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 4 March 2025** at **9.00am** at the Boardroom at Yeovil District Hospital, Yeovil District Hospital, Higher Kingston, Yeovil, BA21 4AT

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

DR RIMA MAKAREM
CHAIR

AGENDA

		Action	Presenter	Time	Enclosure
1.	**Welcome and Apologies for Absence**		Chair	09:00	Verbal
2.	**Questions from Members of the Public and Governors**		Chair		Verbal
3.	**Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 4 February 2024**	Approve	Chair		Enclosure 01
4.	**Action Logs and Matters Arising**	Review	Chair		Enclosure 02
5.	**Registers of Directors' Interests and Receive any Declarations of Interests relating to items on the Agenda**	Note and Receive	Chair		Enclosure 03
6.	**Chair's Remarks**	Note	Chair	09.10	Verbal
7.	**Chief Executive and Executive Directors' Report**	Receive	Peter Lewis	09:20	Enclosure 04
OBJECTIVE 6 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture					
8.	**Our Inclusive Organisation Progress Report**	Receive	Peter Lewis	9.30	Enclosure 05
OBJECTIVE 2 – Provide the best care and support to people					

9.	**Quality and Performance Exception Report**	Receive	Pippa Moger	9.50	Enclosure 06
10.	**Learning from Deaths Framework: Mortality Review Progress Report**	Receive	Katy Darvall	10.10	Enclosure 07
11.	**Assurance Report of the Quality and Governance Assurance Committee meeting held on 29 January 2025**	Receive	Inga Kennedy	10.20	Enclosure 08
Coffee Break - 10.25 – 10.40					
OBJECTIVE 7: To live within our means and use our resources wisely					
12.	**Finance Report**	Receive	Pippa Moger	10.40	Enclosure 09
13.	**Verbal report from the Finance Committee meeting held on 24 February 2025**	Receive	Martyn Scrivens	11.00	Verbal
14.	**Assurance Report from the Charitable Funds Committee meeting held on 24 January 2025**	Receive	Graham Hughes	11.05	Enclosure 10
FOR INFORMATION					
15.	**Follow up questions from the Public and Governors**		Chairman		Verbal
16.	**Any other Business**		All		Verbal
17.	**Risks Identified**		All		Verbal
18.	**Evaluation of the Effectiveness of the Meeting**		Chairman		Verbal
19.	**Items to be discussed at the Confidential Board Meetings** The items presented to the Confidential Board include: suspension and exclusion report; staff survey report (the report has not yet been made publicly available); a homicide investigation report and action plan; an update on the New Hospital Programme; the 2025/26 planning update; the draft capital programme for 2025/26; a business case and contract award for electrical infrastructure; update on the electronic health record OBC position and procurement timeline; and minutes of the Finance Committee meeting held on 27 January 2025.				
20.	**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.				
21.	**Date of Next Meeting** Tuesday 6 May 2025			11.20	

Somerset NHS Foundation Trust

PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 4 FEBRUARY 2025 AT SOUTH PETHERTON COMMUNITY HOSPITAL, BERNARD WAY, SOUTH PETHERTON

PRESENT

Rima Makarem	Chair
Graham Hughes	Non-Executive Director
Martyn Scrivens	Non-Executive Director
Inga Kennedy	Non-Executive Director
Paul Mapson	Non-Executive Director
Peter Lewis	Chief Executive
Andy Heron	Chief Operating Officer/Deputy Chief Executive
Pippa Moger	Chief Finance Officer
Melanie Iles	Chief Medical Officer
David Shannon	Director of Strategy and Digital Development
Isobel Clements	Chief of People and Organisational Development
Hayley Peters	Chief Nurse
Jade Renville	Director of Corporate Services

IN ATTENDANCE

Franchesca Knight	HFMA Management Trainee
Phil Brice	Director of Quality Assurance and Involvement
Ria Zandvliet	Secretary to the Trust

1. WELCOME AND APOLOGIES FOR ABSENCE

1.1. The Chair 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 Alexander Priest (Non-Executive Director) and Jan Hull (Non-Executive Director).

1.3. The Board noted that, due to the absence of two Non-Executive Directors, there was an imbalance between the number of voting non-executive and executive directors and the Board agreed that, if a vote is required, two executive directors will refrain from voting and the Chair will use their second vote to ensure that Non-executive Directors have a majority vote.

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 5 NOVEMBER 2024

3.1. The Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 5 November 2024 as a true and accurate record.

4. ACTION LOGS AND MATTERS ARISING

4.1. The Board received the action log and noted that no actions had been identified at the meeting held on 5 November 2024.

4.2. There were no matters arising from the minutes.

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

5.1. The Board received the Register of Directors' interests and noted that there were no changes to the register.

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

6. CHAIRMAN REMARKS

6.1. The Chair commented that this was her first formal Board meeting following her appointment as Chair to the Trust from 1 January 2025. She advised that she had received a great welcome to the Trust, had met with all Board members and their immediate teams, had visited the Cheddon Road site in Taunton, and had met with Governors. The Chair advised that she was looking forward to meeting more colleagues over the next few months.

6.2. The Chair advised that discussions about the appointment of new Non-Executive Directors were taking place and that proposals for the recruitment process were being developed.

7. CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS REPORT

7.1. The Chief Executive presented the report which was received by the Board.

7.2. The Chief Executive particularly highlighted*:* the delay to the New Hospital Programme Scheme; the receipt of the draft report from NHS England's Maternity Safety Support Programme (MSSP) visit to the Trust; the initial feedback from the Care Quality Commission's inspection of acute paediatric services; and the recent publication of the 2025/26 planning guidance and the review of the planning guidance to determine the impact on the trust's financial plans for 2025/26.

7.3. The Board discussed the report and in particular the Trust's response to the Department of Health and Social Care (DHSC) engagement exercise on the 10-year plan and the recently published planning guidance for 2025/26. The Board noted that guidance on neighbourhood health and expectations had also been published and that this guidance will need to be reviewed alongside the planning guidance. All guidance will be considered as part of the 2025/26 priority setting process and this will be taken forward as part of a Board development session.

8. 2024/25 UPDATED Q3 BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER REPORT

Board Assurance Framework (BAF)

8.1. The Director of Corporate Services presented the report which was received by the Board.

8.2. The Director of Corporate Services highlighted the key risks on the BAF which continued to relate to: workforce shortages; access to primary care/increased ED demand; risk of EHR business case not being approved or delayed; and vacancies within consultant workforce. The Director of Corporate Services advised that the report included more detailed information about deep dives carried out by the committees to provide the Board with assurance about the committee's oversight of the objectives and strategic risks.

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

- Good progress was being made towards the achievement of the longer term aims.
- Objective eight had been updated to reflect the delay in the New Hospital Programme (NHP). Assurance was provided that the Trust was not tied into any contracts which it could not meet as a result of the NHP delay.
- Although progress was being made, there remained a significant number of red rated strategic risks and it was queried whether a focus on a small number of priorities will be helpful. It was noted that a discussion on the priorities for 2025/26 was being scheduled.
- The report did not give an indication of delays, and reasons for delays, in the implementation of action plans and it was therefore difficult for the Board to assess the impact of the delays. The Chief Executive advised that consideration will need to be given as to how progress against the BAF was reported to the Board. The objectives were the right objectives but the question was how the annual plan and delivery of the annual plan was linked to the objectives and reported to the Board. The Board noted that this will be further discussed as part of the governance review strategic session.
- It was queried whether measures to monitor progress could be identified. The Chief Executive advised that it was easier to identify measures for specific

priorities than for wide ranging strategic objectives and this will be kept under review.

8.4. The Director of Corporate Services agreed to review the content of the BAF report in light of the comments made. **Action: Director of Corporate Services**.

Corporate Risk Register

8.5. The Chief Executive presented the report which was received by the Board and highlighted the highest rated risks and the new risks relating to inclusion and discrimination.

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

- The importance to recognise the new risks relating to systemic and process discrimination and the inability to create a compassionate and inclusive culture and the need to further discuss these risks and actions to be taken at Board level.

- Although work on culture within the organisation was taking place, feedback from recent leadership quality walkrounds indicated that not all colleagues were aware of this work. The Chief Nurse commented that this work was well documented and it was unclear why this had not been recognised at the walkrounds.

- The need to distinguish between risks and existing issues. The Chief Executive advised that the need for clear risk descriptions had been raised at the Operational Leadership Team meeting and will be further followed up with the service groups.

9. QUALITY AND PERFORMANCE EXCEPTION REPORT

9.1. 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. The Chief Finance Officer particularly highlighted the reduction in the number of patients waiting over 52 weeks from referral to treatment.

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

- That 142 patients were waiting over 65 weeks at the end of December 2024 and that the target date for treating these patients had been revised to 31 March 2025. The Board noted that at least one patient will be waiting beyond 31 March 2025 as a 3D printed bone from Europe will not be arriving until after 31 March 2025. The Chief Finance Officer advised that the Trust was no longer part of NHS England's monitoring arrangements but the Trust had chosen to continue regular dialogues with NHS England.

- The significant spike in the number of respiratory viral infections during December 2024 and the ability to continue most elective surgery despite this high number of infections.

- The focus on a 100-day discharge sprint to improve the patient flow and no criteria to reside positions. Three areas for improvement had been identified across all adult inpatient wards: the need for clarity of roles – a clear and written procedure will be developed once roles have been clarified so that processes were consistent and standardised; the need for consistency of board rounds – to be carried out seven days a week involving multi-disciplinary teams; and the need for a focus on personalised care – no discussion about me without me. In terms of the 100-day discharge sprint work, it was noted that three sprints will be launched on 5 February 2025; that an event with clinical leaders had been scheduled; and that a measurement plan, aggregate plan in relation to no criteria to reside, and quality measures will be developed by 7 February 2025. The Chief Executive advised that it will be helpful to involve Non-Executive Directors to look at board rounds. **Action: to involve NEDS in looking at board rounds.**

- The call to convey process which was aimed at identifying patients who could be offered a better experience through community alternatives. The Trust had excellent community response services, including a Rapid Response service and Hospital@Home service and if some of the patients planning to attend an ED can have a better experience at home, this will be beneficial for both the patient and the ED. The Board noted that a pilot had commenced with the ICB, the ambulance service and the 111 service to identify patients from the ambulance stack who could be seen in the community. The Chief Operating Officer advised that 4.6% more patients in Somerset were conveyed to hospital than elsewhere in the region and it was felt that there could be a relationship between lower ambulance handover times and the number of patients conveyed as areas with most pressure on ambulance handovers also conveyed less patients to ED. The Chief Operating Officer advised that, if the call to convey process was followed, the positive impact will be seen across many indicators.

- The report was predominantly acute focussed and did not include data or information about community health services, which did not meet the exception reporting criteria, and GP services. Although oversight of GP practices was not within the remit of the Board, it would be helpful to have high level primary care indicators, particularly in relation to the practices managed by Symphony. In addition, top level indicators for all community health services will also be helpful to ensure high level oversight.

  The Chair commented that, if taking a high level view, the majority of services seemed to be under pressure due to a high levels of demand; staff capacity due to vacancies or sickness; or wider national NHS challenges. The report was less clear in terms of other underlying performance factors such as the impact of theatre utilisation, bed turnaround, conveyance and work to reduce demand in acute services. Although the report was rich in terms of data, the

Chair asked for more narrative information to describe the problem and what we are doing about it.

- Criteria-led discharge was one area of focus and a patient can be discharged by a nurse if the patient met the conditions defined by the lead clinician. This work was progressing well and some wards were exceeding their trajectory for nurse led discharge.

- Regional comparisons were being made, and although the Trust performed well compared to regional providers, it was felt that the ambition should be wider than the region. The Chief Operating Officer advised that the overall ambition was wider than regional benchmarking, but regional datasets were important in view of communalities with regional providers. In relation to national performance, the Trust performed well in terms of the productive care programme and 12 hour waits.

- The no criteria to reside performance was below target, but good progress was being made and the 100-day discharge sprints had been set up to improve the position. Solving the no criteria to reside issues was complex and actions will need to be sequenced in the right order.

9.3. The Board discussed the impact of the 2025/26 planning guidance on targets and commented/noted that:

- The planning guidance consisted of two key components – waiting lists and discharge planning – and the use of real time data to show delays.

- The majority of targets set out in the 2025/26 planning guidance were included in the exception report and it was queried how quickly these targets can be achieved. The Chief Executive commented that the timescale will be different for each target. He advised that details of the planning guidance and the impact on elective care services were being reviewed and are to be discussed at a meeting set up for week commencing 10 February 2025. It was known that there will be a number of challenges, including reducing the number of patients waiting over one year for treatment – no more than 1% of patients on the waiting lists waiting over one year – and a reduction in waiting list size will also reduce the number of patients covered by this 1%. He advised that it was critical to be clear about the actions to be taken, especially in relation to discharge and patient flow due to their impact on ED.

- The Trust was performing well in terms of the front end of pathways but that the main challenges related to the back end of the inpatient pathways. Considerable work was taking place to try and make internal processes as efficient as possible e.g. review of job planning and board rounds etc.

- There was a big focus on elective care but that this was not discussed strategically at Board meetings. The Chief Medical Officer proposed focussing on a few elective care indicators at Board level and she highlighted the need to continue to review the waiting list to see whether patients were still waiting appropriately and waiting for the right procedure.

- Two priorities in the planning guidance related to people with mental health conditions waiting more than 12 hours in ED. This was not an area of concern as the Trust was performing well in terms of its mental health service performance but it was recognised that mental health performance will need to continue to be closely monitored as this remained an area of key focus for the Trust.

- The mental health team had set up small projects relating to: people with severe mental health illness; and ADHD referrals to consider how these services can be transformed and delivered in a different way. It was recognised that bringing more mental health services into primary care will be helpful for patients.

9.4. The Chair reiterated the need to include GP indicators and more narrative and asked for progress against patient flow, productive care programme and 100-day discharge sprints to be reported to a future Board meeting.

10. QUALITY STRATEGY

10.1. The Chief Medical Officer presented the report which was received by the Board. The Chief Medical Officer highlighted the key elements of the strategy and requested to re-open previous discussions about the development of a quality plan and measurable targets and what this might look like.

10.2. The Chief Medical Officer advised that the strategy was one of a number of strategies and that it will need to link in with the Quality and Governance Assurance Committee and the BAF and that the BAF and strategic objectives may need to be reviewed in line with the quality strategy. The Chief Medical Officer further commented that another action plan may not be the best way to demonstrate delivery of the strategy as it does not reflect outcomes and real-life stories of how the strategy has positively impacted on patients. Consideration will therefore need to be given to the process for seeking assurance that the strategy was being implemented.

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

- That the quality strategy did not indicate exactly what it will be delivering and that consideration will need to be given as to which cohorts and pathways the quality work will focus on. This focus will give a clear direction and enables progress to be more closely monitored. The Chief Medical Officer commented that a focus on priorities, e.g. clinical, convey, discharge, etc will enable all colleagues in the trust to be involved in different ways. More work will be required on 100-day sprints and this work will enable colleagues to work differently. Doing the same will not be an option as it does not address the quality risks and challenges.

- The need for whole system engagement.

- Quality was not absolute and balancing the focus on quality with safety may be challenging as there could be a need to reduce quality to be able to maintain safety. The Chief Nurse commented that the risk register carried significant quality related risks and that a focus on quality will be essential.

- The need to link all strategies to address pathway challenges, e.g. frailty, and to be able to reduce risks.

- Although a quality plan will be welcomed, the plan will need to clearly set out the areas of focus, deliverables and assurance processes.

- Service groups mainly worked vertically and there was a need to also work horizontally. Focussing on population cohorts or pathways will be a good way to demonstrate horizontal working and this will need to include primary and community services as well as all of Somerset's geographical areas. Working in this way will enable costs efficiencies.

  The Chief Operating Officer advised that a conversation about the need to work horizontally had taken place at a recent senior operational team meeting. The benefits of working in this way were recognised by the operational senior team.

- The importance of focussing on population cohorts rather than on medical conditions was stressed and this was also in line with the population health strategic objective. A focus on medical conditions alone will not identify all elements which impact on a patient with a medical condition whilst the cohort approach will look at all physical, mental health and social care elements which could impact on a particular cohort. In addition, resolving issues for a particular cohort will also resolve issues for other cohorts. However, it will not be possible to focus on all cohorts at the same time and priority cohorts will need to be considered.

- The Chief Nurse and the Chief Medical Officer agreed to review the strategy in the light of the comments made. It was noted that quality work will not be delayed as a result of the delay in the approval of the strategy and discussions were already taking place and some of the work had already commenced.

10.4. The Board asked for the quality strategy to be represented to the Board in four months' time and for an updated strategy to be presented to the Quality and Governance Assurance Committee prior to the Board meeting. The Board asked for the key priority areas to be clearly set out in the strategy.

11. ASSURANCE REPORT OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETINGS HELD ON 30 OCTOBER 2024, 27 NOVEMBER 2024 AND 18 DECEMBER 2024

11.1. Inga Kennedy presented the reports which were received by the Board. She highlighted the areas of assurance received and the areas of concern and follow up by the Committee.

11.2. The areas to be reported to the Board related to:

- The digital risk due to the ongoing delay of securing the unified EHR.
- The overlap between the People Committee and the Quality and Governance Assurance Committee in relation to culture and workforce shortages.
- The need for a Board level update on no criteria to reside.
- To consider the need for a Board development day session on PSIRF and LfPSE in terms of event reporting as a stocktake; and on the process for agreeing the process for identifying the next set of priorities.

11.3. Inga Kennedy further presented verbal feedback from the meeting held on 29 January 2025 and highlighted the following key items discussed: the Birth Rate + review; the governance support summary; the report from the Patient Safety Board; and the Clinical Support and Cancer Services Assurance Report.

11.4. Inga Kennedy further advised that the Committee reviewed and signed off the Maternity Incentive Scheme Year 6 Declaration under delegated authority from the Board. Compliance with three safety actions could not be confirmed and an action plan to address the outstanding areas, together with a bid for funding, had been submitted with the declaration.

12. NEW HOSPITAL PROGRAMME REVIEW

12.1. The Director of Strategy and Digital Development presented the report which was received by the Board. The Director of Strategy and Digital Development provided an overview of the changes to the New Hospital Programme and particularly highlighted the delay to the start date of work on the Musgrove Park Hospital site by at least five years and the next steps.

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

- That work will continue with NHS England in relation to funding critical infrastructure investment required to sustain services over the next ten years.
- The risk in relation to the ability to undertake maintenance work and provide the required upgrades due to the limited ability within the current site footprint to enable the decant of existing facilities.
- The financial impact due to the £8.7 million expenditure on programme development since 2020 to be treated as revenue in 2024/25. It was noted that verbal confirmation had been received that this expenditure will not count towards the control total but written confirmation was awaited. In addition, confirmation was also awaited about the funding of cost implications for the redeployment of the team working on the estate development programme.

- The risk in relation to the ability to sustain the delivery of maternity services due to the condition of the maternity estate and the review to be undertaken of all contingency and estates risks.

- The review of options for medium term investment into the estate to maintain services until the development of the new build and the review of enabling works and short-term redevelopment options to inform a critical infrastructure bid. It was noted that a review of backlog maintenance was taking place and that a working group will be established to look at mitigating options, which could include decants and moving some services off-site whilst work is taking place, and implications.

- That the Board will be kept informed of progress made in relation to the capital development programme and if the national increase to capital availability will enable an opportunity to fund smaller schemes.

- It was queried whether a charitable appeal for a new maternity unit will be an option. It was noted that this had been discussed at the recent Charity Committee but it was felt that the amount of funding required will be too high to be able to manage this in-house. Although the breast cancer appeal had been very successful, the capital required was considerably smaller.

- Although the Trust had indicated that it will continue to work with the New Hospital Programme, concerns were expressed that involvement over a five year period will be challenging for colleagues. The Director of Strategy and Digital Development agreed that it will be challenging to keep colleagues engaged with a programme that will not start for at least five years. He will be meeting with the team in the next few days to discuss the level of involvement in more detail.

- There are risks that funding for the scale of the New Hospital Programme will be available in five years' time and it was agreed the Trust needs to keep looking at options and opportunities to progress the scheme in the interim.

13. GUARDIAN OF SAFE WORKING FOR POSTGRADUATE DOCTORS REPORT

13.1. The Chief Medical Office presented the report which was received by the Board. The Board noted the exception reporting data; the issues arising from the exception reports; and actions identified.

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

- The need to review the size and content of the report.

- The number of exceptions outstanding at the end of the reporting period at YDH and the need to manage these exceptions in a timely manner.

- That both the Guardian of Safe Working for Postgraduate Doctors and individual supervisors have found the current method of exception reporting and actioning difficult to navigate and use.

- The concerns by the Guardian of Safe Working that exception reporting may be under-reported and the need to expedite the implementation of the interim solution.

- That exception reporting was encouraged to ensure that colleagues were appropriately remunerated and to be able to identify areas of particular pressures and concerns.

13.3. The Chief Medical Officer agreed to discuss the information to be reported to the Board with the relevant team. **Action: Chief Medical Officer.**

14. ASSURANCE REPORT OF THE PEOPLE COMMITTEE MEETINGS HELD ON 4 DECEMBER 2024 AND 14 JANUARY 2025

14.1. Graham Hughes presented the reports on behalf of Jan Hull, Chair of the People Committee. The reports were received by the Board. He highlighted the areas of assurance received and the areas of concern and follow up by the Committee.

14.2. It was noted that no areas to be reported to the Board had been identified.

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

- The progress against the implementation of the people strategy. The strategy covered the period 2023 to 2028 and good progress was being made in relation to the delivery of the year 2 ambitions. The Committee took significant assurance from the progress to date but noted the challenges in relation to the cultural work. It was noted that the focus in year three will be on inclusion.

- That the colleague story was positive but that the long time the colleague had spent in a Band 5 post before moving to a more senior role was a concern. The Chief of People and Organisational Development agreed that this long time period was disappointing but this was not uncommon for overseas colleagues. Significant work was taking place in relation to talent management and succession planning and consideration will need to be given how to encourage colleagues to participate in development opportunities for more senior roles.

- The teams were complimented on their work in relation to the ability to triangulate the substantive establishment to financial information. Further work will be required in relation to triangulating whole trust data and information but this was a significant step forward.

15. ASSURANCE REPORT FROM THE MENTAL HEALTH LEGISLATION COMMITTEE MEETING HELD ON 10 DECEMBER 2024

15.1. The Board received the report. Due to the absence of Alexander Priest, Chairman of the Mental Health Legislation Committee, and Jan Hull, member of the Committee, the Board noted the areas of assurance received and the areas of concern and follow up by the Committee.

15.2. The areas to be reported to the Board related to:

- The positive feedback from the CQC report for Holford Ward
- The progress in relation to Section 117
- The ongoing demand on the mental health administration team
- The lack of overall engagement from the police

16. FINANCE REPORT

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

- The in-month surplus of £1.517 million which was in line with the plan for the month.
- The year to date deficit of £8.177million which was breakeven to the plan.
- The in-month agency expenditure of £2.169 million which was £1.073 million below the plan and £0.650 million below the cap.
- The in-month delivery of the cost improvement programme of £6.359 million which was consistent with the plan.
- The year to date delivery of £51.292 million capital expenditure against a plan of £63.672 million.
- The in-month workforce position – 30 WTE (whole time equivalent) under the workforce cap trajectory.

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

- That £8 million of the capital underspend to date related to delays to the Yeovil Diagnostic Centre build programme causing delays to the commencement of the lease, but this was expected to be completed in March 2025.

- That work continued to identify cost improvement savings to the value of £2 million.

- The expectation to deliver a forecast yearend breakeven position.

- The need to identify further opportunities to mitigate ongoing cost pressures and mitigate any further unplanned risks, including remaining within the fixed ERF income envelope recently announced by NHSE.

- The risk of overspending on the budget to manage winter pressures due to escalation capacity issues.

- The risk in relation to the delivery of the elective recovery fund (ERF) and the need to ensure that all activity was coded correctly to ensure that it counted towards the ERF.

17. VERBAL REPORT FROM THE FINANCE COMMITTEE MEETING HELD ON 27 JANUARY 2025

17.1. Martyn Scrivens, Chairman of the Committee, advised that the majority of the key items and risks discussed at the meeting had been discussed as part of previous agenda items.

17.2. Martyn Scrivens highlighted the commercial projects discussion and in particular the discussion in relation to the ICB's elective recovery funding investment in the independent sector. He advised that the ICB had spent more on the independent sector than planned and less on the Trust and this did not seem consistent with the Trust's recovery activity figures. The Chief Finance Officer advised that, from an elective recovery fund (ERF) perspective, there was an over-performance in the independent sector of £4.5 million with under-performance within the Trust, some of which was due to activities not being available. Although the overall position was balanced, the over-investment in the independent sector did have implications for the system as any spend in the independent sector did not contribute to the system's overheads.

17.3. The Chair referred to the performance report where workforce shortages had been raised as an issue and queried whether posts were held or reduced due to financial pressures. The Chief Finance Officer advised that all vacancies were discussed at the monthly finance and performance meetings with each service group and strong controls were in place to manage vacancies. Vacancies could be due to: holding the post; redesign of the pathway; the productive care programme; or due to the inability to recruit. The Chief Finance Officer confirmed that posts had not been reduced due to financial pressures. The Chief Medical Officer advised that, if taking out any clinical post, an equality and quality impact assessment will need to be completed and signed off by the Chief Nurse or the Chief Medical Officer and no assessments had been received.

18. ASSURANCE REPORT FROM THE AUDIT COMMITTEE MEETING HELD ON 15 JANUARY 2025

17.1. Paul Mapson, Chairman of the Aduit Committee, presented the report which was received by the Board. He highlighted the areas of assurance received and the areas of concern and follow up by the Committee.

18.1. The area to be reported to the Board related to:

- The Corporate Risk Register – the need for a strategic risk relating to the Somerset demographics

- People Strategy – Future Workforce Audit Report – the need for a Board level workforce discussion

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

- That the attempted fraud of £3.2 million had been prevented due to the diligence by the finance team. It was noted that the fraud attempt had been a sophisticated attempt and related to a request to change the bank account details from a major contractor. The Board noted the details of the attempted fraud and processes followed to prevent the fraud. The Board complimented the finance team on their due diligence.

- That the Committee expressed concerns about the consistency and robustness of management actions taken in response to some counter fraud investigations and noted that this had been followed up by the executive team and that a report will be presented to the April 2025 Audit Committee meeting.

19. ASSURANCE REPORT FROM THE CHARITY COMMITTEE MEETING HELD ON 21 OCTOBER 2024

19.1. Graham Hughes, Chairman of the Charity Committee, presented the report which was received by the Board. He highlighted the areas of assurance received and the areas of concern and follow up by the Committee.

19.2. The Committee did not identify any issues to be reported to the Board.

19.3. Graham Hughes further provided feedback from the meeting held on 24 January 2025 and highlighted the key items covered: the review of the terms of reference; a bid for charitable funds spending by the cardiology team; the key financial systems audit report; the fundraising report; the major donations and proposed projects progress report; the open mental health proposal; and the finance report. An assurance report will be presented to the March 2025 Board meeting.

20. FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS

20.1. There were no follow up questions from members of the public.

21. ANY OTHER BUSINESS

21.1. There was no any other business.

22. RISKS IDENTIFIED

22.1. The Board did identify the following risks: New Hospital Programme delay; the impact of the 2025/26 planning guidance; and the ongoing financial and performance pressures.

23. EVALUATION OF THE EFFECTIVENESS OF THE MEETING

23.1. The Board agreed that the meeting had been productive with a large number of items covered effectively, and detailed challenging, but that there was a need to consider the length of Board papers.

24. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

24.1. 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.

25. WITHDRAWAL OF PRESS AND PUBLIC

25.1. 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.

26. DATE FOR NEXT MEETING

26.1. 4 March 2025

SOMERSET NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETINGS

HELD ON 4 FEBRUARY 2025

AGENDA ITEM	ACTION	BY WHOM	DUE DATE	PROGRESS
8. Board Assurance Framework	To review the content of the BAF report in light of the comments made.	Ben Edgar-Attwell	May 2025	This will be taken forward as part of the wider governance review.
9. Quality and Performance Report	To involve NEDS in looking at board rounds.	Hayley Peters	April 2025	This will be actioned and NEDs will be invited to future board rounds.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Registers of Directors' Interests
SPONSORING EXEC:	Jade Renville, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Rima Makarem, Chair
DATE:	4 March 2025

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 25 February 2025.
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 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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	
Rima Makarem Chairman	• Chair, Sue Ryder – non-remunerated • Chair, Queen Square Enterprises – remunerated • Lay member, General Pharmaceutical Council – remunerated
Jan Hull Non-Executive Director	• Trustee of the Dulverton Abbeyfield Society. • Formerly Managing Director of South, Central and West Commissioning Support Unit
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	Nothing to declare.
Inga Kennedy Non-Executive Director	• 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)
EXECUTIVE DIRECTORS	
Peter Lewis Chief Executive (CEO)	• Management Board Member, Somerset Estates Partnership (SEP) Board • Director, Somerset Estates Partnership Project Co Limited
Jade Renville	• Executive Director of Corporate Services, Somerset ICB Board • Chair, Richard Huish Multi-Academy Trust (voluntary capacity) • Father is Director and owner of Renvilles Costs Lawyers
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. • Governor at Weston College from 31 January 2025.
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 • Shareholder Director of SSL
Melanie Iles Chief Medical Officer	None to declare

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Chief Executive/Executive Director Report
SPONSORING EXEC:	Peter Lewis, Chief Executive
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Peter Lewis, Chief Executive
DATE:	4 March 2025

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 25 January 2025 to 24 February 2025.
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 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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. INITIATIVES TO IMPROVE DISCHARGE

1.1. One area of continued focus across the trust is on ensuring that those who are medically fit and ready to leave hospital, can do so as soon as possible, to improve patient experience and support patient flow across our services.

1.2. The next phase of the Transfer of Care Hub (ToCH) model was launched to focus on the further development and improvement of the discharge process. As with any transformational change, building on learning is important and following the initial launch of the hubs at both Musgrove Park and Yeovil hospitals in December 2023, the test and learn pilot has now been extended to cover a system-wide approach. This will bring services together to plan discharges and coordinate care and support, through a multi-agency approach.

The vision of the Transfer of Care Hub is:
'A countywide Transfer of Care Hub model covering all acute and community referral routes. With consistent processes, ways of working and integrated multi-disciplinary membership which enables our communities to pull people into the right services and settings for them without delay'.

1.3. The new system-wide hub is a jointly led initiative between our trust and Somerset Council and will operate seven days a week, working to ensure timely and safe discharges. All relevant services – for example, acute, community, primary care, social care, housing and voluntary teams are linked and work together to coordinate care and support for people who need it.

1.4. Key changes of the new system-wide model, include the development of a Universal Referral Form, simplified processes and a single point of contact and review across the system, to reduce unnecessary duplication and prioritise the patients who need support.

1.5. The aim is to help reduce lengths of stay and the number of patients who are medically fit for discharge, in acute settings.

2. GOVERNOR ELECTIONS

2.1. We are holding public and staff governor elections to appoint 11 public governor and two staff governors to our Council of Governors. Nominations will close on Wednesday 5 March 2025.

2.2. Details on the role of a governor, the time commitment, disqualification criteria, and the Trust's Constitution can be found on the Civica Election Services (CES) website.

2.3. The seats up for election are:

- Mendip – 1 seat
- Sedgemoor – 1seat
- Somerset West and Taunton – 4
- South Somerset – 4
- Outside Somerset – 1
- Staff – 2

2.4. Our elections are managed by Civica Election Services (CES) and to stand in the elections, you will be required to complete a nomination form which is available from CES but please note that the nomination form will need to be received by the deadline on 5 March 2025. To request a nomination form:

- Visit: www.cesvotes.com/somerset2025
- Email: ftnominationenquiries@cesvotes.com

3. MODERN SLAVERY AND HUMAN TRAFFICKING ACT 2015 POLICY STATEMENT 2025-2026

3.1. Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps taken to ensure slavery and human trafficking is not taking place in any of its supply chains and in any part of its business.

3.2. The attached statement sets out actions taken by Somerset NHS Foundation Trust, and continue to take, to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls.

3.3. The Trust continues to fully support the government's objective to eradicate modern slavery and human trafficking, and we acknowledge our role in both combating it and supporting victims. The Trust is committed to ensuring our supply chains and our business activities are free from ethical and labour standards abuse.

3.4. The Board is asked to approve the signing of the statement and for the statement to be upload onto the internet.

4. WILLITON COMMUNITY HOSPITAL WELCOMES MP RACHEL GILMOUR

4.1. MP for Minehead and Tiverton, Rachel Gilmour, visited Williton Community Hospital to find see the facilities, find out about the services the hospital offers to the local community and meet colleagues.

4.2. The hospital provides stroke rehabilitation, a busy ambulatory care unit and chemotherapy services are also provided from the hospital. It is also a base for a number of different teams, facilitating good joint working.

4.3. Rachel Gilmour was very impressed by the support the hospital provides to the local community. She said: *"Williton Community Hospital plays a crucial role in the West Somerset community. This service provider offers vital treatment for residents at a local level, which is especially important considering that transport infrastructure is not always good enough to travel to and from appointments in Taunton and beyond. I have had a wonderful time this morning visiting Williton Community Hospital, and I am proud to support our excellent local NHS service providers, like this one in Williton, across our constituency."*

5. DIABETES CARE

5.1. We are committed to revolutionising diabetes care through enhanced data collection and innovative treatment pathways. Our recent initiatives, supported by the National Diabetes Audit Quality Improvement Collaborative (NDA QIC) and anticipated guidelines from NHS England, have significantly improved our service delivery. This dedication to integrating cutting-edge technology, such as insulin pump therapy and hybrid closed loop systems, ensures that our patients receive the best possible care, leading to better diabetes management and overall wellbeing.

5.2. Colleagues involved in the care of people with diabetes have recently taken part in a national initiative that aims to support NHS organisations to improve services across the country. Consultant endocrinologist Dr Alex Bickerton and diabetes nurses Ruth Hammond and Emily Harrod took part from Yeovil Hospital, while consultant endocrinologist Dr Isy Douek represented the diabetes service at Musgrove Park Hospital.

5.3. The main aim of this National Diabetes Audit (NDA) Quality Improvement Collaborative (QIC) was to address the significant gaps in the use of insulin pumps among individuals with type 1 diabetes. Published data indicates that around 90,000 people in England and Wales with blood glucose (HbA1c) levels greater than 69 mmol/mol are not using insulin pumps, which highlights the inequalities based on the person's location, gender, age, ethnicity, and socioeconomic status. To tackle this issue, specialist teams set up a monthly meeting to discuss and implement quality improvement strategies.

5.4. The NDA QIC initiative made a huge difference in helping us to refine our service, ensuring that we can offer advanced technology to patients in a structured and equitable manner. This approach, alongside the technology appraisal, increased the number of individuals using this technology, resulting in improved diabetes management and overall wellbeing.

5.5. The new NICE technology appraisal requires much more data collection and quarterly uploads centrally, to ensure that patient funding continues. We therefore also updated a database for use across both our acute hospitals to

5.6. facilitate this. We also received a commendation from the national quality improvement team for our work to improve the care of people living with diabetes and Diabetes UK added a thanks to the trust for taking part in the qualitive improvement collaborative programme.

6. MEDIA COVERAGE

6.1. An overview of media coverage during the reporting period is attached as appendix A.

7. NATIONAL DEVELOPMENTS

7.1. An overview of national developments during the reporting period is attached as appendix B.

Modern Slavery and Human Trafficking Act 2015 Policy Statement 2025-2026

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps taken to ensure slavery and human trafficking is not taking place in any of its supply chains and in any part of its business.

This statement sets out actions taken by Somerset NHS Foundation Trust, and continue to take, to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls.

The Trust continues to fully support the government's objective to eradicate modern slavery and human trafficking, and we acknowledge our role in both combating it and supporting victims. The Trust is committed to ensuring our supply chains and our business activities are free from ethical and labour standards abuse.

Modern slavery encompasses slavery, servitude, human trafficking and forced labour. Somerset NHS Foundation Trust has a zero-tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings and to putting effective systems and controls in place to safeguard against any form of modern slavery taking place within the Trust or our supply chain.

We are committed to improving our practices to combat slavery and human trafficking. We are fully aware of our responsibilities towards patients, employees and the local community. We have robust ethical values which we use as guidance for our commercial activities. We also expect all suppliers to the Trust to follow the same ethical principles.

Policy on Slavery and Human Trafficking

We are committed to ensuring there is no modern slavery or human trafficking in any part of our business and, in addition require that our suppliers hold similar ethos.

Currently, all suppliers awarded a contract under the NHS Terms and Conditions for either supply of goods or provision of services are contracted under the relevant clause for modern slavery and human trafficking. Similar terms and conditions are also included by the national framework providers. For high-risk contracts, additional specific clauses can be included to strengthen contractual protection. Good Industry Practice including tackling modern slavery in supply chains ensures both Trust and suppliers commitment to anti-slavery and human trafficking; and that they conduct their businesses in a manner that is consistent with the Trust's stance on anti-slavery. In addition, an increasing number of suppliers are implementing the Labour Standards Assurance System (LSAS) as a condition of contract for tenders within high-risk sectors and product categories and indeed this has been referenced in the Government's Modern Slavery Strategy. Many aspects of the LSAS align to the seven reporting areas that the Government has outlined and should appear within any slavery and human trafficking statement.

We operate a number of internal polices which ensure we are conducting business in an ethical and transparent manner. These include:

Recruitment - we operate a robust recruitment policy, including conducting eligibility to work in the United Kingdom checks for all directly employed staff. Agencies on approved frameworks are audited to provide assurance that preemployment clearance has been obtained for agency staff, to safeguard against human trafficking or individuals being forced to work against their will.

Equal Opportunities - we have a range of controls to protect staff from poor treatment and/or exploitation, which complies with all respective laws and regulations. These include provision of fair pay rates, fair terms and conditions of employment, and fair access to training and development opportunities.

Safeguarding - we adhere to the principles inherent within both our safeguarding unborn babies and children and adults' policies. These are compliant with the relevant legislation, the Somerset Safeguarding Adult Board and Somerset Children's Safety Partnership multiagency agreements and provide clear guidance so that our employees are clear on how to raise safeguarding concerns.

Freedom to Speak Up - we operate a Freedom to Speak Up policy so that everyone in our employment knows that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals, and the various ways in which they can raise their concerns.

Standards of business conduct – the Trust's Code of Conduct and Managing Conflicts of Interest Policy clarifies the manner in which we behave as an organisation and how we expect our employees and suppliers to act.

We follow employment checks and standards which include the right to work and depend on receiving suitable references.

We are committed to social and environmental responsibility and have zero tolerance of modern slavery and human trafficking. Any identified concerns regarding modern slavery and human trafficking would be escalated as part of the organisational safeguarding processes in conjunction with partner agencies.

We will:

- comply with legislation and regulatory requirements.
- ensure suppliers and service providers are aware we promote the requirements of the legislation.
- develop awareness of modern slavery issues.
- include modern slavery conditions or criteria in specifications and tender documents within the supplementary terms and conditions.

- encourage suppliers and contractors to take their own action and understand their obligations about these new requirements.
- expect supply chain/framework providers to demonstrate compliance with their obligations in their processes.

Our approach to procurement and our supply chains

Trust staff must contact and work with the procurement departments when looking to work with new suppliers so appropriate checks can be undertaken.

Procurement staff will ensure due diligence by:

- checking draft specifications include a commitment from suppliers to support the requirements of the Act.
- not awarding contracts where suppliers do not demonstrate their commitment to ensuring slavery and human trafficking are not taking place in their own business or supply chains.
- communicating clear expectations to our suppliers through a supplier code of conduct.
- monitoring compliance by suppliers with the requirements of the Act.

Training

Advice and training about modern slavery and human trafficking is available to staff through our mandatory safeguarding children and adults training programmes, our safeguarding policies and procedures, and our safeguarding leads. It is also discussed at our corporate induction training which is mandatory for all our new starters. We are looking at ways to continuously increase awareness within our organisation, and to ensure a high level of understanding of the risks involved with modern slavery and human trafficking in our supply chains and in our business.

Our Performance Indicators

We will know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our business or supply chain if there are no reports from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified.

This statement has been approved by the Trust's Board of Directors who will continue to support the requirements of this legislation. The Board will aim to review and update it on an annual basis.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2026.

Signed on behalf of the Board of Directors

Dr Rima Makarem
Chair

Peter Lewis
Chief Executive

Date:

APPENDIX A

MEDIA COVERAGE

Over the period 25 January 2025 to 24 February 2025 there has been the following media coverage:

1. MEDIA COVERAGE

BBC Morning Live coverage of AI-assisted prostate cancer diagnosis

1.1. We were approached by the national BBC Morning Live team who visited Musgrove Park Hospital to film part of a story about prostate cancer diagnosis, which included our involvement with the Lucida Medical Pi AI diagnosis tool. The coverage included an interview with our consultant radiologist, Dr Elena Newby. You can watch the programme here (30:05 minutes into programme).

Respiratory Hospital @ Home service

1.2. On the back of coverage about winter pressures, we invited ITV Westcountry to find out more about our Respiratory Hospital @ Home service. The coverage features interviews with Dr Phil Raines, our respiratory consultant at Yeovil Hospital, Vicky Melhuish, the service's clinical lead, and also Patient Mike. Read the article and watch the video clip here.

Robotic surgery operating table for MPH's theatres

1.3. Following a proactive press release by the trust, there was coverage on Somerset Live about how surgeons at Musgrove Park Hospital have welcomed the donation of a specialist operating table, funded by Love Musgrove, Bower Cancer Charity, League of Friends and SURE to enhance robotic surgery capabilities. The article is here. In addition, Mr Tom Edwards, one of our colorectal consultant surgeons, was interviewed on BBC Radio Somerset. Listen here (1.08:05 into programme. The story was also covered on BBC Online here, National Health Executive here and Apple FM website here.

Trust pays out nearly £10m in compensation for surgery errors

1.4. Coverage on Somerset Live about how then trust has had to pay nearly £10m in compensation to patients who have suffered from surgery errors, according to new figures. The pay-outs totalling £9,834,052 were made in the past five years, with the highest amount, £4,652,125, in 2023/24. Read more here.

Cleaner celebrating 35 years at Taunton's Musgrove Park Hospital

1.5. Following a proactive press release about cleaner Sue Lee's 35th anniversary of working at Musgrove Park Hospital, there was coverage in the Somerset County Gazette here, and on the Apple FM website here.

Patient died after pressure ulcer repositioning plan ignored

1.6. Coverage in the Nursing Standard about the Coroner's prevention of future deaths report, which says one of our patients developed pressure ulcers and septicaemia in hospital and died, in part due to lack of adherence to her care plan, which included repositioning every 1-2 hours. The article is here.

Birthday celebrations at Taunton and Yeovil hospitals' private units

1.7. Coverage in the West Somerset Free Press about the 35th anniversary of both the Kingston Wing at Yeovil Hospital and Parkside at Musgrove Park Hospital. Read the article here.

Bridgwater Hospital 10th anniversary garden

1.8. Following proactive communication by the trust, there was further coverage on Somerset Live about the 10th anniversary of the new Bridgwater Hospital, where colleagues and volunteers came together to officially open a new hospital garden. The coverage is here.

Praise for Musgrove Park Hospital's care from former Somerset County Gazette chief reporter

1.9. Reporter chief reporter Phil Hill, now a columnist at the Somerset County Gazette, sang the praises of Musgrove Park Hospital in his weekly column. Read it here.

Doctors' Surgery to Expand Amidst Surge in New Housing

1.10. Coverage on the BBC News Online website about how Ryalls Park Medical Centre, run by Symphony Healthcare Services, is set to undergo an expansion to accommodate the influx of patients expected from hundreds of new homes being built in the area. The article is here.

