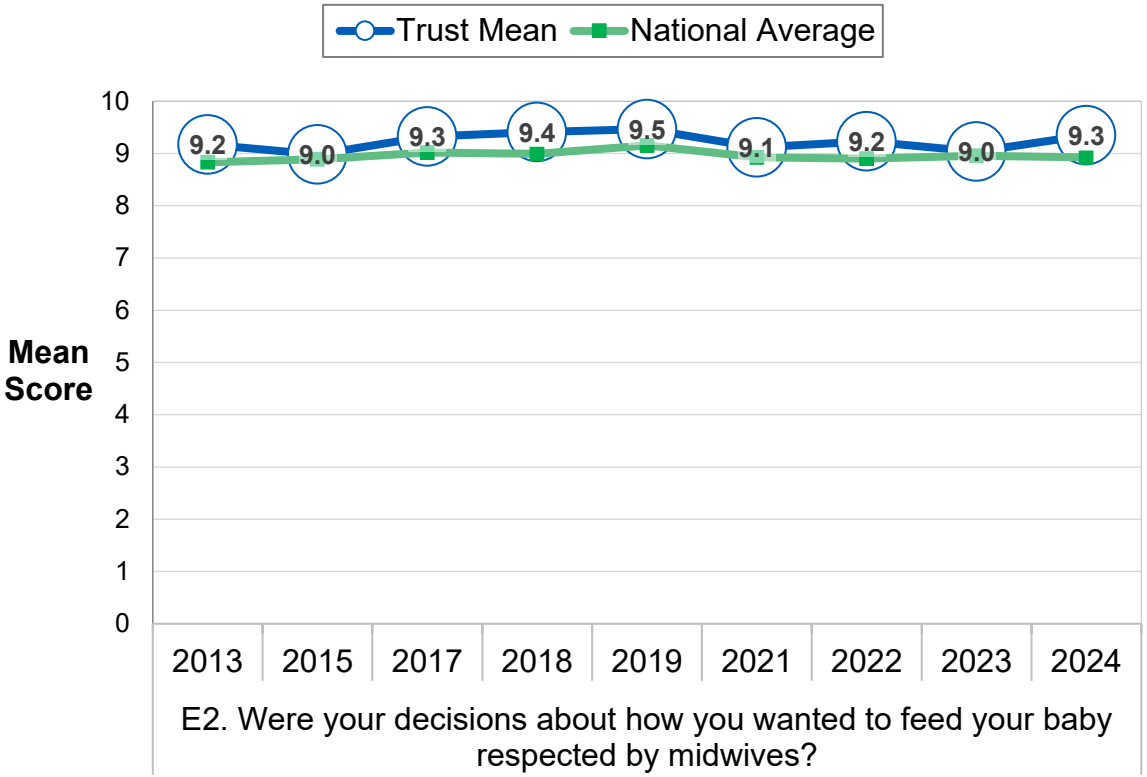
D7. Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?

Significant change 2024 vs 2023	No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth. Respondents who stated that they didn't need any help with pain relief or didn't know / couldn't remember have been excluded.
Number of respondents: 2023: 147; 2024: 135

Section 3. Postnatal Care

Feeding your baby

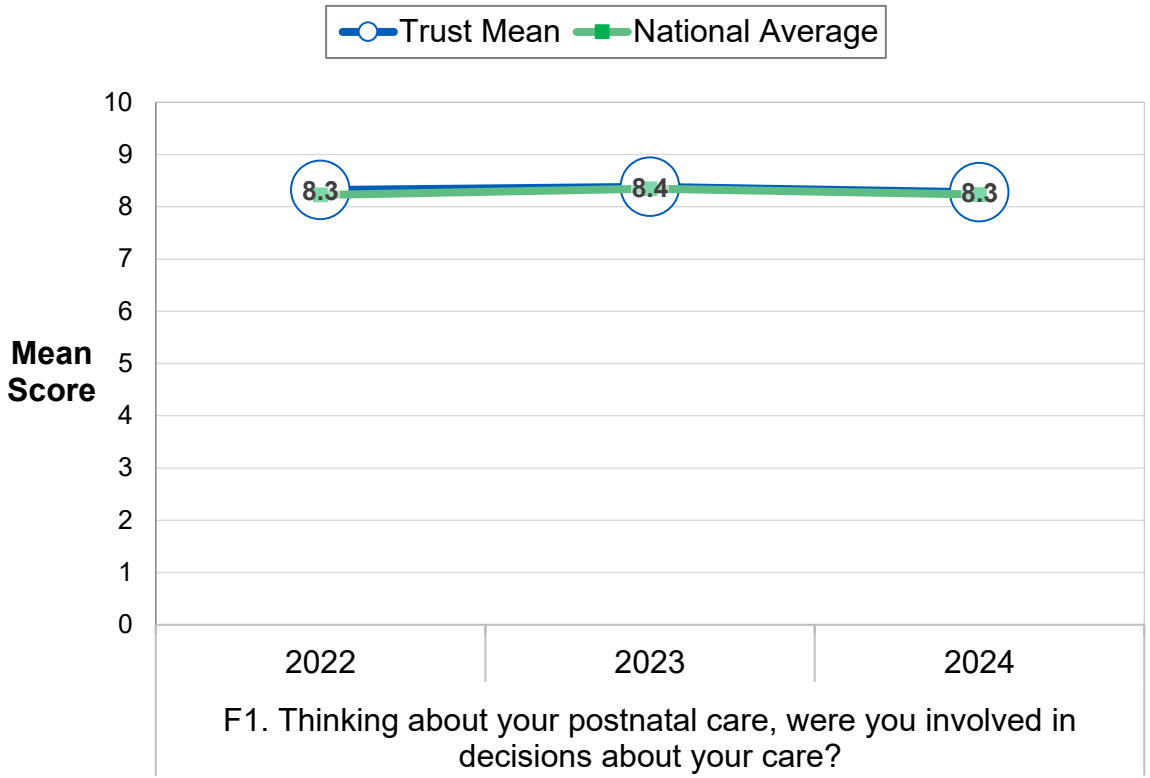


Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 170; 2015: 146; 2017: 140; 2018: 160; 2019: 154; 2021: 172; 2022: 161; 2023: 157; 2024: 149

Section 3. Postnatal Care

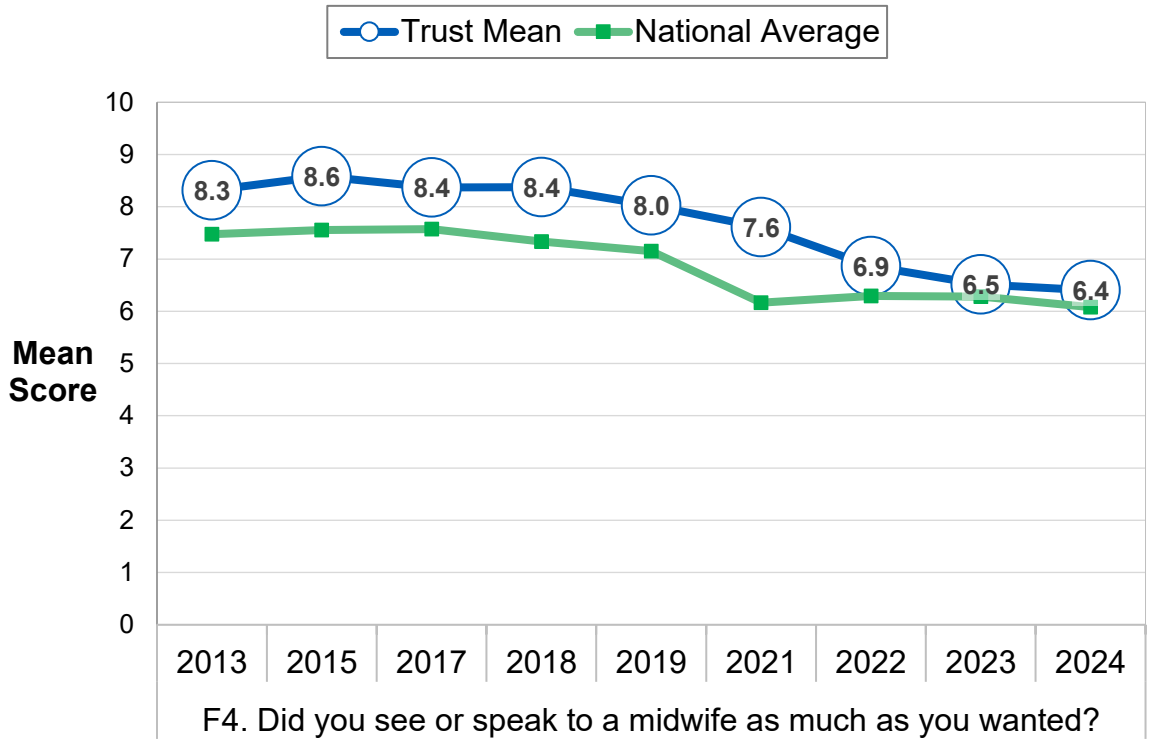
Care at home after birth



F1. Thinking about your postnatal care, were you involved in decisions about your care?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or did not want/ need to be involved have been excluded..
Number of respondents: 2022: 157; 2023: 151; 2024: 144



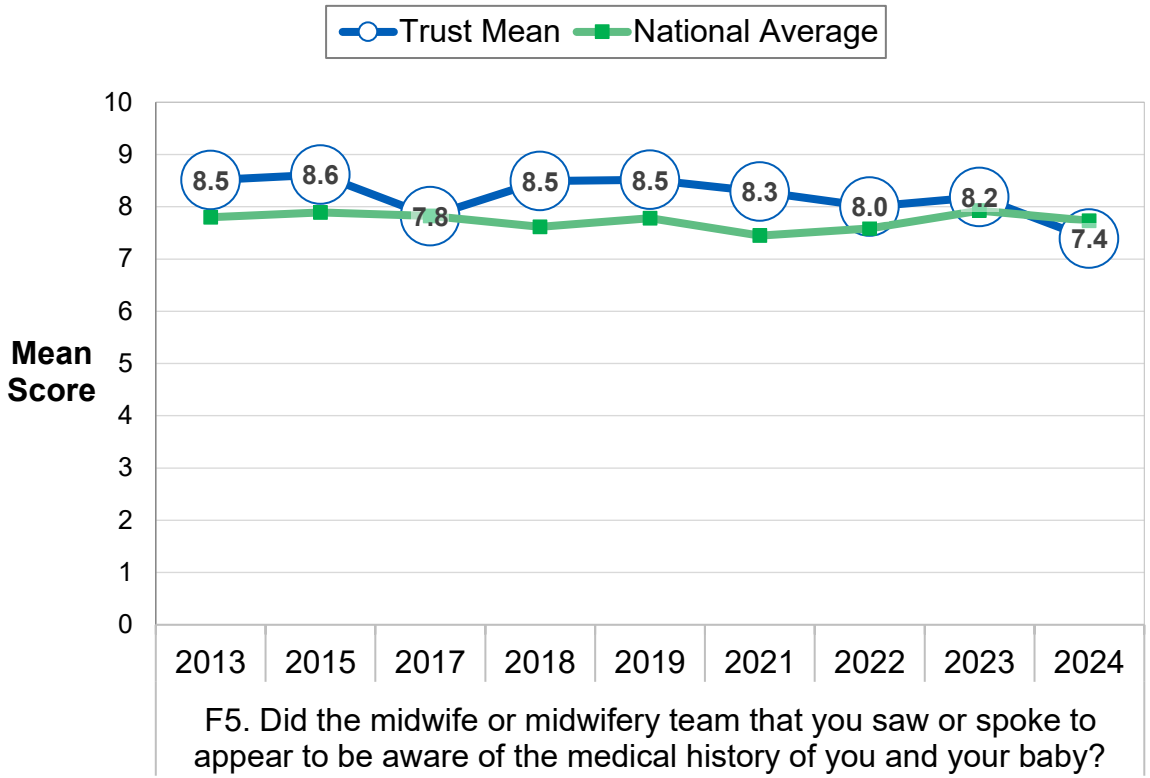
F4. Did you see or speak to a midwife as much as you wanted?

Significant change 2024 vs 2023	No change

Answered by all.
Number of respondents: 2013: 168; 2015: 144; 2017: 142; 2018: 161; 2019: 153; 2021: 171; 2022: 159; 2023: 145; 2024: 149

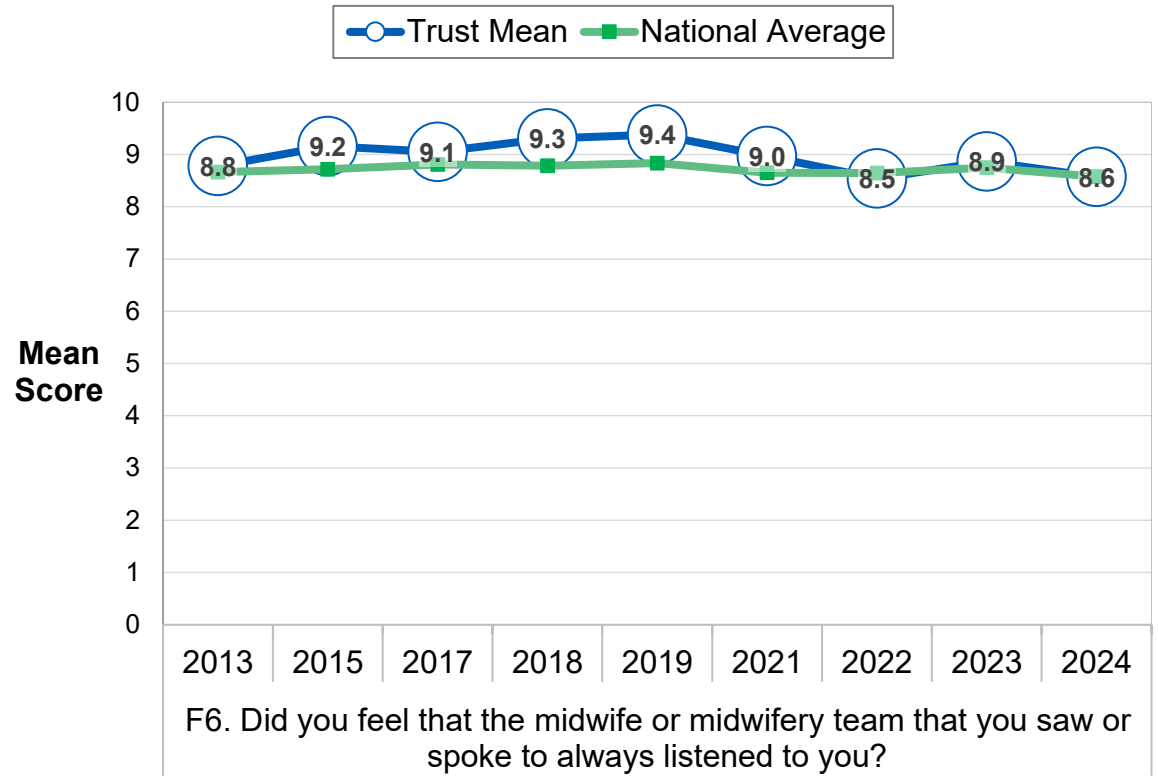
Section 3. Postnatal Care

Care at home after birth



Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2013: 165; 2015: 142; 2017: 135; 2018: 153; 2019: 150; 2021: 158; 2022: 149; 2023: 125; 2024: 137

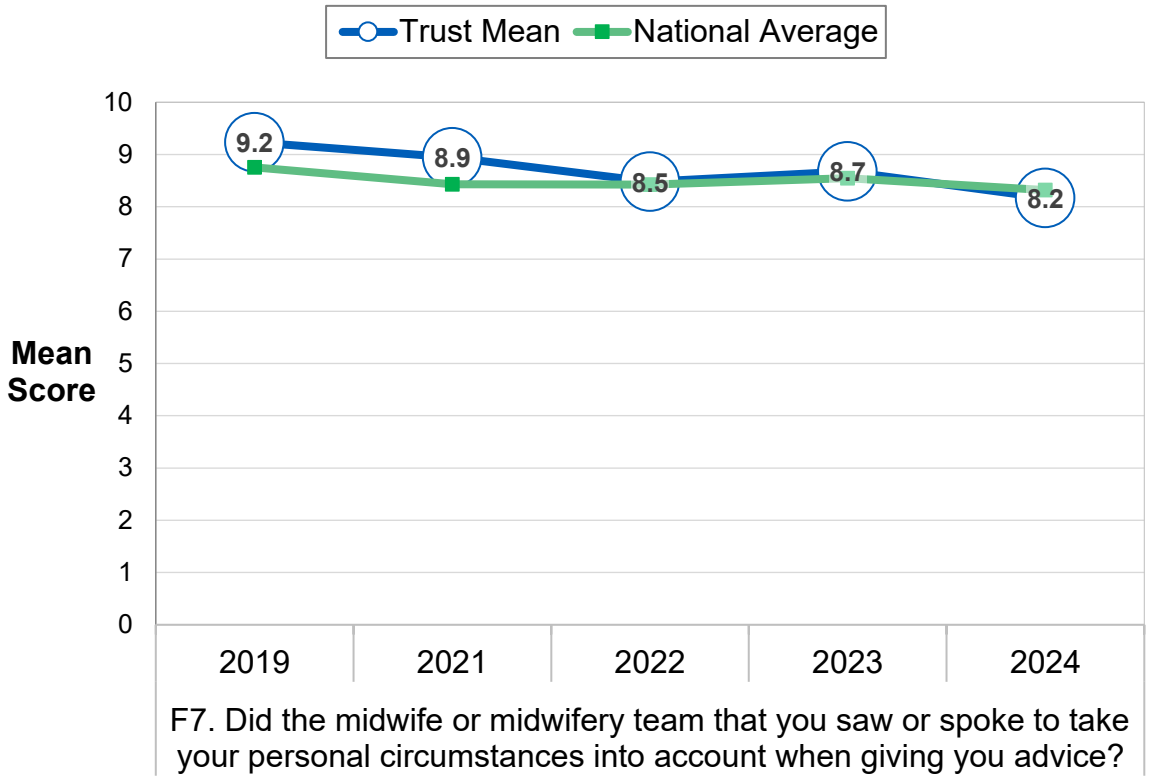


Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 168; 2015: 144; 2017: 142; 2018: 161; 2019: 153; 2021: 170; 2022: 159; 2023: 145; 2024: 147

Section 3. Postnatal Care

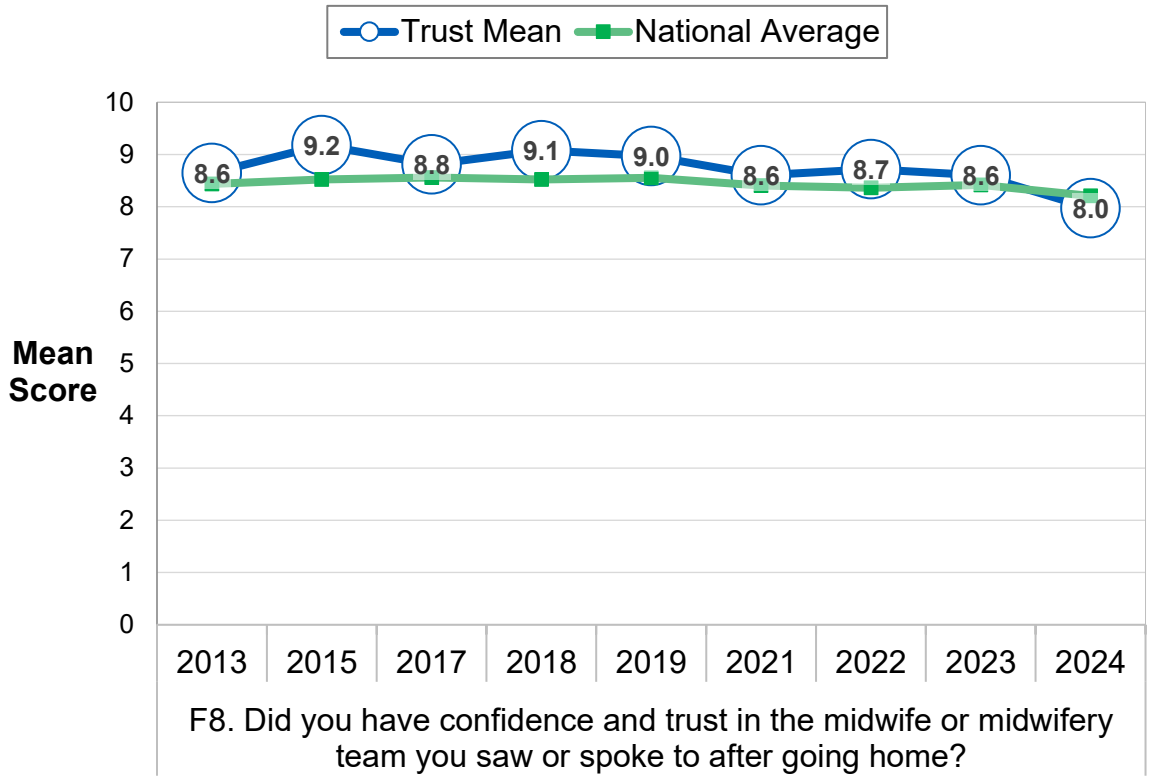
Care at home after birth



F7. Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2019: 150; 2021: 162; 2022: 153; 2023: 138; 2024: 138



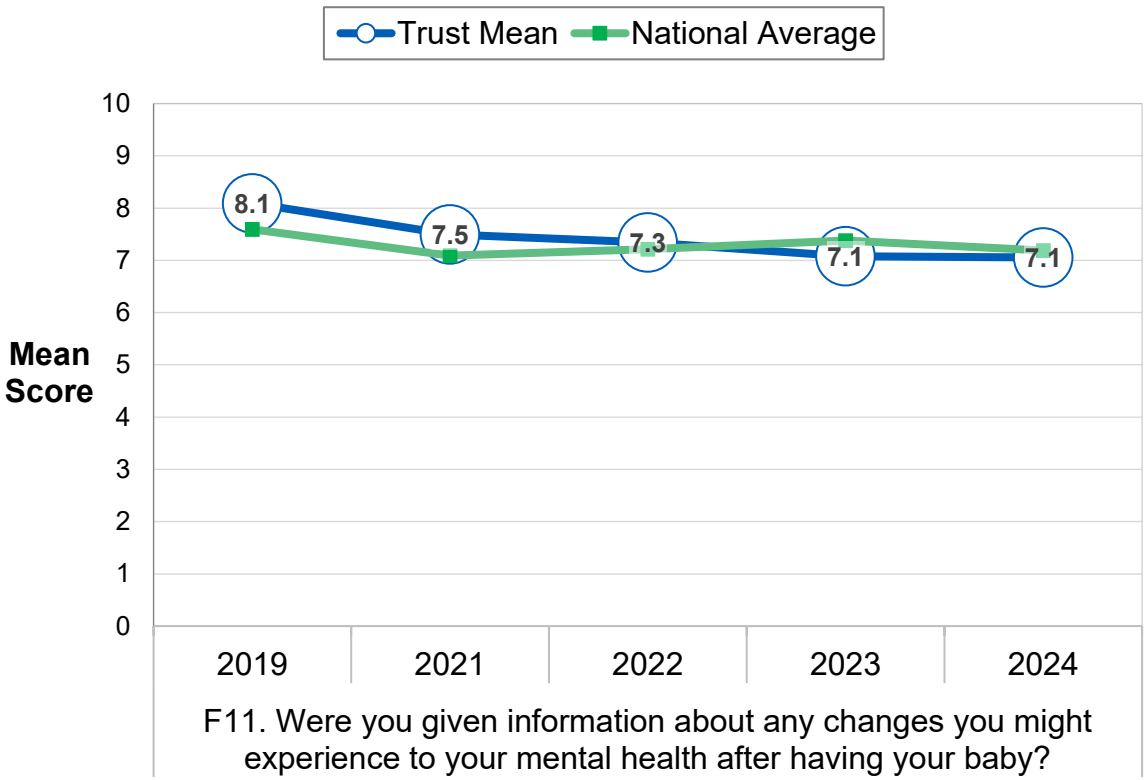
F8. Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?

Significant change 2024 vs 2023	Decrease

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 170; 2015: 144; 2017: 140; 2018: 161; 2019: 153; 2021: 170; 2022: 158; 2023: 145; 2024: 148

Section 3. Postnatal Care

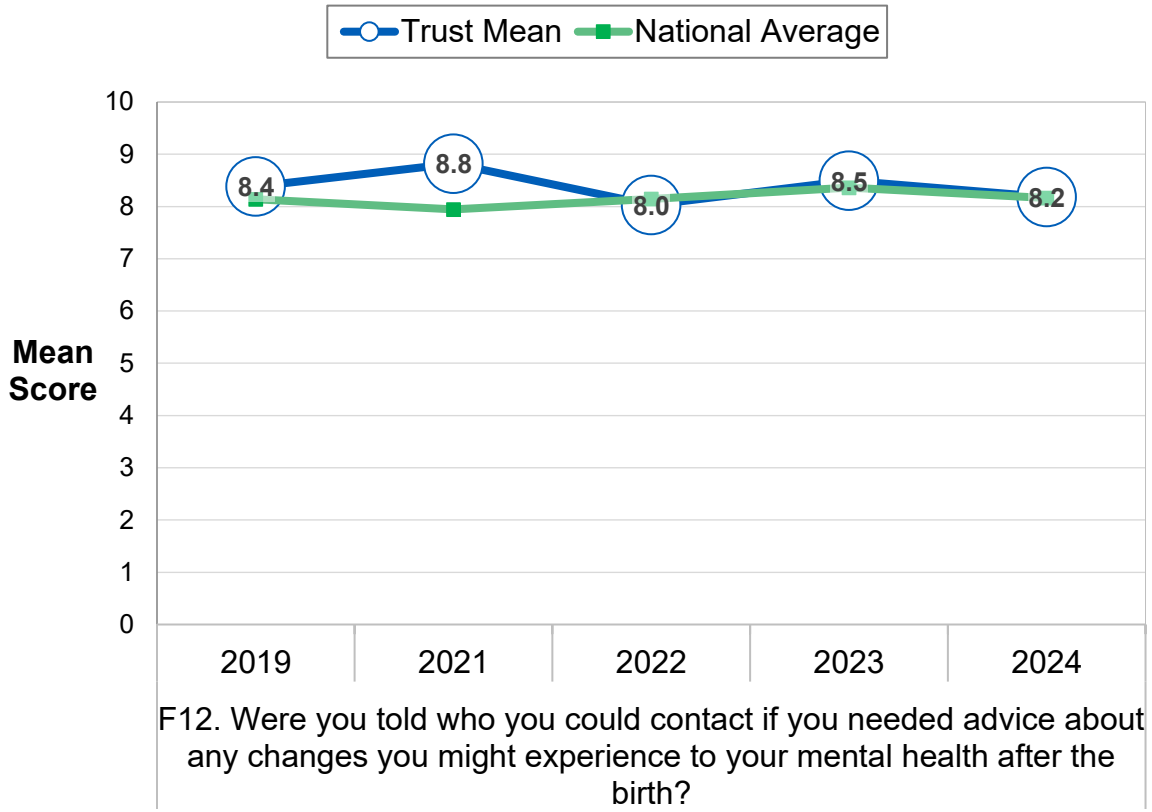
Care at home after birth



F11. Were you given information about any changes you might experience to your mental health after having your baby?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2019: 150; 2021: 168; 2022: 158; 2023: 150; 2024: 142



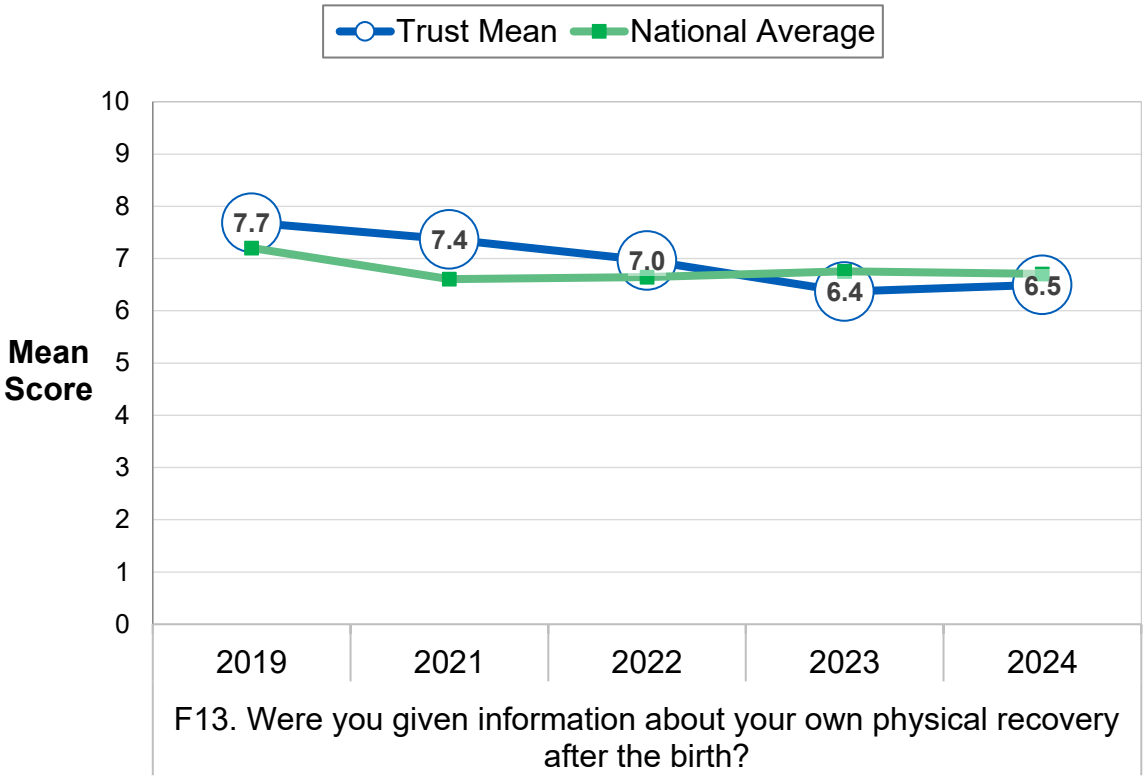
F12. Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?

Significant change 2024 vs 2023	No change

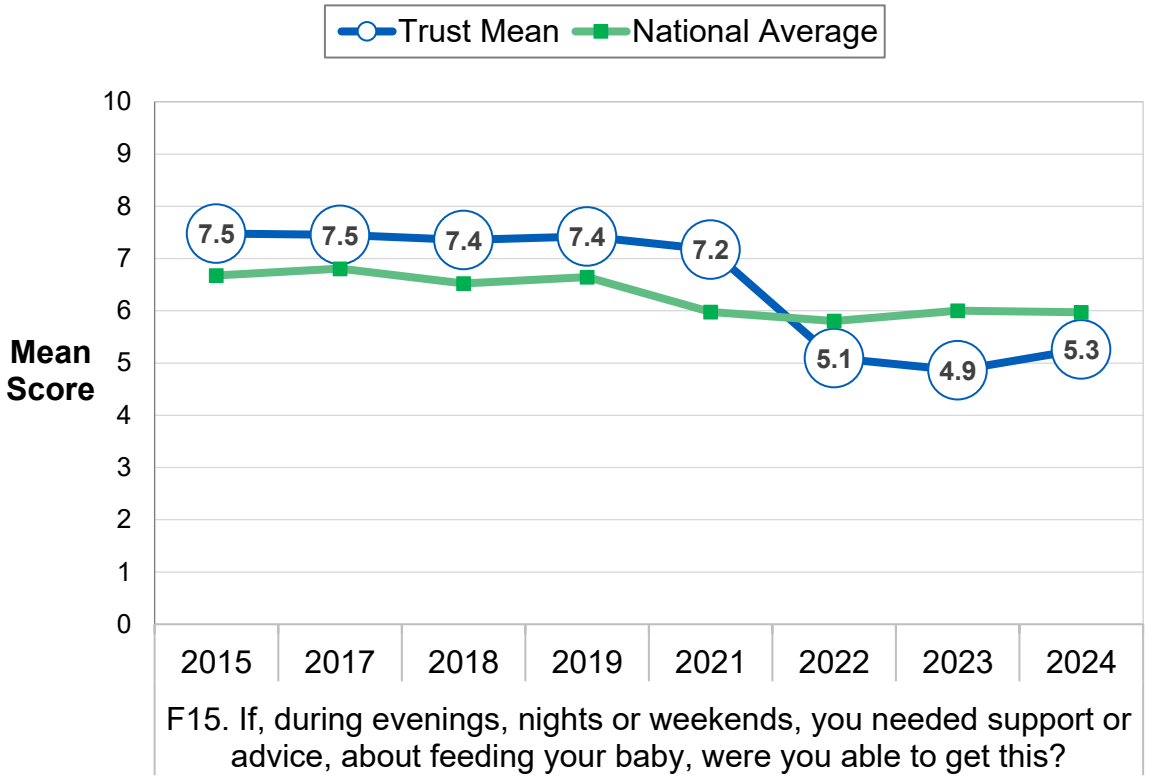
Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2019: 135; 2021: 149; 2022: 151; 2023: 131; 2024: 125

Section 3. Postnatal Care

Care at home after birth



F13. Were you given information about your own physical recovery after the birth?



F15. If, during evenings, nights or weekends, you needed support or advice, about feeding your baby, were you able to get this?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or did not need this information have been excluded.
Number of respondents: 2019: 152; 2021: 167; 2022: 158; 2023: 151; 2024: 147

Significant change 2024 vs 2023	No change

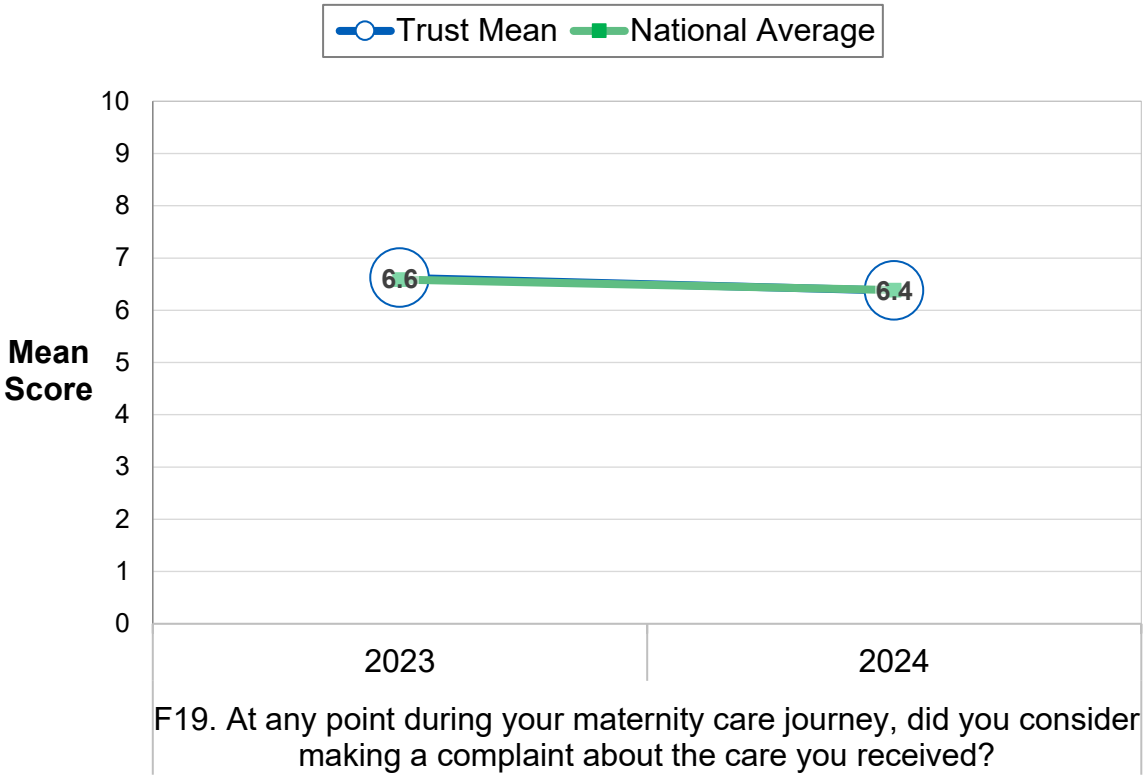
Answered by all. Respondents who stated that they didn't know / couldn't remember or did not need support or advice about feeding their baby have been excluded.
Number of respondents: 2015: 51; 2017: 45; 2018: 57; 2019: 61; 2021: 64; 2022: 68; 2023: 56; 2024: 55

Change over time

Section 4: Complaints

Section 4. Complaints

Complaints



F19. At any point during your maternity care journey, did you consider making a complaint about the care you received?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember whether they considered making a complaint have been excluded.
Number of respondents: 2023: 168; 2024: 160

Comparison to Other Trusts

Comparison to other trusts

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

Much better than expected

- F10. Did a midwife ask you about your mental health?

Comparison to other trusts

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

Better than expected

- C9. The birth of your baby. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?
- E2. Were your decisions about how you wanted to feed your baby respected by midwives?

Comparison to other trusts

The questions where your trust has performed somewhat better when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat better than expected

- B9. During your antenatal check-ups, did your midwives ask you about your mental health?

Comparison to other trusts

The questions where your trust has performed somewhat worse when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts

The questions where your trust has performed worse compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Worse than expected

- B14. During your pregnancy did midwives provide relevant information about feeding your baby?
- F14. In the four weeks after the birth of your baby did you receive help and advice from a midwife about feeding your baby?
- F16. In the four weeks after the birth of your baby did you receive help and advice from midwives about your baby's health and progress?

Comparison to other trusts

The questions where your trust has performed much worse when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much worse than expected

- No questions for your trust fall within this banding.

For further information

Please contact the Survey Coordination Centre:
maternity@surveycoordination.com

NHS
Care Quality Commission
Survey Coordination Centre

National Maternity Patient Experience Survey 2024

Action Plan: National Maternity Survey- 2024	Date Created	7/1/25

Plan Owner :	**Alison Lambert (Family Experience and Inclusion Midwife)**	**Date last updated : (and version no)**	7/1/25
Coproduction with:	**Natalie Griffith GWH & Swindon MNVP Lead -Maternity & Neonatal Voices Partnership**		
Core implementation Group :	**WNB Division Senior Management Team.**	**Next review due by - Group / Committee : Date :**	**Patient Experience Steering Group**

Links to key documents – NHS Maternity Survey 2024

MAT24_Headline Report_RNZ_Salisbu

MAT24_FrequencyT ables and patient cc

The reports are attached but can also be viewed here All Files - NHS Surveys

Executive Summary:

The National Maternity Survey is a requirement by the CQC for all NHS Trusts providing Maternity services.
Women receiving maternity services in January and February 2024 were selected for the survey
289 women were included in the survey and 162 responded (56.4%). The Patient Perspective average response rate for all 30 Trust surveyed was 45%.
The average Mean Rating Score was 81.1%, 1.5% higher than in 2023.
SFT maternity department scored in the top 20% of Trusts on 10 questions and bottom 20% of Trusts on 12 questions out of 63 questions.
4 questions showed at least 10% improvement on the 2023 score, and for 0 questions the score was worse by 10% or more.

- **Our top five scores compared nationally were around the areas of partners being able to stay, induction information and Mental health support.**
- **Our bottom five scores were around care at home after birth and support with feeding.**

Local analysis of the data and free text:

1.1 Care while you were pregnant (Antenatal care)

Positive response:

- Mental health assessments/ and mental health support – Benched marked in the Top 20%
- Women were spoken to in a way they could understand (94%)
- Treated with respect and dignity. (91%)
- Provided with enough information about the warning signs to look out for. (87%)

Areas for Improvement:

- 41% of people felt they didn't receive enough information on infant feeding (23% of people did not have any information, 2% can't remember) Benched marked in the bottom 20%, and a 5% decrease from the previous survey results.
- 33% of people felt their midwife/doctor was not aware of their medical history.- Benched marked in the bottom 20%, and a 5% decrease from the previous survey results.
- 32% of people felt they didn't receive enough information about where to have their baby. -Figures are consistent with the 2023 results.

Free text response themes:

- Continuity: Good examples of care when received, impacted care when not received
- Lack of personalised care
- Lack of communication
- Staff attitude / lack of professionalism
- Induction of Labour: Lack of communication & delays

1.2 Your labour and the birth of your baby

Positive response:

- Before you were induced, were you given appropriate information and advice on the risks associated with IOL. Benched marked in the Top 20% - increase from previous survey of 13%
- Service users involvement in the decision making RE IOL. Benched marked in the Top 20% (new question for 24)
- During your labour were you ever sent home, when you were worried about yourself or your baby 92% (new question for 24)
- Treated with kindness and compassion. Benched marked in the Top 20% and a 3% increase from the previous survey.
- Service users felt they were spoken too in a way they could understand. 93%
- Partners being encouraged to be involved in the care as much as they wanted. 96%

Areas for Improvement:

- 11% of people feel healthcare professionals did not do everything they could to help manage pain (C8)
- 18% of people felt they didn't have the opportunity to ask questions about their labour & birth (C19)

Status tracking		
Complete	Green	G
On plan	Blue	B
Risks slippage	Amber	A
Barriers – not achieved	Red	R

- 10% of people felt their midwives or doctors were not aware of their medical history (C20) *No action*
- 12% of people felt left alone during the early stages of labour.
- 14% of people felt left alone shortly after birth (C11)

Free text response themes:

- Feeling left alone after birth
- Lack of personalised care
- Not knowing when to ask for help & overall what to expect (Antenatal education)
- Lack of communication
- Inadequate/management pain relief
- lack of acknowledgement that the woman is in labour / dismissed by triage system | lack of confidence in the women's own ability to interpret her own body

1.3 Care in the ward after birth (postnatal Care)

Positive responses:

- Extended visiting for partners.-benched mark in the Top 20%
- Treated with kindness and understanding 85%- 5% more than in the previous survey.

Areas for Improvement:

- 60% of people feel their discharge was delayed (D2)
- 10% of people felt they couldn't get help from someone when needed (34% sometimes could get help) (D3)
- 14% of people weren't given enough information about their care (34% said sometimes) (D4)
- 14% of people felt healthcare professionals did not do everything they could to manage pain (20% said yes to some extent) (D7)

Free text response themes:

- Lack of support for personal hygiene / baby care
- Lack of confidence in women's own body
- Lack of debrief after birth
- Medication concerns
- Lack of communication

1.4 Feeding your baby

Positive response:

- Service users infant feeding preference respected by staff. 93% increase of 3% from previous survey. Benched mark in the Top 20%

Area for Improvement:

- 21% of people feel they did not get enough support with feeding | 20% of people got enough support, sometimes (E3)

Status tracking		
Complete	Green	G
On plan	Blue	B
Risks slippage	Amber	A
Barriers – not achieved	Red	R

Free text response themes:

- Lack of infant feeding support on the postnatal ward
- Lack of information on availability of infant feeding team

1.5 Care after birth *(Link with Health Visiting / GP's)*

Positive comments:

- Did the midwife ask you about your mental health? 99% increase of 2% from the previous survey and benched marked within the Top 20 %

Areas for Improvement:

- 36% of people would have liked to see their midwife more (F4)
- 24% of people felt their midwife was not aware of their medical history (F5)

Free text response themes:

- Neonatal: Great care, Separation time of mother & baby following admission
- Not enough staff
- Rushed communication
- Medication concerns (Inadequate pain management, medication errors, not receiving meds promptly, Inconsistent advice on change of medication)
- Delay in discharge (Incomplete paperwork, staffing concerns)
- Lack of debrief
- Lack of ongoing care provision following discharge, no referral pathway to obstetric run PN clinic
- Complicated discharge due to cross boundaries
- Women feel they are discharged too early
- Lack of privacy on PN ward, able to hear conversations, very noisy
- Blood sugar monitoring (Lack of information RE timings, Delay in undertaking BM)

General comments:

- Lack of accessibility - wheelchair access
- Disappointed with the whole experience
- Cross boundary – delay in PN care.
- SFT has an outstanding reputation.
- Better experience than during covid (x2)

Status tracking		
Complete	Green	G
On plan	Blue	B
Risks slippage	Amber	A
Barriers – not achieved	Red	R

Question text	Action What specific actions will be taken to address the issue(s)	#	National Comparisons	Lead by:	Achieve by:	Progress update / notes	Status
1.1 Antenatal care							
Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	The implementation of a 3D Maternity digital tour. Once complete, it will be automatically sent to service users at a given gestation via Badger net. The tours will also be available on the Salisbury Maternity Website.	**B4**	Middle 60%	Inpatient Matron	September 2025	On target	
During your antenatal check ups, did your midwives or doctors appear to be aware of your medical history? *	With the introduction of Badger net will be prepopulated with medical information stored in Lorenzo. This will be migrated at the point of Booking. It is anticipated that this will assist clinicians to undertake a thorough review of the service users past medical history and will be available at each patient contact.	**B6**	Bottom 20%	Digital Matron	February 2025	On target	
During your pregnancy did midwives provide relevant information about feeding your baby?	A locally produced antenatal infant feeding patient information leaflet will be automatically sent via the Badger app (via push notifications), before or around 36 weeks gestation.	**B14**	Bottom 20%	Digital Matron/ Infant Feeding teams	February 25	On target	
	The Infant Feeding Team have extended the online parent education sessions, from ½ hour to an 85-minute session. This is in order to cover the essential elements of infant feeding. *(NB/ the extension to the infant feeding sessions commenced in February 24 after the 2024 data collection, which is why it is now included in the action plan)*			Infant Feeding team	February 2024	Completed	
	It is a Baby Friendly Initiative (BFI) requirement that service users have a conversation with their midwife about her feeding preferences. 'A conversation in pregnancy, key points' documentation will be a mandatory field on Badger net. The midwife is unable to progress with the consultation through Badger net without the completion of the documentation.			Infant Feeding Team	February 2025	On target	

Status tracking		
Complete	Green	G
On plan	Blue	B
Risks slippage	Amber	A
Barriers – not achieved	Red	R

Question text	Action What specific actions will be taken to address the issue(s)	#	National Comparisons	Lead by:	Achieve by:	Progress update / notes	Status
	Production of patient information videos to showcase key elements of infant feeding. These videos will be added to the Now baby TV broadcast in our ANC, or can be accessed via SFT Maternity Website			Infant feeding team/ Family Experience and Inclusion Midwife	July 2025	On target	
	Introduction of the BFI steering group. It is hoped that this multidisciplinary forum will be integral to implementing change and responsive in the progression of the BFI action plan.			Infant Feeding Team	February 2025	On target	
Lack of personalisation/ individualised care	Working in collaboration with the BSW, under the direction and coordination of the LMNS, a local 'My Maternity Choices' booklet has been produced. It is anticipated that the booklet will be offered to service users at the booking appointment. Its purpose is to signpost service users to relevant information at their given gestation. It is hope this will provide an opportunity for the service user to discuss what really matters to them, with her trusted clinician, be it the midwife or obstetrician. Service users will receive a push notification of the PIL following the introduction of Badger net, after their booking appointment.	**Free Text**		Patient experince Midwife	Introduced in paper format in November 2024. Following the implementation of Badger.net the push notification will be sent with the Booking information pack .	Completed in part.	
Concerns around the implementation/ information sharing and delays associated	SFT to attend the LMNS working party RE Induction of labour.	**Free Text**		Quality and Safety team and the In/	January 2025	Completed	

Status tracking		
Complete	**Green**	G
On plan	**Blue**	B
Risks slippage	**Amber**	A
Barriers – not achieved	**Red**	R

Question text	Action What specific actions will be taken to address the issue(s)	#	National Comparisons	Lead by:	Achieve by:	Progress update / notes	Status
with the induction of labour process				Outpatient Matrons			
1.2. Labour and Birth							
Were you (and /or partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, shortly after the birth	A poster will be created to inform service users what to expect following the birth of their baby, including that the staff may leave them for short periods, but with signposting on how to summon assistance.	Free Text C11-4	Bottom 20%	MNVP lead	March 2025	On target	
Do you think your healthcare professional did everything they can to help manage your pain during the labour and birth	Development of a parent education working party, with the focus on service mapping and the implementation of F2F parent education sessions. This will provide service users with a choice of how they would like to receive antenatal parent education. A focus for the working party is on the contents of these sessions. Pain in labour will be considered as part of this planning process.	C8	Middle 60%	Outpatient Marton	September 2025	On target	
	The provision of personalised care in the management of the latent phase of labour, in the event that labour is yet to establish, the service user will be offered a choice of either returning home or a room on BMW.			Inpatient Matron	March 2025	On target	
After the birth, did you have an opportunity to ask questions about your labour and the birth?	Community midwives to ask soft questions in regard to the service user's birthing experience, as part of the daily check on the first day. Further signposting to the Birth reflection service upon discharge from the community, if required.	C 19	middle 60%	Community Teams	March 25	On target	
	Expansion of the Birth Reflection referral criteria – to accept self-referrals.			Patient Experience and Inclusion Midwife	March 25	On target	
	Increase compliance to FFT, service users will be provided an opportunity to complete the FFT survey during the			BMW ward manager	November 2024	Completed	

Status tracking		
Complete	Green	G
On plan	Blue	B
Risks slippage	Amber	A
Barriers – not achieved	Red	R

Question text	Action What specific actions will be taken to address the issue(s)	#	National Comparisons	Lead by:	Achieve by:	Progress update / notes	Status
	immediate postnatal period whilst as an inpatient						
1.3 Postnatal care							
Thinking about the care you received in hospital after the birth of your baby, were you given enough information or explanation you needed.	Undertake a review of the postnatal information provided upon discharge.	D4	Bottom 20%	BMW manager in collaboration with the MNVP lead.	February 25	On target	
	Development of a PIL surrounding instrumental births			Clinical lead for Obstetrics in collaboration with the MNVP	March 24	On target	
Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?	Introduction of self-medication on the BMW	Free Text D7		Inpatient Matron	?	On target	
	Increase service users' awareness to the aid call system on the postnatal ward, by the introduction of a poster at each bed space.		middle 60%	Patient experience midwife	March 2025	On target	
1.4 Infant feeding							
Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?	To increase visibility of the IFT on the ward, the Infant feeding clinic template to be adjusted, thus allowing time in the morning for the team to attend the BMW	E3	Bottom 20%	Infant Feeding Team	January 2025	Completed	
	The provision of consistent, evidence based infant feeding support is the responsibility of **all** clinical staff. The IFT will provide weekly Tea Trolley teaching, in order to increase staff awareness and confidence in supporting service users with complex feeding issues.			Infant Feeding Team	December 2024	Completed	

Status tracking		
Complete	Green	G
On plan	Blue	B
Risks slippage	Amber	A
Barriers – not achieved	Red	R

Question text	Action What specific actions will be taken to address the issue(s)	#	National Comparisons	Lead by:	Achieve by:	Progress update / notes	Status
	'Best start' to breast and bottle feeding PIL will be added to Badger and with a push notification, triggered in the postnatal period.				July 2025	On target	
	Signposting will be provided to service users on the local Facebook support group. The IFT together with the lactation consultant will be available to provide support and advice.			Infant Feeding Team	July 2025	On target	
1.5 Care after birth *(Link with Health Visiting / GP's)*							
During the evening nights and weekends, you needed help and advice about feeding your baby, were you able to get this?	Refer to above action in section 1.4	F15				No additional actions required	
Inadequate staffing levels	To be fully staffed in accordance with Birth rate plus, workforce review.	Free Text		HOM	October 2024	Completed	
Did the midwife or midwives that you saw appear to be aware of medical history of you and your baby?	With the introduction of Badger net, a discharge plan with summary of birth events will be generated, together with ongoing recommendations for future care pathways. This will be sent to the community midwives directly, reducing reliance on potentially unreliable paper discharge summaries.	F5	Bottom 20%	Digital Lead	February 2025	On target	
Comments relating to primary Care to be shared with them directly	MNVP lead to liaise with the Primary care team.	F14 F16 F2	Bottom 20% Middle 60%	MMVP lead via the LMNS	March 2025	On target	
Personalised care in the community	Embedment of the 'My Maternity Choices' booklet in the community setting.	F7	Bottom 20%	Patient Experience and Inclusion	October 24	Completed	

Status tracking		
Complete	Green	G
On plan	Blue	B
Risks slippage	Amber	A
Barriers – not achieved	Red	R

Question text	Action What specific actions will be taken to address the issue(s)	#	National Comparisons	Lead by:	Achieve by:	Progress update / notes	Status
				Midwife			
Would you liked to have seen or spoken to a midwife … more often or less often	To complete a retrospective audit over a 3-month period to establish who is undertaking the postnatal checks. The results will provide information to enable discussion with the community workforce around task allocation.	F4	Middle 60%	Patient Experience and Inclusion Midwife	March 2025	On target	

Measures of success - How will we know the issue(s) have been addressed?	
Monitoring method (e.g. audit, spot check, document produced):	**What issues / action in the plan does this cover?**
CQC survey	**All**

Status tracking		
Complete	Green	G
On plan	Blue	B
Risks slippage	Amber	A
Barriers – not achieved	Red	R

Status tracking		
Complete	Green	G
On plan	Blue	B
Risks slippage	Amber	A
Barriers – not achieved	Red	R

patient PERSPECTIVE

Rigorous survey methods, reliable results.

PATIENT EXPERIENCE SURVEY HEADLINE REPORT

Salisbury NHS Foundation Trust

National Maternity Survey 2024

Sample: Women who received maternity services in January and February 2024

Note: to access full reporting go to www.patientperspective.co.uk

EXECUTIVE SUMMARY

This report summarises the headline findings of the **2024 National Maternity Survey.**

- The National Maternity Survey is required by the CQC for all NHS Trusts providing maternity services.

- Women receiving maternity services in January and February 2024 were selected for the survey.

- 289 women were included in the survey and 162 responded (56.4%). The Patient Perspective average response rate for all 30 Trusts it surveyed was 45%.

- The average Mean Rating Score was 82.1%, 1.5% higher than in 2023.

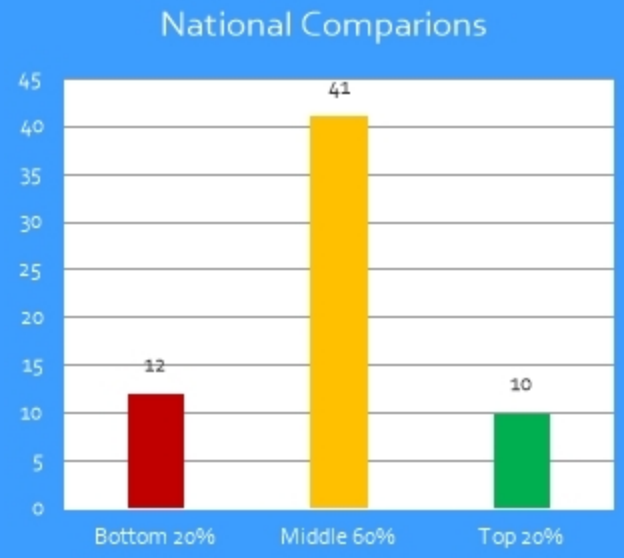
- You scored in the top 20% of Trusts on 10 questions and in the bottom 20% of Trusts on 12 questions out of a total of 63 questions.

- 4 questions showed at least 10% improvement on the 2023 score, and for 0 questions the score was worse by 10% or more.

Full results including tables, free text comments, trends and benchmarks can be found at www.patientperspective.co.uk

patient PERSPECTIVE

RESULTS DASHBOARD
NATIONAL MATERNITY SURVEY 2024



Note: national comparisons are against the 2023 National results apart from questions that are new in 2024, in this case comparison against the 30 Patient Perspective trusts is provided.
The CQC trust-level report, including comparisons against all Trusts, is due for publication in December 2024.

patient PERSPECTIVE

Questions and scores #1

Salisbury NHS Foundation Trust					
Care while you were pregnant (antenatal care)					
Question	Question Text	2023	2024	Change from 2023 to 2024	National Comparisons
B3_5	Were you offered a choice about where to have your baby: No - I was not offered any choices	81%	84%	<10% change	Middle 60%
B4	Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	69%	68%	<10% change	Middle 60%
B6	During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?	72%	67%	<10% change	Bottom 20%
B7	During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?	88%	90%	<10% change	Middle 60%
B8	During your antenatal check-ups, did your midwives listen to you?	93%	92%	<10% change	Middle 60%
B9	During your antenatal check-ups, did your midwives ask you about your mental health?	90%	93%	<10% change	Top 20%
B10	Were you given enough support for your mental health during your pregnancy?	90%	93%	<10% change	Top 20%
B11	During your pregnancy, if you contacted a midwifery team, were you given the help you needed?	87%	86%	<10% change	Middle 60%
B12	Thinking about your antenatal care, were you spoken to in a way you could understand?	94%	94%	<10% change	Middle 60%
B13	Thinking about your antenatal care, were you involved enough in decisions about your care?	89%	89%	<10% change	Middle 60%
B14	During your pregnancy did midwives provide relevant information about feeding your baby?	64%	59%	<10% change	Bottom 20%
B15	Did you have confidence and trust in the staff caring for you during your antenatal care?	86%	81%	<10% change	Middle 60%
B16	Thinking about your antenatal care, were you treated with respect and dignity?	94%	91%	<10% change	Middle 60%
B17	If you raised a concern during your antenatal care, did you feel that it was taken seriously?	93%	88%	<10% change	Middle 60%
B18	Thinking about your antenatal care, were you given information about any warning signs to look out for during your pregnancy?	n/a	87%	n/a	Middle 60%
B20	Thinking about the last time you were triaged, did you feel that your concerns were taken seriously by the midwife or doctor you spoke to?	n/a	83%	n/a	Middle 60%

patient PERSPECTIVE

Questions and scores #2

Your labour and the birth of your baby					
Question	Question Text	2023	2024	Change from 2023 to 2024	National Comparisons
C4	Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?	70%	83%	10% or more better	Top 20%
C5	Were you involved in the decision to be induced?	n/a	81%	n/a	Top 20%
C6	At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	85%	87%	<10% change	Middle 60%
C7	During your labour, were you ever sent home when you were worried about yourself or your baby?	n/a	92%	n/a	Middle 60%
C8	Do you think your healthcare professionals did everything they could to help manage your pain during labour and birth?	73%	76%	<10% change	Middle 60%
C9	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	95%	96%	<10% change	Middle 60%
C10	Did the staff treating and examining you introduce themselves?	91%	93%	<10% change	Middle 60%
C11_1	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, during early labour	88%	88%	<10% change	Middle 60%
C11_2	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, during the later stages of labour	96%	94%	<10% change	Middle 60%
C11_3	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, during the birth	99%	98%	<10% change	Middle 60%
C11_4	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, shortly after the birth	91%	86%	<10% change	Bottom 20%
C11_5	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: No, not at all	79%	71%	<10% change	Bottom 20%
C12	If you raised a concern during labour and birth, did you feel that it was taken seriously?	81%	83%	<10% change	Middle 60%
C13	During labour and birth, were you able to get a member of staff to help you when you needed it?	86%	89%	<10% change	Middle 60%
C14	Thinking about your care during labour and birth, did you feel that the midwives and / or doctors looking after you worked well together?	n/a	85%	n/a	Middle 60%
C15	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	93%	93%	<10% change	Middle 60%
C16	Thinking about your care during labour and birth, were you involved in decisions about your care?	86%	86%	<10% change	Middle 60%
C17	Thinking about your care during labour and birth, were you treated with respect and dignity?	91%	93%	<10% change	Middle 60%
C18	Did you have confidence and trust in the staff caring for you during your labour and birth?	86%	85%	<10% change	Middle 60%
C19	After your baby was born, did you have the opportunity to ask questions about your labour and the birth?	61%	60%	<10% change	Middle 60%
C20	During your labour and birth, did your midwives or doctor appear to be aware of your medical history?	78%	75%	<10% change	Middle 60%
C21	Thinking about your care during labour and birth, were you treated with kindness and compassion?	90%	93%	<10% change	Top 20%

patient PERSPECTIVE

Questions and scores #3

Care in the ward after birth (postnatal care)					
Question	Question Text	2023	2024	Change from 2023 to 2024	National Comparisons
D2	On the day you left hospital, was your discharge delayed for any reason?	60%	60%	<10% change	Middle 60%
D3	If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?	69%	70%	<10% change	Middle 60%
D4	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	68%	69%	<10% change	Bottom 20%
D5	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	80%	85%	<10% change	Middle 60%
D6_1	Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted: Yes	38%	85%	10% or more better	Top 20%
D6_2	Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted: No, as they were restricted to visiting hours	48%	93%	10% or more better	Top 20%
D6_3	Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted: No, as there was no accommodation for them on the maternity ward	80%	97%	10% or more better	Top 20%
D7	Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?	77%	74%	<10% change	Middle 60%

Feeding your baby					
Question	Question Text	2023	2024	Change from 2023 to 2024	National Comparisons
E2	Were your decisions about how you wanted to feed your baby respected by midwives?	90%	93%	<10% change	Top 20%
E3	Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?	74%	65%	<10% change	Bottom 20%

patient PERSPECTIVE

Questions and scores #4

Care after birth					
Question	Question Text	2023	2024	Change from 2023 to 2024	National Comparisons
F1	Thinking about your postnatal care, were you involved in decisions about your care?	84%	83%	<10% change	Middle 60%
F2	If you contacted a midwifery or health visiting team, were you given the help you needed?	85%	82%	<10% change	Middle 60%
F4	Would you have liked to have seen or spoken to a midwife... more often or less often.	67%	62%	<10% change	Middle 60%
F5	Did the midwife or midwives that you saw appear to be aware of the medical history of you and your baby?	81%	74%	<10% change	Bottom 20%
F6	Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?	87%	86%	<10% change	Middle 60%
F7	Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?	86%	81%	<10% change	Bottom 20%
F8	Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?	86%	80%	<10% change	Bottom 20%
F10	Did a midwife ask you about your mental health?	97%	99%	<10% change	Top 20%
F11	Were you given information about any changes you might experience to your mental health after having your baby?	71%	71%	<10% change	Middle 60%
F12	Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	84%	82%	<10% change	Middle 60%
F13	Were you given enough information about your own physical recovery after the birth?	64%	65%	<10% change	Middle 60%
F14	In the four weeks after the birth of your baby did you receive help and advice from a midwife about feeding your baby?	n/a	59%	n/a	Bottom 20%
F15	If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?	48%	53%	<10% change	Bottom 20%
F16	In the four weeks after the birth of your baby did you receive help and advice from midwives about your baby's health and progress?	n/a	67%	n/a	Bottom 20%
F19	At any point during your maternity care journey, did you consider making a complaint about the care you received?	n/a	63%	n/a	Middle 60%

POINTS TO DISCUSS

Points to discuss:

- ❑ What is your overall impression of these results?
- ❑ What are you most pleased about in these results?
- ❑ What are you most unhappy about in these results?
- ❑ What works? What have you learned from your successes in other areas that you can use to help you make improvements to women's experiences of maternity care?
- ❑ What hasn't worked so far? What have you learned from what hasn't worked that you can either avoid doing in future or can do differently next time?
- ❑ What do you see as the priority areas for improving women's experiences of maternity services?

Factors to consider when setting priorities for improvement:

- ❑ **Organisational Fit** – how do these results triangulate with other performance data and existing organisational priorities and service improvement initiatives?
- ❑ **Commissioning requirements** – what external priorities have been set?
- ❑ **National comparisons** – in which areas are you scoring lower than other organisations and National averages
- ❑ **Internal benchmarks** – how do services/departments/wards/teams/parts of the pathway compare?
- ❑ **Actionable topics** – is this an area you can actually do something about? Are there any quick wins that will help get the patient experience improvement programme started?

NEXT STEPS AND ACTIONS

- **Detailed review of the results**
- **Dissemination of results** – consider with which stakeholder groups (internal and external), in which level of detail and in what format to share the results widely
- **Identify your priority areas for improvement** – ensuring these are linked with current priorities and are fully integrated into existing service improvement initiatives will mean they are more likely to be acted upon
- **Involve staff and service users** in deciding upon the actions to take to make the improvements real and lasting
- **Set up a process for ongoing monitoring** of the actions and improvements and regular communication about progress to stakeholders
- **Consider whether any further detailed analysis or support would be helpful** in supporting your quality improvement initiatives and whether there is anything else we can help you with. Our enhanced services include:
  - Detailed thematic analysis of written comments from women to improve the depth of reporting about experiences of care
  - Training for staff (including train the trainer programmes) in the interpretation of survey results and how to get the most from your survey programme will build capacity for improvement
  - Dedicated service improvement workshops and events built around your patient experience survey results

To discuss how we can help you further please contact our Senior Project Manager, Chris Henderson:

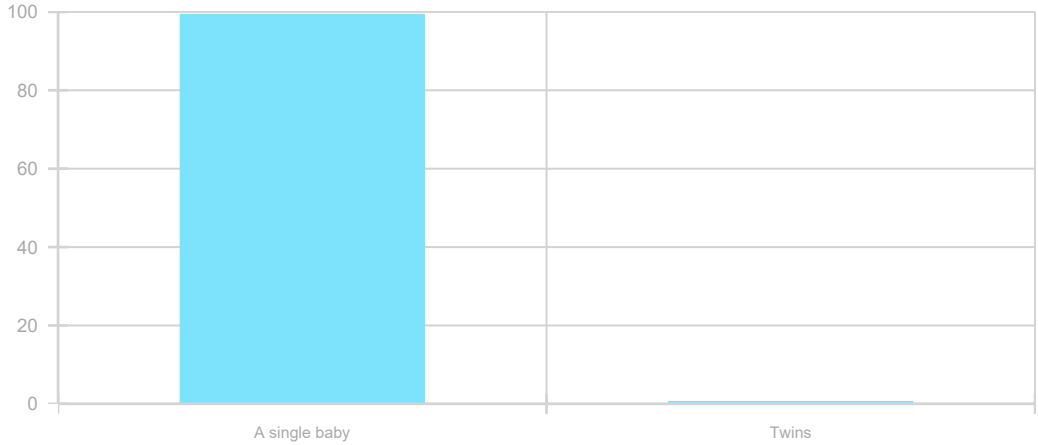
chris.henderson@patientperspective.org

Frequency Table

Survey	National Maternity Survey
Organisation:	Salisbury NHS Foundation Trust
Response Dates:	29 February 2024

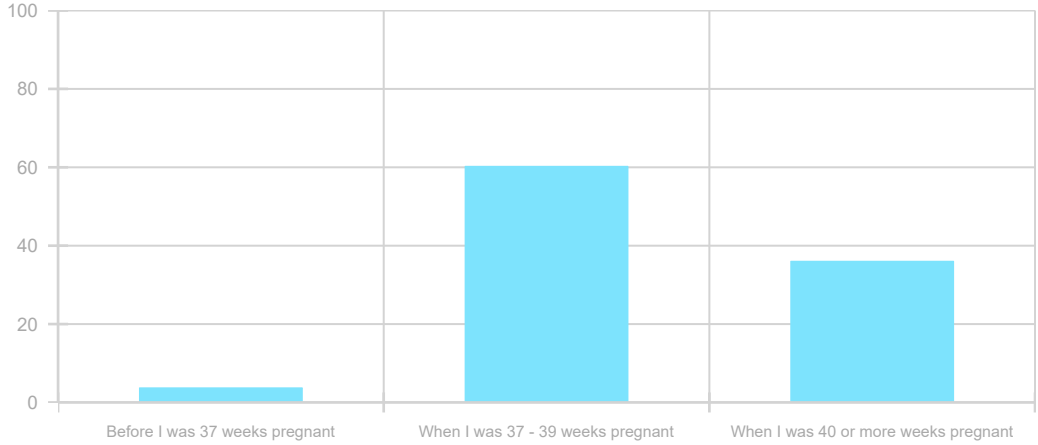
A1: Did you give birth to a single baby, twins or more in your most recent pregnancy?

#	Option	n	Weight	%
1	A single baby	161	0.00	99
2	Twins	1	0.00	1



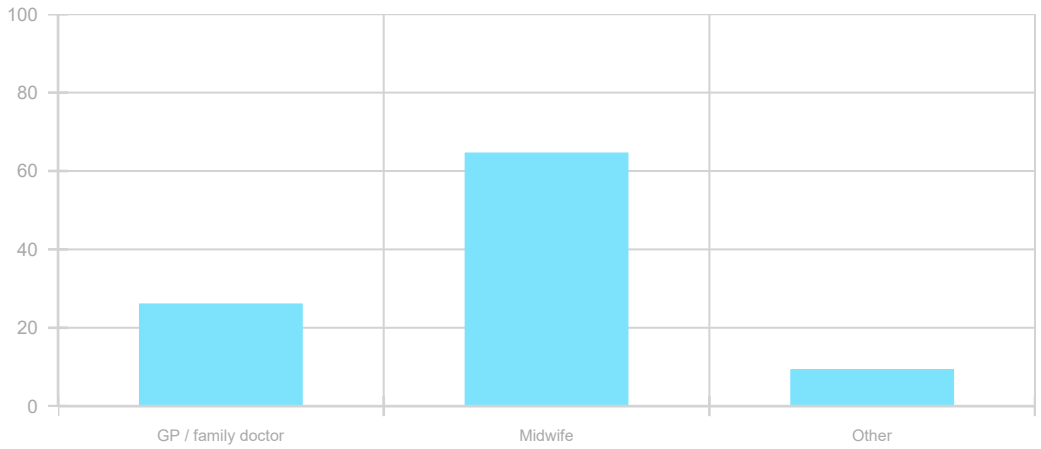
A2: Roughly how many weeks pregnant were you when your baby was born?

#	Option	n	Weight	%
1	Before I was 37 weeks pregnant	6	0.00	4
2	When I was 37 - 39 weeks pregnant	97	0.00	60
3	When I was 40 or more weeks pregnant	58	0.00	36



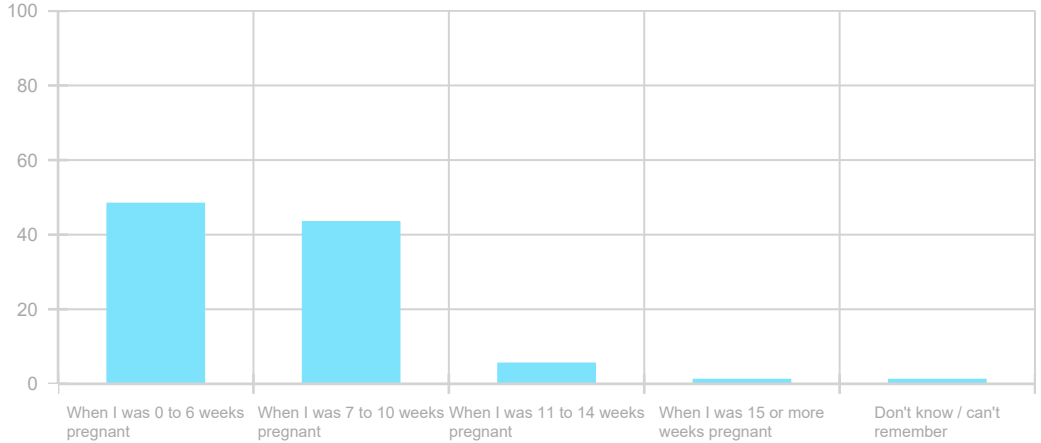
B1: Who was the first health professional you saw when you thought you were pregnant?

#	Option	n	Weight	%
1	GP / family doctor	42	0.00	26
2	Midwife	104	0.00	65
3	Other	15	0.00	9



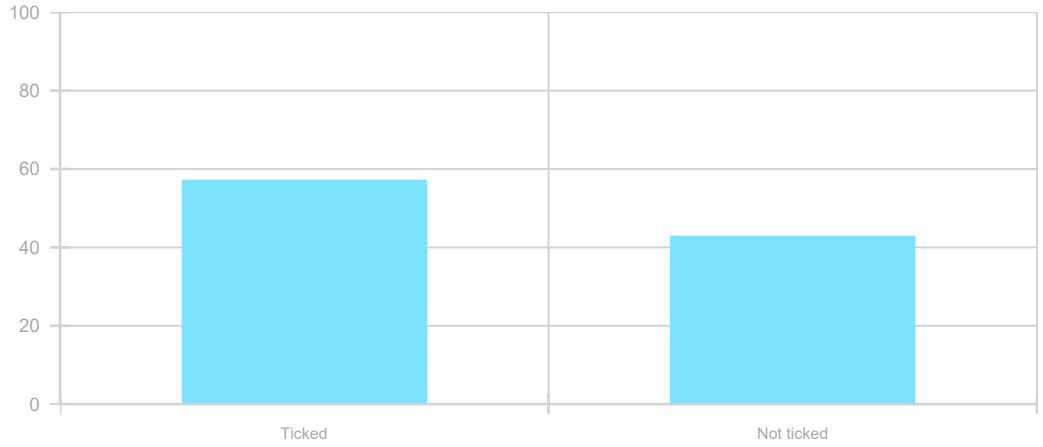
B2: Roughly how many weeks pregnant were you when you first saw or spoke to this health professional about your pregnancy care?

#	Option	n	Weight	%
1	When I was 0 to 6 weeks pregnant	78	0.00	48
2	When I was 7 to 10 weeks pregnant	70	0.00	43
3	When I was 11 to 14 weeks pregnant	9	0.00	6
5	Don't know / can't remember	2	0.00	1
4	When I was 15 or more weeks pregnant	2	0.00	1



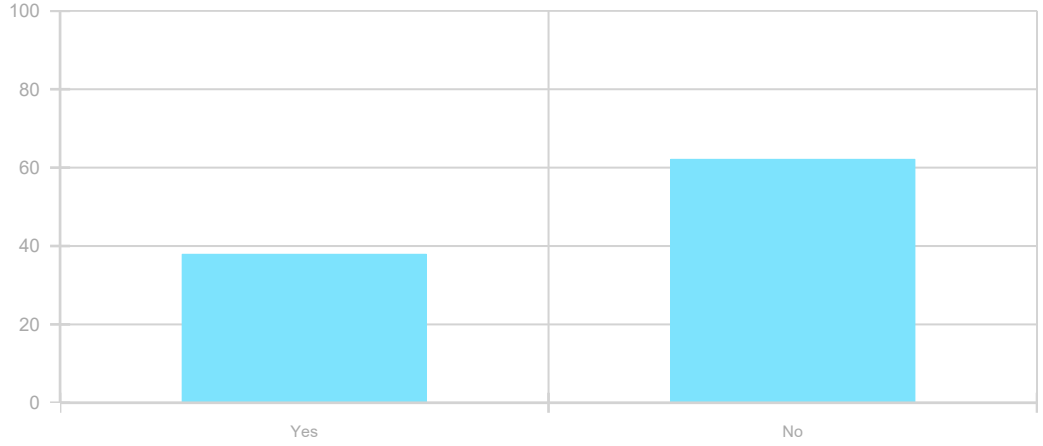
B3_1: Were you offered a choice about where to have your baby: Yes – a choice of hospitals

#	Option	n	Weight	%
1	Ticked	92	1.00	57
2	Not ticked	69	0.00	43



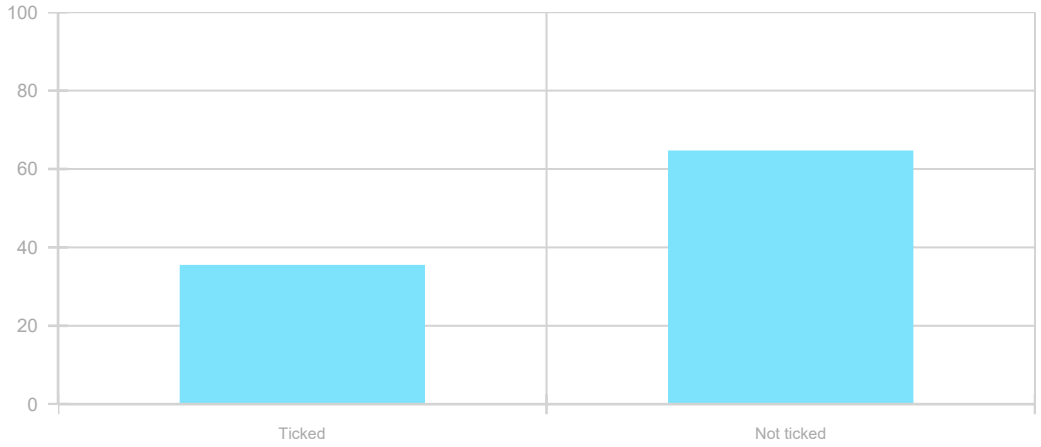
B3_2: Were you offered a choice about where to have your baby: Yes - a choice of birth centres

#	Option	n	Weight	%
1	Yes	61	1.00	38
2	No	100	0.00	62



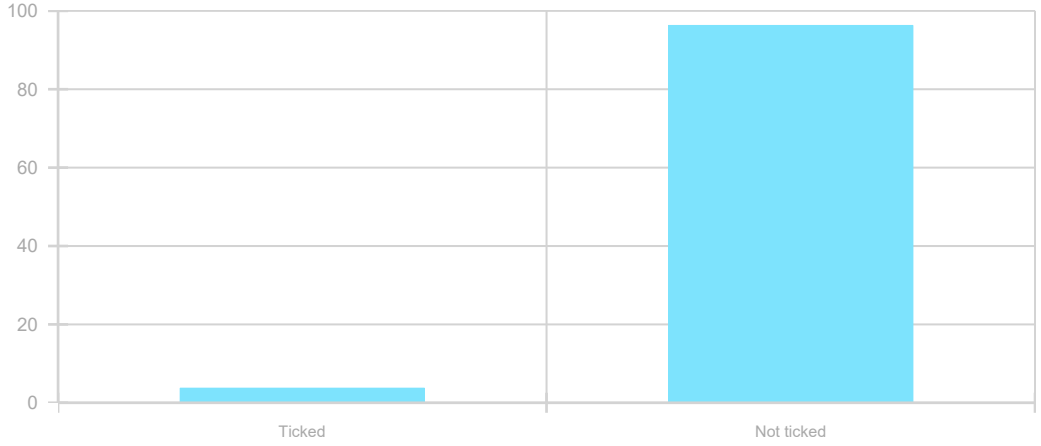
B3_3: Were you offered a choice about where to have your baby: Yes - at home

#	Option	n	Weight	%
1	Ticked	57	1.00	35
2	Not ticked	104	0.00	65



B3_4: Were you offered a choice about where to have your baby: Yes - other

#	Option	n	Weight	%
1	Ticked	6	1.00	4
2	Not ticked	155	0.00	96

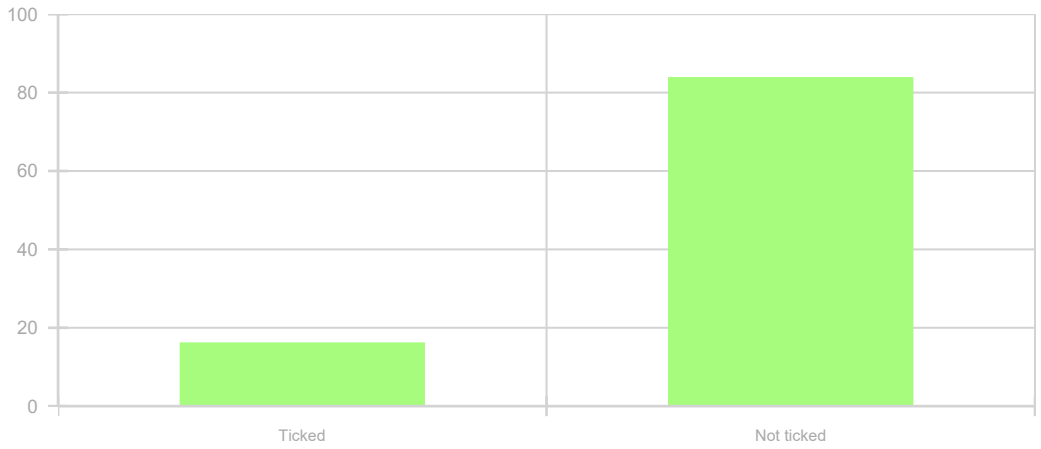


B3_5: Were you offered a choice about where to have your baby: No – I was not offered any choices

#	Option	n	Weight	%
1	Ticked	26	0.00	16
2	Not ticked	135	1.00	84

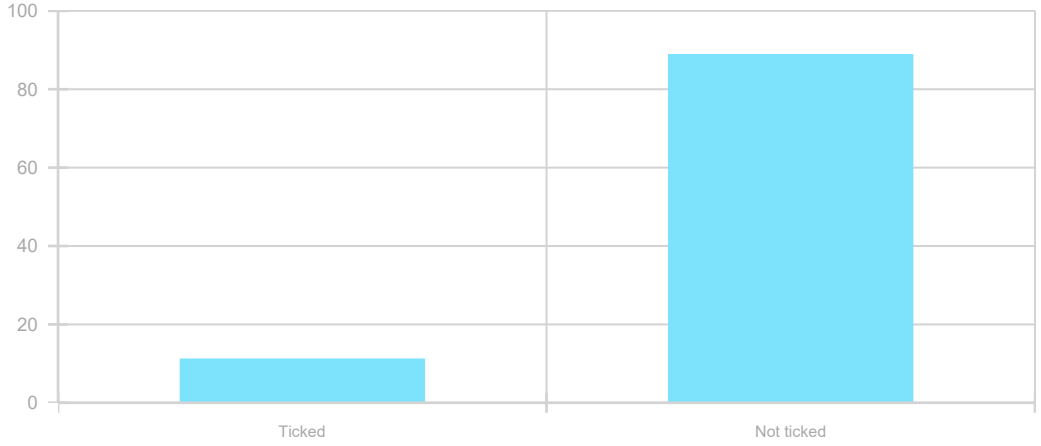
84% MEAN RATING SCORE

161 MRS BASE



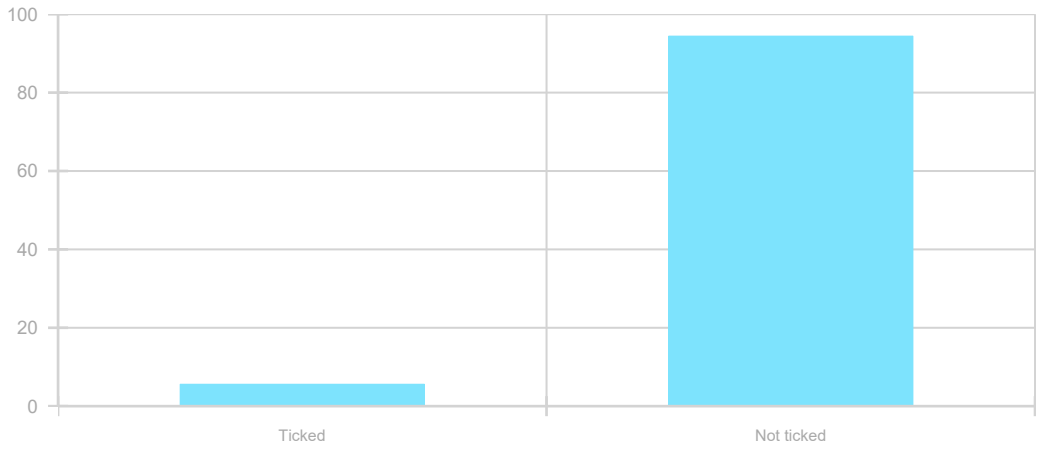
B3_6: Were you offered a choice about where to have your baby: No – I had no choices due to medical reasons

#	Option	n	Weight	%
1	Ticked	18	0.00	11
2	Not ticked	143	0.00	89



B3_7: Were you offered a choice about where to have your baby: Don't know / can't remember

#	Option	n	Weight	%
1	Ticked	9	0.00	6
2	Not ticked	152	0.00	94

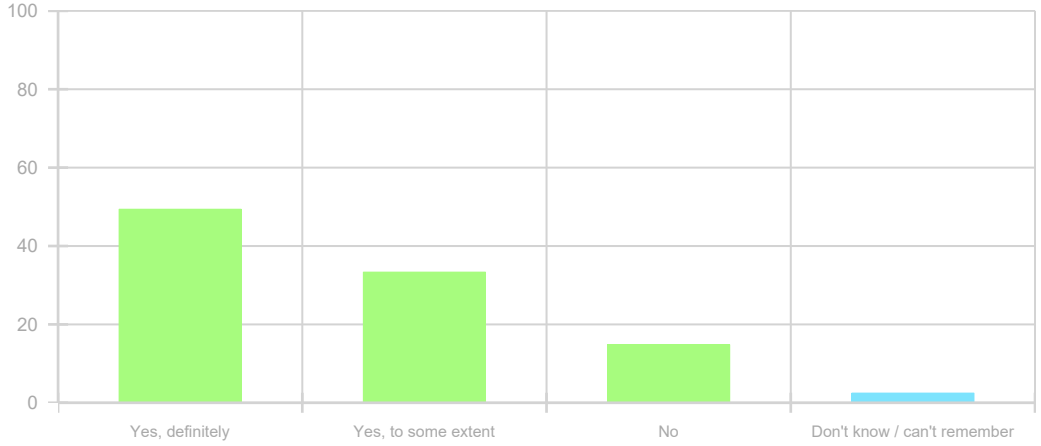


B4: Did you get enough information from either a midwife or doctor to help you decide where to have your baby?

#	Option	n	Weight	%
1	Yes, definitely	80	1.00	49
2	Yes, to some extent	54	0.50	33
3	No	24	0.00	15
4	Don't know / can't remember	4	0.00	2

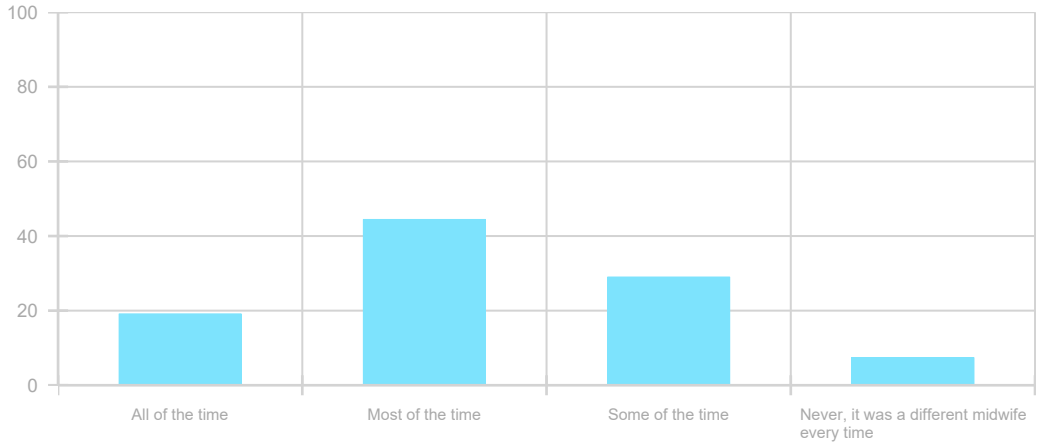
68% MEAN RATING SCORE

158 MRS BASE



B5: At your antenatal checks-ups, how often did you see or speak to the same midwife?

#	Option	n	Weight	%
1	All of the time	31	0.00	19
2	Most of the time	72	0.00	44
3	Some of the time	47	0.00	29
4	Never, it was a different midwife every time	12	0.00	7

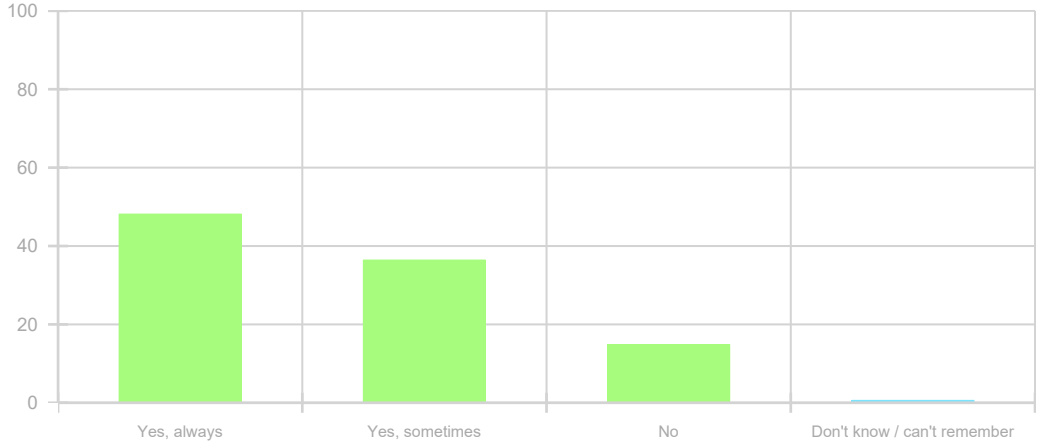


B6: During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?

#	Option	n	Weight	%
1	Yes, always	78	1.00	48
2	Yes, sometimes	59	0.50	36
3	No	24	0.00	15
4	Don't know / can't remember	1	0.00	1

67% MEAN RATING SCORE

161 MRS BASE

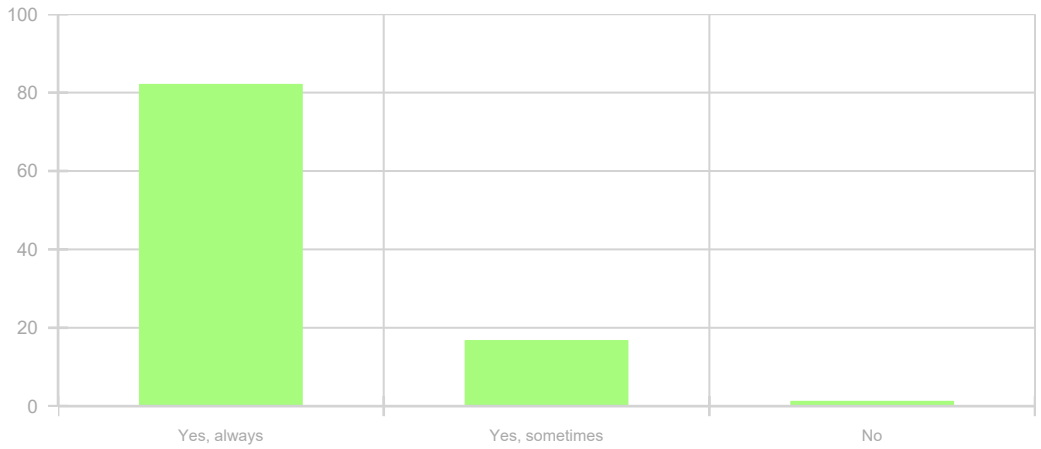


B7: During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?

#	Option	n	Weight	%
1	Yes, always	133	1.00	82
2	Yes, sometimes	27	0.50	17
3	No	2	0.00	1

90% MEAN RATING SCORE

162 MRS BASE

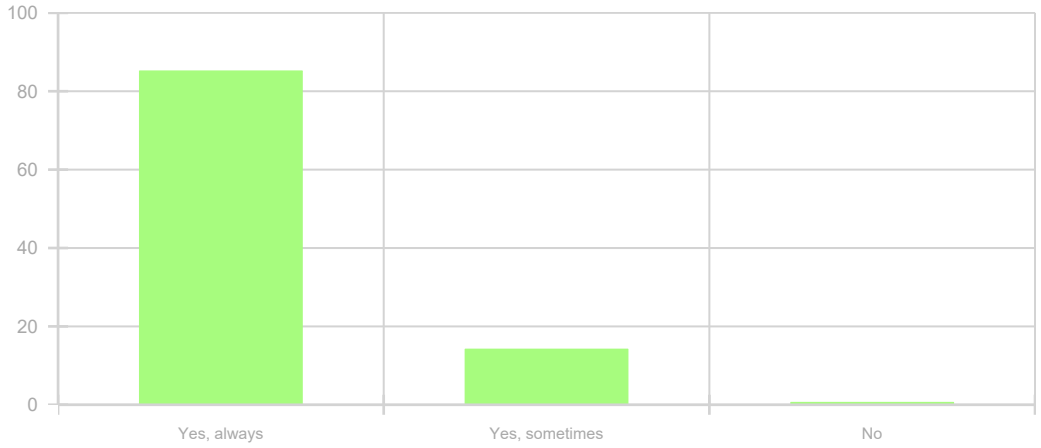


B8: During your antenatal check-ups, did your midwives listen to you?

#	Option	n	Weight	%
1	Yes, always	138	1.00	85
2	Yes, sometimes	23	0.50	14
3	No	1	0.00	1

92% MEAN RATING SCORE

162 MRS BASE

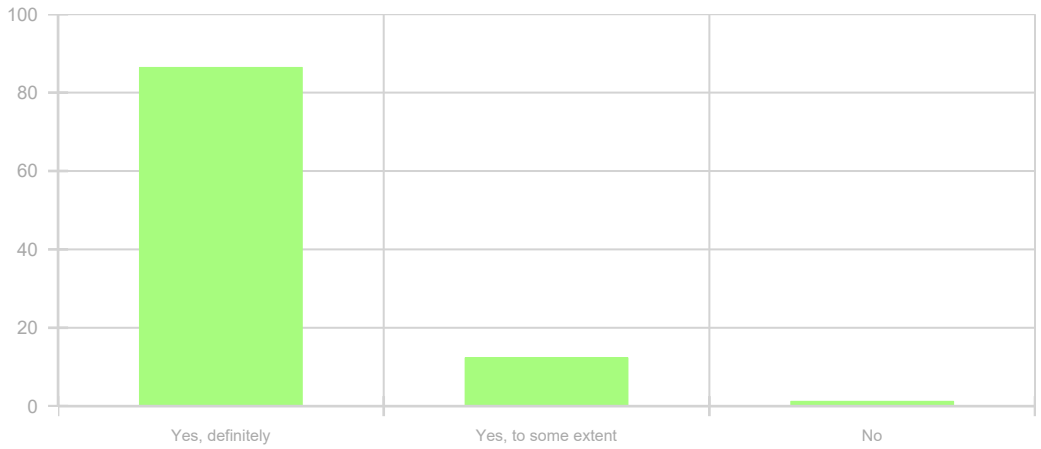


B9: During your antenatal check-ups, did your midwife ask you about your mental health?

#	Option	n	Weight	%
1	Yes, definitely	140	1.00	86
2	Yes, to some extent	20	0.50	12
3	No	2	0.00	1

93% MEAN RATING SCORE

162 MRS BASE

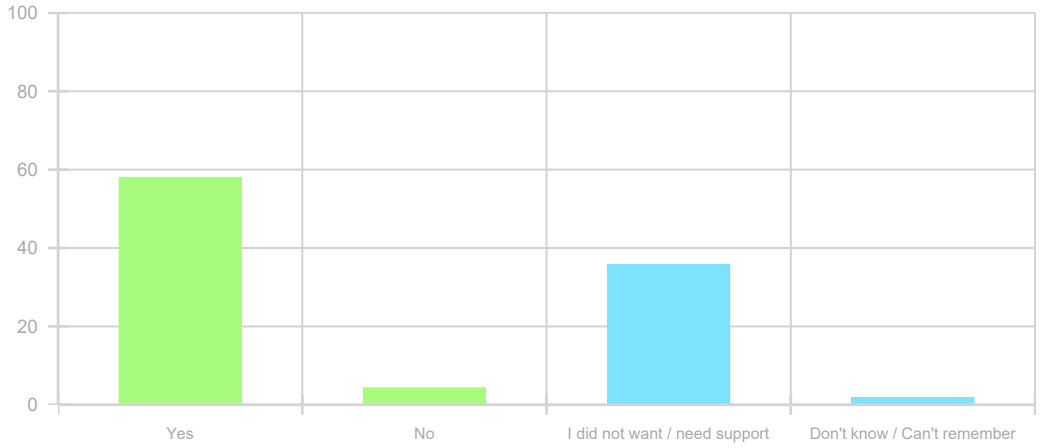


B10: Were you given enough support for your mental health during your pregnancy?

#	Option	n	Weight	%
1	Yes	94	1.00	58
2	No	7	0.00	4
3	I did not want / need support	58	0.00	36
4	Don't know / Can't remember	3	0.00	2

93% MEAN RATING SCORE

101 MRS BASE

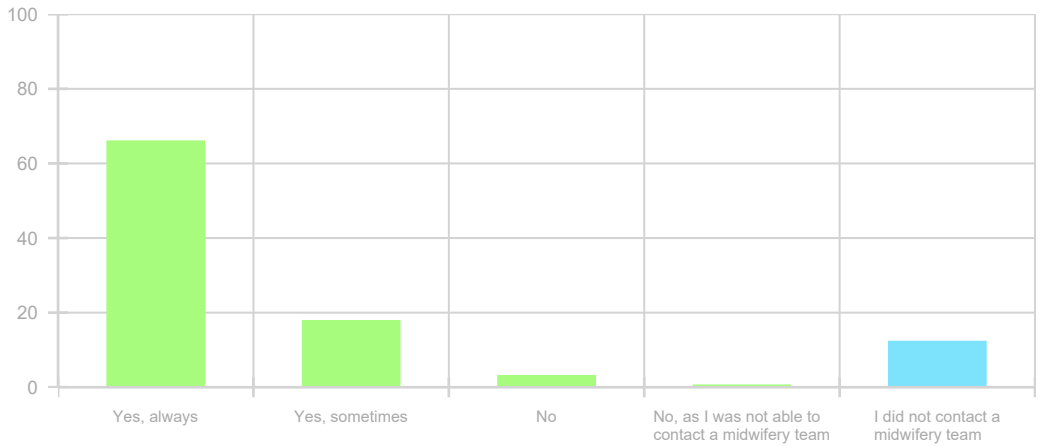


B11: During your pregnancy, if you contacted a midwifery team, were you given the help you needed?

#	Option	n	Weight	%
1	Yes, always	107	1.00	66
2	Yes, sometimes	29	0.50	18
3	No	5	0.00	3
4	No, as I was not able to contact a midwifery team	1	0.00	1
5	I did not contact a midwifery team	20	0.00	12

86% MEAN RATING SCORE

142 MRS BASE

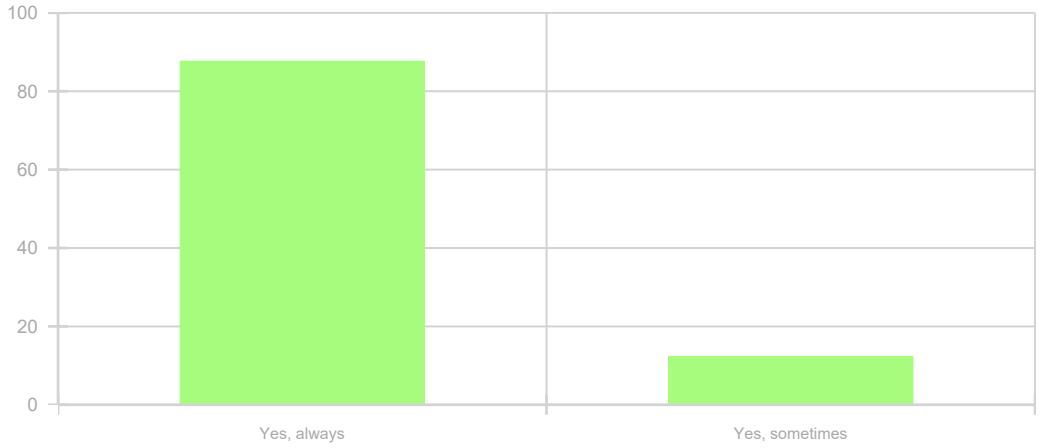


B12: Thinking about your antenatal care, were you spoken to in a way you could understand?

#	Option	n	Weight	%
1	Yes, always	142	1.00	88
2	Yes, sometimes	20	0.50	12

94% MEAN RATING SCORE

162 MRS BASE

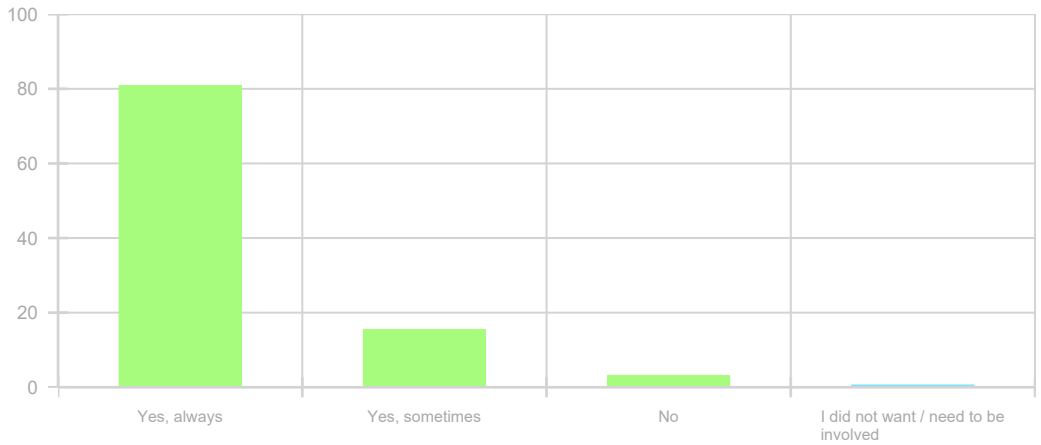


B13: Thinking about your antenatal care, were you involved in decisions about your care?

#	Option	n	Weight	%
1	Yes, always	131	1.00	81
2	Yes, sometimes	25	0.50	15
3	No	5	0.00	3
4	I did not want / need to be involved	1	0.00	1

89% MEAN RATING SCORE

161 MRS BASE

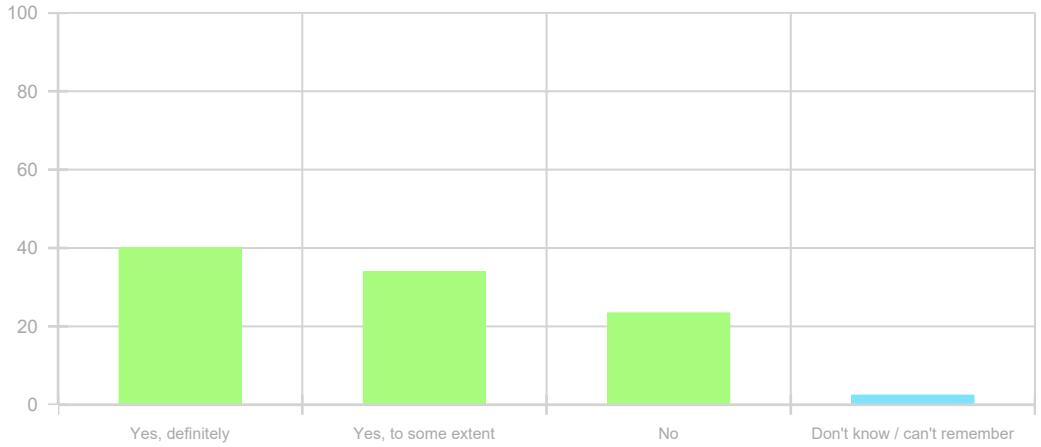


B14: During your pregnancy did midwives provide relevant information about feeding your baby?

#	Option	n	Weight	%
1	Yes, definitely	65	1.00	40
2	Yes, to some extent	55	0.50	34
3	No	38	0.00	23
4	Don't know / can't remember	4	0.00	2

59% MEAN RATING SCORE

158 MRS BASE

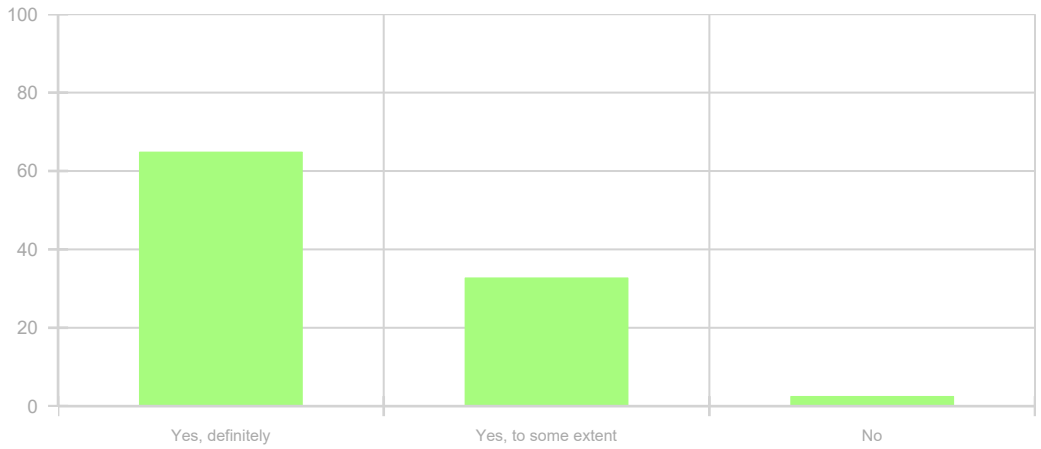


B15: Did you have confidence and trust in the staff caring for you during your antenatal care?

