NHS Somerset NHS Foundation Trust

# SOMERSET NHS FOUNDATION TRUST
# PUBLIC BOARD MEETING

A Public meeting of the Somerset NHS Foundation Trust Board will be held on **Tuesday 4 February 2025** at **9.00am** at South Petherton Community Hospital, Bernard Way, South Petherton TA13 5EF.

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** | | Chairman | 09:00 | Verbal |
| | | | | | |
| 2. | **Questions from Members of the Public and Governors** | | Chairman | | Verbal |
| | | | | | |
| 3. | **Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 5 November 2024** | Approve | Chairman | | Enclosure 01 |
| | | | | | |
| 4. | **Action Logs and Matters Arising** | Review | Chairman | | Enclosure 02 |
| | | | | | |
| 5. | **Registers of Directors' Interests and Receive any Declarations of Interests relating to items on the Agenda** | Note and Receive | Chairman | | Enclosure 03 |
| | | | | | |
| 6. | **Chairman's Remarks** | Note | Chairman | 09.10 | Verbal |
| | | | | | |
| 7. | **Chief Executive and Executive Directors' Report** | Receive | Peter Lewis | 09:20 | Enclosure 04 |
| | | | | | |
| **ALL OBJECTIVES** | | | | | |
| | | | | | |
| 8. | **2024/25 updated Q3 Board Assurance Framework and Corporate Risk Register Report** | Receive | Jade Renville<br>Peter Lewis | 9.30 | Enclosure 05<br>Enclosure 06 |
| | | | | | |
| **OBJECTIVE 2 – Provide the best care and support to people** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| **9.** | **Quality and Performance Exception Report** | Receive | Pippa Moger | 9.50 | Enclosure 07 |
| | | | | | |
| **10.** | **Quality Strategy** | Approve | Hayley Peters/ Melanie Iles | 10.10 | Enclosure 08 |
| | | | | | |
| **11.** | **Assurance Report of the Quality and Governance Assurance Committee meetings held on:**<br>• **30 October 2024**<br>• **27 November 2024**<br>• **18 December 2024** | Receive | Inga Kennedy | 10.25 | Enclosure 09<br>Enclosure 10<br>Enclosure 11 |
| | | | | | |
| **12.** | **New Hospital Programme Review** | Receive | David Shannon | 10.35 | Enclosure 12 |
| | | | | | |
| **Coffee Break - 10.50** | | | | | |
| | | | | | |
| **OBJECTIVE 6 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture** | | | | | |
| | | | | | |
| **13.** | **Guardian of Safe Working for Postgraduate Doctors Reports** | Receive | Melanie Iles | 11.05 | Enclosure 13 |
| | | | | | |
| **14.** | **Assurance Report of the People Committee meeting held on:**<br>**4 December 2024**<br>**14 January 2025** | Receive | Graham Hughes | 11.15 | Enclosure 14<br>Enclosure 15 |
| | | | | | |
| **OBJECTIVE 4 – Reducing Inequalities** | | | | | |
| | | | | | |
| **15.** | **Assurance Report from the Mental Health Legislation Committee meeting held on 10 December 2024** | Receive | Ben Edgar-Attwell | 11.20 | Enclosure 16 |
| | | | | | |
| **OBJECTIVE 7: To live within our means and use our resources wisely** | | | | | |
| | | | | | |
| **16.** | **Finance Report** | Receive | Pippa Moger | 11.25 | Enclosure 17 |
| | | | | | |
| **17.** | **Verbal report from the Finance Committee meeting held on 27 January 2025** | Receive | Martyn Scrivens | 11.45 | Verbal |
| | | | | | |
| **18.** | **Assurance Report from the Audit Committee meeting held on 15 January 2025** | Receive | Paul Mapson | 11.50 | Enclosure 18 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **19.** | **Assurance Report from the Charitable Funds Committee meeting held on 21 October 2024** | Receive | Graham Hughes | 11.55 | Enclosure 19 |
| | | | | | |
| **FOR INFORMATION** | | | | | |
| | | | | | |
| **20.** | **Follow up questions from the Public and Governors** | | Chairman | | Verbal |
| | | | | | |
| **21.** | **Any other Business** | | All | | Verbal |
| | | | | | |
| **22.** | **Risks Identified** | | All | | Verbal |
| | | | | | |
| **23.** | **Evaluation of the Effectiveness of the Meeting** | | Chairman | | Verbal |
| | | | | | |
| **24.** | **Items to be discussed at the Confidential Board Meetings**<br>The items presented to the Confidential Board include: colleague suspensions and exclusions; progress reports from Symphony Healthcare Services and Simply Serve Limited; the MARS scheme; planning 2025/26 update; minutes from the October, November 2024 and 3 January 2025 Finance Committee meetings. | | | | |
| | | | | | |
| **25.** | **Withdrawal of Press and Public**<br>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. | | | | |
| | | | | | |
| **26.** | **Date of Next Meeting**<br>Tuesday 4 March 2025 | | | 12.10 | |
| | | | | | |