Hyper acute stroke unit move

1.11. Coverage on Somerset Live about how Somerset health bosses (NHS Somerset ICB) have defended their planned changes to Yeovil Hospital's stroke unit in the face of longer ambulance waiting times for stroke victims. The article is here.

Metabolic health 28-day plan

1.12. We recently invited the health correspondent from BBC Points West into Wincanton Health Centre where he spoke to GP Dr Campbell Murdoch and health coaches Megan Perrin and Sarah Wiscombe about metabolic health and the 28-day plan. The BBC Online article is here.

Bruton Surgery development

1.13. News about how a planning application has been granted for new homes in the Bruton area, including a new surgery. The article on Somerset Live is here.

Burnham Medical Centre meeting

1.14. Coverage on Burnham-on-Sea Online about an open afternoon being held at Burnham Medical Centre by Patient Participation Group. The article is here.

Swingbridge House development

1.15. Coverage on Somerset Live and Somerset County Gazette about how the trust has submitted a planning application to develop Swingbridge House into a facility that aims to provide specialist care for children and adolescents struggling with eating disorders, ensuring access to education, psychological therapies, and mealtime support within a community-based setting. The Somerset Live article is here and Somerset County Gazette here.

Ten year anniversary of MPH's Jubilee Building

1.16. The Somerset County Gazette looks back at 10 years of the Jubilee Building at Musgrove Park Hospital, including photos of the official opening. The article is here.

Somerset community diagnostic programme sees 500,000th patient

1.17. Further coverage this week on the Somerset Live website about the milestone for our community diagnostic centres, which have now seen 500,000 patients. The article is here. The programme director, David Craig, also gave a briefing to the Health Service Journal about the achievement.

Retirement of assistant facilities manager Steve Watts from MPH

1.18. Following a proactive press release and social media post, there was coverage in the Somerset County Gazette about how Steve Watts, a long-serving estates and facilities colleague at MPH is parking up his porter's trolley as he retires from the NHS. Read more here.

Somerset doctors lead breakthrough study to boost life-saving cancer screenings

1.19. Coverage on BBC Radio Somerset, Somerset Live and Apple FM about how doctors at our trust are leading an important study into whether new mothers or birth parents would prefer to have a cervical screening (smear) test at their six-week postnatal appointment, instead of waiting for 12 weeks. The BBC Radio Somerset interview is here (first part: 1.55:40 into programme until MS Teams had technical issues; second part: 2.42:15 into programme – without technical issues), Somerset Live article here and Apple FM article here.

Somerset hospitals one of the highest in UK for patients with no with criteria to reside

1.20. Coverage in the Somerset County Gazette about how our hospitals in Somerset have among the higher numbers of "medically fit" patients in the

1.21. country, who cannot be discharged because of a lack of post-care services. Read more here.

A&E 12 hour waits

1.22. Coverage on this morning's (Friday 31 January) BBC Radio Somerset news bulletins about a rise in the number of patients who've had to wait for 12 hours or more for a bed following the end of their treatment in A&E. You can hear the piece here (1.01:25 into programme).

Bridgwater health and social care academy work to begin this year

1.23. Coverage in the Bridgwater Mercury about how work on Bridgwater's new health and social care academy will begin by the autumn of 2025, according to Somerset Council. Read more here.

Kind words for MPH's maternity unit from Peter Andre

1.24. Coverage across a number of local media outlets across the UK about positive feedback given by Peter Andre on TV show Loose Women about his family's experience of the maternity unit at MPH. Read more here.

MP Sarah Dyke voices concerns over Somerset stroke care changes

1.25. Coverage in the Somerset County Gazette about how a Somerset MP has raised concerns over the planned relocation of the county's hospital-based stroke services. Read more here.

Charity donations to MPH's children's unit

1.26. Coverage in the Somerset County Gazette about how residents have been thanked for contributing to the 125,000 toys donated to children in need, including at our children's unit at MPH, during the run-up to Christmas. Read more here.

APPENDIX B

NATIONAL DEVELOPMENTS

The report covers the period 25 January 2025 to 24 February 2025, there have been the following national developments:

1. NATIONAL DEVELOPMENTS

NHS England publishes planning guidance for 2025//6

1.1. On Thursday (30 January) NHS England published the priorities and operational planning guidance for 2025/6, which streamlines priorities and success measures from 32 in 2024/5 to 18 in 2025/6.

1.2. National priorities are to:

1. Reduce the time people wait for elective care, improving the percentage of patients waiting no longer than 18 weeks for elective treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement. Systems are expected to continue to improve performance against the cancer 62-day and 28-day Faster Diagnostic Standard to 75% and 80% respectively by March 2026.

2. Improve A&E waiting times and ambulance response times compared to 2024/5, with a minimum of 78% of patients seen within 4 hours in March 2026. Category 2 ambulance response times should average no more than 30 minutes across 2025/6.

3. Improve patients' access to general practice, improving patient experience, and improve access to urgent dental care, providing 700,000 additional urgent dental appointments.

4. Improve patient flow through mental health crisis and acute pathways, reducing average length of stay in adult acute beds, and improve access to children and young people's (CYP) mental health services, to achieve the national ambition for 345,000 additional CYP aged 0 – 25 compared to 2019.

1.3. In delivering on these priorities for patients and service users, ICBs and providers must work together, with support from NHS England, to:

1. Drive the reform that will support delivery of our immediate priorities and ensure the NHS is fit for the future. For 2025/26 NHS England asks ICBs and providers to focus on:

- Reducing demand through developing Neighbourhood Health

Service models with an immediate focus on preventing long and costly admissions to hospital and improving timely access to urgent and emergency care

- Making full use of digital tools to drive the shift from analogue to digital

- Addressing inequalities and shift towards secondary prevention.

2. Live within the budget allocated, reducing waste and improving productivity. ICBs, trusts and primary care providers must work together to plan and deliver a balanced net system financial position in collaboration with other integrated care system (ICS) partners. This will require prioritisation of resources and stopping lower-value activity. To deliver the goals set out above and live within budget, providers will need to reduce their cost base by at least 1% and achieve 4% overall improvement in productivity before taking account of any new local pressures or dealing with non-recurrent savings from 2024/25.

3. Maintain our collective focus on the overall quality and safety of our services, paying particular attention to challenged and fragile services including maternity and neonatal services, delivering the key actions of 'Three year delivery plan', and continue to address variation in access, experience and outcomes.

1.4. ICBs and providers have until 27 March to develop plans to meet the national guidance and local priorities agreed by ICSs.

NHS England publishes monthly performance data

1.5. NHS England this week published the latest NHS performance data. The NHS England press release highlights:

- Waiting list fell in December for the fourth month in a row.

- The overall backlog has dropped again from 7.48 million to 7.46 million, while the estimated number of patients waiting is down from 6.28 million to 6.24 million.

- NHS staff delivered a record 18 million treatments in 2024, hundreds of thousands (4%) more than in 2023 (17.35 million) and 5% more than in 2019 (17.1 million).
- In December alone, the NHS carried out 1.33 million treatments, up 6.5% on 1.25 million the year before.

- The proportion waiting less than 18 weeks was 58.9%, up from 56.6% in December 2023.

1.6. NHS Providers response to the performance data is here. Media reporting of the figures primarily focussed on the number of patients waiting over 12 hours after A&E admission reaching a record high.

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Our Inclusive Organisation Progress Report
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Harriet Jones, Head of Inclusion
PRESENTED BY:	Peter Lewis, Chief Executive
DATE:	4 March 2025

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 paper provides a high-level overview of our progress and next steps for creating an inclusive organisation at Somerset NHS Foundation Trust (SFT). This provides a reflection on the journey we've made so far, the progress we've seen, and our priorities for the next 12 months. We provide a reflection on our key enablers and challenges for creating an inclusive culture and equitable outcomes for our patients and colleagues. This paper also describes the Board's role in leading on inclusion, and to ensure inclusive practice is fully embedded across SFT, holding teams to account on their inclusion objectives, and ensuring we make measurable progress. The paper outlines proposals for development and support for the Board in prioritising and embedding inclusion in their remit.
Recommendation	The Board supports and approves the proposed next steps outlined below.

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	Delivering the vision of the trust by transforming our services through research, innovation and digital technologies.

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?

The paper outlines how SFT will develop and extend our approach to inclusion, which is informed by leading research and practice. Our aim is to ensure our work has a positive and measurable impact on people with protected characteristics – extending our focus from our workforce to include our patients and wider organisational impact.

The attached workforce plan (appendix) outlines data-informed actions that are designed to remove and reduce systemic inequalities and improve outcomes for colleagues 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.

The inclusion workforce plan has been developed based on analysis of workforce data, staff survey data, as well as feedback from colleague networks and other sources. The aim is that developments of patient and carer facing involvement will be co-produced.

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 attached Workforce Inclusion Plan has been reviewed and discussed previously by the People 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

OUR INCLUSIVE ORGANISATION PROGRESS REPORT

1. BACKGROUND AND PURPOSE

1.1 In line with our strategic objectives and the objectives of the People Strategy, we have been working to embed an impactful, systemic, approach to inclusion across SFT. We have made progress; seeing a change in conversations, actions taken, and engagement across the trust. However, we recognise that our work to date has largely focused on our workforce, and more focus is needed on our strategic objective to reduce health inequalities.

1.2 We are now considering how we broaden the scope of our work and apply this approach to everything we do as a Trust, including ensuring the provision of inclusive and accessible care for all our patients, and embedding inclusion across all organisational processes and governance.

1.3 Research highlights that for organisations to make significant progress on inclusion, the tone and direction needs to be set by the Board. The Board has a role in holding all leaders and teams accountable for inclusion and equity outcomes, and for seeking assurance that the Trust is making progress on inclusion aims.

2. PROGRESS TO DATE

2.1 Prior to merger, both Somerset and Yeovil District Hospital NHS Foundation Trusts had activities in place to promote an inclusive workplace. These activities included colleague networks and marking significant events such as Black History Month and International Women's Day.

2.2 Following the merger, we have been working to adopt a research-informed approach that aims to address the causes of inequality and therefore creating measurable impact and change.

2.3 This shift in approach has been welcomed, but it is not easy. It represents a significant change in how people interact with an inclusion team and the activities they expect to see. It also asks all teams to consider the impact they have and the actions they can take to create an inclusive culture and to ensure equitable outcomes.

2.4 Progress has been made. For example:

- We have a new recruitment system that allows us to better understand our diversity data, design a process that as fully accessible, and trial innovative approaches to skills-based and inclusive recruitment. Since the introduction of the new system we have seen an increase in

the number of applicants opting into the disability confident guaranteed interview scheme - from 259 to 400.

- We have made progress in developing a simpler and more streamlined approach to providing reasonable adjustments. Staff survey data shows a gradual increase over time in the proportion of disabled colleagues who have an adjustment in place – up to 81% in 2024.

- We have introduced People Impact Assessments (PIAs) to ensure all people policies and deliverables under the people strategy are designed to be truly inclusive and mitigate any unintended inequitable outcomes. We are planning to embed PIAs in other governance and decision-making processes across SFT.

- We rolled out Allyship training which has been co-delivered by Executive colleagues. This has reached over 500 colleagues, been well received, and there are plans to measure the impact of this training over time.

2.5 Further examples of progress and impact can be seen in Appendix 1 – Workforce Inclusion Plan Update. We have seen a shift in the conversations happening across the Trust and engagement in our approach, but there is more work to be done to embed this approach across the organisation.

2.6 In terms of our work to promote inclusion and reduce inequalities, we have launched a number of programmes that have impacted positively on groups from protected characteristics. These include:

- Targeted cancer screening

- Elective care waiting list prioritisation for people with a serious mental illness or learning disability

- Continuity of care in maternity services

- Establishment of the high impact user group

- Homeless and rough sleeper nursing service

- Primary care cancer screening for people with a learning disability

2.7 We have also established connections with a wide range of representative organisations to inform our service developments through active feedback, including Somerset Diverse Communities; 2BU Somerset; Gypsy Roma and Traveller communities.

3. OUR ENABLERS AND CHALLENGES

3.1 The table below presents a view of our organisational enablers and challenges for making progress on inclusion. These represent the leadership capability, organisational culture and governance mechanisms that can drive a systemic approach and impact.

Enablers	Challenges
New CQC framework: The new CQC strategy and proposed single assessment framework have indicated that regulators expect organisations to embed inclusion across all areas of assessment. By continuing to embed a systemic approach to inclusion, we will be meeting or exceeding CQC expectations.	**Governance and tools for inclusion:** This is a new way of working for many teams and will take time to embed. Work needs to be done to ensure the appropriate tools, data, and governance are in place to enable a systemic approach to inclusion in line with the CQC strategy and expectations.
Engagement and commitment: We see a sincere and meaningful commitment to inclusion across SFT, and there is a growing understanding and engagement in a systemic approach.	**Data and insights:** While we see significant engagement, we aren't consistently providing the data and insight to leaders and teams to enable systemic and impactful action on inclusion for colleagues or patients (as above). The new patient and carer race equality framework (PCREF) provides an opportunity to learn and adopt best practice, initially within mental health services in relation to racialised communities but ultimately across service groups and protected characteristics.
Workforce Inclusion Plan: this is a data-driven action plan aligned with the SFT People Strategy. This plan includes actions responding to nationally required reports including the WRES, WDES and gender pay.	**Wider focus:** There are currently no equivalent data-driven inclusion plans or set of actions for other areas across the trust. For example, this could include actions within Estates to improve accessibility and inclusive environments, or data-driven actions to improve the inclusivity of patient care. A draft trust-wide inclusion strategy was shared with Board in July 2024. This would help support a wider focus, and assessment under the new CQC framework, but has not yet been consulted on or adopted as a trust strategy.
Executive Inclusion Objectives: Each member of the Executive identified their own inclusion objective, with the aim that these objectives were systemic actions (rather than personal development).	**Board leadership on inclusion:** Research consistently highlights that for real progress to be made on inclusion, it must be led by the Board and linked to the organisational mission, vision and strategy. Effectively

	leading on inclusion requires Boards to hold all leaders and teams accountable on inclusion priorities, and to ensure inclusion is considered across all areas of the Board's work.

4 NEXT STEPS

4.1 Supporting the Board to take on a leadership role for inclusion:

- **Board commitment, engagement and leadership of inclusion**: Research highlights[1] that for an organisation to make progress against its stated inclusion goals, inclusion needs to be led and driven at Board level and spread throughout the organisation. Inclusion and inclusive practice should be fully embedded across all Board activities and decision making. A program of work is being planned that will provide development and support for the Board, as well as providing a framework for Board to set accountability, seek assurance and lead by example on inclusion.

- **The diversity of Board**: Research has shown a link between the diversity of Boards and the success and innovation of organisations[2] [3]. There are currently vacant Non Executive Director positions on the Board, which provides an opportunity to adopt a brave and research-informed approach to ensure our Board becomes more diverse over time, as well as recruiting individuals with the relevant skills to lead effectively on inclusion at Board level.

- **The inclusivity of Board**: Research has evidenced[4] that diversity alone is not enough - to gain the benefits of diversity, the Board needs to be an inclusive environment where everyone can contribute, bring different perspectives, and inform decision making. It is important for the Board to reflect on their practices and ways of working to ensure the Board and sub-committees are truly inclusive.

4.2 A trust-wide inclusion strategy:

- Following the development work with the Board (described above), the Board should re-visit the draft inclusion strategy for SFT. This will provide a mechanism for Board to agree governance, accountabilities and monitoring for inclusion beyond a focus on our workforce.

[1] The inclusion imperative for boards | Deloitte Insights
[2] Strengthening-NHS-board-diversity-report.pdf (nhsconfed.org)
[3] Research: Firms with Diverse Boards Achieve Higher ESG Ratings (hbr.org)
[4] Is Your BoardInclusive — or Just Diverse? (hbr.org)

- The aim of the draft strategy is to fully embed inclusion in all trust activities and ways of working, covering the following areas:
    - An innovative approach to culture change
    - People policies and processes that drive inclusion
    - Patient care that is inclusive and addresses health inequalities
    - Physical and digital environments that are accessible and inclusive
    - Communication and engagement that is representative and inclusive
    - Governance processes that embed inclusion in all that we do
- Progressing and adopting this strategy will further support our ability to meet the requirements under the new CQC framework.
- The strategy will also aim to ensure we are not only meeting national requirements (including the WRES, WDES, gender pay gap reporting and PECRF) but taking a holistic view of inclusion rather than these requirements leading to a stand-alone tick-box approach.

4.3 **Designing and implementing a governance framework that drives and embeds inclusion.**

This would include, but is not limited to:

- **Provision of relevant and informative diversity data**: This data would need to be provided in an accessible and informative way and built into existing governance frameworks and reporting. This would include diversity demographic breakdowns of workforce data, colleague and patient engagement and feedback data, as well as patient access and outcome data. This data should inform local workforce plans, service design, and ongoing improvement. We recognise that, at present, this dataset will be incomplete. A first step will be to identify the gaps in data where they exist and to consider how we address these – through further data gathering; additional engagement with people and communities; and/or relevant research.
- **Establishing clear accountability for inclusion**: Our governance frameworks should embed inclusion, with clear accountabilities across the organisation. This would help to articulate the responsibilities and outcomes we expect to see across all areas and teams – i.e. not only in people services. This would include the expectations that PIAs are completed for all service development and transformation programmes and from a core part of any approval process through the Trust's governance systems.

5. RECOMMENDATION

5.1 The Board is asked to approve the proposed next steps described above.

APPENDIX 1 - WORKFORCE INCLUSION WORKPLAN 2023-2028
Update January 2025

Our Workforce Inclusion plan aligns with the SFT People Strategy. Many of the actions below relate to actions in our strategy. The below reflects progress against our actions as of January 2025. We have included a RAG rating for each action, along with an update on progress. We've also added an impact column so that we can measure and track impact over time, and identify further actions needed if we haven't seen the impact expected.

We have recognised that many of the timeframes originally committed to need to be reviewed. Timeframes have changed to due multiple factors including changing team members, restructures, and making financial savings. The timeframes for the actions below will align with our intentions under the People Strategy.

RAG rating:
- Green – complete
- Amber – in progress
- Red – not started.

Action	What we know (2023)	Accountability	Timeframe	Strategic and Reporting Links	Progress	Impact
Key Theme 1: Recruitment						
Procure and embed an Applicant Tracking System (ATS) that enables us to: 1. Undertake a detailed analysis of diversity recruitment data at application, interview, and appointment stages. 2. Ensure we provide an accessible and inclusive hiring process by design. 3. Extend anonymised hiring practices where possible. 4. Ensure the Disability Confident guaranteed interview scheme works in practice.	There is a lack of reliable or accurate data on our recruitment process – impacting our ability to undertake an analysis of diversity trends. The data we do have, suggests a white candidate is more likely to be appointed in comparison to a BAME candidate. The Disability Confident Audit identified that the guaranteed interview scheme does not work in practice due to issues with our current ATS.	- Belinda Lock / Debs Matthewson / Noella Rowton (Resourcing and Supply)	- New ATS in place by June 2024 - Review of inclusion impacts of ATS quarterly (analysis of impact to lead to new actions)	- People Strategy - Retain and attract talent. - WRES Metric 1 & 2 - WDES Metric 1 & 2 - Disability Confident -	**In progress:** Oleeo is in place and was procured to embed inclusive practice. Diversity demographic data is now collected and can be analysed to assess impact. The Disability Confident Scheme has been tested and is working. We now need to embed regular diversity reporting and develop further actions in response to improved data. Data to be made available at service group level.	Diversity demographic data is now available to analyse (significant improvement on previous system). Increased take up of Disability Confident guaranteed interview scheme since introducing Oleeo - 400 applicants vs. 259 in previous system. We have seen an improvement in the accuracy of our data and an increase in applicants declaring a disability – 3.3% of applicants in Trac compared to 4.9% since using Oleeo.
Move towards a skills-based model of hiring. 1. Provide development and up-skilling for recruitment team to understand and implement an inclusive and skills-based approach to hiring. 2. Work with external experts to develop a skills-based model that is designed to be fully inclusive and accessible.	Research suggests skills-based hiring is the most effective model for addressing bias in recruitment and ensuring equitable outcomes.	- Belinda Lock / Debs Matthewson / Noella Rowton (Resourcing and Supply)	- Engage consultant to support the design of an inclusive assessment centre model - July 2024 - Inclusive and skills-based recruitment development for recruitment team - July 2024	- People Strategy - Retain and attract talent. - WRES Metric 1 & 2 - WDES Metric 1 & 2	**In progress:** A Recruitment Oversight Group has been established to oversee this work. Upskilling of the team on Skills Based Recruitment is needed to progress this work. Opportunities for piloting innovative approaches and team	

Action	What we know (2023)	Accountability	Timeframe	Strategic and Reporting Links	Progress	Impact
			- Skills-based and inclusive assessment centre in place by Dec 2024 - Revisit recommendations from RoleMapper – January 2025		development was identified but paused due to costs.	
Embed inclusive recruitment processes and tools that improve applicant experience and equitable outcomes. For example, these include, but not limited to: 1. Ensure we are equipped to provide reasonable adjustments at every stage of the recruitment process. 2. Explore alternative methods of selection as well as or instead of a traditional interview. 3. Pilot providing skills-based and inclusive interview questions in advance to all candidates. 4. Ensure the use of AI tools in recruitment mitigate bias.	Skills-based hiring, and the new ATS will make significant improvements to our recruitment process, and our ability to embed inclusive practice. However, there will be other mechanisms that we need to explore and embed within our process. Recommendations from the Disability Audit identified the need to improve our recruitment process to be more accessible and to provide appropriate adjustments. While there are numerous benefits to using AI in recruitment, emerging research highlights the risks to embedding bias within processes if AI tools aren't designed or assessed from an inclusion perspective. This is something that will need to be considered throughout future pilots and applications of AI.	- Belinda Lock / Debs Matthewson / Noella Rowton (Resourcing and Supply)	- Assess the provision of reasonable adjustments - March 2025 (following implementation of reasonable adjustments policy, and the Work Well program). - Develop bank of interview questions for hiring managers to use and share with candidates before the interview – from Sept 2024. Review impact for pilot groups in March 2025.	- People Strategy - Retain and attract talent. - WRES Metric 2 - WDES Metric 2 - Disability Confident	**In progress** - Improvements have been made to the recruitment process to explicitly promote reasonable adjustments during recruitment. More work is needed to up-skill hiring managers and the recruitment team on supporting these adjustments. Pilots are being run locally where interview questions are being provided in advance. Initial feedback from internationally educated colleagues, and those with disabilities, has indicated that this has been very helpful in preparing for interviews. ChatGPT Pro is being piloted within Estates and Facilities to test mitigation against bias.	Providing interview questions in advance was piloted for all roles in Medical Services. The intention was to support internationally educated colleagues progress into senior roles. Initial impact shows an increase in BAME representation at band 8 and above from 2% in 2023, to 7.8% in 2024.
Review and update the SFT recruitment website to reflect diversity and inclusion, including a focus on: 1. The diversity of images used. 2. Information on accessibility and reasonable adjustments 3. Information on the culture of inclusion at the trust, the progress being made, and colleague networks	Opportunities for improvement were identified through the Disability Confident Audit, this included promoting the trust as an inclusive employer and providing information on arranging reasonable adjustments throughout the recruitment process.	- Belinda Lock / Debs Matthewson / Noella Rowton (Resourcing and Supply) - Lisa Pyrke (Comms)	- Complete – Review and audit of website completed, with improvements made in March 2024. - Review website content March 2025.	- People Strategy - Retain and attract talent. - WRES Metric 2 - WDES Metric 2 - Disability Confident - NHS Rainbow Badge assessment	**Complete:** The recruitment website was reviewed and updated in 2023, and again in 2024. Diversity of images have improved using the new communications team image library.	Positive feedback received from colleagues, and positive feedback in the Rainbow Badge results report.

Action	What we know (2023)	Accountability	Timeframe	Strategic and Reporting Links	Progress	Impact
Develop training for recruitment managers that fully embeds content on inclusive practice and bias mitigation strategies at every stage of the recruitment process.	While the new ATS will enable more inclusive approaches and techniques for hiring, there will still be a need for development for hiring managers.	- Belinda Lock / Debs Matthewson / Noella Rowton (Resourcing and Supply)	- Training on new system rolled out from July 2024 - Ongoing improvement and development of training reviewed annually.	- People Strategy - Retain and attract talent. - WRES Metric 2 - WDES Metric 2 - Rainbow Badge	**In progress:** The recruitment team have built tips on inclusive practice into current training provided for hiring managers. Oleeo has been designed to promote inclusive practice and behaviours. One example is that hiring managers cannot post a role until they have completed the basic training – which will include content on inclusion.	
Key Theme 2: Retention and Progression						
Take steps to improve the progression and retention for internationally educated colleagues. This will include, but is not limited to: 1. Understand the needs of internationally educated colleagues in different staff groups, including nurses, midwives, AHPs, and doctors. 2. Improvements to the induction and onboarding process. 3. Develop and implement Cultural Competency training for managers of culturally diverse teams. 4. Ensure colleagues are not charged as international students when completing qualifications. 5. Review opportunities to support colleagues applying for their right to remain visa (this comes at a significant financial cost to colleagues). 6. Review of the DAL programme, and opportunities to apply positive aspects to internal training. 7. Opportunities to support internationally educated doctors to become consultants. 8. Consider how we meaningfully acknowledge, and value experience gained oversees before joining the NHS.	The majority of BAME colleagues are employed at band 5 – 41% of colleagues at band 5 are BAME. Representation then falls significantly to 12% at band 6. In comparison to 2021, the representation of BAME colleagues has increased from 14%. There has also been an increase across most bands, including an increase from 31% to 41% at band 5, and from 9% to 12% at band 6. In medical and Dental roles, BAME colleagues are more highly represented in SAS roles (51%), compared to 22% in consultancy roles. Representation has not changed at consultant level since 2021.	- Lou Netto / Wendy Powell (Experience & Learning) - Alison Wooton (Senior care team) - Noella Rowton (Medical Workforce Strategic Development)	- Working group to be established to develop a plan for this work – in place by June 2024. - Cultural Competency training in place from September 2024, with regular impact reviews. - Review of impact and lessons learned from DAL programme – July 2024.	- WRES Metric 1 - People Strategy – Retain and attract talent	**In progress:** A scoping exercise has been completed, compiling all data and feedback available to help us understand the barriers to progression and retention for international colleagues. Cultural competency training has been developed and is being launched in April 2025. The training is intended to support managers, especially those who support internationally educated colleagues. 6 colleagues took part in the 2023/24 DAL programme – this is the Developing Aspirant Leaders (DAL) Programme for ethnic minority nurses and midwives, run by NHS England. 4 colleagues are part of the 2024/25 cohort. Guidance on languages spoken at work has been developed and communicated. Our annual leave policy was amended following feedback from internationally educated colleagues that they were not being supported to take longer periods of leave to travel home.	There has been an increase in BAME representation in more senior roles across the Trust. This is likely the result of local action within certain teams and service groups (e.g. some significant improvements in Medical Services). - Band 6 – BAME representation has increased from 12% in 2023 to 15.5% in 2024. - Band 7 – small increase from 5% in 2023 to 6.8%

Action	What we know (2023)	Accountability	Timeframe	Strategic and Reporting Links	Progress	Impact
					International Medical Graduate tutors have been appointed to assist with understanding the needs of internationally educated medical colleagues. There is a CESR lead and mentors within the departments who can support internationally educated medics with the application for the new portfolio pathway.	
Review and improve our reasonable adjustments policy and process.	This was a key finding from the BDO Disability Confident Audit in 2023. In 2022, the NHS staff survey showed that almost a third of colleagues with a disability do not have a reasonable adjustment in place to enable them to carry out their work. This could equate to roughly 1200 people without an adjustment in place. A large number of ongoing HR cases and tribunal cases relate to disability, and often a lack of reasonable adjustments discussed and when offered they were not all fully considered or understood. We also recognised a significant increase in concerns being raised via the Lived Experience and Neurodiversity Networks.	- Lou Netto (Experience & Learning)	- New policy and process ratified and in place by May 2024. - Comms plan implemented throughout 2024. - Training in place by October 2024. - Review of impact of policy and process April 2025. - Pilot programmes supporting neurodiverse colleagues implemented April-July 2024 and reviewed in August 2024.	- Disability Confident - WDES Metric 8 - People Strategy – Retain and attract talent	**In progress:** A working group undertook a holistic review of the reasonable adjustment process. A new policy is due to be ratified early in 2025, a central fund for reasonable adjustments has been created, and toolkits and guides for colleagues and managers have been published. Following feedback from the Neurodiversity network, we have identified pilot approaches that support individuals and their managers to identify suitable adjustments via our new OH provider and Genius Within. Training for the HR Advisor, Colleague Support and Freedom to Speak Up teams is being arranged through Genius Within, to be completed early in 2025. We worked with an external company to review our IT adjustments in 2024, this identified a number of recommendations for further improvement.	Staff Survey 2024 – 81% of colleagues with a disability reported they have an adjustment in place. This has increased by 3% percent from 2023.
Ensure career conversations enable colleagues to effectively plan for their progression, with development opportunities provided by their manager and centrally via People Services. Ensure this is designed to meet the needs of all colleague groups and demographics.		- Debs Matthewson (Resourcing and Supply)	- Year 2 people strategy deliverable – review impact and progress in March 2025	- People Strategy – Develop our people	**In progress:** As part of the implementation of the people strategy, a deliverable group has been established focusing reviewing and improving progression and career conversations.	

Action	What we know (2023)	Accountability	Timeframe	Strategic and Reporting Links	Progress	Impact
Review our parental leave provisions, with a particular focus on: 1. Colleagues are encouraged and feel able to access shared parental and paternity leave. 2. Our policies are explicitly inclusive of LGBTQ+ families. 3. There are clear mechanisms and guidance for keeping in touch and up to date during parental leave. 4. There is a clear process and guidance to support a smooth and successful return from parental leave.	A relatively low number of colleagues are accessing parental and paternity leave. There were no records of colleagues accessing shared parental leave. However, our BAME colleagues are more likely to access these provisions. Within our Rainbow Badge assessment report, the trust scored 0 out of 5 for the review of policies relating to parental leave, as they were not seen to be explicitly inclusive of LGBTQ+ families. The Women's Network undertook a survey of colleagues who had recently taken parental leave in 2021. This was developed into a series of actions that need to be adopted and reviewed within people services.	- Lou Netto (Experience & Learning)	- New policy developed and communicated by June 2024. - Review of impact of policy June 2025.	- People Strategy - Care for our people - Rainbow Badge	**In progress:** A Parental Leave policy was drafted and presented to the networks prior to going to People Policy Group. Following extensive feedback, the policy is now being reconsidered. The main feedback being there were too many policies in one document. Following the feedback the policy is being split into Maternity and parental leave, and a Baby Loss Policy.	
Develop and implement guidance for colleagues who are transitioning. This guidance should include information for the individual and their manager.	As part of the rainbow badge scheme, there was a clear recommendation that the Trust finalises and publishes the draft guidance that has been developed. Feedback has been provided by the LGBT Foundation. Anecdotal feedback from colleagues who are transitioning is that there is very little information or advice available, and managers are unsure how best to support.	- Lou Netto (Experience & Learning)	- New guidance developed and communicated by June 2024. - Comms, information, and training in place by October 2024. - Review impact of guidance June 2025.	- Rainbow Badge	**In progress:** This guidance has been drafted, and consultation has been undertaken with members of the LGBTQ+ network, relevant stakeholders, and managers. People Policy Group reviewed this and agreed the guidance needed to be a policy. The policy is due to be presented again in April 2025.	
Investigate within-band pay gaps, particularly gaps within senior roles. Analysis might include: 1. Analysis of starting salaries to explore whether the negotiation process establishes a pay gap. 2. Gender and race distribution across banding pay points.	There are some gender and race pay gaps within bands, particularly at band 8D and above, and within several Medical and Dental roles.	- Kirstie Lord (Strategy and Profession Development)	- Report on existing data by demographic groups to be presented to pay assurance committee - July 2024 - Further actions developed in response to analysis – September 2024.	- Gender Pay Gap	**Not started** Mandatory gender pay gap reports are submitted annually. These reports have shown little significant changes in our pay gap over the past three years. For the past three years we have also analysed our data to understand our race pay gap. A report was taken to Pay Assurance Committee, but it was agreed this is not the right place to take pay gap work.	

Action	What we know (2023)	Accountability	Timeframe	Strategic and Reporting Links	Progress	Impact
Ensure any future Clinical Excellence Award scheme is implemented and designed to be inclusive, so further pay gaps are not created.	The historic CEA scheme has created a legacy gender pay gap of 30.2%. This compares to the current scheme, where CEAs are shared equally between consultants.	- Noella Rowton (Medical Workforce Strategic Development)	- To commence when guidance is provided on any new national CEA scheme.	- Gender Pay Gap	**Complete**: Clinical Excellence Awards have been ceased with the recent pay rise and amendment to terms and conditions. We will be left with a legacy impact of previous CEAs, but no new inequalities will be created.	
Establish a pay assurance committee to oversee pay agreements outside of Agenda for Change processes. 1. Monitor data to understand whether pay offers are applied equitably, or if pay gaps are established. 2. Review and develop policies associated with discretionary pay to ensure equitable processes and outcomes.	Research shows that discretionary payments and negotiated pay are often where gender and race pay gaps are established and exacerbated.	- Isobel Clements (Chief People Officer)	- Complete - committee in place from April 2024 - Mechanisms for monitoring data by demographics – July 2024 - Review of policies – September 2024 - Annual review of committee data – from April 2025 onwards	- Gender Pay Gap	**Complete**: Committee and terms of reference established April 2024.	
Implement mechanisms, including an exit survey, to understand: 1. People's reasons for leaving the trust and whether this differs across demographic groups. 2. The length of service when someone leaves, to understand whether the rate of retention and turnover differs across demographic groups.	Our leavers data doesn't indicate that any demographic group is more likely to leave than others. However, we aren't sure what contributes to people's decision to leave.	- Lou Netto (Experience & Learning)	- Review available data and success of new mechanisms – August 2024 - Further action developed following review – September 2024	- People Strategy - Retain and attract talent	**In progress:** The trust introduced a new exit survey in 2023; however, uptake of exit questionnaire is low (11% of all leavers). Issues with the leavers process have been identified. The Retention Action Group are reviewing this.	
Key Theme 3: Leadership						
Partner with Executive Team to develop specific inclusion actions and priorities for each member of the Executive Team.	Research and best practice shows the importance of senior leaders visibly taking accountability for, and implementing, actions relating to inclusion.	- Peter Lewis (CEO) & Isobel Clements (Chief People Officer)	- SMART objectives finalised and agreed by June 2024 - Objectives communicated across SFT from September 2024 - Objectives reviewed May 2025 - Progress communicated in June 2025	- People Strategy - Compassionate and inclusive leadership	**In progress:** Each member of the Executive has identified at least 1 inclusion objective. Some members of the Executive Group have also asked their senior teams to develop their own inclusion objective. A discussion with the Executive is needed to explore if these objectives have progressed, how they report on/are accountable for these actions, and identify any impact to date.	
Ensure our leadership development programmes build compassionate and inclusive leadership skills across	Research on successful inclusion strategies consistently highlights the role crucial leaders and managers	- Lou Netto (Experience & Learning)	- Leadership expectations developed – May 2024	- People Strategy - Compassionate and inclusive leadership - WDES Metric 6	**In progress:** An approach to inclusive leadership development was piloted in	

Action	What we know (2023)	Accountability	Timeframe	Strategic and Reporting Links	Progress	Impact
our organisation. Actions would include: 1. Develop and roll out leadership expectations that embed inclusive practice. 2. Review and redesign leadership development programme to reflect the new leadership expectations. 3. Identify further development needs for leaders around inclusion and inclusive practice	play in creating and maintaining an inclusive culture.		- Leadership expectations communicated and embedded throughout 2024. - Review leadership development program – December 2024. - Ongoing review of impact of leadership expectations – December 2024 onwards.		2023/4 at the senior nurse away days, reaching 300+ colleagues. A leadership expectation framework has been developed, and inclusion is embedded. This is due to be launched in March 2025. The leadership development programme is being reviewed as part of the People Strategy. Allyship and Cultural Competency development will be part of the new programme.	
Implement mechanisms for collecting and analysing the diversity of key decision-making committees, as a minimum, this would include: 1. Trust Board 2. Board sub-committees. 3. Governors	WDES and WRES data indicates that some data is missing relating to the diversity of Board.	- Ria Zandvliet (Secretary to the Trust)	- Mechanisms for monitoring in place by December 2024. - Actions developed based on data – March 2025.	- WRES metric 9 - WDES metric 10	**Not started** Vacant non-exec positions provide an opportunity for taking innovative approaches to attract and recruit diverse NEDs, and ensure NEDs have skills in inclusion and inclusive practice.	
Key Theme 4: Workplace Culture						
Develop and progress a Trust-wide strategy on violence and aggression, which addresses the variation of experience for colleagues from diverse groups. This strategy will focus on: 1. Governance - including our reporting mechanisms, support options post-incident, and understanding our data on experiences of violence. 2. Environment – including our approach to providing security, pilots of body cams, and ensuring Trust environments are designed with safety in mind. 3. Behaviour – building de-escalation skills and a trauma informed approach across the trust, setting the tone of the behaviours that are expected, and clear processes and support if these expectations are not met.	Our 2022 staff survey indicated that: - BAME and LGB colleagues were more likely to report experiencing physical violence from patients or service users. - Female, BAME, disabled and LGB colleagues were more likely to report experiencing harassment, bullying or abuse from patients or service users. - Disabled colleagues were less likely to report their experience of violence compared to colleagues with no disability. - A lower proportion of colleagues had made a report of their experience of harassment, compared to physical violence.	- Dave Thomas (Senior care team / topic lead for violence and aggression) - Wendy Powell (Experience & Learning)	- Trust-wide strategy in place with agreed actions by September 2024.	- WRES Metric 5 - WDES Metric 4 - People Strategy - Care for our people	**In progress:** A policy has been written, along with a supporting strategy. It has been agreed the policy and strategy will embed issues relating to discrimination and racism. A project lead has been appointed to support this work. They will build de-escalation skills using a trauma informed approach into relevant processes and skills development. Radar reports are being monitored by ADPCs and are being discussed in regular governance meetings at Service Group level.	
Develop an Inclusion 101 training box set. Short videos will give people the information they need to	Conversations with teams and managers has highlighted a need for basic information and training to	- Lou Netto (Experience & Learning)	- Training and information in place for initial development	- People Strategy - Develop our people	**Not started**	

Action	What we know (2023)	Accountability	Timeframe	Strategic and Reporting Links	Progress	Impact
feel confident with the basics of inclusion. Development needs that have already been identified include: 1. What are pronouns and why are they important? 2. What is a reasonable adjustment and why are they important? 3. What is a People Impact Assessment and how do I use the PIA Tool? Following the development of the above topics, review available data and insight to identity further information and training needs.	improve people's confidence to have conversations around inclusion. This information would impact interactions with colleagues and with patients.		needs – by January 2025 - Review of future training needs – February 2025.			
Develop effective, just, and restorative policies, processes and guidance relating to bullying, harassment and discrimination.	Within the rainbow badge assessment, SFT scored 1 out of a total 4 points on questions relating to discrimination, bullying or harassment policies.	- Lou Netto (Experience & Learning)	- Policies are to be reviewed throughout 2024.	- People Strategy - Care for our people - WDES Metric 4 - Rainbow Badge	**In progress:** A deliverable group for year 1 of the people strategy focused on developing principles for just and restorative policies and processes. The Just & Restorative Principles have been agreed and colleagues from the working group have spent time with the policy development group to support the embedding of these principles. A member of the inclusion team is now part of the HR Advisory team to support the review of all our policies to ensure inclusion is fully embedded, and meaningful people impact assessments are completed. A policy schedule is now in place along with a revised process that all People Policies will go through.	
Develop informative and effective guidance and processes in relation to sexual safety.	The 2023 staff survey included specific questions on sexual safety for the first time. Data from this survey highlighted: - 9.6% of colleagues had experienced unwanted sexual behaviour from patients or visitors.	- Lou Netto (Experience & Learning)	- Review progress against pledges from sexual safety charter July 2024	- People Strategy - Care for our people	**In progress:** The Trust has signed up to the NHS sexual safety charter, which includes a commitment to 10 key actions. A working group is in place to drive this work.	

Action	What we know (2023)	Accountability	Timeframe	Strategic and Reporting Links	Progress	Impact
	- Demographic groups more likely to have experienced unwanted sexual behaviour from patients included colleagues aged 16-20 and 21-30, women, colleagues with a disability, and LGBT colleagues. - 2.5% of colleagues had experienced unwanted sexual behaviour from a colleague. - Demographic groups more likely to have experienced unwanted sexual behaviour from colleagues include colleagues aged 16-20 and 21-30, LGBT colleagues, and colleagues with a disability.				The working group has reviewed and redesigned the reporting of sexual violence incidents and has identified areas to pilot new approaches based on data from Staff Survey. Focus groups have been held to understand what is enabling this behaviour, and what would help managers to address these situations with confidence. A policy is planned to go for approval in March 2025 with a launch with comms and training in April 2025.	
Review our opportunities for speaking up to ensure they are inclusive and colleagues from all demographic groups feel safe to access these options.	The 'Too Hot to Handle' report published in 2024 highlighted a number of concerns in speaking up mechanisms for colleagues experiencing racism across the NHS. There are a number of recommendations for us to review and consider locally.	- Lou Netto (Experience & Learning)	- Review in June 2024 – based on data from productive people services process. - Plan for next steps – August 2024.	- People Strategy - Care for our people	**In progress:** learning from the "Too Hot to Handle" report, a gap analysis has been conducted by the Freedom to Speak up Guardians. A plan is be developed in response.	
Review our wellbeing offerings to ensure they are accessible and inclusive, and meet the needs of diverse demographic groups.	Staff survey data highlights that: - disabled colleagues, LGB and male respondents were less positive about the Trust's action on health and wellbeing. - LGB and disabled colleagues were significantly more likely to report that they had felt unwell as a result of work-related stress.	- Lou Netto (Experience & Learning)	- Review in June 2024 – based on data from productive people services process. - Plan for next steps – August 2024.	- People Strategy - Care for our people	**In progress:** A member of the colleague support team is dedicated to the networks to continue to support and help understand what more is needed from our services.	
Procure and embed an Occupational Health provision that is fully inclusive and supports the reasonable adjustments process.	The work undertaken on the reasonable adjustments policy and process highlighted a number of concerns around our OH provision, and whether the current provision enables practical and effective advice, recommendations and support for colleagues with disabilities and long-term health conditions.	- Lou Netto (Experience & Learning)	- New OH provision in place by Jan 2025	- People Strategy - Care for our people	**Complete**: Contract has been awarded to a supplier that met the requirements set out in the tender which had inclusion principles embedded into this. We are working with new supplier around accessibility for all colleagues with all services they offer. This new contract started in 2025 - we will monitor impact over time.	
Roll out allyship training across SFT 1. Allyship training co-delivered by each member of the Executive Team		- Lou Netto (Experience & Learning)	- Complete – co-delivery with Exec completed 2023/24.	- People Strategy - Care for our people	**In progress:** Allyship training was piloted with the Executive Group late in 2022. Each member of the Executive has	Feedback so far has been very positive. We are developing a more structured approach to tracking and

Action	What we know (2023)	Accountability	Timeframe	Strategic and Reporting Links	Progress	Impact
2. Allyship training co-delivered by the OD & Leadership team. 3. Allyship training content fully embedded within the leadership development program			- Co-delivery with OD – competed by December 2024 - Embed within LDP – December 2024		co-delivered these workshops, which were open to all SFT colleagues. Allyship training continues as an offering with 90 attendees taking places offered centrally. Allyship has been offered to groups that meet such as Ward Leaders, Band 8 nurses and doctors which covers another 350 colleagues. Allyship training has been scheduled throughout 2025, to be delivered by execs and senior managers alongside OD leads.	monitoring impact of this training.
Key Theme 5: People systems and governance						
Ensure there is a consistent and accurate record of colleagues entering formal processes. Review diversity data of colleagues going through processes including: 1. Formal capability processes 2. Formal disciplinary processes 3. Referrals to bodies including the NMC and GMC	Research suggests that bias often increases the likelihood of underrepresented groups entering formal processes. Initial data from the WRES suggests BAME colleagues may be more likely to be involved in formal disciplinary processes. However, numbers are very small, there are concerns around data accuracy, and that data is not currently reflective of all formal processes in place.	- Lou Netto (Experience & Learning) - Kirstie Lord (Strategy and Profession Development) - Alison Wooton (Senior care team / COAG chair) - Melanie Iles (Chief Medical Officer / ROAG chair)	- Data collation methods in place by July 2024 - Review of data November 2024 then annually.	- WDES Metric 3 - WRES Metric 3 - People Strategy - Care for our people	**In progress:** COAG and ROAG have processes in place to ensure demographic data is captured for core members, panel members and cases. COAG have a plan to review this data quarterly. Improvements still need to be made to the recording of cases held by the HR Advisor team.	
Improve completion rates for demographic data in ESR.	Completion rates are particularly low for disability and sexuality. To improve our understanding of trends, we need to improve the completeness and accuracy of our data.	- Mike Scott (Strategy and Profession Development)	- Comms plan developed - May 2024 - Comms plan implemented throughout 2024. - Review progress – October 2024 then every 6 months	- All strategies and reports	**In progress:** A letter to colleagues with missing data in ESR has been drafted but is yet to be sent out.	Completion rates have improved, which we believe is a result of the move to ESR self-service. For example, 28% of colleagues had not answered demographic questions relating to disability in 2021, compared with 20% in 2023, and 14% in Jan 2025.
Ensure our people services digital solutions are designed to drive equitable outcomes, and to be fully inclusive and accessible	The deliverable group focusing on people services digital solutions found that 90% of people services digital systems had not have a people impacts assessment completed (or equivalent).	- Mike Scott (Strategy and Profession Development)	- People services digital board – in place by May 2024. - Annual review of actions and progress – May 2025 onwards.	- People Strategy – Learning and transforming	**In progress:** A people services digital strategy has been developed and includes actions for improving the accessibility of our digital systems, and ensuring systems are designed to be fully inclusive.	The procurement of Oleeo and our new OH provider explicitly included equity and inclusion requirements in tender documentation and KPIs.