#	Option	n	Weight	%
1	Yes, definitely	105	1.00	65
2	Yes, to some extent	53	0.50	33
3	No	4	0.00	2

81% MEAN RATING SCORE

162 MRS BASE

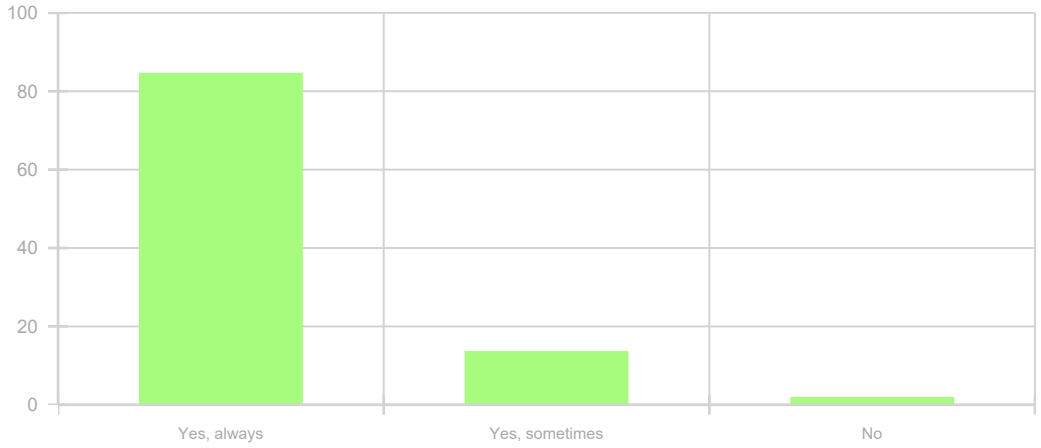


B16: Thinking about your antenatal care, were you treated with respect and dignity?

#	Option	n	Weight	%
1	Yes, always	137	1.00	85
2	Yes, sometimes	22	0.50	14
3	No	3	0.00	2

91% MEAN RATING SCORE

162 MRS BASE

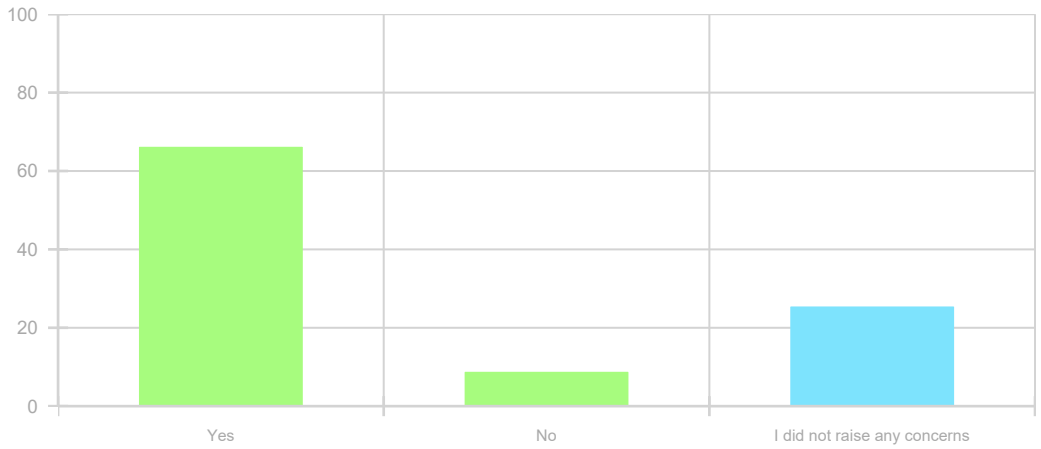


B17: If you raised a concern during your antenatal care, did you feel it was taken seriously?

#	Option	n	Weight	%
1	Yes	107	1.00	66
2	No	14	0.00	9
3	I did not raise any concerns	41	0.00	25

88% MEAN RATING SCORE

121 MRS BASE

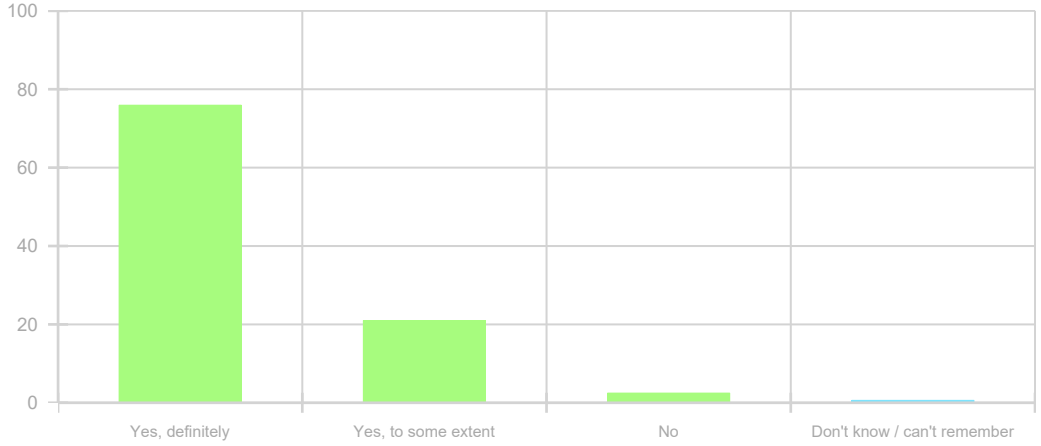


B18: Thinking about your antenatal care, were you given information about any warning signs to look out for during your pregnancy?

#	Option	n	Weight	%
1	Yes, definitely	123	1.00	76
2	Yes, to some extent	34	0.50	21
3	No	4	0.00	2
4	Don't know / can't remember	1	0.00	1

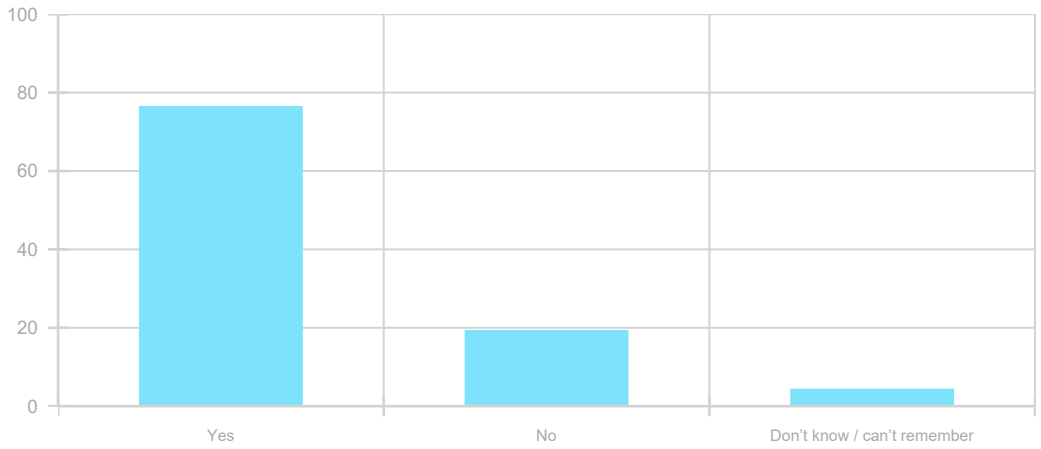
87% MEAN RATING SCORE

161 MRS BASE



B19: At any point during your pregnancy, did you go through triage to have your symptoms assessed?

#	Option	n	Weight	%
1	Yes	123	0.00	76
2	No	31	0.00	19
3	Don’t know / can’t remember	7	0.00	4

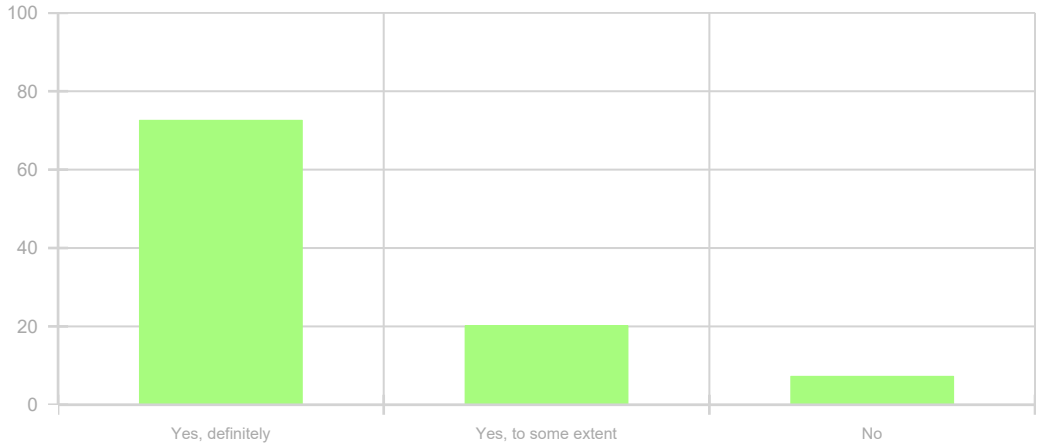


B20: Thinking about the last time you were triaged, did you feel that your concerns were taken seriously by the midwife or doctor you spoke to?

#	Option	n	Weight	%
1	Yes, definitely	90	1.00	73
2	Yes, to some extent	25	0.50	20
3	No	9	0.00	7

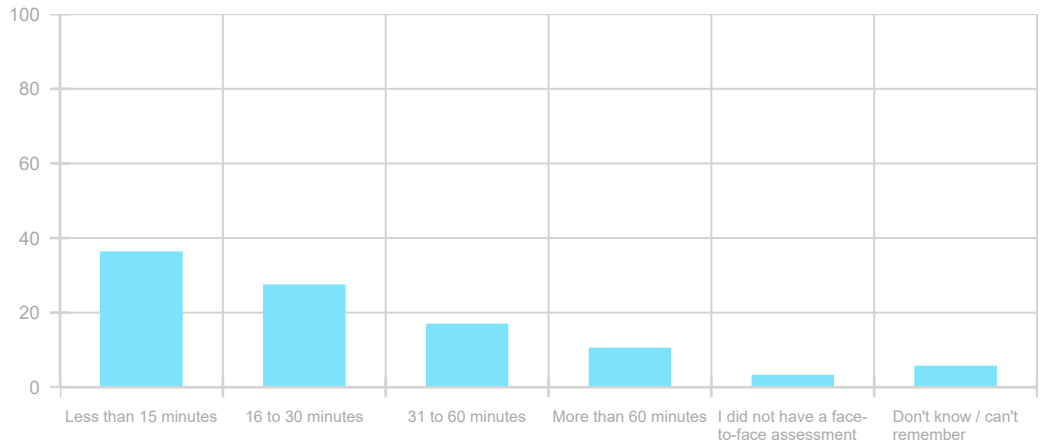
83% MEAN RATING SCORE

124 MRS BASE



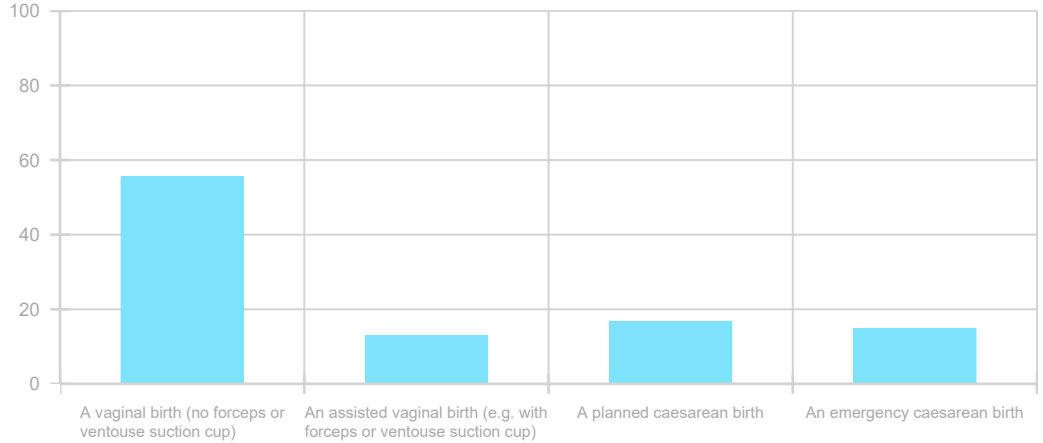
B21: Thinking about your last face-to-face assessment, how long did you have to wait before you were seen by a midwife?

#	Option	n	Weight	%
1	Less than 15 minutes	45	0.00	36
2	16 to 30 minutes	34	0.00	27
3	31 to 60 minutes	21	0.00	17
4	More than 60 minutes	13	0.00	10
5	I did not have a face-to-face assessment	4	0.00	3
6	Don't know / can't remember	7	0.00	6



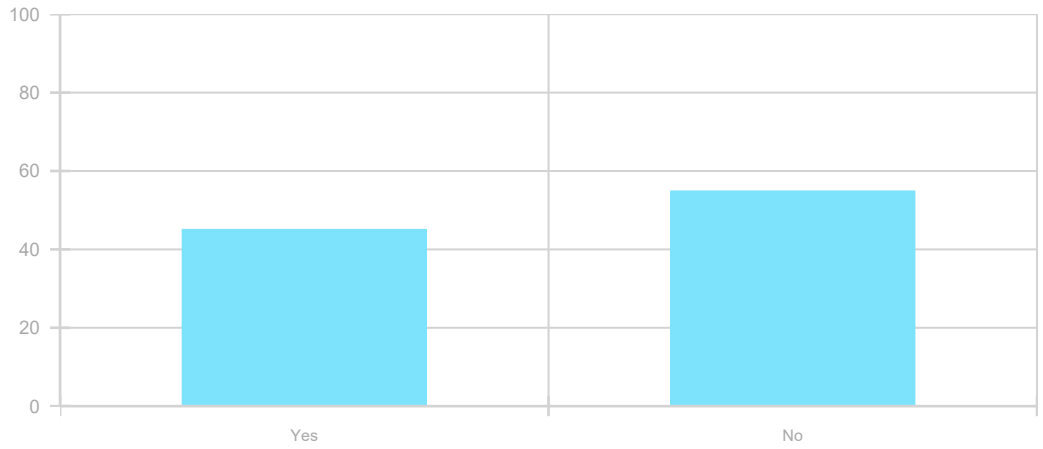
C1: Thinking about the birth of your baby, what type of birth did you have?

#	Option	n	Weight	%
1	A vaginal birth (no forceps or ventouse suction cup)	90	0.00	56
2	An assisted vaginal birth (e.g. with forceps or ventouse suction cup)	21	0.00	13
3	A planned caesarean birth	27	0.00	17
4	An emergency caesarean birth	24	0.00	15



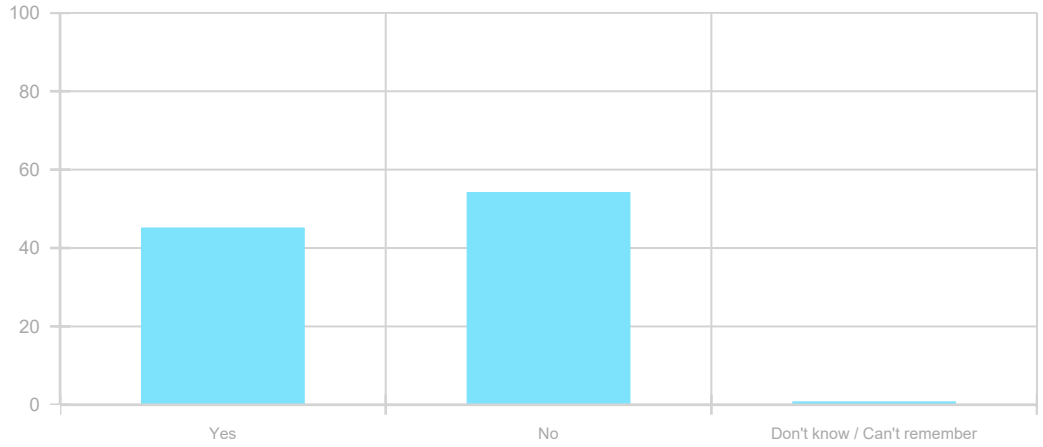
C2: Before your caesarean, did you go into labour?

#	Option	n	Weight	%
1	Yes	23	0.00	45
2	No	28	0.00	55



C3: Thinking about the birth of your baby, was your labour induced?

#	Option	n	Weight	%
1	Yes	60	0.00	45
2	No	72	0.00	54
3	Don't know / Can't remember	1	0.00	1

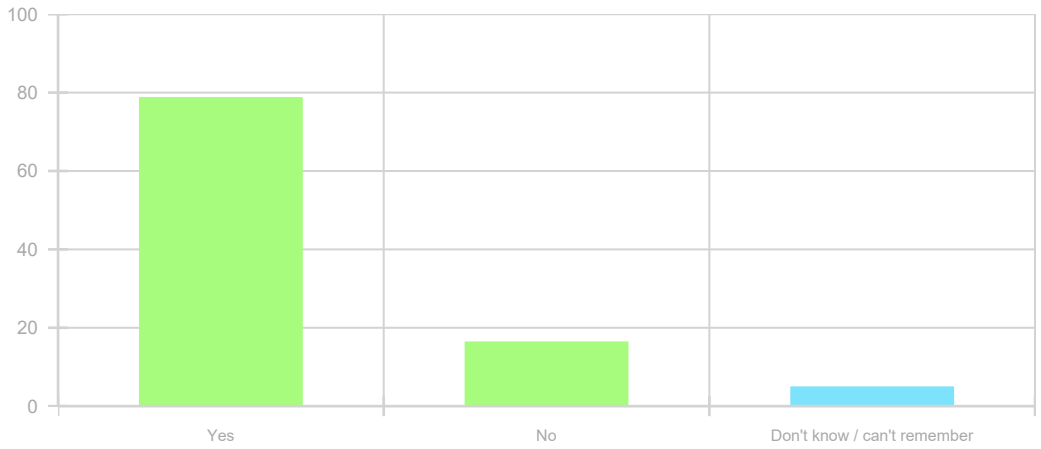


C4: Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?

#	Option	n	Weight	%
1	Yes	48	1.00	79
2	No	10	0.00	16
3	Don't know / can't remember	3	0.00	5

83% MEAN RATING SCORE

58 MRS BASE

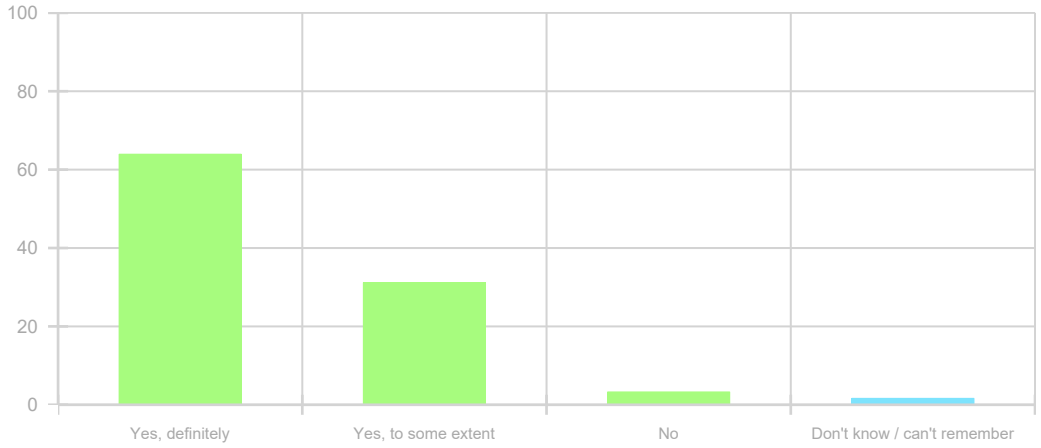


C5: Were you involved in the decision to be induced?

#	Option	n	Weight	%
1	Yes, definitely	39	1.00	64
3	No	2	0.00	3
5	Don't know / can't remember	1	0.00	2
2	Yes, to some extent	19	0.50	31

81% MEAN RATING SCORE

60 MRS BASE

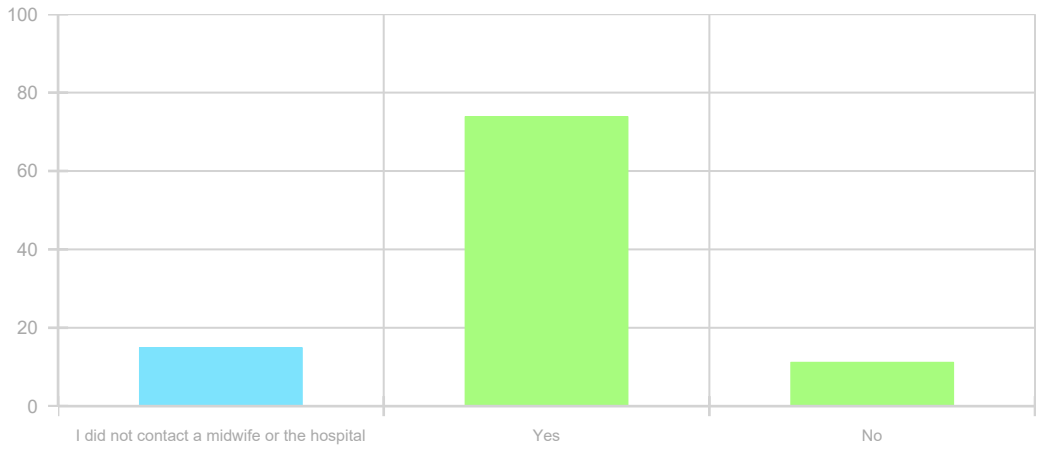


C6: At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?

#	Option	n	Weight	%
1	I did not contact a midwife or the hospital	20	0.00	15
2	Yes	99	1.00	74
3	No	15	0.00	11

87% MEAN RATING SCORE

114 MRS BASE

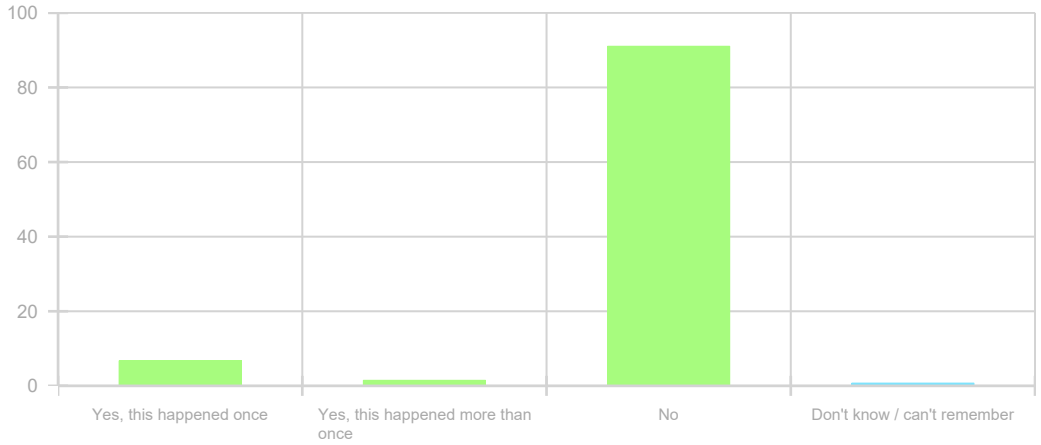


C7: During your labour, were you ever sent home when you were worried about yourself or your baby?

#	Option	n	Weight	%
1	Yes, this happened once	9	0.00	7
2	Yes, this happened more than once	2	0.00	1
3	No	122	1.00	91
4	Don't know / can't remember	1	0.00	1

92% MEAN RATING SCORE

133 MRS BASE

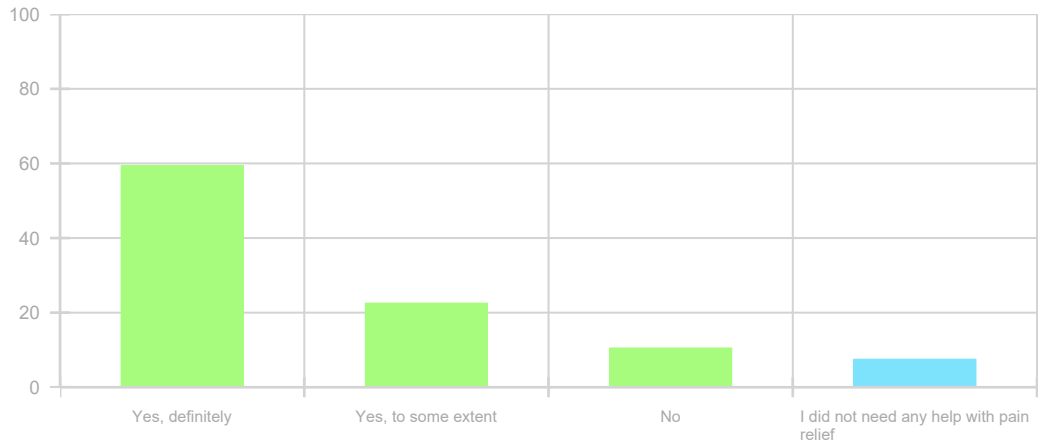


C8: Do you think your healthcare professionals did everything they could to help manage your pain during labour and birth?

#	Option	n	Weight	%
1	Yes, definitely	79	1.00	59
2	Yes, to some extent	30	0.50	23
3	No	14	0.00	11
4	I did not need any help with pain relief	10	0.00	8

76% MEAN RATING SCORE

123 MRS BASE

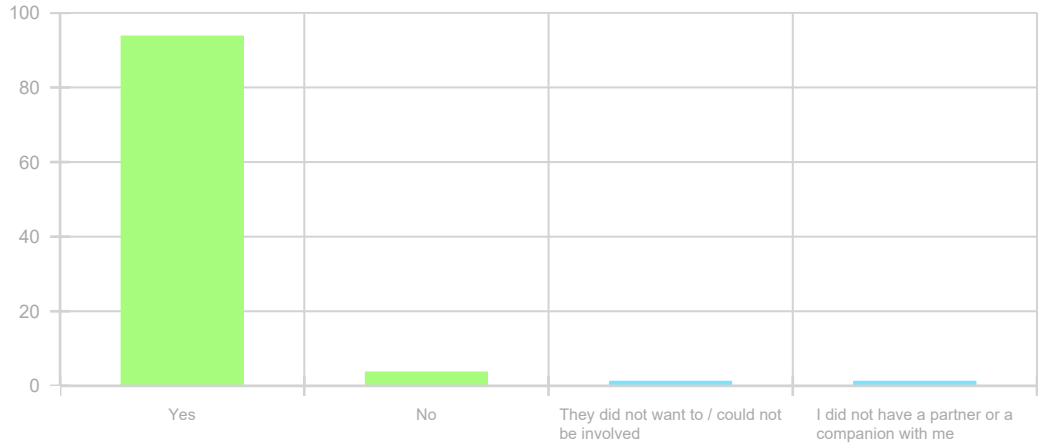


C9: If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?

#	Option	n	Weight	%
1	Yes	151	1.00	94
2	No	6	0.00	4
3	They did not want to / could not be involved	2	0.00	1
5	I did not have a partner or a companion with me	2	0.00	1

96% MEAN RATING SCORE

157 MRS BASE

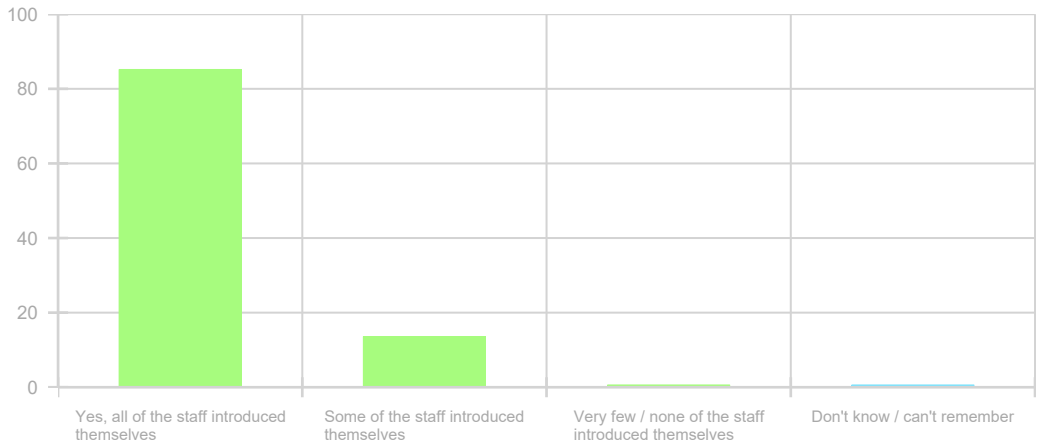


C10: Did the staff treating and examining you introduce themselves?

#	Option	n	Weight	%
1	Yes, all of the staff introduced themselves	138	1.00	85
2	Some of the staff introduced themselves	22	0.50	14
3	Very few / none of the staff introduced themselves	1	0.00	1
4	Don't know / can't remember	1	0.00	1

93% MEAN RATING SCORE

161 MRS BASE

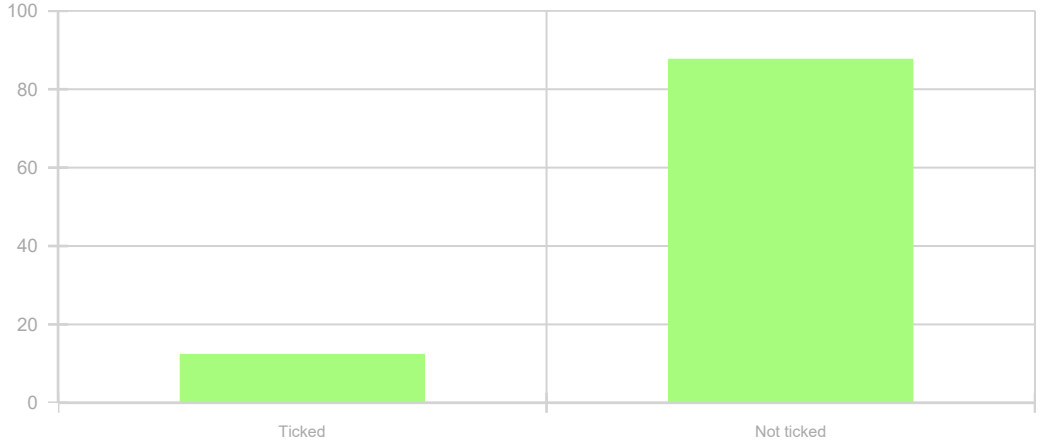


C11_1: Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, during early labour

#	Option	n	Weight	%
1	Ticked	20	0.00	12
2	Not ticked	142	1.00	88

88% MEAN RATING SCORE

162 MRS BASE

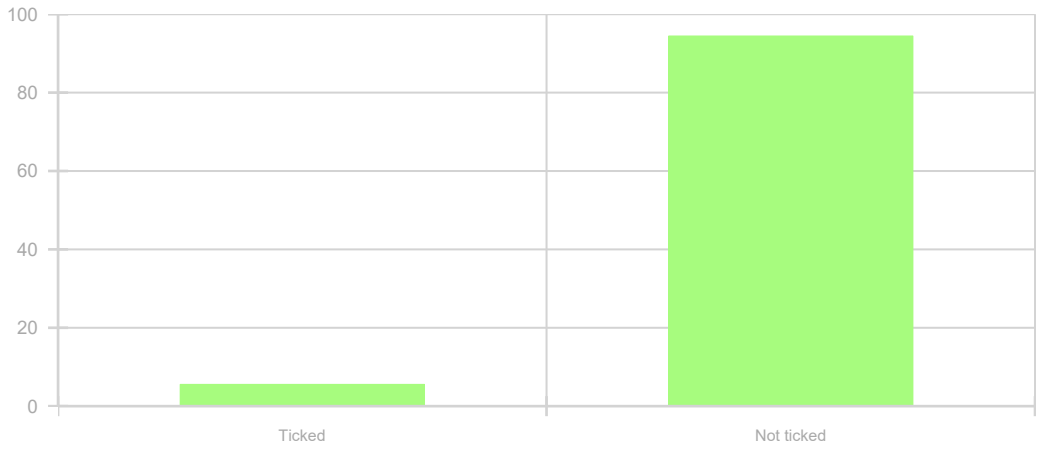


C11_2: Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, during the later stages of labour

#	Option	n	Weight	%
1	Ticked	9	0.00	6
2	Not ticked	153	1.00	94

94% MEAN RATING SCORE

162 MRS BASE

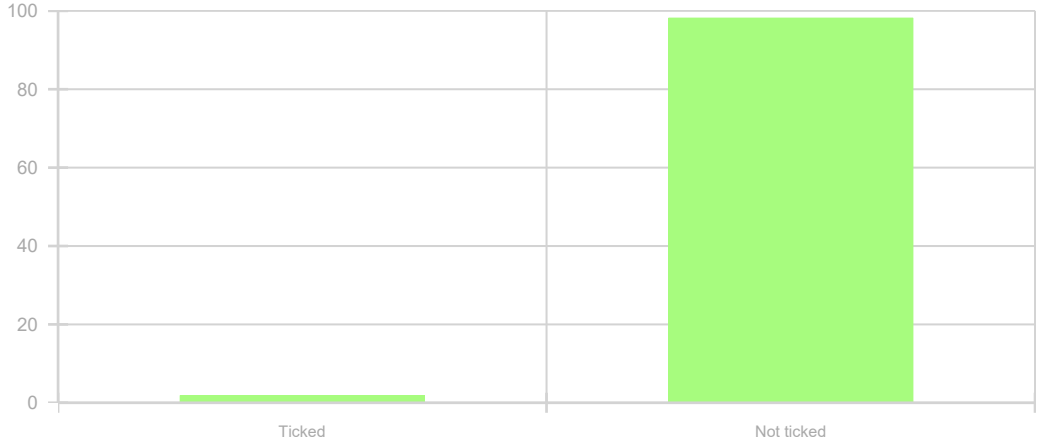


C11_3: Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, during the birth

#	Option	n	Weight	%
1	Ticked	3	0.00	2
2	Not ticked	159	1.00	98

98% MEAN RATING SCORE

162 MRS BASE

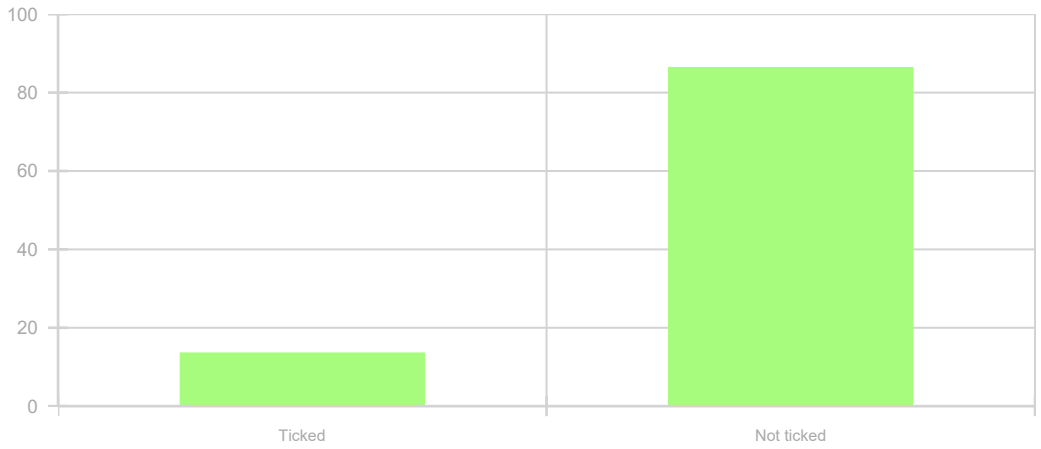


C11_4: Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, shortly after the birth

#	Option	n	Weight	%
1	Ticked	22	0.00	14
2	Not ticked	140	1.00	86

86% MEAN RATING SCORE

162 MRS BASE

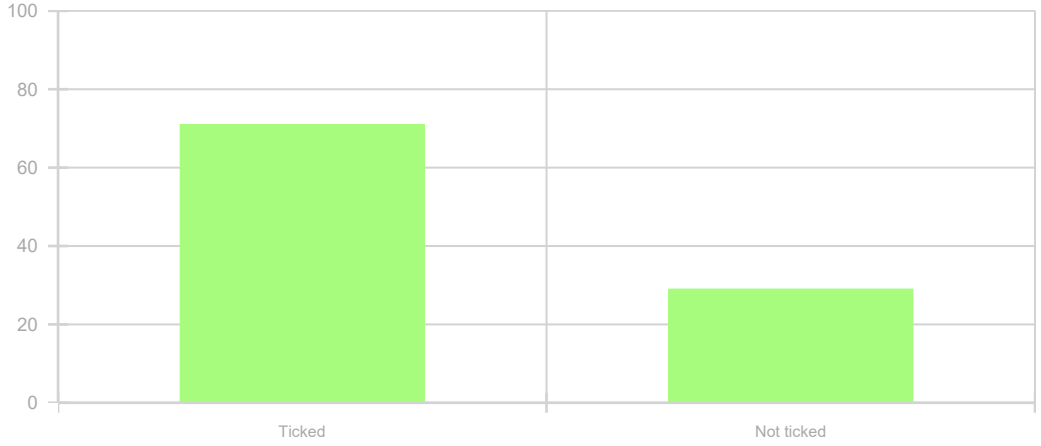


C11_5: Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: No, not at all

#	Option	n	Weight	%
1	Ticked	115	1.00	71
2	Not ticked	47	0.00	29

71% MEAN RATING SCORE

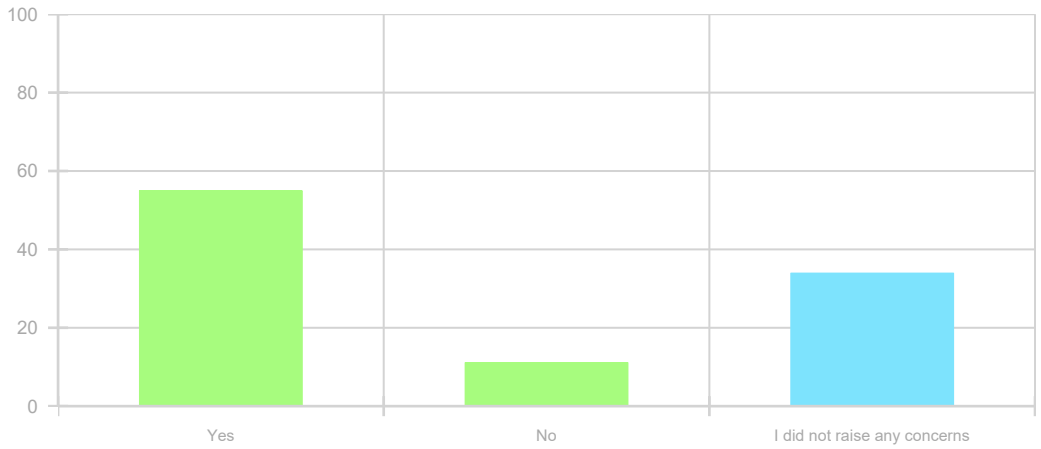
162 MRS BASE



C12: If you raised a concern during labour and birth, did you feel that it was taken seriously?

#	Option	n	Weight	%
1	Yes	89	1.00	55
2	No	18	0.00	11
3	I did not raise any concerns	55	0.00	34

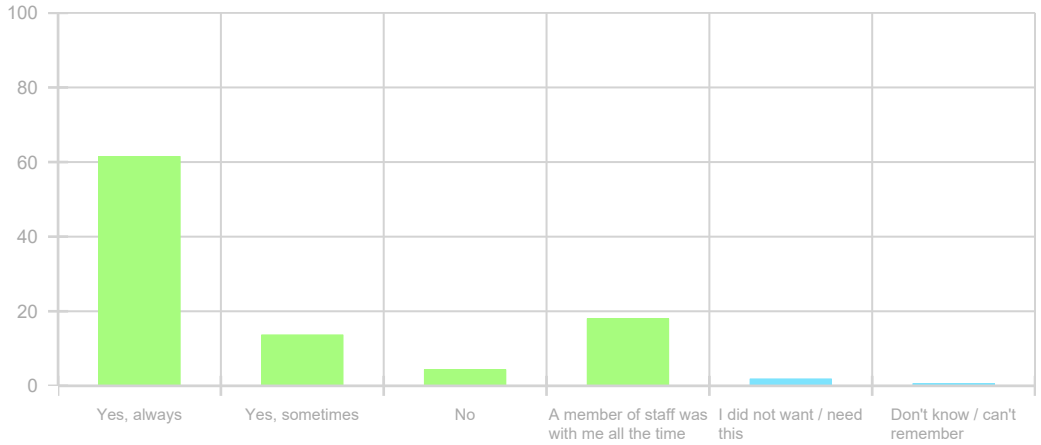
83%	MEAN RATING SCORE	107	MRS BASE



C13: During labour and birth, were you able to get a member of staff to help you when you needed it?

#	Option	n	Weight	%
1	Yes, always	99	1.00	61
2	Yes, sometimes	22	0.50	14
3	No	7	0.00	4
4	A member of staff was with me all the time	29	1.00	18
5	I did not want / need this	3	0.00	2
6	Don't know / can't remember	1	0.00	1

89%	MEAN RATING SCORE	157	MRS BASE

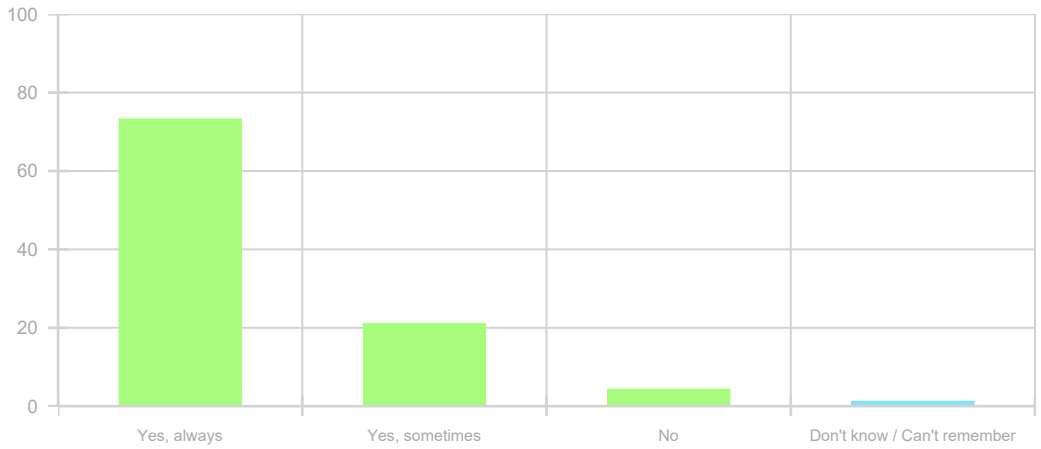


C14: Thinking about your care during labour and birth, did you feel that the midwives and / or doctors looking after you worked well together?

#	Option	n	Weight	%
1	Yes, always	118	1.00	73
2	Yes, sometimes	34	0.50	21
3	No	7	0.00	4
4	Don't know / Can't remember	2	0.00	1

85% MEAN RATING SCORE

159 MRS BASE

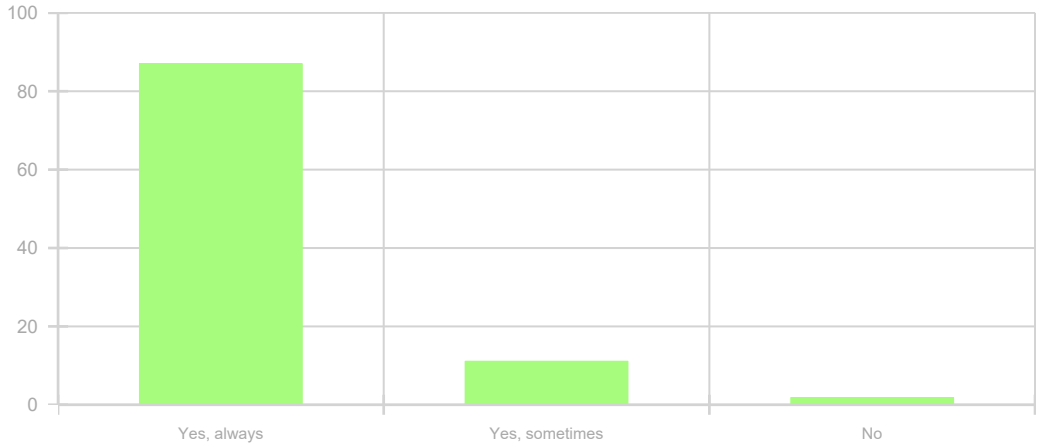


C15: Thinking about your care during labour and birth, were you spoken to in a way you could understand?

#	Option	n	Weight	%
1	Yes, always	141	1.00	87
2	Yes, sometimes	18	0.50	11
3	No	3	0.00	2

93% MEAN RATING SCORE

162 MRS BASE

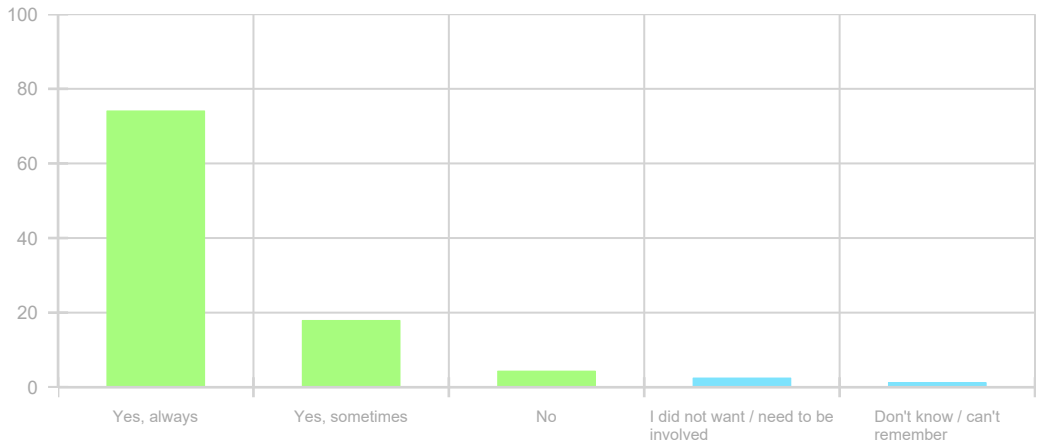


C16: Thinking about your care during labour and birth, were you involved in decisions about your care?

#	Option	n	Weight	%
1	Yes, always	120	1.00	74
2	Yes, sometimes	29	0.50	18
3	No	7	0.00	4
4	I did not want / need to be involved	4	0.00	2
5	Don't know / can't remember	2	0.00	1

86% MEAN RATING SCORE

156 MRS BASE

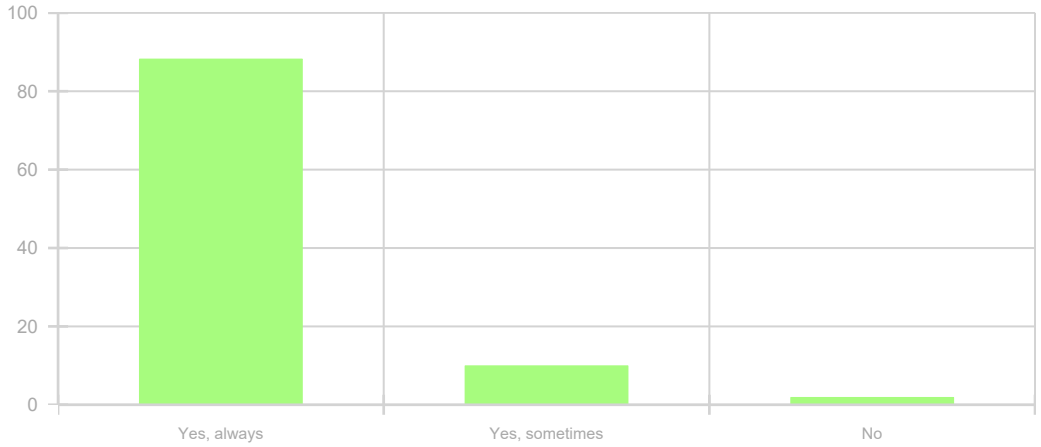


C17: Thinking about your care during labour and birth, were you treated with respect and dignity?

#	Option	n	Weight	%
1	Yes, always	142	1.00	88
2	Yes, sometimes	16	0.50	10
3	No	3	0.00	2

93% MEAN RATING SCORE

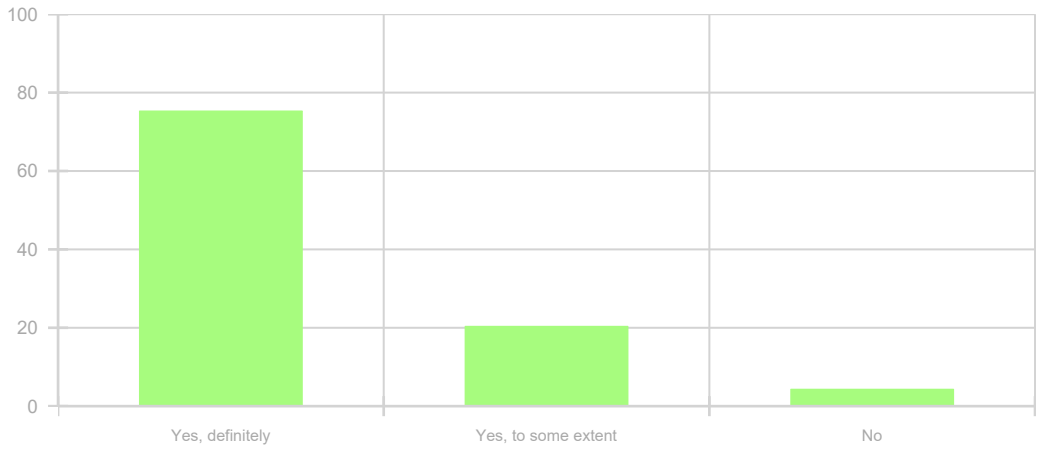
161 MRS BASE



C18: Did you have confidence and trust in the staff caring for you during your labour and birth?

#	Option	n	Weight	%
1	Yes, definitely	122	1.00	75
2	Yes, to some extent	33	0.50	20
3	No	7	0.00	4

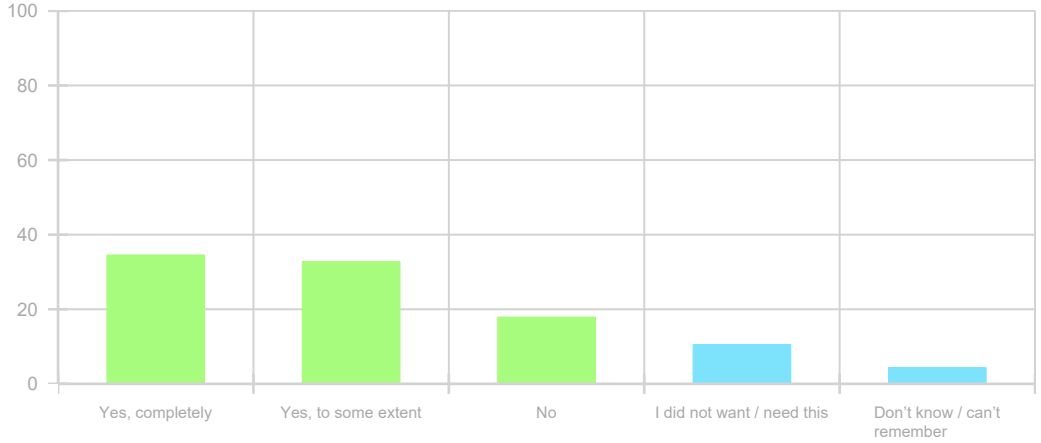
85%	MEAN RATING SCORE	162	MRS BASE



C19: After your baby was born, did you have the opportunity to ask questions about your labour and the birth?

#	Option	n	Weight	%
1	Yes, completely	56	1.00	35
2	Yes, to some extent	53	0.50	33
3	No	29	0.00	18
4	I did not want / need this	17	0.00	10
5	Don’t know / can’t remember	7	0.00	4

60%	MEAN RATING SCORE	138	MRS BASE

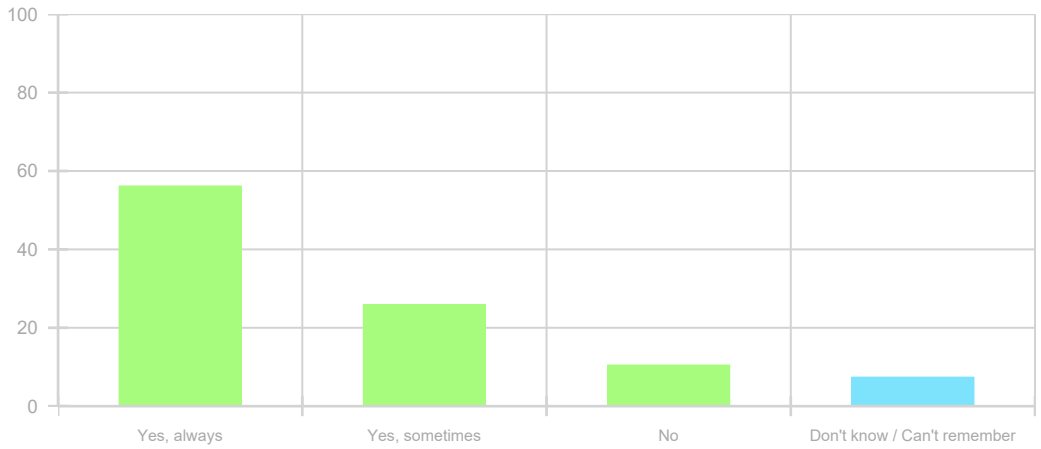


C20: During your labour and birth, did your midwives or doctor appear to be aware of your medical history?

#	Option	n	Weight	%
1	Yes, always	91	1.00	56
2	Yes, sometimes	42	0.50	26
3	No	17	0.00	10
4	Don't know / Can't remember	12	0.00	7

75% MEAN RATING SCORE

150 MRS BASE

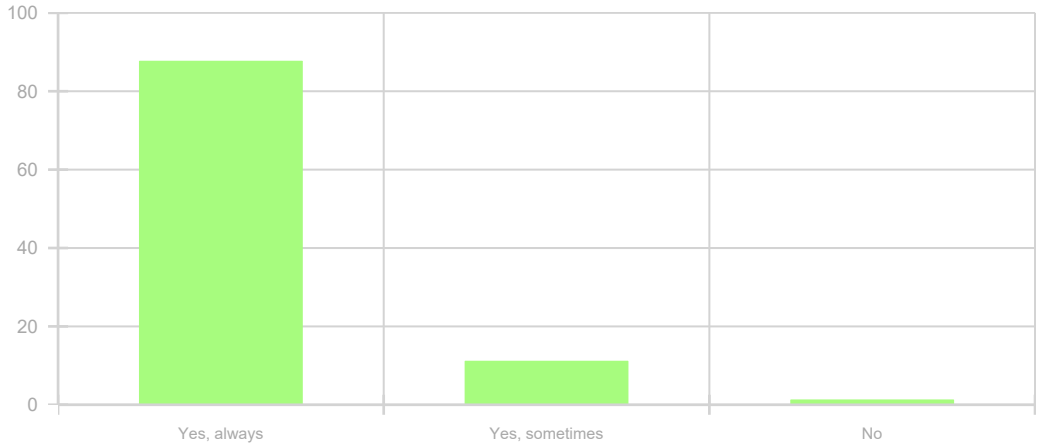


C21: Thinking about your care during labour and birth, were you treated with kindness and compassion?

#	Option	n	Weight	%
1	Yes, always	142	1.00	88
2	Yes, sometimes	18	0.50	11
3	No	2	0.00	1

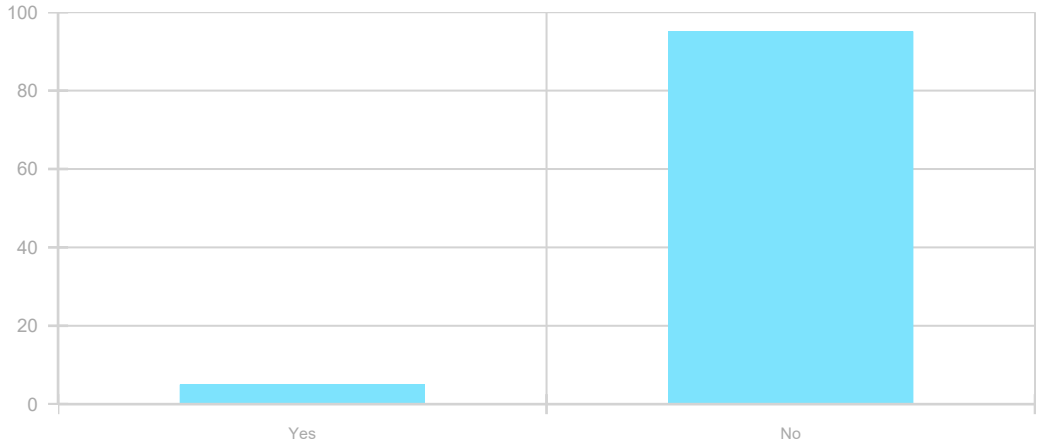
93% MEAN RATING SCORE

162 MRS BASE



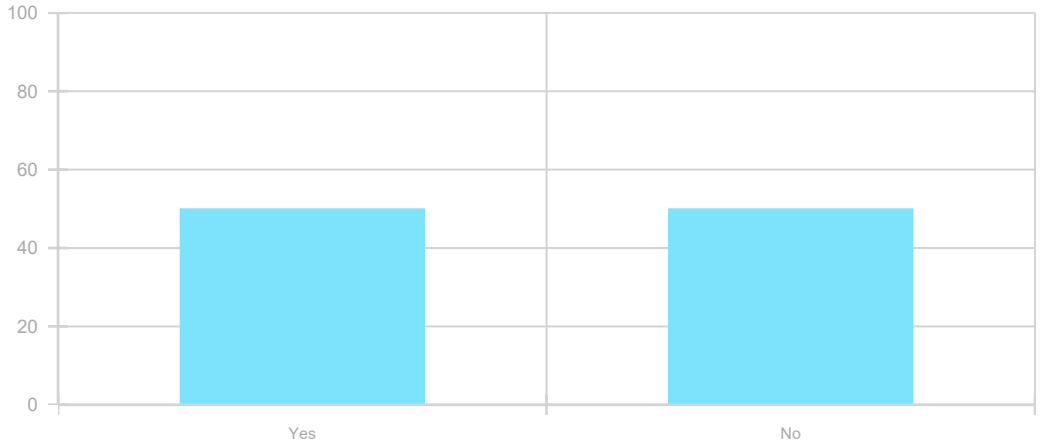
C22: Did you have a home birth?

#	Option	n	Weight	%
1	Yes	8	0.00	5
2	No	154	0.00	95



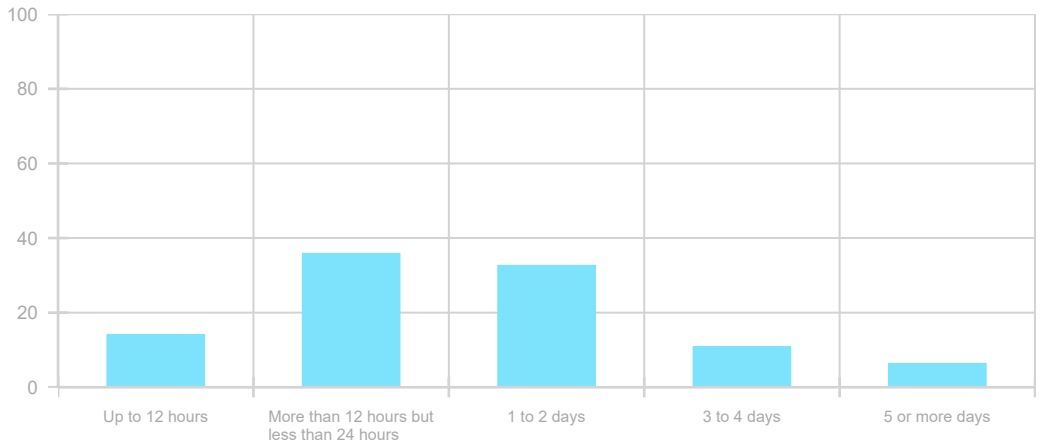
C23: Did you require hospital care immediately after your home birth?

#	Option	n	Weight	%
1	Yes	4	0.00	50
2	No	4	0.00	50



D1: How long did you stay in hospital after your baby was born?

#	Option	n	Weight	%
1	Up to 12 hours	22	0.00	14
2	More than 12 hours but less than 24 hours	56	0.00	36
3	1 to 2 days	51	0.00	33
4	3 to 4 days	17	0.00	11
5	5 or more days	10	0.00	6

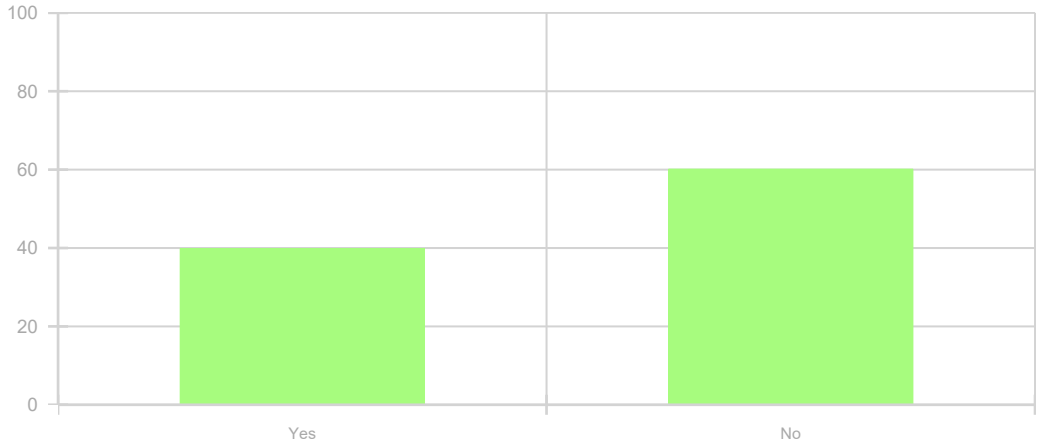


D2: On the day you left hospital, was your discharge delayed for any reason?

#	Option	n	Weight	%
1	Yes	63	0.00	40
2	No	95	1.00	60

60% MEAN RATING SCORE

158 MRS BASE

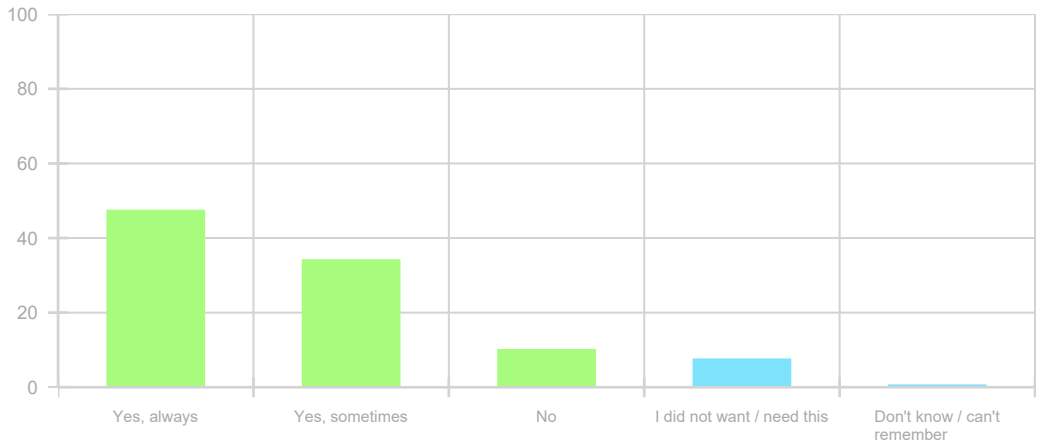


D3: If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?

#	Option	n	Weight	%
1	Yes, always	75	1.00	47
2	Yes, sometimes	54	0.50	34
3	No	16	0.00	10
4	I did not want / need this	12	0.00	8
5	Don't know / can't remember	1	0.00	1

70% MEAN RATING SCORE

145 MRS BASE

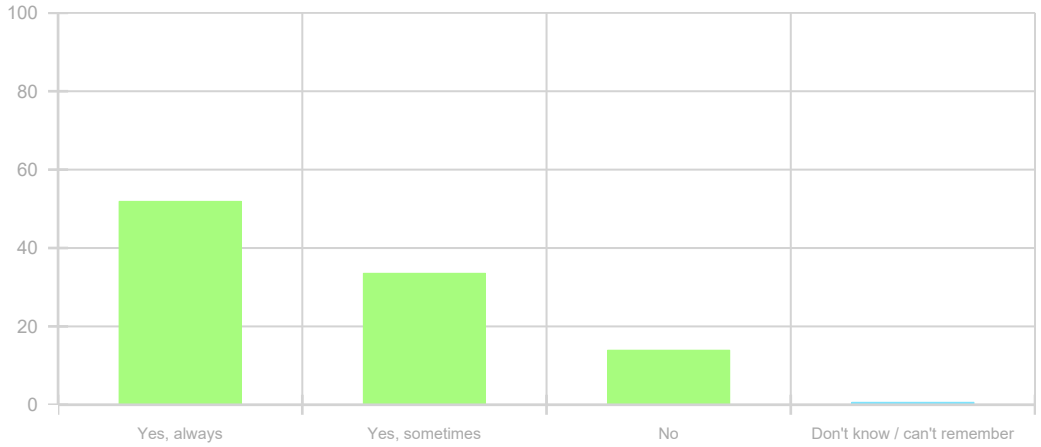


D4: Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?

#	Option	n	Weight	%
1	Yes, always	82	1.00	52
2	Yes, sometimes	53	0.50	34
3	No	22	0.00	14
4	Don't know / can't remember	1	0.00	1

69% MEAN RATING SCORE

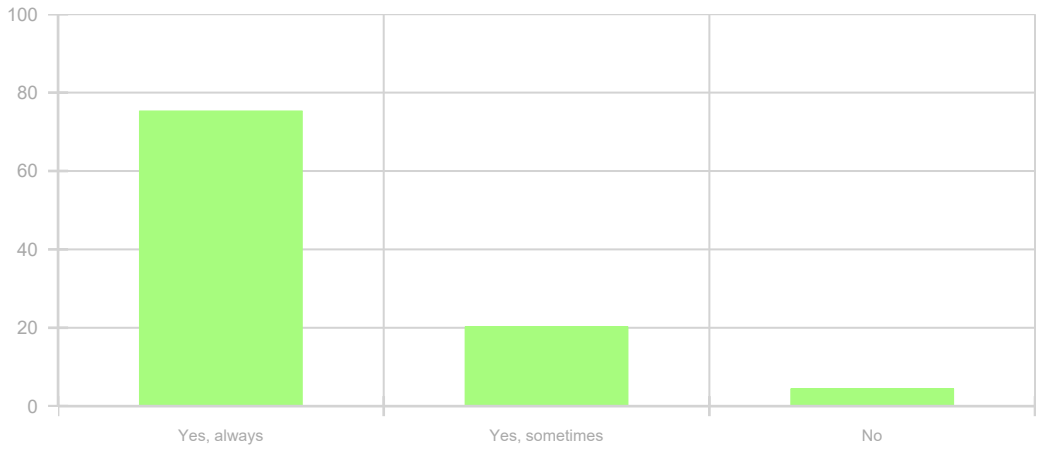
157 MRS BASE



D5: Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

#	Option	n	Weight	%
1	Yes, always	119	1.00	75
2	Yes, sometimes	32	0.50	20
3	No	7	0.00	4

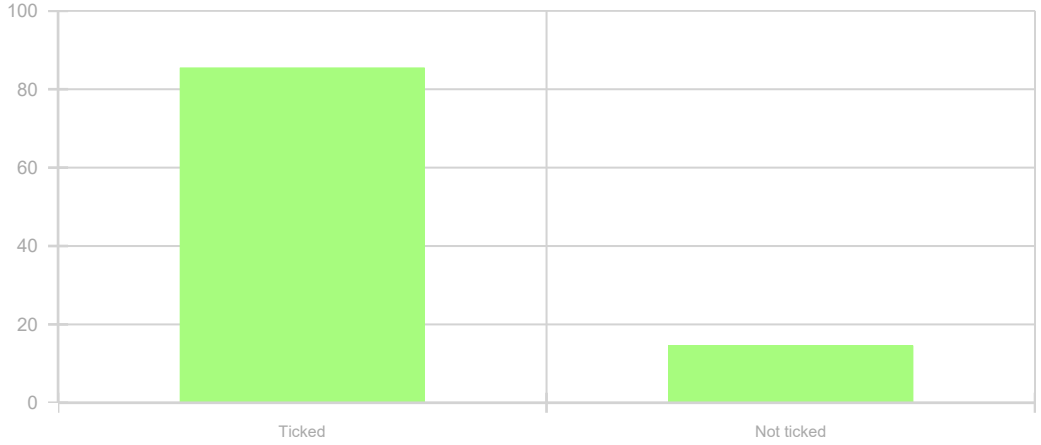
85%	MEAN RATING SCORE	158	MRS BASE



D6_1: Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted: Yes

#	Option	n	Weight	%
1	Ticked	135	1.00	85
2	Not ticked	23	0.00	15

85%	MEAN RATING SCORE	158	MRS BASE

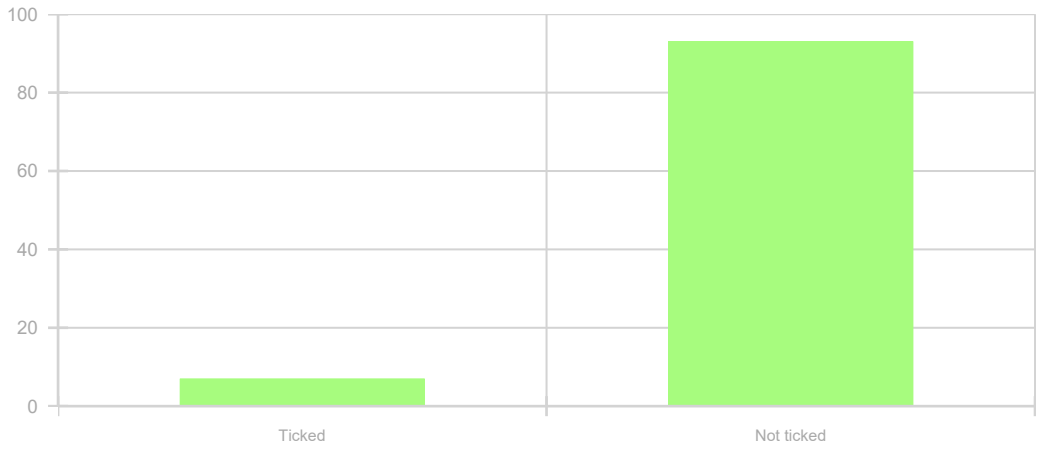


D6_2: Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted: No, as they were restricted to visiting hours

#	Option	n	Weight	%
1	Ticked	11	0.00	7
2	Not ticked	147	1.00	93

93% MEAN RATING SCORE

158 MRS BASE

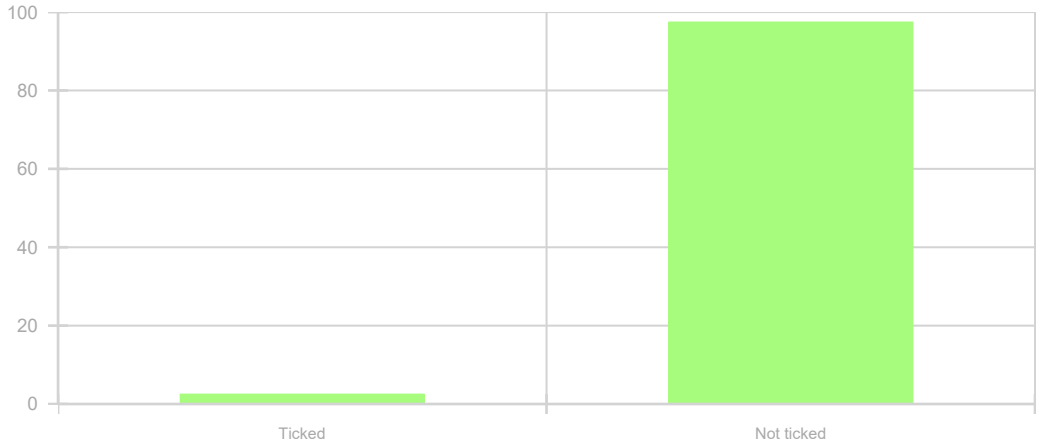


D6_3: Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted: No, as there was no accommodation for them in the hospital

#	Option	n	Weight	%
1	Ticked	4	0.00	3
2	Not ticked	154	1.00	97

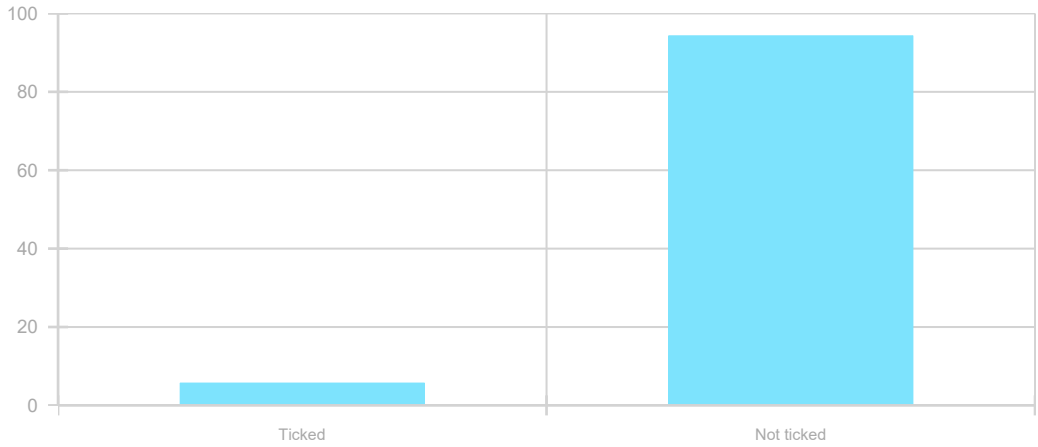
97% MEAN RATING SCORE

158 MRS BASE



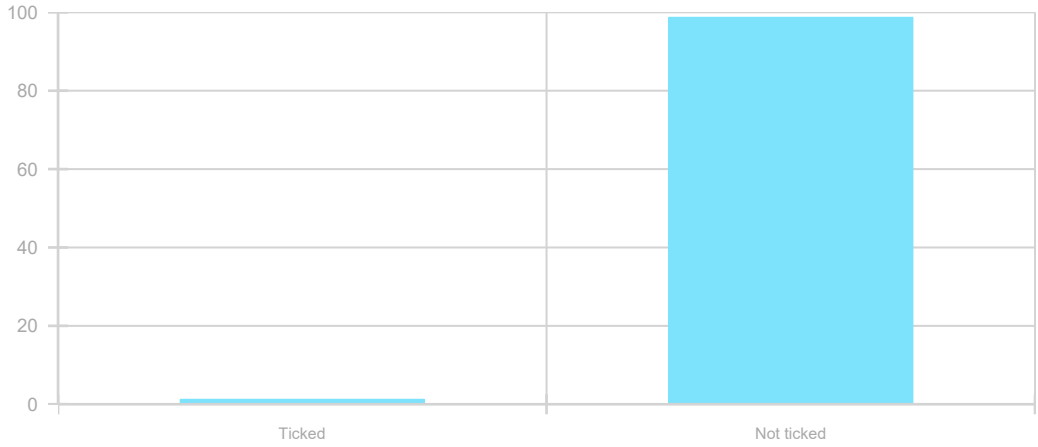
D6_4: Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted: No, they were not able to stay for another reason

#	Option	n	Weight	%
1	Ticked	9	0.00	6
2	Not ticked	149	0.00	94



D6_5: Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted: I did not have a partner / companion with me

#	Option	n	Weight	%
1	Ticked	2	0.00	1
2	Not ticked	156	0.00	99

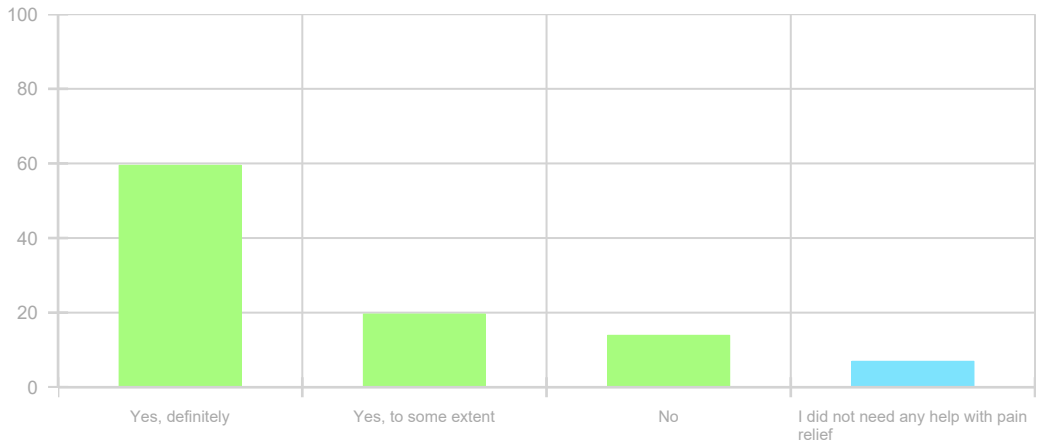


D7: Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?

#	Option	n	Weight	%
1	Yes, definitely	94	1.00	59
2	Yes, to some extent	31	0.50	20
3	No	22	0.00	14
4	I did not need any help with pain relief	11	0.00	7

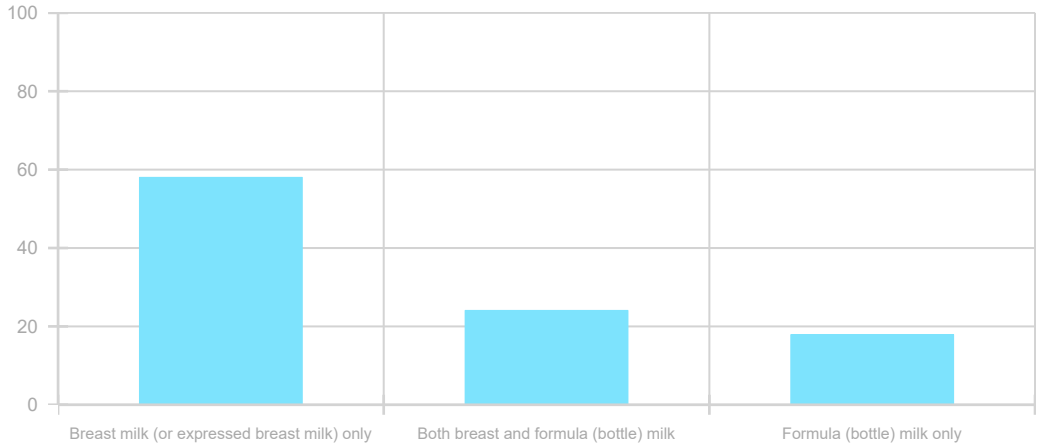
74% MEAN RATING SCORE

147 MRS BASE



E1: In the first few days after the birth how was your baby fed?

#	Option	n	Weight	%
1	Breast milk (or expressed breast milk) only	94	0.00	58
2	Both breast and formula (bottle) milk	39	0.00	24
3	Formula (bottle) milk only	29	0.00	18

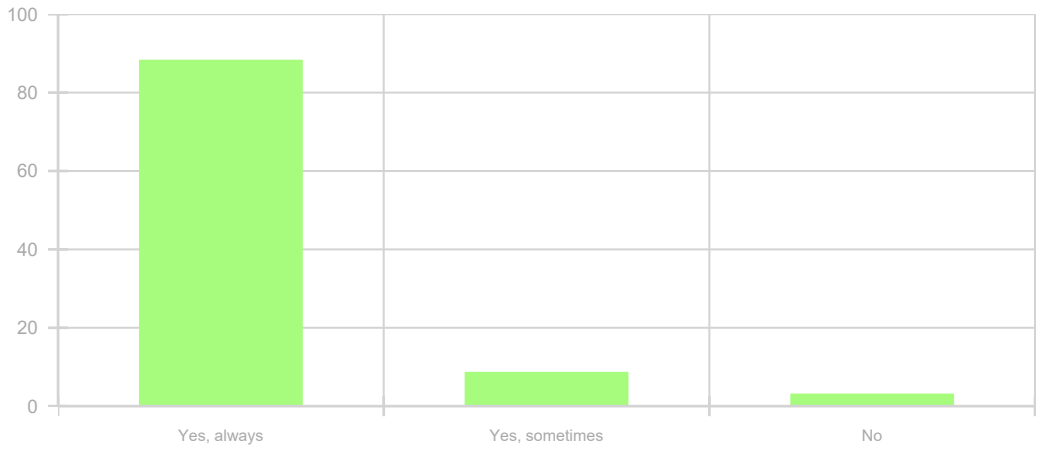


E2: Were your decisions about how you wanted to feed your baby respected by midwives?

#	Option	n	Weight	%
1	Yes, always	143	1.00	88
2	Yes, sometimes	14	0.50	9
3	No	5	0.00	3

93% MEAN RATING SCORE

162 MRS BASE

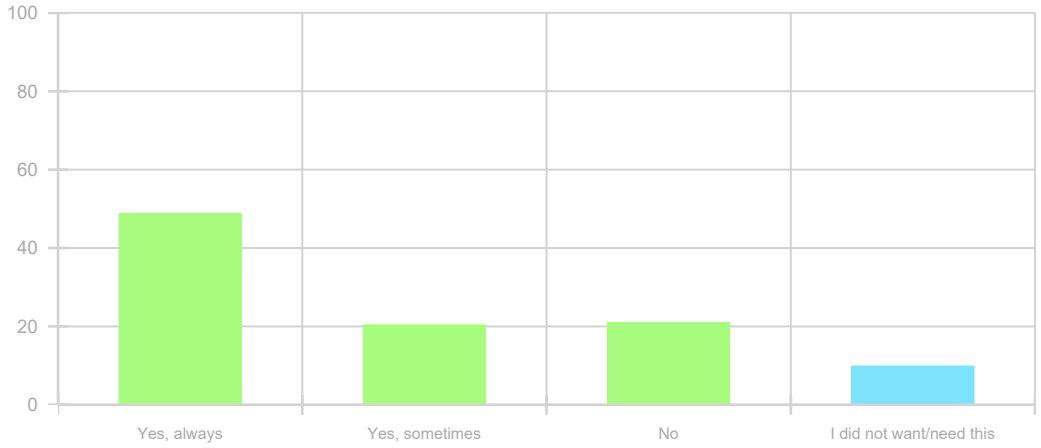


E3: Did you feel that midwives gave you enough support and advice to feed your baby?

#	Option	n	Weight	%
1	Yes, always	79	1.00	49
2	Yes, sometimes	33	0.50	20
3	No	34	0.00	21
4	I did not want/need this	16	0.00	10

65% MEAN RATING SCORE

146 MRS BASE

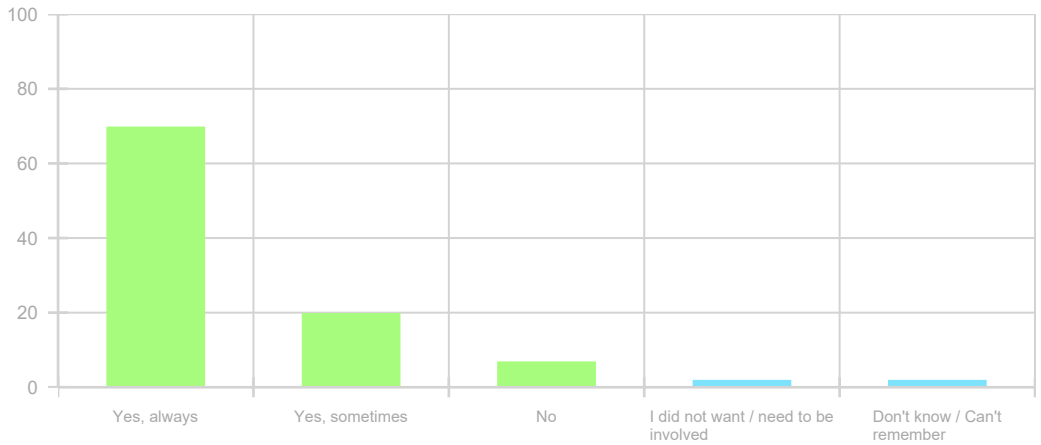


F1: Thinking about your postnatal care, were you involved in decisions about your care?

#	Option	n	Weight	%
1	Yes, always	113	1.00	70
2	Yes, sometimes	32	0.50	20
3	No	11	0.00	7
4	I did not want / need to be involved	3	0.00	2
5	Don't know / Can't remember	3	0.00	2

83% MEAN RATING SCORE

156 MRS BASE

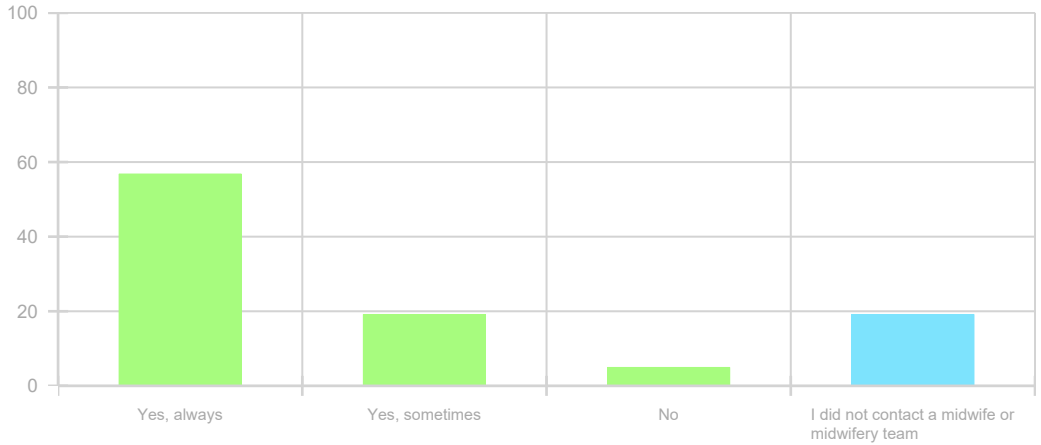


F2: If you contacted a midwife / midwifery team, were you given the help you needed?

#	Option	n	Weight	%
1	Yes, always	92	1.00	57
2	Yes, sometimes	31	0.50	19
3	No	8	0.00	5
4	I did not contact a midwife or midwifery team	31	0.00	19

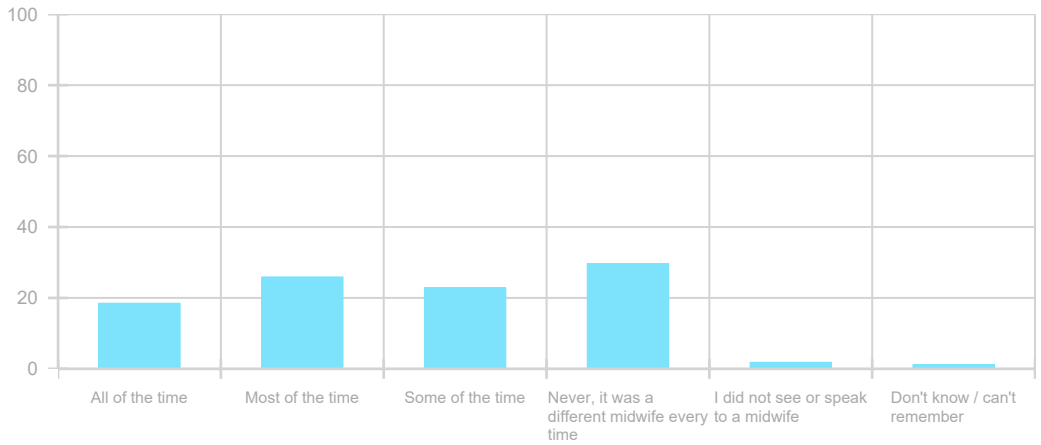
82% MEAN RATING SCORE

131 MRS BASE



F3: At your postnatal check-ups, how often did you see or speak to the same midwife?

#	Option	n	Weight	%
1	All of the time	30	0.00	19
2	Most of the time	42	0.00	26
3	Some of the time	37	0.00	23
4	Never, it was a different midwife every time	48	0.00	30
5	I did not see or speak to a midwife	3	0.00	2
6	Don't know / can't remember	2	0.00	1

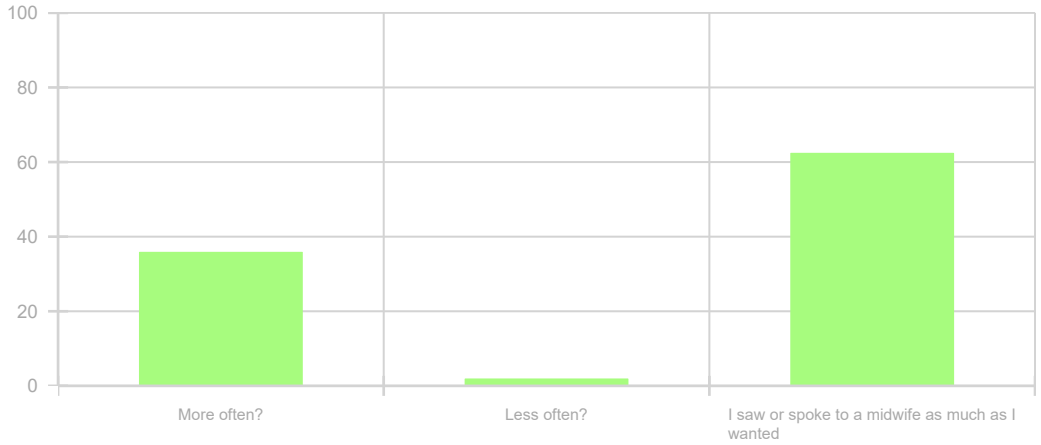


F4: Would you have liked to have seen or spoken to a midwife...

#	Option	n	Weight	%
1	More often?	58	0.00	36
2	Less often?	3	0.00	2
3	I saw or spoke to a midwife as much as I wanted	101	1.00	62

62% MEAN RATING SCORE

162 MRS BASE

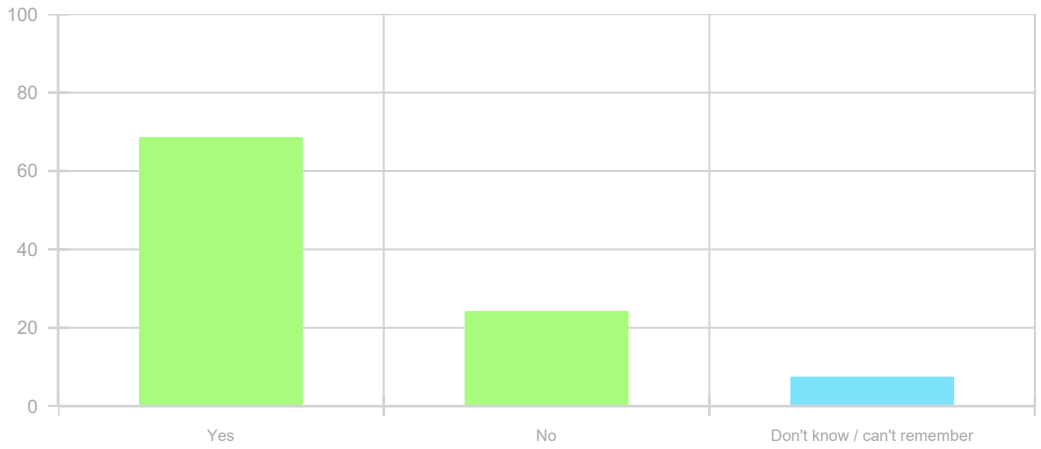


F5: Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?

#	Option	n	Weight	%
1	Yes	111	1.00	69
2	No	39	0.00	24
3	Don't know / can't remember	12	0.00	7

74% MEAN RATING SCORE

150 MRS BASE

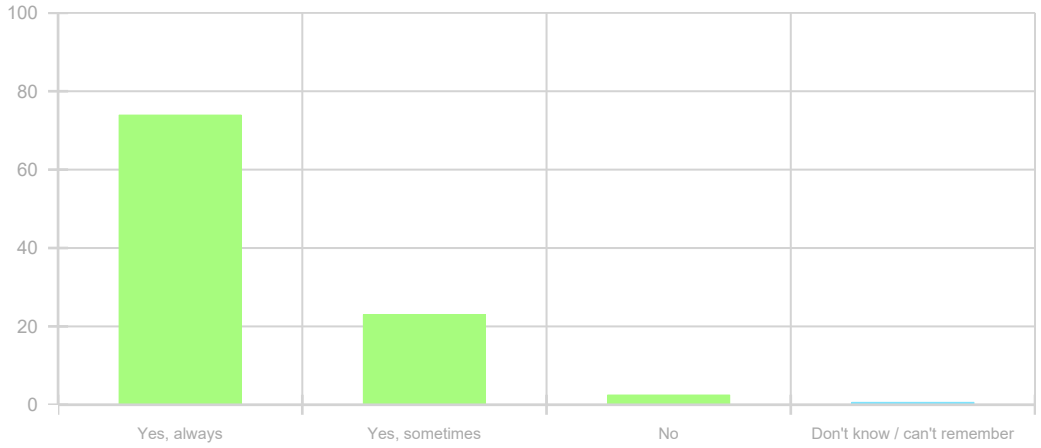


F6: Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?

#	Option	n	Weight	%
1	Yes, always	119	1.00	74
2	Yes, sometimes	37	0.50	23
3	No	4	0.00	2
4	Don't know / can't remember	1	0.00	1

86% MEAN RATING SCORE

160 MRS BASE

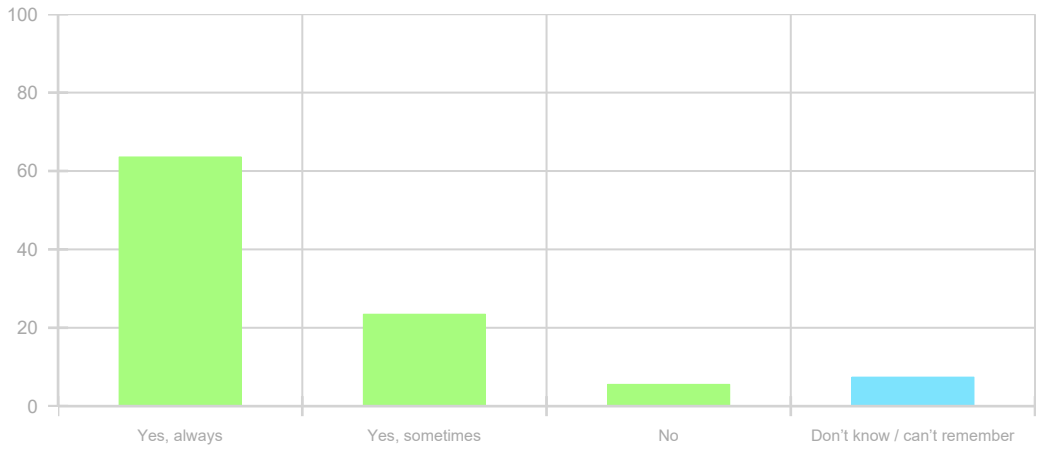


F7: Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?

#	Option	n	Weight	%
1	Yes, always	103	1.00	64
2	Yes, sometimes	38	0.50	23
3	No	9	0.00	6
4	Don’t know / can’t remember	12	0.00	7

81% MEAN RATING SCORE

150 MRS BASE

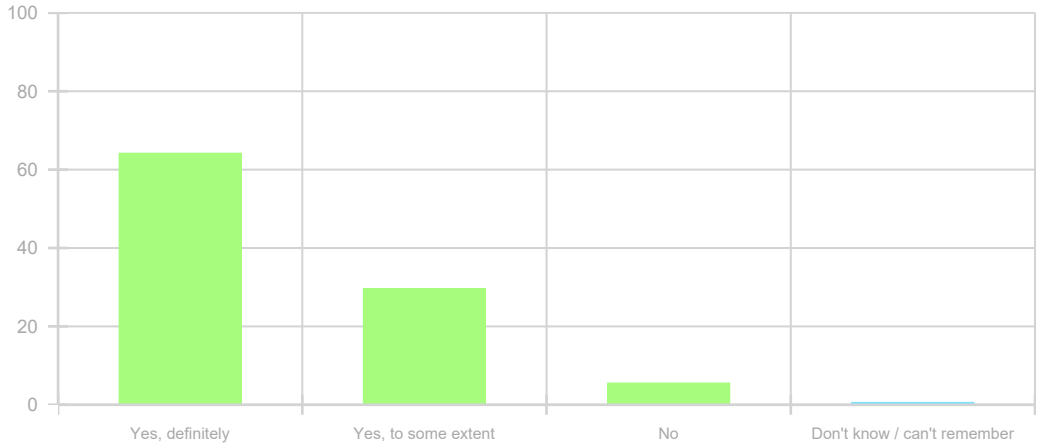


F8: Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?

#	Option	n	Weight	%
1	Yes, definitely	104	1.00	64
2	Yes, to some extent	48	0.50	30
3	No	9	0.00	6
4	Don't know / can't remember	1	0.00	1

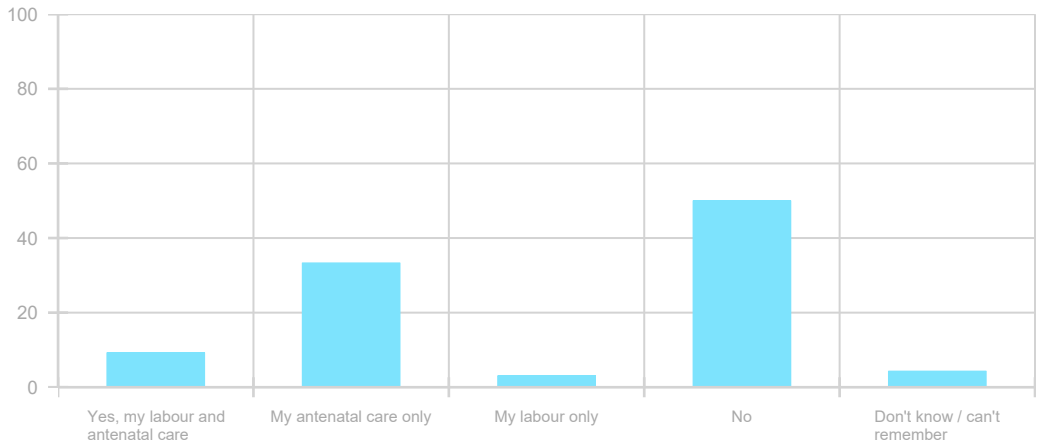
80% MEAN RATING SCORE

161 MRS BASE



F9: Had any midwives who cared for you postnatally also been involved in your labour and antenatal care?

#	Option	n	Weight	%
1	Yes, my labour and antenatal care	15	0.00	9
2	My antenatal care only	54	0.00	33
3	My labour only	5	0.00	3
4	No	81	0.00	50
5	Don't know / can't remember	7	0.00	4

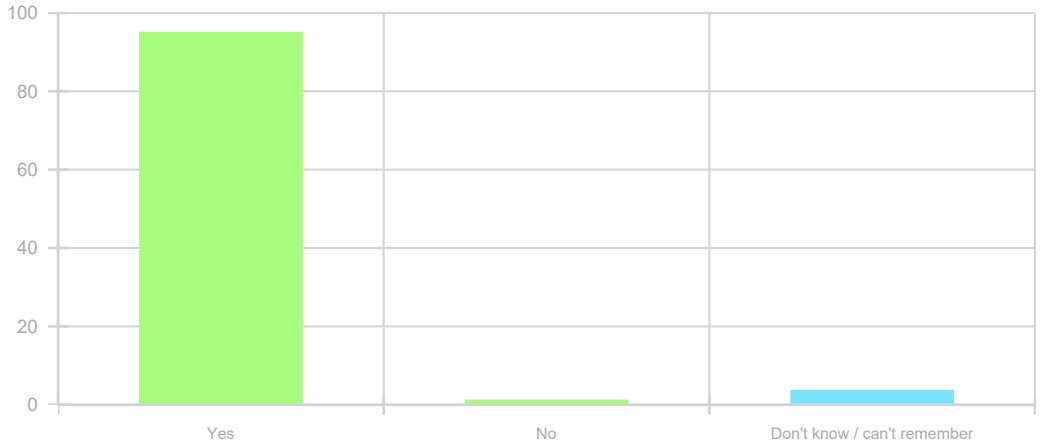


F10: Did a midwife or health visitor ask you about your mental health?

#	Option	n	Weight	%
1	Yes	154	1.00	95
2	No	2	0.00	1
3	Don't know / can't remember	6	0.00	4

99% MEAN RATING SCORE

156 MRS BASE

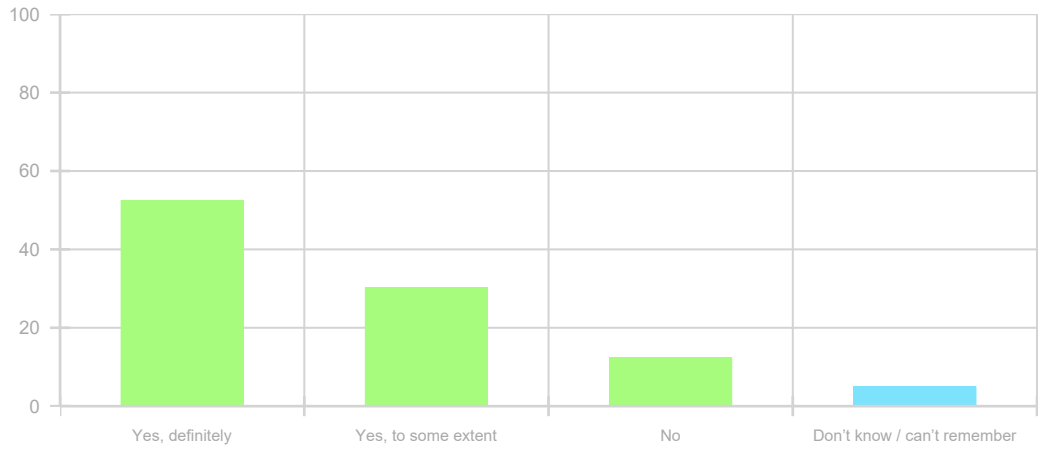


F11: Were you given information about any changes you might experience to your mental health after having your baby?

#	Option	n	Weight	%
1	Yes, definitely	85	1.00	52
2	Yes, to some extent	49	0.50	30
3	No	20	0.00	12
4	Don’t know / can’t remember	8	0.00	5

71% MEAN RATING SCORE

154 MRS BASE

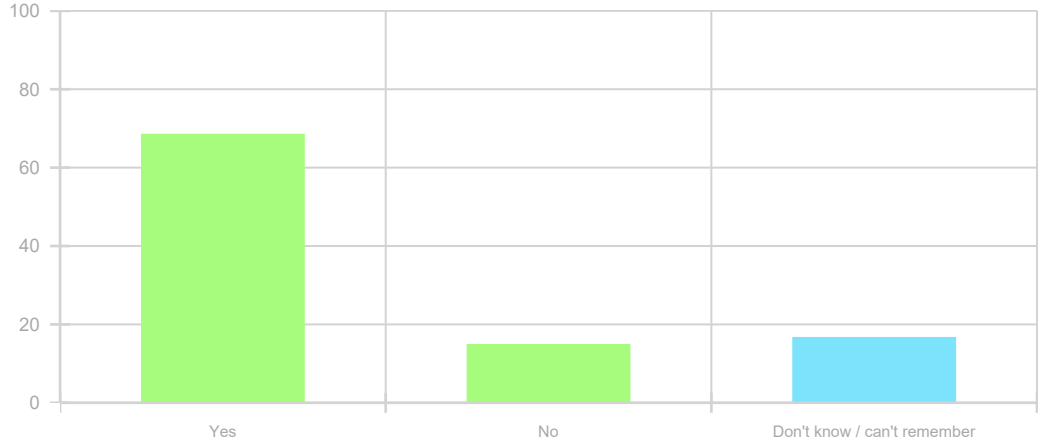


F12: Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?

