Somerset NHS Foundation Trust was created from the merger with Yeovil District Hospital NHS Foundation Trust

NHS Somerset NHS Foundation Trust

SOMERSET NHS FOUNDATION TRUST
PUBLIC BOARD MEETING

A Public meeting of the Somerset NHS Foundation Trust Board will be held on **Tuesday 5 March 20224** at **9.00am** in the Moxon Suite at Frome Community Hospital, Enos Way, Frome, BA11 2FH.

If you are unable to attend, would you please notify Mrs Ria Zandvliet, Secretary to the Trust at Somerset NHS Foundation Trust by email on ria.zandvliet@somersetft.nhs.uk

Yours sincerely

COLIN DRUMMOND
CHAIRMAN

AGENDA

		Action	Presenter	Time	Enclosure
1.	**Welcome and Apologies for Absence**		Chairman	09:00	Verbal
2.	**Questions from Members of the Public and Governors**		Chairman		Verbal
3.	**Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 6 February 2024**	Approve	Chairman		Enclosure A
4.	**Action Logs and Matters Arising**	Review	Chairman		Enclosure B
5.	**Registers of Directors' Interests and Receive any Declarations of Interests relating to items on the Agenda**	Note and Receive	Chairman		Enclosure C
6.	**Chairman's Remarks**	Note	Chairman		Verbal
7.	**Chief Executive and Executive Directors' Report**	Receive	Peter Lewis	09:10	Enclosure D
OBJECTIVE 2 – Provide the best care and support to people					
8.	**Assurance Report of the Quality and Governance Assurance Committee meeting held on 24 January 2024**	Receive	Jan Hull	9:20	Enclosure E
9.	**Learning from Deaths Framework: Mortality Review Progress Report**	Receive	Daniel Meron/ Katy Darvall	9:30	Enclosure F

OBJECTIVE 8 – To develop a high performing organisation delivering the vision of the Trust					
10.	**Quality and Performance Exception Report**	Receive	Pippa Moger	9:40	Enclosure G
OBJECTIVE 6 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture					
11.	**Assurance Report of the People Committee meeting held on 17 January 2024**	Receive	Kate Fallon	9:55	Enclosure H
12.	**Six Monthly Staffing Establishment Report**	Receive	Hayley Peters/ Alison Wootton	10:00	Enclosure I
13.	**Six Monthly Freedom to Speak Up report**	Receive	Isobel Clements	10:15	Enclosure J
10.25 – 10.40 Coffee Break					
OBJECTIVE 7: To live within our means and use our resources wisely					
14.	**Finance Report**	Receive	Pippa Moger	10:40	Enclosure K
15.	**Verbal report from the Finance Committee meeting held on 26 February 2024**	Receive	Martyn Scrivens	10:55	Verbal
16.	**Capital Programme for 2024/25**	Approve	David Shannon	11:00	Enclosure L
17.	**Assurance Report from the Audit Committee meeting held on 10 January 2024**	Receive	Paul Mapson	11:15	Enclosure M
FOR INFORMATION					
18.	**Follow up questions from the Public and Governors**		Chairman	11:20	Verbal
19.	**Any other Business**		All		Verbal
20.	**Risks Identified**		All		Verbal
21.	**Evaluation of the Effectiveness of the Meeting**		Chairman		Verbal
22.	**Items to be discussed at the Confidential Board Meetings** The items presented to the Confidential Board include:				

23.	**Withdrawal of Press and Public** To move that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.				
24.	**Date of Next Meeting** Tuesday 7 May 2024			11:30	

PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 6 FEBRUARY 2024 AT TAUNTON RUGBY CLUB

PRESENT

Colin Drummond	Chairman
Alexander Priest	Non-Executive Director
Martyn Scrivens	Non-Executive Director
Jan Hull	Non-Executive Director
Paul Mapson	Non-Executive Director
Kate Fallon	Non-Executive Director
Graham Hughes	Non-Executive Director
Inga Kennedy	Non-Executive Director
James Phipps	Associate Non-Executive Director (non-voting)
Tina Oakley	Associate Non-Executive Director (non-voting)
Peter Lewis	Chief Executive
Phil Brice	Director of Corporate Services (non-voting)
Andy Heron	Chief Operating Officer
David Shannon	Director of Strategy and Digital Development (non-voting)
Isobel Clements	Chief of People and Organisational Development
Hayley Peters	Chief Nurse
Merry Kane	Deputy Chief Medical Officer (non-voting)

IN ATTENDANCE

Fiona Reid	Director of Communications
Rebecca Lambert	Adult Congenital Heart Disease Nurse (for item 13)
Tom Rees	Guardian of Safe Working (for item 17)
Ben Edgar-Attwell	Deputy Director of Corporate Services (minute taker)

1. WELCOME AND APOLOGIES FOR ABSENCE

1.1. The Chairman welcomed all Board members and attendees to the Board meeting and confirmed that the meeting was quorate.

1.2. It was noted that apologies had been received from Dan Meron (Chief Medical Officer). Merry Kane, Deputy Chief Medical Officer, was deputising in his absence.

1.3. The Chairman reported that Sube Banerjee had stood down from his position as Non-Executive Director on 31 January 2024 as he had recently been appointed as Pro-Vice Chancellor at the University of Nottingham and it was no longer practical for him to continue. The Chairman reported that Inga Kennedy's appointment as an

Associate Non-Executive Director (no voting rights) had been converted into an appointment as a Non-Executive Director (with voting right) from 1 February 2024.

2. QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS

2.1. It was noted that no questions from members of the public had been received.

3. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 7 NOVEMBER 2023

3.1. Kate Fallon proposed, Graham Hughes seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 7 November 2023 as a correct record.

4. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST EXTRA ORDINARY PUBLIC BOARD MEETING HELD ON 20 NOVEMBER 2023

4.1. Kate Fallon proposed, Graham Hughes seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 20 November 2023 as a correct record.

5. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST EXTRA ORDINARY PUBLIC BOARD MEETING HELD ON 6 DECEMBER 2023

5.1. Kate Fallon proposed, Graham Hughes seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 6 December 2023 as a correct record.

6. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST EXTRA ORDINARY PUBLIC BOARD MEETING HELD ON 16 JANUARY 2024

6.1. Pippa Moger advised that her apologies should be recorded for the above meeting as it currently recorded her as in attendance. In addition, the reference to the clinical decisions centre should be amended to community diagnostic centre. Subject to the two amendments, Kate Fallon proposed, Graham Hughes seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 16 January 2024 as a correct record.

7. ACTION LOGS AND MATTERS ARISING

7.1. The Board received the action log and noted that the action regarding scheduling a further discussion on the six-monthly inclusion report was in progress with a deep dive scheduled for the People Committee, feedback from which would be reported to the Board as part of the regular assurance reports.

8. REGISTERS OF DIRECTORS INTERESTS AND RECEIVE AND DECLARATIONS OF INTERESTS RELATING TO ITEMS ON THE AGENDA

8.1. The Board received the Register of Directors' interest and noted the following change:

- Martyn Scrivens – to add "Director of Ardonagh International Limited".

8.2. There were no declarations in relation to any of the agenda items.

9. CHAIRMAN REMARKS

9.1. The Chairman advised that Leadership Quality Walkarounds were being planned for the year, and when dates were confirmed, Governors would be invited to join. Inga Kennedy said that the walkarounds were beneficial, and asked where the outcomes of the visits were reported. The Director of Corporate Services advised that the executive leads are required to complete the feedback reports and the outcomes of these, including any thematic findings, are reported to the Quality and Governance Committee.

9.2. The Chairman highlighted the tremendous input and support provided by the third sector and charitable organisations, including the great support and funding raised for the Breast Unit at Yeovil District Hospital. In addition, the support from volunteers is invaluable. Without the input from all sectors, the NHS and social care system would be in a much more challenging position. The Chairman thanked all for their help and support.

9.3. The Chairman advised that Maurice Dunster, Chairman of Symphony Healthcare Services (SHS), had stood down from his role at the end of January 2024. Kate Fallon has taken on this role until her term as SFT NED ended in May 2424 after which Martyn Scrivens would become Chairman of SHS.

10. CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS REPORT

10.1. The Chief Executive presented the report which set out a number of significant and positive developments. The report was received by the Board.

10.2. The Chief Executive particularly highlighted the decision around acute stroke services. The Somerset Integrated Care Board (ICB) had met in January 2024 and, following public consultation, agreed a proposal to move to a single Hyper Acute Stoke Unit (HASU) at Musgrove Park Hospital in Taunton, providing 24/7 emergency treatment. This would be supported by a HASU in Dorset Country Hospital. The acute stroke units at both Musgrove Park Hospital, Taunton and Yeovil District Hospital, Yeovil would be maintained, meaning that, following their emergency stroke treatment, patients could move to Yeovil Hospital if this was closer to where they live. The decision was made subject to the ICB Finance Committee's findings in terms of required expenditure and affordability.

10.3. Martyn Scrivens noted that this had been discussed at length at the ICB Board meeting, but asked for assurance that Dorset Country Hospital NHS Foundation Trust is able to absorb the increased demand into their HASU. The Chief Executive advised that this was a key point, and the Somerset ICB was to review this as part of the process; no change in service would take place until this has been received. The change would be phased in across the next 18 months.

10.4. In addition, the Board requested that suitable and appropriate communications take place in terms of what this means for both patients and colleagues. The Chief Executive confirmed that this had been discussed at the ICB Board meeting and the ICB will be leading on the wider communications.

10.5. The Chief Executive further highlighted: the recent maternity services Care Quality Commission (CQC) inspection which took place in November as part of the national programme. The formal report had not yet been received. He further highlighted the receipt of planning permission for the new Yeovil Diagnostic Centre with work to commence soon.

10.6. The Board discussed the report and commented/noted:

- The result from the recent CQC inspection of the Burnham and Berrow Medical Centre, which was part of Symphony Healthcare Services. The centre had received a *Good* rating which was a fantastic achievement and turnaround since integration into Symphony. The Chief Operating Officer outlined the work which had taken place in recent months. Although this had been challenging, it was a good resolution for the 16,000 patients served in the area. The Board suggested that it was important to capitalise on this achievement and to share learning across the whole system and particularly across primary care services. The Chief Operating Officer confirmed that this work was taking place with new models of care being developed and transposed to other Primary Care Networks.

- The announcement of Dr Melanie Iles as the Trust's new Chief Medical Officer from 1 April 2024 following Dr Daniel Meron's retirement.

11. BOARD ASSURANCE FRAMEWORK AND Q3 2023/24 CORPORATE RISK REGISTER REPORT

Board Assurance Framework (BAF)

11.1. The Director of Corporate Services highlighted the key risks on the BAF, and the additional detail included to illustrate the position against the Trust's Risk Appetite and Risk Tolerance statements. This amendment highlighted that there are a number of risks to the strategic objectives over and above the appetite level which reflected the challenges faced by the NHS and the Somerset system and which impacted on standards. There are significant risks within primary care services and relationships with primary care services are vital. It was noted that some of the highest risks are around staffing and recruitment challenges.

11.2. A session is planned for April 2024 to review the Trust's Risk Appetite and Risk Tolerance position and the actions being taken to address any variance. The findings from the recent CQC inspections will assist in this process.

11.3. The Board discussed the report and commented/noted that:

- The BAF had been discussed at the relevant Board Committee meetings. The Quality and Governance Assurance Committee (QGAC) was also receiving a series of annual presentations covering the flagship clinical integration priorities and the strategic objectives allocated to the Committee.

- Inga Kennedy said that the work of the QGAC was fantastic, and discussions had taken place about how to plan for the next year and how the various Trust strategies and progress is brought to life, recognising that some strategies will take time to be implemented and outcomes achieved. This would form part of the planned session in April 2024. The Chief Nurse added that it was not intended for the Board to micromanage and create an overly burdensome process for the service groups and services to manage their strategies but recognised that there was a need for flexibility to take account of changes in circumstances.

- Martyn Scrivens highlighted the importance of identifying and acknowledging what was within the Trust's control and acting on this, but to also identify the underlying causes of the risks or issues to be addressed.

Corporate Risk Register

11.4. The Director of Corporate Services presented the report which was received by the Board. The Board discussed the report and commented/noted the following points:

- It was acknowledged that the report included details to outline processes. As this information was repeated on a quarterly basis, it was requested that reoccurring information is moved to an appendix to the report in order to focus discussion on the key risks and issues and have clarity on the movement and changes in the quarterly reports. This would aid identification of themes and the impact on the wider environment. The Director of Corporate Services agreed that this could be useful and provided an update on the processes to move to a single risk management system and the consolidation of risks. The Risk Management team is working through this and using it as an opportunity to focus discussions within the devolved governance model.

- It was agreed that there was a need to be open and flexible in terms of how the Board is assured on the management of risks and this may involve deep dives via the different committees.

- The People Committee has recently amended its approach to managing the risks to the organisation that are related to the committee which involves reflecting on the culture of the organisation and the impact culture has on the organisation. This approach is challenging but should identify less tangible risks that are not always visible through existing reports.

12. FIT AND PROPER PERSON FRAMEWORK UPDATE

12.1. The Director of Corporate Services presented the report which outlined the new Fit and Proper Persons Framework published by NHS England in response to the recommendations made by Tom Kark KC. The changes are not applied retrospectively but apply to any new appointments or leavers.

12.2. A number of proposals were outlined within the report, including extending the scope of the framework to deputies (senior managers deputising for executive directors if required); the need for subsidiary companies to comply with the framework; and the need for an annual report of compliance to be presented to the Board and Council of Governors. The processes, controls and compliance would also be subject to review by internal audit every three years.

12.3. The Deputy Director of Corporate Services added that, since the drafting of the report, recent communications have advised that the Board Member Appraisal Framework was now expected to be published end of Q1 2024/25 and therefore the first annual submission returns for the framework will now be expected in September 2024.

12.4. The Board discussed the report and commented/noted the following points:

- It was noted that this revised framework required additional work and administration and it was questioned what the wider benefit of this would bring to the organisation and whether the Trust could implement what was appropriate and brought about direct benefit. The Director of Corporate Services noted this point but recommended that the framework was implemented in its entirety as it was a national requirement and would form part of any Well-Led inspection of the Trust. The Trust would otherwise need to justify why it was not implementing the framework and this would be difficult to do.

12.5. On this basis, the Board approved the full implementation of the framework and the proposals as outlined within the report.

13. PATIENT STORY – MATTERS OF THE HEART

13.1. Rebecca Lambert, Adult Congenital Heart Disease Nurse, joined the meeting for this item.

13.2. Rebecca Lambert provided context of Adult Congenital Heart Disease (CHD), of which the incidence rate is 8 per 1000 live births. Success of cardiac surgery and cardiology treatment in infancy has improved life expectancy with 95% of CHD patients, including complex, rare and severe conditions reaching adulthood. It is therefore a growing cohort of patients. Care for CHD patients is provided within a network, of which the Trust is a level 3 centre, with Bristol being our level 1 centre. Patients were previously having to travel to multiple appointments for tests and consultations. The Trust now undertakes “one stop” clinics for complex patients

reducing the need for multiple appointments on different dates. This includes all tests and consultant review in one day.

13.3. There had previously been a lack of transition clinics for patients moved from paediatric services to adult services which had caused challenges for patients. Transition clinics have now been in place for the past four years with the Specialist Nurse meeting with all complex patients and families in paediatrics at least once. This allowed for better relationships and individuals planning for transfer to adult services.

13.4. The Board heard patient stories of two different patients, Ashley and Dion, who are seen by the team and the stories showed the brilliant work carried out to tailor the Trust's approach dependent on the needs of the patient. Due to the complex nature of CHD patients, it is not always possible for them to be seen through the one stop clinic and the team have adapted to the needs of patients and relatives. The stories included quotes from Ashley's mum and Dion which demonstrated the difference the flexible approach has made to Ashley and Dion and their families.

13.5. Ashley's mum had said "*Knowing that I can call you with any worries has made a real difference. Ashley hates hospitals and it's sad that you never get to see the real Ashley. However, you try to make things easier for him and we appreciate it*", whilst Dion had said "*Without you, I probably wouldn't have gone to hospital for any appointments. You have made it easier, and you get me*."

13.6. Rebecca Lambert explained that there had been many positive impacts on the wider team, with the Specialist Nurse role able to build relationships with the patients which has led to better compliance and a reduction in DNA rates. There has also been a reduced need for consultant time and appointments and the links with the level 1 centre has led to smoother patient journeys and speedier transfer to Bristol when required.

13.7. The Board discussed the report and commented/noted that:

- Rebecca Lambert and the team were complimented on their excellent work and positive impact on patients.

- It was queried whether there could be improved interaction between the team and mental health workers bearing in mind SFT is a fully integrated trust and there could be real benefit from joint working between the physical and mental health teams. There was also a potential need to improve the transition for carers of patients moving from children to adult services. Rebecca Lambert agreed that there would be benefits of improved working with the mental health team and this work had started. Joined up systems would also support this work as there were currently different systems between physical and mental health services.

- The Chief Nurse suggested that this was a masterclass in reasonable adjustments and person-centred care. There is a national direction about productive care and efficiencies, and this often includes colleagues working at the top of their licence. The Board discussed the benefits and disbenefits to

this approach, which can mean that added value and relationship building is lost – therefore working to the top of licence is not always the best option and in fact is not always rewarding.

- It was recognised that there is a great benefit to a change in approach and communication, such as colleagues using mobile phones and messaging with patients. This will need to be recognised and investment in technology will need to be included in future budgets as there could be a greater benefit in the longer term from this investment at a relatively low cost.

- The Board noted that patients with CHD are often supported and cared for by their parents, who themselves are aging. It was asked what could be done in anticipation of the support that families will need in time. Rebecca Lambert said that this was a growing concern and the team provide support where it can, such as through letters of support to relevant authorities etc. The Chief Nurse questioned whether the voluntary sector could or needed to be part of the one stop clinic arrangements.

- The Deputy Chief Medical Officer highlighted the current different networks for patients in Musgrove Park and Yeovil Hospital. She asked whether there was work to align and work with colleagues across the Trust and networks. Rebecca Lambert said that relationships are being built with colleagues in Southampton to ensure that patients receive the best service for them. It is important to ensure that all patients are receiving the service requirements as part of network standards.

14. ASSURANCE REPORT OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING HELD ON 22 NOVEMBER 2023

14.1. Jan Hull presented the report which was received by the Board. She highlighted the areas of assurance received and the areas to be reported to the Board. The areas to be reported to the Board related to:

- The annual report from the Mental Health and Learning Disabilities Service Group provided strong assurance on the governance processes and the grip and control on their devolved responsibilities. There was an issue specifically noted in the review around a lack of a commissioned service for neurodiversity.

- An update was received on the Patient Safety Incident Response Framework (PSIRF) implementation which was progressing well and the PSIRF policy and plan had been approved.

- The Committee was updated on the strategy and processes for suicide prevention. A lot of assurance was received; however, Somerset was an outlier in this area and there will need to continue to be a focus on this area. There are several complexities for underlying causes for this performance and the Committee will continue to review performance. Access to real time information is challenging.

- The Committee remained concerned about medication reviews on discharge at Musgrove Park. Actions were being taken but there remained concern about the pace of the implementation of actions. This would continue to be reviewed and monitored.

- The Committee reviewed evidence and updates on the Maternity Incentive Scheme which had also been considered at the December meeting. There have been some issues around the detail of the evidence against the ten safety action standards when comparing against the initial feedback from the CQC inspection. The team had commissioned internal audit to support the process with a focussed discussion prior to the declaration being made. The Trust declared compliance with six out of the ten standards. Both Musgrove Park and Yeovil Hospital declared full compliance in previous years. There were changes to the scheme this year and not all changes to evidence required to declare compliance had been identified. This was not about the clinical outcomes for service but non-compliance largely due to how evidence was recorded and monitored. A measured approach will be taken as to how to improve processes for year 6 of the scheme.

15. QUALITY AND PERFORMANCE EXCEPTION REPORT

15.1. The Chief Finance Officer presented the report which was received by the Board. She highlighted the areas of good performance and provided an overview of the key performance challenges across the trust.

15.2. The Board discussed the report and commented/noted:

- The Trust was achieving the 6-week standards for adult and older persons' waiting time for mental health services.

- The perinatal service standard was achieved despite the challenges from a reduction in nurses.

- There was an increase in demand and vacancies in the Talking Therapies service. Although standards were being achieved, it was expected that performance will deteriorate going forward.

- Good performance was noted against the people metrics.

- There continue to be challenges within the emergency departments of both acute sites as a result of the high number of patients with no criteria to reside in both acute hospitals. This aligns with the reduction in ambulance handover time performance, but the Trust does compare relatively well compared to the region.

- The cancer standards have changed on a national level and there are now only three standards. The Trust was below the national standard for the 31-

day target although compared better than the average. There had been a peak in referrals to the suspected breast cancer pathway. Performance against the 62-day standard was below both the national target and the national average due to challenges in urology and colorectal pathways with significantly higher demand. Increases in diagnostic waiting times had also impacted on performance.

- The Board noted the number of ligature point incidents. This was a higher number but related to a relatively small number of patients - 31 of the 39 incidents on Rydon Ward relating to one patient. The service group had completed a deep dive into this area and an assurance visit was being planned by the South West Provider Collaborative which had included experts by experience. The Chief Operating Officer explained that patient pathways are reviewed to consider what is best for the patient as admission to a hospital can generate further stress and anxiety. The review will consider whether the service is more inclined to admit people with complex emotional needs. With regard to the environment, the inpatient wards are relatively modern wards with careful consideration of the design of all aspects of the environment. Ligature incidents can include items not directly related to the ward environment. A review of all data and incidents is ongoing. The Chief Nurse added that both she and the Chief Medical Officer had attended multi-disciplinary team meetings and ward reviews as part of the process. A recalibration of pathways may be required to ensure that community support is available and appropriate.

- There had been an upward trend in pressure ulcers and falls which will be reviewed and discussed at the QGAC meeting. This was in line with a national increase although there were additional challenges with different IT systems. Further validation is taking place, and a dedicated session is also to be held with the Council of Governors on this topic. This work should link back to a review of the basic standards of care.

- Stroke performance continued to be an area of concern at Yeovil Hospital, especially concerning performance of stroke patients admitted to a stroke ward within four hours with a marked difference in compliance for Musgrove Park Hospital. The Chief Nurse advised that the improved performance at Musgrove Park Hospital was linked to the recent bed reconfiguration and the learning from the work at Musgrove Park Hospital will be applied to Yeovil Hospital. In addition, there had been challenges in discharges to and from community services which impacted on performance. The Chief Executive said that this was an important context in terms of the stroke service configuration with challenges in delivering the service at the Yeovil Hospital site.

- The Board highlighted the need to ensure that utilisation rates for diagnostic capacity was reviewed. The Director of Strategy and Digital Development confirmed that this was taking place as part of the work on productive care, and this included a review of booking areas and processes and late cancellation and DNA rates. Theatre utilisation was also being reviewed.

16. ASSURANCE REPORT OF THE PEOPLE COMMITTEE MEETING HELD ON THE 8 NOVEMBER 2023

16.1. Kate Fallon presented the report which was received by the Board. She highlighted the areas of assurance received and the areas for follow up.

16.2. The Committee was reviewing how best to use and monitor data and information for workforce and finance. There are difficulties in linking the datasets, but this was being reviewed. In addition, the leads are working on refining the agendas for the Committee meetings to ensure that the agendas are focused on the right areas, such as recruitment, culture, wellbeing etc. The Committee will triangulate people matters and will meet ten times a year and regular deep dives will be presented to the Committee.

17. GUARDIAN OF SAFE WORKING FOR POSTGRADUATE DOCTORS REPORTS

17.1. Tom Rees, Guardian of Safe Working – MPH, attended the meeting for this item. He presented the report which was received by the Board.

17.2. The Board discussed the report and commented/noted that:

- The number of exception reports continued to be subject to cyclical variations with peaks in September and October and are likely due to the new rotation of postgraduate doctors not familiar with the hospital systems. The reports largely related to overtime. The number of exception reports within Musgrove Park Hospital remains high.

- A new rota management system, with clear reporting processes, will be implemented and it was possible that the increased accessibility could lead to a higher number of reports submitted.

- One immediate safety concern (ISC) had been reported at Musgrove Park Hospital because of a shortened working day relating to an occupational health recommendation. Tom Rees advised that he was meeting with the relevant educational supervisor to ensure that there were adequate cover arrangements during this period.

- There were a number of outstanding exception reports. Tom Rees stated that these should be dealt with quickly and should be easy to resolve. The importance of signing the exception reports off will be raised with the teams and education supervisors.

- It was questioned how the Trust compared to other trusts. The Deputy Chief Medical Officer reported that this had been discussed regionally, and whilst the granular numbers vary, the trends are seen across organisations, including the cyclical nature of reports. Culture is important for site-by-site differences with a higher number of Specialty and Specialist Doctors (SAS) doctors at Yeovil Hospital compared to Musgrove Park Hospital.

The process highlights areas of focus and areas which might require additional support.

18. VERBAL REPORT FROM THE FINANCE COMMITTEE MEETING HELD ON 29 JANUARY 2024

18.1. Martyn Scrivens, Chairman of the Committee, provided feedback from the meeting held on 29 January 2024 and advised that the Committee reviewed the finance report.

18.2. There had been a focus on the capital programme following accounting policy changes and the impact of RPI on the Trust's balance sheet. At present, it is suggested that this impact is reduced from the capital allocation for the following year. This will be a significant amount and the impact was being flagged with the regional and national teams. It was queried whether this would impact on any future project proposals. The Director of Strategy and Digital Development advised that this should not adversely impact proposals although it would need to be planned for. The Yeovil Diagnostic Centre has this impact built into the business case.

18.3. There had been an update on the Electronic Health Record (EHR) programme. The business case is to be developed jointly with Dorset and the funding requirements will be known in due course. It was stressed that a single EHR was a priority.

18.4. The Board discussed the need to review workforce information against the relevant financial data and how these datasets join up, and ultimately where this should be overseen. It was agreed that this would be taken forward outside of the meeting to ensure that adequate assurance on the systems and processes can be provided to the Board.

19. FINANCE REPORT

19.1. The Chief Finance Officer presented the financial report which was received by the Board. She particularly highlighted:

- In December 2023 the Trust recorded a surplus of £0.210m, this was £0.535m adverse compared with the plan for the month. Cumulatively, the Trust is £5.062m in deficit, this is £0.535m adverse when compared with the planned position for the period. The in-month adverse variance resulted from the industrial action in December 2023. Excluding the industrial action, the Trust was consistent with the H2 plan trajectory. No additional funding has been identified to cover this variance and it is not yet known if additional funding would be provided or if it would be an allowable variance.

- Agency expenditure was £0.533m higher than November 2023 although a number of longstanding vacancies had now been filled which should see a reduction in medical agency spend.

- Cumulatively, savings of £20.447m have been delivered compared with the planned delivery of £21.294m at the end of December 2023, an under delivery of £0.121m. Of the savings delivered so far, 54% (£10.963m) are recurrent.

- In terms of planning for 2024/25, the Trust was in an unprecedented position as the detailed planning guidance had not yet been released. The lack of timely guidance was a concern. Assurance was provided to the Board that the finance teams were working on the assumed position, but this was challenging without the detailed guidance and targets. The delay was understood to be a result of ongoing discussion between the NHS and the Treasury.

20. ASSURANCE REPORT FROM THE CHARITY COMMITTEE MEETING HELD ON 14 NOVEMBER 2023

21.1. Graham Hughes presented the report which was received by the Board. He highlighted the following points:

- The work of the fundraising team in raising funds for the Breast Unit at Yeovil Hospital.

- The ongoing work with the League of Friends and the support and work they have provided to the Trust.

- The portfolio of long-term funds had increased in value more than £140k.

21. ASSURANCE REPORT FROM THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON THE 12 DECEMBER 2023

21.2. Alexander Priest presented the report which was received by the Board. He highlighted the areas of assurance received, the areas for follow up and the areas to be reported to the Board. He noted that Governors have asked for a review of how the Trust supports patients on Community Treatment Orders following the outcome of the tragic events in Nottingham. This will be reviewed at the March 2024 meeting.

22. FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS

22.1. There were no follow up questions from members of the public or, specifically, Governors although feedback was received regarding the acoustics of the room which made it difficult to hear all discussions. The Deputy Director of Corporate Services apologised and agreed to review this for future meetings. **Action: Deputy Director of Corporate Services.**

23. ANY OTHER BUSINESS

23.1. The Chief Nurse reported that Musgrove Park Hospital's maternity services had recently been reaccredited for UNICEF Baby Friendly for the third time, meaning that it had achieved this accreditation for over ten years. This was a great achievement and was a credit to the team. The Chairman congratulated the team on behalf of the Board.

24. RISKS IDENTIFIED

24.1. The Director of Corporate Services reiterated the large number of high rated risks and noted the following risks: stroke services reconfiguration and internal performance, pressure ulcers and core standards elements, ligature incidents, and current lack of financial planning guidance.

25. EVALUATION OF THE EFFECTIVENESS OF THE MEETING

25.1. The Board agreed that the meeting had been productive with a wide range of topics covered in detail, including the patient story. It was recognised that some items had overran but it was important to give time to discuss these items. It was agreed that the Board had been open and frank in all discussions.

25.2. The acoustics and meeting facilities will need to be reviewed as will the effectiveness of hybrid face to face and virtual meetings.

26. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

26.1. The Chairman highlighted the items for discussion at the confidential Board meeting and set out the reasons for including these items on the Confidential Board agenda.

27. WITHDRAWAL OF PRESS AND PUBLIC

27.1. The Board moved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

28. DATE FOR NEXT MEETING

5 March 2024

SOMERSET NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETING HELD ON 7 FEBRUARY 2024

	AGENDA ITEM	ACTION	BY WHOM	DUE DATE	PROGRESS
22.	**Follow up questions from the public and governors**	To review the acoustics of meeting venues and the possible need for microphones.	Ben Edgar-Attwell	Ongoing	The layout of meeting venues and acoustics will be considered at every meeting. Discussions are taking place about the loan of table microphones.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Registers of Directors' Interests
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Colin Drummond, Chairman
DATE:	5 March 2024

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
☐ For Assurance	☐ For Approval / Decision	☐ For Information

Executive Summary and Reason for presentation to Committee/Board	The Registers of Interests are presented to the Board at every meeting and reflect the interests of Board members as at 26 February 2024.
Recommendation	The Board is asked to: • note the Register of Interests; • declare any changes to the Register of Interests; • declare any conflict of interests in relation to the agenda items.

Links to Joint Strategic Objectives
(Please select any which are impacted on / relevant to this paper)

☐ Obj 1 Improve health and wellbeing of population
☐ Obj 2 Provide the best care and support to children and adults
☐ Obj 3 Strengthen care and support in local communities
☐ Obj 4 Reduce inequalities
☐ Obj 5 Respond well to complex needs
☐ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☐ Obj 7 Live within our means and use our resources wisely
☐ Obj 8 Develop a high performing organisation delivering the vision of the Trust

Implications/Requirements (Please select any which are relevant to this paper)					
☐ Financial	☒ Legislation	☐ Workforce	☐ Estates	☐ ICT	☐ Patient Safety/ Quality
Details: N/A					

Equality and Inclusion
The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. **How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?**
No impact on people with protected characteristics has been identified as part of the attached report.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History
How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Public or staff involvement or engagement has not been required for the attached report.

Previous Consideration
(Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The report is presented to every Board meeting.

Reference to CQC domains (Please select any which are relevant to this paper)				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	☐ No

REGISTERS OF DIRECTORS' INTERESTS

NON EXECUTIVE DIRECTORS	
Colin Drummond Chairman	• Honorary Vice President of Calvert Trust Exmoor (outdoor holidays for people with disabilities) – current • President of Wadham College Oxford 1610 Society • Deputy Lieutenant for Somerset • Worshipful Company of Water Conservators – Deputy Master
Jan Hull Non-Executive Director	• Trustee of the Dulverton Abbeyfield Society. • Formerly Managing Director of South, Central and West Commissioning Support Unit
Dr Kate Fallon Non-Executive Director (Senior Independent Director)	• Daughter is a Consultant at the Trust • Symphony Health Services Board member • Daughter has been appointed as the Guardian of Safe Working Hours for Junior Doctors • Non-Executive Director Symphony Health Services
Barbara Gregory Non-Executive Director	• RESEC Research into Elderly and Specialist Care Trustee. • Deloitte Associate – with effect from 6 February 2018. • Chair of the CNL (Chairs, Non Executive and Lay members) Faculty of HFMA • Director of AGRF • Non-Executive Director at Torbay and South Devon Healthcare NHS Trust
Alexander Priest Non-Executive Director	• Chief Executive Mind in Somerset
Martyn Scrivens Non-Executive Director (Deputy Chairman)	• Non Executive Director and Chair of Audit Committee of Hampshire Trust Bank Limited • Wife works as a Bank Vaccinator for the Trust • Non-Executive Director and Chairman of Wesleyan Bank Limited, a 100% subsidiary of Hampshire Trust Bank Limited" (with effect from 28 February 2022) ▪ Member of the Boards of Directors of the Ardonagh Group – consisting of the following companies: – Ardonagh Holdco Limited (Jersey)

	– Ardonagh New Midco 1 Limited (Jersey) – Ardonagh Group Holdings Limited (UK) – Ardonagh New Midco 3 Limited (Jersey) – Ardonagh Midco 1 Limited (Jersey) – Ardonagh Midco 2 plc (UK) – Ardonagh Midco 3 plc (UK) – Ardonagh Finco plc (UK) • Director of Ardonagh International Limited
Graham Hughes Non-Executive Director	• Chairman of Simply Serve Limited • Parish Councillor of Babcary Parish Council
Paul Mapson Non-Executive Director	• Advisor to NHS Devon Health System
Inga Kennedy	• IJKennedy Healthcare Consultancy - Position - Director (however this Ltd Company is registered as not trading at this time. • Portsmouth Hospitals University Trust - Position - Non-Executive Director (end of term is Mar 24) • Isle of Wight NHS Trust - Position - Non-Executive Director (end of term is Mar 24)
Tina Oakley	• Son, Dr Tom Oakley, is Chief Executive Officer of a digital medical imaging company, Feedback plc.
EXECUTIVE DIRECTORS	
Peter Lewis Chief Executive (CEO)	• Member of the NHS Confederation Community Network Board • Management Board Member, Somerset Estates Partnership (SEP) Board • Director, Somerset Estates Partnership Project Co Limited
Phil Brice Director of Corporate Services	• Sister works for the Trust • Non-Executive Director of the Shepton Mallet Health Partnership • Shareholder Director of SSL
Isobel Clements Chief of People and Organisational Development	• Sister in law works in the pharmacy department at MPH • Nephew works as a physio assistant within MPH.

Andy Heron Chief Operating Officer/Deputy Chief Executive	• Wife works for Avon and Wiltshire Mental Health Partnership NHS Trust (and is involved in a sub contract for liaison and diversion services) • Director of the Shepton Mallet Health Partnership • Executive Director for SHS
Pippa Moger Chief Finance Officer	• Stepdaughter works at Yeovil District Hospital • Son works for the Trust • Director of the Shepton Mallet Health Partnership • Director of Somerset Estates Partnership Project Co Limited • Member of the Southwest Pathology Services (SPS) Board • Shareholder Director for SSL
Hayley Peters Chief Nurse	None to declare
David Shannon Director of Strategy and Digital Development	• Member of the Southwest Pathology Services (SPS) Board • Daughter is employed as a healthcare assistant at Musgrove Park Hospital • Member of the Symphony Health Care Services (SHS) Board • Director of Symphony Health Services (SHS) • Wife works within the Neighbourhood's Directorate. • Management Board Member, Somerset Estates Partnership (SEP) Board • Director Predictive Health Intelligence Ltd
Daniel Meron Chief Medical Officer	• Visiting Professor, Peninsula Medical School, University of Plymouth

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Chief Executive/Executive Director Report
SPONSORING EXEC:	Chief Executive
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Chief Executive
DATE:	5 March 2024

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
✓ For Assurance	☐ For Approval / Decision	☐ For Information

Executive Summary and Reason for presentation to Committee/Board	The purpose of the report is to update the Board on the activities of the executive and senior leadership team and/or points of note which are not covered in the standing business and performance reports, including media coverage and any key legal or statutory changes affecting the work of the Trust. The report covers the period 27 January to 23 February 2024.
Recommendation	The Board is asked to note the report.

Links to Joint Strategic Objectives
(Please select any which are impacted on / relevant to this paper)

☒ Obj 1 Improve health and wellbeing of population
☒ Obj 2 Provide the best care and support to children and adults
☒ Obj 3 Strengthen care and support in local communities
☒ Obj 4 Reduce inequalities
☒ Obj 5 Respond well to complex needs
☒ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☒ Obj 7 Live within our means and use our resources wisely
☒ Obj 8 Develop a high performing organisation delivering the vision of the Trust

Implications/Requirements (Please select any which are relevant to this paper)					
☒ Financial	☒ Legislation	☒ Workforce	☒ Estates	☐ ICT	☒ Patient Safety/ Quality
Details: N/A					

Equality and Inclusion The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
There are a range of issues covered in the report that highlight work we are doing and/or national initiatives in relation to equality, diversity and inclusion.

All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
The report includes a number of references to work involving colleagues, patients and system partners.

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The report is presented to every Board meeting.

Reference to CQC domains (Please select any which are relevant to this paper)				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	☐ No

SOMERSET NHS FOUNDATION TRUST

CHIEF EXECUTIVE / EXECUTIVE DIRECTOR REPORT

1. SOMERSET TOGETHEHR

1.1. With support from the regional and national NHS England teams, we have reached an agreement with the Integrated Care Board (ICB) and trusts in Dorset to collaborate on the procurement of a unified electronic health record (EHR) across Somerset and Dorset.

1.2. The programme will play an important role enabling us to realise the benefits of coming together as one healthcare provider in Somerset, improving health outcomes in our county. Although acute, community, and mental health services in Dorset are provided across three trusts, there is need for integration between them to support patient care which, together with other objectives, builds on the vision for our EHR.

1.3. We are now working with colleagues across Dorset to extend our business case to include the Dorset trusts and have established partnership and programme boards to support the combined programme. In the last few weeks, we have gone out to the market with high-level revisions to the scope of an EHR for Somerset and Dorset and are working towards launching procurement of the system in September 2024.

1.4. While this work continues, the programme team is engaging with colleagues on several readiness projects. These include a data migration project which will be supported by a data quality communications and engagement plan to promote the importance of accurate data entry and make improvements to our processes. We have secured the services of a data migration partner, and the team are now developing the strategy and scope for this.

2. UPDATE ON INDUSTRIAL ACTION BY JUNIOR DOCTORS

2.1. Planning has continued with service leads to ensure we can run our services safely during the latest period of industrial action by junior doctors that will run from 7am on Saturday 24 February to midnight on Wednesday 28 February.

2.2. We have updated our trust website with advice for the public, and NHS England shared a press release yesterday, linked to the latest national winter performance statistics.

2.3. Further national media is planned over the weekend and our ICB colleagues are supporting with additional signposting messaging targeted towards local communities over the next few days.

3. USE AND GROWTH OF CARE OPINION IN OUR TRUST

3.1. We are using and growing the use of Care Opinion across our trust and it is helping us to further understand and respond to the experiences of our patients and carers.

3.2. Care Opinion is an independent feedback website, which enables anyone to share their experiences of healthcare services through storytelling with the fundamental belief that by sharing honest experiences of care, we learn to see the world differently and patients' and carers' stories, both good and not so good, lead to change.

3.3. Emma Davey, Director of Patient Experience and Engagement, has been working with the Care Opinion team over the last few months and we have recently renewed our subscription to Care Opinion for four more years. The roll out of Care Opinion within our trust is well under way, supported by our patient engagement team, and in the last three months we have seen the numbers of responders grow by a third.

3.4. We currently average 22 stories per month and part of the performance measures of the patient experience and engagement team will be to increase the number of stories being told to inform our service groups and services.

3.5. The visualisation below visually represents the words that respondents have used in their feedback about our services. Green indicates a positive comment and red where things could have been better. In January 2023 there were no comments flagged red. I have also shared a story from a patient's family member and our response, showing how we aim to respond on a human level.

4. HOW WE'RE HELPING TO MAKE HIV TESTING PART OF EVERYDAY LIFE, FOR EVERYONE

4.1. The week of 5 to 11 February 2024 was National HIV Testing Week, and our Starling Clinic and Somerset-Wide Integrated Sexual Health (SWISH) colleagues want to reinforce the message that HIV testing is for everyone.

4.2. The national campaign strapline, 'I Test', serves as a crucial reminder that knowing your HIV status is a key step in maintaining good health and preventing the spread of the virus. HIV can affect anyone, but huge advances in treatment mean that those living with HIV can lead stable and healthy lives, without worrying about passing the virus to others. Treatment is now so good that very few people with HIV in the UK develop AIDS, but early diagnosis is key, and in Somerset, nearly one in two new HIV diagnoses are late, leading to poorer health and increased transmission.

4.3. In 2022, half of those aged 15 and older accessing HIV care in the UK were over 50 years old, compared with 27% in 2013. This rise is because effective treatment has led to fewer HIV-related deaths, and improved survival, as well as on-going diagnoses. In the same year, 50% of adults accessing HIV care were in the white ethnic group, 30% were black African, 11% were among the Asian or mixed or other ethnic group, and 5% were in the black Caribbean or black other ethnic group. And overall, 98% of the people living with a diagnosed inflection in England in 2022 received antiretroviral treatment (ART), compared with 90% in 2011.

4.4. During the week, our colleagues on the acute medical unit at Musgrove Park Hospital offered a free HIV test to every patient admitted to the unit, either from our emergency department or direct from their GP. Each patient was handed a leaflet that explains our HIV testing initiative, and if they have any questions or concerns, they can speak to the team. Of course, patients can choose to decline a test as it's opt-out, but we'll be strongly encouraging them.

How to get a HIV test

4.5. Testing for HIV is free, confidential, quick and easy, and puts you in control. There are a number of ways to test, including:

- **Self-testing at home -** order a test at freetesting.hiv, you just need a finger-prick blood sample and then you can read your own result immediately at home, or send off a blood sample and get results usually within 72 hours of posting
- **SWISH -** can offer a blood test where you get your results within 20 minutes. Go to swishservices.co.uk or call 0300 1245 010
- **The Eddystone Trust** - eddystone.org.uk/pages/testing
- Your local **GP**

- **Starling Clinic, Musgrove Park Hospital**

5. PUTTING SOMERSET ON THE HEALTHCARE SCIENCE MAP

5.1. Working together as the scientific backbone of the NHS is a profession that sets out to accelerate innovation and improve patient outcomes – our healthcare scientists!

5.2. There are over 50,000 healthcare scientists working across the NHS and public health services, including our own team here at Somerset FT. There is currently one fully-qualified consultant healthcare scientist and five trainee consultant healthcare scientists:

5.3. Our healthcare scientist colleagues make a real difference to patients every day, completing 80% of diagnostic imaging, and developing some of the most amazing clinical and technological advancements. They are found in many areas of the trust, typically, medical physics, audiology, cardiology, and neurophysiology.

5.4. Over the past few years, the trust has been developing an independent science faculty, and as part of that work, a unique role for a lead healthcare scientist has been created. The new role will lead the scientific community within the trust and will help to elevate the trust's profile as a leader in healthcare science both regionally and nationally.

6. CHANGES AT SIMPLY SERVE LTD

6.1. There have been a number of changes to the senior management at Simply Serve Limited (SSL) since the end of last year.

6.2. Clive Radstock left SSL at the end of December and Katie Mattravers is now taking on the role of Acting Managing Director of SSL for a period of time while we confirm its future management structure. We hope to conclude that review by 1 April 2024.

6.3. In addition, we have asked Dave Shire, Director of Estates and Facilities for Somerset FT, to work with Katie and the senior estates and facilities management teams in both Somerset FT and SSL, to undertake a review of the estates and facilities management functions across the whole of the trust. This is to consider how we make the greatest benefits from the two models of service we have and deliver the highest standards of estates and facilities support to colleagues, patients, and visitors across all our sites and services.

7. DR JAMES GAGG APPOINTED ROYAL COLLEGE OF EMERGENCY MEDICINE VICE PRESIDENT TREASURER

7.1. Dr James Gagg, an emergency medicine consultant and associate medical director for our medical services group, has been appointed to the prestigious role of RCEM vice president treasurer.

7.2. James follows the footsteps of two previous trust-based presidents of the college – the late Dr Cliff Mann and Mr Chris Cutting, the first consultant appointed in Somerset, who led RCEM when it was the British Association of Emergency Medicine from 1995 to 1998.

7.3. James says that sharing the same heritage as such strong leaders of the college gives him enormous pride. Changing the role of treasurer to vice president treasurer has given James an opportunity to put his own unique stamp on it. He brings a great wealth of RCEM experience after becoming a fellow in 2011 and then joining the research committee in 2016 for five years, before taking on a role as chair of the Southwest Regional Board in 2021.

8. ASSOCIATE DIRECTOR TRISH SPRUCE COLLECTS MBE FROM PRINCE WILLIAM

8.1. Wednesday 7 February 2024 was a very proud day in the Spruce household as our associate director for international recruitment, Trish, was awarded an MBE by Prince William. Trish Spruce was given the honour in a ceremony at Windsor Castle for her outstanding services to the NHS, particularly around recruiting international medics to the NHS.

8.2. Trish has worked in the NHS for over 20 years, originally at a large acute trust in Stoke-on-Trent, but always in recruitment and resourcing, including roles in the private sector where she recruited tyre fitters! She has worked for our trust for seven years, starting off at Yeovil District Hospital where she helped the legacy trust to meet the challenge of high vacancies, a number of looming retirements and a difficulty in retaining colleagues. It was in 2017 that Trish became involved in the first major international recruitment drive when she teamed up with Gemma Jorge, one of our ward sisters at YDH, to discuss a potential visit to the Philippines. With Gemma originally from the Philippines, she was able to use her insight to set up a comprehensive recruitment programme. The programme was so successful that it led to the creation of Yeovil International Recruitment, which recruited on behalf of a number of NHS trusts across England and Scotland, with over 3,500 international candidates working for the NHS nationally.

8.3. A huge thank you and well done to Patricia Spruce MBE!

9. APPOINTMENT OF NEW DIRECTOR OF MIDWIFERY

9.1. Following a very competitive interview process we are pleased to let you know that Sally Bryant will be joining us in the near future as the Director of Midwifery. We are excited that she has accepted the role and joins with a vast amount of experience as the DOM in Royal Devon University Healthcare Trust. She will lead the midwifery leadership team with our two recently appointed heads of midwifery, Ali and Steph.

9.2. We would also like to take this opportunity to thank Sallyann King for her dedication and achievements over the many years working in Somerset and specifically as the Director of Midwifery leading the SFT maternity merger. She plans to work clinically with us for a time, prior to retirement and there will be plenty of opportunities to celebrate and thank her for her passionate leadership of midwifery care in Somerset prior to her leaving the trust.

10. MEDIA COVERAGE

10.1. Over the period 26 January 2024 to 23 February 2024, there has been the following media coverage

- **Post-menopausal bleeding self-referral service to feature on regional news next week**
  On Thursday 22 February we hosted film crews from BBC Points West and ITV Westcountry at Bridgwater Community Hospital, where they heard all about the success of our new self-referral post-menopausal bleeding service. The story is expected to air on ITV Westcountry's evening news (6pm) on Monday 26 February and on BBC Points West's evening news (6:30pm) on Thursday 29 February. Keep an eye out on our social media channels too, where you will be able to hear from a patient and those involved in the service.
  The new service makes it easier to get checked for womb cancer. Since it was launched in September 2023 as a UK first, the average wait for an appointment has gone down from 63 days to just four days. So far over 150 patients have made a self-referral into the service, with two thirds meeting the criteria for an appointment, which they're contacted about by the NHS within 24 hours.

  It has also led to a significant increase in the number of patients in Somerset being given a cancer diagnosis or an all-clear result within 28 days of their referral. This has increased from just 41% for gynaecology in April 2023 to about 79% in January 2024 – which exceeds the national target of 75%.

  Womb cancer, also known as endometrial cancer, is one of the most common cancers that affects older women and those with a womb who've been through the menopause. It's normally treated with a hysterectomy (surgery to remove the womb), with generally positive

clinical outcomes, if found at an early stage.

Traditionally, people used to contact their GP if they had concerns about vaginal bleeding or unusual discharge after the menopause. Now, providing they aren't currently on HRT, or stopped taking HRT at least six weeks ago, they can now make a self-referral via the Somerset FT website, or by calling the trust's gynaecology booking team.

It has meant that most patients no longer need to visit their GP for a referral to the service, with practice receptionists able to signpost patients direct to the service – helping to free up the time of GPs.

So far, every patient who has filled in a survey after their appointment has said that they were very satisfied with their overall experience.

- **BBC One's Dr Xand Con or Cure** – covered our Transcranial Magnetic Stimulation (rTMS) procedure and how it is helping patients with severe depression. Dr Nathan Maynard, Cat Gullick and our patient gave interviews about the treatment and its impact. Somerset was the first county in the South West to offer rTMS treatment for severe depression, free on the NHS. The rTMS treatment is non-invasive brain stimulation that uses a strong magnetic field which changes direction and can stimulate or inhibit different parts of the brain, depending on where the coil is placed and the frequency of change in the magnetic field. Link to the programme on the BBC iplayer (13:55 mins into programme)

- **ITV West Country** – showed the impact of the Somerset Homeless Health Team which includes the Homeless and Rough Sleeper Service run by our trust. Coverage included interviews with service lead Karen George, nurse Justine Brunton, two patients, GP Dr Lisa Horman and public health manager Andy Lloyd. The trust communications team and the ICB communications team have worked together to highlight this service in the media and this piece of coverage was the most recent.

- **BBC's The One Show** – Our trust supported the ICB on a piece about Brave AI which is supporting primary care in Somerset to identify those patients most at risk of becoming seriously ill and needing a hospital admission. Dr James Gagg, our associate medical director for medicine, gave an interview as part of the package. Link to the programme on the BBC iplayer (1:20 into the programme).

- Our trust the first to use the Allurion gastric balloon – coverage on BBC Points west showing a patient having the gastric balloon fitted. The coverage includes interviews with consultant surgeon Prof Richard Welbourn, our specialist nurses Kirsty Lock and Zoe Hall, and follows the story of our patient Dave. The Allurion Gastric Balloon is the world's first and only procedure of its kind that does not require surgery,

endoscopy, or anaesthesia - and we are the first NHS trust in the country, and the first non-private sector organisation in the world, to introduce this innovative procedure. The BBC Points West coverage is no longer available on the BBC iplayer. Link to the online BBC coverage.