Action	What we know (2023)	Accountability	Timeframe	Strategic and Reporting Links	Progress	Impact
Ensure strategic workforce plans and people plans at all levels of the organisation are informed by inclusion data and insight, and include actions designed to improve equality and inclusion outcomes. Review support and development for people partners and service groups to support colleagues to achieve this.		- Kirstie Lord (Strategy and Profession Development)	- Development plan in place by July 2024. - Annual review of people plans at people committee – May 2024 onwards	- People Strategy – Learning and transforming	**Not started** It has been acknowledged that further work is needed to ensure workforce plans are informed by diversity data and inclusion outcomes.	
Our workforce reporting provides meaningful and actionable data relating to diversity demographics and trends. 1. Diversity demographics are included within monthly workforce reporting. 2. Diversity demographics are included in productive care reports. 3. Development of Power BI to make data more accessible 4. Upskilling for colleagues to respond to diversity and inclusion data	We have access to demographic data within ESR, the NHS staff survey, and other core people services systems. However, this data is not always reported or accessible. This data is crucial for informing PIAs, local people plans, and productivity plans.	- Mike Scott (Strategy and Profession Development)	- Productive care reports – complete – demographics included from April 2024 onwards. - Monthly workforce reporting – demographics included from September 2024 - Transition workforce data to Power BI reporting – from April 2025 - Development and training – ongoing, review in April 2025.	- People Strategy – Learning and transforming	**In progress:** High-level demographic data is part of monthly workforce reports, further work is needed to explore the data that can be provided to meet planning needs locally. Initial development conversations have been held with people services teams around interpreting and responding to diversity data, but more work is needed.	
Embed People Impact Assessments across all people services processes, including the development of new strategies, policies, systems and organisational change processes.	The People Impact Assessment tool has replaced the previous Equality Impact Assessment form. The intention to provide guidance and support for colleagues so they can consider inclusion from the start of process, rather than the EIA form being a tick-box exercise at the end of a process.	- Isobel Clements (Chief People Officer)	- PIAs embedded within people strategy work – ongoing since April 2023 - PIAs completed for all new people policies – ongoing from April 2024 onwards. - PIAs embedded within org change policy and processes – December 2024 - Review impacts and improvements – April 2025	- People Strategy – Learning and transforming	**Complete**: People Impact Assessments have been embedded within the people strategy deliverable groups, and people governance processes. This has highlighted further development that is needed across People Services.	

NHS
Somerset
NHS Foundation Trust

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:	Lee Cornell, Associate Director – Planning and Performance Ian Clift, Senior Performance Manager Isobel Clements, Chief of People and Organisational Development Alison Wootton, Deputy Chief Nurse Xanthe Whittaker, Director of Elective Care
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	4 March 2025

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. Areas in which performance has been sustained or has notably improved include: • CAMHS Eating Disorders – Urgent and routine referrals seen within the required time periods remain above the national standards and the national averages. • access to our perinatal service was significantly above the 10% national standard. • compliance in respect of Cancer 28 Day Faster Diagnosis was above 75% for the fourth consecutive month. • the percentage of patients followed up within 72 hours of discharge from our adult mental health wards remained above 90%. • the number of patients waiting 18 weeks or more from referral to be seen by our community services reduced.

	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 numbers of patients in our acute beds not meeting the criteria to reside. • 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 Department. • the number of patients waiting 18 weeks or more to be seen by our community dental service.
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 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

Equality The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics
This report has been assessed against the Trust's People Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planned to mitigate any identified inequalities 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.

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)
Not Applicable.

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	

SOMERSET NHS FOUNDATION TRUST

QUALITY AND PERFORMANCE EXCEPTION REPORT: JANUARY 2025

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.

1.10 Appendix 7 sets out data to evidence how we are fulfilling our core legislative obligations, from a racialised and ethnically and culturally diverse lens, in relation to our mental health services, in accordance with the requirements of the Patient and Carer Race Equality Framework (PCREF).

1.11 Appendix 8 provides additional information and commentary in respect of incidents relating to pressure ulcer damage.

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. • Talking Therapies achieved all nationally mandated standards. • compliance remains high in respect of mental health inpatients receiving a follow-up within 72 hours of discharge. • achievement of the 75% national cancer waiting times Faster Diagnosis Standard for a fourth consecutive month. • the compliance level in respect of mandatory training remains high despite the operational challenges faced by services. • our mental health perinatal service continues to exceed the 10% national reporting standard. • Patients waiting 18 weeks or more for one of our community services significantly decreased.	• 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. • continuing to restore and expand capacity above pre-COVID-19 levels, to address backlogs in routine elective work which has built-up. • 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 inpatients not meeting the criteria to reside and 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): 91 cases, MSSA BSIs: 64, E. coli BSIs: 127 cases, Klebsiella BSIs: 51 Pseudomonas aeruginosa BSIs: 17.

Current performance (including factors affecting this)

- **MRSA:** Two Trust-attributed MRSA bloodstream infections (BSIs) were reported in January 2025, bringing the total for the year to four.
- **MSSA:** There were seven Trust-attributed MSSA BSIs reported in January 2025, bringing the total to 63.
- **E. coli**: There were eight Trust-attributed E. coli BSIs reported in January 2025, bringing the total to 100.
- **Klebsiella:** There were five Trust-attributed Klebsiella BSIs reported in January 2025, bringing the total to 35.
- **Pseudomonas:** There were no Trust-attributed Pseudomonas aeruginosa BSI reported in January 2025, so the total remained at 11.
- **C. diff**: There were eight Trust-attributed cases reported in January 2025, bringing the total to 84.

Respiratory Viral Infections

- **COVID-19:** 58 inpatient cases of COVID-19 were identified during January 2025, of which 34 were healthcare-attributed.
- **Influenza:** 326 inpatient cases were identified during January 2025; the majority were 'Flu A.
- **Respiratory syncytial virus (RSV):** 108 inpatient cases of RSV were identified during January 2025.

Outbreaks

- During January 2025 a total of 13 outbreaks affected inpatient wards.
- Carbapenemase-producing organism: the outbreak on the YDH site remains ongoing.

Surgical Site Infections – Data as of December 2024 (the latest data)

Hip Replacement

- MPH rate of infection = 0%
- YDH rate of infection = 0.8%

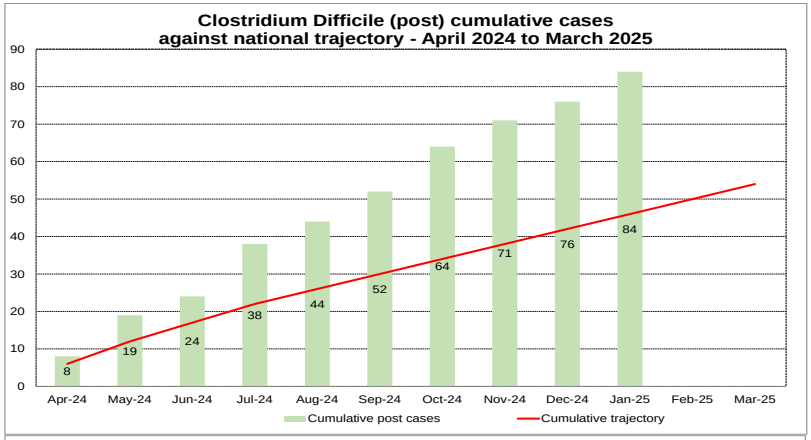
Knee Replacement

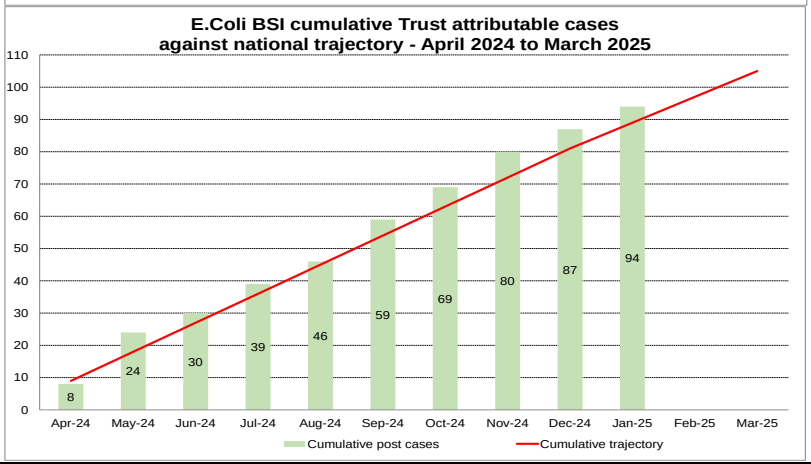
- MPH rate of infection = 0.46%
- YDH rate of infection = 0%

Spinal Surgery

- MPH rate of infection = 1.49%

Line/Bar Charts





Recent performance

Area	Aug	Sep	Oct	Nov	Dec	Jan
MRSA	0	1	0	0	0	2
C.Diff	6	8	12	7	5	8
MSSA	9	4	7	4	9	7
E.coli	7	13	10	11	7	7

afe

Pressure ulcers – we are committed to improving and maintaining high rates of reporting across all services and to reducing the number of incidents resulting in harm to patients.

Current performance (including factors affecting this)

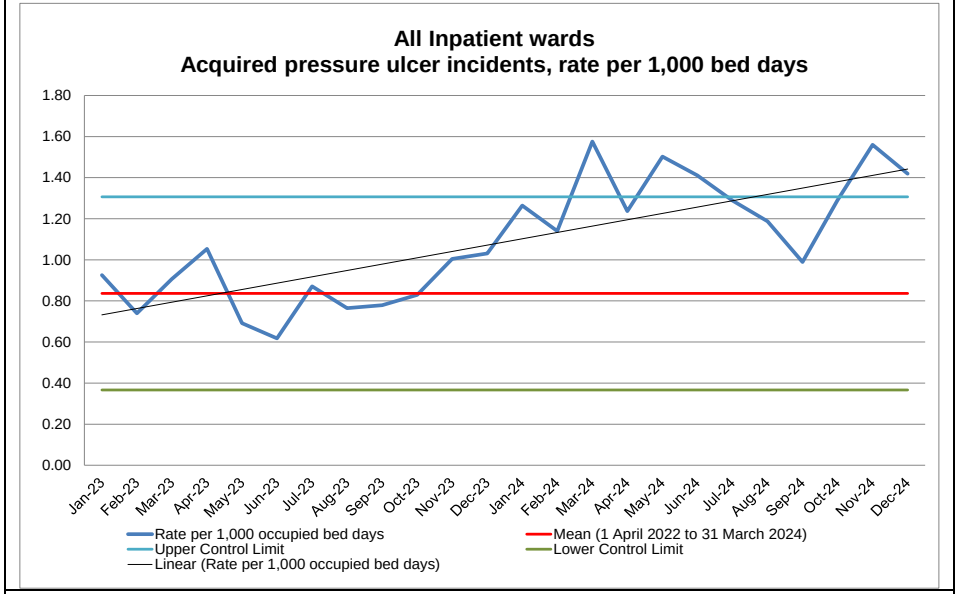
- During December 2024 – the latest validated data available - a total of 57 incidents were reported within all our inpatient services).
- From May 2024, reporting moved to the nationally mandated criteria of Learning from Patient Safety Events (LFPSE).

Focus of improvement work

The Trust's Head of Tissue Viability reports the following work (active during Quarter 3), which contributes to highlighting and addressing this issue:

- The annual Quality Assurance report was submitted during October 2024 - with key recommendations linked to accessibility of incident data via Radar, engagement of Service Groups to drive local improvements, the policy assurance compliance programme that informs local improvement, and the introduction of this quarterly reporting to the Trust Board.
- Work is ongoing with the Governance Support Team to improve the quality and accuracy of the Trust's pressure ulcer dataset.
- The Head of Tissue Viability is involved in the Care Quality Metrics Task & Finish Group, to address inpatient policy assurance.
- The Head of Tissue Viability is on the Intentional Rounding Steering Group, looking to improve key care interventions linked to pressure ulcer prevention.
- Data collection was finalised for the inpatient Pressure Ulcer Prevention Audit linked to the year-long project and data analysis / reporting has commenced.
- Six inpatient areas (with high incidents of pressure ulcers) commenced Silver QI projects together to improve pressure ulcer prevention locally.
- Please also refer to Appendix 9 for more in-depth reporting relating to the topic across all Service Groups / settings.

SPC Chart



How do we compare

In December 2024, the number of incidents and rate per 1,000 bed days decreased compared to November 2024.

Recent Performance

Area	Ju1	Aug	Sep	Oct	Nov	Dec
Number of reported incidents	49	45	37	50	59	57
Rate per 1,000 bed days	1.29	1.19	0.99	1.29	1.56	1.42

Safe

Restraints and prone restraint 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 where possible the use of restraints.

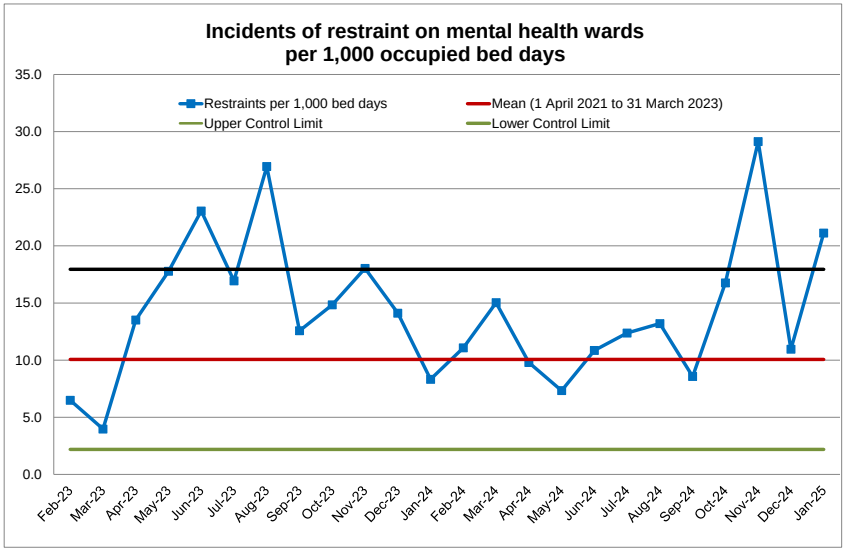
Current performance (including factors affecting this)

- During January 2025 there were 74 Restrictive Interventions (RIs) reported with our mental health wards with a rate of 21.1 per 1,000 occupied bed days, above the Upper Control Limit of 18.0.
- Twenty-one of the interventions resulted in a prone restraint, a rate of 6.0 per 1,000 occupied bed days.
- Of the 74 interventions reported, 31 occurred on Holford Ward, our Psychiatric Intensive Care Unit (PICU), and 19 interventions occurred on Rowan Ward 2, one of our adult mental health wards.
- The reported reasons for RIs were: 30 to prevent violence to others, 14 to facilitate nasogastric feeding, 12 to enforce medication, eight to prevent dangerous behaviours, five to prevent serious intentional harm, two to prevent a patient absconding, one to prevent serious physical injury by accident, one to prevent extreme/prolonged activity and one to search a patient.

Focus of improvement work

- All incidents involving restraint are reviewed to ensure that assessments and care plans accurately reflect observation levels and the management of identified risk.
- We have introduced Safety Pods to all our mental health inpatient wards. Safety Pods are an evidence-based intervention and are now recommended for use to reduce incidences of floor and prone position restraints. They are endorsed by the Care Quality Commission and some of the country's foremost experts in this field.

SPC Chart



How do we compare

The NHS Benchmarking Network's latest Mental Health report for 2023/24, shows that our rates of restraint and prone restraint were lower than the national average for all areas except PICU. Comparison on PICU is difficult as reportedly 50% of PICUs do not have a seclusion facility, and of the prone events reported in Somerset, 72% were as a planned formal seclusion exit, not as an unplanned psychiatric emergency.

Recent Performance

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

Area	Aug	Sep	Oct	Nov	Dec	Jan
Number of incidents	46	28	57	94	36	74
Rate per 1,000 bed days	13.2	8.6	16.8	29.1	11.0	21.1

Safe

To monitor and report on the average number of medical or surgical patients at the 8:00 census time who are not on the appropriate wards, to minimise the impact on patients' wellbeing.

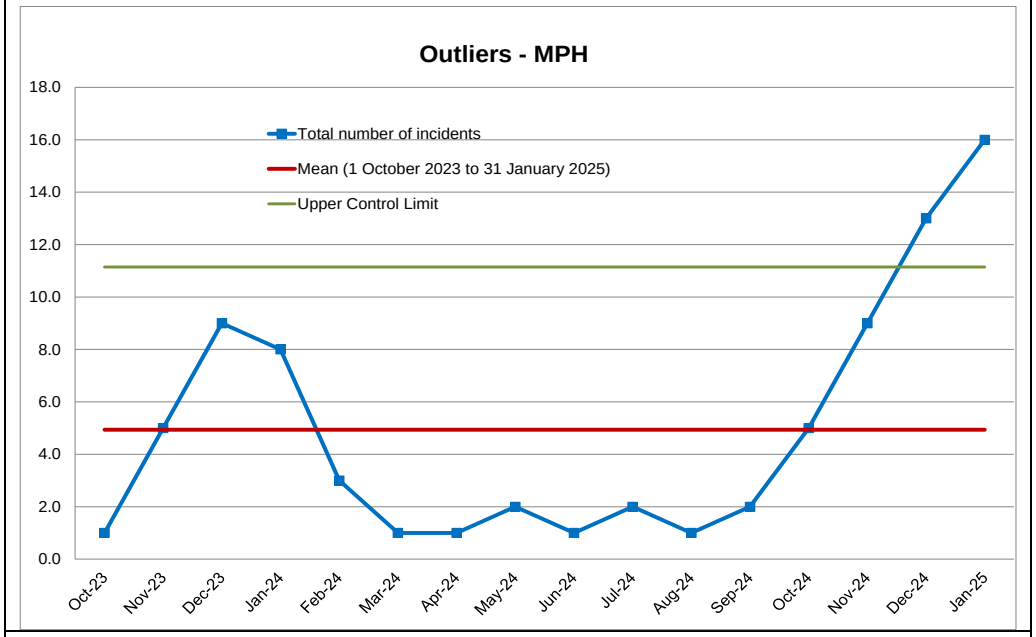
Current performance (including factors affecting this)

- The number of bed days related to patients awaiting to be moved to appropriate wards relevant to their care in January 2025 totalled 496, an average of 16 patients per day.
- This is an increase compared to December 2024 when the total was 399, an average of 13 per day.
- Since September 2024 the monthly average has steadily increased, which is an indicator of pressures on patient flow.
- Increased demand, increased numbers of patients not meeting the criteria to reside, and increased infection control outbreaks have all been factors contributing to increased pressures.
- Tor ward changed from escalation to core beds from 3 January 2025. With the Ward 9 decant, 12 beds were surgical, eight medical and one escalation. Therefore, from 3 January 2025 medical patients above eight are counted as outliers causing an increase in outliers in January 2025.

Focus of improvement work

- The 100-day discharge sprint will start during the week commencing 24 February 2025, focusing on early identification of patients for discharge ahead of medical optimisation; this work aims to reduce length of stay.
- A review of bed modelling is also planned for the week commencing 24 February 2025, with an aim to decrease bed occupancy, and reduce escalation, outliers and length of stay.

Run Chart



How do we compare

The average numbers reported increased during January 2025 compared to December 2024.

Recent performance

The numbers reported in recent months were as follows:

Area	Aug	Sep	Oct	Nov	Dec	Jan
Numbers	32	54	147	259	399	496
Daily average	1	2	5	9	13	16

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, rising to 78% by March 2025.

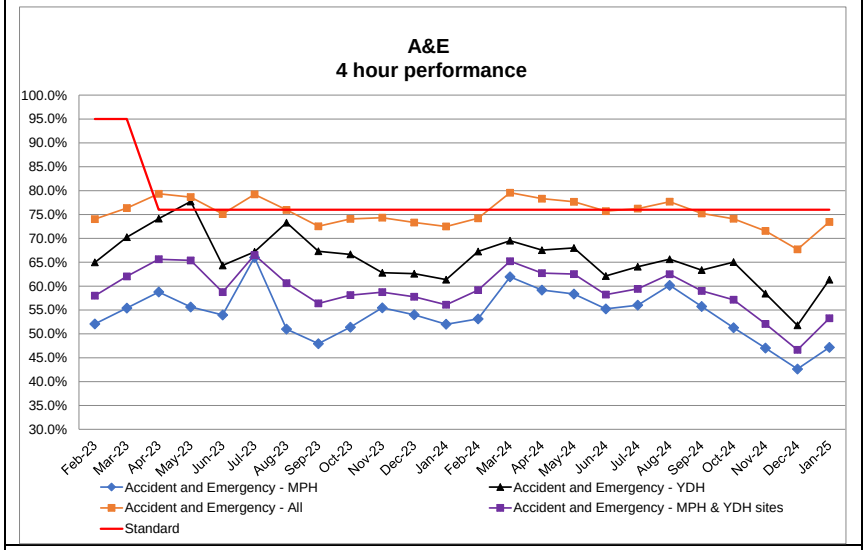
Current performance (including factors affecting this)

- Trust-wide A&E 4-hour performance for our EDs was 53.3% during January 2025, up from 46.6% in December 2024. With Urgent Treatment Centres (UTCs) compliance included at 98.6%, overall compliance was 73.4%, up from 67.7% in December 2024, but below the 76% national standard that took effect from 1 April 2023.
- Compliance in respect of our two A&E departments was:
    - Musgrove Park Hospital (MPH): 47.2%.
    - Yeovil District Hospital (YDH): 61.3%.
- Combined rolling 12-month A&E attendances at MPH and YDH, for the period from 1 February 2024 to 31 January 2025, were 4.1% higher than the same months of 2023/24.
- The number of patients spending more than 12 hours in the departments in January 2025 was 10.4% at MPH and 8.9% at YDH.

Focus of improvement work

- A 'Call to action' meeting is planned for late February 2025, to support achievement of the forthcoming 78% target, to include community and inpatient flow workstream leads.
- Four-hour and 12-hour trajectories have been drafted for 2025/26.
- Potential capital bid opportunities for MPH ED/UTC are being explored in conjunction with the capital projects team.
- Urgent Treatment Rooms at YDH are working well and are significantly improving time to ED doctors. The first version of the UTC standard operating procedure (SOP) has been finalised.
- Data to enable and analysis of the impact of the front door scanner is pending with business intelligence (BI) teams. MPH data for same day emergency care (SDEC) opportunities has been shared with Acute Medicine Physicians for review, to progress the 'front door' future model.
- Work is progressing on the Transfer team pilot at MPH ED to reduce delays in the movement of patients to wards. The aim is for the pilot to commence on 3 March 2025, for two weeks. A benefits monitoring plan has been designed.
- At YDH, GP interviews for the UTC were successful. Five candidates (part time) will be receiving offers imminently.
- Two YDH ED Consultant posts remain out for advert – support has been secured from recruitment teams for 'hard to fill' posts. Two interviews are planned for 3 March 2025 for Locum consultant roles. Two fixed term ST3 posts have been offered at MPH.

Line Chart



How do we compare

In January 2025, the national average performance for Trusts with a major Emergency Department was 57.7%. Our performance was 53.3%. We were ranked 80 out of 121 trusts. With Urgent Treatment Centre attendances included, we were ranked 38, with performance of 73.4%. National average performance was 70.2%.

Recent performance

Area	Aug	Sep	Oct	Nov	Dec	Jan
A&E only	62.5%	59.0%	57.1%	52.1%	46.6%	53.3%
Including UTC	77.7%	75.2%	74.1%	71.6%	67.7%	73.4%

Responsive

Ambulance handovers are to be completed within 30 minutes of arrival at hospital. The target is that at least 95% of patient handovers are within the 30 minute standard.

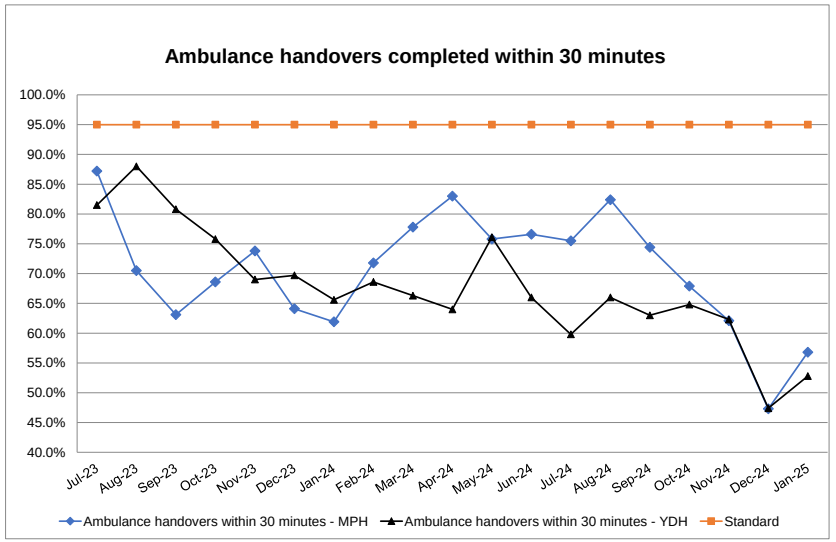
Current performance (including factors affecting this)

- During January 2025, performance for the handover within 30 minutes of patient arrivals by ambulance increased at Musgrove Park Hospital (MPH) and at Yeovil District Hospital (YDH) when compared to December 2024. Compliance in January 2025 was:
  - MPH: 56.8% (1,370 out of 2,414 handovers were within 30 minutes).
  - YDH: 52.8% (660 out of 1,249 handovers were within 30 minutes).
- The average performance across all hospitals served by South Western Ambulance Service NHS Foundation Trust (SWAST) in January 2025 was 47.4%. The national average was 65.2%.

Focus of improvement work

- An additional 123 patients were seen in majors in MPH in January 2025, compared to January 2024. There were also an additional 73 ambulance arrivals. The length of stay in MPH ED for admitted patients has increased from an average of eight hours in January 2024, to nine hours and 40 minutes in January 2025.
- Work is ongoing with site and discharge teams to improve flow into inpatient areas, including the 100-day discharge sprint.
- A meeting with SWAST ambulance liaison officers, to include nursing and medical representatives at YDH, is planned for early March 2025, to support team adoption of Timely Handover Processes.
- The YDH Urgent Treatment Centre is scheduled to open in April 2025.
- Discussions are ongoing with the ICB regarding a collaborative approach to the reduction of timeframes for the Timely Handover Process, to incorporate SWAST achieving the regional conveyance rate average.

Line Chart



How do we compare

In January 2025, 56.8% of all ambulance handovers at Musgrove Park Hospital and 52.8% of all ambulance handovers at Yeovil District Hospital were completed within 30 minutes, above the regional average performance across all hospitals served by SWAST of 47.4%, but below the national average of 65.2%.

Recent performance

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

Area	Aug	Sep	Oct	Nov	Dec	Jan
MPH	82.4%	74.4%	67.9%	62.1%	47.3%	56.8%
YDH	66.0%	63.0%	64.8%	62.3%	47.4%	52.8%

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.

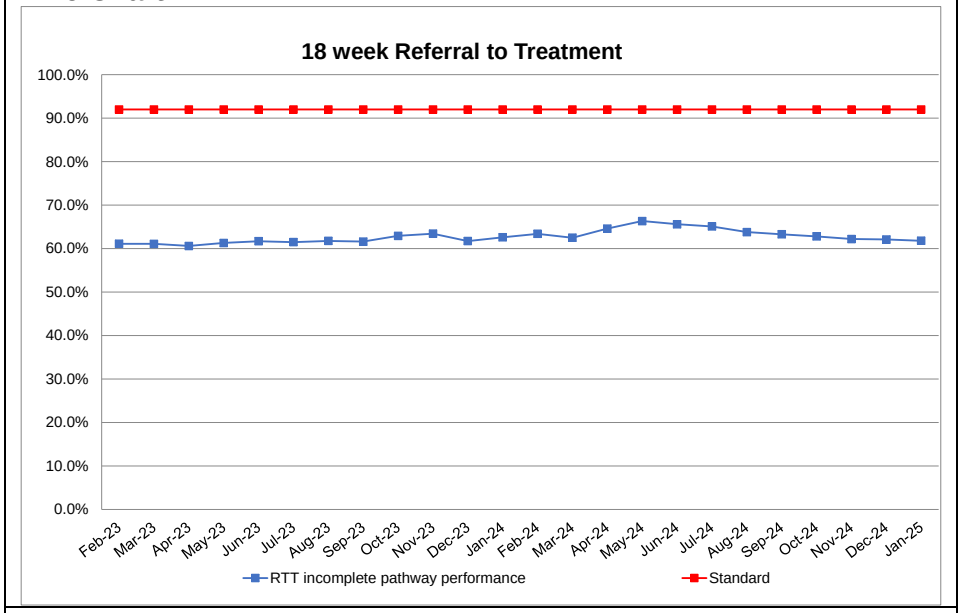
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT was 61.8% (combined acutes + community) in January 2025, down by 0.3% from the December 2024 position.
- The total waiting list size decreased by 1,015 pathways, and was 7,646 higher (i.e. worse) than the planning trajectory (59,061 actual vs. 51,415); this in part represents the Dermatology service transfer, not fully accounted for in the planning trajectory.
- The number of patients waiting over 52 weeks increased by 24 in January 2025 to 1,388 pathways, 524 lower (i.e. better) than the planning trajectory of 1,912.
- The number of patients waiting over 65 weeks increased by four to 146 at month-end, against a trajectory of zero.
- The number of patients waiting 78+ weeks decreased to four in January 2025 from six in December 2024, against a trajectory of zero.

Focus of improvement work

- The number of patients needing a first outpatient appointment or surgery, to avoid becoming a 65-week RTT waiter by the end of March 2025, has been quantified for each specialty to support the development of capacity plans. These plans continue to emphasise productivity and ways of increasing capacity internally, along with insourcing and outsourcing solutions.
- Cohort clearance monitoring reports continue to be updated fortnightly for all high-volume specialties and split by hospital site.
- A significant programme of improvement work to support elective care recovery in the medium and long-term remains in place.
- A programme of waiting list validation continues, which includes contacting patients to check they still need to be seen; additional validation is taking place for each month's 65-week cohort, to check the waiting times are being correctly reported.

Line Chart



How do we compare

The national average performance against the 18-week RTT standard was 58.9% in December 2024, the latest data available; our performance was 62.1%. National performance decreased by 0.2% between November and December 2024; our performance reduced by 0.1%. The number of patients waiting over 52 weeks across the country decreased by 21,514 to 200,375 (2.7% of the national waiting list compared with 2.4% for the Trust). The number of patients waiting over 78 weeks nationally increased by eight to 2,059.

Performance trajectory: 78 week and 65 week wait performance

Area	Aug	Sep	Oct	Nov	Dec	Jan
78-week trajectory	0	0	0	0	0	0
78-week actual	19	11	10	5	6	4
65-week trajectory	125	0	0	0	0	0
65-week actual	370	247	198	144	142	146

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.

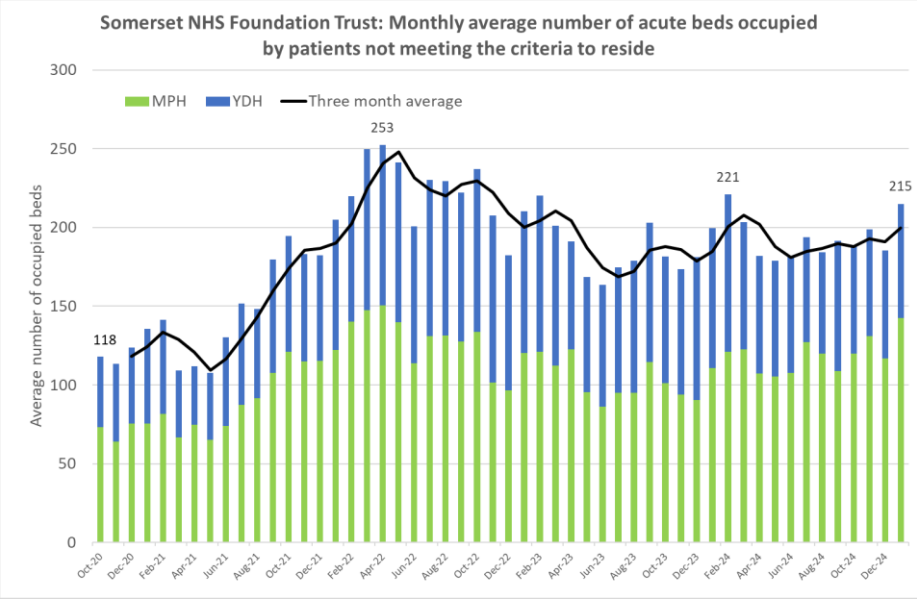
Current performance (including factors affecting this)

- During January 2025, the Trust-wide number of acute bed days occupied by patients not meeting the criteria to reside was 6,667 (4,413 at MPH and 2,254 at YDH), up from 5,744 in December 2024. This equates to 215 fully occupied beds for the month of January 2025, up from 185 in December 2024.
- In our community hospitals, the number of patients not meeting the criteria to reside as at 31 January 2025 was 64, up from 44 as at 31 December 2024.
- Of the 1,747 acute inpatients discharged during January 2025 who had a Discharge Ready Date recorded, the average duration between the Discharge Ready Date and the actual date of discharge was 2.6 days, down from 2.7 days during December 2024. This is currently artificially low as it is presently not possible for YDH wards to input Discharge Ready Dates in respect of Pathway 0 patients.
- Recording of Ready to Discharge Dates in respect of all discharges was 54.7%, up from 52.0% achieved during December 2024.

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 and address the difficulties in the domiciliary care market.
- These actions include the expansion of Criteria-Led Discharge, to discharge patients when they meet pre-agreed clinical criteria for discharge, as identified by the lead clinician. This reduces delays in discharge processes and ensures that discharges are made in an appropriate and timely way.
- A trial is currently being undertaken at YDH by selected wards to test a solution to enable Discharge Ready Dates to be recorded for Pathway 0 patients.

Trend Chart



How do we compare

As at 31 January 2025, national best-quartile performance was that 10.2% of Adult General & Acute and critical care beds were occupied by patients who did not meet the criteria to reside. Our performance as at that date was 24.2% of beds. We were ranked 108 of 119 Trusts nationally.

Recent performance

The numbers of bed days occupied by patients who did not meet the criteria to reside over recent months were as follows:

Area	Aug	Sep	Oct	Nov	Dec	Jan
MPH	3,719	3,269	3,721	3,930	3,620	4,413
YDH	1,991	2,475	2,122	2,031	2,124	2,254
Total	5,710	5,744	5,843	5,961	5,744	6,667

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 dentistry service.

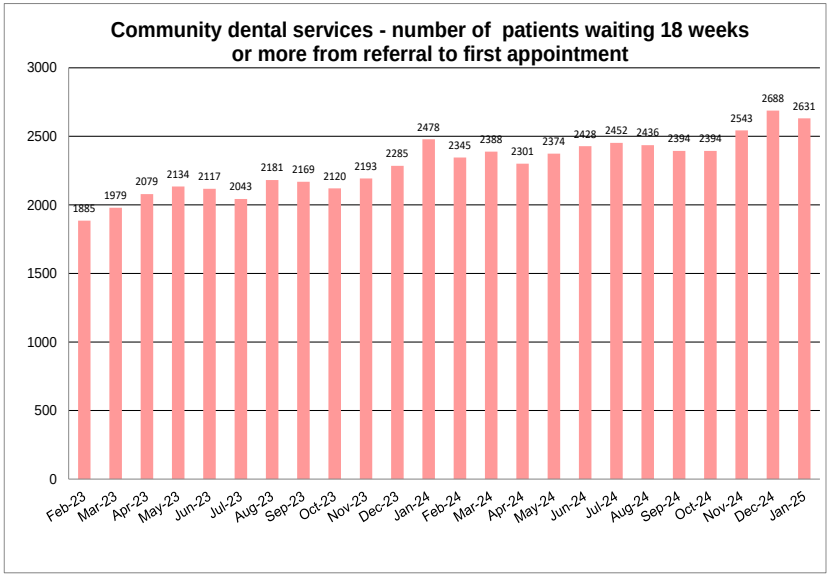
Current performance (including factors affecting this)

- As at 31 January 2025, the number of patients waiting 18 weeks or more totalled 2,631 a decrease of 57 compared to numbers as at 31 December 2024.
- Of the patients waiting 18 weeks or more to be seen, 1,931 were waiting within Somerset down from 1,947 as at 31 December 2024), and 700 were waiting within Dorset (down from 741 as at 31 December 2024).
- The number of people waiting 52 weeks or more increased from 540 as at 31 December 2024 to 559 as at 31 January 2025.

Focus of improvement work

- The service continues to face considerable challenges due to vacancies, sickness absence and insufficient cover for colleagues on maternity leave. However, from March 2025 onwards Somerset is expected to see a significant change in activity levels due to successful recruitment. The service continues its recruitment and is positive about a Consultant recruitment, having shortlisted strong applicants.
- Demand currently exceeds capacity; the service has a Gold Quality Improvement programme in place to review how to manage the overall waiting list. The service has engaged with acute colleagues to work in partnership to fulfil the needs of some minor oral surgery patients.
- The service is balancing seeing core primary care patients and completing their courses of treatment, with those who have been referred into the service, although the volume of referrals into the service remains a significant challenge. The service has requested regular catch-up meetings with the Integrated Care Boards of Dorset and Somerset to assist in finding resolutions to the challenges faced.
- The service works regionally, through the Managed Clinical Network structure, the Local Dental Committee, and with NHS England network managers, to ensure we are able to align with the latest thinking, and to share challenges and initiatives with all other similar services in the South West.
- The service is looking at GIRFT and RTT reporting in order to optimise the way patients are managed through their pathways.

Bar Chart



How do we compare

The number of patients waiting 18 weeks or more as at 31 January 2025 decreased compared to numbers as at 31 December 2024.

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	2,436	2,394	2,394	2,543	2,688	2,631

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).

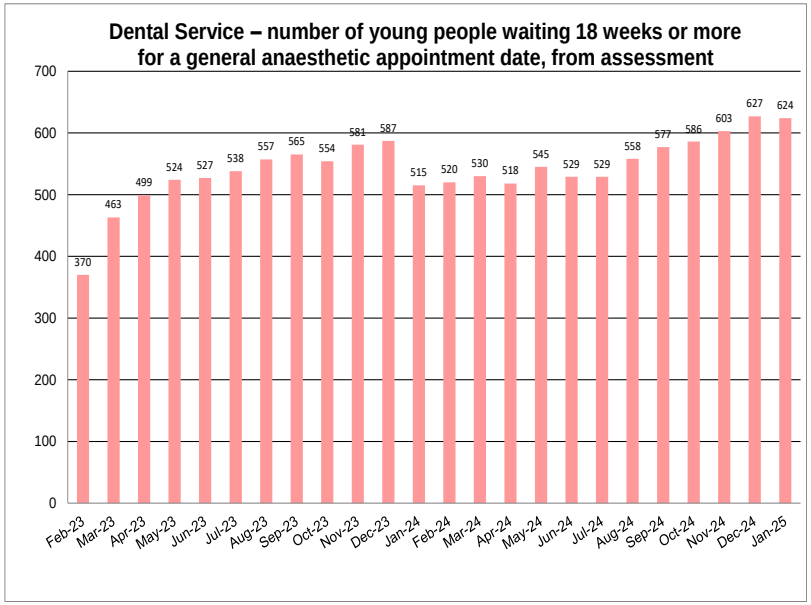
Current performance (including factors affecting this)

- As at 31 January 2025, 624 patients had waited 18 weeks or more, down from 627 at the end of December 2024. Of these, 565 related to our Dorset service (up from 564 as at 31 December 2024), and 59 related to our Somerset service (down from 63 as at 31 December 2024).
- The service continues to have significant levels of vacancies, which is a national issue, exacerbated by four GA dentists now being on maternity leave, for whom there is insufficient cover.
- Winter pressures in Somerset have seen multiple paediatric lists cancelled at Yeovil District Hospital (YDH) due bed availability and this is expected to continue throughout the winter.

Focus of improvement work

- The recruitment of dentists in Somerset is an improving picture and experienced dentists who have been on maternity leave will return by March 2025. Our GA pool for adults in Somerset should be improved with the return of colleagues currently on maternity leave and the Consultant positions have attracted strong candidates for shortlisting.
- Multiple scheduled lists have been stood down at YDH due to winter pressures on the paediatric ward. The service is working with the team at YDH to assess the suitability of holding GA in the modular theatre to support more robust capacity.
- The approval of a business case by Dorset Integrated Care Board, means there will be additional theatre slots throughout 2025/26. This will have a positive impact on reducing the GA waiting list; however two whole time equivalent dentists in the GA pool have announced they will be retiring from May 2025. A Consultant advertisement, which is currently out, will look to counter this risk of reduced GA provision.

Bar Chart



How do we compare

The number of young people waiting 18 weeks or more as at 31 January 2025 decreased when compared to numbers reported as at 31 December 2024.

Recent Performance

The numbers of young 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	558	577	586	603	627	624
% > 18 weeks	61.6%	66.6%	68.8%	73.3%	77.7%	77.3%

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.