#	Option	n	Weight	%
1	Yes	111	1.00	69
2	No	24	0.00	15
3	Don't know / can't remember	27	0.00	17

82% MEAN RATING SCORE

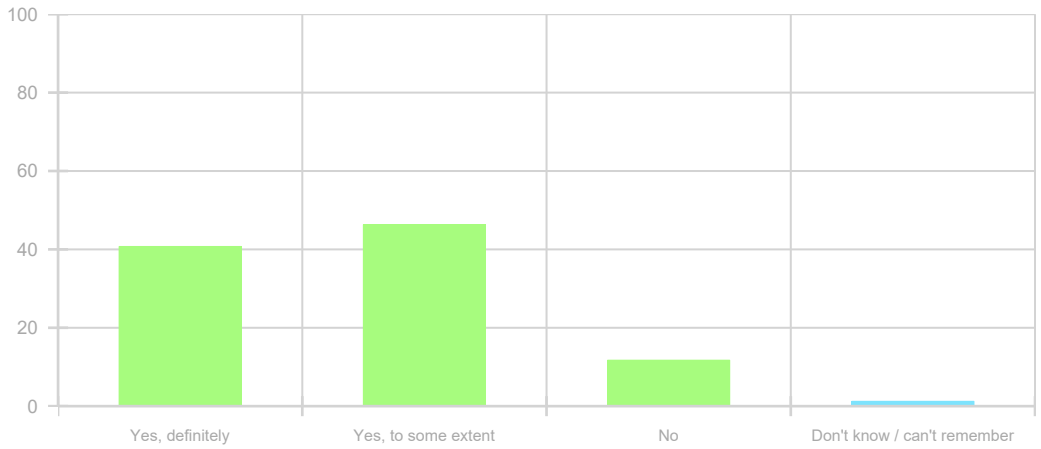
135 MRS BASE



F13: Were you given enough information about your own physical recovery after the birth?

#	Option	n	Weight	%
1	Yes, definitely	66	1.00	41
2	Yes, to some extent	75	0.50	46
3	No	19	0.00	12
5	Don't know / can't remember	2	0.00	1

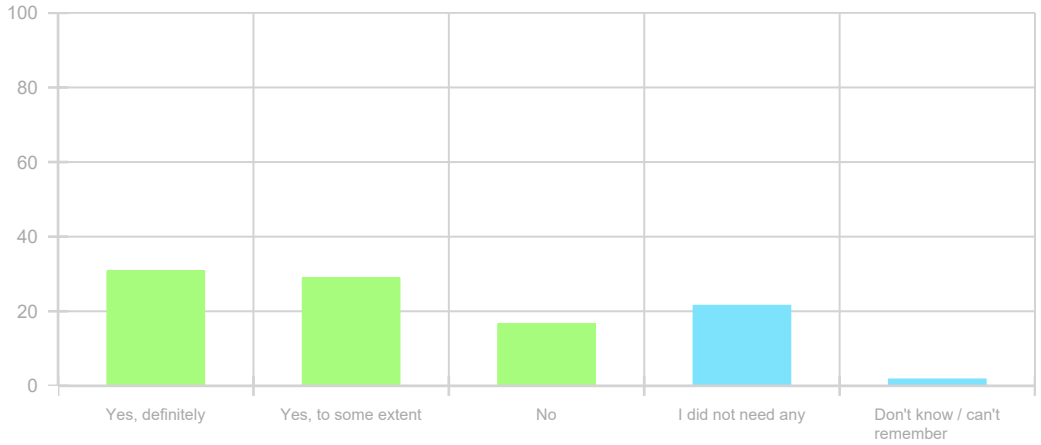
65%	MEAN RATING SCORE
160	MRS BASE



F14: In the four weeks after the birth of your baby did you receive help and advice from a midwife about feeding your baby?

#	Option	n	Weight	%
1	Yes, definitely	50	1.00	31
2	Yes, to some extent	47	0.50	29
3	No	27	0.00	17
4	I did not need any	35	0.00	22
5	Don't know / can't remember	3	0.00	2

59%	MEAN RATING SCORE
124	MRS BASE

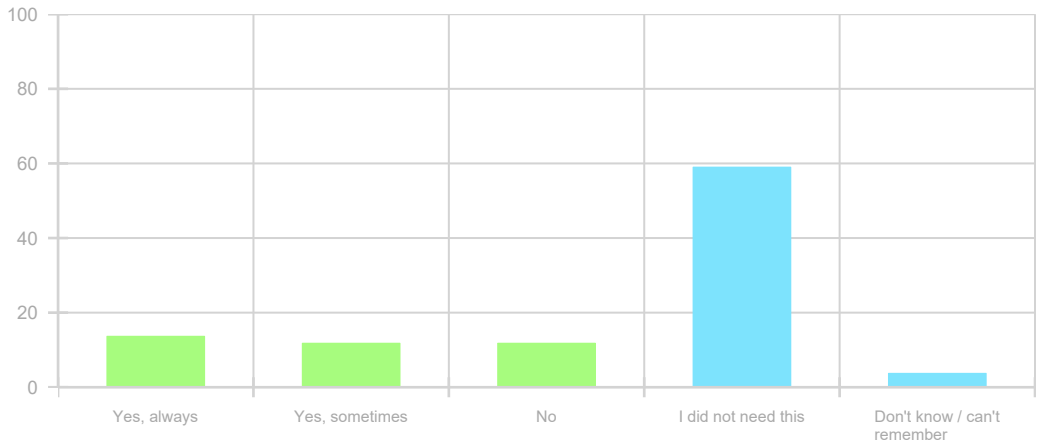


F15: If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?

#	Option	n	Weight	%
1	Yes, always	22	1.00	14
2	Yes, sometimes	19	0.50	12
3	No	19	0.00	12
4	I did not need this	95	0.00	59
5	Don't know / can't remember	6	0.00	4

53% MEAN RATING SCORE

60 MRS BASE

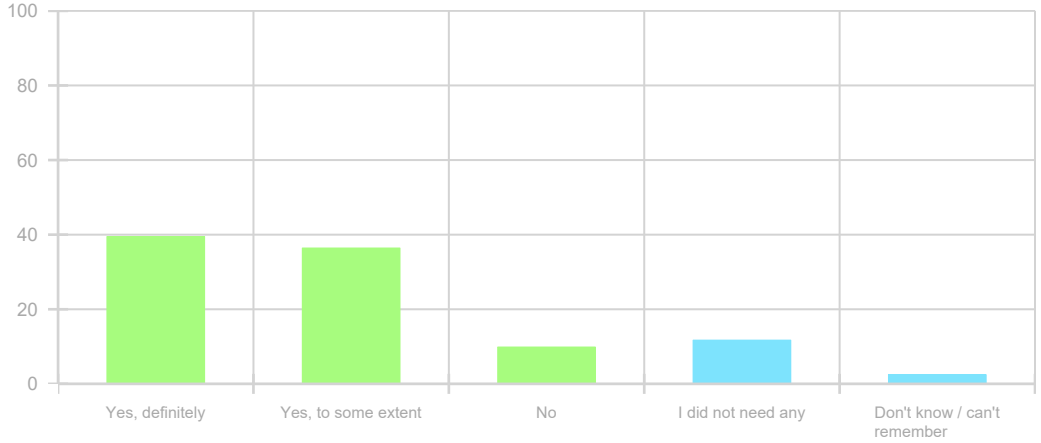


F16: In the four weeks after the birth of your baby did you receive help and advice from midwives about your baby's health and progress?

#	Option	n	Weight	%
1	Yes, definitely	64	1.00	40
2	Yes, to some extent	59	0.50	36
3	No	16	0.00	10
4	I did not need any	19	0.00	12
5	Don't know / can't remember	4	0.00	2

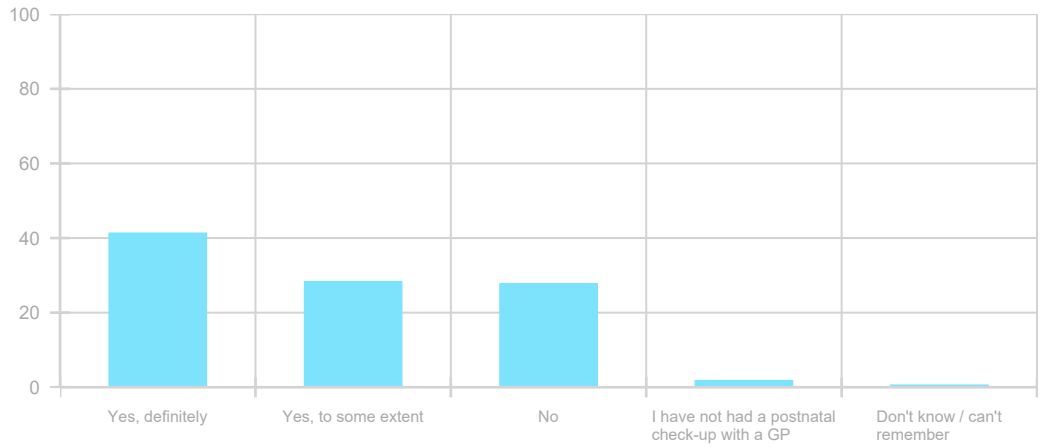
67% MEAN RATING SCORE

139 MRS BASE



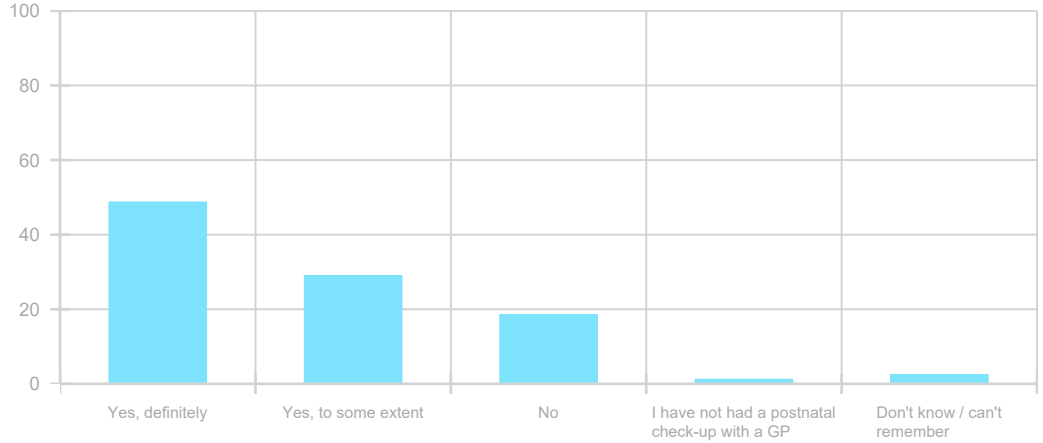
F17: At the postnatal check-up (around 6-8 weeks after the birth), did the GP spend enough time talking to you about your own physical health?

#	Option	n	Weight	%
1	Yes, definitely	67	0.00	41
2	Yes, to some extent	46	0.00	28
3	No	45	0.00	28
4	I have not had a postnatal check-up with a GP	3	0.00	2
5	Don't know / can't remember	1	0.00	1



F18: At the postnatal check-up (around 6-8 weeks after the birth), did the GP spend enough time talking to you about your own mental health?

#	Option	n	Weight	%
1	Yes, definitely	79	0.00	49
2	Yes, to some extent	47	0.00	29
3	No	30	0.00	19
4	I have not had a postnatal check-up with a GP	2	0.00	1
5	Don't know / can't remember	4	0.00	2

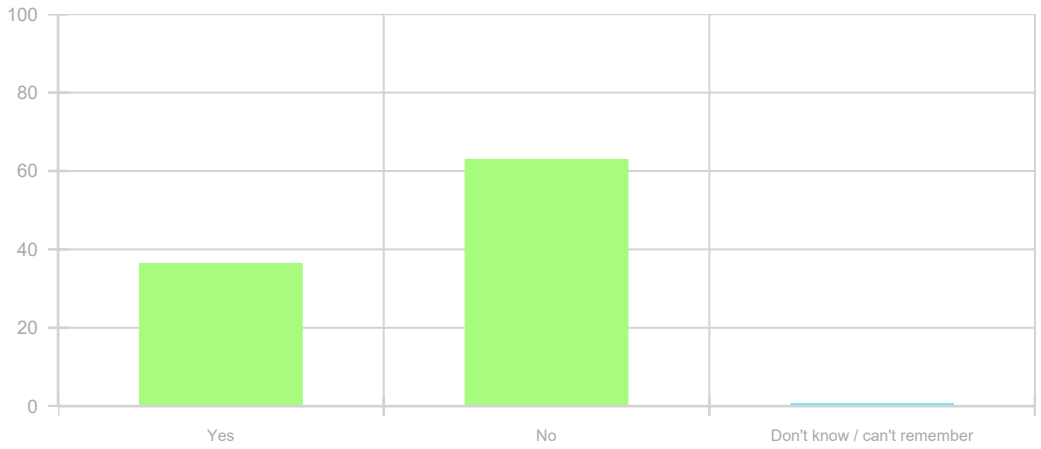


F19: At any point during your maternity care journey, did you consider making a complaint about the care you received?

#	Option	n	Weight	%
1	Yes	59	0.00	36
2	No	102	1.00	63
3	Don't know / can't remember	1	0.00	1

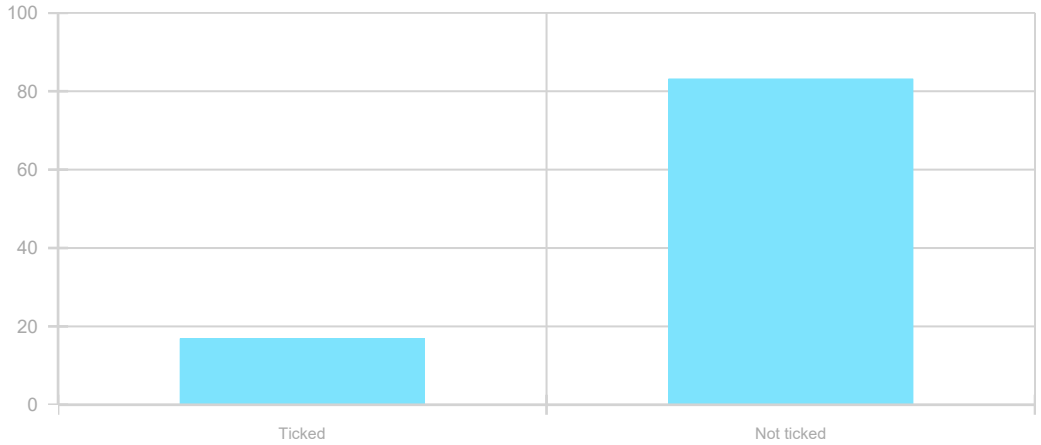
63% MEAN RATING SCORE

161 MRS BASE



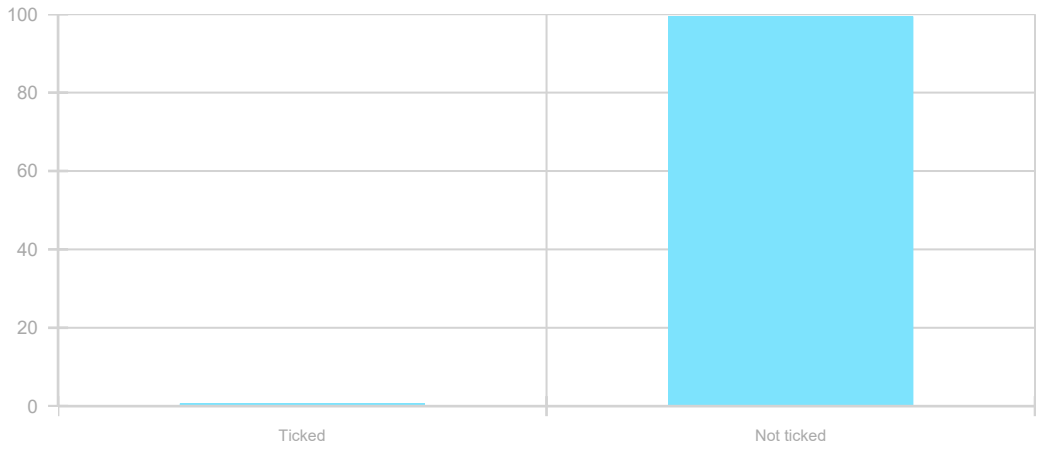
G1_1: Did your baby have any neonatal care? Yes, in a Neonatal Intensive Care Unit (NICU)

#	Option	n	Weight	%
1	Ticked	27	0.00	17
2	Not ticked	133	0.00	83



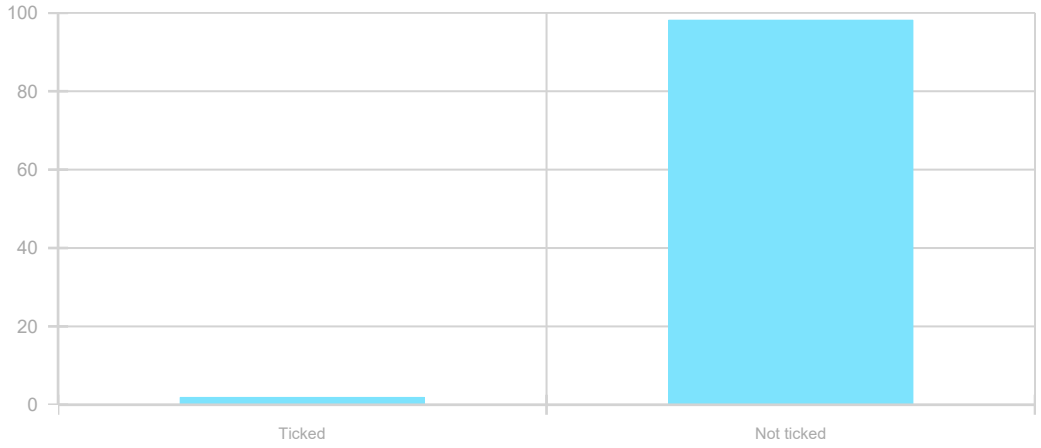
G1_2: Did your baby have any neonatal care? Yes, in a Special Care Baby Unit (SCBU)

#	Option	n	Weight	%
1	Ticked	1	0.00	1
2	Not ticked	159	0.00	99



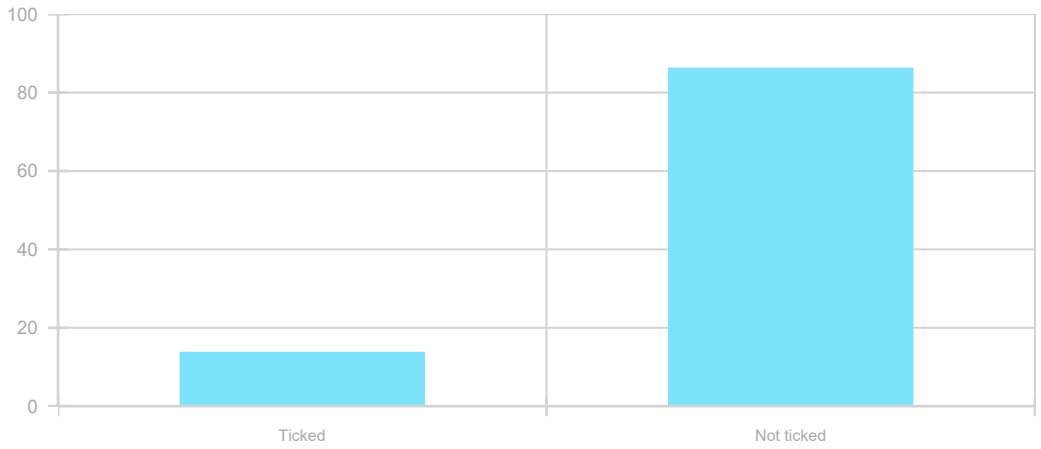
G1_3: Did your baby have any neonatal care? Yes, in the Local Neonatal Unit (LNU)

#	Option	n	Weight	%
1	Ticked	3	0.00	2
2	Not ticked	157	0.00	98



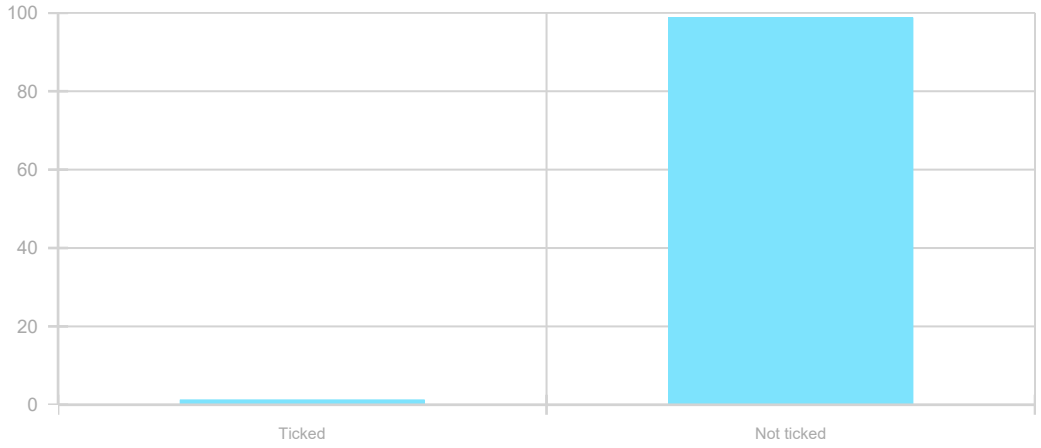
G1_4: Did your baby have any neonatal care? Yes, in the post-natal ward

#	Option	n	Weight	%
1	Ticked	22	0.00	14
2	Not ticked	138	0.00	86



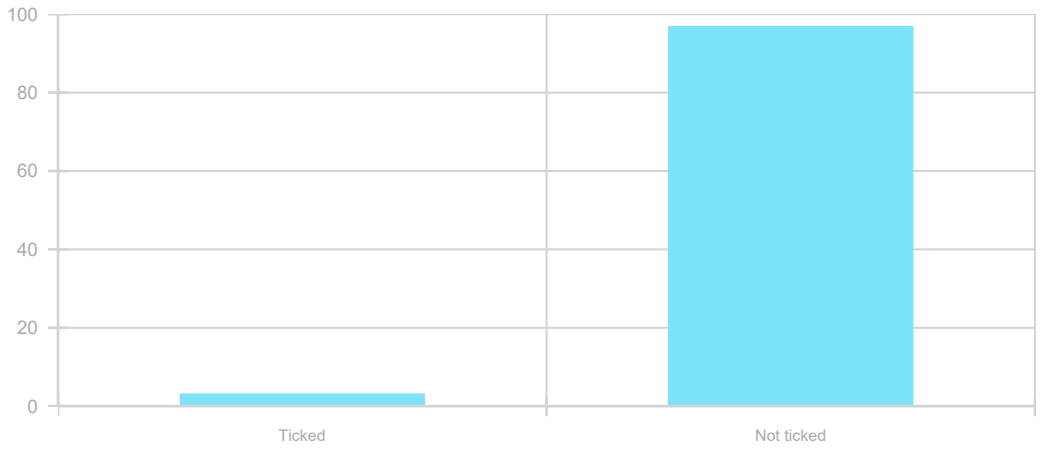
G1_5: Did your baby have any neonatal care? Yes, at home (neonatal outreach service)

#	Option	n	Weight	%
1	Ticked	2	0.00	1
2	Not ticked	158	0.00	99



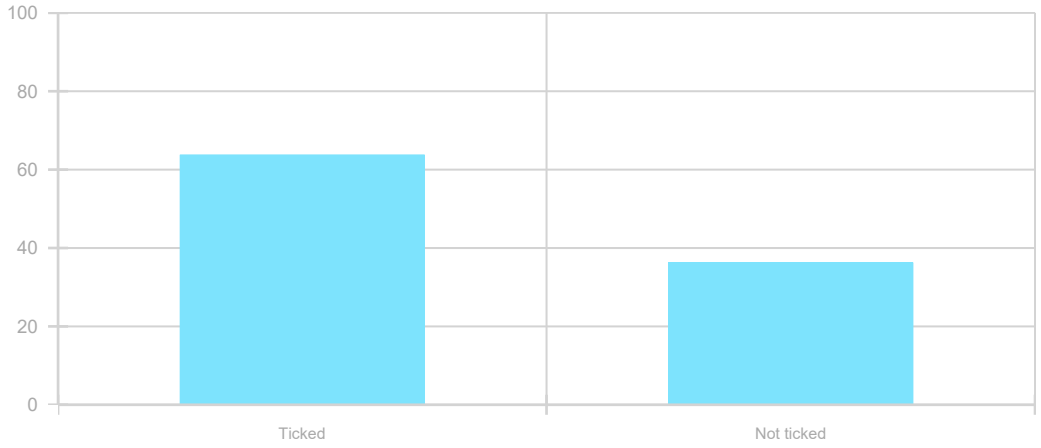
G1_6: Did your baby have any neonatal care? Yes, but I don't know what type of neonatal care

#	Option	n	Weight	%
1	Ticked	5	0.00	3
2	Not ticked	155	0.00	97



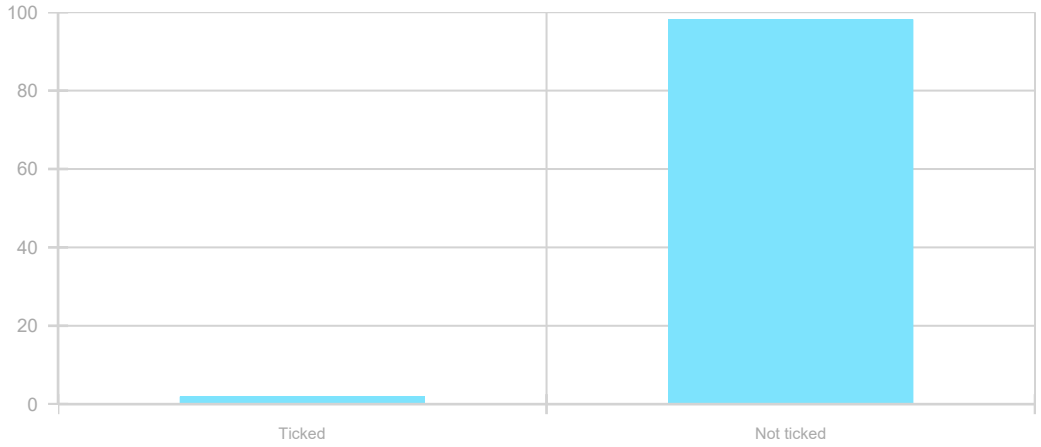
G1_7: Did your baby have any neonatal care? No, my baby did not have neonatal care

#	Option	n	Weight	%
1	Ticked	102	0.00	64
2	Not ticked	58	0.00	36



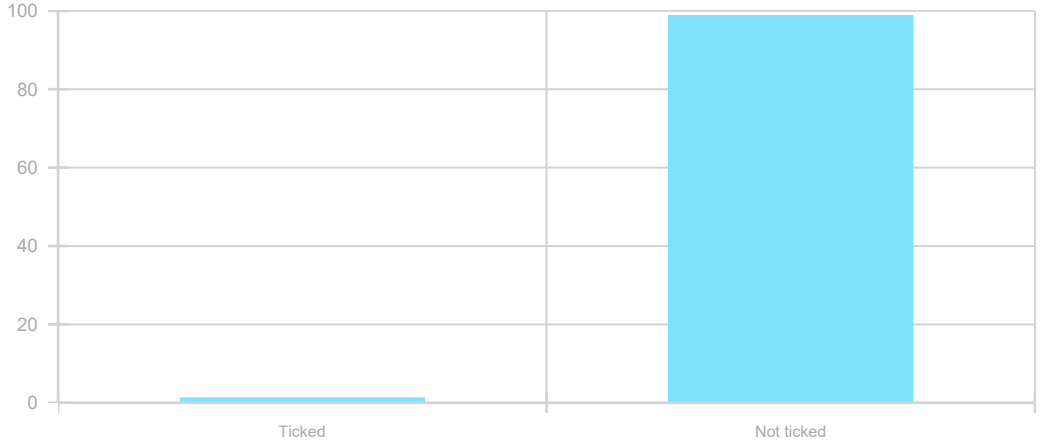
G1_8: Did your baby have any neonatal care? I don’t know if my baby had neonatal care

#	Option	n	Weight	%
1	Ticked	3	0.00	2
2	Not ticked	157	0.00	98



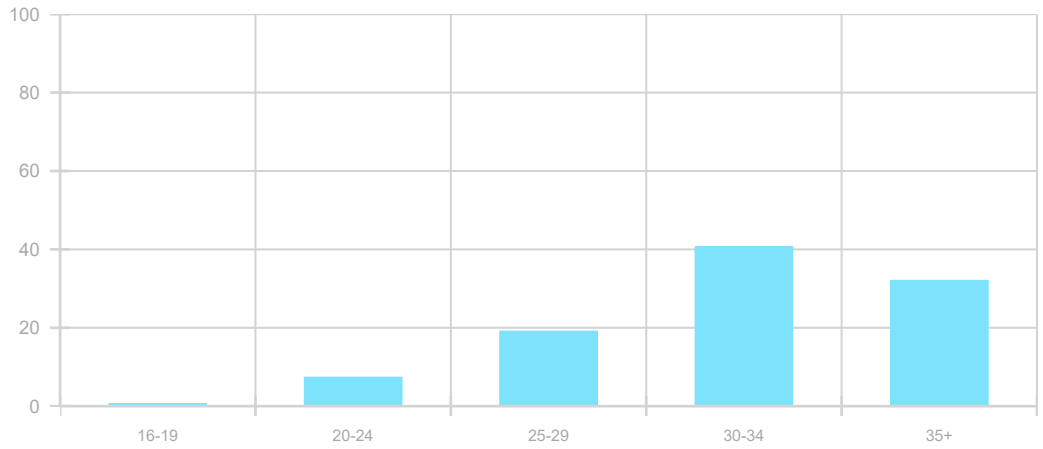
G1_9: Did your baby have any neonatal care? Can’t remember

#	Option	n	Weight	%
1	Ticked	2	0.00	1
2	Not ticked	158	0.00	99



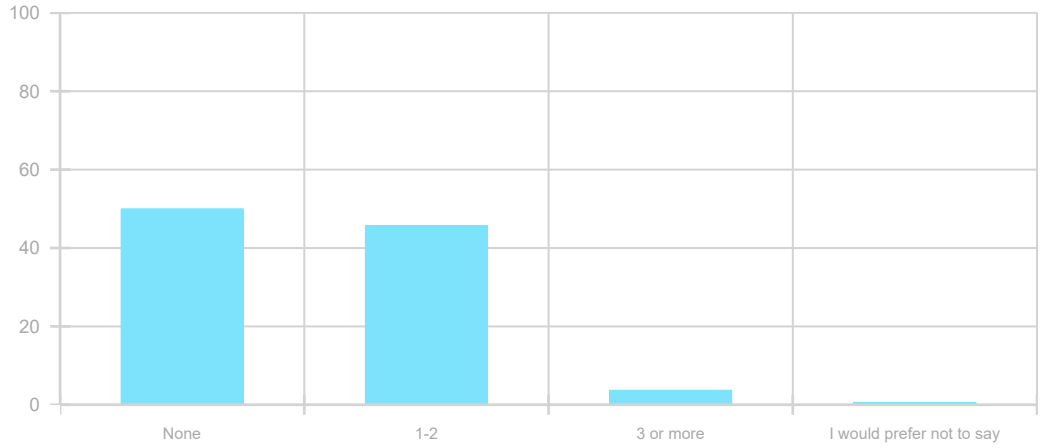
G2: Age

#	Option	n	Weight	%
1	16-19	1	0.00	1
2	20-24	12	0.00	7
3	25-29	31	0.00	19
4	30-34	66	0.00	41
5	35+	52	0.00	32



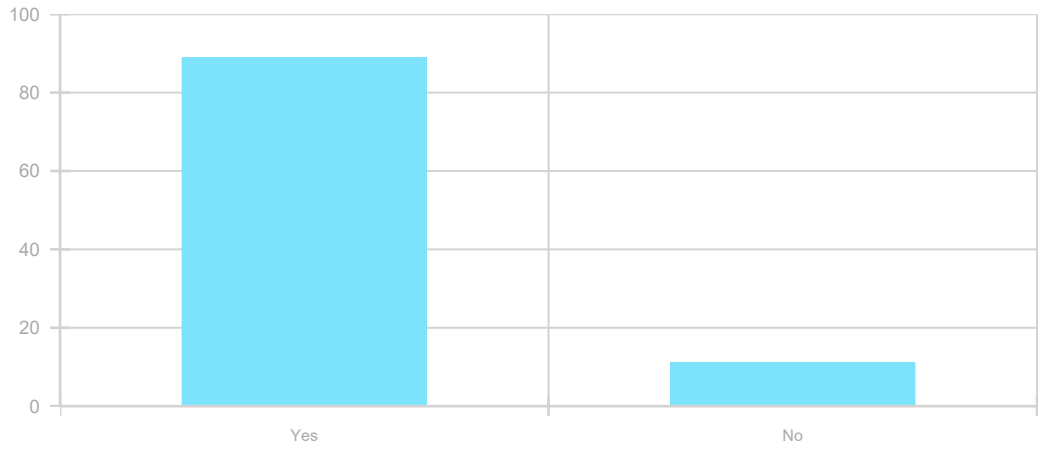
G3: How many babies have you given birth to before this pregnancy?

#	Option	n	Weight	%
1	None	81	0.00	50
2	1-2	74	0.00	46
3	3 or more	6	0.00	4
4	I would prefer not to say	1	0.00	1



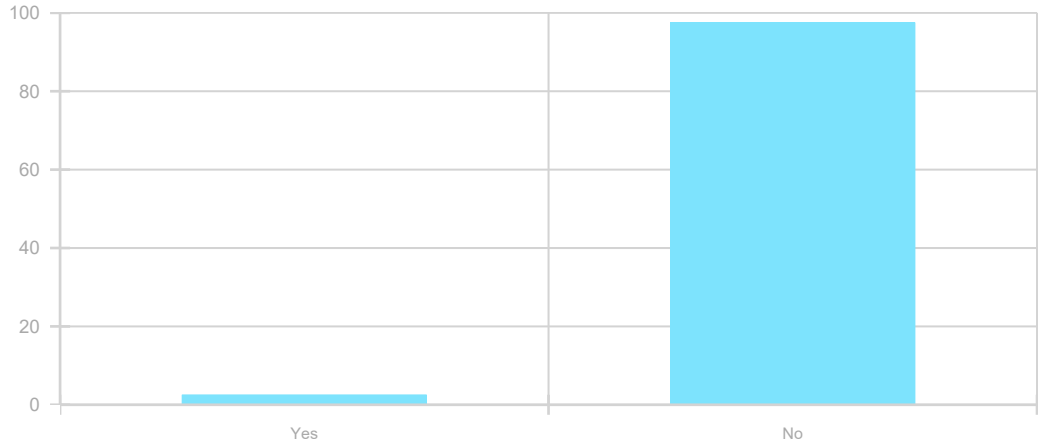
G4: Is English your first language?

#	Option	n	Weight	%
1	Yes	144	0.00	89
2	No	18	0.00	11



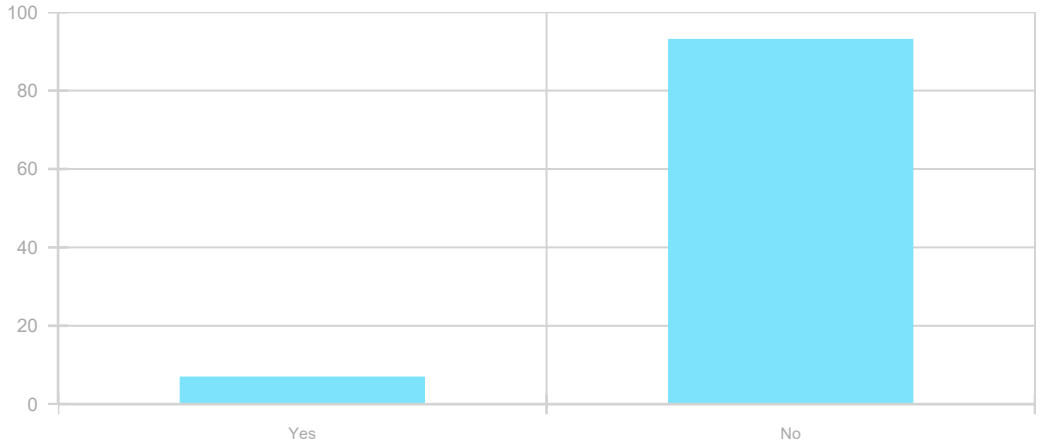
G5_1: Do you have any of the following: Autism or autism spectrum condition

#	Option	n	Weight	%
1	Yes	4	0.00	3
2	No	155	0.00	97



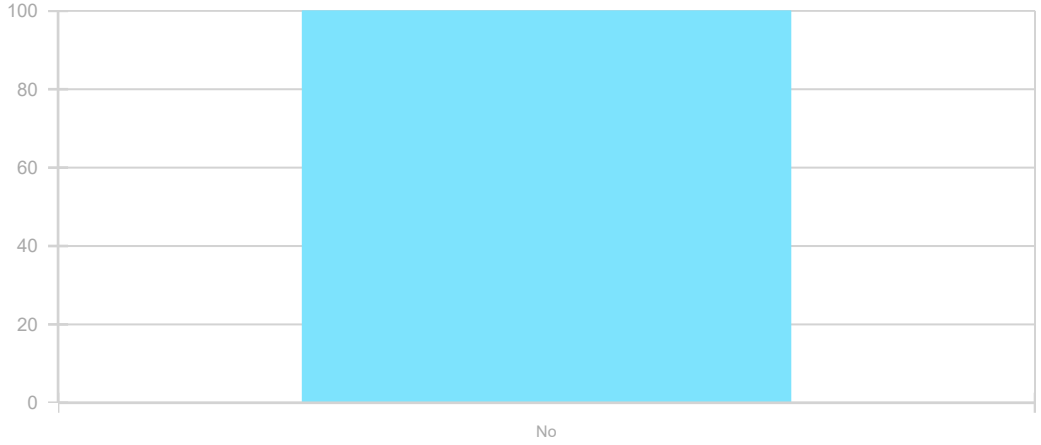
G5_2: Do you have any of the following: Breathing problem, such as asthma

#	Option	n	Weight	%
1	Yes	11	0.00	7
2	No	148	0.00	93



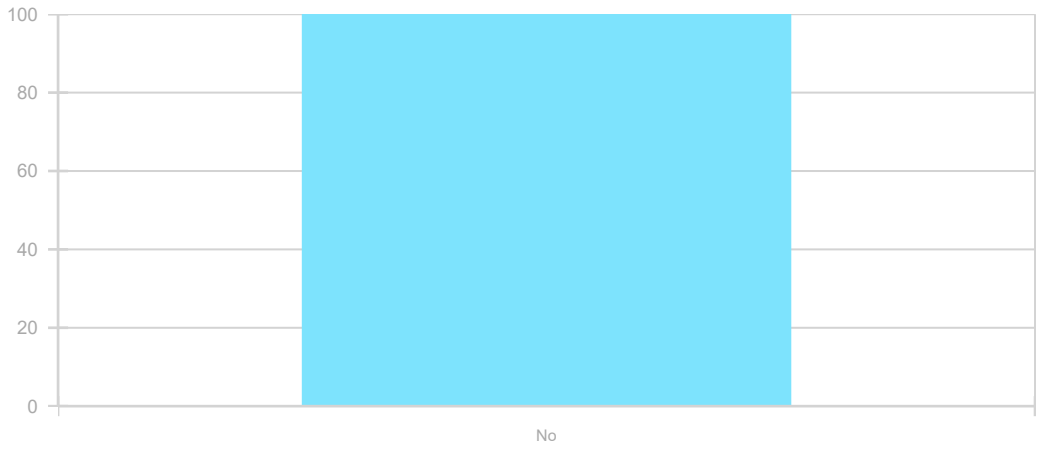
G5_3: Do you have any of the following: Blindness or partial sight

#	Option	n	Weight	%
2	No	159	0.00	100



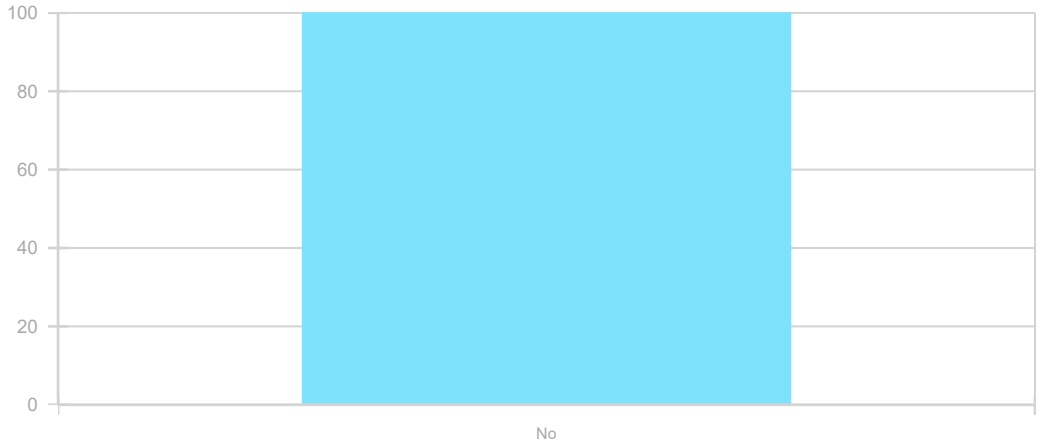
G5_4: Do you have any of the following: Cancer in the last 5 years

#	Option	n	Weight	%
2	No	159	0.00	100



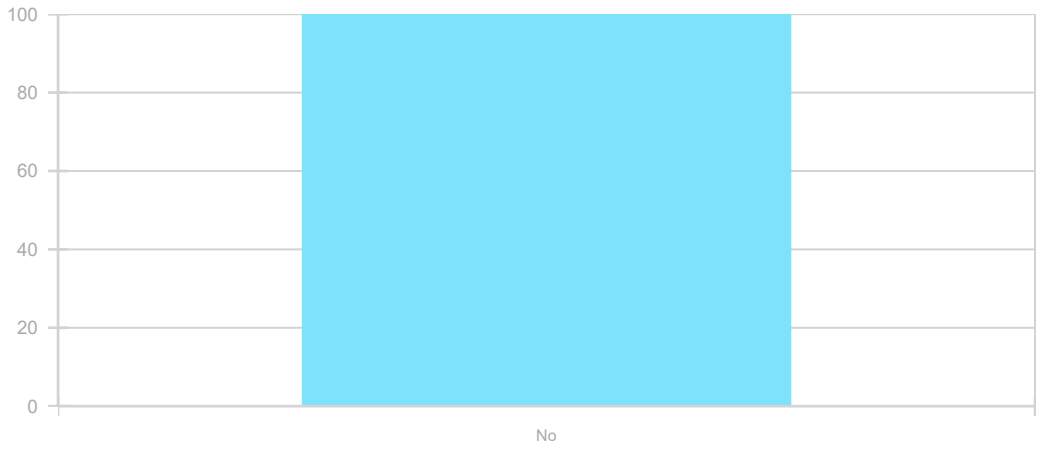
G5_5: Do you have any of the following: Dementia or Alzheimer’s Disease

#	Option	n	Weight	%
2	No	159	0.00	100



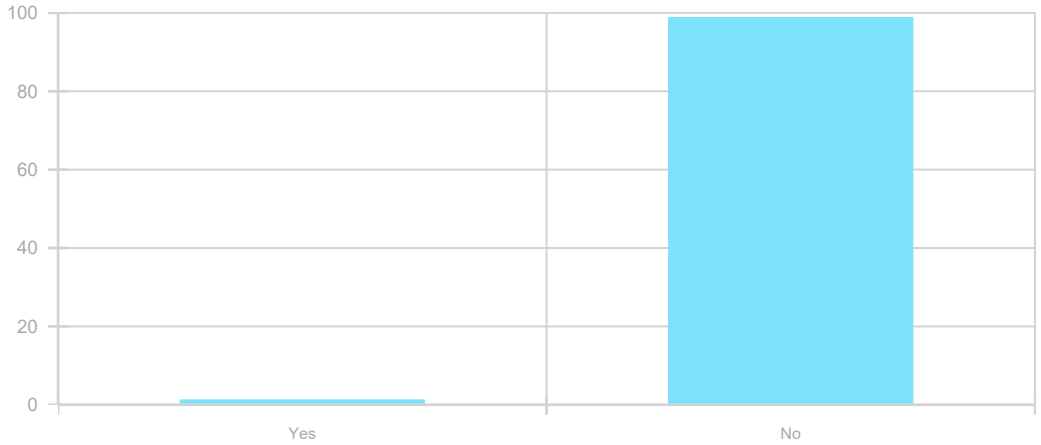
G5_6: Do you have any of the following: Deafness or hearing loss

#	Option	n	Weight	%
2	No	159	0.00	100



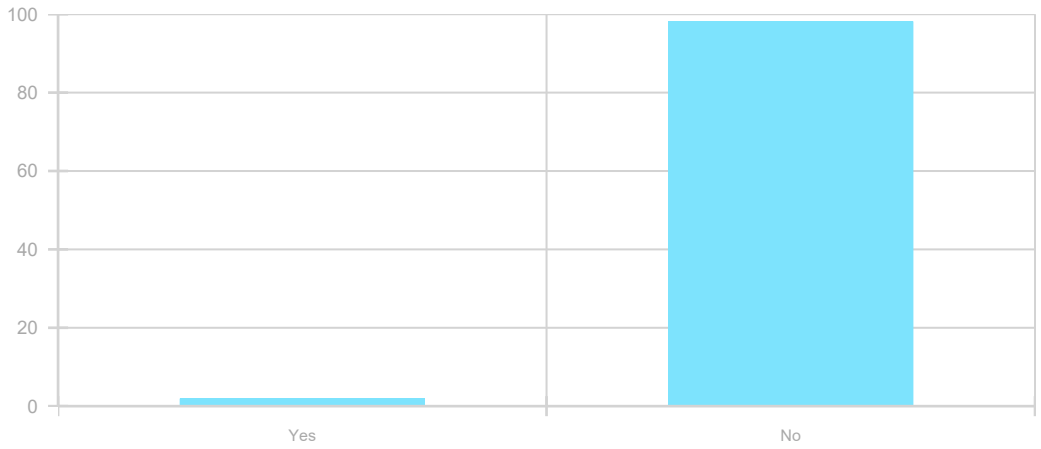
G5_7: Do you have any of the following: Diabetes

#	Option	n	Weight	%
1	Yes	2	0.00	1
2	No	157	0.00	99



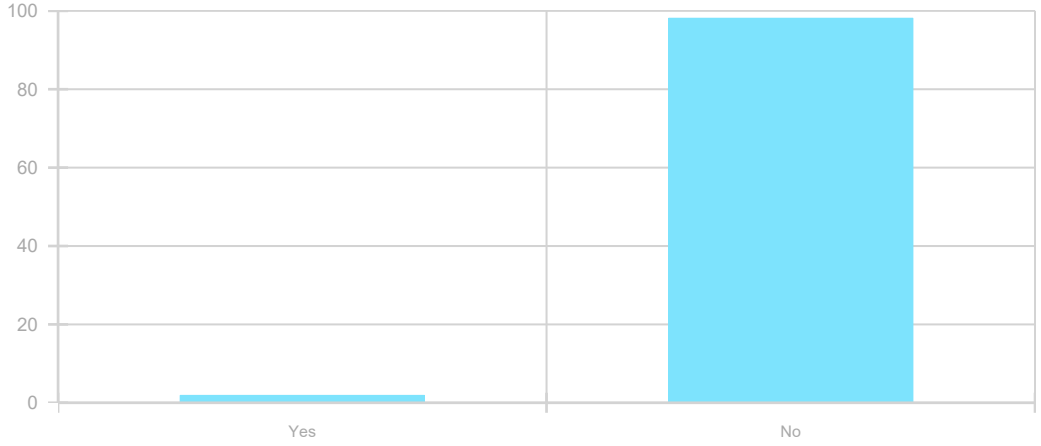
G5_8: Do you have any of the following: Heart problem, such as angina

#	Option	n	Weight	%
1	Yes	3	0.00	2
2	No	156	0.00	98



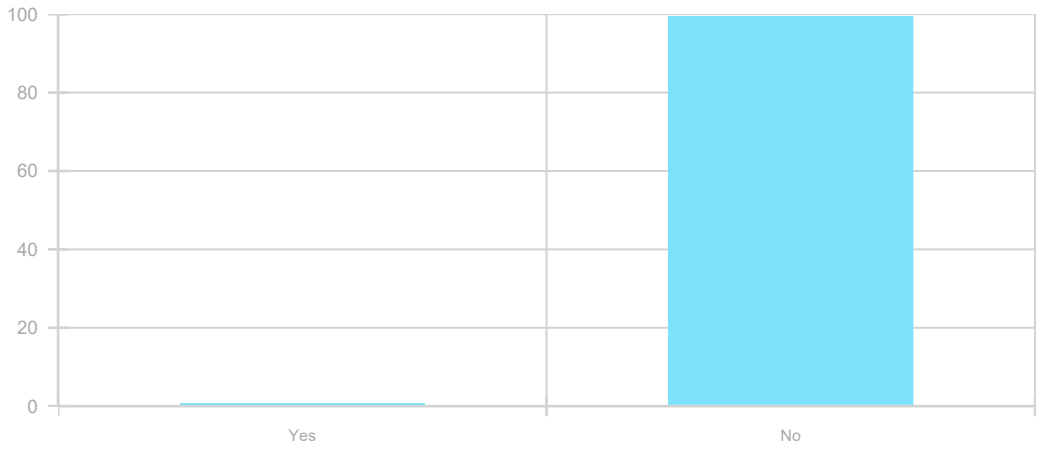
G5_9: Do you have any of the following: Joint problem, such as arthritis

#	Option	n	Weight	%
1	Yes	3	0.00	2
2	No	156	0.00	98



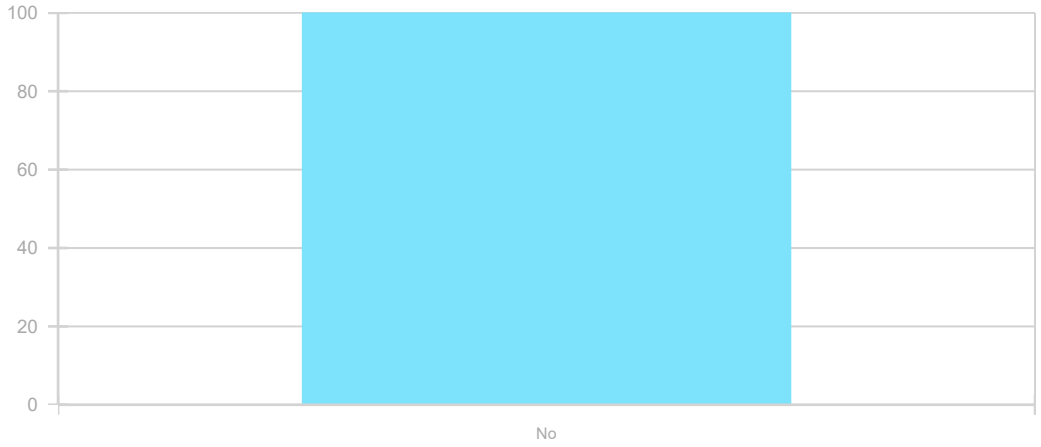
G5_10: Do you have any of the following: Kidney or liver disease

#	Option	n	Weight	%
1	Yes	1	0.00	1
2	No	158	0.00	99



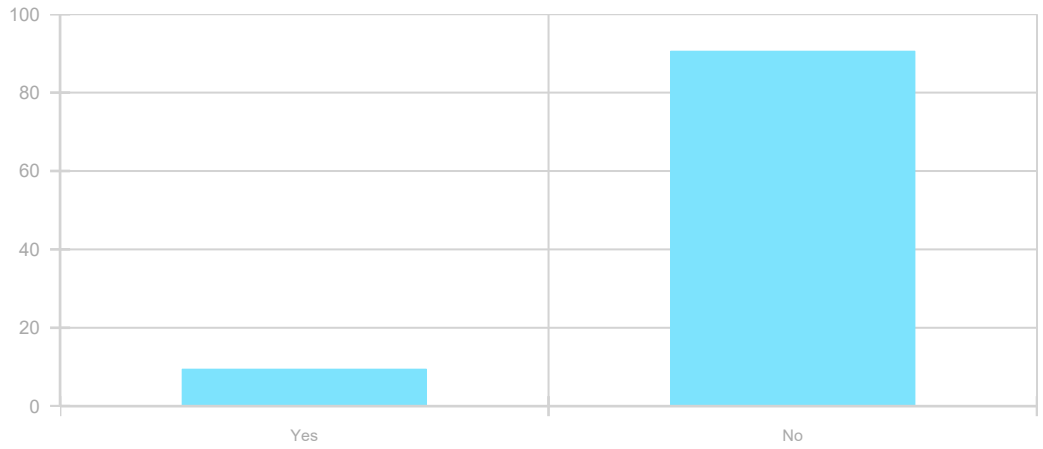
G5_11: Do you have any of the following: Learning disability

#	Option	n	Weight	%
2	No	159	0.00	100



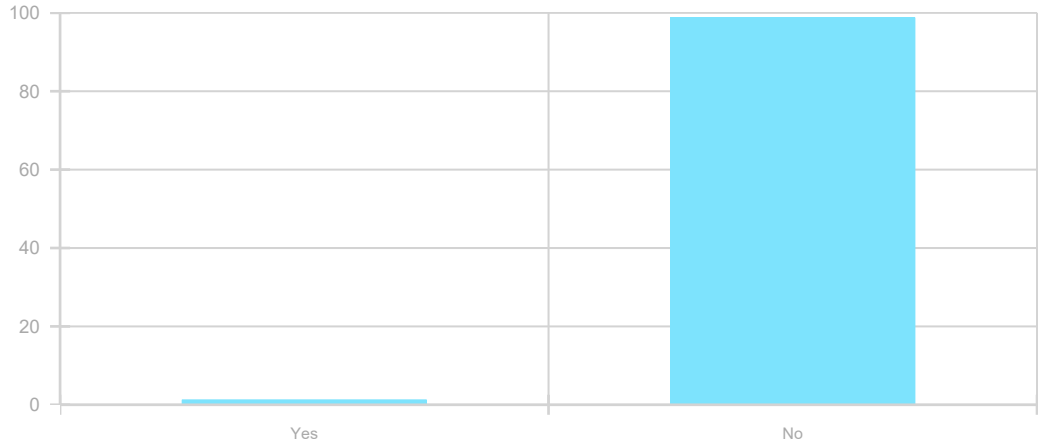
G5_12: Do you have any of the following: Mental health condition

#	Option	n	Weight	%
1	Yes	15	0.00	9
2	No	144	0.00	91



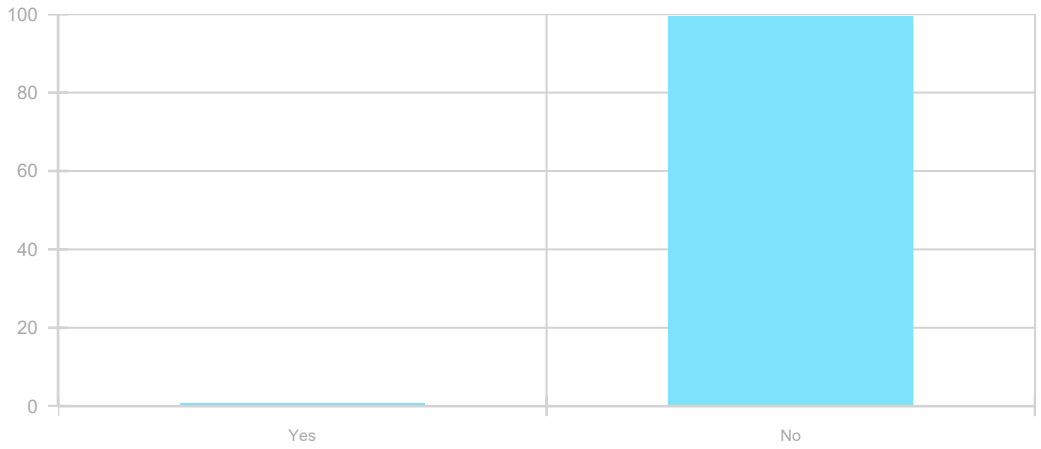
G5_13: Do you have any of the following: Neurological condition

#	Option	n	Weight	%
1	Yes	2	0.00	1
2	No	157	0.00	99



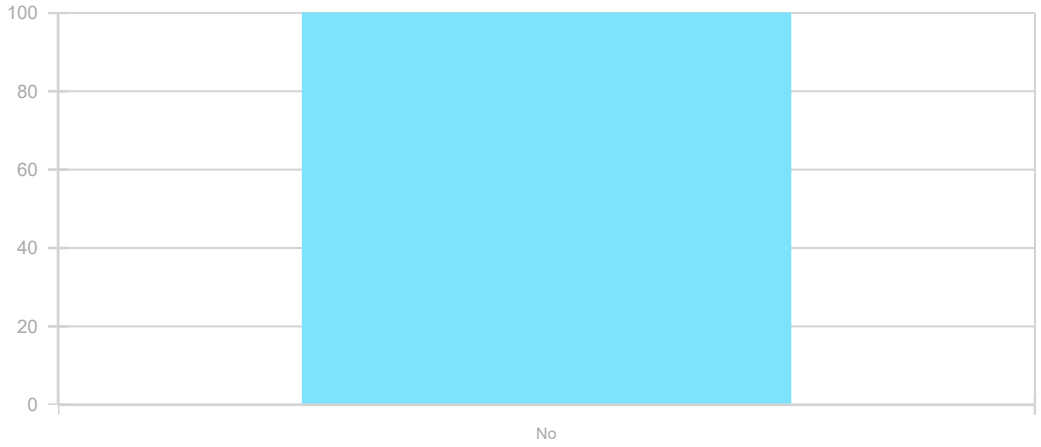
G5_14: Do you have: Physical mobility

#	Option	n	Weight	%
1	Yes	1	0.00	1
2	No	158	0.00	99



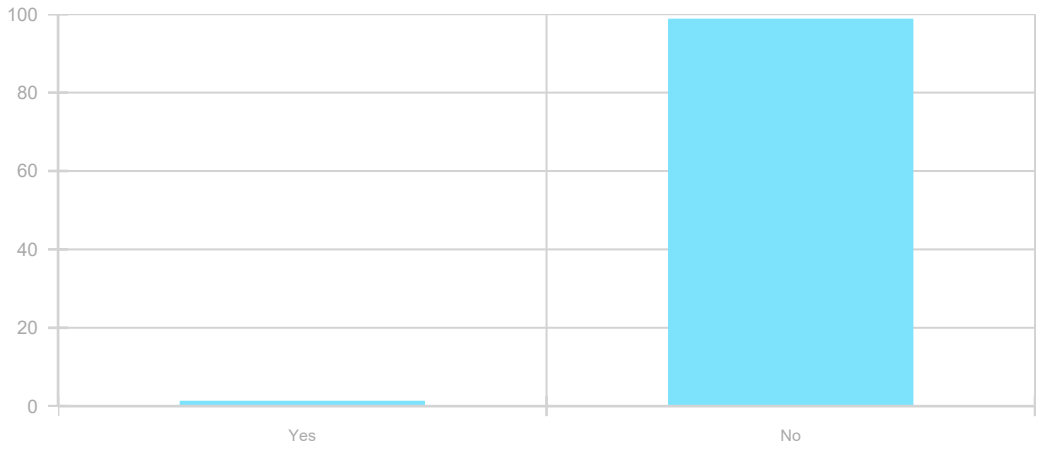
G5_15: Do you have: Sickle cell anaemia

#	Option	n	Weight	%
2	No	159	0.00	100



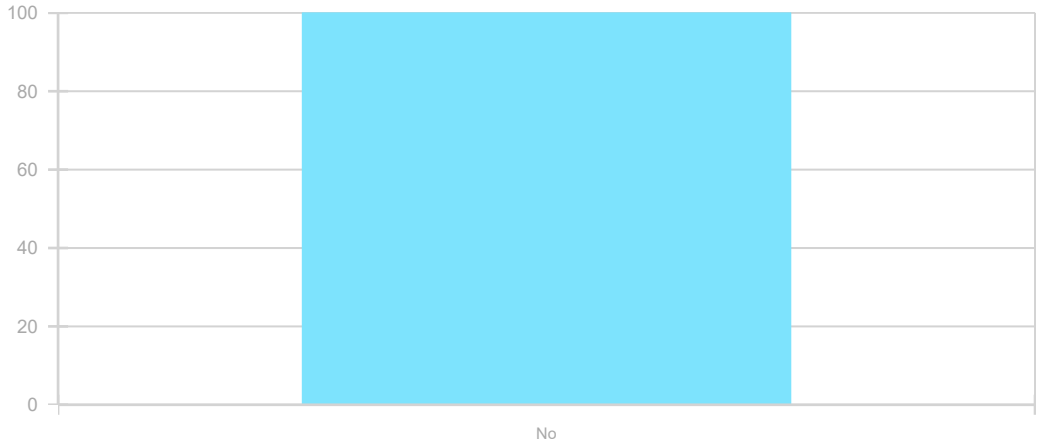
G5_16: Do you have: Thalassaemia

#	Option	n	Weight	%
1	Yes	2	0.00	1
2	No	157	0.00	99



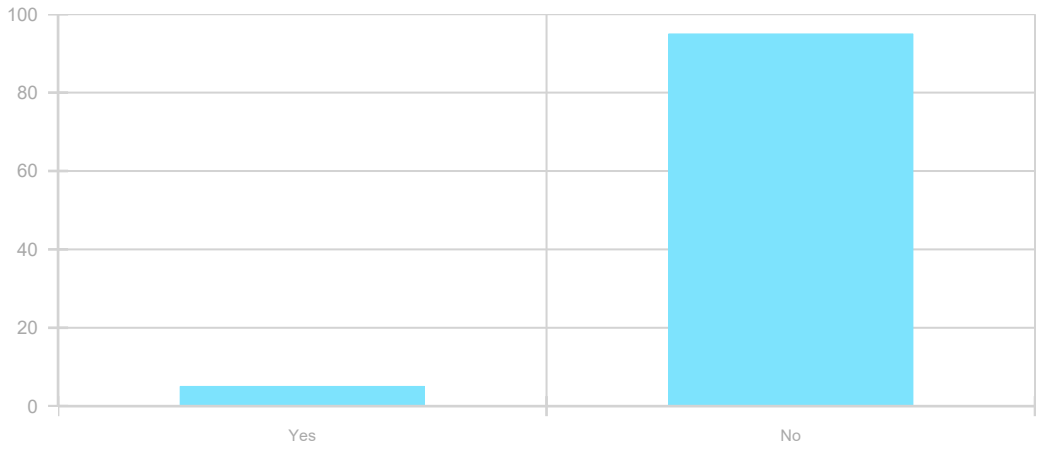
G5_17: Do you have any of the following: Stroke (which affects your day-to-day life)

#	Option	n	Weight	%
2	No	159	0.00	100



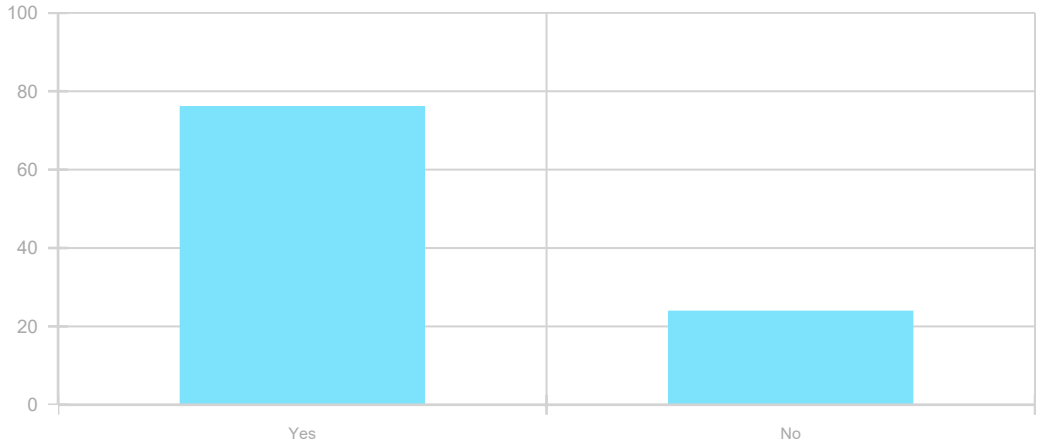
G5_18: Do you have any of the following: Another long-term condition

#	Option	n	Weight	%
1	Yes	8	0.00	5
2	No	151	0.00	95



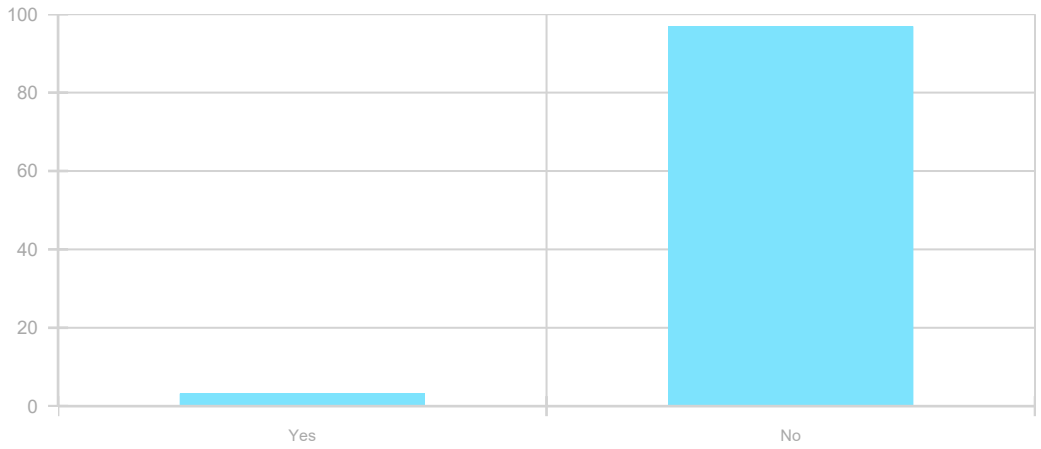
G5_19: Do you have any of the following: None of the above

#	Option	n	Weight	%
1	Yes	121	0.00	76
2	No	38	0.00	24



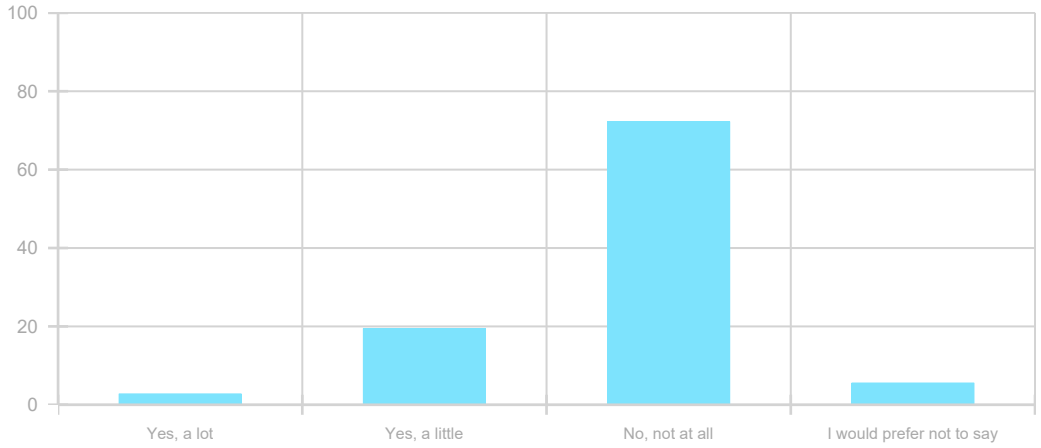
G5_20: Do you have any of the following: I would prefer not to say

#	Option	n	Weight	%
1	Yes	5	0.00	3
2	No	154	0.00	97



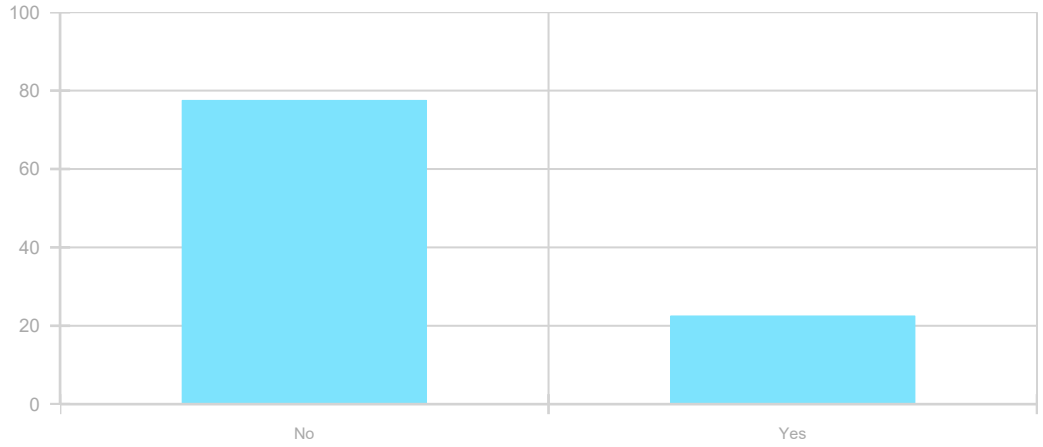
G6: Do any of these reduce your ability to carry out day-to-day activities?

#	Option	n	Weight	%
1	Yes, a lot	1	0.00	3
2	Yes, a little	7	0.00	19
3	No, not at all	26	0.00	72
4	I would prefer not to say	2	0.00	6



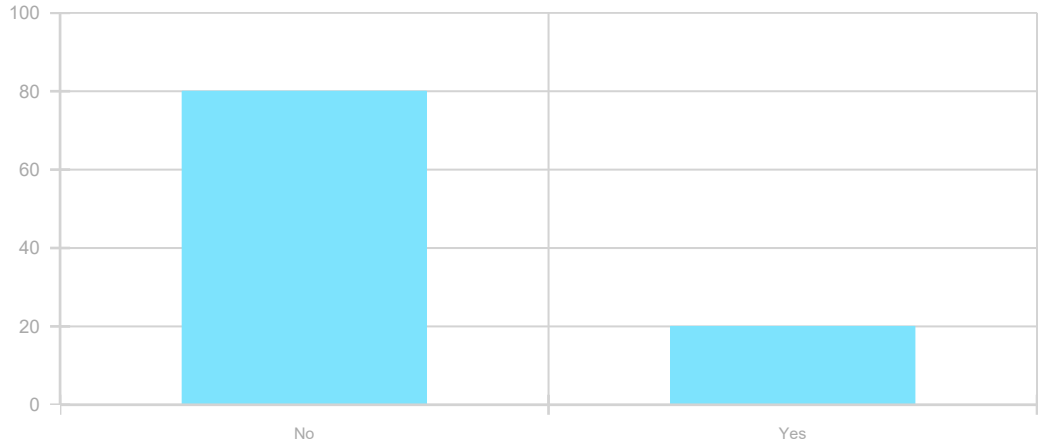
G7_1: Do you have: Pelvic health problems

#	Option	n	Weight	%
1	Yes	36	0.00	23
0	No	124	0.00	78



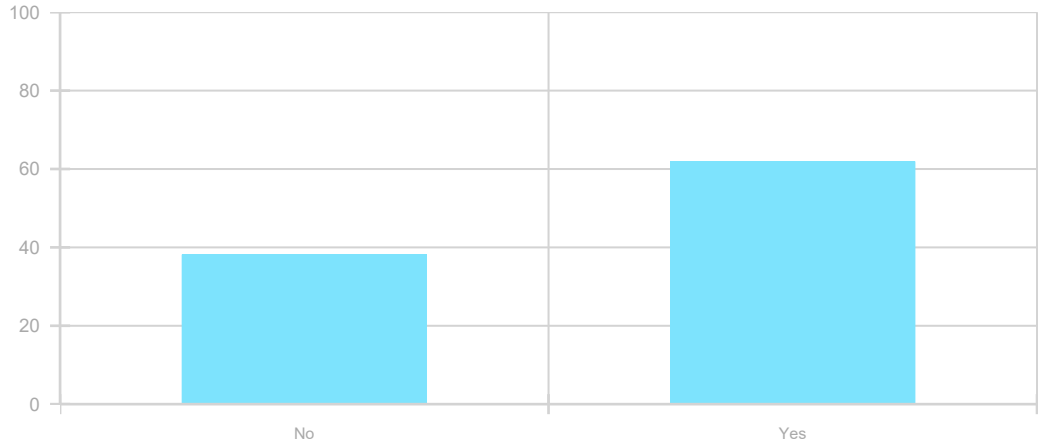
G7_2: Do you have: Another pregnancy-related health condition

#	Option	n	Weight	%
1	Yes	32	0.00	20
0	No	128	0.00	80



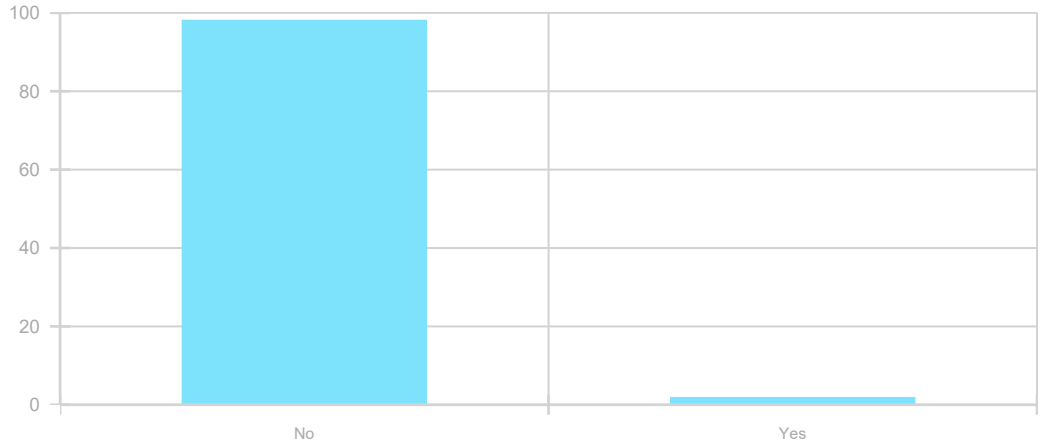
G7_3: Do you have: None of the above

#	Option	n	Weight	%
1	Yes	99	0.00	62
0	No	61	0.00	38



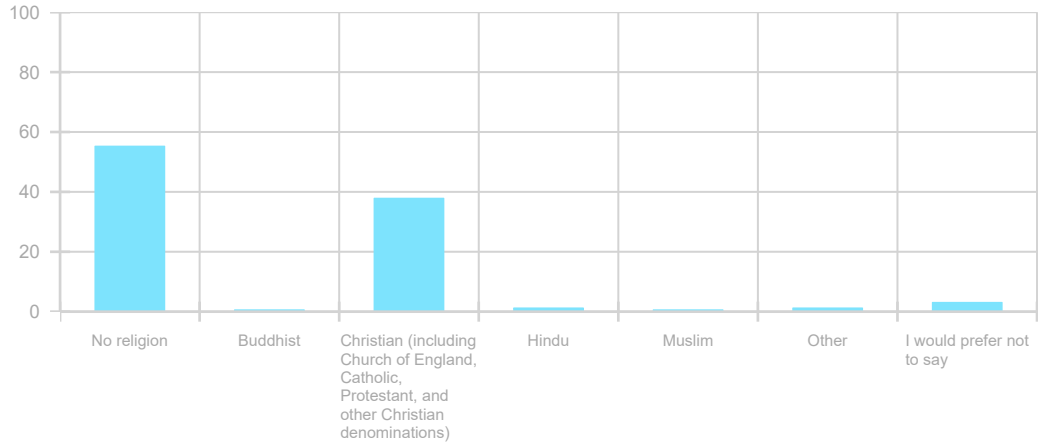
G7_4: Do you have: I would prefer not to say

#	Option	n	Weight	%
1	Yes	3	0.00	2
0	No	157	0.00	98



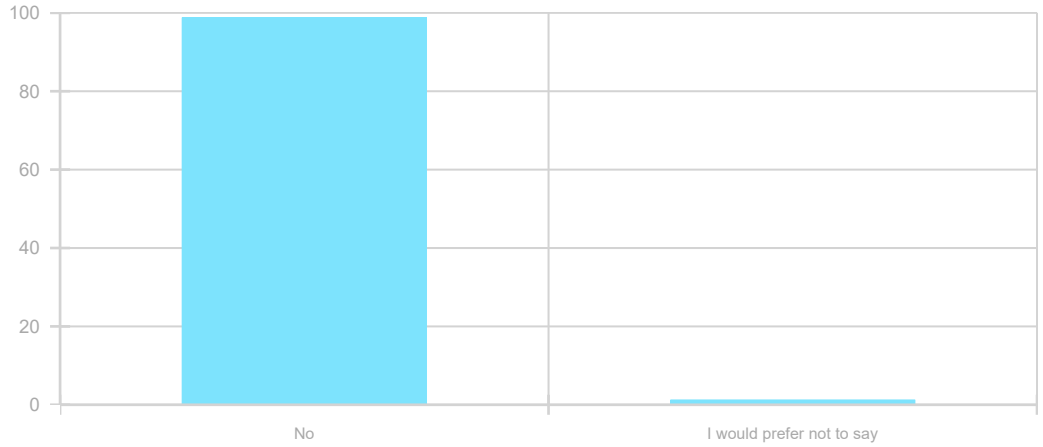
G8: What is your religion?

#	Option	n	Weight	%
1	No religion	89	0.00	55
2	Buddhist	1	0.00	1
3	Christian (including Church of England, Catholic, Protestant, and other Christian denominations)	61	0.00	38
4	Hindu	2	0.00	1
6	Muslim	1	0.00	1
8	Other	2	0.00	1
9	I would prefer not to say	5	0.00	3



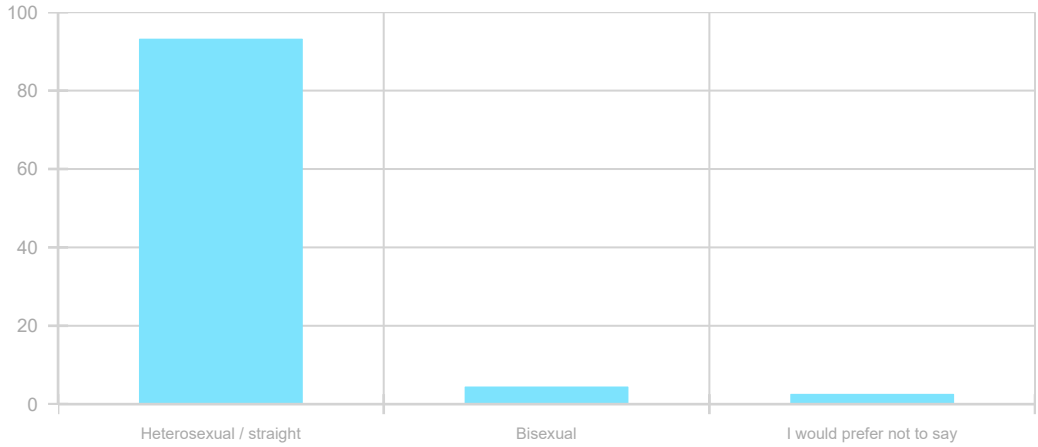
G9: Is your gender different from the sex you were assigned at birth?

#	Option	n	Weight	%
1	No	160	0.00	99
3	I would prefer not to say	2	0.00	1



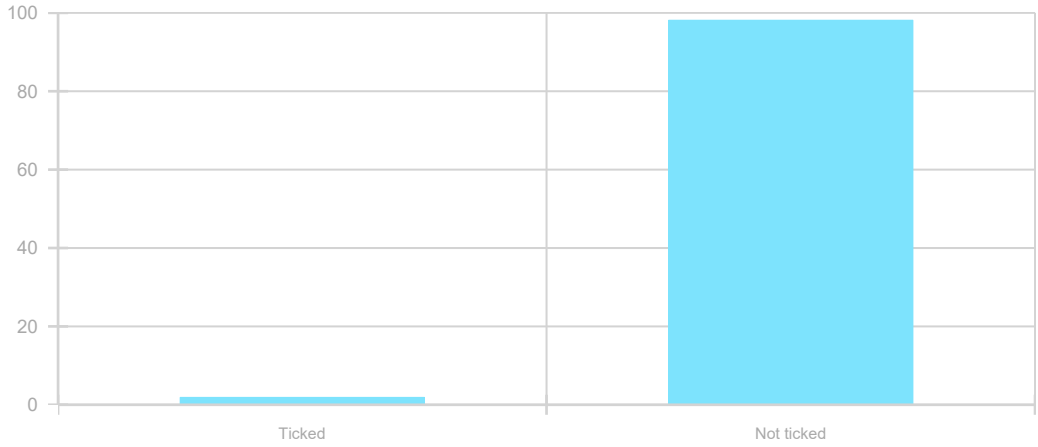
G10: Which of the following best describes your sexual orientation?

#	Option	n	Weight	%
1	Heterosexual / straight	149	0.00	93
3	Bisexual	7	0.00	4
5	I would prefer not to say	4	0.00	3



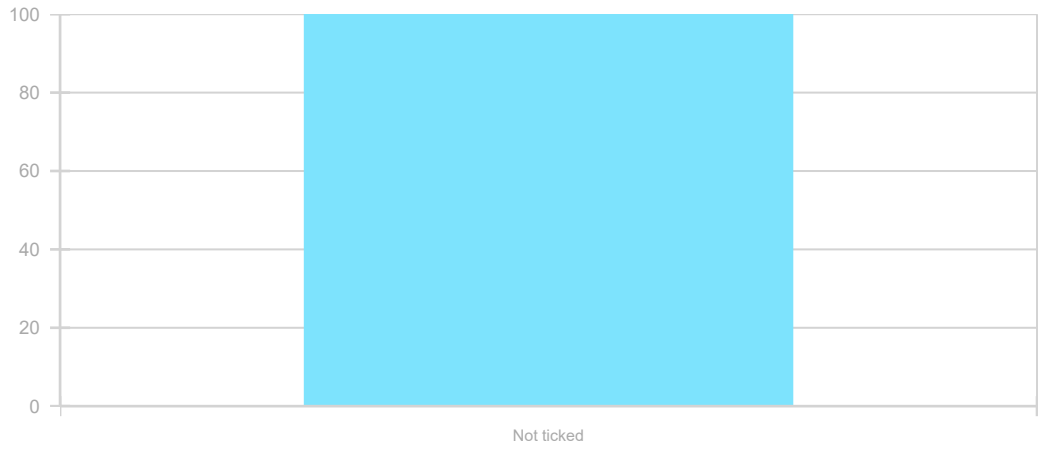
G11_1: Do you have any of the following communication needs?: Translation / interpreter

#	Option	n	Weight	%
1	Ticked	3	0.00	2
2	Not ticked	156	0.00	98



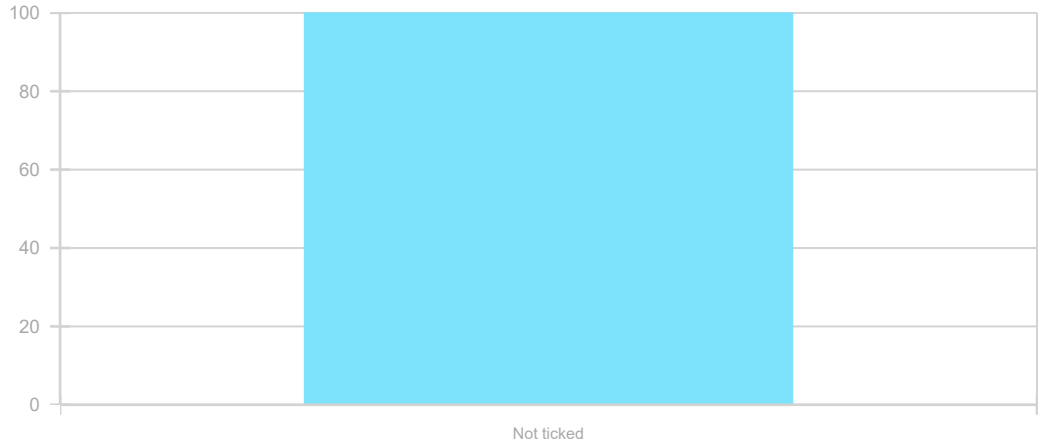
G11_2: Do you have any of the following communication needs?: Sign language / Braille materials

#	Option	n	Weight	%
2	Not ticked	159	0.00	100



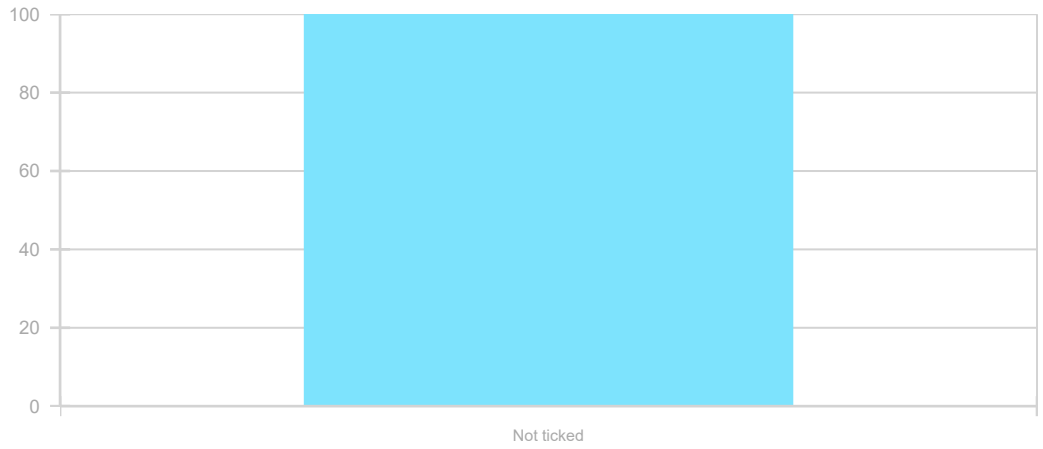
G11_3: Do you have any of the following communication needs?: Easy read materials

#	Option	n	Weight	%
2	Not ticked	159	0.00	100



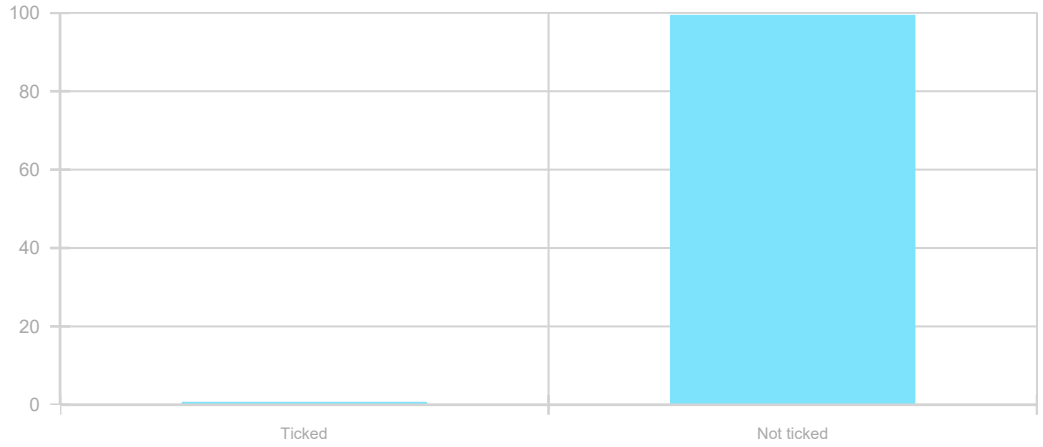
G11_4: Do you have any of the following communication needs?: Large print materials

#	Option	n	Weight	%
2	Not ticked	159	0.00	100



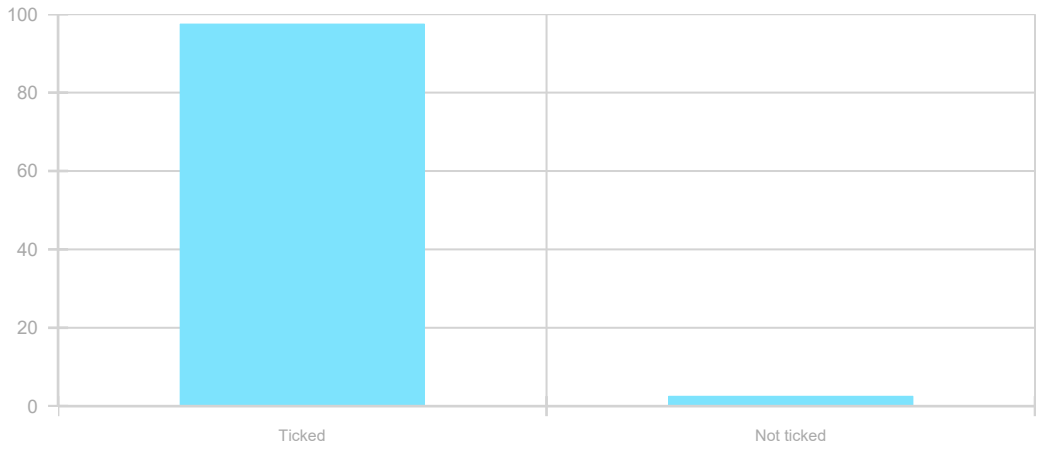
G11_5: Do you have any of the following communication needs?: Other

#	Option	n	Weight	%
1	Ticked	1	0.00	1
2	Not ticked	158	0.00	99



G11_6: Do you have any of the following communication needs?: I do not have any communication needs

#	Option	n	Weight	%
1	Ticked	155	0.00	97
2	Not ticked	4	0.00	3

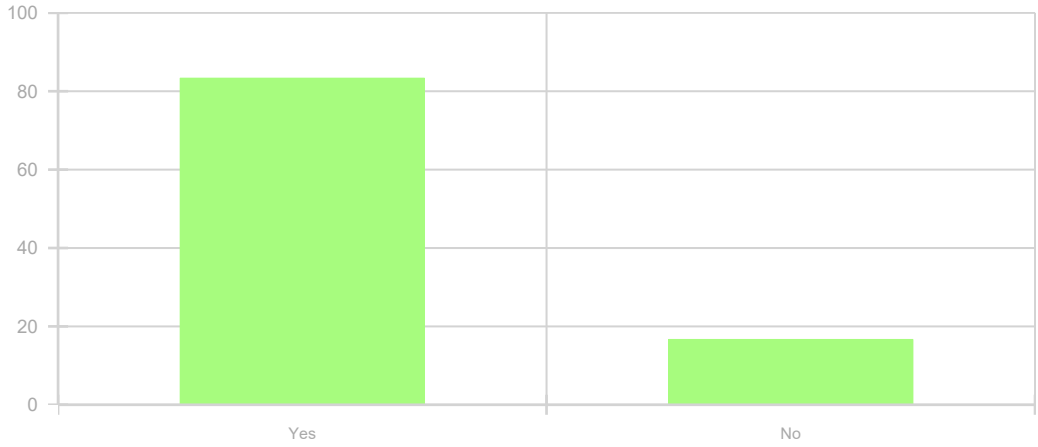


G12: While you were in the maternity unit, did staff help you with your communication needs?

#	Option	n	Weight	%
1	Yes	5	1.00	83
2	No	1	0.00	17

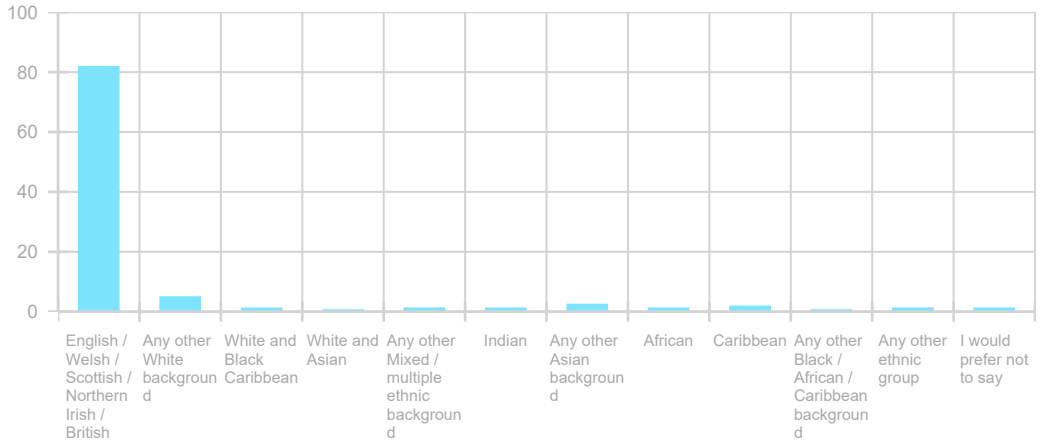
83% MEAN RATING SCORE

6 MRS BASE



G14: What is your ethnic group?

#	Option	n	Weight	%
1	English / Welsh / Scottish / Northern Irish / British	131	0.00	82
5	Any other White background	8	0.00	5
6	White and Black Caribbean	2	0.00	1
8	White and Asian	1	0.00	1
9	Any other Mixed / multiple ethnic background	2	0.00	1
10	Indian	2	0.00	1
14	Any other Asian background	4	0.00	3
15	African	2	0.00	1
16	Caribbean	3	0.00	2
17	Any other Black / African / Caribbean background	1	0.00	1
19	Any other ethnic group	2	0.00	1
20	I would prefer not to say	2	0.00	1



H: If there is anything else you would like to tell us about your maternity care, please do so here.