PUBLIC BOARD MEETING

# MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 5 NOVEMBER 2024 AT FROME COMMUNITY HOSPITAL, ENOS WAY, FROME BA11 2FH

## PRESENT

| | |
|---|---|
| Colin Drummond | Chairman |
| Alexander Priest | Non-Executive Director |
| Jan Hull | Non-Executive Director |
| Kate Fallon | Non-Executive Director |
| Graham Hughes | Non-Executive Director |
| Martyn Scrivens | Non-Executive Director (from item 11) |
| Inga Kennedy | Non-Executive Director |
| Tina Oakley | Non-Executive Director (from item 6) |
| | |
| 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

| | |
|---|---|
| Ben Edgar-Attwell | Deputy Director of Corporate Services |
| Fiona Reid | Director of Communications |
| Charlie Davis | Associate Medical Director, Neighbourhood Service Group, Palliative Medicine Consultant |
| Caroline Sealey | Freedom to Speak Up Guardian (for item 13 only – by Teams) |
| Victoria Bull | Community Rehabilitation Service (CRS) team manager (for item 17 only) |
| Gillian Cook | Neighbourhood Service Lead (Mendip) (for item 17 only) |
| Mr and Mrs S | (for item 17 only) |
| Paul Foster | Consultant Urologist/Clinical Director (for item 15 to item 21) |
| Dr James Sidney | Consultant Anaesthetist and Clinical Lead for Organ donation (for item 20 only – via Teams) |
| Jane Yeandle | Mental Health and Learning Disabilities Service Group Director (for item 23 only – via Teams) |
| Dr Andreas Papadopoulos | Associate Medical Director, Mental Health and Learning Disabilities (for item 23 only – via Teams) |
| Ria Zandvliet | Secretary to the Trust |

## 1. WELCOME AND APOLOGIES FOR ABSENCE

1.1. The Chairman welcomed all Board members and attendees to the Board meeting and confirmed that the meeting was quorate. The Chairman welcomed Charlie Davis to the meeting and advised that he will be observing the meeting as part of his personal development programme.

1.2. It was noted that apologies had been received from Paul Mapson (Non-Executive Director).

## 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 3 SEPTEMBER 2024

3.1. Jan Hull proposed, Kate Fallon seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 3 September 2024.

## 4. ACTION LOGS AND MATTERS ARISING

4.1. The Board received the action log and noted that the review of assurance processes has been included on the Board development day forward programme. The Board further noted that the remaining actions had been completed.

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 Chairman advised that he had met with Baroness Merron, Parliamentary Under-Secretary of State at the Department of Health and Social Care, who was interested in hearing about the trust's mental health services and mental health service developments.

6.2. The Chairman advised that the Chief Executive and he had met with local MPs and the key discussion focussed on the New Hospital Programme and the need for

capital investment to improve the old estate at Musgrove Park Hospital. The need for funding was recognised by the MPs and particularly by the MP for Taunton.

Tina Oakley joined the meeting.

## 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 appointment of Dr Rima Makarem as the new Chair for the Trust; the opening of the Maple Unit (Breast Cancer Unit) on the Yeovil District Hospital site; the launch of the Department of Health and Social Care and NHS England's engagement exercise to harness views to inform a ten year health plan; the publication of the sexual safety framework; and the national award for Vicky Bull for her work to reduce falls.

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

- The Breast Cancer Unit had been opened following a five year fundraising campaign by the trust's charity and, on behalf of the Board, the Chief Executive thanked the local community for their contributions and commitment to the new Breast Cancer Unit.

- The staff survey had identified that 1 in 26 colleagues experienced inappropriate sexual behaviour in the work place and the sexual safety framework was welcomed.