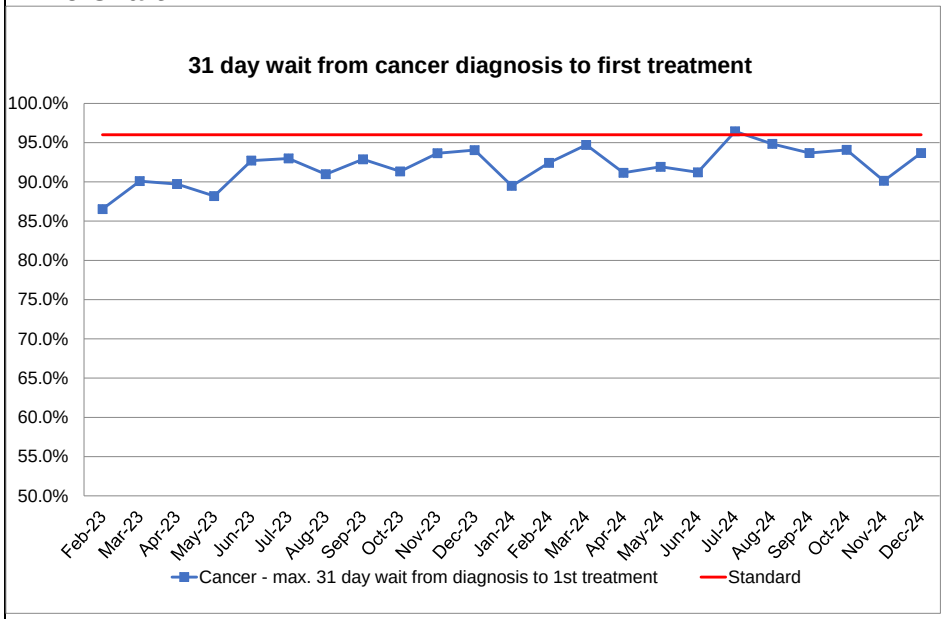
Current performance (including factors affecting this)

- Performance against the 31-day first combined treatment standard was 93.7% in December 2024, below the 96% national standard but above national average performance.
- There were 40 breaches of the standard, of which 27 (68% of breaches) were for skin and six (15%) were for lower gastrointestinal. There were smaller volumes of breaches across a range of tumour sites.
- 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 Hospitals Bristol and Weston NHS Foundation Trust (UHBW) from the start of November 2023.
- 93% of the breaches were for surgical treatments. The ability to start treatment within 31 days of the decision to treat is affected by bulges in demand. Waiting times for skin cancer treatment have improved but are still recovering from the significant seasonal rise in demand over the summer.

Focus of improvement work

- The work outlined in the combined 62-day cancer standard will help to reduce delays in cancer pathways which will also help to smooth bulges in demand for cancer treatments.
- Theatre sessions continue to be booked flexibly, with slots protected for cancer surgery; these slots are filled with routine long waiters closer to the date, if not needed to meet demand following the latest week's Multi-Disciplinary Team decisions and subsequent cancer clinic attendances.
- A dermatology consultant has been appointed, who will fill the gap left by a departure in September 2024. Additional insourcing capacity has been established to meet demand for both first appointments and minor procedures. This insourcing contract has been extended to March 2026, to provide greater resilience. GPs with Extended Roles (GPwERs) also continue to provide capacity for the service.

Line Chart



How do we compare

National average performance for providers was 91.5% in December 2024, the latest data available. Our performance was 93.7%. We were ranked 90 out of 140 providers.

Recent performance

31-day diagnosis to first treatment performance

Area	Jul	Aug	Sep	Oct	Nov	Dec
% Compliance	96.4%	94.8%	93.7%	94.1%	90.1%	93.7%

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.

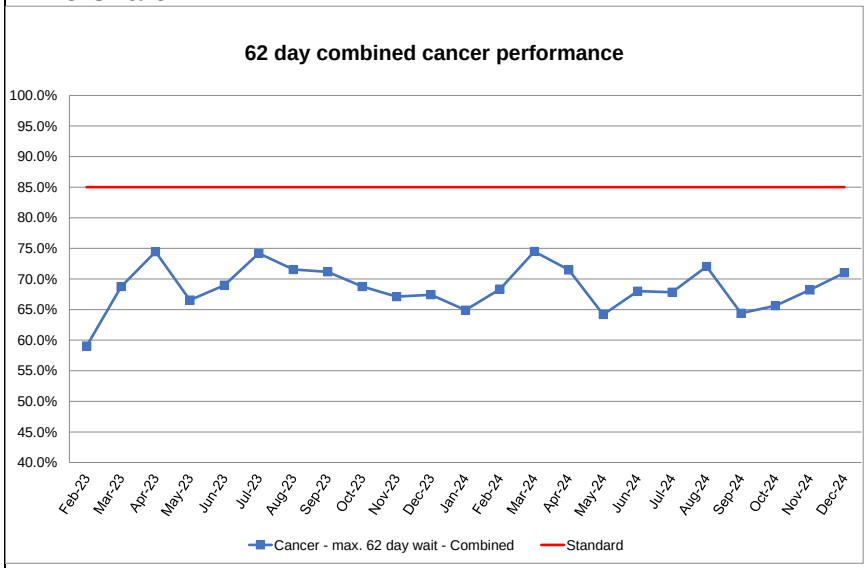
Current performance (including factors affecting this)

- The percentage of patients treated for a cancer within 62 days of referral was 71.0% in December 2025, below the national average performance but above the planning trajectory.
- The main breaches of the 62-day combined cancer standard were in skin (27% of breaches), urology (22%) and lower gastrointestinal (19%).
- The main cause of the breaches continues to be surges in demand which cannot be accommodated within available capacity. This is mainly for the diagnostic phase of cancer pathways, when tests are still being undertaken to confirm whether a patient has a cancer or a benign condition. However, the 28-day Faster Diagnosis Standard was met for 75.8% of patients in December 2024, against the current national target of 75%.
- Thirteen GP referred patients were treated in December 2024 on or after day 104 (the national 'backstop'); please see Appendix 5a.

Focus of improvement work

- A new cancer 'front door' is now partly in place; this is creating a single-entry point for cancer referrals across Somerset helping to smooth demand across the two hospital sites; it includes nurse-led triage and management of the early diagnostic phase of pathways.
- Prostate pathway redesign work continues on the diagnostic phase, focusing on nurse-led management and steps being condensed or removed to achieve a diagnosis sooner.
- Additional colonoscopy capacity is in place through a locum contract in addition to weekend waiting list initiatives.
- Additional CT Colon capacity will come online when the Yeovil Community Diagnostic Centre opens in March 2025.
- Please also see the 31-day exception report for actions relating to additional skin capacity.

Line Chart



How do we compare

National average performance for providers was 71.3% in December 2024, the latest data available. Our performance was 71.0%. We were ranked 97 out of 146 trusts.

Although the national standard remains 85%, the operating plan guidance for 2024/25 sets the improvement target as 70% for March 2025.

Recent performance

62-day GP cancer performance

Area	Jul	Aug	Sep	Oct	Nov	Dec
% Compliance	67.8%	72.0%	64.4%	65.6%	68.2%	71.0%
Trajectory	66.5%	67.1%	66.5%	66.4%	68.8%	70.2%

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.

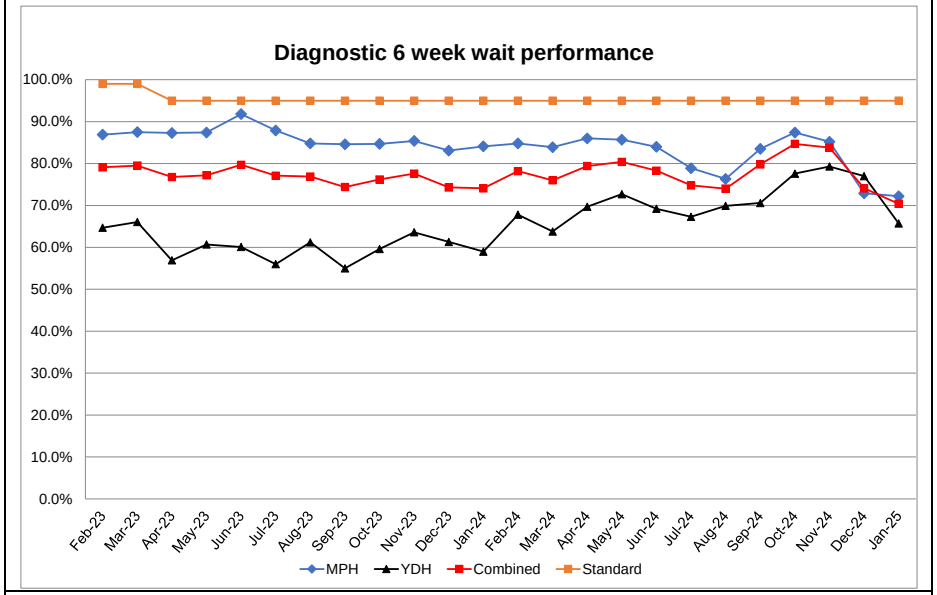
Current performance (including factors affecting this)

- The percentage of patients waiting under six weeks for their diagnostic test decreased to 70.4% in January 2025 from 74.1% in December 2024 and remains below the planning trajectory and below the national average.
- The number of patients waiting over six weeks in January 2025 increased by 971 patients in the month; the highest numbers of patients waiting over six weeks were waiting for the following diagnostic tests:
    - CT (up from 648 to 971; 24% of over six-week waiters).
    - echo (up from 706 to 750; 19%).
    - MRI (up from 640 to 691; 17%).
    - Ultrasound (up from 89 to 583; 14%).
- The total waiting list size increased by just over 15% (1,795 patients); most of this increase was in ultrasound and CT.
- The deterioration in performance in CT and ultrasound reflects the loss of capacity over the Christmas and New Year bank holiday, in addition to staffing challenges due to sickness and departures. The echo backlog reflects staff departures over the last six months. The MRI backlog relates to continued high demand for scans.
- Performance as at 16 February 2025 was just below 78%.

Focus of improvement work

- Additional echo capacity has been established through additional insourcing, and weekend waiting list initiatives.
- The modular MRI scanner at Bridgwater Community Hospital has been swapped for one capable of performing more complex scans work, and the working week is being extended to seven days from five.
- Radiographer vacancies have been appointed to, and locums are being used where possible to fill the gaps until they are filled.
- A CT mobile scanner has been hired and is now in place in Bridgwater; a CT and MRI scanner are also being used in the east of the county, ahead of the opening of the Yeovil Community Diagnostic Centre.

Line Chart



How do we compare

National average performance for NHS providers (i.e. excluding Independent Sector providers) was 76.7% in December 2024, the latest data available. Our performance was 74.1%. We were ranked 112 out of 156 trusts for the 15 high-volume diagnostic tests.

Recent performance

Area	Aug	Sep	Oct	Nov	Dec	Jan
Musgrove Park Hospital (MPH)	76.3%	83.5%	87.4%	85.2%	72.9%	72.2%
Yeovil District Hospital (YDH)	69.9%	70.6%	77.6%	79.3%	77.0%	67.7%
Combined	74.0%	79.8%	84.7%	83.8%	74.1%	70.4%
Trajectory	84.7%	86.6%	88.6%	90.3%	89.4%	92.0%

Responsive

Our aim is to ensure that at least 90% of the complaints we receive are responded to within timescales agreed with complainants.

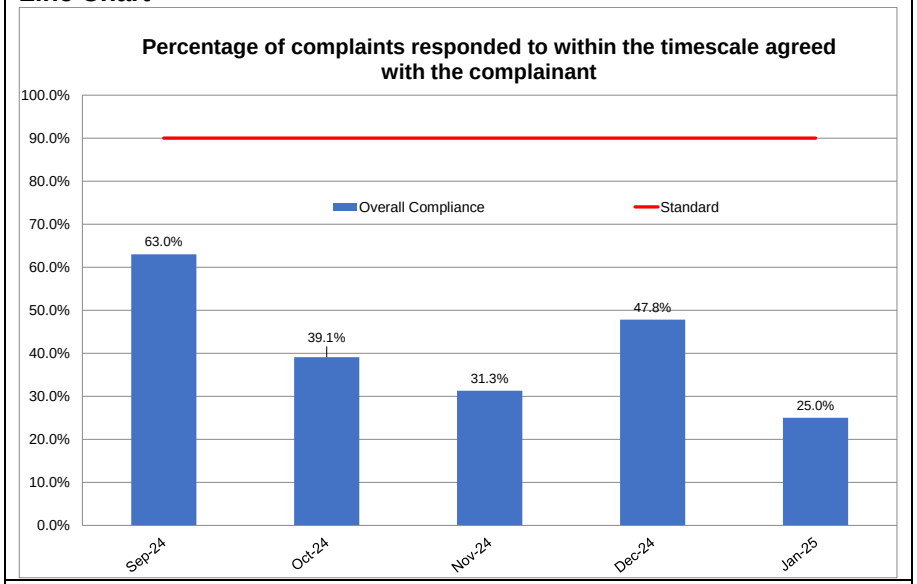
Current performance (including factors affecting this)

- Of 16 complaints responded to during January 2025, a total of four (25.0%) were responded to within the timescales agreed with the complainants.
- Delays occurred due to a combination of reasons including:
    - Ongoing operational and workforce challenges across all areas to be able to review, prioritise and respond to complaints.
    - A change in process, resulting in clinicians not previously involved in handling complaints now taking on this responsibility.
    - Continued complexity, with a large proportion of complaints overlapping teams and service groups, and challenges with service groups identifying a lead for the review and ongoing management of a complaint.
    - The timely availability of paper medical notes when multiple teams are involved across service groups.

Focus of improvement work.

- Implementation of a new RADAR System, which went live on 2 December 2024, to enable oversight from the service groups and complaints team. The system will enable the identification of where delays have occurred and will inform service improvement.
- Regular tracker meetings between complaint co-ordinators and service groups to identify potential delays and escalate concerns.
- Regular meetings between Associate Directors of Patient Care and the Head of Patient Experience to identify causes of delays and potential solutions.
- Review of targets to ensure alignment with national standards.
- A working group has been developed to perform an organisational diagnostic against NHS Complaint Standards. The first meetings took place on 29 November, 13 December 2024 and 14 February 2025. The next meeting, scheduled for September 2025, will review progress against the NHS Complaint Standards action plan.
- Development of an interactive dashboard to increase visibility and timeframes of complaints.

Line Chart



How do we compare

Changes were implemented from September 2024 reflect compliance in respect of complaints responded to within the timescale agreed with complainants.

Recent Performance

Complaints open:

Directorate	Numbers waiting <=20 days	Numbers waiting >20 and <=40 days	Numbers waiting >40 days	Total
Clinical Support	0	0	3	3
CYP & Families	3	2	13	18
Medical Services	4	5	11	20
Mental Health & LD	1	0	5	6
Neighbourhoods	5	0	0	5
Surgical Services	6	3	12	21
Corporate	0	0	3	3
Totals:	**19**	**10**	**47**	**76**

Well Led

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

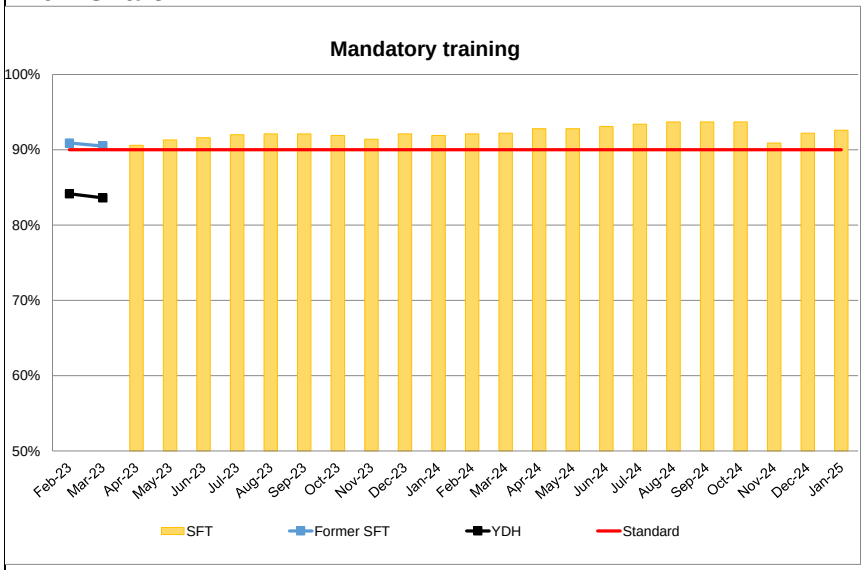
Current performance (including factors affecting this)

- As at 31 January 2025, our overall mandatory training rate was 92.6%, up by 0.4% from the rate as at 31 December 2024.
- Apart from Symphony Health Service (SHS), all colleagues moved to the new Trust training system, LEAP, on 1 April 2023. As at 31 January 2025, compliance reported from the two separate systems was as follows:
  - LEAP: 92.7% (92.2% as at 31 December 2024)
  - SHS: 71.9% (79.0% as at 31 December 2024)
- 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

- Compliance in respect of Fire Safety training increased from 82.9% as at 31 December 2024 to 89.0% as at 31 January 2025. Compliance had decreased due to training moving from three-year to two-year year refresh periods.
- Remapping of over 1,000 colleagues in respect of Level 3 Safeguarding is planned to be undertaken in the forthcoming months and will potentially have a negative impact on overall compliance rates, although colleagues moving to Level 3 will be given six months to undertake and complete courses.
- In January 2025, 33% of resuscitation course spaces were unused (not booked/cancelled/did not attend). Clinical pressures being a significant impact on colleagues' ability to attend training and compliance fell compared to December 2024.
- A questionnaire sent to colleagues who DNAd courses in December 2024 found that colleagues were booking on to multiple courses, expecting the system to 'know' they had already attended, resulting in higher DNA rates. Colleagues are to be encouraged to cancel their spaces if they attend ahead of their original booking
- From end of February 2025, resuscitation staffing levels will be the highest they have been since the April 2023 merger, and it is expected that this will positively influence compliance.

Run Chart



How do we compare

Compliance as at 31 January 2025 increased from the rate reported as at 31 December 2024.

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	93.7%	93.7%	93.7%	90.9%	92.2%	92.6%

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 2025, in respect of appraisals being undertaken at least annually was 78.5%, down from 80.4% reported as at 31 December 2024.
- Estates and Facilities are the best performing area, with a rate of 86.2%, followed by Medical Services with 82.1% and Neighbourhoods at 81.1%.

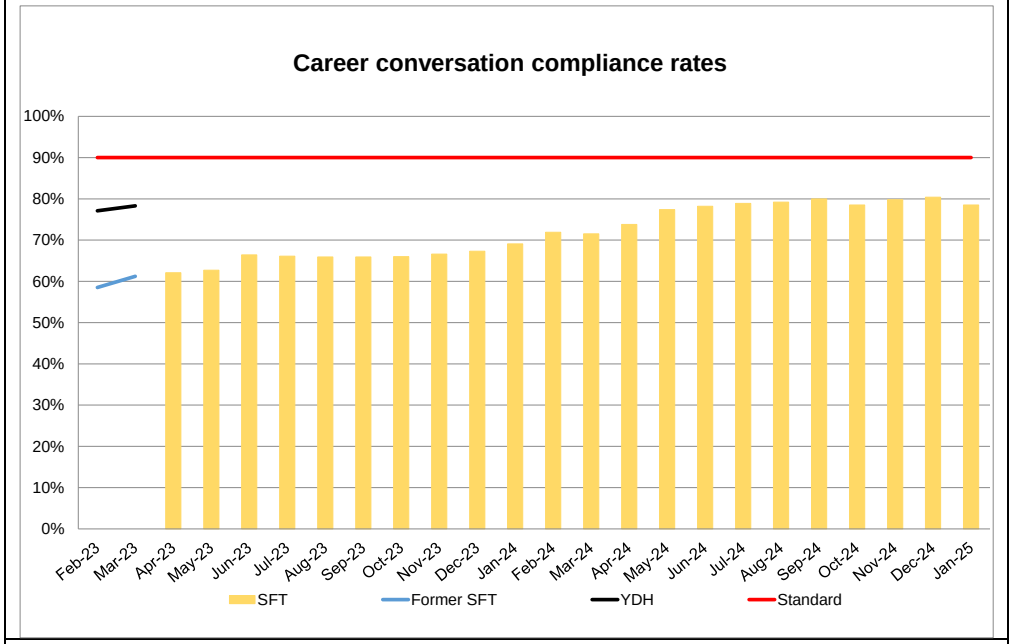
Focus of improvement work

All areas of focus outlined previously are continuing, including:

- Service groups identifying trajectories for improvement, presenting these early in 2025 at their Quality, Outcomes, Finance and Performance meetings, and identifying any concerns regarding achievement.
- The new system to record medical and dental appraisals is now in place, which will improve reporting of compliance rates for the medical and dental workforce as data is pulled across systems automatically.
- The People Strategy deliverable, focused on improving compliance with appraisal rates and modernising the approach to appraisals, is under way.

Run Chart

80.4



How do we compare

Compliance as at 31 January 2025 decreased by 1.9% compared to the position as at 31 December 2024.

Recent performance

The compliance rates in recent months were as follows:

Area	Aug	Sep	Oct	Nov	Dec	Jan
% compliance	79.2%	80.0%	78.5%	79.8%	80.4%	78.5%

Well Led

Sickness/Absence: We are committed to improving the health and wellbeing of our workforce in a supportive work environment, in order to reduce sickness absence and thereby ensure continuity of care and quality service provision. Our aim is to reduce staff sickness absence levels to being no more 5.2% or less. The data outlined shows our monthly sickness absence percentage rate.

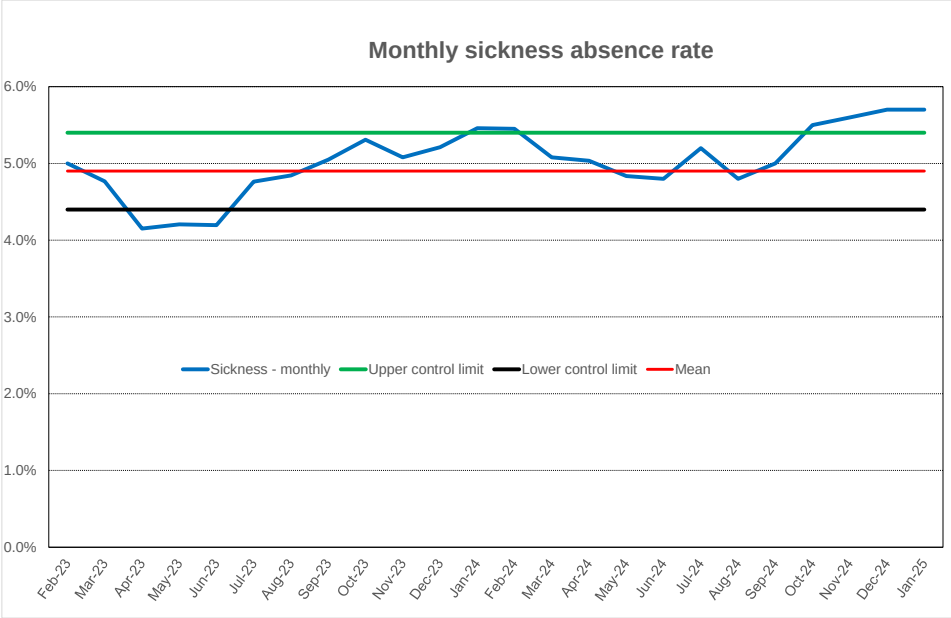
Current performance (including factors affecting this)

- The monthly sickness absence rate for January 2025 was 5.7%, down from 5.8% in December 2024 which had been the highest rate recorded since the formation of the new Trust in April 2023.
- The 12-month rolling sickness absence rate for the period ending 31 January 2025 remained unchanged at 5.2%.
- The monthly increase in short term sickness absence has continued since October 2024; long term absence levels remain unchanged.
- The staff groups with highest rates in absence were estates and ancillary colleagues and healthcare scientists.
- The service group with the highest rate of sickness absence recorded was the Neighbourhoods Service Group with a rate of 7.6%, unchanged from December 2024.
- Anxiety and stress remains the top reason for absence.

Focus of improvement work

- A People Strategy deliverable, focused on burnout and stress, is under way to improve the understanding of, and reduce absence relating to anxiety, stress and depression. This is reported through the Colleague Experience Group (formerly the Cultural Strategy Group).
- Focused support is being developed for the Mental Health & Learning Disabilities and Neighbourhoods service groups to reduce levels in these areas. This is reported through Quality, Outcomes, Finance and Performance (QOFP) meetings.

Run Chart



How do we compare

As the only acute, community and mental health Trust we are currently unable to benchmark our position directly against similar providers.

Recent performance

The sickness absence rates in recent months were as follows:

Area	Aug	Sep	Oct	Nov	Dec	Jan
12-month rolling rate	5.1%	5.1%	5.1%	5.2%	5.2%	5.2%
Monthly rate	4.8%	5.0%	5.5%	5.6%	5.8%	5.7%

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.

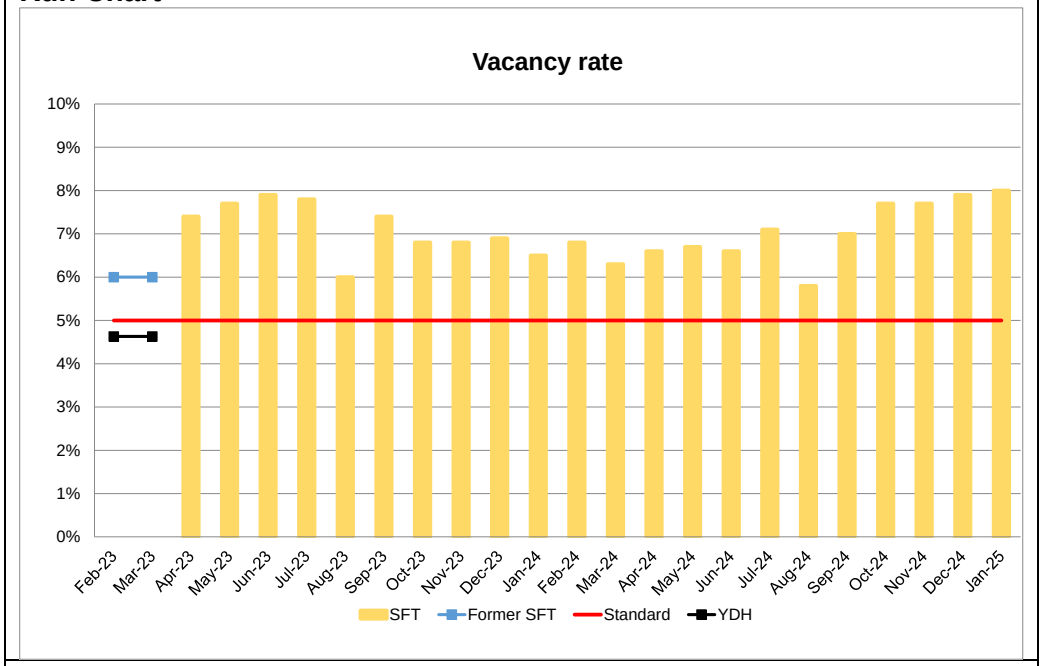
Current performance (including factors affecting this)

- Our vacancy rate as at 31 January 2025 was 8.0%, an increase of 0.1% compared to the rate reported as at 31 December 2024.
- The areas with the highest vacancy rates are:
  - Mental Health and Learning Disabilities: 12.3%
  - Estates and Facilities: 10.9%
  - Neighbourhood Services: 10.4%
- As part of the NHS England workforce whole time equivalent cap, there will be some roles which are deliberately not being filled, as service groups progress their productive care plans.
- Twenty-three risks on the risk register relate to recruitment challenges, spanning many services and roles. The highest-scoring risks are with senior medical and nursing and allied health professional roles with community hospitals, pharmacy, theatres, bowel cancer screening and digital recruitment challenges, scoring 15 and above.
- For many hard-to-recruit roles, there are national and local shortages, making it a very competitive environment in which to recruit.

Focus of improvement work

- The introduction of a vacancy tracker, presented to our People Committee at its January 2025 meeting, will improve visibility of vacancies and how these are being managed.

Run Chart



How do we compare

The vacancy rate within the Trust in January 2025 increased compared to December 2024.

Recent performance

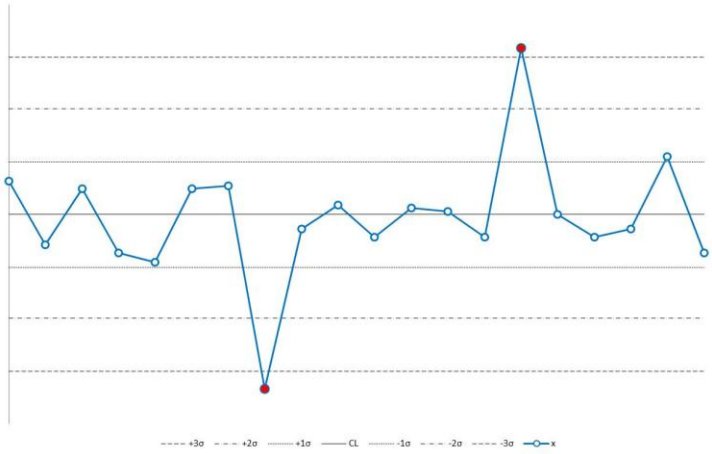
The performance against the vacancy rate standard in recent months was as follows:

Dec	Aug	Sep	Oct	Nov	Dec	Jan
Vacancy rate	5.8%	7.0%	7.7%	7.7%	7.9%	8.0%

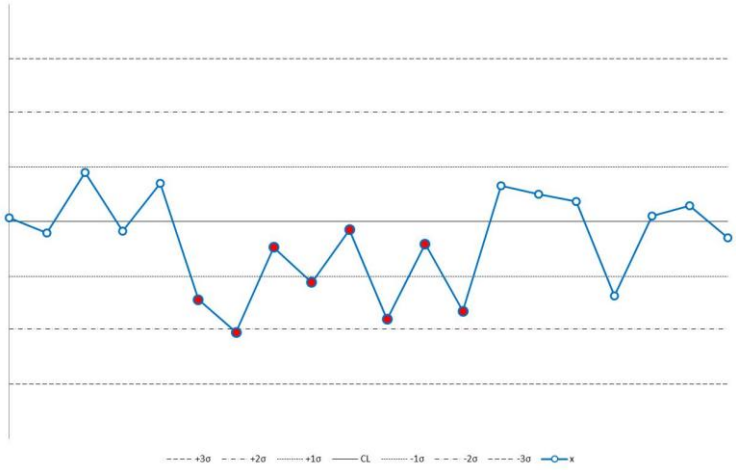
Appendix 1 - Procedure for Interpreting Run Charts

Special Cause Variation Rules

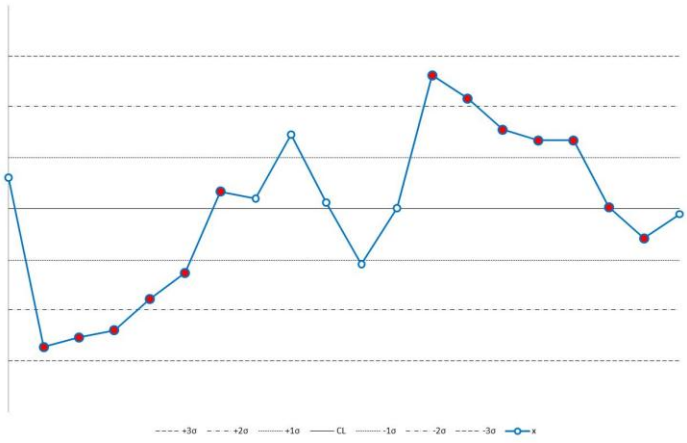
1. A single point outside the control limits



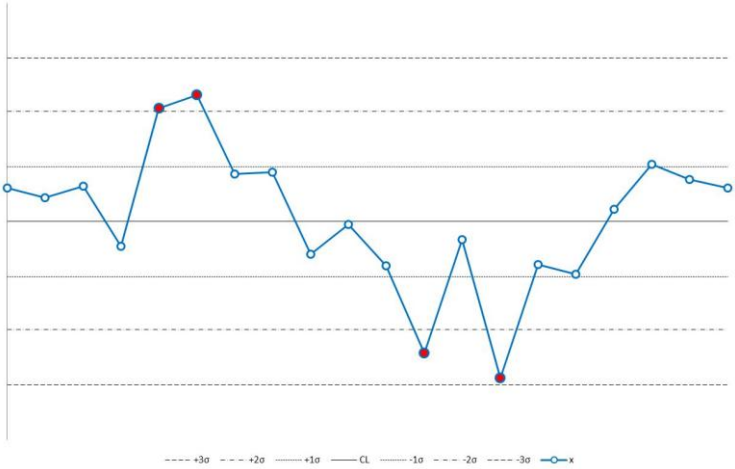
2. A run of eight or more points in a row above (or below) the centreline



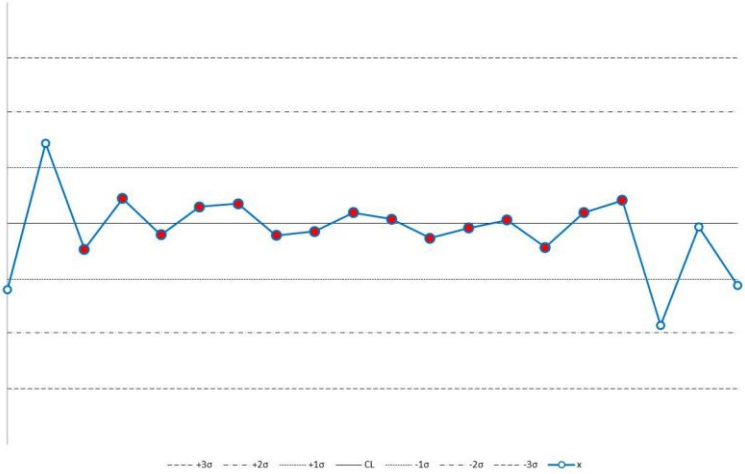
3. Six consecutive points increasing (trend up) or decreasing (trend down)



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

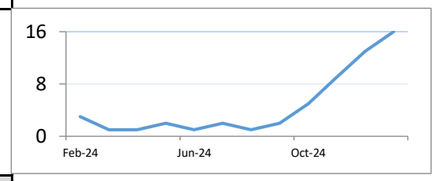
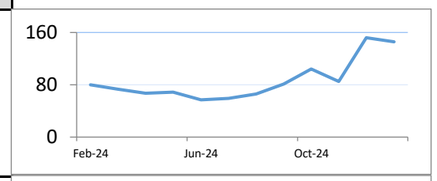
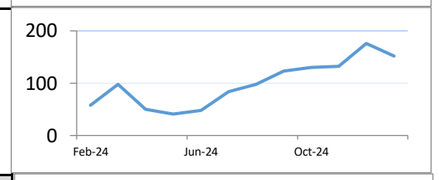
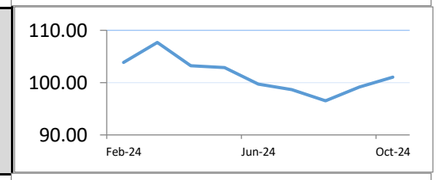
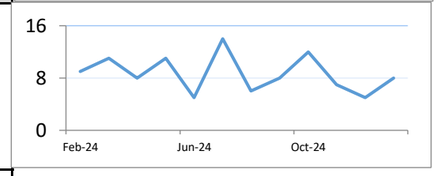
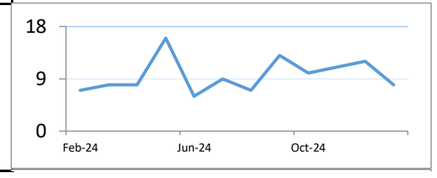
Our current Care Quality Commission ratings are as follows:

	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**

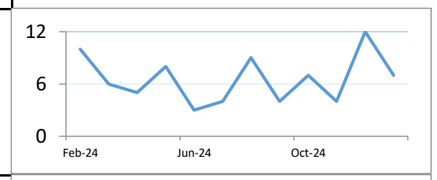
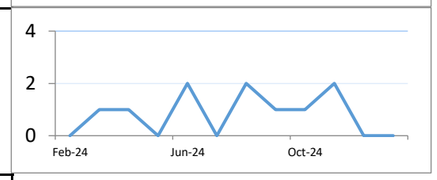
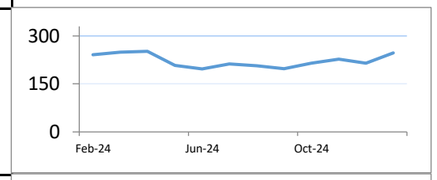
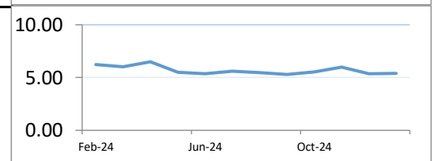
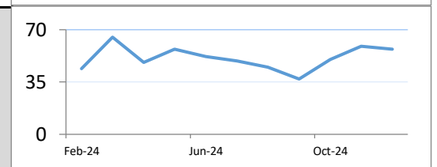
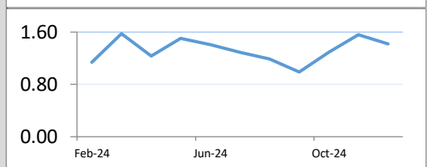
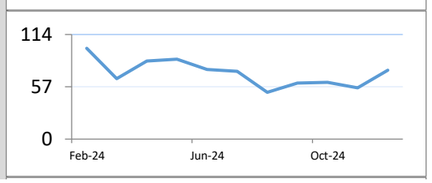
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2024/25

Area	Ref	Measure		Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	
Admissions	1	Average daily number of medical and surgical outliers in acute wards during the month	MPH	3	1	1	2	1	2	1	2	5	9	13	16	
	2		YDH	Reporting criteria to be changed to be same as MPH reported numbers. Awaiting information from our Data Insight Team.												
	3	Number of patients transferred between acute wards after 10pm	MPH	80	73	67	69	57	59	66	81	104	85	152	146	
	4		YDH	58	98	50	41	48	84	98	123	130	132	176	152	
Mortality (acute services)	5	Summary Hospital-level Mortality Indicator (SHMI)		103.86	107.68	103.21	102.89	99.70	98.63	96.52	99.17	101.04	Data not yet due - November 2024 to be reported after February 2025			
Infection Control	6	Clostridium Difficile cases HOHA cases (Hospital Onset Hospital Acquired) and COHA cases (Community Onset Hospital Acquired)		9	11	8	11	5	14	6	8	12	7	5	8	
	7	MRSA bacteraemias (post)		0	0	0	1	0	0	0	1	0	0	0	2	
	8	E. coli bacteraemia		7	8	8	16	6	9	7	13	10	11	12	8	

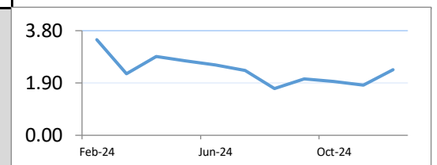
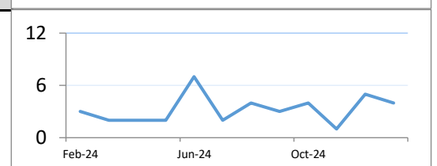
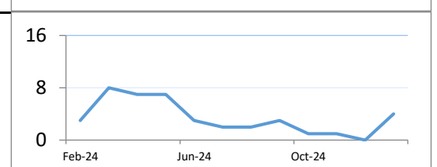
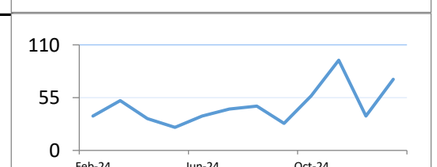
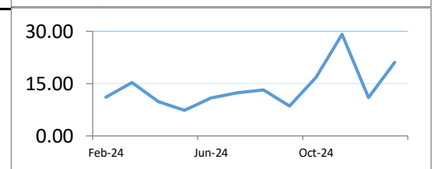
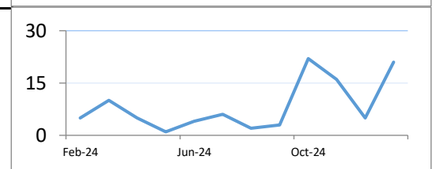
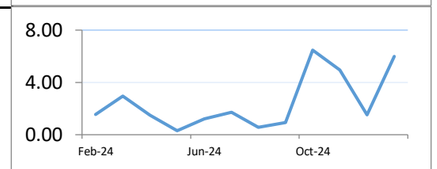
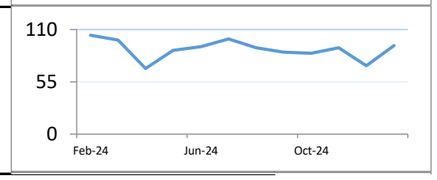
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2024/25

Area	Ref	Measure	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	
	9	Methicillin-sensitive staphylococcus aureus	10	6	5	8	3	4	9	4	7	4	12	7	
Maternity	10	No. of still births	0	1	1	0	2	0	2	1	1	2	0	0	
	11	No. of babies born in unexpectedly poor condition	0	0	0	0	0	0	0	0	0	0	0	0	
Falls	12	Total number of patient falls	241	249	252	208	197	213	207	198	215	227	215	247	
	13	Rate of falls per 1,000 occupied bed days - all services	6.25	6.04	6.49	5.48	5.35	5.60	5.46	5.29	5.55	6.00	5.35	5.40	
Pressure ulcer damage	14	Inpatient wards - number of incidents	44	65	48	57	52	49	45	37	50	59	57	Data not yet due	
	15	Rate of pressure ulcer damage per 1,000 inpatient ward occupied bed days	1.14	1.58	1.24	1.50	1.41	1.29	1.19	0.99	1.29	1.56	1.42		
	16	District nursing - number of incidents	99	66	85	87	76	74	51	61	62	56	75		

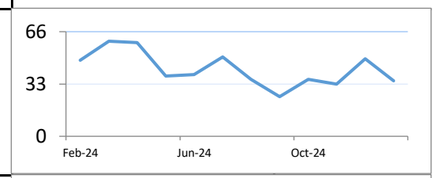
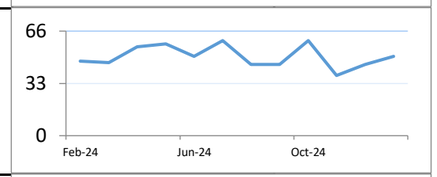
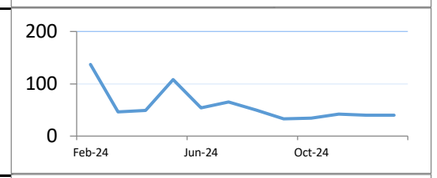
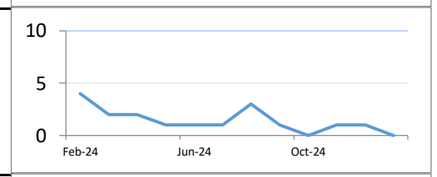
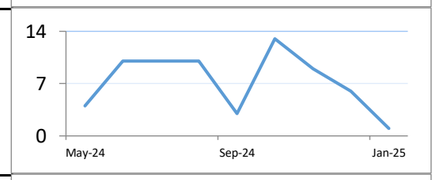
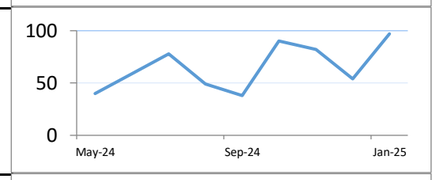
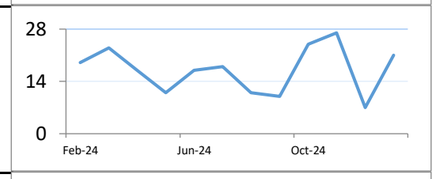
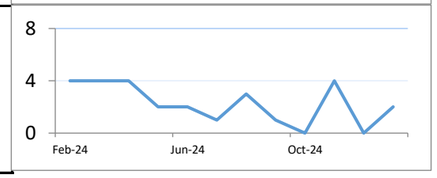
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2024/25