- Coverage of our HIV Testing Week campaign with interviews by Dr Sathish Thomas-William, our consultant physician for genitourinary/HIV medicine, Paula Hill, one of our specialist nurse advisors with SWISH, and Kat Briggs, a targeted outreach assistant practitioner with SWISH on BBC Radio Somerset: Simon Parkin - 09/02/2024 - BBC Sounds (1.09:00 into programme) and Greatest Hits Radio coverage: HIV Testing Week: Somerset's sexual health clinic holds testing pop-ups | News - Greatest Hits Radio (Somerset) (planetradio.co.uk)

- Coverage about our trust's use of the Allurion Gastric Balloon. We're the first NHS trust in the country, and the first non-private sector organisation in the world, to introduce this innovative procedure. Coverage on Radio 5 Live includes interviews with Professor Richard Welbourn; patient Donna, who was the first patient to have a gastric balloon fitted; and Allurion CEO Shantanu Kaur. 5 Live Breakfast - 14/02/2024 - BBC Sounds (1.47:35 into programme).

11. NATIONAL DEVELOPMENTS

Latest NHS performance figures

11.1. NHS England published the monthly performance date for the NHS. In its press release, NHS England said:

- The NHS waiting list fell in December for the third month running.

- winter pressure continued to hit the health service hard with A&E and ambulance services experiencing their busiest ever January.

- The overall Covid backlog fell by more than 6,200 in December for the third consecutive month and is now down by 164,898 since September to 7.6 million.

- The proportion of people waiting over a year for elective care is the lowest it has been since November 2020, at 4.4% of the entire waiting list.

- NHS staff delivered more elective activity in 2023 than in any other year since the start of the pandemic – with more than 17.3 million people treated.

- The data also shows significant demand for services in January, as the NHS managed the longest period of industrial action in its history with 6

days of strikes by junior doctors.

11.2. NHS Providers published a response to the data, Sir Julian Hartley, chief executive, NHS Providers, said: *"The figures show a strike-hit NHS managing to cut waiting lists and reduce unnecessary hospital stays while under extreme pressure across urgent and emergency care and services throughout the system.*

"Seasonal pressure and other factors including staff absences and strikes dealt a blow to elective and diagnostic activity in December. But sheer hard work by trusts has resulted in further reductions to the longest waits for treatment and inroads made to overall waiting lists.

"But persistent pressure across the NHS – not just in hospitals but on ambulance, mental health and community services too – makes further progress a hard task. Hospitals still have more than 13,000 beds taken up every day by patients who are fit to be recovering at or close to home but who can't be discharged, often because of a lack of social care capacity in the community.

"We may not be over the worst of winter with many more people needing to be treated for seasonal illnesses and bugs."

11.3. The quality and performance report for the Trust is included on the agenda of this meeting as a separate agenda item

The King's Fund's '360-degree' review of mental health care in England

11.4. Against a backdrop of rising demand for mental health care, the impact of the Covid-19 pandemic and mental health workforce challenges, the King's Fund has taken a deep dive into the state of mental health care services in England. The review focuses on nine core areas, bringing together data available with expert insights to help the reader understand what is happening in relation to mental health and the wider context.

11.5. NHS Providers has responded to the review with the following statement: *"Trusts want to give patients the best care possible in the best environments possible. For that we need more, long-term government support for mental health.*

"Demand for mental health care is at a record high, with more than 2 million people on waiting lists, piling pressure on stretched services which have too few staff and are crying out for more capital funding to provide care in first-class facilities.

"The King's Fund report echoes what trust leaders tell us. More than nine in 10 are worried about whether their mental health trust can meet demand this year. Trust leaders have long expressed concern about the ability to maintain high-quality services given the pressures on capacity and resources.

"For years mental health services have been starved of adequate capital investment vital to provide high-quality care in the right settings for the good of patients and staff.

"The report acknowledges that the sector has made progress on expanding services and improving access. Mental health must be more of a national priority and backed by the right funding and support to make significant further strides in improving access and the quality of services.

"Adequate funding and support for wider public services is critical too, to make sure that people get the right care and support they may need as quickly as possible." "Trusts want to give patients the best care possible in the best environments possible. For that we need more, long-term government support for mental health.

"Demand for mental health care is at a record high, with more than 2 million people on waiting lists, piling pressure on stretched services which have too few staff and are crying out for more capital funding to provide care in first-class facilities.

"The King's Fund report echoes what trust leaders tell us. More than nine in 10 are worried about whether their mental health trust can meet demand this year. Trust leaders have long expressed concern about the ability to maintain high-quality services given the pressures on capacity and resources.

"For years mental health services have been starved of adequate capital investment vital to provide high-quality care in the right settings for the good of patients and staff.

"The report acknowledges that the sector has made progress on expanding services and improving access. Mental health must be more of a national priority and backed by the right funding and support to make significant further strides in improving access and the quality of services.

"Adequate funding and support for wider public services is critical too, to make sure that people get the right care and support they may need as quickly as possible."

Implementation of first phase of Martha's Rule

11.6. NHS England has announced that the first phase of the introduction of Martha's Rule will be implemented in the NHS from April 2024. Once fully implemented this will give patients, families, carers and staff, round-the-clock access to an urgent review from a separate care team if they are worried about a person's condition.

11.7. Martha Mills died in 2021 after developing sepsis in hospital where she had been admitted with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to promptly and in 2023 a coroner ruled that Martha would probably have

survived had she been moved to intensive care earlier.

11.8. In response to this and other cases related to the management of deterioration, the Secretary of State for Health and Social Care and NHS England committed to implement ‘Martha’s Rule’ to ensure the vitally important concerns of the patient and those who know the patient best are listened to and acted upon.

11.9. The implementation of Martha’s Rule in the NHS will take a phased approach beginning with at least 100 adult and paediatric acute provider sites who already offer a 24/7 critical care outreach capability.

11.10. The focused approach at the initial provider sites will inform the development of wider national policy proposals for Martha’s Rule that can be expanded in a phased way across the NHS from 2025/26. We will also identify ways to roll out an adapted Martha’s Rule model across other settings including community and mental health hospitals where the processes may not apply in the same way.

11.11. Find out more on our Martha’s Rule webpage https://www.england.nhs.uk/patient-safety/marthas-rule/

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 24 January 2024
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Jan Hull, Chairman of the Quality and Governance Assurance Committee
DATE:	5 March 2024

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
☐ For Assurance	☐ For Approval / Decision	☐ For Information

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the Quality and Governance Assurance Committee meeting held on 24 January 2023. The Committee received assurance in relation to: • The corporate risk register, including the addition of a section on risk appetite and risk tolerance, the progress in relation to the procurement of a single risk management system. • The Symphony Health Services Assurance report. • The assurance report from the Clinical Support and Specialist Services service group. • The sign off of Maternity Services Incentive Scheme safety actions. • The actions taken to mitigate the Carbapenemase-Producing Organisms outbreak. The Committee identified the following areas of concern or for follow up: • Corrporate Risk Register – the ongoing work on the subsidiary risk programme; the review of the risk appetite and risk tolerance statements to be undertaken by all Committees; the update on the Minehead Medical Centre and impact on Minehead

	Minor Injury Unit; the Authorising Engineer reports in relation to the fire safety risks at Musgrove Park Hospital. • The Symphony Health Services assurance report the ongoing work in relation to the subsidiary governance process; the risk in relation to the lack of clarity as to SHS's position within the Somerset strategy; the financial position; and the need for more data driven evidence relating to population health and health surveillance. • The assurance report from the Clinical Support and Specialist Services service group relating to the medical physics and ultrasound services risks. • The Maternity Services Update relating to the Care Quality commission inspection. • The non compliance with a number of Maternity Services Incentive Scheme safety actions. The Committee identified the following areas to be reported to the Board: • The Maternity Incentive Scheme compliance declaration. • Assurance from the clinical support and specialist service group. • Assurance from the SHS assurance report.
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Quality and Governance Assurance Committee. The Board is further asked to note the areas to be reported to the Board.

Links to Joint Strategic Objectives (Please select any which are impacted on / relevant to this paper)
☒ Obj 1 Improve health and wellbeing of population
☒ Obj 2 Provide the best care and support to children and adults
☒ Obj 3 Strengthen care and support in local communities
☒ Obj 4 Reduce inequalities
☒ Obj 5 Respond well to complex needs

☒ Obj 6	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☐ Obj 7	Live within our means and use our resources wisely
☒ Obj 8	Develop a high performing organisation delivering the vision of the Trust

Implications/Requirements (Please select any which are relevant to this paper)					
☐ Financial	☐ Legislation	☐ Workforce	☐ Estates	☐ ICT	☒ Patient Safety/ Quality
Details: N/A					

Equality and Inclusion

The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.

How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?

The needs and potential impacts on people with protected characteristics are considered by each individual service group as part of their update to the Committee. The Committee reviews data presented to the Committee and will raise any queries if required.

All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History

How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.

Staff involvement takes place through the regular service group and topic updates.

Previous Consideration

(Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]

The report is presented to the Board after every formal meeting.

Reference to CQC domains (Please select any which are relevant to this paper)				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	☐ No

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING HELD ON 24 JANUARY 2024

1. PURPOSE

1.1. The report sets out the items discussed at the formal meeting held on 24 January 2024, along with the assurance received by the Committee and any areas of concern identified. The meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

Corporate Risk Register

2.1. The Committee received the up-to-date combined Corporate Risk Register report and noted that there were currently 30 corporate risks on the risk registers of which five scored 20 or above. The Committee noted the details of these risks, including the new risks.

2.2. The Committee received feedback on the initial findings of the internal audit on risk maturity and noted that, although the final report was still awaited, initial feedback had been positive.

2.3. The Committee further received an update on the procurement of a risk management system and noted that an implementation board had been set up and that a training programmes were being developed. In addition, the risk register will be further developed to include visibility of the risk approval and oversight arrangements.

2.4. The Committee welcomed the move to a single risk management process but recognised the risks involved in implementing a single risk management system. The Committee noted that the risk had been included on the risk register, and that the risk had been assessed as low in view of the thorough implementation plan.

2.5. The Committee received an update on the development of a system wide risk register and noted that discussions on system wide risks and the development of a system wide framework were progressing. The Committee noted that Somerset Council had agreed to share their strategic risk register when updated.

2.6. The Committee discussed the following risks in more detail:

- Digital system risk as a result of a delay in the implementation of the system - as a result of mitigating actions being taken, the risk level was reducing.

- Pressure ulcers risks – due to the complexities of managing pressure ulcers in the community, it was agreed to add this to the agenda of a future meeting for a deep dive review.

- The inability of nursing staff to hear call bells – this risk was linked to the escalation beds at Musgrove Park Hospital and it was agreed to provide an update outside of the meeting.

- The impact of industrial actions on services, including demand and cancellation of appointments – although there had been an impact on patients due to the cancellation of elective activity, the majority of appointments had been rebooked within the two week period. A number of lessons learned had been identified as a result of the focus on the "front door" and these will be considered for inclusion in "business as usual".

Symphony Health Services (SHS) Assurance Report

2.7. The Committee received the assurance report from SHS.

2.8. The Committee received an overview of the operating model and processes. The Committee noted the primary care practices which were part of SHS and their governance arrangements; the Symphony strategy and the services SHS could offer to the system that would enhance general practice stability and support the general deficit position of SHS; the improvements to the Burnham and Berrow Medical Practice; and the findings of the governance audit and the development of an action plan in response to the audit recommendations.

2.9. The Committee noted the incident reporting and oversight arrangements and the process for the dissemination of lessons learned. The Committee noted the work to support and encourage the reporting of incidents across the organisation and the standardisation of reporting processes.

2.10. The Committee discussed the new emerging risks in relation to individual practices within SHS and received assurance that a robust process for managing and mitigating these risks was in place.

Service Group Assurance Report – Clinical Support and Specialist Services

2.11. The Committee received the assurance report from the clinical support and specialist services group and noted the key highlights from the report, including: the regular governance meetings representing all services; the high compliance with the governance reporting schedule; the weekly governance huddles to provide support and guidance where needed; the work to be undertaken to fully align governance arrangements across the service group; the review of all risks to be undertaken in preparation of the move to a single

risk management system; and the good incident reporting culture within the service group.

2.12. The Committee received an overview of the causes of the incidents reported: care pathway issues; medication or medical gas issues; communication/ documentation/IT; radiotherapy; and staffing issues. In particular the radiotherapy incidents scored low in terms of impact/harm. The Committee further received an overview of the number of complaints received and response times and noted that the top three themes related to: all aspects of clinical treatment; communication; and attitude of staff. The Committee discussed the risks and complaints and noted that the service group was complex as it consisted of a large support function into other services and a large number of risks and complaints were not exclusive to this service group. The Committee recognised that the complaints and PALS data could be further improved and that this will be discussed between the service group and patient experience team.

2.13. The Committee received assurance that the AMD was linked into the governance process and was a member of the service group governance meeting.

2.14. The Committee discussed the complaints theme in relation to communication with patients and noted that, although this had been addressed previously, further work will be required and the People Committee and the Culture Board were looking into identifying what actions could be taken to educate and support colleagues to talk to patients and their families/carers. The Committee noted that this had also been identified as part of the personalised care audit and that an extensive programme of work had been identified to address the internal audit recommendations.

Maternity Services Update Incentive Scheme (MIS)

2.15. The Committee received an update on progress made in relation to achieving the year five requirements of the MIS. The Committee was requested to sign off the annual declaration and discussed each safety action in detail and noted that an internal audit had been commissioned to review the declaration and evidence to show compliance with each safety action.

2.16. The Committee noted that it was intended to declare compliance with the following safety actions and, subject to the internal audit findings, the Committee supported the compliance declaration for five of the ten safety actions and for a further two with action plans, subject to review of all of these by the Trust's internal auditors.

Carbapenemase-Producing Organisms (CPO) Outbreak

2.17. The Committee received an update on the 2022/2023 CPO outbreak and the two new cases with the same CPO strain identified at Yeovil District Hospital. The Committee noted the infection control actions being taken to manage the outbreak.

3. AREAS OF CONCERN OR FOLLOW UP

Corporate Risk Register

3.1. The Committee received an update on the subsidiary risk programme and noted that this work was still ongoing and that any findings from the risk maturity and governance internal audits will be included in the action plan to strengthen risk and governance processes.

3.2. The Committee noted and welcomed the new section in the report relating to risk appetite and risk tolerance which showed that nine risks fell outside of their risk appetite level. This information will enable the Committee to focus their discussions. The Committee noted that all Committees will be asked to undertake an annual review of the risk appetite and risk tolerance statement prior to the discussion at the April 2024 Board development day session.

3.3. The Committee received an update on the position in relation to the Minehead Medical Centre and noted that the Care Quality Commission had served a notice of suspension of registration of the practice with effect from 23 January 2024 following an inspection in 2023 and a follow up inspection in December 2023. The Committee noted that an interim provider had been identified to enable the practice to remain open. The Committee agreed that the risks previously raised about the impact of the issues at the medical centre on the Minehead minor injury unit will need to be reviewed and discussed with the caretaker provider.

3.4. The Committee received an update on the fire safety risks in relation to the maternity and neo-natal intensive care unit at Musgrove Park Hospital and noted that a report from the Authorising Engineer had now been received and that the report will be reviewed. In addition, the Committee noted that the Trust had received a formal letter from the Authorising Engineer in relation to the fire safety risks at the maternity block at Musgrove Park Hospital and further noted that immediate actions had been taken to mitigate these risks. The Committee acknowledged the need for medium to long term decisions in relation to the maternity environment and the significant funding required.

Symphony Health Services (SHS) Assurance Report

3.5. The Committee received the assurance report from SHS and recognised that the assurance process in terms linking the subsidiary companies into the Quality and Governance Assurance Committee and the overall organisational governance processes was still work in progress.

3.6. The Committee received an update on the corporate risks and noted that all corporate risks scoring 12 and above were discussed at the SHS Board meeting as well as at the Governance Executive Committee meetings. Work was taking place to refine some of these risks and further review the details relating to the practice level risks. The Committee particularly noted the risk in relation to the lack of clarity as to where SHS fits in within the general practice position and strategy within Somerset and noted the development of a strategy to set out what SHS can deliver for the wider system. The

Committee further noted the risk in relation to the financial position and the ongoing discussions with commissioners about the contractual funding arrangements.

3.7. The Committee discussed whether the assurance report could provide more data driven evidence to provide greater levels of assurance in regards to population health and health surveillance. The Committee noted that practice level scorecards were available and that summaries of these scorecards were included in the quarterly reports to the Trust Board. As part of the wider governance review, the structure of the SHS report to the Trust Board was being reviewed to provide more context and background information. The Committee agreed that it was essential to be clear about the content to be included in the assurance report to the Committee and to the Trust taking account of the main purpose of the report to the Committee which was to provide assurance and an understanding of the SHS processes to manage and develop the governance within the SHS practices.

Service Group Assurance Report – Clinical Support and Specialist Services

3.8. The Committee received an update on the medical physics risk and the increasing risk relation to ultrasound services and noted that the ultrasound risk was as a result of a shortage of sonographers due to training and registration and the retention of colleagues. Work was taking place to improve the retention rate, including by supporting training pathways. In relation to the medical physics risk, there was a statutory requirement for a medical physics expert (MPE) and this function was being provided by the Exeter and Bath foundation trusts until the end of March 2024 and arrangements were being put in place from April 2024 onwards. The Committee agreed that the innovative approach to providing cover for the statutory functions provided significant assurance.

Maternity Services Update – Care Quality Commission Inspection

3.9. The Committee received an update on the Care Quality Commission inspection across Yeovil District Hospital, Musgrove Park Hospital and the Bridgwater Mary Stanley standalone unit. The Committee noted that high level feedback expressing significant concerns about the quality of the estate and access to equipment, particularly at Musgrove Park Hospital, had been received but that positive feedback had also been received in relation to culture, patient information, feedback from women, and a good colleague awareness of issues. The formal report was still awaited and will be presented to the Committee when available.

Maternity Services Update Incentive Scheme (MIS)

3.10. The Committee received an update on progress made in relation to achieving the year five requirements of the MIS. The Committee, with delegated authority from the Board, was requested to sign off the annual declaration and discussed each safety action in detail and noted that an internal audit had

been commissioned to review the declaration and evidence to show compliance with each safety action.

3.11. The Committee noted that it was intended to declare non-compliance with the following safety actions and this declaration was supported by the Committee: safety action 3, 7, 9. In relation to safety action 3, the Committee noted that the wording of this requirement had changed slightly during the year and that this had not been evident until the evidence review. The Committee noted the areas of non compliance for safety actions 7 and 9.

3.12. The Committee agreed that a full review of evidence required for year six, and any changes to the scheme, will need to be undertaken in a more robust way and noted that appropriate plans were already being developed.

4. RISKS AND ISSUES TO BE REPORTED TO THE BOARD OR OTHER COMMITTEES

4.1 The Committee identified the following issues to be reported to the Board:

- The Maternity Incentive Scheme compliance declaration.
- Assurance from the clinical support and specialist service group.
- Assurance from the SHS assurance report.

5. BOARD ASSURANCE FRAMEWORK (BAF)

5.1 The Committee agreed that it had received assurance in respect of the following areas of the Board Assurance Framework:

- **Objective 2** - the level of significant risks relating to safe and high-quality care which provided negative assurance against the impact of some key plans. In particular the initial outcomes from the maternity CQC inspection and the declarations of non-compliance in relation to the Maternity Incentive Scheme highlighted risks in relation to patient safety and aspects of our governance framework.
- **Objective 2 -** the reports from Symphony and the clinical support and specialist service group gave a level of positive assurance around improving governance but with more work to do. Workforce related risks in primary care and areas such as ultrasound and medical physics impacted on assurance levels in terms of achieving this objective.
- **Objective 3 -** the challenges identified in the Symphony assurance report around staffing and sustainability of primary care were noted and it was agreed to refer these into the People Committee.

5.2 The Board is asked to direct the Committee as to any future areas of deep dives relating to the above objectives and the others within its delegated remit.

Jan Hull
CHAIRMAN OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Learning from Deaths Report
SPONSORING EXEC:	Daniel Meron, Chief Medical Officer
REPORT BY:	Claire Bailey, Learning from Deaths Lead Laura Walker, Head of Patient Safety and Learning Gary Filer, Quality and Safety Lead Analyst
PRESENTED BY:	Katy Darvall, Consultant Vascular Surgeon, SFT Mortality Lead
DATE:	5 March 2024

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
☒ For Assurance	☐ For Approval / Decision	☐ For Information

Executive Summary and Reason for presentation to Committee/Board	The National Guidance on Learning from Deaths (National Quality Board, March 2017) and the Implementing Learning from Deaths framework, key requirements for Trust Boards (NHS Improvement, July 2017), places a number of requirements on NHS Trusts. This includes the need to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public Board meetings. This report also demonstrates the processes in place for how Somerset FT learn from deaths and how this learning is shared and improvements are made.
Recommendation	The Board is asked to discuss this report.

Links to Joint Strategic Objectives (Please select any which are impacted on / relevant to this paper)	
☒ Obj 1	Improve health and wellbeing of population
☒ Obj 2	Provide the best care and support to children and adults
☐ Obj 3	Strengthen care and support in local communities
☒ Obj 4	Reduce inequalities
☒ Obj 5	Respond well to complex needs
☒ Obj 6	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☐ Obj 7	Live within our means and use our resources wisely
☒ Obj 8	Develop a high performing organisation delivering the vision of the Trust

Implications/Requirements (Please select any which are relevant to this paper)					
☐ Financial	☐ Legislation	☐ Workforce	☐ Estates	☐ ICT	☒ Patient Safety/ Quality

Details: To deliver our culture of learning, research, and continuous improvement to improve safety, outcomes, efficiency and effectiveness.

To provide safe, effective, high-quality care in the most appropriate setting.

To improve outcomes for people with complex conditions through personalised, co-ordinated care.

Equality and Inclusion

The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.

How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?

This report has been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics

All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History

How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.

Public or staff involvement or engagement has not been required for the attached report. Staff are involved in the learning from deaths process.

Previous Consideration

(Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]

The report is reviewed by the Quality Governance and Assurance Committee and Operational Leadership Group.

Reference to CQC domains (Please select any which are relevant to this paper)				
☒ Safe	☐ Effective	☐ Caring	☐ Responsive	☐ Well Led

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	☐ No

SOMERSET NHS FOUNDATION TRUST

LEARNING FROM DEATHS REPORT – QUARTER 3 2023-2024

1. BACKGROUND AND PURPOSE

1.1. In December 2016 the CQC report Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England, identified that learning from deaths was not given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed.

1.2. In March 2017 the National Quality Board published national guidance on learning from deaths to initiate a standardised approach to learning which includes several recommendations to be included into Trust's governance frameworks. These recommendations included having a Director responsible for the learning from deaths agenda, a Non-Executive Director to take oversight of progress and implementing a systematic approach to identifying the deaths requiring review, with a robust methodology for case record reviews.

1.3. Ongoing developments included specific guidance for NHS Trusts in working with families, published in July 2018 and the introduction of Medical Examiners who commenced their role in the Trust on 1st July 2020. The intention is to make sure that all deaths not investigated through the coronial process are subject to a degree of independent scrutiny, with increased transparency for the bereaved and an opportunity for them to raise concerns.

1.4. A review of the first year of NHS Trusts implementing the Learning from Deaths National Guidance was published by the CQC in March 2019. This document highlights the progress that has been made with implementation of the Learning from Deaths Programme as observed during the CQC well-led inspections. The report acknowledges the early progress and the need for cultural change in the NHS, especially in respect of engagement with families. The Trust Learning from Deaths Policy has been amended to reflect these developments and the outcomes reported within future quarterly reports.

1.5. On 1 April 2023, a new Trust called Somerset NHS Foundation Trust was created from the merger of Yeovil District Hospital NHS Foundation Trust (YDH) and Somerset NHS Foundation Trust (SFT). Whilst the Learning from Deaths arrangements at the two legacy Trusts have been overseen by the team at SFT since September 2022, all mortality data continued to be reported separately to the board. This report reflects the Learning from Deaths agenda for the new merged organisation and as such brings this data together using a redesigned template.

1.6. The Quarterly Learning from Deaths report confirms our progress with the evolving systems used to identify and learn from a patient's death. The way

we review a patient's death can take many forms with learning identified through several processes. Appendix 1 provides a summary of the reviews undertaken with comparative data from the previous year. These figures are updated at each subsequent Quarterly review period.

2. UPDATE ON THE MORTALITY REVIEW PROCESS

2.1. We continue to work closely with our colleagues in the Bereavement and Medical Examiner's teams to support each other with our alignment and development of processes:

- Claire Bailey has attended a Somerset Medical Examiner Service away day where updates on Learning from Deaths and the Medical Examiner Service were shared. Topics discussed included referral criteria for Learning from Deaths to raise awareness of the criteria that applies to the merged organisation, as well as the impact of the upcoming death certification reforms and statutory Medical Examiner regulations.

- The next phase of the national roll out of the Medical Examiner Service, in which Medical Examiners will provide independent scrutiny to all non-coronial deaths without exception, is progressing as expected. Primary legislation for this was enacted in October 2023, with draft regulations published in December 2023, ahead of the full statutory system coming into force. This is expected to be in April 2024, although a date has not been confirmed. Helen Waldon, the Lead Bereavement and Medical Examiner Officer and Implementation Lead for the Somerset Medical Examiner Service, has been developing the local arrangements to meet the requirements set out for the statutory service. To date, 15 out of 61 GP practices in the catchment area are referring deaths to the Medical Examiner service. Helen has arrangements to meet with a further 12 to bring them on board with the process. In this reporting period, there has been a noted increase in activity. The team have completed reviews on 149 community deaths, compared to 99 in Quarter 2. We have begun to see an impact of this roll-out, with the Medical Examiner team sharing feedback about SFT care for patients who have died in the community, giving us further opportunities to learn and improve our services.

2.2. Alongside our colleagues in the Bereavement team and Patient Experience team, we have developed a clearer pathway for the escalation of concerns raised by families or carers:

- Following the Medical Examiner's Service or Bereavement Team's contact with families and carers, we have agreed that when they consent for their feedback to be shared, whether this be raising concerns or compliments about clinical care, that these will be shared with both Learning from Deaths and Patient Experience. We will work closely with colleagues in Patient Experience to determine the appropriate response. Depending on the nature of the feedback, this

may result in an SJR (or alternative learning response), and/or a PALS query being taken forwards.

- A quarterly meeting between representatives from PALS and Complaints and colleagues from the Patient Safety and Learning arm of the Governance Support Team has now been established. The aim of this is to facilitate closer working through sharing information and discussion of any themes that are arising from the various workstreams.

2.3. Structured Judgement Reviews:

- Following a recent procurement process, Radar has been awarded the contract for providing the risk management software for whole of the new organisation, and preparation work is underway for this. The SJR tool for Physical Health is now being live tested on the radar risk management platform, and we will now begin to roll this out across the organisation. We have identified two specialties who have agreed to support with live testing – oncology and vascular surgery – and with the support of Paula Wiggins, the Governance Systems Development Manager, we will progress with this in the next quarter. We aim to have the SJR for Mental Health services developed and in a testing phase by the end of Quarter 1.

- We continue to develop consistent processes for the completion of SJR's. In the previous report, we described having identified a need to work with colleagues in our Neighbourhood Service Group to ensure that robust processes are in place for completion of SJR's and sharing of learning. To ensure that a meaningful quantity of reviews are undertaken, our colleagues in the service group will implement a process for identifying appropriate deaths to review in addition to any that are highlighted following Medical Examiner scrutiny. New reviewers have been identified and supported with training for completing SJR's. Completed reviews and any learning identified will be discussed at the service group governance meeting as appropriate. This process is starting with our community hospital settings and will expand over time to include other services.

2.4. The core function of the Mortality Surveillance Group (MSG) is to ensure that we have strategic level oversight and can provide assurances that our processes maximise learning from the deaths of people in our care. As previously reported, it was necessary to stand down both meetings in Quarter 2, however we were able to resume MSG during Quarter 3 and met in November.

2.5. The Patient Safety Incident Response Framework (PSIRF) replaces the Serious Incident Framework (SIF) and represents a significant shift in the way NHS Trusts respond to patient safety incidents. The PSIRF model focuses on providing considered and proportionate responses to patient safety incidents and offers a variety of learning response tools to support this. Moving away

from conducting a Root Cause Analysis (RCA), a Patient Safety Incident Investigation (PSII) will be commissioned where this meets national requirements (for instance where the incident meets the Never Events criteria or where there is a death as a direct result of a patient safety incident), as well as when an incident meets locally agreed priorities. Following a stakeholder engagement workshop, the proposed priority areas for the next 12-18 months were signed off by the Patient Safety Board in November 2023. A selection of other patient safety incidents will be reviewed at a local level using one of the other learning response tools. The transition period will commence on 01/01/2024, with full implementation anticipated on 01/04/2024. PSIRF will positively impact on the way we learn from deaths, by maximising opportunities to learn when a death does not meet the criteria for either a PSII or SJR. We are already beginning to see the new learning response tools being used in this way and will be able to report on any learning in due course.

2.6. Aligning with the implementation of PSIRF, there are also changes underway to how patient safety incidents will be reported. Learning from Patient Safety Events (LfPSE) will replace the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS). The LfPSE service supports a learning culture within the Trust and across the wider healthcare system by collecting information that is better suited to improvement. LfPSE expands the types of events that can be reported to enable staff to report outcomes, risks, and good care as well as incidents. With respect to deaths, this will offer greater clarity between deaths that are responded to using the PSIRF pathway, which are thought to relate to a patient safety incident, and deaths that are responded to using the LFD pathway, which are thought to relate to an unexpected poor outcome. At a local level, work is underway to ensure that the form for reporting patient safety events on our risk management system, Radar, will meet the requirements of LfPSE, and that the workforce is prepared for this change in reporting culture.

2.7. In October, Laura Walker and Dan Meron met with colleagues from the ICB to have a preliminary discussion about a system-wide mortality meeting. The aim of this meeting will be to share intelligence and thematic learning to identify trends in the data and opportunities for further learning.

3. LEARNING, IMPROVEMENT AND CHANGE FROM THE MORTALITY REVIEW PROCESS

3.1. Examples of learning:

- The Medical Examiner highlighted concerns about the care of a patient who died on one of our medical wards. Blood tests had been taken, the results of which were highly abnormal, however the clinical team were not alerted to this, nor was the need to chase these handed over to the on-call team. Given these concerns, our gastroenterology team completed an SJR. This was not thought to have had an impact on the

outcome as the abnormal results were deemed to be an indication of a terminal decline rather than a reversible event. However, it was acknowledged that this may have prompted earlier conversations with the patient and their family about probable end of life, and this has led to wider learning for the team around recognising signs of this kind of decline. On ward training days, the team have included teaching around the effects of blood clotting in patients with liver disease and the risk of potential bleeds in patients with a history of a high INR.

- Several SJRs completed by colleagues in our oncology team, have highlighted excellence around EOL planning:

    - A patient was admitted with abdominal symptoms, secondary to progressive disease. It was quickly recognised that this patient needed palliative support and the focus of care was switched to good symptom control. When discussed with the patient, it was understood that they wanted active treatment to be withdrawn, but that it was important to them that they remained well enough to see a close family member who was travelling from overseas to be with them. The management plan was tailored in line with the patient's wishes, and they died peacefully with their family present.

    - A patient receiving palliative chemotherapy was admitted unwell due to a recent chest infection. Initial management was to consider reversible causes; however, it was quickly established that the patient was suffering with disease progression and the focus of care was switched to EOL support. This was difficult for the family who were initially resistant to the administration of EOL medication when the patient was distressed and unsettled, fearing that this would hasten death. The team provided a high level of support to the family to understand the important role of medication in EOL care, and with the reassurance that this provided, the family were accepting of the management plan.

    - A patient with metastatic cancer had been admitted with decreased mobility and confusion. They were initially treated for an infection, however they rapidly deteriorated whilst in hospital and it was thought that they were approaching the end of their life. The patient requested discharge as they wanted to die in their own home. In line with their wishes, the team were able to facilitate discharge within a matter of hours, with support in place from the District Nurse service and the palliative care team. The patient died peacefully at home with their family present the following day.

  Through discussing these cases, the team have been able to spend time reflecting on what went well and the positive impact that the care had for the patients and their families, as well as the colleagues involved.

- An RCA was completed by colleagues in our mental health service group following the sad suicide of a patient who had been referred for assessment by one of our community mental health teams. The investigation identified that the patient experienced unnecessary delays when trying to access mental health support. Whilst the referral was actioned in line with expected timescales, an administrative oversight meant that appointment letters were not sent to the patient. There was also an instance where the patient cancelled their appointment, however no reason for this was recorded. During the investigation, it was found that this coincided with a significant life event, and this may have been a missed opportunity to identify potentially escalating risk. Learning has come from this investigation as it was found that there were inadequate systems in place to identify and rectify administrative errors. An audit of the waiting list confirmed that this was not an isolated incident. A clear, consistent countywide process for monitoring referrals has now been implemented. Each locality now maintains a referral tracker, which is reviewed weekly to ensure that all actions have been completed, including those for follow-up when a patient does not attend their appointment. In addition, guidelines have also been drawn up for how to respond to patients who cancel their appointment, including recording and escalation criteria.

- A SJR was completed by our vascular team concerning a patient who sadly died on one of our Critical Care Units. The patient had been admitted for a planned repair of their abdominal aortic aneurism, but sadly deteriorated in the days following this, requiring further emergency surgery for an ischaemic bowel. Sadly, the patient continued to deteriorate, and the focus of care was switched to palliation. The review identified excellence in the patient's clinical management during their admission, with regular consultant reviews and rapid responses to the changes in their clinical condition. There were however concerns raised with the processes that took place after the patient’s death. The team did not feel that the cause of death that was registered was accurate, resulting in a missed referral to the coroner. This has resulted in learning for SFT and the Medical Examiner Service, and the process for completion of paperwork has been reviewed. It has been agreed that when a patient dies whilst on Critical Care, then the medical or surgical team as well as Critical Care colleagues, will be included in discussions after death.

- The PMRT process has been concluded following the sad early neonatal death of a baby born prematurely on one of our labour wards. The review identified that there were care issues that may have made a difference to the outcome for the baby. When the mother presented with abdominal pain, this could have indicated a need for further review by a doctor, as well as a need to check blood markers for infection. This has resulted in learning around the triage process. It has been recognised that since moving to Badgernet, prompts for bloods and reviews that were on the previous paper-based care bundle, are no

longer available. The antenatal lead is developing an aide to help staff, and guidance has been shared with staff.

- Our cardiology team at MPH have shared an annual report summarising their Morbidity and Mortality meetings throughout 2023. In the cases reviewed, they have found that most patients were considered to have good or excellent care. Most of the deaths were deemed to be unavoidable or were thought to have “slight” or “possible but not very likely” evidence of avoidability. There were 2 cases where the patients care was thought to be poor, with care issues identified prior to them arriving in a cardiology setting. 1 case was deemed to be “probably avoidable”. Sadly, this patient experienced a known complication during an angiogram. The team considered that, given that the patient’s frailty and co-morbidities, this likely contributed to multiple organ failure and hastened death. Learning from this case has been described in a previous report, and led to the writing of a new protocol, which means that patients awaiting a TAVI do not routinely need an angiogram. The second case is still under review and is due to be discussed jointly between colleagues in our cardiology and vascular team.

3.2. The following section of the report describes the differing processes used to identify learning such as that noted above. Where there has been activity within the reporting period this is included along with details of any more general themes identified.

- **Scrutiny through the Medical Examiner service**
  There is an expectation that all patients who die in our bedded care settings have an initial review of the notes completed by the Medical Examiner. Whilst the Medical Examiner service is independent of SFT, this scrutiny enables early identification of any case where a potential problem exists, for example where a potential omission in care or poor management is identified, or where the bereaved raise a significant concern. These are then referred to Learning from Deaths for consideration for further review. The Medical Examiner also ensures the appropriate direction of deaths to the coroner. Medical practitioners have a duty to report deaths to a coroner for which they are unable to ascertain the cause of death, the cause of death is unnatural, or the death occurred in custody or state detention, e.g., whilst under a section of the Mental Health Act.

  The Medical Examiner’s office had 654 deaths of patients under the care of SFT reported to them between October and December 2023. Of these, 591 were within our acute hospitals, 63 were within our community hospitals, and 0 deaths were in our mental health inpatient settings. 93% of the 654 deaths were scrutinized by the Medical Examiner team. In total, 54 deaths were highlighted to Learning from Deaths.

- **Structured Judgement Reviews**
  Structured Judgement Reviews (SJR's) are carried out by clinicians using adapted versions of the tools developed by the Royal College of Physicians and the Royal College of Psychiatrists. There is a mandatory requirement for SJR's to be completed on cases where concerns exist, in accordance with the automatic inclusion criteria as described in the Trust's Learning from Deaths Policy. These cases are identified via the Medical Examiner service or the incident reporting system, and completion of these reviews is overseen by the Learning from Deaths Lead. In addition to these reviews, specialities may also routinely undertake SJR's on a sample of cases in the absence of any particular concern about care. The output from all completed reviews is collated so that common themes and trends can be seen from looking at good practice as well as problems with quality of care. This can then inform the Trust's quality improvement work.

  In the previous 3 quarters, the Medical Examiner service have highlighted a potential theme around deaths on the Ready to Go wards and referred 11 deaths in line with this theme. There have been no additional cases flagged during this quarter. We have requested SJR's for these deaths, and to date 10 have been completed. We are in the process of collating the data and will report on any outcomes in due course.

- **LeDeR review**
  All deaths of patients with Learning Disabilities are reported in line with national requirements and reviewed using the LeDeR methodology. Unless the death meets the threshold for investigation as an incident using PSIRF methodology, all acute hospital inpatient deaths will be subject to an SJR. Once completed, the output of these reviews are shared with the local LeDeR team.

  During this reporting period 5 inpatient deaths met the criteria for SJR. These deaths were flagged by the Medical Examiner service, who raised concerns about the care that one of these patients received. To date, 1 SJR has been completed and shared with LeDeR. There were no reported incidents associated with the deaths of these patients.

- **Incident process**
  The twice weekly rapid review meetings enable pan-organisational discussion where significant concerns about a death have been raised by the Medical Examiner and/or an incident report. The meeting is usually chaired by a member of the Medical Leadership Team and is typically attended by clinicians or managers from the area involved, members of the senior nursing team, and governance team. These meetings focus on three core questions: 1. Is there anything that needs to be changed now to prevent this happening again? 2. What support is in place for patients/family/colleagues? 3. What is the most appropriate way to investigate this, to ensure we get the best learning from this incident?

Within this reporting period, seven deaths have been discussed at rapid review meetings. Two of these deaths met the criteria for internal investigation using PSII methodology, one of which will also be reviewed externally by the Child Death Overview Panel (CDOP). A further two deaths will be subject to a Structured Judgement Review. One case will be looked at internally using the Perinatal Mortality Review Tool (PMRT). For the remaining two deaths, no further internal review was required, and it was identified that all learning had already been actioned. One of these deaths will be subject to an external review by the CDOP.

- **PALS and complaints**

  During this quarter, 11 PALS queries and two formal complaints have been raised concerning the deaths of patients in our care. Common themes are around poor communication, inadequate discharge planning and concerns about care and treatment at the end of life.

- **Maternal and Perinatal Deaths**

  There have been no maternal deaths during this reporting period.

  Eligible perinatal deaths are reviewed using the Perinatal Mortality Review Tool (PMRT). A monthly PMRT meeting is held to enable regular review of cases with the multidisciplinary team (MDT) and an external representative, allowing for a 'fresh eyes' perspective. A joint action plan for each month's review of cases (unless being investigated as a patient safety incident) enables the maternity governance team to highlight any common actions and identify themes from reviews. All finalised reports and subsequent action plans are shared with the parents according to their wishes. In this reporting period, there were three perinatal deaths that were eligible for PMRT. The PMRT process has been concluded for one case, and the learning identified has been described elsewhere in this report. For the remaining two, PRMT processes are ongoing.

  The Maternity and Newborn Safety Investigations (MNSI) programme investigates certain cases of early neonatal deaths, intrapartum stillbirths, and maternal deaths. Where the criteria for these investigations are met, this will replace an NHS trust's internal investigation. None of the above-mentioned deaths have met these criteria.

  Further details of any reviews undertaken, as well as any findings and subsequent action plans, are held within the quarterly report provided to the Trust Board by maternity services.

- **Paediatric Deaths**
  Reviews of these deaths are mandatory and undertaken by the Child Death Overview Panel (CDOP). Notification of a child death to the local Safeguarding Children Board is made at the time of any agency becoming aware of the death of a child. Where the death occurs within the hospital, responsibility for completing this notification is usually undertaken by the paediatrician managing the case.

  During this reporting period, there have been two paediatric deaths, both deaths were taken through the rapid review process. One of these cases concerned an unexpected inpatient death. In the rapid review meeting, it was thought that there was likely learning for the trust. This death will be investigated internally using the PSII tool in addition to the external CDOP review. The second case concerned a young person known to our Child and Adolescent Mental Health Service (CAMHS). No internal review was required for this death, but it will be reviewed externally by the CDOP.

- **Coronial activity**
  During this reporting period, there were 45 new enquiries from the coroner concerning the deaths of patients known to SFT. Formal statements have been requested for all cases.

  Several inquests pending from previous reporting periods have been concluded during this quarter. This includes 42 read-only inquests, 5 inquests heard with witnesses called, and 1 inquest heard with a jury present. There have been 2 pre inquest review hearings heard for inquests that are due to be heard at a later date. There have been no prevention of future deaths reports since July 2022 at legacy SFT and November 2021 at legacy YDH.

3.3. Standardised mortality

3.3.1 Summary Hospital-level Mortality Indicator (SHMI), October 2022 - September 2023

Source: NHS England (February 2024)

Note: All sub-national counts have been rounded to the nearest five, with SHMI values calculated from the unrounded values.

Trust level

Trust	Provider spells	Observed deaths	Expected deaths	SHMI value
Somerset NHS FT	75,220	2,905	2,940	0.9892 As expected

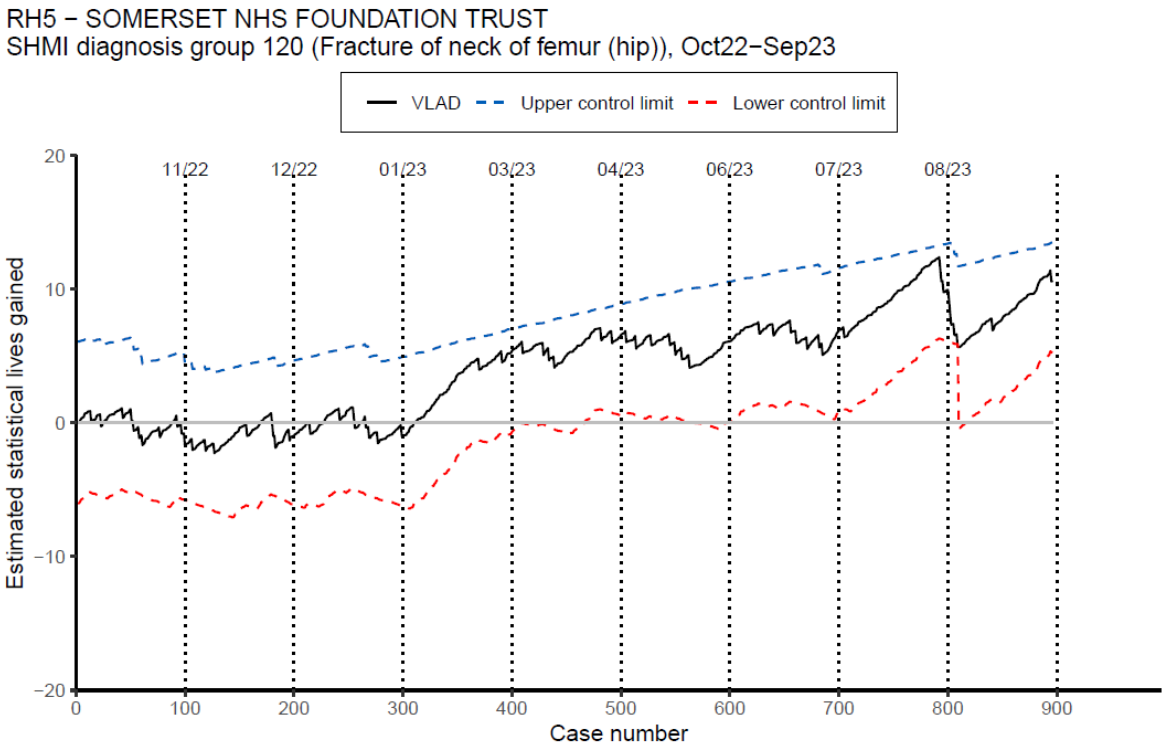
Site level *Acute hospitals and exceptions*

Site	Provider spells	Observed deaths	Expected deaths	SHMI value
Musgrove Park Hospital	50,905	1,725	1,760	0.9797 As expected
Yeovil District Hospital	22,345	1,025	1,055	0.9731 As expected
Frome Community Hospital	175	30	20	1.7913 **Higher than expected**

Diagnosis group *Reported groups by exception*

Diagnosis group	Provider spells	Observed deaths	Expected deaths	SHMI value
Septicaemia (except in labour), Shock	1,410	280	340	0.8302 **Lower than expected**

Visual life adjusted display (VLAD) – recent alerts



Diagnosis group	Provider spells	Observed deaths	Expected deaths	SHMI value
Fracture of neck of femur (hip)	895	60	70	0.8494 As expected

3.3.2 Standard mortality ratios from HED

Source: HED.nhs.uk - SHMI HES and HSMR HES modules (9 January 2024)

This report refers to two measure of standardised mortality: summary hospital-level mortality index (SHMI) and hospital standardised mortality ratio (HSMR). For information regarding these indicators please refer to the quick guide in Appendix A.

Trust level

Trust	SHMI (Nov 22 – Oct 23)	HSMR (Dec 22 – Nov 23)
Somerset NHS FT	98.8 (As expected) 95% CI: 95.2 - 102.6 Observed: 2,790 Expected: 2,823 Spells: 71,711	106.5 **(Above expected)** 95% CI: 101.7 - 111.5 Observed: 1,866 Expected: 1,752 Spells: 50,952

Site level *Acute hospitals and exceptions using 95% confidence intervals*

SIte	SHMI (Nov 22 – Oct 23)	HSMR (Dec 22 – Nov 23)
Musgrove Park Hospital	96.9 (As expected) 95% CI: 92.2 - 101.7 Observed: 1,643 Expected: 1,696 Spells: 49,088	113.8 **(Above expected)** 95% CI: 106.9 - 121.0 Observed: 1,026 Expected: 902 Spells: 31,869
Yeovil District Hospital	98.8 (As expected) 95% CI: 92.8 - 105.2 Observed: 1,001 Expected: 1,013 Spells: 20,830	93.1 (As expected) 95% CI: 86.5 - 100.0 Observed: 737 Expected: 792 Spells: 17,215

Site	SHMI (Nov 22 – Oct 23)	HSMR (Dec 22 – Nov 23)
Crewkerne Hospital	144.5 (As expected) 95% CI: 72.1 - 258.7 Observed: 11 Expected: 8 Spells: 75	200.7 **(Above expected)** 95% CI: 100.1 - 359.2 Observed: 11 Expected: 5 Spells: 33
Frome Community Hospital	175.9 **(Above expected)** 95% CI: 116.8 - 254.2 Observed: 28 Expected: 16 Spells: 156	201.5 **(Above expected)** 95% CI: 121.2 - 314.7 Observed: 19 Expected: 9 Spells: 76
Rowan	500 **(Above expected)** 95% CI: 100.5 - 1,460.9 Observed: 3 Expected: 1 Spells: 111	0 (As expected) 95% CI: 0.0 - 12,227.0 Observed: Expected: Spells: 3
West Mendip Community Hospital	131.9 (As expected) 95% CI: 79.4 - 206.1 Observed: 19 Expected: 14 Spells: 123	195.8 **(Above expected)** 95% CI: 111.9 - 318.0 Observed: 16 Expected: 8 Spells: 68

Site	SHMI (Nov 22 – Oct 23)	HSMR (Dec 22 – Nov 23)
Williton Hospital	101.9 (As expected) 95% CI: 57.0 - 168.1 Observed: 15 Expected: 15 Spells: 83	217.8 **(Above expected)** 95% CI: 112.4 - 380.5 Observed: 12 Expected: 6 Spells: 48
Wincanton Community Hospital	174 **(Above expected)** 95% CI: 104.7 - 271.7 Observed: 19 Expected: 11 Spells: 105	178.9 **(Above expected)** 95% CI: 107.7 - 279.4 Observed: 19 Expected: 11 Spells: 54

3.3.3 **Plans for reviews in response to Standardised Mortality Data:**

- In line with previous reports, we continue to see above expected numbers of deaths at some of our community hospitals. This has been a consistent trend. We have previously co-ordinated reviews into these deaths which provided assurance that there were no clinical concerns with the care that the patients received. As part of our ongoing monitoring, Katy Darvall, our Trust Mortality Lead has recently undertaken clinical reviews looking at excess mortality at Crewkerne, West Mendip and Frome Community Hospitals. To date, Katy has completed a detailed report of her findings concerning Crewkerne Community Hospital, please see appendix 2 for the executive summary from this report. Overall, the quality of care was found to be very good or excellent and there was no evidence of avoidability for any of the deaths reviewed. There were some incidental learning points which will be shared with the clinical teams, but these were unrelated to the deaths. The reports concerning West Mendip and Frome Community Hospitals are in the process of being written up, but initial scrutiny of the data has shown comparable findings. In light of these findings, as well as the known compatibility issues with using existing mortality metrics at site level for Community Hospitals, it is suggested that we cease using these as a trigger for concern. As described elsewhere in this report, we have begun to work closely with colleagues in the Neighbourhoods service group to develop a robust mortality review process utilising SJR methodology within our community hospital settings.

- Rowan Ward has flagged as above expected for the first time and we have extracted the patient level data for further review of these 3 deaths. Internal processes have already been concluded for 2 of these deaths (1x RCA, 1x SJR). We will look at the care for the third case and report our overall findings in due course.

- As previously mentioned, Katy Darvall is in the process of reviewing a number of deaths within the diagnostic group of influenza. In addition, there are plans to review a cohort of low-risk diagnostic groups and peritonitis.