Date	Response	Org
29/02/2024	The doctor who handled my care for induction was rude, dismissive and didn't treat me as a person, just a statistic.	National Maternity Survey
29/02/2024	When I was transfered to the postnatal ward I feel my concerns about my baby's health were ignored and were partially the reason we ended up with a nicu stay 2 days after her birth for 5 days. I feel this was because I was a first time mum. . I also believe the unit wasn't staffed properly due to it being the weekend and I was unable to receive the information I needed to prevent our nicu stay including the support I required with breastfeeding.	National Maternity Survey
29/02/2024	My care during my pregnancy was excellent, although I very rarely had the same midwife at any antenatal appointments, so found I was always having to re-explain my situation at every appointment. I would?ve much preferred the same midwife, so they understood my needs and circumstances every appointment, without having to explain myself - I do understand this is not possible due to staff changes but may help other people in the future.. . Straight after giving birth when I was still in the labour ward, my partner & I were left to spend time with our baby. After 4 hours, a student midwife expected me to be ready to move wards, however I had not moved since giving birth. I was not given any help to get off the bed & shower myself off or get dressed. My partner couldn?t help as he was holding our newborn. I then walked in a lot pain, carrying our newborn up to postnatal to then find out I should have been offered a wheelchair - I was absolutely exhausted & couldn?t believe I was made to walk	National Maternity Survey
29/02/2024	Overall I was very pleased with the care I received by the Stonehenge midwife group and felt listened to by all the midwives I saw and they were understanding of me having my daughter with me at appointments, I would like to add I was very pleased the the midwife Imogen who delivered my baby with two other ladies I can?t remember names my husband was unable to be with me Due to having our daughter to look after and she was able to support and comfort me during labour and her and the team on shift were very generous and allowed my husband and daughter to come in and see me shortly after our baby was born and then later allowed my mother in law to come in which I very much appreciated as they didn?t need to do that but definitely feel they went above and beyond for us	National Maternity Survey
29/02/2024	Not left for hours waiting to be treated, in labour room being listened too when you know you?re own body	National Maternity Survey

29/02/2024	I had some incredible care during my complicated pregnancy. From MCAs to Obstetricians, I think I must have been lucky to meet the kindest people on each team. There were very few members of staff I didn?t click with and found at times on post natal ward there were some older school midwives I didn?t click with but I?m sure for others that?s exactly what they want. I do think the post natal ward has a long way to go when it comes to disabled access and care. Staff need to know what facilities are suitable and where they are. Many staff don?t know what healing looks like for wheelchair users. Items kept in hallways block wheelchairs from getting around and some equipment is unusable from a wheelchair such as the height of the cots. The milk kitchen is entirely inaccessible which piles the load onto staff to support disabled parents with feeding. The doorbell on post natal is a nightmare for patients and staff. Whilst I am pointing out issues, I am thankful for my experience.	National Maternity Survey
29/02/2024	My antenatal care was done by Lancashire NHS trust in Burnley, the care I received was awful, I was constantly dismissed, never saw the same midwife, they made multiple mistakes with my documents, were impossible to contact, wouldn't see me at triage when I had concerns and denied me access to my records. . . I moved to Wiltshire Tidworth at 38 weeks pregnant and received incredible care from the team.	National Maternity Survey
29/02/2024	Got left in labour room after birth for 6 hours before discharge with no checks from midwife/Doctor	National Maternity Survey
29/02/2024	The labour team was absolutely fantastic at Salisbury Hospital, I was in hospital for 4 days, 3 of those days on the labour ward and the staff was just so lovely, understanding and made me feel at ease. As this was my first baby, they made sure they spoke me though every step of the way, ensuring I was ok and comfortable, they went out there way to make myself and a my partner feel at home. I felt sad to leave them when we did and I don?t think I got the opportunity to thank them as much as I wanted or could. These are people who helped bring my baby girl Ocean into the world and people I will not forget for making my experience so rememberable for all the right reasons.	National Maternity Survey
29/02/2024	The care during the week before being induced was poor. It took me having to ask to see consultant to be induced as I was concerned about baby. It took too long and baby was born stressed.	National Maternity Survey
29/02/2024	Health Care Advisor not advised of my pregnancy in time for a home visit or any communication before I gave birth. Not assigned to a particular midwife, each visit saw a different person. Midwives during labour were amazing, felt so at ease and in good hands.	National Maternity Survey
29/02/2024	My midwife that I had during my Labour and the beginning of my birth was called Mel. She changed my whole experience and made my experience positive. She connected with me and made me feel empowered even when I was rushed to theatre. She is a credit to the team and wish I could see her again to personally thank her for the help of the birth of my beautiful baby girl, she was outstanding. . My postnatal care wasn?t as great, the ward was understaffed as been told my the midwives on the ward, one lady was running around like crazy and it delayed my discharge and my pain medication wasn?t kept on top on, resulting in a family member having to bring my my own pain management. We didn?t get much information upon leaving as the lady was just too busy, so she just put it in a plastic wallet and we were sent on our way. I was told I had to urinate 4 times after birth from having an episiotomy and catheter but I only managed one and was allowed to be released.	National Maternity Survey
29/02/2024	I felt that they stuck to protocols rather than dealing with the patient in front of them. I was given an injection to stop my contractions without them checking how far dilated I was and it turns out I was 10cm which led to me having to wait before I could start pushing leading to my baby's having a large swelling on her head.. This also led to needing forceps and then an emergency c section as my contractions did not get back to normal strength.. I feel before adminestering this they should have checked actually how my labour was progressing.	National Maternity Survey
29/02/2024	The team during my labour and postnatal were amazing! I could not have asked for better midwives and nurses looking after us! Only during the birth and after did I truly feel respected and acknowledged as a new mummy and not just another patient.	National Maternity Survey
29/02/2024	Brilliant labour, lovely lady that stayed over her shift time to see my baby born.	National Maternity Survey
29/02/2024	Being put in a side room on the post natal ward in early labour was very isolating. We felt that we were left to our devices and were not able to get the support or care for a women in early labour. We also felt that we were not given enough information of when to ask for help in early labour or what warranted assistance. More guidance was needed as to how far contractions needed to be before getting help. Equally not getting a bed on Labour ward I also feel delayed my labour as I wasn?t in the right frame of mind or space to have my child. Do not put labouring women away from Labour ward in a side room on the opposite side of the unit!!!	National Maternity Survey
29/02/2024	I feel that as a whole each individual midwife is amazing. However, the postnatal system as a whole needs improvement. . . I have been left with physical complications post birth with no follow up care plan. The doctor I had at 9 weeks for my 6-8 week check, told me over the phone I did not need the appointment. I am left in limbo as to who to talk to and whilst caring for a newborn it is left to me to seek out further care for complications which could have potentially been prevented. Whilst I did not have a ?serious? and majorly traumatic experience, I did have a birth I feel needed a debrief and a post birth operation which needed a follow up care plan. I was left ?stitched up? and passed from department to department before landing in a gynae triage appointment where the dr had no knowledge of me nor my condition. . . Even a midwife reading my notes could not fully tell me what happened as the handwriting in them was so atrocious they could not decipher the events of my sons birth.	National Maternity Survey
29/02/2024	I was sent home after my C-Section without any blood thinning medication	National Maternity Survey

29/02/2024	The maternity team, midwife and hospital were amazing. I had issues with my GP after giving birth (at the 6-8 week checks). I felt very judged and looked down on, there was also little talk about myself.	National Maternity Survey
29/02/2024	Maternity team where very attentive, I always had clean water, always offered cups or tea, very pleasant to speak to and enjoyed talking to the midwives. . . I was so anxious about my delivery due to having a previous emergency ga and haemorrhage. I expressed this to the midwife (Iv forgotten her name but she was so lovely) who spent a lot of time listening to me and got the consultant to talk with me about my options- there was discussion about being induced and the consultant said ?we aren?t going to make you do anything you don?t want to do?- then we came up with a plan together. . . The consultant wrote a clear plan in my notes and it was followed well by the midwife caring for me. . My only criticism is after I delivered I had a retained placenta (I had with my previous pregnancy which caused me to haemorrhage) and I just wanted to get to theatre asap and it felt like it was taking forever and I didn?t enjoy the first 1hour after having her because I was so anxious.	National Maternity Survey
29/02/2024	During my birth the staff were very stressed. Poor communication between the maternity staff. There was a lack of staff. When I arrived at the hospital, I was waiting at the reception whilst having contractions with other people who were waiting for scans etc. I was 5 cm dilated by the time I arrived to the hospital as the maternity team asked me to stay at home and take a bath, take paracetamol etc. I was waiting for a cup of tea and toast for a long time and when it arrived it was cold (my first food after giving birth) Poor after care, when changing my bedding the assistant commented on how tired she was and that she has been doing a 13 h shift. Not something you want to hear after being in labour for 2 days. I feel like I was ?left to it? just because my husband was there to help me. However, the theatre staff including the Doctors were very professional and I am forever grateful for the assistance I received during my birth. The antenatal care was also fantastic.	National Maternity Survey
29/02/2024	Poor mother health check from GP. . . Didn?t even look at c-section scar to check healing	National Maternity Survey
29/02/2024	I may have messed up on the questionnaire. Everyone at the hospital before, during and after were incredible! I wouldn?t change a thing! They were amazing! . . The only problem I had was after I had been discharged from the hospital and was going to my postnatal meetings. I told the midwives how much discomfort I was in, they checked my stitches and told me everything was fine and normal. . . Two weeks later I was rushed to hospital in an ambulance because I was loosing a lot of blood (very nearly fainted), had a piece of placenta inside me, an infected womb and infected stitches. This was a terrifying experience that could have been avoided.	National Maternity Survey
29/02/2024	Salisbury provided such kind and compassionate care. They were a great team and I felt in very safe hands. The only point of improvement I feel could be made is more support from the midwifery team on feeding and tongue ties. We left the hospital with a baby who had not fed successfully and had a severe tongue tie (and no advice on what we should do about this).	National Maternity Survey
29/02/2024	Very little support in recovery/postnatal ward with regards to feeding. First time mum and baby wouldn't latch yet no advice given. Put under pressure to feed immediately after glucose test for baby less than an hour post-birth. Stressful as he wouldn't feed. Formula fed for 3 days until milk came in and nipple shields arrived. No advice from postnatal care team.	National Maternity Survey
29/02/2024	Brilliant maternity care at Salisbury. Felt very safe and secure. Through the whole journey, particularly while in labour.	National Maternity Survey
29/02/2024	Was quite upset after leaving the hospital as we received no care or support until my baby was 4 days old. The Monday morning our widwifes phoned to say they were coming to visit however at the time my address had changed but I had informed my midwife of this and she said it was not a problem as they would still see me as I was in the area. They refused to see me and my daughter where I was concerned about her jaundice and I offered to drive to the previous address which was my parents house 20 minutes down the road and they said they couldn?t I was out the area. Thankfully for the midwife?s in Trowbridge got hold me and took over the care however I was sent into hospital to have my daughters jaundice checked and my blood pressure was high. Up until my labour our midwife?s were amazing, I just felt abandoned after having my baby until I saw the Trowbridge team.	National Maternity Survey
29/02/2024	I feel like I was shoved out of the hospital as soon as possible, I was in hospital just on 24hrs but then the next day I ended up with a post-dural puncture headache and had to go back in for a blood patch. It could have helped and I would have been able to get the blood patch earlier and not had to wait all day in pain, if I had been able to stay another 24hrs. Like with my first child	National Maternity Survey
29/02/2024	The only point I would like to make is that once having my baby no one told me how often I should feed my baby and I believe as a result made my baby?s jaundice worse than it needed to be as in the first day she wasn?t fed enough.	National Maternity Survey
29/02/2024	I was originally registered with Poole maternity hospital, however due to the poor experiences I had with my pre natal care and the terrible accounts I?d heard from other new mums I decided to transfer to Salisbury hospital for the birth, I also wanted my partner to be able to stay the whole time and Salisbury seemed to be the only hospital that could guarantee this. The staff at Salisbury were wonderful including my district midwife. My personal decision to have an elective c-section was completely respected. . . The only mild negatives were on the post natal ward, it was very warm with no way of cooling down, it was incredibly loud which caused quite a persistent headache and there is simply no privacy, a curtain is not adequate for discussing your private medical information on a busy ward, everyone can here your private information. I decided to go home the day after surgery for the above reasons rather than being completely ready to go home.	National Maternity Survey

29/02/2024	My antenatal and postnatal care by the community Pembroke team was incredible, Kara Humeniuk showed such kindness to my family and I had such trust in her. I also felt that I was cared for well during my labour. Postnatally within the hospital I felt that I was abandoned, I?d asked for pain relief multiple times, and asked for someone to assist me to wash as I?d had a spinal for a repair of a 3rd degree tear neither of which were given. There was also a lot of bad advice given regarding breast feeding which resulted in my baby being admitted to NICU as he?d lost so much weight.	National Maternity Survey
29/02/2024	When I was induced my midewife taking care of me was brilliant and so lovely, honestly felt so calm with her and completely trusted her. When it came to breaking my waters, within the hour I was fully dilated and the baby was here, so it was a very quick labour. About half hour after before my baby was born, the midwives changed, and as a result I had a midwife that even though she introduced herself, I didn?t know who she was or what she was like, which panicked me and as a result, I my last 30 mins of labour felt quite traumatic and not a labour I look back on with fondness. I wish they can be some layaway on staffing change over and it?s really did affect me and my experience. I also spent the next hour afterwards being stitched whilst my baby lied crying on my stomach, which I had to ask a few times if someone could move him up so I could try and feed him, but they were more interested in stitching me with little dignity for me while my legs were in stirrups. Postnatal ward was fab	National Maternity Survey
29/02/2024	At times it was fantastic but the bedside manner of some left me distraught several times and I am still in constant and severe pain from an emergency c-section that I did not want.	National Maternity Survey
29/02/2024	Just wanted to praise my midwife Ophelia who did my last few antenatal appointments and attended my home birth. She was the perfect midwife and treated me with so much respect. All midwives should take lessons from her!	National Maternity Survey
29/02/2024	I switched from Poole hospital to Salisbury hospital during my pregnancy because of Salisbury?s outstanding reputation. I was not disappointed. The care at Salisbury was absolutely fantastic. The midwives are actual angels and I felt like nothing was too much to ask of them. I even opted to stay an extra night because they took such good care of me. . The antenatal checks with my midwife were also so much better once I?d switched over. Emma in the forest team was so lovely, understanding and kind. Previously I had been going to Wimborne children?s centre where I would see someone different every time and I felt my concerns were dismissed during my pregnancy. . . I have been singing the praises of Emma and the midwives at Salisbury since giving birth, I think every local expectant mother should experience the wonderful care that I did. . . Thank you so much to them for being so wonderful.	National Maternity Survey
29/02/2024	I have already spoken to PALs in relation to my experience.	National Maternity Survey
29/02/2024	The male consultant I saw during an antenatal appointment and came to see me before I had my c-section has a disgusting attitude and is rude. He?s made me cry twice during 2 different pregnancies because of his attitude and decided to personally attack me for my decision of a c-section despite the fact I?d been told a c-section would be the safest option for me and my baby. Trying to worry a mother who is just about to go through a c-section and is already extremely worried about having one is absolutely vile. He has no compassion for anyone and is the rudest person I?ve ever had the displeasure of meeting.	National Maternity Survey
29/02/2024	I would like to say that my labour team were amazing my birth plan didn?t go to Plan due to my little boys heart rate needing to be monitored as it kept dropping they kept me reassured throughout this. I was a little bit disappointed when we arrived on the postnatal ward it was lovely we were given the space and time to bond with my baby but it felt very hands off and as a first time mum it would have been nice for them to chekc in a little more that I was happy with everything and whether I needed any support	National Maternity Survey
29/02/2024	Disappointing to have only seen the same midwife once or twice at antenatal check ups.. The postnatal midwife assistant who did the first home visit STANK of cigarette smoke and then of course held my newborn baby to do checks. Disgusting. . Postnatal ward was so busy that I don't feel like I got the best care: very limited feeding support, told to give formula when I told them I was intending to breastfeed, pain meds not brought round in timely manner, and medical notes updated with medication that had not in fact been administered.	National Maternity Survey
29/02/2024	I had to attend DAU on several occasions at Salisbury hospital during the end of my pregnancy, every visit was horrific. The worst being I was made to wait 8 hours just for a doctor to sign my paperwork, with no food. I broke down in tears and was shaking by the time I was eventually seen due to lack of food being heavily pregnant, I had to almost beg for anything, in the end I was given a slice of toast and sent on my way.	National Maternity Survey
29/02/2024	We received excellent antenatal care from the community midwife, it was beneficial seeing the same midwife each time for continuity of care and to build a rapport. If I had needed mental health support I feel this would be more comfortable to ask for as I felt comfortable to discuss this with her. . . During labour I felt that the midwives did an excellent job of advocating for my wishes when discussing with the consultants and feel very fortunate to have been able to access the new Beatrice birthing unit.	National Maternity Survey

29/02/2024	I would like to say a massive thank you to all the team working within the NICU department. What amazing people you are and I couldn?t have got through those few weeks without you! They have helped care for both of my children and their kindness, compassion and love is outstanding. I can not fault the care not only my children received but the support given to myself and my family! Thank you so much! . I do feel that the post natal ward care could do with some improvement. I felt very overwhelmed after the birth of both of my children and felt the care I received on this ward could have been much better. Especially for first time mums, it?s completely overwhelming and some personalised care and one to one care would be a much better improvement to how I felt after the birth of both my babies. You are just left alone and I feel that the staff could be more attentive. I?m happy to be contacted to discuss further.	National Maternity Survey
29/02/2024	Beccy who delivered our baby was amazing.. So helpful, kind and caring. . Highly respectful to us to and made labour enjoyable to some extent as wss so approachable	National Maternity Survey
29/02/2024	I would just like to say how amazing my midwife was when I was in labour. It was a totally different experience from the birth of my first child, which was quite traumatic for me, and she is to thank for that. She was so calm and made me feel that I could put all my trust in her and just do everything she told me to do. Even when I asked for pain relief she knew my baby would be here soon and I didn't need anything I just needed to keep going!	National Maternity Survey
29/02/2024	Felt there was a lack of breast feeding support on the ward. On discharge the pain relief given was not strong enough. Post discharge living on the boundary the care was inconsistent.	National Maternity Survey
29/02/2024	My whole birthing experience was ruined just by one midwife who I feel did not provide me with the care I required. Which is such a shame as we had lovely midwife?s while I was in hospital up until my birth.	National Maternity Survey
29/02/2024	The midwives who brought my children in to the world were absolutely incredible !	National Maternity Survey
29/02/2024	The postnatal ward at SDH appeared to be critically understaffed which led to a very poor experience including administering 2x medicine containing penicillin- despite red allergy bands - and a double dose of ibuprofen. Resorted to taking own pain relief as was not offered in a timely manner to keep ontop of pain post CS. Unless significant improvements are made, I will be requesting to be cared for another hospital for any future births.	National Maternity Survey
29/02/2024	The care by the midwives leading up to on the day of birth and post birth was fantastic. Salisbury new forest team were amazing! However I found that the health visitor was not as good in staying in contact and being supportive and should continue to reach out more post birth to check in with mum and baby health.	National Maternity Survey
29/02/2024	Overall, I felt very safe and comfortable at Salisbury Maternity Unit. My waters broke whilst I was being monitored for movement in the day assessment unit and was sent straight around to the labour ward. I felt very happy with my midwife and trainee midwife and was equally happy with the theatre team when I needed extra assistance with forceps.	National Maternity Survey
29/02/2024	Antenatal and postnatal care was excellent . . The care I received during labour was excellent. . However, almost immediately after I had given birth after 17 hours of labour I was left completely alone covered in blood, unable to move my legs (from epidural) with my baby left on my chest with no help or ability to reach the call button or my hospital bag for 6 hours until I was moved onto the ward when I was then told there were no cots available and so I had to hold my baby (still unable to move my legs) for another 4 hours until one became available. In total after giving birth I was left holding my baby for 9 hours after 17 hours of labour.	National Maternity Survey
29/02/2024	I was really grateful to my midwife for my antenatal care as she was aware I had a traumatic previous birth and so made every effort to see me herself and have continuity of care. She made a huge difference to my experience and I am very grateful.	National Maternity Survey
29/02/2024	It was a good labour experience	National Maternity Survey
29/02/2024	I was seen by different midwives, as I have put in my answers, but the community team were so small that this wasn?t an issue for me. I loved them all, and they all knew me and my pregnancy. .	National Maternity Survey
29/02/2024	I was cared for antenatally but the Wiltshire team and post natally by the Hampshire team as I live on the Hampshire/Wiltshire border but chose to deliver in Salisbury rather than Winchester. During my first pregnancy this did not matter as both counties used the same paper notes but for this pregnancy, Hampshire was using badger online notes and Wiltshire still paper. Therefore my mat appointments were all in Wiltshire rather than the surgery I live next door to in Hampshire... This was the only negative. . . Communication between the teams was good.	National Maternity Survey
29/02/2024	Post natal ward was awful! I?m yet to put my complaint in but having to wait over 8 hours for pain relief after a section is not acceptable despite the fact it was asked for multiple times.	National Maternity Survey

29/02/2024	Generally speaking I would say our birth experience was very mediocre and in some circumstances lesser than what I would expect for the standard of care. I'm aware that my husband and I may have higher expectations because we both work in the medical field, but I think overall we were disappointed with the experience as a whole. I never felt mistreated or disrespected, nor did I believe there to be any incidence of poor practice. The staff were all extremely kind. However, I think two of our biggest complaints and concerns come from the ineffective communication from all members of staff not only with each other but to us as well. I'm happy to be contacted to discuss this and have considered ringing Salisbury Hospital to discuss this feedback. A few examples include: I was given no pain relief despite a request for an epidural (by the time the staff was ready I needed to start pushing), inappropriate comms between staff resulting in me having a U-cath placed when I didn't need one, etc	National Maternity Survey
29/02/2024	The midwives during my labour were all excellent and I recieved a very high standard of care.. . We had to spend time in the NICU Post both as baby lost weight due to milk not coming in (emergency c section). All the staff there including the infant feeding team were fantastic.	National Maternity Survey
29/02/2024	Maternity labour ward was fantastic care but awful care for the three days I stayed on postnatal ward due to my baby having complications. I felt there was no support at all, I had to go and find someone everytime I needed pain relief and there seemed to be nobody about.	National Maternity Survey
29/02/2024	From 29 weeks my baby was in breech position. At 36 weeks it was decided I would have a cesarean as baby had not turned. At 37/5 I started to have intense false labour pains. Occurring between 10 and 5 mins apart. After several hours of this I called maternity triage as I was worried I may have been going into labour and having to either have an emergency section or vaginally breech delivery if it was left too late. I had also been told by my midwife to call as soon as i had any signs of labour because they didn't want to risk this happening. The midwife that answered was very dismissive and said it was probably braxton hicks and to take some paracetamol. When I explained I was concerned as by baby was breech. She asked why I was worrying about that and asked if I was a first time mother. She said not to come in unless my pains were 4 mins apart or less. I felt very let down, dismissed and scared by this response and feel she did not understand my concerns. .	National Maternity Survey
29/02/2024	Amazing midwife for labour. However, my experience in the postnatal ward was very inadequate. The midwife was unable to recall who I was despite multiple interactions. Forgot 3 times over 6 hours to complete my discharge despite my being told I was otherwise suitable for discharg. She repeated the same questions to me each time I enquired about my discharge paper progress demonstrating she had no idea who I was.. . I had heavy bleeding pre labour, during and post but was told in the postnatal ward that my blood tests had come back showing no issues. I was unwell for months after and only found out at 4.5 months postpartum at a GP review that my blood tests post birth showed both iron deficiency and infection, neither of which were treated. This negatively affected my recovery and health in the postpartum period.	National Maternity Survey
29/02/2024	My antenatal care was good, although I didn?t see the same midwife. . To this day, I still don?t know what caused my daughter to be born at 35weeks. It took the team longer than 30 minutes to deliver my daughter by emergency c section. It was nice to be able to stay on Labour ward for the extra hours before being moved to Postnatal. . Postnatal ward is the most horrendous place. The trainee midwives are the ones that helped the most, spoke to me and checked in on me. I was separated from my daughter, she was in the NICU. I didn?t get to move over to her for 2 days. I had to take the milk I was expressing over each time. I couldn?t keep up and missed out on being with my daughter and no one helped, . When I moved into the NICU, it was amazing, the staff went above and beyond. They helped me in every way, they made me feel safe and gave me the support I needed. Nothing was too much for them. They are incredible. And I wish every new mother could have the support they give.	National Maternity Survey
29/02/2024	I had very good care the whole way through my pregnancy and birth. The only point I?d like to mention is that when I first arrived at the hospital in labour, the day assessment unit nearly sent me home because they thought I was only 2-3cm (there was no physical examination because my waters had broken). I felt I was much further along than that and luckily asked to stay as that?s where I felt safest. Not long after, when I was taken to the birthing suite and examined by my midwife she quickly realised I was 9cm. My care was exceptional from there. But it was lucky that I didn?t go home as it could have been quite a different story.	National Maternity Survey
29/02/2024	I feel as though I did not receive the necessary care that I required after the birth of my son !. I was discharged on the Tuesday after almost passing out on the ward the evening before. My episiotomy ripped on the Thursday when home ! I was in and out of consciousness with my eyes rolling in the back of my head and the labour ward did not want to see me ! They advised my partner I was in the best place being at home ! . I ended up being taken to A & E where I was told my iron levels were 79 and I should not of been discharged if below 100. I had to have 2 transfusions !. I also had an infection in my wound and required antibiotics.	National Maternity Survey
29/02/2024	Lilly my midwife in pregnancy was lovely and always answered my questions and was very informative. . . The midwives at the hospital when I was induced were all so lovely	National Maternity Survey
29/02/2024	I would like to thank everyone who helped out in any way during my pregnancy journey . From the first weeks of checks with midwife to the scans and to labour, I may not remember your names and may not mention it here but do know that your work is Appreciated. . Thank you for the support..even having to witness the ugliest push ever? thank you??. My baby is 13 weeks old and looking back all I can say is that ..I could never have done it without you all.. . So Thank you.	National Maternity Survey

29/02/2024	Phoned the OOH maternity ward when I had problems urinating & was not able to at all. They were very dismissive & told me it was likely a UTI and not to worry. I made it clear I have had UTI infections before & it was not that. But they just said they were sure it was & to call my Gp In the morning. I was I agony all night & called gp first thing, they sent me to hospital,I was placed in the major department, it turned out I had severe urinary retention. I could have been very poorly & even needed emergency surgery had I waited any longer. I mentioned this on the phone but the person I spoke to dismissed this. I made the midwife aware when I was in labour about to give birth as I have done so before & knew she was coming and again was dismissed & they said you can?t be as you were only 2cm 1 hour ago. I went with my own instinct, pushed & she came out in one push, the midwife was not prepared at all, my partner had to press emergency buzzer whilst my baby was left to fend for herself	National Maternity Survey
29/02/2024	The midwifery team I had were exemplary for all the appointments both ante and postnatal. They listened to my concerns regarding fears over another vaginal delivery after the traumatic birth of my first child in 2021 and were very supportive and understanding about my desire to have a planned cesarean. Unfortunately the same could not be said of the consultant I met with first to discuss this. The midwifery team then organised for me to speak with another consultant who although I felt did not fully support the decision was at least courteous enough to respect that it was the choice I had made rather than trivialise my previous traumatic birth.	National Maternity Survey
29/02/2024	The care for mental health I think needs to be improved. It?s offered to you, but it?s never felt like it?s something you can actually have, I felt like I could deal with things, but looking back I don?t think I could and I think that talking to someone would have been really beneficial, but it felt like a scary thing to do when I had just had Monty. I think mental health should be a standard thing that every woman is allowed someone to talk to regardless if they ask for it. . . I also didn?t get my 6 week check up and my son and I didn?t have this till he was 9 weeks old.	National Maternity Survey
29/02/2024	I would just like to say that during my planned C-Section my ODP Amy Witney was absolutely amazing with her support and kindness during the whole process. From talking to me throughout my spinal when I felt a little unwell, to keeping me calm when I became nervous and her outstanding empathy towards me was amazing. . . Also Denise the midwife who?s support towards me after my section was calm, helpful and knowledgable. She made me feel at ease and safe	National Maternity Survey
29/02/2024	I thought the majority of my care was fantastic. The induction was delayed due to staffing shortages which was unfortunate and meant I was in pain, with labour not progressing, for much longer than I?d have liked to have been. I also tried to arrange an assessment with a physio after the birth but was told I didn?t meet the criteria. I then saw a private physio who diagnosed a prolapse and I continue to have symptoms relating to this. It would be good to have a pelvic examination as standard practice.. also pelvic floor exercises were mentioned as part of the post natal conversations but no one explained why they were important and what to expect as normal pelvic symptoms postnatally vs abnormal. The team we had around us during the induction and active labour part were absolutely fantastic. The theatre team were also amazing, particularly the anaesthetist. And I could sing NICUs praises for days. Overall it was a very positive experience.	National Maternity Survey
29/02/2024	We have already made a complaint and received a letter admitting fault!. Our baby came at 34 weeks 3 days and at first point of call is where we were massively let down the midwife?s that I initially spoke to did not follow protocol and there for negligence occurred. We were very lucky that our baby survived and received amazing care on the NICU.	National Maternity Survey
29/02/2024	Post natal care on the ward definitely seemed to suffer because of junior doctor strikes, it was sometimes hard to find ward staff/nurses/midwives which made getting feeding support and getting pain relief difficult sometimes but when available the care given by all staff was great.	National Maternity Survey
29/02/2024	My care on labour ward and throughout my birth was amazing. We were looked after beautifully through an unusual labour and an emergency Caesarian.. . The after care was good but a few things stood out to me. I wasn?t given an opportunity to discuss my birth or see the doctor afterwards. My baby didn?t drop down at any point throughout induction and there were theories as to why but I never found out if there was a reason after the section. . . On the post natal ward I was offered feeding support but it was rushed and with different people each time and I never succeeded in getting a good latch. I had a very difficult feeding journey and was often left confused after seeing a midwife in hospital and in the community. . . My 8 week check was not good. I was asked about mental health but nothing else and wasn?t examined at all. My scar wasn?t checked. . . Overall the care was amazing but there were just a couple of things as stated above that could potentially be improved.	National Maternity Survey
29/02/2024	I have to say the care I received the second time around (son born in 2020) was much better. Having said that, it was lockdown and my husband wasn't allowed in much. But my midwife who spent the day with me was outstanding. (Polish midwife at Salisbury Hospital). The evening staff were much better too. Didn't just chat loudly in a room.	National Maternity Survey
29/02/2024	On the Sunday we were in hospital there was only 1 midwife on duty. She was great but couldn't do everything that needed to be done all by herself! We weren't discharged to go home until 21.45! And that was after the night shift staff had arrived. I don't know if this was planned or due to sickness etc but this was not very good.	National Maternity Survey

29/02/2024	I gave birth to my son on my own at home, when the midwifes arrived they were very quick to notice my sons breathing was fast. We were taken to hospital that night. Once in hospital (maternity ward) Roman wasn't seen for hours, we were waiting all night. My partner had to find someone to help and push for him to be looked at because of his breathing. We kept being told the doctor was busy. Once checked we were then rushed to NICU. . He needed to of been checked properly as soon as we arrived by ambulance, he spent 5 days in NICU on oxygen. . He needed to of been on oxygen as soon as we arrived and I hope the hours and hours we had to wait with no checks through the night hasn't had any lasting damage for him for lack of oxygen. . Once in NICU the staff were incredible, they went above and beyond to care for roman and made our stay very comfortable at a scary time for us. .	National Maternity Survey
29/02/2024	The care I received at Salisbury hospital was fine and I never felt like I was in danger. But the staff left the room when I said I wanted to start pushing during labour with no explanation. They didn?t answer my question of ?is it ok for me to push now?? before leaving.. After birth my baby needed 12hr obs. The staff in the post natal unit didn?t seem to know this because his obs weren?t started until 4 hours after birth. This delayed our departure because we couldn?t leave until he?d been cleared. The lady in the post natal ward told me off for going to feed him because she needed to take his blood but that had already been done. She still insisted on doing it then came back later to say she needed to take more blood as the machine hadn?t printed the blood sugar number. I didn?t want her near him again as I felt she was rude and it would have been his 3rd blood sample when there should only have been 1! Lack of communication between depts and lack of staff was clear!	National Maternity Survey
29/02/2024	I felt there were a lot of follow up appointments in the 2 weeks following my delivery that meant attending the Drs surgery or hospital for routine checks, some of which could have been combined. As a result it really impacted the amount of time my husband got to spend with his daughter in his paternity leave. . My baby was weighed one day and then the next had to go to the same place for her hearing test, then the next day another midwife check. It was a lot and meant it took longer to bond. The delayed jaundice screening was also not handled very well and I was left waiting for hours for the Dr to do the blood test and then didn't get the results for over 24hours. As this was carried out over 2 weeks after my delivery my husband was back at work and I was left to attend alone, which made me stressed and upset.	National Maternity Survey
29/02/2024	This is my 3rd baby I have had at Salisbury hospital I would never go anywhere else they were all so lovely nothing was to much trouble. They talked through all my options for pain relief I allowed me to choose without pressure. I was always treated with respect I'm so thankful for them helping me bring my 3rd little boy into the world. Thankyou	National Maternity Survey
29/02/2024	My maternity care was on the whole fantastic. The only negative experience I had was when I was due to go in for my planned c-section. We were 1st in that day (2/2/24) & were prep?d (med team checks) & gowned ready to go up. A few minutes before we were due to go up, the other pregnant lady due in surgery after me complained the baby movements weren?t as high as normal. As a result the surgeon & midwife did monitoring checks & delayed our surgery. Once monitoring was complete the surgeon wasn?t concerned. However the mother was concerned she might get moved to the following Monday as she was second on the schedule. As a result she was asked if she ?would prefer to go 1st?. She said yes & went up almost 2 hours after we were due to go in (they weren?t even prep?d). No one spoke to us during this time - other than to quickly say we would now be second. We were left for hours until we were finally briefed at 1300 ish. My wellbeing, concerns & anxiety were not considered at all.	National Maternity Survey
29/02/2024	The surgeon was very unprofessional just before my surgery. She gave me extremely personal potential results in front of other patients with no warning or confidentiality in mind. Basically she told me very loudly in front of other patients that I might have HIV about a hour before my operation. I didn?t. It was a marker on my bloods for glandular fever. Even the midwives apologised profusely to me for her conduct. She had no bedside manner and made me extremely anxious right before my c-section. So much so I didn?t even want her to do the operation. I have thought about making a formal complaint but I don?t have the energy and don?t really want to relive it.	National Maternity Survey
29/02/2024	The midwife who I saw for the majority of my antenatal and postnatal appointments was amazing - very caring, knowledgeable and understanding.. . There were some discrepancies in information given regarding my options of where to give birth. Although we?d decided on a hospital birth, it wasn?t clear whether the MLU or birthing pool would be an option due to my high blood pressure. . . Following the birth of my baby, the wrong injection was given to assist with delivery of placenta. This caused my blood pressure to go extremely high. . . Postnatally there were issues finding the correct dose and organising a change in blood pressure medication with conflicting advice and information from different health professionals. I had not been prepared for this change pre-birth. It was confusing and impacted on my first few days at home as I was ?bounced? back up to DAU with high readings on three occasions. Added challenge was GP not wanting to take full responsibility for decision making at this time.	National Maternity Survey
29/02/2024	I just want to say we had an incredible young midwife named Morgan, who cared for us so well. I also wanted to say thank you to our anesthetist (I can?t remember his name) after two days of induced labour we were exhausted emotionally and physically but he really made us feel at ease during the emergency c-section.	National Maternity Survey

29/02/2024	My care during labour was amazing, I felt listened to&they advocated my needs. . . I was diagnosed with pre-eclampsia on DAU, they gave me medication to drop my blood pressure&as it was so busy, this was done on a chair in the waiting room, I felt horrendous&there was no where to lay down. post natal ward needs to be looked at. It was busy, not enough midwives&help was lacking. My baby needed blood sugars and the midwife was cross that she didn?t get it done in time. I was only offered paracetomel as pain relief&they couldn?t get in contact with a doctor for additional analgesia. They also wanted to discharge me on Dalteparin, when explained I am needle phobic, they asked my partner to inject me at home. I declined the Dalteparin. We were are forgotten after our Day 3 check, we had to call DAU to contact the community midwives&were finally discharged on Day15.	National Maternity Survey
29/02/2024	A lot of the interactions a had with staff just felt like ?box ticking? and asking questions for the sake of answering them, not that they really cared/were interested or listened to the answers that were given. . . Most of the staff on the ward seems rushed and stressed and didn?t have enough time to spend with each patient, which made it feel like an inconvience if you asked for something/more help needed.	National Maternity Survey
29/02/2024	The care was outstanding, we felt valued, very well looked after and part of the family. Thank you all!	National Maternity Survey
29/02/2024	I would like to share that immediately after a c section the midwife should not arrange a hearing test for the baby or any other test as it is very difficult for the mother to get out of the bed within 3 days of delivery.. . Thank you	National Maternity Survey
29/02/2024	I found my maternity care to be very inconsistent. I was told some of my routine checks were late due to not seeing the same person. My diabetes test was later than it should have been. They also wanted to test me for a short cervix which would have involved an internal check even though I was over 20 weeks pregnant. I informed them I?d not needed this with my two previous pregnancies snd that it?s a test that should be carried out at a much earlier stage. Ultimately I refused the test as I didn?t think it was necessary. I wasn?t informed that my husband could have stayed with me after the birth and I received no help. The midwife forgot to give me my painkillers as she mixed me up with a different bed. I was discharged the very next day. There was a problem with my son and he was put into NICU and then sent to Southampton. The midwives at Southampton were awful. Very little compassion. I asked to be re-admitted as I was only 1 day post section and they refused. It was an awful time.	National Maternity Survey
29/02/2024	My care at Salisbury General Hospital was generally very positive. However, my pregnancy was labelled ?high risk? due to gestational diabetes and as a result of this I felt constantly pushed into having an induced birth, despite there being no risk factors SPECIFIC TO ME AND MY BABY that meant this was necessary. Too often I felt that I was simply part of a numbers exercise and pushed into following a certain protocol based on the labels on my maternity notes, rather than based on MY body, MY own risk factors and MY wishes. In the end I had the labour I wanted, with no interventions, but I felt that I had to fight for it every step of the way. Someone less confident/able to advocate for themselves would probably have gone along with an induced birth, even if it was not what they wanted. On more than one occasion doctors were unable to explain the relative and absolute risk factors for a certain course of action.	National Maternity Survey
29/02/2024	The survey doesn't take into account if a baby was admitted to the NICU. Quite a lot of my answers were different as I was transferred to a different hospital and had support in NICU, not from midwives. Given my baby arrived so early there is also a difference in the care I received eg. Feeding advice	National Maternity Survey
29/02/2024	1) Care was systematically geared against home births at all stages of pregnancy, despite my clear stated wish for a home birth. This caused anxiety and distress. [unreadable comment]	National Maternity Survey
29/02/2024	I believe my sepsis in labour could have been caused by my amniotic fluid leaking. This was picked up twice in scans but never tested as the following weeks it was normal again. I believe I should have been tested earlier. . Then when I felt my waters break I went into hospital and was tested and I was told my waters hadn't broken as the test is very accurate. But when sent down to the labour ward they found I didn't have a drop of amniotic fluid left. I have had x2 babies before so I obviously know what having your waters breaking feels like. . When in labour I felt really rushed to make a decision to have an emergency c-section due to discovering I had a high temperature. I had to try and sign the form whilst having strong contractions. I wanted a little time to think but felt pressured by one surgeon in particular but luckily the midwife saw I needed a few minutes to think and discuss it with my husband. I also didn't get to hold my baby until the next day or try and feed her	National Maternity Survey
29/02/2024	I feel that tongue tie should be standard check to avoid delayed diagnosis. Also I had an overseas trainee doing one of my checks. I felt that should be supervised as didn't do a lot of things other nurses did to make me more comfortable.	National Maternity Survey
29/02/2024	The midwives during labour were wonderful. I was looked after by Lisa Simpson on the Salisbury labour ward. She was so kind, supportive and professional and stayed with me the whole time. It was a really positive experience.	National Maternity Survey

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.6
Date of meeting:	6th March 2025		

Report tile:	Salisbury NHS Foundation Trust Maternity Self Certification NHS Resolution Maternity Incentive Scheme, Board Assurance Report - January 2025			
Status:	Information	Discussion	Assurance	Approval
			x	x
Approval Process: (where has this paper been reviewed and approved):	Divisional Management Team –22/1/2025 Clinical Governance Committee 28th January 2025 Extraordinary Trust Board February 6th, 2025			
Prepared by:	Vicki Marston – Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos – Chief Nursing Officer			

Recommendation:

The Trust Board to note the requirements as set out by NHSE CNST Maternity Incentive Scheme Year 6 and note the enclosed report evidencing compliance with all **10** Safety Actions.

When presented to Extraordinary Trust Board on 6th February 2025, the Trust Board agreed the below as per guidance from NHSE:

- The Trust Board must then give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. If the form is signed by another Trust member this will not be considered
- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution
- The Board declaration form must be then sent to NHS Resolution nhsr.mis@nhs.net pre 3rd March at 12 noon.

Executive Summary:

The Clinical Negligence Scheme for Trusts (CNST) is a scheme for handling clinical negligence claims against NHS Trusts. The Trust pays an annual premium to the CNST scheme, plus an additional amount towards the Maternity Incentive Scheme (MIS). The Maternity Incentive Scheme (MIS)

establishes 10 safety actions to support safer maternity care. Trusts that can demonstrate that they have achieved all 10 safety actions in full recover the additional 10% of the maternity contribution charged under the scheme, plus a share of the monies paid into the scheme by the hospitals that did not achieve.

Salisbury NHS Foundation Trust Maternity and Neonatal Services have made continued progress from 2021 to 2024 and as such are declaring compliance with 10 out of 10 Safety Actions for year 6 of the scheme.

	NHSR Maternity Incentive Scheme- Year 6 Submission				
Are we well led?		Description	Yr 3 Submission	Yr 4 Submission	Yr 5 Submission	YR 6 submission
	1	**Perinatal Mortality Review Tool** using to required standard for all perinatal deaths	Non Compliant	Compliant	Compliant	Compliant
	2	**Maternity Services Data Set** submission to required standard	Compliant	Compliant	Compliant	Compliant
	3	**Transitional Care Data Set** minimise separation to mothers and babies	Non Compliant	Non Compliant	Compliant	Compliant
	4	**Clinical Workforce Planning** effective system	Non Compliant	Compliant	Compliant	Compliant
	5	**Midwifery Workforce Planning**	Compliant	Compliant	Compliant	Compliant
	6	**Saving Babies Lives Care Bundle V3** compliance with all elements	Non Compliant	Non Compliant	Non Compliant	Compliant
	7	**Service User Involvement and co-Production**	Compliant	Compliant	Compliant	Compliant
	8	**Multidisciplinary Training**	Non Compliant	Non Compliant	Compliant	Compliant
	9	**Board Assurance** Board to Ward to Board	Non Compliant	Non Compliant	Compliant	Compliant
	10	**HSIB and EN Reporting**	Compliant	Non Compliant	Compliant	Compliant
Person Centred & Safe	Professional	Responsive	Friendly	Progressive		

The Divisional Triumvirate comprising of the Director of Midwifery, Clinical Director and Divisional Director of Operations are satisfied that the evidence collated demonstrates achievement of all of the ten maternity safety actions and meets the required safety actions sub-requirements as set out in the safety actions and technical guidance document in the CNST MIS document.

In addition, the Chief Nursing Officer for SFT, Non-Executive Safety Champion, Chief Nursing Officer for ICB and LMNS lead Midwife have all reviewed in full the detailed evidence and agreed that it meets the requirements for the standards of complaince fo all 10 Safety actions.

When presented to Trust board it will be recommended for the Board to note the contents of the report and formally record to the Trust Board minutes.

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

Salisbury NHS Foundation Trust - NHS Resolution Maternity Incentive Scheme, Board Assurance Report January 2025

1. Introduction

The Clinical Negligence Scheme for Trusts (CNST) is a scheme for handling clinical negligence claims against NHS Trusts. The Trust pays an annual premium to the CNST scheme, plus an additional 10% towards the Maternity Incentive Scheme (MIS).

Now in its sixth year of operation, NHS Resolution's Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST MIS fund. Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution relating to the CNST MIS fund and they will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST MIS fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the MIS fund and is subject to a cap decided annually by NHS Resolution.

The Divisional Triumvirate comprising of the Director of Midwifery, Divisional Medical Director and Divisional Director of Operations are satisfied that the evidence provided to demonstrate achievement of all ten maternity safety actions meet the required safety actions sub-requirements as set out in the safety actions and technical guidance document included in the MIS document.

This report has been reviewed and ratified by the Women and Newborn (WNB) Divisional Management Team. The Chief Nursing Officer for SFT, the Non-Executive Safety Champion for SFT, Chief Nursing Office for ICB and LMNS lead Midwife (as AO for ICS) have reviewed in full all pieces of the detailed evidence and agree the evidence meets the requirements for the standards for which compliance is being declared.

There has been gradual progress with compliance from a submission of 4 out of 10 in 2022 to date and in January 2024 the Maternity service at Salisbury NHS Foundation Trust (SFT) was successful in achieving compliance in 9 of the 10 criteria for NHS Resolution (NHSR), Clinical Negligence Scheme for Trusts (CNST).

	NHSR Maternity Incentive Scheme- Year 3, 4, 5 Submission			
Are we well led?		Description	Yr 3 Submission	Yr 4 Submission	Yr 5 Submission
	1	**Perinatal Mortality Review Tool** using to required standard for all perinatal deaths	Non Compliant	Compliant	Compliant
	2	**Maternity Services Data Set** submission to required standard	Compliant	Compliant	Compliant
	3	**Transitional Care Data Set** minimise separation to mothers and babies	Non Compliant	Non Compliant	Compliant
	4	**Clinical Workforce Planning** effective system	Non Compliant	Compliant	Compliant
	5	**Midwifery Workforce Planning**	Compliant	Compliant	Compliant
	6	**Saving Babies Lives Care Bundle V3** compliance with all elements	Non Compliant	Non Compliant	Non Compliant
	7	**Service User Involvement and co-Production**	Compliant	Compliant	Compliant
	8	**Multidisciplinary Training**	Non Compliant	Non Compliant	Compliant
	9	**Board Assurance** Board to Ward to Board	Non Compliant	Non Compliant	Compliant
	10	**HSIB and EN Reporting**	Compliant	Non Compliant	Compliant
Person Centred & Safe	Professional	Responsive	Friendly	Progressive				

As of February 2025, Salisbury NHS Foundation Trust are declaring compliance with all **10 safety actions** for submission for year 6 of the NHS Resolution (NHSR), Clinical Negligence Scheme for Trusts (CNST).

1.1 Maternity incentive scheme year Six: Conditions

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution (nhsr.mis@nhs.net) by **12 noon on 3rd March 2025** and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the director of midwifery/head of midwifery and clinical director for maternity services.
- The Trust Board must then give their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- The Trust's CEO must sign to confirm that:
    - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
    - There are no reports covering either year 2023/24 or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/ MNSI investigation reports etc.). All such reports should be brought to the MIS team's attention before 3 March 2025.
    - Any reports covering an earlier time-period may prompt a review of a previous MIS submission

• In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICS) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

• Trust submissions will be subject to a range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England &

Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD) MNSI and NHS Resolution for the number of qualifying incidents reportable (safety action 10, standard a).Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

1.2 Evidence for submission

The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided internally in the Trust to support the Trust Board decision only. This will not be reviewed by NHS Resolution unless requested.

- On the Board Declaration form Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- Only for specific safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.
- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners.
- Trusts will need to report compliance with MIS by 12 noon 3 March 2025 using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.
- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by AO of Clinical Commissioning Group/Integrated Care System.

1.3 Timescales and appeals.

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net prior to the 3 March 2025.
- The Board declaration form must be sent to NHS Resolution via nhsr.mis@nhs.net between 17 February 2025 and 3 March 2025 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2025.
- Submissions and any comments/corrections received after 12 noon on 3 March 2025 will not be considered. • The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.
- There are two possible grounds for appeal:
  - Alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation.

- Technical errors outside the Trust's control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.

- The NHS Resolution MIS clinical team will review all appeals to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC.
- Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered.
- Appeals must be made in writing to NHS Resolution on the agreed template within two weeks of the final notification of results.

1.4. For Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progress. To apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on 3rd March 2024 to NHS Resolution nhsr.mis@nhs.net.

Action plans submitted must be:

- Submitted on the action plan template in the Board declaration form.
- Signed and dated by the Trust CEO.
- Specific to the action(s) not achieved by the Trust.
- Details of each action should be SMART (specific, measurable, achievable, realistic, and timely) and will enable the financial calculation of the funding requested.
- Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE).
- Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
- Action plans should not be submitted for achieved safety actions.

2. MIS Year 6 Criteria Safety Actions

Table 1 below describes the ten safety actions and provides overall current compliance for SFT for January 2025.

Table 1.

	Criteria for Maternity CNST	RAG SCORING
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	
10	Have you reported 100% of qualifying cases to Maternity and Newborn Investigations (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 8th December 2023 to 30th	

3. Analysis

3.1 Safety action 1:

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

PMRT was designed and will be developed further with user and parent involvement to support high quality standardised perinatal mortality reviews on the principle of 'review once, review well'. Introduced in 2018 PMRT is a collaboration led by MBRRACE-UK, who were appointed by the Healthcare Quality Improvement Partnership (HQIP) to develop and establish a national standardised tool building on the work of the DH/Sands Perinatal Mortality Review 'Task and Finish Group'.

The PMRT has been designed to support the review of the care of the following babies:

- All late fetal losses 22+0 to 23+6
- All antepartum and intrapartum stillbirths
- All neonatal deaths from birth at 22+0 to 28 days after birth
- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

Required standard	a) **Notify all deaths:** All eligible perinatal deaths should be notified to MBRRACE UK within seven working days
	b) **Seek parents' views of care:** For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.
	c) **Review the death and complete the review:** For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8th December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.
	d) **Report to the Trust Executive:** Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.
Minimum evidential requirement for trust Board	Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see technical guidance regarding the introduction of the NHS Submit a Perinatal Event Notification system - SPEN). The PMRT must be used to review the care and reports about individual deaths should be generated via the PMRT. A report should be received by the Trust Executive Board each quarter that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review

	eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
What is the relevant time period?	From 8 December 2023 to 30 November 2024

The maternity service can confirm that the PMRT is used in review processes and can confirm the above criteria has been fully met as below and in the evidence file.

a) It should be noted that from the 8th December there were 10 eligible cases by mother (11 babies as one set of twins died at 21+5 weeks as neonatal deaths) requiring notification to MBRRACE. These were all reported within 7 working days.

b) For 100% of all deaths eligible for PMRT review (4 babies) who died in our Trust from 8th December 2023, the parents' perspectives of care were sought, and they were given the opportunity to raise questions.

c) 100% of all eligible deaths from 8th December 2023 of babies suitable for review using PMRT (4 babies) had the PMRT review commenced within two months of the death.

100% of all eligible deaths from 8th December 2023 of babies suitable for review using PMRT (4 babies) had the PMRT report published and generated by the tool within the 6-month timeframe.

d) Quarterly reports have been submitted to the Trust Executive Board in the Quarterly Quality and Safety Report from 8th December 2023 and include details of all deaths reviewed and consequent action plans.

Quarterly reports have also been discussed with the Trust maternity safety and Board level Safety champions.

Salisbury NHS Foundation Trust are declaring full compliance with safety action 1.

3.2 Safety action 2:

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Required standard	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.
	1. Trust Boards to assure themselves that at least 10 out of 11 MSDS-only (see technical guidance) Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024. Final data for July 2024 will be published during October 2024.
	2. July 2024 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001).
Minimum evidential requirement for trust Board	The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.
What is the relevant time period?	From 2 April 2024 to 30 November 2024

1. SFT have passed **all** of the Clinical Quality Improvement Metrics (CQIMs) associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024.
2. In July 2023, 97.8% of women booked in the month contained a valid ethnic category (Mother).

Salisbury NHS Foundation Trust are declaring full compliance with safety action 2

3.3 Safety action 3:

Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?

Required standard	a) Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice Or Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and present this to your Trust & LMNS Boards.
	b) Drawing on insights from themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay. Progress on initiatives must be shared with the Safety Champions and LMNS.
Minimum evidential requirement for trust Board	**Evidence for standard a) to include:** **For units with TC pathways** • Local policy/pathway of TC admission criteria based on BAPM framework for Transitional Care and meeting a minimum of at least one element of HRG XA04. **For units working towards TC pathways** • An action plan signed off by Trust and LMNS Board for a move towards the TC pathway based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5. **Evidence for standard b) to include:** 1. By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team 2. By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.
What is the relevant time period?	From 2 April 2024 to 30 November 2024

a) A local policy has been in place since CNST year 4 and was updated in 2023 and reviewed through maternity governance and signed off by the DOM, DMD, clinical leads for neonatology and obstetrics. Quarterly audits of compliance are completed and discussed at Divisional Clinical governance committee.

b) Drawing on insights from themes identified from term admissions to the neonatal unit, a quality improvement initiative to decrease admissions and reduce length of stay by reducing separation times for mothers and babies was implemented in January 2024. Improving together methodology was used to progress the initiative and input from service users was considered to improve care . Progress on initiatives and the project has been shared at the Safety Champions Meetings and LMNS Safety Sub-group and LMNS Board.

Salisbury NHS Foundation Trust are declaring full compliance with safety action 3

3.4 Safety action 4:

Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required standard	**a) Obstetric medical workforce** 1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold a certificate of eligibility (CEL) to undertake short-term locums. 2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf 3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance. rcog-guidance-on-compensatory-rest.pdf 4) Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service roles-responsibilities-consultant-report.pdf when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further nonattendance.
	b) Anaesthetic medical workforce A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)
	c) Neonatal medical workforce The neonatal unit meets the relevant BAPM national standards of medical staffing. or the standards are not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).
	d) Neonatal nursing workforce The neonatal unit meets the BAPM neonatal nursing standards. or The standards are not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal ODN.
	Obstetric medical workforce

Minimum evidential requirement for trust Board	1) Trusts/organisations should audit their compliance via Medical Human Resources. Information on the CEL for short term locums is available here: www.rcog.org.uk/cel This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk) A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk 2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance. 3) Trusts/organisations should be working towards developing standard operating procedures, to assure Boards that consultants/senior SAS 15 doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and senior SAS doctors about their ability to take appropriate compensatory rest in such situations. NB. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG 4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS.
	Anaesthetic medical workforce The rota should be used to evidence compliance with ACSA standard 1.7.2.1. This can be a representative month of the rota.
	Neonatal medical workforce The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).
	Neonatal nursing workforce The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal ODN.
What is the relevant time period?	From 2 April 2024 to 30 November 2024

Obstetric workforce

1) Short Term Locum usage

An audit of compliance was completed for the time period 1st February 2024 - 31st August 2024, in line with the technical guidance. The audit demonstrated, that during this period, 74 short term locum shifts were required.

In total 7 Doctors completed these shifts, 4 of these Doctors were Salisbury NHS Foundation Trust employed Doctors and 3 of these not employed at Salisbury NHS Foundation Trust at the time of undertaking the shifts, however all were working in their local unit (within the Wessex area) on their Tier 2 or 3 rota.

The audit has been shared with Trust Board level safety champions and the LMNS.

Salisbury NHS Foundation Trust is 100% compliant with the criteria described above.

2) Long Term Locum usage

During the time period 1st April 2024 – 30th September 2024 (Q1 and Q2) the trust utilised 4 long term middle grade locum doctors.

For all standards the trust is 100% compliant to RCOG guidance on engagement of long-term locums.

The audit has been shared with Trust Board level safety champions and the LMNS.

3) Compensatory Rest

The obstetric department has a Compensatory rest Standard Operating Procedure (SOP) that was implemented as part of MIS Year 5 and the team continues to discuss and review feedback from the medical teams on their ability to take the rest.

Compensatory rest is not being measured formally as part of MIS Year 6, but the service continues to work towards the guidance and implement the SOP when required.

4) Consultant Attendance

For the period 1st April 2024 – 30th July 2024 there were 11 cases meeting the criteria above.

The audit demonstrates 90% compliance to the standard.

There was 1 case where the Consultant was not in attendance, however the case was discussed with the Consultant on-call at the time. The case was reviewed using the 72-hour review process and it was concluded that the non-attendance did not have any impact on the clinical case and it was managed appropriately from a clinical perspective. The medical teams are aware of the expectation of consultant attendance for future cases.

Audits for this element of Safety Action 4 continue monthly within the maternity and obstetric service.

Anaesthetic workforce

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and has clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they can delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. The rota is fully compliant to Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1.

Neonatal Medical Workforce

The Salisbury LNU does not meet the BAPM national standards of medical staffing.

The area of staffing for which Salisbury is **not compliant** is in the Tier 1 cover, which BAPM dictates should have a Tier 1 cover 24 hours a day, 7 days per week, *that does not cover both general paediatrics and the neonatal unit*. In Salisbury the Tier 1 medic is exclusively available 09.00-17.00hrs for the neonatal unit. After 17.00hrs the tier 1 medic covers both neonatal and general paediatrics.

The Salisbury paediatric staffing model is outlined below in Table 1.

Table 1.

Salisbury paediatric staffing model October 2024	
Tier 1	*GPVTS ST1/2 or F2 or trust grade SHO*
Tier 2	*paediatric ST3-8 or consultant out of hours (shared with general paediatric service)*
Tier 3	*Consultant cover*
Monday – Fri 09.00- 17.00	
Tier 1	*1 doctor on rota for NICU / Postnatal ward and Births*
Tier 2	*Joint cover for NICU / maternity and general paediatrics (minimum 1 doctor)*
Tier 3	*Resident Consultant*
Monday - Friday 17.00-21.00	
Tier 1	*1 doctor joint cover NICU and general paediatrics.*
Tier 2	*Joint cover for NICU / maternity and general paediatrics (minimum 1 doctor)*
Tier 3	*Resident Consultant*
Monday - Friday 21.00-09.00 and weekends 24 /7	
Tier 1	*1 doctor covering NICU and general paediatrics.*
Tier 2	*resident on call consultant or registrar shared with Paediatrics*
Tier 3	*Consultant on call*

Based on mitigating factors, the Trust Board has previously accepted that the neonatal unit is staffed safely with our current staffing structure described above.

To meet the current standard, the neonatal unit would require a minimum of 8 WTE staff who are exclusively working in the neonatal unit 24 hours a day.

Current Mitigating Factors

To date, the mitigating factors for non-compliance with BAPM standard for medical staffing have been:

1. There have been no clinical incidences, datix events or concerns regarding non-availability of a Tier 1 doctor for the neonatal unit, due to them covering neonates and paediatrics at the same time.
2. If there is a clinical concern with a baby, then the most useful and safest clinical approach is to have early on-site consultant involvement in the baby's care. Due to the working rota of the paediatric consultants (including resident nights at middle grade level), there is a resident paediatric consultant immediately available within the hospital for approximately 80% of the total 168 hours of the week. This is a greater proportion of resident consultant availability throughout the entirety of the week (including nights and weekends) than any regional NICU has within their rota'd hours.
3. There is a unit culture of early escalation to middle grade/ consultant for neonatal issues aligned to the size of our LNU and paediatric unit.
4. General Paediatric /NICU / maternity areas are in close geographical proximity.
5. NICU nurses undertake some extended roles including attending preterm or complex births with the medical team, taking bloods and siting IV cannulas.

An action plan in Year 5 of the MIS was created, with the action to write a Business Case to increase the clinical cover to the Neonatal Unit to reach BAPM standards. The Business case has been written and is currently under divisional review, following which it will progress to Trust board for consideration and approval. The request is to increase the medical workforce by 6.8wte Advanced Neonatal Practitioners.
An action plan for Year 6 of the MIS has been written to address the shortfall, this can be found at the end of this section. The report and the action plan has been shared with the LMNS and the Neonatal Operational Delivery Network (ODN).

Neonatal nursing workforce

To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the Neonatal nurse staffing standards set out in the BAPM Service and Quality Standards (2022).

The Neonatal Nursing Workforce Calculator (2020) is used on a quarterly basis to calculate compliance to the standards. The results for Q2 are documented below. **The Neonatal unit is not compliant with BAPM standards, and this non-compliance is consistent on a quarterly basis**. The tool calculates workforce based on activity and acuity and consistently the requirement to meet the BAPM standards would need to include an:

- Increase in registered nursing hours by 0.2wte - 0.4 wte.
- Increase in non-registered nursing hours by 2 wte.

Q2 SFT LNU WORKFORCE DEMAND	FUNDED	IN POST	Calculated requirement (from tool)	Adverse Variance Funded vs required
Total direct care nurses	22.19	20.07	24.55	2.36
Total registered nurses (band 5 and above)	21.39	18.05	21.66	0.27
of which QIS	14.99	13.19	15.16	0.17
Total Non-QIS	6.40	4.86	6.50	0.1
Total Non-Reg	0.80	2.02	2.89	2.09
% REGISTERED NURSES QIS QUALIFIED		73.1%	70.0%	

An action plan in Year 5 of the MIS was created, with the action to write a business case to increase the registered and non-registered nursing establishment. The Business case has been written and is currently under Divisional Review, following which it will progress to Trust board for consideration and approval.
An action plan for Year 6 of the MIS has been written to address the shortfall, this can be found at the end of this section. The report and the action plan has been shared with the LMNS and the Neonatal Operational Delivery Network (ODN).

Salisbury NHS Foundation Trust are declaring full compliance with safety action 4.

ACTION PLAN SAFETY ACTION 4

	Area	Action	Owner	Complete Y/N	Current progress made
MIS YEAR 5	**Neonatal Medical workforce** **NON-COMPLIANCE to BAPM standards**	**Business Case to be written to support increase in Neonatal medical workforce to ensure compliance to BAPM standards**	Mary Pedley Neonatal Clinical Lead		In Draft with the divisional team for review
	Neonatal Nursing workforce **NON-COMPLIANCE to BAPM standards**	**Business Case to be written to support increase in Neonatal nursing workforce to ensure compliance to BAPM standards**	Geoff Dunning Neonatal Unit Matron		In Draft with the divisional team for review
MIS YEAR 6	**Neonatal Medical workforce** **NON-COMPLIANCE to BAPM standards**	**Business Case to be reviewed by divisional team and submitted through business case approval process to board for consideration and review.**	Mary Pedley Neonatal Clinical Lead Women and Newborn Divisional Triumvirate	In progress	Divisional sign off by: 31/01/2025 Trust Investment Group by: 28/02/2025 Trust Management Committee by: 31/03/2025 Trust Board by: 31/05/2025
	Neonatal Nursing workforce **NON-COMPLIANCE to BAPM standards**	**Business Case to be reviewed by divisional team and submitted through business case approval process to board for consideration and review.**	Geoff Dunning Neonatal Unit Matron Women and Newborn Divisional Triumvirate	In progress	Divisional sign off by: 31/01/2025 Trust Investment Group by: 28/02/2025 Trust Management Committee by: 31/03/2025 Trust Board by: 31/05/2025

3.5 Safety action 5:

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift. d) All women in active labour receive one-to-one midwifery care. e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.
Minimum evidential requirement for trust Board	The midwifery staffing report submitted will comprise evidence to support a, b, c and d progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. o The midwife to birth ratio o The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with

	supernumerary labour ward co-ordinator on duty at the start of every shift and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.
What is the relevant time period?	From 2 April 2024 to 30 November 2024

a) BirthRate+ assessment was last completed out in 2023 and reported fully in February 2024. An increase in establishment was recommended and agreement received from Trust Board and ICB in May and June 2024 respectively. Midwifery staffing budget currently reflects the establishment calculated as of 2024 and is compliant with the standard above.

b) Six monthly staffing reports to CGC and Trust board have been submitted with evidence of birthrate+ calculation. Trust board have agreed to fund establishment in line with this calculation and this is reflected in our budget.

c) The midwife on the labour ward is supernumerary and this is audited in real time using the acuity tool every 4 hours. Each occasion when this has been breached is reviewed, reported via datix and it has been only sporadic and not a recurrent event. The maternity Escalation plan details the process for provision of a substitute co-ordinator if the was no co-ordinator at the start of a shift

d) All women in labour within our Trust receive 1:1 midwifery care. This is evidenced by data extracted from the acuity tool which reviews labour ward activity 4 hourly

e) A Midwifery staffing oversight report that covers staffing/safety issues has been to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period. Additionally staffing oversight reports are reported monthly in the perinatal Quality Slides which are shared with and reported to Clinical Governance Committee, LMNS Board and Trust Board for full scrutiny monthly.

Salisbury NHS Foundation Trust are declaring full compliance with safety action 5.

3.6 Safety action 6:

Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Required standard	Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.
Minimum evidential requirement for trust Board	Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust. These discussions should include the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate. *The Three-Year Delivery Plan for Maternity and Neonatal Services* set out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory. Trusts should be able to provide a signed declaration from the executive Medical Director declaring that Saving Babies lives Version 3 is fully/will be in place as agreed with the ICB.
What is the relevant time period?	From 2 April 2024 to 30 November 2024

The Saving Babies lives care bundle version was published in June 2023 and provides evidence based best practice, for providers and commissioners of Maternity care across England with an aim to reduced perinatal mortality.

It brings together six elements of care:

1. Reducing smoking in pregnancy
2. Fetal Growth: Risk assessment, surveillance, and management
3. Raising awareness of Reduced Fetal Movements
4. Effective Fetal Monitoring

5. Reducing preterm Birth
6. Management of pre-existing diabetes in pregnancy

Compliance covering the relevant timeframe 02/04/2024 - 30/11/2024:

17/05/2024 self-assessment submission and 24/06/2024 LMNS validated assessment.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	20%	Partially implemented	20%
Element 2	Fetal growth restriction	Partially implemented	50%	Partially implemented	50%
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%
Element 4	Fetal monitoring in labour	Partially implemented	20%	Partially implemented	20%
Element 5	Preterm birth	Partially implemented	37%	Partially implemented	48%
Element 6	Diabetes	Partially implemented	33%	Partially implemented	17%
All Elements	TOTAL	Partially implemented	37%	Partially implemented	40%

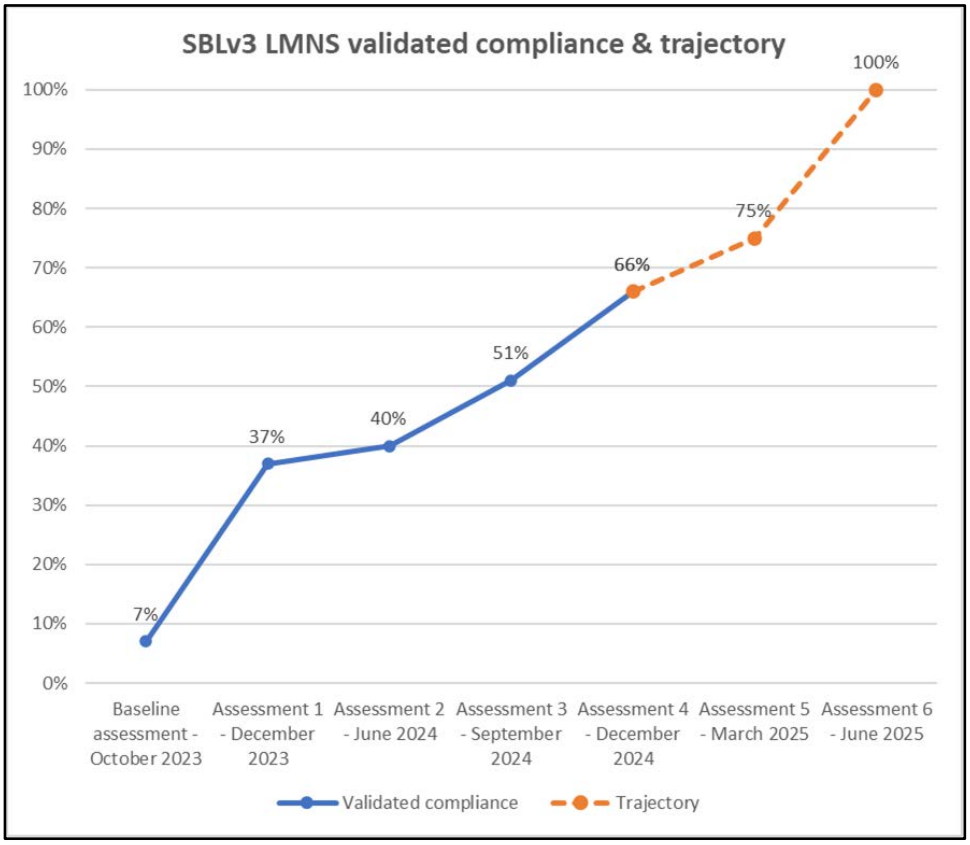
30/08/2024 self-assessment submission and 13/09/2024 LMNS validated assessment

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	70%	Partially implemented	40%
Element 2	Fetal growth restriction	Partially implemented	55%	Partially implemented	70%
Element 3	Reduced fetal movements	Fully implemented	100%	Partially implemented	50%
Element 4	Fetal monitoring in labour	Partially implemented	20%	Partially implemented	40%
Element 5	Preterm birth	Partially implemented	70%	Partially implemented	52%
Element 6	Diabetes	Partially implemented	67%	Partially implemented	17%
All Elements	TOTAL	Partially implemented	63%	Partially implemented	51%

29/11/2024 self-assessment submission and 02/12/2024 LMNS validated assessment.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	60%
Element 2	Fetal growth restriction	Partially implemented	55%	Partially implemented	70%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Partially implemented	20%	Partially implemented	60%
Element 5	Preterm birth	Partially implemented	70%	Partially implemented	63%
Element 6	Diabetes	Partially implemented	67%	Partially implemented	67%
All Elements	TOTAL	Partially implemented	66%	Partially implemented	66%

Progress since initial baseline assessment on 25/10/2023:



% of interventions fully implemented	Baseline assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4
	25/10/2023	23/12/2023	24/06/2024	13/09/2024	02/12/2024
Compliance – LMNS validated	**7%**	**37%**	**40%**	**51%**	**66%**

The Trust has not yet fully implemented every element of the saving babies lives care bundle, however as per technical guidance:

*"**Where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been***

made towards full implementation, in line with the locally agreed improvement trajectory."

SFT have confirmation from the LMNS and ICB that they are assured that all best endeavors and sufficient progress has been made as shown above and that they are in agreement that compliance has been reached for safety action 6.

Salisbury NHS Foundation Trust are declaring full compliance with safety action 6.

3.7 Safety action 7:

Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Required standard	Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting: a) Engagement and listening to families. b) Strategic influence and decision-making. c) Infrastructure.
	2. Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.
Minimum evidential requirement for trust Board	1. a) Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan. b) Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member, (Trusts should work towards the MNVP Lead being a quorate member), such as: • Safety champion meetings • Maternity business and governance • Neonatal business and governance • PMRT review meeting • Patient safety meeting • Guideline committee c) Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: • Job description for MNVP Lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare costs 20 • If evidence of funding support at expected level is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.
	2. Evidence of review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis, such as an action plan.
What is the relevant time period?	From 2 April 2024 to 30 November 2024

Our mechanisms for service user feedback are through the family experience midwife and the Maternity and Neonatal Voices Partnership (MNVP)

The MNVP group is a conduit between service users and maternity and neonatal services, the MNVP is well-embedded and works collaboratively within the Trust and LMNS.

a) The MNVP meets with services within the LMNS and the MNVP Chair is represented on the operational and board LMNS meetings which are monthly and attended by SFT representatives from the maternity unit. The MNVP reflects the experiences of the local community but remains independent and accessible to all sections of the community. Within the maternity incentive scheme period the MNVP have worked collaboratively with SFT to co-produce the local maternity and Neonatal services and the local MNVP representative meets monthly with the Family Experience Midwife to facilitate this. Examples of this work are:
    - Increasing women's choice of place of birth- our birth centre has been open for two years, and MNVP have been involved with co-production of continuing to broaden the criteria for birthing on our birth centre
    - Involvement of MNVP with gaining feedback from service users from the global majority and those living in socially deprived areas
    - Involvement of MNVP with gaining feedback from service users attending antenatal clinics and the community hubs
    - Attendance at local governance and safety champion meetings
    - Involvement of updating our website
    - Working with the Family Experience Midwife around complaints and compliments from users.
    - Using social media
    - Providing a perinatal parent engagement group for service users via WhatsApp.
    - Feedback to SFT from users
    - Co-production of an action plan following the annual CQC Maternity Survey
    - Supporting the development of the 'My Maternity booklet'
    - Reviewing service user written information such as our leaflets around pharmacy and the use of domperidone
    - The LMNS has signed off the MNVP work programme which also includes prioritisation around feedback and access for minority groups.
b) Terms of Reference show the MNVP as core members of the groups specified for attendance, as per evidence provided, and minutes evidence that they are regular attendees of the named meetings.

c) SFT can confirm that we have evidence of MNVP infrastructure being in place, written confirmation has been provided form the LMNS/ICB to confirm this.

Salisbury NHS Foundation Trust are declaring full compliance with safety action 7.

3.8 Safety action 8:

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Required standard and Minimum evidential requirement	90% of attendance in each relevant staff group at: 1. Fetal monitoring training 2. Multi-professional maternity emergencies training 3. Neonatal Life Support Training See technical guidance for full details of relevant staff groups. ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for MIS. It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.
Minimum evidential requirement for trust Board	*See technical guidance for details of training requirements and evidence. https://resolution.nhs.uk/wp-content/uploads/2024/04/MIS-Year-6-guidance.pdf
What is the relevant time period?	From 1 December 2023 to 30 November 2024

Table 3.

Fetal monitoring	
Staff group	Compliance
Midwives	97.54%
Obstetricians – consultants	100%
Obstetricians – other grades	100%

Compliance with fetal monitoring as of November 30th, 2024, is shown in table 4. We have achieved compliance for the training requirements of fetal monitoring for 2024.

Table 4.

MDT PROMPT TRAINNG	
Staff group	**Compliance**
Midwives	93.44%
MCA's	90%
Obstetricians – consultants	100%
Obstetricians – other grades	100%
Obstetric Anaesthetists - consultants	94.74%
Obstetric Anaesthetists – other grades	95.24%

Compliance with PROMPT for 12 consecutive months as of November 30th 2024, is shown in table 4. 90% or more of each relevant maternity unit staff group have attended an 'in house' one day multi-professional training day, that includes maternity emergencies and with one scenario being conducted in the clinical area.

Table 5.

Newborn Life support	
Staff group	Compliance
Midwives	93.44%
Neonatal nurses	90.48%
Paediatricians - consultants	90%
Paediatricians – other grades	92.31%

Compliance with newborn life support training as of November 30th 2024, is shown in table 5. We have achieved compliance in NLS training.

The new MIS Year 5 requirement was that Resus Council trained instructors must deliver all in-house NLS training. As of year 6 all NLS training has been delivered by instructors holding GIC qualified status.

Salisbury NHS Foundation Trust are declaring full compliance with safety action 8.

3.9 Safety action 9:

Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Required standard	a) All Trust requirements of the PQSM must be fully embedded.
	b) The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). With evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings.
	c) All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures.
Minimum evidential requirement for trust Board	**Evidence for point a) and b)** • Evidence that a non-executive director (NED) has been appointed and is working with the BSC to develop trusting relationships between staff, the frontline maternity, neonatal and obstetric safety champions, the perinatal leadership team 'Quad', and the Trust Board to understand, communicate and champion learning, challenges, and best practice. • Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set at every meeting. This should be presented by a member of the **perinatal** leadership team to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback. • Evidence of collaboration with the LMNS/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM. • Evidence of ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024. • Evidence that in addition to the regular Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.
	Evidence for point c): Evidence that the Board Safety Champions are supporting their perinatal leadership team to better understand and craft local cultures, including identifying and escalating safety and quality concerns and offering relevant support where required. This will include:

	• Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented. • Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.
What is the relevant time period?	From 2 April 2024 to 30 November 2024

A non-executive safety Champion continues to work alongside the Executive Safety Champion to address quality issues, they meet monthly as part of the safety champions forum, which is chaired by the Chief Nursing Officer (Executive Board Safety Champion), as well as being present monthly at Trust Board and reviewing perinatal Quality in both forums, including review of the minimum data set monthly at trust board.

The quarterly quality & safety reports to Trust board and the monthly Perinatal Quality Slide sets report on all of the agreed metrics in this action. Board safety champions undertake a walk round of the department monthly to hear any concerns raised by staff relating to safety issues. Progress on actions from walk abouts and staff feedback is collated and reviewed and has been made available to staff in 'you said, we did' format on the Safety Champions boards in all areas.

The Trust has reviewed it's claims scorecard alongside incident and complaint data and at least twice in the MIS reporting period at a Trust level quality meeting. This data is reviewed quarterly at Divisional Governance and escalated upwards from here to Trust Board in the quarterly Divisional Governance escalation report. In addition, it is included in the quarterly Quality and Safety report which is reported to, and discussed at Trust Board.

Discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance are continuing to take place at Board level monthly and are all incorporated into the Perinatal Quality Surveillance slides presented by the Director of Midwifery monthly at Trust Board.

As per CNST MIS requirements the Board Safety Champion(s) are meeting with the perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented. These meetings are monthly at Safety Champions forums.

The perinatal Quadrumvirate continue to progress the Maternity and Neonatal Culture Improvement plan, this is monitored by safety champions at the monthly meeting and also in the perinatal Quality slides which are presented and monitored at Trust Board. The perinatal Quadrumvirate have also sought support as

needed through Trust Board and presented a full Board report demonstrating and detailing the programme to enable Trust Board to maintain full oversight.

Salisbury NHS Foundation Trust are declaring full compliance with safety action 9.

3.10 Safety action 10:

Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Required standard	a) Reporting of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.
	b) Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 8 December 2023 until 30 November 2024.
	c) For all qualifying cases which have occurred during the period 8 December 2023 to 30 November 2024, the Trust Board are assured that: i. the family have received information on the role of MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.
Minimum evidential requirement for trust Board	**Trust Board** sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
What is the relevant time period?	From 8 December 2023 to 30 November 2024

A. All qualifying cases for the qualifying timeframe were reported to the Maternity and Newborn investigation branch (MNSI). During the reporting period there have been two term babies born with HIE. Only one of those babies qualified for MNSI investigation and Early Notification. Both HIE cases were referred to MNSI with one case being a grade 2 HIE that was cooled and accepted for investigation and, the other case being rejected as it was a potential mild HIE grade 1 and therefore did not qualify.

B. The one qualifying case between 8 December 2023 and 30 November 2024 has been investigated and was referred to the Early Notification scheme.

C.

i. The family received written information regarding MNSI and ENS. Both the letter templates and redacted copy of the letter are included in the evidence bundle for the one family that met HSIB and ENS criteria. *The reporting wizard for ENS is completed by the head of litigation as per email and NHSR have confirmed current eligible reported cases (see redacted emails in evidence bundle).

ii. Duty of candour compliance is confirmed.

Salisbury NHS Foundation Trust are declaring full compliance with safety action 10.

4. Conclusion

The Trust board is asked to review the content of this report and note compliance with all 10 Safety actions.

All evidence has been collated and reviewed by the Divisional triumvirate of Director of Midwifery, Divisional Medical Director, and Divisional Director of Operations. In addition, it has been reviewed in full by the Chief Nursing Officer for SFT, Non-Executive Maternity Safety Champion and the Chief Nurse for the ICB as Accountable Officer, to ensure complete scrutiny and transparency around evidence provided to support SFT's compliance.

The CEO is requested to sign the Board declaration form prior to submission to NHS resolution.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.7
Date of meeting:	6th March 2025		

Report tile:	CQC Inspection Report (Inspection September 2024) Salisbury NHS Foundation Trust Maternity Services.			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	CGC 25th February 2025			
Prepared by:	CQC Shared by: Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the contents of the published CQC report for Maternity Services following an unannounced Inspection in September 2024.

Executive Summary:

The CQC carried out an unannounced Inspection of Maternity Servies at Salsbury NHS Foundation Trust on September 24th, 2024.

CQC last inspected Maternity services in March 2021. Following this inspection the service was rated as overall 'Requires Improvement, with a rating of 'Requires Improvement' for Safe and 'Inadequate' for well-led and a section 29A warning notice was issued. The warning notice was lifted in October 2021.

Following the inspection in September 2024 the CQC inspection report was published on 14th February 2025.

An overall improved rating of Good was achieved, with acknowledgement and comment throughout the repot of improvements made.

The CQC inspected 15 quality statements across the safe, caring and well-led key questions and combined the scores for those areas with scores from the last inspection to give the overall rating.

Inspectors found:

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

However:

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

The press release from the CQC describing the rating and improvements can be found here: CQC rates maternity services at Salisbury District Hospital as good - Care Quality Commission

The full report is available as a link here: Salisbury District Hospital HTML report for assessment AP5984 - Care Quality Commission

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.8
Date of meeting:	06 March 2025		

Report tile:	Patient Feedback Report – Q3 2024/25			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Clinical Governance Committee 25th February 2025 Scheduled for Patient Experience Steering Group – 26th February 2025. Scheduled for Trust Board – 6th March 2025			
Prepared by:	Victoria Aldridge - Head of Patient Experience			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			
Appendices (list if applicable):	None.			

Recommendation:

This report is for assurance and noting by the Committee.

Executive Summary:

This report provides summary and insights drawn from the various methods by which our patients feedback on our services. This includes analysis of complaints, concerns, compliments, Friends and Family Testing and any National surveys reported during Q3 of 2024/25.

To summarise the contents of this paper:

Complaints/concerns/compliments and enquiries:

Patient activity across the Trust has increased this quarter, the total number of complaints and concerns has also increased. A total of 110 were logged for Q3, compared with 77 in Q2.

A total of 347 comments/enquiries were logged by the PALS team in Q3, this is less than the previous quarter. Of these, 54 (16%) were requests for information (largely related to Medical Records, followed by Cardiology and, Respiratory.

A total of 257 compliments were recorded on Datix this quarter across the Trust (88 more than last quarter).

For Q3 the top three most prevalent high-level themes for complaints across the Trust were largely the same as those seen in both Q1 and Q2. These were in relation to **Patient Care** (44%) and **Communication** (17%). However, **Appointments including delays and cancellations** is a new theme this quarter (10%) – see Table 1.2.

Within these themes **unsatisfactory treatment, lack of** or **insensitive communication** and **delays in receiving appointment** were the highest sub-categories (see Tables 1.1a - 1.2c).

Meeting the 85% target for **complaints response within timescale** continues to be a challenge, (see Figure 1.3). Despite efforts across all Divisions in December which saw this target achieve 63% (in-month reporting), the Trust averaged a 48% closure on target rate for complaints and concerns in Q3.

The number of **reopened complaints/concerns** this quarter is currently estimated to be around 7%.

The PALS team and the Divisions continue to focus on early resolution and de-escalation of complaints. 31 complaints/concerns were considered to achieve an earlier resolution than anticipated in Q3, the highest number so far this year. 35% (respectively) were achieved by Medicine and Surgery.

Friends and Family Test (FFT) in total for Q3 there was a total of 16,039 a small decrease on Q2, consistent with this time of year. This equates to an average response rate of 16% (of eligible population), exceeding the Trust's target. FFT experience ratings have however decreased slightly to 94%, this is below the Trust's target for satisfaction. Positive themes around staff attitude noted and negative themes around waiting times were also noted.

Triangulation of data with ICB Acute Trusts:
Themes for complaints are largely similar, communication and clinical/nursing care being the top themes across all three Trusts.

Positive themes for FFT are similar with staff attitude being top. Amongst the top negative themes, waiting times is a common theme across noted.

Local Surveys:

Real-time feedback (RTF) remains a standing item for discussion at the PESG. Overall good satisfaction rates, improvements seen this quarter on Q2. However, some issues still noted around noise at night and involvement with discharge plans. High levels of satisfaction related to cleanliness of the ward areas, receiving enough to eat and drink and having trust in those undertaking your care. A total of 94 surveys across 13 inpatient wards were completed during this quarter and an average overall satisfaction rating of 87.6% being achieved.

Your Views Matter quarterly report has been replaced with the National Audit for End of Life Care (NACEL) Survey. The Q3 report is noted to have had a significantly lower uptake (41% reduction), this is considered to be a factor in the decline in overall performance for the Trust this quarter. 66% of SFT's respondents described their overall rating of care and support given by the hospital to the dying person as "excellent", compared with 22% who described this as "Poor", there is however a significant increase in the poor rating (going from 22% from 6%).

In summary, the Trust's comparative performance with our South West peers has maintained 6th position in the overall ratings comparisons.

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

Salisbury NHS Foundation Trust

Patient Experience - Patient Feedback

Q3 Report 2024/25

Purpose of paper

To provide assurance that the Trust is responding appropriately to complaints and demonstrate that learning and actions are being taken to improve services in response to feedback.

This paper will also outline the other methods of patient feedback that the Trust collects, and as these processes develop will seek to triangulate these various data sets to provide balanced insight to how patients experience our hospital.

Background

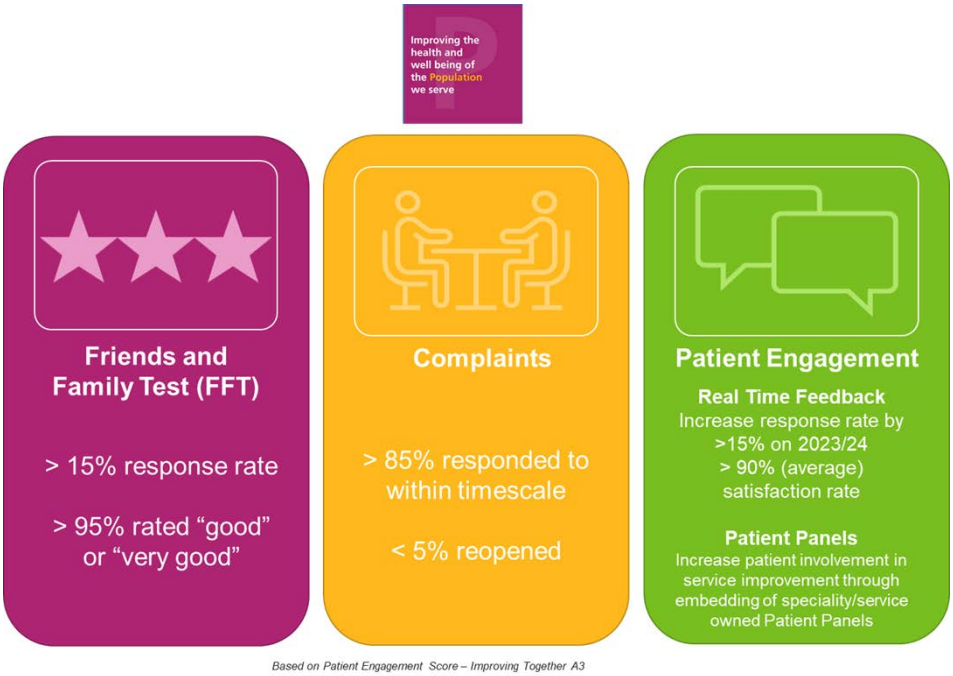
Patient experience is defined as “the sum of all interactions, shaped by an organisation’s culture that influence patient perceptions across the continuum of care”. Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and feedback is an imperative. This includes learning from feedback and in transparency and honesty on when healthcare goes wrong.

Concerns and complaints can surface, and the quality of the investigation, response and actions allow improvements in the safety and quality of care delivery. We strive to create an open culture where concerns and complaints are welcomed and learnt from. This can also be said of the many compliments received that far outweigh these complaints and concerns. Compliments can also help improve practice by allowing good practice to be disseminated and shared where possible.

In line with the Trust’s Improving Together Methodology and under the Patient Experience Quality Priorities approved through the Patient Experience Steering Group, the following areas remain the focus for 2024/25. Friends and Family Testing, Complaints and Patient Engagement.

Friends and Family Testing and Complaints are covered in this Patient Experience report. Progress against the Patient Engagement objectives are covered separately under the Patient Engagement annual report.

Summary of the performance metrics in relation to these areas is summarised below:



Contents

1. Complaints, Concerns and Compliments - Trust Overview

There were a total of 2 items of feedback posted on the NHS Website* in Q3.

Average rating on responses for this quarter:

	Positive	Neutral	Negative	Average star rating
Q3 24/25	**1**	**0**	**1**	««
Q2 24/25	4	0	3	««««
Q1 24/25	3	0	0	««««««
Q4 23/24	2	1	0	««««««
Rolling year Total / Average	**10**	**1**	**4**	«««««

*All feedback is available here: Ratings and reviews - Salisbury District Hospital - NHS (www.nhs.uk)

Patient Activity

Table 1.1 shows the breakdown for patient activity across the Divisions and total for the Trust. This is used to calculate feedback on a per 1,000 basis within this report (see Figure 1.1). The Trust is continuing to see a higher level of patient activity, quarter on quarter.

Table 1.1 – Patient activity

Patient Activity by Division / Quarter	Clinical Support and Family Services	Medicine	Surgery	Women & Newborn	Total
Q3 2024 - 25	36,087	37, 514	44,472	5,052	123,125
Q2 2024 - 25	36,567	36,800	43,222	5,273	121,862
Q1 2024 - 25	36,630	38,139	42,344	5,291	122,404
Q4 2023 - 24	36,547	37,402	41,456	4,576	119,981
Q3 2023 - 24	33,495	35,002	41,789	4,471	114,757

Compliments

Compliments are sent directly to the Chief Executive, PALS or via the SOX inbox and are acknowledged and shared with the staff/teams named. Where individual staff members are named in a compliment the PALS team complete a SOX which is sent to the SOX administrator for formal recognition. Whilst compliments continue to be retained locally within the department areas, the PALS team have been working to promote the importance of sharing these to allow for more formal reporting. This ensures for more robust reporting and changes to the Datix system now allow for theming of compliments to enable reporting alongside complaints and FFT.

Complaints and Concerns

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

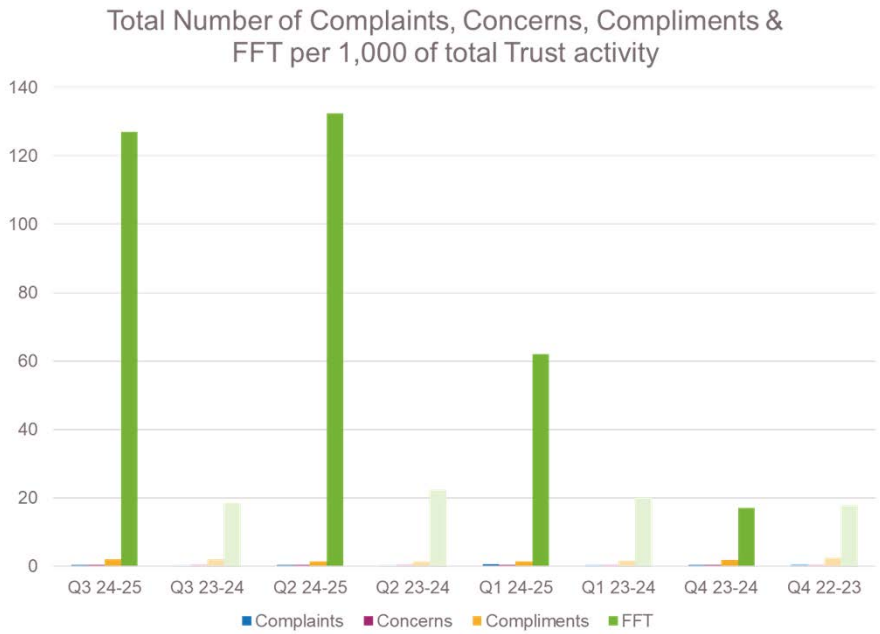


Figure 1.1 shows a slight increase in the total number of both complaints and concerns received for Q3, in comparison with Q2. These numbers are comparative with the same period last year *(opaque graphs show 2023/24 reporting)*.

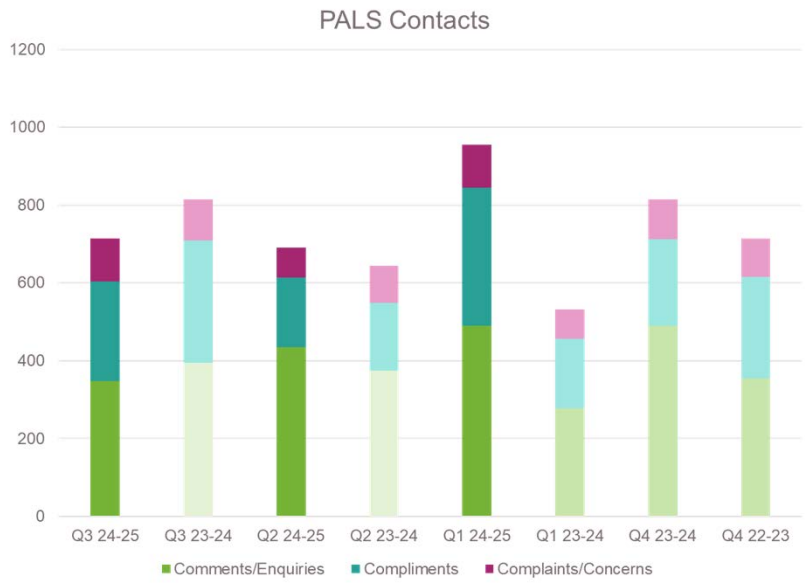
FFT feedback continues to maintain high response rates, exceeding the Trust target again this quarter. An average 94% satisfaction rate is maintained from Q2.

Compliment numbers have continued to fluctuate, as we balance the continued promotion of formally recording these with PALS and the resources needed to undertake this. At the time of writing this report, there were at total of 257 compliments recorded on Datix for Q3. 86 more than Q2.

In Q3 the PALS department logged 347 comments/enquiries. 88 less than Q2. Of these, 54 (16%) were requests for information, largely related to Medical Records, followed by Cardiology and, Respiratory.

This equates to an average of 2.8 contacts per 1,000 patient activity across the Trust. These contacts are in addition to the complaints, concerns and compliments.

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



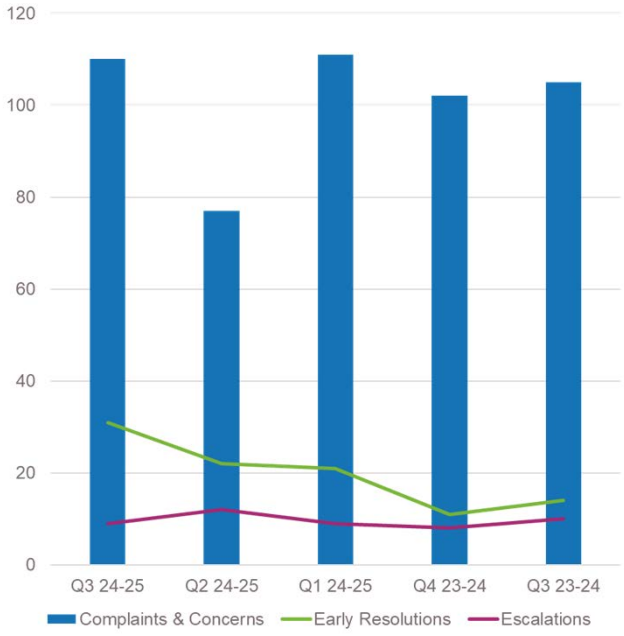
During Q3 there were a total of 110 complaints and concerns logged (77 in Q2).

This increase in concerns and complaints and reduction in "other" contacts is in part due to a change in process within the department improving the quality of categorisation and processing of PALS contacts.

This process is now more aligned to our Trust policy and definitions as outlined in Appendix 1 of the Trust's Complaints Policy.

Changes to the complaints process over the past 6-12months coupled with targeted work through PALS to adopt the PHSO principles on **early resolution** of complaints continues to be emphasised.

Figure 1.1b Total Number of Complaints & Concerns, Early resolutions, and Escalations



31 complaints/concerns were considered to achieve an earlier resolution than anticipated in Q3.

9 were noted to have escalated from a comment or enquiry into a concern or complaint.

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

Figure 1.1c

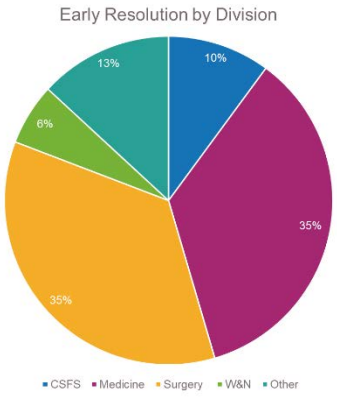


Figure 1.1c shows how the de-escalated complaints/concerns were distributed across the Trust.

Surgery is noted to have considerable improved this quarter to adopt the principles around early resolution and de-escalation, and this is evidenced by achieving the same proportion as Medicine.

Themes from Complaints/concerns

Table 1.2 below shows the themes for complaints and concerns received in Q3 (trust wide).

Highlighted are the top three most prevalent themes. **Patient Care** and **Communication** are consistent themes with the previous quarter, however **Appointments, including delays and cancellations** is a new theme for this quarter. These top three themes are further broken down into sub-categories for deeper analysis in Tables 1.2a, 1.2b and 1.2c.

Table 1.2 Raw data - Themes from Q3 Complaints/concerns

	CSFS	Medicine	Surgery	Women & Newborn	Non-clinical	Total by theme	% of total by theme
Access to treatment or drugs	0	2	4	0	0	6	5%
Admissions, discharge and transfers	1	2	3	0	0	6	5%
Appointments including delays and cancellations	**0**	**3**	**7**	**1**	**0**	**11**	**10%**
Clinical Treatment	1	1	2	0	0	4	4%
Commissioning Services	0	0	1	0	0	1	1%
Communications	**3**	**10**	**3**	**3**	**0**	**19**	**17%**
End of Life Care	0	1	1	0	0	2	2%
Facilities Services	0	3	0	0	0	3	3%
Other	0	0	0	0	0	0	0%
Patient Care	**5**	**15**	**18**	**10**	**0**	**48**	**44%**
Prescribing errors	0	0	0	0	0	0	0%
Privacy, dignity & wellbeing	0	0	0	0	0	0	0%
Values and behaviours (Staff)	2	2	5	0	0	9	8%
Total by Division	**12**	**40**	**44**	**14**	**0**		
Divisions Total	**110**						

The following tables show a further breakdown for these three themes across the Trust.

Unsatisfactory treatment was again the highest sub-category this quarter under **Patient Care** (see Table 1.2a). This was the same for both Q1 & Q2.

Insensitive and lack of communication was again the highest causes for complaints under the **Communications** category (see Table 1.2b). This was the same for Q2.

Appointments including delays and cancellations is a new theme for Q3. With delay in receiving appointment featuring as the highest causes under this category (see Table 1.2c). There is no theme within this sub-subject, as relate to four separate locations (ENT, Ophthalmology, Urology and Respiratory).

Table 1.2a

Patient Care	48	44%
Unsatisfactory treatment	**24**	**50%**
Nursing Care	7	15%
Further complications	6	13%
Pain management	4	8%
Inappropriate treatment	3	6%
Delay in making diagnosis	1	2%
Falls	1	2%

Learning Disability	1	2%
Meal not available	1	2%

Table 1.2b

Communication	19	17%
Insensitive communication	**7**	**37%**
Lack of communication	**6**	**32%**
Information not given to patient	3	16%
Wrong information	2	11%
Information not given to family	1	5%

Table 1.2c

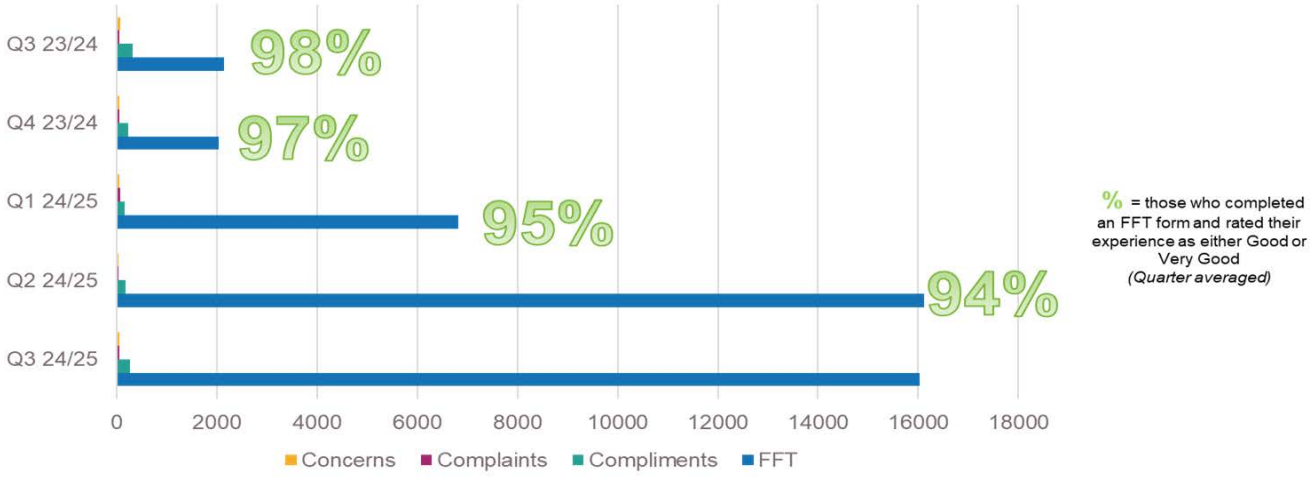
Appointments including delays and cancellations	11	10%
Delay in receiving appointment	**4**	**36%**
Unsatisfactory Outcome	2	18%
Appointment system - procedures	2	18%
Appointment date required	2	18%
Appointment postponed	1	9%

Complaints and concerns continue to be small when compared with the number of Friends and Family Test (FFT) feedback received across the Trust and satisfaction rates associated with these. This comparison is demonstrated in Figure 1.2.

This demonstration represents the proportion of good or very good experiences (as rated by our service users) and how vast this is in comparison to the number who have raised a complaint or concern.

We have continued to see a slight decrease in satisfaction this quarter, dropping below the 95% Improving Together target, however it is recognised that this is largely due to the significant increase in quantity of feedback in this period.

Figure 1.2 – Reiterates the FFT feedback rates compared with complaints, concerns and compliments (based on a per 1,000 patient activity) but also demonstrates the patient experiences rates obtained from these.

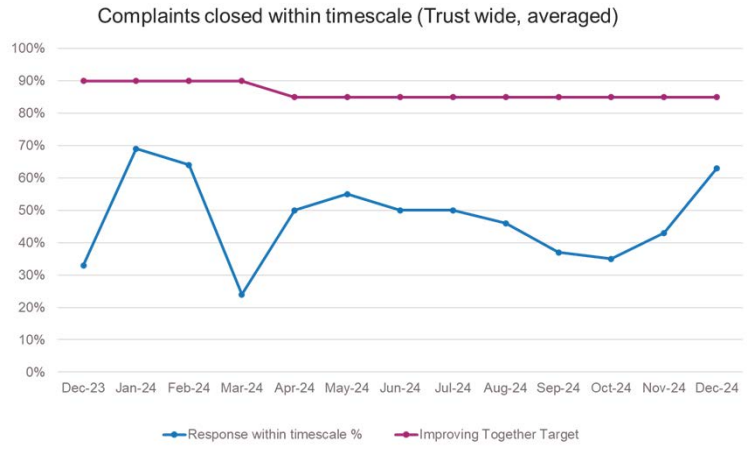


Overdue Complaints

The Trusts Improving Together Target for response to complaints within their agreed timescale for 2024/25 is 85%. Overdue complaints will therefore continue to be a focus for the Patient Experience Quality Priorities going into 2024/25.

Live performance data is monitored monthly via the Patient Experience Steering Group, and the tracking of this target through this forum is being demonstrated in Figure 1.3.

Figure 1.3 – Complaints closed within timescale (live, in month reporting at PESG)



There are various factors that can influence the inability to achieve the timescale for response.

PALS continue to work with individual areas to understand these challenges and to help improve processes to progress towards achieving the 85% target.

Significant strides towards this were evident in December 2024.

This target also continues to be monitored via the Integrated Performance Report (IPR) as a watch metric and also features in the Patient Engagement Score Improving Together A3.

The Trust averaged a **48%** closure on target rate for complaints and concerns in Q3.

Reopened Complaints

Figure 1.4 – Number of re-opened complaints or concerns

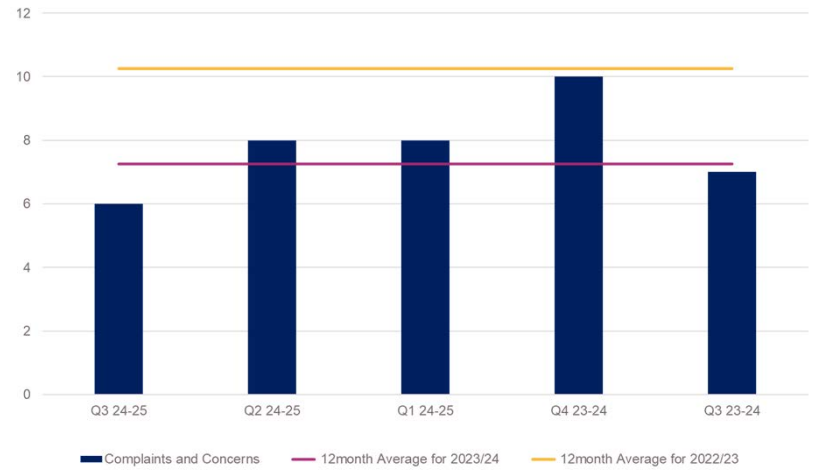


Figure 1.4 shows the number of reopened complaints and concerns (in total), compared with previous quarters.

The yellow lines show the average for 2022/23.

The pink line is a calculated average for 2023/24 acting as a benchmark for comparison.

The Patient Experience Quality Priorities for 24/25 aims for a less than 5% of total number of complaints/concerns to be reopened. So far, for 2024/2025 we are estimated to be averaging approximately 7%.

The number of reopened complaints and concerns is less this quarter and is noted to be lower than the 2023/24 average.

2. Learning from Patient Experience

Patient Stories

November PESG:
Patient story presented in person by Ken. Ken shared his story from symptoms onset to diagnosis and through treatment for myeloma. The story was largely positive noting the impact of staff (both clinical and non-clinical) on his experience. He talks candidly about the importance of good communication and empathy, ensuring the patient understands what is being said to them and that they have the right support around them. Ken is a member of the Trusts Cancer Patient Panel (PPV group).

Questions and observations raised by the group:

- Noted the difference in experience of receiving the same news between orthopaedics and haematology. The small difference to the environment/who was around/how this was communicated and impact on the patient's experience.

Lots of examples of where the experience under the circumstances positive, various references to the impact that staff have on the patient experience, especially those not directly related to the clinical care (i.e. housekeeping).

Patient Experience Division Presentations

The development of the Patient Experience Steering Group agenda ensuring there are equal opportunities for sharing patient experiences seen through DMT's and Clinical Governance Sessions. Throughout Q3, complaints and FFT data from Q2 was shared at Divisional Governance sessions as an opportunity to share patient experience data with front-line teams and encourage reflections on what mitigations could be considered to change poor experiences and replicate those things which are being done well.

Work continues to embed the process for Divisions attending the Patient Experience Steering Group to reflect on their data and provide updates on any areas of focus which they are pursuing which may be informed by this.

Table 1.3 – Q2 Patient Experience data presented to Divisions during Q3:

Division	Data presented to Division	Division update to PESG
Surgery	15th January 2025*	*Deferred to February 2025*
CSFS	19th December 2024	*Deferred to February 2025*
Medicine	12th November 2024	30th October 2024
Women & Newborn	15th November 2024	27th November 2024
Facilities (Food & Nutrition /PLACE)	3rd December 2024	30th October 2024

Facilities Update to PESG (30th October 2024):
Summary of services and celebration of SOX's. Car parking update: funding to implement changes to ANPR cameras being worked through. Main changes include blue badge holders being in a separate car park not covered by ANPR so no additional registrations needed, just display of the badge. A barrier will be introduced via a 'help' button to alleviate unnecessary charges and exemptions. Plans for implementation by 14/02/25. PLACE audit scheduled for the 07/11/2024, results expected mid-February 2025.

Medicine Division Update to PESG (30th October 2024)
Summary of services and celebration of SOX's. Updates on how ED are improving patient experience using A3 thinking. There is focus on proactive management/resolution of complaints. They are also streamlining processes and having additional staff on duty to ensure patients are streamed to the

appropriate department more efficiently, this is reducing waiting times. Pitton are looking a ward redesign to improve functionality. Other workstreams included looking at enhanced care for 'complex needs patients' with an aim to reduce the risk of falls. Challenges noted around pressure damage, increased violence and aggression towards staff, delays in Cardiology follow up and back-log of letters – (on divisions Risk register) working alongside PALS to tackle the backlog and manage the communication around this.

Women and Newborn Division Update to PESG (27th November 2024):
Achievements, compliments, SOX nominations for the Division noted.

Challenges within neonatal related to the meal trolleys, women are asked to complete meal choices on post-natal ward and then their choices are wheeled down to the neonatal ward. Food getting cold is becoming a theme as a result. Capital bid being worked through for a heated trolley.

Gynae meet bi-weekly to discuss themes from FFT and complaints, concerns. Negative themes coming through FFT related to waiting times for appointments on the day, this is being monitored. Waiting lists are also an issue but this has been an Improving Together Driver for Gynae and they have reduced waiting times for several clinics as a result of this focus.

Maternity and neonatal have developed a triangulation forum, this is an MDT style with representation from maternity and neonatal voices partnership. Risks, claims, complaints and FFT are also discussed here. Engagement groups event undertaken in November with the Family Nurse Practitioner. The focus was on the younger population and there are further plans to link with local Afghanistan refugees.

3. Training & Development for Staff

The Patient Experience Team and PALS continue to work with Division leads and individual staffing groups to ensure staff are understand the complaints process and the role of PALS within this.

Training packages were delivered in October 2024 to Bands 7 and 8 staff as part of the leadership training package offered by the Trust.

Introduction to PALS and use of actual events based scenario is now included within the Trust's communication course, this launched in November 2024.

PALS have been asked to provide enhanced complaints training for Amesbury Ward (in collaboration with Legal Services), additional training for Band 7 ED staff and de-escalation training for the Respiratory Administration team to help with managing difficult calls. These training events are scheduled to take place throughout Q4.

4. CQC & PHSO Complaints Summary

CQC

Concerns raised through the CQC can emit three main types of action/response.

- These can be for information only and no further action.
- These can be general action requests for assurances either related to a specific area of the hospital or particular staff group.
- These can be actions, responses or assurances related to a specific complainants case details.

In Q3 the Trust received 2 concerns from the Care Quality Commission (CQC) – these are summarised below, with outcomes and listed chronologically.

Summary of the requests for this period are shown in Table 4.1:

Table 4.1 Summary of concerns received via the Care Quality Commission (CQC) for Q3

Concern (listed chronologically)	Location / Area related	Request from CQC	Outcome
Concern 1	Durrington and Pitton Ward	Advised individual to contact the Trust's PALS team.	Letter now received from the daughter. PSR in relation to this as the Local Authority had raised an s42 safeguarding for the patient concerned. The s42 was closed as it was submitted after the patient had deceased. A PSR has been completed and closed, though the duty of candour remains open. This aspect has been followed up with the Division.
Concern 2	Longford Ward	Recorded feedback in relation to discharge packages. Further information required on the support and contact details provided to patients wishing to access support and advice when they are discharged from spinal rehabilitation inpatient care.	Details discussed with the Spinal Matron. Case subsequently closed on 30/12/2024.

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

	Q3 24-25	Q2 24-25	Q1 24-25	
Across all Directorates	62	56	4	

Parliamentary Health Service Ombudsman (PHSO)

The Ombudsman investigate complaints about government departments and the NHS in England. They make the final decisions on complaints that have not been resolved by the Trust. Every complainant is advised of their option to take their complaint to the PHSO once they have received their final response from the Trust. The service is free for everyone.

In Q3 the Trust received 2 requests for further information from the PHSO – these are summarised below, with outcomes and listed chronologically.

Table 4.2 Summary of concerns received via the Ombudsman (PHSO) for Q3

Concern / Complaint	Location/Area related	Request from PHSO	Outcome
Complaint	Pitton Ward	Request for complaint file, medical records and some further questions.	Initial update from PHSO suggests complainant is out of timescale for their consideration. Awaiting formal outcome/ notification of closure.
Concern	Emergency Dept	Request for medical records and complaint file.	No update yet, awaiting outcome from PHSO.

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

	Q3 24-25	Q2 24-25	Q1 24-25	
Across all Directorates	52	0	0	

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

This quarter leads from Risk, Patient Safety, Experience and Freedom to Speak Up held the third data triangulation meeting this year.

This meeting reviewed data from Q3 and Table 5.1 below is a summary of the key conclusions from these discussions:

Table 5.1 Triangulating Data – Leads Meeting Summary – Q3 24/25

This was presented to the Clinical Management Board in February as the appropriate escalation committee for this report.

This escalation report will also be presented to the "We Are Safe and Well Committee".

Triangulating Data Leads Meeting
Reporting Period: Q3 2024/25

Summary

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.
• F2SPU – worker safety (60%) of reported concerns – majority related to understaffing causing low morale, burnout and anxiety and other noted themes around management of ill-health/sickness management and performance management processes.
ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.
• Triangulation noted with feedback from the Eye Clinic (FFT top location for negative comments in relation to wait time, environment and staff attitude) and incidents related to loss to follow-up. There is awareness at Divisional level and OD&P are noted to be involved with culture support. • Concerns noted with ED having 50% of the outstanding PSR II's (17 in total), however, currently has support from the Risk and Patient Safety Team. Main themes were in relation to diabetes management, communication and medications.
ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.
• Nil of note.