Area	Ref	Measure		Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	
	17	Rate of pressure ulcer damage per 1,000 district nursing contacts		3.47	2.24	2.87	2.71	2.56	2.36	1.70	2.05	1.95	1.82	2.38	Data not yet due	
Cardiac Arrests	18	No. ward-based cardiac arrests - acute wards	MPH	3	2	2	2	7	2	4	3	4	1	5	4	
Cardiac Arrests	19	No. ward-based cardiac arrests - acute wards	YDH	3	8	7	7	3	2	2	3	1	1	0	4	
Restraints (mental health wards)	20	Total number of incidents	Mental Health Wards	36	52	33	24	36	43	46	28	57	94	36	74	
	21	Restraints per 1,000 occupied bed days	Mental Health Wards	11.1	15.3	9.8	7.3	10.9	12.4	13.2	8.6	16.8	29.1	11.0	21.1	
	22	Number of prone restraints	Mental Health Wards	5	10	5	1	4	6	2	3	22	16	5	21	
	23	Prone restraints per 1,000 occupied bed days	Mental Health Wards	1.54	2.95	1.48	0.31	1.21	1.73	0.57	0.92	6.47	4.96	1.52	5.99	
nts	24	Total number of medication incidents	MPH	104	99	69	88	92	100	91	86	85	91	72	93	

SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2024/25

Area	Ref	Measure		Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	
Medication incider	24	Total number of medication incidents	YDH	48	60	59	38	39	50	36	25	36	33	49	35	
	24	Total number of medication incidents	Community & Mental Health	47	46	56	58	50	60	45	45	60	38	45	50	
Ligatures and ligature points	25	Ligatures: Total number of incidents	Mental Health Wards	137	46	49	108	54	65	50	33	34	42	40	40	
Ligatures and ligature points	26	Number of ligature point incidents	Mental Health Wards	4	2	2	1	1	1	3	1	0	1	1	0	
Violence and Aggression	27	Violence and Aggression: Number of incidents patient on patient (inpatients only)	Acute, Community Hospitals and Mental Health wards	Reporting changes due to Learning from Patient Safety Events (LFSPE)			4	10	10	10	3	13	9	6	1	
	28	Violence and Aggression: Number of incidents patient on staff	Acute, Community Hospitals and Mental Health wards				40	59	78	49	38	90	82	54	97	
Seclusion	29	Number of Type 1 -Traditional Seclusion	Mental Health Wards	19	23	17	11	17	18	11	10	24	27	7	21	
	30	Number of Type 2 -Short term Segregation	Mental Health Wards	4	4	4	2	2	1	3	1	0	4	0	2	

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Thresholds
1	Accident and Emergency / Urgent Treatment Centre 4-hour performance	Accident & Emergency department (ED) - MPH	2	53.1%	61.9%	59.2%	58.4%	55.2%	56.0%	60.2%	55.7%	51.3%	47.0%	42.6%	47.2%	From April 2024 >=76%= Green >=66% - <76% =Amber <66% =Red (the standard will rise to 78% in March 2025)
2		Accident & Emergency department (ED) - YDH		67.3%	69.5%	67.5%	68.0%	62.1%	64.1%	65.6%	63.4%	65.0%	58.4%	51.8%	61.3%	
3		Accident & Emergency department (ED) - Combined		59.2%	65.2%	62.7%	62.5%	58.2%	59.4%	62.5%	59.0%	57.1%	52.1%	46.6%	53.3%	
4		Urgent Treatment Centres (formerly Minor Injury Units)		95.1%	97.9%	98.9%	97.3%	98.1%	98.3%	98.5%	97.8%	97.5%	98.4%	97.4%	98.6%	
5		Trust-wide		74.2%	79.6%	78.3%	77.7%	75.7%	76.2%	77.7%	75.2%	74.1%	71.6%	67.7%	73.4%	
6	Accident and Emergency / Urgent Treatment Centres: percentage of patients spending more than 12-hours in the department	Accident and Emergency department (ED) - MPH	2	3.3%	2.4%	1.1%	1.4%	1.3%	2.1%	1.4%	2.5%	4.3%	6.1%	10.8%	10.4%	<=2%= Green >2% - <=5% =Amber >5% =Red
7		Accident and Emergency department (ED) - YDH		3.6%	5.1%	4.7%	2.3%	3.3%	5.9%	5.2%	5.0%	4.4%	4.4%	8.5%	8.9%	
8		Urgent Treatment Centres (formerly 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: MPH		2	71.8%	77.8%	83.0%	75.8%	76.6%	75.5%	82.4%	74.4%	67.9%	62.1%	47.3%	56.8%	>=95%= Green >=85% - <95% =Amber <85% =Red
10	Ambulance handovers waiting less than 30 minutes: YDH			68.6%	66.3%	64.0%	76.1%	66.0%	59.8%	66.0%	63.0%	64.8%	62.3%	47.4%	52.8%	
11	Cancer - 28 days Faster Diagnosis All Cancers		1,2	84.7%	84.1%	78.6%	80.6%	75.0%	70.0%	70.9%	75.4%	79.0%	76.5%	75.8%	Data not yet due	>=75%= Green <75% =Red (the standard will rise to 77% in March 2025)
12	31 day wait - from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment			92.4%	94.7%	91.2%	91.9%	91.2%	96.4%	94.8%	93.7%	94.1%	90.1%	93.7%	Data not yet due	>=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			68.3%	74.5%	71.5%	64.2%	68.0%	67.8%	72.0%	64.4%	65.6%	68.2%	71.0%	Data not yet due	>=85%= Green From April 2024 at or above trajectory =Amber and below trajectory =Red
14	Cancer: 62-day wait from referral to treatment for urgent referrals – number of patients treated on or after day 104			22	29	21	20	23	21	19	22	33	23	13	Data not yet due	0= Green >0 = Red
15	CAMHS Eating Disorders - Urgent referrals to be seen within 1 week - (rolling 3 months)		1,2,5	-	-	100.0%	100.0%	100.0%	-	100.0%	100.0%	100.0%	100.0%	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)		1,2,5	96.9%	96.9%	97.1%	97.3%	97.1%	96.6%	100.0%	95.7%	95.7%	95.5%	95.5%	96.4%	>=95%= Green >=85% - <95% =Amber <85% =Red

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CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Thresholds
17	Mental health referrals offered first appointments within 6 weeks	All mental health services	1,2,3	96.8%	92.8%	93.0%	95.7%	95.7%	96.2%	93.5%	93.9%	94.9%	94.4%	96.2%	94.5%	>=90%= Green >=80% - <90% =Amber <80% =Red
18	Mental health referrals offered first appointments within 6 weeks	Adult mental health services		96.1%	92.2%	92.1%	94.7%	92.5%	94.2%	91.5%	90.4%	90.3%	92.5%	89.6%	92.0%	>=90%= Green >=80% - <90% =Amber <80% =Red
19		Older Persons mental health services		96.0%	90.3%	93.8%	97.0%	100.0%	97.2%	93.8%	93.4%	97.8%	94.7%	97.7%	91.1%	
20		Learning disabilities service		100.0%	100.0%	83.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%	
21		Children and young people's mental health services		100.0%	100.0%	95.0%	95.4%	95.3%	98.5%	97.8%	98.8%	97.8%	96.3%	97.5%	97.3%	
22	Percentage of women accessing specialist community Perinatal MH service - 12 month rolling reporting		1,2	12.4%	12.6%	12.9%	13.0%	13.1%	13.3%	13.8%	13.7%	14.2%	14.1%	14.4%	14.3%	>=10%= Green >=7.5% - <10% =Amber <7.5% =Red
23	Diagnostic 6-week wait - acute services	MPH	1,2	84.8%	83.9%	86.0%	85.7%	84.0%	78.9%	76.3%	83.5%	87.4%	85.2%	72.9%	72.2%	From March 2024 At or above regional ambition 85% = Green Above trajectory = Amber Below trajectory = Red
24		YDH		67.8%	63.8%	59.4%	72.7%	69.2%	67.3%	69.9%	70.6%	77.6%	79.3%	77.0%	65.7%	
25		Combined		78.2%	76.0%	79.4%	80.4%	78.3%	74.8%	74.0%	79.8%	84.7%	83.8%	74.1%	70.4%	
26	RTT incomplete pathway performance: percentage of people waiting under 18 weeks		1,2,4	63.4%	62.5%	64.6%	66.3%	65.6%	65.1%	63.8%	63.3%	62.8%	62.2%	62.1%	61.8%	>=92%= Green <92% =Red
27	52 week RTT breaches - Patients of all ages			2,158	2,270	1,969	1,871	1,873	1,842	1,769	1,536	1,445	1,371	1,364	1,388	From April 2023 At or below trajectory = Green Above trajectory = Red
28	52 week RTT breaches - Patients aged 18 or under			New reporting - to commence from May 2024			185	168	165	162	115	91	86	87	104	
29	65 week RTT breaches - Patients of all ages			538	434	463	484	493	426	370	247	198	144	142	146	
30	Referral to Treatment (RTT) incomplete pathway waiting list size			53,800	53,524	54,625	55,014	56,599	57,442	57,619	58,112	58,725	59,585	60,076	59,061	

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CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Thresholds
31	Average length of stay of patients discharged from acute wards - (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).	MPH	2,7	6.4	6.0	5.9	5.8	5.8	5.8	5.9	6.0	5.8	6.2	6.5	6.7	Monitored using Special Cause Variation Rules. Report by exception.
32		YDH		6.9	7.1	7.0	6.7	6.3	5.5	6.4	5.7	6.2	5.8	6.0	7.1	
33	Patients not meeting the criteria to reside: % of occupied bed days lost	MPH	2,7	20.5%	21.0%	18.9%	19.2%	19.4%	23.2%	22.4%	19.6%	19.0%	22.7%	20.0%	19.5%	<=9.8%= Green >15% =Red
34		YDH		29.5%	23.0%	21.8%	23.4%	23.0%	21.0%	19.9%	26.4%	21.3%	20.8%	20.2%	20.9%	
35	Acute bed days lost due to patients not meeting the criteria to reside	MPH	2,7	3,516	3,805	3,215	3,267	3,230	3,939	3,719	3,269	3,721	3,930	3,620	4,413	TBC
36		YDH		2,891	2,495	2,238	2,284	2,230	2,070	1,991	2,475	2,122	2,031	2,124	2,254	
37	Community service waiting times: number of people waiting over 18 weeks from referral to first appointment (excluding dental)		1,2,3	1,107	1,399	1,590	1,712	1,870	1,944	1,937	1,736	1,426	1,061	768	592	From June 2024 At or below trajectory = Green Above trajectory = Red
38	Community service waiting times: number of people waiting over 52 weeks from referral to first appointment (excluding dental)			229	264	257	259	280	277	277	263	240	95	26	9	
39	Community service waiting times: number of people waiting over 104 weeks from referral to first appointment (excluding dental)			35	45	45	49	57	73	88	93	86	25	7	1	
40	Community dental services - General, Domiciliary or Minor Oral surgery waiting 18 weeks or more		1,2,3	2,345	2,388	2,301	2,374	2,428	2,452	2,436	2,394	2,394	2,543	2,688	2,631	From April 2024 <1,979 = Green >=1,979 = Red
41	Community dental services - General, Domiciliary or Minor Oral surgery waiting 52 weeks or more			575	574	531	584	620	600	538	533	489	491	540	559	From April 2024 <574 = Green >=574 = Red
42	Community dental services - Child GA waiters waiting 18 weeks or more		1,2,3	520	530	518	545	529	529	558	577	586	603	627	624	From April 2023 <463 = Green >=463 = Red
43	Early Intervention In Psychosis: people to begin treatment with a NICE-recommended care package within 2 weeks of referral (rolling three month rate)		1,2,3	93.3%	87.5%	86.7%	73.7%	77.8%	70.6%	84.6%	87.5%	100.0%	100.0%	91.7%	94.1%	>=60%= Green <60% =Red
44	Talking Therapies RTT : percentage of people waiting under 6 weeks		1,2,3	78.4%	83.0%	84.3%	84.0%	85.4%	82.7%	88.0%	86.5%	86.8%	85.6%	79.4%	81.6%	>=75%= Green <75% =Red
45	Talking Therapies RTT: percentage of people waiting under 18 weeks		1,2,3	99.2%	98.9%	99.0%	98.9%	98.7%	98.2%	99.6%	98.9%	98.3%	97.8%	98.4%	99.3%	>=95%= Green <95% =Red
46	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) Recovery Rates		1,2,3	60.7%	56.6%	58.6%	60.2%	59.6%	58.9%	61.2%	54.8%	53.0%	56.9%	56.5%	56.1%	>=50%= Green <50% =Red

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CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Thresholds
47	Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Improvement		1,2,3	74.1%	75.9%	69.7%	78.5%	72.3%	74.3%	77.8%	76.5%	73.8%	75.9%	70.9%	75.9%	>=67%= Green <67% =Red
48	Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Recovery		1,2,3	57.0%	54.8%	54.9%	57.9%	56.0%	55.4%	58.7%	53.3%	52.6%	52.6%	49.7%	54.1%	>=48%= Green <48% =Red
49	Adult mental health inpatients receiving a follow up within 72 hrs of discharge		1,2	100.0%	92.9%	97.6%	90.9%	90.5%	100.0%	96.2%	97.4%	96.9%	100.0%	97.1%	100.0%	>=80%= Green <80% =Red
50	Inappropriate Out of Area Placements for non-specialist mental health inpatient care. Number of 'active' out of area placements at the month-end		1,2	1	1	2	1	3	3	3	3	4	2	1	1	1= Green >1 = Red
51	Intermediate Care - Patients aged 65+ discharged home from acute hospital beds on pathway 0 or 1		1,2,3	96.1%	93.3%	95.1%	94.1%	94.3%	94.7%	93.8%	94.9%	94.8%	94.8%	93.2%	95.9%	>=95%= Green >=85% - <95% =Amber <85% =Red
52	Urgent Community Response: percentage of patients seen within two hours		1,2,3	91.6%	95.9%	90.5%	87.8%	87.5%	87.4%	89.5%	85.8%	87.4%	87.1%	90.9%	Data not yet due	>=70%= Green >=60% - <70% =Amber <60% =Red
53	% Stroke Patients direct admission to stroke ward in 4 hours	MPH	1,2,5	Change in reporting criteria		38.3%	49.1%	50.0%	52.4%	54.3%	34.9%	The provider of the software system used to record all stroke activity implemented changes to the dataset in October 2024 which resulted in reports currently being inaccessible nationally. Our Data Analytics Team have been awaiting patch updates from software provider to enable reporting to recommence. It is planned that reporting will recommence by April 2025.				>=90%= Green >=75% - <90% =Amber <75% =Red
54		YDH				15.2%	50.0%	27.6%	35.6%	40.0%	41.2%					
55	Patients spending >90% of time in stroke unit - acute services	MPH	1,2,5			85.0%	80.2%	88.5%	94.1%	94.0%	98.2%					>=80%= Green >=70% - <80% =Amber <70% =Red
56		YDH				50.0%	54.6%	67.7%	70.3%	56.3%	74.2%					
57	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, YDH, Community Hospitals and Mental Health wards	1,2,5	76.0%		72.5%		75.6%		79.2%		63.0%		A review of the audit form is being undertaken, deferring the audit until April 2025.		>=90%= Green >=80% - <90% =Amber <80% =Red
58	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services	MPH	1,2,5	77.8%	95.3%	94.4%	91.9%	83.3%	100.0%	90.9%	87.1%	92.3%	90.6%			
59	Percentage of emergency patients screened for sepsis - Emergency Departments			100.0%	96.6%	87.5%	96.2%	90.9%	77.8%	91.0%	90.7%	92.8%	94.2%			
60	National paediatric early warning system (PEWS)	MPH	1,2,5	80.0%	100.0%	64.3%	87.5%	Reporting has been moved from a paper method to a digital solution, which will improve the robustness of recording. It was planned that reporting would commence from February 2025 but a review of all questions is now being undertaken.								

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CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Thresholds
61	Percentage of complaints responded to within the timescale agreed with the complainant		6	New reporting - to commence from September 2024							63.0%	39.1%	31.3%	47.8%	25.0%	>=90%= Green >=80% - <90% =Amber <80% =Red
62	Mandatory training: percentage completed	Combined	6	92.1%	92.2%	92.8%	92.8%	93.1%	93.3%	93.7%	93.7%	93.7%	90.9%	92.2%	92.6%	All courses >=90%= Green Overall rate <80% =Red Any other position = Amber
63	Monthly percentage of days lost due to sickness		6	5.5%	5.1%	5.0%	4.8%	4.8%	5.2%	4.8%	5.0%	5.5%	5.6%	5.8%	5.7%	SPC (Upper Control Limit 5.4%)
64	Sickness absence levels - rolling 12 month average (Trust-wide)		6	5.3%	5.3%	5.2%	5.2%	5.2%	5.2%	5.1%	5.1%	5.1%	5.2%	5.2%	5.2%	SPC (Upper Control Limit 5.2%)
65	Career conversations (12 months) - formerly 'Performance review (12-month)'		6	71.9%	71.5%	73.8%	77.4%	78.2%	78.9%	79.2%	80.0%	78.5%	79.8%	80.4%	78.5%	>=90%= Green >=80% - <90% =Amber <80% =Red
66	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)		6	6.8%	6.3%	6.6%	6.7%	6.6%	7.1%	5.8%	7.0%	7.7%	7.7%	7.9%	8.0%	<=5%= Green >5% to <=7.5% =Amber >7.5% =Red
67	Retention rate – rolling 12 months percentage of colleagues in post		6	89.0%	89.2%	89.1%	89.0%	89.2%	89.0%	88.8%	88.3%	88.7%	88.7%	88.8%	88.8%	>=88.3%= Green >=80% to <88.3% =Amber <80% =Red
68	Percentage of colleagues in a senior role (band 8a and above and consultant roles):	Who are of an ethnic minority	4,6	21.6%		21.8%			21.0%			21.6%			Quarterly reporting	>=Trajectory = Green <=10% below trajectory = Amber >10% below trajectory = Red
69		Who are female	4,6	58.1%		58.3%			58.0%			57.9%				
70		With a recorded disability	4,6	3.0%		3.0%			3.4%			3.9%				
71	Number of formal HR case works (disciplinary, grievance and capability).		6	38	38	33	38	62	62	53	59	49	62	47	50	SPC (Upper Control Limit 78

Appendix 5a – Specialty and tumour-site level performance

Table 1 – Performance against the RTT performance standard in January 2025, 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	672	2044	51	67.1%
Urology	1656	3680	171	55.0%
Trauma & Orthopaedics	3406	8232	442	58.6%
Ear, Nose & Throat (ENT)	2388	5079	180	53.0%
Ophthalmology	1622	4900	27	66.9%
Oral Surgery	1317	2919	29	54.9%
Plastic Surgery	71	191	1	62.8%
Cardiothoracic Surgery	19	38		50.0%
General Medicine	29	66		56.1%
Gastroenterology	1192	2783	47	57.2%
Cardiology	987	3604	5	72.6%
Dermatology	960	2942	16	67.4%
Thoracic Medicine	605	1838	5	67.1%
Neurology	856	1941	20	55.9%
Rheumatology	251	836	2	70.0%
Geriatric Medicine	132	545	1	75.8%
Gynaecology	2031	4802	86	57.7%
Other – Medical Services	1031	3310	5	68.9%
Other - Paediatric Services	517	1649	14	68.6%
Other - Surgical Services	2457	6355	276	61.3%
Other – Other Services	391	1307	10	70.1%
Total	**22590**	**59061**	**1388**	**61.8%**

Table 2 – Performance against the 62-day GP cancer standard in December 2024.

Tumour site	No of breaches	Trust performance
Breast	6.0	82.9%
Colorectal	17.0	45.2%
Gynaecology	5.0	72.2%
Haematology	3.0	76.9%
Head & Neck	3.0	62.5%
Lung	7.0	70.8%
Other	0.0	100.0%
Skin	24.0	72.9%
Upper GI	4.0	72.4%
Urology	19.0	67.5%
Total	**88.0**	**71.0%**

Thirteen patients were treated in December 2024 on or after day 104 (the national 'backstop' for GP pathways). A breakdown of the breaches is as follows:

- Five patient pathways had internal delays mainly related to a lack of capacity. These pathways also had elements of unavoidable delays, due to additional investigations, medical complexity, waiting times at other organisations and periods of patient choice.
- Four pathways were delayed due to a lack of capacity within the Trust.
- Two 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.
- Two pathways were delayed due to patient choice to defer tests, appointments and/or treatment.

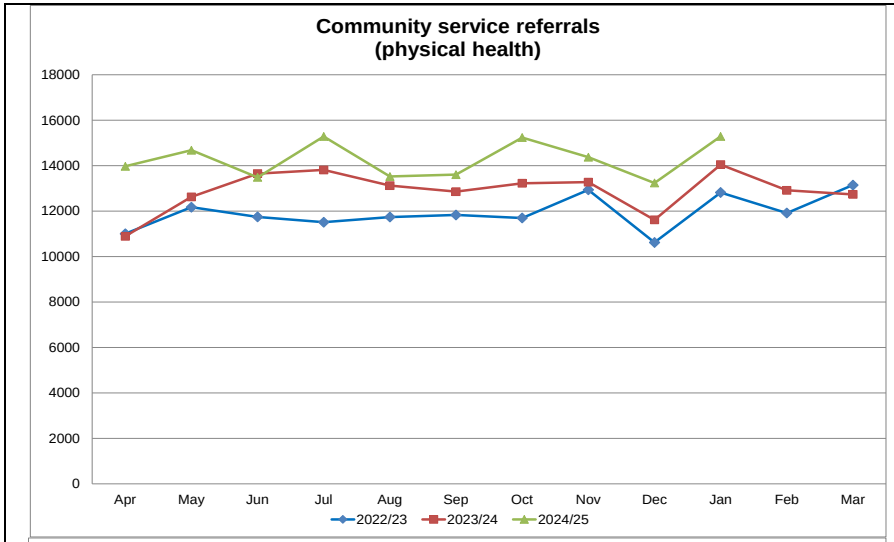
Appendix 2 – RTT validation progress

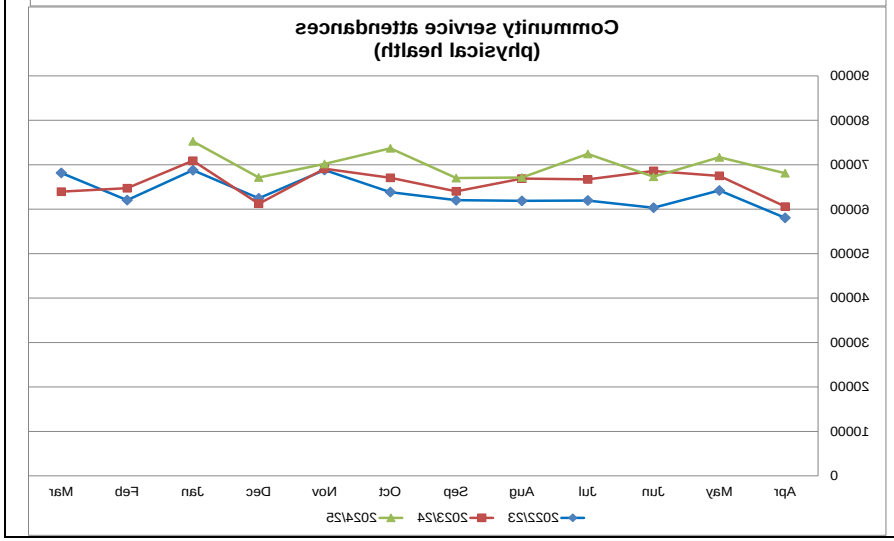
The national target is to reach a level of 90% validation of patients waiting 12 weeks and over from Referral to Treatment (RTT) by 31 October 2023. Validation includes both the administrative/technical validation and also contacting the patient to confirm they still wish to be seen.

RTT waiting times bands	Week ending 12th May	Week ending 9th Jun	Week ending 14th Jul	Week ending 11th Aug	Week ending 8th Sep	Week ending 13th Oct	Week ending 10th Nov	Week ending 15th Dec	Week ending 12th Jan	Week ending 16th Feb
12 weeks and over	75%	76%	69%	67%	70%	69%	74%	55%	54%	69%
26 weeks and over	77%	76%	77%	76%	77%	76%	72%	57%	57%	69%
52 weeks and over	97%	99%	99%	95%	100%	99%	99%	92%	85%	95%

Operational context

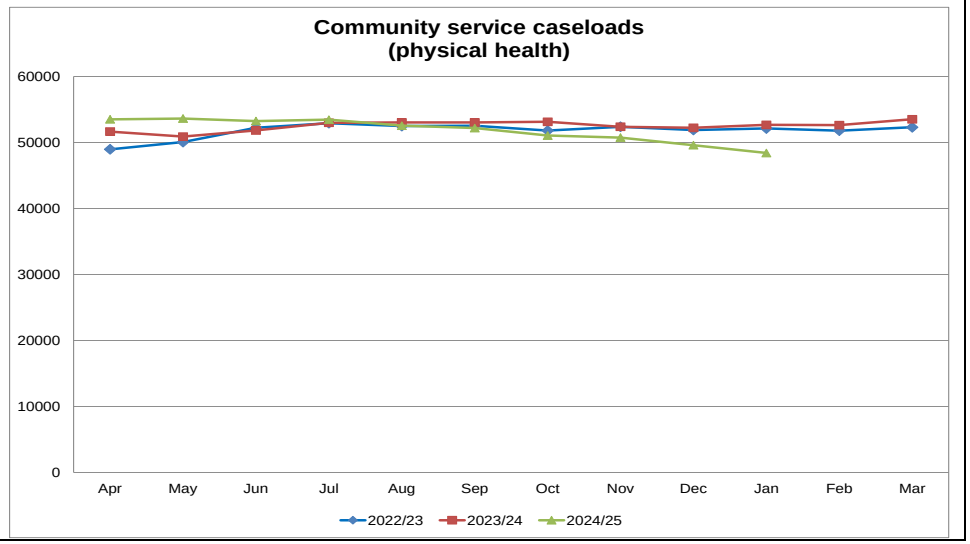
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





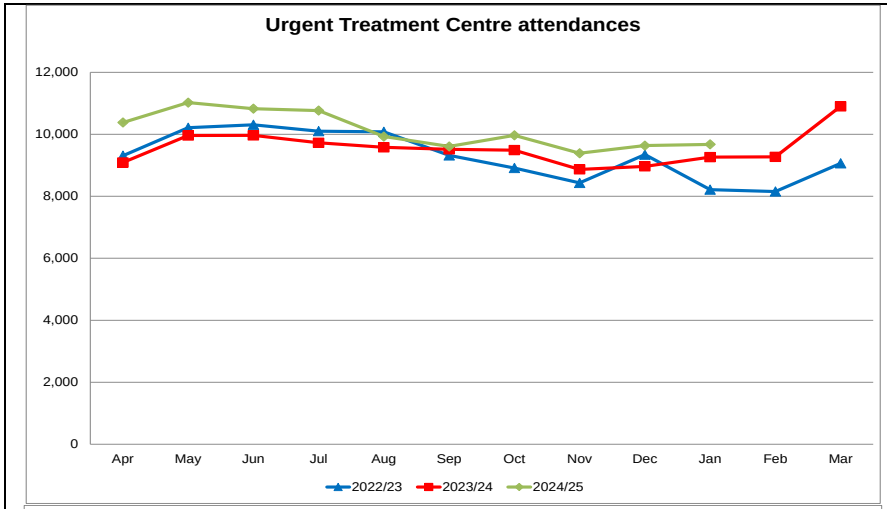
Summary:

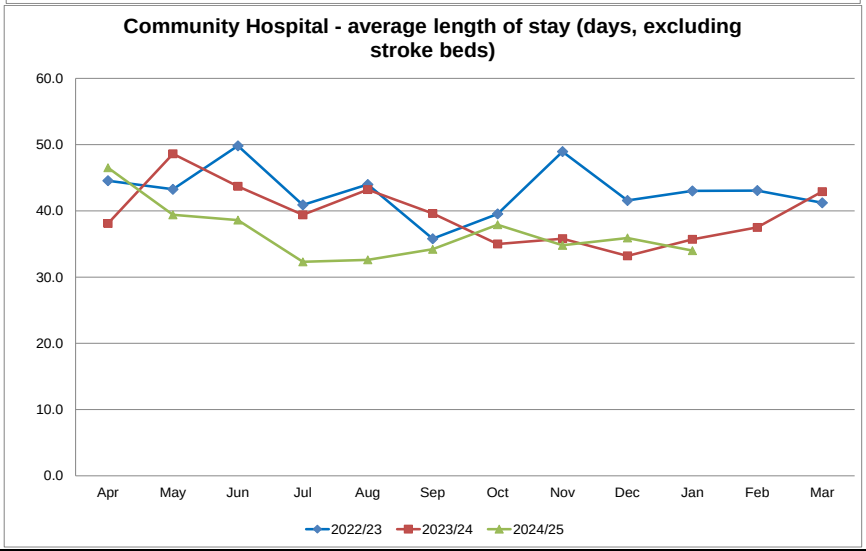
- Direct referrals to our community physical health services between 1 April 2024 and 31 January 2025 were 10.5% higher than the same months of 2023/24 and 20.8% higher than the same months of 2022/23. Services with the highest increases include Rapid Response, Diabetes Integrated Care and District Nursing.
- Attendances for the same reporting period were 5.6% higher than the same months of 2023/24 and 10.7% higher than the months of 2022/23.
- Community service caseload levels as at 31 January 2025 were 8.1% lower than as at 31 January 2024, and 7.1% lower than 31 January 2023 levels.



Operational context

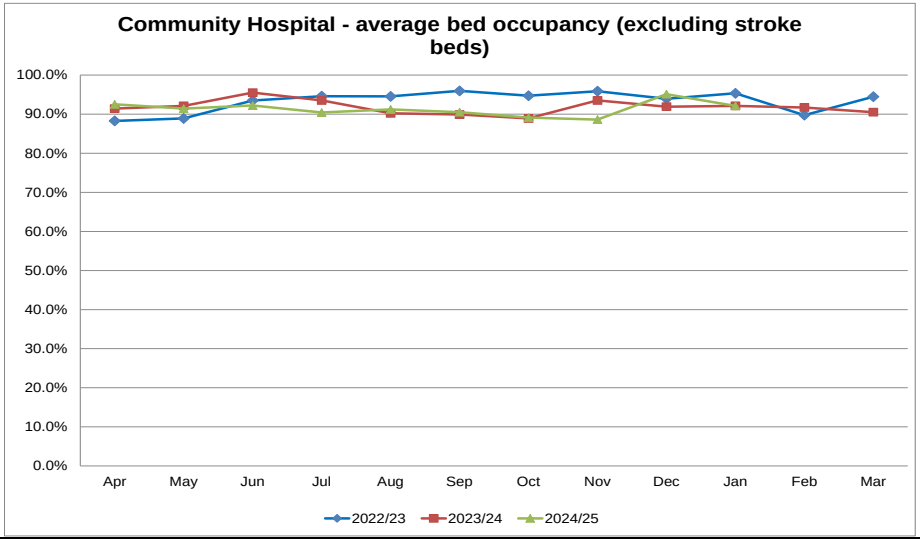
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





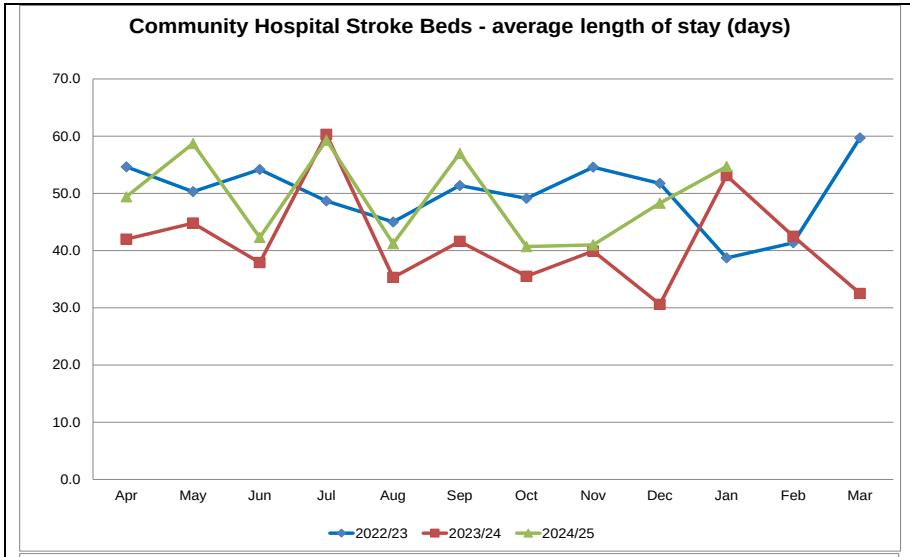
Summary:

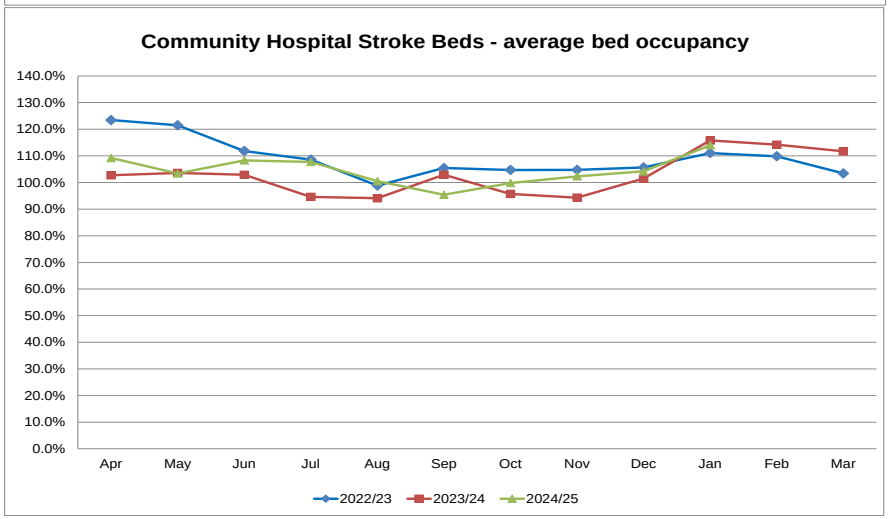
- Between 1 April 2024 and 31 January 2025, the number of Urgent Treatment Centre attendances was 7.2% higher than the same months of 2023/24, and 7.4% higher than the same months of 2022/23. During January 2025, 98.6% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 76%.
- The average length of stay for non-stroke patients in our community hospitals in January 2025 was 34.0 days, a decrease compared to December 2024. The year-to-date average length of stay for non-stroke patients was 36.6 days, compared to 39.2 days in the same months of 2023/24. The community hospital bed occupancy rate for non-stroke patients in January 2025 decreased to 92.1%, from 95.1% in December 2024.



Operational context

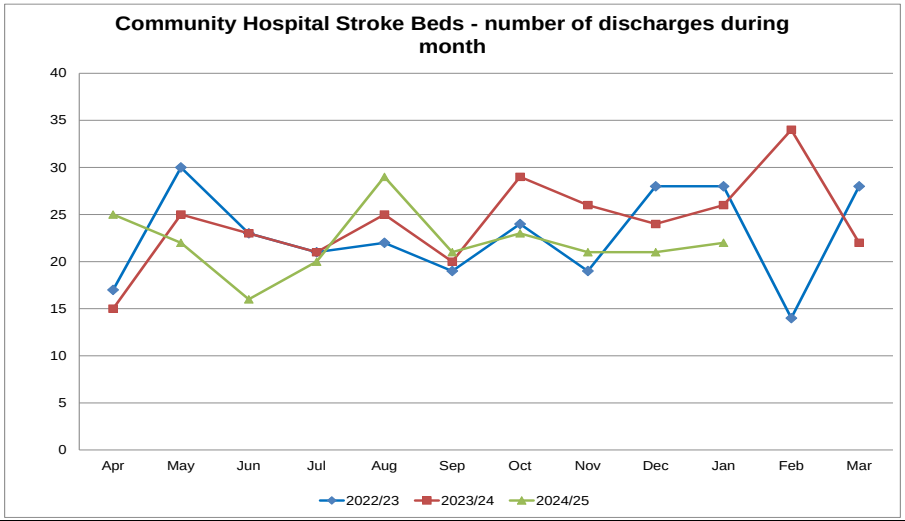
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





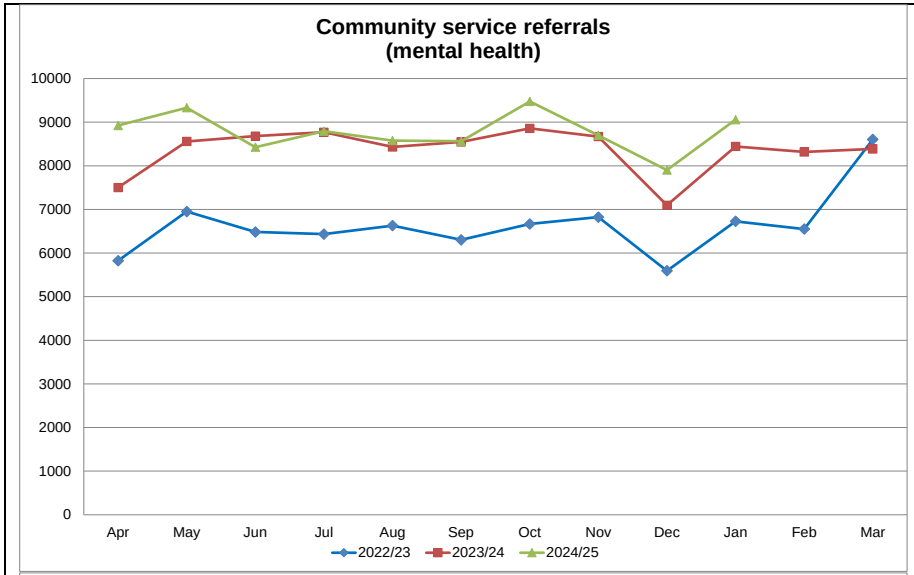
Summary:

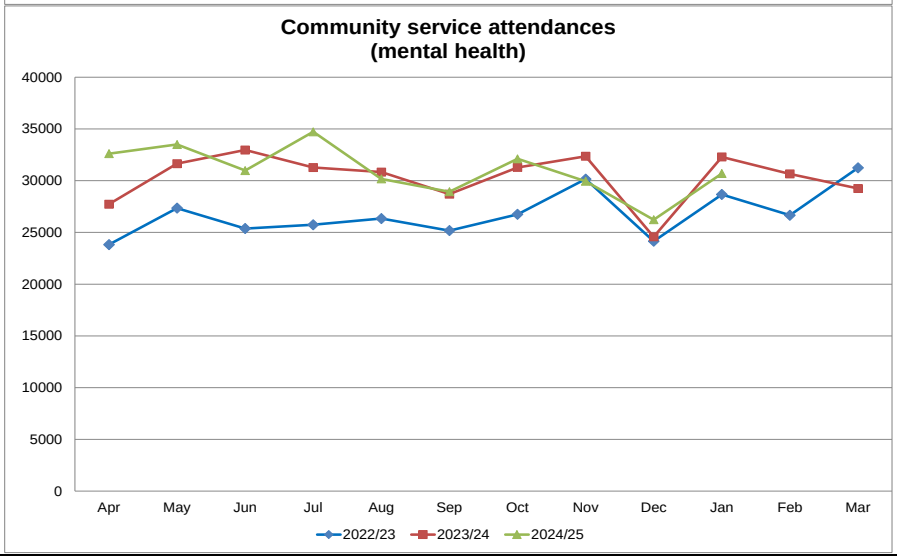
- The average length of stay for stroke patients in our community hospitals in January 2025 increased to 54.7 days, from 48.3 days in December 2024. Two patients discharged during January 2025 had a length of stay exceeding 100 days, with one South Petherton patient having a length of stay of 174 days.
- The year-to-date average length of stay for stroke patients was 49.1 days, up from 41.7 days in the same months of 2023/24. This is due principally to an increase in the numbers of patients discharged with very long lengths of stay.
- Stroke bed occupancy in January 2025 increased compared to December 2024.
- During January 2025 there were 22 discharges of stroke patients, compared to 21 during December 2024.



Operational context

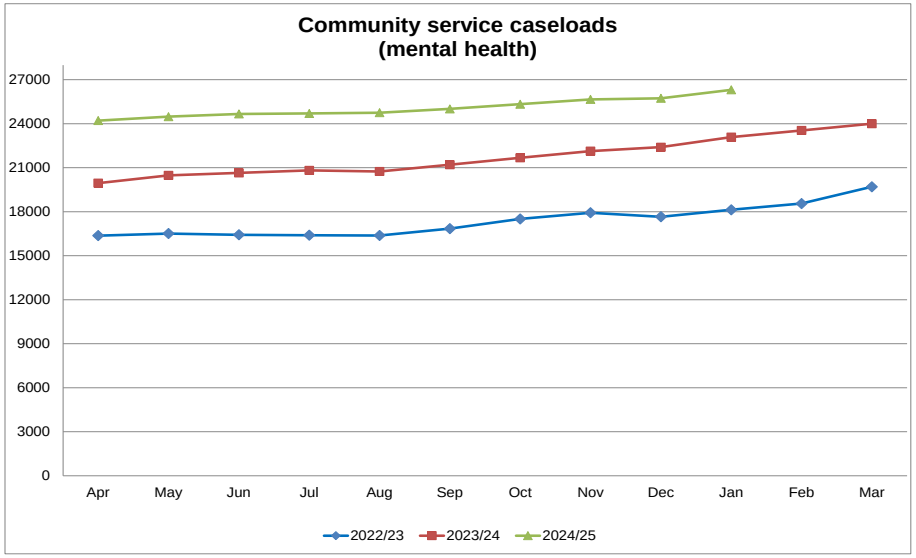
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





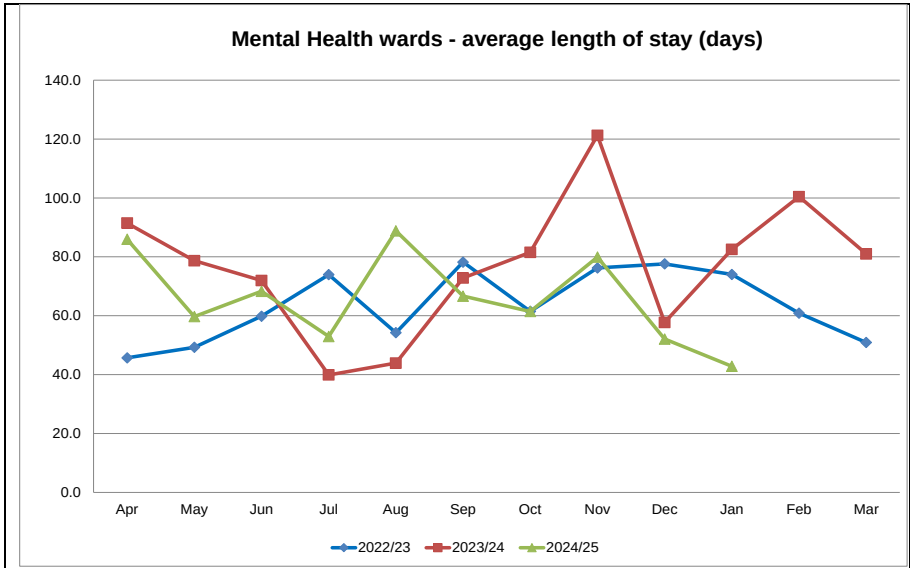
Summary:

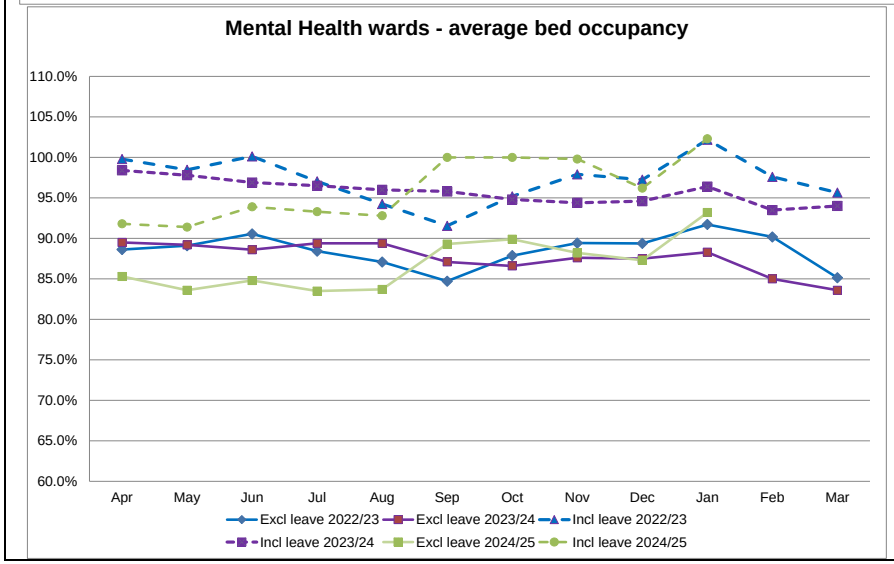
- Direct referrals to our community mental health services between 1 April 2024 and 31 January 2025 were 5.0% higher than the same months of 2023/24 and 36.2% higher than the same months of 2022/23.
- Attendances for the reporting period were 2.1% higher than the same months of 2023 and 17.6% higher than the months of 2022/23. 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 2025 increased by 14.0% when compared to 31 January 2024 and were 45.1% higher than as at 31 January 2023. It should be noted that investment has facilitated the expansion of some community mental health services.