Somerset NHS Foundation Trust was created from the merger with Yeovil District Hospital NHS Foundation Trust

Appendix 1

NHS Somerset NHS Foundation Trust

		2022/2023								2023/2024										
		Oct	Nov	Dec	Q3 total	Jan	Feb	Mar	Q4 total	April	May	June	Q1 total	July	Aug	Sept	Q2 total	Oct	Nov	Dec	Q3 total
ACUTE INPATIENTS*	Total deaths (including ED)	187	183	275	645	275	227	223	725	182	203	202	587	157	183	156	502	187	171	233	591
	Total Scrutinised by ME	180	164	215	559	264	221	213	699	182	199	190	571	157	183	156	502	175	168	207	550
	SJR's requested by LfD	14	12	13	39	24	12	16	52	12	9	8	29	14	10	12	36	9	9	10	28
	SJR's completed	42	31	33	106	56	23	31	110	23	14	21	58	23	22	12	57	6	4	4	14
	Problems in care**	1	0	0	1	6	2	1	9	5	2	1	8	0	2	1	3	0	0	0	0
	Serious Incident process initiated	2	0	0	2	0	1	0	1	0	0	0	0	0	0	0	0	1	0	0	1
	Learning Disabilities: internally all deaths in acute inpatient settings are subject to review or investigation																				
	Total deaths	2	1	5	8	3	1	3	7	3	0	2	5	4	0	2	6	1	2	2	5
	Review/investigation completed	2	1	2	5	3	1	3	7	2	0	1	3	4	0	1	5	0	1	0	1
COMMUNITY HOSPITAL	Total deaths	14	22	28	64	16	16	21	53	22	22	16	60	19	18	29	66	24	22	17	63
	Total scrutinised by ME	11	17	15	43	8	11	18	37	22	19	15	56	19	18	29	66	24	22	17	63
	SJR's requested by LfD	0	0	1	1	0	0	1	1	0	1	1	2	1	0	2	3	0	1	0	1
	SJR's completed	0	0	1	1	0	0	0	0	0	1	1	2	0	0	0	0	0	1	0	1
	Problems in care**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incident process initiated	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MENTAL HEALTH	Total deaths (reported as incident)	3	7	4	14	6	9	9	24	5	10	6	21	8	10	3	21	4	9	6	19
	Total scrutinised by ME	0	0	1	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	1	1
	SJR's requested by LfD	1	4	3	8	2	6	7	15	1	5	3	9	1	0	2	3	2	2	1	5
	SJR's completed	1	4	3	7	2	5	7	14	1	5	3	9	1	0	1	2	0	0	0	0
	Problems in care**	0	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incident process initiated	0	1	1	2	0	1	0	1	0	1	0	1	1	0	0	1	0	0	1	1
COMMUNITY SERVICES	SJR's requested by LfD	0	0	1	1	0	0	0	0	0	0	1	1	0	0	0	0	1	0	0	1
	SJR's completed	3	1	3	7	2	2	1	5	0	0	1	1	0	0	0	0	1	0	0	1
	Problems in care**	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incident process initiated	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total deaths subject to Coroner's Inquests		15	17	11	43	19	19	27	65	17	30	16	63	10	11	9	30	12	18	15	45

* Note – figures for legacy SFT and YDH Trusts have been combined for this report
**Where SJR has identified that a death was thought more likely than not to be related to problems with care

APPENDIX 2

PATIENT LEVEL CLINICAL REVIEW – 'Excess' deaths in Crewkerne Community Hospital

EXECUTIVE SUMMARY

Concern
Published mortality metrics have shown 'excess' mortality at site-level for Crewkerne Community Hospital. This has been sustained across 3 reporting periods prompting a patient-level clinical review.

Figures from July 2023 shown here:
SHMI for April 2022 – Mar 2023: 208.3 (119.0 – 338.3), Observed deaths 16, Expected deaths 8.
HSMR for April 2022 – Mar 2023: 167.6 (93.7 – 276.4), Observed deaths 15, Expected deaths 9.

Likely explanation
SHMI and HSMR are both designed for assessing mortality in non-specialist hospital inpatients. The likely explanation for the 'excess' mortality seen is the considerable difference in case mix in a community hospital, including many patients being admitted specifically for end-of-life care. Previous reviews of our community hospitals prompted by similar triggers have found no concerns.

Aim of report
To review the deaths of patients who died in Crewkerne Community Hospital or within 30 days of discharge between May 2022 and April 2023 to provide assurance and/or to identify areas of concern for further review.
Further aims were to assess the quality of care provided and identify any positive or negative learning to be shared.

Findings
22 patients, with a mean age of 86 years, were included in the review and half were admitted specifically for end-of-life care. Most patients were admitted from Yeovil Hospital, but nearly a quarter were admitted directly from home. For patients who died having been admitted for rehab (Pathway 2), that decision was appropriate at the time.

Both mortality risk scores (SHMI and HSMR) did not adequately reflect patients admitted for end-of-life care – when this was taken into account, there was no excess mortality using either score. Palliative care coding (which has a significant impact on HSMR) is low in (legacy) SFT and high in YDH mainly due to different models of palliative care delivery.

15 of 18 patients who died in hospital underwent scrutiny by the Medical Examiner service. No concerns regarding care relating to death were raised by either Medical Examiners or families.

6 patients died within 3 days of admission to Crewkerne; all were admitted for end-of-life care. There was no evidence of avoidability in any of these deaths. A couple of learning points but unrelated to death will be raised with the clinical team.

8 patients who were admitted on Pathway 2 died. There was no clear evidence of avoidability in any of these deaths; there was a possible delay in escalation for 1 patient and this will be reviewed by the clinical team. It is felt unlikely that this contributed to the death. Further learning points around thromboprophylaxis will be raised with the clinical team.

There was no evidence of avoidability in the deaths of the remaining 8 patients.

Overall, quality of care provided before death was very good or excellent and many examples are given in the main text of this review. There were no specific concerns with care but some suggested areas for review have been suggested to the clinical team/Service Group.

Overall, quality of care provided after death was also excellent. There were 2 occasions when the verification of death was delayed. It is suggested that the recently updated Verification of Death policy is shared widely with the clinical teams using some of the examples included in this review.

Suggestions/Actions

At Trust level:

1. Agree to stop using HSMR and SHMI at site-level as a trigger of concern for community hospital deaths – NHS England admit that neither metric is appropriate for community hospitals and multiple internal reviews using these triggers have not highlighted concerns.
2. Ongoing investment in clinical coding to ensure accuracy and timeliness of diagnosis, comorbidity and palliative care coding.

At Service Group level:

1. Agree upon a new set of triggers for mortality review in community hospitals to continue to provide assurance.
2. Review thromboprophylaxis guidance in the community hospital setting and share policies with clinical teams.
3. Share the updated Verification of Death Policy and to include the ICD deactivation pathway with clinical teams, possibly including the examples of where this hasn’t been followed in this review.

At Site level:

1. Two specific cases will be fed back to the clinical team for review regarding provision of high flow oxygen and NEWS scoring.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Quality and Performance Exception Report
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Associate Director – Planning and Performance Senior Performance Manager Chief of People and Organisational Development Deputy Chief Nurse Director of Elective Care
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	5 March 2024

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
☒ For Assurance	☐ For Approval / Decision	☒ For Information

Executive Summary and Reason for presentation to Committee/Board	Our Quality and Performance Exception Report sets out the key exceptions across a range of quality and performance measures, and the reasons for any significant changes or trends. The growth in the size of waiting lists, as a result of the Covid-19 pandemic, continues to have a significant impact on a range of access standards, whilst restoration work is being undertaken to reduce the number of patients waiting and to shorten waiting times. As referrals recover to pre-Covid-19 levels this will also have an impact on services and numbers waiting. Urgent and emergency patients continue to be prioritised, to receive the treatments they need. Areas in which performance has been sustained or has notably improved include: • CAMHS Eating Disorders - Routine referrals to be seen within four weeks remains above the national standard and the national average. • Access to our perinatal service was significantly above the 10% mandated standard. • Patients followed up within 72 hours of discharge from an adult mental ward.

	Areas in respect of which the contributory causes of, and actions to address, underperformance are set out in greater detail in this report include: • the percentage of patients seen within four hours and spending longer than 12 hours, in our accident and emergency department and minor injury units. • the percentage of people waiting under six weeks for a diagnostic test. • the percentage of ambulance handovers completed within 30 minutes of arrival at our Emergency Departments.
Recommendation	The Board is asked to discuss and note the report.

Links to Joint Strategic Objectives (Please select any which are impacted on / relevant to this paper)	
☒ Obj 1	Improve health and wellbeing of population
☒ Obj 2	Provide the best care and support to children and adults
☒ Obj 3	Strengthen care and support in local communities
☒ Obj 4	Reduce inequalities
☒ Obj 5	Respond well to complex needs
☒ Obj 6	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☐ Obj 7	Live within our means and use our resources wisely
☒ Obj 8	Develop a high performing organisation delivering the vision of the Trust

Implications/Requirements (Please select any which are relevant to this paper)					
☐ Financial	☒ Legislation	☒ Workforce	☐ Estates	☐ ICT	☒ Patient Safety/ Quality

Details:

The report provides an update on issues relating to patient safety and quality of service delivery, in Section 1 and also in Appendices 3, 4, 5, and 6. (patient safety and quality)

The report provides an update on issues relating to staffing, in Section 1 and also in Appendix 4. (workforce)

The report provides an update, by exception, on the position relating to statutory Fire training, in Section 1. (legislation)

Equality and Inclusion
The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
A range of key indicators, relating to waiting times for treatment including acute hospital services, cancer services, and mental health services, are routinely monitored to provide assurance that there is equity of provision and access in relation to people with protected characteristics. This includes standards delivered according to recorded ethnicity and learning disability. Our workforce measures also include indicators relating to ethnicity, gender and disability.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History
How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Not considered for this report.

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The report is presented to every Board meeting.

Reference to CQC domains (Please select any which are relevant to this paper)				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	☐ No

SOMERSET NHS FOUNDATION TRUST

QUALITY AND PERFORMANCE EXCEPTION REPORT: JANUARY 2024

1. BACKGROUND AND PURPOSE

1.1 Our Quality and Performance exception report sets out the key exceptions across a range of quality and performance measures, and the reasons for any significant changes or trends.

1.2 The report presents information relating to the five key questions which the Care Quality Commission considers when reviewing and inspecting services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they well-led?
- Are they responsive to people's needs?

1.3 Underpinning each of these key questions are Quality Statements, which outline the commitments that providers, commissioners and system leaders should live up to. Expressed as 'we statements', these show what is needed to deliver high-quality, person-centred care. As a provider, we aim to ensure that we meet the requirements of these 'we statements', as well as the accompanying 'I statements', which reflect what people have said matters to them.

1.4 The exception reports include run charts, produced using Institute for Healthcare Improvement (IHI) methodology, and in consultation with the Academic Health Sciences Network. An explanation of how to interpret these charts is attached as Appendix 1.

1.5 A summary of our current Care Quality Commission ratings is included as Appendix 2.

1.6 A summary of the monthly data and run charts for our key quality measures is attached as Appendix 3.

1.7 Our Corporate Balanced Scorecard is attached as Appendix 4. The measures included in the Corporate Balanced Scorecard may change during the year as new priority areas are identified.

1.8 Supporting information relating to referral levels, activity levels, lengths of stay, tumour-site-specific activity and performance, and other key measures for our community and mental health services is included in Appendix 5. The

activity information in Appendix 5 shows the levels and trends for the current year and previous two years.

1.9 Appendix 6 provides additional details and commentary in relation to Infection Control and Prevention.

CHIEF FINANCE OFFICER

Overview

The table below provides a summary of key successes, priorities, opportunities, risks and threats in relation to our current levels of performance.

Successes	**Priorities**
• our eating disorders service for children and young people continued to exceed the national waiting times standard for routine appointments. • the national 28-day Faster Diagnosis Standard for cancer pathways was again met in the month. • compliance remains high in respect of mental health inpatients receiving a follow-up within 72 hours of discharge. • there was a significant reduction in the number of patients waiting over 65 weeks RTT. • the compliance level in respect of mandatory training remains high despite the operational challenges faced by services.	• continue to maintain a safe service and making sure urgent patients are treated as quickly as possible within the context of the challenges the current coronavirus outbreak brings. • continue to support the health and wellbeing, both physically and psychologically, of colleagues across the Trust, as they continue to deliver high quality care to patients whilst managing significant and ongoing pressures associated backlogs arising from the time of the COVID-19 pandemic, and rising levels of demand. • continue to restore and expand capacity above pre-COVID-19 levels, to address backlogs in routine elective work. • work with the Somerset system to encourage continued referrals and presentations at hospital where needed and appropriate, especially in respect of urgent or emergency care.
Opportunities	**Risks and Threats**
• continue to progress the health and wellbeing plans for our colleagues at pace; this includes the psychological support offered alongside practical aspects of support such as accommodation provision and nutrition. • continue with new ways of working, particularly through the use of technology. • continue to adapt our recruitment practice, developing more innovative arrangements and reducing time to hire significantly. • develop reporting solutions to improve robustness of recording and reporting.	• the growth in the size of waiting lists caused by the reduction in capacity during the COVID-19 pandemic continues to present a significant challenge to the restoration of waiting times. • delays in discharge of medically fit patients needing domiciliary care will result in further cancellations of surgery which will reduce our capacity to treat long waiting patients. • significantly increasing levels of demand, particularly for urgent care and mental health services, leading potentially to increased pressures on teams and longer waiting times. • Sickness / absence presents a challenge for colleagues within some critical areas, and we need to ensure that we continue to support colleagues accordingly.

Safe

Infection Prevention and Control (IPC) performance is assessed by means of the numbers of key healthcare associated infections (HCAI) (Trust apportioned) against agreed thresholds. These are: MRSA bloodstream infections (BSI): zero tolerance, Clostridioides difficile (C. diff) infection (CDI): 54 cases, MSSA BSIs: 64, E. coli BSIs: 105 cases, Klebsiella BSIs: 31 Pseudomonas aeruginosa BSIs: 15.

Current performance (including factors affecting this)

- **MRSA:** One Trust-attributed MRSA bloodstream infection (BSI) was reported in January 2024. Since 1 April 2023 there have been three incidents.
- **C. diff**: There were 13 Trust-attributed cases reported in January 2024, bringing the total to 74 against a threshold for the year of 54.
- **MSSA:** There were 10 Trust-attributed MSSA BSIs reported in January 2024, bringing the total to 58 against an internal threshold for the year of 64.
- **E. coli**: There were seven Trust-attributed E. coli BSIs reported in January 2024, bringing the total to 117 against a threshold for the year of 105.
- **Klebsiella:** There were three Trust-attributed Klebsiella BSIs reported in January 2024, bringing the total to 45 against a threshold for the year of 31.
- **Pseudomonas:** There were no Trust-attributed Pseudomonas aeruginosa BSI reported in January 2024, leaving the total at 15, which meets the threshold for the year.

Respiratory Viral Infections

- **COVID-19:** 269 inpatient cases of COVID-19 were identified during January 2024, of which 110 were healthcare-attributed.
- **Influenza:** 116 inpatient cases were identified during January 2024, almost all of which are Flu A.
- **Respiratory Syncytial Virus (RSV):** 57 inpatient cases of RSV were identified during January 2024.

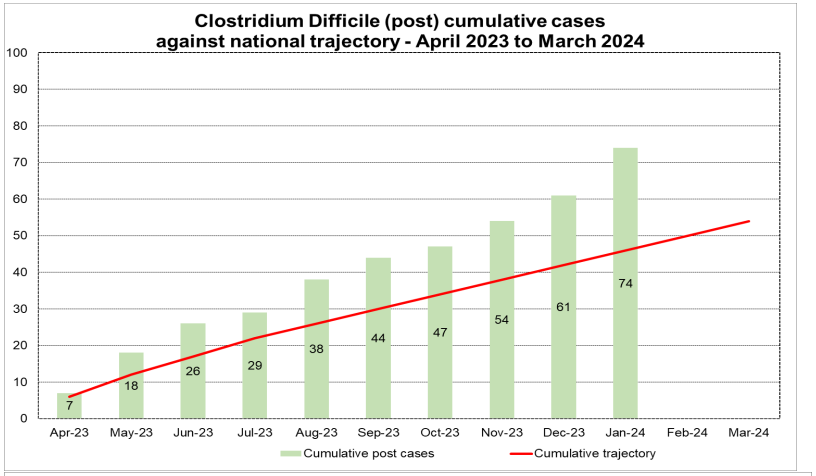
Outbreaks

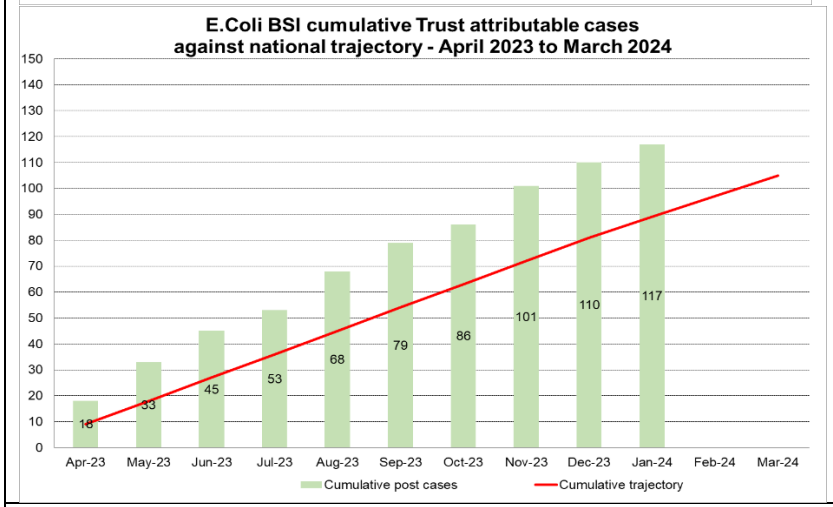
- During January 2024 a total of 25 outbreaks affected inpatient wards, 15 due to COVID-19, six due to Influenza and four due to norovirus.

Surgical Site Infections

- A rise in infections following joint replacement surgery has been noted on the Yeovil District hospital site. Further details are in Appendix 6.

Line/Bar Charts





Recent performance

Area	Aug	Sept	Oct	Nov	Dec	Jan
MRSA	1	0	0	0	0	1
C.Diff	9	6	3	7	7	13
MSSA	6	6	4	5	5	10
E.coli	15	11	7	15	9	7

Safe

Ligatures and ligature point incidents – monthly numbers of incidents reported via our RADAR reporting system. Our aims are to maintain high rates of reporting, have a low proportion of incidents which result in harm, and minimise the use of ligatures.

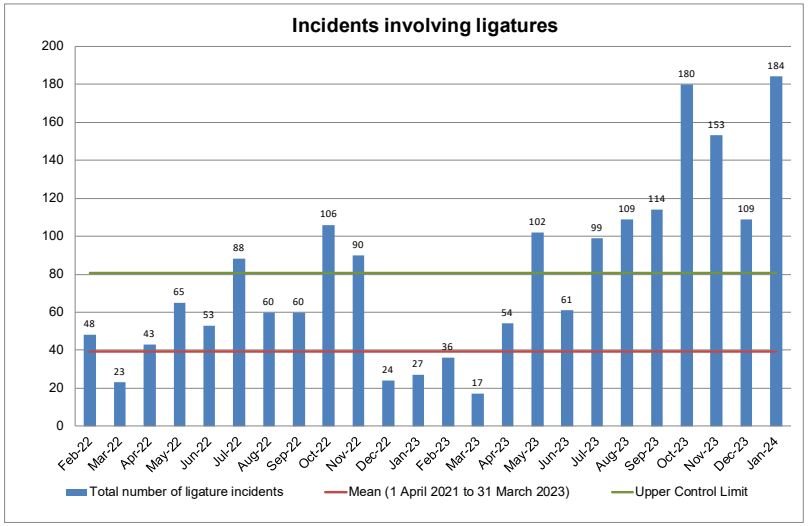
Current performance (including factors affecting this)

- During January 2024 a total of 184 ligature incidents were reported, involving 14 patients. There were also four reported ligature point incidents, involving two patients.
- Of the 184 ligature incidents, 77 occurred at Rydon ward 1, involving three patients, with 50 relating to one patient. Holford ward, our psychiatric intensive care unit, reported 70 incidents, with 69 relating to one patient.
- Of the 184 ligature incidents, 32 resulted in minor harm and three in moderate harm. No higher levels of harm were recorded.
- Of the four incidents involving ligature points, none resulted in harm.

Focus of improvement work

- All incidents involving ligatures are reviewed to ensure that assessments and care plans accurately reflect observation levels and the management of identified risk. A review of risks and observation levels is also undertaken at all handovers for each individual patient.
- The Rydon ward 1 patient is diagnosed with Recurrent Depressive Disorder and has been involved in a total of 312 incidents since May 2023.
- Risk management plans are in place and are carefully managed in order not to adopt an overly restrictive approach, which could severely impact on patients' privacy and dignity.
- Potential technological solutions to reduce the risk of fixed ligature incidents are currently available including door-top alarms, and room monitors which will continue to be evaluated. Any use of technological solutions will continue to be supported with evidenced-based risk assessment and appropriate observation and engagement.
- Work is currently being undertaken to finalise the strategy for implementing a Complex Emotional Needs Clinical Pathway. This will place a greater emphasis on localities and Multi-Disciplinary Teams determining whether inpatient admission is indicated for patients who might be at an increased risk of self-harm following admission to hospital.

SPC Chart



How do we compare

The latest NHS Benchmarking Network report, covering the year 2022/23, showed that Somerset NHS Foundation Trust had a higher level of reported adult acute mental health and PICU ligature incidents than peer providers nationally.

Recent Performance

The monthly numbers of incidents in recent months were as follows:

Area	Aug	Sep	Oct	Nov	Dec	Jan
Number of Ligature incidents	109	114	180	153	109	184
Number resulting in harm	19	7	7	11	16	35

Responsive

The Accident & Emergency (A&E) 4-hour standard is a measure of the length of wait from arrival in an Emergency Department (ED) to the time the patient is discharged, admitted or transferred to another provider. The target is that at least 76% of patients will wait less than four hours in the Emergency Department by March 2024.

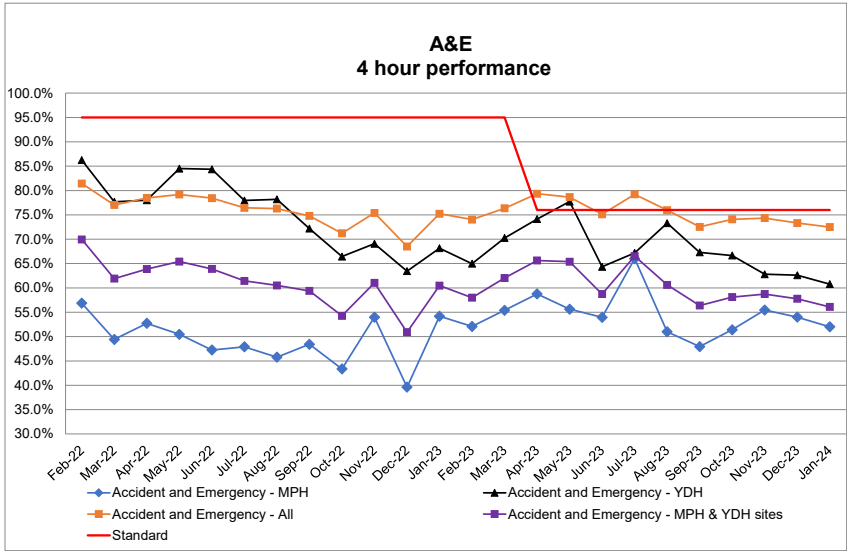
Current performance (including factors affecting this)

- Trust-wide A&E 4-hour performance for was 56.1% during January 2024, down from 57.8% in December 2023. With Minor Injury Units (MIUs) compliance included at 96.0%, our overall compliance was 72.5%, below the revised 76 % national standard.
- Compliance in respect of our two A&E departments was:
  - Musgrove Park Hospital (MPH): 52.0%.
  - Yeovil District Hospital (YDH): 60.8%.
- Combined year-to-date A&E attendances at MPH and YDH from 1 April 2023 to 31 January 2024 was 1.1% higher than the same months of 2022/23 with several pronounced daily 'spikes' in activity levels, which have affected performance against the four-hour standard.
- The position has also been affected by high numbers of inpatients at both sites who do not meet the criteria to reside.
- The number of patients spending more than 12 hours in the departments was 6.2% at MPH and 7.6% at YDH.

Focus of improvement work

- Work is ongoing with the Site Director and the ED senior team to review escalation/flow processes.
- A new ambulance arrivals programme has been successfully implemented.
- On the MPH site, work is progressing in respect of the new urgent care CT scanner.
- Work is aimed to be completed by March 2024, to review ED medical rotas on both acute sites to enable shift patterns to match demand, within our current financial envelope.
- Work was initiated in January 2024 to review triage processes at both acute sites.
- Focused work on Criteria Led Discharge is underway. This has the aim of facilitating earlier discharge and improving ED flow.
- A joint-site Same Day Urgent Care (SDEC) task and finish exercise is planned, to aim towards a seven-day service, 12 hours per day, aiming for implementation by 29 February 2024.

Line Chart



How do we compare

In January 2024, the national average performance for Trusts with a major Emergency Department was 55.4%. Our performance was 56.1%. We were ranked 55 out of 122 trusts. With Minor Injury Unit attendances included, we were ranked 27, with performance of 72.5%. National average performance was 67.3%.

Recent performance

Area	Aug	Sep	Oct	Nov	Dec	Jan
A&E only	60.6%	56.4%	58.1%	58.7%	57.8%	56.1%
Including MIU	76.0%	72.5%	74.1%	74.3%	73.3%	72.5%

Responsive

Ambulance handovers are to be completed within 30 minutes of arrival at an Emergency Department (ED). The target is that at least 95% of patient handovers are within the 30 minute standard.

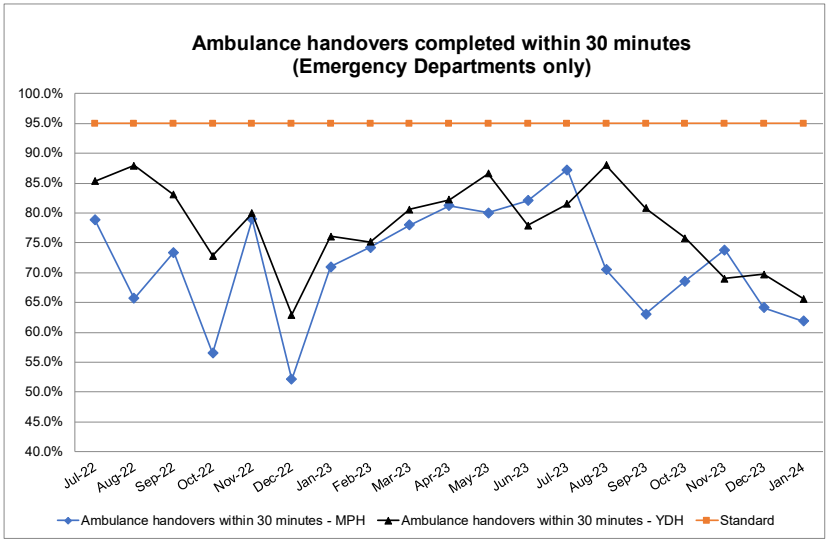
Current performance (including factors affecting this)

- During January 2024, performance for the handover within 30 minutes of patient arrivals by ambulance received decreased at Musgrove Park Hospital (MPH) and at Yeovil District Hospital (YDH) compared to December 2023. Compliance in January 2024 was as follows:
  - MPH: 61.9% (1,497 out of 2,417 handovers were within 30 minutes).
  - YDH: 65.6% (883 out of 1,346 handovers were within 30 minutes).
- The average performance across all hospitals served by SWAST in January 2024 was 52.3%.

Focus of improvement work

- The South Western Ambulance Service NHS Foundation Trust (SWAST) and acute sites have successfully implemented a new ambulance arrival screen and a new ambulance handover process to run alongside it. We will now monitor the effects on ambulance handover times and are working with system partners to review the implementation and continuation of the process.
- Acute sites are working with SWAST and community partners to look at alternative pathways for patients to follow. This has seen a reduction in conveyances, and work on this project will continue.
- We are working with SWAST to streamline and improve direct access pathways to Same Day Emergency Care (SDEC) at MPH.
- The Rapid Assessment and Triage (RAT) process is to be reviewed and streamlined across both acute sites.
- We are currently working through the implementation of a new escalation process, as released by NHS England, for long-waiting ambulance handovers.
- A review and redesign of ED escalation is ongoing, which will include internal response to ambulance handover delays.
- In February 2024, a senior operational walk-through is planned, to review all elements of ambulance handover between acute sites and SWAST, to identify any further improvements.

Line Chart



How do we compare

In January 2024, 61.9% of all ambulance handovers at Musgrove Park Hospital and 65.6% of all ambulance handovers at Yeovil District Hospital were completed within 30 minutes. The average performance across all hospitals served by SWAST was 52.3%.

Recent performance

Performance in recent months against the 30-minute standard was as follows:

Area	Aug	Sep	Oct	Nov	Dec	Jan
MPH	70.5%	63.1%	68.6%	73.8%	64.1%	61.9%
YDH	88.0%	80.8%	75.8%	69.0%	69.7%	65.6%

Responsive

Referral to Treatment Time (RTT) is a measure of the length of time a patient waits from the point of referral through to receiving treatment. The target is for at least 92% of patients, who have not yet received treatment, to have been waiting less than 18 weeks at the month-end. Trusts should have no patients waiting over 65 weeks for treatment by 31 March 2024.

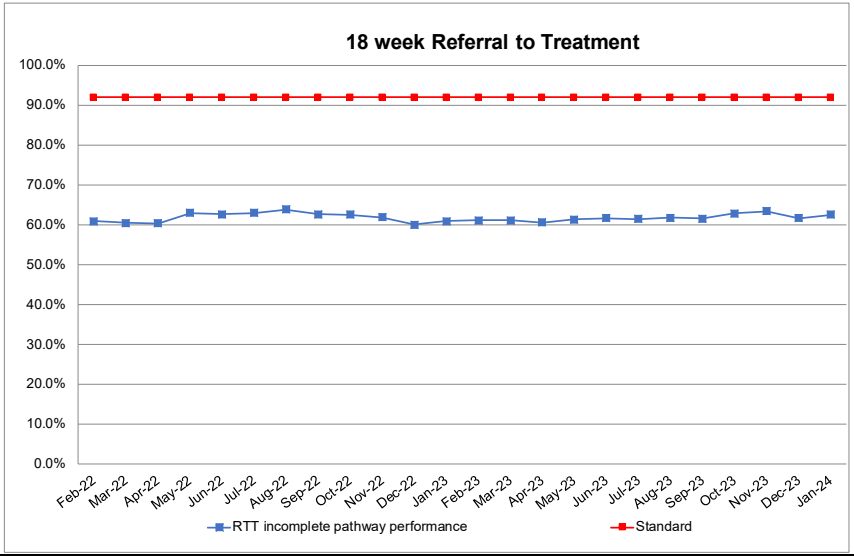
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT was 62.6% (combined acutes + community) in January 2024, up from 61.7% in December 2023.
- The total waiting list size increased by 120 pathways, and was 3,624 lower (i.e. better) than the planning trajectory (53,787 actual vs. 57,411).
- The number of patients waiting over 52 weeks decreased by 267 pathways in January 2024 to 2,252 pathways, against a trajectory of 3,005 or fewer. The number of patients waiting over 65 weeks was 605 at month-end, 105 better than the revised trajectory of 710 or fewer. The number of patients waiting 78+ weeks decreased by 11 to 50, meeting the revised trajectory for January 2024 of 50 or fewer. We reported no patients waiting over 104 weeks.
- Until November 2021 Musgrove remained one inpatient theatre's worth of capacity down due to the conversion of a theatre into critical care capacity. This along with other factors has resulted in a backlog of more complex, longer routine cases on the waiting list.

Focus of improvement work

- The number of patients needing surgery this year to avoid becoming a 65-week RTT waiter by March 2024 has been quantified for each specialty, and detailed plans continue to be progressed to manage these volumes through improved productivity, increased capacity (including use of the Independent Sector) and reprioritisation of available theatre capacity across the System.
- A significant programme of work to support elective care recovery in the medium and long-term is in place.
- A programme of waiting list validation has been established, which includes contacting patients to check they still need to be seen.
- The Trust has implemented the national patient choice programme (PIDMAS).

Line Chart



How do we compare

The national average performance against the 18-week RTT standard was 56.6% in December 2023, the latest data available; our performance was 61.7%. National performance declined by 1.7% between November and December 2023; our performance also declined by 1.7%. The number of patients waiting over 52 weeks across the country decreased by 17,962 to 337,450 (4.4% of the national waiting list compared with 4.2% for the Trust).

Performance trajectory: 78 week and 65 week wait performance

Area	Aug	Sep	Oct	Nov	Dec	Jan
78-week trajectory	31	17	12	62	55	50
78-week actual	66	70	55	49	61	50
65-week trajectory	933	1,040	1,218	682	734	710
65-week actual	724	741	687	661	725	605

Appendix 5a shows a breakdown of performance at specialty level.

Responsive

Acute bed days lost due to patients not meeting the criteria to reside: Working with strategic partners to facilitate the timely and appropriate discharge of patients from our hospitals, and reduce the number of patients occupying a bed who no longer require treatment or therapy.

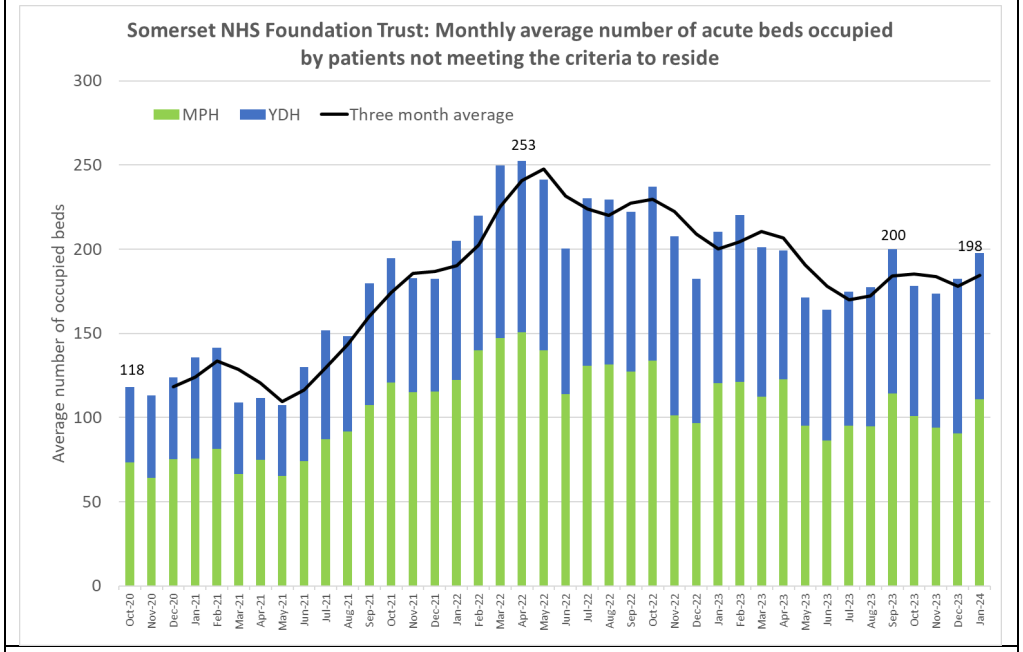
Current performance (including factors affecting this)

- During January 2024, the Trust-wide number of acute bed days occupied by patients not meeting the criteria to reside was 6,126 (3,435 at MPH and 2,691 at YDH), up from 5,651 in December 2023. This equates to 198 fully occupied beds during the month of January 2024, up from 182 in December 2023.
- In our community hospitals, the number of patients not meeting the criteria to reside also increased, from 53 as at 31 December 2023 to 73 as at 31 January 2024.
- Of the 1,286 acute inpatients discharged during January 2024 who had a Discharge Ready Date recorded, the average duration between the Discharge Ready Date and the actual date of discharge was 3.7, days compared to 4.8 days during December 2023. 83.3% of patients discharged in January 2024 were discharged within seven days of their Discharge Ready Date, and 94.2% were discharged within 14 days,

Focus of improvement work

- A range of actions are being taken to improve patient flow, care for people at home where appropriate, facilitate timely and appropriate discharge from hospital, and address the difficulties in the domiciliary care market.
- These actions include the expansion of Criteria-Led Discharge, to discharge a patient when they meet pre-agreed clinical criteria for discharge, as identified by the lead clinician. This reduces delays in the discharge process and ensures that patients can be discharged in an appropriate and timely way.

Trend Chart



How do we compare

The number of bed days lost due to patients not meeting the criteria to reside significantly increased at MPH but decreased at YDH during January 2024 compared to December 2023.

Recent performance

Bed days lost where patients did not meet criteria to reside over recent months were as follows:

Area	Aug	Sep	Oct	Nov	Dec	Jan
MPH	2,942	3,432	3,134	2,819	2,807	3,435
YDH	2,565	2,569	2,386	2,394	2,844	2,691
Total	5,507	6,001	5,520	5,213	5,651	6,126

Responsive

Intermediate Care – Our aim is to ensure that at least 95% of patients aged 65 years or over discharged from acute hospital beds are discharged home on pathway 0 or 1.

Current performance (including factors affecting this)

During January 2024, 94.3% of patients aged 65 or over who were discharged from acute hospital beds within Somerset were transferred onto Pathway 0 or Pathway 1.

Pathway 0

These are discharges to patients' homes that are arranged at ward level and do not require core intermediate care support on discharge. These discharges are often supported by the voluntary sector and/or other community health services such as district nursing and the community rehabilitation service (CRS).

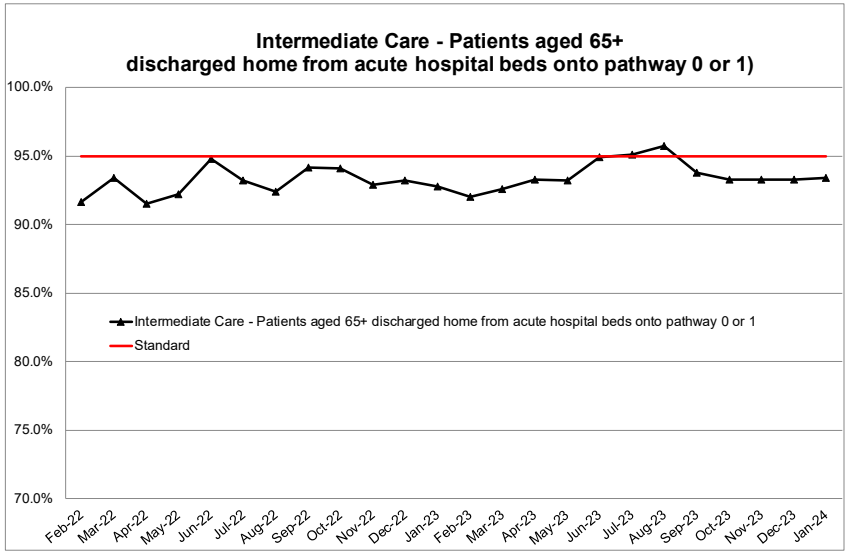
Pathway 1

These discharges are supported by the Intermediate Care Discharge to Assess Service (D2A). These people require reablement and ongoing assessment within their own home.

Focus of improvement work

1. **Reducing acute No Criteria to Reside (NCTR) levels and Increasing Pathway 0 discharges** – this remains a priority. Somerset System and Design group are leading on actions.
2. **Community NCTR** – package of care and self-funder delays remain low. Outstanding social care assessments and sourcing care home placements remain the major reasons for delays for people leaving intermediate care bedded pathways. There has been minimal change in recent months. Adult Social Care (ASC) delay improvement plans and improvement trajectories are due to be set.
3. **Community hospital length of stay (LOS)** – trajectories have been set as part of the winter bed modelling and the Better Care Fund. Improvement plans have been outlined and a reduction in LOS is evident. Progress against the improvement plans will be reported on a monthly basis via a LOS improvement group.
4. **Strengthening the transfer of care hub (TOCH)** – Transfer of Care Hub (TOCH) models went live on 1 December 2023 to reduce NCTR numbers and increase P0 volume, and at the same time reduce P2/3 referral volumes. This has been unsuccessful on MPH site currently. An improvement workshop is planned.

Trend Chart



How do we compare

The percentage of patients aged 65 or more transferred onto pathway 0 or 1 during January 2024 improved slightly compared to December 2023.

Performance over the last six months

Area	Aug	Sep	Oct	Nov	Dec	Jan
Total Discharges	2,625	2,336	2,182	2,165	2,132	2,139
Pathway 0	2,298	1,927	1,788	1,720	1,745	1,727
Pathway 1	213	263	247	300	244	290
% onto P0 or P1	95.7%	93.8%	93.3%	93.3%	93.3%	94.3%

Responsive

Percentage of stroke patients directly admitted to an acute stroke ward within four hours – Patients who have had a stroke should be admitted directly to a specialist acute stroke unit. Our aim at least 95% of patients are so admitted.

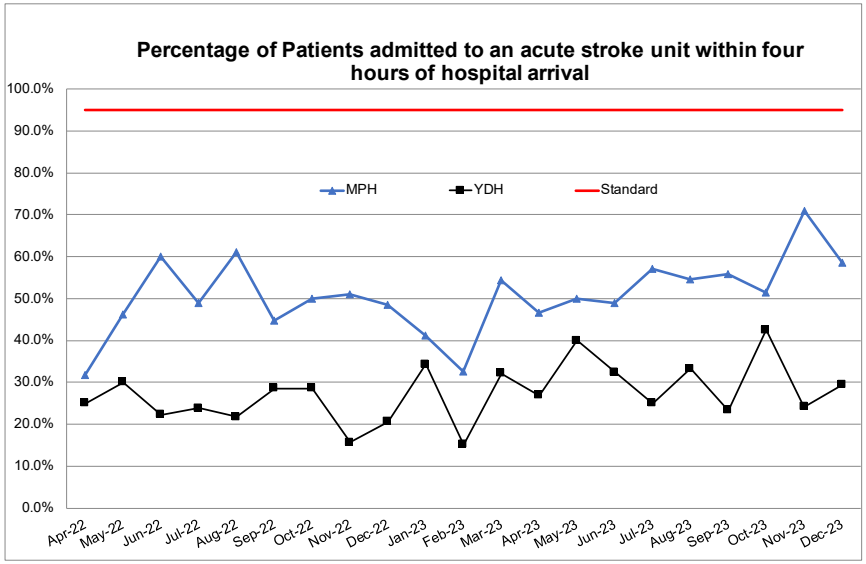
Current performance (including factors affecting this)

- During December 2023, compliance decreased at Musgrove Park Hospital but increased at Yeovil District Hospital when compared to November 2023. Both sites remained below the reporting standard of 95% with performance as follows:
  - Musgrove Park Hospital (MPH): 58.6%
  - Yeovil District Hospital (YDH): 24.9%
- Performance continues to be heavily influenced by bed availability, clinical presentation that may not immediately suggest stroke on admission, and medical decisions as when appropriate to move/transfer patients from the emergency departments (EDs) to the wards.

Focus of improvement work

- The Stroke team are proactive in aiming to identify promptly patients who present to ED with stroke symptoms, to ensure that any delays to transferring to a stroke unit are minimised.
- Current performance levels are reflective of wider pressures on the hospital rather than a disjointed pathway of treatment for patients, and when bed availability and flow are favourable, the four-hour target is achieved in the majority of cases. On review, the majority of those who are not admitted to a stroke bed within the four-hour standard transpire to be patients with stroke-like symptoms who have not actually had a stroke.
- Two Allied Clinical Professionals (ACPs) have recently been appointed. These ACPs will aid patient flow.
- The number of hyper acute stroke beds available at MPH increased from four to eight in January 2024.

Line Chart



How do we compare

During December 2023 compliance decreased at Musgrove Park Hospital but increased at Yeovil District Hospital when compared to November 2023.

Performance over the last six months

Area	Jul	Aug	Sep	Oct	Nov	Dec
% compliance MPH	57.1%	54.6%	55.9%	51.4%	71.0%	58.6%
% compliance YDH	25.0%	33.3%	23.3%	42.5%	24.2%	29.4%

Responsive

Patients spending >90% of time in stroke unit – Stroke units are able to offer the best quality of stroke care both acutely and in the long-term. Management of eligible patients in a stroke unit will result in long-term reductions in death, dependency and the need for institutional care. Our aim at least 80% of patients spend more than 90% of their pathway in designated stroke wards.

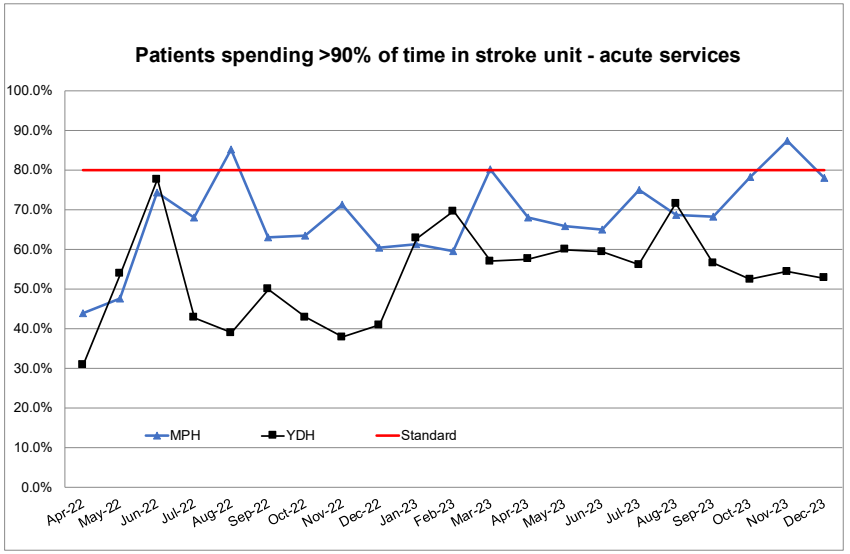
Current performance (including factors affecting this)

- During December 2023, compliance decreased at Musgrove Park Hospital, and also at Yeovil District Hospital, and was below the reporting standard. Performance at the two sites was as follows:
  - Musgrove Park Hospital (MPH): 78.1%
  - Yeovil District Hospital (YDH): 52.9%
- As is the case with the four-hour standard, performance in respect of this reporting standard is heavily influenced by patient flow and the availability of stroke beds.

Focus of improvement work

- For details of the improvement work being undertaken, please refer to the report on the four-hour direct admission standard.
- It should be noted that, regardless of whether or not they are on a Stroke ward, all patients remain on a stroke pathway throughout the whole time of their care and are seen by specialist stroke practitioners on non-Stroke wards and also throughout their time with our community Stroke rehabilitation services.

Line Chart



How do we compare

During December 2023, compliance decreased at both Musgrove Park Hospital and Yeovil District Hospital when compared to November 2023.

Performance over the last six months

Area	Jul	Aug	Sep	Oct	Nov	Dec
% compliance MPH	75.0%	68.9%	68.4%	78.4%	87.5%	78.1%
% compliance YDH	56.2%	71.7%	56.7%	52.5%	54.5%	52.9%

Safe

Out of Area Placements – The Five Year Forward View for Mental Health stated that placing people out of area for non-specialist acute mental health inpatient care due to local bed pressures was to be eliminated entirely by no later than 2020/21.

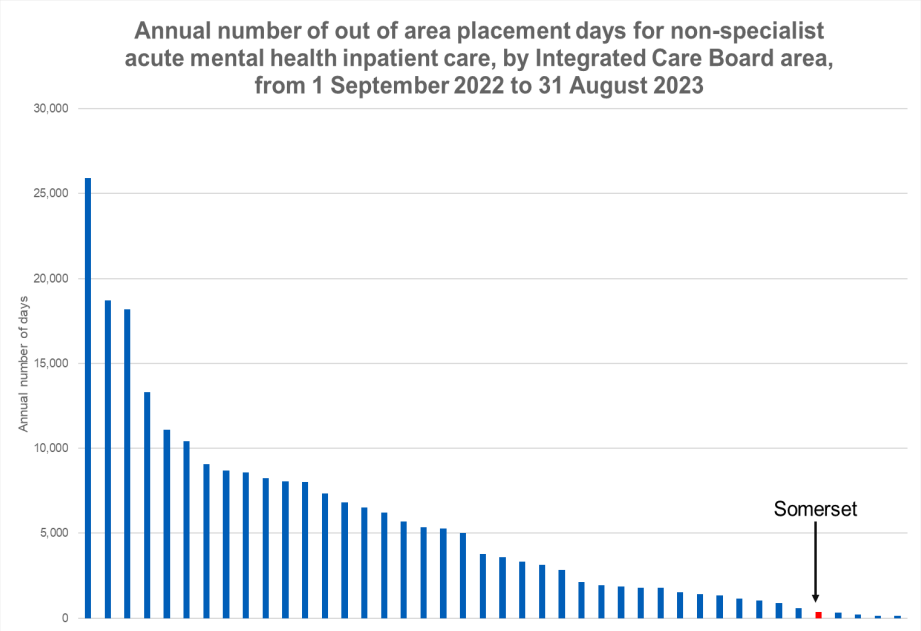
Current performance (including factors affecting this)

- During January 2024 two patients were placed out of area. One patient so placed on 1 December 2023 was repatriated back into a Somerset based bed on 1 February 2024. This decision was clinically indicated due to the patient requiring a male-only ward because of risks towards females during crisis.
- The other patient who was placed out of county on 18 January 2024 remains so placed. This decision is also clinically indicated due to the patient requiring a male-only ward due to risk towards females and was a transfer from prison. This patient will return to prison when well enough.

Focus of improvement work

- We continue have amongst the lowest levels of inappropriate out of area placements of all providers of mental health services nationally.
- The majority of out of area placements are due to patients requiring admission into our Psychiatric Intensive Care Unit (PICU). With only ten beds available there are occasions when, due to clinical acuity or gender, it would be unsafe to admit a patient.
- When a patient is so placed, a key worker is immediately assigned to maintain regular contact with the patient until the patient is either transferred back to our wards, discharged, or moved to secure services. The placements sought are always as close to Somerset as possible.
- At times, episodes relate to patients awaiting transfer to secure services. We work closely with other NHS providers, to facilitate such transfers and closely monitor processes to minimise risk.
- The service has reviewed processes to ensure barriers to repatriation and/or discharge of patients are minimised and escalated with system partners where appropriate.

Bar Chart



How do we compare

Data published by NHS Digital shows that we continue have amongst the lowest levels of out of area placements for non-specialist acute mental health inpatient care of all providers of mental health services nationally.

Recent Performance

The monthly numbers of patients who were placed out of area, and the numbers of patient days spent out of area over the last six months were as follows:

Area	Aug	Sep	Oct	Nov	Dec	Jan
Number of Days	0	0	10	10	34	45
Number of patients	0	0	1	1	2	2

Responsive

Waiting Times – One of our key priorities is to ensure that patients are able to access our services in as timely a manner as possible, and without unnecessary delays. Our aim is to reduce the number of people waiting over 18 weeks from being referred to having their first appointment. The data shown relates to our community physical health services, including dentistry.