Next meeting – Q4 review (24th April 2025)

6. Triangulation of data – ICB Acute Trusts

The Heads of Patient Experience across the three acute Trusts (Salisbury, Bath and Swindon) are working together to create a format to compare activity and themes across complaints, concerns, compliments and FFT. A template has now been agreed and trialled with Q3 data. This has demonstrated the following contrasts across the three acute trusts:

- PALS and Patient Experience department structure and resourcing
- Trust KPIs for response to complaints/concerns within timescale;

Table 6.2a Trust KPI's for complaints/concerns

Trust	Complaint	Concern
GWH	25 working days	7 working days
SFT	40 or 60 working days	25 working days (5 working days for informal concerns)
RUH	35 working days or Agreed with complainant	2 working days for acknowledgement

- The Trust's compliance with these timescales;

Table 6.2b KPI target compliance (Q3)

	Salisbury Hospital	Great Western Hospital	Royal United Hospital	
Target	85%	80%	90% (for within 35 w/days)	75% (for within 14 w/days)
Performance	48%	61%	71.6%	82%

- Total number of contacts (including complaints, concerns and compliments) recorded through the PALS and Patient Experience department (calculated on a per 1,000 patient activity for relative comparison);

Table 6.2 Total contacts via PALS (per 1,000 patient activity) – Q3

	Salisbury Hospital	Great Western Hospital	Royal United Hospital
Total patient Activity	123, 125	167, 565	204, 192
Number of complaints and concerns (per 1,000 patient activity)	0.89	6.35	3.72
Number of total PALS contacts (per 1,000 patient activity)	5.79	9.64	7.74

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

Positive themes for FFT are similar with staff attitude being top. Amongst the top negative themes, waiting times is a common theme across noted.

The full data set used to make these comparisons is available on request.

SFT's PALS team undertook a "Go See" in December 2024 to understand the variation in complaints closed within timescale targets noted at RUH, given their significantly higher complaint numbers and shorter turnaround requirements. This will be presented to PESG during Q4 and summarised in the next quarterly report.

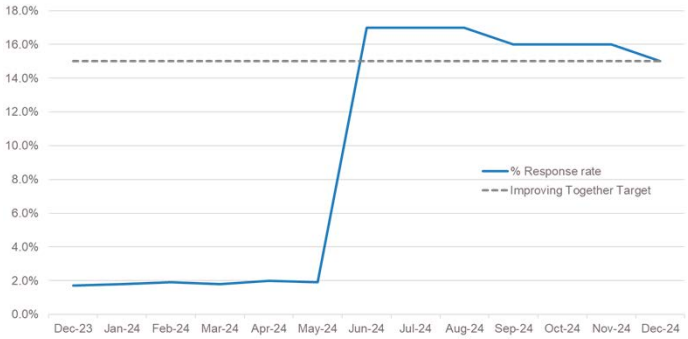
7. Process reviews, audits and policies

Nil to update this quarter.

8. Friends and Family (FFT)

Response Rates

Fig 9.1 Number of FFT responses, broken down by quarter with Trust response rate target.



A total of **16,039** patients provided feedback through the paper form for the Friends and Family Test (FFT) in Q3. This is **84 less** than the previous quarter, however this reduction is not concerning as it is in-keeping with activity fluctuations in Q3's of previous years.

The up surge in June 2024 was owed to the launch of the digital SMS system. From the 1st June 2024 the Trust commended SMS messaging of the FFT questions for ED and all maternity and outpatient services. The FFT card system remains in place for Daycase and Inpatient areas.

The overall target response rate for the quarter has achieved the Trust target, however the overall satisfaction rate has decreased below the Trust's target of 95%.

94% Of those surveyed rated their experience of our hospital as Good or Very Good (average for Q3 2024-25)

16%* Response rate (*of eligible population and averaged for Q3 2024-25)

Of the 16,039 comments received during this period the following positive/negative themes (and their proportion of these comments) are demonstrated below:

Positive

- 50% Staff attitude
- 26% Implementation of care
- 19% Environment

Negative

- 3% Staff attitude
- 2% Environment
- 2% Waiting Time

Table 9.1 and 9.1a show the quarterly comparatives for both response rates and satisfaction rates. The satisfaction rate is noted to have dropped below the Trust's target of 95% however, this was anticipated owed to the significant increase in sampling.

Table 9.1 Response rate across the Trust by per 1,000 patient activity – rolling annual comparison

	Q3 24-25	Q2 24-25	Q1 24-25	Q4 23-24	Q3 23-24
Across all Directorates	6126.86 (123, 125)	5132.31 (121, 862)	561.91 (122, 404)	617.00 (119, 981)	618.66 (114, 757)

Table 9.1a Satisfaction rate across the (averaged from responses received)

	Q3 24-25	Q2 24-25	Q1 24-25	Q4 23-24	Q3 23-24
Across all Directorates	694% (16, 039)	694% (16, 123)	696% (7, 578)	697% (2, 042)	498% (2, 141)

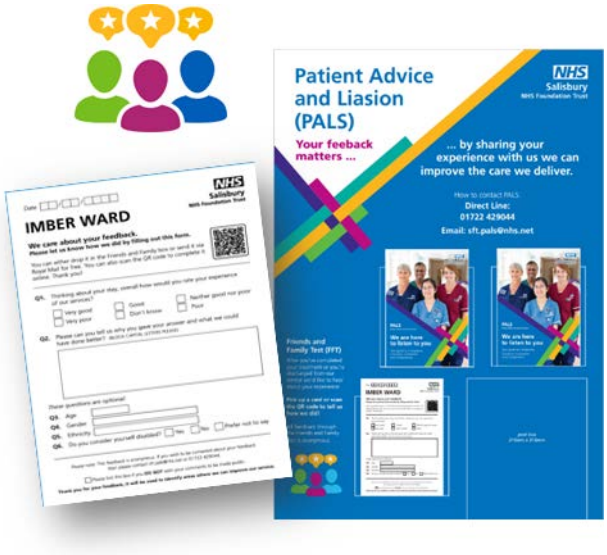
Friends and Family Test – Digital Go Live

Progress to update all FFT boards in the inpatient areas, using the opportunity to align with the PALS services and also bring these on brand is well underway.

The FFT cards have also been redesigned to mirror the format of the new SMS system and also include additional demographic information.

Examples shown here.

Speech and Language was added as new area during Q3, patients attended this clinics are now invited to send their FFT feedback by SMS.



9. Patient and Public Feedback – Local Surveys

Real-Time Feedback (RTF)

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

Surveys are taken at the patient's bedside and results are sent to ward leads within one week of these being completed for reflection. Real-time feedback is not currently undertaken within the maternity inpatient areas or on Sarum ward.

The survey mirrors the focuses of the National Inpatient survey and includes questions to assess the following areas: Admission to hospital, the ward environment, Doctors & Nurses, care and treatment, operations and procedures, leaving hospital, respect & dignity and overall experience.

In Q3 a total of 94 surveys were completed – achieving an overall average satisfaction rating of 87.6%. This quarter has seen similar numbers of surveys completed to that in Q2 (n~100), and the overall satisfaction score has remained the same as. See Table 10.1 for in month breakdown.

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

Table 10.1 Number of inspections and locations visited

Month	Total number of surveys	Number of inpatient areas visited	Wards surveyed	Average Score
October	35	13	Amesbury, AMU, Breamore, Britford, Chilmark, Downton, Laverstock, Odstock, Pembroke, Pitton, Redlynch, Tisbury, Whiteparish	88.4%
November	44	13	Amesbury, AMU, Britford, Chilmark, Downton, Durrington, Farley, Longford, Odstock, Pembroke, Spire, Tisbury, Whiteparish	85.3%
December	15	5	Breamore, Laverstock, Odstock, Pembroke, Redlynch	89.1%
Total	**94**	**13**	87.6%	

Table 10.1a Average ratings breakdown by ward (October 2024):

Area	Number of inspections	Average score
Pembroke	**1**	**100%**
Odstock	**2**	**95.65%**
Pitton	**3**	**93.96%**
Chilmark	**3**	**92.53%**
Whiteparish	**3**	**91.05%**
Tisbury	**1**	**90.83%**
Britford	**3**	**89.62%**
Amesbury	**3**	**87.05%**
Breamore	**2**	**87.02%**
Redlynch	**5**	**86.98%**
Laverstock	**4**	**85.20%**
AMU	**1**	**81.74%**
Downton	**4**	**79.64%**

Table 10.1b Average ratings breakdown by ward (November 2024):

Area	Number of inspections	Average score
Odstock	**1**	**100%**
AMU	**5**	**99.60%**

Tisbury	4	91.24%
Downton	4	90.89%
Pembroke	2	89.64%
NICU	1	89.17%
Chilmark	4	86.68%
Durrington	3	84.33%
Farley	5	84.28%
Longford Ward	2	83.13%
Whiteparish	4	83.04%
Britford	3	75.45%
Amesbury	4	69.57%
Spire	2	68.09%

Table 10.1c Average ratings breakdown by ward (December 2024):

Area	Number of inspections	Average score
Pembroke	3	99.05%
Laverstock	5	92.78%
Odstock	3	87.84%
Redlynch	2	81.49%
Breamore	2	74.96%

Tables 10.2 and10.3 shows the breakdown of average response to specific questions (highest and lowest).

Table 10.2 highest scoring questions:

Question Text	Answer score (% good)	Responded Answers
How would you describe the trust and confidence you have in those involved in your care?	93%	93
How would you describe the level of assistance you receive for basic care such as eating, drinking and washing?	90%	61
How would you rate the cleanliness of the ward you are in?	89%	94
How would you rate the level of privacy when being examined or treated?	87%	93
How well did the staff explain how you might feel following your operation or procedure?	87%	92
How would you describe the quality of written information provided about your operation or procedure?	79%	45

Table 10.3 lowest scoring questions:

Question Text	Answer score (% poor)	Responded Answers
How would you describe the noise level on the ward at night?	25%	92
How would you rate your overall wait time for your admission to hospital?	17%	92
How would you describe your understanding or involvement with your discharge plan?	12%	68
How would you describe the quality and selection of dietary options available to you?	12%	91
How would you describe your involvement with decisions around your care and treatment?	10%	89
Are you able to access pain relief when you need it?	10%	48

There are notable consistency with last quarter in relation to negative themes around noise at night, however these percentages are noted to be an improvement on last quarter. Involvement with discharge plans continues to be a negative theme, there is an active quality workstream focusing on this currently. Access to pain relief when needed, is showing as a theme this quarter is focus for April's fundamentals of care workstream.

Positive themes are also largely consistent, pertaining to the cleanliness of the ward, confidence in those responsible for caring for patients and levels of assistance around basic care. The results show there has been an improvement around quality of written and verbal information given this quarter.

National Audit for End of Life Care (NACEL) Survey Summary – Q3 Report 2024/25

The survey response rate has remained largely static this quarter (33%), however, due to a lower percentage of surveys being sent (23% from 60% in Q2), this has resulted in a overall sampling of just 8% of bereaved families, compared to 22% in Q2.

There was a total of 18 completed surveys received in Q3.

66% of SFT's respondents described their overall rating of care and support given by the hospital to the dying person as "excellent", compared with 22% who described this as "Poor".

This is a static performance on the excellent rating for Q2 (66%) there is however a significant *increase* in the poor rating (going from 22% from 6%).

In summary, the Trust's comparative performance with our South West peers has maintained 6th position in the overall ratings comparisons.

Successes to note: The following areas the Trust continued to respond well and outperform our peers both locally and nationally are in relation to:

- The person had support to drink or receive fluid if they wished – improvement on Q2 noted.
- Staff at the hospital involved the person in decisions about care and treatment as much as they would have wanted in the last 2 to 3 days of life

- Staff tried to provide care for the person's emotional needs Fig 3.6)
- The person had enough relief of symptoms other than pain". However, remains a outlier when compared with our South West and National comparisons.
- The person had an advance care plan in place before they died
- Staff looking after the person had the skills to care for someone at the end of their life

Challenges to note: The following areas the Trust's position has negatively changed from Q2, going from outperforming nationally and against peers to becoming an outlier. These were in relation to:

- Explained to the person that they were likely to die in the next few days
- Families and others were given enough spiritual/religious/cultural support
- Staff behaved with compassion and care
- Families and others were kept updated and had enough opportunity to discuss the person's condition and treatment with staff
- Staff looking after the person treated them with dignity
- Staff behaved with compassion and care

The Trust has remained an outlier this quarter in relation to:

- A member of staff at the hospital explained to families and others that the person was likely to die in the next few days
- There was a co-ordinated care approach by hospital staff during the final admission, including with health and care providers outside the hospital where appropriate
- The hospital staff regularly checked and addressed the person's needs
- If families and others wanted to be with the person when they died, they received timely communication to be there

It is however recognised that the significant reduction in sampling this quarter may be a factor in some of these areas seeing a reduced performance as a consequence of the relative sample being significantly reduced, 44 surveys were analysed in Q2 compared with just 18 surveys in Q3.

The NACEL survey remains unable to robustly correlate complaint themes by location with this data, changes to the process implemented at the end of Q2 has been unsuccessful in allowing for location to be correlated with feedback and subsequently other data sets such as complaints. A decision has been taken by the CMO and CNO to allow for NACEL to be replaced by the Trust's YVM survey from Q1 2025/26.

8 survey participants requested a call-back from PALS, only one of these expressed unhappiness with aspects of care. No formal complaint was raised.

Full report was presented to the End of Life Care Steering Group on the 24th February 2024 and scheduled for the Patient Experience Steering Group on the 26th February 2024.

10. Patient and Public Feedback – National Surveys

Nil to report this quarter.

Scheduled Reporting of Surveys

- Urgent and Emergency Care Survey – will be reported in (Q4) 24/25
- Children and Young People Survey 2023 – will be reported in (Q4) 24/25

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.9
Date of meeting:	6th March 2025		

Report tile:	Q3 Learning from Deaths Report 2024-25			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	
Approval Process: (where has this paper been reviewed and approved):	Mortality Surveillance Group Clinical Governance Committee 25th February 2025			
Prepared by:	Mr Charles Ranaboldo, Trust Mortality Lead Dr Ben Browne, Associate Medical Director			
Executive Sponsor: (presenting)	Mr Duncan Murray, Chief Medical Officer			

Recommendation:

The paper is to provide assurance to the committee that the Trust is learning from deaths and making improvements.

Executive Summary:

Summary:

- The latest SHMI figure for the Trust is 0.96 (12-month period ending in August 2024). This is the lowest recorded figure for some time. According to NHSE this figure remains statistically within the expected range for the Trust (see graphs at the bottom of this executive summary).
- We have adjusted processes to allow teams undertaking primary reviews to quickly redirect cases to other specialities for review as required. This feature is particularly helping specialties such as palliative medicine, where the patient may have received care under another specialty before their involvement in care.
- Certificates of achievement will now be awarded to staff engaging with the process and completing high numbers of mortality reviews.
- The Medical Examiners Officers recently identified a small number of Influenza cases where there was no recorded entry in the notes for why Tamiflu had not been offered as per NICE guidance. This observation was rapidly escalated and cascaded to clinical teams for learning.
- Other BSW Trusts have requested insight from us about the use of the MaMR module and our processes for its use in the Trust.
- There has been interest from other users of MaMR nationally in adopting the Salisbury (same "currency" or terminology as SJR) abbreviated cross specialty proforma/template. MSG will be asked to approve sharing, potentially contributing to improved patient safety and quality of care beyond SFT.
- A video of how to use the MaMR platform has been completed and circulated.
- SII/PSIRF reviews will now be attached to mortality records within MaMR to improve record keeping.

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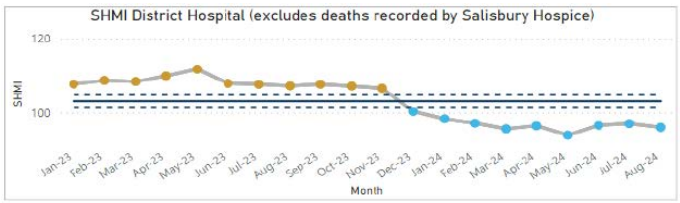

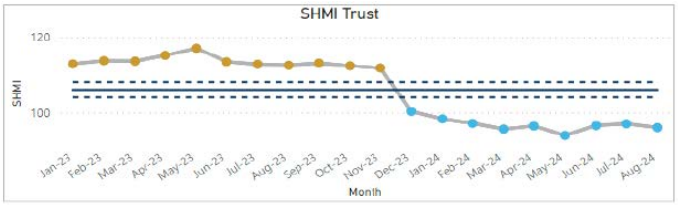

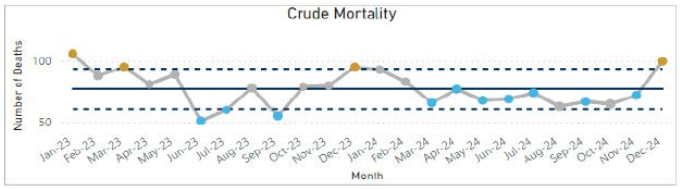

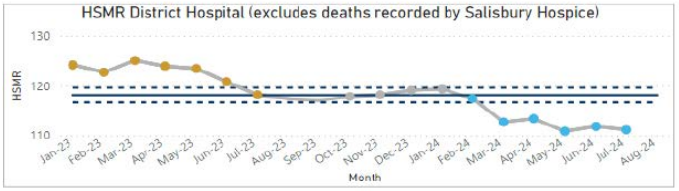

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	Yes
Partnerships: Working through partnerships to transform and integrate our services	Yes
People: Supporting our People to make Salisbury NHS Foundation Trust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

CLASSIFICATION: UNRESTRICTED

Salisbury NHS Foundation Trust

QUARTER 3 2024/25 LEARNING FROM DEATHS REPORT

February 2025

A summary document outlining the learning from deaths at Salisbury NHS Foundation Trust during the third financial quarter of 2024/25. Data as available on 20.01.2025 [unless otherwise stated in the report]

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GLOSSARY OF TERMS

CHARLSON COMORBIDITY INDEX (CCI) SCORE
The Charlson Comorbidity Score is a method of measuring comorbidity. It is a weighted index that predicts the risk of death based on the number and severity of 19 comorbid conditions.

CUSUM
A cumulative sum statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The line is then reset to half the starting position and plotting of patients continues. The CQC monitor CUSUM's at a 99.9% threshold to determine outliers.

HSMR
The Hospital Standardised Mortality Ratio (HSMR) is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity.

MaMR
The Mortality and Morbidity Review Module that the Trust uses for electronic recording of learning from deaths.

ME
Medical examiners (MEs) are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. The purpose of the medical examiner system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths, ensure the appropriate direction of deaths to the coroner, provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased, improve the quality of death certification, and improve the quality of mortality data. The Medical Examiner (ME) system was introduced in April 2020 and was established in the Trust by August 2020.

MSG
The Mortality Surveillance Group (MSG) meets bi-monthly and is responsible for reviewing deaths to identify problems in care and commissioning improvement work, to reduce unwarranted variation and improve patient outcomes. To identify the learning arising from reviews and improvements needed.

PALS
The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters and they provide a point of contact for patients, their families and their carers. A complaint is an expression of dissatisfaction made to an organisation, either written or spoken, and whether justified or not, which requires a formal response from the Chief Executive. A concern is a problem raised that can be resolved/responded to by the clinical or non-clinical teams concerned. Concerns include issues where the patient/family member has said that they don't want to make a formal complaint.

PSII
Patient Safety Incident Investigation

PSIRF
Patient Safety Incident Response Framework

RESPECT
The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) provides a personalised recommendation for an individual's clinical care in emergency situations whether they are not able to make decisions or express their wishes.

SFT
Salisbury NHS Foundation Trust.

SHMI
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. It covers in-hospital deaths and deaths that occur up to 30 days post discharge for all diagnoses excluding still births. The SHMI is an indicator which reports on mortality at trust level across the NHS in England and it is produced and published as an official statistic by NHS Digital.

SJR
The Structured Judgement Review (SJR) is a process for undertaking a review of the care received by patients who have died.

SMR

A calculation used to monitor death rates. The Standardised Mortality Ratio (SMR) is the ratio of observed deaths to expected deaths, where expected deaths are calculated for a typical area with the same case-mix adjustment. The SMR may be quoted as either a ratio or a percentage. If the SMR is quoted as a percentage and is equal to 100, then this means the number of observed deaths equals that of expected. If higher than 100, then there is a higher reported mortality ratio.

SOX

Sharing Outstanding Excellence (SOX) is a method of paying a compliment to a team or a member of staff. It is a way of learning from when things go well.

NHS Salisbury NHS Foundation Trust

Learning from Deaths Report – Quarter 3

Purpose and Background

To comply with the national requirements of the Learning from Deaths framework, Trust Boards must publish information on deaths, reviews, and investigations via a quarterly report to a public board meeting. The Learning from Deaths initiative aims to promote learning and improve how Trusts support and engage bereaved families and carers of those who die in our care.

Executive Summary

- The latest SHMI figure for the Trust is 0.96 (12-month period ending in August 2024). This is the lowest recorded figure for some time. According to NHSE this figure remains statistically within the expected range for the Trust.
- We have adjusted processes to allow teams undertaking primary reviews to quickly redirect cases to other specialities for review as required. This feature is particularly helping specialties such as palliative medicine, where the patient may have received care under another specialty before their involvement in care.
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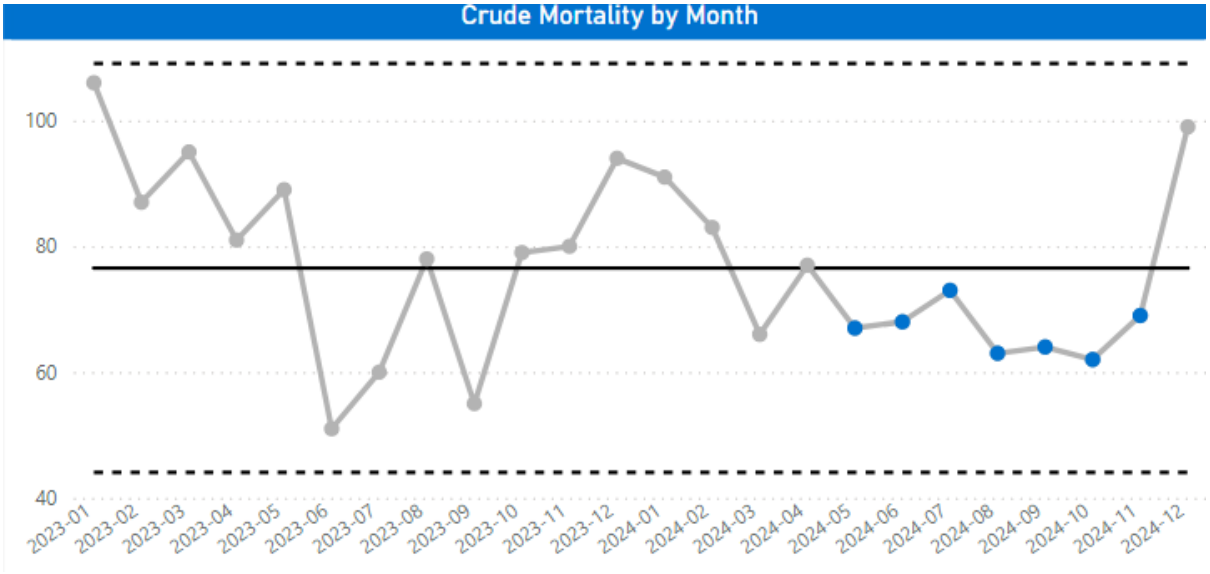
- A video of how to use the MaMR platform has been completed and circulated.
- SII/PSIRF reviews will now be attached to mortality records within MaMR to improve record keeping.

Salisbury NHS Foundation Trust

Learning from Deaths in Q3

The hospital mortality group (MSG) met on 12th November 2024 during Q3, where learning, improvement themes and actions arising from mortality diagnosis group alerts and individual case reviews were discussed. The learning outlined in this report reflects a summary of the key highlights, and the information reviewed and discussed at the MSG.

1. Data Overview



1.1. The graph above has been obtained from the Trust Power-Bi data dashboard and it shows the number of deaths occurring in SFT, as reported monthly. The crude mortality increased in December whereas below average numbers had been observed for the previous seven months recorded. The graph and table on the next page provide a more detailed breakdown of these figures.

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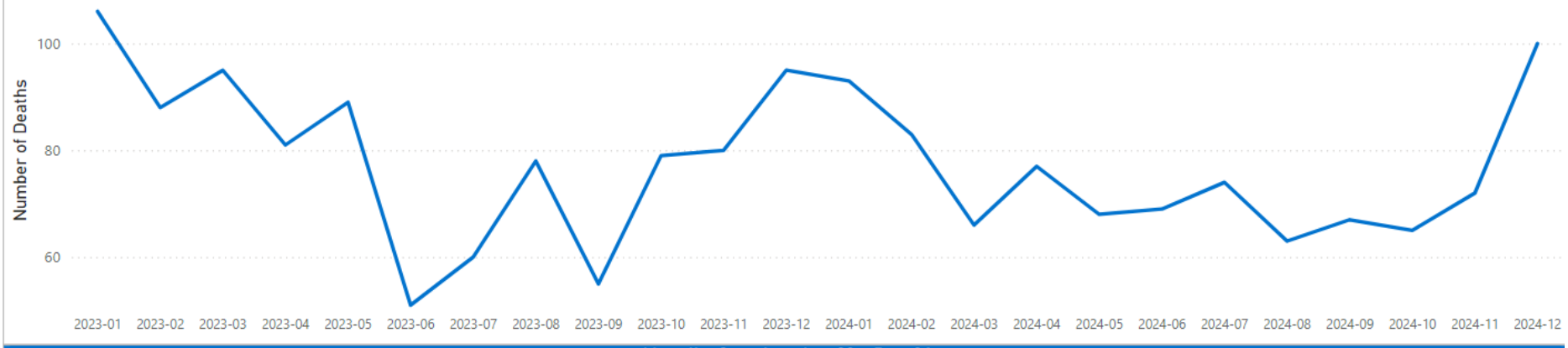
Total Deaths as Reported by the Medical Examiner: Jan-23 - Dec-24



Mortality Overview: Jan-23 - Dec-24

Year-Month	Total Deaths as Reported by the ME	Deaths Reviewed by the ME	SJRs Requested by the ME	ED Deaths	Hospice Deaths	Covid19 as Primary Cause of Death (1a)	Total Stillbirth Deaths	Late Miscarriage 22 - 23+6 Weeks	Stillbirths >24+0 - 36+6	Stillbirths >37+0	Total Neonatal Deaths	Total Maternal Deaths	Total Learning Disability Deaths	Total Serious Mental Illness Deaths
2024-12	100	97	7	7	12	1	2	0	1	1	0	0	0	0
2024-11	72	70	2	6	14	2	0	0	0	0	1	0	0	0
2024-10	65	65	2	2	11	2	1	0	1	0	0	0	0	0
2024-09	67	66	3	2	18	2	0	0	0	0	0	0	0	0
2024-08	63	62	4	2	14	2	0	0	0	0	0	0	2	0
2024-07	74	72	5	5	17	1	0	0	0	0	0	0	2	0
2024-06	69	67	5	3	12	4	0	0	0	0	0	0	0	2
2024-05	68	67	5	2	14	0	0	0	0	0	0	0	1	1
2024-04	77	76	7	5	6	0	0	0	0	0	0	0	1	1
2024-03	66	66	4	2	9	1	0	0	0	0	0	0	0	0
2024-02	83	82	4	6	15	0	1	0	1	0	1	0	2	0
2024-01	93	93	2	6	11	3	0	0	0	0	2	0	1	0

2. Learning and Actions Taken during Q3 [1st October 2024 – 31st December 2024]

2.1. Total deaths:237

Total reviewed (ME):232 (98%)

Number of primary reviews (SJRs) requested by the ME:11

Total number of primary reviews undertaken for patients who died during Q3: 54

Number of further reviews requested (e.g., another speciality asked to review): 13

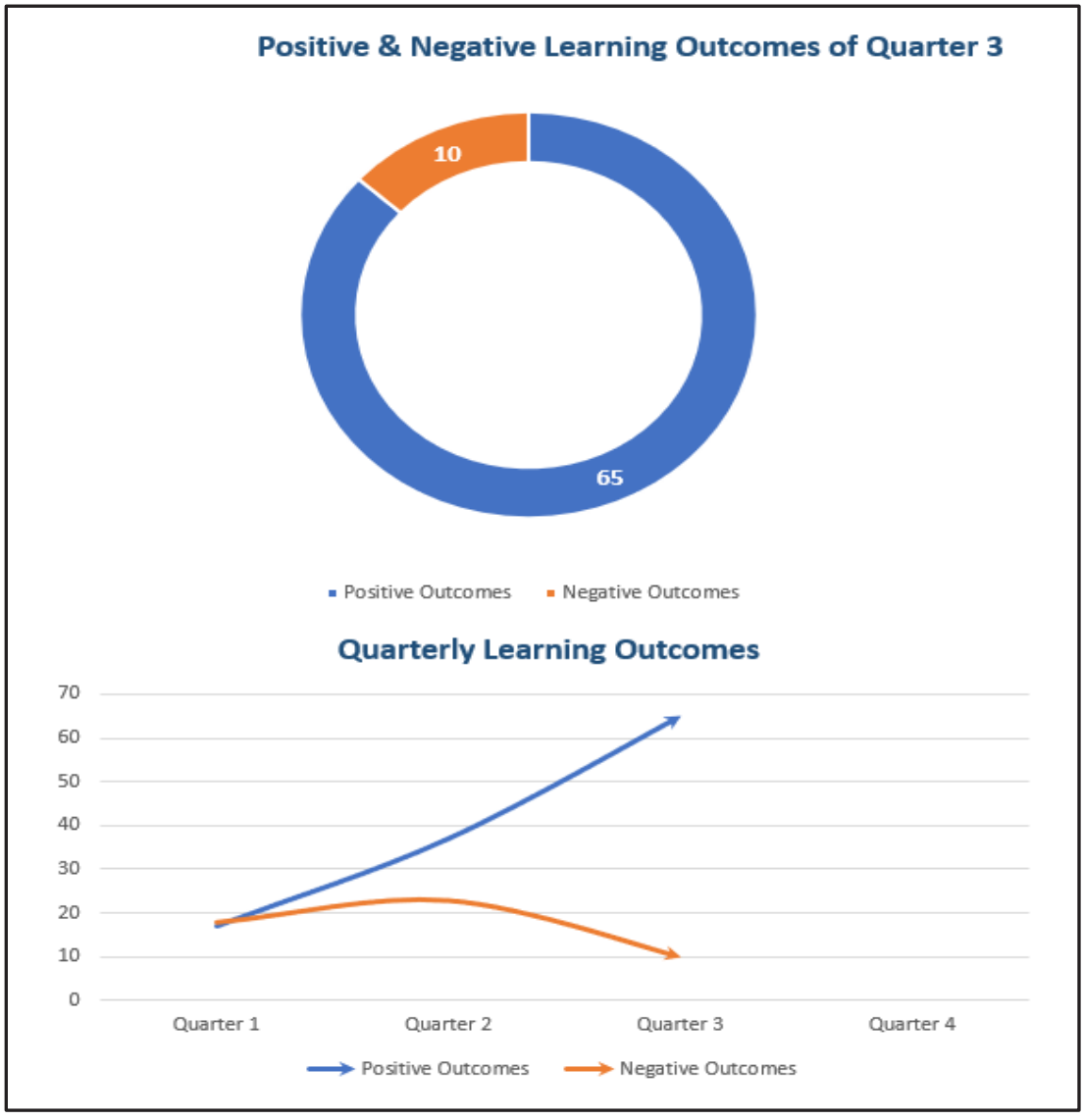
Number of secondary reviews (higher level reviews) requested: 1

Summary of Learning During Q3 Cont.

2.2. One of the key objectives of the mortality group is to ensure that clinical teams review all the cases of patients who died under their care. It is anticipated that individual teams reflect upon their practice, are self-critical, and continually learn from the cases reviewed. Clinical teams regularly face significant operational pressures, and therefore this activity can sometimes be challenging when needing to prioritise the care of current inpatients.

The mortality group also need to continually reflect and learn. Therefore, to ensure that the burden is spread evenly, our process have recently been modified to allow teams undertaking primary reviews to quickly redirect to the most appropriate team. This is particularly helping specialties such as palliative medicine, where the patient may have received care under another specialty before their involvement in care. These changes appearing to be improving uptake of reviews.

2.3. Whilst tracking learning outcomes, we find that engagement is rising as shown. Far more positive outcomes are being logged. Detailed data for these charts can be found in the appendices in section 6 of this report.



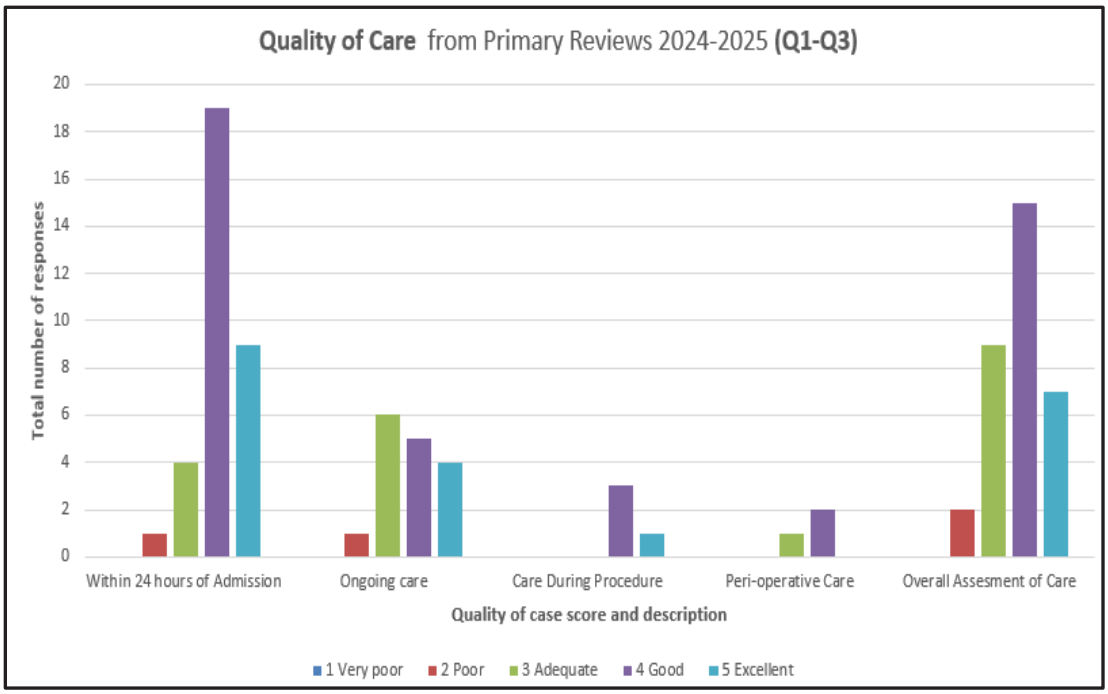
2.4. Two main domains have been derived from these data.

I. Communication with relatives/carers has been identified as good, and the ***reSPECT*** (a form that details what is important to the individual and the treatments they would prefer in an emergency) discussion has been appropriate and timely.

II. There have been some examples of poor documentation, linked to missing ***reSPECT*** forms or part of the patient record sometimes being incomplete/non present. Focus is required on re-emphasising the importance of keeping this document visible at the start of the patient's records.

2.5. The Trust are reintroducing certificates of achievement for staff completing mortality reviews. There are three levels Bronze, Silver, and Gold, awarded to any staff member achieving set levels of completed reviews. These can be used in portfolios and appraisals as evidence of engagement in quality improvement activities.

2.6. With regards to Quality of Care the MaMR data gives us an overview of how teams are performing across a wide variety of clinical settings. There were no recorded instances of 'very poor' care and 4 cases where the care was judged by the reviewer to be 'poor' during quarters 1-3 of this financial year. The Trust mortality process enables concerns to be escalated by the reviewer, who may then request a secondary (higher level) review (see **2.12** for further information).



2.7. The Medical Examiners Officers recently identified a small number of Influenza cases where there was no documentation in the notes for why Tamiflu had not been offered as per NICE guidance. This observation was rapidly escalated and cascaded to clinical teams for learning.

2.8. Collaborative working amongst the acute Trusts in BSW has led to requests for insight from us about the use of the MaMR module and our Trust mortality processes. The MSG have

sanctioned the sharing of our experience and processes with partner organisations, hopefully establishing a common currency both for data collection and learning domains.

2.9. Interest from other organisations outside of BSW in the use MaMR have also been received, in consideration of adopting the Salisbury abbreviated cross specialty proforma/template. This is an abbreviated version of the SJR review template which has been developed by the Trust to support clinical specialties with undertaking reviews on a wider range of cases. For instance, routine reviews where no prior learning has been identified by the Medical Examiners. The Trust's mortality group will be asked approve sharing, potentially contributing to improved patient safety and quality of care beyond SFT.

2.10. To engage all staff involved in mortality reviews a video of how to use MaMR has been completed and circulated. Forthcoming communications to heads of service and mortality leads will continue to invite them to view this resource.

2.11. SII/PSIRF reviews will now be attached to the mortality record in MaMR to improve record keeping.

2.12. The Hogan Score is a judgement score used to record the avoidability of death from a secondary review (higher level review). There has been a total of 4 cases that have gone to secondary review or PSII during this financial year. Four secondary reviews were completed (one in Q1, two in Q2, and one in Q3). The outcomes were: two required no further action, one was for PSII, and one was for a comprehensive patient safety review (PSR2). It has been agreed at MSG that when known that a PSII is already being undertaken, that this will take precedence over primary/secondary reviews. The final report will subsequently be received by the Trust's mortality group (MSG) to ensure that the learning has been shared.

Avoidability of death score - taken from secondary reviews

Score	Definition	Total
1	Definitely avoidable	0
2	Strong evidence of avoidability	0
3	Probably avoidable (more than 50:50)	1 (25%)
4	Possibly avoidable but not very likely	1 (25%)
5	Slight evidence of avoidability	2 (50%)
6	Definitely not avoidable	0
Total number of responses		4 (1%)

2.13. Following an alert from Telstra UK relating to a cohort of patients with an admission diagnosis of Septicaemia (non-labour), a review of a random sample of case notes was carried out by the Trust Mortality Lead. With no appropriate intervention, sepsis can progress to severe sepsis or septic shock, which are associated with a mortality rate of 30% and 50% respectively. Early recognition and resuscitation within the first hour of deterioration have been shown to reduce mortality. Adherence to a couple of the 6 principles of sepsis (known as sepsis 6) were identified as needing improvement and this was escalated for a Trust wide refresh. Although an alert was triggered, the latest data shows that the Trust is not a statistical outlier (see funnel plot in appendices, **6.7**).

3. End of Life care

3.1. From 1st April 2024 the NACEL survey replaced the Trust's Your Views Matter (YVM) survey for 9-months to allow for national benchmarking to take place for this period.

3.2. The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England, Wales, and Jersey. NHS Benchmarking Network is commissioned by Health Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government. NACEL is featured on NHS England's Quality Accounts list for 2024/25.

NACEL collects data from four sources:

Quality Survey: This is an online survey completed by relatives, carers and those important to the person who died in hospital, to report their experiences of the care and support received at the end of life.

Case Note Review: This is data collected from patient notes about the care they received during their final admission to hospital. It focusses on 10 indicators of care, including recognition of dying, timely review of the dying and deceased patient, etc.

Hospital/ Site Overview: questions focus on the specialist palliative care workforce, staff training, anticipatory prescribing and quality and outcomes within the hospital/site.

Staff Reported Measure: this survey is completed by staff who are most likely to come into contact with dying patients and their loved ones. The survey asks questions about staff confidence and experience in delivering care at the end of life, the support they receive and the culture of their workplace. This is not a staff satisfaction survey such as the NHS staff survey. About NACEL — National Audit of Care at the End of Life

The NACEL bereavement survey focuses on the insights taken from the Quality Survey.

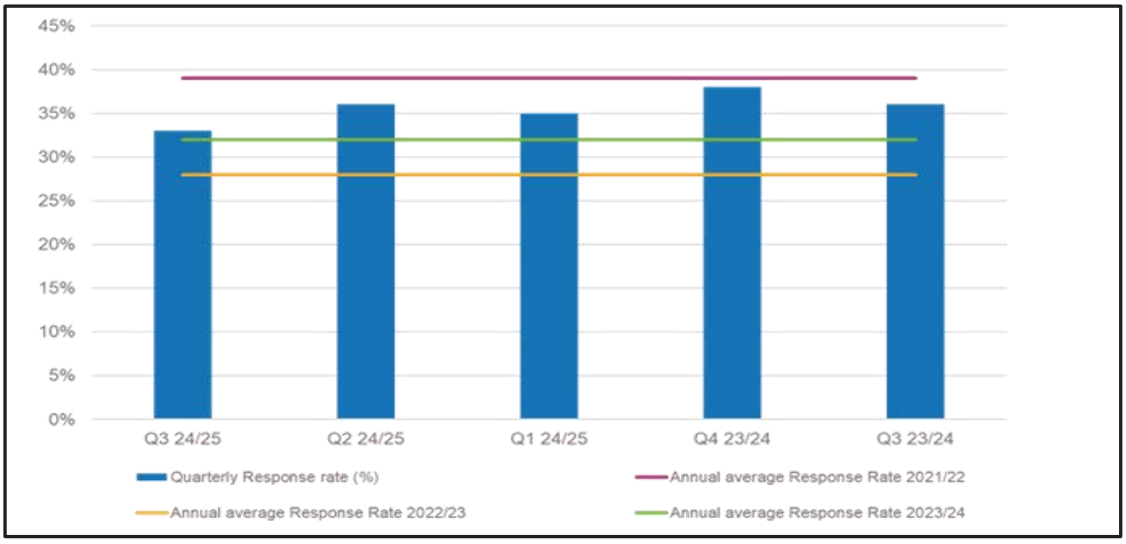
3.3. In total, during Q3 2024/25 there were 237 deaths, 33 more than during Q2. There were 55 surveys sent during this period. This achieved a consistent return rate of 33% (with previous quarters) however, due to the low number of surveys sent we were only able to achieve an average sampling of 8% of bereaved families. This is compared to the 22% achieved in Q2. The reason for this reduction in sampling has been highlighted by the Medical Examiners who have previously raised concern over the current process being limited to paper-based forms, increasing the length of time needed for the bereavement follow-up call due to:

- increasingly more digital method of sharing information with bereaved families and postal correspondence now becoming by exception.
- increased number of mandated questions to ask relatives (impacting resourcing) means the inclusion of an optional bereavement survey is becoming hard to include.
- concern for resourcing after the New Year – may mean they are unable to support with continuing to obtain the consent for inclusion in the survey and process the sending of paper surveys.

The MEOs feel this could be mitigated by reverting to YVMs, offering this as digital survey, which can be sent out electronically alongside the mandated information or only sending the

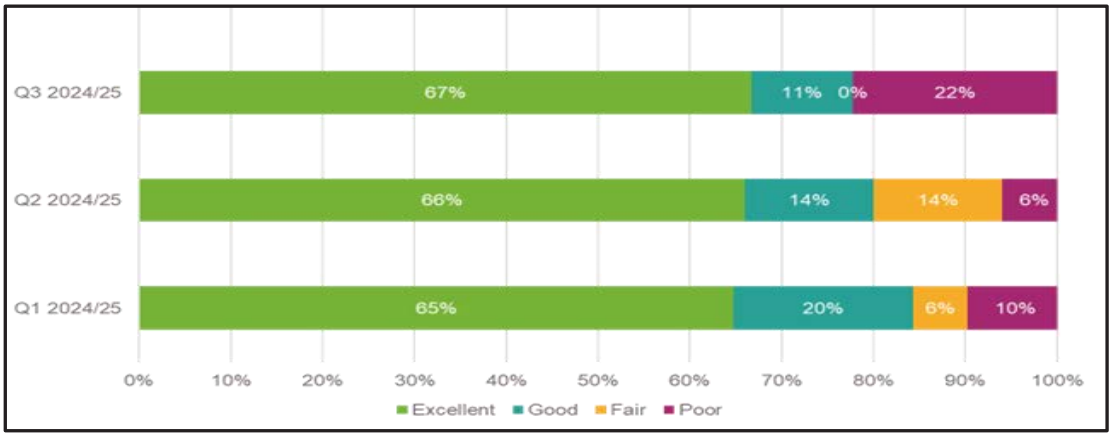
NACEL in a digital format, this will sacrifice other local data and any opportunity for PALS call-back.

3.4. The response rate achieved for Q3 was 33%. This is slightly lower than last quarter (36%) but marginally higher than the average for 2023/24 (32%).

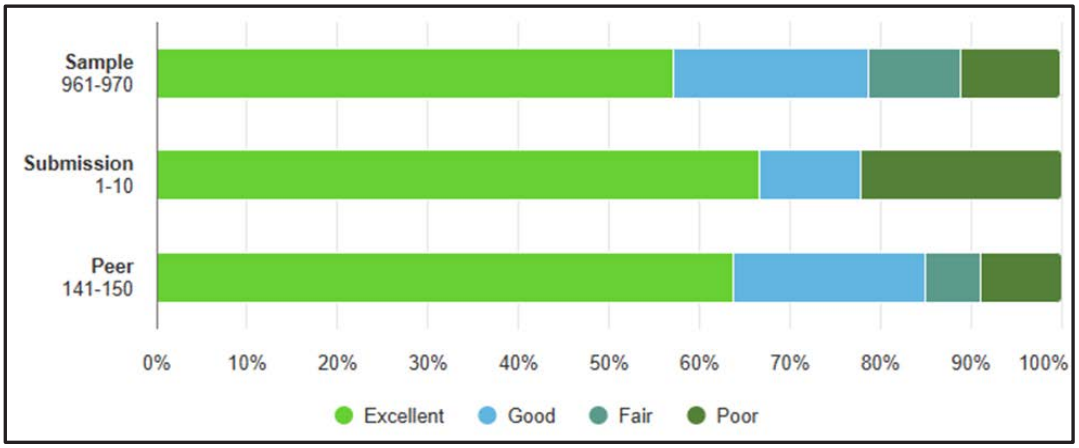


NACEL Survey Quarterly Response Rates for SFT (Compared to National Average)

3.5. During Q3 66% of SFT's respondents described their overall rating of care and support given by the hospital to the dying person as "excellent", compared with 22% who described this as "Poor". This is a static performance on the excellent rating for Q2 (66%) there is however a significant *increase* in the poor rating (going from 22% from 6%)

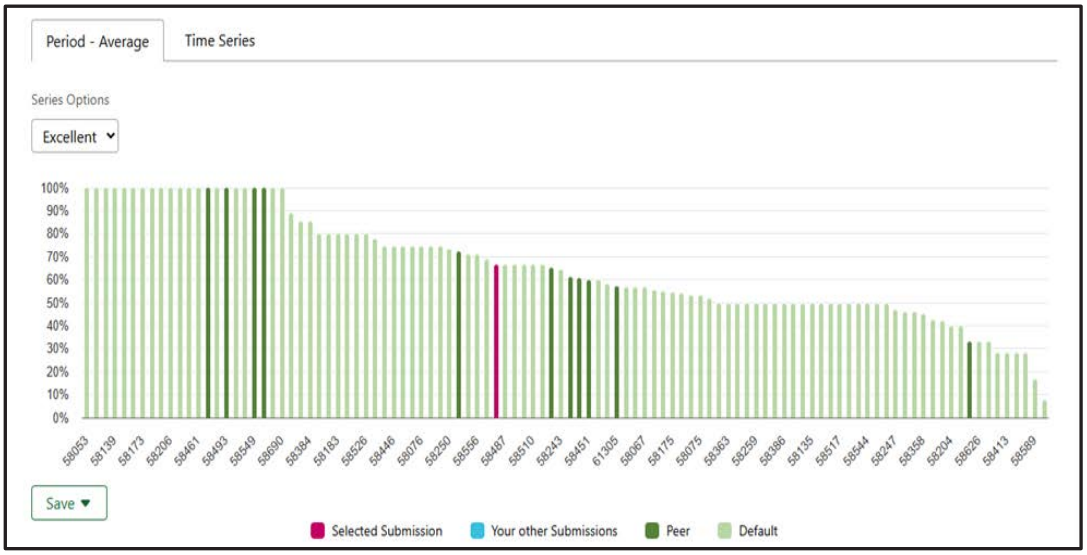


3.6. For the same question, the graph below shows how SFT (*submission*) compares with the national Sample (England and Wales) and with our Peers in the South West. This demonstrates SFT as a positive comparative outlier again this quarter.



3.7. The graph below shows how SFT ranks in comparison to peers across the South West (SW) (shown in dark green) in overall rating of care. Although this % has increased marginally, overall, the Trust's rating has remained in the same position as Q2 in response to this question.

3.8. The Trust's comparative performance with our South West peers remains static at 6th position overall.

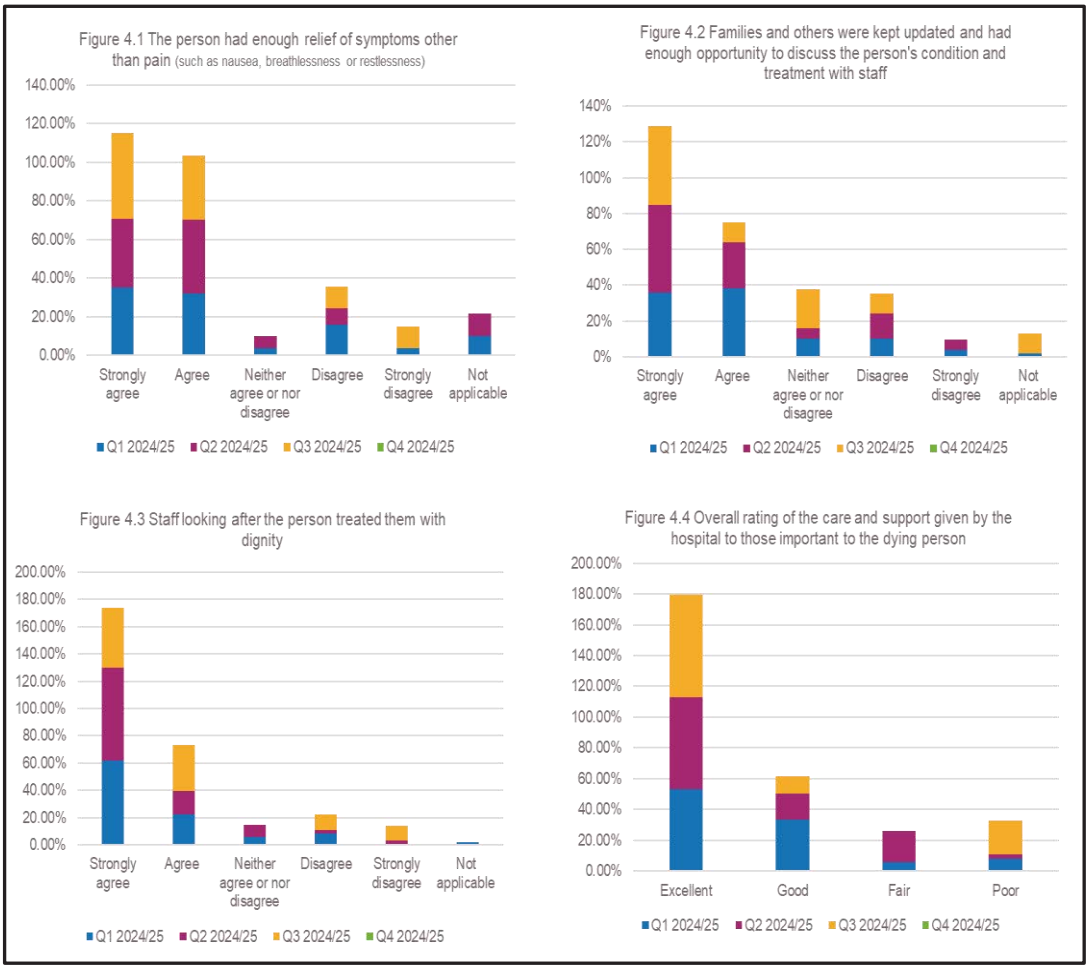


3.9. 8 survey participants requested a call-back from PALS, none of these resulted in a formal complaint being raised.

Figures 4.1 to 4.4 show the overall ratings in the key areas of patient experience.

3.10. SFT was noted to have only remained a positive outlier for performer both nationally and against our South West peers in relation to the question in figure **4.4**. This was also noted to have improved on Q2 comparison.

However, the Trust is noted to have declined in comparison to National and South West Peers in relation to questions **4.2 and 4.3.** The Trust remains an outlier in relation to pain relief, question **4.1.** As such, pain management will be a focus at one of the Trust's 'fundamentals of care' months in April 2025, which is an improvement workstream being led by the Deputy Chief Nursing Officer.



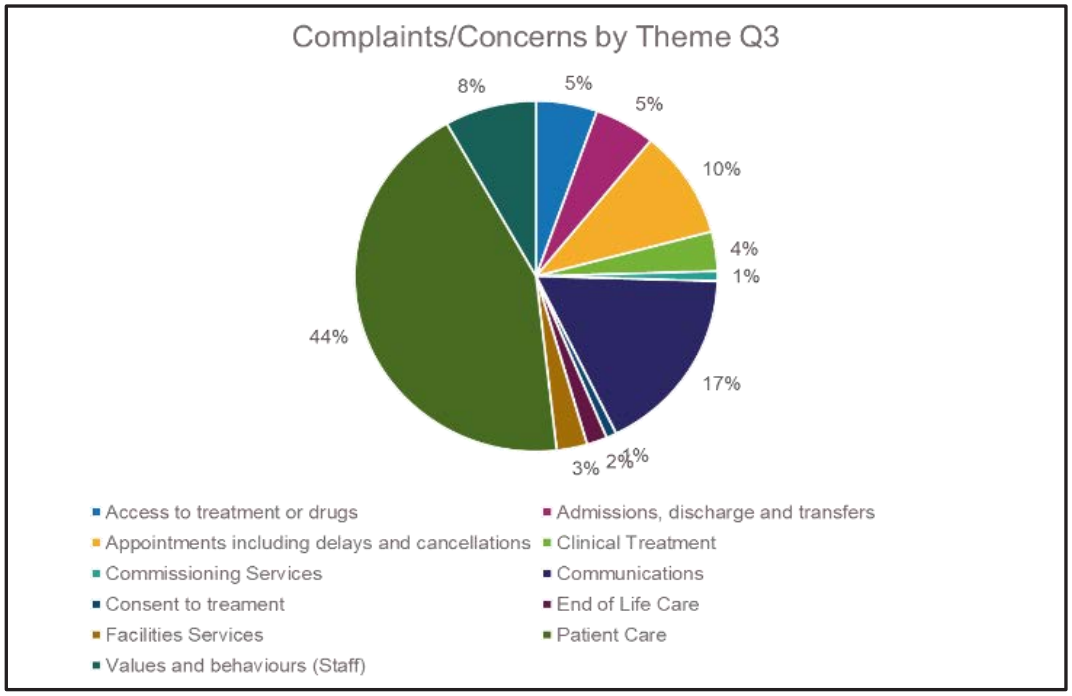
EOL Care Cont. – Correlation with Complaints

3.11. The chart adjacent shows the themes for complaints during Q3.

3.12. There was a total of 110 complaints/ concerns logged during this period, of which less than 2% (n~2) were related to end-of-life care.

3.13. Both complaints had themes of poor communication and not recognising death was imminent.

3.14. The NACEL survey format means that the Trust is unable to reliably correlate complaint themes by location with this feedback, this is a recognised limitation of this survey.



4. Medical Examiners (MEs)

Please refer to the mortality overview table in section 1 for the full breakdown of data

4.1. The ME system was introduced to ensure excellence in care for the bereaved and learning from deaths to drive improvement. The Medical Examiners aim to scrutinise all acute hospital deaths, and a local network of MEs exists to share learning and provide an independent review facility if needed.

4.2. 11 Structured Judgement Reviews were requested by the Medical Examiners during Q3 out of a total of 200 patient cases reviewed.

4.3. Overall, 98% of all patients who died whilst under the care of SFT were subject to a Medical Examiner review during Q3 (similar figures were observed during Q1 and Q2).

4.4. There were no maternal deaths or deaths in patients with a serious mental illness reports during Q3 (as per Q2). There were also no deaths in patients with a learning disability/autism during quarter 3, which, as per standard practice would be subjected to a mortality review (using the validated SJR method) and a review by our learning disability/autism nurse for a specialist input of potential learning. The learning disability /autism cases are also submitted to the national LeDer programme to support further learning (NHS England » Learning from lives and deaths – People with a learning disability and autistic people (LeDeR).

4.5. There were three stillbirth deaths and one neonatal death during Q3.

5. Litigation

New Enquiries from the Coroner During Q3

5.1. During this reporting period, there were four new enquiries from the coroner concerning the deaths of patients known to SFT.

5.2. Statements have been requested in all four of those cases; two of which relate to falls and one of these has a PSII in progress.

Inquests Concluded in Q3 from Previous Reporting Periods

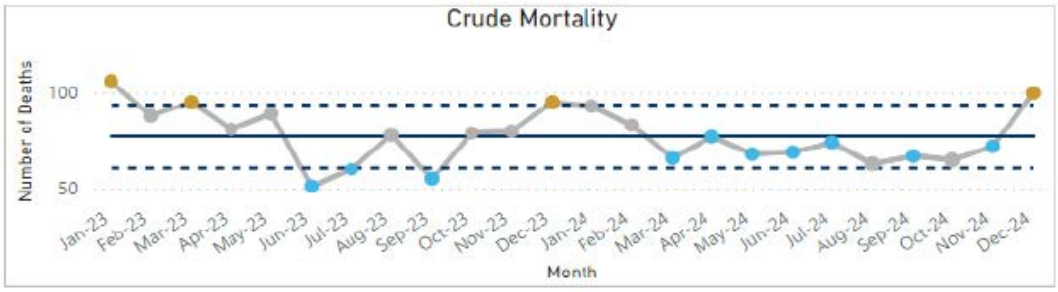
5.3. One inquest was concluded in this quarter.

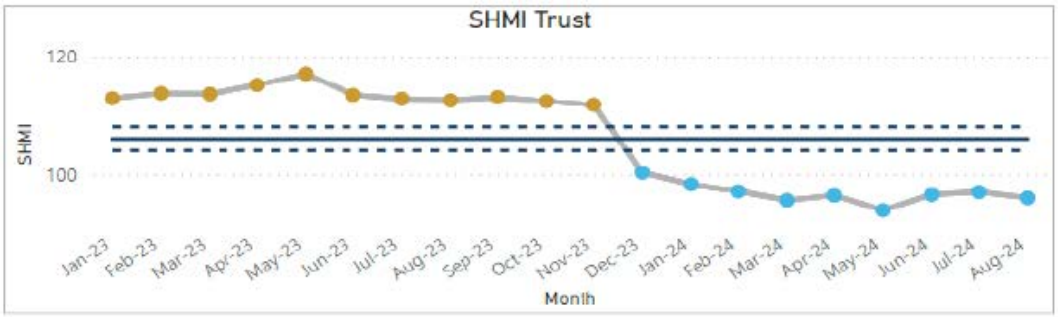
5.4. Statements were provided by SFT for above inquest, but the Trust was not an interested party. This was a read only inquest related to a fall which happened in a care home.

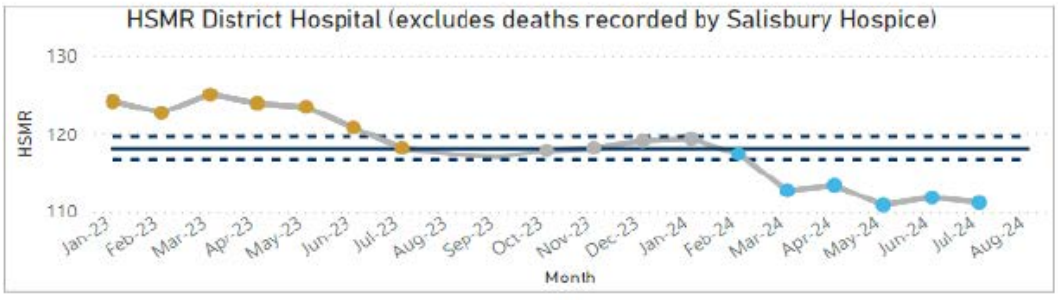
APPENDICES – Supplementary Data

6. HSMR and SHMI Rolling 12-month Trends

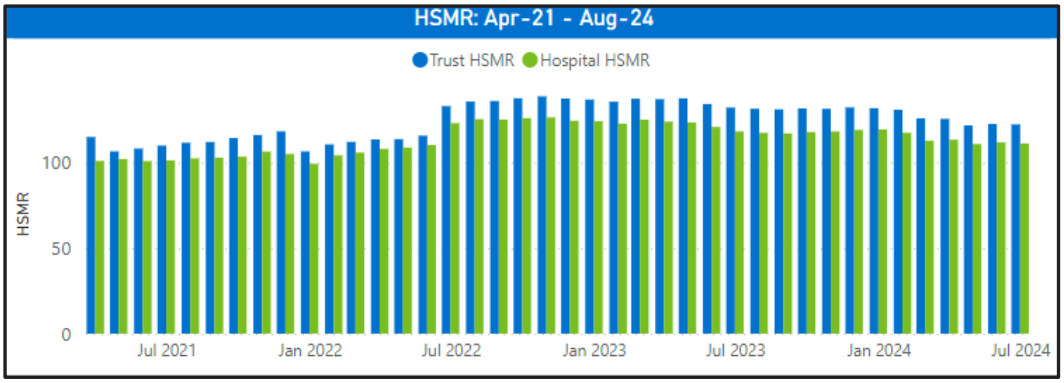
6.1. A two-month time lag has been applied to the HSMR data to improve the accuracy of data for the 12-month period. This is due to a potential coding backlog for the two most recent months of discharge data. Therefore, the latest published HSMR is for the 12-month rolling period ending in August 2024. Both the HSMR and SHMI have continued to see an overall decline in recent months. A national revision to the modelling of the SHMI came into effect from the 12-month rolling period ending in December 2023 onwards, resulting in no distinction between the Trust and District SHMI figures beyond this time.

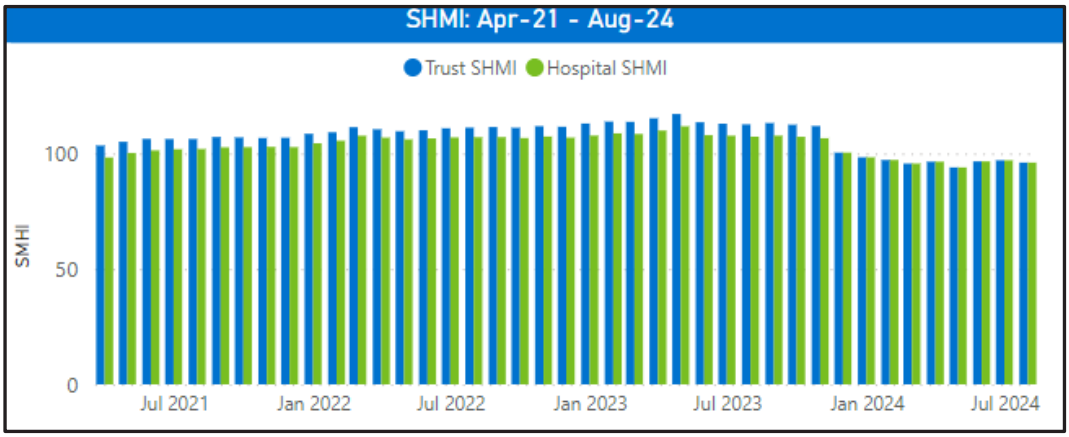






6.2. HSMR and SHMI Represented as Bar Charts





Salisbury NHS Foundation Trust

6.3. Latest SHMI data supplied by Telstra U.K. (Dr Foster)

SHMI - Summary Hospital Mortality Indicator

Period: Sep 23 - Aug 24

Provider: RNZ - SALISBURY NHS FOUNDATION TRUST

Region: SOUTH WEST

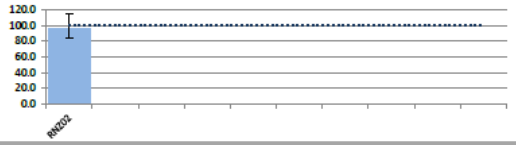
☐ Click to enable bespoke peer

SHMI - Published (With Over Dispersion)

*click group name to filter; click header title to clear

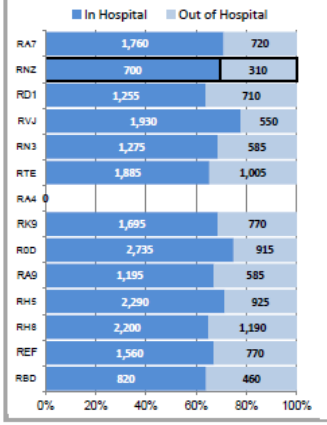
	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RBD	Dorset County Hospital NHS Foundation Trust	33,880	1,280	1,205	75	106.34	87.43	114.37
REF	Royal Cornwall Hospitals NHS Trust	65,435	2,335	2,245	90	103.96	87.93	113.73
RH8	Royal Devon University Healthcare NHS Foundation Trust	100,905	3,390	3,565	-175	95.06	88.15	113.45
RH5	Somerset NHS Foundation Trust	86,030	3,210	3,160	50	101.66	88.10	113.51
RA9	Torbay And South Devon NHS Foundation Trust	42,760	1,775	1,870	-95	94.96	87.81	113.88
R0D	University Hospitals Dorset NHS Foundation Trust	100,120	3,650	4,180	-530	87.36	88.20	113.38
RK9	University Hospitals Plymouth NHS Trust	81,180	2,465	2,210	255	111.58	87.92	113.74
RA4	Yeovil District Hospital NHS Foundation Trust	0	0	0	0	0.00	0.00	0.00
RTE	Gloucestershire Hospitals NHS Foundation Trust	103,615	2,890	2,475	415	116.82	87.98	113.66
RN3	Great Western Hospitals NHS Foundation Trust	64,370	1,860	1,815	45	102.55	87.79	113.91
RVJ	North Bristol NHS Trust	95,875	2,480	2,595	-115	95.63	88.01	113.63
RD1	Royal United Hospitals Bath NHS Foundation Trust	63,600	1,965	2,100	-135	93.68	87.89	113.78
RNZ	Salisbury NHS Foundation Trust	34,135	1,010	1,050	-40	96.06	87.29	114.57
RA7	University Hospitals Bristol And Weston NHS Foundation Trust	113,450	2,480	2,725	-245	90.86	88.03	113.59
Group		985,355	30,790	31,195	-405	98.70		

Site - All Diagnosis	Den	Obs	Exp	SHMI	Low	High
SALISBURY DISTRICT HOSPITAL	34,130	1,010	1,050	96.06	85.98	116.31

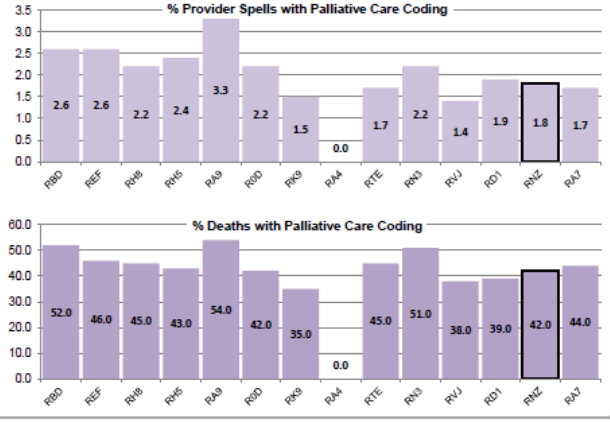


SHMI Group	Obs	Exp	SHMI	Low / High
Septicemia (except in labour), Shock	45	45.00	98.00	73.66 135.77
Cancer of bronchus, lung	30	25.00	116.21	66.85 149.59
Secondary malignancies	15	25.00	58.22	67.62 147.88
Fluid and electrolyte disorders	15	15.00	79.26	60.03 166.60
Acute myocardial infarction	15	25.00	62.14	67.51 148.13
Pneumonia	160	150.00	107.34	80.83 123.72
Acute bronchitis	10	15.00	59.05	60.68 164.79
Gastrointestinal haemorrhage	15	15.00	111.11	57.57 173.70
Urinary tract infections	25	20.00	115.63	60.57 165.09
Fracture of neck of femur (hip)	20	25.00	86.44	67.72 147.68

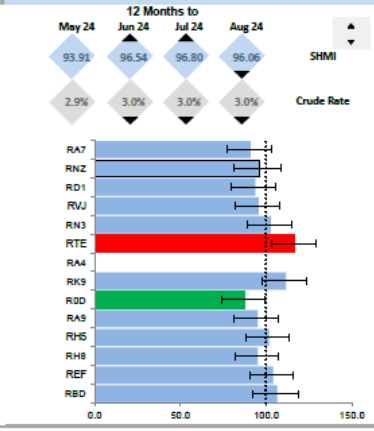
Deaths: In / Out Hospital



% Palliative Care Coding



Trend / Rate



SHMI Group - With 95% CI (Dr Foster)

SHMI Group	Obs	Exp	SHMI	Low / High
(113) Other connective tissue disease	15	10	150.00	83.89 247.42
(78) Pleurisy, pneumothorax, pulmonary collapse	15	10	150.00	83.89 247.42
(65) Congestive heart failure, nonhypertensive	40	35	114.29	81.64 155.63
(123) Joint disorders and dislocations, trauma-related, Spinal cord injury, Skull and face fractures,	20	15	133.33	81.41 205.93
(42) Mental retardation, Senility and organic mental disorders	20	15	133.33	81.41 205.93
(75) Chronic obstructive pulmonary disease and bronchiectasis	35	30	116.67	81.25 162.26
(66) Acute cerebrovascular disease	60	65	92.31	70.44 118.82
(77) Aspiration pneumonitis, food/vomitus	25	25	100.00	64.70 147.63

*Dr Foster "SHMI Group" values based on published, rounded values with 95% CI's

HEALTH | dr foster

SHMI_Sep23_Aug24

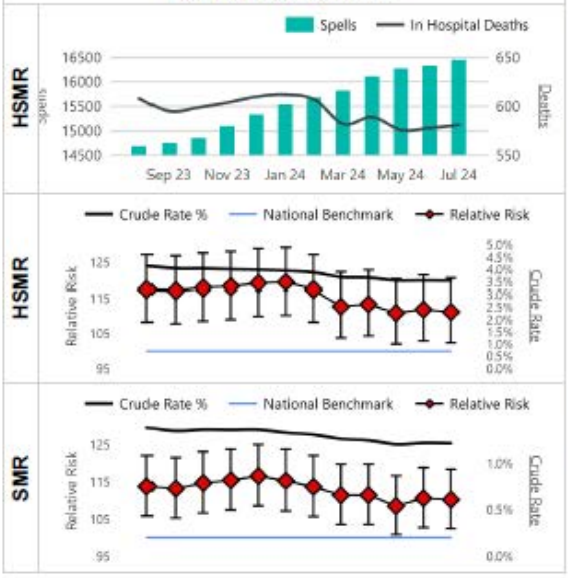
6.4. HSMR for the 12 Month Period Ending in July 2024 for Salisbury District Hospital [Excludes Hospice Data]

dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to Jul-2024 as at 21/01/2025

SALISBURY NHS FOUNDATION TRUST - SALISBURY DISTRICT HOSPITAL (RNZ02)

Rolling 12 month trends



Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Cancer of kidney and renal pelvis	1	5	1.3	385.6	127.5	
Other hereditary and degenerative nervous system conditions	0	5	1.5	329.2	106.1	
Senility and organic mental disorders	1	14	7.4	190.3	103.9	
Pneumonia	0	127	104.5	121.5	101.3	

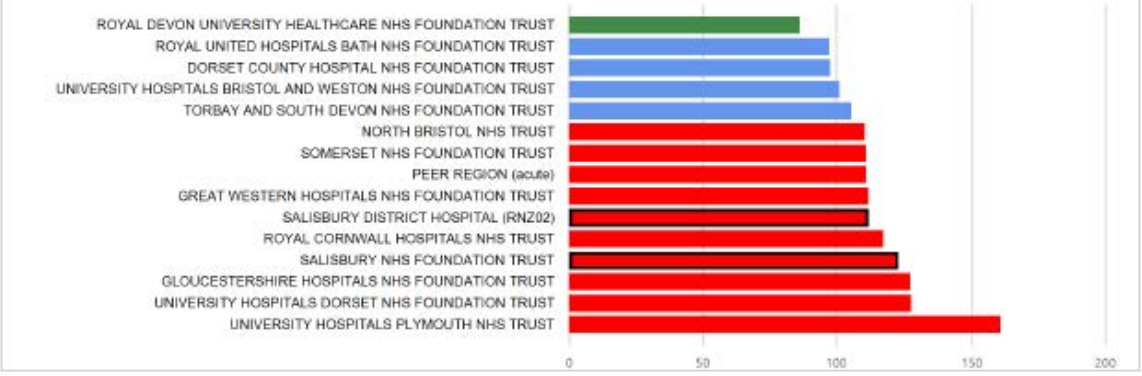
CUSUM 95% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Senility and organic mental disorders	1	14	7.4	190.3	103.9	
Bacterial infection, unspecified site	1	6	2.3	266.3	97.3	
Chronic obstructive pulmonary disease and bronchiectasis	1	27	18.6	145.1	85.6	
Other connective tissue disease	1	9	4.7	192.8	88.0	
Septicemia (except in labour)	1	37	31.8	116.5	82.0	
Other lower respiratory disease	1	10	5.9	170.7	81.7	

CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Septicemia (except in labour)	1	37	31.8	116.5	82.0	

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR	111.2	122.3	110.7	99.8
SMR	110.2	126.3	109.5	99.6
Non-elective (HSMR)	111.3	121.9	110.9	99.6
Weekday, emergency (HSMR)	110.0	121.5	109.1	98.5
Weekend, emergency (HSMR)	116.2	123.9	115.9	103.3
Saturday, emergency (HSMR)	114.5	117.5	116.6	102.7
Sunday, emergency (HSMR)	117.1	130.0	115.9	104.1
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)	46.1%	52.3%	45.4%	45.0%
% Non-elective spells with palliative care (HSMR)	3.9%	4.7%	4.8%	5.0%
% Spells in Symptoms & Signs chapter	6.3%	6.3%	8.1%	6.8%
% Non-elective spells with Elixhauser comorbidity score = 0 OR less than 0 (HSMR)	33.8%	33.5%	28.3%	26.3%
% Non-elective spells with Elixhauser comorbidity score = 20+ (HSMR)	22.4%	22.7%	26.4%	29.5%
% Non-elective spells in Risk Band (0-10%) (HSMR)	85.7%	85.3%	82.9%	81.2%
Average frailty score		6	6	6

HSMR Peer Comparison



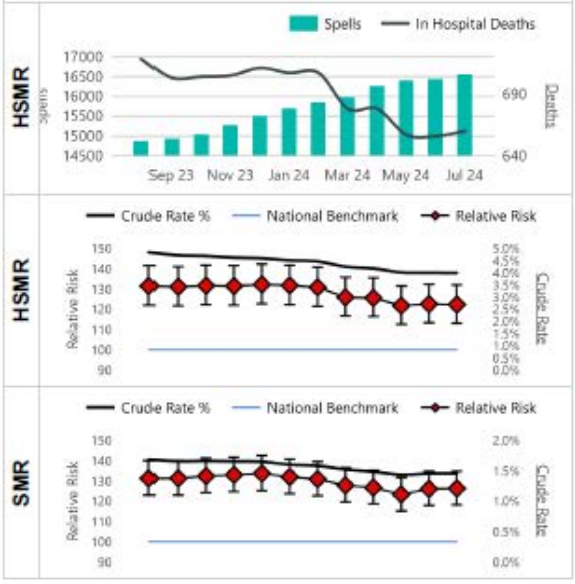
6.5. HSMR for the 12 Month Period Ending in July 2024 for SFT [Includes Hospice Data]

dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to Jul-2024 as at 21/01/2025

SALISBURY NHS FOUNDATION TRUST - All Sites

Rolling 12 month trends



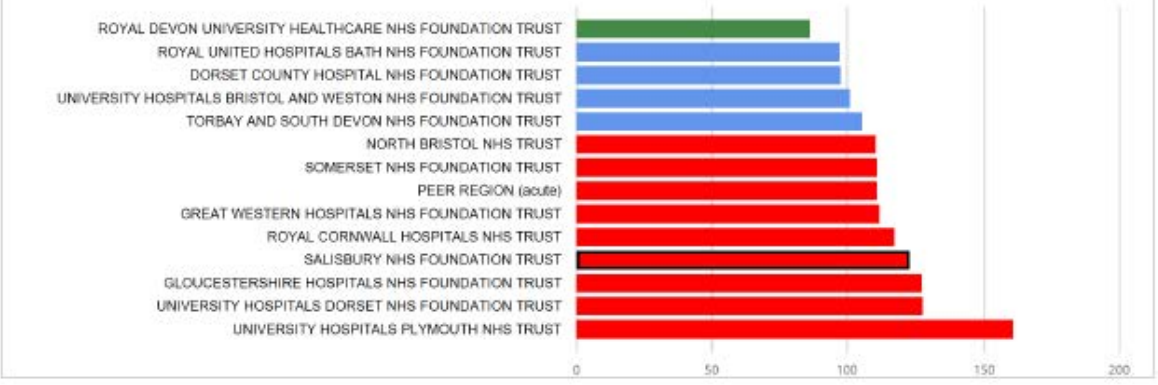
Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Cancer of brain and nervous system	1	5	1.2	423.6	136.6	
Other hereditary and degenerative nervous system conditions	0	6	1.7	352.6	132.4	
Leukaemias	1	10	3.8	261.3	125.1	
Other lower respiratory disease	1	13	6.0	216.9	115.4	
Intestinal obstruction without hernia	1	23	13.1	175.0	110.9	
Senility and organic mental disorders	1	15	7.6	197.2	110.3	
Cancer of bronchus, lung	1	30	19.4	154.4	104.1	
Chronic obstructive pulmonary disease and bronchiectasis	1	29	18.8	154.1	103.2	
Pneumonia	0	128	104.6	122.3	102.1	
Cancer of prostate	1	10	4.7	212.7	101.8	
CUSUM 99% Threshold (Top 6)	**CUSUM**	**Obs**	**Exp**	**RR**	**LCI**	**Trend**
Other lower respiratory disease	1	13	6.0	216.9	115.4	
Intestinal obstruction without hernia	1	23	13.1	175.0	110.9	
Senility and organic mental disorders	1	15	7.6	197.2	110.3	
Cancer of bronchus, lung	1	30	19.4	154.4	104.1	
Chronic obstructive pulmonary disease and bronchiectasis	1	29	18.8	154.1	103.2	
Secondary malignancies	1	18	11.4	157.7	93.4	
CUSUM 99.9% Threshold (Top 6)	**CUSUM**	**Obs**	**Exp**	**RR**	**LCI**	**Trend**
Leukaemias	1	10	3.8	261.3	125.1	
Other lower respiratory disease	1	13	6.0	216.9	115.4	
Intestinal obstruction without hernia	1	23	13.1	175.0	110.9	
Cancer of bronchus, lung	1	30	19.4	154.4	104.1	
Secondary malignancies	1	18	11.4	157.7	93.4	
Septicemia (except in labour)	1	38	31.9	119.2	84.3	

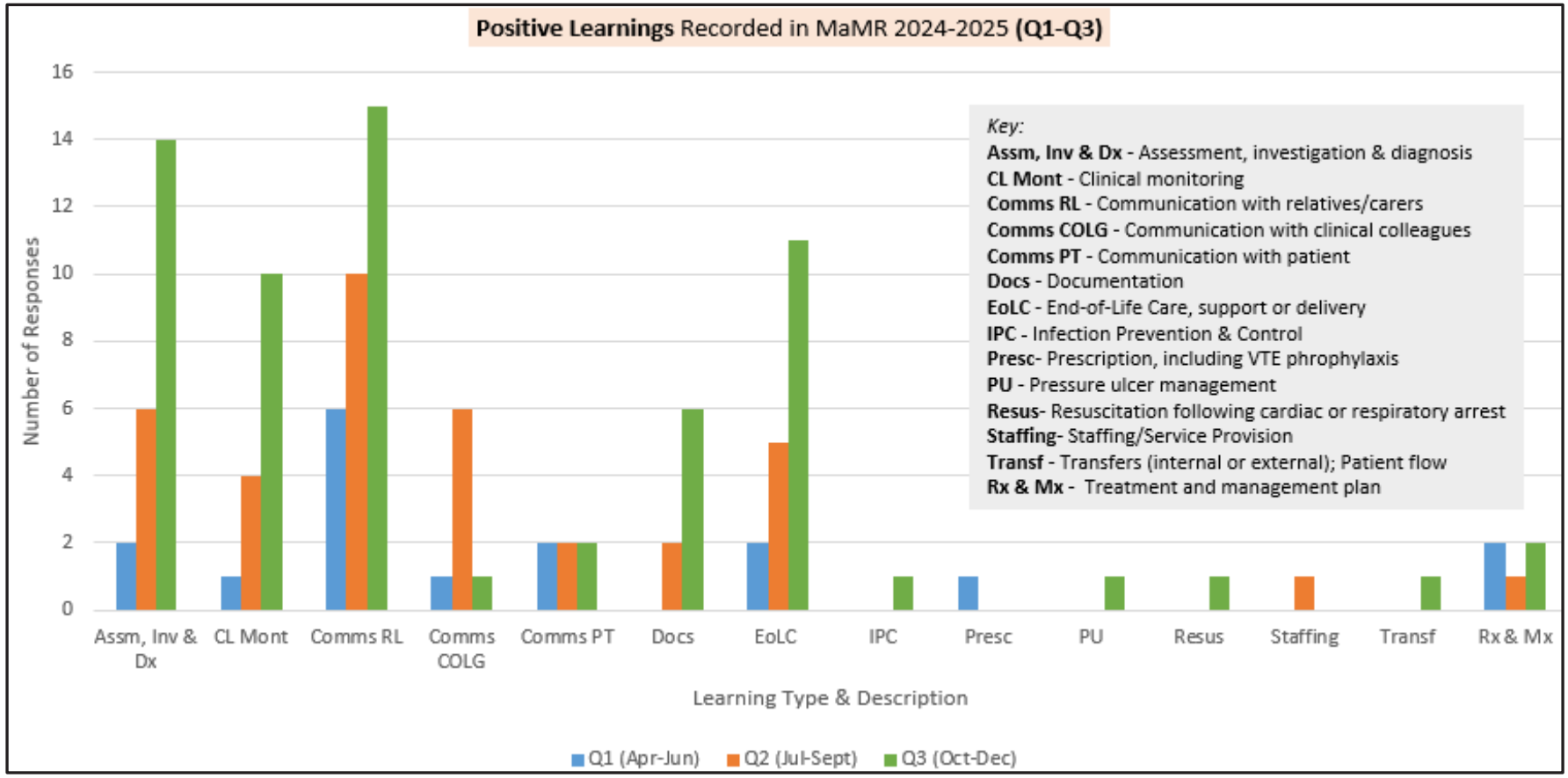
Mortality Influencers

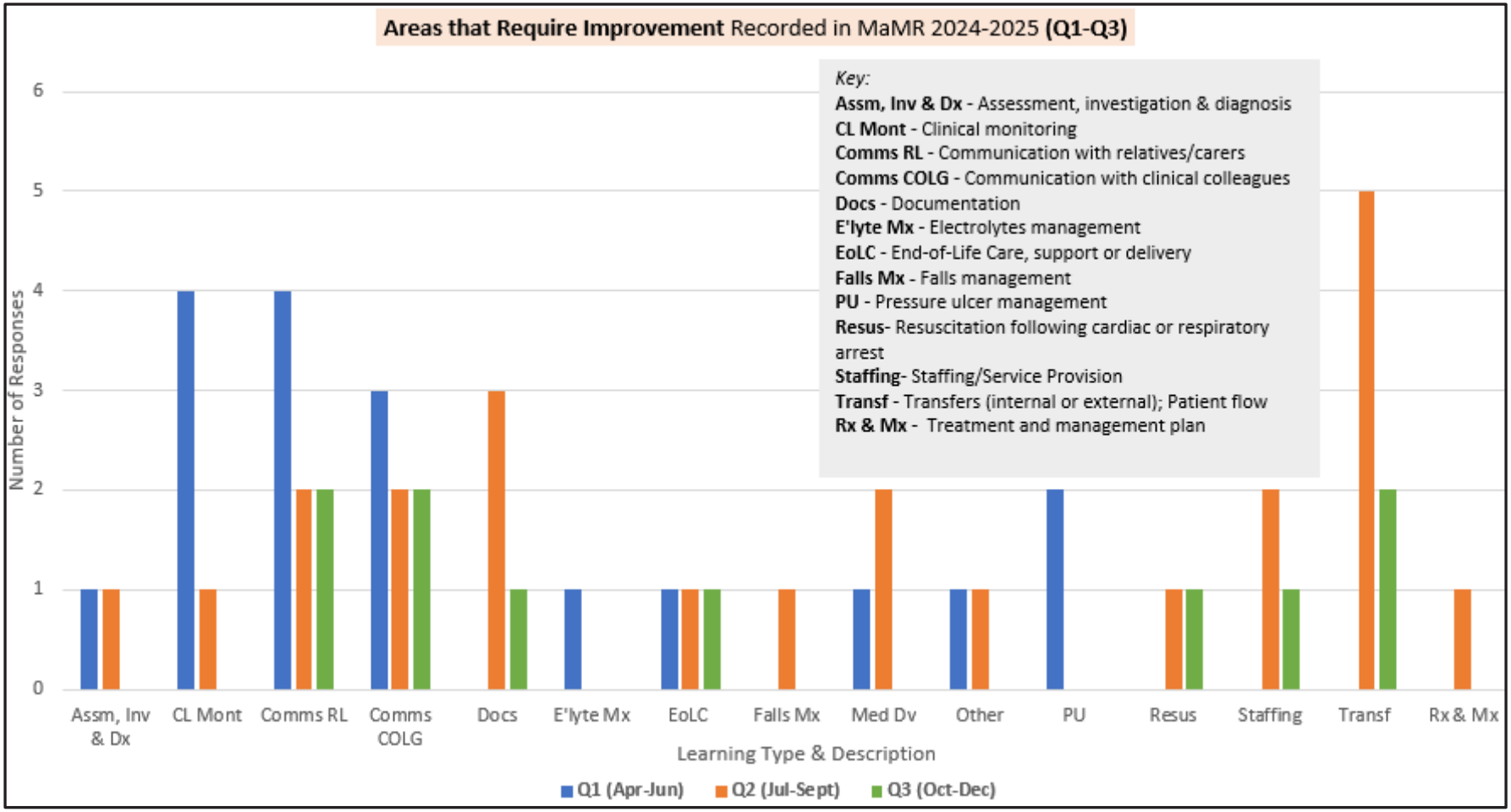
Performance	Site	Trust	Peer	National
HSMR		122.3	110.7	99.8
SMR		126.3	109.5	99.6
Non-elective (HSMR)		121.9	110.9	99.6
Weekday, emergency (HSMR)		121.5	109.1	98.5
Weekend, emergency (HSMR)		123.9	115.9	103.3
Saturday, emergency (HSMR)		117.5	116.6	102.7
Sunday, emergency (HSMR)		130.0	115.9	104.1
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)		52.3%	45.4%	45.0%
% Non-elective spells with palliative care (HSMR)		4.7%	4.8%	5.0%
% Spells in Symptoms & Signs chapter		6.3%	8.1%	6.8%
% Non-elective spells with Elixhauser comorbidity score = 0 OR less than 0 (HSMR)		33.5%	28.3%	26.3%
% Non-elective spells with Elixhauser comorbidity score = 20+ (HSMR)		22.7%	26.4%	29.5%
% Non-elective spells in Risk Band (0-10%) (HSMR)		85.3%	82.9%	81.2%
Average frailty score		3	3	3

HSMR Peer Comparison

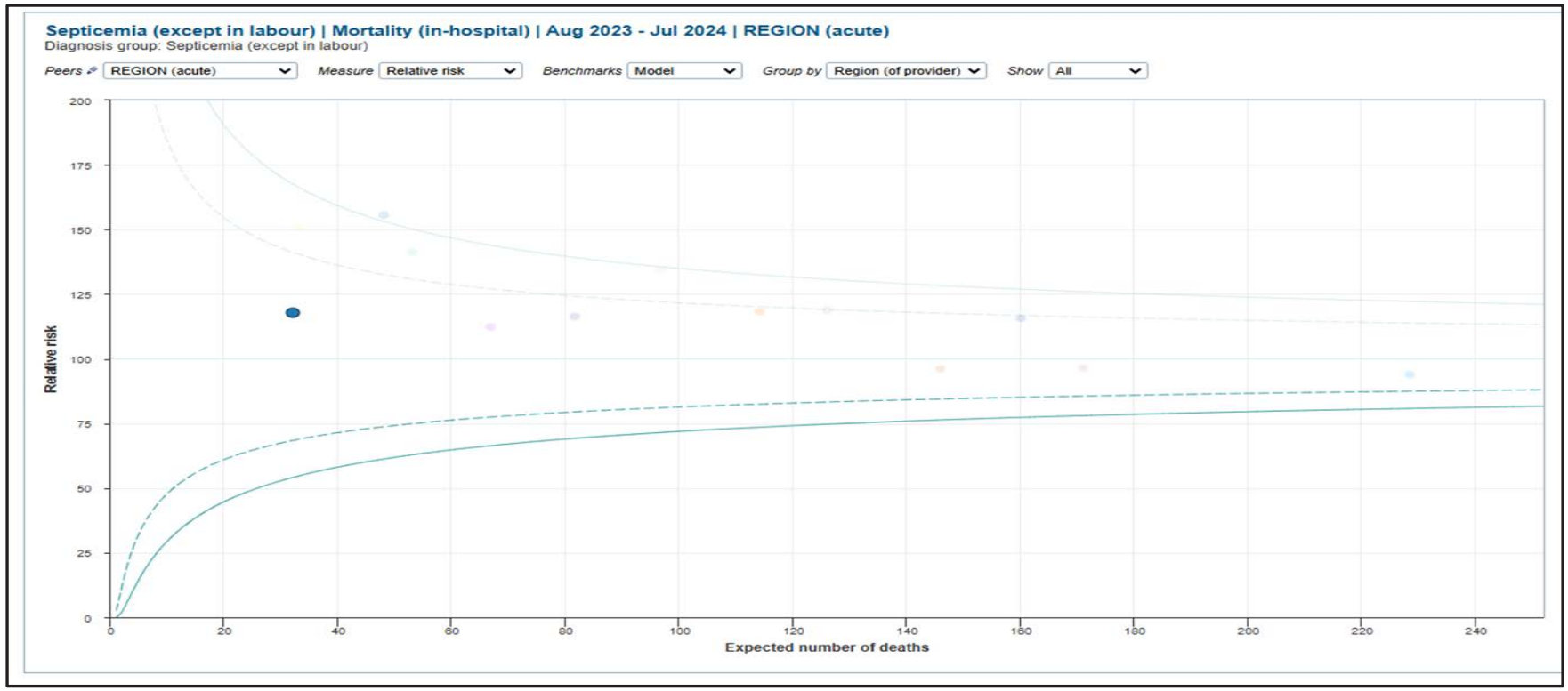


6.6. Positive learning and areas for improvement. These data are used to derive charts in section 2.




Areas that Require Improvement Recorded in MaMR 2024-2025 (Q1-Q3)
Key:
Assm, Inv & Dx - Assessment, investigation & diagnosis
CL Mont - Clinical monitoring
Comms RL - Communication with relatives/carers
Comms COLG - Communication with clinical colleagues
Docs - Documentation
E'lyte Mx - Electrolytes management
EoLC - End-of-Life Care, support or delivery
Falls Mx - Falls management
PU - Pressure ulcer management
Resus- Resuscitation following cardiac or respiratory arrest
Staffing- Staffing/Service Provision
Transf - Transfers (internal or external); Patient flow
Rx & Mx - Treatment and management plan
Number of Responses
0
1
2
3
4
5
6
Assm, Inv & Dx
CL Mont
Comms RL
Comms COLG
Docs
E'lyte Mx
EoLC
Falls Mx
Med Dv
Other
PU
Resus
Staffing
Transf
Rx & Mx
Learning Type & Description
Q1 (Apr-Jun)
Q2 (Jul-Sept)
Q3 (Oct-Dec)

6.7. Funnel plot for the ‘Septicaemia (non labour) – Trust position represented by the blue dot



NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.1
Date of meeting:	6 March 2025		

Report tile:	Emergency Preparedness Resilience & Response (EPRR)			
Status:	Information	Discussion	Assurance	Approval
			✓	
Approval Process: (where has this paper been reviewed and approved):	No other forum			
Prepared by:	Steve Court – Head of EPRR			
Executive Sponsor: (presenting)	Niall Prosser – Chief Operating Officer/EPRR Accountable Officer			

Recommendation:

The Trust Board is asked to support the ongoing work required to fulfil our EPRR duties and responsibilities, and to sign off this annual EPRR assurance report as part of the NHSE assurance process.

Purpose of Report:

To provide assurance to the Trust Board as part of the National EPRR Assurance process.

The Trusts self-assessment against the National EPRR Core Standards has been confirmed by NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB) and approved by NHSE, as delivering Full Compliant assurance.

This report, through a summary of EPRR activity, including the assurance process and training and exercising demonstrates our compliance.

Background:

The Trust is defined as a category 1 responder under the Civil Contingencies Act and is subject to civil protection duties discharged through the EPRR assurance process.

Executive Summary:

Based on the National RAG status for EPRR compliance SFT has been rated by NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board and NHS as 'Full' compliant for this year. As a category One responder we are meeting our civil protection duties under the Civil Contingencies Act (2004).

Full compliance means that arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve to the minimum level.

Board Assurance Framework – Strategic Priorities	Select as applicable:

Population: Improving the health and well-being of the population we serve	✓
Partnerships: Working through partnerships to transform and integrate our services	✓
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	✓
Other (please describe):	

Emergency Preparedness Resilience & Response (EPRR) Annual Report 2024

1. Purpose

This paper provides an annual report on the Trust's emergency preparedness in order to meet our statutory requirements of the Civil Contingencies Act (CCA) (2004) and the NHS England Emergency Preparedness Resilience and Response (EPRR) Framework 2022 and NHS England Business Continuity Framework.

2. Background & Statutory Framework

The Civil Contingencies Act outlines a single framework and establishes clear roles and responsibilities. SFT are defined as a category 1 responder in the CCA 04 and is subject to the following civil protection duties:

- Assess the risk of emergencies occurring and use this to inform contingency planning.
- Put in place Emergency Plans.
- Put in place Business Continuity Arrangements.
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency.
- Share information with local responders to enhance co-ordination.
- Co-operate with other local responders to enhance coordination.

3. National EPRR Framework & Core Standards

The NHS England EPRR Frameworks contain principles for health emergency planning for the NHS in England and the NHS Core Standards for EPRR provides the minimum standards that an NHS organisation must meet.

It is expected that that the level of preparedness will be proportionate to the role of the organisation and the services provided:

- SFT must meet the minimum core standards and provide evidence these standards are being met.
- SFT must identify an Accountable Office (Chief Operating Officer) who is responsible for ensuring these standards are met.

4. NHS Bath and North East Somerset, Swindon and Wiltshire EPRR Assurance process 2023-24

The responsibility for undertaking the local assurance process for SFT was undertaken by the NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB) in conjunction with NHSE. SFT provided the ICB with a core standard spreadsheet with each standard RAG rated with supporting evidence for those standards requested by the ICB.

Our self-assessment stated (September 2024): As part of the national EPRR assurance process for 2023/24, Salisbury NHS Foundation Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against the core standards which are applicable to the organisation, Salisbury NHS Foundation Trust:

The ICB conducted the 'confirm and challenge' meeting on Tuesday 10th September 2024, with Rachael Backler, AEO and Louise Cadle, Associated Director of Emergency Preparedness Resilience and Response & Deputy AEO from NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board. In attendance from SFT, Niall Prosser, Chief Operating Officer; Jane Dickinson, Deputy Chief Operating Officer and Steve Court, Head of EPRR. Anja Richardson, EPRR manager was in attendance as an observer.

The outcome letter on the 30th October from Rachael Backler detailed SFT progress and the Headlines are:

There have been several changes within SFT as Niall has taken on the role of Interim Chief Operating Officer and Accountable Emergency Officer. Elise Jones resigned, and Anja Richardson has been appointed as Deputy Head of EPRR to Steve Court.

The EPRR team played a key role in coordinating their internal incident response to industrial action from Junior Doctors and Consultants which has impacted the team's ability to deliver some training and exercising. It has also been noted that training normally provided by UK Health Security Agency hasn't materialised (Loggist, Emergo and Defensible Decision Making)

The team have worked closely with planned Estate and ICT work which has provided a degree of resilience to the trust and successful implementation.

SFT colleagues have also supported several work streams across BSW Local Health Resilience Partnership – Risk Working Group, Training and Exercising.
Set priorities for 2025 include:

- Further develop the EPRR portfolio and longer-term team development
- Continual horizon scanning of what may happened next and embed learning.

The outcomes of this assurance review will be included in the annual EPRR System assurance summary letter which is submitted to NHS England South West. The ICB will be required to present a system summary of the assurance process to the LHRP. NHS England will produce and submit a regional report to the NHS England National Team by end of December 2024.

Finally, thanks must go to you and the EPRR team for your hard work over the last year, while managing other concurrent issues and incidents.

SFT Is compliant with 100% of the Standards - the overall rating is '**FULL'.**

See figure 1 below for compliance levels:

Overall EPRR assurance rating	**Criteria**
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action

	plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis

Figure 1:

5. Training & Exercising

Statutory requirement set out that the Trust will undertake:

- Live Exercise – Every 3 years (if there hasn't been an incident which required a full response from the organisation)
- Table Top Exercise – Yearly
- Communication Test – Every 6 month

A variety of training and exercising and live events have taken place in the last year, despite the ongoing Incident response to industrial action.

See tables below in relation to training and awareness and exercises and live incidents:

Training August 2023 – to September 2024

Training	Date	Participants
CBRN &PRPS	23/11/2023, 08/12/2023, 15/01/2024, 17/04/2024	24
PRPS Train the Trainer	31/05/2024, 28/08/2024/ 29/08/2024	6
Duty Executive/Manager Overview	28/11/2023, 20/06/2024	24
Principles of Health Command	24/11/2023, 30/04/2024, 07/05/2024	11
Executive on-call	29/04/2024, 07/10/2024	2
Multi agency Operational	13/09/2023	2
New Loggist	04/04/2024, 16/09/2024	3
Loggist refresher	23/04/2024	1

Exercising Schedule – dates planned

Live Exercises	Table Tops	Communications Test	Training
Porton Down (LRF) 21st Jan 2025	IT failure 28th Jan 2025	18th Feb, 30th July, 8th Dec 2025	CBRN/PRPS 14th Feb, 14th Mar, 11th April, 16th May 2025
Isambard 2 (LRF) 4th Feb 2025			BSI Auditor 20th – 24th Jan 2025
Soprafratta (LRF) 12th Feb 2025			Risk Management 27th & 28th Feb 2025
CBRN 8th April 2025			Loggist 1oth Feb, 10th Mar, 14th April, 18th May 2025
Mass Casualty 10th July 2025			
Mass Casualty Recovery 11th July 2025			
	NPO 24th Nov 2025		

6. Exercises and Live Incident including internal incident responses - September 2023 to September 2024.

Exercises

Name of Exercise	Type of Exercise	Date & Timings	Exercise Lead	Participants
Suspect package	Tabletop	22nd February 10:00hrs	Head of EPRR	8 x SFT staff
Ward evacuation	Live	22nd February 13:00hrs	Head of EPRR	10 x SFT staff
Baby Abduction	Live	11th March 12:50hrs	Head of EPRR	9 x SFT staff
Toucan	Communications	16th May 10:30hrs	NHSE	2 x SFT staff
Echo Relay	No notice Communications	24th July 18:55hrs	Deputy Head of EPRR	20 x SFT staff
Reveille	Communications	16th August 11:36hrs	ICB	2 x SFT staff
Dynamo	NPO Tabletop	3rd September 09:00hrs	LRF	2 x SFT staff
Propaganda	Cyber Tabletop	9th October 09:00hrs	ICB	2 x SFT staff
Flooding Recovery	Recovery Tabletop	5th November 09:00hrs	LRF	1 x SFT staff

Incidents

Incident	Audience/Description	Date	Learning Outcomes
Power outage	Trust wide power outage causing the generators to be activated	14th Oct 2023	• Recovery check list for senior managers • Escalation process to the ICB
Emergency Department ceiling water leak	Emergency department, leak causing normal pathway to be altered.	20th Oct 2023	• Alternative pathway for Resus patients
Storm Ciaran	High winds and rain	2nd Nov 2023	SFT not impacted by the storm
Theatre 1 Anaesthetic room	Contractor drilled through pipeline	14th Nov 2023	• Clear escalation process for out-of-hours significant work to include clinical site team. • On-call managers to cascade information to the ICB. • Switchboard to support linking of mobile connections.
SSL RO failure	Sterile Services failure	14th Nov 2023	• SSL Business Continuity Plans to be reviewed. • Clarity of Red Flag process • Past equipment issues to be logged. • Clear understanding from departments of what equipment they have. • Investigate if more trays of instruments can be funded. • Tracking of equipment when going off site. • Preventative maintenance of the plant • Contractual agreement of who is responsible. • Agree SOP with external partners. • Train an AP from on-site staff.

PAC'S failure	PAC'S failure in the backup system so no images available.	6th Dec 2023	• Business Continuity plans reviewed
Power outage	Short power outage to the Trust due to trees hitting the HV line	8th Dec 2023	• Business Continuity plans to be reviewed
Telemetry failure	Failure in AMU	27th Feb 2024	Business Continuity plans to be reviewed
Critical Incident	Pressure from attendances and patient discharge	9thy April 2024	• Comms team to be at Critical Incident activation meeting. • To include senior clinicians at the incident meetings. • Cancel senior meetings whilst in Critical Incident. • Senior clinicians to support F2's when identifying patients for discharge. • Look at enhanced bed meetings before Bank Holidays. • "Perfect day" after Bank Holidays. • IT to review staff working at weekends.
Theatre filtration test failure	Theatre 6 filtration test failed	10th April 2024	Business Continuity plans to be reviewed
External telephone lines down	Paging system & external telephone lines have failed	30th June 2024	Outage lasted for 2hrs and business continuity plans enacted and reviewed.
Mass IT outage	Multiple issues with IT systems	19th July 2024	• Action cards to perform checks on critical equipment • Training and action cards to be discussed regarding IT Business Continuity plans. • Communications process to include 3rd parties who work onsite. • List showcasing visibility of apps hosted on site and off to be created.
National disruption to 999 services	National disruption	31st July 2024	No learning for SFT.

Power outage	Power outage which caused generators to be used	8th Aug 2024	• Direct contact number for duty managers going into switchboard. • Checklist for Duty Managers so they know if critical areas are up and running. • Switchboard to check RED phone is available in power outage. • Agree location of incident response if it's not a declared incident. E.g., clinical site office.
Generator Failure	Failed switch when conducting a generator test which meant the mains power wouldn't revert to generator power	29th Aug 2025	• EPRR Team to train on-call staff from departments • EPRR team to identify process for informing the correct stakeholders. • To ensure correct information is available quickly. • Review essential power sockets in theatres. • Review Business Continuity plans for Obstetrics. • Review Business Continuity plans for all departments with regards UPS. • NICU to review Business Continuity plan to incorporate Sarum ward. • Investigate if Diathermic machine can use batteries. • Explore power back up for high flow ventilators in NICU. • Explore the resilience for the Day unit. • Generators lacking fault monitoring.

All exercises and live events are debriefed so lessons learnt, and action plans can be captured, and plans updated/modified as required.