Assurance and Leading Indicators

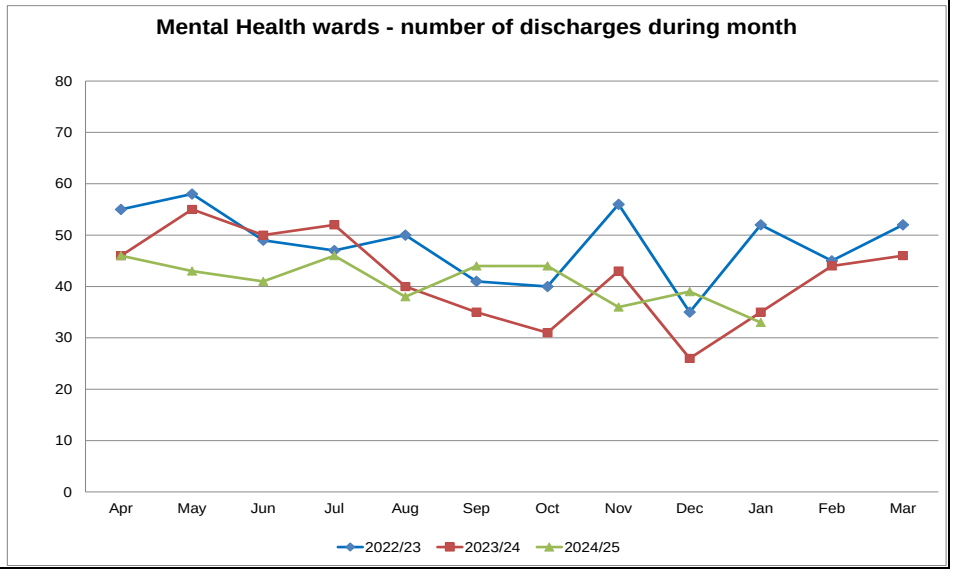
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





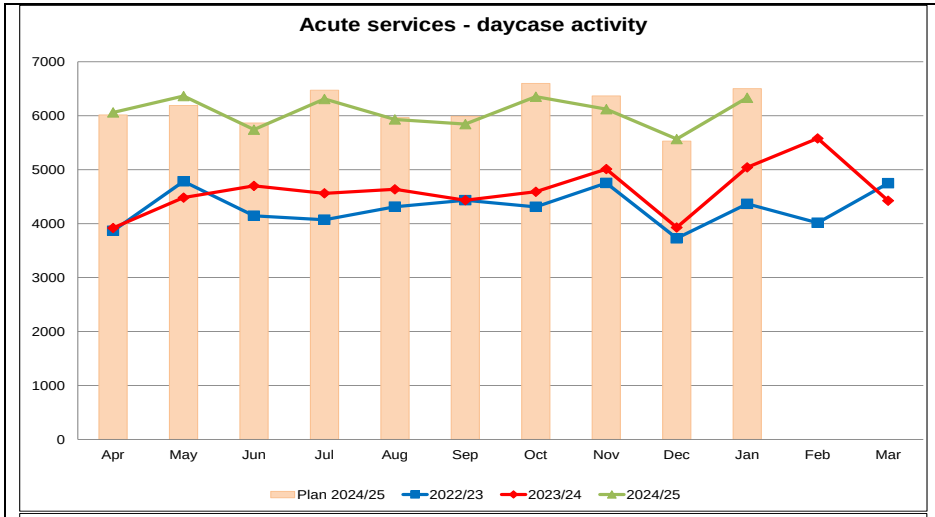
Summary:

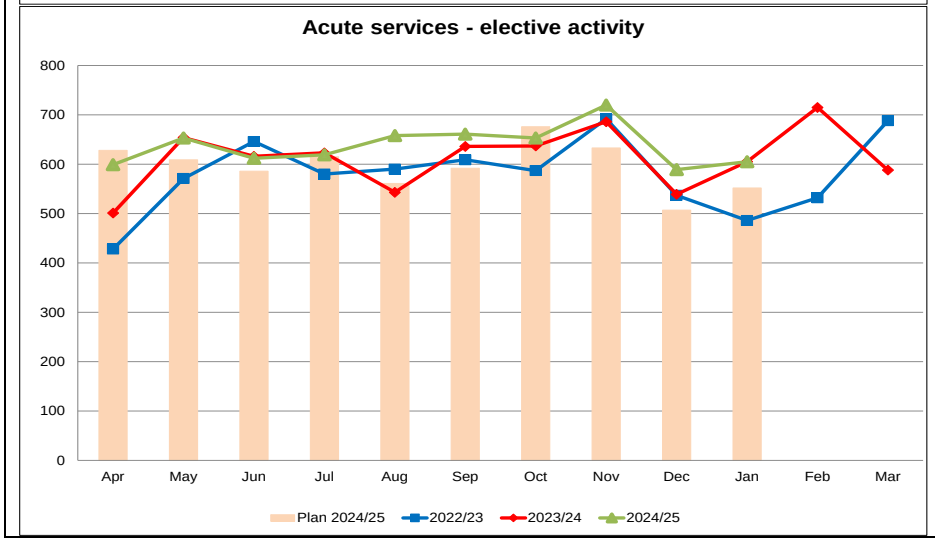
- The average length of stay across all of our mental health wards in January 2025 was 42.8 days, down from 52.1 days in December 2024. During January 2025, three patients were discharged with lengths of stay of 100 days or more, including one patient discharged from Rydon 1, one of our adult acute wards, who had a length of stay of 174 days.
- The average length of stay across all of our mental health wards for the year to date was 57.3 days, compared to 63.8 days in the same months of 2023/24.
- The mental health bed occupancy rates, on the basis of excluding and including leave, increased in January 2025 compared to December 2024. A total of 33 patients were discharged in January 2025, down from 39 in December 2024.



Operational context

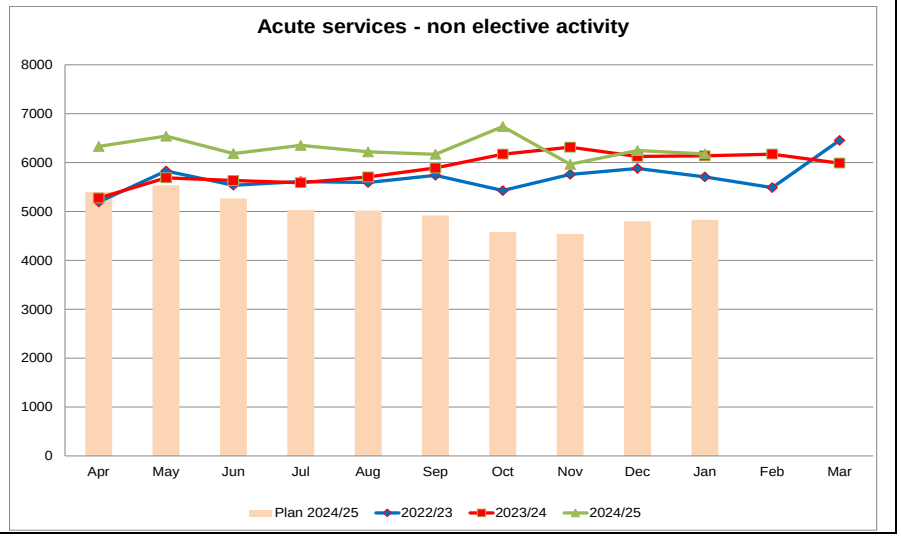
Acute services: This section of the report provides a summary of the levels of day case, elective, and non elective activity during the reporting period, compared to the previous months and prior years.





Summary:

- The number of day cases undertaken by our acute services between 1 April 2024 and 31 January 2025 increased by 33.8% compared to the same months of 2023/24 and by 41.8% compared to the same months of 2022/23. Activity for the year to date was 1.4% below the current year plan.
- Over the same period, elective admissions were 5.4% higher than the corresponding months of 2023/24 and 11.2% higher compared to the same months of 2022/23. Activity for the year to date was 6.9% above the current year plan.
- Non elective admissions also saw increases, of 7.5% compared to 2023/24 and 11.8% compared to 2022/23. Activity for the year to date was 26.1% above the current year plan.



Appendix 6 – Infection Control and Prevention – January 2025

MRSA bloodstream infections	Commentary on MRSA /MSSA BSIs
Musgrove Park Hospital = 1 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0	In November 2024 there were upgrades to electronic systems for the laboratory and the infection control team. When testing of a specimen is finished in the lab, relevant results feed into the infection control electronic system. An issue within the lab system was identified in February 2025 which has meant several specimens have not fed into the infection control system. Around 20 blood culture specimens have subsequently been reported that relate to the reporting period of December 2024 and January 2025. Therefore, case numbers in this report reflect the missing specimens and will be different to those reported in December. Although these missing results were not visible to the infection control team no clinical harm has occurred. Blood cultures are directly issued to clinical teams from the Consultant microbiologists therefore patients were treated at the time of the result. The issue with the system has not affected case numbers of MRSA but three cases of MSSA were not known in December 2024 and have therefore been added to the total figures in this report. Overall, case numbers remain above our internal trajectory. The rise of MSSA bloodstream infections is occurring nationally and the overall reasons for this are not clear. However, internally our focus remains on reducing cases related to peripheral vascular catheters. Over the winter, work on this improvement has had to pause to manage winter pressures but this will restart as soon as pressures relent.
MSSA Bloodstream Infections	
Musgrove Park Hospital = 5 Yeovil District Hospital = 2 Community Hospitals / Mental Health = 0	
E. coli bloodstream infections	**Commentary on Gram-negative bloodstream infections**
Musgrove Park Hospital = 4 Yeovil District Hospital = 4 Community Hospitals / Mental Health = 0	The issue with the lab system has affected case numbers of E. coli and Klebsiella. Five cases of E. coli and two of Klebsiella were not known in December 2024 and have therefore been added to the total figures in this report. Pseudomonas has not been affected. Overall, for all the gram-negative bloodstream infections the trust remains under trajectory.
Klebsiella bloodstream infections	
Musgrove Park Hospital = 3 Yeovil District Hospital = 2 Community Hospitals / Mental Health = 0	
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 = 6 Yeovil District Hospital = 2 Community Hospitals / Mental Health = 0	C. difficile results have not been affected by the issue in the lab system. Case numbers of C. difficile are stable however, we remain over trajectory. As a trust we still have some of the lowest rates in comparison with the rest of the region. This remains a national problem with case numbers increasing and reasons for this are not clear. A national incident team has been set up to review the situation.
Respiratory Viral Infections - inpatients	**Commentary on Respiratory Viral Infections**
COVID (Trust Cases) = 34 Musgrove Park Hospital = 22 Yeovil District Hospital = 7 Community Hospitals / Mental Health = 5 **Influenza = 326 (Inpatients)** Musgrove Park Hospital = 193 Yeovil District Hospital = 116 Community Hospitals / Mental Health = 17 **Respiratory Syncytial Virus (RSV) = 108 (Inpatients)** Musgrove Park Hospital = 59 Yeovil District Hospital = 33 Community Hospitals = 16	**Respiratory Viruses** COVID and 'Flu A case numbers remained at similar levels to December 2024 and RSV case numbers decreased. The main respiratory burden was still 'Flu A. This has had a significant impact on workload of the infection control team and has affected bed capacity and patient flow through the trust. Nationally, case numbers of 'Flu A have been higher than the recent four years when COVID has been the dominant respiratory virus.
Outbreaks	**Commentary on outbreaks**
COVID = 3 – All Musgrove Park Hospital **Influenza = 7** Musgrove Park Hospital = 2 Yeovil District Hospital = 3 Community / Mental Health = 2	The outbreaks have been particularly challenging since January 2025. Some of the wards affected have had outbreaks of more than one infection at the same time. One ward had simultaneous outbreaks with Flu, RSV, COVID and norovirus. Outbreaks with multiple infections are extremely complex to manage as these infections have different transmission routes, different controls and different incubation periods.

RSV = 2 Musgrove Park Hospital = 1 Community / Mental Health = 1 **Norovirus = 1 -** Musgrove Park Hospital **Carbapenemase Producing Organism (CPO)** • **YDH -** Since January 2022 there have been 72 cases of CPO identified on the YDH site.	**Carbapenemase Producing Organism (CPO) - YDH** This has been managed as a Trustwide outbreak however, links between clusters of cases have been difficult to definitively confirm. UKHSA have done further typing of specimens using whole genome sequencing to help us determine which cases are linked. As previously reported, sequencing has identified DNA links between MPH cases with Yeovil, yet some patients have never been in Yeovil District Hospital, suggesting spread across our population rather than acquisition within Yeovil Hospital. Final results are still not available.
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 Total Hip Replacement (THR), Total Knee Replacement (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 commenced on total knee replacement surgery from January 2024.	**Musgrove Park Hospital Site** • **Hip Replacement** Within the last year (January 2024 to December 2024) a total of 356 operations have been undertaken with no infections identified. • **Knee Replacement** Within the last year (January 2024 to December 2024) a total of 218 operations have been undertaken and 1 infection identified giving an infection rate of 0.46% which is slightly above the national benchmark of 0.4%. • **Spinal Surgery** Within the last year (January 2024 to December 2024) a total of 335 operations have been undertaken and 5 infections identified giving an infection rate of 1.49%. This is a little above the national benchmark of 1.2%. **Yeovil District Hospital Site** • **Hip Replacement** Within the last year (January 2024 to December 2024) a total of 377 operations have been undertaken and 3 infections identified giving an infection rate of 0.8%. This is higher than the national benchmark of 0.5% but remains stable.

	• **Knee Replacement** Within the last year (January 2024 to December 2024) a total of 405 operations have been undertaken with no infections identified. The national rate is calculated over the period April 2018 to March 2023 and therefore not directly comparable to trust infection rates. However, as a trust the national benchmark is always used as a guide and has triggered some internal actions.

SOMERSET NHS FOUNDATION TRUST

PATIENT AND CARER RACE EQUALITY FRAMEWORK

1. INTRODUCTION

1.1 The Patient and Carer Race Equality Framework (PCREF) was originally published by NHS England in October 2023 and updated in May 2024. The framework is designed to support providers of mental health services to improve access, experiences and outcomes for racialised and ethnically and culturally diverse communities.

(*The term 'racialised communities' refers to ethnic, racial and cultural communities who are minoritised populations in England, have been racialised, and who experience marginalisation. This includes white minorities such as Gypsy, Roma and Irish Traveller groups.*

The term 'ethnically and culturally diverse' refers to people with distinct cultural or ethnic identities, which can include diverse language groups and communities upholding specific cultural customs and spiritual beliefs).

1.2 The PCREF is a mandatory framework for all mental health providers, with an aim that they become actively anti-racist organisations by ensuring that they are responsible for co-producing and implementing concrete actions to reduce racial inequalities within their services. Assessment of progress against this will become part of future CQC inspections.

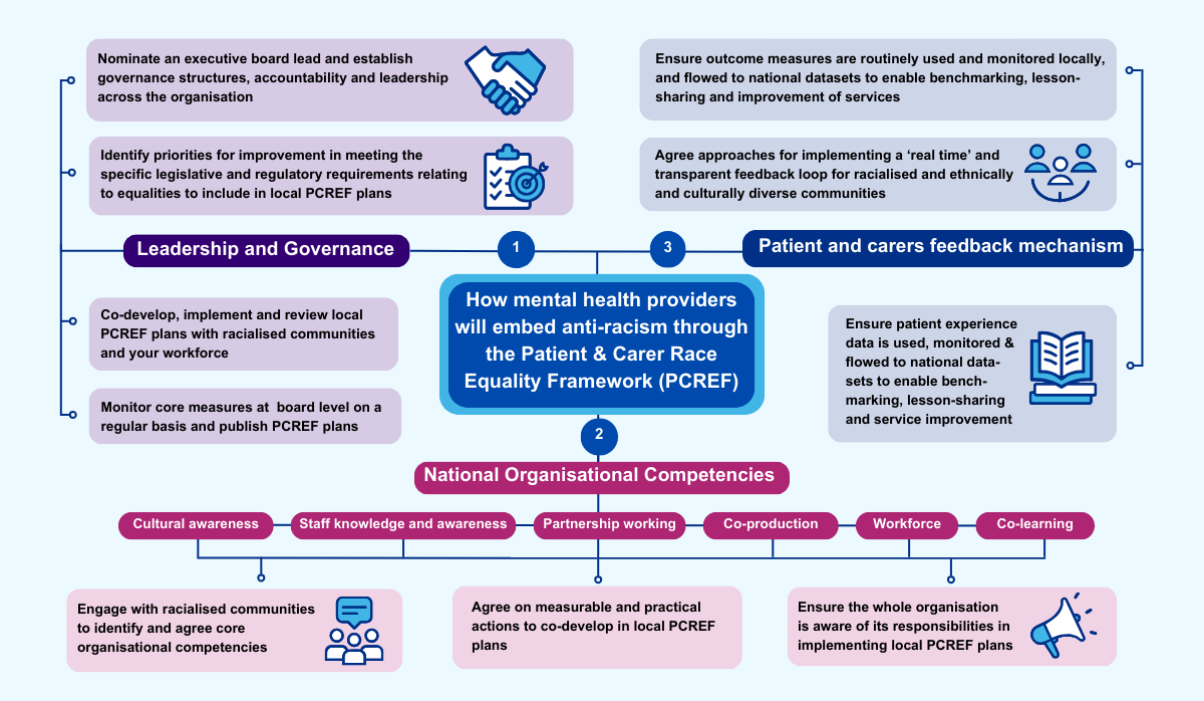
1.3 The PCREF will support improvement in three main domains:

- **Leadership and governance**: trusts' boards will be leading on establishing and monitoring concrete plans of action to reduce health inequalities, including the assurance that trusts are meeting their statutory and regulatory obligations. To evidence this, new data sets on improvements in reducing health inequalities will need to be published, as well as details on ethnicity in all existing core data sets for all mental health service.

- **Organisational competencies**: the framework includes a set of 6 organisational competencies against which trusts are required to assess themselves, working with service users, carers and communities and develop and action plan to improve them.

- **Feedback mechanisms**: visible and effective ways for patients and carers to feedback will be established, as well as clear processes to act and report on that feedback.

1.4 In summary, the expectations of PCREF are captured in the graphic below:



1.5 It is important to note that, although mental health trusts are responsible for delivery of the PCREF, it is very much envisaged as a collaborative and participatory approach between health service providers, local authorities, criminal justice services, social care provider, the voluntary sector, and service users and carers from racialised and ethnically and culturally diverse communities.

2. DATA COLLECTION AND MONITORING

2.1 To evidence how we are fulfilling our core legislative obligations, from a racialised and ethnically and culturally diverse lens, we need to collect and monitor data in relation to our mental health services, broken down by ethnicity and publish at the end of the financial year, including as a minimum:

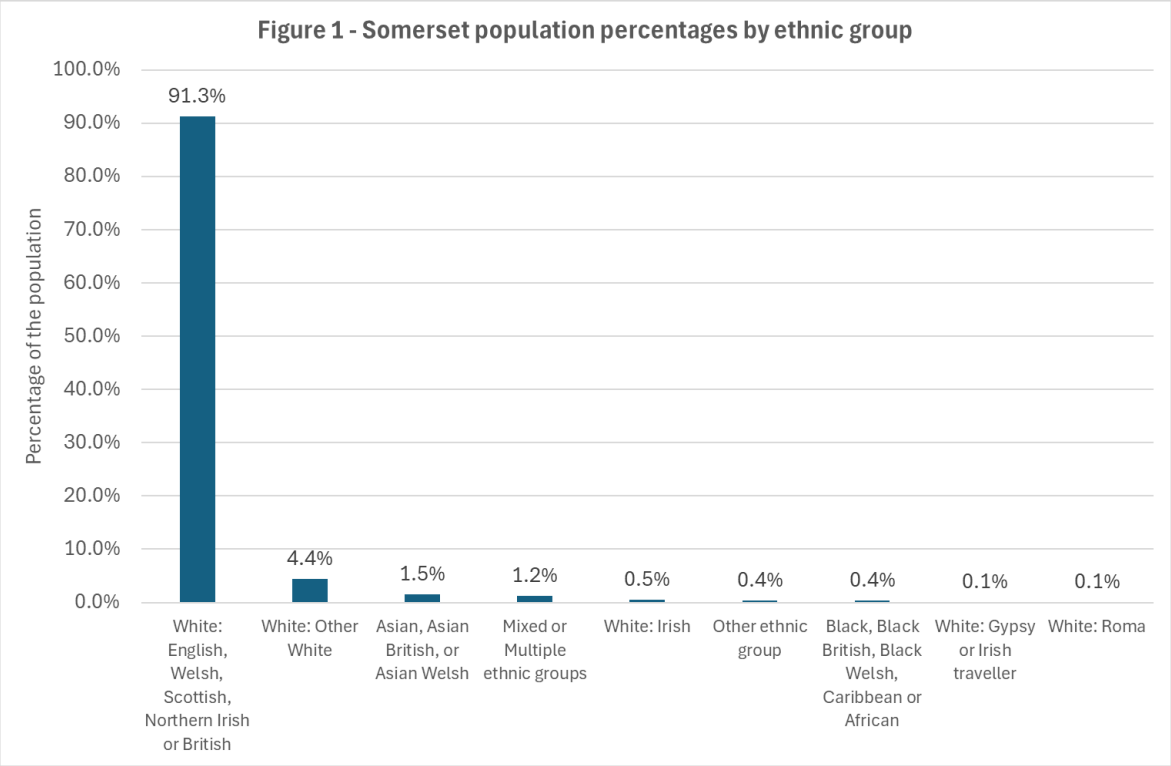
- The number of cases of detention under the MHA, and the cause and duration of these detentions
- Restraint including the type of restraint (physical, mechanical, chemical or use of isolation) and by ethnicity, age and gender as aligned with the MHA Code of Practice guiding principles
- As required by Core20Plus5:
  - physical health checks for those adults (18+) with Severe Mental Illness (SMI).
  - improve access rates to Children and Young People's mental health services for 0-17 year olds.
- A sample of locally agreed access, experience and outcomes metrics where inequalities are the most evident. This may include Mental Health Act detentions (i.e. the duration of community treatment orders, out of area placements, aftercare placements and suicidal rates by ethnicity).
- Reports on any deaths in mental health inpatient units, notified to CQC, by protected characteristics.

We will be expected to provide a narrative explanation of data trends and over time and aim to be able to demonstrate reduced inequalities, using national mental health statistical data published on the Mental Health Services Data Set (MHSDS) where NHS England have developed a mental health data quality dashboard on protected characteristics.

2.2 The information set out below represents an initial view of the data for each of the respective indicators. Our aim is to build upon this starting point, producing quarterly updates to the data, introducing trend analyses, and broadening the range of information through the inclusion of further indicators.

Ethnicity profile of Somerset

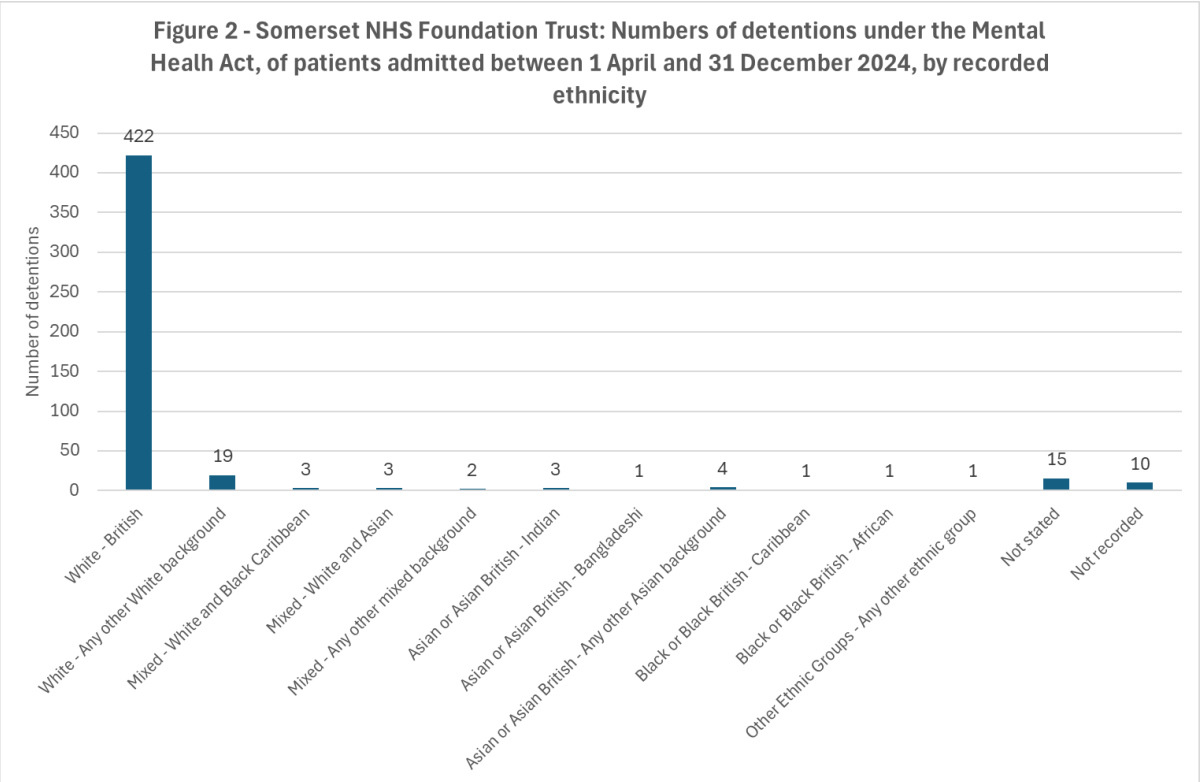
2.3 The ethnicity profile of Somerset is set out in Figure 1 below. This information is drawn from the 2021 Census data, as published on the 'Somerset Intelligence' website.



2.4 The chart shows that 96.2% of Somerset residents class themselves as being from a White ethnic group.

Detentions under the Mental Health Act

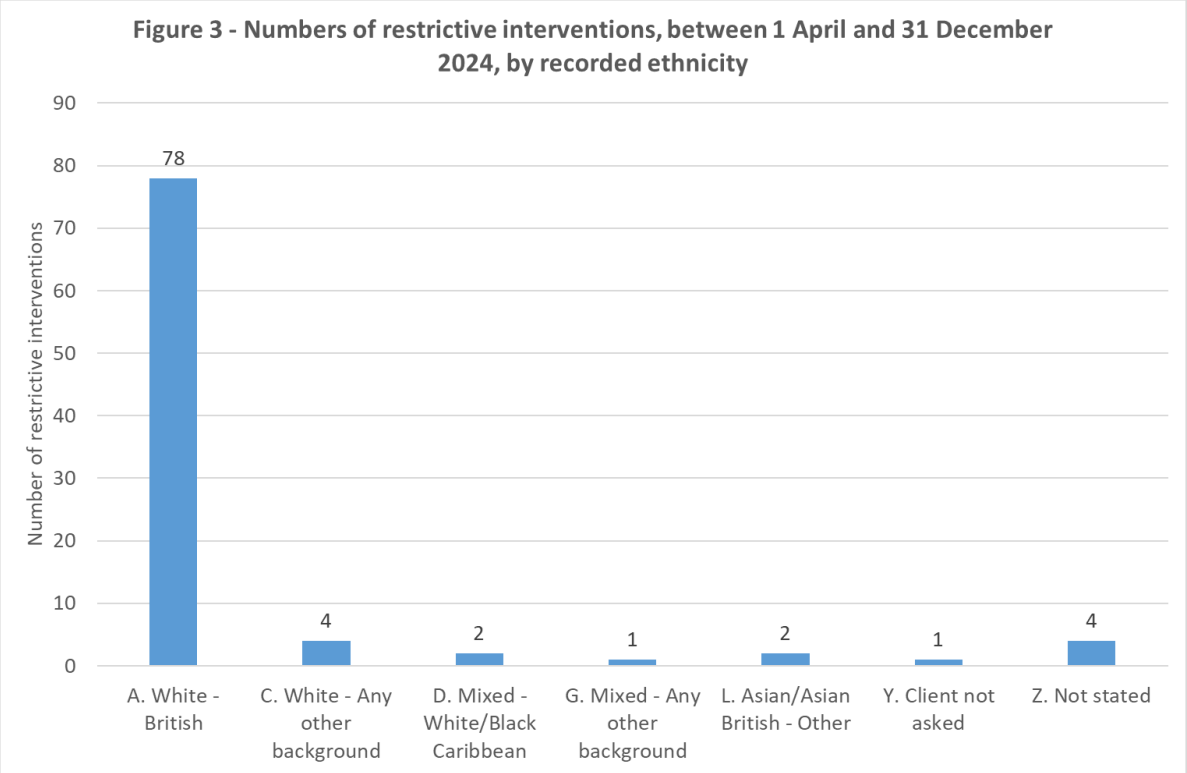
2.5 The numbers of detentions under the Mental Health Act during the period from 1 April to 31 December 2024, by recorded ethnicity, are set out in Figure 2 below.



2.6 The data shows that, of the total of 485 detentions during the period, 441 (90.9%) were of patients from a White ethnic group, and 25 (5.2% of detentions) were of patients whose ethnicity was either not stated (3.1%) or not recorded (2.1%). Patients whose ethnicity was Asian or Asian British comprised 1.6% of detentions, which is similar to the Somerset ethnicity profile percentage of people who are Asian or Asian British (1.5%).

Restrictive Interventions

2.7 The numbers of restrictive interventions (i.e. restraints, seclusions, and segregations) during the period from 1 April to 31 December 2024, by recorded ethnicity, are set out in Figure 3 below.



2.8 The data shows that, of the total of 92 restrictive interventions during the period, 82 (89.1%) were of patients from a White ethnic group, and five (5.4%) were of patients whose ethnicity was either not stated (4.3%) or was not asked (1.1%).

Physical health checks for adults with Severe Mental Illness (SMI)

2.9 Table 1 below shows the numbers of patients admitted as a mental health inpatient with severe mental illness (SMI) during the period from 1 April to 31 December 2024, by recorded ethnicity, for whom a physical health check was completed.

Table 1 - Physical health checks for adults with Severe Mental Illness (SMI), by recorded ethnicity

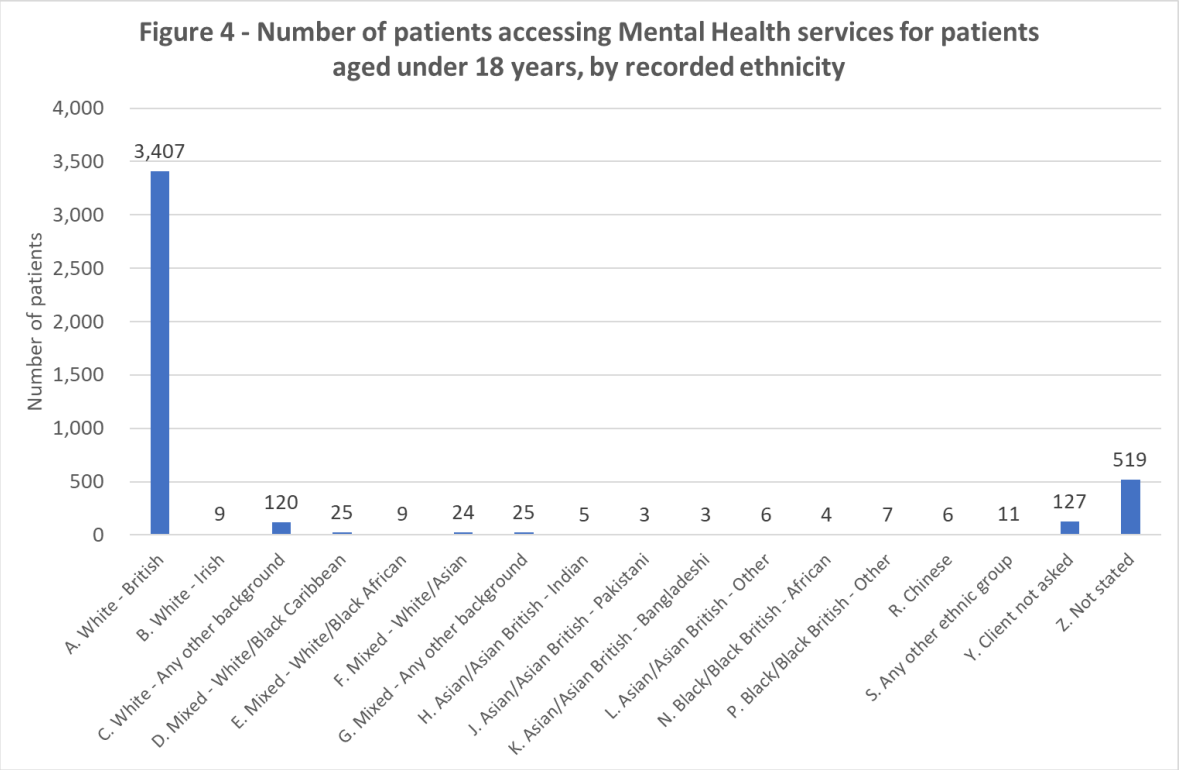
Recorded ethnicity	Physical health check completed	Physical health check not completed	Percentage with physical health check completed
A. White – British	48	2	96%
C. White - Any other background	4	0	100%
F. Mixed - White/Asian	1	0	100%
M. Black/Black British - Caribbean	1	0	100%
Y. Client not asked	1	1	50%
Total	**55**	**3**	**95%**

2.10 The data shows that overall compliance for the completion of a physical health check was 95%, with all recorded ethnicity groupings at or above that level, with the exception of 'Client not asked' (50%; one health check out of two not completed).

2.11 Of the 58 patients admitted with SMI, 54 (93.1%) were patients from a White ethnic group, with one patient (1.7%) each recorded as 'Mixed - White/Asian' and 'Black/Black British – Caribbean'.

Access to Children and Young People's mental health services for 0-17 year olds

2.12 The numbers of patients accessing mental health services during the period from 1 April to 31 December 2024, for patients aged under 18 years, by recorded ethnicity, are set out in Figure 4 below.



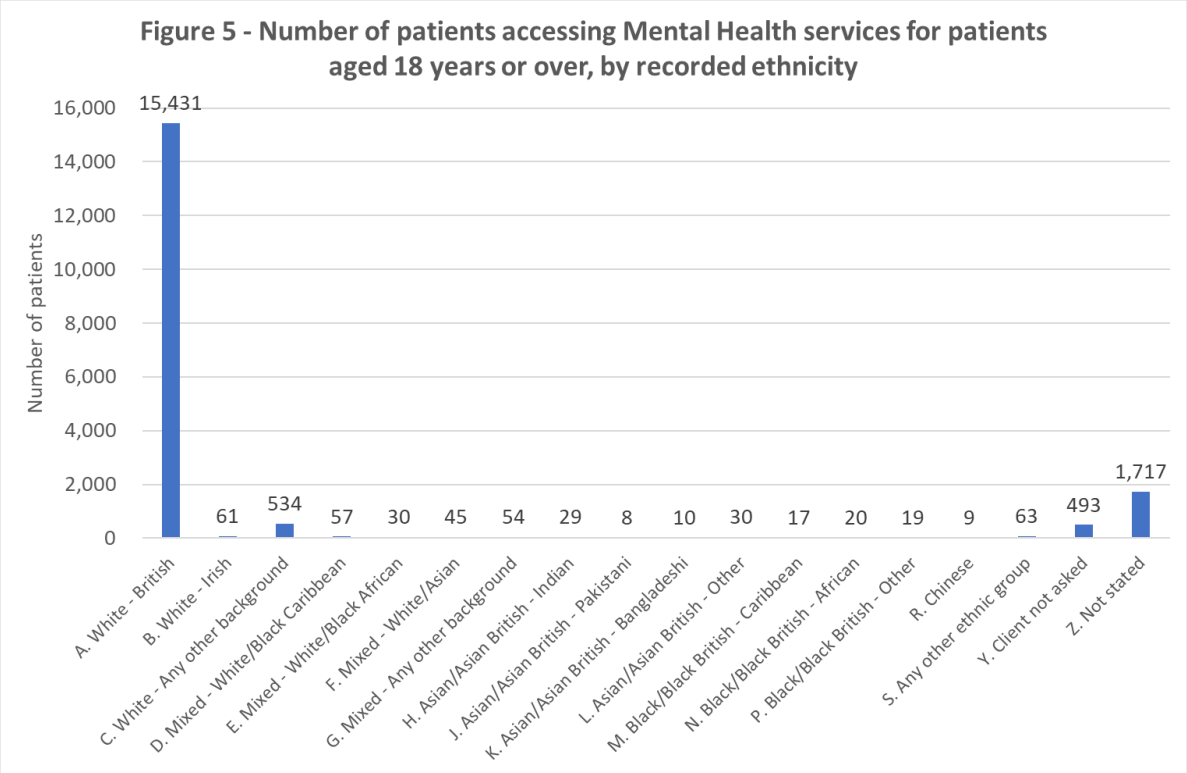
2.13 The data shows that, of the total of 4,310 patients accessing mental health services during the period, 3,536 (82.0%) were patients from a White ethnic group, and 646 (15.0%) were patients whose ethnicity was either not stated (12.0%) or was not asked (3.0%).

2.14 Patients of mixed ethnicity comprised 1.9% of the total, compared to 1.2% for the wider population of Somerset (all ages), and patients recorded as Black / Black British made up 0.3% of patients, compared to 0.4% for the wider population of Somerset (all ages).

2.15 It is notable that patients whose ethnicity was Asian or Asian British comprised only 0.4% of the total, compared to 1.5% for the wider population of Somerset (all ages).

Access to mental health services for adults and older adults

2.16 The numbers of patients accessing mental health services during the period from 1 April to 31 December 2024, for patients aged 18 years or over, by recorded ethnicity, are set out in Figure 5 below.



2.17 The data shows that, of the total of 18,627 patients accessing mental health services during the period, 16,026 (86.0%) were patients from a White ethnic group, and 2,210 (11.9%) were patients whose ethnicity was either not stated (9.2%) or was not asked (2.7%).

2.18 Patients of mixed ethnicity comprised 1.0% of the total, compared to 1.2% for the wider population of Somerset (all ages), and patients recorded as Black / Black British made up 0.3% of the total, compared to 0.4% for the wider population of Somerset (all ages).

2.19 As is the case with access to mental health services for children and young people, it is notable that patients aged 18 years or over whose ethnicity was Asian or Asian British comprised only 0.4% of the total, compared to 1.5% for the wider population of Somerset (all ages).

Community treatment orders

2.20 Table 2 below shows the numbers of community treatment orders (CTOs) which were in place as at 31 December 2024, by recorded ethnicity, and by year of commencement of the CTO.

Table 2 - CTOs in place as at 31 December 2024, by recorded ethnicity, and by year of commencement

Year	White – British	Not known	White - Any other White background	Mixed - White and Black Caribbean	Black or Black British – Caribbean	Any other ethnic group	Total
2012					1		**1**
2016	2						**2**
2017	1					1	**2**
2018	4						**4**
2019	2						**2**
2020	4						**4**
2021	1						**1**
2022	4						**4**
2023	3						**3**
2024	14	1	1	1			**17**
Total	**35**	**1**	**1**	**1**	**1**	**1**	**40**

2.21 The data shows that, of the total of 40 CTOs which were open as at 31 December 2024, 36 (90.0%) related to patients from a White ethnic group.

3. CONCLUSION

3.1 The data shows that the ethnicity profile for the majority of the measures is broadly in line with the wider ethnicity profile of the county of Somerset.

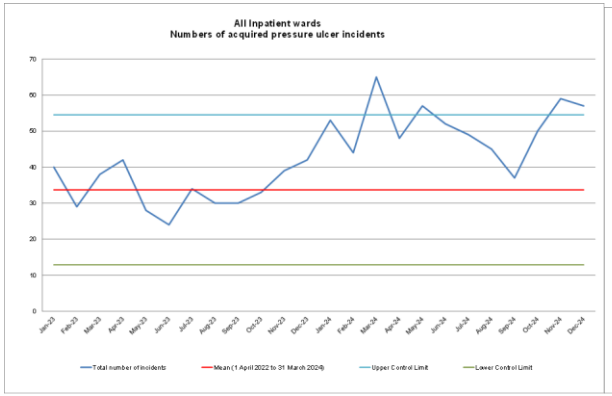
3.2 For the measures ‘Access to Children and Young People’s mental health services for 0–17 year olds’ and ‘Access to mental health services for adults and older adults’, the percentages of patients whose ethnicity was Asian or Asian British were both lower than the percentage for the wider ethnicity profile of the county of Somerset.

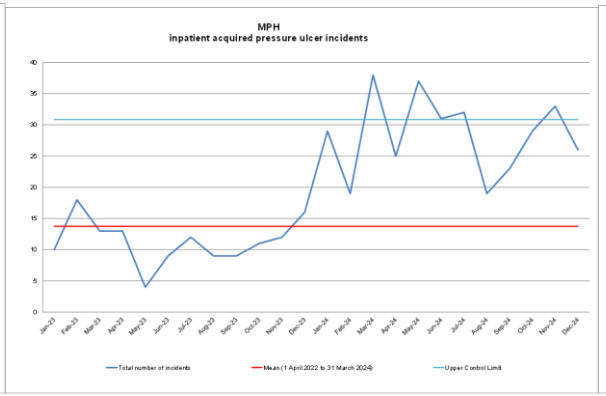
3.3 The percentages of patients whose ethnicity was either not stated or not asked for those two measures were 15.0% and 11.9% respectively. We need to undertake work to improve the recording of ethnicity for both of those measures.