- Vicky Bull's work in relation in the reduction in falls had been carried out jointly with a geriatrician at the Royal United Hospital in Bath (RUH) and the Board congratulated Vicky on this achievement. Consideration will need to be given how to roll this work out to other areas within Somerset. In response to a concern raised about the focus of the falls work on RUH, the Chief Executive advised that the RUH provided acute and inpatient services for the population of Mendip. Community services in Mendip were, however, provided by the trust. He felt that the focus should be on the needs of the local population rather than on which trust provides care.

- Change NHS: helping shape a health service fit for the future - It was suggested that community mental health services will need to be used to their full potential and that mental health and community services should have a higher focus as the current focus was very much on acute services. Governors were not aware of all services delivered by the trust and this would also be the view of the general public. The overarching focus should be on population health and providing an overview of services, including preventative services, on the basis of a patient's life journey and personalised care will be helpful for patients. The Chief Executive advised that this information, and links to the trust's aims and objectives, was currently being produced. The trust's objectives included "improve the health and wellbeing of the population", "reduce inequalities" and "respond well to complex needs",

which covered a wide range of services and were focussed on personalised care. It was noted that the reference to personalised care will be changed to person centred care which was felt to be more appropriate.

Moving care to the community was not a new strategic concept and, as an integrated trust, the trust had the opportunity to bring this to life and develop and communicate clear outcomes. The communications in relation to the establishment of the Exmoor health hub had been excellent and the same approach could be used to bring other development and services to the forefront.

## 8. CONSTITUTION AND STANDING ORDERS REVIEW

8.1. The Secretary to the Trust presented the report which was received by the Trust. The Secretary to the Trust set out the proposed changes in relation to the Non Executive Director appointment process and the disqualification criteria for staff governors.

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

- The additional disqualification criteria related to the suspension of a staff governor from their governor role whilst being suspended from their employment pending the outcome of an investigation. It was highlighted that the suspension of a colleague was a mutual, and not a punitive, act with the aim to protect the colleague during the investigation.

  It was acknowledged that the role of the staff governor was linked to their main role, e.g. staff governors were elected by staff members based on their main role. The suspension did not indicate pre-empting the outcome of the investigation but it was good governance practice to align the suspension of their main role with the suspension of their staff governor role until the investigation has been concluded.

8.3. Melanie Iles proposed, Graham Hughes seconded and the Board approved the proposed changes as set out in the report. It was noted that the proposed changes will be presented for approval to the December 2024 Council of Governors meeting.

## 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.

9.2. The key areas where performance had been sustained or notably improved related to: CAMHS eating disorder services; access to perinatal services; the number of patients waiting 52 weeks or more from referral to acute treatment; and the number of patients followed up within 72 hours of discharge from an adult mental health ward.

9.3. The key areas of under-performance against targets and areas of concern related to: no criteria to reside within acute beds which continued to impact on patient flow; the percentage of people waiting under six weeks for a diagnostic test; the percentage of ambulance handovers completed within 30 minutes of arrival at the Emergency Departments; the number of patients waiting 18 weeks or more for a community service; and the number of patients waiting 18 weeks or more to be seen by the community dental service.

9.4. The Chief Finance Officer commented that a discussion took place at the September 2024 Board meeting about pressure ulcer reporting and advised that it had been agreed with the Head of Tissue Viability to undertake a deep dive into performance on a quarterly basis. There was a time lag in data reporting and, as performance at Musgrove Park Hospital met the exception criteria, performance information, including areas of improvement work, had been included in the report.

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

- 247 patients were waiting over 65 weeks at the end of September 2024 and the target date for treating these patients had been revised to 22 December 2024. Alternative options, including patient choice and treatment outside of Somerset, were being considered, specifically for trauma and orthopaedic services.

- It was queried whether urgent treatment centre performance will positively impact on the overall four hour emergency department (ED) target. The Chief Executive advised that a higher performance in urgent treatment centres will impact on the overall performance but that ED and urgent treatment centres (UTCs) performance was also reported separately. The Chief Executive highlighted that the use of UTC performance data, alongside ED performance data, was common in most trusts in urban and rural areas.