The EPRR Team have been involved with other aspects of response for the Trust which include:

- Decarbonation Project – We have coordinated the planned work with SFT estates team and departments so clear communications are used and changes in location of patient services for that day.
- High Voltage shutdown – Agreed response with clear communications to all areas affected and set up mini response team on the day. (No issues identified)
- Storm Ciaran – supported the communications to Trust staff and highlighted risk to the site for equipment that may come loose due to high winds.
- Industrial action planning and support for all departments and wards to ensure safe levels of staffing.
- GO-JO project which the EPRR team we significantly involved with to support the transition of dispensers and products.
- Supported the refurbishment of the helipad project as liaison to partner agencies.
- Support the IPC team with MPox planning and training of staff.
- Attended LRF meetings to support the information cascade from summer rioting.
- Reset Week – supported the site team with the organisation of the week.
- Supporting the Trust with the W75 project with clinical teams in ED & the Trust.

7. Partnership Working

Externally the Trust is embedded in multi-agency planning through the Wiltshire & Swindon Local Health Resilience Partnership LHRP. This ensures a proactive and coordinated approach to planning and sharing of best practice. The Trust participates on a regular basis on the Everbridge SWAST communications cascade as well as regular Health Community Response Plan activities, and actively works on the LHRP task and finish groups where appropriate and works with partners with the coordinated planning of the modular response tool iRespond which has been implemented across the health economy in Wiltshire. The work of the LHRP has all been completed via face to face and virtually and SFT have also been supporting GWH and Gloucester Hospitals with sharing of documentation to ensure a consistent approach across partner organisations.

This partnership working has involved the EPRR team being significantly involved with the ICB Risk, Training & Exercising, and CBRN working groups as well as LRF mortality working group.

8. Developments to consider for 2024.

As the EPRR portfolio continues to expand, we need to consider the longer-term development of the EPRR Team, and how we continue to support the organisation and use our skills to enhance and further embed the EPRR culture across the Trust. The goal for the EPRR Team will always be, to be the best we can and aspire to ‘Gold’ standards and not to simply achieve the minimum required, this drive is enhanced by working with partners and colleagues who are professional and aspire to support the Trust and the wider community.

As the team have lost an officer it was a good time to review the structure, and this has enabled the team to have a Deputy Head of EPRR to support decision making and to look

at allocation of project leads within the portfolio, to give the Head of EPRR a more Strategic approach.

The EPRR team are supporting the Emergency Department with organising CBRN training as there has been a large turnaround of staff so having a trained person on shift 24/7 had been a challenge but now the Clinical Site Team are able to support as they attended sessions. We have now 5 staff trained as PRPS train the trainers, so we are looking at delivering more courses in 2025.

National Power Outage planning will continue going into 2025 and further training with support from the ICB and partners to develop our Tactical & Strategic Commanders, so they are confident to respond to anything which may happen.

9. Identified Gaps in EPRR portfolio & Next Steps

Gaps	Action	Date
Instigate a switchboard automated procedure for our internal cascade procedures	Netcall project is at the testing stage so should be in place early 2025	2025
In a mass casualty type MI response, ED currently no robust process for unidentifiable patients	ED have found a solution so will be exercised in 2025	Exercise 2025
Maintain compliance against the core standards and improve on these minimum standards	To ensure we maintain full compliance at the next Core Standards ICB Confirm and Challenge meeting	August 2025
Continue to build on the links with the Wessex network of the LHRP, to ensure a consistent approach for response to an incident linking the Trauma Centre and Units and to build on the relationships and sharing with MTW	Continued participation in regional exercising, building on links with partners at other organisations	2025
Emergo Tabletop Trust - Wide Mass Casualty exercise	This will include a recovery exe4rcise the following day	July 2025

10. Summary

Based on the National RAG status for EPRR compliance SFT has been rated by NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group and NHS England as ‘FULL”. As a category One responder we are meeting of our civil protection duties under the Civil Contingencies Act (2004).

11. Recommendation

The Trust Board is asked to support the ongoing work required to fulfil our EPRR duties and responsibilities, and to support the work required within the EPRR portfolio as we transition into the Integrated Care System (ICS) Structures in 2025 and to approve this Full

compliance statement by signing off this annual EPRR assurance report as part of the NHS England assurance process.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.3
Date of meeting:	6 March 2025		

Report title:	Board Meeting Schedule Proposal			
Status:	Information	Discussion	Assurance	Approval
		x		x
Approval Process: (where has this paper been reviewed and approved):	The GWH Board have considered and approved the proposed changes			
Prepared by:	Tapiwa Songore, Head of Corporate Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices	One			

Recommendation:

The Board is being asked to approve the following changes.:

a) Reduce the number of Board meetings to six in the year.
b) Move full Board (public and private) meetings to alternate months and in the intervening months, hold a Board seminar (x 5) with the opportunity of a private Board as required.
c) Two of the seminars will be held locally as Board Development Days, and the other three will be shared with the other Trusts. All Board members across the three hospitals will meet as one.
d) There will be no meetings in August.

Executive Summary:

The development of new working arrangements for the BSW Group continues and a comprehensive stocktake of the 3 Trust's formal governance meetings has been undertaken and reviewed by the Group CEO & Managing Director's (MDs).

The purpose of this report is to seek Board approval for the alignment of SDH Board meetings with the BSW Group Hospitals. A new cadence of meetings is proposed to enable better working arrangements from 2025/26 onwards. The GWH and RUH Board are both reviewing the working arrangements to ensure their meetings align with the Group.

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

1.0 Introduction

The development of new working arrangements for the BSW Group continues at pace and a comprehensive stocktake of the 3 Trust's formal governance meetings has been undertaken and reviewed by the Group CEO & MDs. This report outlines the proposed changes to ensure alignment of governance meetings within the BSW Group Hospitals for 2025/26 onwards.

2.0 Current arrangements

Currently there are eight full public and private Board meetings with four seminars a year, and the Board meets on the first or second Thursday of the month. The other two Trusts have different arrangements, and these are summarised below.

Type of Meeting	GWH	SDH	RUH
Full Board	9	8	6
Seminar	3	4	5

It is therefore important to ensure the meetings are aligned within the BSW Group Hospitals, with the least amount of disruption.

3.0 Proposed arrangements

It is proposed that Board reduces the number of Board meetings to six in the year and move to full Board (public and private) meetings in alternate months, and in the intervening months hold a seminar (x 5) with the opportunity of a private Board as required. There will be no meetings in August.

Two of the seminars will be held locally as Board Development Days, and the other three will be shared with the other Trusts. All Board members across the three hospitals will meet as one.

The impact on the three Trusts is summarised below

Trust	Impact on number of full Board meetings	Impact on number of seminars
GWH	3 less	2 more
SFT	2 less	1 more
RUH	No impact	No impact

From the cadence that was approved by the Board, the impact of the proposal is summarised in appendix 1 below, and the following changes will be made.

- The Board Development session scheduled for 5 June will be cancelled and an all-Trusts seminar will be arranged and hosted by RUH. Date is yet to be confirmed.
- The Board meeting to approve the Annual Report and Accounts will go ahead as scheduled on 19 June 2025.

- The Board Development Day in August will be cancelled as no meetings will be held.
- The Board meeting scheduled for 2 October will be cancelled and an all-Trusts seminar will be arranged and hosted by SDH. Date is yet to be confirmed.
- The Board Development day on 6 November will be changed to a full Board meeting.
- The Board meeting on 4 December will be changed to a Board Development day.
- The Board Development day on 5 February will be cancelled and an all-Trusts seminar will be arranged and hosted by GWH. Date is yet to be arranged.

The changes will take effect from the beginning of the 2025/6 financial year.

4.0 Recommendations

The Board is being asked to approve the following changes.

e) Reduce the number of Board meetings to six in the year.

f) move full Board (public and private) meetings to alternate months and in the intervening months, hold a Board seminar (x 5) with the opportunity of a private Board as required.

g) Two of the seminars will be held locally as Board Development Days, and the other three will be shared with the other Trusts. All Board members across the three hospitals will meet as one.

h) There will be no meetings in August.

Salisbury NHS Foundation Trust

Appendix 1

Board Dates 2025/26			
2025	Current	Proposed	Change
3 April 2025	Board Development Day	Board Development Day	No change
1 May 2025	Public/Private Board	Public/Private Board	No change
5 June 2025	Board Development Day	All Trusts seminar	All Trusts seminar hosted by RUH. Date 4th June
19 June 2025	Board – Annual Report and Accounts	Board – Annual Report and Accounts	No change
3 July 2025	Public/Private Board	Public/Private Board	No change
7 August 2025	Board Development Day	No meetings	No meetings in August. Cancel Board Development Day
4 September 2025	Public/Private Board	Public/Private Board	No change
2 October 2025	Public/Private Board	All Trusts seminar	Cancel Board meeting – All Trusts seminar hosted by SDH. 2nd October
6 November 2025	Board Development Day	Public/Private Board	Change Board Development Day to Board meeting
4 December 2025	Public/Private Board	Board Development Day	Change Board meeting to Board Development Day
2026			
8 January 2026	Public/Private Board	Public/Private Board	No change
5 February 2026	Board Development Day	All Trusts seminar	All Trusts seminar hosted by GWH. 12th Feb
5 March 2026	Public/Private Board	Public/Private Board	No change

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.4
Date of meeting:	6 March 2025		

Report title:	Group Joint Chair Role			
Status:	Information	Discussion	Assurance	Approval
				x
Approval Process: (where has this paper been reviewed and approved):	Input from all Trust Chairs and Corporate Governance Leads			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive Sponsor: (presenting)	Eiri Jones, NED and Senior Independent Director			
Appendices	Appendix 1: Guide to the appointment of Group Chair Appendix 2: Joint Chair and Local Lead NED tasks and assumptions			

Recommendation:

The Board is requested to:

- Support the development of a Job Description and Person Specification for a Joint Chair in support of the Nominations Committee of the Council of Governors recommendation to the Council of Governors (CoGs); and,
- Consider and recommend to respective CoGs the options to appoint a Joint Chair as outlined in section 4.

Executive Summary:

At the Board meetings of the Great Western Hospitals NHS FT, Royal United Hospitals Bath NHS FT on 22 July 2024 and Salisbury NHS FT on 5 September 2024 each Board of Directors approved the Case for Change to move to a Group model, which included the approval of shared leadership and to identify a BSW Hospitals Group Chief Executive and a Joint Chair for the Trusts.

On 1 November 2024 Cara Charles-Barks was appointed as BSW Hospitals Group Chief Executive. The proposed next step is to appoint a Joint Chair to support Group development leadership.

The post would be a single role across three separate statutory organisations, each responsible for delivering their own services, but ensuring a strengthened delivery of joint commitments for improving quality of care, effectiveness and efficiency for the BSW population we serve.

The focus and test of effectiveness must be about the benefit to patients, and whether these are being delivered.

A Joint Chair is expected to create a number of benefits whilst recognising the potential of a discreet number of associated disbenefits.

There is no legal restriction that would impede an individual simultaneously being the Chair of more than one Trust.

There are Statutory requirements and National guidance to consider in respect of the appointment process.

The BSW ICB Chair has indicated support for the recruitment of a Joint Chair, considering the role will enable a strong response to the significant system challenges BSW faces. NHS England's Regional team also supports recruitment of a Joint Chair and establishment of Joint Committee arrangements.

To facilitate the appointment of the Joint Chair as early as is practical, it is recommended that each Council of Governors agree a clear process for nominating a Joint Chair, working with the Senior Independent Directors (SIDs) and with support of People Services.

It is recommended that the Councils of Governors establish a Joint Nominations Committee with responsibility for undertaking the selection process of the Joint Chair and making a recommendation to each Council of Governors of a preferred candidate. Options are presented for consideration and further development by the Joint Nominations Committee.

A job description and person specification will be initiated for consideration and further development by the joint Nomination Committee [in March] incorporating the already agreed current roles and responsibilities of a Trust Chair plus the additional responsibilities of the new group role.

The time commitment for the Joint Chair role is proposed as between three to four days per week.

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

1. Background

1.1 At the Board meetings of the Great Western Hospitals NHS FT, Royal United Hospitals Bath NHS FT on 22 July 2024 and Salisbury NHS FT on 5 September 2024 each Board of Directors approved the Case for Change to move to a Group model, which included the approval of shared leadership and to identify a BSW Hospitals Group Chief Executive and a Joint Chair for the Trusts.

1.2 On 1 November 2024 Cara Charles-Barks was appointed as BSW Hospitals Group Chief Executive following a robust recruitment process and approval from each of the Council of Governors.

1.3 The proposed next step is to appoint a Joint Chair to support Group development leadership.

2. Introduction

2.1 The proposed Joint Chair appointment follows similar approaches being adopted by hospital providers across England and reflects wider NHS provider collaboration policy.

2.2 The post would be a single role across three separate statutory organisations, each responsible for delivering their own services, but ensuring a strengthened delivery of joint commitments for improving quality of care, effectiveness and efficiency for the BSW population we serve.

2.3 The creation of a joint post does not indicate any desire for or proposals for merger between the Trusts. There is no system pressure for a merger between the Trusts and all three Trusts remain distinct organisations with their own Board of Directors.

2.4 The focus and test of effectiveness must be about the benefit to patients, and whether these are being delivered.

2.5 A Joint Chair is expected to create the following benefits:-

- Enables a cross fertilisation of cultures, learning and practice between the Trusts.
- Assists building relationships across trusts, helping stabilise leadership teams.
- Facilitates more joined-up care and increased alignment of the Trusts, reduction in unwarranted variation, encouragement of collaboration in service provision, including specialised services.
- Aids system working and the creation of an integrated healthcare system – working with partners and sharing services.
- Supports BSW Hospitals to address significant operational and financial system challenges ahead.
- Creates a unified governance structure for measuring delivery of Group ambitions.
- Supports taking of difficult decisions by the Trusts, in the current and future interests of wider BSW population.
- Helps to facilitate mutual support.
- Supports the BSW Hospitals Group Chief Executive to create environment to deliver the benefits of working as a Group, including the BSW Hospitals Case for Collaboration, set out in May 2024.

2.6 Some potential disbenefits to be managed have also been identified:-

- Potential loss of local leadership and visibility.
- Potential impact on individual relationship development between Chair and Governors.
- In response, it is envisaged that the Chair will put governance arrangements in place to support them in their role, with emphasis on the role of the Vice Chairs in each Trust - whilst being clear that the responsibility to provide visible leadership remains that of the Chair. **Appendix 2** sets out potential division of roles between Joint Chair and Vice Chairs.

3. Governance, legal or regulatory considerations

3.1 There is no legal restriction that would impede an individual simultaneously being the Chair of more than one Trust.

3.2 **Statutory Requirement**: The National Health Service Act 2006 (NHSA) requires NHS foundation trusts to have a chair.

The Council of Governors is responsible at a general meeting for the appointment, re-appointment and removal of the Chair and other non-executive directors (paragraph 17(1) of Schedule 7 to the NHSA).

The Council of Governors must also decide the remuneration and allowances, and the other terms and conditions of office of the Chair and other non-executive directors (paragraph 18(1) of Schedule 7 to the NHSA)

3.3 **National Guidance**: The Code of Governance for NHS Provider Trusts (April 2023) sets out the following points in respect of the appointment of the Chair:

A Nomination Committee, with external advice as appropriate, is responsible for the identification and nomination of non-executive directors (paragraph 2.1).

The Nominations Committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust, and the skills and expertise required within the board of directors to meet them (paragraph 2.1).

The governors should agree with the Nominations Committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the Nominations Committee should make recommendations to the Council of Governors (paragraph 2.4).

When considering the appointment of non-executive directors, the council of governors should take into account the views of the Board of Directors and the Nominations Committee.

3.4 **System and Regional support**: The BSW ICB Chair has indicated support for the recruitment of a Joint Chair, considering the role will enable a strong response to the significant system challenges BSW faces. NHS England's Regional team also supports recruitment of a Joint Chair and establishment of Joint Committee arrangements.

3 Process to recruit a Joint Chair

4.1 To facilitate the appointment of the Joint Chair as early as is practical, it is recommended that each Council of Governors agree a clear process for nominating a Joint Chair, working with the Senior Independent Directors (SIDs) and with support of People Services.

4.2 It is recommended that the Councils of Governors establish a Joint Nominations Committee with responsibility for undertaking the selection process of the Joint Chair and making a recommendation to each Council of Governors of a preferred candidate.

4.3 Options for consideration and further development by Joint Nominations Committee

Options	Timeline Assumptions, Risks and Benefits
Option 1 • Open external recruitment process, assume internal candidates short-listed.	• Executive Search firm confirmation: end March • Recruitment process April - July • If new post holder, settling-in period Sept – March 26 • Risks/ benefit. Impact on benefits delivery during challenging period for Group – including during recruitment exercise and settling period. Benefit of external process – perceptions among stakeholders regarding process strength/ wider pool of candidates. • Assume 3-year role, with standard additional term potential.
Option 2 • Interim appointment, pending completion of external open recruitment process. • Role ringfenced to current Chairs of Trusts. Applications and interview process. Propose 6-8 months role.	• Interim appointment potentially in Q1 • Risk/ benefit. Supports stabilisation and benefits delivery during challenging period for Group. • 6-8 month term to allow time for an open recruitment process supporting stabilisation. • To be followed Q1-Q3 by external recruitment exercise.

4.4 A guidance document has been developed outlining the recruitment process to support the governors and SIDs in this process, attached as **appendix 1**.

5. Job Description

5.1 A job description and person specification will be initiated for consideration and further development by the joint Nomination Committee [in March] incorporating the already agreed current roles and responsibilities of a Trust Chair plus the additional responsibilities of the new group role.

5.2 The time commitment for the Joint Chair role is proposed as between three to four days per week for the following reasons:-

- The limit allows focus on the strategic role of the Chair without encroaching on the role of the CEO and the Executives.
- As described in s. 2.6 above, it is anticipated that the Chair will put governance arrangements in place which support them in their role, with a particular emphasis on the role of the Vice Chairs. **Appendix 2** *[NOTE: Document to be developed further]* outlines a summary of the suggested disposition of Chair tasks between a Chair and a Vice-Chair for consideration and further development by the Nominations Committee. It is suggested that the Vice-Chair role time commitment would increase to accommodate this support to six days per month, with no committee responsibilities.
- Formation of joint committees and committees in common in due course, where appropriate, will mitigate some time pressures.

6. Recommendations

6.1 The Board is requested to:

- Support the development of a Job Description and Person Specification for a Joint Chair in support of the Nominations Committee of the Council of Governors recommendation to the Council of Governors; and,
- Consider and recommend to respective CoGs the options to appoint a Joint Chair as outlined in section 4.

Guide to the appointment of Joint Chair

Table of Contents

Table of Contents (continued)

1. Purpose of Document

1.1 The aim of this document is to:

- Support Governors of the three BSW Hospital Group Trusts in relation to the process for the appointment of a Joint Chair including their role and the role of the Boards of Directors (Board), Senior Independent Directors (SID) and other stakeholders.
- Ensure that the appointment is made as smoothly and effectively as possible in a fair, open and transparent way.
- Ensure that the successful candidate has the skills and experience to lead three Trusts over the coming years.

2. Context

2.1. A Joint Chair is defined as '*an individual who is appointed to chair more than one Trust to maximise the potential for synergy*'; in particular to:

- Lead and enable the three organisations to harness the strengths of each other
- Share resources, innovation and leadership for the benefits of the populations we serve
- Provide leadership to the acute and community health collaborative arrangements in the system of which the Trusts are part.

2.2 The Joint Chair will be a single post across the three separate organisations, each responsible for delivering their own services but ensuring a strengthened delivery of joint commitments for improving the quality of care and efficiency for the populations we serve.

2.3 The Joint Chair will chair the three separate Trust Boards and three Councils of Governors.

2.4 The aim of the recruitment process is to ensure the Trusts appoint the best person to lead the organisations within the context they are currently operating in, particularly in respect of a move towards greater collaboration within a Group model and beyond.

3. Responsibilities

3.1 **Role of Governors**

Under the National Health Service Act 2006, the Council of Governors appoints the Chair and decides their remuneration, allowances and other terms and

conditions of office. **It is proposed that the Councils of Governors agree to form a Joint Nominations Committee to undertake the selection process of the Joint Chair and to make a recommendation of a single preferred candidate to each Council of Governors**. The Joint Nominations Committee does not have any formal powers delegated by the individual Trusts or Councils of Governors; all responsibilities are undertaken in support of the Councils of Governors who each hold the responsibility for decisions relating to the appointment of the Joint Chair.

Following the start of the selection process, all three Councils of Governors will be offered separate informal drop-in sessions to enable them to raise questions and keep governors informed during the selection process. It is anticipated one of the sessions for each Council of Governors will be led by the Chief Executive (CEO) and respective SID.

The Joint Nominations Committee will be responsible for identifying a single preferred candidate on behalf of each Council of Governors. A recommendation for appointment will then be presented to each Council of Governors.

3.2. **Role of the Boards**

It is important that the views of the Board and the CEO in particular are taken into account with regards to the skills and experience required for the Joint Chair role particularly in respect of Board balance and succession planning as well as both the local and national NHS context in respect of the Chair.

3.3. **Role of the Joint Nominations Committee**

The membership of the Joint Nominations Committee (Joint NomCo) comprises of the following from each Trust:

- [Two] nominated Governors from each Trust.
- Senior Independent Directors (SIDs) – one to be chair of the Joint NomCo
- CEO.

The SIDs and CEOs are non-voting members of the Joint NomCo. As detailed in its terms of reference, the Joint NomCo will have delegated responsibility to select candidates to fill the Joint Chair role and recommend a candidate to each Council of Governors for appointment. This includes:

- Establishing an open and transparent process in line with the Nolan Principles and other good practice guidance.
- Carrying out the selection process on behalf of the Councils of Governors for the selection of a suitable candidate from the current Trust Chairs who fits

the criteria for the appointment of the Joint Chair set out in the job description developed by the Boards.

- Appointing an external recruitment agency to facilitate the search and support the overall recruitment process.
- Preparing a description of the role, capabilities, skills, knowledge and experience and expected time commitment required taking account of the recommendations of the Boards. In particular, account shall be taken of the focus on improving population health, changing external landscape and the Trusts' role as an integrated care system leader. The views of NHS England and the ICB will also be sought and reflected.
- Recommending to each Council of Governors the Joint Chair's remuneration and terms and conditions of office including time commitment.
- Ensuring compliance with any mandatory guidance and relevant statutory requirements.
- Agreeing the members of the interview panel. The recruitment process and in particular the interview process demands a certain level of experience and understanding by Joint NomCo members and this will be borne in mind when agreeing the members of the interview panel. The interview panel shall include a representative of NHSE / the ICB. All Governors involved on the interview panel will be required to attend refresher training which also covers the relevant equality and diversity requirements prior to interviews taking place.
- Providing assurance to the Councils of Governors that it has followed due process and highlight the proposed candidate's significant attributes.

3.4 **Role of the Recruitment Agency**

A recruitment agency will be appointed by the Joint NomCo to lead the search. Working in partnership with the Joint NomCo the agency will use their expertise to help identify the best candidates for the vacancy. The agency will support with the preparation, generate the candidate pool, and support with the selection process:

- Preparation: this will include understanding the demands of the role, criteria, the timetable and advertising opportunities
- Generating the candidate pool: this will include developing a pool of candidates for the role using their relevant networks and contacts, and ensuring diversity through a fair, balanced and inclusive process, as well as undertaking relevant Fit and Proper Persons checks
- Selection: this will cover support throughout the recruitment process including with sifting, longlisting, shortlisting, stakeholder panels and interviews.

4. Joint Chair Role Description and Person Specification

As mentioned above, the development of the Joint Chair role description and person specification will be undertaken by the Joint Nominations Committee, and the views of Boards, NHSE and the ICB will also be sought and reflected.

The role description and person specification will be included within the Candidate Information Pack. This will include specific responsibilities and the essential and desirable skills, knowledge, experience and attributes required to undertake the Joint Chair duties including ensuring the Boards can function efficiently and effectively given the existing composition of the Boards, the Trusts' vision and strategic priorities, as well as the external NHS environment.

5. Terms and Conditions

The terms and conditions, including appropriate remuneration and required working days, are also considered by the Joint NomCo. Remuneration will be considered using benchmarking information and ensuring that it reflects the time commitment and responsibilities of the role. In addition, consideration will be taken of the NHSE guidance on Chair remuneration and other benchmarking information.

The Joint NomCo will provide recommendations to the Councils of Governors for approval.

6. Recruitment Campaign

The vacancy will be advertised as agreed with the recruitment agency and will include both local and national advertising as well as through social media, and the use of the Trusts' own internal communications function. An advert will be included in the Candidate Information Pack. During the advertising phase, potential candidates will have the opportunity of having information conversations with the CEOs and/or Chairs/SIDs or other colleagues including other Board members and Governors if requested.

7. Internal Candidates

It is proposed that internal candidates be asked to submit an expression of interest and those that submit an expression of interest would be guaranteed a place on the final shortlist of candidates. Final decisions about invitation to interview will be on merit alongside external candidates.

Internal candidates are those operating as a Trust Chair at any of the three Trusts.

8. Selection Process

This section covers arrangements from the applications closing date to completion of interviews.

This section covers arrangements from the applications closing date to completion of interviews.

8.1. Sifting

The sifting process will be undertaken to reduce the number of applications to a manageable list for review. This would usually take the form of grading each applicant for consideration for the next stage, e.g. recommended, marginal, not recommended. This process will be undertaken by the **recruitment agency** to ensure that candidates to be considered for longlisting have met the application requirements and agreed competencies of the post as included in the person specification.

8.2. Longlisting

Information on all applicants will be circulated to the members of the **interview panel and SIDs** for consideration prior to the longlisting meeting. This will include the 'sift' summary, the application letters and CVs and also an equal opportunity monitoring report. The aim of the longlisting meeting is to identify those applicants who meet the application requirements and agreed person specification, and to invite them to a preliminary interview with the recruitment agency. Those not longlisted will be advised accordingly by the agency.

8.3. Preliminary Interviews

The **recruitment agency** will undertake preliminary competency and values-based interviews with those applicants confirmed as longlisted. The interviews will explore the applicant's background and achievements, their style and overall suitability for the role. The interview will also cover other considerations such as time commitment, conflicts of interest and remuneration. A report on the preliminary interviews will be produced by the recruitment agency. This will highlight the strengths and areas of concern/development for each candidate interviewed, and include recommendations for shortlisting, the grading of each applicant based on the interview, and an equal opportunity monitoring report.

8.4. Shortlisting

The shortlisting process is conducted by the **interview panel** with the aim of identifying suitable candidates for interview, supported by **SIDs** as well as the recruitment agency. The agency will provide a report following the preliminary interviews which details the suitability, eligibility and credibility of applicants; the recommendations are based on the person specification.

Only those applicants who have been shortlisted will then be invited to interview; those applicants who are not shortlisted will be advised by the recruitment agency.

8.5. **Interview Panel**

The Joint NomCo agrees the composition of the interview panel which would comprise:

- Governors: [Two] from each Trust who will be voting members
- Chair of panel who will be an independent NHS provider Chair (ie ideally an experienced Chair in Common/Joint Chair role)
- NHSE: one representative
- ICS representative

All SIDs will attend the interviews as observers.

In line with the Trusts' practice, the interview panel will include diverse representation.

8.6. Role of the Interview Panel

The role of the interview panel is to make objective and reasoned decisions concerning the relative merit of competing candidates against the criteria included in the person specification, and thereby identify the appointable candidate for recommendation to the Joint NomCo and subsequently to the Councils of Governors.

The key elements of the interview panel's role are to:

- Determine which applicants should be longlisted on the basis of the available information about them, ensuring equal consideration of all candidates
- Determine which applicants should be shortlisted on the basis of the feedback from the preliminary discussions led by the recruitment agency
- Interview each candidate against the established selection criteria
- Assess which candidates are appointable in the light of all the relevant evidence including the interview and taking account of feedback from stakeholder panels, etc
- Identify appointable candidates, describing how and the extent to which they met the key criteria
- Preserve the confidentiality of candidates throughout the selection process
- Ensure any personal or family relationships with particular candidates are declared within the panel and dealt with appropriately and consistent with the principles of fairness and merit.

8.7. Role of the Governors on the Interview Panel

In addition to the roles described in 8.6 above and following due consideration, the Governor representatives on the interview panel will vote on a suitable

candidate for appointment to the Joint Chair role for recommendation to the Joint NomCo and subsequently to the Councils of Governors. The candidate must be considered appointable by NHSE.

8.8 Role of the Independent Chair and other Independent Assessors

The independent assessors:

- Ensure that selection is made on merit after a fair, open and transparent process
- Are independent of the appointing organisation
- Provide guidance to the interview panel on the calibre, ability and attributes of the candidates at interview
- Contribute to the discussion among interview panel members when discussing the candidates' performance in the post interview discussions
- Play a full part in the interview process, i.e. will ask questions
- Do not vote.

8.9 **Recruitment Refresher Training**

Governors on the interview panel will be required to attend a refresher recruitment training session to ensure there is a common understanding and consistent approach and which also covers the relevant equality and diversity requirements. In addition, a briefing session with the CEO will be held for all Governors on the importance of the relationship between the Joint Chair and CEO.

8.10. **Informal Meetings/Discussions**

Applicants will be provided with the opportunity of having an informal conversation with the SIDs/CEO (and others as requested, such as Governors) during the application period.

8.11. **Stakeholders Survey**

The Joint NomCo may decide to carry out a stakeholder survey. The aim is to provide staff, Governors, service users and carers, and external stakeholders with the opportunity of sharing their views as to the key qualities they would like to see in the new Chair. Key themes identified can be used to help inform the questions asked at or presentations required at the stakeholder sessions.

8.12. **Governor Engagement and Communications**

Following the start of the recruitment process, Councils will be offered regular, separate informal drop-in sessions to enable them to raise questions and keep them informed during the lengthy identification and selection process. It is anticipated one of the sessions each will be joined by the CEO and SIDs.

8.13. Checks and References

The Trusts will:

- Take up references for the candidates shortlisted for interview in advance of the interview
- Carry out relevant checks including Fit and Proper Persons checks, disqualification checks with Companies House and other government agencies, and due diligence checks including various media searches.

8.14. **Stakeholder Sessions**

In addition to the formal interviews, there will be an opportunity for key stakeholders to meet with the candidates on an informal structured basis. The questions and focus at these sessions may be based on the feedback from the stakeholder survey. The key stakeholders panels usually included are:

- Directors from the three Boards, Governors, service users, staff and carers
- System stakeholders (representatives of the ICSs, usually the Chairs and CEOs)
- External stakeholders (e.g. representatives from local authorities, MPs, voluntary and partner organisations, other Trusts within the ICSs, etc).

Although the focus and questions and/or presentations will differ for the different stakeholder groups, the sessions will be structured so that the same format and the same questions/requirements are asked of each candidate and will be supported by an independent representative. The stakeholder groups' views will be shared with both the interview panel and Joint NomCo either by the independent representative or a member of the stakeholder group during the post-interview discussion to aid deliberations.

8.15 **The Interview**

The aim of the interview is to identify the most suitable candidate for the role.

(a) Interview Preparation

Prior to the interviews, the interview panel will decide on a set of questions to ask each candidate taking account of the essential criteria in the person specification and the Trusts' values. The interview panel will be chaired by the independent Trust Chair who will manage the welcome and closing remarks at the interview, as well as post interview discussions. All interview panellists should ensure that they have reviewed the applications in preparation for the interview and remind themselves of the key requirements and role description of the Joint Chair.

(b) Interview

Interview packs will be provided consisting of the interview programme and questions sheet as well as the role description, person specification, and CVs and application forms.

All interview panellists will have the opportunity of asking a question(s) and, where appropriate, asking follow-up or probing question(s).

The following best practice principles should be noted and applied throughout the interview process:

- The same questions should be posed to each applicant: these should be investigative and open ended with probing questions asked where needed
- The interview should start by easing the candidate into the interview – asking them to talk through their application form – ensuring any gaps in their employment history are explored
- Questions should be based on the criteria detailed in the person specification and the Trusts' values
- Personal questions/yes or no questions/leading questions/multiple questions in one/discriminatory questions should be avoided
- Notes should be taken during the interview to support with identifying whether the candidate is appointable or not and to allow the ranking of those identified as appointable. This will also form part of the audit trail to confirm that the process is fair.
- Each candidate should be scored; the interview panel will agree the final scores for each applicant
- All candidates should be asked as part of the interview process whether there are any reasons known to them that would create a conflict of interest or, in the event of their appointment, bring the Trust into disrepute (alternatively this will be taken up by the recruitment agency)
- Any gaps in employment, questions relating to referees or convictions disclosed should be addressed and a note kept on the applicant's interview notes of the discussion (alternatively this will be taken up by the recruitment agency)
- Candidates will be advised of the next steps including when a decision will be made, how they will be communicated with and how they can access feedback. The interview timetable will provide sufficient time for the interviews plus the opportunity to finish writing notes. For interviews that are held in person, copies of the interview panel interview notes will be collected by the Trusts for filing in line with Trusts' records retention policy. For interviews that are held virtually, interview panellists will be asked to either scan their interview notes and email to a designated Trust Secretary or asked to post the hard copies to the designated Trust Secretary.

SIDs will attend all interviews as observers.

8.16. **Recommendation to Appoint**

Following completion of all interviews, the interview panel, chaired by the Independent Chair, will review the evidence collected as part of the recruitment process including the responses and scores to interview questions to support with identifying the preferred candidate. At this meeting, which will include the full Joint NomCo as observers, the interview panel will:

- Hear the advice and opinion of the non-voting interview panel members
- Hear from interview panel members regarding their opinion of each candidate
- Hear the views from the stakeholder sessions.

Once agreement has been reached, references for the preferred candidate which will have been obtained in advance, will be provided to the interview panel for review or the Trusts will confirm that the relevant references and checks have been undertaken and are satisfactory. [***Note: process to be confirmed with CPOs & Trust Secretaries***] With these being considered satisfactory and the interview panel in agreement, the Joint NomCo will formally receive the outcomes of the interviews and appointment recommendation.

Members of the Joint NomCo will have the opportunity to ask questions for clarification and assurance.

Unsuccessful candidates should be offered feedback.

8.17. **Decision to Appoint: Council of Governors**

A report from the Joint NomCo will be presented to each Council of Governors at separate meetings in private with the appointment recommendation. This report should also provide a detailed overview of the various stages of the selection process and the reasoning behind the selection proposal, including the attributes of the preferred candidate. Due to representation from each constituent Nominations Committees, it is anticipated that decisions reached by the Joint NomCo will be endorsed when presented to each Council of Governors. Any decision by a Council of Governors not to appoint must be reasonable and full reasons for the decision provided.

9. Post Selection Actions

Following approval by the Councils of Governors of the appointment to the Joint Chair role, the Chief People Officer will formally inform the successful candidate of their appointment. The appointment letter will include the terms and conditions of office and a Memorandum of Understanding [***MOU to be developed, will confirm Joint Chair hosting, remuneration, division of costs between Trusts, allocation of time arrangements, and so forth***]; the individual will be required to sign and return both documents.

10. New Starter Requirements and Induction

10.1. **New Starter Requirements**

The following will also need to be actioned (but not limited to):

- Relevant HR processes including DBS checks and OH referral
- Completion of FPPTF checks
- Preparation of a joint Press/Media Release and communications to staff
- Update Trusts' websites
- Complete New Staff Starter Form
- Arrange access to IT systems
- Order ID badge(s)

10.2. **Induction**

The successful candidate will be required to undertake the Trusts' induction programme, complete mandatory online training, and attend NHS Providers relevant development programmes.

11. Background/Reference

11.1. **Relevant Statutory Requirements (National Health Service Act 2006):**

The Council of Governors are responsible at a general meeting for the appointment, reappointment and removal of the Chair and other NEDs.

11.2. **NHS England Code of Governance for NHS Provider Trusts**

[Note: Correct Numbering]

2. Appointments to the Board of Directors:

2.1 The Nominations Committee, with external advice as appropriate, is responsible for the identification and nomination of NEDs. The Nominations Committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise required within the Board to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the foundation trust should engage with NHS England to agree the approach.

2.3 The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.

2.4 The Governors should agree with the Nominations Committee a clear process for the nomination of a new Chair and NEDs. Once suitable

candidates have been identified the Nominations Committee should make recommendations to the Council of Governors.

2.6 the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority… and also a majority of Governor representation on the Interview Panel.

2.14 Commitment:
The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to do what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved, and the council of governors should be informed of subsequent changes.

5. Development, information & support

5.2 Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.

11.3. **Fit & Proper Persons Test Framework (FPPTF)**

- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) introduced a “fit and proper person requirement” (Regulation 5) for all Board Directors of NHS bodies. Compliance with the Regulations will be monitored and enforced by the CQC as part of their inspection regime
- Under the regulations all provider organisations must ensure that Director-level appointments meet the FPPTF and the regulations place a duty on NHS providers not to appoint a person or allow a person to continue to be an Executive Director (or equivalent) or a Non-Executive Director under given circumstances.
- The Trust must demonstrate that it has appropriate systems and processes in place to ensure that all new appointees and current Directors are, and continue to be, fit and proper persons
- The purpose of the FPPTF is not only to hold Board Directors to account in relation to their conduct and performance but also to instil confidence in the public that the individuals leading NHS organisations are suitable to hold their positions. There is an expectation of senior leaders to set the tone and culture of the organisation that leads to staff adopting a caring and compassionate attitude.

Annex 1 – Joint Chair Recruitment Roadmap

Trust Council of Governors (3 separate meetings)	**Key Decisions**: To establish a Joint Nominations Committee between GWH, RUH & SFT and to approve responsibility for the selection process of the Joint Chair
Meeting 1 - Joint Nominations Committee	**Key Decisions**: Review first draft of Joint Nomination Committee terms of reference, candidate information pack, role description and person specification
Meeting 2 - Joint Nominations Committee	**Key Decisions**: Approve final versions of above documents ready for recommendation to full COGs
Trust Council of Governors (3 separate meetings)	**Key Decisions:** Ratify Joint Nominations Committee recommendations
Meeting 3 - Joint Nominations Committee	**Key Decisions:** Chair terms and conditions including remuneration, stakeholder and interview panel membership, survey questions (if required)
Post advert - survey to staff, governors and stakeholders (if required	***N.B.*** *Candidates will have the opportunity to speak to Chairs/CEO/Lead Governors*
Longlist Meeting	*Conducted by Interview Panel & SIDS*
Agency preliminary interviews	*Conducted by Recruitment Agency*
Shortlist Meetings	*Conducted by Interview Panel & SIDS* ***N.B.*** *Candidates will have the opportunity to speak to key stakeholders to gather key insights about the organisations*
Stakeholder sessions and formal interviews	
Decision Meeting -Interview Panel	**Key Decision:** Joint Nominations Committee to observe interview panel discussion, and agree appointment recommendation to formal Council of Governors
Trust Council of Governors (3 separate meetings)	**Key Decision:** COGs to receive and approve the Joint Chair appointment recommendation

Appendix 2

Introduction & Summary:

This appendix 2 contains the following:

1. Proposed division of tasks/ responsibilities between the BSW Hospitals Group Joint Chair and the proposed Local lead or Vice Chair NED [*name of role to be confirmed*].

2. Proposed Assumptions in Relation to Joint Chair and Vice Chair/ Local Lead NED for BSW Hospitals Group.

3. Summary role description for Vice/Deputy/Lead NED for BSW Hospitals Group.

1. Proposed Role/ Task Division between Joint Chair and Vice Chair

Task/responsibility	Local 'Lead/ Vice or Deputy NEDs'	Single Chair	Notes
4. Board Agendas and meetings		Y	Agreed
5. Appraising and performance managing CEO		Y	Agreed
6. Appraising NEDs	TBC	Y	Responsibility of Single Chair but activity for collating and presenting feedback needs to be spread through a single system facilitated by A N Other
7. Interface with Region /ICB		Y	Agreed
8. Interface with and Chairing CoG		Y	Agreed
9. Induction of new Governors	Y	Y	Both need to be involved from time to time
10. Interface with Lead Governor	Y	Y	Both need to be involved from time to time
11. Interface with MD/other Execs	Y	(Y)	Single Chair only occasionally
12. Chair for local appeals	TBC		Delegate to a NED
13. Consultant interviews and pre-interviews	TBC		Delegate to a NED
14. Anchor organisation representative	TBC		Delegate to a NED
15. Other ambassadorial/ceremonial roles - external	TBC		Decide *ad hoc*
16. Ceremonial roles – internal	TBC	(Y)	Decide *ad hoc* but Single Chair should be prepared to participate in some
17. Interface with subsidiaries	TBC		
18. Local Go and See visits/Birthday Break chats with staff/ward accreditations	Y		Decide *ad hoc* but principally Deputy Chair
19. Chair Rem Coms	(Y)	Y	Work towards Group Rem Com Chaired by Single Chair. Soley local issues to Deputy Chair
20. Meetings with other local providers/stakeholders	Y		
21. Meetings with MPs			Decide *ad hoc*
22. Attending HWBs			Decide *ad hoc*

2. Proposed Assumptions in Relation to Joint Chair and Vice Chair/ Local Lead NED

It is proposed that:

1. ***Senior NED roles***. It would be appropriate to divide the formal SID roles from a Vice Chair position

2. ***Role description***. The JD for the Vice Chair for the Foundation Group in the Midlands has been used as a base for a draft BSW Hospitals Group Vice/ Deputy Chair role [refer section 3 below].

3. ***Time commitment***. The requirement would be 1.5 days pw; one of these days being on site.

    a. *To do: further develop BSWHG Vice Chair JD in parallel to Joint Chair JD.*

4. ***Coordination of NED recruitment***. Subject to approval by respective CoGs new NEDs would be recruited through a single Group campaign (first one late Spring early Summer 2025) with aspirations to recruit Shared NEDs and cover skills gaps across all three hospitals.

    a. *To do: Establish NED succession, development, and recruitment system.*

    b. ***BSW Hospitals Group NED Development Roles***. All three Trusts would work together to create a system of development post "Associate NEDs" and "Specialist NEDs" *To do: Establish system. [CC, AR, CPO?]*

5. ***Succession Planning***. Chairs would arrange with current NEDS on the verge of departure to facilitate this timetable.

6. ***NED Capacity/ Workload and Associated Board Paper Content and Quality***. It is difficult to see how shared NEDs could cope with the current load of attending Board meetings. The majority of the work will need to be done at Committee so the quality of "Reports Up" will need to be enhanced.

    a. *To do: Develop plan with committee leads to enhance quality of 'reports up'. Include in 'Ideal Board' workstream plan.*

7. ***NED Capacity/ Workload Alignment of Board Committees and Agendas***. Bringing Board committee meeting agendas into alignment at an early date will help to reduce loads on NEDs.

    a. *To do: 'Ideal Board' workstream to prioritise*.

8. ***Joint Committee Scope and NED Membership Considerations***. If Joint Committee covers the majority of the responsibilities for the Group including delivery, then voting members of each Board need to be in attendance so they can discharge their fiduciary duties. However, if the JC is only doing a selection of the work, then we can choose which NEDs should attend.

    a. To do: To help us confirm and communicate our approach, Browne Jacobson are advising our Joint Committee working Group, how other NHS Groups are approaching NED membership.

3. BSW Hospitals Group [Based on South Warwickshire Trust – Foundation Group]

VICE CHAIR ROLE DESCRIPTION

Reports to: Chair
Time Commitment: minimum commitment of 1.5 days per week (one day on site)
Remuneration: TBC per annum (Non-Executive + responsibility allowance)

As part of our evolution as the **BSW Hospitals Group**, and in support of the appointment of a shared chair (the "Chair") for those organisations, each of the individual Trusts will have a Vice Chair to assist the Chair in delivering the key responsibilities of that role.

The role of the Vice Chair is predominantly internally focussed; the main external partner relationships being conducted by the Chair on behalf of the all the Boards. The Vice Chair shall be a non-executive director and shall have the additional responsibilities in addition to their duties as a non-executive director.

The Vice Chair will support the work of the chair in ensuring collaboration not only between the three Trusts and unitary boards, but also just as importantly, with the places throughout the BSW system, through working with fellow ICS and Place leads.

The Vice Chair, in common with all Non-Executive Directors, has the same general responsibilities to the Trust as any other director. The Board as a whole is collectively responsible for promoting the success of the Trust to help drive the delivery of sustainable healthcare services for the local population

There is an expectation to support working across the three different organisations and on site as required to ensure the Trust delivers safe, effective and efficient services.

Duties and Responsibilities

- To work with the Chair to ensure that the board is able to carry out its responsibilities effectively
- Helping to ensure that the individual Trust board is fit for purpose to support the organisation's activities and contribute to the achievement of its statutory objectives, by ensuring that clear corporate and business plans are set
- To maintain and improve the credibility and governance standards of the Trust within the Group Model, ensuring the board understands its accountability for governing the organisation
- To support the chair in ensuring all board directors participate fully in developing and determining the trust's vision, values, strategy and overall objectives to deliver organisational purpose and sustainability (and for the trust, have regard to the council of governors' views)

- Ensuring organisational design supports the attainment of strategic objectives providing visible leadership in championing the health needs of the local population and developing a healthy, open, and transparent patient-centred culture for the organisation, where all staff have equality of opportunity to progress, the freedom to speak up is encouraged, and ensuring that this culture is reflected and modelled in their own and in the board's behaviour and decision-making
- To provide visible leadership with at least one day per week on site that may comprise walk around activity, to support developing a healthy, open and transparent patient-centred culture for the organisation, where all staff have equal opportunity to progress, the freedom to speak up is encouraged, and ensuring that this culture is reflected and modelled in their own and in the board's behaviour and decision-making
- To support the chair in ongoing horizon scanning utilising the collective skills of the board to support and challenge assumptions and long-term strategy.
- To ensure that constructive relationships based on candour, trust and mutual respect exist between executive and non-executive directors and between elected and appointed members of the council of governors and between the board and the council
- To be the critical link between the chair and boards ensuring effective and timely communications, messages, actions and feedback.
- To help ensure the board sees itself as a team, has the right balance and diversity of skills, knowledge and perspectives, and the confidence to challenge on all aspects of clinical and organisational planning
- To lead on continual non-executive director and, governor development of skills, knowledge and familiarity with the organisation and health and social care system, to enable them to conduct their role on the board/council effectively, including non-executive director induction and annual appraisal
- To demonstrate visible, ethical, compassionate and inclusive personal leadership by modelling the highest standards of personal behaviour and ensuring the board follows this example
- Ensure that governors have the dialogue with directors they need to hold the non-executive directors (which includes the trust chair), individually and collectively to account for the board's performance.

Board of Directors

To work with the chair on planning of the annual board cycle and agenda setting. The Vice chair shall normally preside at meetings of the Board of Directors in the following circumstances:

a) when the Chair is unavailable to chair.
b) on occasions when the Chair declares a pecuniary interest that prevents them from taking part in the consideration or discussion of a matter before the Board of Directors.

Council of Governors
The Vice Chair shall normally preside at meetings of the Council in the following circumstances:

a) when there is a need for someone to have the authority to chair any meeting of the Council when the Chair is not present

b) when the remuneration, allowance and other terms and conditions of the Chair are being considered

c) when the appointment of the Chair is being considered, should the current Chair be a candidate for re-appointment

d) on occasions when the Chair declares a pecuniary interest that prevents them from taking part in the consideration or discussion of a matter before the Council

Condition of office

- The vice chair shall be appointed (and, where necessary, re-appointed or removed) by the Council
- The term of office for the vice chair shall be the same as the term of office for which the non-executive director (holding office as vice chair) has been appointed to the Board of Directors
- In addition to this Role Description, the vice chair shall comply with the Role Description for non-executive directors and any Code of Conduct or other relevant policies approved by the Council

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.1
Date of meeting:	6th March 2025		

Report title:	Gender Pay Gap Annual Report & Action Plan 2024/25			
Status:	Information	Discussion	Assurance	Approval
			x	x
Approval Process: (where has this paper been reviewed and approved):	OD&P Management Board 21 Jan 2025 People and Culture Committee 27 Feb 25			
Prepared by:	Harjinder Bahra, Head of Inclusion and Wellbeing Ian Crowley, Deputy Chief People Officer			
Executive Sponsor: (presenting)	Melanie Whitfield, Chief People Officer			

Recommendation:

The Trust Board is **asked to note for assurance** the 2024/25 Gender Pay Gap Report (Appendix 1), compiled in accordance with The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017

and **approve the report** for publication on the Trust website by 31st March 2025.

Executive Summary:

The UK government requires organisations with 250 or more employees to report annually on their gender pay gap. This gender pay gap report is based on a snapshot of the workforce on 31 March 2024, when SFT's total workforce was 4,665 employees, comprised of 3,508 female employees (75%) and 1,157 male employees (25%). This data represents an increase of 345 employees from 2023, with 221 additional female staff and 124 additional male staff. The gender ratio remains virtually the same as in last year's report.

Information is drawn from the Electronic Staff Record (ESR) system and includes all employee grades and professions.

1. **Mandated requirement**. Under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, we are required to publish six specific pay-related metrics (Slides 7-10):

   i. The difference between the **mean hourly rate of pay** of male full-pay relevant employees and that of female full-pay relevant employees.

   Year on year the Trust has continued to reduce the Mean hourly gender pay gap. The 2024 data show that the Trust has a mean hourly pay gap of 15.75% a decrease from the 2023 figure of 16.47%, this has been achieved by an improved proportionality of female staff in the upper quartile of pay.

ii. The difference between the **median hourly rate of pay** of male full-pay relevant employees and that of female full-pay relevant employees.

Our Median hourly pay gap has increased slightly by 0.44% to 1.02%, noting that in 2017 this gap stood at 8.1%. This increase is due to the proportionally greater numbers of female staff who joined the Trust in the lower middle pay quartile, which has just nudged the median value a little lower for female staff and thus increased the median pay gap.

iii. The difference between the **mean bonus pay** to male relevant employees and that paid to female relevant employees.

The Trust does not pay traditional performance bonuses. Historically, for the purposes of gender pay gap reporting, national clinical excellence (CEA) awards and local clinical excellence awards (LCEAs), for which only medical and dental consultants are eligible are considered as bonus pay.

The mean bonus pay gap in 2023/24 was 20.06%. This is a 3.7% increase from 2022/23 (16.36%). For 2023/24 new award rounds for CEA and LCEA ceased as per the consultants pay deal in 2024. This meant that bonus pay was only calculated based on consolidated awards from previous years, which had historically favoured a larger number of senior male doctors, hence with CEA awards frozen there will be a period when the bonus pay mean gap becomes larger until the historical awards are overtaken by time.

iv. The difference between the **median bonus pay** paid to male relevant employees and that paid to female relevant employees.

There was no pay gap between median bonus pay for female or male relevant employees. This is because of the decision taken in 2020 to distribute equally the CEA bonuses, which are no longer consolidated to pay. Over time the numbers of staff with legacy consolidated bonus awards has reduced significantly and therefore the median average is unaffected by historical consolidated awards.

v. The **proportions of male and female relevant employees who were paid bonus pay**.

Of the 194 consultants paid a bonus 107 (55%) were male and 87 (45%) were female. This historic position supports the requirement to seek to make more senior jobs available to female medical staff.

vi. The proportions of male and female full-pay relevant **employees in the lower, lower middle, upper middle and upper quartile pay bands.**

At SFT, 77% of female staff are employed in the lower-paying quartiles (1-3), compared to 68% of male employees. However, in the highest-paying quartile (quartile 4), the proportions are reversed: only 23% of female staff are in this quartile, compared to 32% of male staff. There are more males in the upper quartile, where salaries are highest, and this contributes to the mean hourly rate pay gap.

Essentially, the difference in pay between quartile 4 and the other quartiles, combined with the higher proportion of male staff in this quartile, drives the pay gap. Compared to 2023 data, there has been some shift in the proportion of male and female staff within each quartile, likely due to normal staff turnover. Notably, there was a net gain of 25 female staff in quartile 4 compared to 2023. This positive change has contributed to the reduction in the mean hourly pay gap this year.

2. Additional Reporting. In addition to the mandated reporting, SFT consider gender pay gap by staff group (Slides 11-13).

In 2024, we conducted a detailed analysis of pay gaps across different staff groups to better understand the overall mean hourly pay gap of 15.76%. This analysis revealed that six staff groups had a gender pay gap where women earned less than their male colleagues. Two of these groups had particularly significant pay gaps: Administration & Clerical: 15.90% (compared to 15.97% in 2023), Medical and Dental: 10.95% (compared to 10.23% in 2023). The pay gap in Medical and Dental is largely due to the high proportion of male doctors in senior positions. In Administration & Clerical, the gap is because there are more males than females in senior management roles.

3. Comparison against Staff Survey Questions (Slide 14). Three key staff survey questions, relating to gender inequality are included in our pay gap data.

Q4b '*Satisfied the organisation values my work'* - 40.9% of female employees said that they were satisfied that the organisation values their work. This was a 0.4% reduction on the previous years' staff survey result. 47.3% of male employees said that they were satisfied that the organisation values their work, an increase of 5.7% on the previous years' staff survey result. The gap between male and female job satisfaction has further widened in this year's staff survey. Further analysis will be conducted as part of the action plan to investigate the reasons why female staff feel that SFT values their work contributions less than male employees.

Q4c '*Satisfied with levels of pay'* - 32.2% of female employees said that they were satisfied with levels of pay, an 8.5% increase on 2023. 33% of male employees said that they were satisfied with levels of pay, a 3% increase on 2023. Although an improvement, at around 30%, this still demonstrates a wide sense of dissatisfaction on pay for both males and females.

Q4d '*Satisfied with the opportunities for flexible working patterns'* - 56.4% of female employees said that they were satisfied with the opportunities for flexible working patterns, an increase of 4.9% on last years' staff survey result. 59.1% of male employees said that they were satisfied with the opportunities for flexible working patterns, a 5.1% increase on the previous years' staff survey result. Both male and female staff felt that opportunities for flexible working were better than previously, however fewer female staff members were satisfied. The Trust's flexible working policy was ratified on 6 April 2024 and further promotion/visibility of the policy may encourage additional take-up by female staff.

4. Progress against the previous Gender Pay Gap Action Plan (Slides 15 -17). The Trust is making good progress against the 2023/24 GPG action plan, particularly in relation to implementing prioritised recommendations from the Mend the Gap report – an independent review into gender pay gaps in medicine in England to improve access to senior roles for women and enhanced transparency in gender pay gaps. Some work will be carried forward in relation to the Athena Swan programme (Slide 17)

5. Gender Pay Gap Action Plan (Slide 19). The plan to further address areas of concern raised in the pay gap report contains 4 actions designed to address the areas of greatest concern raised by the data. These are:

- Improve female staff opportunities to address work-life balance through flexible working.
- Narrow the pay gap in the Admin and Clerical Staff Group, the staff group with the highest mean pay gap.

- Improve staff satisfaction for female staff through initiatives to increase female staff's view that their work is valued by the trust.
- As part of the Mend the Gap action plan, a focus on our aim to make senior jobs more accessible to female staff for the medical and dental staff group. This in addition to ongoing work to use the Athena Swan programme to support gender equality.

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

Salisbury NHS Foundation Trust

Gender Pay Gap (GPG)

Annual Report and Action Plan

2024/2025

Introduction and Background to Gender Pay Gap 2024/25

Introduction and background

The UK government requires organisations with 250 or more employees to report annually on their gender pay gap. This mandate, under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, requires the publication of six specific pay-related metrics. These include:

- the difference between the **mean hourly rate of pay** of male full-pay relevant employees and that of female full-pay relevant employees.
- the difference between the **median hourly rate of pay** of male full-pay relevant employees and that of female full-pay relevant employees.
- the difference between the **mean bonus pay** to male relevant employees and that paid to female relevant employees.
- the difference between the **median bonus pay** paid to male relevant employees and that paid to female relevant employees.
- the **proportions of male and female relevant employees who were paid bonus pay**.
- the proportions of male and female full-pay relevant **employees in the lower, lower middle, upper middle and upper quartile pay bands.**

About this annual report and action plan

Evidence indicates that disparity in pay has a lasting socioeconomic impact on staff. The purpose of the annual gender pay gap reporting is to shed light on the differences in pay between male and female employees, encouraging employers to take action to reduce these disparities. This system not only promotes fairness and accountability but also pushes for a shift towards gender equality in the workplace and retention.

This gender pay gap report is a snapshot as of 31 March 2024. Previous SFT's Gender Pay Gap annual reports for 2018, 2019, 2020, 2021, 2022 and 2023 can be found here.

Executive Summary (1/2)

The gender pay gap report is based on a snapshot of the workforce on 31 March 2024, when SFT's total workforce was 4,665 employees, comprised of 3,508 female employees (75%) and 1,157 male employees (25%). This represents an increase of 345 employees from 2023, with 221 additional female staff and 124 additional male staff, maintaining a nearly identical gender ratio to the previous year. This information is based on data from the Electronic Staff Record (ESR) system and includes all employee grades and professions.

Mean pay gap (slide 7)

Year on year the Trust has continued to reduce the **Mean** hourly gender pay gap. The 2024 data show that the Trust has a mean hourly pay gap of **15.75%** a **decrease** from the 2023 figure of 16.47%, resulting from an improved proportionality of female staff in the upper quartile.

Median pay gap (slide 7)

Our Median hourly pay gap has **increased** slightly by **0.44%** to **1.02%.** In 2017 this gap stood at 8.1%. this is due to the proportionally greater numbers of female staff who joined the Trust in the lower middle pay quartile, which has nudged the median value a little lower and thus increased the median pay gap.

Quartile data analysis (slide 9)

At SFT, **77%** of female staff are employed in the lower-paying quartiles (1-3), compared to 68% of male employees. However, in the highest-paying quartile (quartile 4), the proportions are reversed: only 23% of female staff are in this quartile, compared to 32% of male staff. There are more males in the upper quartile, where salaries are highest, and this contributes to the mean hourly rate pay gap.

Essentially, the difference in pay between quartile 4 and the other quartiles, combined with the higher proportion of male staff in this quartile, drives the pay gap. Compared to 2023 data, there has been some shift in the proportion of male and female staff within each quartile, likely due to normal staff turnover. Notably, there was a net gain of 25 female staff in quartile 4 compared to 2023. This positive change has contributed to the reduction in the mean hourly pay gap this year.

Bonus pay (slide 10)

The mean bonus pay gap in 2023/24 was **20.06%**. This is a **3.7% increase** from 2022/23 (16.36%). The Trust does not pay traditional performance bonuses. Historically, for the purposes of gender pay gap reporting, national clinical excellence (CEA) awards and local clinical excellence awards (LCEAs), for which only medical and dental consultants are eligible are considered as bonus pay. For 2023/24 new award rounds for CEA and LCEA ceased as per the consultants pay deal in 2024. This meant that bonus pay was only calculated based on consolidated awards from previous years.

Gender pay gap by staff group (slide 11)

In 2024, we conducted a detailed analysis of pay gaps across different staff groups to better understand the overall mean hourly pay gap of **15.76%.** This analysis revealed that five staff groups had a gender pay gap where women earned less than their male colleagues. Two of these groups had particularly significant pay gaps: **Administration & Clerical: 15.90%** (compared to 15.97% in 2023), **Medical and Dental: 10.95%** (compared to 10.23% in 2023). The pay gap in Medical and Dental is largely due to the high proportion of male doctors in senior positions. In Administration & Clerical, the gap is because there are more males than females in senior management roles.

Staff survey questions (slide 15)

Three key staff survey questions, relating to gender inequality are included in our pay gap data.

Q4b Satisfied the organisation values my work

40.9% of female employees said that they were satisfied that the organisation values their work. This was a **0.4% reduction** on the previous years' staff survey result. **47.3%** of male employees said that they were satisfied that the organisation values their work, an **increase of 5.7%** on the previous years' staff survey result. The gap between male and female job satisfaction has widened in this year's staff survey. Further analysis will be conducted as part of the action plan to better understand why this is the case.

Executive Summary (2/2

Q4c Satisfied with levels of pay

32.2% of female employees said that they were satisfied with levels of pay, an **8.5% increase** on 2023. **33%** of male employees said that they were satisfied with levels of pay, a **3% increase** on 2023. Although an improvement, at around 30%, this still demonstrates a wide sense of dissatisfaction on pay for both males and females.

Q4d Satisfied with the opportunities for flexible working patterns

56.4% of female employees said that they were satisfied with the opportunities for flexible working patterns, an **increase of 4.9%** on last years' staff survey result. **59.1%** of male employees said that they were satisfied with the opportunities for flexible working patterns, a **5.1% increase** on the previous years' staff survey result. Both male and female staff felt that opportunities for flexible working were better than previously, however fewer female staff members were satisfied. The Trust's flexible working policy was ratified on 6 April 2024 and further promotion/visibility of the policy may encourage additional take-up by female staff.

Progress against the previous Gender Pay Gap Action Plan (slides 15 - 17)

The Trust is making good progress against the 2023/24 GPG action plan, particularly in relation to implementing prioritised recommendations from the Mend the Gap report – an independent review into gender pay gaps in medicine in England to improve access to senior roles for women and enhanced transparency in gender pay gaps.

Gender Pay Gap Action Plan 2025/26 (slide 19)

Our action plan on addressing GPG in 2025/26 is highlighted on slide 19. These development objectives are:

1. Improve female staff opportunities to address work-life balance
2. Aim to narrow the Gender Pay Gap in the Administration & Clerical Staff Group
3. Aim to increase staff satisfaction that the Trust values their work
4. Mend the Gap Action - Aim to make senior jobs more accessible for female Medical & Dental Staff Group

Gender Pay Gap Definitions

Key word	Gender Pay Gap Definitions
Pay gap	Difference in the average pay between two groups.
Mean gap	Difference between the mean hourly rate for female and male employees. Mean is the sum of the values divided by the number of values.
Median gap	Difference between the median hourly rate of pay for female and male employees. Median is the middle value in a sorted list of values. It is the middle value of the pay distribution, such that 50% of employees earn more than the median and 50% earn less than the median.
Mean bonus gap	Difference between the mean bonus paid to female and male employees. Mean is the sum of the values divided by the number of values.
Median bonus gap	Difference between the median bonus pay paid to female and male employees. Median is the middle value in a sorted list of values. It is the middle value of the bonus pay distribution, such that 50% of employees earn more than the median and 50% earn less than the median.
Bonus proportions	Proportions of female employees who were paid a bonus, and the proportions of male employees who were paid a bonus.
Quartile pay bands	Proportions of female and male employees in the lower, lower middle, upper middle and upper quartile pay bands. Quartile is the value that divides a list of numbers into quartiles.
Equal pay	Being paid equally for the same/similar work.

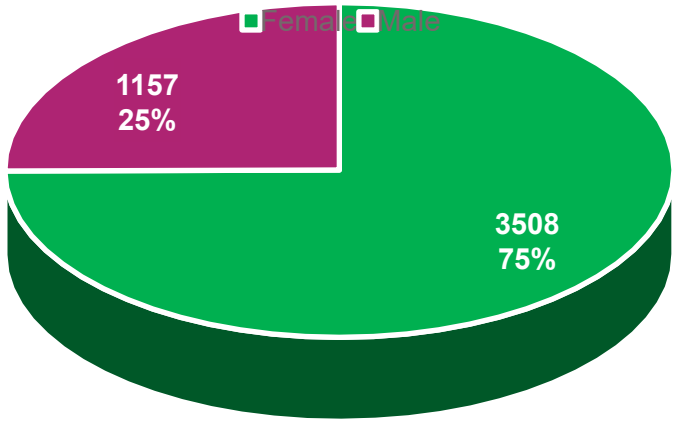
‘We need to create a world where women are paid equally for their work.'

Malala

Total Workforce by Gender

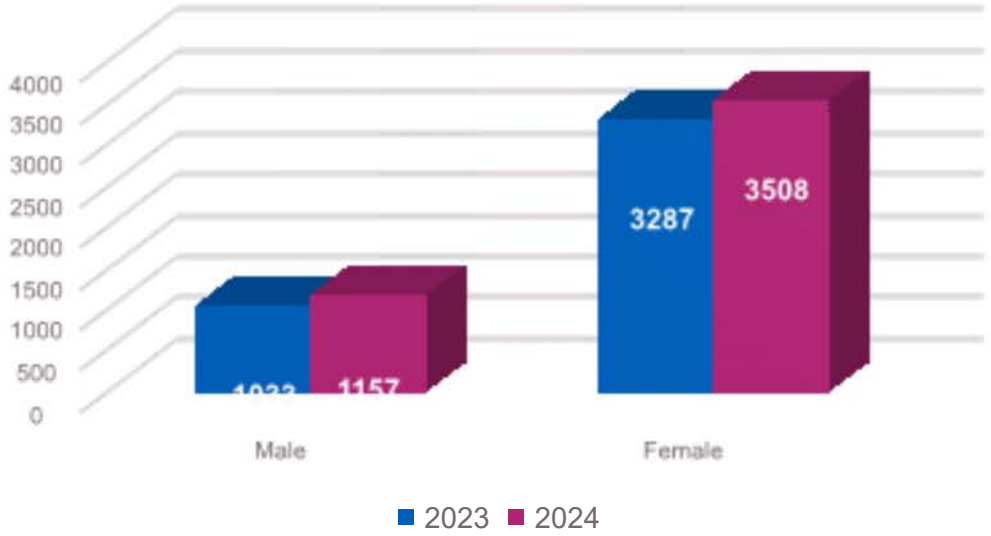
SFT collected a snapshot of data on 31 March 2024 when the total workforce (4665) consisted of 75% female (3508) and 25% male staff (1157). This figure represents the total workforce including all grades and professions and is based on ESR data.

Note: ESR data is dependent on staff reporting their protected characteristics on ESR via Self-Service.



Compared to 2023, female staff increased by 6.7% (221) while male staff increased by 12% (124) in 2024.

This equates to a 7.4% (345) increase in the number of staff employed by the Trust



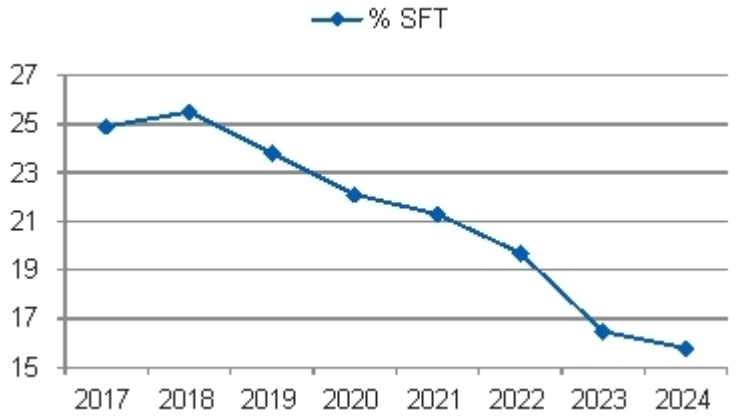
Mean and Median pay gap

The graphs below show the difference between mean and median hourly rates of pay for male and female employees.

Year on year the Trust has continued to reduce the **Mean** hourly gender pay gap. The 2024 data show that the Trust has a mean hourly pay gap of **15.75%** a **decrease** from the 2023 figure of 16.47%, resulting from an improved proportionality of female staff in the upper quartile.

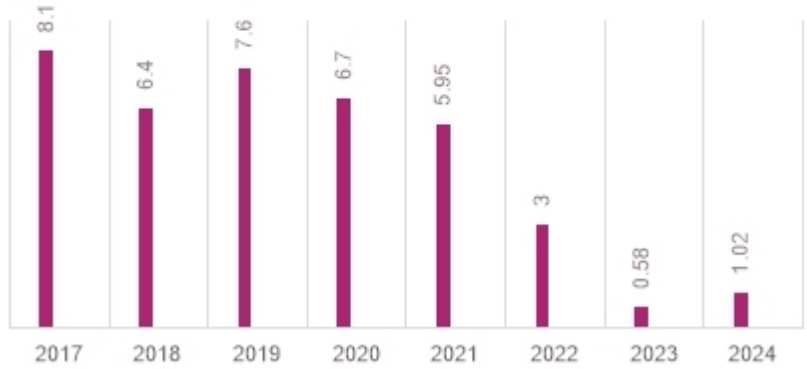
The 2024 data also shows that the Trust had a slight **increase** in the **Median** hourly pay gap from 0.58% in 2023, to **1.02%** an increase of **0.44%**

MEAN HOURLY PAY GAP



Gender	Mean Hourly Rate	Median Hourly Rate
Male	£23.23	£18.06
Female	£19.57	£17.87
Difference	£3.66	£0.18
Pay Gap %	**15.75%**	**1.02%**

MEDIAN HOURLY PAY GAP %



The difference between SFT's mean and median pay gap provides insight to the difference between male and female pay. A group of very high earners can make the mean larger than the median, this is the case at SFT, where there are proportionally more males in the upper quartile and more at the higher pay bands, for example there 9 more male consultants than female in the Trust.

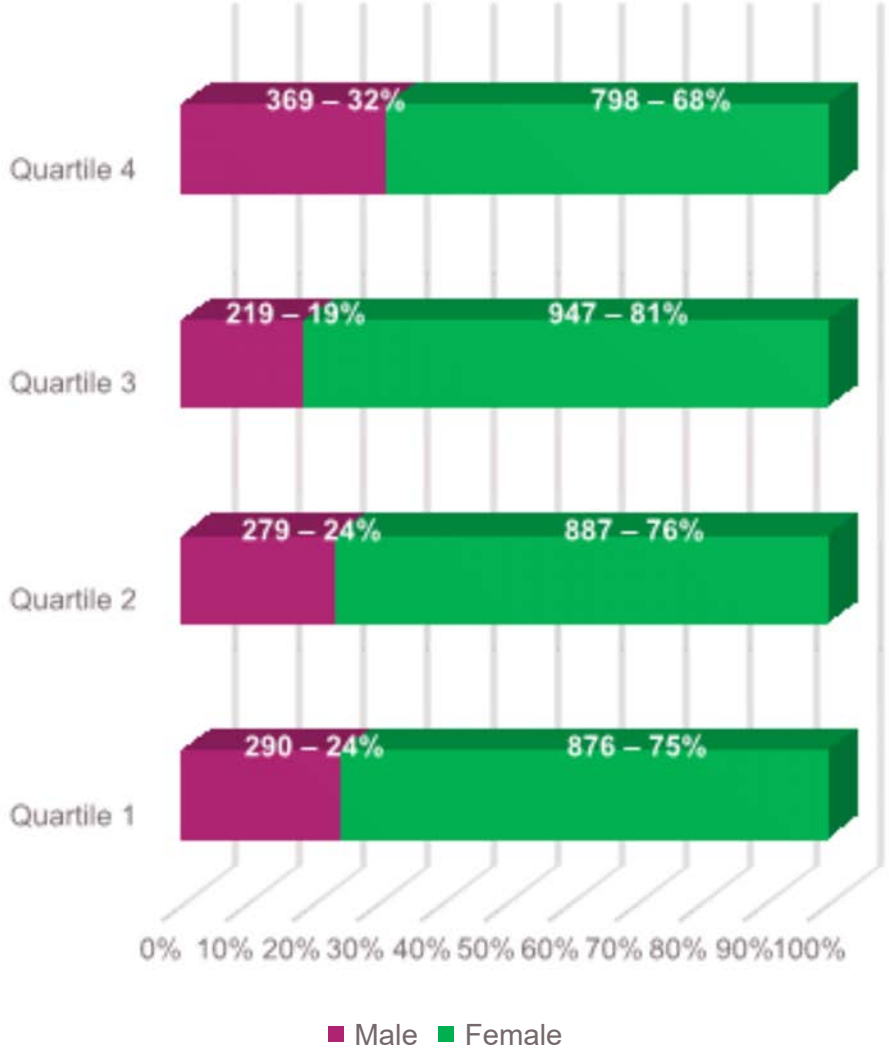
The SFT gender profile is 75% female and 25% male. If we look at the pay quarters (see next slide) across the Trust we can see that while the gender split for the lower and lower middle pay quarters are very similar to the workforce profile, the gender split across the upper and upper middle quartiles does not represent the workforce profile, with a greater balance of female staff in the upper middle and male staff in the upper quartile.

This weighting affects the mean hourly rate, due to the high pay differentials the top quartile brings but has less effect on the median hourly rate as the overall numbers balance at a more equitable mid-point.

However, in comparison to 2023, there has been a slight **increase (0.44%)** in the median pay gap (0.58% to 1.02%), this is due to the proportionally greater numbers of female staff who joined the Trust in the lower middle pay quartile, which has nudged the median value a little lower and thus increased the median pay gap.

2024 Quartile Data

The Trust is required to rank its employees from highest to lowest paid, divide this into four equal parts (quartiles) and to show the gender split in each. Please note some bands fall into more than one quartile, as some staff enhance their pay by working unsocial hours, overtime etc.



Quartile 4

Examples include:

- VSM Pay Scale
- Senior Medical staff - Consultants and Registrars
- AfC Band 7 -9 Nurses, Therapists and Managers

Quartile 3

Examples Include

- Band 5 and 6 Nurses, Therapists and other Clinical and Scientific Staff

Quartile 2

Examples Include:

- Bands 3 to 4 Nursing Assistants, Admin, Therapists and other Clinical and Scientific Staff

Quartile 1

Examples Include:

- Bands 2 and 3 Nursing Assistants, Admin, Facilities, Cleaning and Therapy Support staff

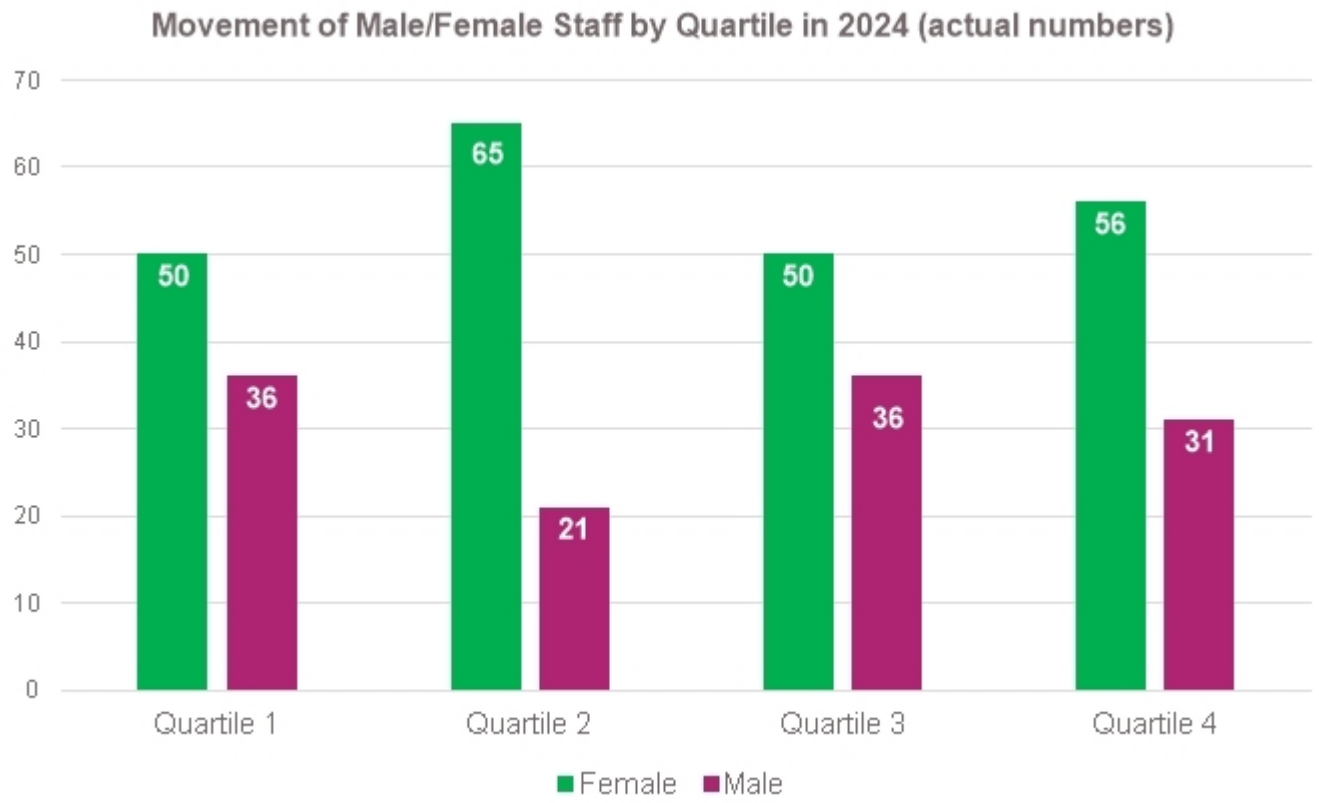
2024 Quartile Analysis

At SFT 77% of female staff are employed in quartiles 1-3, compared to 68% of male employees, whereas in quartile 4, the highest paid quartile the proportions are reversed as only 23% of female staff are in this quartile, compared to 32% of male staff. There are more males in the upper quartile, which attracts the highest pay levels. It is the differential in pay between quartile 4 and the other quartiles, combined with higher numbers of male staff in this quartile that drives the mean hourly rate pay gap.

Essentially, the difference in pay between quartile 4 and the other quartiles, combined with the higher proportion of male staff in this quartile, drives the pay gap.

Compared to 2023 data, there has been some shift in the proportion of male and female staff within each quartile, likely due to normal staff turnover.

Notably, there was a net gain of 25 female staff in quartile 4 compared to 2023. This positive change has contributed to the reduction in the mean hourly pay gap this year



Bonus pay

Gender	Mean Bonus Pay	Median Bonus Pay
Male	6,945.27	3,406.98
Female	5,552.21	3,406.98
Difference	1,393.06	0.00
Pay Gap %	20.06%	0.00%

Proportion of male and female relevant employees who were paid bonus pay.

Of the 194 consultants paid a bonus 107 (55%) were male and 87 (45%) were female.

The Trust does not pay traditional performance bonuses. Historically, for the purposes of gender pay gap reporting, national clinical excellence (CEA) awards and local clinical excellence awards (LCEAs), for which only medical and dental consultants are eligible are considered as bonus pay. Our data compares relevant employees for bonus awards from the medical and dental cohort only.

In 2022/23 the total CEA values was £688,210 and in line with the national guidance the Trust equally distributed the CEA to all eligible 176 consultants which equated to £3936.20 each regardless of gender.

For 2023/24 new award rounds for CEA and LCEA ceased as per the consultants pay deal in 2024. This meant that bonus pay was only calculated based on consolidated awards from previous years.

The mean bonus pay gap in 2023/24 was 20.06%. This is a 3.7% increase from 2022/23 (16.36%) and reverses previous downward trends due to previous years benefitting from equal distribution of LCEA to all qualifying doctors from 2020.

The mean pay gap is therefore impacted by historical CEA awards which were previously consolidated to pay and reflect the greater number of senior male staff receiving higher bonuses historically.

The table above also demonstrates that there was no pay gap between median bonus pay for female or male relevant employees. This is because of the decision taken in 2020 to distribute equally the CEA bonuses, which are no longer consolidated to pay.

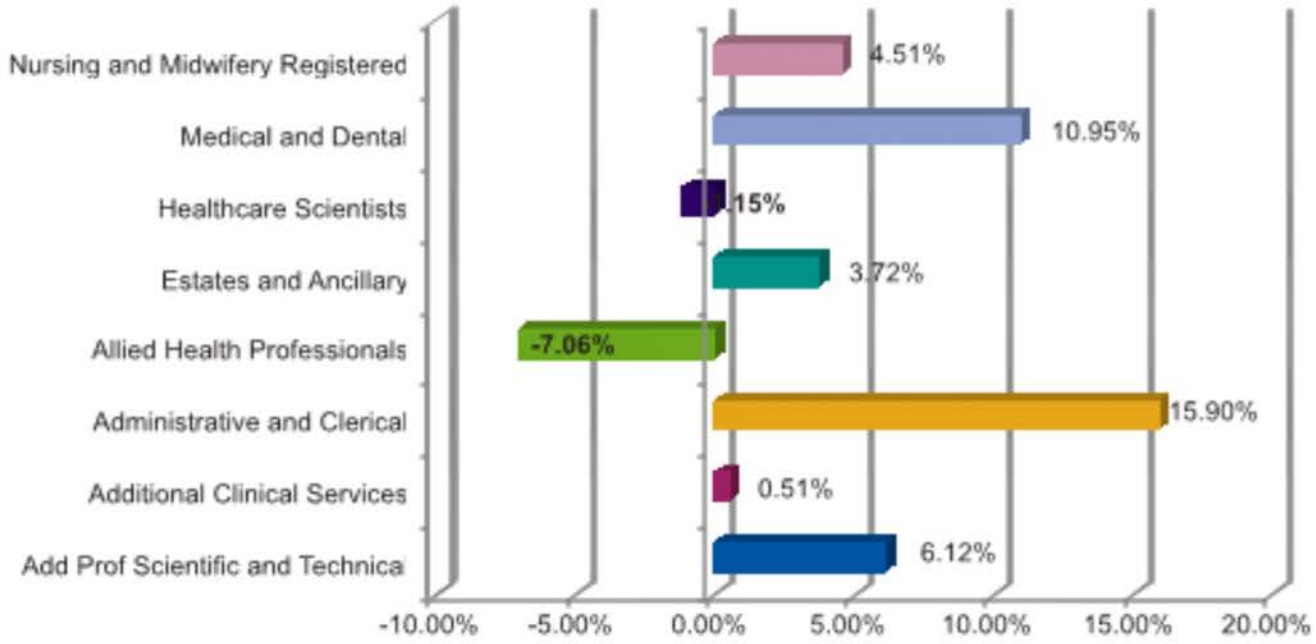
Over time the numbers of staff with legacy consolidated bonus awards has reduced significantly and therefore the median average is unaffected by historical consolidated awards.

Gender Pay Gap by Staff Group

For better analysis, we have broken down the gender pay gap in the workforce by staff group. The tables on the right show the breakdown of the **15.75%** mean hourly pay rate by staff groups. Six staff groups show a gender pay gap where female staff are paid less than their male counterparts with two of these staff groups running into a double digit pay gap. A negative % indicates that female staff are paid more than male staff.

- Administrative and Clerical **15.90%** pay gap (15.97% in 2023)
- Medical and Dental **10.95%** pay gap (10.23% in 2023)
- Add Prof Scientific and Technical **6.12%** pay gap (4.78% in 2023)
- Nursing and Midwifery Registered **4.51%** pay gap (3.13% in 2023)
- Estates and Ancillary **3.72%** pay gap (minus 1.49% in 2023)
- Additional Clinical Services **0.51%** pay gap (1.42% in 2023)
- Health Scientists **minus 1.15% pay gap** (minus 6.56% in 2023)
- Allied Health Professionals **minus 7.06%** pay gap (minus 1.86% in 2023)

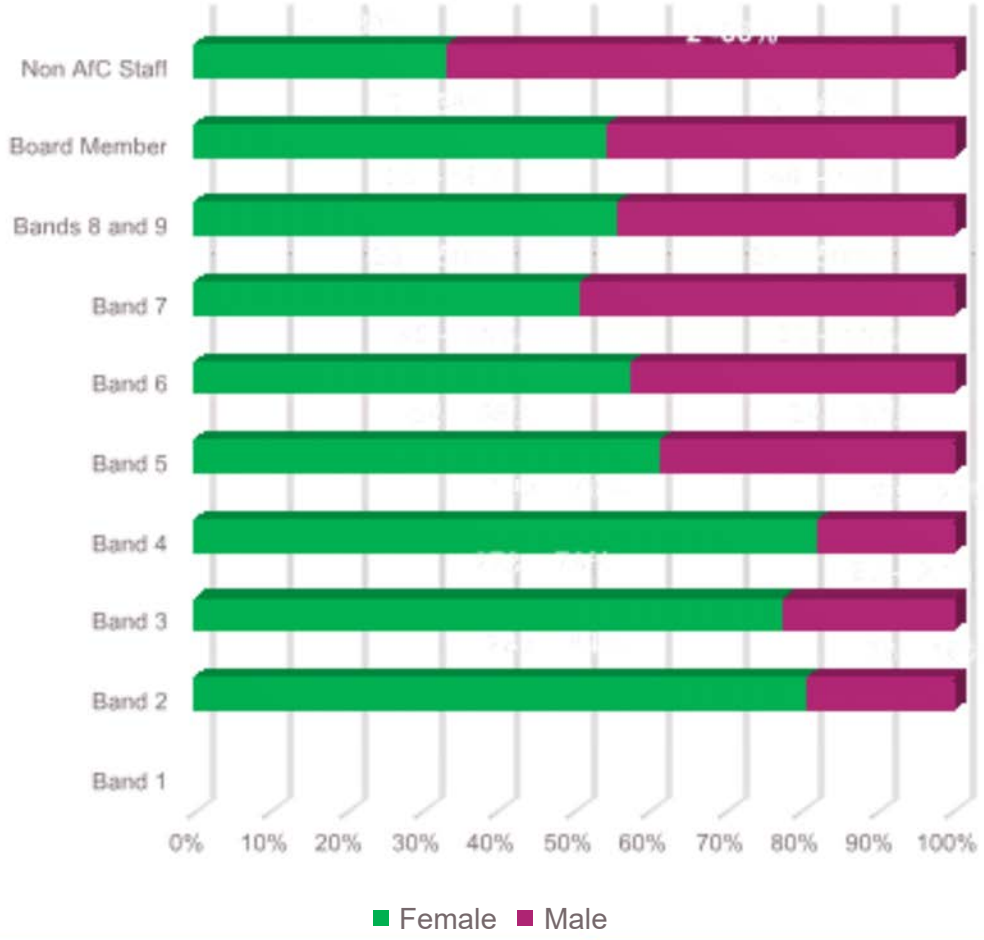
31 March 2024	Count	Female	Male	Difference	%
Add Prof Scientific and Technical	281	£35,766	£38,097	£2,331	**6.12%**
Additional Clinical Services	790	£27,615	£27,757	£142	**0.51%**
Administrative and Clerical	1185	£30,658	£36,455	£5,797	**15.90%**
Allied Health Professionals	264	£43,705	£40,822	-£2,883	-7.06%
Estates and Ancillary	281	£27,291	£28,345	£1,054	**3.72%**
Healthcare Scientists	92	£44,716	£44,209	-£507	-1.15%
Medical and Dental	521	£79,300	£89,048	£9,747	**10.95%**
Nursing and Midwifery Registered	1251	£41,542	£43,506	£1,964	**4.51%**
Grand Total	4665	£38,261	£45,418	£7,157	**15.75%**

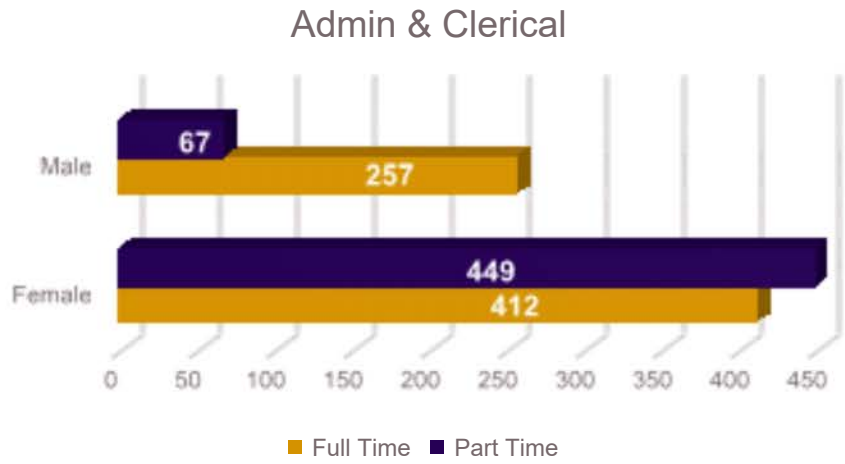


Administration and Clerical (15.90% gender pay gap)

In 2024 the gender pay gap for the Administration and Clerical staff group is 15.90% compared to 15.97% (2023). The high pay gap is due to the larger proportions of male staff in bands 6 and above and a slightly higher proportion of female staff in bands 2-4 compared to the trust ratio of female to male staff (75:25). In other staff groups the ratio is less severe in bands 6-9 particularly.

Additionally, in this staff group proportionately more men work full time than women, which increases pay comparisons.





The 2024 data shows a **small shift** in the working pattern for both male and female staff in this group moving from full-time work to part-time compared to 2023.

Of the 1185 Admin and Clerical staff **43% (516)** are working on part time contracts. This is a **decrease of 9%** from 2023 (52%).

52% (449) of female Admin and Clerical staff work part-time. This is a **decrease of 9%** from 2023 (61%)

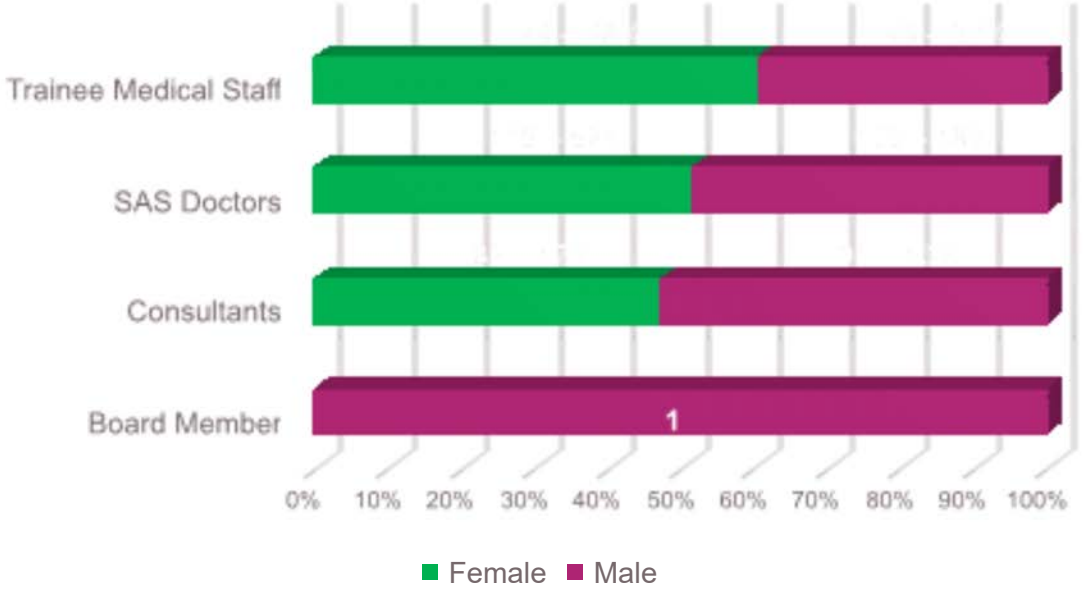
21% (67) of male Admin and Clerical staff work part-time. This is a **decrease of 4%** from 2023 (25%)

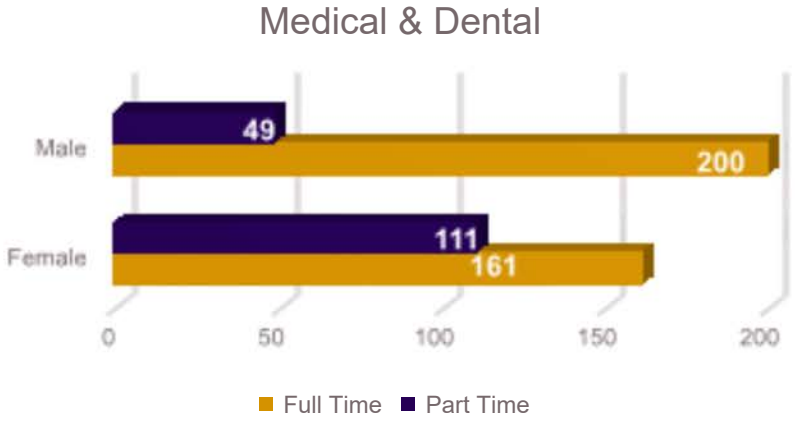
Medical and Dental (10.95% gender pay gap)

In 2024 the gender pay gap for the Medical and Dental group is **10.95%** compared to **10.23%** (2023)

There are 521 medical and dental staff of which 52% (272) are female and 249 are male.

The breakdown of Medical Staff by grade is in the table below





Of the 521 medical and dental staff, **31%(160)** are working on part time contracts compared to **60%** in 2023. This is a significant increase in full time numbers.

41% (111) of female doctors work part-time. This is a **decrease of 28%** compared to 2023 (69%)

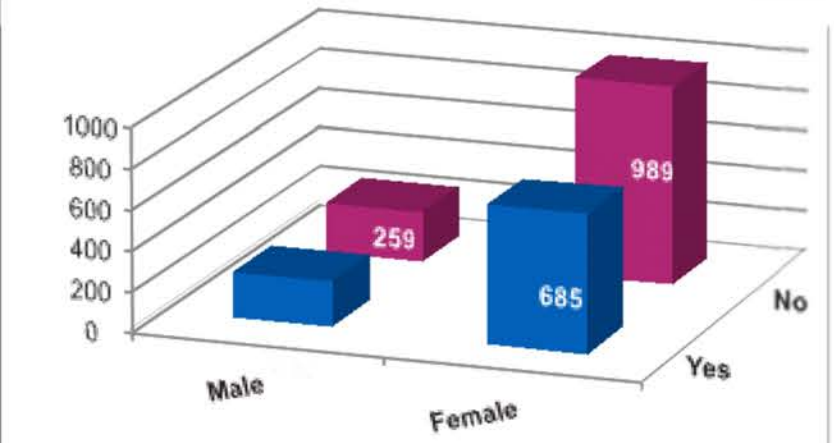
20% (49) of male doctors work part-time. This is a **decrease of 32%** compared to 2023 (52%)

The combination of a higher proportion of male doctors in higher paid consultant positions, with proportionally lower numbers working part-time contributes to the high gender pay gap for this staff group, and overall, across the Trust

Staff Survey 2023

2265 staff responded to the 2023 survey – Female (1674) and Male (489)

Q4b Satisfied the organisation values my work:

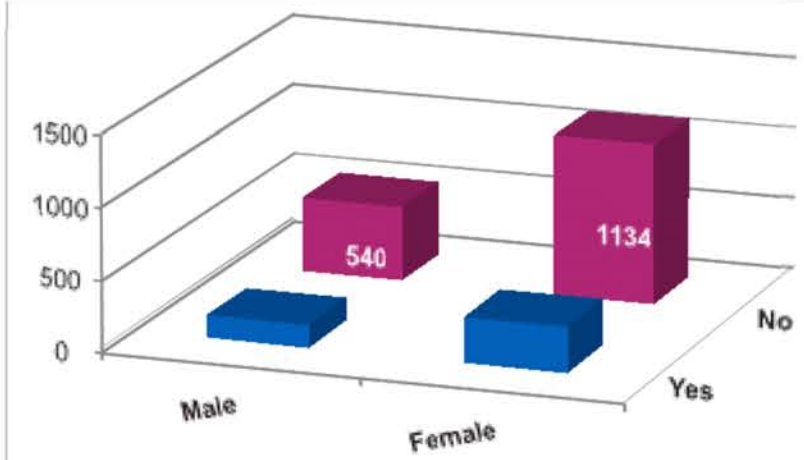


40.9% of female employees said that they were satisfied that the organisation values their work. This was a **0.4% reduction** on the previous years' staff survey result.

47.3% of male employees said that they were satisfied that the organisation values their work, an **increase of 5.7%** on the previous years' staff survey result.

The gap between male and female job satisfaction has further widened in this year's staff survey. Further analysis will be conducted as part of the action plan to investigate the reasons why female staff feel that SFT values their work contributions less than male employees.

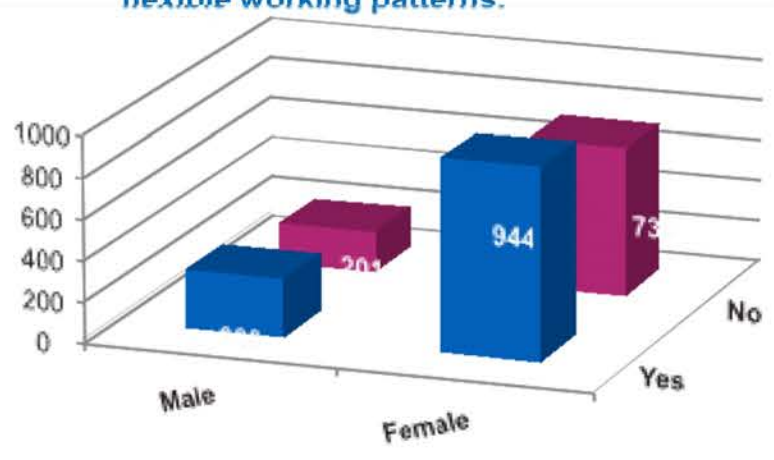
Q4c Satisfied with levels of pay:



32.2% of female employees said that they were satisfied with levels of pay. This was an **8.5% increase** on the previous years' staff survey result. **33%** of male employees said that they were satisfied with levels of pay. This was a **3% increase** on the previous years' staff.

These responses demonstrate a reduction in the sense of dissatisfaction on pay levels by females compared to males, narrowing the gap to less than one percent between males and females. External factors continue to play into staff responses to this question, including the impact of pay settlements across the public sector and cost of living concerns in the Wiltshire area, particularly for housing and accommodation.

Q4d Satisfied with opportunities for flexible working patterns:



56.4% of female employees said that they were satisfied with the opportunities for flexible working patterns, an **increase of 4.9%** on last years' staff survey result.

59.1% of male employees said that they were satisfied with the opportunities for flexible working patterns. This was an **5.1% increase** on the previous years' staff survey result.

It is pleasing to note that both male and female staff felt that opportunities for flexible working were better than in the previous period. Fewer female staff members are satisfied with opportunities and the opportunity to continue to implement action plans to support flexible working for female staff should be maintained.

Progress against the previous Gender Pay Gap Action Plan

The SFT Gender Pay Gap Action plan for 2022/23 contained 4 principal actions which sought to: Improve opportunities for career progression for female staff; provide a Staff Network to maintain support encouragement to female staff in the Trust; to increase visibility and uptake of flexible working opportunities for female staff; and to address elements of gender pay issues in the Medical and Dental staff group through analysis and implementation of the Mend the Gap report recommendations. Progress against these actions is shown in the next two slides.

	Development Objective	Action	Progress	Next Steps
1	• Career Progression for female staff members in management positions. • Coaching and Mentoring Support for Staff	• A service is available to release the potential and talent of staff within the organisation to support development needs identified in performance appraisals as part of the Trust Talent Management strategy. • Identify numbers of female staff accessing coaching and mentoring support and improve availability for women with the first 3 quarters of the new financial year.	• Leadership Programmes have seen a take up of 279 female staff, compared to 53 males, and coaching uptake has seen a 36:6 male to female split, proportionally increasing female representation in career development opportunities. • The Trust's Mentoring Network launched in December 2024.	Career progression course now embedded in the trust. Action maintained as business as usual.
2	• The Women's Staff Network plays an important part in promoting a positive working environment, highlighting areas for improvement and areas of success. • Empowering the Women's network to deliver against their plan to support, motivate and drive inclusion for our female staff.	• Secure a stable leadership for the network through executive oversight, a supported and empowered chair and a re-invigorated community within the network. • Publish and Support a programme of events and activity to achieve the agreed objectives of the Network	• The Women's staff network now has a robust leadership structure and has secured an active executive sponsor. • The network has planned and executes events to support female staff and conducted a survey to establish future priorities. • On 23 Oct 2024, the network launched a Mum's Café to support working mums in the Trust	Business as usual with a meaningful programme of events and activity identified and advertised through Trust and Network communications channels
3	• We are committed to supporting all staff to achieve an effective balance between work and life's other needs, while continuing to meet the needs of our services. • We have flexible working and hybrid working provisions. • Staff survey results have improved in, but female staff feel less satisfied than male counterparts in this area.	• With a high proportion of female staff in roles which require on site attendance against specified shift patterns, conduct analysis of options to improve the uptake of flexible working in these lower paid groups, starting with ward-based staff. Options for ward-based staff to be understood	• The Trust's Flexible Working policy was launched on 6 April 2024, and staff survey results have indicated an increase in female satisfaction with flexible working options. • Data has been collated to indicate uptake of flexible working at a ward level.	Maintain oversight of ward level data, with routine support to line managers to inform on the policy and its implementation

Progress against the previous Gender Pay Gap Action Plan

	Development Objective	Action	Progress	Next Steps
	Mend the Gap Priority Actions			
	Employers should promote a flexible working culture when advertising jobs.	1. Ensure that all job adverts for the medical offer flexible working options 2. Ensure policies are available on our website. 3. Understand Less than Full Time medical trainees	1. All job adverts now refer to flexible working options 2. On EOLAS 3. Numbers now tracked (205 LTFT currently)	Completed
	As far as possible use standard rates for additional paid activity that are consistent and transparent (for example, waiting list initiatives, locum work)	Review the rates in our current policy. Work in collaboration with BSW to ensure standardisation across the trusts.	Now using a BSW rate card for bank rates, now standardised.	Completed
	Increase the use of national pay contracts in place of local pay arrangements for hospital doctors	Complete the transition of all Locally Employed Drs to the 2016 contract. Date done?	99% Completed, continue to approach those on old contracts to see if they want to transition to newer contracts	Compile a contractual status report
	Separate the medical gender pay gap from other professional groups in gender pay gap reports	1. Breakdown and identify the governance group. 2. Take to governance committee	Action in place - See earlier slides in this report.	Completed
4	Implement a national equality scheme based on the Athena Swan programme in HEIs	Research the Athena Swan programme to understand how it would value us and how applicable it would be for the Trust	1. Initial research completed into the Athena Swan Programme and its value to the NHS Gender Pay Gap in the UK 2. Headline criticisms, limitations and recommendations of the Athena Swan can be seen on **slide 17** of this report	Explore further the recommendations from the research and its application to SFT
	Use current evidence on wellbeing to create an atmosphere where all doctors feel valued and welcome, especially in relation to caring responsibilities	Continue to ensure we are listening to feedback from the medical workforce to continually improve our health and wellbeing offer. Utilise the professional group breakdown from the staff survey.	We continue to hold listening sessions including staff survey and Resident Dr Forums Trust wide carers policy launched in Feb 2024.	Completed
	Extend enhanced pay for shared parental leave to all doctors to overcome a cultural barrier to men playing more of a role in caring and to challenge stereotypical assumptions about gender roles	Review our current policy, what do we currently pay, and explore adoption and cost of any enhancements. Understand the implications if enhanced rates are available for Dr's only.	Relaunched shared parental leave policy in July 2024	Completed
	Review clinical excellence and performance payments	Irrelevant now LCEA's have ceased	LCEA new award rounds have now ceased as part of the consultant pay deal	Business as usual.

Athena Swan Programme and its Value to the NHS Gender Pay Gap in the UK

The Athena Swan Charter, established in 2005, is a framework used in UK higher education to promote gender equality. Originally focused on women in STEMM (science, technology, engineering, mathematics, and medicine), it now includes all disciplines and staff, including professional, support staff, and trans individuals. This reflects a commitment to intersectionality, recognising that gender intersects with other identities like race, sexuality, and disability.

Impact and Criticisms

Evidence suggests the Charter has positively impacted gender representation in leadership. However, criticisms remain:

- Bias towards privilege: Participation may favour those with existing advantages, potentially reinforcing inequalities.
- Focus on academics: The needs of other female university staff, such as administrative and support staff, may be overlooked.
- Oversimplification: Treating "women" as a homogenous group fails to address the unique challenges faced by women from different backgrounds, including ethnic minorities, LGBTQ+ communities, and migrant women
- Resource intensive: Completing applications can be burdensome, often falling on already busy female academics, leading to a "box-ticking" approach rather than addressing deep-rooted issues. This can create perverse incentives to hide problems or prioritise easily achievable goals.

Value and Recommendations for the SFT

Despite these criticisms, the Charter remains a significant initiative. Its focus on data collection and action planning provides a framework to identify and address gender imbalances.

To be truly effective, it needs to:

- Acknowledge intersectionality.
- Value lived experiences.
- Avoid creating new forms of inequality.

Specific recommendations for applying the learning at SFT

Address intersectionality: Ensure that SFT considers how gender intersects with other identities like race, ethnicity, sexual orientation, and disability.

Focus on qualitative data: Encourage the collection and analysis of qualitative data to understand the experiences of women at SFT and the barriers they face.

Promote transparency and accountability: Develop mechanisms to ensure SFT is held accountable for implementing action plans and achieving tangible results in promoting gender equality including reducing gender pay gap.