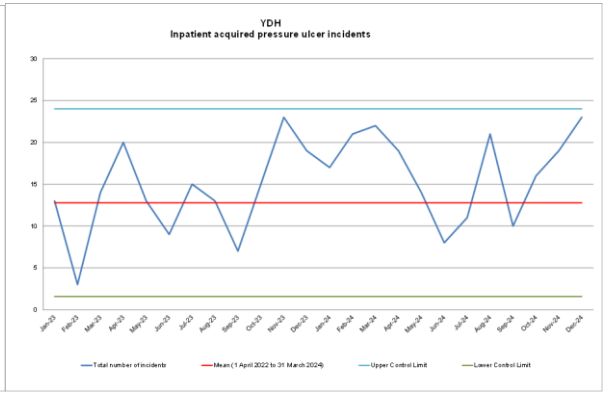
3.4 Our aim is to build upon the data set out above, producing quarterly updates to the data, introducing trend analyses, and broadening the range of information through the inclusion of further indicators.

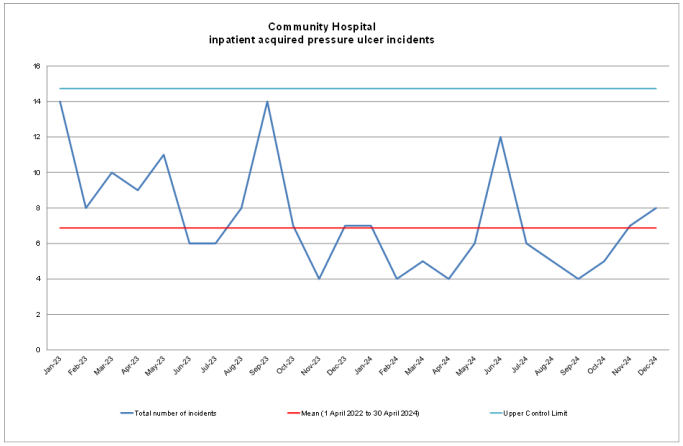
Appendix 8 – Pressure Ulcers – February 2025 reporting on Quarter 3 (October – December 2024)

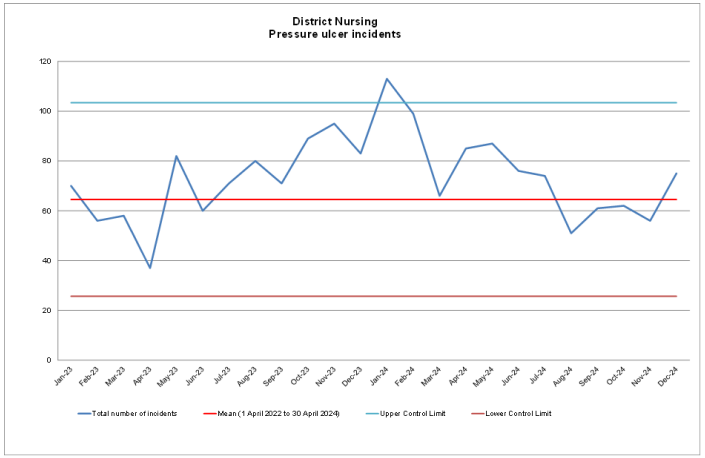
Data (Episode of Care cases reported by setting)











NB – it is important to note that the Districting Nursing figures are a combination of cases classed as "Caseload" – those patients who have received planned care in the previous 7 days and "System" cases – those patients who are on the DN caseload for intermittent care needs and potential rely on other agencies within the system to support their pressure ulcer prevention plan – the Service Group receive this data broken down.

Exceptions in Quarter	Commentary on Exceptions
Musgrove is noted as being above the upper limit in November 2024. The overall inpatient data is noted to be above the upper limit in November and December 2024.	The key activity to address these exceptions are highlighted in the main Board Report section and below. The inpatient ward areas with the higher levels of incidence are included in the current QI project running each area is putting at least one colleague through the Silver QI award and the overall project is put of a Gold QI project for the newly appointed TV Education and QI Co-ordinator.
Issue	**Commentary of Issues**
It is important to acknowledge that the Tissue Viability Service had been working on increasing its establishment (in the first part of 2024) via a Business Case that was partially awarded in Summer 2024. There was a risk associated with the level of staffing entered on the register, noting the organisational impact of under-resourcing the service. Since the award, the risk has transferred to not being staffed to establishment due to sickness, HR absences and delays in achieving recruitment; this reduced staffing has resulted in slippage of key topic activity to drive improvement and reduction in patient harms.	
Issues with the quality and accuracy of the pressure ulcer data available via *Radar*.	There have been ongoing issues with quality and accuracy of the pressure ulcer data. Since LfPSE was introduced, there have been changes in the system which have further impacted the data. Ongoing discussions with the Governance Support Team (GST) to rectify the issues to improve the dataset and work towards a single dashboard in Radar instead of three separate ones for each TVN Team to validate PU incidents. We are aware that there are a number of outstanding "Outcome" cases that requires review and during January 2025 we have identified that a cohort of Episode of Care (EOC) cases that have not had the validation information from local managers have not been altered in the form, this is impacting overall data in terms of accuracy.
High levels of pressure ulcers across the various settings, particularly inpatients.	Commencement of six Silver QI projects for ward areas which have the higher levels of incidents of Pressure Ulcers, alongside a Gold QI Project led by newly appointed TV Education and QI Co-ordinator and supported by QI Team.
Lack of available assurance data to support Policy compliance.	Previous assurance reports have used manual audit data to demonstrate policy standard compliance and capacity only allowed annual audits by the TVN Team.

	The Head of Tissue Viability is on the Quality Care Metrics Task and Finish Group, which is working on routine assurance data against Policy standards on a variety of topics for inpatient areas. Work will then be needed to develop data sets with the GST and Information team for identified gaps.
Service Group and local team engagement in pressure ulcer prevention.	The Senior Leadership Team has requested that there is routine reporting of the topic via Quality, Outcomes, Finance and Performance (QOFP) meetings, and pressure ulcer reduction targets. Meetings are needed with the Associate Directors of Patient Care (ADPCs), to agree processes for the above, to ensure the engagement of the Service Groups in improvement activity.
Lack of standardised approach to Pressure Relieving Equipment within inpatients areas.	Agreed an air mattress for use in inpatient areas during summer 2024. Mattress audit completed in Community Hospitals during summer 2024. Plan for mattress audit within acute settings during Quarter 4. Product evaluation event for standard foam mattress during Quarter 3 – product agreed. Product evaluation event for heel protection devices during Quarter 3 – decision pending.
Standardised approach to documentation of pressure ulcer prevention interventions.	Review of Waterlow assessments for adult inpatient/community areas to inform the Waterlow How To Video and align as able. Care Plan documents require review and alignment. The Head of Tissue Viability is involved in the Intentional Rounding Steering Group – which aims to review and improve a key process for demonstrating PU Prevention interventions in a standardised way.

Actions for next Quarter

- Finalise Trust Pressure Ulcer Work Plan and utilise as the working document for the Pressure Ulcer Steering Group to demonstrate progress against objectives;
- Meet with ADCPs to agree plans and standards for QOFP reporting within Service Groups and local reduction targets (initial meeting completed in January 2025);
- Work with Governance Leads/Groups within Service Groups to develop the reporting template for QOFPs – this will in turn feed into these Board updates;
- Work with the GST on moving to a single dashboard for Radar validation within the TVN Teams for three current dashboards;
- Working through QI steps for the Pressure Ulcer Prevention Project with the six inpatient areas;

- Ensure there is a process, such a Radar Amesty within the TVN Teams, to address the issues and gaps in data;
- Finalise Procurement product evaluations for Pressure Relieving Equipment (PRE), develop preferred product list across the inpatient settings and develop a PRE Selection Guide;
- Mattress audit within Acute settings;
- Finalise Waterlow How To video for LEAP and PU Prevention resources for PU Learning Framework.

Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Learning from Deaths Report
SPONSORING EXEC:	Melanie Iles, Chief Medical Officer
REPORT BY:	Claire Bailey, Learning from Deaths Lead Laura Walker, Head of Patient Safety and Learning Gary Filer, Quality and Safety Analyst
PRESENTED BY:	Katy Darvall, Learning from Deaths Consultant Lead
DATE:	4 March 2025

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 is a requirement of 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). Executive Summary and highlights from this report: **Learning from the Deaths** Our learning appears to be aligned with our Patient Safety Incident Response Framework (PSIRF) priorities, themes of Treatment Escalation Plans (TEP), managing the deteriorating patient and communication with people who matter continue to be seen. **Learning from the Detail** Medical examiners are reviewing 100% of SFT deaths, totalling 622 in Quarter 3, with concerns being cascaded appropriately. The Learning from Deaths team co-ordinate the triage of these so an agreement can be reached on a proportionate response. **Learning from the Data** Our overall Trust Mortality Rate continues to be as expected – SHMI **1.02.**
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	Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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.

Not applicable.

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 2024-2025

1. BACKGROUND AND PURPOSE

1.1. A CQC review in 2016 'Learning, Candour and Accountability: a review of the way trusts review and investigate the deaths of patients in England' found that some trusts did not focus on the opportunity to learn and improve from deaths. Subsequently, in 2017 the National Quality Board (NQB) published its National Guidance on Learning from Deaths. This guidance initiated a standardised approach to identifying and reviewing a proportion of deaths, guidance on supporting the bereaved and staff affected by death, as well as introduced a mortality surveillance mechanism and public board reporting requirements. In 2018, the NQB produced further guidance on working with bereaved families and carers.

1.2. The 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. The Mortality Surveillance Group (MSG) met on 10th December 2024. An issue was raised regarding Treatment Escalation Plans (TEPs). A case was discussed in which the patient had a TEP documenting their wishes to not be resuscitated. They were subsequently admitted to another hospital within the trust where they sadly died following a cardiac arrest and unsuccessful CPR. It was thought that they would have had a more peaceful death had their TEP status been known. It was acknowledged that there is an ongoing quality improvement project to develop a system wide digital TEP that would be a single, live document. However, this is not operational across SFT services due to complexities around integration with existing digital systems. Currently, staff need to take a proactive approach to identifying a patient's TEP status. Colleagues in attendance reflected that there may be a practice of automatically defaulting to a new TEP form rather than checking if there is already a TEP in place, and it was agreed that this would be explored further with the local team.

2.2. Colleagues from our End-of-Life Service reported to MSG that a new EOL care plan has been launched across one of our acute sites alongside a package of training that will be delivered to staff across all wards. This includes a comprehensive assessment and symptom control chart, prompting staff to respond when red scores are triggered. The expectation is that this will significantly improve EOL care.

2.3. On 21 November 2024, Paul Foster and Claire Bailey attended a system wide mortality group meeting chaired by the ICB. A presentation was shared by system partners outlining the Suicide Prevention Strategy for Somerset. It was acknowledged that the suicide rate in Somerset has been higher than the national average for over 20 years. Within the Somerset system, there is a Suicide Prevention Partnership (SuPPa), a multiagency forum that meets on a quarterly basis with the shared aim of reducing suicide and associated harm. An annual action plan and report will be produced to support the delivery of the strategy and provide updates on progress. Whilst different parts of the system will lead on the responses and actions for different workstreams, the system wide mortality group will have overarching responsibility and oversight.

2.4. The 2023-2024 Annual Report from the End-of-Life Group within the Integrated Care System was shared at this meeting. Key developments highlighted included:

- The TEP form has been updated to facilitate a conversation that will result in treatments and interventions that are person centred, with the paper version launched in June 2024. The digital version became available across part of the system in July 2024, with the ability to print a PDF version of this since October 2024. The value of the digital TEP will increase as it becomes more accessible across the healthcare community.

- The Standard Operation Policy for the Just in Case (Drugs) Box Protocol has been updated to include a roadmap for how medications could be administered safely by family members or carers. This could help to reduce the distress experienced by patients and their loved ones whilst waiting for healthcare professionals to attend to administer these medications.

- The Verification of Death Policy has been updated and acts as a common policy for the whole system to reduce confusion and allow more timely clarity for the bereaved.

- Ongoing commitment to provide education support to system partners.

2.5. An update was shared with the Patient Safety Board on 20 November 2024 about Martha's Rule, a patient safety initiative which provides patients and their families/carers with a way to request an urgent review in the event of a suspected deterioration that they are concerned is not being responded to. SFT are one of 143 pilot sites across the country that are involved in phase 1 of the initiation of Martha's Rule. Work has been underway to support the 3 components of Martha's Rule. It has been confirmed that our Critical Care Outreach Teams are well embedded across both acute sites, with colleagues reporting feeling well supported by them. A further workstream is to develop a system for patients and families/carers to make a direct referral for review. This will be to our Critical Care Outreach Teams and will be called a "call for concern". In this way, making a "call for concern" will initiate the same response regardless of whether the referral comes from patients,

families/carers, or staff. Another project is looking at the process of intentional rounding. This will involve asking patients and families how they are feeling, whether they are feeling better than the previous day, and acting on the response given. Following an initial test period that was scheduled to start by the end of November 2024 on a selection of wards across our acute sites, it is hoped that this can be rolled out to other areas at our acute sites. It is anticipated that all other areas, such as our Mental Health wards and Community sites, will be included in phase 2 of the implementation.

2.6. The Mental Health homicide sub-group was stood up in 2022 to ensure that we have robust processes in place to review these deaths. It has now been formally agreed that this group will focus solely on overseeing the reviews and any subsequent action plans from deaths that meet the definition of a Mental Health Homicide, and other relevant homicides and “near misses” will be overseen by the Learning from Events Governance Group. A thematic review was commissioned through the Mental Health homicide sub-group to look at near miss incidents that had the potential to result in a mental health homicide. This review identified 5 key themes: clinical risk management, mental health care and treatment, communication, safeguarding and carer/family engagement, involvement, and support. Learning points have been identified from this review, for example around responding to concerns raised by people who matter, and the management of dual diagnosis. Actions and learning will be taken forward by the Serious Mental Illness steering group.

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

3.1. **Examples of learning:**

- An SJR was completed by colleagues in our vascular team following the death of a patient under their care. The patient had been admitted with worsening pain thought to be due to known critical limb ischaemia. Despite treatment, the patient deteriorated during the admission with sepsis secondary to cholecystitis. Sadly, after being found unresponsive a CT scan showed intracranial bleeding, and they later died. Whilst the death was thought to be unavoidable, the SJR did identify some areas for learning. There was evidence of good communication, with early discussions with the patient about amputation, good multidisciplinary working across specialties and sharing of information with the family. It was found that when there were signs of intraabdominal pathology, the deterioration was well managed. However, there was a delay in considering sepsis as being the cause of the deterioration. It was also thought that their fluid and electrolyte management could have been better at the start of the admission. This will be considered as part of teaching updates for medical staff.

- Two Patient Safety Incident Investigation's (PSII's) that concerned patients who died were discussed at Patient Safety Board during this quarter.

- A patient sadly died following an incident on one of our Mental Health Inpatient Wards involving a non-fixed ligature. The PSII made several patient safety recommendations which the Mental Health and Learning Disability service group are currently reviewing and will develop an action plan. However, it is acknowledged that considerable work has been done since this death, including an update to the observation policy and plans to change how training for this is delivered, ligature awareness training and the development of a clinical strategy for Complex Emotional Needs.

- A patient with Learning Disability died unexpectedly whilst an inpatient in one of our acute hospitals. The PSII made several patient safety recommendations in line with the trust's Patient Safety Priority of engaging people who matter. This included a need to update the Learning Disability policy to include the whole organisation and include more detail on the use of hospital passports. The hospital passport should provide clarity on any additional care needs, outlining when, how and who should deliver this care. This is especially important when external carers are providing support alongside trust staff. It has further been recommended that external carers should be included in safety huddles for the patient they are supporting.

- Several SJRs have been completed by colleagues concerning patients who died in our Community Hospitals. Learning has been identified through the SJR's around care in the last days of life:

- Recognition and management of symptoms at the end of life. There were cases where multiple stat doses of Just in Case medications had been given across several days. For one patient, the family needed to request symptom relief for their loved one, causing unnecessary distress. Another case described a patient who had been recognised as approaching the end of life however there was no evidence of timely anticipatory prescribing. For these patients it was thought that an earlier initiation of a syringe driver would have helped with symptoms and improved patient comfort. Learning from these SJR's includes a need for education around recognition of deteriorating patients, symptom management, and proactive, anticipatory prescribing.

- Poor recognition, timely management and treatment of constipation and associated signs and symptoms likely caused unnecessary distress and symptoms. For one patient, an aperient was prescribed that was not in line with the patient's expressed wishes. It was several days before a medical review involving the patient took place to resolve this. In another case, the patient reported abdominal pain. This was not initially recognised as being associated with constipation and the

patient was given pain relief that potentially exacerbated the symptoms. This has been highlighted as a training need for ward staff.

- A formal complaint was made by the family of a patient with metastatic cancer who had been under the care of our oncology team. In the complaint, the family had asked if a discharge from hospital in the weeks before the patient died was a safe one. The patient had been admitted due to shortness of breath caused by a malignant pleural effusion, resulting in a pleural drain being inserted. In line with the patient's wishes, arrangements were made for discharge. They were given a small supply of spare drains, and their local District Nursing team were asked to provide ongoing care. Unfortunately, it was not known that the District Nurse team were unfamiliar with the type of pleural drain that had been fitted and were unable to use them without training. This caused distress to the patient and their family who were worried about how this would be managed whilst the patient was becoming physically uncomfortable and resulted in them having to return to hospital for care. It was recognised that this caused unnecessary distress at an already difficult time. The patient story has been shared across the team to raise awareness of the need to ensure that the receiving team have the knowledge and expertise to use the equipment provided, and if not, alternative provisions should be made prior to discharge.

- A patient was admitted with a severe pneumonia and sadly died despite treatment. The Medical Examiner raised concerns following their scrutiny of the notes that in the hours prior to the death, the patient had not been reviewed despite a deterioration being noted by the nursing team. An SJR was completed by the Care of the Older Person team. They found that the patient's overall care was satisfactory, however this element of their care was poor. There was evidence of an earlier increase in oxygen requirement, however this was not escalated to medical staff. It was thought that the significance of this may not have been recognised as their NEWS score remained stable. There was a later request for a medical review when the patient's NEWS score increased, however this did not take place, and nursing staff did not initiate the sepsis 6 pathway. This has been taken forward by the matrons across the trust, with education for staff around NEWS and escalation.

- During the quarter, 2 inquests were concluded which highlighted significant learning for the trust.

- An inquest was held following the death of a patient who had presented to one of our Minor Injury Units (MIU's). At the time, there was no standard for waiting times in MIU's and patients were typically seen in chronological order as opposed to in response to the urgency of their clinical need. Since this sad death, MIU's have become Urgent Treatment Centres, with a triage process for new referrals that is in line with our Emergency Departments. The standard set is for new patients

to be seen for an initial triage, including any basic observations, within 15 minutes of booking in.

- An inquest was held following the death of a patient on one of our inpatient mental health wards. There has been significant learning for the trust following the incident. It was identified that there were changes that needed to be made to the ward environment. These were included in a major programme of refurbishment that had been scheduled for the building, which has since been completed. This includes changes to the purpose of the room as well as to its door locking mechanism. To adhere to the principle that there should be no unsupervised access to this room, the door will automatically lock when closed and only staff can open it using a fob. All inpatient areas have reviewed their provision of blind spot mirrors and arranged for additional mirrors to be installed wherever required, as well as reviewed the control measures for where window restrictors are in situ.

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**
  Since 09/09/24, all non-coronial deaths will have a proportionate review of their medical records completed by a Medical Examiner. Whilst the Medical Examiner service is independent of SFT, this initial 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 622 deaths of patients under the care of SFT reported to them between October and December 2024. Of these, 547 were within our acute hospitals, 68 were within our community hospitals and 7 patients were under the care of Hospital @ Home. The Medical Examiner team looked at 100% of these deaths and shared feedback on 105 deaths to Learning from Deaths. This feedback is triaged and shared as appropriate for instance by a review methodology such as an SJR, PALS or Complaint response, or PSIRF learning response.

- **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. During this reporting period, 33 SJR's were requested through this pathway. In addition to these reviews, specialities should 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.

- **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 is shared with the local LeDeR team.

  During this reporting period there were 4 inpatient deaths of a person with Learning Disability. Concerns were raised by the Medical Examiner service as well as via an incident report about the care of one of these patients, which will be considered within an SJR.

- **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, 3 deaths have been discussed at rapid review meetings. As a result, 2 of these deaths were deemed to meet the criteria for a Patient Safety Incident Investigation, and the other death will be subject to an SJR.

- **PALS and complaints**
  During this quarter, 17 PALS queries and 4 formal complaints have been raised concerning the deaths of patients in our care. Common themes are around:

  - Poor communication. An example being of a family who reported that they were given bereavement leaflets but no one from the ward spoke to them about what was happening.

  - Concerns about care and treatment at the end of life. An example being of families who reported that pain management and personal care was poor.

  - Concerns with diagnosis and management. An example being of whether an issue should have been picked up during a pre-operative assessment.

- **Maternity Deaths**
  In this reporting period there were 5 perinatal deaths eligible for notification to MBRRACE-UK, one of which met the criteria for local review using the Perinatal Mortality Review Tool (PMRT).

  There has been 1 additional neonatal death at another trust where we will contribute to the PMRT process as we provided care.

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

  There have been no maternal deaths during this reporting period.

- **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. There were 2 deaths of young people. One of these deaths was expected, one was unexpected. In both cases, there were no immediate concerns about SFT care raised. These will be reviewed internally in addition to the CDOP review.

- **Coronial activity**
  During this reporting period, there were 63 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 30 read-only inquests and

5 inquests heard with witnesses called. A further 3 pre inquest review hearings have been heard.

It has been noted that there have been several deaths involving pressure ulcers scheduled for inquest. This will be considered as a potential theme that may need to be further looked at.

3.3. Standardised mortality

3.3.1 Summary Hospital-level Mortality Indicator (SHMI), September 2023 – August 2024

Source: NHS England (January 2025)

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

The SHMI methodology has been changed from May 2024. Changes include the inclusion of covid cases and improving the identification of admitting diagnosis.

Trust level

Trust	Provider spells	Observed deaths	Expected deaths	SHMI value
Somerset NHS FT	86,030	3,210	3,160	1.02 As expected

Site level *Acute hospitals (Note: SHMI values are no longer published for other sites)*

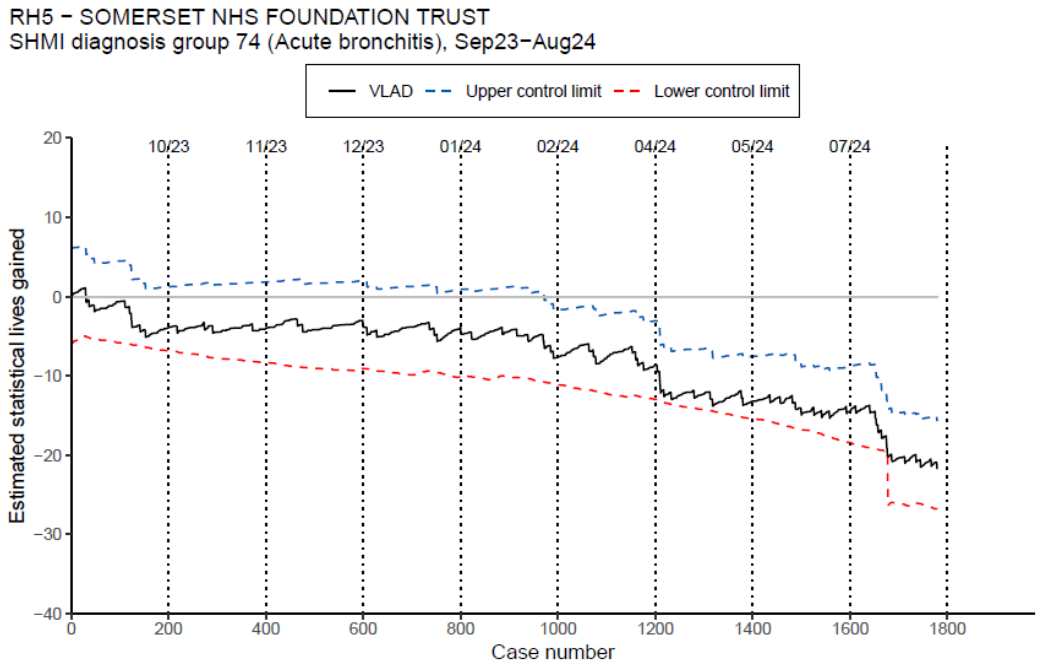
Site	Provider spells	Observed deaths	Expected deaths	SHMI value
Musgrove Park Hospital	61,725	1,960	1,970	1.00 As expected
Yeovil District Hospital	22,665	1,095	1,080	1.06 As expected

Diagnosis group ***Reported groups by exception***

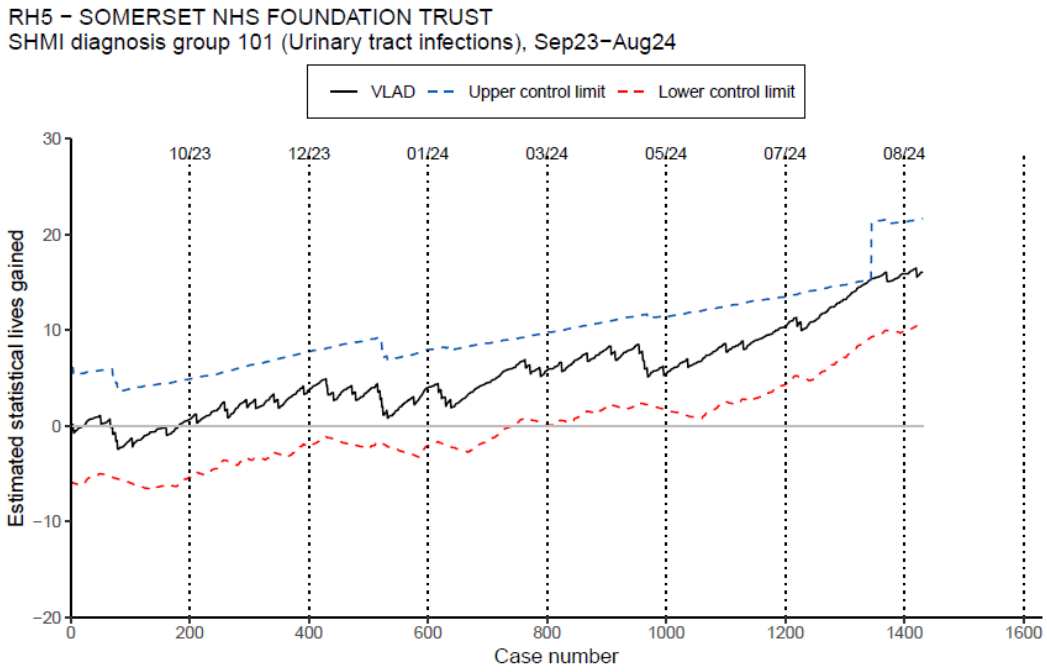
Diagnosis group	Provider spells	Observed deaths	Expected deaths	SHMI value
Acute bronchitis	1,780	78	50	1.43 Higher than expected

Visual life adjusted display (VLAD) – recent alerts

In January, there was a VLAD alert for acute bronchitis diagnosis group relating to cases around July 2024.



There was also a positive alert for the urinary tract infection diagnosis group from August 2024.



3.3.2 **Standard mortality ratios from HED**

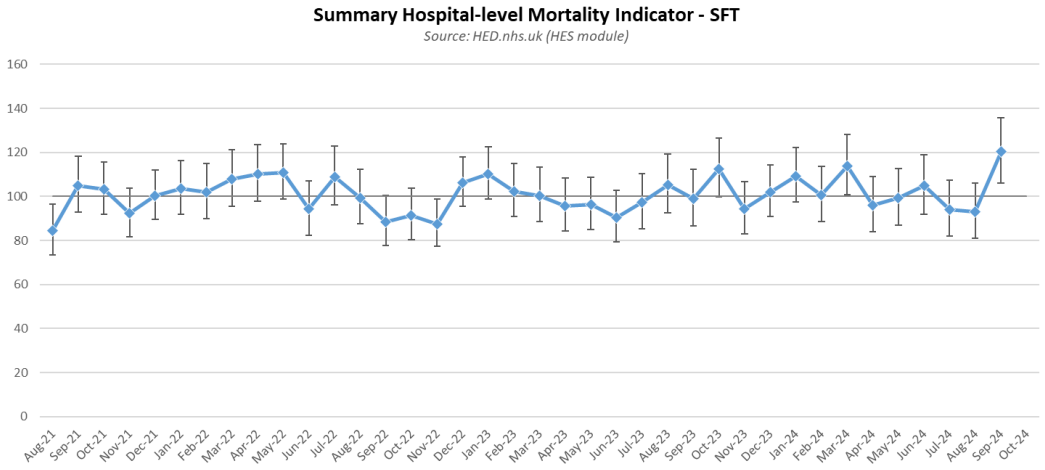
Source: HED.nhs.uk - SHMI HES and HSMR HES modules (20th January 2025)

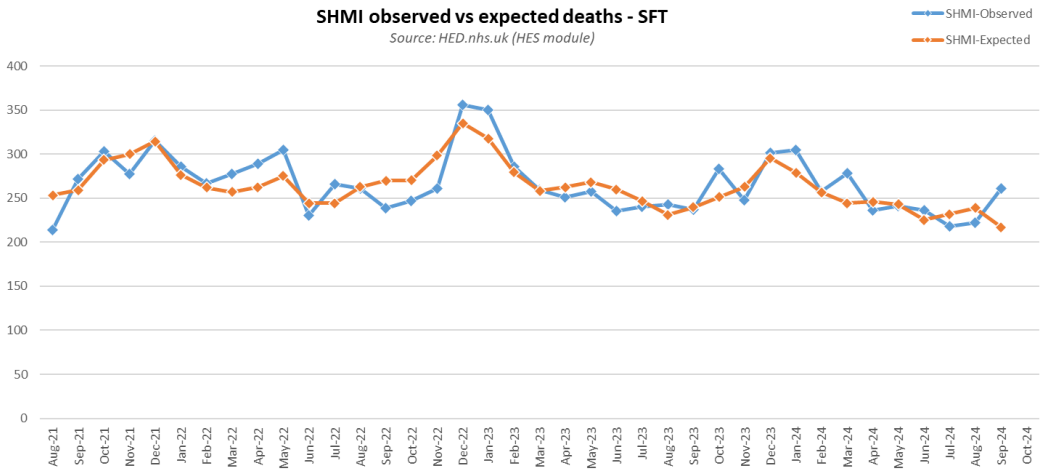
This report refers to two measures of standardised mortality: summary hospital-level mortality index (SHMI) and hospital standardised mortality ratio (HSMR).

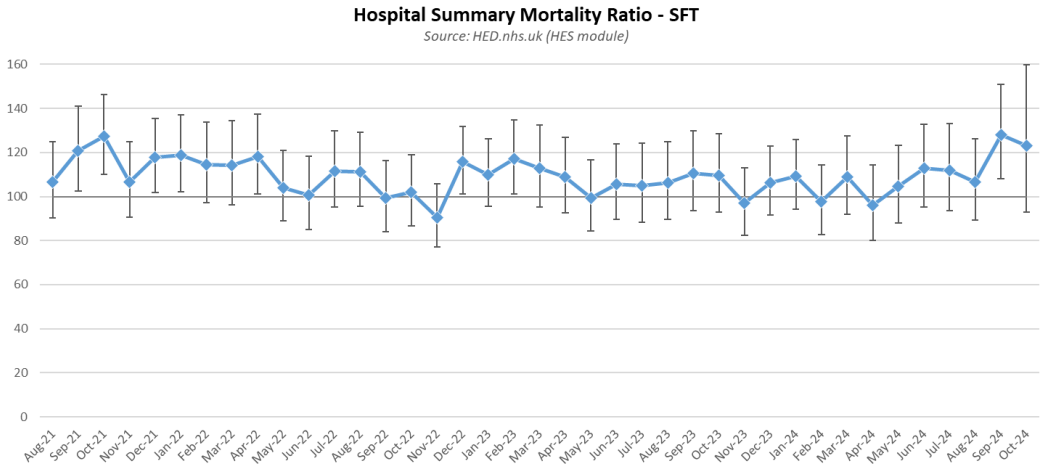
The following alerts are based on confidence intervals to allow for earlier identification of possible differences.

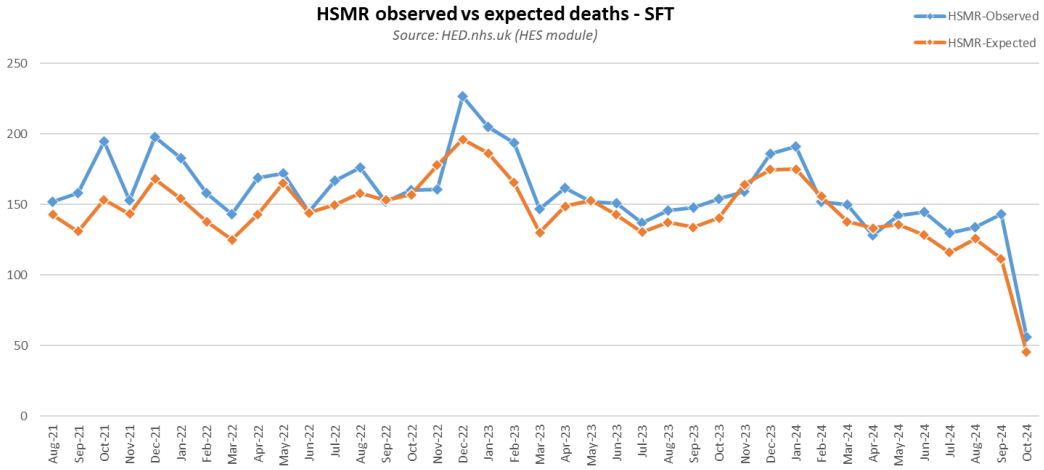
Trust level

Trust	SHMI (Oct 23 to Sep 24)	HSMR (Nov 23 to Oct 24)
Somerset NHS FT	101.8 (As expected) 95% CI: 98.2 - 105.6 Observed: 2,944 Expected: 2,891 Spells: 855	107 **(Above expected)** 95% CI: 102.0 - 112.2 Observed: 1,716 Expected: 1,604 Spells: 54,388









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

Site	SHMI (Oct 23 to Sep 24)	HSMR (Nov 23 to Oct 24)
Musgrove Park Hospital	101.2 (As expected) 95% CI: 96.6 - 105.8 Observed: 1,887 Expected: 1,865 Spells: 562	114.5 **(Above expected)** 95% CI: 107.5 - 121.9 Observed: 981 Expected: 857 Spells: 33,502
Yeovil District Hospital	103.0 (As expected) 95% CI: 96.9 - 109.4 Observed: 1,057 Expected: 1,026 Spells: 293	93.8 (As expected) 95% CI: 86.8 - 101.2 Observed: 661 Expected: 705 Spells: 18,914

Diagnosis group *Reported groups by exception using 95% confidence intervals*

Diagnosis group (CCS)	SHMI (Oct 23 to Sep 24)	HSMR (Nov 23 to Oct 24)
7 - Viral infection	0.0 **(Below expected)** 95% CI: 0.0 - 70.2 O: 0 E: 5 S: 1,054	
68 - Senility and organic mental disorders	136.11 **(Above expected)** 95% CI: 110.4 - 166.1 O: 97 E: 71 S: 642	139.62 **(Above expected)** 95% CI: 107.0 - 179.0 O: 62 E: 44 S: 51
71 - Other psychoses	328.52 **(Above expected)** 95% CI: 141.5 - 647.4 O: 8 E: 2 S: 167	
99 - Hypertension with complications and secondary hypertension	476.36 **(Above expected)** 95% CI: 128.2 - 1,219.6 O: 4 E: 1 S: 23	
125 - Acute bronchitis	144.91 **(Above expected)** 95% CI: 113.6 - 182.2 O: 73 E: 50 S: 1,712 VLAD alerts in last 3 months: 1	150.36 **(Above expected)** 95% CI: 108.8 - 202.6 O: 43 E: 29 S: 34
127 - Chronic obstructive pulmonary disease and bronchiectasis	113.25 (As expected) 95% CI: 90.5 - 140.0 O: 85 E: 75 S: 1,191	132.88 **(Above expected)** 95% CI: 103.2 - 168.5 O: 68 E: 51 S: 61
149 - Biliary tract disease	56.2 **(Below expected)** 95% CI: 31.4 - 92.7 O: 15 E: 27 S: 1,480	40.49 **(Below expected)** 95% CI: 14.8 - 88.1 O: 6 E: 15 S: 18
159 - Urinary tract infections	74.36 **(Below expected)** 95% CI: 54.4 - 99.2 O: 46 E: 62 S: 1,309 VLAD alerts in last 3 months: 1	76.26 (As expected) 95% CI: 48.9 - 113.5 O: 24 E: 31 S: 31
199 - Chronic ulcer of skin	186.44 **(Above expected)** 95% CI: 113.8 - 288.0 O: 20 E: 11 S: 182	148.77 (As expected) 95% CI: 89.5 - 232.3 O: 19 E: 13 S: 13
200 - Other skin disorders	0.0 **(Below expected)** 95% CI: 0.0 - 92.9 O: 0 E: 4 S: 383	
218 - Uncomplicated pregnancy and/or delivery	39040.33 **(Above expected)** 95% CI: 510.3 - 217,214.8 O: 1 E: <6 S: 2,677	
219 - Short gestation; low birth weight; and fetal growth retardation	18.57 **(Below expected)** 95% CI: 5.0 - 47.5 O: 4 E: 22 S: 189 VLAD alerts in last 3 months: 1	
245 - Syncope	345.73 **(Above expected)** 95% CI: 172.4 - 618.7 O: 11 E: 3 S: 514	239.78 **(Above expected)** 95% CI: 103.2 - 472.5 O: 8 E: 3 S: 6
250 - Nausea and vomiting	294.72 **(Above expected)** 95% CI: 134.5 - 559.5 O: 9 E: 3 S: 271	

Diagnosis group (CCS)	SHMI (Oct 23 to Sep 24)	HSMR (Nov 23 to Oct 24)
254 - Rehabilitation care; fitting of prostheses; and adjustment of devices	571.46 **(Above expected)** 95% CI: 114.9 - 1,669.7 O: 3 E: 1 S: 92	

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

- Diagnosis groups that are showing “above expected” mortality will be review by the Trust Mortality Lead and discussed between the LfD team and at MSG to review requirements for further in-depth review.

Appendix 1

NHS Somerset NHS Foundation Trust

		2023/2024								2024/2025											
		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	171	233	591	236	195	201	632	163	179	153	495	150	147	182	479	170	176	201	547
	Total Scrutinised by ME	175	168	207	550	231	193	195	619	156	179	153	488	150	147	182	479	170	176	201	547
	SJR's requested by LfD	10	9	10	29	10	9	8	27	10	8	13	31	10	12	12	34	10	8	12	30
	SJR's completed	22	24	24	70	30	20	22	72	19	22	18	59	19	17	13	49	6	4	6	16
	Problems in care**	2	0	0	2	2	0	1	3	0	1	0	1	1	0	0	1	0	0	2	2
	Serious Incident/PSIRF***	1	0	0	1	1	1	1	3	2	4	3	9	1	0	1	2	0	0	1	1
	Learning Disabilities: internally all deaths in acute inpatient settings are subject to review or investigation																				
	Total deaths	1	1	2	4	3	2	5	10	0	0	2	2	1	0	0	1	1	0	3	4
	Review/investigation completed	0	1	1	2	2	1	4	7	0	0	2	2	1	0	0		1	0	0	1
COMMUNITY HOSPITAL	Total deaths	24	22	17	63	19	15	20	54	19	18	22	59	25	23	22	70	20	26	22	68
	Total scrutinised by ME	24	22	17	63	19	15	20	54	19	18	22	59	25	23	22	70	20	26	22	68
	SJR's requested by LfD	0	1	0	1	0	0	0	0	0	0	1	1	0	1	0	1	0	0	2	2
	SJR's completed	0	1	0	1	0	0	0	0	0	0	3	3	2	3	2	5	2	1	1	4
	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/PSIRF***	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MENTAL HEALTH	Total deaths (reported as incident)	4	9	6	19	10	4	9	23	3	5	5	13	10	8	4	22	6	3	7	16
	Total scrutinised by ME	0	0	1	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0	1	1
	SJR's requested by LfD	2	2	1	5	3	0	2	5	1	2	3	6	5	2	2	9	0	1	0	1
	SJR's completed	2	2	1	5	2	0	2	4	1	2	3	6	5	1	1	7	0	0	0	0
	Problems in care**	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incident/PSIRF***	0	0	1	1	2	0	1	3	1	1	2	4	2	1	0	3	2	1	1	4
COMMUNITY SERVICES	SJR's requested by LfD	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	SJR's completed	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	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/PSIRF process initiated	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	3
Total deaths subject to Coroner's Inquests		14	20	18	52	24	19	23	66	13	21	21	55	21	18	17	56	15	21	27	63

* 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
***All PSIRF learning responses included from January 2024

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee business meeting held on 29 January 2025
SPONSORING EXEC:	Peter Lewis, Chief Executive
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Inga Kennedy, Chairman of the Quality and Governance Assurance Committee
DATE:	4 March 2025

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 business meeting held on 29 January 2025. The Committee received degrees of assurance in relation to: • The MHA Bed Rail Alert and actions taken • The Maternity Incentive Scheme (MIS) Year 6 Declaration and Sign Off – the areas of compliance • The BirthRate+ Review • The Executive Concerns Update • The Governance Support Summary • The Patient Safety Board Report • The Clinical Support and Cancer Services Assurance Report The Committee identified the following areas of concern or for follow up: • The Premises Assurance Report • The Board Assurance Framework • The Corporate Risk Register

	• The Maternity Incentive Scheme (MIS) Year 6 Declaration and Sign Off - the areas of non-compliance • The Governance Support Summary • The Patient Deterioration Audit Report The Committee identified the following issue to be reported to the Board: • The Maternity and Perinatal Incentive Scheme (MIS) Year 6 Declaration and Sign Off
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 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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 FOCUS MEETING HELD ON 29 JANUARY 2025

1. PURPOSE

1.1. The report sets out the items discussed at the business meeting held on 29 January 2025, along with the assurance received by the Committee and any areas of concern identified. The meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

MHRA Bed Rails Alert

2.1. The Committee noted the reduction in the risk in terms of regulatory intervention. The Committee noted that the outstanding action will require systemwide work. The Committee agreed to close this action from a Committee perspective but noted that the work in relation to the risk assessments for equipment in community setting, including in adult social are services, will be followed up with the ICB.

Maternity Incentive Scheme (MIS) Year 6 Declaration and Sign Off

2.2. Under its delegated authority from the Board, the Committee received an update on the final Year 6 compliance declaration and, based on the information and updated presented to the Committee, the Committee agreed to declare compliance with the following safety actions: 1, 2, 3, 5, 7, 8 and 10.

2.3. The Committee thanked Sally Bryant and the team on their significant efforts and work required to achieve this declaration.

Birth Rate + Review

2.4. The Committee received an update on the Birth Rate + review and noted that Birth Rate+ provided a framework for workforce planning and strategic decision-making relating to the midwifery establishment and to an element of midwifery practice that could potentially safely be undertaken by support workers in the post-natal period.

2.5. The Committee noted that the review had been commissioned in the summer of 2024 and that a second draft of the report had been issued at the end of November 2024. The Committee noted the key findings of the report: the 224 fewer births compared to 2021; the increase in acuity in the % of women in categories IV and V at YDH and the increase in category V and the decrease in categories IV at MPH; the current skill mix and the decision to retain the current clinical staffing levels at YDH; and the deficit in the total funded establishment, primarily in the additional specialist roles.