  The Chief Executive advised that performance clearly showed the challenge faced by EDs and that the focus will remain on improving ED performance. The Chief Executive highlighted: the review of the medical admission pathway to ensure that the pathway was as effective as possible; the impact of the patient flow challenges on discharge flows, and consequently on ED performance; the establishment of an urgent treatment centre in both acute hospitals with the urgent treatment centre in Yeovil District Hospital (YDH) expected to be in place soon; and the expected completion of the diagnostic centre at Yeovil District Hospital (YDH) in February 2025.

- It was queried whether there was a relationship between the delayed transfers of care and the increase in the number of pressure ulcers. It was noted that there was no evidence of a statistical correlation.

- The length of time between a patient being declared medically fit and being discharged varied from days to months. The barriers to discharge also varied and reporting the exact reasons for each delay was difficult as the reasons could vary depending on the stage of the patient's discharge journey. It was

noted that the majority of patients were currently delayed on a pathway 1 (discharged to their home with reablement support) and that conversations were taking place with Somerset Council about additional capacity. The Chief Executive advised that the quality of pathway 1 reablement support varied across the county and that it will be important to ensure a consistent high quality service across the county.

The Chief Executive further highlighted the challenges in relation to pathway 3 patients (patients requiring long-term residential or nursing home care) and the lack of clarity about the process managing patients on this pathway. The Chief Executive set out the changes to pathway 3 which were aimed at reducing the need for moving patients following the completion of their pathway 3 intervention and requiring ongoing long term care. It was noted that over 70 patients with no criteria to reside were waiting for a longer term care placement.

- The 62-day GP cancer standard performance showed a significant breach relating to urology services which was due to a surge in demand over the last few months. The Chief Operating Officer advised that recent media coverage had resulted in an increase in demand and actions being taken included: a redesign of the prostrate pathway; the development of a new urology strategy; and the development of a urology investigation unit. The Chief Medical Officer advised that demand in primary care services had also increased and that the impact on urology services and activity levels will be closely monitored.

- The number of medication incidents was shown as a total figure and it was noted that detailed site based information was presented to the Medication Management Group.

## 10. ASSURANCE REPORT OF THE PEOPLE COMMITTEE MEETING HELD ON 8 OCTOBER 2024

10.1. Tina Oakley, Chairman of the People Committee, presented the report which was received by the Board. She highlighted the areas of assurance received and the areas of concern and follow up by the Committee.

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

- An update on the work taking place within people services to be provided to a future Board Development Day.

- The development of an assurance dashboard that identifies actions/ accountabilities/dates and RAG status.

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

- Inclusion was a key area of focus and an inclusion progress report will be presented to the February 2025 Board meeting. The Chief of People

and Organisational Development advised that the significant work taking place was not reflected in improved inclusion indicators and it was, therefore, difficult to know what difference this work had made.

The Board agreed that inclusion was the responsibility of everyone and that everyone had the right to be treated in an inclusive way.

There had a high focus on inclusion in respect of colleagues and work was now also taking place in relation to patient and the wider population and a report will be presented to a future Board meeting.

- The statistics included in the national sexual safety report were concerning and it was queried how the Board could be assured that the trust was doing everything it can to ensure that all colleagues felt safe. The Chief of People and Organisational Development advised that the national staff survey included two specific questions about sexual safety and the trust scored well in these questions - under the national average. However, in spite of these scores, it was known that there were specific areas of concern and these were being addressed. The assurance process will need to be strengthened as currently concerns were raised in a number of different ways and not all concerns may be captured. Consideration was being given to the reporting of sexual safety issues, taking account of recently published national guidance, and it was noted that an update will be presented to a future People Committee meeting.

- The issues raised were linked to culture and it was felt that culture was not discussed sufficiently at Board level. It was noted that culture had not been discussed at Board level for some time and the Chief Executive agreed that it will be helpful to have a discussion at a future Board meeting or development day.

- Considerable work was taking place to ensure that leaders felt confident and assertive and this included assuring leaders that the trust will support them in taking required actions. The Chief Operating Officer commented that the NHS is uniquely under the microscope and unanimously surveyed and any issues identified will be followed up. It will be important to be clear with leaders about their accountability and responsibility in terms of culture.

- Assurance was provided that cultural issues were being identified; that actions, including disciplinary actions, were being taken; and that changes had been made as a result.

10.4. The Board thanked the Committee for its hard work.

## 11. GUARDIAN OF SAFE WORKING FOR POSTGRADUATE DOCTORS REPORT

11.1. 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.