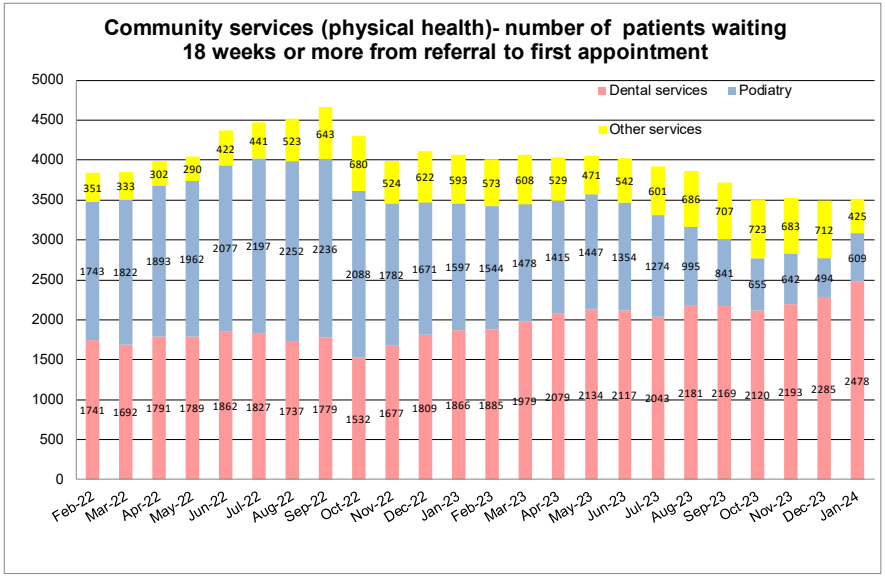
Current performance (including factors affecting this)

- As at 31 January 2024, the number of patients waiting 18 weeks or more totalled 3,512, an increase of 21 compared to 31 December 2023.
- Our Somerset and Dorset dental service had 2,478 patients waiting 18 weeks or more to be seen, up from 2,285 as at 31 December 2023 (Somerset: 1,734 patients, up from 1,530 and Dorset: 744 patients, down from 755).
- The number of people waiting 18 weeks or more to be seen by our Podiatry service increased to 609 patients, from 494 as at 31 December 2023 predominantly due to sickness within the service. The Podiatry service continues to have significant levels of vacancies, which is a national issue.
- Of the numbers within 'Others', 49.2% related to our Children and Young People Therapy Service, which decreased from 343 as at 31 December 2023 to 209 as at 31 January 2024.
- As at 31 January 2024, a total of 810 patients had waited 52 weeks or more to be seen (up from 758 in December 2023), 461 had waited 65 weeks or more (up from 401 in December 2023), and 256 had waited 78 weeks or more (up from 205 in December 2023).

Focus of improvement work

- In Podiatry, priority continues to be given to high risk vascular / diabetic foot care and acute nail surgery cases. All routine patients are contacted by letter and telephone to provide advice and guidance. The waiting list initiative to reduce the number of patients waiting and the length of wait, which began in September 2022, remains ongoing.
- The Dental service continues to face considerable challenges due to vacancies, sickness absence and insufficient cover for colleagues on maternity leave and continues with various recruitment initiatives.
- The Children and Young People Therapy Service were undertaking a waiting list initiative that commenced in November 2023.

Bar Chart



How do we compare

The number of patients waiting 18 weeks or more as at 31 January 2024 increased by 21 when compared to 31 December 2023.

Recent performance

The numbers of people waiting 18 weeks or more at the month end, in recent months were as follows:

Area	Aug	Sep	Oct	Nov	Dec	Jan
Number waiting	3,862	3,717	3,498	3,518	3,491	3,512

Responsive

Waiting Times – One of our key priorities is to ensure that patients are able to access our services in as timely a manner as possible, and without unnecessary delays. Our aim is to reduce the number of people waiting over 18 weeks from being referred to having treatment. The data shown relates to our Somerset and Dorset Dental services, specifically children and young people waiting 18 weeks or more from assessment for an appointment to have a procedure requiring a general anaesthetic (GA).

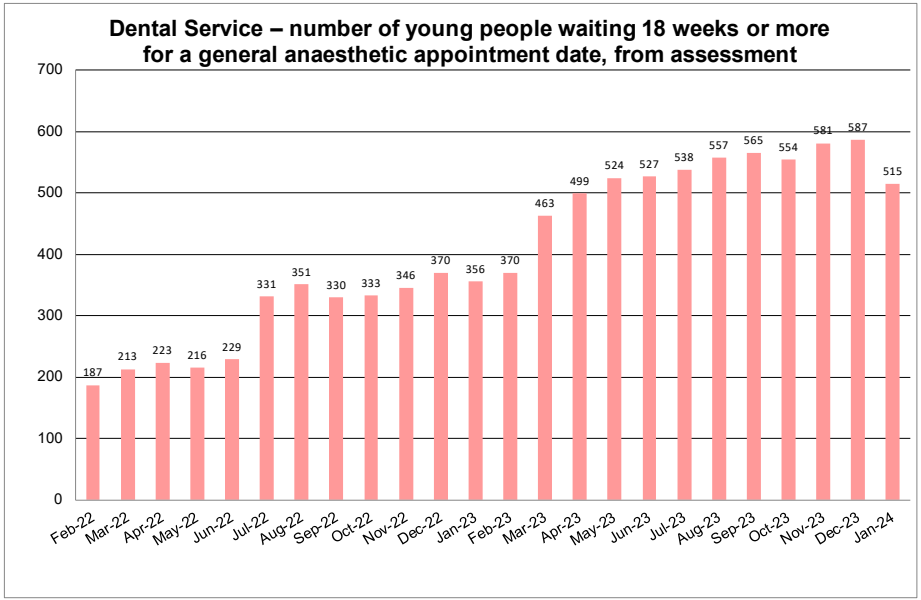
Current performance (including factors affecting this)

- As at 31 January 2024 a total of 515 young people had waited 18 weeks or more, down from 587 as at 31 December 2023.
- Of the 515 patients waiting, 465 related to our Dorset service (down from 538 as at 31 December 2023), and 50 related to our Somerset service (up from 49 as at 30 November 2023).
- The service continues to have significant levels of vacancies, which is a national issue, exacerbated by sickness/absence affecting capacity within the service, as well as the loss of some theatre slots.

Focus of improvement work

- The service continually reviews its recruitment programme and clinical delivery structure and other initiatives in order to encourage applicants. When new colleagues commence in post, their contribution is gradual until they are fully up to speed. A recruitment campaign for senior specialist posts is underway.
- Following active engagement, and the development of an options appraisal to which the service contributed, the Dorset Integrated Care Board (ICB) has allocated funding for Paediatric GAs, as an active intervention. This will be at a lower level than originally planned, but in-sourcing is set up to provide up to 100 patients with a GA. This work commenced on 20 January 2024, with ongoing negotiations for more sustainable capacity in future.
- Across both Dorset and Somerset, a review to improve efficiencies of theatre utilisation continues to reduce loss of capacity due to the availability of anaesthetists and to ensure slots available are not lost to avoidable circumstances.

Bar Chart



How do we compare

The number of young people waiting 18 weeks or more as at 31 January 2024 decreased compared to 31 December 2023.

Recent Performance

The numbers of young people waiting 18 weeks or more at the month end in recent months were as follows:

Area	Aug	Sept	Oct	Nov	Dec	Jan
Number waiting	557	565	554	581	587	515
% > 18 weeks	66.8%	65.8%	63.0%	67.0%	68.3%	66.7%

Responsive

31-day decision to treat to cancer treatment is a measure of the length of wait from the patient agreed decision to treat, through to treatment. The standard is for at least 96% of patients to be treated within 31 days of a decision to treat. This target includes first and subsequent treatments for cancer.

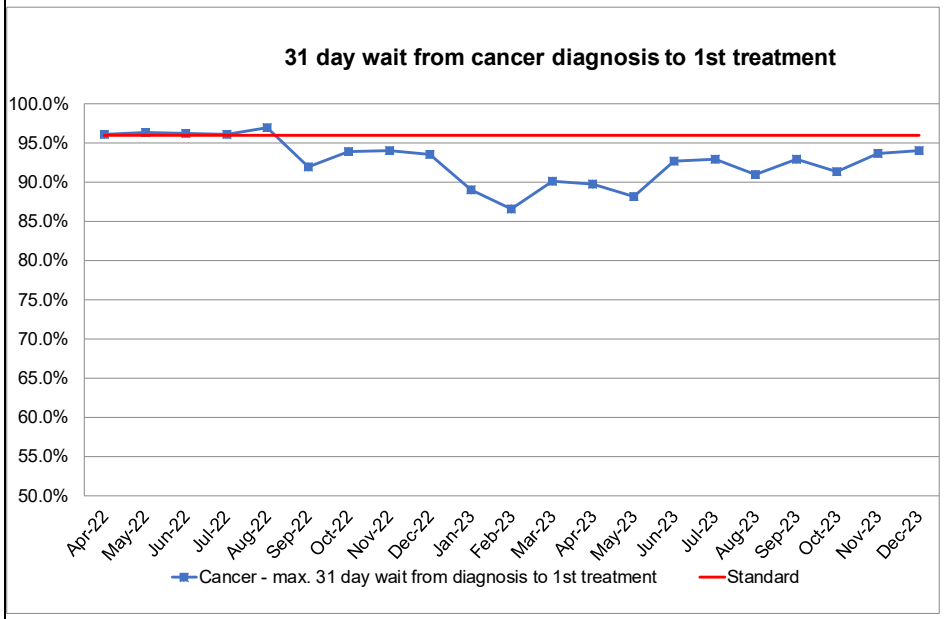
Current performance (including factors affecting this)

- Performance against the 31-day first combined treatment standard was 94.0% in December 2023, below the 96% national standard but above the national average performance.
- There were 38 breaches of the combined treatment standard, 17 (45% of breaches) for breast and seven (18%) for skin. There were smaller volumes of breaches across a range of tumour sites.
- Over the last three months, Breast cancer referrals have increased by 21% relative to the same period in 2019/20, creating a bulge in demand.
- There has been an increase in breaches of the 31-day standard for skin patients which has followed the full repatriation of the skin cancer service for the west of the county from University Hospital Bristol & Weston NHS Foundation Trust (UHBW) from the start of November 2023.
- 89% of the breaches were for surgical treatments. The ability to operate within 31 days of the decision to treat is affected by bulges in demand, which we have been seen in several tumour sites.
- Industrial action has had a limited impact on planned cancer treatments. However, any delays or cancellations of surgery are clinically risk assessed on a case-by-case basis by the operating surgeon.

Focus of improvement work

- Capacity and demand modelling has been undertaken for the repatriated dermatology two-week wait service. Additional capacity continues to be established, including further consultant appointments, GPs with Extended Roles being trained and insourcing. Allied service capacity is also being planned for, including pathology, plastics and melanoma oncology.
- The work outlined in the combined 62-day GP will also help to reduce delays in cancer pathways which will also help to smooth bulges in demand for cancer surgery.

Line Chart



How do we compare

National average performance for providers was 91.1% in December 2023, the latest data available. Our Trust-wide performance was 94.0%. We ranked 71 out of 138 providers.

Recent performance

31-day diagnosis to first treatment performance

Area	Jul	Aug	Sep	Oct	Nov	Dec
% Compliance	93.0%	91.0%	92.9%	91.3%	93.7%	94.0%

Responsive

62-day Cancer is a measure of the length of wait from referral from a GP, screening programme or consultant, through to the start of first definitive treatment. The target is for at least 85% of patients to be treated within 62 days of referral. The 28-day Faster Diagnosis is the first part of the 62-day pathway.

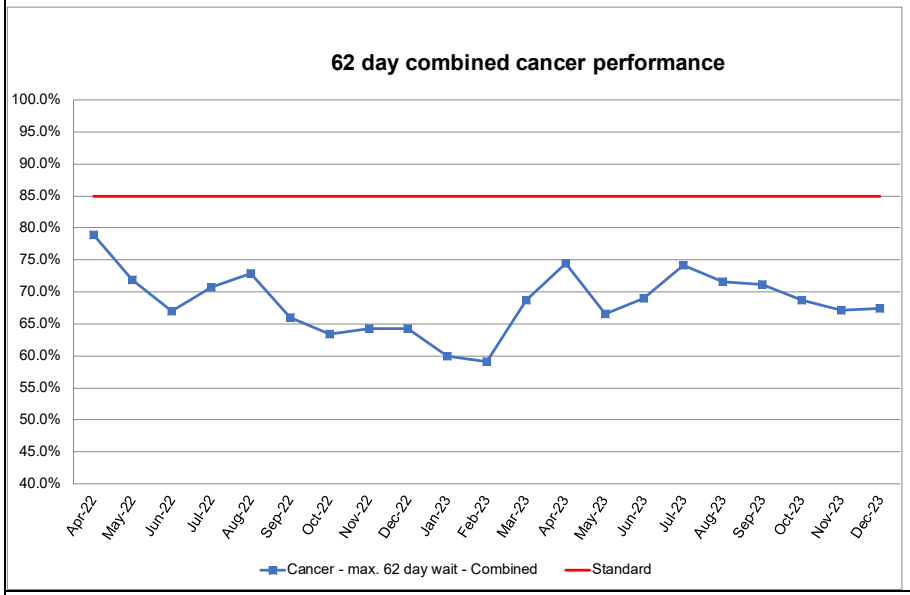
Current performance (including factors affecting this)

- The percentage of patients treated for a cancer within 62 days of referral was 67.4% in December 2023, below the national standard of 85% but above the national average.
- The main breaches of the 62-day GP cancer standard were in urology (37% of breaches), colorectal (14%) and skin (12%).
- The main cause of the breaches continues to be high demand (urology 26% growth and colorectal 9% growth in referrals, relative to the same three-month pre-COVID period). This has resulted in an increase in diagnostic and treatment waiting times, both at the Trust and at other treating providers. The increase in skin breaches relates to the sooner than planned repatriation of the service from University Hospitals Bristol & Weston NHS Foundation Trust (UHBW).
- Twenty-three GP referred patients were treated in December on or after day 104 (the national 'backstop'); see Appendix 5a.
- The number of patients referred by their GP waiting over 62 days at the end of January 2024 was 61 patients above (i.e. worse than) the recovery trajectory (203 against a plan of 142). At the time the trajectory was set plans were not in place to repatriate the skin service in-year, with skin currently making up 23% of the backlog.

Focus of improvement work

- Pathway redesign work is continuing for prostate, across both MPH and YDH, to align both sites and reduce any delays.
- Additional prostate and colorectal diagnostic capacity continue to be established, to try to meet increasing demand.
- The community-based one-stop self-referral gynaecology pathway for post-menopausal bleed patients commenced in September 2023.
- Please also see the 31-day exception report for actions relating to the skin cancer pathway.
- The Trust reported 28-day Faster Diagnosis performance of 76.6% against the 75.0% standard in December 2023, linked with improvements in the colorectal and gynaecology pathways

Line Chart



How do we compare

National average performance for providers was 65.9% in December 2023, the latest data available. Our performance was 67.4%. We were ranked 75 out of 144 trusts.

The target for the end of March 2024 is 70%, although the national standard remains 85%.

Recent performance

62-day GP cancer performance

Area	Jul	Aug	Sep	Oct	Nov	Dec
% Compliance	74.2%	71.7%	71.3%	68.8%	67.1%	67.4%

Appendix 5a provides a detailed breakdown of tumour-site level performance.

Responsive

The Diagnostic six-week wait is a measure of the length of wait from referral through to diagnostic testing being carried out. This standard is applied to the top 15 national high-volume tests. The target is for at least 95% of patients to have been waiting less than six weeks for a test at the month-end, by March 2025.

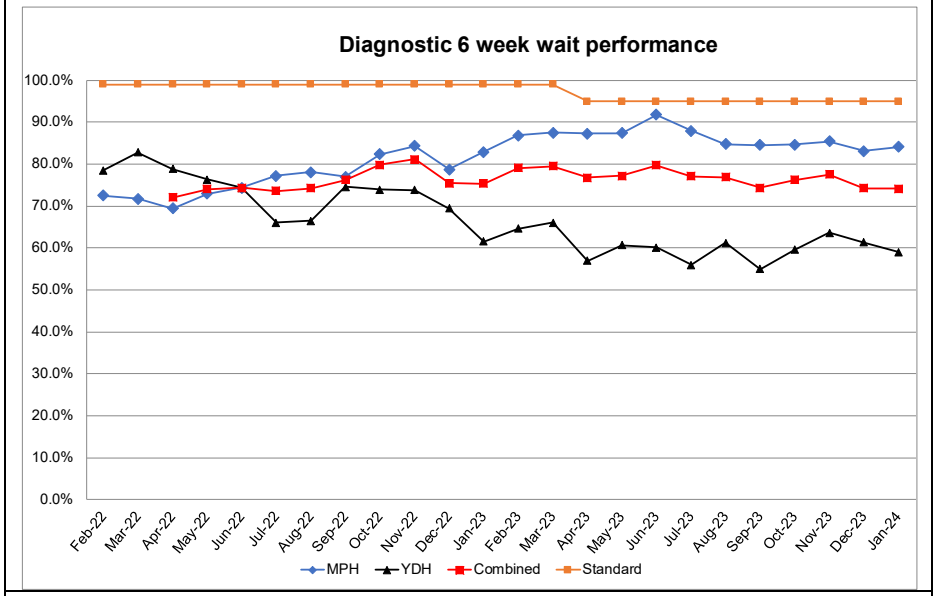
Current performance (including factors affecting this)

- The combined percentage of patients waiting under six weeks for their diagnostic test was 74.1% in January 2024, slightly below the regional March 2023 ambition of greater than 75%.
- The number of patients waiting over six weeks in January 2024 decreased by 43 patients in the month; the highest numbers of patients were waiting for an MRI (up from 660 to 664; 22% of over six week waiters, gastroscopy (down from 480 to 450; 15%), colonoscopy (down from 443 to 437; 14%), non-obstetric ultrasound (down from 373 to 343; 11%) and sleep studies (up from 277 to 309; 10%), together making up 72% of the long waiters.
- The total waiting list size decreased by 2%, due to high activity levels in the period. This was the main driver for the slight reduction in six-week wait performance.

Focus of improvement work

- Additional endoscopy sessions have been established at the weekend in Yeovil; appropriate patients are also being offered Musgrove Park and Bridgwater Community Hospitals as an alternative site for their surveillance procedure.
- Endoscopy capacity and demand modelling for the Yeovil site is being refreshed, to look at the proportion of capacity that needs to be dedicated to each procedure type.
- Additional weekend and in-week endoscopy sessions continue to be run at Musgrove.
- Additional ultrasound capacity has been established through waiting list initiatives and insourcing. The Musgrove and Yeovil sites are working together to share demand across available capacity.
- Additional MRI capacity has been established, through the rental of a mobile scanning van for an eight-week period, starting in mid-February 2024. Plans are in place to increase the number of scans undertaken at the Taunton Diagnostic Centre.

Line Chart



How do we compare

National average performance for NHS providers (i.e. excluding Independent Sector providers) was 72.7% in December 2023, the latest data available. Our performance was 74.3%. We were ranked 95 out of 156 trusts for the 15 high-volume diagnostic tests.

Recent performance

Area	Aug	Sep	Oct	Nov	Dec	Jan
Musgrove Park Hospital (MPH)	84.8%	84.6%	84.7%	85.4%	83.1%	84.1%
Yeovil District Hospital (YDH)	61.2%	55.0%	59.6%	63.6%	61.3%	59.0%
Combined	76.9%	74.4%	76.2%	77.6%	74.3%	74.1%

Well Led

Mandatory training – Our aim is to maintain a compliance rate of 90% or more for all mandatory and statutory training courses.

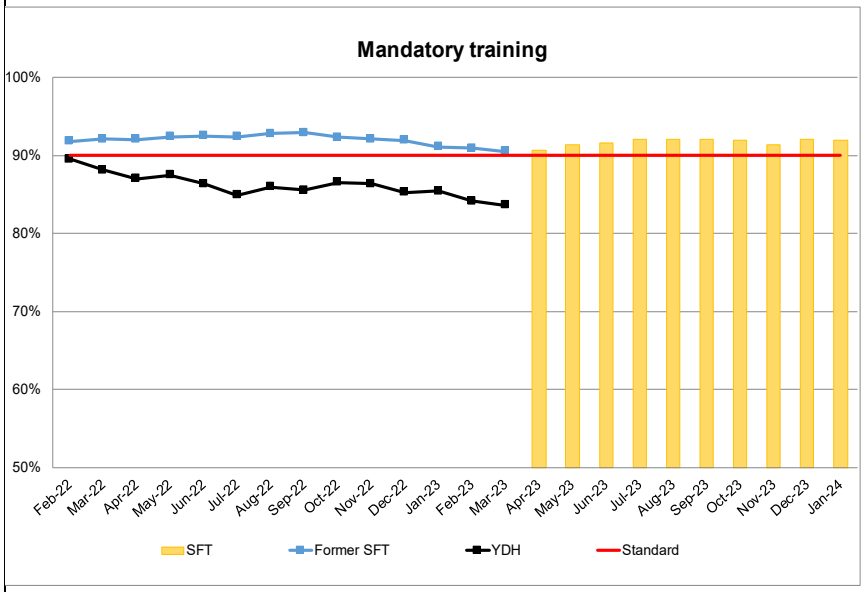
Current performance (including factors affecting this)

- As at 31 January 2024, our overall mandatory training rate was 91.9%, down from 92.1% as at 31 December 2023.
- Apart from Symphony Health Service (SHS), all colleagues moved to the newly commissioned Trust training system, LEAP, on 1 April 2023. As at 31 December 2023, compliance reported from the two separate systems was as follows:
  - LEAP: 91.9% (92.1% as at 31 December 2023)
  - SHS: 74.8% (76.5% as at 31 December 2023)
- Operational pressures, and limited capacity in areas with large backlogs such as life support and safeguarding continue to remain a challenge to full recovery.

Focus of improvement work

- Resuscitation compliance reversion to 12-months has now been completed, so figures are expected to become more stable. Work also continues in this area on reducing 'did not attends' and cancellations. Paediatric courses are now scheduled to run between adult sessions, so colleagues are able complete both sets of training on the same day.
- Service Groups and Corporate Directorates continue to receive tailored reports via their People Business Partners and have real-time access via the learning management system to data on their teams, and access to Sharepoint reports to help identify areas which require action.
- The Safeguarding Team continue to undertake a review to consider moving a risk-based solution to cover periods when operational pressures occur.
- The Deputy Chief People Officer and members of their senior management team are following up reported compliance of SHS to confirm actions being undertaken to improve performance.
- A group is reviewing mandatory training in respect of doctor and consultant colleagues.

Run Chart



How do we compare

Compliance as at 31 January 2024 decreased by 0.2% compared to 31 December 2023.

Recent Performance

The overall month-end compliance rates for mandatory training in recent months are set out below:

Area	Aug	Sep	Oct	Nov	Dec	Jan
% Compliance	92.1%	92.1%	91.9%	91.4%	92.1%	91.9%

Well Led

Career Conversations: We are committed ensuring that colleagues have timely and appropriate career reviews, at least annually, to outline all aspects of their role, to highlight and promote excellence and identify core or developmental training needs to enable colleagues to progress in their chosen careers.

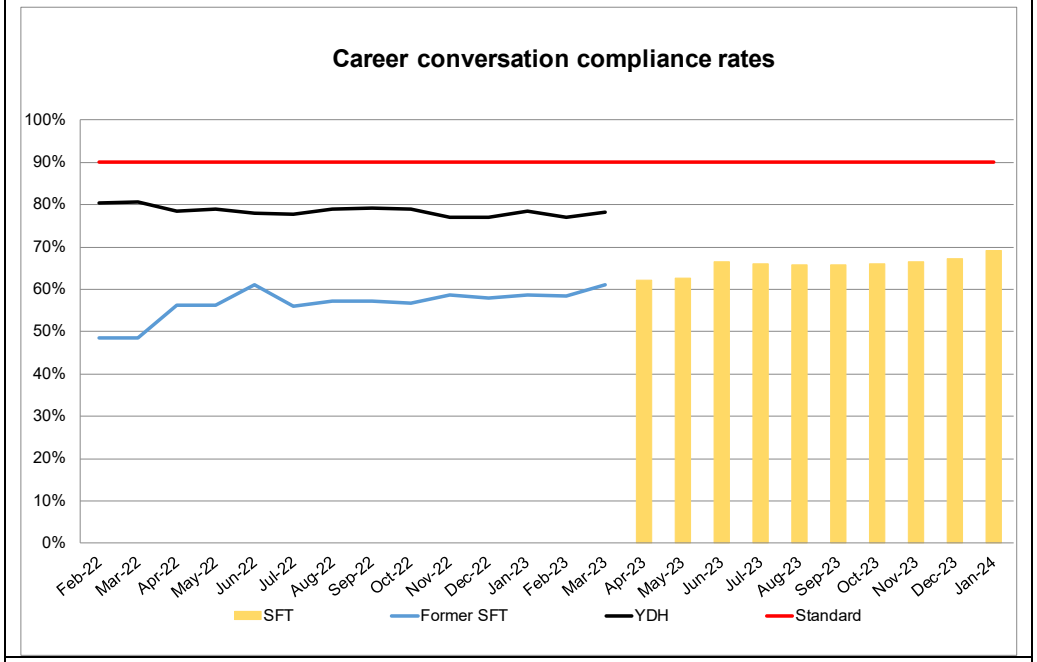
Current performance (including factors affecting this)

- Compliance as at 31 January 2024, in respect of career conversation reviews being undertaken at least annually, was 69.1%, up from 67.3% as at 31 December 2023, but below the standard of 90%.
- Operational pressures continue to affect compliance, along with reported difficulties in recording completed reviews on the reporting system.

Focus of improvement work

- Work is being undertaken to understand the reported difficulties with updating the reporting system, and to provide appropriate support and guidance.
- All service groups and corporate areas have been asked to review their performance and provide an update and planned trajectory for improvement during the February 2024 Finance and Performance meetings. Following this, an identified timescale for improvement will be available at Trust level.
- Work has been carried out to automate reporting between LEAP (the learning system on which legacy SFT colleagues complete and record career conversations) and ESR (the system from which reporting is taken). This should have resolved the issues around data quality previously raised by service groups.

Run Chart



How do we compare

Compliance as at 31 January 2024 increased compared to the position as at 31 December 2023.

Recent performance

The compliance rates in recent months were as follows:

Area	Aug	Sep	Oct	Nov	Dec	Jan
% compliance	65.9%	65.9%	66.0%	66.6%	67.3%	69.1%

Retention: We are committed to improving retention as a priority within our People Strategy, leading by example and being recognised for our success in retaining our talent. Our aim is to reduce the rate of colleagues leaving the Trust within 12 months of commencing employment.

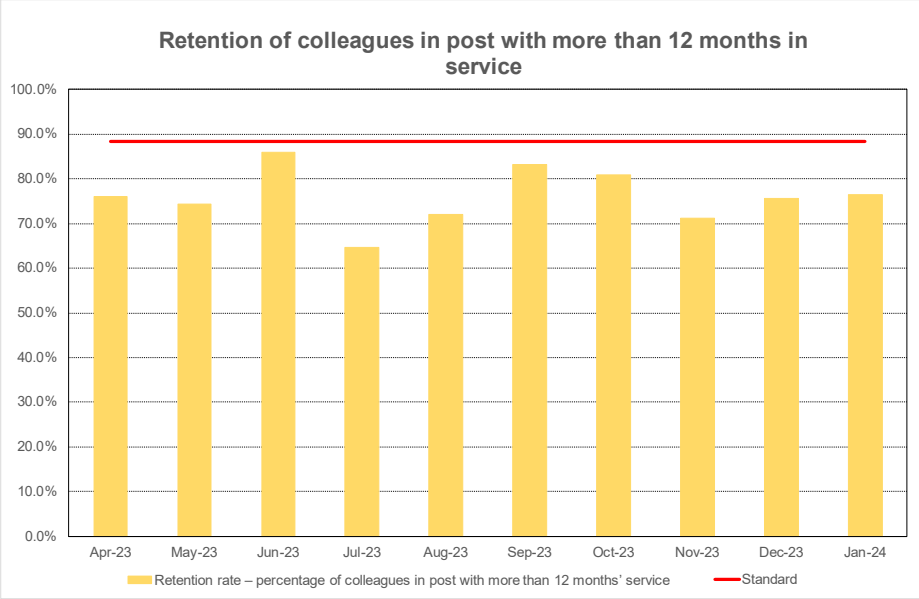
Current performance (including factors affecting this)

- Of 81 colleagues who had commenced employment on or after 1 February 2023, a total of 62 (76.5%) were still with the Trust as at 31 January 2024.
- Three areas were below the Trust average of 76.5% for January 2024. The Surgical service group reported a rate of 69.2%, with nine out of 13 colleagues being still in post after 12 months, Simply Serve recorded a rate of 50.0% with three out of six remaining in post after 12 months, and Corporate Services recorded a retention rate of 71.4% with five out of seven colleagues remaining in post after 12 months.
- The highest rate was reported by the Children and Young People and Families service group which had a retained rate of 100% of their new starters in the 12-month period.

Focus of improvement work

- Following the completion of a retention internal audit, the retention measure is being reviewed.
- The Allied Health Professional (AHP) and support to AHP leaver rates increased between April 2022 and July 2023 and these rates are higher than the national average. Work is underway to understand this trend and identify solutions across the Trust.
- Key areas of focus for the People Promise work include the local induction improvement project, stay conversation pilots, implementing legacy mentoring and developing a detailed flexible working improvement project.
- Retention is a key element of the People Strategy 2023 to 2028. A year-one deliverable focuses on implementing a talent management framework to support retention.

Trend Chart



How do we compare

The retention rate increased by 0.9% during January 2024 compared to December 2023.

Recent performance

The retention rates in recent months were as follows:

Area	Aug	Sep	Oct	Nov	Dec	Jan
Monthly rate	72.0%	83.3%	80.8%	71.1%	75.6%	76.5%

Well Led

Female colleagues in senior a role (band 8a and above and consultant roles): We are committed to providing a compassionate and inclusive environment where female colleagues in senior roles reflect the overall percentage of female colleagues employed within the Trust.

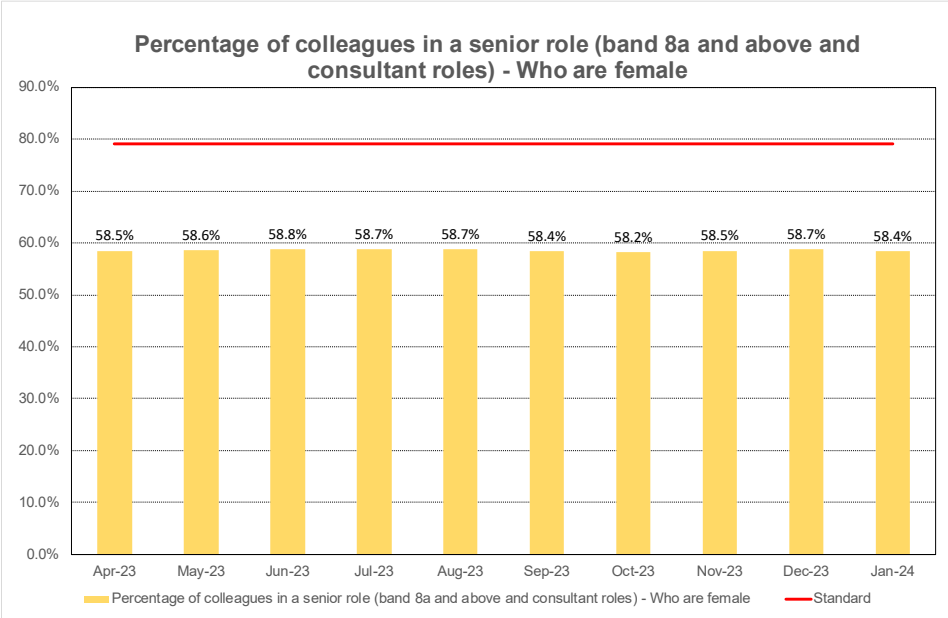
Current performance (including factors affecting this)

- Across Somerset NHS Foundation Trust as a whole, 79% of colleagues (excluding bank, locums and those on secondment) identify as female. Even though our organisation is female dominated, there is a lower representation of women in senior roles, which influences our organisational-wide pay gap.
- As at 31 January 2024, of 1,902 colleagues employed at Band 8a or above, a total of 1,111 identified as female, a rate of 58.4%. This is a slight decrease from the rate reported as at 31 December 2023.
- Our mean gender pay gap is 20% (female colleagues on average paid less than male colleagues). When looking at role-type and pay bands, pay gaps within agenda for change bands are relatively low. However, there are much larger pay gaps within our medical and dental workforce.
- Analysis of the Clinical Excellence Awards identified inequalities in relation to race and gender, with women and BAME colleagues being less likely to apply and being awarded lower value awards.

Focus of improvement work

- Focus areas for action include improving the progression of female medical colleagues into consultant roles and female colleagues into senior roles.
- The inclusion workplan sets out a number of areas which will help improve our position in this area, for example there is specific focus on developing skills-based recruitment.
- Service groups with the greatest gap between their workforce and senior roles are:
    - Surgical Services
    - Medical Services
    - Clinical Support and Cancer Services

Run Chart



How do we compare

Nationally:

- 77% of the NHS workforce are women.
- 80% of Agenda for Change colleagues are women, 69% of bands 8a-9 are women.
- 45% of medical and dental colleagues are women, 37% of consultants are women, 53% of doctors in training are women.

Recent performance

Compliance over recent months were as follows:

Area	Aug	Sep	Oct	Nov	Dec	Jan
Monthly rate	58.7%	58.4%	58.2%	58.5%	58.7%	58.4%

Well Led

Colleagues recorded with a disability in senior a role (band 8a and above and consultant roles): We are committed to providing a compassionate and inclusive environment where colleagues in senior roles reflect the overall percentage of disabled colleagues employed within the Trust.

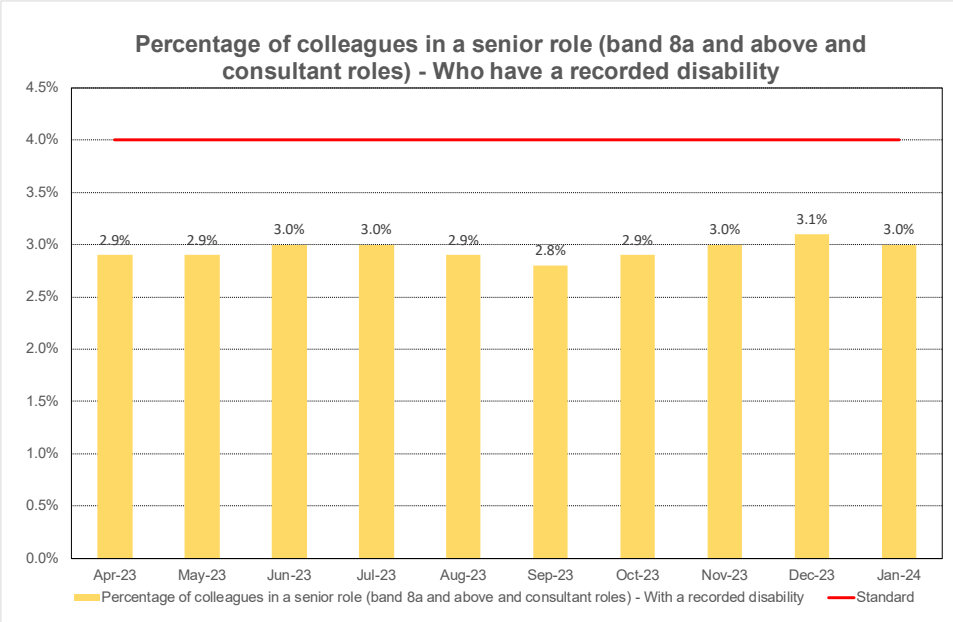
Current performance (including factors affecting this)

- Within Somerset NHS Foundation Trust, 4% of colleagues are recorded as having a disability.
- As at 31 January 2024, of 1,902 colleagues employed at Band 8a or above, a total of 58 (3.0%) were recorded as having a disability, down slightly from 31 December 2023. A total of 625 colleagues have no recorded disability status.
- Colleagues with a disability are under-represented when compared to the general population and under-represented at senior levels.
- Our data indicates that the proportion of colleagues who have not completed their data in ESR increases with seniority.

Focus of improvement work

- 20% of colleague records do not state whether or not they have a disability. Improving declaration rates will enable us to build a better picture of representation. Data relating to disability is missing for half of Board members. Board members are asked to update this information or seek support to update this.
- Included in the inclusion workplan and supported by a recent BDO audit are plans to progress as a Disability Confident Employer. This includes the development of a reasonable adjustment policy and supporting toolkits, which are ready to be launched.
- A review of the disability status by service group identifies the areas with the greatest difference in senior roles are:
    - Operational Management
    - Simply Serve Corporate
    - Mental Health & Learning Disabilities
- The People Business Partner will be working with the services to develop their improvement plan.

Run Chart



How do we compare

Nationally, 3.7% of the NHS workforce have declared a disability.
59% of trusts have five or fewer disabled staff in senior positions (bands 8c and above, including medical consultants and Board members).

Recent performance

Compliance over recent months was as follows:

Area	Aug	Sep	Oct	Nov	Dec	Jan
Monthly rate	2.9%	2.8%	2.9%	3.0%	3.1%	3.0%

Well Led

Vacancy: We are committed to recruiting and maintaining a strong workforce. Our aim is to reduce and maintain vacancy levels to 5% or less. The data outlined shows the difference between contracted full time equivalent (FTE) number of colleagues in post and our budgeted establishment.

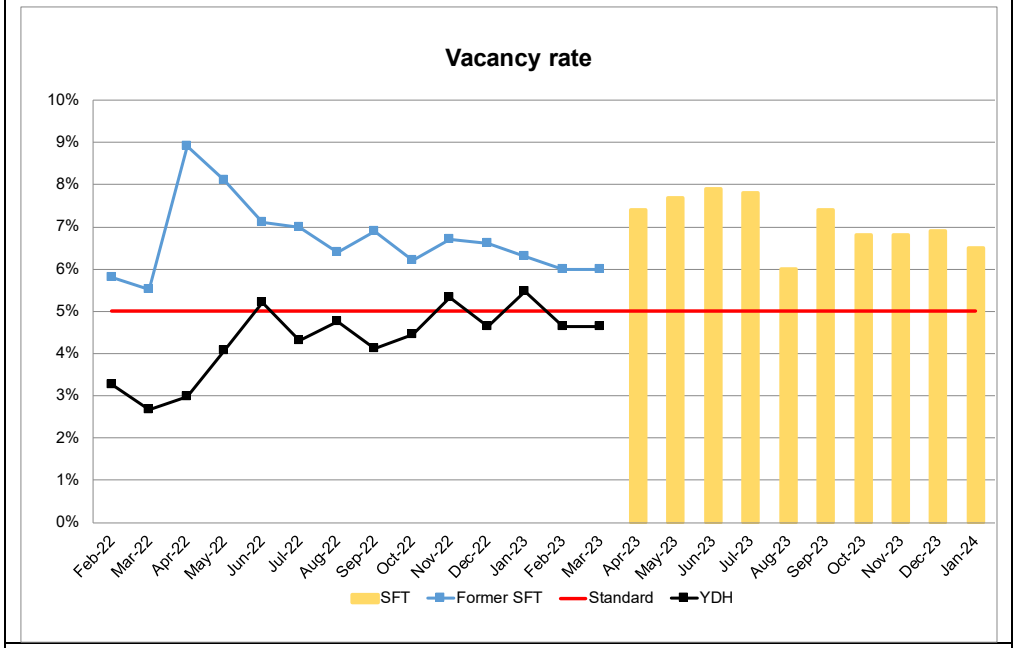
Current performance (including factors affecting this)

- The vacancy rate as at 31 January 2024 was 6.5%, down from 6.9% reported as at 31 December 2023.
- The areas with the greatest vacancy position are:
  - Simply Serve: 17.7%
  - Mental Health and Learning Disabilities: 12.2%
  - Estates and Facilities: 9.1%
- Across the Trust, medical and dental, Allied health professionals (AHPs), maintenance and a few specialist roles across Digital and People Services are particularly hard to recruit roles, affected by either national or local shortages.

Focus of improvement work

- Service groups continue to prioritise workforce plans for areas with hard to fill roles and identify solutions to reduce vacancy levels.
- Formation of talent pools (reservists, redeployment, SWAPs, and bank), adjustment of local recruitment processes to increase time to hire and reduce vacancies.
- The vacancy, retention and temporary staffing reduction meeting for nursing, support to nursing and AHP roles, meets monthly to drive improvements in these areas.
- The medical leadership team continues to focus on solutions to improve medical recruitment and workforce planning.

Run Chart



How do we compare

The vacancy rate within the Trust for January 2024 decreased slightly when compared to December 2023.

Recent performance

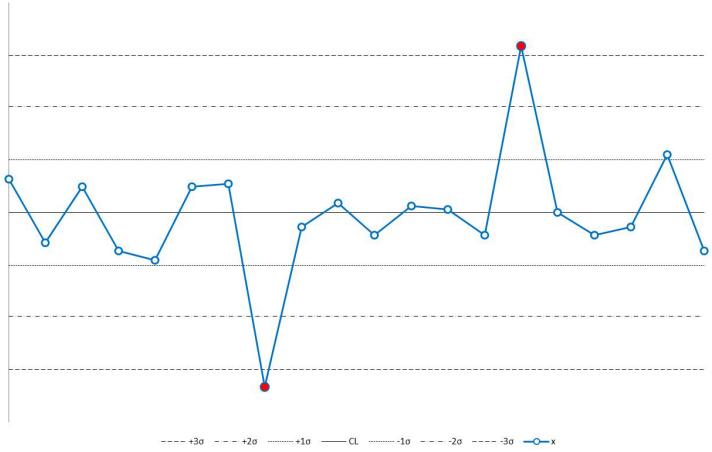
The performance against the vacancy rate standard in recent months was as follows:

Dec	Aug	Sep	Oct	Nov	Dec	Jan
Vacancy rate	6.0%	7.4%	6.8%	6.8%	6.9%	6.5%

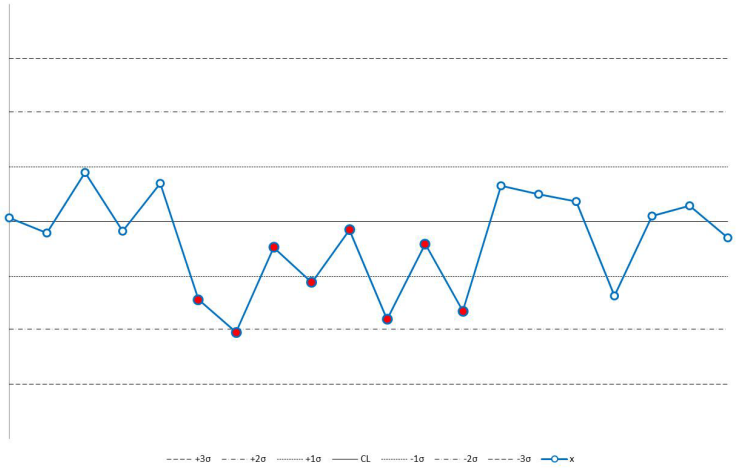
Appendix 1 - Procedure for Interpreting Run Charts

Special Cause Variation Rules

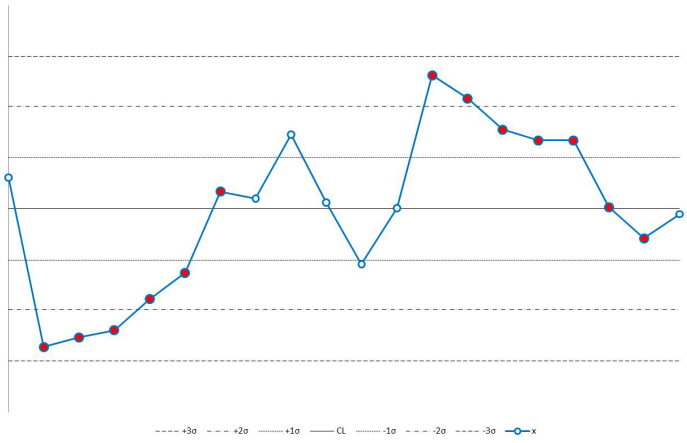
1. A single point outside the control limits



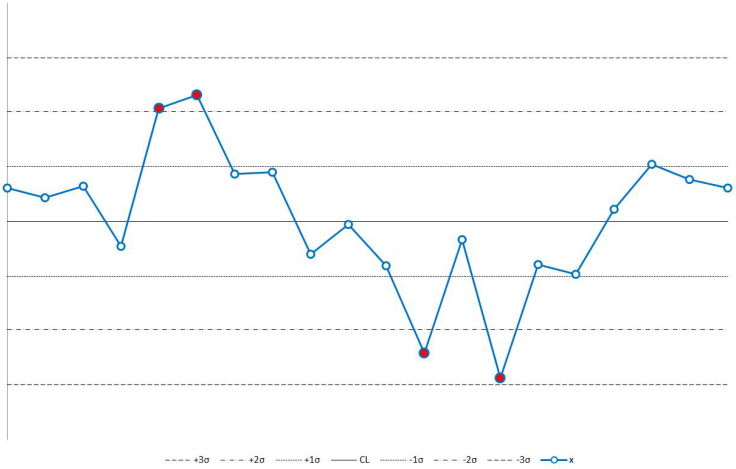
2. A run of eight or more points in a row above (or below) the centreline



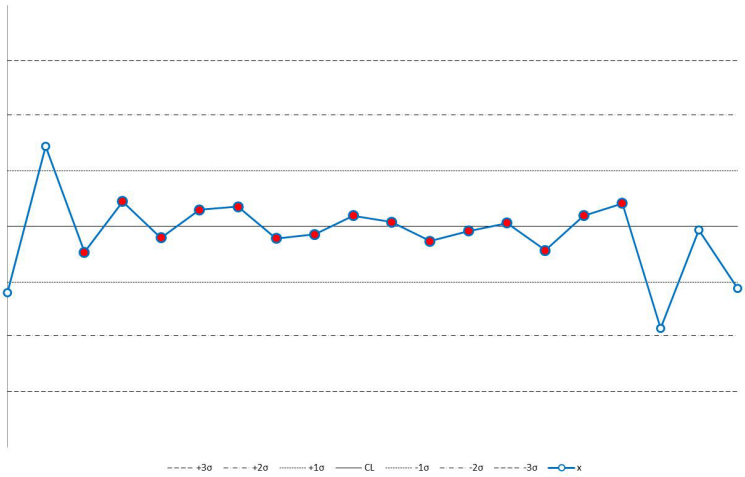
3. Six consecutive points increasing (trend up) or decreasing (trend down)



4. Two out of three consecutive points near (outer one-third) a control limit



5. Fifteen consecutive points close (inner one-third of the chart) to the centreline



APPENDIX 2

OUR CARE QUALITY COMMISSION RATINGS

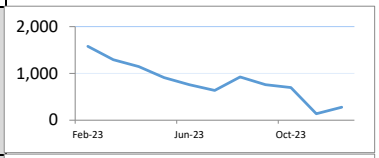
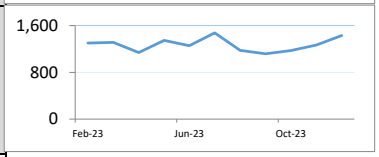
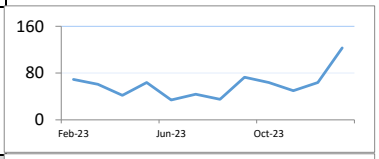
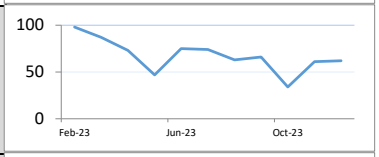
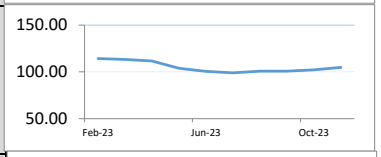
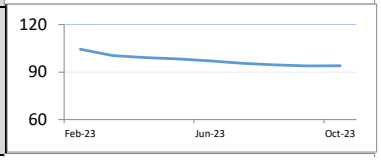
Our current Care Quality Commission ratings are as follows:

	Former Somerset NHS Foundation Trust	Yeovil District Hospital NHS Foundation Trust
Overall rating for the Trust	**Good**	**Good**

Are services safe?	**Requires improvement**	**Requires improvement**
Are services effective?	**Good**	**Good**
Are services caring?	**Outstanding**	**Good**
Are services responsive?	**Good**	**Good**
Are services well led?	**Good**	**Good**

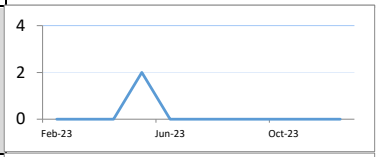
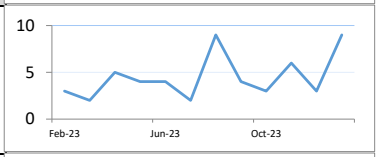
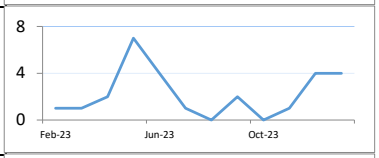
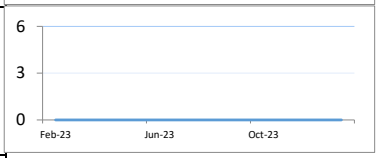
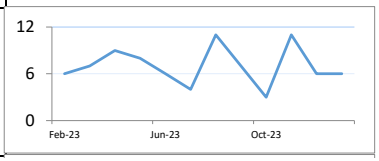
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	
Admissions	1	Number of medical and surgical outliers in acute wards	MPH	1,579	1,293	1,145	911	757	635	925	761	700	138	278	Data awaited	
	2		YDH	1,302	1,313	1,138	1,347	1,254	1,475	1,175	1,117	1,172	1,267	1,431	Data awaited	
	3	Admissions of under 16 year olds to adult mental health wards		0	0	0	0	0	0	0	0	0	0	0	0	
	4	Mixed sex accommodation breaches	Acute wards	0	0	0	0	0	0	0	0	0	0	0	0	
	5	Number of patients transferred between acute wards after 10pm	MPH	69	61	42	64	34	44	35	73	64	50	64	123	
	6		YDH	98	87	73	47	75	74	63	66	34	61	62	Data awaited	
Mortality (acute services)	7	Hospital Standardised Mortality Ratio (HSMR)		114.26	113.28	111.63	103.77	100.68	98.99	100.69	100.79	102.15	104.90	December 2023 to be reported after January 2024		
	8	Summary Hospital-level Mortality Indicator (SHMI)		104.44	100.48	99.2	98.31	97.08	95.6	94.54	93.89	93.94	November 2023 to be reported after January 2024			

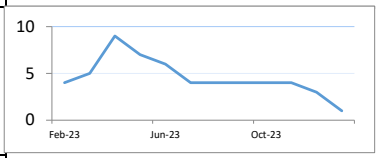
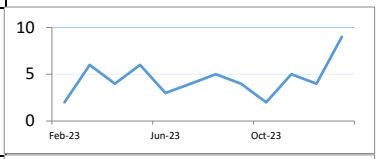
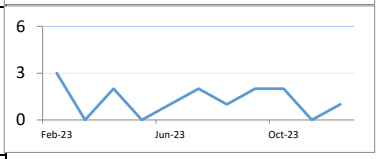
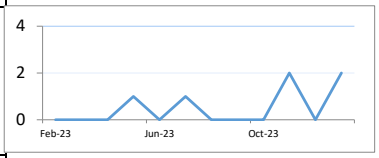
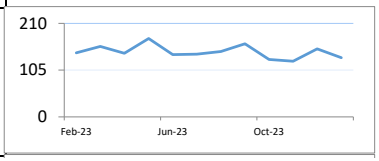
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	
Incident reporting	9	Number of Never Events		0	0	0	2	0	0	0	0	0	0	0	Data awaited	
Infection Control	10	Clostridium Difficile cases HOHA cases (Hospital Onset Hospital Acquired) and COHA cases (Community Onset Hospital Acquired)	MPH,	3	2	5	4	4	2	9	4	3	6	3	9	
	11		YDH	1	1	2	7	4	1	0	2	0	1	4	4	
	12		Community Hospitals and Mental Health wards	0	0	0	0	0	0	0	0	0	0	0	0	
	13	MRSA bacteraemias (post)	MPH,	0	0	0	1	0	0	1	0	0	0	0	1	
	14		YDH	0	0	0	0	0	0	0	0	0	0	0	0	
	15		Community Hospitals and Mental Health wards	0	1	0	0	0	0	0	0	0	0	0	0	
	16	E. coli bacteraemia	MPH,	6	7	9	8	6	4	11	7	3	11	6	6	

SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	
Infection Control	17	E. coli bacteraemia	YDH	4	5	9	7	6	4	4	4	4	4	3	1	
	18		Community Hospitals and Mental Health wards	0	0	0	0	0	0	0	0	0	0	0	0	
	19	Methicillin-sensitive staphylococcus aureus	MPH,	2	6	4	6	3	4	5	4	2	5	4	9	
	20		YDH	3	0	2	0	1	2	1	2	2	0	1	1	
	21		Community Hospitals and Mental Health wards	0	0	0	0	0	0	0	0	0	0	0	0	
Maternity	22	No. of still births		0	0	0	1	0	1	0	0	0	2	0	2	
	23	No. of babies born in unexpectedly poor condition		0	0	0	0	0	0	0	0	0	0	0	0	
Falls	24	Total number of patient falls	MPH	144	158	143	176	140	141	147	164	129	125	153	133	

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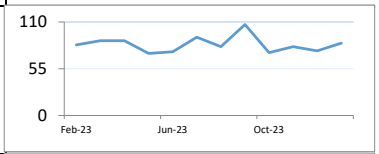
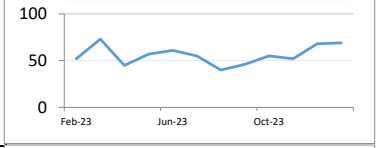
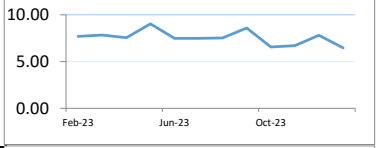
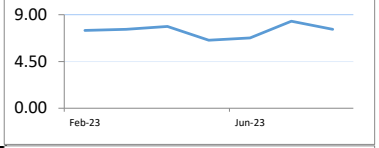
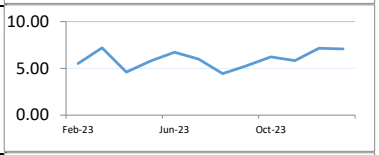
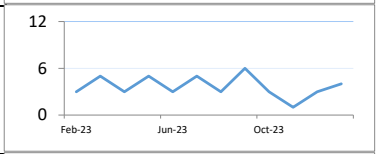
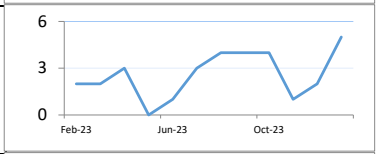
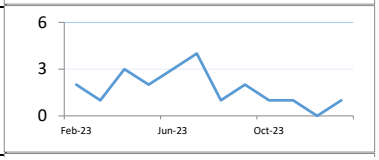
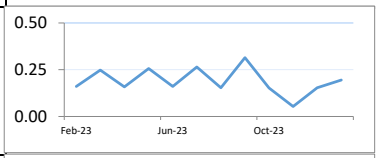
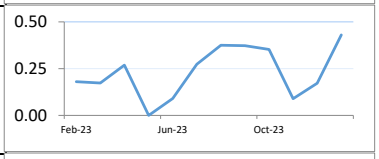
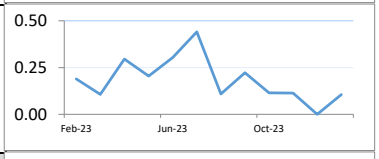
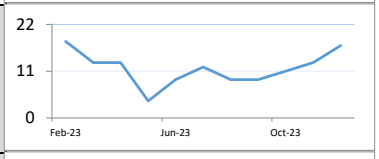
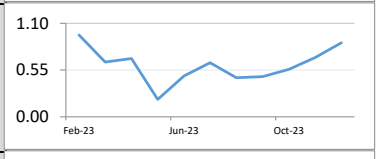
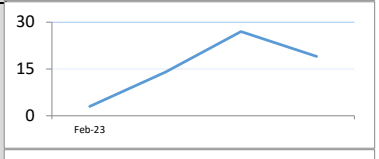
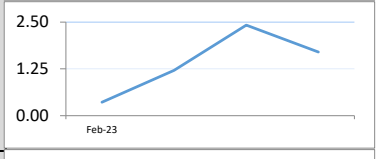
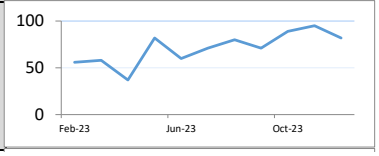
QUALITY MEASURES - 2023/24

Area	Ref	Measure		Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	
Falls	25	Total number of patient falls	YDH	83	88	88	73	75	92	81	107	74	81	76	85	
	26		Community Hospitals and Mental Health wards	52	73	45	57	61	55	40	46	55	52	68	69	
	27	Rate of falls per 1,000 occupied bed days - all services	MPH	7.70	7.84	7.56	9.03	7.48	7.47	7.52	8.60	6.57	6.69	7.81	6.47	
	28	Rate of falls per 1,000 occupied bed days - all services	YDH	7.48	7.60	7.88	6.55	6.77	8.37	7.59	9.97	6.53	7.20	6.54	7.31	
	29		Community Hospitals and Mental Health wards	5.53	7.20	4.60	5.78	6.72	5.99	4.44	5.29	6.24	5.84	7.15	7.09	
	30	Moderate Harm - Number of falls resulting in moderate harm - all services	MPH	3	5	3	5	3	5	3	6	3	1	3	4	
	31	Moderate Harm - Number of falls resulting in moderate harm - all services	YDH	2	2	3	0	1	3	4	4	4	1	2	5	
	32	Moderate Harm - Number of falls resulting in moderate harm - all services	Community Hospitals and Mental Health wards	2	1	3	2	3	4	1	2	1	1	0	1	

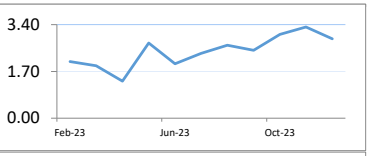
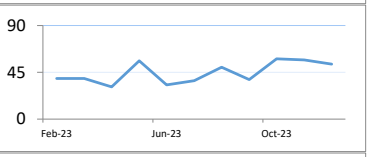
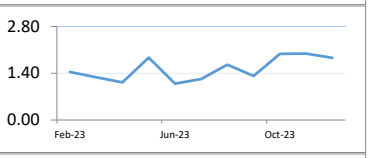
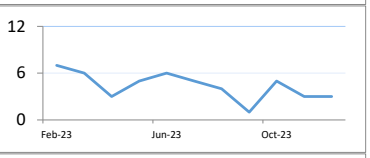
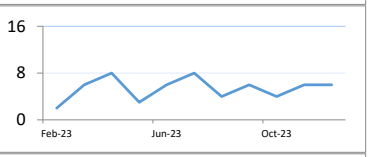
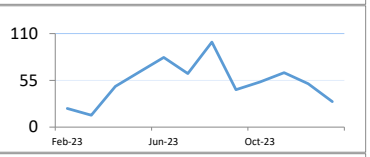
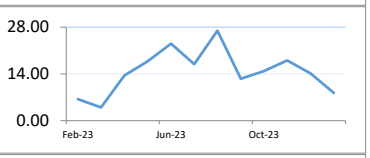
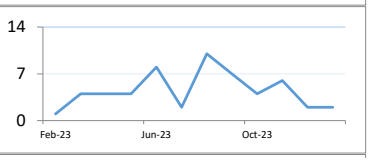
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	
Falls	33	Moderate Harm - Rate of falls resulting in moderate harm per 1,000 occupied bed days - all services	MPH	0.16	0.25	0.16	0.26	0.16	0.27	0.15	0.31	0.15	0.05	0.15	0.19	
	34		YDH	0.18	0.17	0.27	0.00	0.09	0.27	0.37	0.37	0.35	0.09	0.17	0.43	
	35	Moderate Harm - Rate of falls resulting in moderate harm per 1,000 occupied bed days - all services	Community Hospitals and Mental Health wards	0.19	0.11	0.30	0.20	0.30	0.44	0.11	0.22	0.11	0.11	0.00	0.11	
Pressure ulcer damage	36	Acute wards - number of incidents	MPH	18	13	13	4	9	12	9	9	11	13	17	Data awaited	
	37	Rate of pressure ulcer damage per 1,000 acute ward occupied bed days	MPH	0.96	0.64	0.69	0.21	0.48	0.64	0.46	0.47	0.56	0.70	0.87	Data awaited	
	38	Acute wards - number of incidents	YDH	3	14	27	19	Reported incidents are being reviewed by the Tissue Viability lead to ensure reported numbers are robust.								
	39	Rate of pressure ulcer damage per 1,000 acute ward occupied bed days	YDH	0.36	1.21	2.42	1.70									
	40	Community hospitals - number of incidents		56	58	37	82	60	71	80	71	89	95	82	Data awaited	

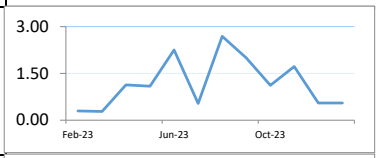
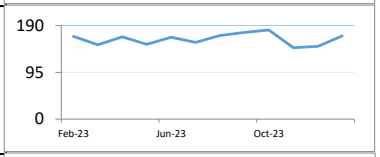
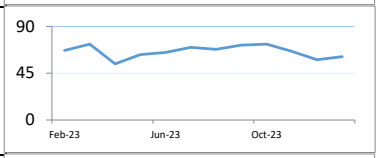
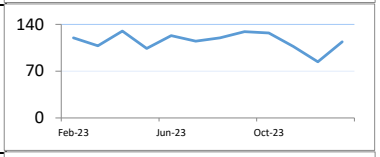
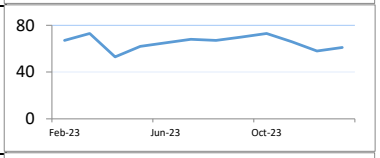
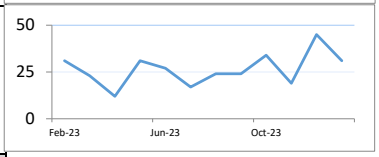
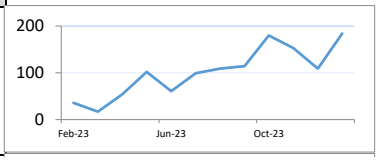
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	
Pressure ulcer damage	41	Rate of pressure ulcer damage per 1,000 community hospital occupied bed days		2.06	1.90	1.35	2.73	1.98	2.36	2.65	2.47	3.04	3.31	2.88	Data awaited	
	42	District nursing - number of incidents		39	39	31	56	33	37	50	38	58	57	53	Data awaited	
	43	Rate of pressure ulcer damage per 1,000 district nursing contacts		1.44	1.28	1.13	1.87	1.09	1.23	1.66	1.32	1.98	1.99	1.86	Data awaited	
Cardiac Arrests	44	No. ward-based cardiac arrests - acute wards	MPH	7	6	3	5	6	5	4	1	5	3	3	Data awaited	
	45		YDH	2	6	8	3	6	8	4	6	4	6	6	Data awaited	
Restraints (mental health wards)	46	Total number of incidents	Mental Health Wards	22	14	48	65	82	63	100	44	53	64	51	30	
	47	Restraints per 1,000 occupied bed days	Mental Health Wards	6.49	3.97	13.51	17.77	23.05	16.94	26.94	12.57	14.84	18.03	14.11	8.32	
	48	Number of prone restraints	Mental Health Wards	1	4	4	4	8	2	10	7	4	6	2	2	

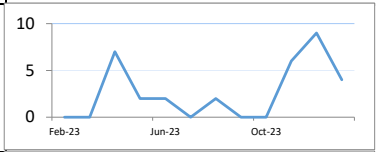
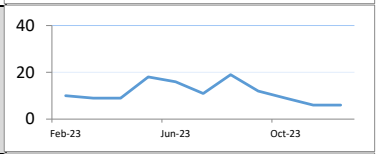
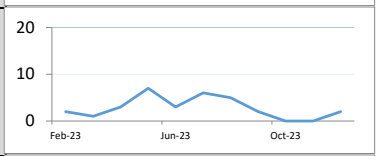
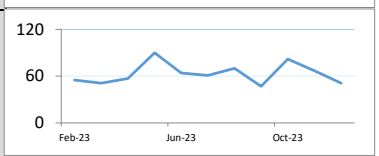
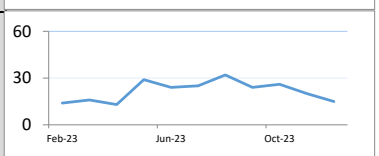
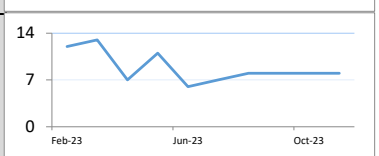
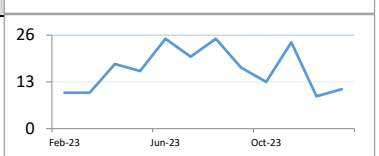
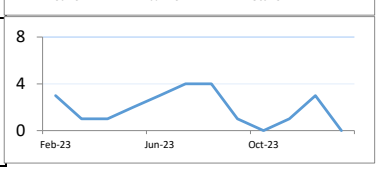
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	
Restraints (mental health wards)	49	Prone restraints per 1,000 occupied bed days	Mental Health Wards	0.30	0.28	1.13	1.09	2.25	0.54	2.69	2.00	1.12	1.72	0.55	0.55	
Medication incidents	50	Total number of medication incidents	MPH, Community Hospitals and Mental Health wards	168	151	167	152	166	156	170	176	181	145	148	169	
	51		YDH	67	73	54	63	65	70	68	72	73	66	58	61	
	52	Medication incidents - drug errors	MPH, Community Hospitals and Mental Health wards	120	108	130	104	123	115	120	129	127	107	84	114	
	53	Medication incidents - drug errors	YDH	67	73	53	62	65	68	67	70	73	66	58	61	
	54	Medication incidents - incorrect storage	MPH, Community Hospitals and Mental Health wards	31	23	12	31	27	17	24	24	34	19	45	31	
Medication incidents	55	Medication incidents - incorrect storage	YDH	This data category is not captured within Ulysses, the current YDH incident reporting system.												
Ligatures and ligature points	56	Ligatures: Total number of incidents	Mental Health Wards	36	17	54	102	61	99	109	114	180	153	109	184	

SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	
Ligatures and ligature points	57	Number of ligature point incidents	Mental Health Wards	0	0	7	2	2	0	2	0	0	6	9	4	
Violence and Aggression	58	Violence and Aggression: Number of incidents patient on patient (inpatients only)	MPH, Community Hospitals and Mental Health wards	10	9	9	18	16	11	19	12	9	6	6	Data awaited	
	59	Violence and Aggression: Incidents resulting in harm - patient on patient (inpatient only)	MPH, Community Hospitals and Mental Health wards	2	1	3	7	3	6	5	2	0	0	2	Data awaited	
	60	Violence and Aggression: Number of incidents patient on staff	MPH, Community Hospitals and Mental Health wards	55	51	57	90	64	61	70	47	82	67	51	Data awaited	
	61	Violence and Aggression: Incidents resulting in harm - patient on staff	MPH, Community Hospitals and Mental Health wards	14	16	13	29	24	25	32	24	26	20	15	Data awaited	
Unexpected deaths	62	Unexpected Deaths: Total number of incidents to be investigated	Community and mental health services	12	13	7	11	6	7	8	3	3	8	Data awaited	Data awaited	
Seclusion	63	Number of Type 1 -Traditional Seclusion	Mental Health Wards	10	10	18	16	25	20	25	17	13	24	9	11	
Seclusion	64	Number of Type 2 -Short term Segregation	Mental Health Wards	3	1	1	2	3	4	4	1	0	1	3	0	

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Thresholds
1	Accident and Emergency / Minor Injury Unit 4-hour performance	Accident & Emergency department (ED) - MPH	4, 6, 9	52.1%	55.4%	58.8%	55.6%	54.0%	66.0%	51.0%	48.0%	51.4%	55.5%	54.0%	52.0%	From April 2023 >=76%= Green >=66% - <76% =Amber <66% =Red
2		Accident & Emergency department (ED) - YDH		65.0%	70.3%	74.1%	77.7%	64.3%	67.2%	73.3%	67.3%	66.6%	62.8%	62.6%	60.8%	
3		Accident & Emergency department (ED) - Combined		58.0%	62.0%	65.6%	65.4%	58.7%	66.5%	60.6%	56.4%	58.1%	58.7%	57.8%	56.1%	
4		Minor Injury Units		96.8%	96.7%	98.1%	97.1%	96.9%	96.9%	97.5%	95.1%	96.9%	97.4%	96.3%	96.0%	
5		Trust-wide		74.0%	76.3%	79.3%	78.7%	75.1%	79.2%	76.0%	72.5%	74.1%	74.3%	73.3%	72.5%	
6	Accident and Emergency / Minor Injury Units: percentage of patients spending more than 12-hours in the department	Accident and Emergency department (ED) - MPH	4, 6, 9	5.3%	2.6%	2.3%	2.1%	1.8%	0.7%	2.9%	4.7%	2.4%	1.7%	4.8%	6.2%	<=2%= Green >2% - <=5% =Amber >5% =Red
7		Accident and Emergency department (ED) - YDH		6.2%	4.4%	3.3%	1.1%	3.4%	3.6%	1.6%	3.2%	3.3%	4.1%	5.9%	7.6%	
8		Minor Injury Units		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
9	Ambulance handovers waiting less than 30 minutes		4, 6, 9	73.5%	76.9%	80.2%	79.0%	81.8%	86.2%	70.5%	63.1%	68.6%	73.8%	64.1%	61.9%	>=95%= Green >=85% - <95% =Amber <85% =Red
10	Ambulance handovers waiting less than 30 minutes			75.1%	80.6%	82.3%	86.6%	77.9%	80.8%	88.0%	80.8%	75.8%	69.0%	69.7%	65.6%	
11	Cancer - 28 days Faster Diagnosis All Cancers			67.1%	68.6%	73.6%	70.6%	72.0%	79.4%	78.8%	76.0%	77.0%	76.9%	76.6%	Data awaited	>=75%= Green <75% =Red
12	31 day wait - from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment			New reporting		89.7%	88.0%	92.7%	93.0%	90.9%	92.9%	91.3%	93.7%	94.0%	Data awaited	>=96%= Green <96% =Red
13	Cancer - 62 day wait - from an Urgent Suspected Cancer or Breast Symptomatic Referral, or Urgent Screening Referral, or Consultant Upgrade to a First Definitive Treatment					73.8%	67.0%	68.8%	74.2%	71.7%	71.3%	68.8%	67.1%	67.4%	Data awaited	>=85%= Green <85% =Red
14	Cancer: 62-day wait from referral to treatment for urgent referrals – number of patients treated on or after day 104			29	20	14	23	22	26	22	28	22.5	23	23	Data awaited	0= Green >0 = Red
15	CAMHS Eating Disorders - Urgent referrals to be seen within 1 week - (rolling 3 months)		3, 4, 9	Reporting change from a rolling 12 months to a rolling 3 month period					100.0%	100.0%	-	-	-	-	-	>=95%= Green >=85% - <95% =Amber <85% =Red
16	CAMHS Eating Disorders - Routine referrals to be seen within 4 weeks - (rolling 3 months)		3, 4, 9						100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>=95%= Green >=85% - <95% =Amber <85% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Thresholds
17	Mental health referrals offered first appointments within 6 weeks	All mental health services	4, 6, 9	94.6%	94.4%	88.2%	90.0%	93.6%	93.2%	92.8%	92.5%	90.0%	93.9%	93.6%	94.2%	>=90%= Green >=80% - <90% =Amber <80% =Red
18	Mental health referrals offered first appointments within 6 weeks	Adult mental health services		92.7%	94.0%	89.6%	92.4%	94.5%	95.2%	90.4%	93.7%	91.6%	92.2%	93.9%	93.6%	>=90%= Green >=80% - <90% =Amber <80% =Red
19		Older Persons mental health services		95.2%	94.4%	86.5%	87.2%	92.0%	91.2%	94.0%	89.0%	87.5%	95.3%	93.0%	93.7%	
20		Learning disabilities service		100.0%	92.9%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	87.5%	100.0%	
21		Children and young people's mental health services		96.5%	95.4%	93.6%	95.1%	95.4%	93.2%	96.9%	100.0%	92.0%	96.6%	94.7%	96.1%	
22	Percentage of women accessing specialist community Perinatal MH service - 12 month rolling reporting		4, 6, 9	8.4%	8.6%	9.0%	9.4%	9.5%	9.9%	10.5%	11.0%	11.1%	11.7%	11.6%	12.2%	>=10%= Green >=7.5% - <10% =Amber <7.5% =Red
23	Diagnostic 6-week wait - acute services	MPH	4, 9	86.9%	87.5%	87.3%	87.4%	91.8%	87.9%	84.8%	84.6%	84.7%	85.4%	83.1%	84.1%	From April 2023 >=95%= Green >=90% - <95% =Amber <90% =Red
		YDH		64.7%	66.1%	56.9%	60.7%	60.1%	56.0%	61.2%	55.0%	59.6%	63.6%	61.3%	59.0%	
		Combined		79.1%	79.5%	76.8%	77.2%	79.7%	77.1%	76.9%	74.4%	76.2%	77.6%	74.3%	74.1%	
24	RTT incomplete pathway performance: percentage of people waiting under 18 weeks		4, 6, 9	61.1%	61.1%	60.6%	61.3%	61.7%	61.5%	61.8%	61.6%	62.9%	63.4%	61.7%	62.6%	>=92%= Green <92% =Red
25	40 week RTT breaches			5,015	4,975	5,359	5,524	5,409	5,430	5,748	5,701	5,542	5,688	6,301	Data awaited	TBC
26	52 week RTT breaches			2,216	2,187	2,247	2,340	2,396	2,375	2,419	2,504	2,547	2,577	2,519	2,252	From April 2023 At or below trajectory = Green Above trajectory = Red
27	65 week RTT breaches			New reporting		714	710	712	659	724	741	687	662	725	605	
28	78 week RTT breaches		4, 6, 9	179	68	84	87	61	49	66	70	55	49	61	50	From April 2023 At or below trajectory = Green Above trajectory = Red
29	Referral to Treatment (RTT) incomplete pathway waiting list size			51,542	52,869	53,351	53,856	54,319	55,037	54,986	55,532	54,777	53,406	53,667	53,787	

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Thresholds
30	Average length of stay of patients on wards (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).	MPH	4, 9	6.8	6.2	6.5	6.2	6.1	5.9	6.0	6.4	6.5	6.1	6.1	6.4	Monitored using Special Cause Variation Rules. Report by exception.
31		YDH		7.8	7.9	7.3	6.5	6.7	6.4	6.4	6.4	6.3	6.1	6.8	7.0	
32	Patients not meeting the criteria to reside: % of occupied bed days lost	MPH	4, 9	19.8%	19.1%	21.9%	16.7%	15.1%	17.2%	16.5%	20.3%	18.1%	17.1%	15.9%	18.4%	SPC (Upper Control Limit 25.1%)
33		YDH		25.0%	23.2%	20.5%	21.1%	21.1%	22.1%	23.7%	23.3%	22.1%	21.0%	24.7%	22.9%	SPC (Upper Control Limit 28.1%)
34	Acute bed days lost due to patients not meeting the criteria to reside	MPH	4, 6, 9	3,392	3,484	3,682	2,954	2,588	2,947	2,942	3,432	3,134	2,819	2,807	3,435	TBC
35		YDH		2,775	2,751	2,293	2,359	2,333	2,476	2,565	2,569	2,519	2,394	2,844	2,691	
36	Waiting times: number of people waiting over 18 weeks from referral to first appointment - community services including dental		4, 6, 9	4,002	4,065	4,023	4,052	4,013	3,918	3,862	3,717	3,498	3,518	3,491	3,512	From April 2023 <4,065 = Green >=4065 = Red
37	52 week RTT breaches			New reporting		1,455	1,442	1,319	1,146	863	785	712	747	758	810	From April 2023 At or below trajectory = Green Above trajectory = Red
38	65 week RTT breaches					887	930	840	642	440	392	371	386	402	461	
39	78 week RTT breaches					514	565	466	335	223	220	184	209	205	256	
40	Community dental services - Child GA waiters waiting 18 weeks or more		4, 6, 9	370	463	499	524	527	538	557	565	554	581	587	515	From April 2023 <463 = Green >=463 = Red
41	Early Intervention In Psychosis: people to begin treatment with a NICE-recommended care package within 2 weeks of referral (rolling three month rate)		4, 6, 9	68.8%	83.3%	88.2%	82.4%	83.3%	81.3%	83.3%	82.4%	84.6%	85.7%	82.4%	89.5%	>=60%= Green <60% =Red
42	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) RTT : percentage of people waiting under 6 weeks		4, 6, 9	60.9%	67.2%	65.9%	68.2%	70.3%	73.7%	74.6%	72.4%	77.7%	77.8%	82.9%	81.1%	>=75%= Green <75% =Red
43	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) RTT: percentage of people waiting under 18 weeks		4, 6, 9	97.6%	98.9%	98.0%	98.5%	99.1%	99.0%	99.0%	99.5%	98.9%	99.6%	98.5%	99.4%	>=95%= Green <95% =Red
44	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) Recovery Rates		4, 7, 9	59.2%	64.3%	60.2%	59.8%	58.1%	59.8%	60.4%	55.5%	58.2%	59.3%	59.8%	57.1%	>=50%= Green <50% =Red
45	Adult mental health inpatients receiving a follow up within 72 hrs of discharge		4, 9	90.3%	100.0%	97.8%	100.0%	97.3%	100.0%	96.2%	96.9%	100.0%	97.0%	100.0%	100.0%	>=80%= Green <80% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Thresholds
46	Inappropriate Out of Area Placements for non-specialist mental health inpatient care (monthly number of patient days)		4, 5, 9	0	34	78	67	57	14	0	0	10	10	34	45	0= Green >0 = Red
47	Intermediate Care - Patients aged 65+ discharged home from acute hospital beds on pathway 0 or 1		4, 5, 9	92.0%	92.6%	93.3%	93.2%	94.9%	95.1%	95.7%	93.8%	93.3%	93.3%	93.3%	94.3%	>=95%= Green >=85% - <95% =Amber <85% =Red
48	Urgent Community Response: percentage of patients seen within two hours		4, 5, 9	79.0%	92.0%	94.3%	93.6%	90.9%	94.6%	92.3%	94.4%	93.8%	95.9%	90.9%	Data awaited	>=70%= Green >=60% - <70% =Amber <60% =Red
49	% Stroke Patients direct admission to stroke ward in 4 hours	MPH	4, 6, 9	32.6%	54.4%	46.7%	50.0%	48.9%	57.1%	54.6%	55.9%	51.4%	71.0%	58.6%	Data awaited	>=90%= Green >=75% - <90% =Amber <75% =Red
50		YDH		15.2%	32.1%	26.9%	40.0%	32.4%	25.0%	33.3%	23.3%	42.5%	24.2%	29.4%	Data awaited	
51	Patients spending >90% of time in stroke unit - acute services	MPH	4, 6, 9	59.6%	80.3%	68.1%	65.9%	65.2%	75.0%	68.9%	68.4%	78.4%	87.5%	78.1%	Data awaited	>=80%= Green >=70% - <80% =Amber <70% =Red
52		YDH		69.7%	57.1%	57.7%	60.0%	59.5%	56.2%	71.7%	56.7%	52.5%	54.5%	52.9%	Data awaited	
53	Percentage of patients with a National Early Warning Score (NEWS) of 5 or more acted upon appropriately - The registered nurse should immediately inform the medical team caring for the patient	MPH, community hospitals and mental health wards	4, 9	67.2%		69.9%		75.8%		79.7%		89.8%		Bi-monthly reporting. Data being validated		>=90%= Green >=80% - <90% =Amber <80% =Red
54	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services	MPH	4, 9	Due to capacity within the Governance Team required audits have been delayed. Testing of a reporting solution using electronic forms has now been completed by the Trust's Digital Team. Identified users of systems started to received training in the second week of September 2023 and reporting via this system is to commence by February 2024.												>=90%= Green >=49% - <90% =Amber <49% =Red
55	Percentage of emergency patients screened for sepsis - acute services	MPH		92.0%		98.0%			93.0%			89.5%			Quarterly reporting	
56	Percentage of complaints responded to within 40 working days - Trust-wide	Former SFT	9	37.5%	56.7%	51.5%	48.4%	51.5%	The review of this area of reporting has been completed. The intention is to commence reporting compliance for responses to complainants within an agreed time period, to be introduced from 1 April 2024							>=90%= Green >=75% - <90% =Amber >75% =Red
57		YDH		100.0%	100.0%	100.0%	100.0%	100.0%								
58		Combined		New reporting		56.8%	52.9%	56.0%								
59	Mandatory training: percentage completed	Former SFT	1, 8, 9	90.9%	90.5%	Post merger										All courses >=90%= Green Overall rate <80% =Red Any other position = Amber
60		YDH		84.6%	84.5%											

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Thresholds
61	Mandatory training: percentage completed	Combined	1,8,9	New reporting		90.6%	91.3%	91.6%	92.0%	92.1%	92.1%	91.9%	91.4%	92.1%	91.9%	
62	Proportion of days lost due to sickness		1,8,9	5.0%	4.8%	4.2%	4.2%	4.2%	4.8%	4.8%	5.0%	5.3%	5.1%	5.2%	5.4%	SPC
63	Sickness absence levels - rolling 12 month average (Trust-wide)		8, 9	5.8%	5.6%	5.2%	5.1%	5.1%	4.9%	4.9%	5.0%	5.0%	5.0%	4.9%	4.9%	SPC
64	Career conversations (12 months) - formerly 'Performance review (12-month)'		1,8,9	New reporting		62.1%	62.7%	66.4%	66.1%	65.9%	65.9%	66.0%	66.6%	67.3%	69.1%	>=90%= Green >=80% - <90% =Amber <80% =Red
65	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)		8, 9			7.4%	7.7%	7.9%	7.8%	6.0%	7.4%	6.8%	6.8%	6.9%	6.5%	<=5%= Green >5% to <=7.5% =Amber >7.5% =Red
66	Retention rate – percentage of colleagues in post with more than 12 months' service		8, 9			76.0%	74.4%	85.9%	64.7%	72.0%	83.3%	80.8%	71.1%	75.6%	76.5%	>=88.3%= Green >=80% to <88.3% =Amber <80% =Red
67	Percentage of colleagues in a senior role (band 8a and above and consultant roles):	Who are of an ethnic minority	1,8,9			19.8%	19.8%	19.8%	19.5%	20.5%	20.3%	20.8%	20.9%	20.9%	21.2%	>=17%= Green >=14% to <17% =Amber <14% =Red
68		Who are female	1,8,9			58.5%	58.6%	58.8%	58.7%	58.7%	58.4%	58.2%	58.5%	58.7%	58.4%	>=79%= Green >=70% to <79% =Amber <70% =Red
69		With a recorded disability	1,8,9			2.9%	2.9%	3.0%	3.0%	2.9%	2.8%	2.9%	3.0%	3.1%	3.0%	>=4%= Green >=2% to <4% =Amber <2% =Red
70	Number of formal HR case works (disciplinary, grievance and capability).		1,8,9	Reporting in respect of this new indicator was being developed								31	23	23	38	TBC

SOMERSET NHS FOUNDATION TRUST

OUR CORPORATE OBJECTIVES

1 To develop our inclusive culture of learning, research and continuous improvement to improve safety, outcomes, efficiency and effectiveness.
2 To work in collaboration with our partners in Somerset to develop an Integrated Care System and deliver the Fit for My Future strategy
3 To enable people to live healthy independent lives, to prevent the onset of avoidable illness and support active self-management (Clinical Strategy Aim 1)
4 To ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting (Clinical Strategy Aim 2)
5 To provide support in neighbourhood areas with an emphasis on self-management and prevention (Clinical Strategy Aim 3)
6 To value all people alike, addressing inequalities and giving equal priority to physical and mental health (Clinical Strategy Aim 4)
7 To improve outcomes for people through personalised, co-ordinated support (Clinical Strategy Aim 5)
8 To develop a workforce that is:
- Safe, with the skills and expertise needed to enable innovation and provision of a high quality service.
- Diverse, engaged, motivated and resilient, demonstrating the values and behaviours we expect
- Resourced appropriately, flexible and agile to support outstanding care in the most appropriate setting

9 To deliver levels of performance that are in line with our plans and national standards.
10 To achieve financial sustainability, enabling appropriate investment in the delivery of outstanding care.

Appendix 5a – Specialty and tumour-site level performance

Table 1 – Performance against the RTT performance standard in January 2024, including the number of patients waiting over 18 weeks, the number of patients waiting over 52 weeks, and the average (mean) number of weeks patients have waited on the Trust's waiting list.

RTT specialty	Over 18-week waiters	Over 52-week waiters	Incomplete pathways	Incomplete pathways performance
General Surgery	669	81	2187	69.4%
Urology	1288	171	3001	57.1%
Trauma & Orthopaedics	3206	614	8148	60.7%
Ear, Nose & Throat (ENT)	2234	223	4873	54.2%
Ophthalmology	2244	229	5197	56.8%
Oral Surgery	983	67	2334	57.9%
Plastic Surgery	79	9	181	56.4%
Cardiothoracic Surgery	13		23	43.5%
General Medicine	2		12	83.3%
Gastroenterology	790	34	2132	62.9%
Cardiology	499	3	3468	85.6%
Dermatology	283	4	1945	85.4%
Thoracic Medicine	739	4	1991	62.9%
Neurology	734	17	1738	57.8%
Rheumatology	439	16	1052	58.3%
Geriatric Medicine	108	2	533	79.7%
Gynaecology	1388	94	3698	62.5%
Other – Medical Services	972	194	2659	63.4%
Other - Paediatric Services	547	11	1677	67.4%
Other - Surgical Services	2565	461	5881	56.4%
Other – Other Services	341	18	1057	67.7%
Total	**20123**	**2252**	**53787**	**62.6%**

Table 2 – Performance against the 62-day GP cancer standard in December 2023.

Tumour site	No of breaches	Trust performance
Breast	6.0	85.7%
Colorectal	14.0	61.6%
Gynaecology	3.0	71.4%
Haematology	7.0	66.7%
Head & Neck	10.0	47.4%
Lung	9.0	53.8%
Other	1.0	75.0%
Skin	11.5	81.9%
Upper GI	2.0	87.5%
Urology	36.5	50.0%
Total	**100.0**	**67.4%**

Twenty-three patients were treated in December 2023 on or after day 104 (the national 'backstop' for GP pathways). All were deemed as having unavoidable delays. A breakdown of the breaches is as follows:

- Eleven patients had a complex pathway, including patients requiring additional or repeat diagnostics, transferring from a different cancer pathway and being treated at the same time for another cancer.
- Three patients chose to delay their investigations and treatment planning for a significant period of time.
- Nine patient pathways had internal delays, which in some cases resulted in a late transfer to the treating provider. But these pathways also had unavoidable delays, as a result of waiting times being longer than ideal for investigations and appointments at other providers. There were also periods of patient choice and medical deferral for some patients.

Appendix 2 – RTT validation progress

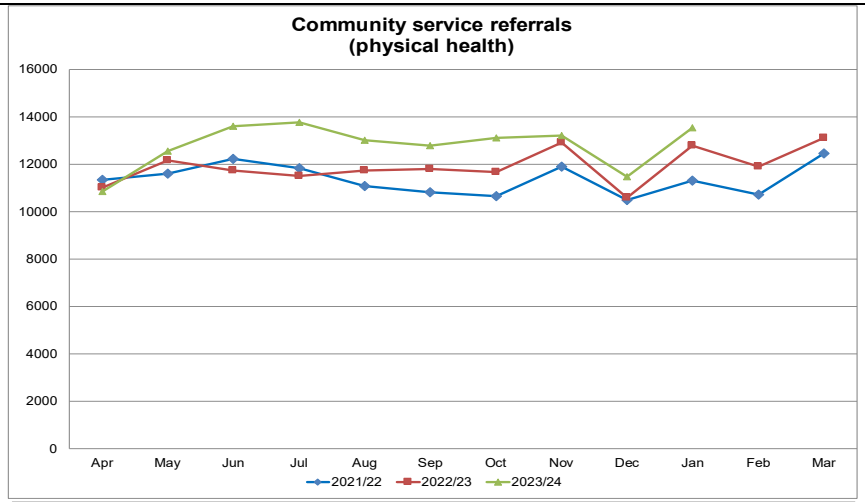
The national target is to reach a level of 90% validation of patients waiting 12 weeks and over from Referral to Treatment (RTT) by the 31 of October 2023. Validation includes both the administrative/technical validation and also contacting the patient to confirm they still wish to be seen.

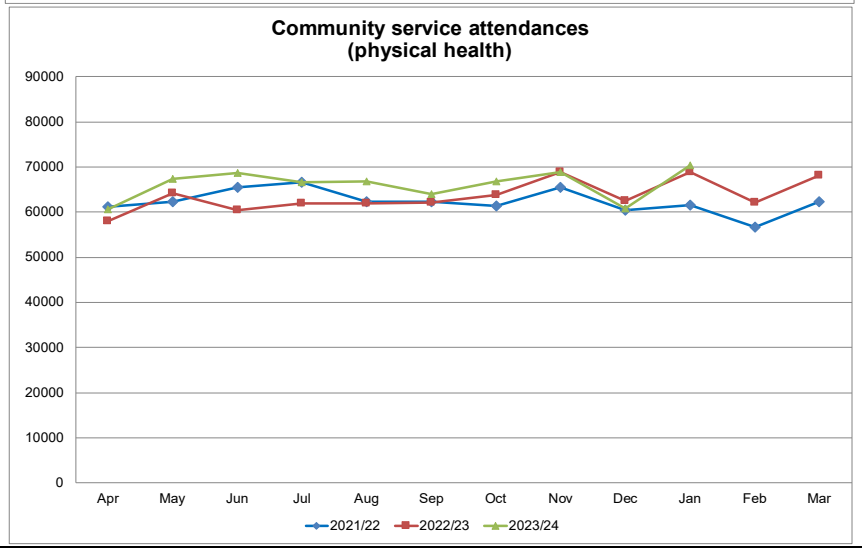
RTT waiting times bands	Week ending 10 September 2023	Week ending 8 October 2023	Week ending 12 November 2023	Week ending 17 December 2023	Week ending 14 January 2024	Week ending 4 February 2024
12 weeks and over	34%	44%	63%	69%	70%	69%
26 weeks and over	54%	57%	72%	76%	73%	72%
52 weeks and over	85%	90%	92%	89%	89%	87%

Please note, that across the remainder of quarter 4, a cohort of circa 1,100 patients will be contacted, which were found to have been incorrectly excluded from our contacts list. The exact numbers are still being worked through, but we are expecting this to take performance for the 12 weeks and over cohort, to circa 76% by the end of March 2024.

Operational context

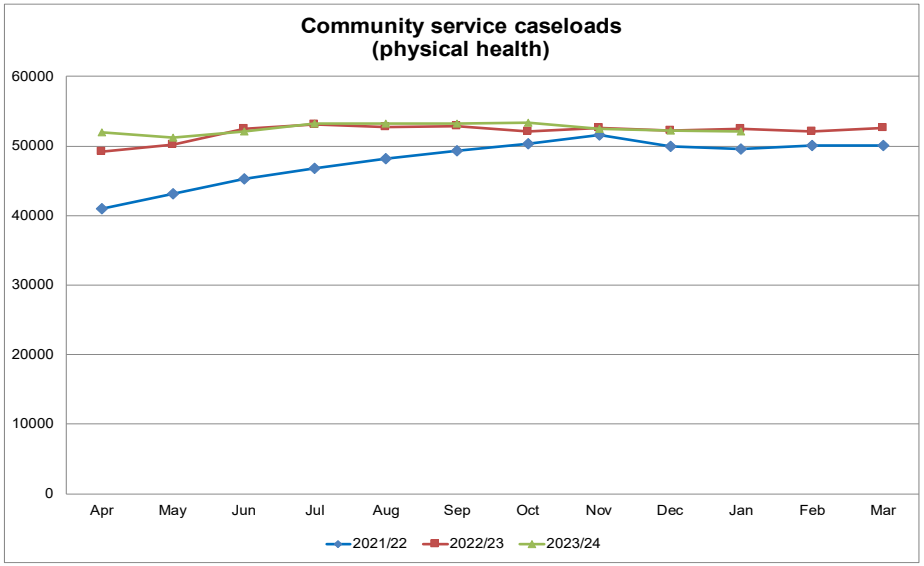
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





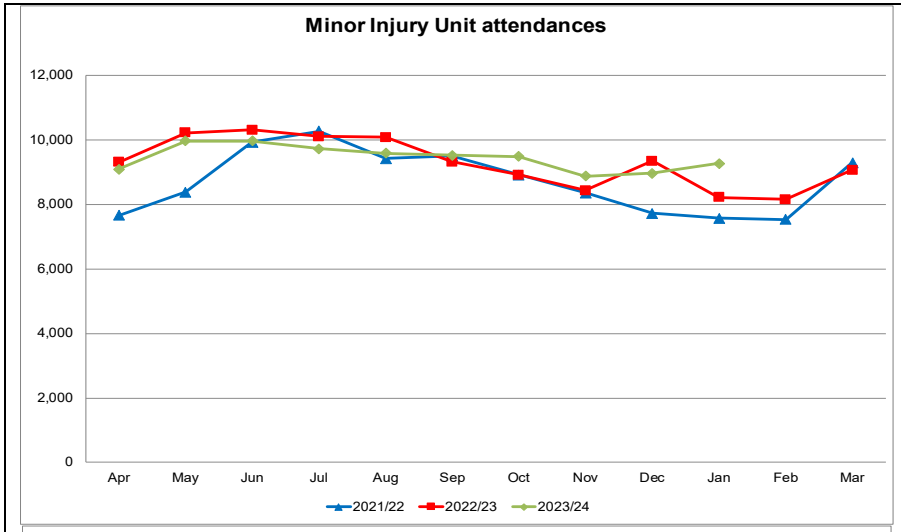
Summary:

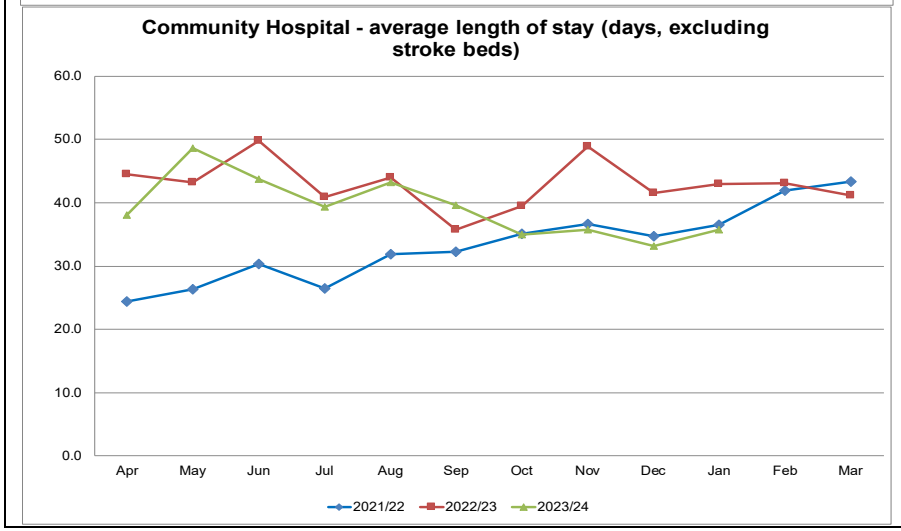
- Direct referrals to our community physical health services between 1 April 2023 and 31 January 2024 were 8.4% higher than the same months of 2022/23 and 12.9% higher than in the same months of 2021/22.
- Attendances for the same period were 4.5% higher than the same months of 2022/23 and 5.0% higher than the same months of 2021/22.
- Community service caseload levels as at 31 January 2024 were 0.6% lower than as at 31 January 2023, but 5.2% above 31 January 2022 levels.



Operational context

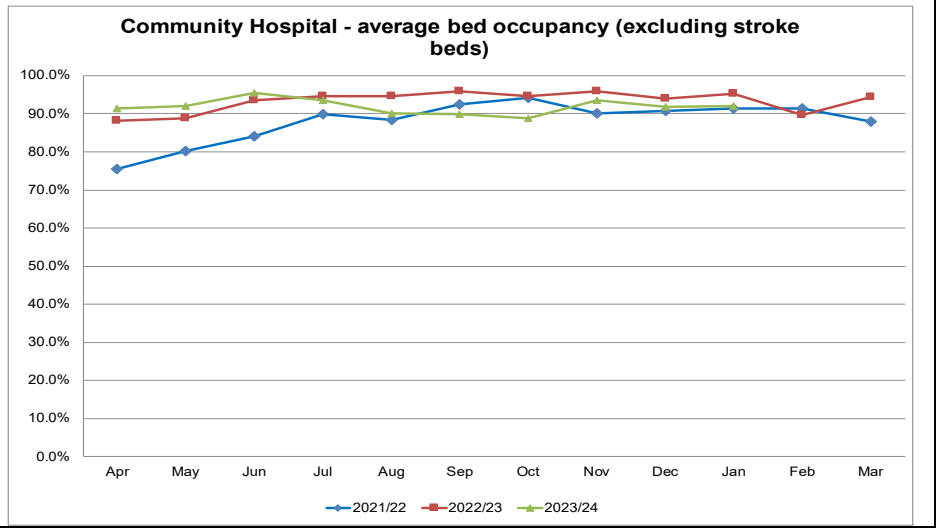
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





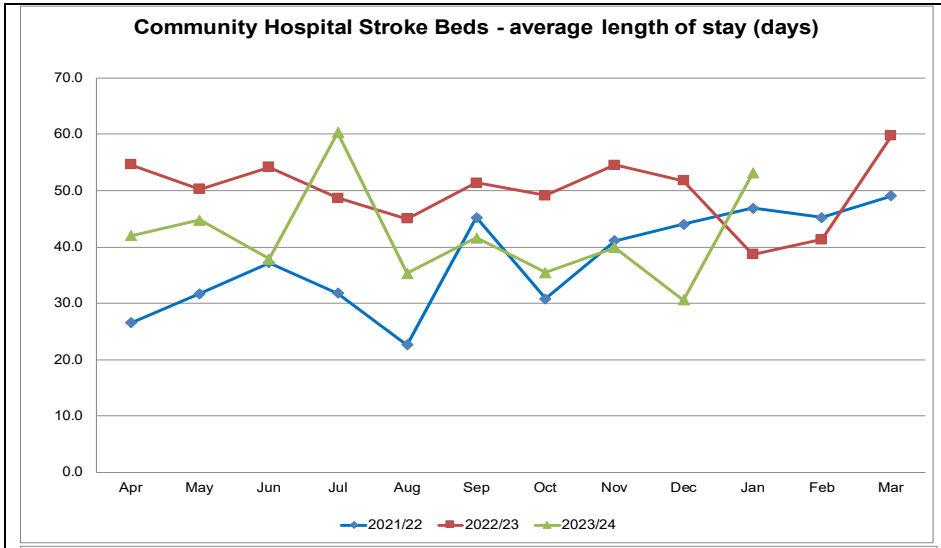
Summary:

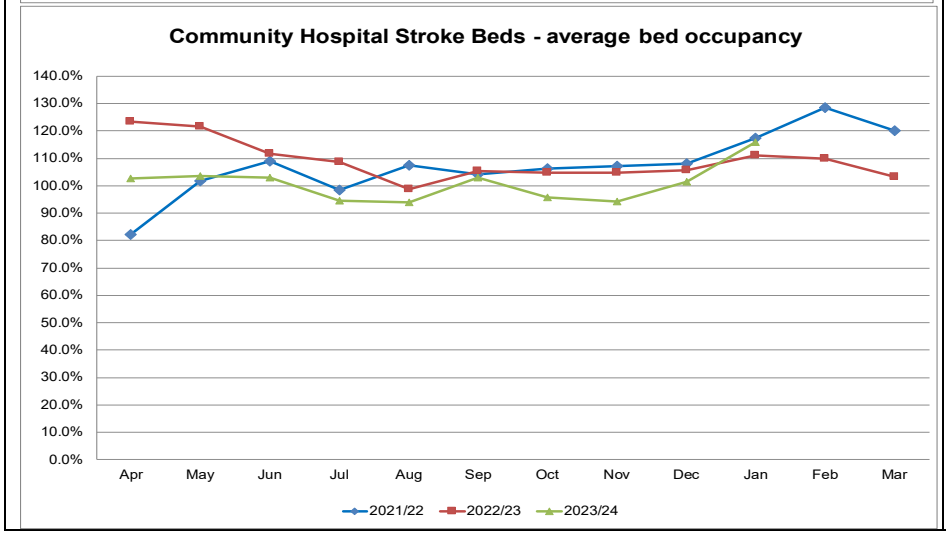
- Between 1 April 2023 and 31 January 2024, the number of Minor Injury Unit attendances was 0.2% higher than the same months of 2022/23, and 7.7% higher than same months of 2021/22. During December 2023, 96.0% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 76%, to be achieved by March 2024.
- The average length of stay for non-stroke patients in our community hospitals in January 2024 was 35.7 days, an increase compared to December 2023. Four patients were discharged with lengths of stay longer than 100 days; the longest was 114 days for a patient at West Mendip community hospital. The community hospital bed occupancy rate for non-stroke patients in January 2024 increased to 92.1%, from 91.9% in December 2023.