2.6. The Committee further received an update on: the review of the specialist midwifery team; the review of the whole staffing workforce establishment and the proposed phased implementation plan. The Committee noted that the review was being undertaken in response to the CQC report and that the review had a direct link to quality and safety. The Committee further noted that it was expected that it any vacant posts resulting from the reviews can be recruited to. The Committee noted that the Birth Rate + review report will be shared with the Operational Leadership Team.

Executive Concerns - Update

2.7. The Committee received briefings in relation to the following topics: the emerging national concerns including the delays in the New Hospital Programme; the emerging priorities for 2025/26 - the acute service/fragile service sustainability, a shift to neighbourhood working, a focus on back to basics and what this means across the organisation; the ongoing winter pressures; feedback from the Care Quality Committee (CQC) inspection of paediatric services; the development of the Care-Co and Hospital@Home services hub in 2025 and the opportunity to divert requests for ambulances to community services; the development of a "call before you convey" system; and the 100-day discharge sprint initiative.

Governance Support Summary

2.8. The Committee received the summary report and noted the key highlights: feedback from the Quality Assurance Group meetings held in November and December 2024; feedback from the Mortality Surveillance Group meeting held in December 2024; feedback from the Data Review Group meeting held in January 2025.

Patient Safety Board Report (PSB)

2.9. The Committee received the report and noted the key highlights from the report: feedback from the PSB meeting held on 15 January 2025 and the topics covered at the meeting, including work around national strategies, such as Martha's Rule, learning from patient safety events; the sign off of a patient safety incident investigation (PSII); and the commissioning of two patient safety incident investigations.

2.10. The Committee noted that the two PSIIs were linked to deteriorating patients and treatment escalation plans and not to the "people who matter" thematic priority. The Committee noted: that the "people who matter" priority related to engagement with people who matter to patients who could not advocate for themselves; that some of the PSIIs that have already been completed and reported to the meeting have included investigations around engaging with carers and patients; and that the list in the report to the Committee only includes open PSIIs.

2.11. The Committee noted that the work of the PSB was still developing and that a level of maturity will need to be reached where the Committee can be confident about the data and the information presented to the Committee.

Service Group Assurance Report – Clinical Support and Cancer Services (CSCS)

2.12. The Committee received an update on the service group's governance assurance arrangements and noted: the uniqueness of the service group covering multiple small services and the resulting vulnerabilities due to the size of services and specialties; the workforce risks; the highly regulated services with strong service-level governance arrangements; the development of the governance arrangements over the last year; the high level involvement from heads of services using the governance arrangements to progress integration; and the greater level of information which allows the service group to have richer conversations and share learning across services.

2.13. The Committee further noted: the need for collaboration in respect of risks, complaints and incidents crossing service group boundaries; the work to maximise the use of Radar to enable thematic analysis to inform decisions and service developments; the review of health and safety processes and the identification of key risks relating to physical space, aged estate, wellbeing burn-out for colleagues, and regulatory headlines in terms of radiation protection and COSHH.

2.14. The Committee further noted the concerns in relation to the portfolio and the diversity of the portfolio covered by the service group and noted that the portfolio will be considered as part of the Service Group Review project.

2.15. The Committee welcomed the focus of the report on learning and maturing information and data.

General Comments

2.16. The Committee agreed that the reports presented to the meeting had mostly been of a reasonable quality with some triangulation across the reports. The key themes of the reports covered capacity, staffing, aged estates, and data integrity.

3. AREAS OF CONCERN OR FOLLOW UP

Premises Assurance Report

3.1. The Committee acknowledged the need to provide benchmarked evidence in support of the self-assessment and further noted that a progress report will be presented to a future committee meeting.

Board Assurance Framework

3.2. The Committee received brief updates against the following objectives and noted:

- Objective 2 - the ongoing pressures in primary care; the continued increase in emergency department (ED) demand; the actions being taken to improve controls relating to the ward accreditation programme, the urgent treatment centre and estates and maintenance. The

Committee particularly noted the need to review the impact of the delay of the New Hospital Programme.

- Objective 3 – the highest rated risks: fragility of primary care and possible impact of GP collective action, and shortfalls in social care capacity; and the negative assurance received in relation to the uptake of the Hospital@Home programme.

- Objective 4 – that a report on inclusion, including aspects of inequalities, will be presented to the March 2025 Board meeting and that a detailed discussion was scheduled for the February committee meeting.

- Objective 5 – the highest rated risk related to the number of patients with a length of stay greater than 21 days due to insufficient intermediate care capacity. This risk had increased to 16 but remained within risk appetite levels.

Corporate Risk Register (CRR)

3.3. The Committee received the CRR update and noted: the 25 corporate risks, five of which scored 20 or above; the 40 risks managed at service group level; the new risk relating to the inability to isolate inpatients in accordance with national IPC requirements due to lack of capacity within Trust inpatient areas. The Committee further noted the risks which fell within the remit of the Committee, nine of which were outside of the agreed risk appetite level and four within the agreed risk appetite level. The Committee agreed to seek further assurance on the safeguarding and decontamination risks.

3.4. The Committee noted that a review of the risk appetite levels for objectives 2, 3, 4 and 5 will be undertaken at its February 2025 meeting.

Maternity Incentive Scheme (MIS) Year 6 Declaration and Sign Off

3.5. Under its delegated authority from the Board, the Committee received an update on the final Year 6 compliance declaration.

3.6. The Committee agreed to declare non-compliance with safety action 4 due to non-compliance with elements of the obstetrics medical workforce requirements. The Committee noted the reasons for the non-compliance declaration and further noted that an action plan had been developed to set out how the outstanding requirements will be met in Year 7. The Committee signed off the action plan.

3.7. The Committee agreed to declare non-compliance with safety action 6 as not sufficient progress had been made in the implementation of all elements of the Saving Babies' Lives Care Bundle Version Three. The Committee signed off the action plan.

3.8. The Committee agreed to declare non-compliance with safety action 9 due to the inability to evidence some of the elements covered under this safety action. The Committee recognised that the requirements for this safety action were complex and that actions need to be taken to strengthen evidence-based governance and assurance. The Committee signed off the action plan.

Governance Support Summary

3.9. The Committee received an update in relation to an inquest into the care of an elderly patient with significant skin damage and noted that a Regulation 28 Preventing Future Deaths report was likely to be issued. The Committee noted that, once issued, the trust will need to respond to the report within 56 working days. Concerns in relation to the occurrence of pressure ulcers have already been raised at the Committee and Board.

Paediatric Early Warning System (PEWS) Audit Report

3.1. The Committee received the internal audit report and noted the moderate assurance for design and the limited assurance for design effectiveness. The Committee agreed to consider the audit findings as part of its review pending the outcome of the CQC inspection of paediatric services. The Committee also noted that the outcomes and actions in relation to the audit into frailty services will be reviewed at a future meeting.

4. AGENDA ITEMS DISCUSSED AT THE COMMITTEE'S FOCUS MEETING HELD ON 26 FEBRUARY 2025

4.1. The Committee discussed the following items at its meting held on 26 February 2025:

- The Board Assurance Framework and Corporate Risk Register
- The Objective 4 Priority Programmes: Reduce Inequalities
- The Patient and Carer Race Equality Framework
- The Annual Risk Appetite discussion for Board and sub committees
- The Learning from Deaths Q3 Report
- The Maternity Services Update

4.2. Feedback from the meeting will be included in the assurance report to be presented to the May 2025 Board meeting.

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

5.1. The Committee identified the following issue to be reported to the Board:

- The Maternity Incentive Scheme (MIS) Year 6 Declaration and Sign Off

6. BOARD ASSURANCE FRAMEWORK (BAF)

6.1. The Committee agreed that it had received both positive and negative assurance for a number of objectives which fall within the remit of the Committee.

6.2. The Committee agreed that it had received the following assurance:

- Objective 2 – some positive assurance in terms of the MPIS and BirthRate+ reports with plans to address aspects of negative assurance received. The Committee noted the risks associated with the requirements for financial and workforce investment in relation to these plans and asked that those risk assessments are completed.

  The Committee also noted the acute paediatric CQC inspection and will await the outcome. For both maternity and paediatrics, the impact of the delay in the NHP programme and the ongoing premises assurance risk will need to be reviewed.

  The Committee further noted the significant challenges around patient flow and infection control; and the 100-day discharge project that linked to the corporate risk and asked for this to be kept under review and an update to be provided to the next meeting.

- Objective 3 - the Committee noted the update on work taking place to address the lower than anticipated levels of referral into Hospital@Home. This remained an issue for delivery of this objective and will be subject to a focus meeting review in April 2025.

- Although not under the direct remit of the Committee, issues in relation to estates, clinical space and staff-wellbeing space, were identified in the service group assurance report and impacted on Objective 6.

6.3. 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.

Inga Kennedy
CHAIRMAN OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Group 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:	4 March 2025

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 Group. It includes commentary on the key issues, risks, and variances, which are affecting financial performance.
Recommendation	The Board is requested 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 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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 report itself has not been assessed against the Trust's Equality Impact Assessment Tool but the impact on protected characteristics will be considered as part of the overall financial plan.
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 Applicable

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 – e.g. 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, the Trust recorded a surplus of £2.185m, this was in line with the planned position for the month. Cumulatively, the Trust is £5.992m in deficit, which is also breakeven to plan.

1.2 The main January headlines are:-

- Agency expenditure in month was £2.219m, this was £1.210m below the plan for the month. It was also £0.109m below the ceiling for the month but £0.050m higher than December expenditure. Cumulatively, the Trust has spent £5.6m less than in the equivalent 2023/24 period.
- CIP of £7.556m was delivered in January, in line with plan. Of this, recurrent savings were £4.055m (54% of total). Cumulatively, total efficiencies of £48.628m have been delivered which is on plan, of these, £18.504m (38%) are recurrent. The unidentified gap has reduced again this month and are now c£1.4m.
- Total whole time equivalents for all staff groups were 12,615 in January, this was 5 above the expected trajectory for the month. We remain on course to deliver the cap.

2. INCOME AND EXPENDITURE

2.1 Table 1 below sets out the summary income and expenditure account to 30 January 2024:

Table 1: Income and Expenditure Summary January

Statement of Comprehensive Income	Annual Plan	Current Month 10			Year to date		
		Plan	Actual	Fav./ (Adv.) Variance	Plan	Actual	Fav./ (Adv.) Variance
	£000	£000	£000	£000	£000	£000	£000
Income							
Patient Care Income	998,826	83,059	86,377	3,318	833,284	852,939	19,655
Other Operating Income	72,568	6,859	7,257	397	58,830	65,397	6,568
Total operating income	**1,071,394**	**89,918**	**93,633**	**3,715**	**892,113**	**918,336**	**26,223**
Operating expenses							
Employee Operating Expenses	(739,738)	(61,098)	(57,525)	3,574	(618,134)	(625,429)	(7,295)
Drugs Cost: Consumed/Purchased	(93,770)	(7,686)	(7,878)	(192)	(79,232)	(79,520)	(287)
Clinical Supp & Serv Exc-Drugs	(32,992)	(1,859)	(8,598)	(6,739)	(29,857)	(57,200)	(27,343)
Supplies & Services - General	(35,549)	(2,962)	(3,684)	(722)	(29,625)	(29,629)	(4)
Other Operating Expenses	(158,268)	(13,205)	(11,261)	1,944	(132,024)	(125,567)	6,456
Total operating expenses	**(1,060,316)**	**(86,811)**	**(88,946)**	**(2,135)**	**(888,872)**	**(917,346)**	**(28,473)**
Operating Surplus/Deficit	11,078	3,108	4,688	1,580	3,241	991	(2,250)
Finance Expense	(13,070)	(1,089)	(1,705)	(615)	(10,894)	(9,688)	1,206
Finance Income	2,424	202	202	(0)	2,020	3,358	1,338
Other	0	(1)	(1,039)	(1,038)	(1)	(1,041)	(1,040)
Overall Surplus/(Deficit)	432	2,219	2,146	(73)	(5,635)	(6,380)	(745)
Depr On Donated Assets	1,397	116	94	(23)	1,164	834	(330)
Donated Assets Income	(2,591)	(216)	(7)	209	(2,159)	(1,689)	470
Amortisation	9	1	66	65	8	73	65
Impairments (Reversals)	0	0	(1,039)	(1,039)	0	0	0
Other	753	63	927	864	630	1,172	542
Adjustments to control total	(432)	(36)	41	77	(357)	390	747
Adjusted Financial Performance	0	2,185	2,185	0	(5,992)	(5,992)	0

2.2 The tables below set out pay expenditure and whole time equivalent (wte) information by month. Actual performance is compared with plan in each table.

2.3 In January, overall staffing levels were 5 wte above the workforce cap trajectory for the month:

- Substantive staff were 106 wte over plan
- Bank staff were 77 wte under plan
- Agency staff were 23 wte over &
- Locums were 1 wte over the planned cap

2.4 The Trust endeavours to operate effective oversight and control processes to manage our workforce numbers and costs. The annual Cap wte (12,505) is the workforce target the organisation has committed to try and achieve by the end of March 2025 in line with the NHSE planning expectation and is based on October 2023 staffing levels. Based on our progress to date we remain on track to deliver this. This has only been possible through the sustained focus and challenge that services have undertaken all year.

2.5 Overall temporary staffing numbers were under plan in month and January's wte's decreased by 54.09 wte when compared with December. The agency increase was 22.91 wte. January was exceptionally challenging operationally and combined with the usual peaks in colleague sickness this drove the increased use of agency

Table 2: Pay expenditure information

2024/25 Monthly Pay Expenditure analysis	Apr-24 £000	May-24 £000	Jun-24 £000	Jul-24 £000	Aug-24 £000	Sep-24 £000	Oct-24 £000	Nov-24 £000	Dec-24 £000	Jan-25 £000	2024/25 In Month Plan £000	F/(A) Variance £000	2024/25 Total £000	2024/25 YTD Plan £000	F/(A) Variance £000
Temporary staff															
Bank Staff	2,090	1,927	1,894	1,882	1,975	1,826	2,767	2,064	1,977	2,116	2,292	177	20,517	21,654	1,137
Medical Agency	1,830	1,685	1,275	1,411	1,779	1,424	1,865	1,722	1,418	1,535	2,132	597	15,944	18,993	3,049
Medical Locums	1,152	1,032	938	1,159	818	1,000	908	1,023	995	881	503	(378)	9,908	5,034	(4,873)
Nursing Agency	771	618	547	547	486	369	501	384	441	490	1,000	509	5,153	9,825	4,671
Other Agency	484	497	391	405	331	317	331	323	311	194	297	104	3,582	2,830	(751)
Total Temporary Staff	**6,326**	**5,759**	**5,044**	**5,404**	**5,388**	**4,936**	**6,372**	**5,516**	**5,142**	**5,216**	**6,225**	**1,009**	**55,103**	**58,336**	**3,233**
Nursing	15,075	14,998	15,079	14,949	14,854	14,993	18,511	15,649	15,664	15,862	16,740	878	155,634	166,374	10,740
Support to Nursing	6,307	6,229	6,256	6,106	5,999	6,061	7,302	6,082	5,967	6,084	5,483	(601)	62,394	54,961	(7,433)
Medical	12,773	10,722	11,723	12,261	12,263	12,138	15,250	16,541	13,071	13,642	12,102	(1,539)	130,385	123,949	(6,436)
AHP's	8,615	8,680	8,658	8,656	8,616	8,646	11,165	9,279	9,360	9,238	9,748	510	90,912	97,401	6,488
Infrastructure Support	9,657	9,326	9,461	9,302	9,599	9,355	11,518	9,686	9,662	9,842	7,542	(2,300)	97,409	84,685	(12,723)
Other	3,191	4,956	3,611	4,026	3,845	4,164	3,955	4,012	4,190	(2,359)	3,258	5,617	33,592	32,428	(1,164)
Substantive Staff	**55,618**	**54,912**	**54,789**	**55,300**	**55,176**	**55,357**	**67,701**	**61,250**	**57,915**	**52,309**	**54,873**	**2,565**	**570,326**	**559,798**	**(10,528)**
Total All Staff	**61,943**	**60,671**	**59,833**	**60,704**	**60,565**	**60,293**	**74,073**	**66,765**	**63,057**	**57,525**	**61,098**	**3,574**	**625,429**	**618,134**	**(7,295)**
% Temporary	10.21%	9.49%	8.43%	8.90%	8.90%	8.19%	8.60%	8.26%	8.15%	9.07%	10.19%		8.81%	9.44%	

Table 3: WTE information

2024/25 Monthly Workforce analysis	Apr-24 WTE	May-24 WTE	Jun-24 WTE	Jul-24 WTE	Aug-24 WTE	Sep-24 WTE	Oct-24 WTE	Nov-24 WTE	Dec-24 WTE	Jan-25 WTE	In Month WTE	In Month Plan WTE	F/(A) Variance WTE	Plan	F/(A) Variance WTE
Temporary staff															
Bank Staff	588.90	493.89	493.02	516.60	518.54	487.53	554.72	519.78	498.22	524.28	524.28	601.85	77.57	539.24	14.96
Medical Agency	74.57	67.68	59.07	68.38	69.16	62.13	76.13	68.32	63.53	71.21	71.21	73.32	2.11	60.16	(11.05)
Medical Locums	31.19	25.72	26.61	33.27	32.54	29.98	28.65	29.85	29.25	30.16	30.16	22.05	(8.11)	19.76	(10.40)
Nursing Agency	94.58	69.57	64.96	70.88	67.02	46.30	47.29	48.55	59.27	67.91	67.91	93.59	25.68	76.79	8.88
Other Agency	67.26	77.61	59.76	58.10	58.65	55.32	52.70	45.45	42.74	49.33	49.33	53.69	4.36	44.05	(5.28)
Total Temporary Staff	**856.50**	**734.47**	**703.42**	**747.23**	**745.91**	**681.26**	**759.49**	**711.95**	**693.01**	**742.89**	**742.89**	**844.50**	**101.61**	**740.00**	**(2.89)**
Nursing	3,380.35	3,402.66	3,406.98	3,419.94	3,422.15	3,422.59	3,467.42	3,457.94	3,460.86	3,469.54	3,469.54	3,419.62	(49.92)	3,419.62	(49.92)
Support to Nursing	2,171.87	2,153.16	2,159.23	2,138.57	2,097.38	2,088.21	2,067.51	2,031.07	2,014.00	2,013.29	2,013.29	2,097.34	84.06	2,097.34	84.06
Medical	1,079.95	1,084.89	1,079.97	1,074.69	1,205.17	1,142.05	1,137.58	1,131.15	1,121.14	1,127.30	1,127.30	1,090.01	(37.29)	1,090.01	(37.29)
AHP's	1,590.04	1,589.92	1,586.06	1,600.67	1,607.25	1,626.72	1,653.37	1,649.77	1,658.43	1,656.14	1,656.14	1,594.06	(62.09)	1,594.06	(62.09)
Infrastructure Support	2,484.95	2,470.55	2,477.64	2,471.69	2,465.93	2,465.71	2,462.85	2,483.64	2,473.16	2,464.88	2,464.88	2,507.10	42.22	2,507.10	42.22
Other	1,136.01	1,161.37	1,145.51	1,126.36	1,127.82	1,134.55	1,113.43	1,130.66	1,140.14	1,140.80	1,140.80	1,056.87	(83.93)	1,056.87	(83.93)
Substantive Staff	**11,843.17**	**11,862.55**	**11,855.39**	**11,831.92**	**11,925.70**	**11,879.82**	**11,902.15**	**11,884.23**	**11,867.73**	**11,871.94**	**11,871.94**	**11,765.00**	**(106.94)**	**11,765.00**	**(106.94)**
Total All Staff	**12,699.67**	**12,597.02**	**12,558.81**	**12,579.15**	**12,671.61**	**12,561.08**	**12,661.64**	**12,596.18**	**12,560.74**	**12,614.83**	**12,614.83**	**12,609.50**	**(5.33)**	**12,505.00**	**(109.83)**
% Temporary	6.74%	5.83%	5.60%	5.94%	5.89%	5.42%	6.00%	5.65%	5.52%	5.89%	5.89%	6.70%		5.92%	

2.6 January agency expenditure was £2.219m, £0.907m lower than in the equivalent period in 2023/24 but £0.050m higher than December. When compared to the same period last year, the Trust has spent £5.6m less on agency to date and remains on course to deliver £6.8m of recurrent CIP.

2.7 Total medical agency in January was £1.535m (£0.118m higher than December). Vacancies continue to be the largest driver of agency usage and accounted for £1.127m (73% of the total SFT agency spend in month).

2.8 The Trust agency cap is £27.390m and is based on a 3.2% of planned pay spend. At the end of January, we are £2.100m above the cap. This variance has decreased by £0.109 in January. Clinical service groups continue to ensure they have grip and control on their agency use. Usage is reviewed regularly by senior colleagues on a regular basis.

2.9 In addition to operating controls to manage temporary staffing usage, the Trust continues to explore recruitment opportunities overseas. All service groups are working with their People Business Partners to explore additional supply avenues and review alternative staffing models to mitigate the difficulty of recruiting into hard to fill vacancies e.g. overseas consultants, clinical fellows and using a different skill mix.

3. COST IMPROVEMENT PROGRAMME

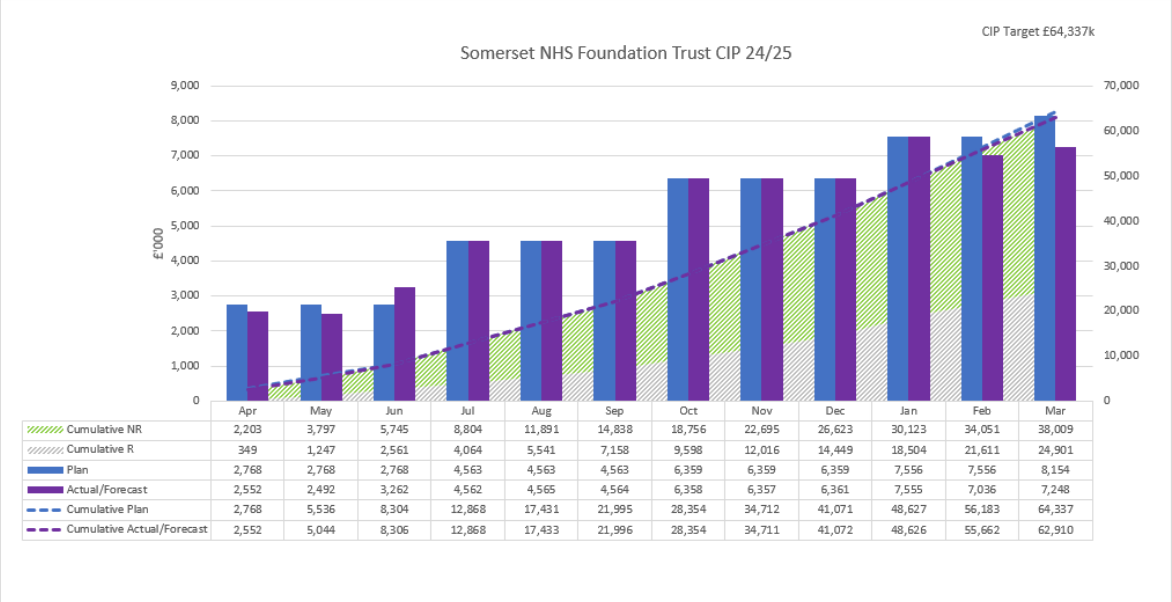
3.1 In January, savings of £7.556m were delivered. This was breakeven to plan. Recurrent savings formed £4.055m of the savings achieved (54%).

3.2 All schemes are continually risk assessed and categorised by their stage of maturity as part of the month end reporting process. The status of the schemes indicates 4% (December 5%) with a risk rating of red are largely all currently classified as non-recurring schemes. Low risk schemes are 88% (December 87%) and the remaining 8% medium (December 8%)

3.3 The level of savings achieved in month is reassuring, particularly as January was extremely challenging operationally. The profile of savings required in Quarter 4 presents the biggest challenge, however, the overall forecast achievement at service level remains consistent.

3.4 Further analysis is shown in the charts below: -

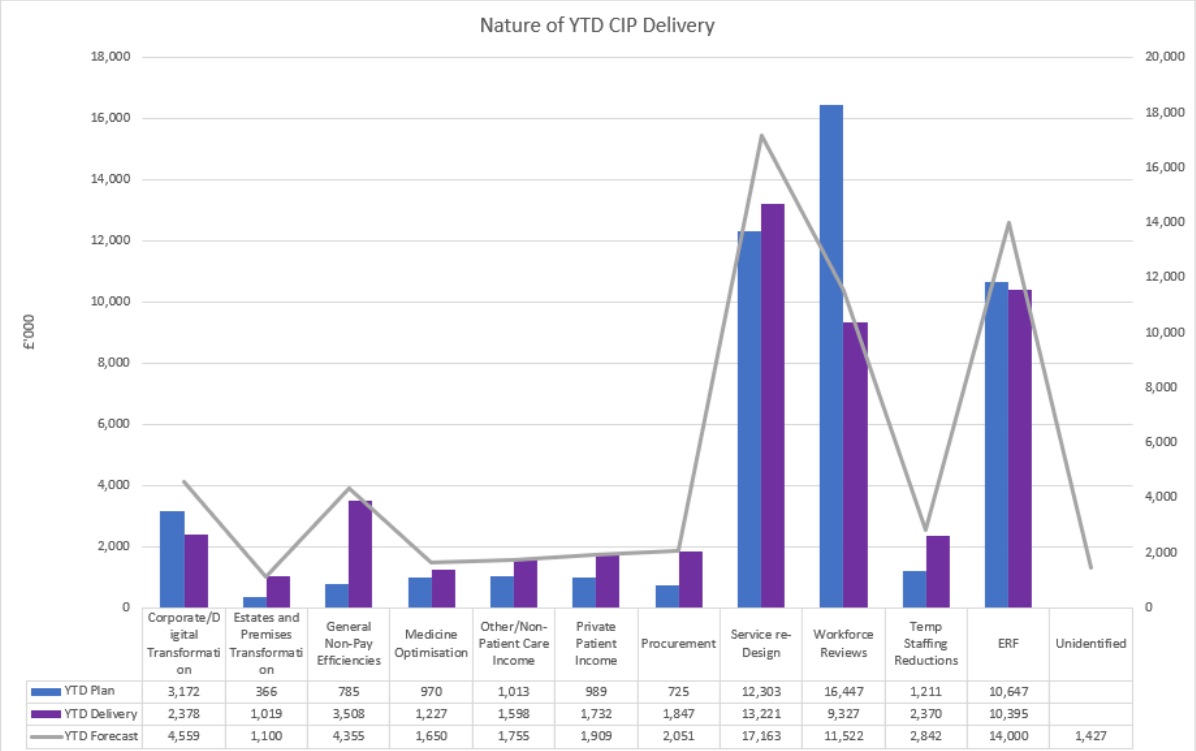
Chart 1: CIP Plan 2024/25



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative NR	2,203	3,797	5,745	8,804	11,891	14,838	18,756	22,695	26,623	30,123	34,051	38,009
Cumulative R	349	1,247	2,561	4,064	5,541	7,158	9,598	12,016	14,449	18,504	21,611	24,901
Plan	2,768	2,768	2,768	4,563	4,563	4,563	6,359	6,359	6,359	7,556	7,556	8,154
Actual/Forecast	2,552	2,492	3,262	4,562	4,565	4,564	6,358	6,357	6,361	7,555	7,036	7,248
Cumulative Plan	2,768	5,536	8,304	12,868	17,431	21,995	28,354	34,712	41,071	48,627	56,183	64,337
Cumulative Actual/Forecast	2,552	5,044	8,306	12,868	17,433	21,996	28,354	34,711	41,072	48,626	55,662	62,910

3.5 The nature of the schemes within the cost improvement plan are summarised and categorised below. A large element of the forecast savings is classified as service redesign; £17.163m. Workforce reviews; £11.522m and general non-pay efficiencies; £4.355m being the two next largest contributors, respectively.

Chart 2: Nature of CIP delivery



	Corporate/Digital Transformation	Estates and Premises Transformation	General Non-Pay Efficiencies	Medicine Optimisation	Other/Non-Patient Care Income	Private Patient Income	Procurement	Service re-Design	Workforce Reviews	Temp Staffing Reductions	ERF	Unidentified
YTD Plan	3,172	366	785	970	1,013	989	725	12,303	16,447	1,211	10,647	
YTD Delivery	2,378	1,019	3,508	1,227	1,598	1,732	1,847	13,221	9,327	2,370	10,395	
YTD Forecast	4,559	1,100	4,355	1,650	1,755	1,909	2,051	17,163	11,522	2,842	14,000	1,427

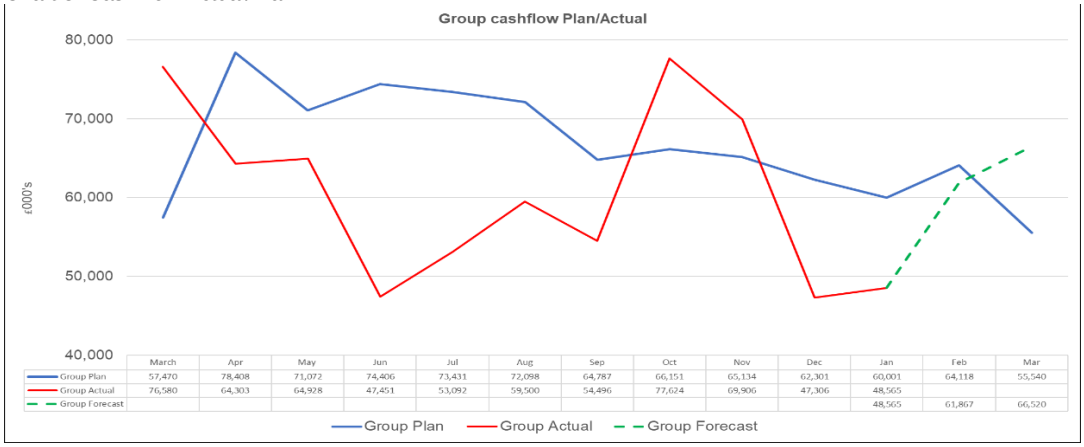
3.6 We continue to identify further opportunities to close the gap. The level of unidentified savings has reduced again in January and is now c£1.4m an improvement of £0.6m since December.

4. CASH

4.1 Cash balances at 31 January were £48.565m; £11.436m lower than plan, this is primarily due to £12.446m of contract variations awaiting finalisation (including £10.500m for Elective recovery fund income).

4.2 The planned, actual and forecast cash balances are set out in Chart 3 below:-

Chart 3: Cash flow Actual/Plan



	March	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Group Plan	57,470	78,408	71,072	74,406	73,431	72,098	64,787	66,151	65,134	62,301	60,001	64,118	55,540
Group Actual	76,580	64,303	64,928	47,451	53,092	59,500	54,496	77,624	69,906	47,306	48,565		
Group Forecast											48,565	61,867	66,520

5. STATEMENT OF FINANCIAL POSITION (BALANCE SHEET)

5.1 The movement in public dividend capital relates to monies drawn down to support the capital programme, including £8.924m for the Surgical Centre.

5.2 Deferred income in-month movement is driven by £4.660m education income (including psychology students).

Dec-24	Jan-25	Movement		Mar-24	Jan-25	Movement in Year
£000	£000	£'000		£000	£000	£000
41,507	43,281	1,774	Intangible Assets	37,954	43,281	5,327
412,189	413,763	1,575	Property, plant and equipment, other	390,563	413,763	23,201
26,759	26,581	(178)	On SoFP PFI assets	28,360	26,581	(1,779)
81,232	81,394	162	Right of use assets	83,020	81,394	(1,626)
14	14	0	Investments	14	14	0
14	14	0	Other investments/financial assets	14	14	0
3,132	3,120	(12)	Trade & other receivables > 1yr	2,957	3,120	163
564,847	**568,168**	**3,321**	**Non-current assets**	**542,883**	**568,168**	**25,286**
11,682	11,421	(262)	Inventories	11,005	11,421	415
24,586	15,301	(9,285)	Trade and other receivables: NHS receivables	7,081	15,301	8,220
29,175	38,352	9,177	Trade and other receivables: non-NHS receivables	24,932	38,352	13,420
466	466	0	Non current assets held for sale	466	466	0
54,091	48,976	(5,115)	Cash	76,580	48,976	(27,604)
120,001	**114,516**	**(5,485)**	**Total current assets**	**120,064**	**114,516**	**(5,548)**
(106,314)	(97,094)	9,221	Trade and other payables: non-capital	(96,052)	(97,094)	(1,042)
(11,213)	(11,265)	(52)	Trade and other payables: capital	(14,419)	(11,265)	3,155
(25,009)	(19,971)	5,038	Deferred income	(16,340)	(19,971)	(3,631)
(17,050)	(17,292)	(241)	Borrowings	(14,364)	(17,292)	(2,928)
(4,979)	(4,708)	271	Provisions < 1yr	(7,805)	(4,708)	3,097
(164,565)	**(150,329)**	**14,236**	**Current liabilities**	**(148,980)**	**(150,329)**	**(1,349)**
(44,564)	**(35,813)**	**8,751**	**Net current assets**	**(28,916)**	**(35,813)**	**(6,897)**
(104,412)	(105,036)	(624)	Borrowings > 1yr	(111,977)	(105,036)	6,941
(4,334)	(4,334)	0	Provisions > 1yr	(3,073)	(4,334)	(1,261)
(1,488)	(1,466)	22	Deferred income > 1yr	(1,682)	(1,466)	216
(110,234)	**(110,837)**	**(603)**	**Total long-term liabilities**	**(116,732)**	**(110,837)**	**5,896**
410,049	**421,519**	**11,470**	**Net assets employed**	**397,234**	**421,519**	**24,285**
			Financed by:			
383,329	394,396	11,067	Public dividend capital	363,752	394,396	30,644
77,897	77,897	0	Revaluation reserve	77,897	77,897	0
1,782	(354)	(2,136)	Other reserves	(4,441)	(354)	4,088
(2,471)	(2,471)	0	Financial assets at FV through OCI reserve	(2,471)	(2,471)	0
(50,885)	(48,508)	2,377	I&E reserve	(38,050)	(48,508)	(10,458)
			Other's equity			
397	558	162	Non-controlling Interest	548	558	11
410,049	**421,519**	**11,470**	**Total financed**	**397,234**	**421,519**	**24,285**

6. CAPITAL

6.1 Schemes are being progressed in accordance with the agreed programme for the year. There are several timing differences within the internal programme: backlog maintenance, major medical and surgical equipment and IT (including digital and EHR) that continue to be reviewed to ensure the full programme is delivered.

6.2 Year to date, capital expenditure is £58.522m compared with the plan of £72.912m, resulting in an underspend of £14.390m, £8m relates to delays to the Yeovil Diagnostic Centre build programme causing delays to the commencement of the lease, but this is expected to complete in March 2025.

6.3 The continued pressure on access to clinical areas remains an ongoing risk and is hindering the progress on a number of backlog schemes. This is being actively managed between the estates and site teams on a weekly basis. Reviews have been carried out with all capital project managers to assess the likely outturn capital expenditure for the financial year and several

additional schemes have been identified to mitigate any potential shortfall in the originally agreed programme and we remain confident that our total capital funding will be fully utilised by year end.

6.4 A summary at overall programme level, together with the outturn position is shown in Table 4 below:

Table 4: Capital Programme monitoring

Capital Programme 2024-2025	Plan £000	Revised Budget £000	YTD Plan £000	YTD Actual £000	Variance Act v plan YTD £000	Forecast Outturn £000	Variance Forecast v Revised Budget £000
Backlog Maintenance	**9,108**	**8,613**	**7,050**	**3,479**	**(3,570)**	**8,781**	**168**
Essential Facilities Improvement Wo	**1,450**	**1,622**	**1,064**	**1,239**	**175**	**1,990**	**368**
Service Redesign Enabling Works	**3,920**	**3,983**	**2,924**	**3,500**	**576**	**5,084**	**1,101**
Service Redesign Enabling Works -	**8,660**	**7,700**	**3,478**	**857**	**(2,621)**	**6,541**	**(1,159)**
Infrastructure	**906**	**906**	**295**	**15**	**(280)**	**762**	**(144)**
Rolling IT & Digital Development	**13,519**	**13,202**	**10,884**	**7,191**	**(3,693)**	**12,204**	**(998)**
Replacement Medical Equipment	**5,550**	**5,550**	**4,448**	**1,955**	**(2,494)**	**6,203**	**653**
Other	**410**	**530**	**375**	**313**	**(62)**	**542**	**12**
Total Internal Capital Envelope	**43,523**	**42,106**	**30,518**	**18,550**	**(11,968)**	**42,106**	**0**
Externally Funded Capital Schemes	**Plan £000**	**Revised Budget £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**	**Forecast Outturn £000**	**Variance Forecast v Revised Budget £000**
PDC STP 3 - MPH Surgical Centre	24,631	24,631	19,717	24,422	4,704	24,631	0
PDC NHP - MPH	900	1,040	743	857	113	1,040	0
PDC NHP Enabling	1,137	1,137	1,137	932	(205)	1,137	0
PDC Pathology Network	222	100	143	0	(143)	100	0
PDC Diagnostic Network	733	856	478	182	(296)	715	(141)
PDC Endoscopy - MPH	549	549	275	352	77	549	0
PDC Cyber Security	0	55	0	0	0	55	0
PFI Funded IFRIC 12 - SFT MES	424	876	318	876	558	876	0
Donated Acute MPH	50	56	41	56	15	56	0
PDC Tif - Elective Recovery/Theatre expans	4,076	4,076	2,795	3,626	831	4,076	0
PFI Funded IFRIC 12 - YDH MES	333	641	249	641	392	641	0
Donated Salix (Slippage)	0	1,777	0	336	336	1,777	0
Donated Acute YDH Breast Unit	1,000	1,285	887	1,264	377	1,285	0
Donated YDH	0	32	0	32	32	32	0
PDC Yeovil CDC	1,292	1,292	1,292	599	(693)	1,292	0
PDC Somerset CYP Safe Spaces	275	275	165	42	(123)	275	0
Donated Community	110	110	137	0	(137)	110	0
PDC Diagnostic Screening-Colposcopy	0	176	0	0	0	176	0
PDC Critical Infrastructure	0	1,456	0	4	4	1,456	0
PDC LED Lighting	0	160	0	0	0	160	0
Total Additional Schemes	**35,732**	**40,580**	**28,378**	**34,218**	**5,840**	**40,439**	**(141)**
IFRS Leases	14,523	14,523	14,016	5,754	(8,262)	14,523	0
TOTAL TRUST PROGRAMME	**93,778**	**97,209**	**72,912**	**58,522**	**(14,390)**	**97,068**	**(141)**

6.5 We are waiting for further clarity on how the costs incurred to develop the NHP scheme any wind down costs will be managed.

7. CONCLUSION AND RECOMMENDATION

7.1 We remain on track to deliver a balanced plan. There are a number of key actions we need to continue making progress on:-

- Clarification on how the impact of the delay to the Musgrove Park hospital redevelopment to wave 2 of the NHP programme will impact the financial performance of the Trust.

- Close the £1.4m CIP gap and support delivery of service group schemes in line with their forecasts.

- Identify further opportunities to mitigate ongoing cost pressures and mitigate any further unplanned risks.

- Review elective recovery performance forecast to determine any financial risk in terms of expected costs committed to deliver the expected level of performance.

- Manage the impact of winter pressures within the agreed funding envelope.

- Continue to focus on medical agency reduction and ensure our forecasts accurately and honestly reflect the expected run rate in the remaining months.

7.2 The Board are asked to discuss the financial performance for January 2025.

CHIEF FINANCE OFFICER

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Charity Committee meeting held on 24 January 2024
SPONSORING EXEC:	Director of Strategy and Digital Development
REPORT BY:	Katie Fry, Executive PA
PRESENTED BY:	Graham Hughes, Chairman of the Charity Committee
DATE:	4 March 2025

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 Charity Committee meeting held on 24 January 2025. The Committee received assurance in relation to: • Terms of Reference • Cardiology Fund • SFT Key Financial Systems Report • Major Donation & Proposed Projects • Garden Update • Open Mental Health Proposal • Business cases 159, 176, 177, 179 and 180. The Committee will follow up progress on finalising the major donation allocation. The Committee did not identify any issues to be reported to the Board.
Recommendation	The Board is asked to note the assurance and areas for follow up identified by the Charity Committee.

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.

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE CHARITY COMMITTEE MEETING HELD ON 24 JANUARY 2025

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 24 January 2025, along with the assurance received by the Committee and any areas for follow up identified. The meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

Terms of Reference

2.1. The Committee reviewed the updated terms of reference. The committee discussed the changes and specifically identified the number of Non Executive Directors as an issue for ongoing quoracy. David Shannon agreed to update the Terms of reference and circulate to the committee.

Cardiology Fund

2.2. Mohammad Sahebjalal attended the meeting to present the Cardiology's departments intended use for their accrued funds. These included AV equipment for MDT meetings, a small ventilator, equipment for a new service which would reduce transfers to London and Bristol as well as cardiac monitors and blood gas machines.

2.3. If the proposed purchases/spend goes ahead, this will be approximately £150,000-200,000 in the next financial year.

2.4. Mohammad Sahebjalal will work with Nick Boatwright and James Kirton to progress and develop these business cases.

SFT Key Financial Systems Report

2.5. Pippa Moger presented the reported from BDO which included four recommendations:

- Timely "thank you" for Donations
- Donations and Acceptance
- Inactive Funds
- Management Response

2.6. James Kirton acknowledged the need for improvement regarding thank you communications and committed to monitor this going forward.

2.7. Nick Boatwright explained some inactive funds are restricted and he has contacted the Charities Commission for guidance. He will proceed with redesignated unspent research funds to make them available for small research grants.

Fundraising Report

2.8. £50,000 in donations for the Beacon Centre have been received.

2.9. £15,000 in donations have been received for Childrens' Services.

2.10. James Kirton confirmed the Breast Appeal has now been formally closed.

Major Donation and Proposed Projects

2.11. James Kirton has been working with Glastonbury Festival's donor team on how to use the £2,000,000 donation received. The festival's family have varied interests making it challenging to finalise decisions. The agreed projects include:

- Specialist Investigations Unit located in the new surgical centre.
- Refurbishing the St Andrews building at Wells Priory.
- Gardens and outdoor spaces, approximately £500,000 including specific gardens at Glastonbury, the Westminster Garden and the Holford Therapeutic Garden.
- Flexible Allocation.

Garden Update

2.12. James Kirton highlighted the frustration with underused outdoor spaces and the state of some areas. The Charities Committee will fund projects that are agreed suitable, with costed plans for maintenance.

External Charity Use of SFT Facilities

2.13. James Kirton will draft a memo to communicate the policy which states that external fundraisers cannot use any SFT estates for fundraising activities.

Open Mental Health Proposal

2.14. The Open Mental Health proposal is making grants of up to £10,000 available through Open Mental Health to help keep people out of hospital.

2.15. James Kirton committed to circulating guidance that outlines the grant criteria.

Finance Reports and Approvals

2.16. Nick Boatwright highlighted the Breast Appeal Fund and Unspent Research Funds as inactive.

2.17. Nick Boatwright will proceed making the unspent research funds available for small research grants.

2.18. The following business cases were ratified:

- Improvements to the HC Cancer Fund at Saint Margaret's Hospice.
- Purchase of equipment for the cardiology department.
- Improvements to the oncology unit at Saint Margaret's Hospice.
- Funding for the relatives' room for stroke patients.
- Purchase of a blood gas machine for the cardiology department.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. There were no areas of concern or follow up.

4. AREAS TO BE REPORTED TO THE BOARD OR OTHER COMMITTEES

4.1 The Committee did not identify any issues to be reported to the Board.

Graham Hughes
CHAIRMAN OF THE CHARITY COMMITTEE