Gender Pay Gap Action Plan 2025/26

	Development Objective	Action	Lead	Delivery Partners	Deadline
1	**Improve female staff opportunities to address work-life balance.** Seek to improve scores on staff survey Q4d 'Satisfied with opportunities for flexible working patterns' to above 60% for female staff.	• Use Women's Staff Network and internal comms to Promote the Trust's Flexible Working policy (launched 6 April 2024) to help staff achieve a better work-life balance. Target line managers to ensure support for female staff • Assess ward-level adoption and implementation of the Trust's Flexible Working policy and share findings to improve adoption.	Head of Inclusion & Wellbeing	Clinical Division People BPs	Q1 2025/26
2	**Aim to narrow the Gender Pay Gap in the Administration & Clerical (A&C) Staff Group** In 2024 the pay gap in Administration & Clerical staff group was **15.90%** (compared to 15.97% in 2023). This objective seeks to reduce the mean pay gap in the admin and clerical group by a further 2%.	• Use comparison data to look at the opportunities to improve the proportion of female staff in admin and clerical roles in the upper quartile of A&C staff. • Improve the proportion of male staff in the lower quartile of A&C roles through improved advertising and recruitment activity.	Head of Inclusion & Wellbeing	Head of Workforce Informatics Medical Workforce People BP Payroll Team Finance Team Resources Team	Q1 2025/26 Q3 2025/26
3	**Aim to increase staff satisfaction that the Trust values their work** Staff Survey - Q4b Satisfied the organisation values my work (2023) - **40.9%** of female employees said that they were satisfied that the organisation values their work. This was a **0.4%** reduction on the previous years' staff survey result. **47.3%** of male employees said that they were satisfied that the organisation values their work, an increase of **5.7%** on the previous years' staff survey result. This objective seeks to increase female employees' views that the Trust values their work through improved engagement by Line Manager with female staff, particularly part time staff	• Review line management guidance for wellbeing and career conversations with female staff. • Comms plan to promote uptake of appraisals amongst part time staff, identifying the need to recognise performance from that cohort of staff. • From staff survey data identify key areas of concern by staff group and location, focusing on Nursing and Midwifery and Admin and Clerical staff groups initially. Once identified target comms from Execs and Divisional Management teams to support recognition of staff working in those areas.	AD ODC&L	AD CECR Widening Participation and PP Manager Head of Inclusion & Wellbeing	Q4 2025/26
4	**Mend the Gap Action - Aim to make senior jobs more accessible for female Medical & Dental (M&D) Staff Group** Talent management and training programmes should be used to develop staff and increase appointment of a more balanced senior workforce, such as Associate Specialists and Consultants. Outcome is to improve the proportion of Female medical and dental staff in the upper pay quartile and therefore	• Use comparison data to investigate the proportion of female staff in medical and dental roles in the upper quartile of M&D staff. • Analyse feedback from Clinical Leads Leadership programme and make recommendations for further development of that programme, noting attendance proportions. • Implement succession planning for medical and dental staff through identification of newly appointed consultants, likely retirements and pathways for further development, noting the requirements of male and female staff • Identify support mechanisms for newly appointed consultants. • Identify numbers on CESR/Portfolio Pathway and develop routes for female staff to participate.	AD ODC&L	Medical Workforce People BP OD&L Team Director Medical Education Deputy Chief Medical Officer	Q1 2025/26

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.1
Date of meeting:	6th March 2025		

Report tile:	Estates Strategy – Executive Summary			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Strategic Capital Committee Trust Management Committee			
Prepared by:	Laurence Arnold, Programme Director Edmund Ellert, Head of Capital Projects Julia Gregory, Capital Projects Manager			
Executive Sponsor: (presenting)	Mark Ellis, Chief Financial Officer			

Recommendation:

Trust Board is asked to consider, provide feedback and ultimately approve key points of the estates strategy developed by Exi.

Executive Summary:

Exi Design Group, in collaboration with the Trust, have produced the attached executive summary of the overall estates strategy. It sets out the priority areas for development, reflecting projections on future needs and the Trust's campus redevelopment plans. It identifies potential solutions for where replacement services might be located and the enabling works required. The report suggests how these developments might contribute to the delivery of the net zero agenda and what impact it will have on the backlog maintenance associated with the site. Finally, the reports suggest an indicative cost to deliver the whole strategy and an indicative timeline. The strategy will be reviewed on a regular basis.

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

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PROJECT MANAGEMENT // DESIGN // STRATEGIC & TECHNICAL ADVISORY
COST CONSULTANTS // DIGITAL MANAGEMENT // BUILDING SERVICES

Salisbury NHS Foundation Trust
Short, Medium and Long-Term Estate Strategy
Executive Summary

Technical Report // V2.3 – 20.08.24

Contents//

Document Quality Management.

Title	PS6347 - Estate Strategy: Executive Summary
Date	July 2024
Prepared by	Aaron McPhie, with inputs from each discipline & Cliniplan
Checked by	Joe Kinnersley/ Steve Kennedy
Authorised by	Ben Flounders

Document History.

Version	Date Issued	Brief Summary of Change	Author	Check	Approver
1.0	26/06/24	First Issue (DRAFT) - Stage 3 Executive summary presentation	AM	JK/SK	BF
2.0	16/07/24	Final Draft for exi QA	AM	JK/SK	BF
2.1	17/07/24	Client Issue	AM	JK/SK	BF
2.2	09/08/24	Updated following client review	AM	JK	SK
2.3	20/08/24	Approved Programme and Sequencing slide inserted	AM	JK	SK

00 Executive Summary

Salisbury NHS Foundation Trust has identified the need to progress with an estates transformation programme which must be aligned to the Trust's Clinical Strategy, service transformation and the wider Acute Services ICS.

We acknowledge the following Trust strategic objectives have been identified to underpin the delivery of this Estates Strategy;

1) To provide a clear vision and strategy in the context of the ICS; to inform discussions with ICS partners, utilisation of the systems estate, and therefore 'best use' within the system;
2) To deliver an Estate Strategy, which provides direction and vision for the estate over the next 10 years, broken down into;
    - '*Short to Medium term' plan for 0-7year period*.
    - '*Long Term Plan' needed for next 8–10+ year period*.
3) To provide a robust baseline (Development Control Plan) and set the strategic context to attract future capital funding.

Aligning with the Trust's existing 2022-2026 clinical strategy, the completed Estate Strategy will be used to meet the following key criteria:

- Assessment and alignment of clinical and clinical site strategies,
- Strategic fit with ICS,
- Organisational fit across the Trust's retained estate and community,
- Site-fit to illustrate the Trust's Development Control Plan (DCP),
- High-level Programme/cash flow/phasing plan,
- High-level capital costs including inflation,
- Estates Strategy document.

01 Strategy Overview

As an output of this strategy, we provide the following recommendations and acknowledge the Trust's need to undertake the following key activities;

- Lock down and fix the 0-7year short to medium-term projects
  - To ensure there is a firm Capital plan,
  - Show where Salisbury moves are required,
- Develop Feasibility Studies for 0-7 projects – To secure funding it is recommended individual feasibility studies are to be progressed for the 0–7-year projects. The feasibility studies will be used to develop a timeline and cost envelope for each project. This will demonstrate that they are back-to-back with the estate's strategy and developed in line with the clinical strategy.
- Space Utilisation – The development control plans will assist with identifying where space is created/required for development.
- Community Services – Tender submitted to provide community services with Bath and Swindon
- Set out our Net Zero Aspiration – Salisbury NHS Foundation Trust recognises that sustainable development is a critical factor in being able to deliver world-class healthcare, both now and in the future. We have ambitious future green plans, which include addressing the challenge of achieving net zero carbon. These include:
  - Meeting NHS Net Zero Carbon targets through the radical transition away from fossil fuel-based infrastructure to electric heat pumps and deep geothermal energy technology.
- Retained Estate – The retained estates will be reassessed to ensure patient safety and good quality working environment. The Trust will need to carry out the assessments using a standard methodology in alignment with ICS/ICB.
- Estates Strategy - The estates strategy will remain as a live document which will be refreshed on a 12-month basis. It is recommended the Trust appoint a consultant team to carry out a 'plan do check' on the progress of the estate's strategy and provide a report to be taken through the approved governance structure. Any updates would be made following the approval process as/if required.

02 Summary Of The 3-Stage Approach.

Salisbury NHS Foundation Trust

STAGE 1 - Where are we?

- Review acute model of care; Acute and Community
- Establish list of entrained projects
- Develop Clinical strategy for 0-5yr, 5-10yr and 10-15yr periods
- Establish Digital baseline
- Prepare Activity Demand & Capacity model >15years
- Estates analysis
  - Current Estate: Size
  - Current Estate: Physical Condition, Functional Suitability, Space Utilisation, Quality & Fire and Health & Safety
  - Site Analysis: Access and Flows, SWOT
  - Site Analysis: Core Flex and Tail
- MEP Infrastructure / NetZero baseline
- Agree backlog / critical infrastructure risk as a baseline

STAGE 2 - Where do we want to be?

- Set future strategies (NZC, Digital, Service Transformation etc.)
- Activity demand & capacity modelling >5years, >15years
- Agree HLPAs & Clinical Strategy
- engagement session with IC/Place colleagues
- Undertake Critical Infrastructure Risk assessment, aligned to business continuity
- Produce operational brief 0-5yr, 5-10yr & 10-15yr
- Set estates performance metrics
- Develop design strategies
- Define Capital costing strategy
- Outline high level capital costs against design strategies
- Prepare and agree scope for Stage 3 output
- Provide presentational outputs

STAGE 3 - How do we get there?

- Refinement of acute site brief to establish clear strategy
- Develop the estate solution and DCP for the Preferred Option;
  - Development zones
  - Massing & Stacking
  - Adjacencies
  - Sequencing, Phasing & Programming
  - Capital Costs, Backlog Maintenance and Cashflows
- Forecast effect of estate strategy on Backlog Maintenance position to years 05, 10 and 15
- Identify organisational priorities against time continuum
- Identify key/tactical projects to inform prioritisation
- Delivery of a formal 'written' estate strategy report and supporting appendices

03 Summary Of Estate Analysis

Stage 1 – Where are we now?

In parallel to the development of the functional briefing and to inform this strategy we have undertaken assessment for each site, against the following:

- Size and functional use, across each site
- Physical Condition, Functional Suitability, Space Utilisation, Quality & Fire and Health & Safety
- Access and Flows, Strengths, Weaknesses, Opportunities and threats for each sit
- Identified the "Core Flex and Tail" estate across each site
- Integrated the latest entrained developments on the Salisbury District Hospital site
- Undertaken analysis on key MEP and Infrastructure to inform any future engineering strategies
- Set out framework to baseline Carbon usage to inform future NZC assessments
- Undertaken desktop review to establish a baseline for Back Log Maintenance for each site, using existing evidence base

This data provides us with an accurate baseline position to inform future assessment

Extract map showing site locations (refer to main report for more detail)

Building Key

C- Nunton Entrance, North Level 2
D- Springs Entrance, North Level 2
E- A & E/Emergency Dept, North Level 3
F- Main entrance, North Level 3
G- Link bridge corridor, North level 4
H- Sarum Entrance, North Level 3
I- The Green Entrance, Central
J- Hedgerows Entrance, Central
K- SDH Central Entrance, Central
L- Spinal Unit Entrance, Central
M- Maternity Entrance, Central
N- The Laing Entrance, South
O- The Hospice Entrance, South
P- Parking
Q- Key Worker Accommodation
R- Odstock Leisure Centre
S - Helipad

Land Ownership Boundary
3rd Party Lease
SDH North
SDH Central
SDH South

Existing:

Areas (as ERIC data 2022/23)	Unit	Salisbury District Hospital	PFI
Gross internal floor area	m²	93,577	13,254
Site land area	m²	210,000	-
Site land area	Hectare	21	-

03 Context of Salisbury Hospital Masterplans

The Trust have been working with Salutem to develop a masterplan for the site. Part of the redevelopment includes the eastern land adjacent to the existing hospital site.

The current plan includes for Life Sciences, Recreational Spaces, Education and Innovation, Day Surgery, Maternity, Cancer Unit and Welcome Centre. The proposals also includes multi-level car parking.

04 Functional Briefing Outputs

Salisbury NHS Foundation Trust

The brief was generated by the demand and capacity modelling discussed in previous reports and projected for year 5 and 15.

These were then translated into a spatial brief by applying established briefing metrics: most typically NHS Health Building Note data. Where NHS HBN metrics were not available, experience of other comparator projects was applied.
A grouping of clinical services was then created to enable high-level and sized, building blocks to be identified. These building blocks were then be used to configure a series of estate options to deliver the required functional content, compatible with the service aspirations that emerged during consultation and the agreed high-level planning assumptions detailed in the sections above.

The building blocks have been identified as:

- Women's and Childrens'
- Urgent and Emergency Care
- Imaging
- Inpatients incl Theatres and Critical Care
- Burns and plastics Surgery
- Spinal Injury
- Ambulatory
- Cancer Care
- Support Services

The following exclusions have been adopted:

- Residential Accommodation – it is acknowledged that the Trust are working on a strategy to develop the residential accommodation.

Using this approach, the following high-level functional content was assessed to be:

Overall 'Demand for Space'

	Year 5	Year 15
Functional components	GIFA (m2)	GIFA (m2)
Women's and Childrens	6,159	6,271
Urgent and Emergency Care	6,658	7,695
Imaging	759	822
Inpatients incl Theatres and Critical Care	17,299	19,552
Burns and Plastics Surgery	2,069	2,281
Spinal Injuries	2,444	2,640
Ambulatory	10,126	11,472
Cancer Centre	2,304	2,338
Support Services	14,181	15,654
Sub Total	62,000	68,726
Plant @ 21%	13,020	14,432
Comms @ 17%	10,540	11,683
Total Uplift	23,560	26,116
Building **'Demand'** GIFA	85,560	94,842

05 Priority Projects

Following discussions with the Trust team, the below list outlines the current thinking of a priority list of projects which is either based on risk to service due to condition of the building or capacity issues.

Enabling Works – a MSCP is required to free up development space and any displaced parking associated with this.

1. Day Surgery Unit – a new build Day Surgery Unit due to significant infrastructure risks with the current building. There is potential for education at first floor level (possibility to create FF shell for future use). Feasibility for scheme under development.
2. Same Day Emergency Care (SDEC) – Expansion for SDEC required due to service and capacity needs.
3. Spinal Unit – Refurbishment of the spinal building required due to condition of the interior and services within the building.
4. Maternity Services – a new build Maternity unit due to infrastructure risks within the current building.
5. Cancer Services – the expansion and refurbishment of existing cancer services in current location – project to be charitably funded. Feasibility for scheme under development.
6. Mortuary – expansion to existing mortuary due to capacity issues. Feasibility for scheme under development.
7. In Patient Wards – Rolling refurbishment of wards to upgrade interior and ventilation services. 5/6 wards already complete.
8. In Patient Theatres – Rolling refurbishment of theatres to general upgrade works and MEP services upgrades to bring up to current HBN/HTM standards
9. CSSD – Is there a possibility to relocate off site as part of a wider ICS strategy and create a central hub for the area? Would create development zone opportunities within the SDH North Level 2

Other projects/services to note:

- Improvement required to Staff Wellbeing and rest facilities incl change – there is a need for separate male and female change facilities within the hospital and the Trust are working through options/ideas at present to create a central change area.
- Outpatients – future aspirations to provide a suite of generic OP rooms and clinic areas. Possibility to provide as new build or within SDH North in the future
- Genetics – Possibility of an opportunity to relocate in the future – offsite or an alternative setting

06 Development Control Plans.

To be able to develop the design strategies, an assessment of the site has been carried out. This has identified which buildings within the current estate fall into the following three categories of Core, Flex and Tail. This helps to shape the development control plan and give an understanding as to which buildings are able to be reused, are fit for purpose - with an element of refurbishment and which buildings are no longer fit for purpose and would require disposal.

Core, Tail and Flex Assessment – shown above Salisbury Hospital Site Plan

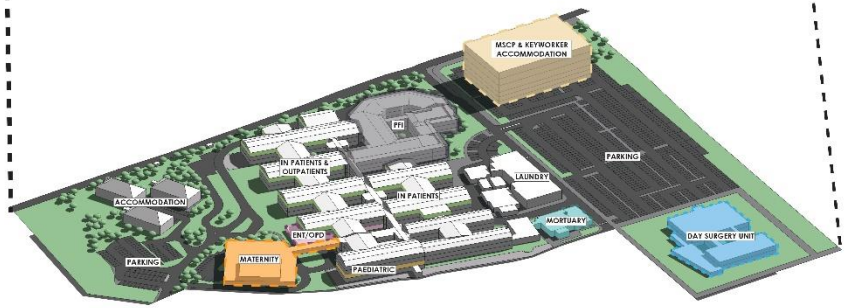
06 Development Control Plan.

SDH North – Short to Medium Term Development Control Plan

The below images show the works that can be completed within the short to medium term in the Northern zone of the site.

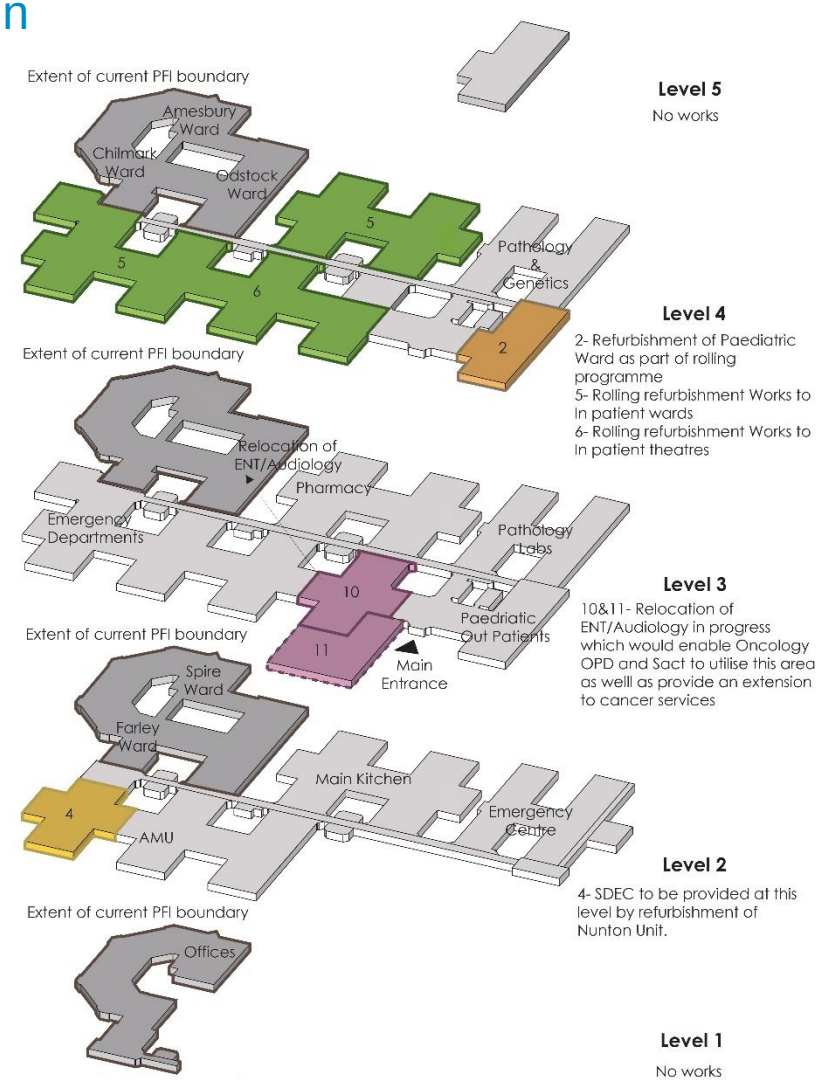
Overall Site Plan

SDH North Area Plan



KEY

- Women's & Children
- Urgent and Emergency Care
- In Patients
- Spinal Injuries
- Ambulatory
- Cancer Centre
- Support Service
- Enabling Works- MSCP
- Demolition
- New Build (colour corresponds to service)
- Refurbishment (colour corresponds to service)



SDH North

06 Development Control Plan.

SDH North – Short to Medium Term Development Control Plan

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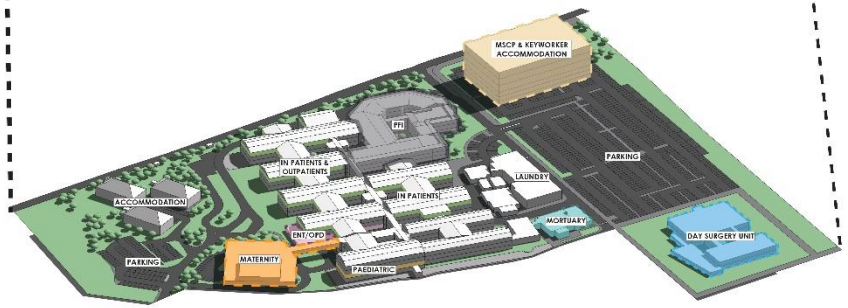
Overall Site Plan

SDH North Area Plan



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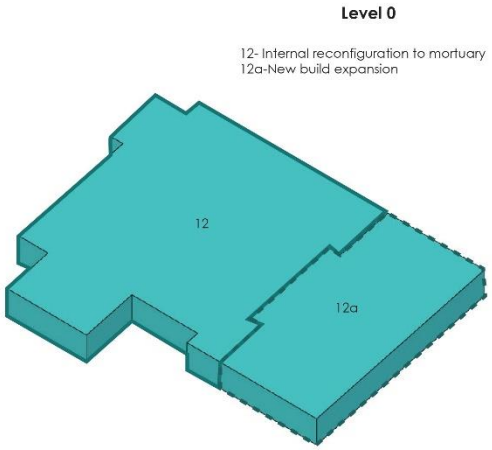
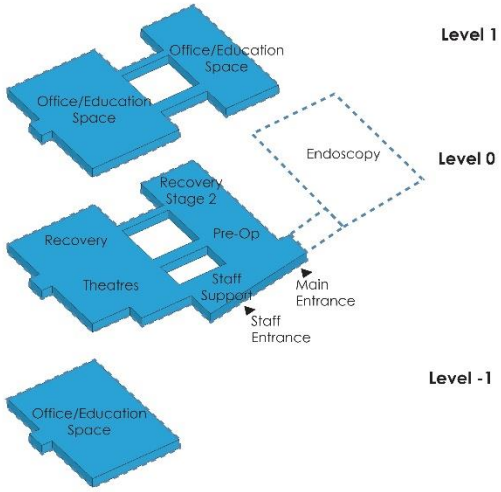
MSCP & Keyworker Accommodation



Mortuary



Day Surgery Unit

06 Development Control Plan.

SDH Central – Short to Medium Term Development Control Plan

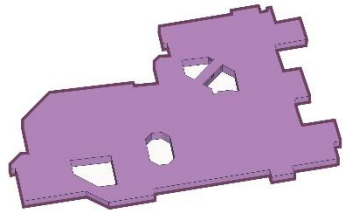
The below images show the works that can be completed within the short to medium term in the central zone of the site.

Overall Site Plan

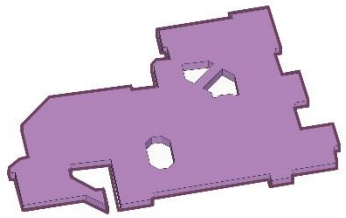
SDH Central Area Plan

KEY

- Women's & Children
- Urgent and Emergency Care
- In Patients
- Spinal Injuries
- Ambulatory
- Cancer Centre
- Support Service
- Enabling Works- MSCP
- Demolition
- New Build (colour corresponds to service)
- Refurbishment (colour corresponds to service)



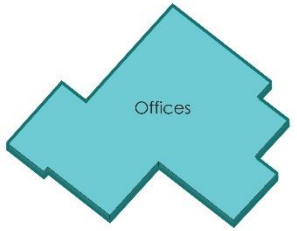
Level 0
High level refurbishment



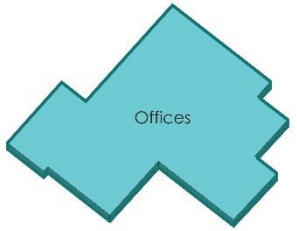
Level -1
High level refurbishment

*Long term plan for Spinal Treatment Centre to be developed

Spinal Treatment Centre



Level 1
Refurbishment of existing DSU to create offices



Level 0
Refurbishment of existing DSU to create offices

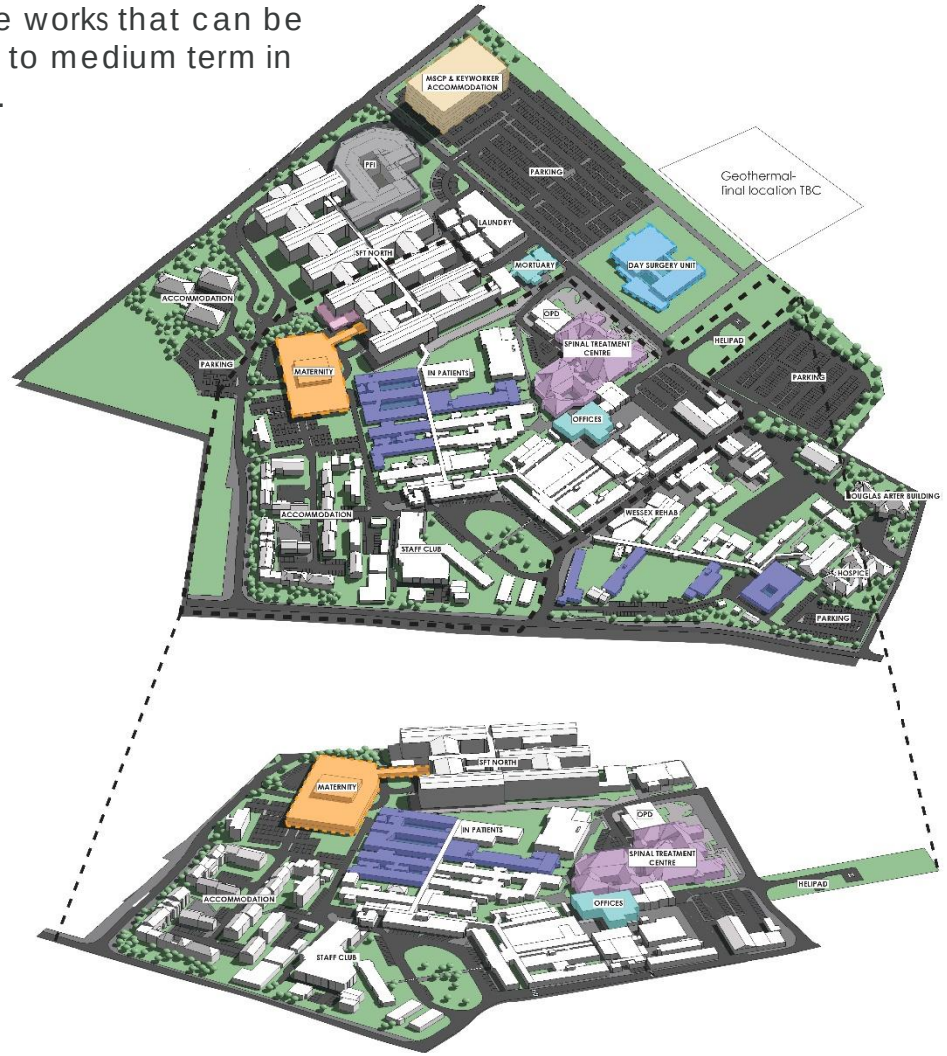
Existing Day Surgery Unit

06 Development Control Plan.

SDH Central – Short to Medium Term Development Control Plan

The below images show the works that can be completed within the short to medium term in the central zone of the site.

Overall Site Plan



SDH Central Area Plan

KEY

- Women's & Children
- Urgent and Emergency Care
- In Patients
- Spinal Injuries
- Ambulatory
- Cancer Centre
- Support Service
- Enabling Works- MSCP
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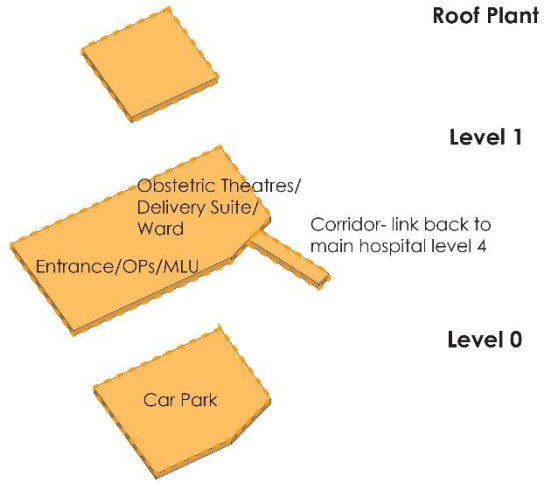


Maternity

06 Development Control Plan.

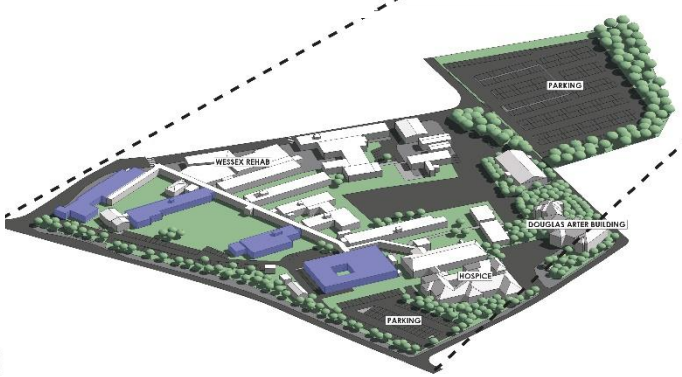
SDH South – Short to Medium Term Development Control Plan

The below images show the works that can be completed within the short to medium term in the Southern zone of the site.

*No works proposed for SDH within years 0-5yr except demolition of buildings identified.

Overall Site Plan

SDH South Area Plan



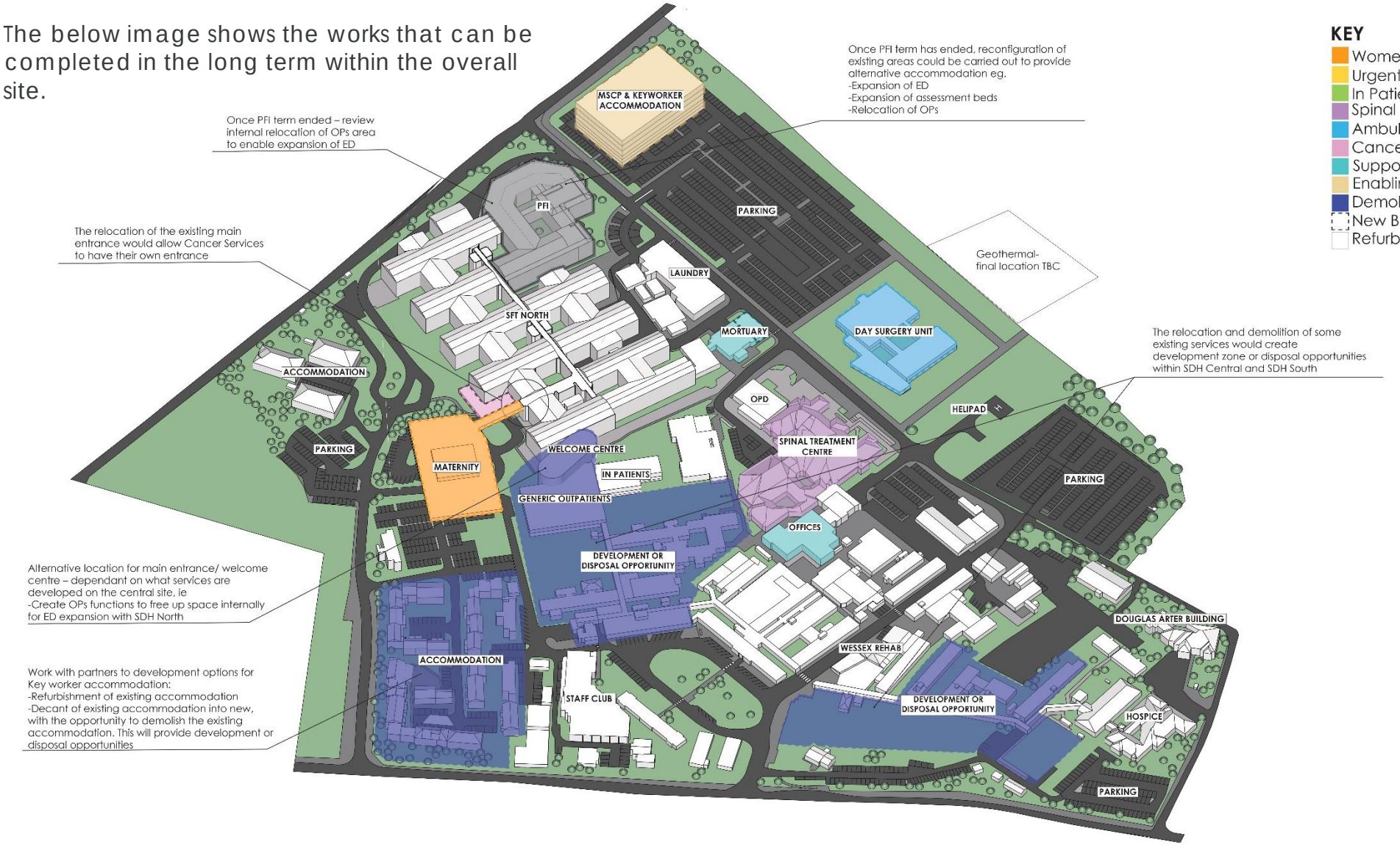
KEY

- Women's & Children
- Urgent and Emergency Care
- In Patients
- Spinal Injuries
- Ambulatory
- Cancer Centre
- Support Service
- Enabling Works- MSCP
- Demolition
- New Build (colour corresponds to service)
- Refurbishment (colour corresponds to service)

06 Development Control Plan.

Overall Site – Long Term Development Control Plan

The below image shows the works that can be completed in the long term within the overall site.



KEY

- Women's & Children
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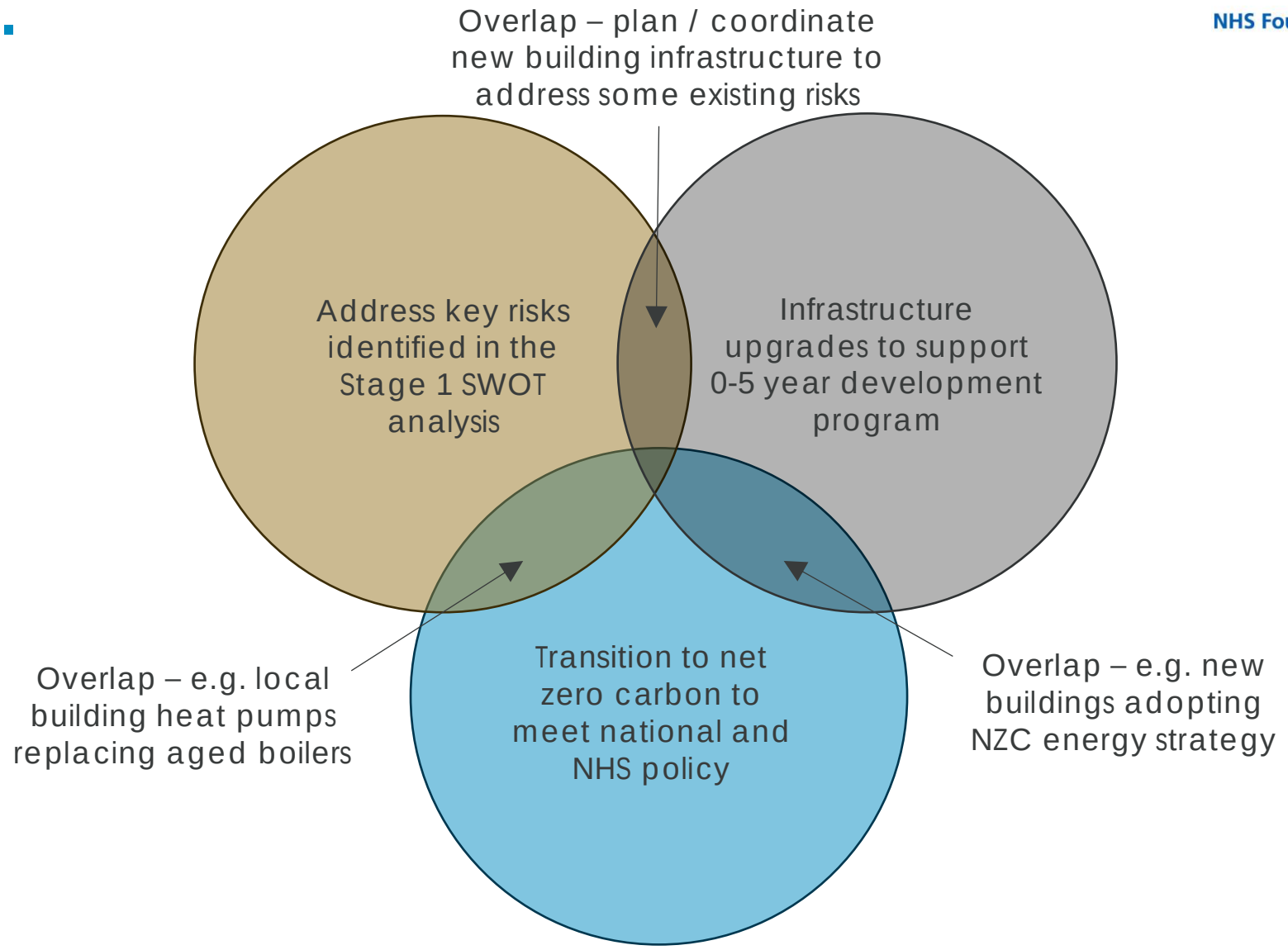
- In Patients
- Spinal Injuries
- Ambulatory
- Cancer Centre
- Support Service
- Enabling Works- MSCP
- Demolition
- New Build (colour corresponds to service)
- Refurbishment (colour corresponds to service)

07 MEP Strategy.

There are three key priorities that come together to inform the MEP strategy for 'Where do we want to be?'. These are:

- Address key risks.
- Infrastructure to support short and medium term development.
- Transition to net zero carbon.

Whilst these represent distinct requirements there are overlaps where two or more are met through delivering the same strategy. The image below presents the crossovers.



07 MEP Strategy.

Following discussions with the Trust team, the below list outlines the current priority list for projects based on either risk to service due to condition of the building, or capacity issues. These projects are listed under one of the three categories below:

- Refurbishment.
- Local extension.
- New Build.

09 Net Zero Carbon.

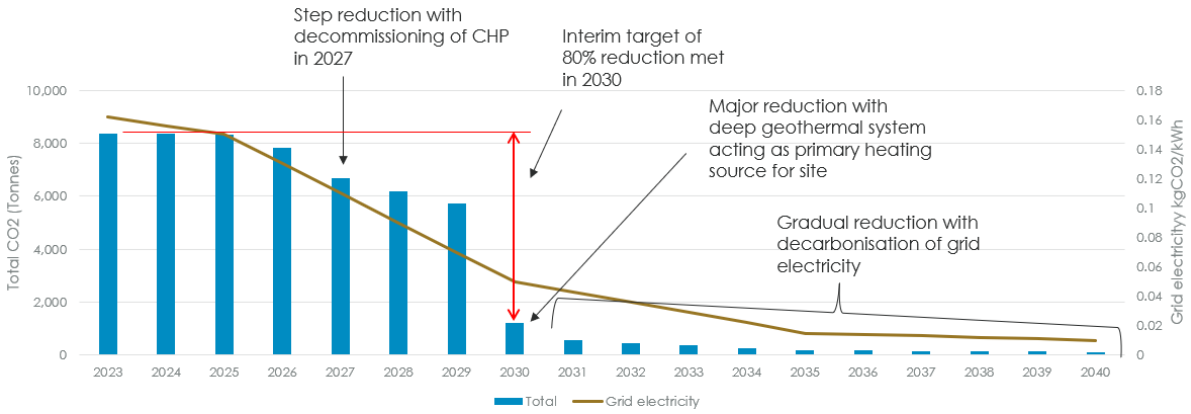
Salisbury NHS Foundation Trust

Demand reduction measures have been proposed for various elements of a buildings and vary according to the level of refurbishment that would be carried out for the works. This is shown below.

	Low refurbishment	Medium refurbishment	High refurbishment	New build
Thermal envelope	No works	Upgrade external doors & pitched roof loft insulation to **Part L2B**[2] table 3 & 5 standards	Upgrade windows, doors, walls & roof to **Part L2B**[2] table 3 & 5 standards	Meet **NHS net zero carbon**[3] MPT for thermal envelope
Lighting	Replace lighting >5 years with LED lighting	New LED lighting and controls throughout	New LED lighting and controls throughout	Meet **NHS net zero carbon**[3] target for 2W/m²/100 lux
Ventilation	Re-use existing natural and mechanical ventilation	Replace existing mech vent to **non-domestic guide**[1] SFP 2.2W/l/s, 45% HR	Mech. vent throughout to **non-domestic guide**[1] SFP 2.2W/l/s, 45% HR	Mech. vent to meet **NHS net zero carbon**[3] SFP 1.3W/l/s, 80% HR
Variable speed drives	No works	All pumps and fans with variable speed drives	Variable volume on air and pipework systems	Variable volume on air and pipework systems
Water efficiency	No works	12.5% improvement in line with **BREEAM NC**[4]	25% improvement in line with **BREEAM NC**[4]	Water recycling to assist 50% reduction for **BREEAM NC**[4]
Controls	Replace missing / faulty radiator TRVs	New local temperature controls and metering	New BMS, local temperature controls, and metering	BMS monitoring of energy use to meet **NHS net zero carbon**[3]
Target reduction	0% thermal 2% electrical	10% thermal 5% electrical	20% thermal 10% electrical	85% thermal 20% electrical From current baseline

This table has been applied to this estates strategy and the graph below shows the results of what following this Estates Strategy will achieve.

- This is based on projected decarbonising of grid electricity (CCC 6CB Balanced Pathway).
- The results demonstrate that the interim target of 80% reduction is met in the last year of the 2028-2032 target period and the net zero is 98.5% achieved by 2040. The final achieving of net zero is dependent on the grid achieving the same.



10 Digital – Identified Opportunities.

Salisbury NHS Foundation Trust

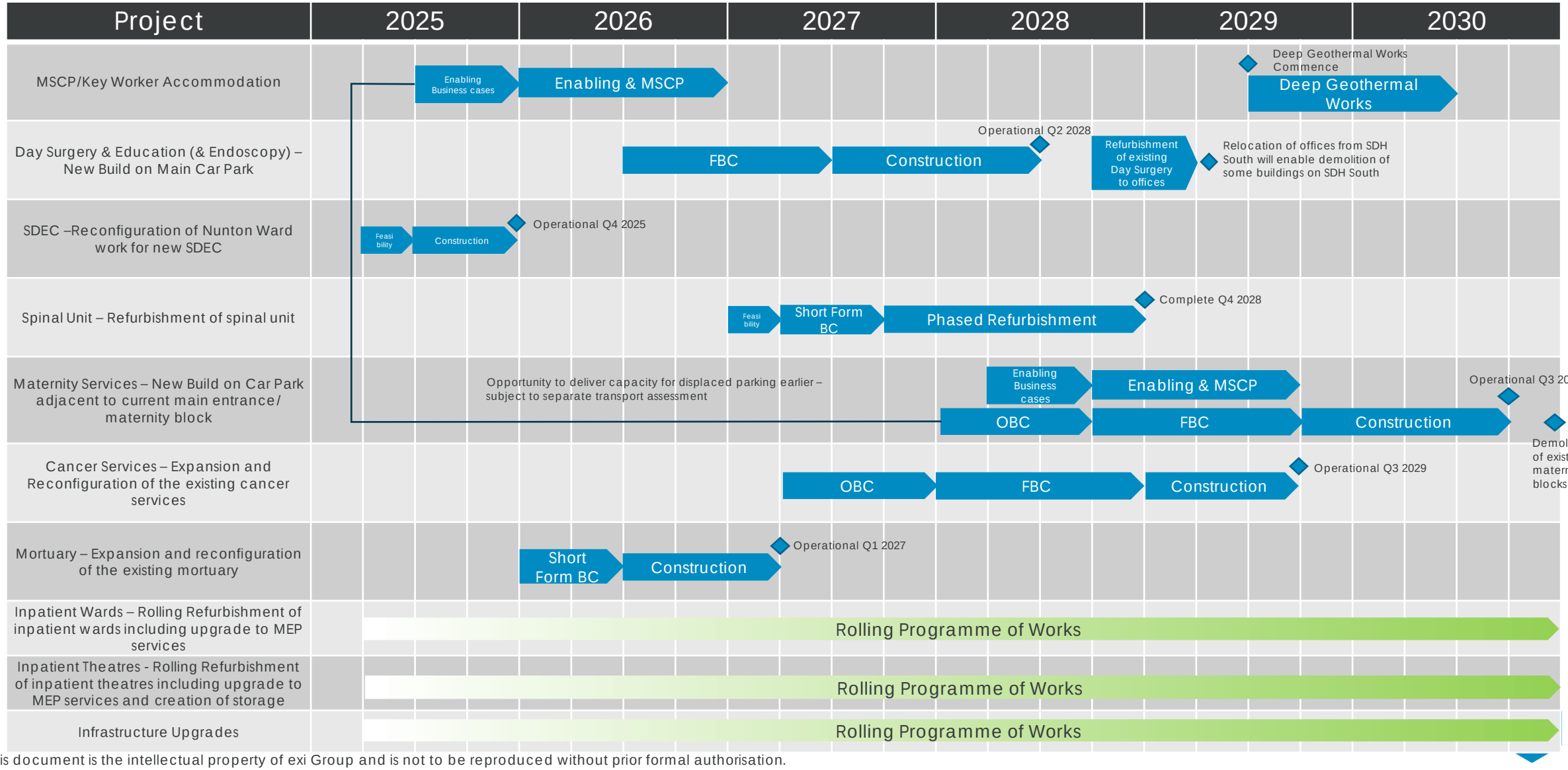
Through the engagement undertaken it has been possible to identify more specific technologies which if implemented would aid the digital development of the Trust. The table below explains why these would be advantageous and beneficial to the Trust.

Digital Opportunity	Why?
EPR System	The implementation of the EPR system will allow for enhanced patient safety and more effective handling and better quality of patient data and consequently improved decision making and planning. The system also allows information to be shared across the Trust on a unified system, allowing for data to be shared to those who need it. EPR also reduced the need for notes storage – releasing prime space for clinical repurposing.
4G/5G Mobile Networks	4G/5G Mobile networks solve the problem of poor mobile signals and connectivity. This enables effective use of any patient apps also for users not connected to WIFI but also for staff to use their devices and not be fully reliant on WIFI networks.
Estates Infrastructure being maximised to cope with own devices	Maximising infrastructure and creating the ability to charge and use devices in more areas across the hospital would ultimately allow for staff to have greater access to infrastructure to undertake their work.
Tablets	Handheld devices will allow staff to access patient information and undertake work on the go and not be reliant on desktop computers and to work remotely were required (this could be at home or to attend patient appointments in the community).
Increase cloud-based systems	Cloud based systems allow for accessibility anywhere from any device, which would aid staff who are using various devices and allows for more availability of information stored which would benefit different services needing to access the same information. It also allows scalability and removes the need for hardware and creates a centralised area for information.
Smart Scheduling	Smart scheduling systems would benefit the Trust across all services. The systems are designed to remove human error, quickly and effectively schedule tasks, shifts and appointments. Consequently, these systems will bring time efficiency, cost savings and better time management.
RFID Systems	Implementing RFID systems will allow for a streamline of care history, patient identification, equipment management and traceability. This will inevitably benefit processes and aid staff across the Trust.
Increase home attendance	By creating the ability for virtual and home appointments, will enable patients who struggle to attend hospital appointments to be seen and treated more easily and also allows staff to fit appointments in where it may have difficult before – improving staff efficiency and patient throughput. This saves time and cost, and they are quicker to undertake than in person appointments. The appointments can also be recorded and reviewed as required. For home-based visits, staff can use devices that work remotely and undertake patient care as they would in the hospital.

11 Programme and Sequencing v1.2.

Salisbury NHS Foundation Trust

The table below provides a high-level representation of the sequencing, phasing and programmes for delivery.



12 Approach to Capital Costs.

Salisbury NHS Foundation Trust

The Capital cost summary from the OB Form is below. The costs shown are for the total outturn cost.

These costs have been developed in line with the HPCG and business case guidance and include the following allowances:

1. Departmental rates based on HPCG
2. Inflation as BCIS PUBSEC INDICE 250
3. On-costs allowances
4. Professional fees at 15%
5. Equipment at 15% (of dept. costs)
6. Planning contingency at 10%
7. Optimism Bias at 20%
8. Inflation to construction mid-point
9. VAT at 20%

Total costed GIFA 36,381m2
Out turn rate £11,094m2

Please refer to the appended OB form for more details

CAPITAL COSTS SUMMARY

			Cost Excl. VAT £	VAT (at 20%) £	Cost Incl. VAT £
1	Departmental Costs (from Form OB2)		68,787,063	13,757,413	82,544,475
2	On Costs (from Form OB3) (a) (47.11%of Departmental Cost)		32,404,276	6,480,855	38,885,131
3	Works Cost Total (1+2) at HPCG reporting level (PUBSEC 173)		101,191,339	20,238,268	121,429,606
4	Indexation: Inflation to NHSi advised reporting level (PUBSEC 250) (44.51% of Works Cost Total)		45,038,920	9,007,784	54,046,703
	Provisional location adjustment (b) - 100 (as NHSi reporting) (2.00% of Departmental Cost Total plus indexation)		2,276,520	455,304	2,731,824
5	Sub Total (3+4)		148,506,778	29,701,356	178,208,133
6	Fees (c) (15.00%of sub-total 5)	15.00%	22,276,017	n/a - see item (d) below	22,276,017
7	Non-Works Costs (from Form OB4) (e)		613,805	122,761	736,566
8	Equipment Costs (from Form OB2) (15.00%of Departmental Cost)		14,910,631	2,982,126	17,892,758
9	Planning Contingency (Trust)	10.00%	14,850,678	2,970,136	17,820,813
10	SUB TOTAL (5+6+7+8+9)		201,157,909	35,776,378	236,934,287
11	Optimism Bias	20.00%	40,231,582	8,046,316	48,277,898
12	TOTAL (for approval purposes) (10+11)		241,389,491	43,822,695	285,212,185
13	Inflation adjustments (f):				
a.	to current PUBSEC INDICE level 312 Q3 2024	24.80%	59,864,594	11,972,919	71,837,513
b.	to furthest PUBSEC forecast Q1 2026	4.52%	13,616,685	2,723,337	16,340,022
c.	to construction mid-point Q1 2028	8.00%	25,189,662	5,037,932	30,227,594
14	FORECAST OUTTURN BUSINESS CASE TOTAL (12+13)		340,060,432	63,556,883	403,617,315

12 Capital Cost Summary.

Salisbury NHS Foundation Trust

Cashflow forecasts have been prepared and are based on the OB forms and the 7-year DCP Programmes as discussed on the previous section.

Below is the predicted Salisbury cash flow forecast.

Financial Year	Out-Turn Cost Turnover (£m)
2025/26	£38m
2026/27	£50m
2027/28	£107m
2028/29	£107m
2029/30	£67m
2030/31	£35m
Total	£404m

A summary of overall capital costs for years 0-7 is noted as follows;

Salisbury Hospital	Cost
Cost Excl. VAT £	340,060,432
VAT (at 20%) £	63,556,883
Cost Incl. VAT £	403,617,315

13 Backlog Maintenance.

When applying the proposed exi design strategy to the latest Trust ERIC backlog data return this results in a significant backlog reduction of £13m as per the table below:

Element	Cost to eradicate specific backlog
Cost to eradicate high risk backlog	£0
Cost to eradicate significant risk backlog	£5,831,751
Cost to eradicate moderate risk backlog	£47,062,715
Cost to eradicate low risk backlog	£11,975,796
Total	£64,870,262

Critical Infrastructure Risk £5.8m

Risk Adjusted Backlog £594k

Whilst the design strategy has a significant positive impact on the current Trust Backlog with an overall reduction of 17% it is worth noting that this does not represent the true 'out-turn' cost of fully eradicating the backlog, which is estimated to be in the region of £103m including for professional fee's, contractor costs & risk.

Please refer to the appended backlog report for more details.

14 Headline Summary of Conclusions.

As an output of this strategy, we provide the following recommendations and acknowledge the Trust need to undertake the following key activities;

- Lock down the 0-2year necessary projects
  - *Enabling works/MSCP and DSU*
  - *To ensure there is a firm capital plan*
  - *Show where Salisbury moves are required.*
- Develop Feasibility Studies for 0-7+ projects - To secure funding, feasibility studies are to be progressed for the 0–7+-year projects. The feasibilities will be used to develop a timeline and cost for each project. This will demonstrate that they are back-to-back with the estate's strategy developed in line with the clinical strategy.
- Space Utilisation – The development control plans will assist with identifying where space is created and required for development.
- Set out our Net Zero Aspiration – Salisbury NHS Foundation Trust recognise that sustainable development is a critical factor in being able to deliver world-class healthcare, both now and in the future. We have ambitious future green plans, which include addressing the challenge of achieving net zero carbon. The following metrics will be used to guide the Trusts Net Zero goals:
  - Lighting
  - Ventilation
  - Variable speed drives
  - Water efficiency
  - Controls
  - Target reduction
  - Improving electrical infrastructure

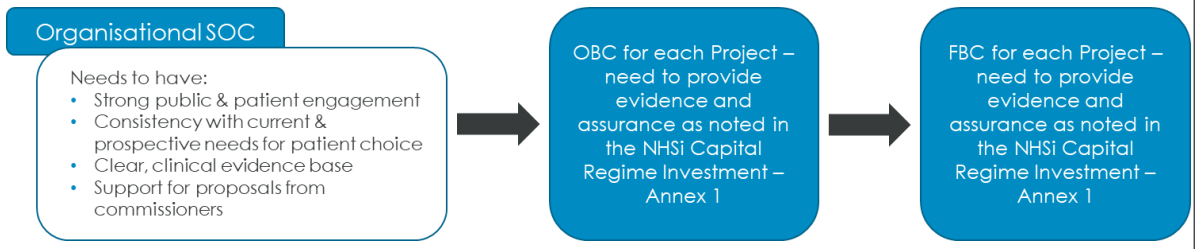
(Further NZC information can be found in section 29 of the Stage 3 Report)

15 Conclusion: Short to Medium Term Projects.

The outcome of the estate's strategy has identified that the proposed DCP, from an estates and technical perspective, is the optimum in performance to deliver service change within a 0-7 & 8-10+ year timeframe whilst addressing the high and significant estates risks.

It has identified that there would be a significant reduction in backlog as a result of the investment, however noting it does not eradicate backlog entirely. The DCP responds to the clinical strategy for reconfiguration and future service transformation model.

The next steps for the Trust are shown in the diagram below (for projects over £15m):



To progress with the implementation of the Estates Strategy and a realisation of the benefits of the DCP, it is recommended that a series of phased capital projects are required to be taken forward to Short Form Business Case, Outline Business Case and Full Business Case. These are as follows:

Enabling Works Incl. Infrastructure Upgrades and MSCP/Key Worker Accommodation

A number of infrastructure upgrades will need to take place either prior to any development taking place on site, as enabling works, or as part of any new development. These works will include:

- HV/LV Electrical Infrastructure Works & Resilience.
- Heating Infrastructure Works.
- Cooling Infrastructure Works.
- Medical Gas and Pneumatic Tube Works.
- IT Infrastructure Works.
- Water Infrastructure Works.

Details of these can be found in the Stage 3 MEP Report and the approach taken will need to be considered in each specific project and discussed/agreed with the Authorised Engineer(s),

The development zone for the Day Surgery & Office/Education build currently sits on part of the main car park. Therefore, the will require the displacement of existing car parking, which will need to be provided prior to construction taking place.

Therefore, as an enabler to the Day Surgery project a new MSCP/Car Deck will be required. An exercise will need to be carried out to determine the exact number required.

The Trust would like to develop their strategy for Key Worker & residential accommodation and there may be an opportunity to provide residential accommodation on the upper levels of this car park.

15 Conclusion: Short to Medium Term Projects.

Day Surgery & Office/ Education (& Endoscopy) – New Build on Main Car Park

The Day Surgery Unit & Office/Education facilities are proposed to be provided within a new build. The location of the Day Surgery Unit is proposed to be located on part of the main car park.

Before the works can commence a new MSCP/Parking deck will need to be provided to accommodate the displaced car parking within the development zone and is therefore an enabler to the project and as described above.

The project will also require the following Engineering works:

- New A&B substation with 2no transformers and associated A&B generators and fuel storage.
- Discussions with the incumbent HV specialist required as to whether this would come from a new HV ring or whether to make this the start of a second ring.
- Consideration to incorporating the 2nd Oxygen VIE in this scheme so that it's in place when the existing VIE is re-located for Maternity at a later date.

Feasibility studies are already in progress for this project and will continue to be developed including the engineering works required.

Following a recent inspection of the existing Endoscopy Unit, there is a need to increase the Endoscopy Room provision at SDH. There is minimal opportunity at present to extend the existing Endoscopy Unit, therefore an opportunity would be to provide a new build Endoscopy Unit either linked to the Day Surgery Unit or as a standalone building (site to be confirmed).

A feasibility for the Endoscopy Unit is to be developed using the briefed size which has been modelled as part of the Estates Strategy. This would free up space within the footprint of the existing Endoscopy Unit for expansion on outpatients or ED functions.

SDEC – Reconfiguration of Nunton Ward Work for New SDEC

The location of SDEC is to be provided in the footprint of the existing Nunton Ward. In order to provide SDEC accommodation it will require the refurbishment and reconfiguration of the Nunton Ward in line with HBN 15-02 Facilities for same day emergency care/ambulatory emergency care.

The refurbishment will include upgrades to the following:

- New and reconfigured wall partitions.
- New doors.
- New floor finishes.
- New and reconfigured ceiling grids.
- New wall finishes and redecoration of walls.
- New fixtures and fittings incl reception desks etc.
- Upgrades and reconfigured mechanical and electrical services.

The project will require the decanting of the existing Nunton Ward prior to works commencing on site. A strategy for this will be developed as part of the feasibility study.

15 Conclusion: Short to Medium Term Projects.

Maternity Services – New Build on Car Park Adjacent to Current Main Entrance/Maternity Block

The Maternity Services (excluding Gynae and Paediatrics) facilities are proposed to be provided within a new build. The location of the Maternity Unit is proposed to be located across 2no. car parks adjacent to the main entrance and existing maternity services.

Before the works can commence a new MSCP/Parking deck will need to be provided to accommodate the displaced car parking within the development zone and is therefore an enabler to the project and as described above. There may be an opportunity to develop the car parking strategy as part of the Day Surgery Unit enabling project.

Due to the topography on site, there may be an opportunity to provide undercroft parking, with the maternity services being provided at the upper level. There is a further requirement to have a direct link back into the main building which is currently identified above the existing Main Entrance.

The project will also require the following Engineering works:

- Potential need to re-locate existing VIE to new location with access for deliveries required.
- Potential need to provide temporary heating plantroom to serve SDH central, depending on footprint of this building, though ideally this would be avoided.
- New A&B substation with 2no transformers and associated A&B generators and fuel storage.
- Discussions required with the incumbent HV specialist as to whether this substation can come from existing ring.

A feasibility study is to be developed using the briefed schedule which has been modelled as part of the Estates Strategy. This will include adjacencies and flows, spatial concept plans, massing, mechanical and electrical strategies both internally and externally as described above.

Spinal Unit – Refurbishment of Spinal Unit

The spinal unit is to remain in its current location as part of the Development Control Plan. However, in order to bring the condition of the building up to Condition B, refurbishment and upgrades to the existing services will be required to the whole building.

To maintain the services continuity, the refurbishment will need to be carried out as a phased approach. A feasibility will need to be developed to review the existing accommodation against the brief, which has been generated as part of the Estates Strategy. This will ensure the correct number of rooms, beds, clinic rooms are provided and understand the works required.

Using the 6-facet information and a 'go-look-see' the existing building will be reviewed against the proposals to provide the refurbishment works and upgrade works required. Using this information and as part of a feasibility study a robust phasing plan will need to be prepared and any decant provision identified.

15 Conclusion: Short to Medium Term Projects.

Cancer Services – Expansion and Reconfiguration of The Existing Cancer Services

Cancer services are to be provided through a reconfiguration of the existing department, ENT OPD and includes a new build extension to provide the brief.

A feasibility study has been carried out but will require a refresh to ensure it is in line with the current brief.

The options require the relocation of the existing ENT OPD which is proposed to be relocated to an identified area. Following the relocation of ENT OPD the refurbishment works can commence within the area. The project may require a phased approach and/or decant provision required during the construction works.

The feasibility will include proposed general arrangement plans, MEP strategy and phasing/decant requirements.

Mortuary – Expansion and Reconfiguration of The Existing Mortuary

The mortuary services are to be provided as a reconfiguration of the existing department and includes a new build extension to provide the demand space required to achieve the brief.

A feasibility study has been carried out but will require a refresh to ensure it is in line with the current brief.

The options require the reconfiguration of the existing mortuary and may require a phased approach and/or decant provision required during the construction works.

The feasibility will include proposed general arrangement plans, MEP strategy and phasing/decant requirements.

Inpatient Wards – Rolling Refurbishment of Inpatient Wards Including Upgrade to MEP Services

The inpatient wards will remain in their current location, however, to build on the work which has already taken place, a programme of rolling refurbishment works is to be undertaken.

Using the 6-facet information and a further 'go-look-see' exercise, a proposal for the refurbishment works is to be prepared which will include internal refurbishment works and mechanical and electrical upgrades works.

The programme of works will be required in a phased approach and any decanting requirements will need to be identified as part of the proposals.

Inpatient Theatres - Rolling Refurbishment of Inpatient Theatres Including Upgrade to MEP Services and Creation of Storage

The inpatient theatres will remain in their current location, however due to their tired condition, a programme of rolling refurbishment works is to be undertaken.

Using the 6-facet information and a further 'go-look-see' exercise, a proposal for the refurbishment works is to be prepared which will include internal refurbishment works and mechanical and electrical upgrades works.

The programme of works will be required in a phased approach and any decanting requirements will need to be identified as part of the proposals.

16 Conclusion: Potential Opportunities – Long Term Projects.

New Build – to Provide Generic Outpatients and New Welcome Centre

The modelling has noted the requirement for additional outpatient clinic rooms. It is an aspiration of the Trust to develop any additional OPD rooms as generic clinic rooms which would have the flexibility of being used by multiple services.

There is a development zone opportunity created if the new maternity block was constructed, as it would free up the existing maternity buildings for redevelopment. Due to the condition of the existing buildings, they would be demolished to create the development zone for the new build outpatient's building.

There is an opportunity to create a Welcome Centre which would be located in a more prominent location than the existing main entrance.

A feasibility study would be required to explore the options for a new build for the outpatients' functions and welcome centre.

Residential Accommodation – to Either Refurbish Existing Accommodation or Provide New Build on Site.

Using the 6-facet information and discussions with the Trust, there is a desire to develop a strategy for the re-provision of Residential Accommodation due to the current condition of the existing buildings on site.

Potential opportunities to explore is refurbishment of the existing accommodation or provide as new build. Feasibility studies are to be carried out to explore the options to identify the brief, development zones and proposals.

17 Main Report Structure.

Salisbury NHS Foundation Trust

This exec summary report is supported by a detailed written report outlining the following sections and appendix. Please refer to these documents for further detail to support this summary.

1.0 EXECUTIVE SUMMARY
2.0 STAGE 1 - WHERE ARE WE NOW?
3.0 MEP INFRASTRUCTURE
4.0 NET ZERO CARBON POLICY OVERVIEW
5.0 BACKLOG MAINTENANCE COSTS
6.0 TOWN AND COUNTRY PLANNING
7.0 DIGITAL
8.0 MASTERPLANS
9.0 STAGE 2 - WHERE DO WE WANT TO BE?
10.0 GENERATION OF FUNCTIONAL CONTENT
11.0 EXCELLING IN PROVIDING EXCELLENT SUSTAINABLE HEALTHCARE
12.0 TRAVEL AND TRANSPORT
13.0 CAPITAL PLAN AND SCHEDULED PROJECTS – TRUST PRIORITY SPEND
14.0 NHS ESTATE IN RESPONSE TO COVID 19
15.0 DISPOSAL OF LAND
16.0 MODERN METHODS OF CONSTRUCTION
17.0 FIVE YEAR ESTATES STRATEGY
18.0 FLEXIBILITY
19.0 LOCAL AND OPERATIONAL ADAPTABILITY
20.0 ARCHITECTURAL DESIGN STRATEGY
21.0 MEP DESIGN STRATEGY
22.0 NET ZERO CARBON
23.0 DIGITAL
24.0 COST
25.0 STAGE 3 - HOW DO WE GET THERE?
26.0 DEVELOPMENT CONTROL PLAN OPTION
27.0 DEVELOPMENT CONTROL PLANS
28.0 MEP – INFRASTRUCTURE WORKS
29.0 ROADMAP TO DELIVERING NET ZERO CARBON
30.0 CONSTRUCTION DESIGN & MANAGEMENT REGULATIONS (2015)
31.0 DIGITAL – IDENTIFIED DIGITAL OPPORTUNITIES
32.0 COST
33.0 CONCLUSION
34.0 APPENDICES

Appendix

Design

A. Estates Strategy Stage 1-3 Report
B. Development Control Plans
C. Schedule of Accommodation
D. Departmental Plans
E. 6 Facet Surveys Information

MEP

F. Salisbury Estates Strategy Stage 1-3 MEP & NZC Report

Cost

G. Stage 3 Cost Report
H. Salisbury District Hospital Yrs 0-5 OB Cost Forms
I. Estates Strategy Stage 3 Backlog Report
J. Estates Strategy Cashflow
K. Stage 3 Cost Benchmarking Report
L. Stage 2 Cost Narrative Paper

Stage 2 Final Output Report

M. Output PDF

Understand.
Own.
Deliver.

PROJECT MANAGEMENT // DESIGN // STRATEGIC & TECHNICAL ADVISORY
COST CONSULTANTS // DIGITAL MANAGEMENT // BUILDING SERVICES

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CIBSE Directory of Member Practices

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In aid of Birmingham Children's Hospital Charity

CHANGE MAKERS

Report to:	Trust Board (Public)	Agenda item:	6.2
Date of meeting:	6th March 2025		

Report title:	Service Strategy Responses			
Status:	Information	Discussion	Assurance	Approval
	X		X	
Approval Process: (where has this paper been reviewed and approved):	CMO & CNO Clinical Validation			
Prepared by:	*Clinical Service Leads & Divisional Triumvirates* [Compiled by] Tony Mears, Associate Director of Strategy			
Executive Sponsor: (presenting)	Lisa Thomas, Managing Director			

Recommendation:

It is recommended that Board **note** the specialty level responses to master Trust strategy and **take assurance** regarding strategic alignment across the organisation.

Executive Summary:

In 2023 service and specialty level responses to the Trust strategy were commissioned by the executive team. This work was paused in late 2023 to support the community services tender process and resumed in late 2024 as we flexed our corporate resource to support our priorities in line with the Improving Together methodology.

Each of our 44 services have responded to the Trust master strategy, bringing specificity and clarity in how they are delivering on the strategy over the medium and longer term (with shorter term covered by OMS deployment via specialty scorecard agreements).

Services completed significant documentation, latterly condensed into this one-page per service format as a product for Board. This process gave our teams at the specialty level the opportunity to articulate both their vision for the future of their service, but also how our strategy is being delivered right across the organisation.

Vision

The Trust's vision focuses on providing an outstanding experience for patients, their families, and staff. This is supported by three strategic priorities:

- Improving the health and wellbeing of the **population**
- Working through **partnerships** to transform and integrate services
- Supporting our **people** to make Salisbury NHS Foundation Trust the Best Place to Work

Current Context and Challenges

Since publishing the previous strategy, the Trust has grown to over 4,400 colleagues serving an ageing population of 275,000 with significant complex co-morbidity amongst the patient subset of that population. Significant health

inequality exists, with the poorest neighbourhoods expecting to life 8 years fewer than the richest. Significant organisational, political, and demographic changes have occurred and continue to do so.

Key Demographic and Service Pressures

The Trust faces several significant challenges which emerged as common themes throughout the responses.

- An ageing population, with over-85s projected to increase by 87% by 2040.
- Growing complexity of health conditions, with 9.1 million people in England projected to have major illness by 2040.
- Digital transformation expectations from both patients and service requirements.
- Recovery of performance metrics while reducing health inequities.
- Increasing demand across specialties, particularly in services for elderly patients.

Divisional Responses

Each service area has identified short, medium and long-term priorities aligned with the Trust's strategic direction. Common themes across services include:

- Demography changes at the forefront of our services minds.
- Throughout clinical validation of the responses by CNO and CMO, it was clear the opportunities of EPR are opaque to many specialty leaders and support will be needed to help them maximise those opportunities.
- Workforce challenges, particularly around having the right staff with the right skills and developing new practice models.
- Service integration including primary and community care, and network development across a range of specialties i.e. Pathology.
- Health inequalities and the growing differential in access across socioeconomic groups and genders.
- Capacity and infrastructure.
- Quality and safety in line with national direction of travel and the trade offs that may be necessary in recovering our elective or financial position.

Next Steps

Further to providing an oversight of service level vision and strategy delivery, this work provides a platform for our interim strategy statement and serves as the initial engagement on how the organisation has been bringing our strategy and long-term intent to bear for our population.

This work has also prepared specialties to consider what actions they take regarding our new Strategic Initiative 'Designing services to meet population needs'.

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

Service Strategy Responses

2024

The 10 Year Plan

3 Strategic Shifts

Hospital to Community

- Moving more care from hospitals to communities is necessary to meet our changing needs for health care.
- People are living longer but with more complex health conditions. 9.1 million people in England are projected to be living with major illness by 2040, and people in the 10% most deprived areas can expect to be diagnosed with major illness a decade earlier than people in the least deprived 10%. Much of this projected growth relates to conditions managed mainly in primary care and community health services.

Analogue to Digital

- Technology holds huge potential for improving the quality of care. It can empower patients to better manage their health and improve efficiency.
- To realise these benefits, the NHS need to make the most of existing technologies, such as electronic patient records, as well as incorporating the latest advances in technology and AI.

Sickness to Prevention

- The NHS was not set up to go it alone. Rebuilding the nation’s health depends on a wider system of public services and support, with a new approach needed to place good health at the heart of national policy decisions.
- Spotting illness earlier and tackling the causes of ill health could help people stay healthy and independent for longer and take pressure off health and care services.

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

As part of our aspiration to be the Best Place to Work, we have listened to our staff and partners and reaffirmed that our vision and values remain supported and relevant as drivers for our new strategy.

Maintaining this vision at the heart of what we do will ensure that we priortise the things that are most important to our local communities and our people.

We will focus on improving the quality of the care and services we provide, the quality of the experience of coming to our hospital, the experience of working with us as a partner and the experience of working as part of our Team. We want all of these things to contribute to better health for our local population.

In order to deliver Our Vision, our Strategic Priorities are:

Improving the health and well being of the Population we serve

Working through Partnerships to transform and integrate our services

Supporting our People to make Salisbury NHS Foundation Trust the Best Place to Work

As an organisation focussed on delivering outstanding, high quality care for our population, we have developed our new strategic priorities to shape the development of our hospital and the services we provide.

This will help our communities, partners and our people identify, understand and contribute to the three strategic priorities that are most important to us.

Strategic Planning Framework: 2025-26

Vision

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

People
working for us

Population
our patients and their families

Partnerships
working with us

Vision metrics 7 – 10 years

- Increasing staff engagement
- Increasing staff retention
- Staff are treated equitably
- Reducing wait times
- Reducing patient harm
- Our population help improve our services
- Reducing inequity in healthy life years
- Reducing overall length of stay
- Organisational Sustainability

Strategic initiatives 3-5 years

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

Corporate Projects

Breakthrough Objectives 18-24 months

- Recognising and managing patient deterioration well
- Reducing patients' wait time to first outpatient appointment
- Increasing additional clinical staff retention
- Creating value for our patients

Since we published our strategy…

More than **4,000** people were born here and **1,870** people spent their last moments in our care.

Team Salisbury has grown to more than **4400** colleagues, and we serve a population of over **275,000**.

Our population have presented to us **in ED over 100,000** times.

Our poorest neighbourhoods can expect to live **8 years** fewer than the richest.

Implementing our Strategy

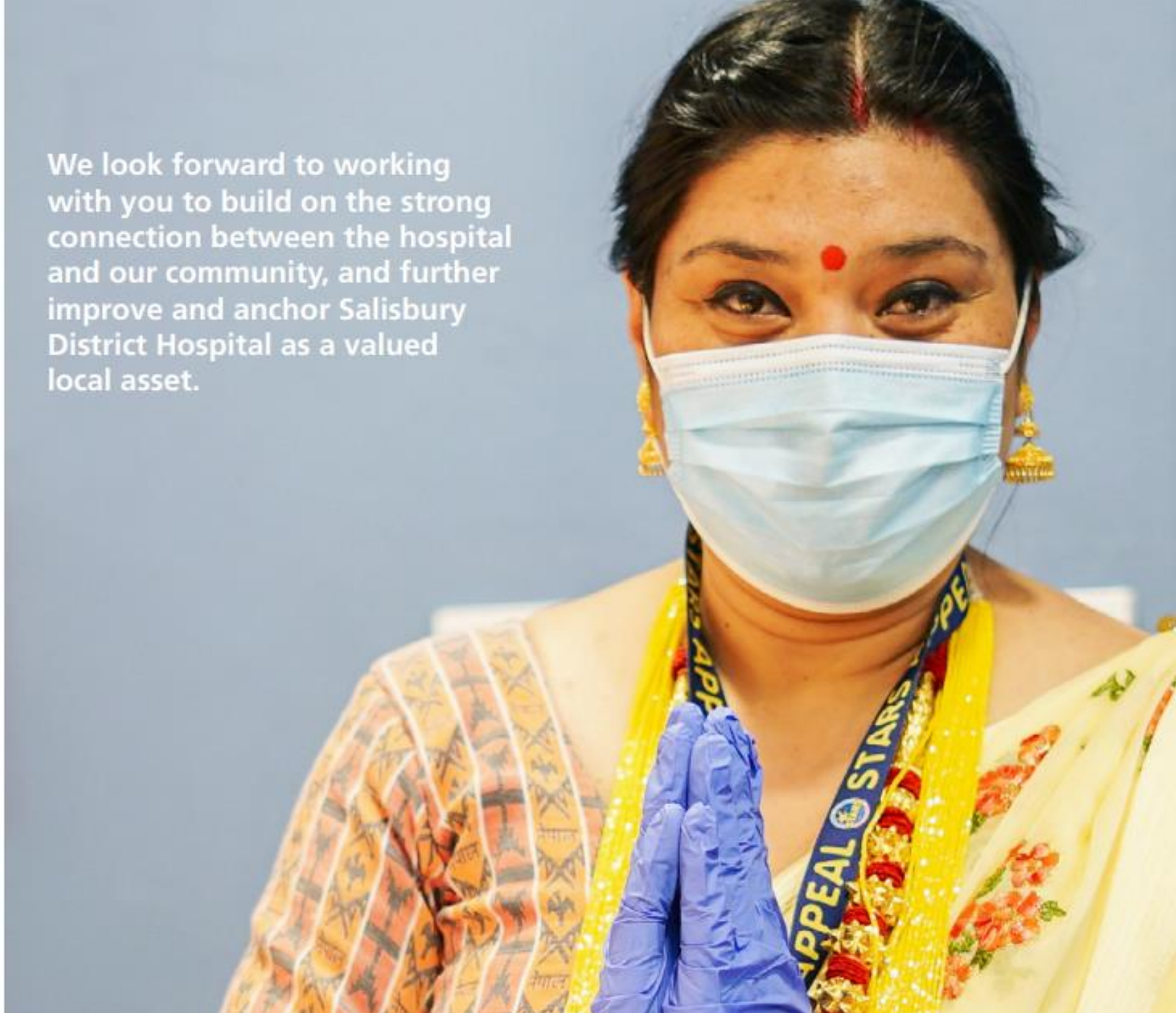
The publication of our strategy is just the start of the process to deliver our priorities. We will be responsive and flexible to adapt to the challenges that we will face in the next 5 years. In a period of significant challenge and change in our services, we need our strategy to underpin a clear prioritisation of the work we do during the recovery from COVID-19. Through Improving Together, our operational planning and the development of our breakthrough objectives will be driven by our three strategic priorities.

We want our strategy to be the focus which aligns the work we do as a hospital, in partnership with other agencies and on behalf and with our communities. To achieve this, we will engage widely with our staff, partners and communities about our strategic priorities, to help us shape specific and regularly updated and monitored plans to achieve them.

We will empower all of our staff to play their part in achieving our strategic ambitions. With our divisional and corporate teams, we will use a consistent way of undertaking strategic service reviews across our services and functions.

These reviews will focus on how our clinical and corporate services can contribute to the delivery of our strategic priorities, help us to make decisions about the future shape and configuration of our services and help us to ensure that our strategy remains the key driver for service planning and transformation.

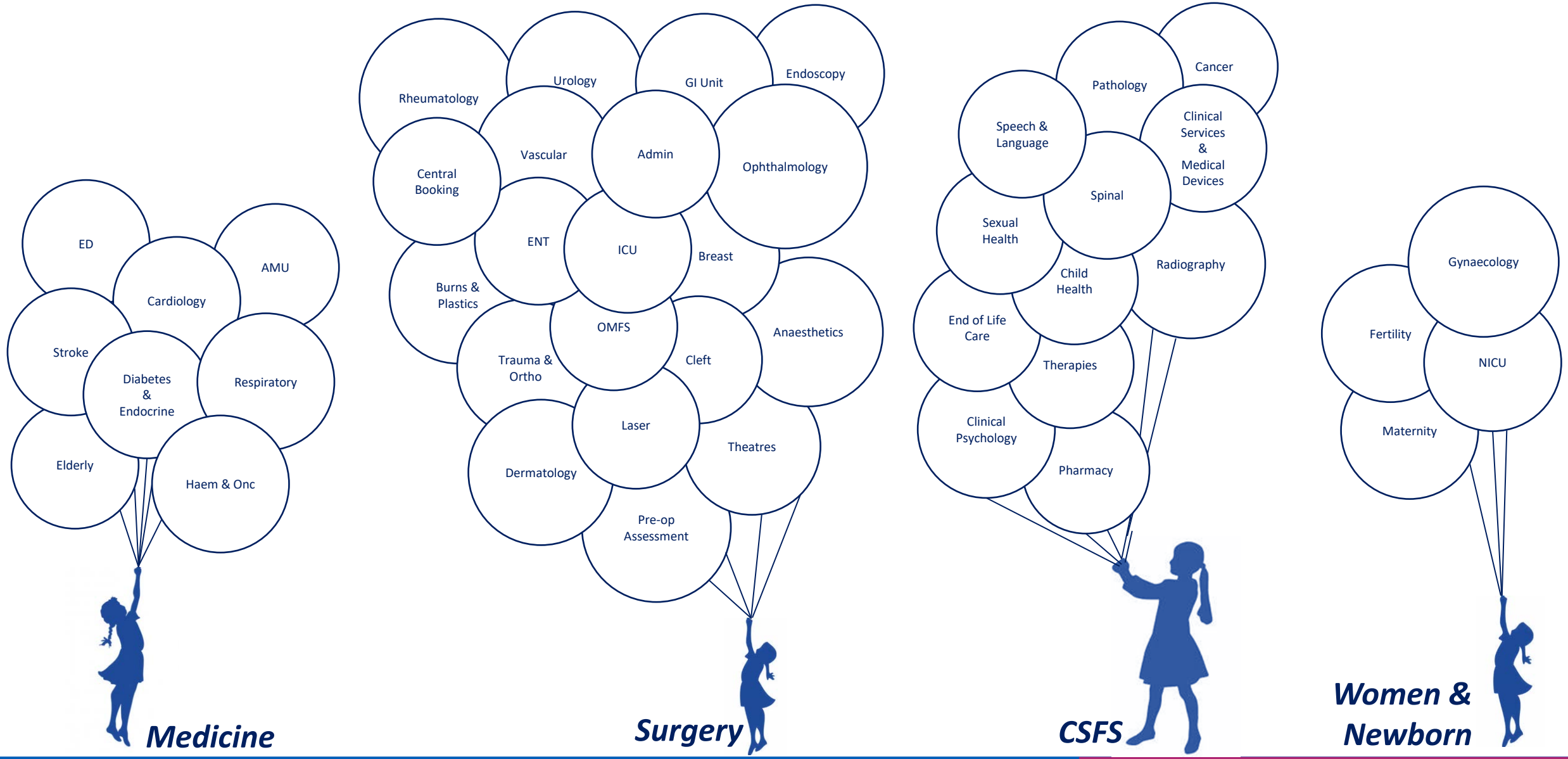
We look forward to working with you to build on the strong connection between the hospital and our community, and further improve and anchor Salisbury District Hospital as a valued local asset.



Throughout 2023 our services and specialties, as defined by divisions, responded to the Trust master strategy setting out how they would bring this to life and develop their services over the coming years.

This document provides a high-level summary of that work.

Our divisions, services, and specialties

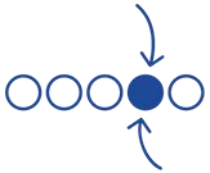


Shared response themes

While England's **population** is ageing rapidly, this trend is further pronounced in BSW and is more acute still in Wiltshire. Our population of over 85s will increase by more than 30% in the coming years, and by 87% come 2040 – driving enormous demand for our services and increasing the complexity of cases.

In addition to the centre pursuing more ambitions technological enablement, **digitisation**, and modernisation within NHS providers, our patients will have higher expectations and digital literacy.

Recovering performance in the time patients wait for care is going to be a multi-year programme of work which must sit alongside reducing the growing inequity in access to, and outcomes of, our services between the richest and poorest, and between men and women.



In addition to macro trends affecting our whole population there are more specific but impactful changes such as a growth of conditions like eating disorders, transgender patients, fertility needs, and changing wound care practice.

Medicine

AMU, Cardiology, Diabetes & Endocrine, Emergency Department, Elderly Care, Haematology & Oncology, Respiratory, and Stroke.

AMU

NHS Salisbury NHS Foundation Trust

People

- Continue to build on local processes that allows staff to have career progression, including support for Advanced Practice and CESR applications.
- Support staff to have opportunities to develop leadership and education skills.
- Deliver a workforce that meets the requirements to provide best patient care and experience

Population

- Prioritise developing closer links with AFU and OPAL given the expected 43% increase in over 65 population in the next 5 years. And co-locate with SDEC to support increasingly complex patients.
- Treat all patients as ambulatory until proven otherwise to help keep patients at home rather than in hospital beds.
- Delivering SDEC and Acute Medical Consultant cover 7-days per week
- Develop more ambulatory pathways such as the new Heart failure pathway that facilitates treatment as an outpatient rather than admitted saving an admission of 10 days+

Partnerships

- Work with Specialist Medicine to develop specialty in reach into AMU to support patients with specialist needs
- Work with radiology to protect dedicated space for AMU Diagnostics to support rapid decision making within AMU/SDEC.
- Develop aligned working with AFU and Frailty SDEC to support Medical and Frailty SDEC expansion
- Develop potential for AMU clinics to support Primary Care with complex medical patients through SDEC.

National

- 7 day working
- 7 day SDEC services and staffing
- NICE guidance evolving to cover support for ED targets and improved SAM targets.

System

- Use of the 'Future NHS' Platform to help develop and expand AMU SDEC provision with the wider national AMU Network.

Place

- Develop partnerships with the Wessex Emergency Care Collaborative (WECC) to deliver evidence based, recognised, and supported ACP training to our workforce.

Our key service relationships and interdependencies

- Hospital flow
- Specialty in-reach to AMU
- Primary care capacity
- ED/AFU
- Radiology provision

Our Priorities

Short term (12-18m):
- Consolidation of SDEC working
- Recruit to vacant posts
- Begin long term staffing model business case
- Development of virtual services, including virtual wards

Medium term (3-5y):
- Increase consultant numbers
- Development of specialty in reach service

Long term (7-10y):
- 7 day working
- SDEC workforce integration with primary care
- Integrated AMU/AFU footprint

Our patients today are…

Drawn from a large geographical footprint, ageing, and more frail than ever before.

Arrive with us through ever increasing modes of referral (111/SWAST/H@H/GP etc)

In 10 years our patients will be…

Older still, and more frail.

Larger in number, as housing and rebasing programmes continue.

Our demand is…
- 1/3 of patients over 80 years
- Increasing front door pressure (average take per month - 1100+ compared with ca. 900 in 2019), increasing complexity and age
- Higher numbers of speciality specific patients on the medical take (haematology/cardiology)

Our capacity to meet that demand is…
- Limited numbers of downstream beds and absence of flow impair function of AMU
- Increased demand on inpatient workload
- Despite yearly increase in Front Door attendances of 13%, on call medical team has not increased.

Cardiology

People

- Explore opportunities for new roles (clinical and non -clinical)
- Deploy new procedures and opportunities to attract, retain, and develop staff
- Support our people to adopt, adapt, and deploy the latest technological advancements and innovation.
- Support expected need for increased healthcare scientist workforce by supporting training programmes

Population

- Faster access to diagnostics
- Wherever possible, moving treatment and provisions of services closer to patients.
- Reducing length of stay for our patients
- Redesigning our cardiac rehabilitation service

Partnerships

- Participate in West of England ICCN – Heart Valve Workstream Group, Heart Failure/Breathlessness Workstream Group., ACS/Non-Stemi Workstream Group.
- Continue development of Community Diagnostics Centres
- Continue to work collaboratively to improve community Heart Failure Service.
- Continue MDT weekly discussions with UHS.
- Use capacity of Cardiac CT referrals in Nuffield, and Cardiac MRI in UHS.
- Work with GP partners to decrease inappropriate referrals

National

- Develop workstreams in conjunction with national healthcare inequalities framework, focusing on social deprivation and treating hypertension.
- Engage further with GIRFT guidance and aligning practices with recommendations

System

- Work continuously with the West of England networks to align services in line with national recommendations on developing network models.
- Develop a CDC service in line with regional CDC projects.

Place

- Develop stronger ties to UHS through ongoing MDT
- Improving collaboration with community services (specifically the Heart Failure Service).

Our key service relationships and interdependencies

- Internally: Radiology
- Externally: community heart failure service (provider relationship and physical space); CDCs

Our Priorities

Short term (12-18m):

- Improving utilisation of the cardiac suite
- Developing a sustainable model for TT1OP and follow-up referrals
- Developing clear career pathways for ANP/CNS/ACP workforces

Medium term (3-5y):

- Enhanced and co-located cardiology estate footprint
- Leverage EPR for specific heart failure pathways (similar to Royal Free model.

Long term (7-10y):

- Become the BSW electrophysiology centre
- Ensure latest advances in cardiological care are available to our population
- Prevention of structural heart disease.

Our patients today are…

Of mixed age and demographics from right across our geographical catchment.

In 10 years our patients will be…

Older and more complex.

Recipients of specialist electrophysical services for all of BSW.

Our demand is…

- Driven by poor flow and wait times. Delays in patients arriving on Tisbury ward leads to longer LoS in AMU.
- Driven by high referrals from primary care

Our capacity to meet that demand is…

- Limited due to an increasing number of referrals, work is ongoing to maximise our clinics to meet ongoing demand

Diabetes

NHS Salisbury NHS Foundation Trust

People

- Succession planning for future service resilience.
- Recruit, train, and retain nurses, dieticians, consultants, and podiatrists.

Population

- Annual reviews in consultant led clinics resulting in PIFU, dietetics follow up, or a higher cadence of consultant oversight.
- Continued training development for Type 1 diabetes patients

Partnerships

- Closer working with primary care (A&G) on type 2 diabetes management.
- Appropriate pathway integration with community provider(s).
- More integrated digital systems for information sharing.

National

- 7-day cover to support GIRFT
- National audit
- NICE guideline full implementation
- 'Obesity crisis' and likely national policy focus in years ahead, including GLP-1 programme.

System

- Roll-out of Hybrid Closed Loop pumps
- Continued engagement with local GIRFT initiatives

Place

- Collaboration with community diabetes teams

Our key service relationships and interdependencies

- Internally: surgical and oncology referrals, maternity
- Externally: community provider(s), UHD vascular hub, UHS pituitary service, ICB network, primary care

Our Priorities

Short term (12-18m):
- Resolve community service provision.
- Introduce Roche diabetes platform
- 1st cohort of patients on closed loop pumps.

Medium term (3-5y):
- Recruitment and succession planning resolved.
- Reduce diabetes and endocrine bed base.
- Standardise triage for new endocrine patients.

Long term (7-10y):
- 7-day service
- Standardise triaged and pre-investigation fully embedded
- Fully embedded A&G pathway for diabetes

Our patients today are…

15-20% of all inpatients.
Benefitting from recent technology developments.
In the case of type 1, 80% are using technology such as libre or Dexcom to manage their condition.

In 10 years our patients will be…

Making use of a greater number of technologies and medications targeted at helping patients manage type 1 diabetes.

GLP-1 receptors will have an impact on population wide diabetes prevalence.

Our demand is…
- Beyond our capacity to meet, particularly in type 1 diabetes and close loop pumps.
- Greater complexity of type 2 diabetes
- 60% increase in gestational diabetes cases compared to 19/20.
- Increasing endocrine demand from oncology.

Our capacity to meet that demand is…
- Limited, in the case of closed loop pumps we can do 50 a year, 450 are eligible.
- Dependant on primary and community providers handling their pathway elements.
- Capacity is fixed despite growing demand.

ED

People

- Focus on recruitment and retention.
- Develop more career pathways within the department including into leadership and advanced practice.
- Support our workforce to provide the best possible patient experience.

Population

- Encourage engagement with the population over the appropriate setting for their needs.
- Ensure alternative access points to avoid presentation.
- Focus efforts on population groups identified in the CORE20PLUS5 model and Wiltshire JSNA.

Partnerships

- Working with the ICB Group, and Medvivo to deliver a range of services in partnership for our population needs.
- Working with commissioners and primary care on remote provision of urgent care where appropriate.
- Work with SWAS FT to facilitate training and development of relevant staff groups.

National

- Evolving national models such as SDEC, RAMBO, and RATT.
- National considerations of paediatric emergency care pathways.

System

- Continued development of trauma audit and research network (NMTR), service to better integrate into the Wessex trauma network (WTN).

Place

- Develop partnerships with the Wessex Emergency Care Collaborative (WECC).
- Closer working with community and primary care on admission avoidance.

Our key service relationships and interdependencies

- Internally: flow, radiology
- Externally: community mental health, primary care, ambulance services

Our Priorities

Short term (12-18m):

- Complete future workforce plan in line with ECIST/GIRFT.
- Continue to develop streaming model.

Medium term (3-5y):

- **Design for 'future'ED in line with pathway and demographic need.**
- Evolve paediatric Emergency care model.

Long term (7-10y):

- Rebuild the ED

Our patients today are…

20% are over 75.
25% are paediatric attendances.
Cardiology, respiratory, and frailty the highest using presentations.
Low and minor illness presentations due to deprivation level in the community.

In 10 years our patients will be…

Older, more complex, and more likely to present in our already high presentation specialty areas.

Likely to have higher acute mental health presentation.

Our demand is…

- Increasing 12%, which is above the national average of ~9%.
- Our average acuity score is also above the national average, driving complexity in our demand.
- Higher at weekends

Our capacity to meet that demand is…

- Limited as evidenced by missed 4h performance.
- Limited at weekends when demand is higher and staffing lower.
- Limited by absence of other options like on site GP or walk in centre.

Elderly Care

NHS Salisbury NHS Foundation Trust

People

- Focus on recruitment and retention.
- Develop career pathways that provide different types of role, including in the community.
- Develop advanced practice so as to reach into other specialties and support patients and staff there.

Population

- Ensuring access to earlier intense intervention to support patients to stay at home (through services such as AFU).
- Early advanced care planning.
- Increased provision of wrap around care for patients.
- All patients over 65 will have access to elderly medicine specialists regardless of admitting specialty.

Partnerships

- Working to integrate services with primary and community care colleagues.
- Delivering virtual wards with technology partners.
- Building deeper partnerships with social services, elderly leads at the ICB, and SWASFT.

National

- All patients over 65 should receive a clinical frailty score on attending ED.
- Delivery of NICE [CG124] which states that all patients admitted with a fractured Neck of Femur should receive Orthogeriatric assessment and aftercare

System

- System approach to Hospital@Home.

Place

- Working in Collaboration with our community partners to provide Hospital@Home
- Collaboration with GP 's in the locality to establish a dedicated Frailty SDEC to address admission avoidance.

Our key service relationships and interdependencies

- Internally: Site Team, Discharge Team, Parkinson's Lead, Dementia & Delirium Lead, OPAL Team & Adult Social Care.
- Externally: HCRG Community Services Provider, GP'S in the locality.

Our Priorities

Short term (12-18m):

- Fully embed AFU into elderly care working.
- Ensure adequate staff and model to cover clinical areas.
- Work on reducing falls and deconditioning

Medium term (3-5y):

- Ensure robust staffing and care model for Imber.
- Further integration with community services.
- AFU / SDEC alignment and Trust-wide frailty training.

Long term (7-10y):

- Succession planning
- Fully integrated service with resource moved to the community.
- Rotational roles between community and acute teams.

Our patients today are…

Frail elderly with multiple co-morbidities.
Some social admissions when community services cannot meet demand.
Younger patients with neurological conditions such as MS.
Morbidly obese patients with medical and rehab needs.

In 10 years our patients will be…

The vastly expanded cohort of over 65s and over 80s, representing perhaps the most drastic demand profile change on SFT services.

This cohort may also be sicker as healthy life expectancy is falling, while absolute life expectancy remains static.

Our demand is…

- Increasing in line with projections for Wiltshire to increase an above national average increase in population age.
- Rising in line with new models of care such as hospital at home, and a lack of primary care capacity.
- Increasing regarding internal education and AFU

Our capacity to meet that demand is…

- Limited by staffing of current service model.
- Limited by fluctuations in nursing staff skill mix, including retention of those staff.
- Limited by therapies capacity.
- Limited by community capacity and flow

Haematology & Oncology

People

- Introduction of flexible working wherever possible to aid recruitment and retention.
- Build new staffing models to develop career pathways and reduce single points of failure.
- ACCEND framework used to develop non-medical staff to deliver outstanding care.

Population

- MCCU – Providing cancer care in the community, reducing patient travel and providing 1:1 care closer to home.
- Improving pathways of self-administration and closer to home delivery for treatment, keeping people at home and maximising capacity

Partnerships

- Radiotherapy delivery through partnership with UHS, UHD and RUH, and other Trusts.
- Third sector organisations (Macmillan, HOPE)
- SWAG Cancer Alliance and Wessex Cancer Alliance
- Diagnostic laboratories: UHS / specialist genomics / laboratory networks.

National

- Number of NICE approved SACT treatments and indications of increasing.
- Move to personalised medicine
- 7 day AO service delivered using SDEC

System

- Specialist commissioning moving to ICB

Place

- Seek ways of delivering care closer to home
- Wessex and SWAG
- Primary and community care involvement and engagement

Our key service relationships and interdependencies

- Internally: pharmacy, Aseptics, radiology, cancer MDTs, pathology.
- Externally: UHS as regional hub providing multiple services to SFT, STARS, SWAG and WESSEX CA, HOPE, Macmillan.

Our Priorities

Short term (12-18m):
- Stem cell transplant business case.
- Shared oncology plan with UHS.

Medium term (3-5y):
- Increased home and self-administration of systemic anti-cancer therapy (SACT).
- Aim to keep patients at home through SDEC, ambulatory, and virtual ward pathways.

Long term (7-10y):
- Develop as a CAR-T centre
- Enhanced cancer treatment environment and estate.
- Deliver all SACT and Immunotherapy at SFT

Our patients today are…
Patients at all stages of disease (diagnosis to EOLC).
Stem cell treatment patients.
Still travelling to UHS in some cases as we do not offer all tumour sites.
Not radiotherapy patients, this is delivered at UHS, Bath, and Poole.

In 10 years our patients will be…
Multiple lines of palliative treatment and in receipt of more complex biological and targeted treatments.
Older in line with broader demographics, and more complex to treat.

Our demand is…
Driven by greater complexity and co-morbidity requiring consultant and MDT input.
Increasing for stem cell transplants, nurse led pre-assessment, and as a consequence of more NICE approved treatments;

Our capacity to meet that demand is…
Limited as regards pharmacy capacity to make SACT.
Likely to be limited in future as the same staffing model tries to deliver an increasing variety and number of treatments.

Respiratory

People

- Develop a workforce model that encourages recruitment and retention.
- Develop a process that allows staff to have a career progression and opportunities to move into different roles including leadership, advance practice and education.
- Expand advanced practice to enable a service that is able to in reach into other specialties for support.

Population

- Improve the lives and outcomes of people with respiratory disease by diagnosing and treating conditions earlier and making sure that people with respiratory disease are receiving the right medication.
- Targeted lung health checks – early diagnosis.
- Patient education.

Partnerships

- Increased community and primary care collaboration.
- Enhanced engagement with social care and the local authority.

National

- Draft NICE guidance exploring how to treat more respiratory patients out of hospital.
- Direction of travel to escalate provisions at the local and network level to develop discharge support systems.

System

- Group collaboration on pathway and service improvement.

Place

- SWAG and Wessex networks for improvement.
- Increased engagement with community and primary care.
- Closer working with the local authority.

Our key service relationships and interdependencies

- Internally: radiology, day surgery
- Externally: Targeted Lung Health Check

Our Priorities

Short term (12-18m):
- Create capacity to service increasing demand.
- Upskilling of Laverstock workforce.

Medium term (3-5y):
- Highly specialised nurse and AHP led clinics.
- Respiratory high care unit establishment.

Long term (7-10y):
- Completed transition of Dorset sleep service.

Our patients today are…
A mixture of all ages and demographics. Respiratory disease patients, smokers, obese patients with medical and rehab needs. Chronic illness patients that need longer term input.

In 10 years our patients will be…
Suffering the consequences of vaping, increasingly obese, older, and co-morbid.

Served by an ageing workforce.

Have high expectations of their care.

Our demand is…
Increasing, particularly across lung function testing, sleep services, oxygen service, consultant clinics, and seasonal presentations.

While running above target, time to first outpatient is broadly static.

Our capacity to meet that demand is…
Limited by long waits for physiotherapy and a lack of experience in some areas with Nasal high flow.

Pressurised by higher RSV, Covid, and Flu cases.

Stroke

People

- Develop opportunities for training and progression within and beyond role to support recruitment and retention
- Develop education programmes aimed at improving recognition of Stroke within the hospital

Population

- Provision of needs based acute stroke rehabilitation with focus on person centred approach to early rehabilitation following stroke and supporting discharge as soon as appropriate.

Partnerships

- Working in collaboration with partner organisations, specifically community partners and voluntary organisations (Stroke Assoc) to enable efficient and effective transfers of care and working together to support service delivery across the pathway.
- Working with educational providers to become a partner for students to conduct their placements.

National

- RCP guidelines, SFT to pursue A rather than A/B rating.
- SNNAP guidance changes effective for Q2 2024.

System

- System approach to rehabilitation and recovery.
- Leveraging system and digital scale to enable different types of rehabilitation provision.
- Working within the system to provider CT profusion service

Place

- Flow and therapy intensity work, and collaborative working with community provider(s).

- Internally: Radiology, Site team, ED
- Externally: UHS, community providers, local universities

NHS Salisbury NHS Foundation Trust

Our Priorities

Short term (12-18m):

- Continuing workforce model innovation utilising senior nurses
- Develop Education programme focusing on diagnosis and recognition
- Improve the provision of therapy minuets

Medium term (3-5y):

- ESD model enabling discharge to community or specialist neuro bed base.
- 24 rehabilitation
- 7 day therapy service

Long term (7-10y):

- BSW stroke rehab and recovery hub model.
- New roles and practice embedded

Our patients today are…

Stroke patients ranging from those with minimal symptoms and a 1-2 day LoS, to those with complex and severe disability with LoS up to six weeks.

All patients require therapy input, with 75% requiring OT/physio interventions too.

There are also some non-stroke neuro needs

In 10 years our patients will be…

Benefitting from treatment advances, older, cared for closer to or at home, and requiring more personalised rehabilitation plans in response to complex co-morbidity.

Our demand is…

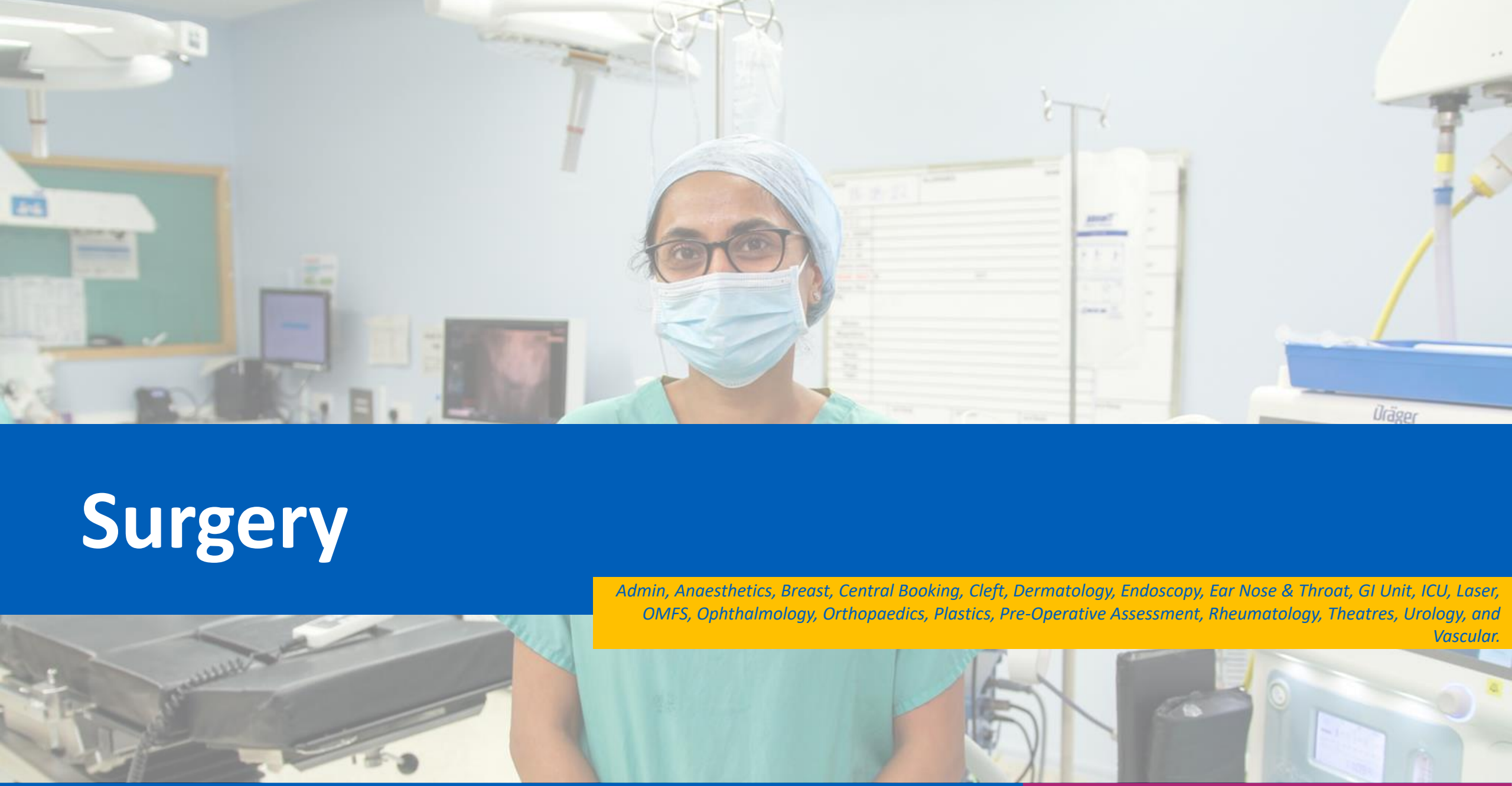
Increasing by 60% from 2015 to 2025.