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

- The large increase in the number of exception reports generated at YDH.
- The lower number of exception reports compared to historical averages at MPH.
- 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. It is noted that the reporting system at YDH was replaced with a spreadsheet based system until the new e-rostering will be functional and that the exception reporting sign off difficulties are being further explored.

Martyn Scrivens joined the meeting.

- The report had been presented to the Operational Leadership Group meeting by Tom Rees and no concerns about the level of reporting had been raised. It was noted that focussed sessions on exception reporting had been held which may have resulted in increased reporting. A further factor which may have impacted is the reconfiguration of wards during this reporting period. Service groups have been asked to look into the reporting levels in more detail and reporting levels will kept under close review.

11.3. The Board thanked the team for their excellent work.

## 12. GMC NATIONAL TRAINEE SURVEY RESULTS

12.1. The Chief Medical Officer presented the report which was received by the Board. It was noted that the report had been discussed at the October 2024 People Committee meeting. The Board noted the findings of the survey; the key strengths; the actions taken so far; and progress made.

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

- That the findings had not highlighted any concerns of which the trust was not aware and which were not already being explored. The findings had also highlighted areas of improvement
- The need to progress the integrated model of care and leadership structure across the organisation to be able to fully address the issues raised, particularly at Yeovil District Hospital (YDH) as it was recognised that these issues cannot be addressed by YDH colleagues in isolation.
- That the Directors of Medical Education provided good leadership and had played a major role in improving the paediatric service survey findings.

- That specialty tutors had been asked to review their findings and produce an action plan.

- The need to triangulate learner experience with other metrics so that this source of evidence and feedback can be used to its full potential.

- The need for a focus by both YDH and MPH colleagues on moving to an integrated model of care to address the inequalities and experiences across both acute sites.

- The link to culture and the need to focus on developing a positive culture across both acute sites.

12.3. The Board thanked the Chief Medical Officer for the report.

## 13. FREEDOM TO SPEAK UP SIX MONTHLY GUARDIAN REPORT

13.1. Caroline Sealey presented the report which was received by the Board. Caroline Sealey particularly highlighted*:* the increase in the number of Freedom to Speak Up cases received by the National Freedom to Speak Up Guardian office; the review to be undertaken to understand the speak up experience of international colleagues; the significant increase in the number of cases received by the trust; the number of concerns containing an element of patient safety/quality, worker safety and wellbeing, inappropriate attitudes/behaviours or bullying and harassment; the key themes; the breakdown of the themes as well as the breakdown of staff groups reporting; the excellent compliance with the Freedom to Speak Up mandatory training module; the learning identified and the actions being taken.

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

- The key themes related to: behaviours, poor leadership, communication and wellbeing.

- The report was excellent and Caroline Sealey was congratulated on her hard work and on the continued development of the report and data.

- It was queried whether triangulation, e.g. with the culture strategy work and the work of the networks, was taking place and whether triangulation was making a difference in terms of patient and colleague experience and quality of care. The Chief Executive advised that triangulation was taking place and that data and information was received from different sources and discussed at regular meetings with the Freedom to Speak Up Guardians and members of the executive team. Generally, the issues brought up by the Freedom to Speak Up Guardians were similar to the issues known to the executive team. The Chief Executive advised that understanding patient and colleague experience should be an essential part of performance reporting, alongside quantitative data and, although reporting had improved, a more structured approach will be required. Areas of good practice and lessons learned had been identified from the North Cumbria Integrated Care NHS

Foundation Trust and these will be followed up to ensure a more integrated and structured approach.

- The Quality and Governance Assurance Committee had recently received an update from the neighbourhood service group and this had highlighted a high number of freedom to speak up cases within this service group. Caroline Sealey advised that all cases have to be reported as individual cases and, if a group of five colleagues report a common concern, this will need to be counted as five individual cases. The high number of cases were mainly due to one particular concern raised by a number of colleagues. The service group leadership was aware of the concern which was being addressed.

- The culture strategy group received a large amount of data and the volume of the data was challenging. Good progress was however being made in relation to the triangulation of colleague experience data. The Chief of People and Organisational Development confirmed that none of the data presented to, and discussed by, the group had come as a surprise.

- A leadership behavioural framework had been developed and will be integrated into the leadership programme from January 2025.