Operational context

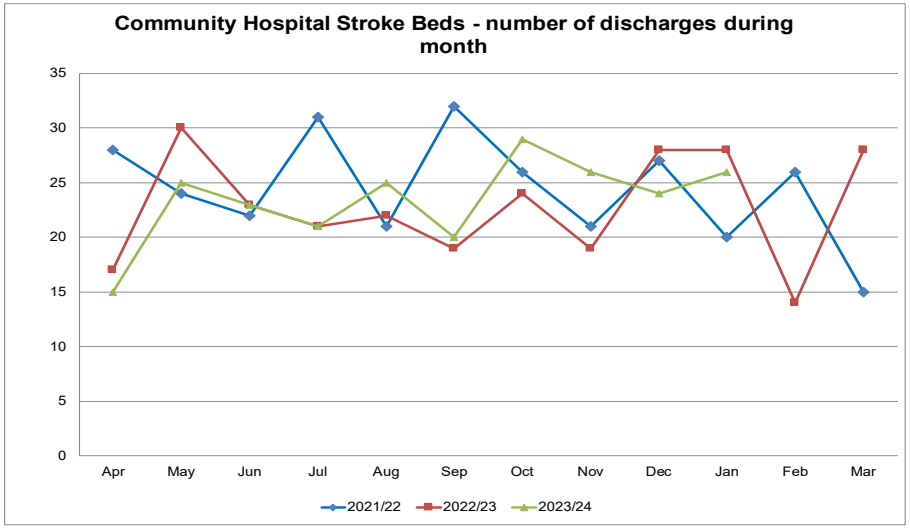
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





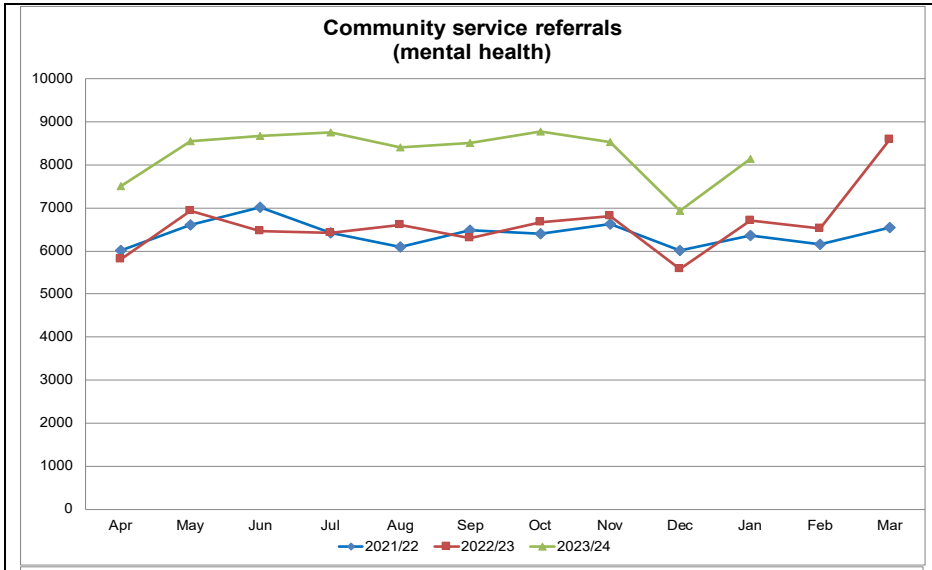
Summary:

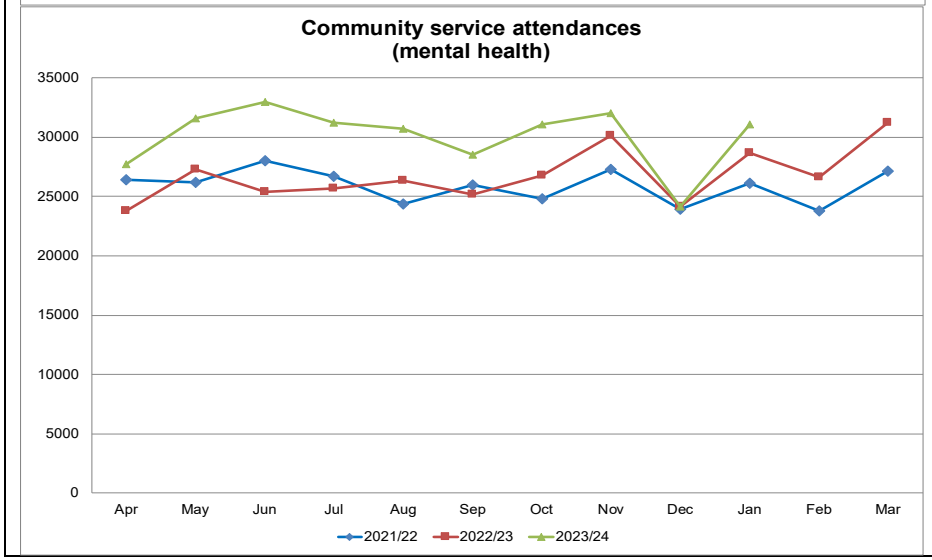
- The average length of stay for stroke patients in our community hospitals in January 2024 significantly increased to 53.1 days, from 30.6 days in December 2023, mainly due to the discharge of a South Petherton community hospital patient with a length of stay of 392 days.
- Stroke bed occupancy in January 2024 also significantly increased compared to December 2023.
- During January 2024 there were 26 discharges of stroke patients, up from 24 discharged during December 2023.



Operational context

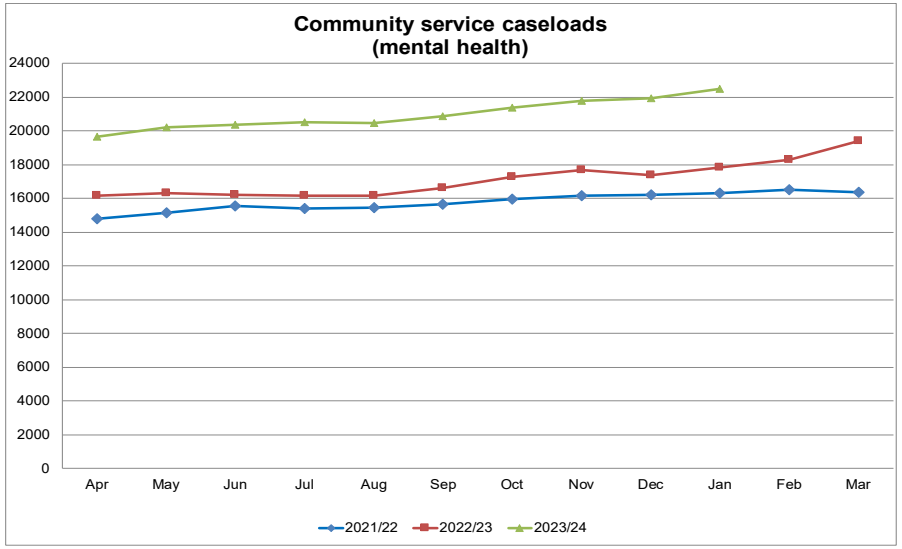
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





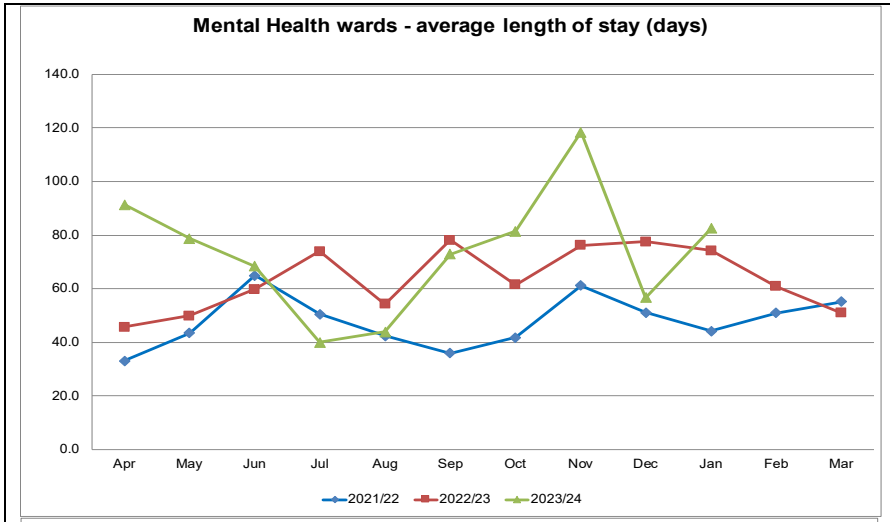
Summary:

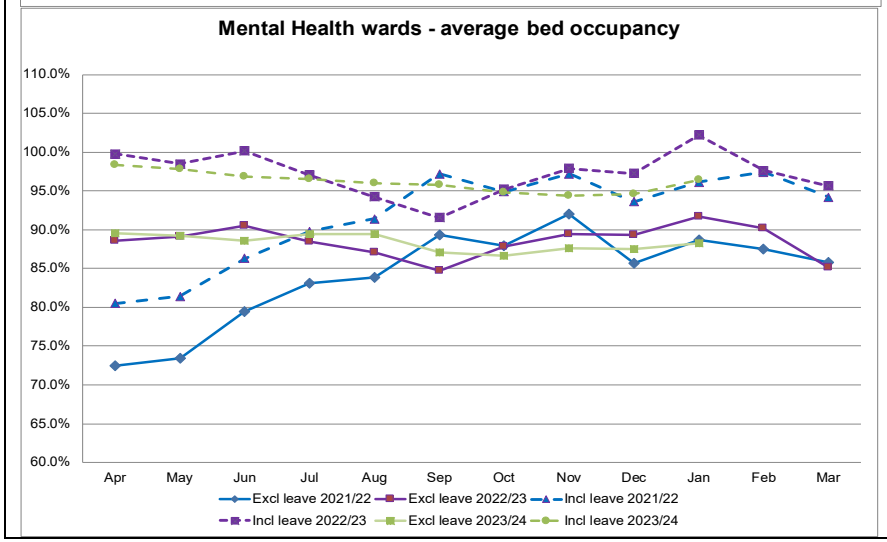
- Referrals to our community mental health services between 1 April 2023 and 31 January 2024 were 28.7% higher than the same months of 2022/23 and 29.3% higher than the same months of 2021/22.
- Attendances for the same reporting period were 14.3% higher than the same months of 2022/23 and 15.8% higher than the months of 2021/22. Services which have seen significant increases in recorded activity include Primary Care Mental Health Services (Open Mental Health), Home Treatment, and Older People's Community Mental Health services.
- Community mental health service caseloads as at 31 January 2024 increased by 26.1% when compared to 31 January 2023 and were 38.2% higher than as at 31 January 2024. It should be noted that investment has facilitated the expansion of some community mental health services.



Assurance and Leading Indicators

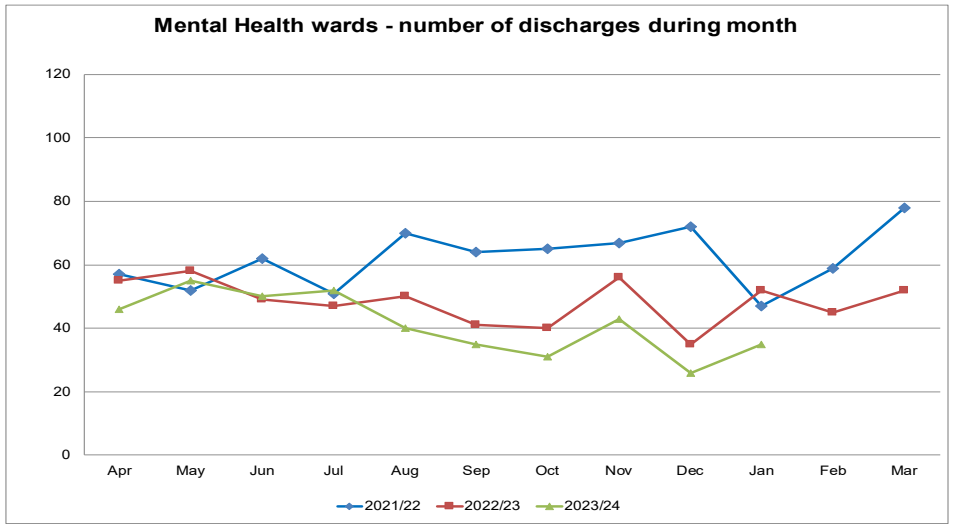
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





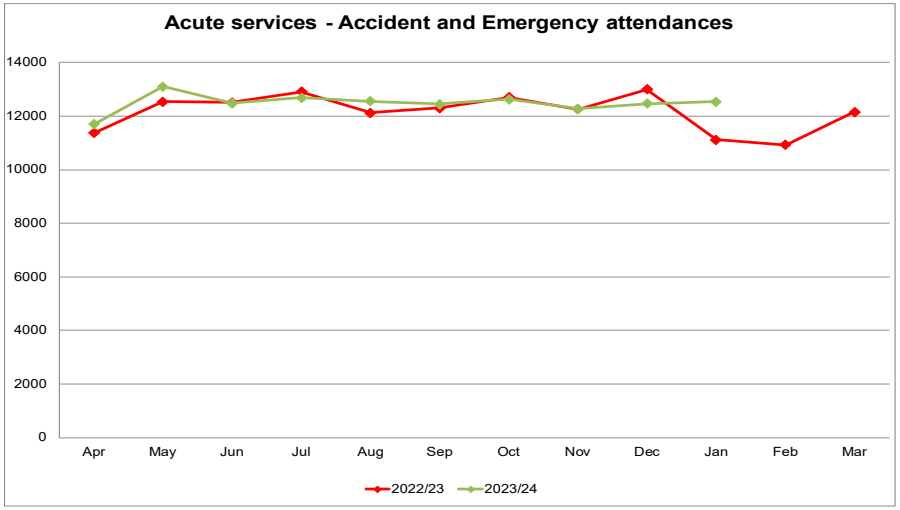
Summary:

- The average length of stay in our mental health wards in January 2024 increased compared to December 2023. During January 2024, 14 patients were discharged with lengths of stay of 100 days or more, including one patient discharged from Willow ward our rehabilitation unit, who had a length of stay of 368 days.
- The mental health bed occupancy rates, including and excluding leave in January 2024 decreased slightly when compared to December 2023.
- A total of 35 patients were discharged in January 2024, up from 26 in December 2023.



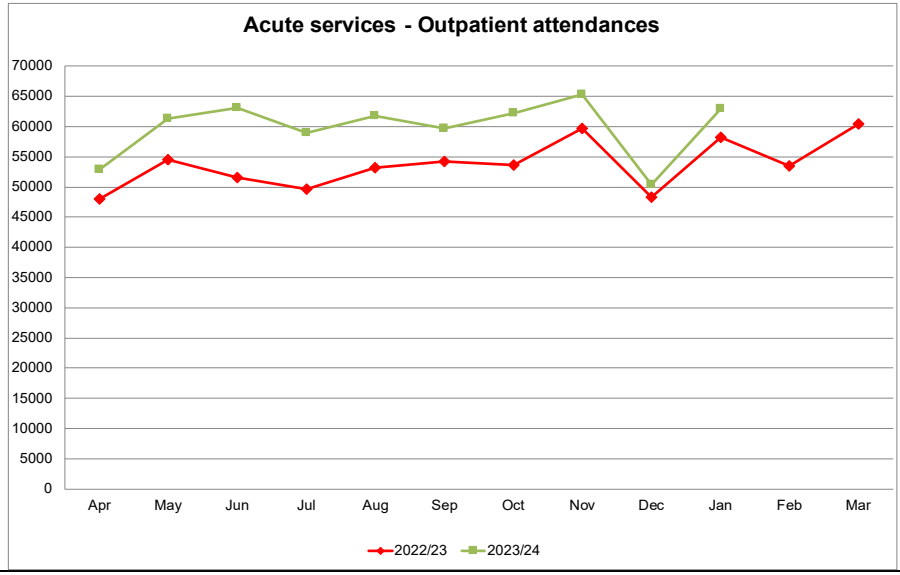
Operational context

Acute services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.



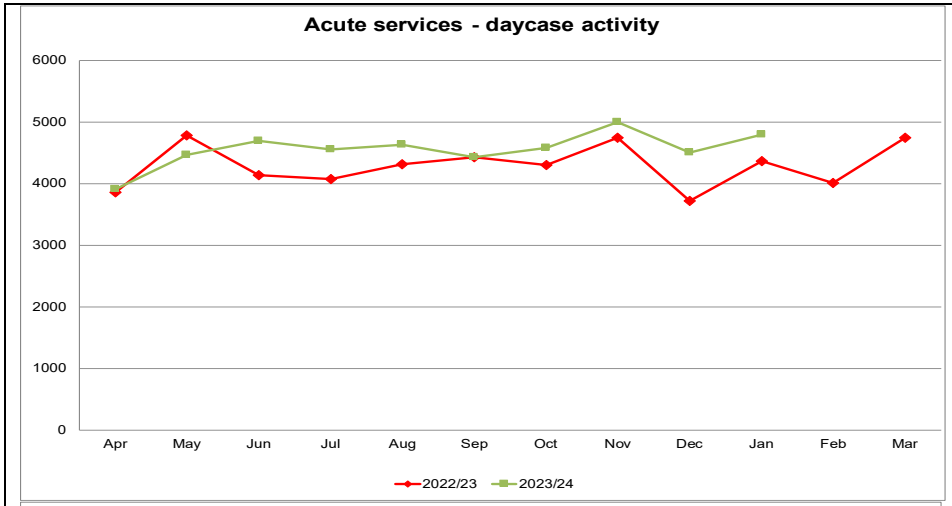
Summary:

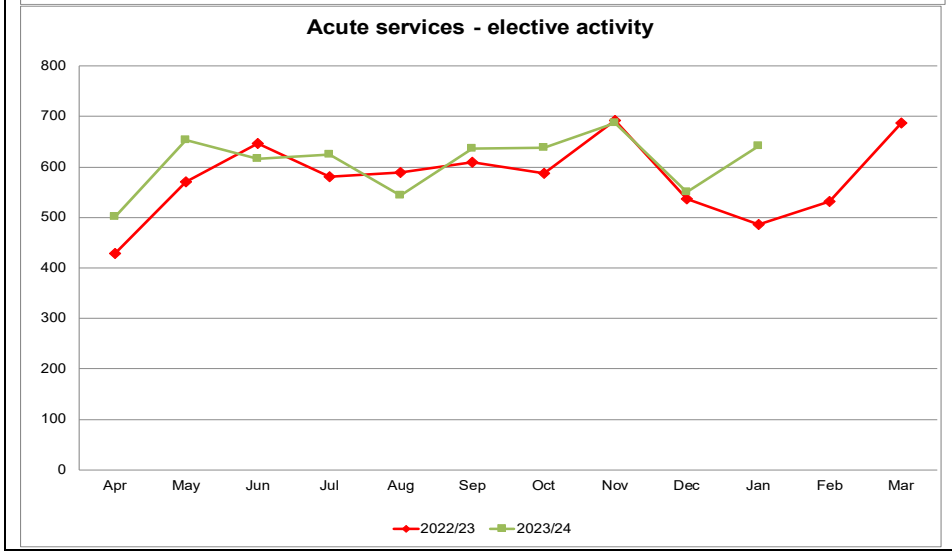
- Between 1 April 2023 and 31 January 2024 attendances to Accident and Emergency were 1.7% higher than the same months of 2022/23. In January 2024, 56.1% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 76%.
- GP and Dental referrals information is awaited and should be included within the next report.
- Outpatient attendances for the same period were 12.7% higher than the same months of 2022/23



Operational context

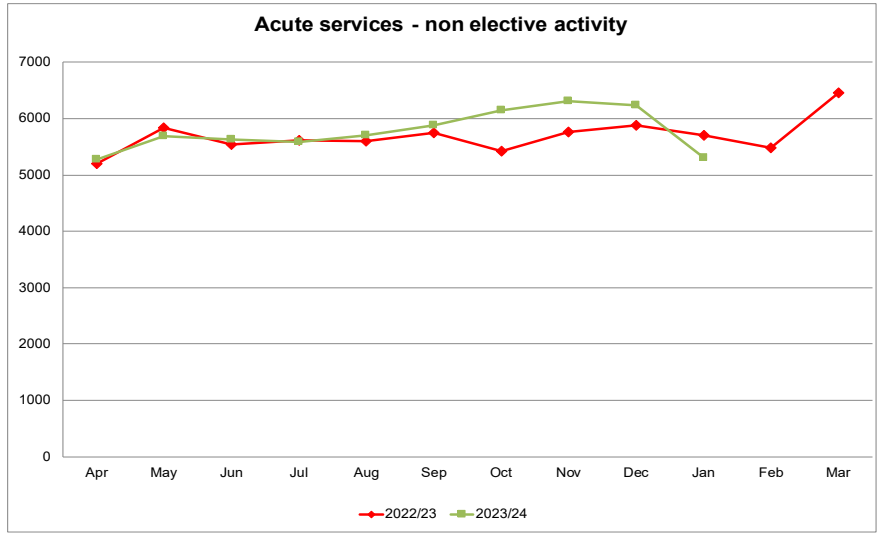
Acute services: This section of the report provides a summary of the levels of day case, elective, and non elective activity during the reporting period, compared to the previous months and prior year.





Summary:

- The number of day cases undertaken by our acute services between 1 April 2023 and 31 January 2024 increased by 6.6% compared to the same months of 2022/23.
- Over the same period, elective admissions were 6.4% higher than the corresponding months of 2022/23 despite the significant operational pressures experienced at Musgrove Park Hospital over recent months.
- Non elective admissions between 1 April 2023 and 31 January 2024 were 2.6% higher than the same months of 2022/23.



Appendix 6 – Infection Control and Prevention – January 2024

MRSA bloodstream infections	Commentary on MRSA / MSSA BSIs
Musgrove Park Hospital = 1 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0	The monthly case numbers doubled in January, predominantly on the Musgrove Park Hospital Site. Nationally case numbers are also rising and the reason for this is not completely clear. For our Trust the focus of improvement has been around reducing the number of cases relating to peripheral vascular cannula (PVC). To date our cases relating to PVC are almost half what they were last year. Work is still needed to reduce this further, but progress has been made. The cases in January have not been fully analysed but several seem to be due to skin / soft tissue. This needs more investigation as it appears to be a rising trend.
MSSA Bloodstream Infections	
Musgrove Park Hospital = 9 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0	
E. coli bloodstream infections	**Commentary on Gram-negative bloodstream infections**
Musgrove Park Hospital = 6 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0	**E. coli / Klebsiella** Case numbers have stabilised in January for both organisms. Although as a trust we have breached our annual threshold, in comparison with the rest of the region we have one of the lowest rates at 23.4 cases per 100,000 occupied bed days with the regional range being 15.32 to 115.41.
Klebsiella bloodstream infections	
Musgrove Park Hospital = 3 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0	**Pseudomonas** There have been no more cases linked to the outbreak of cases following cystoscopy. The investigation has identified issues with the decontamination of these complex instruments. Training is in place for staff which is almost complete.
Pseudomonas bloodstream infections	
Musgrove Park Hospital = 0 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0	
C. difficile	**Commentary on C. difficile**
Musgrove Park Hospital = 9 Yeovil District Hospital = 4 Community Hospitals / Mental Health = 0	The number of cases has significantly risen this month and the annual threshold of 54 cases has been breached. The reason for this has not yet been fully analysed but there is likely to have been an increase in antibiotic use over the winter which could be a factor. The trust rate for C diff infections is 18.2 cases per 100,000 occupied bed days which places us amongst the lower rate in the region with the range being 9.29 to 67.32.

Respiratory Viral Infections - inpatients	**Commentary on Respiratory Viral Infections**
COVID (Trust Cases) = 110 Musgrove Park Hospital = 57 Yeovil District Hospital = 36 Community Hospitals / Mental Health = 17	**COVID** COVID cases increased slightly during January as expected but levels are less than last year at this time.
Influenza = 116 Musgrove Park Hospital = 84 Yeovil District Hospital = 31 Community Hospitals = 1	**Influenza** Levels of influenza have increased significantly during January Most cases are Flu A which is the strain that usually causes outbreaks.
Respiratory syncytial virus (RSV) = 57 Musgrove Park Hospital = 26 Yeovil District Hospital = 28 Community Hospitals = 3	**RSV** Levels of RSV reduced during January and most were adults.
Outbreaks	**Commentary on outbreaks**
COVID = 15 Musgrove Park Hospital = 10 Yeovil District Hospital = 3 Community Hospitals = 2 **Influenza = 5** Musgrove Park Hospital = 4 Yeovil District Hospital = 1 **Norovirus = 4** Musgrove Park Hospital = 3 Community Hospitals = 1	**Respiratory Outbreaks** Outbreaks due to COVID in January remained at the same levels experienced in December. They have predominantly occurred on the Musgrove Park Hospital site and the reason for this is unclear. In addition, there were 5 outbreaks due to Influenza A. Overall, while outbreaks have been significant so far this winter, they have been less than last winter. **Norovirus** There were 4 outbreaks due to norovirus in January which is lower than anticipated as January is normally peak norovirus season. It is possible that the return to seasonal levels in the population has not yet occurred post pandemic.

Surgical Site Infections	Commentary on Surgical Site Infections
Surgical Site Infection Surveillance enables early recognition of infections to inform remedial and improvement actions. **Musgrove Park Hospital Site** Continuous surveillance for THR, TKR and Spinal surgery has been in place on the MPH site since 2009 **Yeovil District Hospital Site** Continuous surveillance on total hip replacement surgery has been in place on the YDH site since April 2022 and continuous surveillance was commence on total knee replacement surgery from January 2023.	**Musgrove Park Hospital Site** Rates of infection for Spines and Total Hip Replacement remain in line with national data. Since December 2023 a total of 193 Total Knee Replacement procedures were undertaken and 2 infections identified, giving an infection rate of 1.04%. This is slightly higher than the national benchmark which is around 0.4%. However, the national rate is calculated over the period April 2018 to March 2023 therefore it is not directly comparable. This situation is being monitored closely. **Yeovil District Hospital Site** Since January 2023 a total of 311 Total Hip Replacement procedures were undertaken and 6 infections have been identified, giving an infection rate of 1.93%. This is higher than the national benchmark of 0.5%. However, as previously described the national data is calculated over a different period and therefore not directly comparable but used as a guide. The data for Total Knee replacements is not yet available as the initial surveillance period or 30 days has not yet been reached for procedures undertaken in January. All the infections across both acute sites are being reviewed in more depth. In addition, a joint piece of work is being undertaken with the Service Group using the national One Together framework. This framework is specific to surgical site surveillance and allows trusts to review each part of the patient journey following surgery. This will be used to identify any areas of improvement.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the People Committee meeting held on 17 January 2024
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Kate Fallon, Chairman of the People Committee
DATE:	5 March 2024

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
☐ For Assurance	☐ For Approval / Decision	☐ For Information

Executive Summary and Reason for presentation to Committee/Board	The attached report provides a highlight of the discussion at the People Committee meeting held on 17 January 2024 about the remit of the Committee. The meeting was conducted as a video conference call.
Recommendation	The Board is asked to discuss the report.

Links to Joint Strategic Objectives
(Please select any which are impacted on / relevant to this paper)

- ☐ Obj 1 Improve health and wellbeing of population
- ☐ Obj 2 Provide the best care and support to children and adults
- ☐ Obj 3 Strengthen care and support in local communities
- ☐ Obj 4 Reduce inequalities
- ☐ Obj 5 Respond well to complex needs
- ☒ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
- ☐ Obj 7 Live within our means and use our resources wisely
- ☐ Obj 8 Develop a high performing organisation delivering the vision of the Trust

Implications/Requirements (Please select any which are relevant to this paper)					
☐ Financial	☐ Legislation	☒ Workforce	☐ Estates	☐ ICT	☐ Patient Safety/ Quality
Details:					
Equality and Inclusion					

The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
This was not required as part of this report.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
This was not required as part of this report.

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The assurance report is presented to the Board after each meeting.

Reference to CQC domains (Please select any which are relevant to this paper)				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	☐ No

SOMERSET NHS FOUNDATION TRUST (SFT)

ASSURANCE REPORT FROM THE PEOPLE COMMITTEE

1. PURPOSE

1.1. The attached report provides a highlight of the discussion at the People Committee meeting held on 17 January 2024 about the remit of the Committee.

1.2. The meeting was conducted by way of a video conference call.

1.3. In view of the different nature of this meeting, the assurance report does not follow its usual format.

2. REMIT OF THE COMMITTEE

2.1. The Committee discussed the remit of the Committee, taking account of the comments received in advance from Tina Oakley and James Phipps, and recognised that the Committee had, initially, been set up explicitly to develop and deliver the people strategy rather than as a formal assurance committee.

2.2. The Committee noted the suggestion that the Committee meeting agendas should be driven by the Board Assurance Framework; that, as well as a focus on delivering the strategy, there should also be a focus on the risks of delivering the strategy; and that the frequency of the meetings need to be reviewed to ensure that the Committee is able to provide the required assurance to the Board.

2.3. The Committee noted that an initial review of agenda items suggested that the agenda should:

- Relate to the Board Assurance Framework.
- Assure delivery of the people strategy, as divided into sections, looking at themes within each section.
- Include a strong focus on culture.
- Include updates on recruitment and retention.

2.4. The Committee discussed the potential for meetings, if held frequently, to move into operational detail and agreed that consideration should also be given to the sub structure assurance process.

2.5. The Committee further agreed that a set of key performance indicators (KPIs) may help to reviewing the progress in delivering the strategy.

2.6. The Committee approved the following actions:

- To move to ten meetings a year.
- To set up a small sub group led by Kate Fallon and Isobel Clements, with membership to include: Tina Oakley, James Phipps and Kirstie Lord, to discuss the agenda for the next six meetings.
- To present a report to the next meeting setting out the plan for future meetings and the process for gaining assurance from sub groups.

Kate Fallon
CHAIRMAN OF THE PEOPLE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Six monthly safe staffing establishment report
SPONSORING EXEC:	Hayley Peters, Chief Nurse
REPORT BY:	Alison Wootton, Deputy Chief Nurse, SFT (Development of report informed by the Associate Directors of Patient Care in service groups)
PRESENTED BY:	Hayley Peters, Chief Nurse Alison Wootton, Deputy Chief Nurse
DATE:	5 March 2024

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
☒ For Assurance	☒ For Approval / Decision	☐ For Information

Executive Summary and Reason for presentation to Committee/Board	This report provides a six-monthly update, July 2023 – December 2023, of safer staffing assurance for all Somerset NHS Foundation Trust (SFT) inpatient wards, critical care, and emergency departments. SFT is comprised of the legacy Yeovil District Hospital (YDH) and SFT, this report covers data inclusive of these areas. Maternity safe staffing is not covered in this paper as it is presented separately to the Quality and Governance Assurance Committee as part of the Maternity Incentive Scheme and issues escalated to the Board if required. The paper provides information on associated safer staffing risks and the controls and mitigations in place for these risks. This report offers high level assurance that safe staffing is reviewed formally every six months and that it is reviewed on a dynamic basis so that appropriate action is in place to support safest and best possible quality of care. The paper provide assurance that safe staffing is reviewed holistically considering a variety of metrics, data, and professional opinion to ensure that we are anticipating seasonal flux or changes in case mix that may require alterations in staffing ratios or professions. Over the last six months we have experienced continued pressures from:

	• Delays to discharge with high numbers of people who are medically fit for discharge, many who still have complex nursing needs. • High pressures on emergency care. • Medical colleagues' industrial action. • On going use of escalation beds including the reopening of the community escalation beds towards the later end of the report period. The Board is asked to note the following: • Safe staffing levels have been reviewed as detailed in this report and have broadly been found to meet the standards and guidance. • There remains disruption and challenges to service delivery requiring a focus on a dynamic approach to monitor and oversee safe staffing. • Some services have vulnerabilities that require on going and close monitoring as well as action to mitigate and deliver safe care. • There is service level ownership and oversight of these risks and issues and there is a clear and accessible escalation process to raise concern if the risk is considered inadequately managed or mitigated.
Recommendation	The Board is offered reassurance that the Trust is taking all reasonable and available measures to ensure safe staffing levels in ward areas and where this is not possible, escalation and actions are followed to try and mitigate the risks of working with a compromised level of staffing. The Board is asked to approve this report for publication on the public website as per requirements. The Board is asked to note the business case for paediatrics to be reviewed as part of the wider business planning process and an outcome reported to board once this is completed. The Board is asked to support the adjustment to the Wessex Ward establishment which has been reviewed following sustained reduced occupancy.

Links to Joint Strategic Objectives (Please select any which are impacted on / relevant to this paper)
☒ Obj 1 Improve health and wellbeing of population. ☒ Obj 2 Provide the best care and support to people. ☒ Obj 3 Strengthen care and support in local communities. ☒ Obj 4 Reduce inequalities. ☒ Obj 5 Respond well to complex needs. ☒ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive, and learning culture. ☒ Obj 7 Live within our means and use our resources wisely. ☒ Obj 8 Develop a high performing organisation delivering the vision of the Trust.

Implications/Requirements (Please select any which are relevant to this paper)					
☐ Financial	☐ Legislation	☒ Workforce	☐ Estates	☐ ICT	☒Patient Safety / Quality
Details: N/A					

Equality and Inclusion
The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
By reviewing safer staffing levels, we will consider the individual needs of colleagues and patients on a daily basis and actions will be taken to meet individual needs where they can be, or other mitigation will be considered. The narrative in this report does not negatively impact on equality or inclusion.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
Senior nursing and service group level leadership teams have been involved in the preparation of this report.

We include intelligence from Healthwatch and other patient and service user groups although we acknowledge that this could be strengthened, and we are exploring this.

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The six-monthly review was last presented to the Board in September 2023 covering the period of January – June 2023.

Reference to CQC domains (Please select any which are relevant to this paper)				
☒Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	☐ No

SOMERSET NHS FOUNDATION TRUST

SIX MONTHLY STAFFING ESTABLISHMENT REPORT

1. BACKGROUND AND PURPOSE

1.1. This report is part of the safe staffing requirement in response to the Francis Report (2013) and subsequent guidance and policy including the National Quality Board (2016) guidance to deliver the right colleagues, with the right skills, in the right place at the right time. NHSI (2018) safeguards to support providers to deliver high quality care through safe and effective staffing built on previous guidance to support organisations and Boards to demonstrate that safe staffing levels have been reviewed for all clinical groups, and that a robust governance framework is in place to support these reviews and any proposed changes in staffing level or skill mix.

1.2. The intention of this report is to provide data, thematic issues, risks, and mitigations that allow the Board to be assured that Somerset NHS Foundation Trust (SFT) have planned core safe nurse staffing levels across all in-patient ward areas, and that we respond to changes in care requirements in our ward areas. This report covers the reporting period for July 2023 to the end of December 2023.

2. BUSINESS CASES

2.1 There is one business case attached to this report (see Appendix 3) that puts forward the case to increase the establishment on the children's ward at Yeovil District Hospital (YDH). This business case has been prepared by the Children, Young People, and Families Service Group. Concern over the funded establishment in this area has been raised over the year by the service group through the quality, finance, and performance meetings. This area has been running on a level of staffing for several years that has not been formally funded. Since the merger the new leadership team have worked with the nursing and medical teams in this area to review if any reconfiguration is possible to try and reduce this unfunded staffing need. There is an ambition to reduce the number of beds in use in the area but even if this is successful the level of colleagues required would not reduce due to the nature of the requirements for staffing levels when caring for children of various ages.

2.2 The Deputy Chief Nurse has worked with the nursing team and confirms that without the proposed level of staffing the risk in this area would not be managed leading to significant safety concerns. It is proposed that this business case is put forward and assessed as part of the financial planning for 2024/25. The service group continue to review and work with the area to ensure safe care is provided on a day-to-day basis, albeit incurring agency costs.

3. DATA METRICS

3.1. Standard data is used through the report to assure registered and unregistered nursing shift fill rate, care hours per patient day, absence, turnover, and vacancy rates. This data is presented at a combined high level but also at service group level as part of the appendix.

4. RISKS

4.1. A summary of risks above 15 that relate to **all** nursing and AHP staffing within service groups are now all overseen at a corporate level under risk R1815, and this is summarised in the chart below. This extract was from December 2023 to cover the period of the report.

4.2. The non-medical staffing risks that are held in the service groups are managed and overseen by the Associate Directors of Patient Care (ADPC) for each area. New or changing risks are reviewed in local governance meetings and then escalated through the service groups Quality, Outcomes, Finance and Performance (QOFP) meetings to be discussed with the wider corporate leadership team. A quarterly review of these risks, mitigations and actions is undertaken by the Deputy Chief Nurse and the Deputy Director of Integrated Governance with the ADPCs so that reassurance can be provided that these are being managed in a robust way.

4.3. Service groups and individual areas will have risks that relate to safe staffing that score below 15, these are not detailed in this report, these risks are discussed as part of service group governance and can be escalated through QAFP meetings if the service group has concerns about the risk management.

Corporate Risks 15+

R1815	16	⇔	Vacancies and absence rates within nursing and AHP teams

Service Group / Corporate Function Risks 15+

R1396	20	⇔	Insufficient nursing establishment funding in cardiac cath lab
R0440	16	⇔	Inability to provide a robust, continuous streamlined service for direct current cardioversion patients
R0513	16	⇔	Limited provision of specialist neurological rehabilitation and neuropsychiatry service
U868 / R1755	16	⇔	Insufficient Clinical Nurse Specialist cover – Gynaecology oncology
U886 / R1856	16	⇔	Lack of radiology nursing cover
R0916	16	⇔	Insufficient critical care Rehabilitation establishment
U1070	16	⇔	Lack of funding for Paediatric Physiotherapy out of hours
U1110	16	NEW	Lack of funding for specialist Paediatric Physiotherapy service
R1148	16	⇔	Theatres do not have the required safe staffing numbers in the establishment to deliver the service
R1324	16	⇔	High levels of vacancies and absences across community and urgent care teams
R1491	16	⇔	Inability to provide endoscopists to meet capacity for colonoscopy lists
R1551	16	↑	Insufficient Psychologist staffing due to vacant posts
R1630	16	⇔	Insufficient Learning Disability Liaison Team establishment
R1679	16	⇔	Weight Management Service staffing
R1706	16	⇔	Cath Lab staffing establishment due to vacant posts
R1798	16	⇔	Insufficient Weight Management Dietitian staffing due to vacancies
R1966	16	↑	Insufficient staffing within the vaccination team due to vacant posts as a result of the delay in the publication of the National Vaccination Strategy
R1993	16	⇔	Insufficient resource within Asthma service

Corporate Risks 15+

R1815	16	⇔	Vacancies and absence rates within nursing and AHP teams

Service Group / Corporate Function Risks 15+

U1022/ R1758	15	⇔	Significant staffing vacancies in the Emergency Department - nursing and ENPs
U1040	15	⇔	Lack of Occupational Therapy staffing causing delays in patients receiving timing treatment
R1301	15	⇔	Wards under resourced and insufficient skill mix of staff – Nurses & HCAs
R1450	15	⇔	Insufficient staffing to manage continuous growth in demand for ultrasound services (antenatal and general ultrasound services)

Key: Risk Score = 15-25 R = Risk on RADAR U = Risk on Ulysses 01 = Unique Risk Reference
Service Group / Corporate Functions - Children, Young People & Families; Clinical Support and Cancer; Medical; Mental Health & Learning Disabilities; Neighbourhoods; Surgical; Corporate Functions; SFT Trustwide Corporate Risk: SSL Risk SHS Risk

External Risks – Risks which are predominately outside of the control of the organisation to mitigate

Internal Risks – Risks which are predominately within the control of the organisation to mitigate

5. SIX MONTHLY REVIEW OF SAFE STAFFING

Narrative for acute, community and mental health inpatient areas.

5.1. High level combined data

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Measure	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Registered Nursing Fill Rate	93%	92%	91%	91%	92%	92%	
Unregistered Nursing Fill Rate	101%	98%	98%	96%	100%	100%	
All Staff Fill Rate - Day	97%	94%	93%	92%	94%	95%	
All Staff Fill Rate - Night	100%	99%	98%	98%	100%	100%	
All Staff Fill Rate - Overall	98%	96%	95%	95%	97%	97%	
Care Hours per Patient Day	8.7	8.5	8.3	8.5	8.7	8.5	
Registered Hours per Patient Day	4.5	4.5	4.3	4.5	4.5	4.4	
Completing Safer Staffing Measures	85%	85%	85%	89%	88%	85%	
Sickness	5.6%	5.8%	6.1%	6.3%	5.9%	5.3%	
Labour Turnover Rate	9.2%	9.5%	9.6%	9.2%	9.1%	9.3%	
Registered Nurse Vacancy Rate	6.3%	6.6%	6.5%	5.3%	0.3%	5.1%	
Unregistered Nurse Vacancy Rate	-0.9%	-1.3%	1.6%	2.2%	-3.7%	1.4%	
All Clinical Staff Vacancy Rate	6.9%	7.1%	7.0%	5.8%	0.8%	5.4%	

5.2. Due to the reconfiguration of beds across both the MPH and YDH sites there is an issue with the high-level data as the roster templates were not updated at the same time as the changes were made. The data had been provided but the data for fill rates for registered nurses is flawed due to these delays. It is important to read the narrative in the service groups (Appendix 1) to gain reassurance that fill rates have been managed or mitigated on the day.

5.3. Over the last six months we have experienced continued pressures from:

- Over the last few Delays to discharge with high numbers of people who are medically fit for discharge, many who still have complex nursing needs.
- High pressures on emergency care.
- Industrial action.

- On going use of escalation beds including the reopening of the community escalation beds towards the later end of the report period.

5.4. months, we have experienced some improvements:

- A stabilisation in colleague sickness levels.
- Following reconfiguration of beds on the MPH site we have seen improved flow, a reduction in length of stay and a reduction in the number of medical outliers.
- Ward sisters are more consistently getting their supernumerary time to support and develop their teams.
- We have inducted less new nurses as our vacancy level has improved and the training and development of teams is leading to more confident and skilled teams, but this development is ongoing.

5.5. Following the work of previous years, each inpatient area has a core level of staffing agreed that we aim to meet the usual care needs for that speciality. Each area is established with a wholetime equivalent head count, that if all posts are recruited, can support these numbers being rostered and an allowance for a planned level for annual leave, study leave and sickness cover. In each area, the ward sister has an amount of non-clinical supervisory time to support quality care, to develop and manage the team and ensure efficient running of the areas.

5.6. Currently, in most ward areas, we continue to see a generally positive and improving position of registered and unregistered nurse vacancy, but we do still have some pockets of higher levels of vacancy where areas are more difficult to fill vacancy due to lack of speciality specific colleagues. Examples of this would be in mental health, paediatrics, and intensive care, but all areas are seeing an improvement, either with a reducing vacancy level or with planned recruitment that will improve the picture over the coming months.

5.7. The improvement in vacancy level for unregistered colleagues in the two acute sites has continued and this has supported to mostly stop the use of any agency for unregistered colleagues but still maintain good fill rates in the wards. Some specialist unregistered nurses are booked to support patients with specific enhanced care needs. We have also seen a good reduction in the use of agency nurses in most ward areas apart from the specialist areas described in 5.3.

5.8. Over recent years, it has been more difficult to recruit to our community hospitals, leading to temporary closure of some units. We are seeing an improving picture in the community hospitals that remain open, but this improvement would not support re-opening of any of the closed areas.

6. AREAS OF NOTE

Paediatric Ward at YDH.

6.1. The funded establishment on the children's ward at YDH does not currently meet the outline guidance for safe numbers of colleagues per bed, when the ward is full, and the acuity is high. Further work to improve staffing levels in the long term is required, this is underway, and a business case is attached in Appendix 2.

6.2. Over the last two years to ensure Ward 10 is safely staffed, agency colleagues have been required at short notice to supplement the core number of colleagues. This is a very expensive resource and does not offer continuity to the patients or the nursing team. Please see staffing costs below:

YDH Paediatrics in-patient unit	**Actual**	**Actual**	**Estimated**
Ward 10	**Outturn**	**Outturn**	**Outturn**
Agency	**2021-22**	**2022-23**	**2023-24**
Qualified Nurse	39,921	324,783	420,307
HCA	13,198	36,589	0
	53,119	**361,372**	**420,307**
Estimated Feb & Mar as per Dec & Jan run rates			

6.3. Concern about the staffing establishment has been a long-standing issue and is being reviewed frequently by the leadership team in the CYP and Families Service Group and raised with our Executive team.

6.4. Currently, it is felt that safe staffing numbers are achieved with the use of agency colleagues. However, the funding of the business case will allow for recruitment to a core establishment that can cover the staffing requirements of the unit.

6.5. **Bridgwater Community Hospital – inpatient ward.** Over the period of this report Waverly Ward at Bridgwater Community Hospital has required an enhanced level of staffing at night. This increase has mainly been due to the ongoing care of one patient with very complex needs. The service group have kept this under close review and staffing has been rostered to meet the needs of the patient, but there is ongoing concern that the acuity and dependency of patients in this ward is more complex than before and may require an enhancement of staffing level if other mitigation can not be implemented. The service group are reviewing this locally and the unit are going to commence the Safer Nursing Care Tool assessment in March (see section 9 for information of this process), output of this will be reviewed if care needs remain high after the complex patient is discharged.

6.6. **Wessex House – Tier 4 CAMHS Unit**. Wessex House has experienced reduced bed occupancy for most of 2023, with the occupancy over the last

three months being 50% or less. During this period, staffing levels have been maintained at predetermined safer staffing levels set which were set for full occupancy. Mental Health and Learning Disability Service Group have been asked to review safer nursing staffing levels in line with the current occupancy levels.

6.7. Wessex House has previously had a high proportion of patients from the Bristol, North Somerset, and South Gloucestershire (BNSSG) area because Riverside, their 'home' young person's unit was closed to inpatient admissions due to their refurbishment programme and upon reopening could only admit a finite amount of young people. They were limited initially by their reduced staffing levels. Riverside has successfully recruited and has been able to open an increased number of inpatient beds meaning fewer patients from their area are referred to Wessex House.

6.8. The team is comprised of both nursing and multidisciplinary colleagues as detailed below:

6.9. Current safer nursing staffing numbers for full occupancy are:

- *Early – 2 x RNs and 4 x HCAs.*
- *Late – 2 RNs and 3 HCAs and 1 X HCA on a twilight shift (maintaining six colleagues on duty until 11pm).*
- *Night – 2 RNs and 3 HCAs.*
- *Middle – the current roster template enables us to allocate optional 9am – 5pm shifts should the clinical need dictate*.

6.10. Wessex House has a significant multidisciplinary team available during the working week: 5 x medical colleagues including a Consultant Psychiatrist working various hours; 1.6 x Clinical Psychologists; 1.8 x Assistant Psychologists; 1 x social worker; 0.8 x Systemic therapist; 1 x Family Support Worker; 1 x Social Worker and currently 1 x Learning Mentor (with a second out to advert).

6.11. The ward runs a therapeutic timetable within the working week with structured education, psychosocial and therapeutic groups which patients are actively encouraged and expected to attend.

6.12. The management team at Wessex House do feel it is clinically appropriate to reduce safer nursing staffing levels in line with reduced occupancy.

6.13. We would suggest the staffing numbers below are set until occupancy reaches seven inpatients (58.3% occupancy) and upon an eighth patient being admitted to the ward (66.7% occupancy), that the ward revert to safer nursing staff levels set for full occupancy as noted above.

- *Early – 2 x RNs and 3 x HCAs*
- *Late – 2 RNs and 3 x HCAs* ***or*** *2 x RNs and 2 x HCAs and 1 x HCA Twilight (the rationale for the latter being that most incidents on the ward happen in the evening and ward-based staffing numbers*

significantly decrease at 5pm when the multidisciplinary team finish their working day).

- *Night - 2 RNs and 3 HCAs.*

7. BED AND STAFFING RECONFIGURATION

7.1. Each year we undertake a predicted demand and capacity modelling exercise for the acute beds in the Trust. Following the last two years when escalation pressures have grown, it is very important that we understand this demand and make the best plan we can to prepare for this.

7.2. As part of this modelling, Medical and Surgical Service Groups, in the acute part of the Trust, had agreed to re-allocate some of the previous bed allocation to try and better match the required demand and capacity model. This new model required movement of ward specialities and bases.

7.3. The model indicated that the acute part of the Trust will require a higher number of beds overall than we have, and over previous years, we have achieved this with temporary escalation beds and the use of temporary staffing. In the reconfiguration plan, some of the escalation beds became part of the core number, and the establishments and ratios of staffing had all been reviewed with a staffing plan agreed and signed off by the Chief Nurse.

7.4. The acute beds escalation plan does still have some escalation beds that may be used when we are at full capacity, however, these beds do not have funded staffing levels but do have agreed staffing models and standard operating procedures for when they are used. If utilised staff for this area would be booked through temporary staffing or through agency workers.

7.5. Over the period of this report all the wards were moved, and nursing teams re-settled in new areas / speciality mixes. At the point of writing, these moves seem to have improved flow within the MPH site, where dramatic changes were enacted. These changes appear to of led to a decreased length of stay for patients on medical wards, but ongoing evaluation is still required.

7.6. It was noted in the last paper that there was a risk during the transition period to safe staffing. This has been carefully monitored and since the changes have been implemented no areas are raising concern that there staffing levels have not been correctly re-set.

8. SAFER NURSING CARE TOOL (SNCT)

8.1. National Quality Board (2016) and Developing Workforce Standards (2018) provide a framework that underpins the principles of safer staffing combining evidence-based tools, professional judgement, and outcomes to ensure the right colleagues with the right skills are in the right place at the right time. This tool is known as the Safer Nurse Staffing Tool (SNCT). The adoption of this tool across the NHS is highly recommended and is endorsed by the Chief Nurse for

England. The Trust is now in position to start using this tool to inform decisions around nursing workforce and match this to patient acuity and activity across our acute inpatient areas and will be able to provide additional assurance to the Board on the quality of patient care and associated outcomes.

8.2. Training in use of the tool has been completed across all inpatient areas in MPH, YDH and community hospitals. The audits need to be run over a month period twice a year. Most wards have now run a practice set of data, but all areas will be formally running their audits in March 2024 and then this will be repeated in September 2024. The output of these audits needs to be reviewed over time and reviewed against other known metrics and professional opinion for the area.

9. RECOMMENDATION

9.1 The Board is asked to discuss and approve the report. There is a requirement for this report to be published on our public website once it is approved.

9.2 The Board is further asked to consider if this provides the required assurance on actions being taken to maintain and monitor safe staffing levels across Somerset Foundation Trust inpatient areas.

9.3 The Board is asked to note that the business case for paediatrics is to be reviewed as part of the wider business planning process and an outcome reported to the Board once this is completed.

9.4 The Board is asked to support the adjustment to the Wessex Ward establishment which has been reviewed following sustained reduced occupancy.

APPENDIX 1

Service Group and Inpatient Level Data

(Minus numbers in red indicate over recruitment; numbers in black are vacancy levels)

1. CLINICAL SUPPORT AND CANCER SERVICES, NARRATIVE FROM THE ASSOCIATE DIRECTOR OF PATIENT CARE:

CSCS	MPH

Measure	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Registered Nursing Fill Rate	95%	94%	94%	94%	97%	95%	
Unregistered Nursing Fill Rate	100%	97%	101%	92%	97%	93%	
All Staff Fill Rate - Day	98%	93%	95%	92%	97%	92%	
All Staff Fill Rate - Night	99%	99%	103%	99%	99%	100%	
All Staff Fill Rate - Overall	98%	95%	98%	94%	98%	95%	
Care Hours per Patient Day	7.3	7.0	8.7	7.3	7.5	7.3	
Registered Hours per Patient Day	4.6	4.4	5.4	4.7	4.8	4.7	
Completing Safer Staffing Measures	79%	79%	73%	77%	77%	79%	
Sickness	5.2%	2.5%	6.1%	5.9%	5.5%	4.4%	
Labour Turnover Rate	2.6%	2.6%	3.3%	3.3%	3.3%	2.3%	
Registered Nurse Vacancy Rate	3.0%	5.1%	2.1%	-9.7%	-4.2%	-3.9%	
Unregistered Nurse Vacancy Rate	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	
All Clinical Staff Vacancy Rate	3.0%	5.1%	2.1%	-9.7%	-4.2%	-3.9%	

(This area is only two ward areas, so the over recruitment represents one or two nurses)

1.1. We continue to strive for sustainable staffing levels across all services within the service group, though we are currently holding a number of risks associated with workforce shortages within many professions and services, but these do not affect the two ward areas.