Increasing further still as our population ages.

Growing for complex rehabilitation in the build up to, through, and after discharge.

Our capacity to meet that demand is…

Currently appropriate, and allows for us to meet key performance targets – however this is unlikely to be sustainable in the face of demographic shifts and without additional neuro rehabilitation capacity / dedicated beds.



Surgery

Admin, Anaesthetics, Breast, Central Booking, Cleft, Dermatology, Endoscopy, Ear Nose & Throat, GI Unit, ICU, Laser, OMFS, Ophthalmology, Orthopaedics, Plastics, Pre-Operative Assessment, Rheumatology, Theatres, Urology, and Vascular.

Admin

People

- The admin team is committed to:
  - responding to staff survey results with listening groups for Admin staff
  - conducting wellbeing conversations
  - improving flexible working opportunities
  - facilitating development opportunities for staff

Population

- High-quality NHS administration can enhance patient experience, improve care, and create a better work environment for staff. It's crucial for addressing inequalities, as poor admin disproportionately affects certain groups.
- Our admin function will help us meet our wait metrics linked to Trust vision metric.

Partnerships

- Delivering Financial sustainability in BSW – The secretarial teams are directly involved with ensuring referrals that require funding applications / prior approval are managed appropriately to reduce wasted clinic appointments and frustrating experiences for patients and clinicians.
- Working with BSW for process mapping for shared EPR
- Working with colleagues in Cleft Network.

National

- Further participation in the Proud to be Ops movement to foster a collegiate atmosphere and promote shared learning opportunities from further afield

System

- Implementation of shared EPR
- Shared collaboration on admin best-practice

Place

- Roll out of Healthroster across all specialties resulting in improved productivity

- All surgical specialties clinical teams, medical records, central booking

Our Priorities

Short term (12-18m):

- Division-wide review of admin function
- Use of voice recognition, NHS App and other digital tools to improve productivity
- Create career pathways within admin structure

Medium term (3-5y):

- Maximise opportunity of shared EPR introduction
- Use of AI technologies to drive further productivity gains

Long term (7-10y):

- Leverage developments in digital pathways and systems to increase efficiencies and key performance indicators

Our patients today are…

Those served by the surgical specialties and broadly in line with local population demographics.

In 10 years our patients will be…

Changing in line with wider demographic shifts, increasing in age and complexity.

However, the populations digital literacy and expectations of healthcare will also evolve.

Our demand is…

- Increasing as performance recovers and population grows
- Over 100,000 letters typed annually
- Weekly, monthly and annual surgery rotas
- National database submissions

Our capacity to meet that demand is…

- Limited due to workforce challenges (high volumes due to retire and inability to attract at Band 2&3)
- Constrained by paper systems
- Potentially unlocked by shared EPR and AI technologies

Anaesthetics

People

- Finding ways to support flexible working amongst the clinical workforce. Develop a workforce model that encourages recruitment and retention.
- Develop a process that allows staff to have a career progression and opportunities to move into different roles including leadership, advance practice and education.
- Expand advanced practice to enable a service that is able to in reach into other specialties for support.

Population

- Increasing theatre throughput
- Reducing waiting times for surgery
- Allowing patients to return to improved levels of health sooner.
- Increasing complexities/comorbidities/health inequalities - understand impact on current staffing model

Partnerships

- Working with surgeons and primary care to reduce patient LoS and analgesia use
- Preoperative service working with medical specialties to optimise patients prior to surgery.

National

- GIRFT-
- Deliver effective pre operative assessment
- Streamline surgical pathway
- Reduce cancellations

System

- Collaboration working with BSW partners to share best practice
- Population modelling with BSW/ICB- understanding impact on Anaesthetics service
- Partnering with primary care to optimise management of chronic pain.

Place

- Reduced numbers of clinicians being trained in the speciality of Anaesthetics-
- Collaboration with the Wessex Deanery.
- Running training courses for regional Anaesthesia
- Development of research funding.

Our key service relationships and interdependencies

- Ward bed capacity across specialties to facilitate discharge from recovery.
- Operating theatre staffing including post operative care ward.

Our Priorities

Short term (12-18m):

- Open additional theatres to support elective recovery plan.
- Recruitment
- Agree workforce model
- Optimising Chronic pain treatment/ Develop Chronic pain service
- Develop the preoperative service

Medium term (3-5y):

- Provision of high quality anaesthetic care to support enhanced recovery/early discharge.
- Introduction of EPR systems
- Development of surgical hubs
- Role of the Sulis project

Long term (7-10y):

- Review impact of population growth
- Establish surgical hubs and workforce model
- Succession planning

Our patients today are…

Those in receipt of elective and emergency surgery.

Those receiving maternity care.

In 10 years our patients will be…

Significantly older, with pain services likely to be stretched by the 30% increase in over 65s by 2025.

Our demand is…

- An increase from 185 to 197.5 PAs per week of anaesthesia to support our elective recovery plan.
- The need to provide an out of hours service to theatres, obstetrics, and intensive care.

Our capacity to meet that demand is…

- Short 4.7 WTE, 6.6 WTE including the elective recovery plan commitment.

Breast

People

- Ensure mammographers are working to the top of their license and trained to report.
- Develop regional partnership working to support the service, i.e. with UHS via shared plastics workstream.
- Support future workforce planning including consultant succession planning.

Population

- One stop clinics and enhanced health promotion to reduce risk and support early diagnosis/impact of health inequalities work.
- Continued support for preoperative assessment clinics and local support and social groups to support patient population out of hospital. Including the wellbeing programme.
- Increased recruitment to clinical trials.

Partnerships

- Continued leadership role across the Wessex Breast Network.
- Deeper partnership with local primary care including training for the expansion of the one-stop service and family history clinic.

National

- GIRFT breast reconstruction standard.
- SFT focus to be on performing better against national comparators.

System

- Closer working across BSW and leveraging the role of our anchor institution to further proactive engagement regarding the service.

Place

- Wessex pathology, UHS partnership, and Wessex Breast Network – relationships to deepen and mature.

Our key service relationships and interdependencies

- Internally: radiology, cancer, plastics
- Externally: primary care, AHA partners, UHS, Wessex Breast Network

Our Priorities

Short term (12-18m):

- Achieving and maintaining 28d faster diagnosis standard
- Improving wait time for delayed reconstructions
- Strengthening radiology capacity

Medium term (3-5y):

- Consider alternative workforce options (GPSI's, Consultant mammographers/Practitioner pathways).
- Increase plastics capacity in partnership with UHS.
- Increase pathology capacity across Wessex.

Long term (7-10y):

- Consultant workforce succession planning.
- Equipment resource to support enhanced capacity.

Our patients today are…

Symptomatic breast patients
Cancer patients
Reconstruction patients
Follow up care cases

In 10 years our patients will be…

Significantly older, and therefore with more demand for complex diagnoses and reconstruction.

Our demand is…

- Increasing to ~3600 referrals in 23/24 up from 3000 in 22/23 – growth that while currently manageable will not be in future.
- 11% of referrals convert to cancer diagnosis.

Our capacity to meet that demand is…

- Provided by a team of three consultants
- Currently adequate (despite fluctuations beyond capacity in winter for surgery and reconstruction).

Central Booking

NHS Salisbury NHS Foundation Trust

People

- Improved working environment
- Wellbeing conversations and increasing appraisal compliance rates
- Flexible working opportunities as turnover is reduced
- Structuring the team to support more development opportunities for staff

Population

- High-quality NHS administration can enhance patient experience, improve care, and create a better work environment for staff. It's crucial for addressing inequalities, as poor admin disproportionately affects certain groups.
- Our admin function will help us meet our wait metrics linked to Trust vision metric.

Partnerships

- Largely with primary care and other referrers, including private, fostering relationships to achieve better referrals and an understanding of pathways.

National

- Contribute to NHS 2025/26 priorities, eliminating 65week waits and improving admin productivity

System

- Implementation of shared EPR
- Shared collaboration on bookings best-practice

Place

- Closer working with primary care to improve referrals and referral pathways

All specialties clinical teams, medical records, SSL, theatre management team, performance team, insourcing teams, local Independent Healthcare providers and associates

Our Priorities

Short term (12-18m):

- Embed new team structure
- Develop KPIs to measure productivity
- Reduce turnover and improve morale
- Eradicate 65ww and contribute to RTT recovery.

Medium term (3-5y):

- Maximise opportunity of shared EPR introduction
- Use of AI technologies to drive further productivity gains
- Support the recovery of RTT to 18 weeks

Long term (7-10y):

- Leverage developments in digital pathways and systems to increase efficiencies and key performance indicators

Our patients today are…

Those served across all Clinical Divisions and broadly in line with local population demographics.

In 10 years our patients will be…

Changing in line with wider demographic shifts, increasing in age and complexity.

However, the populations digital literacy and expectations of healthcare will also evolve.

Our demand is…

- Time taken to process referrals
- Driven by clinic and theatre capacity and ulitisation.

Our capacity to meet that demand is…

- Limited due to workforce challenges (recruitment and retention of Band2 & 3) Potentially unlocked by shared EPR and AI technologies

Cleft

People

- Recruit to missing core staffing posts within the service and increase training in regards to the cleft patient pathway for these new team members
- Improve wellbeing of team members following recent challenges
- Focus on additional consultant support to deliver high quality service across the network

Population

- Continue to serve the cleft population within our catchment areas
- Ensure access to PHDU/PICU care post-operatively for our more complex patients
- Prioritise patient groups experiencing health inequality by making restorative dentistry services available locally rather than having to travel to the Oxford centre
- Have a social media presence where service users can interact freely with the multidisciplinary team
- PPI involvement

Partnerships

- Work with other NHS Trust providers and community based services to ensure our patients can access care locally as part of their cleft patient pathway journey
- Ensure that the national CRANE database for cleft services is constantly evolving with audit data to facilitate annual reports reflecting our outcomes
- Working alongside the TV&W ODN to improve and maintain service for our paediatric patients

National

- Due to be an active participant in the NIHR Cleft@18-23yrs research programme starting in early 2025
- Participating in the submission of SSQD data to demonstrate our performance against the national NHSE KPI for primary cleft lip and palate surgery

System

- Working with the TV&W Paediatric Operational Delivery Network (ODN) to ensure the service is sustainable and that KPIs can be achieved
- Await information on whether cleft will move from specialist commissioning block contract to regional ICB funding

Place

- Joint network working between Salisbury and Oxford
- Access to external SDH inpatient support for complex patients where appropriate (Oxford or Southampton)
- Clinics on Isle of Wight for our patients who struggle to access SDH

Our key service relationships and interdependencies

- Internally: orthodontics, OMFS and lab, theatres, wards, safeguarding, audiology/ENT, speech therapy, clinical genetics, play therapist, paediatric respiratory medicine
- Externally: regional clinical cleft networks, tertiary hospitals with PHDU/PICU support, NHSE, TV&W ODN, CFSGBI (Craniofacial Society)

NHS Salisbury NHS Foundation Trust

Our Priorities

Short term (12-18m):

- Address staffing gaps in service provision to enhance the patient experience through recruitment of: restorative dentist, paediatric dentist, additional cleft nurse & OMFS surgeon following retirement
- Establish a robust pathway for our highly complex/cardiac patients
- Continue work with the TV&W Paediatric ODN to further progress recommendations from our NHSE deep dive review in 2022

Medium term (3-5y):

- A clear and robust transition pathway for patients aged teen to adults within the service
- Digitisation of cleft notes and integrated EPR access across both hub sites
- Ability to support national TIG fellowship scheme

Long term (7-10y):

- Purpose built cleft facility on SDH site
- Accessing additional theatre capacity at OUH site
- Digital archive suite for all photographic, dental and speech audit records

Our patients today are…

- On average 1 in every 700 births
- More occurrences of complexity and associated syndromes alongside the cleft diagnosis
- Active within the cleft service from 0-20 years of age as per the patient pathway

In 10 years our patients will be…

- Driven by fluctuations in birth numbers but likely to increase with growth in population of the areas we serve
- Requiring multi-specialty care with access to local support within the community

Our demand is…

- Driven by birth numbers and referrals when patients move into our catchment areas so fluctuates yearly
- Expected to increase over the next 5 years in relation to second opinion/speech related referrals

Our capacity to meet that demand is…

- Currently stretched as a single consultant practice based on site at Salisbury
- Dependent on patient needs in regards to complex post-op care and appropriate access to services
- Potentially vulnerable to winter pressures in relation to ward (Sarum) capacity

Dermatology

NHS Salisbury NHS Foundation Trust

People

- Optimise speciality training, review workforce model- multidisciplinary roles- ie nurses, pharmacists and Gp's
- Agree workforce model. Continue to build on local processes that allows staff to have career progression, including support for Advanced Practice and CESR applications.
- Support staff to have opportunities to develop leadership and education skills.
- Deliver a workforce that meets the requirements to provide best patient care and experience

Population

- Reduced waiting lists/follow up
- Public education campaign on skin cancer and checking skin/understanding impact of health inequalities
- Support and advice available 5 days a week for previous patients.
- Establish recommended patient pathway

Partnerships

- Network across BSW
- Develop regional/subregional services
- Greater working with primary care and community teams-
- Implementation of digital systems /uptake of digital technology.

National

- New and higher cost medicines on the horizon (i.e., JAKS).
- Changes to acne medication protocol/introduction of new biologics.

System

- Regularised group partnership working.
- Role of the dermatology service at SFC/ICB
- Working with new community services provider to bring BSW community dermatology offer up to the standard of similar geographies.

Place

- Increased primary care engagement planned.
- Harmonising the Wiltshire offer between the north and south in partnership with primary and community care providers.

Our key service relationships and interdependencies

- Internally: Plastics, central booking
- Externally: Primary care, ICB, community provider(s).

Our Priorities

Short term (12-18m):

- Reduce number of patients waiting over 52 weeks/Reduce follow ups
- Implementation of the MOHS service.
- Develop workforce model- Opportunities to introduce practitioner model-
- Understand current demand/capacity
- Introduce tele dermatology service

Medium term (3-5y):

- Review skin cancer pathway-
- Agree workforce model- consultant/medical workforce-25% gap.
- Review 7 day working
- Recover RTT position to 18 weeks

Long term (7-10y):

- Short wait lists and additional consultant capacity
- ANP clinics
- Happy, educated staff in a positive environment

Our patients today are…

From across the full spectrum of age demographic and including acne treatment, allergy testing, 2ww patients, minor surgery, biologic and systemic treatment for managed conditions like psoriasis.

In 10 years our patients will be…

Likely greater numbers of patients requiring biologics as treatments change.

As the population grows in the 65+ and 85+ groups we will see a rise in skin lesion cases.

Our demand is…

- Increasing in line with broader demographic demand.
- Supported by an outsourcing agreement.

Our capacity to meet that demand is…

- Trust only capacity to meet demand would only cover ~30% due to the outsourcing picking up the rest. If skin cancer was included this would be just 10%.

Endoscopy

People

- Maintain optimisation of 4 room capacity creating value for our patients by maximising activity and productivity
- Embed Improving Together to empower our staff to make changes.
- Leverage the advantage of being within the GI Unit to offer training more widely in the organisation and offer training to our staff in the wider GI Unit / region.
- Develop workforce model-
- Supporting staff throughout the unit to join regional networks such as green endoscopy network / ERCP networks

Population

- Develop pre-operative assessment process to support the added complexity of an ageing population.
- Amendment of pathway for those with unique needs and different experiences of healthcare – i.e. introduction of quiet spaces.
- Introduction of a faecal calprotectin pathway. This would reduce waiting times on our gastro outpatient waiting list and speed access to definitive diagnosis for patients with suspected IBD.

Partnerships

- Development of the service across the group to improve resilience.
- Positive relationships with equipment supplier, including innovative ways to introduce new tools and manage demand.
- Regional endoscopy and cancer network engagement, which delivers access to training funding.
- Closer working with primary care.

National

- FIT testing introduction.
- NICE recommendations regarding specific stents.
- Bowel cancer screening programme expansion.

System

- ECRP service sustainability – new SLA with UHS.
- Regional endoscopy networks have provided huge support for training and this will continue.
- Exploration of out of hospital diagnostic endoscopy across the ICS.

Place

- Closer working with primary care regarding referrals.
- Potential to support IBS as well as IBD in out of hospital settings.

Our key service relationships and interdependencies

- Internally: Shared EPR programme, GI Unit, SSL
- Externally: Regional networks (inc. cancer), UHS, Group colleagues.

Our Priorities

Short term (12-18m):

- Develop more robust pre-operative assessment for uppers and lowers.
- Invest in endoscopy training.
- Develop understanding of patients on wait lists – P-CAP
- Agree/implement ERCP service model
- Recover DM01 performance

Medium term (3-5 years)

- Resilience of therapeutic endoscopy service.
- Establish role of CDC's – and endoscopy services
- Maintain JAG accreditation.
- Relocate Endoscopy Service to include Room 5

Long term (7-10y):

- Develop further practitioner led diagnostic endoscopy service.
- Sustainable workforce.
- Environmentally sustainable endoscopy unit.

Our patients today are…

Patients requiring upper or lower endoscopy for both cancer and benign pathways.
Patients requiring disease monitoring for IBD, Varices, Barrett's oesophagus, and post-op review.
Patients requiring therapeutic endoscopy i.e., stenting.

In 10 years our patients will be…

More complex due to age profile, the interventions may no longer be appropriate.
Continued focus on early diagnosis of cancer.
Greater focus on eradicating health inequity, and pursuing environment sustainability of the service.

Our demand is…

Increasing in line with broader demographic
demand.
Increasing due to changes in BCSP
Analysis of surveillance demand underway

Our capacity to meet that demand is…

Analysis underway – optimisation of capacity go live November 2024

Ear, Nose & Throat

People

- Development of non-consultant workforce.- opportunities to develop wilder multidisciplinary team- including specialist nursing roles/Allied health professionals.
- Strong internal team relationships across the workforce/agree workforce model.

Population

- Continue to offer a significant range of treatment options for a hospital of our size, i.e., cochlear implants.
- Work with the armed forces to deliver timely and specialist care to the military and veteran community.
- Working toward a one stop or diagnostic first service to provide quicker diagnosis.

Partnerships

- Strong relationships maintained with the Wessex Deanery.
- Working across the Group to identify opportunities for improvement.
- Military organisation relationships.

National

- No planned changes to national directives or guidance affecting the service.

System

- Continued strong relationships with UHS and HHFT (including on call rota).
- Expansion of Group relationships, especially on shared wait list initiatives.

Place

- Local primary care relationships to be strengthened.

Our key service relationships and interdependencies

- Internally: Head and Neck service, OMFS, Plastics, Laser, ED, ITU
- Externally: Group, UHS, HHFT

Our Priorities

Short term (12-18m):

- Recruit to current vacant posts
- Agree workforce model/develop practitioner pathway
- Review current patient pathway/opportunities to reduce follow up and ambulatory pathways.
- Complete demand/capacity exercise- understand impact of growth.

Medium term (3-5y):

- Shared head and neck service
- including incorporation of OMFS.
- Thyroid service department established.
- Consultant led rather than delivered service. Development of practitioner pathways.
- Assess current on call provision- 7 day working.
- Recover RTT position to 18 weeks.

Long term (7-10y):

- Head and neck theatre
- One stop and diagnostic first pathway options.
- Development of current workforce in line with evolved service.

Our patients today are…

A mixture of all age and demographics, with referrals to the head and neck cancer service, audiology/aural care and the emergency clinic – particularly for epistaxis, dominated by those in the older age demographics.

In 10 years our patients will be…

The anticipated increase in the 75+ age demographic will impact on the subspecialties named in today's users. There is also likely to be increased paediatric demand, particularly as there is no private medical care available for children within Salisbury.

Our demand is…

- Currently being analysed but has been growing in line with broader demographic trends.

Our capacity to meet that demand is…

- Based on staffing, approximately 20% below necessary.
- However, this doesn't fully account for planning to assess backlog demand and is therefore at a worse position.

GI Unit

People

- We will invest in our workforce to allow additional time and support for training. This may involve job plans which allow staff to attend other organisations for training and development. Upskilling and developing existing roles such as CNS scoping in endoscopy, IR nurses developing ascitic drain service.
- Celebrating successes - conference presentation / posters. Staff awards / SOX, Successful business cases.

Population

- We will continue to develop community supported pathways aiming to reduce time to diagnosis and appropriate care
- We will develop the roles of our pathway navigators to support surveillance of patients at high risk of cancer.
- Work with alcohol charities to develop community support for patients.
- Development of holistic pathways to avoid unnecessary invasive diagnostics

Partnerships

- Develop partnership with Southampton hospital to support IBD service
- Develop partnership with GWH and UHS to support ERCP service
- Develop partnership with RUH hospital to support ERCP service mentorship and nutrition
- Develop partnerships with primary care to support with intermediate level pathways
- Involvement in regional networks
- Engagement with community diagnostic hub providers to support pathway for early identification of liver disease in line with national strategy
- Engagement with cancer services to support development of innovative pathways to achieve cancer targets.

National

- We are an outlier (negatively) relative to peers for length of stay and outpatient capacity.
- We must to work towards national IBD standards, and IQILS accreditation in Hepatology.

System

- Partnerships across BSW to be strengthened
- Group assessment of GI services and opportunities underway.
- Partnerships with UHS to be preserved.
- Regional cancer network engagement to be preserved.

Place

- Local primary care pathways to be expanded.
- Greater working with population health colleagues.

Our key service relationships and interdependencies

- Internally: Endoscopy
- Externally: NHS targets, BSW partners, UHS, Primary care, agency staff providers, SWETA

Our Priorities

Short term (12-18m):

- Progress hybrid ERCP service proposal
- Substantive plan for consultants
- Co-location of unit workforce
- Innovative workforce model to address demand.
- Retention of staff
- GI Unit OD&L programme
- Achieving and maintaining 28d faster diagnosis standard

Medium term (3-5y):

- Reduce reliance on agency staff
- Reducing in wait times
- Increased digital maturity
- Recover RTT position to 18 weeks.

Long term (7-10y):

- Innovative reputation.
- Robust and sustainable gastro service.
- Paper-lite service.

Our patients today are…

Newly diagnosed and existing IBD, Hepatology, and general gastroenterology patients.
Cancer patients.
A mixed demographic broadly representative of the wide population.
Often frustrated at seeing multiple clinicians for their chronic care.

In 10 years our patients will be…

More digitally mature and with higher expectations around waits and innovative interventions.

Our demand is…

- Broadly static for the past 18 months, with the focus on reducing longer wait times.
- Some areas, such as GI bleeds, are highly variable month on month.

Our capacity to meet that demand is…

- Broadly appropriate, although utilisation of theatre capacity has been static at ~70% for the past 12 months.
- High DNA and cancellation rates have affected outpatient efficiency.

Intensive Care Unit

NHS Salisbury NHS Foundation Trust

People

- Flattened hierarchy with most junior staff empowered to speak up & challenge senior decision makers
- Many roles outside ICU (risk group, surgical ops, transfusion, deteriorating patient, college examiner)
- Plans to enhance skill mix among nursing workforce.

Population

- Prevention of falls by using physios & nursing staff to support mobility
- Constant awareness of and implementation of strategies to reduce delirium
- Improved care for increasing number of bariatric patients
- Collaborative working with specialties & support highly specialised services (examples are burns service, COVID) and with Mental Health liaison team
- Bereavement follow up service to help signpost relatives to help
- Organ donation – no missed donors, a culture of donation consideration on unit.

Partnerships

- Thames Valley & Wessex -All our clinical pathways of note collaborate with either SGH or RBH – this is appropriate time wise for patients. Also collaborate with use of & access to the critical care transfer service, and educational resources
- Dorset & Wilts critical care cell – informal network collaborating for things like capacity transfers if needed.

National

- National push towards "enhanced care" or level 1.5. i.e., respiratory support area run by physicians but with ICU input.
- GPICS requirements, standards & guidelines.

System

- Shared EPR
- Dorset & Wiltshire critical care cell hosts regular online meetings to share ideas and challenges.
- Wessex network with regular meetings.

Place

- Largely wrapped up in system level work, minimal relationships necessary with primary and community care.

Our key service relationships and interdependencies

- Internally: All specialties, site and bed management
- Externally: ICS, Dorset & Wilts critical care cell, Thames Valley and Wessex networks, UHS.

Short term (12-18m):

- Review current bed model.
- Agree admission/discharge processes./surge capacity and escalation processes.
- Reduce delayed discharge from the unit- improve patient experience/LOS
- Review current staffing model for IUC/CCOT service
- Agree pathway for NIV patients.
- Implement Marthas law

Medium term (3-5y):

- Increased flexibility of footprint.
- Develop enhanced care model
- Improve skill mix resilience within critical care and the CCOT service.
- Improve use of digital technology.
- Develop practitioner model
- Demand/Capacity -understand impact of population growth.

Long term (7-10y):

- Agree longer-term bed model
- Understand and implement digital opportunities.

Our patients today are…
Increasingly obese, older, ventilated, and with more complex co-morbidity.

Small, but highly acute numbers of burns patients due to our tertiary provision.

Spinal patients due to our tertiary provision.

In 10 years our patients will be…
Lower dependency and more co-morbid.

Increased numbers of children with disabilities surviving into adulthood. And Increased mental health issues.

Potentially suffering from future pandemics.

Our demand is…

- For a 24 hour service with medical and nursing cover.
- Fluctuates in regards to side room requirements.

Our capacity to meet that demand is…

- Broadly appropriate, although capacity is limited for SALT and pharmacy provision.
- Resident medical cover shared with theatres and obstetrics.

Laser

People

- Plans for the Laser Fellowship will be developed in the coming year with the lead Clinicians for both Laser and Plastics. The deanery will be approached as to process and requirements.
- Progression and development within both the roles and the staffing structure is encouraged. With plans to expand the service staffing as the demand and capacity of the service grows.

Population

- A large majority of our referrals are seen within weeks.
- We offer laser treatments to our population using modern, gold standard lasers. These treatments are carried out by either laser nurse specialists or plastic surgeons.
- Where treatment is not available through NHS funding, patients can self-pay for the same quality of treatment and profits go back into the NHS.

Partnerships

- SFTs laser service has set up a strong laser research network with the burns units in the UK that have laser capability and continue to work together on future research.
- The Laser Clinic has always lacked a strong academic affiliation but has worked closely with both Bournemouth and Exeter University. These links could be further matured.
- Laser Clinic works closely with GP practices to add them to perform informed funding requests, and with commissioners to assess what may be funded without prior approval.

National

- Our ELABS research study may start to formulate a NICE guideline for the laser treatment of hypertrophic burn scars.
- We use British Medical Laser Association standards for. We also work closely with British Burns Association

System

- Our laser service is the only one within BSW ICS.
- Work to be scoped across the Group to ensure referrals to SFT where possible.

Place

- Closer relationships with GPs.
- Growth of local advertising and private offer.

Our key service relationships and interdependencies

- Internally: Plastics, dermatology, colorectal, ENT, Head & Neck.
- Externally: Primary care, Bournemouth and Exeter Universities, research study partners

NHS Salisbury NHS Foundation Trust

Our Priorities

Short term (12-18m):
- Agree workforce model
- Advertising, website, and clinic refresh.
- Capital funding for CO_2 laser upgrade.
- Increase private income to £15,000 per month/develop links with primary care/Gps

Medium term (3-5y):
- Opportunities to develop wider Multidisciplinary
- Laster clinical fellowship
- More research activity
- System and primary care network development.
- Increase private income to £20,000 per month.

Long term (7-10y):
- Increase science workforce
- Increase service capacity including private service.
- Increase private income to £25,000 per month.

Our patients today are…
For NHS patients: burn scars, birthmarks, epilatory.

For private patients: epilatory, tattoo, rosacea, spider veins, brown marks.

In 10 years our patients will be…
For NHS patients: expand epilatory services for complex diseases, hairy diseases and stoma sites. Also expand ablative work for Rhinophyma.

For private patients expand skin rejuvenation and fine lines using CO_2 laser, expand tattoo service, expand Botox services.

Our demand is…

- More than 50% private work.
- All new patients are seen within 3 months and the majority of work is follow ups, with waits not exceeding 6 months.

Our capacity to meet that demand is…

- Not inhibited by equipment.
- Occasionally inhibited by staff absence (~60 nurse sessions in 2023).

Oral & Maxillofacial Surgery

NHS Salisbury NHS Foundation Trust

People

- Development of retirement succession plan for Cleft/maxillofacial surgery.
- Altering the skill mix of staff to provide supervision through senior clinicians.
- Career progression and training for dental nurses including additional competencies such as CBCT and sedation.

Population

- SFTs orthodontic service is the only orthodontic secondary care centre in Wiltshire and accepts referrals from a wider than catchment population due to a lack of capacity across Dorset, Hampshire, and Swindon.
- Reduce waiting times for treatment especially for patients
- Development of intermediate dental services in Wiltshire
- Development of off-site clinics in key locations

Partnerships

- Expansion to provide more community dental services and military dental provision.
- Significant partnership work takes place with UHS for head and neck cancer workload and prosthetic lab work.
- Partnership with AHA to bid for intermediate dental care services

National

- Clearer focus on referral management and triage systems, specialised Paediatric Surgery Operational Delivery Networks (ODNs) to support children's oral health, and improving data capture and coding
- GIRFT – Orthodontics review
- Challenges with capacity in NHS dentistry

System

- AHA bid to provide intermediate oral surgery services
- BSW referral triage hub
- Involvement in regional ODNs
- Paediatric health inequalities working groups
- Collaboration with UHS regarding OMFS on call

Place

- Joint working with military to improve access to care to improve deployability
- Exploring opportunities to use dental chair space in the community to increase capacity

Our key service relationships and interdependencies

- Special care dentistry
- UHS – restorative dentistry and oncology
- SSL – High volume MOPS
- DSU/Theatres

Our Priorities

Short term (12-18m):

- Understanding demand and capacity – improving productivity
- Rolling upgrade of infrastructure
- Reduction of TT1O
- Improving staff morale
- Bid for intermediate dental care services
- Digital Dental referrals across Wiltshire
- Workforce plan for OMFS/H&N and Oral Surgery
- 3D printing in the prosthetics lab

Medium term (3-5y):

- Reconfiguration of services
- Service expansion to include intermediate dental care services separate from hospital dentistry
- Recover RTT position to 18 weeks.

Long term (7-10y):

- Succession planning
- Hub and Spoke model for orthodontics – centralised in Salisbury

Our patients today are…

The SDH catchment as well as specialist cohorts including the military, prison population, and cleft work including Oxfordshire patients.

In 10 years our patients will be…

More digitally mature
Continued focus on early diagnosis of H&N cancer.
Greater focus on eradicating health inequity, and pursuing environment sustainability of the service.

Our demand is…

- Growing in line with broader demographic trends.

Our capacity to meet that demand is…

- Broadly adequate with improvement to be made in hospital dentistry skill mix as well as dental surgery and nurse availability.

Ophthalmology

People

- Plan to re-introduce Improving Together supporting staff with training and development in tools and techniques.
- Leadership development work and development of a behaviour charter
- Workforce development plan to include development on non-medical support roles for nurses / AHPs.
- Work to improve workforce sustainability – work on retention of b3/4 staff through development of roles / training / admin processes.

Population

- Offering our patients the latest innovative techniques in treatment for cataracts, AMD, and Glaucoma.
- Developing screening pathways to minimise numbers of patients needing to see a consultant.
- Management of wait list capacity so new patients and follow ups are managing in a timely way.
- Engaging in the development and deployment of shared EPR.

Partnerships

- Developing relationships with local Optometrists in the community to succession plan for specialist services such as contact lenses.
- Involvement with ICB to understand future plans for primary care and acute ophthalmology services.

National

- Increased use of virtual review pathways
- Digital development to improve referral / triage / A&G/ asynchronus reviews / AI
- Frictionless data sharing

System

- Expansion of community hubs in partnership with Group and ICB colleagues.
- BSW electronic urgent eye referral and triage system.
- Become the tertiary regional provider for oculoplastics
- Group cataract surgical hub plans

Place

- Community hub expansion and enhancement of current community services to provide care closer to home.
- Development of a digital road map
- Sustainable workforce development
- Surgical hub – development of cataract service to increase market share

Our key service relationships and interdependencies

- Internally: Finance, workforce planning
- Externally: ICB, Primary Care, Group

NHS Salisbury NHS Foundation Trust

Our Priorities

Short term (12-18m):

- Ophthalmology dashboard
- Demand and capacity work
- Leadership development
- Workforce review – development of Non-medical clinical support roles – nursing / AHP
- Improving Together relaunch

Medium term (3-5y):

- Development of Ophthalmology treatment centre – high volume cataracts / Injections / Laser
- Consultant led not delivered care – high volume virtual review pathways
- Bi-directional image sharing – effective A&G
- Recover RTT position to 18 weeks.
- Repatriate activity from ISTC.

Long term (7-10y):

- Demand meeting capacity consistently
- Use of AI to support high volume diagnostics

Our patients today are…

Predominantly over 60 and presenting with acute changes to eye health or long-term vision change and condition management, i.e., glaucoma.

Primary care management (GPs do not have the equipment and skills to manage in the community), and cancer patients (Oculoplastics).

In 10 years our patients will be…

Older and more numerous due to broader demographic changes and likely age profile of those accessing the service.

Increased diabetic(retinopathy), stroke, and oculoplastics cases are expected in line with a growing older population.

Our demand is…

- Increasing, by 5% between 2022 and 2023.
- Long term increases highly likely, 8.8% of over 65s have visual impairment and over 85s population due to grow by 87% by 2040.

Our capacity to meet that demand is…

- Currently at stretch and unlikely to cope with further demand increases without alternative modes of provision or additional resource.

Orthopaedics

People

- Workforce development plan to include development on non-medical support roles for nurses / AHPs.
- Develop a workforce model that's resilient and supports future succession planning.

Population

- Increasing day case procedures to address elective backlog.
- Increasing capacity across the system to reduce long waits
- Explore development of ambulatory pathways
- Service development to address health inequalities and population demographics

Partnerships

- Working across the system on initiatives to enhance our system elective recovery position, such as working across the ICB and with group partners on Sulis capacity.
- Development of fracture liaison service with community provider(s).

National

- Elective surgery guidelines for ring fenced bed capacity
- 7 day therapy services
- Trauma co-ordinators
- 24 hour access to MRI for suspected cauda equina syndrome cases

System

- BSW joint procurement
- Elective capacity opportunity at Sulis.
- Regional hubs and networks for spine services and revision arthroplasty.

Place

- Fracture liaison service development with community provider(s).
- Greater collaboration with primary care

Our key service relationships and interdependencies

- Internally: therapies, anaesthetics, radiology, pre-op assessment, orthogeriatrics, central booking
- Externally: ICB, Group, Community services provider(s)

Our Priorities

Short term (12-18m):

- Improved resilience of spinal service
- Improved LoS and theatre efficiency
- Improved patient flow
- Increase day case arthroplasty day case practice
- Relocation of activity to SEOC (Sulis)
- Review outpatient pathways to reduce number of follow ups.

Medium term (3-5y):

- Orthopaedic elective unit reconfiguration.
- Increase capacity of fracture clinic
- Additional foot and ankle workforce.
- Recover RTT position to 18 weeks.
- Repatriate activity from ISTC.

Long term (7-10y):

- Expansion of orthopaedic geriatric support services.
- Enhanced training offer for orthopaedic nursing workforce

Our patients today are…

Fragility fractures, low and high energy trauma patients, osteoarthritis, degenerative spinal conditions, and with all increasing in complexity with a higher number of deconditioned patients.

In 10 years our patients will be…

Higher in number due to fragility fracture prevalence in older populations.

Our demand is…

- Increasing. Since 2019/20 routine referrals are up 35%, and urgent referrals up 560%.

Our capacity to meet that demand is…

- Largely static since 2021 with waits rising due to inability to meet increasing demand.
- Increased capacity avaialble during 25/26 owing to BSW SEOC model.

Plastics

People

- Develop a workforce model that's resilient and supports future succession planning
- Workforce development plan to include development on non-medical support roles for nurses / AHPs.
- Recruitment plans to new service model that addresses demand.
- Supporting staff to pursue relevant education opportunities.

Population

- Public education regarding skin cancer checking and melanoma.
- Establishing stronger networks as a regional specialist service
- Continuing to address elective backlog.
- Understand impact of health inequalities

Partnerships

- Development of primary care relationships, particularly around appropriate referrals.
- Working across the network to ensure robust pathways and sustainability of service.

National

- Clear understanding of demand forecasting to meet cancer standard/regional pathway work.

System

- Building plastics and dermatology relationships across the Group.
- Continue to develop patient pathways with Wessex trauma network
- Working with ICB/Bath/Swindon

Place

- Closer working with primary care on A&G and referrals.
- Develop regional plastics service with UHS, UHD and Hampshire Hospital

Our key service relationships and interdependencies

- Internally: therapies, histopathology, theatres, estates, finance
- Externally: Group, UHS, UHD, HHFT, Southwest burns clinical network, primary care and PCNs.

NHS Salisbury NHS Foundation Trust

Our Priorities

Short term (12-18m):

- Review surgeon job plans
- Partnership working with primary care regarding 2ww referrals.
- Stabilise skin cancer pathway.
- Review current pressure ulcer service
- Conclude strategic partnership review with UHS
- Review of complex pathways to establish profitability

Medium term (3-5y):

- Full utilisation of outpatient physical capacity.
- Demand and capacity modelling to support future case for change.
- Recover RTT Position to 18 weeks.

Long term (7-10y):

- Implementation of future service model to support increased demand and complexity.
- Opportunity for service to innovate

Our patients today are…

Largely 2ww referrals with a high volume of older patients with complex needs.

Patients have high expectations and complaints have increased as waits have.

In 10 years our patients will be…

Older and more complex, with an increase in skin and early diagnostic work.

Our demand is…

- Increasing by almost 50% by 2030.
- Increasing due to both demographic pressures and work to reduce the elective backlog.

Our capacity to meet that demand is…

- Growing in 2023/24, however due to an existing gap between demand and capacity this is insufficient to mitigate demand growth.

Preoperative Assessment

NHS Salisbury NHS Foundation Trust

People

- Focus on continued development of autonomous preoperative nursing roles.
- Develop service models that maximise efficiency of anaesthetist time.
- Engage fully with the shared EPR programme as a means to streamline processes for staff and reduce frustration.

Population

- Our theatre resources will be better utilised helping our recovery plans to increase access to surgical therapies in a timely manner for all our population
- Post-operative complication rates and lengths of stay will be reduced by improved patient prehabilitation and shared decision making.
- Digital by default services, including e-referrals and electronic communications with patients.

Partnerships

- Make every contact count, helping patients to live longer lives in better health.
- Initiating the early screening programme will provide widespread integration of services helping to drive the "left shift" which the Trust and ICS are striving for, as well as improving outcomes for our surgical patients.

National

- Mandated early health screening for all surgery patients.
- NICE led co-morbidity specific peri-operative guidance updates, e.g., Recent AF update

System

- Improved collaboration with community services.
- Support to BSW elective surgical hubs through shared waiting lists.

Place

- Working to reduce health inequity in access and surgical outcomes.
- Closer relationships with primary care.

Our key service relationships and interdependencies

- Internally: IT, anaesthetics, theatres, surgical specialties
- Externally: Group, primary and community providers.

Our Priorities

Short term (12-18m):
- Patient portal and early screening
- Agree workforce model

Medium term (3-5y):
- Pre-operative assessment for all patients.
- EPR implementation

Long term (7-10y):
- Automation of digital processes.
- Increase in nursing autonomy and leadership

Our patients today are…

Not benefitting from pre-assessment in many cases, exposing them to unwarranted variation in outcomes across BSW.
Co-morbid in 75% of day surgery patient cases.
Limited in access to anaesthetic consultations – 50% of those who do receive these decide not to proceed with surgery.

In 10 years our patients will be…

Older, with more complex co-morbidity, and with higher expectations of access time and treatment range.

More engaged in their health ahead of surgery if digital engagement is designed well.

Our demand is…

- Increasing due to new NHS contract arrangements mandating early screening of all patients and waiting list addition point.

Our capacity to meet that demand is…

- Due to vacancy and digital challenges 85% of patients receive no form of pre-assessment.
- Limited by consultant anaesthetist allocation.

Rheumatology

People

- Focus on making the department and attractive place to work.
- Support the Nunton infusion and Rheumatology infusion to integrate to form a cohesive and combined infusion suite staff team.
- Review current workforce model to support the Infusion service/outpatient's service.

Population

- Develop a fracture liaison service to reduce fragility fractures in are aging population Gain expert patient feedback to support the combining of the infusion units, understand what the patients want from the new combined service.
- Increase the number of research trials available for patients to participate in.
- Develop an u/s pathway for GCA patients to reduce need for invasive screening (TAB).

Partnerships

•Work with the Nunton team and all other stake holders around the combining of the 2 infusion units.
•To work collaboratively with Bath and Swindon, to ensure equity of care for Rheumatology patients in our ICB
•Develop links with primary care to understand the impact of health inequalities on the service/patients.

National

- Continue to work along specialist societies/Royal college. makes specific recommendations.
- GIRFT (network model)- ensure recommendations are embedded in the service.

System

- Network best practice sharing.
- Group opportunity

Place

- Further work with primary care regarding referrals./training opportunities.
- Allign with ICB colleagues/bath and Swindon

Our key service relationships and interdependencies

- Internally: Ultrasound, estates, orthopaedic geriatric service, all specialities that will be utilisation new combined infusion unit including Gastro and Haematology
- Externally:

NHS Salisbury NHS Foundation Trust

Our Priorities

Short term (12-18m):

- Integrating new infusion service- developing workforce model to support combined service
- Recruit new consultant
- Continue to improve time to first appointment.
- Stream line patient pathways- follow Up's and undertaken gap analysis identify demand and capacity review.
- Establish PIFU pathways
- Work with community partners to establish Fracture Liaision Service
- More research opportunities

Medium term (3-5y):

- Work towards Nurse/Allied health practitioner model
- Agree skill set of current CNS team alongside service need. Develop CNS IA injection clinic
- Recover RTT position to 18 weeks.

Long term (7-10y):

- Service development to ensure ability to treat increasingly older population with increased co-morbidities.
- Embrace medication developments to improve patient long term outcomes.

Our patients today are…
All inflammatory patients.

In 10 years our patients will be…
Older, complex co-morbid patients with increased likelihood of MSK problems.
More elderly patients will also result in more inflammatory patients.
Able to benefit from medication developments to treat rheumatic conditions.

Our demand is…

- Up 29% relative to 18/19 levels.

Our capacity to meet that demand is…

- Stable, but insufficient.

Theatres

People

- Significant expansion to the theatre education team to better support practitioners at all levels
- Increased commitment to anaesthetic 'top up' training and ODP apprenticeships
- Successful training grant application for National AHP funding
- The launch of a 'civility and respect' campaign to include an evolving theatre 'behaviours charter'
- The launch of improving together huddles to engage all in change activities

Population

- Revisiting booking and Pre-op processes to increase capacity
- work alongside BSW and network partners to merge theatre lists, share resources and maximise expertise wherever possible. This remains especially important as we look to support those who have been waiting for surgery for the longest
- Developing a dedicated discharge facility within DSU to improve the patient experience
- Redevelop the theatre timetable to ensure that speciality capacity and demand are matched.

Partnerships

- Modernising patient flow through DSU to include improved admissions processes.
- Deliver greater productivity to drive income supporting organisational sustainability.

National

- Further national and regional scrutiny, as to theatre performance against BADS and GIRFT standards, is expected.

System

- Improved collaboration across BSW on digital systems, in particular supporting pre-operative assessment.
- Shared lists working with Group peers and geographic peers.

Place

- Further work with primary and community care regarding prehabilitation.

Our key service relationships and interdependencies

- Internally: Pre-operative assessment, anaesthetics, estates
- Externally: Group, primary and community providers

Our Priorities

Short term (12-18m):

- Consolidation across the team.
- Incremental increase in capacity to 16 theatres.
- Introduction of civility and respect charter
- Achieve top quartile status for Model Hospital performance
- Identify exit strategy for non-theatre based actiity

Medium term (3-5y):

- Consistent delivery of HVLC and GIRFT targets
- Embedding advanced practice
- Improved building and equipment maintenance.
- Relocate DSU to Elective Care Centre

Long term (7-10y):

- Deploy more innovative procedures and methods.

Our patients today are…

Ageing, with increased co-morbidity (75% of all day surgery cases have at least one).
Receiving increasingly complex surgery and arriving in a more deteriorated state due to a range of health affecting social and economic factors.

In 10 years our patients will be…

Older and more co-morbid.

Engaged more pre-surgery as we deploy better digital and engagement tools to our population.

Our demand is…

- Not well mapped by specialty need and complicated further by non-specific job plans.
- Increasing, particularly in line with weekend working ambitions and elective backlogs.

Our capacity to meet that demand is…

- Currently sufficient, but occasionally limited by our ability to staff our theatre capacity.
- Limited by anaesthetist availability.
- At risk of an estate failure.

Urology

People

- We work in a dedicated Urology Centre where all urology staff are located, and this helps us to provide streamline patient focussed care and provide clinical support and advice.
- We provide innovative pathways and have always been responsive to developing nurse and ACP led pathways and services to increase capacity, reduce wait times and introduce new and innovative techniques as they are developed

Population

- Increased activity levels are resulting in the treatment of more patients from our population than we were last year. However, with growing demand our wait times are still rising.
- Future developments include PTNS and My Patient Record for cancer care
- Addressing health inequalities within the service, (for e.g. men's health)

Partnerships

- We work with GPs to provide advice and guidance and urology care for our patients.
- We work with the community continence team as well as private providers for medical devices and self-catheterisation teaching
- As part of the urology area network (UAN) we work closely with colleagues in Southampton and HHFT. 5 of our 7 urology consultants also work in Southampton which strengthens links between the two hospitals.

National

- GIRFT standards and balancing against local performance pressures.

System

- Urology network with HHFT and UHS
- Urology AHA

Place

- Continue collaboration with primary care for community led continence service
- Support continuation of GPSI haematuria pathway for suspected cancer patients

Our key service relationships and interdependencies

- Internally: theatres, pathology, central booking, clinical coding, diagnostics, radiology, pre-operative assessment
- Externally: Wessex Urology Area Network

Our Priorities

Short term (12-18m):

- Demand & capacity modelling to reduce waiting list
- Spinal cord injury specialist recruitment (business case going to TMC)
- Addressing cancer waits and workforce requirements
- Review of capacity in Urology Centre versus service demands.
- Achieving and maintaining 28d faster diagnosis standard

Medium term (3-5y):

- Network recruitment with Hampshire and wider workforce review
- Review Urology outpatient activity and ambulatory pathways
- Recover RTT position to 18 weeks.

Long term (7-10y):

- Leverage use of digital technologies and AI to support pathways
- Continued close working with primary care

Our patients today are…

Regional spinal patients in addition to our standard geographical catchment.
Tertiary and network referrals for benign prostate hyperplasia.
Paediatric urology.
Cancers of the prostate, kidneys, penis, or bladder.

In 10 years our patients will be…

Older and more co-morbid, and therefore likely higher in number as most urological diseases increase with age.

Expecting more as regards innovative treatment and timely engagement with clinicians.

Our demand is…

- Significantly higher than historic levels across both new outpatient engagements and procedures.
- Driven by a large elective backlog.
- This is driven by suspected cancer performance.

Our capacity to meet that demand is…

- Insufficient, with long waits for clinic and theatre despite increased activity levels.
- This is slightly mitigated by overtime lists on Saturdays.
- Female urology has insufficient capacity.

Vascular

People

- Training – we will invest in our workforce to allow additional time and support for training. This involves job plans which allow staff to attend other organisations across the network for training and development.
- Upskilling and developing existing roles such as ACP delivered EVLT
- Planned creation of Lead Sonographer / Scientist role to provide development opportunity at SFT

Population

- Effective One Stop clinic pathway for assessment and treatment planning – reducing attendances for patients
- Providing care to increasing numbers of the population as the increase in prevalence of certain cardiovascular risk factors increases susceptibility to vascular disease creating increased demand for surgical intervention

Partnerships

- Dorset and Wiltshire Vascular Network (including UHD, Dorchester and Jersey)
- As part of the DWVN we work closely with colleagues in UHD with members of staff working across the sites, some regularly, and others adhoc for training and development opportunities. This strengthens links between the two hospitals and collaborative relationships across the network

National

- The vascular society makes specific recommendations.
- GIRFT (network model)
- Improve prehabilitation for AAA, PVD and CEA, particularly with regards to perioperative medical input

System

- Network best practice sharing.
- Group opportunity

Place

- Further work with primary care regarding referrals.
- Training for community teams i.e., leg ulcers.

Our key service relationships and interdependencies

- Internally: IT, central booking, diabetic foot service, plastics, spinal, stroke
- Externally: Dorset Wiltshire Vascular Network, group

Our Priorities

Short term (12-18m):
- Advanced practice EVLT across network
- Consistent network consultant cover
- Stabilise/upgrade digital infrastructure @ SFT.

Medium term (3-5y):
- Digital interoperability between SFT and UHD.
- Develop network pathways.
- Clinics for leg ulcers targeting health inequity.
- Primary care referral improvements.

Long term (7-10y):
- Community leg ulcer training
- Workforce remodelling and succession planning

Our patients today are…
Requiring treatment for arterial or veinous vascular conditions, lymphoedema patients, leg ulcer and diabetic foot patients, and a range of others for which vascular forms a small part of their pathway.

In 10 years our patients will be…
Demand increases as the increase in prevalence of certain cardiovascular risk factors increases susceptibility to vascular disease creating increased demand for surgical intervention. 30% more over 65s, diabetes prevalence increasing in Wiltshire, leg ulcer prevalence increasing as people live longer.

Our demand is…
- Increasing in line with demographic trends and the growth experienced by other specialties.

Our capacity to meet that demand is…
- Expanded to meet the demand and th service is achieving more activity than ever before.

Clinical Support & Family Services

Cancer, Child Health, Clinical Psychology, Clinical Sciences & Engineering, End of Life Care, Pathology, Pharmacy, Radiology, Speech and Language Therapy, Sexual Health, Spinal, and Therapies.

Cancer

People

- Build a confident and competent workforce using the ACCEND and other framework to deliver outstanding cancer care, ensuring these staff can develop and make use of breakthrough innovation like genomics or AI.
- Review roles to ensure people are working at the top of their licence.
- Explore new role types such as cancer pathway navigators, who have a demonstrable impact on faster diagnosis.
- Continue to leverage external resource to support our workforce.
- Ensure Supervision for our teams to support wellbeing.

Population

- Patients and those important to them receive a personalised care interventions.
- Shared decision making and What Matters is our default approach.
- Through pre and rehabilitation patients are supported to increase activity levels, improve nutrition, and self-manage symptoms wherever possible.
- People have the information they need to empower them.
- Reduce health inequalities
- Deliver against the standards to minimise impact on lives through faster and earlier diagnosis.

Partnerships

- Strong working relationships have been built and will be maintained with tertiary centres our patients travel to for radiotherapy (UHS, UHD, RUH).
- Links continue to be strengthened with primary and social care due to the role they play in our patients care.
- A focus on bringing new innovations to bear for our patients, including surgical innovation, AI, automation.
- Utilise the Third Sector.

National

- 3 new integrated targets replace 10 previously.
- Expectation for ICS' to collaborate across sites and use community hubs.
- Personalised care interventions for every patient.

System

- CDC integration work
- Opportunities to collaborate between our cancer network members.
- Research opportunities.

Place

- Improving local primary care relationships alongside non-place or BSW ones such as with UHS and UHD.

Our key service relationships and interdependencies

- Internally: as a cross-cutting service cancer relies on, and is relied upon, many other specialties. STARS.
- Externally: UHS, UHD, the RUH, SWAG, Macmillian, ICB, Alliance Medical, Specialist commissioning

Our Priorities

Short term (12-18m):

- Operational performance – 28d, 62d
- Early detection and diagnosis
- Addressing treatment variation from GIRFT.
- Funded Therapy service
- Personalised care interventions for all patients.

Medium term (3-5y):

- CDC integration with potential to move services off site.
- Personalised care plans shared with primary care.
- 'ACCEND' embedded for all cancer careers.

Long term (7-10y):

- Cancer unit
- All patients have end of treatment summaries

Our patients today are…

Suspected and confirmed cancer patients.
Surveillance, screening, and stratified follow-up patients.
Cancer patients but with limited access to prehabilitation and dietetic input.

In 10 years our patients will be…

'A higher proportion of self-referred
Have improved access to specialist AHPs.
Have a commissioned Prehabilitation service

Our demand is…

- Growing, cancer diagnosis are predicted to double by 2030.
- 2000 new patients per year and 1500 supported on self-supportive management pathways (SSMP).
- Cancer is now considered a long-term condition due to survival increase.

Our capacity to meet that demand is…

- Inadequate for the prehabilitation referral numbers
- Currently adequate but likely unable to meet future demand.

Child Health

People

- Increase training regarding complex mental health patients.
- Career progression for nurses through a defined career pathway.
- A focus on consultant leadership.

Population

- Prioritise patient groups experiencing health inequity.
- Using advanced practitioners to see the person with the appropriate expertise sooner.
- Integrate clinics with primary care to move care closer to home where appropriate, especially in geographies with low engagement.

Partnerships

- Work with CAMHS and introduce youth worker roles to reduce pressures caused by mental health demand.
- Working with the ICB to establish joint clinics with primary care to improve access for paediatric patients.
- Make the most of shared EPR across the system.

National

- We are going to be an active participant in Thames valley and Wessex operational delivery network
- Participation in multi-disciplinary networks – including Diabetes network & PIER (Paediatric Innovation Education & Research)

System

- Working with the ICB on local CYP response to national directives, Inc. CYP CORE20PLUS5.
- SW paediatric MH network membership to improve provision.
- Alignment with RUH and GWH.

Place

- Joint working with primary care, including clinics and out of hospital activity support where appropriate.
- A&E / DAU co-location

Our key service relationships and interdependencies

- Internally: ED, Diagnostic services
- Externally: local primary care, CAMHS, ICB CYP team, regional clinical networks.

Our Priorities

Short term (12-18m):
- Improve capacity to meet mental health demand increase.
- Closer working with primary care.

Medium term (3-5y):
- Increased AHP and community provision.
- Improved nursing career pathways.

Long term (7-10y):
- Co-located DAU and A&E service
- Move away from consultant delivered to consultant led
- CoE for elective surgery

Our patients today are…

Ever more complex mental health cases resulting in inappropriate long stays. And an increasing prevalence of respiratory, MH, eating disorders, and complex pain.

High usage by military families, and often cases resulting from family breakdowns.

In 10 years our patients will be…

Likely more highly acute due lack of capacity in primary care because of the ageing population.

Presenting in greater numbers with eating disorders and anxiety related problems.

Our demand is…

- Flatter across the year than historic trends
- Driven ever more by an increase in complex mental health needs
- Driven by a lack of capacity in primary care

Our capacity to meet that demand is…

- Consultant heavy due to limited AHP capacity.
- Maxed out for urgent referrals in DAU
- Vulnerable to winter pressures
- Frustrated by 8% DNA rate

Clinical Psychology

People

- Provide expertise to Trust wellbeing leads.
- Supporting our teams to improve the service through Improving Together.
- Continue leading elements of the 'compassionate leadership' programme for staff.

Population

- Continue to help patients to psychological wellness, leading to better patient flow and better outcomes for patients.
- Continue deploying virtual service where this works for patients, reducing pressure on acute settings and brining care into communities and homes.
- Continue engaging with our population through our large volunteer network (Engage programme).

Partnerships

- SFT is well placed to provide BSW wide leadership.
- Plans to work into the community, third sector, and primary care at place to help integrate care and drive prevention.
- Future partnerships with the HINs and NHSE regional programme teams to identify opportunities to adopt innovation.

National

- Push for organisations (Inc. ICBs) to surface more psychological profession perspectives at board level.
- Psychology input guidance for every disease site (i.e. Cancer and Burns) continues to evolve.

System

- SFT is the most mature service in BSW and will seek to take a leading role across the acute group.
- HIN partnerships

Place

- Greater ICA working including support into primary and community care to reduce acute demand.

Our key service relationships and interdependencies

- Internally: referring wards, spinal rehab, mental health, occupational health, fit and healthy board
- Externally: NHSE, SWAG Cancer Alliance, ICB, AWP, CAMHS, HCRG, Health Innovation Network, AHA peer teams

NHS Salisbury NHS Foundation Trust

Our Priorities

Short term (12-18m):
- Embed leadership transition
- Recruit to vacancies

Medium term (3-5y):
- Greater partnership working with community services
- Review approach to measuring intervention outcomes and implement pathway improvements

Long term (7-10y):
- System leadership role for physical health psychology
- Collaborate with HINs to implement and evaluate innovation.

Our patients today are…

Inpatients from across the hospital, outpatients with cancer diagnosis under our care, and outpatients with any diagnosis from Hampshire and Dorset while under our care.

In 10 years our patients will be…

Likely to grow as most cancer referrals are over 65, and cancer rates are also growing.

Support for a increased neurodiverse diagnosed patients to make the most of physical healthcare.

Our demand is…

- Increasing at ~6% a year.
- Driven by cancer and maternity referrals but with increasing requests from other areas such as stroke, IBD, Dermatology, and Rheumatology

Our capacity to meet that demand is…

- Under pressure due to 1.4WTE vacancy resulting in a 56 hour weekly shortfall in capacity.

Clinical Sciences & Engineering

People

- Development and career pathways for staff across the teams.
- Promote apprenticeship programmes across all professions to aid recruitment and retention.
- Maximise healthcare support worker roles.

Population

- Offer PIFU and virtual appointments where that is appropriate and desirable.
- Greater integration across rehabilitation services.
- Work with primary care to deliver clinics closer to patients.

Partnerships

- Continue to work with regional wheelchair services for provision of specialist seating and rehab engineering.
- Engage with medical physicists across BSW to build service resilience.
- Ensure changes in digital systems are used to maximum effect across the sub-specialties.

National

- National regulations in medical physics are becoming more stringent.
- Most services have minimum staffing criteria.
- Current practice will evolve to match new national standards.

System

- Continued engagement in regional forums.
- Opportunities exist to align clinical neurophysiology, medical physics, and clinical scientist training across the ICS and Wessex.

Place

- Greater working with primary care and community provision across the sub-specialties.

Our key service relationships and interdependencies

- Internally: referring services (i.e. rehab, diagnostics), radiology.
- Externally: Group colleagues, regional networks, those providing services through contract.

Our Priorities

Short term (12-18m):

- Appropriate leadership roles in sub-specialties. I.e., new medical physicist.
- Local wheelchair services.

Medium term (3-5y):

- Full staff compliment to enable avoidance of breaches and better cover across services / avoidance of single points failure.
- Restructure of medical devices management services team.

Long term (7-10y):

- Align Medical Physics across the ICS
- Integrate medical devices management services
- Scientific and clinical services engaged in education and training

Our patients today are…

Broadly representative of the population with most patients seen in an outpatient setting wherever possible.

Some patients require highly specialised equipment in rehab and diagnostics. Technology expectations have also increased.

In 10 years our patients will be…

Complex co-morbidity and population growth will drive increased demand and complexity.

Greater expectations of technology.

Our demand is…

- Varied across the sub-specialties but broadly beginning to encounter difficulties as the Trust increases activity to address backlog.

Our capacity to meet that demand is…

- Currently appropriate in Orthotics but under pressure in Clinical Neurophysiology, Medical Engineering, Medical Physics and MDMS.

End of Life Care

NHS Salisbury NHS Foundation Trust

People

- Education, development and career pathways to attract and retain.
- Support our colleagues across the Trust to be competent and confident in providing outstanding compassionate care.
- Robust mandatory education programme.

Population

- By 2040 the population over 85 in Wiltshire will increase by 87% and those over 65 by 43%. Those over 65 will represent a third of the population.
- Survival rate are improving, having a significant impact on healthcare services with more people living longer with 44% of patient in the last year of life have multiple long-term conditions.
- Personalised approach to end-of-life care, recognising those who are experiencing health inequity .

Partnerships

- Be an active member of the BSW Palliative and End of Life Care Alliance, instrumental in driving positive change in the care of patients approaching the end of their lives.
- Ensure patients can die in their preferred place of death.
- Using the ICR to share one version of the truth.

National

- Ambitions for Palliative and End of Life Care 21-26.

System

- Work with the BSW PEOLC Alliance.

Place

- ICR, digital ReSPECT

Our key service relationships and interdependencies

- Internally: all clinical services. Specialist Palliative Care, resus committee, Chaplaincy.
- Externally: Primary care, Hospices, community services, Adult Social Care, BSW group, ICB, Southwest PEOLC Forum.

Our Priorities

Short term (12-18m):
- Understand the impact of the community contract.
- Agree short term establishment.
- Focus on Education
- Key projects- ReSPECT, ICR, recognising uncertainty, fast track, certification of death.

Medium term (3-5y):
- 7 day Intergrated Eol and Palliative Care service that is funded for Acute Trust.
- Education Strategy
- Understand what Outstanding looks like.

Long term (7-10y):
- Develop the service in line with the aging population.
- Develop a ACP and Non Medical Consultant roles.

Our patients today are…

On the Personalised Care Framework, who are approaching the last days of their life

Supported patients and those important to them to have a good experience of death.

In 10 years our patients will be…

Complex co-morbidity and population growth will drive increased demand and complexity.

People approaching the last weeks of life.

Our demand is…

- Increased of 14%- in referrals since 2018/19.
- 16% increase in patients dying in the Trust
- These fluctuate year on year.

Our capacity to meet that demand is…

- Limited as our WTE has not increased in line with demand.
- Estate limits us, due to location and size.
- Lack of admin support.

Pathology

NHS Salisbury NHS Foundation Trust

People

- Support work experience and university placements
- Promote wellbeing of staff to aide recruitment and retention
- Program of seminars, tutorials and presentations to support staff
- Staff meetings to disseminate information, update staff and gather staff feedback regarding issues and service improvements.
- Members of staff are invited to participate in joint activities with other members of staff across the Division and Trust eg with regards to the Staff Survey to share information and enable staff suggestions to be developed and acted upon.

Population

- Understanding limitations and having contingency plans to ensure turnaround times are met
- Contribution towards 28 day Faster Diagnosis standard
- Utilisation of available technologies to provide timely, accurate results
- Education of users to make sure best use of service available

Partnerships

- Support for Point of Care Testing in the community
- Development of rapid/syndromic testing
- Close working and communication with partnership organisations and other stakeholders from an early stage to facilitate change, for example pathology networking.
- Pathology walk-in service
- Contract with outsourcing companies to support Histopathology reporting service
- SLA with HHFT for Clinical Scientist 1.5 days a week

National

- CDC establishment
- Requirement to form a pathology network
- Kidney failure risk equation implementation (2024)
- Digital pathology targets by 2026.

System

- BSW pathology work (CDC focussed)
- Southern Counties Pathology Network

Place

- Balancing Wessex and ICS networks.
- GP and community relationships and work, particularly in context of network development.
- Support for point of care testing in the community.

Our key service relationships and interdependencies

- Internally: almost all clinical services require pathology services.
- Externally: Southern Counties Pathology Network, UHS, UHD, HHFT, RUH, GWH, UKHSA Bristol, local primary and community providers.

Our Priorities

Short term (12-18m):

- Southern Counties Pathology Network final form.
- Shift pattern reconfiguration in laboratory medicine.
- Serology assay work to improve time to result.

Medium term (3-5y):

- More molecular testing
- LIMS and digital pathology

Long term (7-10y):

- Local hub performing tests for wider partners
- Reduced outsourcing
- Voice recognition
- Strong voice in network.

Our patients today are…

Half internal, and half from primary and community care.

Drawn from almost every specialty in the trust and as such broadly represent our catchment demography.

In 10 years our patients will be…

Changed by impact of CDCs on which patients come to site, southern counties pathology network impacts, ageing, and increasingly engaged with in the community.

Our demand is…

- Increasing in laboratory medicine partly due to backlog work.
- Increasing from primary and community care.

Our capacity to meet that demand is…

- Broadly appropriate with some stress due to running vacancies.
- Other space and equipment issues prevent full capacity being realised.

Pharmacy

NHS Salisbury NHS Foundation Trust

People

- We invest in our people to give them what they need to be able to have a good life at work
- Increased response to the staff survey
- Improving Together has started in the dispensary and is next to come to the clinical team

Population

- Be part of the development and roll out of ePMA to virtual clinics allowing the immediate sending of prescriptions to community pharmacies
- Reducing harm caused by the use of medications.

Partnerships

- Health inequalities: scope the development of a by post code focused discharge scheme aimed at those in the poorest post codes with a shared rota across the AHA of clinical pharmacy staff calling patients to counsel them on their discharge meds 2-5 days post discharge
- Our ICS – Shared outpatient dispensing services, shared developments such as an inequality focused discharge scheme and shared consultant pharmacist posts
- Link in with the local GP practices so that they can speak to a specialist pharmacist when needed to about their patients who have just been discharged

National

- Procurement is being restructured and expanded to ensure that each staff member is working to the limit of their skills and license
- The dispensary is registered with the GPhC

System

- Group network and engagement with ICS chief pharmacist.
- Development of an aseptic hub and spoke model for the region.
- Shared EPR, Electronic FP10 prescribing system

Place

- Community pharmacy partnerships and potential acquisition.
- Wessex cancer network.

Our key service relationships and interdependencies

- Internally: almost all clinical services require pharmacy services. BI, porters, estates, OD&P.
- Externally: Group network, Wessex networks, local primary and community care.

Our Priorities

Short term (12-18m):
- Workforce structure
- Digital changes embedded.

Medium term (3-5y):
- Workforce upskilling, review of pharmacy support services.
- Review of outpatient dispensary services.

Long term (7-10y):
- Aseptics hub and spoke
- Electronic prescribing and transmission to community pharmacy

Our patients today are…
Drawn from every specialty in the trust and as such broadly represent our catchment demography.

Increasing in complexity.

In 10 years our patients will be…

Ever more complex as a higher number of patients fall in the elderly co-morbid category.

Our demand is…

- Increasing due to unfunded service model changes such as virtual wards and SDEC.
- Outstripping capacity for medicines reconciliation in line with NICE guidance.

Our capacity to meet that demand is…

- Broadly appropriate for some aspects such as cancer.
- Establishment is not fully staffed resulting in pressures to capacity.
- A consequence of trade offs between TTOs, Med Rec provision, and CD audits

Radiology

People

- Mental health first aiders, therapy dog visits, and out of work social events.
- Support for flexible working.
- Deploying improving together
- Focussing on staff survey engagement, celebrating success, and acting on areas for improvement.

Population

- Facilitating 28-day Faster Diagnosis Standard and 62 day cancer.
- Smoking cessation advice available from Sonographers when attending for pregnancy scans.

Partnerships

- More extended scope roles provide more opportunities for health promotion in line with the revised HCPC standards for proficiency for Radiographers
- Contract with InHealth to provide mobile CT and MRI scanners, as part of the CDC
- Contracts with outsourcing companies to support reporting.

National

- Saving babies lives, care bundle 3.
- Full CDC implementation.
- 28d faster diagnosis standard
- 62d cancer standard.

System

- Group workforce sharing opportunities.

Place

- Wessex networks.

Our key service relationships and interdependencies

- Internally: IT, procurement, medical physics
- Externally: UHS (isotopes), UHD, Medicare, InHealth, Group, BSW ICB.

Our Priorities

Short term (12-18m):

- Explore network options to support sub-specialist work.
- Retention.

Medium term (3-5y):

- Equipment replacement
- Ultrasound workforce development.
- Supporting work to reduce cancer waits.

Long term (7-10y):

- Staffing the CDC CT and MRI scanners.
- Maximising AI benefits
- Development of advanced practice roles.

Our patients today are…

Almost all of our patients, 90%+ of secondary care patients will need imaging.

High numbers of cancer patients.

In 10 years our patients will be…

Taking advantage of a greater number of technological developments in imaging.

More complex and co-morbid.

Our demand is…

- Driven by other services and increases in line with diagnostic work to support waits performance.

Our capacity to meet that demand is…

- Broadly adequate, as evidenced through DM01, but stretched as services require more radiology capacity to meet their increased activity.

Speech & Language Therapy

NHS Salisbury NHS Foundation Trust

People

- To support staff retention we will:
  - create career structure enabling progression that rewards skills, experience, competency and responsibilities.
  - ensure job satisfaction by ability to provide adequate dosage of treatment for patient benefit

Population

- Cleft SaLT is part of a Specialist Regional Service and is active in research.
- Continue to use new technology and IT to deliver effective treatments.
- Currently engaging in the new EPR to improve records in relation to SaLT patients.
- Continue to use telehealth to reduce unnecessary travel for patients and staff.
- Patient engagement groups currently under development.

Partnerships

- Support to other departments within SFT for joint MDT clinics (Cleft, ENT, Radiology, Stroke) to support LoS improvement.
- Work with regional providers to improve service and organisational resilience.
- Working to reduce inequity of access to, and quality of, services across the region.

National

- Regularly updated cleft national service recommendations.
- Spinal SaLT provision guidance set out by 'Spinal Cord Injury Clinical Network *standards of care for rehabilitation*'.

System

- Work to integrate BSW VCSE community partners into service models.

Place

- Work to integrate with and support the fragmented service delivery across Wiltshire.

Our key service relationships and interdependencies

- Internally: Stroke, Radiology, ENT, AMU, IT, Finance
- Externally: Community SaLT teams, ICB, Regional network

Our Priorities

Short term (12-18m):
- SaLT provision to Imber
- Dedicated SaLT for ITU patients
- Improved flexible career structure

Medium term (3-5y):
- Dedicated SaLT for regional spinal unit.
- SaLT training for hospital MDT staff.

Long term (7-10y):
- Access to intensive SaLT treatment
- Recognised specialist centre for instrumental assessment
- Review impact of ICS on cleft commissioning

Our patients today are…
Regional cleft pathways, non-cleft speech referrals, stroke unit, general acute, and outpatients.
Cleft is mostly children, adults with acquired medical disorders include stroke, head injury, tumour, spinal, Parkinson's, MND, MS, dementia, and ENT specific conditions.

In 10 years our patients will be…
Potentially benefitting from integrated commissioning.
Due to ageing populations a greater number of AMU and AFU patients may need specialist SaLT support.
Experiencing less unwarranted variation if we succeed in our improvements.

Our demand is…
- Up ~ 115% over the last 15 years.
- Driven by improvements in LoS performance in Stroke (pressure to complete pathway pre-discharge).
- Increasing as regards instrumental assessments and intensivity.

Our capacity to meet that demand is…
- Adequate across the regional cleft service, but under establishment for the non-cleft workload.
- Currently no provision of SaLT to critical care due to capacity constraint.
- Unmet need across outpatient workload

Sexual Health

People

- Flexible about teams working patterns as possible to help with retention.
- All trained clinical staff are dual trained and non-trained are currently progressing through pathway.
- Due to being a small team, resilience does have a big impact on the team.

Population

- Groups we're failing to reach including young people are not routinely accessing the service, although work with schools, SARC and Maternity takes place to ensure patients accessing all service are able to get what they need.
- Limited online testing available for those who chose not to or cannot access clinics.
- Urgent slots accommodated throughout the week for those who need to be seen.
- Clinical record system – there could be efficiencies through having one single system.

Partnerships

- Targeted work – could develop a specific outreach team who could do events / target groups we fail to reach across BSW.
- Consideration to be given to service sustainability give than existing commissioning arrangements are loss making for SFT.

National

- Specialised commissioning covering the service may be devolved to ICBs.

System

- Work to integrate across the Group.
- Reconcile (as with HINs and Pathology networks) our three organisations facing different networks.

Place

- Increased outreach activity to groups and communities we currently fail to reach.

Our key service relationships and interdependencies

- Internally: menopause, dermatology, gynaecology, IT
- Externally: ICB, Group, regional network

Our Priorities

Short term (12-18m):
- Enhance phone response rate
- Recruit to establishment
- Reporting and IT improvements.

Medium term (3-5y):
- Online booking and testing
- Long-acting reversible contraception (LARC) guidance adherence
- Conclude current contract and renegotiate terms.

Long term (7-10y):
- Better reach into target demographics.
- Increased access and service opening times.
- Financial sustainability in new contract.

Our patients today are…

Accessing us as an 'open access service' – for anyone from anywhere.

Could be seen in better settings but come to Sexual Health due to longer waits elsewhere.

Drawn from a large military population.

In 10 years our patients will be…

Drawn from more of the groups we fail to reach as we improve outreach aspects of the service.

More complex, particularly in the HIV diagnosed population.

Our demand is…

- Increasing for contraception and STI screening.
- Demand for menopause management, dermatological and gynaecological issues places additional pressure on the service.
- Only 25 % of patients are currently offered an appointment within 48 hours (target >98%)

Our capacity to meet that demand is…

- Not resilient due to a small team with single points of failure.
- Strained by the need to deliver unfunded activity beyond contract.
- Limited as regards home testing.
- Unable to deliver outreach clinics.

Spinal

People

- Staff wellbeing- temperature checks as part of the Improving together drive metric
- Reputation- Guttmann conference hosts for 2024
- Improving Together- weekly huddles and scorecard agreement set
- Behaviours – sign up from staff around expected behaviours.

Population

- Personalised care, patient directed where possible.
- Working toward national standards- full implementation dependent on workforce model.

Partnerships

- Referring teams- Network model to help transition to a more seamless model.
- Community teams- working with charities and national colleagues to address gap in community service provision.
- Network- SFT clinical lead for the Network.

National

- Nation standards and service specification need review.
- Commissioning may move to ICBs
- Network approaches to deepen.

System

- ICB commissioning.
- Guttmann conference hosts 2024.
- System offer in the event new estate is secured around tangential and skill sharing services.

Place

- Improved working with local community services to support discharge for Wiltshire patients.

Our key service relationships and interdependencies

- Internally: diagnostics, therapies
- Externally: national network, major trauma centres, charities, local community services

Our Priorities

Short term (12-18m):
- Embedding and delivering improving together scorecard
- Implementation of new national standards of care
- Optimising capacity

Medium term (3-5y):
- Scoping alternative models of delivery
- Improved environment
- Fully integrated network model

Long term (7-10y):
- Centre of excellence
- Preservation of supra-regional service.

Our patients today are…
Traumatic and non traumatic patients with spinal cord injury.
Older than they once were, 58 is not the average age of our users, in 1990 this was 43.
Often living with multiple co-morbidities.
Benefitting from safer vehicles, better health and safety at work, and

In 10 years our patients will be…

Older still and presenting with more complex co-morbidity, including mental health conditions.

Our demand is…
- Beyond commissioned service, we have 48 beds and 39 are commissioned.
- Driven by our role as a regional provider of the spinal cord injury service.

Our capacity to meet that demand is…
- Broadly appropriate.
- Increasing with the acquisition of additional estate.

Therapies

People

- A focus on rehabilitation and recovery will enable greater understanding of the areas of need for development and training, increasing professional development opportunities and thinking differently about the development of new roles to meet patient need in the right place, with the right skills and at the right time.

Population

- A personalised approach to rehabilitation and recovery across 24 hours
- Equitable access to ensure recovery throughout the patient pathway
- Education for patients and their family and carers to enable confidence in understanding and management of their condition

Partnerships

- Collaborative working with partners in health and social care, and third sector
- We will have good knowledge of services and be able to signpost to appropriate services, developing good links and enabling continuity of care

National

- NICE guidelines after Critical illness and GPICS require OT provision on ICU
- BSSH and BAHT National Standards of care in Hand Trauma. These have just been re-written and updated
- Stroke 7-day service and new guidance.

System

Contribution to AHP workforce projects managed from GWH

Manage AHP workforce projects for:

- Calderdale
- Practice Education
- Preceptorship

Support AHP faculty and council.

Place

- New working relationships with changing community providers.
- Reduction of NC2R numbers.

Our key service relationships and interdependencies

- Internally: medicine and surgical DMTs
- Externally: Group peers, Wessex network South west regional AHP network

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Our Priorities

Short term (12-18m):

- Review leadership roles
- Support NCTR improvements
- Complete practice educator training for 2 staff and embed roles
- Pilot reablement roles in ward numbers
- Reframe OT role (currently filling gap in discharge coordinators)

Medium term (3-5y):

- Job Planning
- Demand and capacity planning across group
- EPR

Long term (7-10y):

- Long term rehab plan and commitment

Our patients today are…

Mostly over 65 with complex co-morbidities and ongoing care needs.

Drawn from all socio-economic demographics representing the local community, but more so in recent years from the military community and those with decreased family support systems.

In 10 years our patients will be…

Older still and presenting with more complex co-morbidity. Likely with longer recovery times due to more complex surgery on older and more frail patients.

A greater proportion of military patients.

Our demand is…

- Across acute inpatients, rehab inpatients (Spinal, Burns, plastics and Stroke) and out patients (hands, Wessex and burns)
- Increasing frailty and dependence of patients take increase time and numbers to manage.
- Driven by increased orthopaedic elective surgery
- Turnaround time for NC2R patients increases demand and pressure.

Our capacity to meet that demand is…

- Stretched, and unable to always meet demand
- Limited opportunity for Rehab impacts system pressures.
- Limited further in the event therapies are prioritised for NCTR work.
- Needs to be included in BCs which increase work which impacts Therapy.

Women & Newborn

Fertility, Gynaecology, Maternity, and Neonatal Intensive Care Unit.

Fertility

People

- Giving training and development opportunities to our medical, embryology and nurse staffing by aiming for advanced practice, delivering clinics, to support with staff well-being and maximise retention, job satisfaction and career progression.
- Support training opportunities for specialist registrars to develop services with involvement in service improvement.
- Improvement in appraisal rate and quality for staff retention, development and morale.

Population

- Using advanced technologies PGTA (Preimplantation Genetic Testing of Aneuploidy)/embryo biopsy – improves KPIs.
- Expanding peripheral clinics to grow service and fully utilise laboratory resource.
- Nurse led infertility clinics increase to free up consultant time, drive productivity and enhance patient experience.
- Advanced nurse practice and prescribing to increase efficiency.
- Driving patient engagement in care.

Partnerships

- Partnerships with peripheral clinics in primary and secondary care to align care models and provide community care where possible.
- Military health service engagement to provide equitable access.
- HFEA (human fertilisation & embryology authority) engagement.
- Homecare company – Healthnet Homecare
- Mellowood Medical
- Bristol Pathology for accredited testing

National

- HFEA continues to evolve regulation, particularly in light of new treatments.

System

- Improving and maintaining outreach clinics.
- Exploring what Group opportunities exist to collectively expand services and ensure resilience.

Place

- Work with primary care and ensure offer to local population is improving. I.e. donor sperm banking to prevent travelling out of area.

Our key service relationships and interdependencies

- Internally: Pathology, Procurement, theatres, finance
- Externally: Mellowood Medical, HFEA, Bristol Pathology, ICB, Military organisations, Healthnet Homecare

Our Priorities

Short term (12-18m):

- Increasing procedure activity while maintaining performance.
- Workforce stabilisation.
- Safe nurse and embryology working.
- Procedures and treatments under sedation out of the theatre environment.
- Clearly articulated business plan

Medium term (3-5y):

- Increased egg collection activity
- Improve QMS, purchase and integration of Ipassport
- Full utilisation of a digital system.

Long term (7-10y):

- Donor sperm bank
- Bigger premises with parking, own procedural rooms and better embryo storage.
- Maintenance of NHS assisted conception service within acute setting for complex patients.

Our patients today are…

Drawn from a larger geography than most of our DGH services.

Quite diverse due to societal changes, i.e. more same sex couples, and older couples.

In 10 years our patients will be…

More likely, based on emerging trends, to include a higher prevalence of transgender, single patients, same sex couples, and egg freezing. While longer term, global fertility rates are decreasing with global population peaking in the middle of this century. This may increase demand for fertility services.

Our demand is…

- Largely driven by IVF/ICSI and FET cases. Smaller volumes exist for egg freezing, IUI, DI, sperm banking, surgical sperm retrieval, and ovulation induction.
- Demand is highly variable.

Our capacity to meet that demand is…

- Fragile due to vacancy, space pressures and theatre capacity challenges
  Skill mix is currently quite junior and this limits activity and expansion opportunity.

Gynaecology

NHS Salisbury NHS Foundation Trust

People

- Training and development opportunities for nursing, allied health professional, and non-Consultant Medical staff to provide efficient and cost-effective activity.
- Development of staff to enable succession planning for clinical leadership.
- Improvement in appraisal rate and quality to contribute towards retention aims and improve staff morale.

Population

- Using advancing technologies such as robotic surgery to offer other options to our population.
- Decreasing time to first outpatient appointment and gynaecology wait times.
- Recover 19/20 RTT position and improving faster diagnosis.
- Focus on equality by ensuring services are accessible to all groups
- Increasing patient engagement in personalised care and service development.
- Reduction in follow ups in secondary care setting and promoting self-care closer to home.

Partnerships

- Engagement across BSW on women's health hubs and moving care into the community.
- Engaging primary care to design referral-free pathways which move from community into secondary care and out, without heavy administration.
- Promotion of cervical screening for population health, targeted toward groups we fail to reach and JSNA target populations.

National

- Supporting national FDS and change to CWTs.

System

- Development of Group level service resilience and sub-specialism.
- Clinical networks to be maintained across Wessex.

Place

- Women's health hubs.
- More aligned pathway management with primary care.
- Training offer to local GPs.

Our key service relationships and interdependencies

- Internally: Theatres, cancer, pathology, ultrasound, dermatology.
- Externally: ICB, Wessex clinical networks, community providers, military establishments

Our Priorities

Short term (12-18m):
- Increase in nurse led activity.
- Reducing time to first outpatient appointment.
- Theatre efficiency.
- Greater proportion of one-stop provision.

Medium term (3-5y):
- Expansion of advanced practitioner roles.
- Building partnerships with primary care and community providers.
- More sustainable MVA service.

Long term (7-10y):
- Outpatient treatments off-site.
- Referral free patient pathways.
- Sub-specialty services shared across the group eg pelvic floor, menopause, vulval skin.

Our patients today are…

Expecting timely care and access to senior clinicians.

Often choosing SFT over other sites, driving demographic diversity in the patient cohort.

In 10 years our patients will be…

Older and more complex with increased need for 2ww referrals for bleeding and HRT services.
More demanding regarding options.
increase expected in transgender patients.

Our demand is…

- Largely driven by recovering our waits performance.
- National campaigns ie. Cervical screening
- Patient expectations

Our capacity to meet that demand is…

- Broadly adequate and increasing as efficiency work takes effect.
- Somewhat dependent on our ability to build partnerships with community services.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.3
Date of meeting:	6th March 2025		

Report title:	SPF Refresh 2025/26			
Status:	Information	Discussion	Assurance	Approval
	X			X
Approval Process: (where has this paper been reviewed and approved):	Executive Directors Trust Management Committee Improving Together Board			
Prepared by:	Tony Mears, Associate Director of Strategy			
Executive Sponsor: (presenting)	Alex Talbott, Director of Improvement			

Recommendation:

It is recommended that the Board **approve** the changes to the SPF for 2025/26.

Executive Summary:

Our refreshed strategic planning framework continues our progress against the vision to provide "an outstanding experience for our patients, their families and the people who work for and with us."

The framework is structured around three key pillars: People, Population, and Partnerships.

The refresh includes several important changes for 2025-26:

Breakthrough Objectives (18-24 month focus):

- After sustained improvement (6 months in a row at target), the patient deterioration objective will evolve to specifically target pressure injury prevention
- After sustained improvement (6 months in a row at target), the staff retention focus will shift to increasing completed appraisal rates
- Continuing objectives include reducing time to first outpatient appointment and creating value for our patients.

Strategic Initiatives (3-5 year horizon):

- "Creating a culture of continuous improvement" transitions to "embedding" this culture, reflecting growing maturity in the improvement methodology
- Digital care focus sharpens to specifically target pathway design improvements
- Developing a sustainable workforce continues
- Health inequalities work evolves into "Designing services to meet population needs" to better align with system-wide healthcare transformation

Vision Metrics (7-10 year measures):

- The healthy life years metric will be refined to specifically track inequity gaps in the data
- Aiding our collective constancy of purpose, other key metrics remain unchanged, including staff engagement scores, turnover reduction, wait times, harm incidents, patient engagement, length of stay and organisational sustainability.

Process Improvements:

- Implementation timelines have been accelerated to enable both divisional and specialty-level scorecard agreements before the new financial year
- Additional support clinics have been stood up for vision metrics, and strategic initiative versions of these are due to begin in March 2025.

The framework maintains continuity in key areas while evolving to meet emerging needs and organisational maturity. There's particular emphasis on embedding improvements in areas where progress has been made and pivoting our improvement work as sustained improvement is delivered.

The refresh positions the Trust to better integrate with system partners and respond to population health needs while maintaining focus on operational excellence and staff development. Implementation will be supported by a structured timeline to ensure effective deployment across all levels of the organisation and be overseen via the Improving Together Board.

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

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Strategic Planning Framework Refresh 2025/26

Our Strategy 2022-26
IMPROVING together

Strategic Planning Framework: 2024-25

Vision

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

Salisbury NHS Foundation Trust

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
- Helping people live healthier lives for longer
- Reducing overall length of stay
- Organisational Sustainability

Strategic initiatives 3-5 years

- Creating a culture of continuous improvement
- Developing a sustainable workforce
- Delivering Digital Care
- Improving health and reducing health inequalities

Corporate Projects

Breakthrough Objectives 12-18 months

- Recognising and managing patient deterioration well
- Reducing patients' wait time to first outpatient appointment
- Increasing additional clinical staff retention
- Creating value for our patients

Strategic Planning Framework: 2025-26

Vision

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

Salisbury NHS Foundation Trust

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 inequity in healthy life years
- Reducing overall length of stay
- Organisational Sustainability

Strategic initiatives 3-5 years

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

Corporate Projects

Breakthrough Objectives 18-24 months

- Recognising and managing patient deterioration well → Pressure injury
- Reducing patients' wait time to first outpatient appointment
- Increasing additional clinical staff retention → Appraisal rates
- Creating value for our patients

Summary of changes

Breakthrough Objectives

- Constancy of purpose through continued commitment until sustained improvement.
- Following sustained improvement ‘managing patient deterioration’ will move to addressing ‘pressure injury’, and ‘retention of staff’ will move to increasing our ‘appraisal rate’.

Strategic Initiatives

- ‘Creating a culture of continuous improvement’ moves to ‘Embedding our culture of continuous improvement’ in recognition of the position our improving together methodology deployment is in. This also ensure our continued focus on the OMS.
- ‘Delivering Digital Care’ receives a refresh and tighter focus to become ‘Delivering Digital Care to improve pathway design’. Making sure we leverage the digital opportunities available to us in the coming years, including EPR.
- ‘Improving Health and Reducing Health Inequalities’ is reshaped to ‘Designing services to meet population needs’ which will allow us to encompass more of our service redesign and external partner engagement as we seek to play a role in the left shift of healthcare with our system partners. This will, by necessity, include focus on reducing health inequity in both outcomes and access to our services.

Vision Metrics

- To ensure there remains a focus on health inequity our vision metric tracking healthy life years will be narrowed to the inequity gap that exists within that data.

Process

- We have timed the SPF refresh cycle to facilitate the specialty layer scorecard agreements in addition to the divisional agreements, ahead of the new financial year.
- We have stood up additional support clinics for vision metric and strategic initiative owners to develop this work, and further our understanding of fully deploying the methodology in these areas.

Timeline

Step	Date
Final exec sign off and scorecard prep	28th January
Exec > TMC scorecard	17th February
Divisional scorecard agreements	17th – 28th February
Specialty scorecard agreements	3rd – 14th March
Trust-wide Comms & MD Start the week	17th March
New SPF Visual & Trust-wide Comms	31st March
Operationalisation	April DPRs & PRMs

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Our **Strategy** 2022-26

IMPROVING together

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.4
Date of meeting:	6th March 2025		

Report title:	Strategy Horizon Extension			
Status:	Information	Discussion	Assurance	Approval
		X		X
Approval Process: (where has this paper been reviewed and approved):	Managing Director & Director of Improvement (by correspondence)			
Prepared by:	Tony Mears, Associate Director of Strategy			
Executive Sponsor: (presenting)	Alex Talbott, Director of Improvement			

Recommendation:

It is recommended that the Board:

- **Approve** a two year extension to the 2022-26 SFT Strategy, taking us to 2028.
- **Approve** an interim strategy statement (2026 – 2028), and stocktake of strategy delivery, to be published in March 2026.

Executive Summary:

This paper proposes a two-year extension to Salisbury NHS Foundation Trust's current 2022-2026 strategy, which would align our strategic timeline across BSW Hospitals Group. This alignment presents a significant opportunity for strategic harmonisation across our region.

Since publishing our current strategy in 2022, the healthcare landscape has evolved considerably. The COVID-19 pandemic's immediate effects have been superseded by other strategic developments including a change in national government, the statutory formation of Integrated Care Systems, changes in Trust leadership, and the establishment of the BSW Hospitals Group.

With both RUH and GWH having strategic horizons ending in 2028, and the BSW Integrated Care System strategy also running until 2028, extending our own strategy would create alignment across all major healthcare organisations in our region. This synchronisation would facilitate more cohesive planning and implementation of shared priorities.

The proposed approach includes:

- Extending our current 2022-2026 strategy by two years to 2028
- Publishing an interim strategy statement and delivery stocktake in March 2026

The interim statement would not constitute a wholly new strategy but would:

- Update stakeholders on critical contextual changes
- Take stock of strategy delivery progress to date

- Outline next steps through to 2028
- Utilise focused engagement, particularly drawing on service strategy responses

This approach provides several benefits including alignment with our partners, time to mature the Group Strategic Planning Framework, and an opportunity to refine our direction based on the evolving context.

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

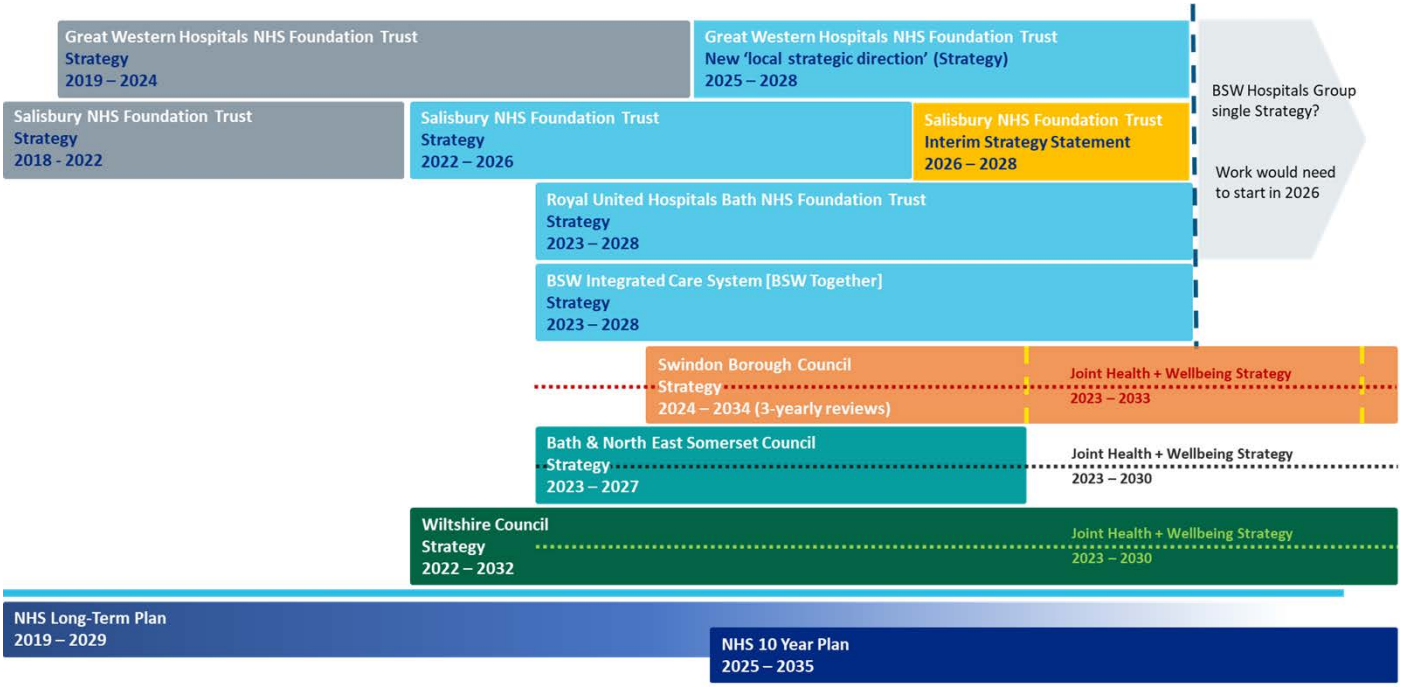
STRATEGY HORIZON EXTENSION

1. Background & Context

1.1 In 2020 Salisbury NHS Foundation Trust (SFT) published a four year strategy covering 2022-26. This followed a previous iteration 'Salisbury NHS Foundation Trust Strategic Plan 2018 – 2022'.

1.2 When the current strategy was published in 2022 the effects of the COVID 19 pandemic were still the dominant strategic context. Since then, there has been a change of national government, the formation of integrated care systems (ICS) into their statutory form out of shadow form, several changes in Trust leadership, and the formation BSW Hospitals Group.

1.3 There has historically been little strategic alignment (as regards time horizons) across BSW. However, with the ICS strategy running from 2023 – 2028, the Royal United Hospitals (RUH) Bath NHS Foundation Trust strategy running from 2023 – 2028, and the Great Western Hospitals (GWH) NHS Foundation Trust strategy running from 2025 – 2028, there is a clear opportunity for strategic harmonisation and having one strategy for BSW Hospitals Group.



2. Recommendation

2.1 That Board **approve** a two year extension to the 2022-26 SFT Strategy, taking us to 2028.

2.2 That Board **approve** an interim strategy statement (2026 – 2028), and stocktake of strategy delivery, to be published in March 2026.

3. Rationale & Benefit

3.1 With our BSW Hospitals Group peers both having committed to strategy horizons ending in 2028 there is a significant opportunity for us to align Group strategy beyond that with minimal disruption to existing strategic work.

3.2 Group Strategic Planning Framework (SPF) work continues to mature, with the first Group-level Engine Room planning for 25/26. We will have time to practise our Improving Together methodology for strategy deployment at Group ahead of publishing a 2028 strategy.

3.3 There are further alignment opportunities available at the system level due to the strategy horizon of the BSW ICS concluding in 2028. This will allow us the option to build aligned strategies across both the Group and ICS.

3.4 Publishing an interim strategy statement will give us the opportunity to hone our strategic direction grounded in a context that has evolved significantly since 2022. By 2028 there will have been two sets of elections across the Wiltshire geography, a general election will be within 12 months, and Strategic Authorities will be forming which have the potential to disrupt existing public service (including health) geographic boundaries. All of which will require an aligned strategic response.

3.5 Publishing an interim strategy will also give us the opportunity to issue a stocktake of strategic delivery over the life of the 2022-26 strategy.

4. Next Steps

4.1 By March 2026, building on the service strategy responses and Improving Together scorecard agreements, conduct a stocktake of strategic delivery by the organisation.

4.2 By March 2026, prepare an interim strategy statement charting the strategic direction of the organisation to 2028. This interim statement would not be a wholly new strategy but:

- 4.2.1 Provide updates to where critical context has changed, such as the formation of BSW Hospitals Group and the change in national policy direction.
- 4.2.2 Take stock of strategy delivery to date, and what our next steps are until 2028.
- 4.2.3 Would utilise some, but not full, engagement – the service strategy responses providing key clinical input for example.

ANNEX A – SFT STRATEGIES

Our Strategy 2022 – 2026: ourstrategy_2022-2026.pdf

Our Strategy 2018 – 2022: sfttruststrategyfeb18.pdf

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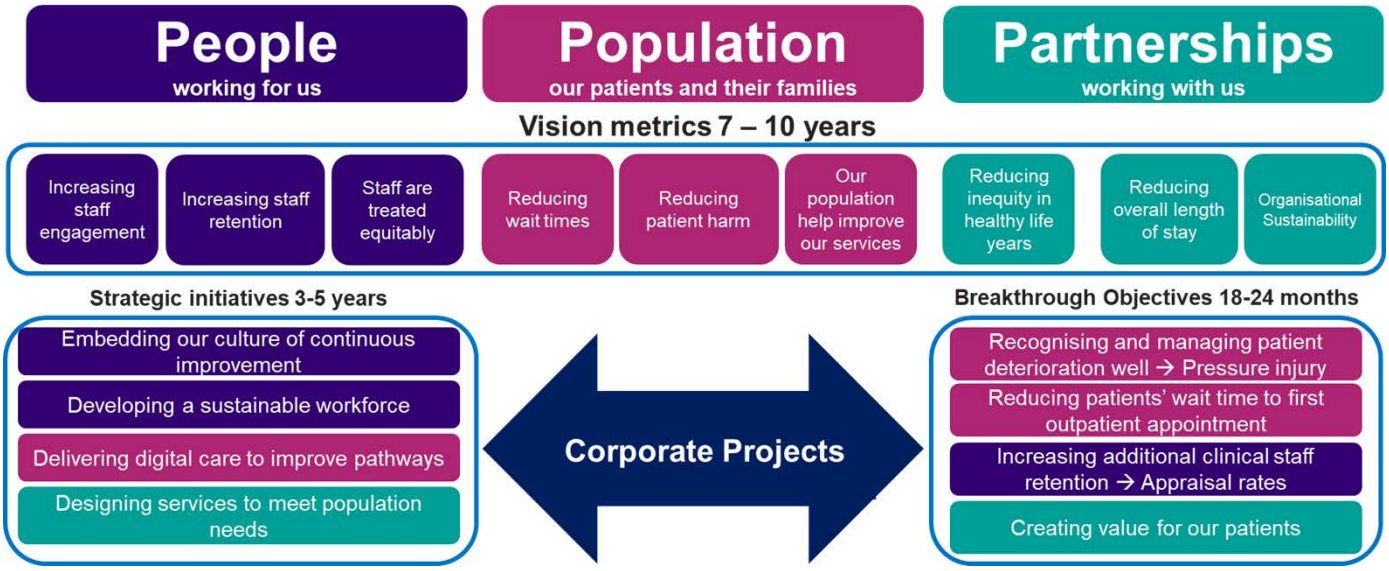
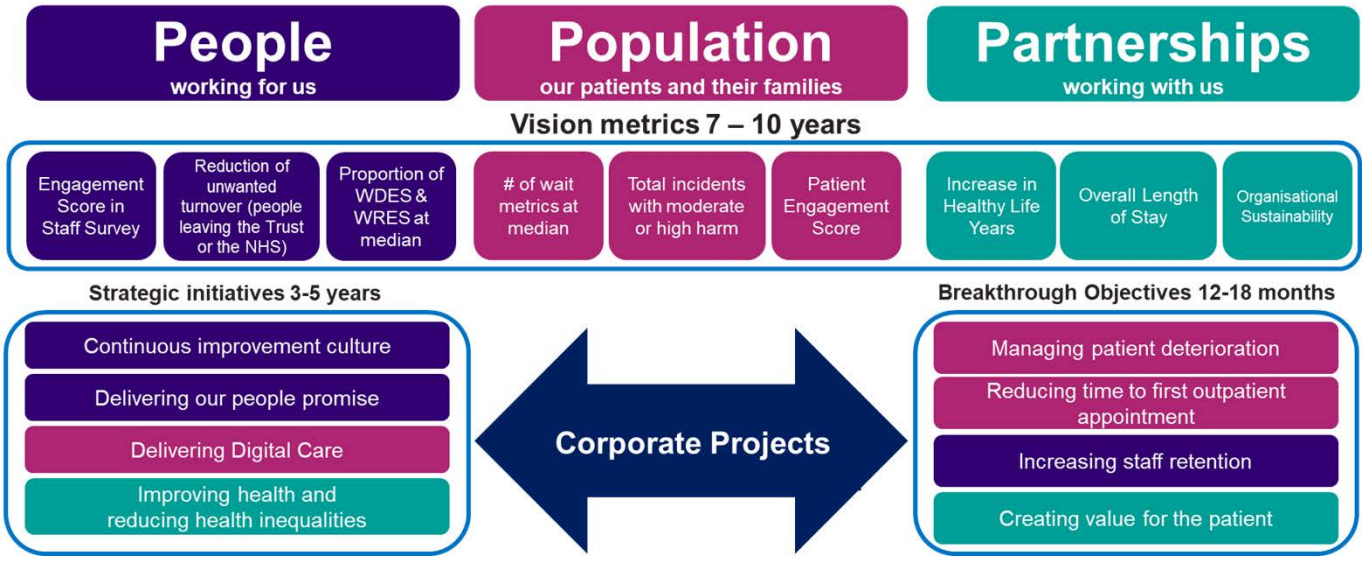
ANNEX B – STRATEGIC PLANNING FRAMEWORKS

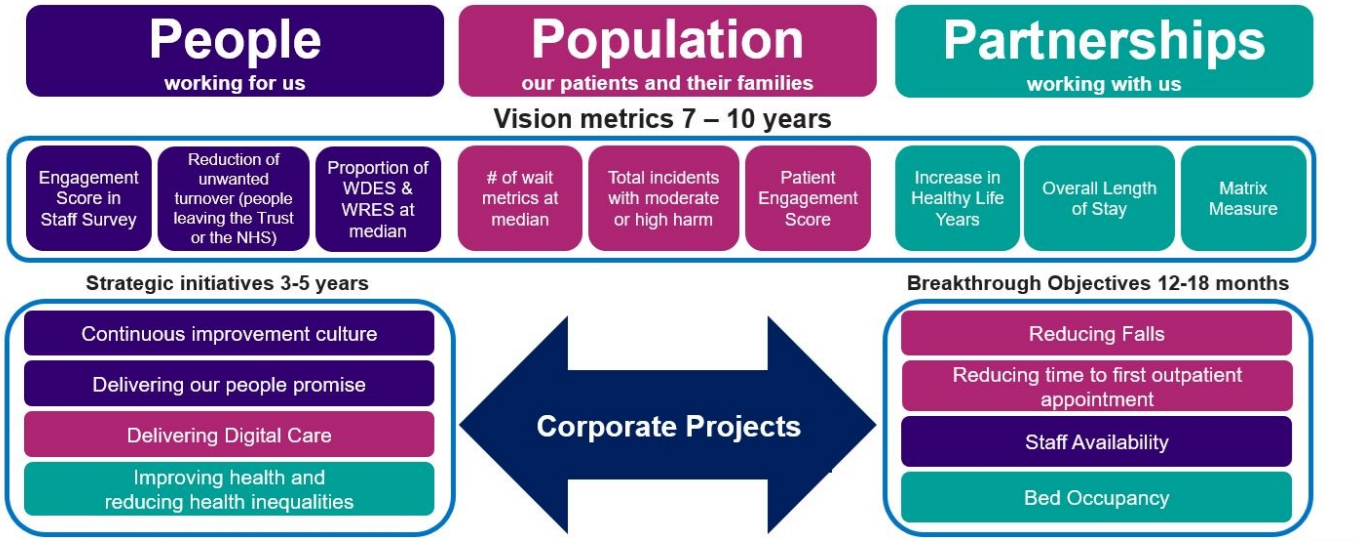
2025-26



2024-25



2023-24


People
working for us
Population
our patients and their families
Partnerships
working with us
Vision metrics 7 – 10 years
Engagement Score in Staff Survey
Reduction of unwanted turnover (people leaving the Trust or the NHS)
Proportion of WDES & WRES at median
# of wait metrics at median
Total incidents with moderate or high harm
Patient Engagement Score
Increase in Healthy Life Years
Overall Length of Stay
Matrix Measure
Strategic initiatives 3-5 years
Continuous improvement culture
Delivering our people promise
Delivering Digital Care
Improving health and reducing health inequalities
Corporate Projects
Breakthrough Objectives 12-18 months
Reducing Falls
Reducing time to first outpatient appointment
Staff Availability
Bed Occupancy