- The report included feedback that policies and processes were not always clear. The Chief of People and Organisational Development advised that policies were still being integrated following the merger but, whilst the day to day arrangements in the legacy policies may be different, the legislation on which the policies were based was clear. The differences created challenges and managers had a level of discretion in terms of managing these challenges based on their knowledge and understanding of their team members and this was part of good management and leadership skills.

13.3. The Board thanked Caroline Sealey for the excellent report.

## 14. WELLBEING GUARDIAN SIX MONTHLY REPORT

14.1. Graham Hughes, Non-Executive Director wellbeing champion, presented the report which was received by the Board. He particularly highlighted:

- The full wellbeing presentation to the People Committee meeting held on 8 October 2024 and the key focus of the presentation on compliance with Care Quality Commission quality statements relevant to wellbeing.

- The new occupational health support arrangements and the commitment by the new provider to significantly reduce the sickness absence rate and the length of sickness absences.

- The MSK challenges and the need to allow colleagues to take breaks when taking part in extended Teams or other meetings.

- The risks in relation to the funding of the Physio4U service and the additional costs for occupational health services.

- The future work.

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

- The wellbeing team were doing excellent work and their support made a significant difference to colleague.

- The demand for the service exceeded capacity and it was important to be clear with colleagues what support could and could not be provided. It was noted that a waiting list had to be set up for colleagues to access this service.

- A steering group was launching a campaign “green time before screen time” to remind colleagues of the need to take breaks during the day and during meetings. In addition, the campaign will remind colleagues to consider the length of meetings – do meetings have to be a standard 60 minutes or could they be shorter? The Chief Operating Officer stressed the need for Board members to set the example and accommodate breaks and flexibility in terms of Teams meeting behaviours, e.g moving around during the meeting, length of meetings, use of the camera, etc.

- The lack of space for 1:1 meetings impacted on the ability to have quality conversations.

- Physio4U acted as a fast track service for colleagues with MSK issues but the Physio4U service was overprescribed. As MSK was the top reason for sickness absence, this will remain a key area of focus.

- In terms of the “green time before screen time” initiative, it will be important to encourage colleagues to be as active as possible and consideration will need to be given as to opportunities for earlier intervention and the use of Youtube exercise videos.

- The financial wellbeing risks were highlighted and it was queried whether there was sufficient evidence of the benefits of the wellbeing services. The Chief of People and Organisational Development advised that the occupational health provider expected savings to be achieved as a result of a reduction in the sickness absence rate and length of sickness absence. If achieved, this will deliver a financial benefit but it will also benefit colleagues. Funding will continue to be a challenge in view of the demand on services. Personal self care will continue to be a key area of focus and data will need to be reviewed on an ongoing basis. She further advised the pressures to deliver level 5 specialist support and the need to consider whether more support will need to be provided.

14.3. The Board thanked Graham Hughes, the Chief of People and Organisational Development, and the wellbeing team for their excellent work.

## 15. MEDICAL APPRAISAL AND REVALIDATION ANNUAL REPORT

15.1. The Chairman advised that, due to the submission deadline of 31 October 2024, electronic Board approval was sought and obtained.

15.2. Kate Fallon proposed, Jan Hull seconded and the Board ratified the electronic approval of the recommendation to support the content of the report and to receive assurance that due diligence is being paid to the medical appraisal and revalidation processes.

15.3. Paul Foster joined the meeting.

## 17. PATIENT STORY – "PERSONALISED CARE AND SUPPORT FROM THE COMMUNITY REHABILITATION SERVICE

17.1. This item was moved forward on the agenda.

17.2. Vicky Bull, Gillian Cook, and Mr and Mrs S joined the meeting for this agenda item.

17.3. Vicky Bull advised that the patient story will show how, through a personalised care approach, Mr and Mrs S have been enabled to improve their independence at home and take control of their own health. Vicky Bull advised that Mrs S had been referred to the team by her GP following a fall and admission to Royal United Hospital Bath (RUH) and Frome community hospital. Mrs S had reduced mobility, a lack of confidence, and a fear of falling resulting in Mrs S becoming isolated in her home with a further deterioration of her mobility and independence.

17.4. Vicky Bull set out the care provided to Mrs S: a full occupational therapy assessment at home which embraced the principles of personalised care by supporting Mrs S with priorities that were important to her: improving her confidence; being able to carry out tasks in her kitchen, accessing the bathroom and going upstairs. In addition, Mrs S was also referred to the falls and frailty clinic to review the reasons for her falls and medication and Mr and Mrs S felt that the support from the clinic and the team had been very beneficial.