1.2. We continue to trial ambulatory care on Ward 9 (haematology), though require additional nursing colleagues to realise maximal impact from this initiative.

1.3. We have escalating risks associated with nursing capacity for delivering out-patient chemotherapy within our Yeovil Day Unit. Turnover is high, there have been multiple resignations, and the training of new recruits is being supported through locum engagement.

1.4. Our transformation and productive care work will help to align service delivery across sites and identify opportunities for improved workforce development and planning. Our areas of focus are leadership capability, retention, and skills mix (from pre-registration apprenticeships to Enhanced and Advanced practitioners).

(Toni Hall, ADPC)

2. FAMILY SERVICES, NARRATIVE FROM THE ASSOCIATE DIRECTOR OF PATIENT CARE:

CYP & Families Services	MPH						
Measure	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Registered Nursing Fill Rate	88%	90%	90%	90%	96%	94%	
Unregistered Nursing Fill Rate	82%	81%	85%	80%	94%	88%	
All Staff Fill Rate - Day	90%	91%	94%	91%	99%	95%	
All Staff Fill Rate - Night	88%	87%	88%	88%	95%	94%	
All Staff Fill Rate - Overall	89%	89%	91%	90%	97%	95%	
Care Hours per Patient Day	13.0	11.9	10.3	10.5	11.5	12.1	
Registered Hours per Patient Day	9.6	8.8	7.6	7.8	8.3	8.8	
Completing Safer Staffing Measures	82%	87%	83%	81%	77%	78%	
Sickness	5.4%	4.6%	4.9%	6.4%	7.0%	7.0%	
Labour Turnover Rate	6.3%	6.4%	7.0%	6.2%	7.0%	8.2%	
Registered Nurse Vacancy Rate	8.8%	7.5%	7.2%	2.1%	2.0%	4.1%	
Unregistered Nurse Vacancy Rate	7.1%	2.2%	6.1%	14.2%	12.7%	3.4%	
All Clinical Staff Vacancy Rate	8.7%	7.5%	7.1%	2.0%	1.9%	3.6%	

CYP & Families Services	YDH						
Measure	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Registered Nursing Fill Rate	94%	89%	89%	89%	96%	93%	
Unregistered Nursing Fill Rate	73%	68%	72%	64%	74%	67%	
All Staff Fill Rate - Day	84%	78%	81%	80%	87%	82%	
All Staff Fill Rate - Night	97%	91%	90%	91%	95%	92%	
All Staff Fill Rate - Overall	89%	83%	84%	84%	90%	86%	
Care Hours per Patient Day	19.6	19.1	17.3	15.1	13.8	16.1	
Registered Hours per Patient Day	15.4	14.7	13.1	12.5	10.7	12.8	
Completing Safer Staffing Measures							
Sickness	4.7%	5.9%	6.9%	7.1%	4.1%	1.9%	
Labour Turnover Rate	12.8%	13.3%	14.8%	13.8%	15.8%	17.7%	
Registered Nurse Vacancy Rate	-1.6%	-3.5%	-5.0%	-4.6%	-2.9%	-3.5%	
Unregistered Nurse Vacancy Rate	-30.8%	-20.4%	-14.8%	-11.5%	-38.6%	-23.7%	
All Clinical Staff Vacancy Rate	-1.6%	-3.5%	-5.0%	-4.6%	-2.9%	-3.5%	

2.1. Issues for Ward 10 noted in main body of report and the business case (Appendix 3).

2.2. The data for families covers the children's wards, the Neonatal Unit and maternity services, all of these areas have fluctuating levels of occupancy over the 24/7 period, we try to adjust staffing ratios based on occupied beds rather than funded beds so although the figures for fill rate may not look optimal, they are usually matched to the actual occupancy.

2.3. Maternity safe staffing is not directly covered in this report as this is reported separately through the Quality and Governance Committee, but Appendix 2 is provided to demonstrate this information.

2.4. Recruitment of paediatric nurses at MPH has been challenging for several years, all opportunities to recruit nurses are taken and a pipeline of international colleagues have been essential in closing the vacancy gap but a longer induction into practice is often required but supported within the unit.

(Suki Norris, ADPC)

3. MEDICAL SERVICES, NARRATIVE FROM THE ASSOCIATE DIRECTOR OF PATIENT CARE.

Medical Services	MPH						
Measure	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Registered Nursing Fill Rate	95%	93%	94%	93%	95%	95%	
Unregistered Nursing Fill Rate	98%	101%	100%	101%	102%	99%	
All Staff Fill Rate - Day	98%	97%	95%	94%	95%	94%	
All Staff Fill Rate - Night	101%	102%	104%	105%	106%	104%	
All Staff Fill Rate - Overall	99%	99%	99%	99%	100%	99%	
Care Hours per Patient Day	7.7	7.5	7.4	7.9	7.8	7.5	
Registered Hours per Patient Day	4.0	3.8	3.7	3.9	3.9	3.8	
Completing Safer Staffing Measures	77%	78%	77%	82%	83%	80%	
Sickness	5.3%	5.6%	6.5%	5.9%	5.5%	5.3%	
Labour Turnover Rate	7.6%	8.2%	9.5%	9.4%	8.5%	8.5%	
Registered Nurse Vacancy Rate	8.6%	9.5%	11.2%	11.7%	-14.9%	9.2%	
Unregistered Nurse Vacancy Rate	-12.8%	-13.4%	-6.1%	-4.0%	-35.8%	2.7%	
All Clinical Staff Vacancy Rate	8.6%	9.5%	11.2%	11.7%	-14.9%	9.2%	

Medical Services	YDH						
Measure	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Registered Nursing Fill Rate	93%	101%	92%	95%	94%	93%	
Unregistered Nursing Fill Rate	102%	97%	102%	99%	100%	99%	
All Staff Fill Rate - Day	99%	100%	98%	97%	98%	97%	
All Staff Fill Rate - Night	101%	103%	101%	102%	100%	99%	
All Staff Fill Rate - Overall	100%	101%	99%	99%	99%	98%	
Care Hours per Patient Day	6.2	6.4	5.8	5.9	5.9	5.8	
Registered Hours per Patient Day	3.1	3.4	2.9	2.9	3.0	3.0	
Completing Safer Staffing Measures	100%	100%	98%	100%	100%	99%	
Sickness	5.0%	5.0%	5.2%	4.6%	5.6%	3.6%	
Labour Turnover Rate	15.3%	12.1%	11.6%	10.9%	11.1%	10.3%	
Registered Nurse Vacancy Rate	-4.5%	-2.8%	-5.9%	-5.2%	-3.6%	-2.2%	
Unregistered Nurse Vacancy Rate	-0.6%	-1.6%	-4.9%	8.6%	-2.1%	5.9%	
All Clinical Staff Vacancy Rate	-2.7%	-1.0%	-4.0%	-3.3%	-1.7%	-0.4%	

3.1. In summary, the last six months have seen a continued improvement within the nurse staffing in the Medical Service Group, we continue to see a large reduction in nurse agency spend on the MPH site, but some work still to do on the YDH site. Factors on the YDH site driving up our agency spend is the continued pressures on our Emergency Department (ED) and the opening of escalation beds at short notice. We still have some work to do with the temporary staffing spend, but the data sent through from the bank team suggests we do have a strong bank fill rate. Our observation and support requests are decreasing within the service group, due to focussed support and training.

3.2. Our Registered Nurse (RN) vacancy position remains positive, with 21.4 vacancies across the service group. On average, we are receiving 6-8 registered nurses through our overseas pipeline, monthly onto the MPH site, and currently the pipeline has been switched off on the YDH site due to achieving a positive recruitment position. We have seen a much-improved picture from our large deficit of HCAs this time last year. January figures ae showing a vacancy of 17.2 WTE for the service group. The People Services

support has been invaluable to offer advice and to help us understand how we can improve retention, and this is something that aligns with our medical service group quality strategy. Skill mixes on our wards has improved over the last six months, but this remains a focused piece of work we will continue with the support of our clinical skill facilitators. We do have several senior nurses new into post that are requiring a high level of support from the matrons but are progressing well. We have recently appointed another matron on the MPH site and introduced cross county working for two of the matrons which is currently a test of change but has been well received. Our band 7s are achieving supernumerary time and they are now able to spend time clinically teaching and mentoring the new members of the team.

3.3. The bed and ward reconfiguration work has now been completed, alongside the increase of our hyper acute stroke beds and moving around areas on the Dunkery Stroke and Neurology Unit, this has destabilised some of our nursing teams, but we are confident that over the coming months with the continued support of the senior leadership teams and our Organisational Development (OD) support are teams will stabilise and thrive in their new work environments.

3.4. We have enacted our escalation beds at times of extreme pressure which has resulted in some areas having additional beds within their wards. This has resulted in an increase in the use of bank colleagues to mitigate patient safety and staff wellbeing concerns particularly in our EDs and our Emergency Assessment Unit (AEU) on YDH, where we have needed to enact our standard operating procedure to use corridor nursing.

3.5. The matrons/ADPCs have good oversight and good grip and control over our over established areas, drilling down rosters day by day and plans are made to cover the gaps and move colleagues should this be required. They also review each request that comes in for enhanced care or observation and support to ensure that those patients that require a higher level of support are prioritised, however although there has been a reduction in the request for enhanced care and observation and support, we had seen an increase in our requests for Registered Mental Health Nurses (RMN), in the month of November, resulting in high costs to the service group with some delays in mental health bed transfers. These requests for RMN, are reviewed by the Psychiatric Liaison Team (PLT) and they support the teams to produce a plan of care for our patients presenting with mental health concerns.

3.6. During the last six months sickness levels have come down month on month, the most recent data shows December as 3.6%, the highest cause remains musculoskeletal pain.

(Jacqueline Phillips – ADPC)

4. MENTAL HEALTH AND LEARNING DISABILITIES, NARRATIVE FROM THE ASSOCIATE DIRECTOR OF PATIENT CARE.

Mental Health and Learning Disabilities MH wards

Measure	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Registered Nursing Fill Rate	98%	98%	100%	100%	103%	102%	
Unregistered Nursing Fill Rate	110%	110%	103%	107%	113%	118%	
All Staff Fill Rate - Day	98%	97%	93%	95%	98%	97%	
All Staff Fill Rate - Night	105%	106%	102%	105%	112%	112%	
All Staff Fill Rate - Overall	101%	100%	96%	99%	103%	102%	
Care Hours per Patient Day	12.2	12.4	12.6	13.0	13.1	13.0	
Registered Hours per Patient Day	4.8	5.0	5.0	5.0	5.0	4.8	
Completing Safer Staffing Measures	80%	83%	85%	89%	88%	81%	
Sickness	6.0%	7.5%	7.3%	7.4%	6.3%	5.3%	
Labour Turnover Rate	9.6%	9.4%	8.3%	7.8%	7.5%	7.7%	
Registered Nurse Vacancy Rate	17.6%	16.3%	16.7%	14.8%	13.7%	14.8%	
Unregistered Nurse Vacancy Rate	5.9%	4.6%	4.8%	6.3%	7.0%	7.5%	
All Clinical Staff Vacancy Rate	20.0%	18.2%	19.1%	17.2%	15.1%	16.1%	

4.1. As reported in previous submissions, staffing remains challenging on the mental health inpatient wards, with additional colleagues being required for managing vacancies, sickness, and complex high-risk individuals. Where additional observation and supervision is required for this complex patient group, this will sometimes artificially inflate the average fill rates for HCAs.

4.2. All the mental health inpatient wards have robust processes for managing and reviewing staffing levels for all shifts. This involves routine and regular core staffing level reviews taking account of patient presentation, acuity, dependency and needs, escalation processes to more senior clinical managers, moving colleagues across the wards to support, as well as ensuring temporary staffing is available if this is indicated.

4.3. The nursing fill rates on the wards are monitored regularly through the operational management team meeting. During this meeting, the following areas have been identified:

- The ward nursing fill rate levels fluctuate when managing complex and vulnerable patients requiring additional 1:1 / 2:1 staffing, sometimes for lengthy periods. Especially on the Psychiatric Intensive Care Unit (PICU) when vulnerable females need to be supported on a mainly male ward.

- Newly recruited internationally educated nurses will be recorded as supernumerary on band 4 until they have completed their conversion training and received their PIN, at this point they will be recorded as registered nurses. For this group of nurses, additional supervision, and support from the registered nurses is required until they have completed their OSCE and are competent and confident. We continue to have regular cohorts of international nurses throughout the year. This can potentially cause a pressure on the wards if this group of staff are taking an extended time to attain the competencies and understanding the ward and mental health processes within the UK.

- In the absence of RNs to cover shifts, and to ensure the wards remain safe, the wards will undertake a risk assessment at the time and sometimes prefer and agree a nursing associate or an experienced HCA who is familiar with the ward to work alongside the registered nurse and other team members to ensure safety and stability of the ward, as an alternative to employing an unknown RN agency worker, who may not know the ward or patients.

- The service group employ a two non mental health Registered Nurses (RN) one of these may take charge of Rowan Ward where they work, but they always work alongside a RMN as this is required for reasons relating to the Mental Health Act. Agency general registered nurses are never booked to work in our mental health wards and staffing gaps are mitigated in other ways.

- Rydon wards will be fully recruited by the end of Spring 2024, which will be the first time this has happened for many years, thanks to the international as well as effective student recruitment and retention.

- On St Andrews Ward, most colleagues on the ward will be relocating to Rowan Ward 2. Rowan Ward is continuing to over recruit in preparation for the move of St Andrews Ward to the Summerland's site. St Andrews still have vacancies however we are utilising block booked agency to cover this due to the delays in the completion of the building works. The new Rowan Ward is currently due to open in April 2024.

- The ward teams aim to complete twice daily patient acuity and dependency scoring, however due to a change in reporting from once to twice a day due to the introduction of 'SafeCare live', work continues to improve the accuracy.

- The service group have been successful in recruiting over 60 international educated nurses over the last 2.5 years, which has supported the nursing vacancies across all wards.

- The wards continue to manage daily challenges through their capacity meetings and continue to strive to reduce reliance on temporary and agency staffing. The recruitment team have stated that they will prioritise Mental Health HCA recruitment over the next period.

- Over the last year the service group have continued to develop the skills mix on the inpatient wards to ensure additional senior clinical leadership is available on each site seven days a week. All three trainee Advanced Nurse Practitioners are working well across Rydon Wards, Rowan and St Andrews and Pryland Wards, which enhances the clinical support available to the wards.

- All ward managers use the risk register to reflect where concerns are raised around staffing and recruitment to the service group, which are

reviewed within the regular governance meeting and operational management meetings.

- In Wessex House (CAMHS inpatient) we have reviewed the current safer staffing numbers due to the reduced occupancy over the past months. Guidance has been developed to allow for when occupancy levels are reduced, to reduce the staffing level in line with this. Details are provided in section 6.6 of main narrative but full situation briefing is below..

  (Alison van Laar, ADPC)

Staffing at Wessex House - briefing

Situation

4.4 Wessex House has experienced reduced bed occupancy for most of 2023, with the occupancy over the last three months being 50% or less. During this period, staffing levels have been maintained at predetermined safer staffing levels set which were set for full occupancy. The Inpatient and Urgent Care Directorate have been asked to review safer nursing staffing levels in line with the current occupancy levels.

Background

4.5 Wessex House has previously had a high proportion of patients from the Bristol, North Somerset, and South Gloucestershire (BNSSG) area because Riverside, their 'home' young person's unit was closed to inpatient admissions due to their refurbishment programme and upon reopening could only admit a finite amount of young people. They were limited initially by their reduced staffing levels. Riverside has successfully recruited and has been able to open an increased number of inpatient beds meaning fewer patients from their area are referred to Wessex House.

Assessment

4.6 The staff team is comprised of both nursing staff and multidisciplinary colleagues as detailed below:

4.7 Current safer nursing staffing numbers for full occupancy are:

10. *Early – 2 x RNs and 4 x HCAs.*
11. *Late – 2 RNs and 3 HCAs and 1 X HCA on a twilight shift (maintaining six staff on duty until 11pm).*
12. *Night – 2 RNs and 3 HCAs.*
13. *Middle – the current roster template enables us to allocate optional 9am – 5pm shifts should the clinical need dictate*.

4.8 Wessex House has a significant multidisciplinary team available during the working week: 5 x medical colleagues including a Consultant Psychiatrist working various hours; 1.6 x Clinical Psychologists; 1.8 x Assistant Psychologists; 1 x social worker; 0.8 x Systemic therapist; 1 x Family Support

Worker; 1 x Social Worker and currently 1 x Learning Mentor (with a second out to advert).

4.9 The ward runs a therapeutic timetable within the working week with structured education, psychosocial and therapeutic groups which patients are actively encouraged and expected to attend.

Recommendation

4.10 The management team at Wessex House do feel it is clinically appropriate to reduce safer nursing staffing levels in line with reduced occupancy.

4.11 We would suggest the staffing numbers below are set until occupancy reaches seven inpatients (58.3% occupancy) and upon an eight patient being admitted to the ward (66.7% occupancy), that the ward revert to safer nursing staff levels set for full occupancy as noted above.

- *Early – 2 x RNs and 3 x HCAs*
- *Late – 2 RNs and 3 x HCAs **or** 2 x RNs and 2 x HCAs and 1 x HCA Twilight (the rationale for the latter being that most incidents on the ward happen in the evening and ward-based staffing numbers significantly decrease at 5pm when the multidisciplinary team finish their working day).*
- *Night - 2 RNs and 3 HCAs.*

4.12 Other control measures:

There may be occasions that the ward can be managed by one registered nurse if they feel experienced enough to manage the ward – however should this occur, then an HCA will backfill the RN shift. - The leadership team retain discretion to increase staffing in the short term should acuity dictate this is clinically necessary. - All substantiative colleagues will have their contracted hours allocated to them. - This reduction in safer nursing staffing hours would not be outside of the QNIC standard 2.1.3 (July 2019) because we would not be managing 12 inpatients.

The standard states:

- *'A typical unit with 12 beds includes a minimum of two registered nurses, with relevant experience of working with children and young people, per day shift and one at night. At least one of these should have completed preceptorship.'*

4.13 Wessex House will aim to start working towards reduced safer nursing staffing numbers from the w/c 20.11.2023.

5. NEIGHBOURHOODS AND COMMUNITY SERVICES, NARRATIVE FROM THE ASSOCIATE DIRECTOR OF PATIENT CARE.

Neighbourhood Services	Community

Measure	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Registered Nursing Fill Rate	94%	95%	96%	96%	97%	102%	
Unregistered Nursing Fill Rate	100%	103%	106%	109%	107%	112%	
All Staff Fill Rate - Day	99%	100%	101%	102%	103%	109%	
All Staff Fill Rate - Night	100%	103%	107%	110%	106%	109%	
All Staff Fill Rate - Overall	99%	101%	103%	105%	104%	109%	
Care Hours per Patient Day	7.5	7.8	7.8	8.1	7.6	7.5	
Registered Hours per Patient Day	3.1	3.2	3.2	3.3	3.1	3.0	
Completing Safer Staffing Measures	88%	86%	93%	92%	92%	88%	
Sickness	6.0%	4.6%	4.4%	6.7%	7.2%	6.7%	
Labour Turnover Rate	8.2%	10.0%	10.6%	10.0%	8.9%	9.3%	
Registered Nurse Vacancy Rate	14.1%	13.5%	10.9%	10.9%	12.6%	11.4%	
Unregistered Nurse Vacancy Rate	3.2%	5.2%	6.0%	5.6%	6.5%	5.1%	
All Clinical Staff Vacancy Rate	13.4%	12.7%	10.2%	10.1%	11.9%	10.6%	

5.1. Community hospitals have consistently reported increased dependency levels relating to dementia and delirium and have increasingly required non-registered agency to safely care for patients with challenging behaviours in addition to establishment which would account for an increased agency spend. There is an element of existing colleagues not feeling confident or equipped to deal with this different cohort of patient and work is underway to offer training and support, linking with the dementia and delirium team which might reduce some but not all of this spend.

5.2. One area where this has been more acutely felt is Bridgwater Hospital as described in section 6.5 in main body of report.

5.3. In addition to this escalation beds and super-surge beds were opened earlier in the year than planned so the agreed uplift in establishments has also impacted on agency spend.

5.4. The community hospitals will be joining the Trust roll out of the safe staffing acuity tool this year which will provide an accurate picture of the reported increased acuity. In the interim, transformation and bed-flow leads are leading a more local audit to better understand the increased acuity/dependency.

5.5. The Community Nursing Safe Staffing Audit tool has been piloted twice across district nursing and isn't yet sufficiently accurate to include in this report, but the expectation is that the results will be reportable very soon.

(Debra Nash – ADPC)

6. SURGICAL CARE NARRATIVE, FROM THE ASSOCIATE DIRECTOR OF PATIENT CARE.

**** note the data below is affected by the reconfiguration of the wards and the roster templates were not changed at the same time – please read narrative for reassurance.**

Surgical	MPH						
Measure	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Registered Nursing Fill Rate	92%	85%	82%	82%	80%	81%	
Unregistered Nursing Fill Rate	108%	90%	86%	79%	86%	86%	
All Staff Fill Rate - Day	98%	87%	83%	81%	82%	84%	
All Staff Fill Rate - Night	103%	94%	88%	86%	87%	89%	
All Staff Fill Rate - Overall	100%	90%	85%	83%	85%	86%	
Care Hours per Patient Day	11.1	9.2	8.8	9.7	11.4	10.4	
Registered Hours per Patient Day	6.0	5.2	5.1	5.5	6.3	5.8	
Completing Safer Staffing Measures	80%	78%	77%	81%	80%	78%	
Sickness	6.4%	6.9%	7.1%	6.8%	5.7%	6.3%	
Labour Turnover Rate	8.2%	9.0%	8.1%	8.4%	8.5%	8.8%	
Registered Nurse Vacancy Rate	4.1%	3.9%	6.0%	5.2%	5.4%	2.2%	
Unregistered Nurse Vacancy Rate	2.1%	-0.2%	1.6%	-8.0%	-0.6%	-9.4%	
All Clinical Staff Vacancy Rate	4.1%	3.9%	6.0%	5.2%	5.1%	1.9%	

Surgical	YDH						
Measure	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Registered Nursing Fill Rate	90%	93%	89%	93%	90%	88%	
Unregistered Nursing Fill Rate	99%	94%	100%	97%	98%	98%	
All Staff Fill Rate - Day	94%	96%	95%	96%	94%	95%	
All Staff Fill Rate - Night	93%	93%	92%	96%	94%	92%	
All Staff Fill Rate - Overall	94%	95%	94%	96%	94%	94%	
Care Hours per Patient Day	8.1	8.4	8.7	8.3	8.1	8.1	
Registered Hours per Patient Day	4.9	5.4	5.4	5.3	5.1	5.0	
Completing Safer Staffing Measures	100%	100%	98%	100%	100%	99%	
Sickness	5.5%	5.3%	4.3%	5.4%	5.9%	3.9%	
Labour Turnover Rate	10.1%	14.0%	13.6%	12.4%	12.9%	11.7%	
Registered Nurse Vacancy Rate	-1.3%	3.5%	0.8%	-1.7%	-2.2%	1.2%	
Unregistered Nurse Vacancy Rate	15.1%	18.9%	35.3%	12.6%	35.2%	-16.8%	
All Clinical Staff Vacancy Rate	-1.3%	3.5%	0.8%	-1.7%	-2.2%	1.2%	

6.1. After the recent ward bed reconfiguration, there were adjustments made to the nursing staffing ratios. Unfortunately, these changes were not promptly updated on the roster templates, creating the appearance that shifts were left uncovered when this was not the case. It is important to clarify that the MPH ward data position merely reflects a position in the number of available shifts rather than a failure to cover them adequately. This oversight has now been rectified, with the roster templates aligned to accurately represent the revised staffing ratios. We anticipate a noticeable improvement in scheduling accuracy in the upcoming quarter, ensuring a more transparent and efficient staffing system.

6.2. The reported sickness percentage reflects an accurate representation, especially during the winter season, which tends to see an increase in coughs and colds among colleagues. We have also pushed a hard vaccination prevention campaign however, that despite best efforts, uptake on the offered vaccines has been lower across the service group. This seems to have resulted

in heavier burden viral illnesses. To address this, we are offering a robust return-to-work conversations and well-being checks for our colleagues. These measures aim to ensure that colleagues receive adequate support during and after illness, promoting a healthy and productive workforce. By proactively engaging in these initiatives, we strive to maintain a balance between addressing seasonal health challenges and sustaining a resilient and well-supported team.

6.3. Within Intensive Care Units, across both sites, the requirement for nursing colleagues fluctuates at least daily and this will affect the fill rate. The rota is managed on a day-to-day basis and at times the units run below their core numbers for the three pods, (overall not nursing outside of GPICS ratio's) however without the skill and runners required for the pods. They utilise their skilled core bank colleagues before offering overtime to colleagues, with the last resort going for agency cover – this tends to happen when there is a sudden increase in patient numbers and or acuity in a short period of time. Also, not being at establishment has impacted the data and there is an active phased approach in recruitment for both trained, untrained and those colleagues doing the trainee nursing associate route.

6.4. Within theatres, recruitment and retention remains a consistent challenge. Colleague turnover in YDH theatres is at 13.5% and 10% at MPH. A lot of work is going in across the service to remedy, plan, recruit and build the workforce, to service the requirements both now and for the new surgical build.

(Melody Schultz – ADPC)

Appendix 2 – YDH Paediatric Ward Business Case

Appendix 3 - CYP Paediatric Ward Bus

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Freedom to Speak Up Guardian (FTSU) Report
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Caroline Sealey, Lead Freedom to Speak Up Guardian
PRESENTED BY:	Isobel Clements, Chief of People and Organisational Development
DATE:	5 March 2024

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
☑ For Assurance	☐ For Approval / Decision	☐ For Information

Executive Summary and Reason for presentation to Committee/Board	All organisations which regulate or provide NHS healthcare should implement the principles and actions set out in the report Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. This paper provides an update regarding FTSU activity in Somerset Foundation Trust (SFT) covering the period April 2023 - September 2023. It informs the Trust Board about the number of concerns received and the professional background of the colleagues contacting the service. It also outlines the themes of the concerns, the service progress and planned actions. A total of 144 cases were raised in this period. This is an increase of 34.5% compared to the previous two quarters. Data collected demonstrates that most concerns in this period were raised by Nursing and Midwifery colleagues and Additional Clinical Service colleagues. A significant number of concerns (49%) contained an element of bullying / harassment or inappropriate attitudes / behaviours.
Recommendation	The Board is asked to note and discuss the report.

Links to Joint Strategic Objectives (Please select any which are impacted on / relevant to this paper)
☐ Obj 1 Improve health and wellbeing of population
☐ Obj 2 Provide the best care and support to children and adults
☐ Obj 3 Strengthen care and support in local communities
☐ Obj 4 Reduce inequalities

☐ Obj 5	Respond well to complex needs
☑ Obj 6	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☐ Obj 7	Live within our means and use our resources wisely
☐ Obj 8	Develop a high performing organisation delivering the vision of the Trust

Implications/Requirements (Please select any which are relevant to this paper)					
☐ Financial	☐ Legislation	☐ Workforce	☐ Estates	☐ ICT	☑ Patient Safety/ Quality
Details: N/A					

Equality and Inclusion

The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.

How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?

Colleagues are asked to provide demographic information so data trends can be reviewed.

FTSU guardians link with the colleague networks and inclusion team.
The diversity of the FTSU team is extended via the Wellbeing champions.

All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History

How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.

Colleagues who have used the FTSU service are asked to provide feedback via an MS Forms survey.

Previous Consideration

(Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]

The previous SFT and YDH Freedom to Speak Up six monthly progress report was presented at the September 2023 Board meeting. The Assurance report was presented in April 2023 and regular reports to Operational Leadership Team commenced in March 2024.

Reference to CQC domains (Please select any which are relevant to this paper)				
☑ Safe	☐ Effective	☐ Caring	☐ Responsive	☑ Well Led

Is this paper clear for release under the Freedom of Information Act 2000?	☑ Yes	☐ No

SOMERSET NHS FOUNDATION TRUST

FREEDOM TO SPEAK UP GUARDIAN REPORT

1. INTRODUCTION

1.1 The Freedom to Speak Up (FTSU) service is now fully established across Somerset Foundation Trust (SFT). This is the first paper presented to Board with combined data for the entire organisation following the merger between the former SFT and Yeovil District Hospital in April 2023.

1.2 This paper is presented in a structured format to ensure compliance with guidance published, June 2022, Freedom to Speak Up: A guide for leaders in the NHS and organisations delivering NHS services. B1245_ii_NHS-freedom-to-speak-up-guide-eBook.pdf (england.nhs.uk)

1.3 The FTSU model consists of a full-time lead guardian, Caroline Sealey, and a full time guardian. This post was previously occupied by Stephanie Hayward who left in November 2023 and has been replaced by Sarah Kerrigan who commenced in post on 1 March 2024.

1.4 Our vision is to provide an open and transparent culture across our Trust to ensure all colleagues feel safe, supported and confident to speak up and raise their concerns and that learning and continuous improvement happens as a result of speaking up.

1.5 Caution when reading this report as local data refers to Q1 and 2 2023/24 however, national data presented refers to year ending 31 March 2023.

1.6 We are looking to align presentation to board with national reporting timescales.

2. ASSESSMENT OF FTSU CASES

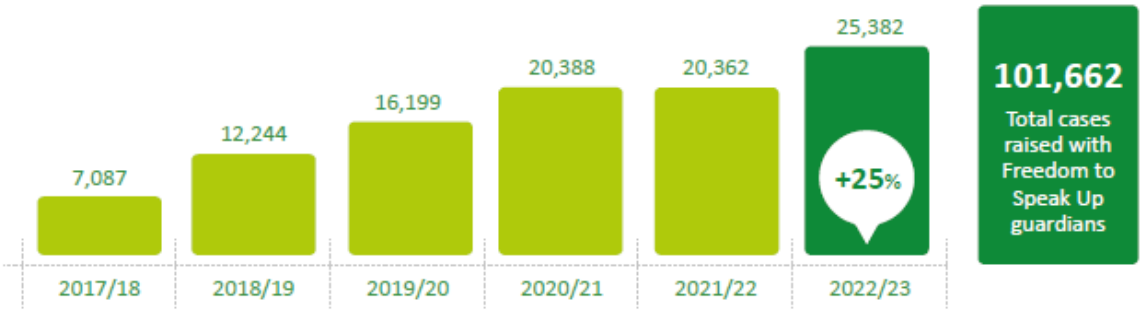
2.1 In November 2023, the National Guardian's Office (NGO) published "Making Speaking Up Business as Usual'. This is the annual report covering 1st April 2022- 31st March 2023" (NGO_AR_2023_Digital.pdf (nationalguardian.org.uk). Cases of speaking up rose to 25,382 in 2023 which is a 25% increase compared to 2021-22.

Highlights from the National report include:

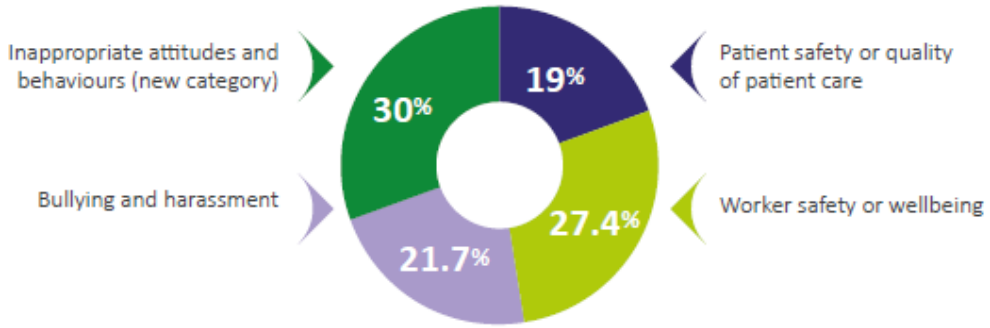
Speaking up to Freedom to Speak Up guardians

25,382 cases raised with Freedom to Speak Up guardians.

(1 April 2022 to 31 March 2023 / 25% increase on the previous year).



What are people speaking up about to guardians?



Anonymous cases[12]

9.3%

This continues the downward trajectory from 2019, when 17.7% of cases were raised anonymously.

Detriment

3.9%

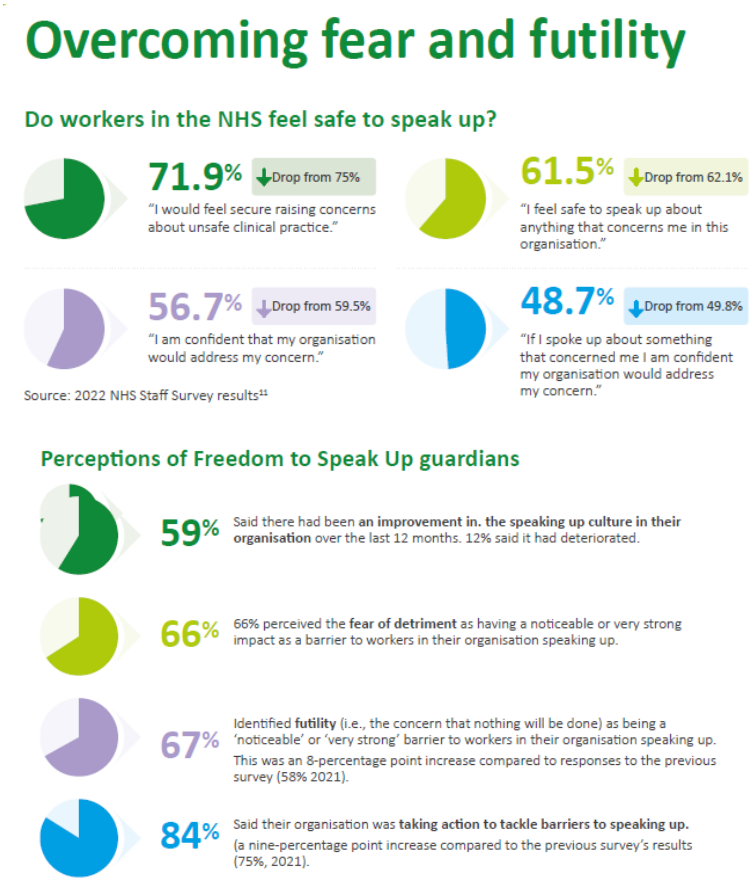
Detriment for speaking up[13] was indicated in 3.9% if cases.

Although there has been a drop in percentage given the rise in numbers, this equates to 1,000 cases.

Would you speak up again?

82.8%

Over four-fifths of those who gave feedback to their Freedom to Speak Up Guardian said they would speak up again.



2.2 The NGO's strategic framework sets out the intention of obtaining greater assurance about speaking up cultures and the quality and consistency of how the FTSUG role is implemented:

Workers: To champion and support workers to speak up by:

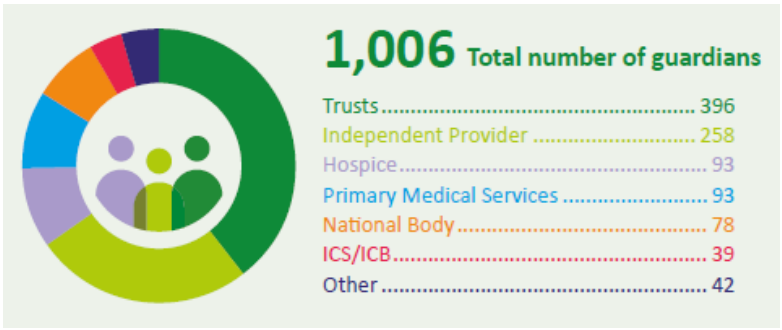
- Overcoming fear and futility.
- Supporting workers with knowledge of how to speak up.
- Raising awareness.
- Listening to workers.

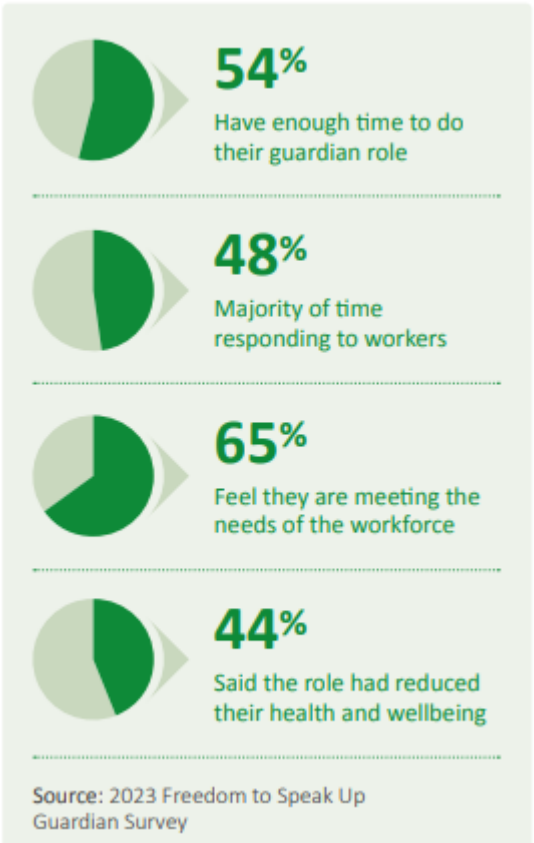
Leadership: To support and encourage leadership at all levels to foster a Speak Up, Listen Up and Follow Up Culture by:

- Offering supportive guidance and training tools.
- Having an increased focus on leadership through important reviews such as the Messenger review.
- Ensuring that how mangers and leaders listen and respond is included in appraisals and performance management frameworks.

Freedom to Speak Up Guardians: To enhance the FTSU Guardian role by:

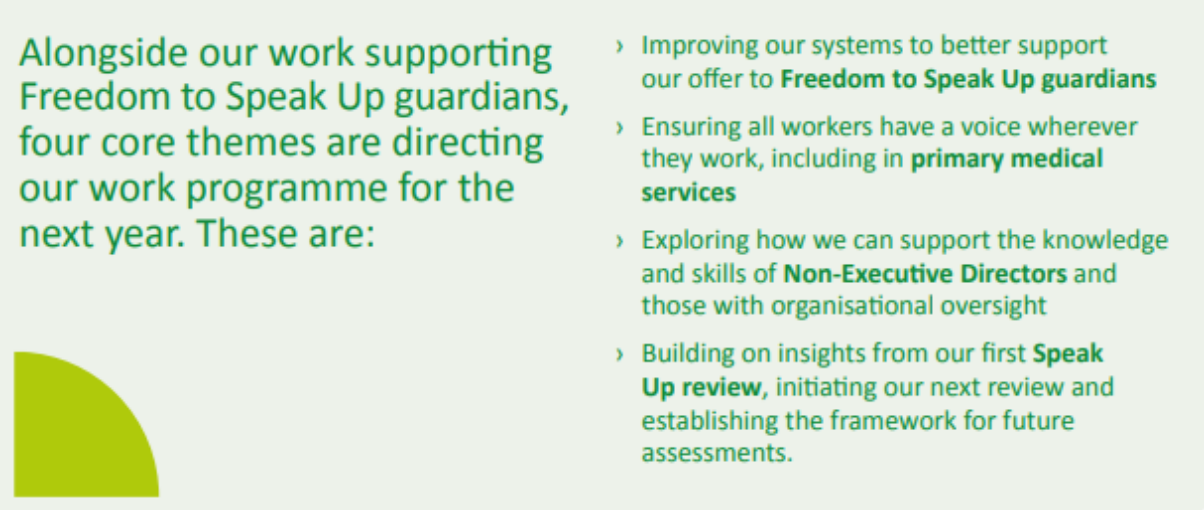
- Evolving the network
- Bringing Guardians together for networking and shared learning
- Gaining greater assurance of the quality and consistency of performance through enhanced training and registration process
- Supporting inclusivity working in partnership with the Workforce Race Equality Standards Team





Healthcare System: To support health system alignment and accountability by:

- Improving partnership working including the updated FTSU policy and Guidance for the NHS
- Increasing the depth of the well-led domain CQC inspections around the Speak Up culture
- Sharing and escalating concerns to members of the emerging concerns protocol
- Continuing work with the Speaking Up Partnership Group, which brings together regulators to ensure a consistent approach to listening up



3. LOCAL DATA FOR SFT

3.1 Concerns raised through the FTSU route are detailed in Table 1:

Table 1

Quarter	Number of concerns raised	Number of cases raised anonymously	Disadvantageous and / or demeaning treatment
Q1: 2023-24	53	11	1*
Q2: 2023-24	91	23	0

* "I feel that I have a 'black mark' above my name, communication with myself has been lacking, decisions have been made without any consultation or consideration from myself."

3.2 As of 15 February 2024, the FTSU Guardians are supporting 24 cases of speaking up.

Themes (for period 1st April 2023 – 30 September 2023)

- Leadership that lacks visibility, clear communication and support
- Behaviours that are not in line with Trust values
- Discrimination and lack of equity
- Work pressures and demands impacting on patient safety, colleague wellbeing and morale
- Post merger changes and consultations
- Challenging team cultures / dynamics

3.3 The tables below show the breakdown by quarter of the themes as well as the breakdown of staff groups reporting. This is data that has been mandated and submitted to the (NGO) in line with the reporting guidance Recording Cases and Reporting Data (nationalguardian.org.uk).

Table 2

	Number with an element of patient safety/ Quality*	Number of concerns with an element of worker safety or wellbeing*	Number with an element of bullying or Harassment*	Number with an element of inappropriate attitudes / behaviours*	Number of other concerns*
Q1 2023-24	**10**	**22**	**11**	**14**	**17**
Q2 2023-24	**16**	**35**	**16**	**29**	**47**

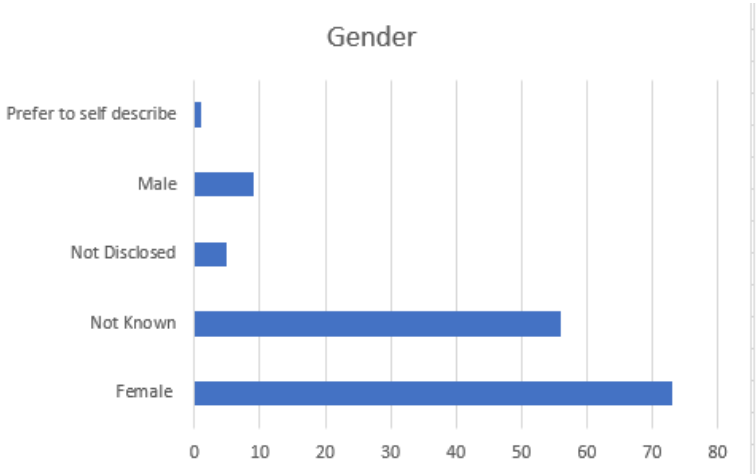
* Some concerns have elements that span multiple categories

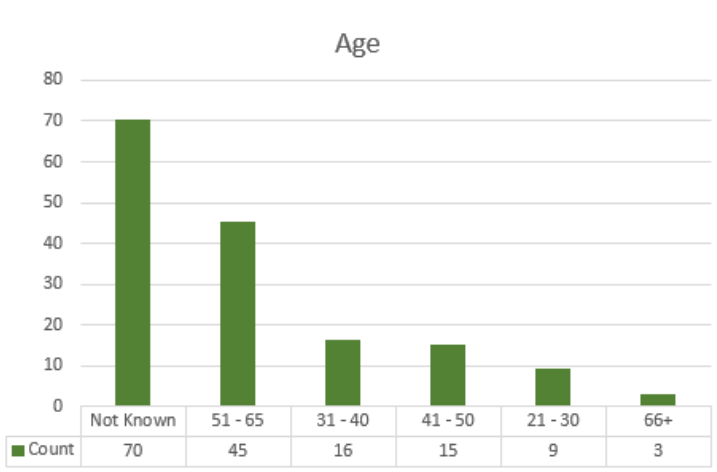
Table 3 Professional / Worker Group of colleagues speaking up:

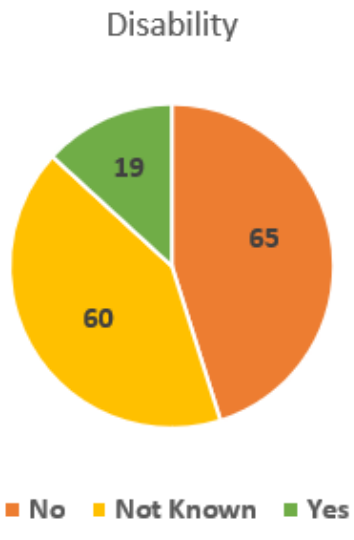
Professional / Worker Group	Q1: 2023-24	Q2: 2023-24	Totals
Additional clinical services	8	18	26
Additional professional scientific & technical	0	4	4
Admin and clerical	9	10	19
AHP's	6	7	13
Estates and ancillary	2	7	9
Healthcare scientists	1	1	2
Medical and dental	1	4	5
Nursing and midwifery - registered	18	16	34

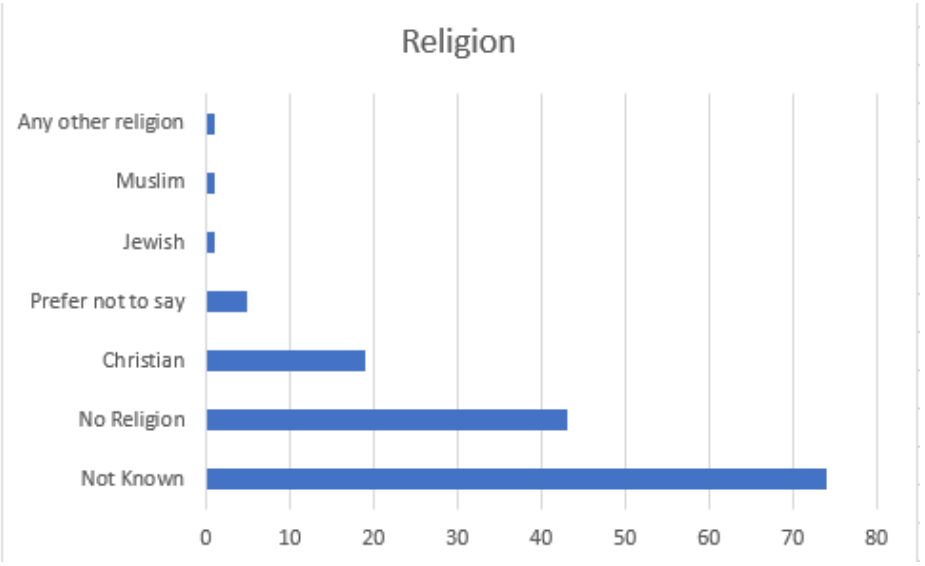
Professional / Worker Group	Q1: 2023-24	Q2: 2023-24	Totals
Students	0	0	0
Other	0	0	0
Not Known	8	24	32
Totals	**53**	**91**	**144**

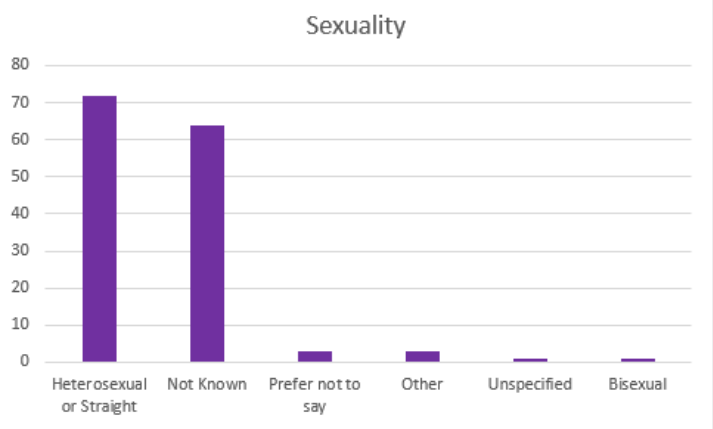
3.4 Demographic information for colleagues who raised concerns in Q1 and Q2 is as follows:

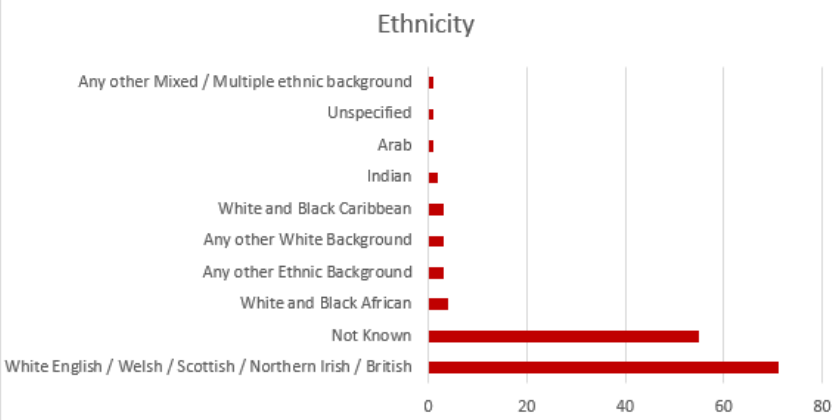












Some examples of speaking up in this period include:

- Several colleagues raised concerns regarding suspicion of fraud and how their concern had been handled when raised with their line manager. This was escalated to the counter fraud team and also the service director for action. A formal process followed.

- Multiple concerns were raised regarding the senior leadership within a service, colleagues feeling 'silenced' and also working conditions that were impacting on colleague wellbeing and potentially on patient safety. This was escalated to executive level – a listening event was held, a change in leadership implemented and review of processes and procedures to ensure safety for patients and colleagues.

- A colleague approached FTSU following a breakdown in relationship with their manager. They were encouraged to have a Respectful Resolution conversation which they did following some coaching. This colleague has now gone on to be a wellbeing champion within their team.