17.5. Vicky Bull further highlighted the referral of Mr S to the team following a review by a Parkinson's Nurse due to him becoming more unsteady. Mr S was assessed at home and attended the Balance Safety Group for an eight week therapy programme. Following the completion of the eight week programme, Mrs S was also invited to attend the Group and Mr and Mrs S attended the exercise element of this group together. In addition, a full fire safety review of their home was commissioned and Mr S was looking into other exercise classes in the area. As a result of the personalised care approach, Mr and Mrs S were now able to support one another with their home exercise program. Their confidence had improved, and they were now able to go shopping together, and Mrs S could now access upstairs safely. Her confidence has increased significantly over the last few months.

17.6. Mrs S set out her story and advised that she fell in her kitchen two years ago and was admitted to RUH following a long lie and fractured hip. She advised that she did

not enjoy her stay at the RUH – she experienced rudeness by patients to staff; staff were not around when needed; other patients were looking out for her to ensure her safety when getting out of bed; physio therapy was not available in the weekends; and generally she felt that there was no motivation to get her walking again so that she could go home. Mrs S advised that she had to be readmitted to hospital after one week at home, but this time she was admitted to Frome community hospital. Mrs S advised that her experience at the community hospital was very different and that she received excellent care.

17.7. Mr S advised that the team was able to advise on the support available and the wide range of services available was excellent. Mr S felt that the availability of these services should be publicised more. Mr S set out his medical background and advised that the eight week therapy programme, including educational talks, had been excellent and covered: personal allowance; information on fire safety and a fire safety check; information on how to get up after a fall at home; and information on trip risks. He advised that, overall, there were more positive than negative stories to tell about the NHS. Mr S's recommended the re-introduction of matrons; improvements in technology; and the need to move services back into the community with only complex issues to be dealt with in acute services.

17.8. The Board discussed the story and commented/noted that:

- Vicky Bull was congratulated on her award for her work to reduce falls.
- The reference to the need to publicise the range of community services was helpful.
- It was queried whether the balance safety classes were unique to Frome and, if so, whether this could be rolled out across the county. Vicky Bull advised that balance classes were available across Somerset (excluding Taunton, Burnham and Bridgwater). The classes were stopped during Covid and subsequently reinstated in the majority of teams but at different levels. Vicky Bull advised that the falls and frailty clinic with support from geriatricians was unique for the Mendip area. A clinic had been set up in Frome and in Shepton Mallet with the involvement of a geriatrician from the RUH and a clinic was being set up in Yeovil with the involvement of a YDH consultant. Vicky Bull advised that the CRS team would be keen to be involved in rolling the clinics out across Somerset, but the clinic will need to have sign up from acute, community and primary care services.
- Mrs S's experience of RUH was disappointing and the Chief Nurse was confident that the Chief Nurse at RUH would be interested in hearing the story and feedback from Mrs S. The Chief Nurse will follow this up with Vicky Bull.
- Referral into the service was through self referrals from patients, referral from GPs, other health professionals or carers and the team would visit the patient to assess their needs and either develop a personalised care plan or refer the patient to the most appropriate service to support them.

- The story was linked to other issues discussed at today's Board meeting, e.g. Lord Darzi's diagnosis of the NHS, digital development, a shift from hospital to community services, prevention of falls and the heart monitor arrangements. These issues, as well as personalised care, were key areas of focus for the Board. In terms of the reference to physiotherapy services not working seven days a week, although not all services could be provided seven days a week, it was unacceptable to be admitted to a hospital bed and not receiving any physiotherapy services over the weekend. It was highlighted that physiotherapy should not just be the role of physiotherapists and ward staff should also be encouraging patients to exercise, especially over the weekend.

- The story had been enlightening for all Board members.

17.9. The Chairman thanked Vicky Bull, Gillian Cook for their excellent work. The Chairman further thanked Mr and Mrs S for attending the meeting to share their story.

## 16. STAFFING ESTABLISHMENT SIX MONTHLY REPORT

16.1. The Chief Nurse presented the report which was received by the Board. The Chief Nurse particularly highlighted: the inclusion of the first dataset showing performance against a range of measures; the key areas to note; the update in relation to the bed and staffing reconfiguration; and the safer nursing care tool.