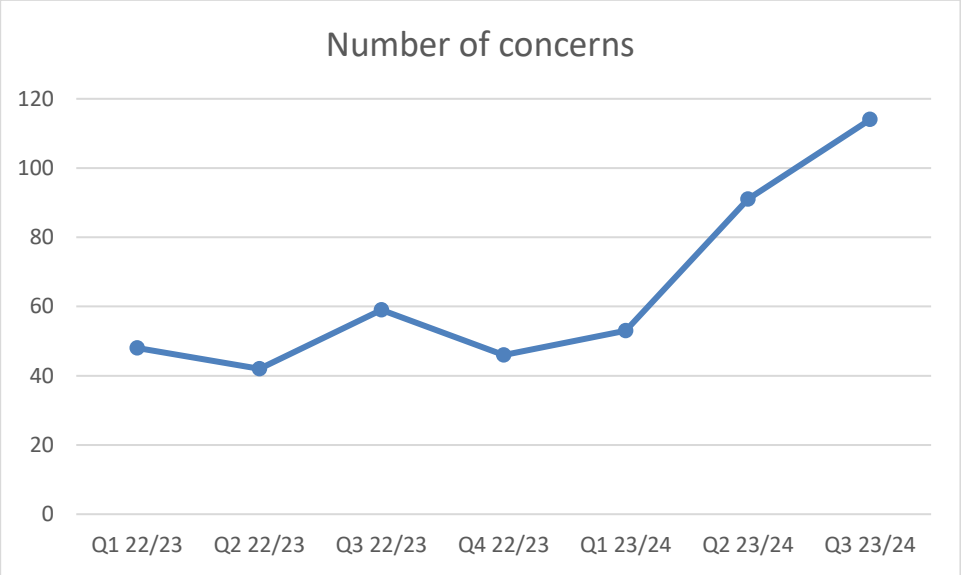
- A concern about sexual safety was raised. This was escalated initially to the executive team, the service group triumvirate and People services. Support was prioritised for the individual and a formal investigation resulted. This case is helping inform the implementation of the Sexual Safety Charter.

3.5 In line with service monitoring and standards, an audit of response times from point of first contact has been undertaken. The target is to respond to all concerns within three working days.

Quarter	Working Days taken to respond				
	0	1	2	3	3+
1 (53 concerns)	51 (96%)	2 (4%)	0	0	0
2 (91 concerns)	85 (93%)	4 (5%)	1 (1%)	1 (1%)	0

3.6 Local data for Q1- Q2 2023/24 has shown:

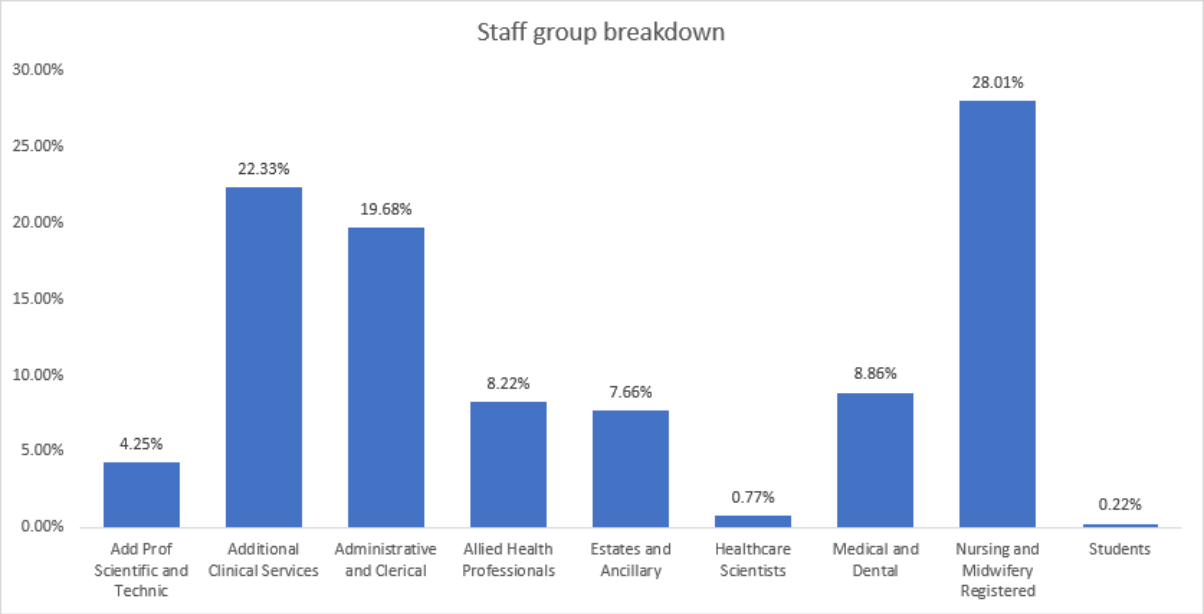
- 35% increase in total reported cases from Q3 – Q4 (2022-23) and a 60% increased from Q1-Q2 (2022-23)



- 18% of cases raised this period contained an element of patient safety / quality compared to a combined total of 15% in Q3 - Q4.
- 19% of cases raised this period contained and element of bullying and harassment compared to a combined total of 31% in Q3 – Q4.
- 30% of cases raised in this period contained an element of inappropriate attitudes and behaviours compared to a combined total of 21% in Q3 – Q4.
- Combining concerns with an element of bullying and harassment with those containing an element of inappropriate attitudes and behaviours gives a total of 49% in this reporting period.
- 40% of concerns contained an element of worker safety or wellbeing compared to a combined total of 14% Q3-Q4.
- 24% of cases were raised anonymously compared to a combined total of 20% in Q3 – Q4.

- Disadvantageous and / or demeaning treatment as a result of speaking up is less than 1% (0.7%), a drop from 1.2% in Q3 – Q4.

- 24% of concerns raised came from Nursing and Midwifery colleagues, 18% from Additional Clinical Services, 13% from Admin and Clerical colleagues but 22% of concerns were raised by colleagues of unknown professional group. The staff group breakdown as of December 2023 for comparison is outlined below and this suggests that reporting is in line with the workforce distribution:



- Over 94% of those who gave feedback said they would speak up again. This is a very slight reduction from Q3- Q4 which was 95%.

4. ACTIONS AND RECOMMENDATIONS

4.1 Our progress to raise awareness of FTSU and create a positive speaking up culture continues across the whole organisation. As shown below, we have 94.9 % compliance with the 'Speaking Up' module of mandatory training for substantive colleagues following the launch in August 2021. Bank colleagues is significantly lower at 57.9% but is an improvement of 11.8% compared to that reported in September 2023. The mapping for bank colleagues is inaccurate and the data cleanse continues with payroll to resolve this. This training will have a 3 yearly compliance cycle mandated from April 2024.

Service Group	Number to be Trained	Certified	Percentage Trained Q3 Oct-Dec 2023	Percentage Trained Q2 Jul-Sep 2023	Increased/ Decreased from last report	Expired/ Training Required
Clinical Support and Cancer Services	1455	1397	96.0%	94.4%	1.6%	58
Corporate Support Services	1578	1524	96.6%	95.3%	1.3%	54
Current Assets	5	4	80.0%			1
CYP & Families Services	1273	1208	94.9%	94.2%	0.7%	65
East Revenue	1	1	100.0%	100.0%	0.0%	
Medical Services	1817	1656	91.1%	91.3%	-0.2%	161
Mental Health and Learning Disabilities	1175	1132	96.3%	96.0%	0.3%	43
Neighbourhood Services	2223	2149	96.7%	96.1%	0.6%	74
Operational Management	125	117	93.6%	88.1%	5.5%	8
Simply Serve	294	282	95.9%	95.0%	0.9%	12
Surgical Services	2564	2404	93.8%	93.8%	0.0%	160
Freedom to Speak Up for Quarter 3 October - December 2023 by Directorate (Excludes Bank and New Starters)	**12510**	**11874**	**94.9%**	**94.2%**	**0.7%**	**636**
Freedom to Speak Up for Quarter 3 October - December 2023 by Directorate BANK STAFF (Excludes New Starters) ONLY	**2077**	**1202**	**57.9%**	**50.8%**	**7.1%**	**875**
Freedom to Speak Up for Q2 July - September 2023 by Directorate ALL STAFF (Substantive, Bank and New Starters)	**15283**	**13565**	**88.8%**	**86.0%**	**2.8%**	**1718**

Data from 8th January 2024

4.2 The 'Follow Up' module for colleagues at band 8a and above was launched in May 2023 and compliance for former SFT colleagues as of 08th January 2024 is as follows:

Service Group	Number to be Trained	Certified	Percentage Trained Q3 Oct-Dec 2023	Percentage Trained Q2 Jul-Sep-23	Increased/ Decreased from last report	Expired/ Training Required
Neighbourhood Services	82	64	78.0%	64.0%	14.0%	18
Corporate Support Services	176	128	72.7%	68.2%	4.5%	48
Clinical Support and Cancer Services	162	111	68.5%	53.5%	15.0%	51
CYP & Families Services	115	75	65.2%	54.5%	10.7%	40
Medical Services	86	55	64.0%	50.0%	14.0%	31
Mental Health and Learning Disabilities	100	62	62.0%	46.9%	15.1%	38
Surgical Services	194	110	56.7%	41.1%	15.6%	84
Operational Management	14	7	50.0%	28.6%	21.4%	7
Freedom to Speak Up Follow Up Module for for Q3 October - December 2023 by Directorate (Excludes Bank and New Starters)	**929**	**612**	**65.9%**	**52.9%**	**13.0%**	**317**
Freedom to Speak Up for Follow Up Module for Q3 October - December 2023 by Directorate BANK STAFF ONLY (Excluded New Starters)	**55**	**6**	**10.9%**	**5.5%**	**5.4%**	**49**
Freedom to Speak Up Follow Up Module for Q3 October - December 2023 by Directorate ALL STAFF (Substantive, Bank and New Starters)	**1012**	**628**	**62.1%**	**49.9%**	**12.2%**	**384**

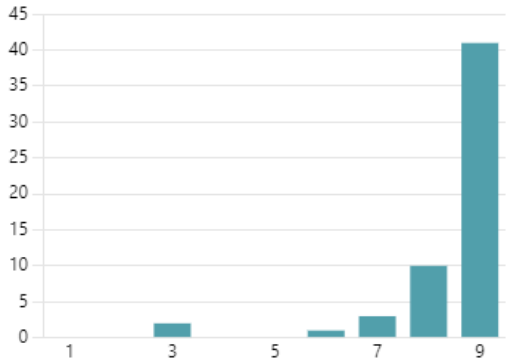
4.3 This is an increase of 42.7% for substantive colleagues compared to that reported in September 2023. Former YDH colleagues have been mapped to this requirement from 15 January 2024.

4.4 Colleague satisfaction with the FTSU service from the start of Q1 2023/24 is currently 8.46 out of 9. This is a slight decrease from 8.71 reported previously:

5. How satisfied are you with the Freedom To Speak Up Process? (1 = totally disagree to 9 = totally agree)

More Details Insights

8.46
Average Rating



*the rating is only available from Q3 2021-22 due to a change in feedback provider

4.5 The service collates feedback from service users and some of the feedback received is detailed below:

- I found the response from the FTSUG calm, capable and proactive. I was very frustrated with a situation I could not resolve and felt no one I went to was either interested or wanted to help until I reached out to the FTSUG.
- The experience I had with you was really good, the kind of support you gave me was great and it made me feel lot better psychologically and in all ramifications.
- Caroline was very attentive and I felt listened to. She gave me good advice on how to follow up my issues.
- Quickly available, supportive, regular check in's.
- I raised a concern with the FTSG Team and I received an immediate response within the day and a call to discuss the concerns. Very helpful, supportive and practical options discussed to improve the situation for my colleagues.
- I received a quick reply and equally quick action to the problem
- It was brilliant.
- Very professional and confidential.

- Caroline was very sensitive and supportive, immediately understanding the several layers to my concerns. I was not made to feel guilty or blamed for any of the things that made me worried to speak up before.

- Prompt. Calming, reassuring and took immediate action alongside me. I felt supported.

- Easy to arrange, staff felt easy to speak to and took the concerns seriously. The anonymity provided reassurance.

- I started off with no trust but Caroline instantly gained my trust she gave me the reassurance I needed to know I would be safe if I spoke up and supported me

- Caroline was very friendly and took my complaints seriously and made sure the complaints was dealt with. I felt confident and not afraid to speak up.

4.6 The team are continuing to build on the progress achieved to date supporting the creation of a culture where every colleague, irrespective of role, feels safe to speak up. This proactive work has slowed slighted due to service capacity but includes:

- Increasing visibility in both acute hospitals and throughout the community sites through day to day working, planned 'drop-in' sessions and walkarounds with a focus on bank colleagues.

- Continuing to work collaboratively across the organisation and in particularly within the newly formed Experience and Learning portfolio to:
  - ✓ offer timely, bespoke, integrated support for individuals, teams and the organisation that can be tailored according to need and intensity.
  - ✓ Triangulate and review data / intelligence with actions planned, instigated, and evaluated. This coordinated approach reduces duplication and improves communication.
  - ✓ Identify areas of good practice that can be shared, extended and replicated across the organisation.

- Alongside the wellbeing lead, supporting the wellbeing champion model across the organisation by providing training and support sessions to extend the reach and diversity of the FTSU service. Further work will be undertaken later this year to ensure compliance with new guidance released by NGO. Freedom to Speak Up Champions and Ambassadors (nationalguardian.org.uk)

- Continuing to work with the procurement and governance team regarding the implementation of a reporting system for the merged organisation which aims to be in place by mid 2024

- Refreshing and updating the FTSU face to face training sessions and extending this to colleagues completing the ‘Theatre Induction Programme’ as well as continued support to the ‘Prepare to Care’, Safety Day and Doctor Induction programmes.

- Supporting teams with departmental / ward training and development either post incident or proactively.

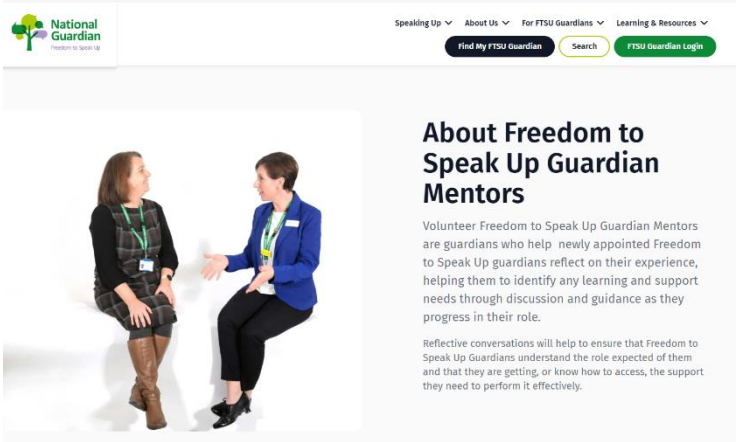
- Completing ‘walkarounds’ with the temporary staffing team to address the barriers bank / agency colleagues have to speaking up. Lessons learnt have been shared across the organisation.

- Continuation of monthly meetings with the CEO and Executive lead for FTSU to discuss themes, areas of concern and develop a plan for support and assurance.

- Working in union with Network chairs and Inclusion team to raise the profile of FTSU, address barriers to speaking up and also ensure effective resolution to concerns raised through the networks.

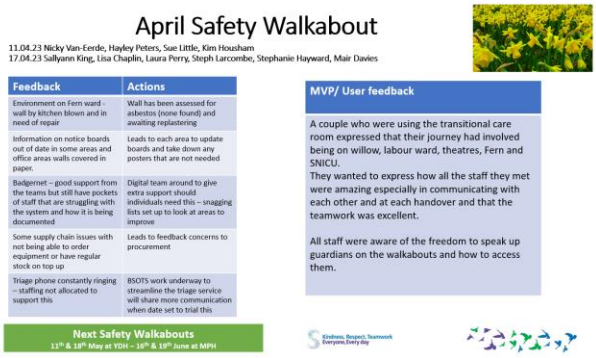
- Attending the Safety Action Group to allow triangulation of safety specific data and themes.

- The lead guardian has been mentoring new guardians from around the country and this in turn has resulted in reflection and independent challenge to our own service.



- Updates to the FTSU mandatory training videos and promotional materials

- Supporting the Maternity Safety Walkabouts as /when capacity allows



April Safety Walkabout

11.04.23 Nicky Van-Eerde, Hayley Peters, Sue Little, Kim Housham
17.04.23 Sallyann King, Lisa Chaplin, Laura Perry, Steph Larcombe, Stephanie Hayward, Mair Davies

Feedback	Actions
Environment on Fern ward - wall by kitchen blown and in need of repair	Wall has been assessed for asbestos (none found) and awaiting replastering
Information on notice boards out of date in some areas and office areas walls covered in paper.	Leads to each area to update boards and take down any posters that are not needed
Badgernet – good support from the teams but still have pockets of staff that are struggling with the system and how it is being documented	Digital team around to give extra support should individuals need this – snagging lists set up to look at areas to improve
Some supply chain issues with not being able to order equipment or have regular stock on top up	Leads to feedback concerns to procurement
Triage phone constantly ringing – staffing not allocated to support this	BSOTS work underway to streamline the triage service will share more communication when date set to trial this

Next Safety Walkabouts
11th & 18th May at YDH – 14th & 18th June at MPH

MVP/ User feedback

A couple who were using the transitional care room expressed that their journey had involved being on willow, labour ward, theatres, Fern and SNICU.
They wanted to express how all the staff they met were amazing especially in communicating with each other and at each handover and that the teamwork was excellent.

All staff were aware of the freedom to speak up guardians on the walkabouts and how to access them.

Kindness, Respect, Teamwork
Everyone, Every day

- Supporting the Chief Nurse call following the media release of the Lucy Letby case.

- Focusing on 2 key barriers to speaking up: fear and futility during Speak Up Month and Black History Month

- Continue to listening to the silence; It is essential that these missing voices are identified and sought out, as they too can contribute to learning and improvement for the benefit of patients and colleagues.

- Completed the Reflection and Planning tool alongside the Exec and Non-exec lead for FTSU. This will be further discussed with the Board in April 24. B1245_iii_Freedom-To-Speak-Up-A-reflection-and-planning-tool_060422.docx-RC_RW_Final_Arial12.docx (live.com)
B1245_ii_NHS-FTSU-Guide-eBook.pdf (nationalguardian.org.uk)

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Finance Report
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Mark Hocking, Deputy Chief Finance Officer
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	5 March 2024

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
☒ For Assurance	☐ For Approval / Decision	☒ For Information

Executive Summary and Reason for presentation to Committee/Board	The Finance report sets out the overall income and expenditure position for the Trust. It includes commentary on the key issues, risks, and variances, which are affecting the financial position.
Recommendation	The Board is requested to discuss the report**.**

Links to Joint Strategic Objectives
(Please select any which are impacted on / relevant to this paper)

- ☐ Obj 1 Improve health and wellbeing of population
- ☐ Obj 2 Provide the best care and support to children and adults
- ☐ Obj 3 Strengthen care and support in local communities
- ☐ Obj 4 Reduce inequalities
- ☐ Obj 5 Respond well to complex needs
- ☐ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
- ☒ Obj 7 Live within our means and use our resources wisely
- ☐ Obj 8 Develop a high performing organisation delivering the vision of the Trust

Implications/Requirements (Please select any which are relevant to this paper)					
☒ Financial	☐ Legislation	☐ Workforce	☐ Estates	☐ ICT	☐ Patient Safety/ Quality
Details:					

Equality and Inclusion

The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.

This report has been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics.

All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
n/a

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
Monthly report

Reference to CQC domains (Please select any which are relevant to this paper)				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	☐ No

SOMERSET NHS FOUNDATION TRUST

FINANCE REPORT

1. SUMMARY

1.1 In January 2024, the Trust recorded a deficit of £0.696m, this was £1.790m adverse compared with the plan for the month. Cumulatively, the Trust is £5.758m in deficit, this is £2.325m adverse when compared with the planned position for the period.

1.2 The in-month adverse variance has been driven by the impact of December and January's industrial action which was not funded. The financial impact is twofold:

i) The costs of backfilling medical staff on strike days was £0.740m.

ii) The impact of elective activity stood down on strike days meant a reduction in income of £0.870m.

1.3 Excluding industrial action, performance in January and a forward look based on run rate indicates we are consistent with the H2 plan trajectory. Agency cost increased in January; however detailed forecast suggests this level of cost is expected to decline inline within our planning assumptions.

2. INCOME AND EXPENDITURE

2.1 Table 1 below sets out the summary income and expenditure account to 31 January 2024:

Table 1: Income and Expenditure Summary January

Statement of Comprehensive Income	Annual Plan	Current Month 10			Year to date		
	£000	Plan £000	Actual £000	Fav./ (Adv.) Variance £000	Plan £000	Actual £000	Fav./ (Adv.) Variance £000
Income							
Patient Care Income	928,490	77,616	88,412	10,796	773,763	804,183	30,421
Other Operating Income	54,102	4,648	4,613	(35)	44,698	56,370	11,673
Total operating income	**982,592**	**82,265**	**93,026**	**10,761**	**818,460**	**860,554**	**42,094**
Operating expenses							
Employee Operating Expenses	(674,225)	(55,947)	(62,720)	(6,773)	(562,792)	(584,192)	(21,400)
Drugs Cost: Consumed/Purchased	(71,060)	(5,990)	(6,874)	(884)	(59,644)	(62,884)	(3,240)
Clinical Supp & Serv Exc-Drugs	(45,272)	(3,223)	(5,722)	(2,499)	(39,294)	(67,369)	(28,075)
Supplies & Services - General	(27,780)	(2,315)	(2,979)	(664)	(23,150)	(29,054)	(5,904)
Other Operating Expenses	(151,017)	(12,601)	(14,802)	(2,202)	(125,977)	(114,616)	11,361
Total operating expenses	**(969,354)**	**(80,076)**	**(93,097)**	**(13,022)**	**(810,857)**	**(858,116)**	**(47,259)**
Operating Surplus/Deficit	13,238	2,189	(72)	(2,261)	7,603	2,438	(5,165)
Finance Expense	(12,651)	(1,054)	(1,096)	(42)	(10,542)	(9,715)	827
Finance Income	613	51	520	469	510	3,898	3,388
Other	0	8	0	(8)	(5)	0	5
Overall Surplus/(Deficit)	1,200	1,194	(648)	(1,842)	(2,434)	(3,379)	(945)
Depr On Donated Assets	1,386	115	90	(26)	1,155	952	(203)
Donated Assets Income	(2,591)	(216)	(138)	77	(2,159)	(3,338)	(1,180)
Amortisation	9	1	1	(0)	8	7	(0)
Impairments (Reversals)	0	0	0	0	0	0	0
Other	(4)	(0)	0	0	(3)	0	3
Adjustments to control total	(1,200)	(100)	(48)	52	(1,000)	(2,379)	(1,379)
Adjusted Financial Performance	(0)	1,094	(696)	(1,790)	(3,433)	(5,758)	(2,325)

2.2 Agency expenditure was £0.126m higher than December at £3.127m in January. In month, this was £1.023m over the plan and £0.272m above the ceiling. At the end of January, the Trust is c£5.8m above the cap.

2.3 February's industrial action (5 days) is expected to cost c£1.1m (total costs of backfill and lost elective income). Funding surrounding the cost of backfill has been agreed and it is expected this will be recognised in February. The loss of income has yet to be confirmed in terms of a funding mechanism.

3. COST IMPROVEMENT PROGRAMME

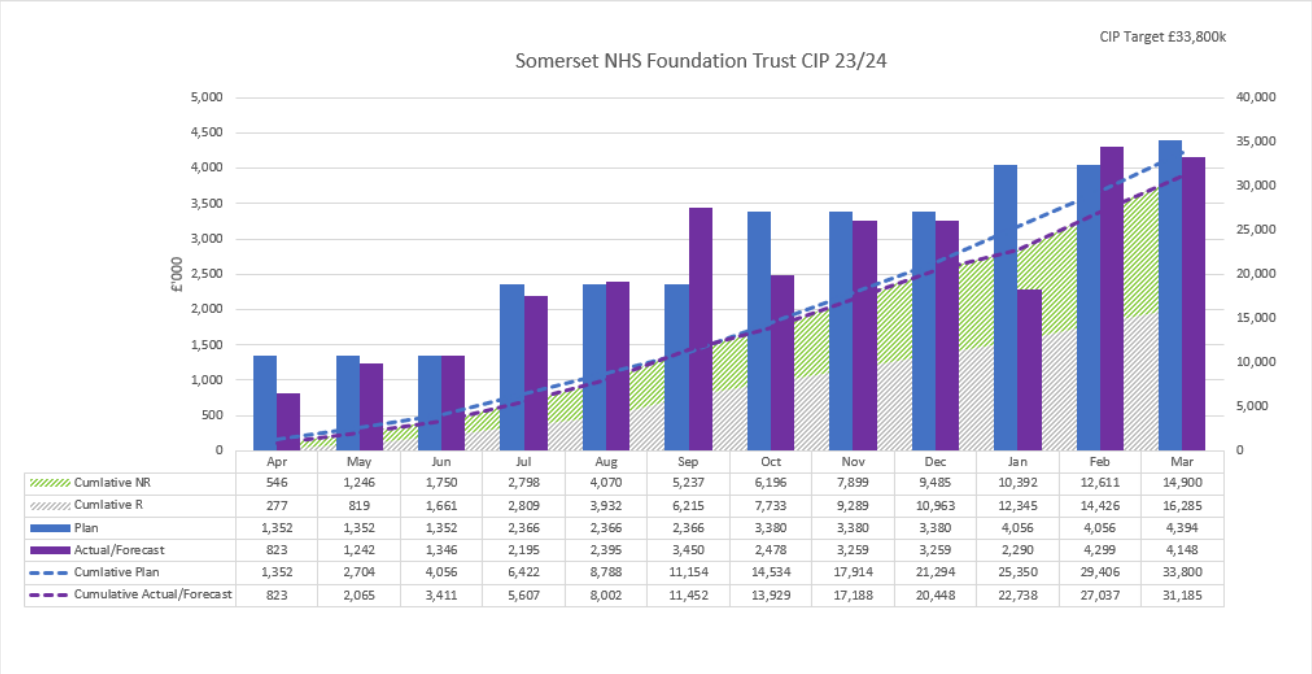
3.1 In January, savings of £2.290m were delivered which was an under-performance of £1.766m against the plan. Recurrent savings were £1.382m (60%).

3.2 Cumulatively, savings of £22.738m have been delivered compared with the planned delivery of £25.350m at the end of January, an under delivery of £2.612m. Of the savings delivered so far, 54% (£12.345m) are recurrent.

3.3 The level of savings already achieved represents a significant amount of work and services continue to explore further opportunities to close gaps in their plans, but it is acknowledged the significant additional pressure of winter will interrupt these efforts. The primary focus is on developing plans for 2024/25 through the Productive Care Programme.

3.4 Further analysis is shown in the chart below:

Chart 1: CIP Plan 23/24

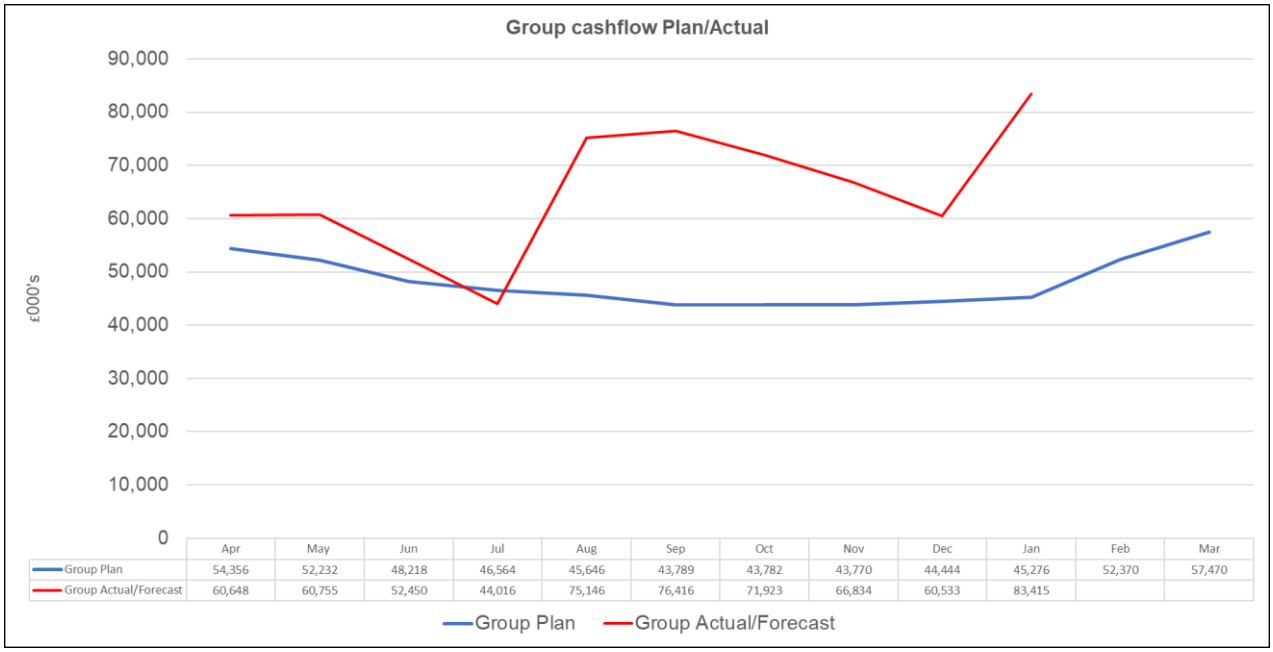


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumlative NR	546	1,246	1,750	2,798	4,070	5,237	6,196	7,899	9,485	10,392	12,611	14,900
Cumlative R	277	819	1,661	2,809	3,932	6,215	7,733	9,289	10,963	12,345	14,426	16,285
Plan	1,352	1,352	1,352	2,366	2,366	2,366	3,380	3,380	3,380	4,056	4,056	4,394
Actual/Forecast	823	1,242	1,346	2,195	2,395	3,450	2,478	3,259	3,259	2,290	4,299	4,148
Cumlative Plan	1,352	2,704	4,056	6,422	8,788	11,154	14,534	17,914	21,294	25,350	29,406	33,800
Cumulative Actual/Forecast	823	2,065	3,411	5,607	8,002	11,452	13,929	17,188	20,448	22,738	27,037	31,185

4. CASH

4.1 Cash balances as at 31 January were £83.4m, £38.1m higher than plan; primarily driven by Somerset Council paying their annual invoice in advance, receivable balances and capital programme lower than plan. The actual/plan forecast cash flow for the year is shown in Chart 2 below:

Chart 2: Cash flow Actual/Plan



5. CAPITAL

5.1 Year to date, capital expenditure is £53.7m compared with the plan of £60.2m, resulting in an underspend of £6.5m. Further details at programme level are shown in Table 2 below:

Table 2: Capital Programme monitoring

Acute Programme MPH	Plan £000	Revised Budget £000	YTD Plan £000	YTD Actual £000	Variance Act v plan YTD £000	Forecast Outturn £000
Total MPH Site Risks / Plant & Equipment	3,980	4,034	2,827	1,760	(1,067)	4,357
Total MPH Site and Service Development	2,048	2,208	1,773	280	- 1,493	1,881
Acute Programme YDH	**Plan £000**	**Revised Budget £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**	**Forecast Outturn £000**
Total YDH Main Site Budgets	3,800	4,544	2,756	2,776	21	5,822
Total - YDH Site and Service Development	6,091	4,601	1,189	1,176	(14)	3,907
Total - YDH Site Risks / Plant and equipment Replacement	370	406	310	427	117	724
Total Acute	**16,289**	**15,793**	**8,855**	**6,419**	**(2,436)**	**16,691**
Community/Mental Health Programme	**Plan £000**	**Revised Budget £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**	**Forecast Outturn £000**
Total Community / Mental Health Site and Service Development	6,620	5,619	5,439	3,520	- 1,918	4,322
Total Community / Mental Health - Site Risks / Plant & Equipment	835	1,118	560	875	315	981
Total Community/Mental Health	**7,455**	**6,737**	**5,999**	**4,396**	**(1,603)**	**5,303**
Trustwide	**Plan £000**	**Revised Budget £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**	**Forecast Outturn £000**
Trustwide	**9,315**	**8,955**	**7,356**	**5,447**	**(1,909)**	**9,491**
Total Internal Capital Envelope	**33,059**	**31,485**	**22,210**	**16,261**	**(5,948)**	**31,485**
Additional Capital Schemes	**Plan £000**	**Revised Budget £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**	**Forecast Outturn £000**
Total Additional Schemes	**47,821**	**47,465**	**37,480**	**29,530**	**(7,950)**	**46,925**
IFRS Leases	3,535	3,781	524	7,944	7,420	8,230
TOTAL TRUST PROGRAMME	**84,415**	**82,731**	**60,214**	**53,736**	**(6,478)**	**86,640**

5.2 Monthly monitoring is undertaken by the Capital Delivery Group to ensure schemes remain on track and where there is slippage this is identified quickly to enable corrective action to be taken or alternative schemes accelerated. The Finance Committee receive a regular capital monitoring update at their meetings.

5.3 STATEMENT OF FINANCIAL POSITION (BALANCE SHEET)

Dec-23	Jan-24	Movement		Mar-23	Jan-24	Movement in Year
£000	£000	£'000		£000	£000	£000
21,806	31,315	9,509	Intangible Assets	25,142	31,315	6,173
376,676	371,509	(5,167)	Property, plant and equipment, other	356,521	371,509	14,988
27,632	28,746	1,114	On SoFP PFI assets	24,654	28,746	4,092
87,358	82,163	(5,195)	Right of use assets	82,143	82,163	20
698	1,381	684	Investments	296	1,381	1,085
14	14	0	Other investments/financial assets	14	14	0
3,415	3,422	7	Trade & other receivables >1yr	3,113	3,422	309
517,598	**518,550**	**952**	**Non-current assets**	**491,883**	**518,550**	**26,667**
12,324	12,184	(140)	Inventories	10,833	12,184	1,351
31,918	22,027	(9,891)	Trade and other receivables: NHS receivables	39,244	22,027	(17,217)
24,451	19,359	(5,092)	Trade and other receivables: non-NHS receivables	22,158	19,359	(2,799)
466	466	0	Non current assets held for sale	0	466	466
60,533	83,415	22,882	Cash	64,388	83,415	19,027
129,692	**137,450**	**7,759**	**Total current assets**	**136,623**	**137,450**	**827**
(92,729)	(105,049)	(12,320)	Trade and other payables: non-capital	(124,670)	(105,049)	19,621
(8,006)	(10,605)	(2,599)	Trade and other payables: capital	(10,942)	(10,605)	337
(38,193)	(35,890)	2,303	Deferred income	(8,524)	(35,890)	(27,366)
(12,439)	(12,778)	(340)	Borrowings	(6,210)	(12,778)	(6,568)
(4,592)	(5,606)	(1,014)	Provisions <1yr	(4,893)	(5,606)	(713)
(155,958)	**(169,929)**	**(13,970)**	**Current liabilities**	**(155,239)**	**(169,929)**	**(14,690)**
(26,267)	**(32,478)**	**(6,212)**	**Net current assets**	**(18,616)**	**(32,478)**	**(13,862)**
(102,463)	(97,119)	5,346	Borrowings >1yr	(103,041)	(97,119)	5,922
(3,931)	(4,354)	(423)	Provisions >1yr	(4,034)	(4,354)	(320)
(1,747)	(1,725)	22	Deferred income >1yr	(1,941)	(1,725)	216
(108,142)	**(103,198)**	**4,944**	**Total long-term liabilities**	**(109,016)**	**(103,198)**	**5,818**
383,190	**382,874**	**(316)**	**Net assets employed**	**364,251**	**382,874**	**18,623**
			Financed by:			
342,311	342,647	337	Public dividend capital	322,064	342,647	20,583
70,036	70,488	452	Revaluation reserve	76,094	70,488	(5,606)
(2,471)	(2,471)	0	Other reserves	(2,472)	(2,471)	1
(26,685)	(27,790)	(1,105)	I&E reserve	(31,435)	(27,790)	3,645
383,190	**382,874**	**(316)**	**Total financed**	**364,251**	**382,874**	**18,623**

6. CONCLUSION AND RECOMMENDATION

6.1 The recent H2 planning process enabled the system to agree a robust financial plan for the remainder of 2023/24 that will achieve a balanced position for all organisations if the assumptions prove to be sound. The industrial action in December through to February will create an unplanned pressure of £4.3m. Backfill cost in relation to pay is expected to be transacted in February, totalling £2.3m. The loss of income impact has yet to be finalised by NHSE. The outcome of this is especially important as the Trust is reliant on additional capital of £1.5m in 2024/25 as a benefit of delivering the agreed plan.

6.2 Agency expenditure remains under constant review and scrutiny as we work with services to seek ongoing assurance that their controls and review mechanisms are well embedded and work effectively. There was slight increase in run rate in January compared to December, however it is expected this will reduce towards the year end due to the continual focus around international recruitment and expected arrival of previously appointment staff across a variety of staffing groups. We are expecting a further reduction in our cap for 2024/25 so we will need to do more to continue to reduce our temporary staffing expenditure.

6.3 Through our governance and performance management processes we will continue to exercise robust oversight of our financial performance including the delivery of our activity plans. Monthly meetings remain in place for all service groups and corporate functions to ensure we maintain strong levels of grip and control and identify emerging risks at the earliest opportunity.

6.4 The Board are asked to note the financial performance for January.

CHIEF FINANCE OFFICER

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	2024/25 Capital Programme
SPONSORING EXEC:	David Shannon, Director of Strategy and Digital Development
REPORT BY:	Ian Boswall, Director of Redevelopment Neil Murray, Strategic Accountant
PRESENTED BY:	David Shannon, Director of Strategy and Digital Development
DATE:	6 March 2024

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
☐ For Assurance	■ For Approval / Decision	☐ For Information

Executive Summary and Reason for presentation to Committee/Board	The report sets out the Capital Plan for 2024/25 for approval.
Recommendation	To review and approve the capital programme for the 2024/25 financial year.

Links to Joint Strategic Objectives
(Please select any which are impacted on / relevant to this paper)

☒ Obj 1 Improve health and wellbeing of population

☒ Obj 2 Provide the best care and support to children and adults

☒ Obj 3 Strengthen care and support in local communities

☒ Obj 4 Reduce inequalities

☒ Obj 5 Respond well to complex needs

☒ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture

☒ Obj 7 Live within our means and use our resources wisely

☒ Obj 8 Develop a high performing organisation delivering the vision of the Trust

Implications/Requirements (Please select any which are relevant to this paper)					
☒ Financial	☐ Legislation	☐ Workforce	☒ Estates	☐ ICT	☐ Patient Safety/ Quality
Details: N/A					

Equality and Inclusion The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
This report has not been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics

Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Public Engagement events for a number of the major projects including Rowan Ward and Surgical Centre. Further public and staff engagement planned for New Hospital Programme. Public engagement exercise undertaken in August 2023 in Yeovil Diagnostic Centre.

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
Monthly finance reports to Trust Board. Quarterly progress updates to Finance Committee and Financial Resilience and Commercial Committee.

Reference to CQC domains (Please select any which are relevant to this paper)				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	☐ No

SOMERSET NHS FOUNDATION TRUST

2024/25 CAPITAL PROGRAMME

1. INTRODUCTION

This report sets out the capital programme for the 2024/25 financial year and identifies the challenges and risks through the delivery of the programme.

2. 2024/25 Capital Programme

2.1 A capital programme is attached at appendix A. The capital envelope for Somerset Integrated Care System is set by NHS England (NHSE) and currently stands at £31.267m.

2.2 The capital envelope of £31.267m includes a £1.538m additional allocation for achieving the system revenue plan for the 2023/24 financial year.

2.3 There are also further sources of funding from PDC funded Capital schemes of £45.616m, Charitable Donations of £1.160m, PFI funding of £0.757m and IFRS 16 CDEL allocated envelope of £20.147m. Details are included in Appendix A

The table below identifies the key areas of investment.

Scheme	Value
	£'m
Surgical Centre	26.006
Yeovil 5th Theatre and Modular Ward	5.262
Stroke Services Reconfiguration	1.000
Mental Health and Community Schemes	2.000
Digital and IT replacement	8.365
Electronic Heathe Record (external Funding)	11.427
Backlog maintenance and equipment replacement	15.480
Electrical Infrastructure	2.550
New Hospital Programme	2.791
Diagnostic equipment	1.332
Other smaller schemes (including Donated Assets)	4.470
Leases renewals and additions including Yeovil Diagnostic Centre	20.147
Total	100.830

2.4 The programme has been set with an overcommitment (detailed in Appendix A) of £2.890m (9.2% of allocated internal CDEL envelope). This is within budget setting guidance issued by NHSE and follows the System practice of previous years in slightly oversetting budgets in anticipation of

2.5 The delay in expenditure of the electronic health record project during 24/25 has allowed the infrastructure budgets to be maintained for the year and in line with previous levels of investment.

2.6 The impact of these changes in funding and commitments has reduced the level of risk from schemes that could not be supported. There are several risks which still remain.

- There is a small contingency included in the programme, but should there be significant infrastructure failure this will require further reprioritisation of planned schemes.

- Capacity in the construction industry continues to drive inflationary pressures and challenge the timescales for delivery.

- Operational pressures: a number of programmes will require access to clinical areas to undertake essential maintenance and upgrades. Should the current high level of occupancy and clinical pressures continue this will impact on the ability to deliver the overall programme.

2.7 The position for 2025/26 and 2026/27 are still in draft. The 5 year plan will be updated after the updated EHR business case is further clarified in the coming weeks.

3. RECOMMENDATIONS

3.1 The Trust Board is asked to approve the capital programme for 2024/25.

Appendix A	
Somerset Capital Plan - Sources of Funding	**£'m**
Somerset Permitted Capital Envelope Funding	29.729
Additional Allocation to Somerset ICB system for achieving Breakeven Position in 2023/24	1.538
Further Capital Funding Sources NHS – specific PDC allocation	45.616
Further Capital Funding Sources Donations	1.160
PFI funded refresh programmes	0.757
Lease Funding (IFRS16)	20.147
Total Capital Available	98.947

Planned Expenditure	**£'m**
Musgrove Park Hospital Surgical Centre	26.006
Yeovil District Hospital 5th Theatre and Modular Ward	5.262
Stroke Services Reconfiguration	1.000
Mental Health and Community Schemes	2.000
Digital and IT replacement	8.365
EHR (external Funding)	11.427
Backlog and equipment	15.480
Electrical Infrastructure	2.550
New Hospital Programme	2.791
Diagnostic & MES	1.332
Balance of Capital Investment (including Donated Assets)	4.470
Leases renewals	20.147
Total Schemes	100.830

ICB Capital Schemes	**£'m**
Total ICB	1.007
TOTAL ICS CAPITAL EXPENDITURE	101.837

Total Planned Overcommitment	(2.890)

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance report from the Audit Committee meeting held on 10 January 2024
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Paul Mapson, Chairman of the Audit Committee
DATE:	5 March 2024

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
✓ For Assurance	☐ For Approval / Decision	☐ For Information

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the Audit Committee meeting held on 10 January 2024 and the assurance received by the Committee. The meeting was conducted as a video conference call. The Committee received assurance in relation to: • The Internal Audit escalation process • The oversight of the Board Assurance Framework • The work of the counter fraud service • The timely implementation of counter fraud recommendations • The progress made on the internal audit plan • The findings of the Preventing Violence and Aggression audit • The findings of the No Criteria to Reside audit • The findings of the Retention audit • The findings of the Safeguarding audit • The External Audit initial audit plan and the external audit progress report • The losses and special payments report

	• The single quotation/tender waiver action report • The Terms of Reference progress report • The Committee effectiveness review The Committee identified the following areas of concern or for follow up: • The Corporate Risk Register • The findings of the personalised care audit • The findings of the procurement audit • The overdue internal audit recommendations The Committee identified the following area to be reported to the Board: • The findings of the Personalised Care Audit Report (Quality and Governance Assurance Committee). • The findings from the Procurement Audit Report (Finance Committee). • The overdue internal audit recommendations (Operational Leadership Team).
Recommendation	The Board is asked to note the assurance and areas of concern identified by the Audit Committee. The Board is further asked to note the areas to be reported to the Board or to Committees.

Links to Joint Strategic Objectives (Please select any which are impacted on / relevant to this paper)
☒ Obj 1 Improve health and wellbeing of population
☒ Obj 2 Provide the best care and support to children and adults
☐ Obj 3 Strengthen care and support in local communities
☐ Obj 4 Reduce inequalities
☐ Obj 5 Respond well to complex needs
☐ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☒ Obj 7 Live within our means and use our resources wisely
☐ Obj 8 Develop a high performing organisation delivering the vision of the Trust

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Implications/Requirements (Please select any which are relevant to this paper)					
☒ Financial	☒ Legislation	☐ Workforce	☐ Estates	☐ ICT	☐ Patient Safety/ Quality
Details: N/A					

Equality and Inclusion
The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
This report has not been assessed against the Trust's Equality Impact Assessment Tool.

All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History
How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
N/A

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The assurance report is presented to the Board after each meeting.

Reference to CQC domains (Please select any which are relevant to this paper)				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	☐ No

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SOMERSET NHS FOUNDATION TRUST

AUDIT COMMITTEE MEETING HELD ON 10 JANUARY 2024

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 10 January 2024.

2. ASSURANCE RECEIVED

Internal Audit Escalation Process

2.1. The Committee discussed the process for the escalation of issues of concern identified by the Audit Committee, including concerns arising from internal audit reports and the implementation of audit recommendations. The Committee considered the role of the Operational Leadership Team, the Board Sub Committees, the Subsidiary Company boards as well as the role of the Audit Committee as part of the process and approved the escalation process.

Board Assurance Framework

2.2. The Committee discussed the Board Assurance Frameworks (BAF) and noted that the actions had been updated and that the BAF will be presented to the February 2024 Board meeting.

2.3. The Committee noted that the format of the BAF had been amended to include further information on the risk appetite levels for each of the strategic risks. The Committee discussed the risk appetite levels and noted that an annual review of the risk appetite and risk tolerance statements will be undertaken at the April 2024 Board meeting.

2.4. The Committee agreed that consideration will need to be given as to how to reflect strategic risks which are outside of the control of the trust and ensure that these risks are captured on the system wide BAF which is currently being developed.

2.5. The Committee recognised that the strategic risks were longer term risks and that these risks were unlikely to change significantly in a short period of time. This was in contrast to the corporate risks which could be mitigated in a shorter period of time.

Counter Fraud Progress Report

2.6. The Committee received the counter fraud progress report and noted the proactive work, investigations and performance against the functional standards.

2.7. The Committee noted the improvements to the temporary staffing invoice approval process and further noted that invoices to the value of £62,000 had been rejected for payment due to a number of different reasons.

2.8. The Committee discussed the counter fraud e-learning compliance rate at YDH and noted that the compliance rate was lower than in other services due to a change in the way the training is now being delivered. This training was previously not part of the mandatory training programme and the Committee received assurance that performance will continue to be closely monitored.

2.9. The Committee discussed the investigations, and in particular whether the relationship between the counter fraud investigations and the disciplinary process was sufficiently robust and noted that recommendations will be made as part of the counter fraud investigation process.

2.10. The Committee agreed that the report provided significant assurance about the work of the counter fraud service.

Counter Fraud Recommendations Tracker

2.11. The Committee received the counter fraud recommendations follow up report and the Committee agreed that the report provided significant assurance about the implementation of the recommendations.

Internal Audit progress report

2.12. The Committee received the internal audit progress report and agreed that good progress was being made implementing the internal audit plan.

Preventing Violence and Aggression

2.13. The Committee received the audit report and noted that this was an advisory report and that an audit opinion had therefore not been provided. A number of recommendations had been identified and will be implemented.

No Criteria to Reside Audit Report

2.14. The Committee received the audit report and noted that a moderate opinion had been issued for both design and design effectiveness.

2.15. The Committee agreed that this was a significant area of risk for the trust and that the audit provided a good level of assurance that the trust understands the data and level of risk.

Retention Audit Report

2.16. The Committee received the audit report and noted that a moderate opinion had been issued for both design and design effectiveness.

Safeguarding Audit Report

2.17. The Committee received the audit report and noted that a moderate opinion had been issued for both design and design effectiveness.

External Audit Initial Audit Plan

2.18. The Committee received the draft plan for the 20232/24 external audit process and noted that the final plan will be presented to the April 2024 Audit Committee meeting.

2.19. The Committee noted that the audit risks are in line with the risks in previous external audits.

External Audit Progress Report and Technical Update

2.20. The Committee received the progress report and noted the work completed since the October 2023 Audit Committee meeting.

2.21. The Committee noted the technical updates.

Losses and Special Payments

2.22. The Committee received the losses and special payments report and noted the reasons for the losses and special payments.

2.23. The Committee agreed that the reports did not highlight any areas of concern.

Single Quotation/Tender Waiver Action report

2.24. The Committee received the single quotation/tender waiver action report for the trust and for Simply Serve Ltd and noted the single quotation and tender waiver actions and the reasons for these actions.

Terms of Reference Progress Report

2.25. The Committee received the report which monitored progress against the Committee's Terms of Reference.

2.26. The Committee agreed that the report provided significant assurance.

Committee Effectiveness Review

2.27. The Committee discussed the findings from the Committee effectiveness review. The Committee agreed that, based on the assessment, and discussion at the meeting, it was compliant with its Terms of Reference. One action to follow up is the induction of new Non-Executive Directors and this was already being progressed.

3. AREAS OF CONCERN/FOLLOW UP

Corporate Risk Register (CRR)

3.1. The Committee received and discussed the report. The Committee noted the key themes; the high scoring corporate risks and the mitigating actions being taken. The Committee agreed that good progress was being made in relation to the management of corporate risks but recognised that the number of high scoring risks reflected the significant operational pressures and remained a concern.

3.2. The Committee noted that the risks had been assessed against the risk appetite and risk tolerance statement and noted the risks which had been assessed as outside of the risk tolerance level and which should be a key area of focus.

3.3. The Committee discussed the new risks in relation to the electronic staff record (ESR) and noted that these risks had been identified as part of the merger of the legacy ESR systems.

3.4. The Committee further received an update on the procurement of a single risk management system.

Personalised Care Audit Report

3.5. The Committee received the audit report and noted that a moderate opinion had been issued for design and a limited opinion for design effectiveness.

3.6. The Committee noted that the report has been presented to the Operational Leadership Team and will further be presented to the Quality and Governance Assurance Committee.

3.7. The Committee discussed the findings and noted that it had been recognised that further work on personalised care was required and the audit findings will act as the baseline for a wider, and longer term, programme of work, which will include the Integrated Care Board.

Procurement Audit Report

3.8. The Committee received the audit report and noted that a moderate opinion had been issued for design and a limited opinion for design effectiveness.

3.9. The Committee noted the findings and further noted that the report will be presented for further discussion to the Finance Committee.

Follow Up Report

3.10. The Committee received the report and noted the progress made implementing the 2022/23 audit recommendations.

3.11. The Committee noted the overdue recommendations and agreed to keep the implementation of these recommendations under close review. In relation to the job planning recommendations, and in line with the approved escalation process, the Committee agreed to escalate these to the Operational Leadership Team.

3.12. The Committee discussed the changes in the recommendations implementation dates and agreed that recommendations should be categorised as overdue as soon as the original implementation date has passed.

4. RIS MKS AND ISSUES TO BE REPORTED TO THE BOARD OR OTHER COMMITTEES

4.1. The Committee identified the following issue to be reported to the Executive Team or other committees:

- The findings of the Personalised Care Audit Report (Quality and Governance Assurance Committee).
- The findings from the Procurement Audit Report (Finance Committee).
- The overdue internal audit recommendations (Operational Leadership Team).

CHAIRMAN OF THE AUDIT COMMITTEE