16.2. The Board discussed the report and noted:

- The two wards at Yeovil District Hospital (YDH) with a lower nurse to patient ratio at night compared to national benchmarking and the interim actions taken to improve the nurse to patient ratio.

- The significant investment to increase staffing levels and the need to further review staffing levels to understand the reasons for the remaining gap in staffing levels.

- The lower ratio of unregistered colleagues at night on the Portman Ward and the mitigating actions taken.

- That the maternity staffing levels had not been included in the report as the findings of the Birth Rate Plus and external assessment were still awaited. A separate report will be presented to the Quality and Governance Assurance Committee and to the February 2025 Board meeting.

- That, although the report referred to staffing increases, previous reviews have also included a reduction in establishments. The suggested increases were a reflection of an increase in the acuity of patients and dependency. The Chief Nurse advised that service groups were becoming more agile in moving resources around and an increase in staffing establishment was only suggested if all other options had been considered.

- That the final version of the maternity report will be presented to the Quality and Governance Assurance Committee and to the Board.

16.3. The Board thanked the Chief Nurse for the report and accepted the recommendations as set out in the report.

## 18. ASSURANCE REPORT OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING HELD ON 25 SEPTEMBER 2024

18.1. Jan Hull, Quality and Governance Assurance Committee Chair for the September 2024 meeting, presented the report which was received by the Board. She highlighted the areas of assurance received and the areas of concern and follow up by the Committee.

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

- The Maternity and Perinatal Incentive Scheme (MPIS) – risks of non-compliance.
- The Fractured Neck of Femur concerns.
- The findings from the GMC survey.
- Progress in relation to the Hospital@Home programme.
- The impact from the Building Safety Regulations.
- The positive assurance provided by the Service Group Assurance report.
- The positive assurance in relation to the Patient Safety Board report.

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

- The Hospital@Home service was currently under-used but it was expected that the number of referrals into the programme will increase following the establishment of a new Care Co-ordination Hub in the next few weeks. This hub linked different community services, including the 111 service, Hospital@Home and the South West Ambulance Trust together. In addition, the trust was now also able to pull suitable patients from the ambulance waiting stack and treat these patients in community services.
- The establishment of the new Care Co-ordination Hub was welcomed and long awaited.
- The aim was for Hospital@Home to focus largely on admission prevention and the patient story was a good example of patients who could benefit from this service but a cultural change will be required. It was queried whether sufficient discussions were taking place with clinicians to give them ownership

of this agenda. The Chief Medical Officer confirmed that clinicians were keen to be involved in looking at different ways of working.

18.4. Inga Kennedy provided feedback from the meeting held on 30 October 2024 and advised that the meeting had focussed on strategic objective 2 “provide the best care and support to people” and had covered the following agenda items: a presentation on the quality strategy and quality priorities; the report on the Nottingham Healthcare CQC findings; a progress report on policies and procedures; the Learning from Deaths quarterly report; and a maternity services progress report.

18.5. The Board thanked the Committee for its hard work.

## 19. ASSURANCE REPORT OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING HELD ON 4 OCTOBER 2024

19.1. Inga Kennedy, Chair of the Quality and Governance Assurance Committee, presented the report which was received by the Board. She advised that the report set out the assurance received in relation to: Safeguarding Adults; Safeguarding Unborn Babies and Children; Emergency Planning, Response and Resilience (EPRR); Patient Experience (including Complaints and PALS); Infection Prevention and Control; Information Governance; and Health and Safety.

19.2. Inga Kennedy advised that the annual reports demonstrated high levels of assurance for the trust across the following key statutory and regulatory areas: Safeguarding Adults; Safeguarding Unborn Babies and Children; Emergency Planning, Response and Resilience (EPRR); Patient Experience (including Complaints and PALS); Infection Prevention and Control; Information Governance; and Health and Safety.

19.3. Inga Kennedy set out the key highlights from the reports: good examples of integration; concerns about capacity in relatively small teams working across the trust; the ongoing development of the devolved governance arrangements; the need for further improvements to the consistency of approach across the different parts of the organisation; the continued impact and risk of multiple digital systems; and the need to improve patient and carer engagement in governance processes. She advised that the reports provided clear evidence of a key focus on quality improvement.

19.4. The Board thanked the Committee for the review of the annual reports and thanked all relevant teams for producing the reports and for their excellent work.

## 20. REPORT FROM THE ORGAN AND TISSUE DONATION COMMITTEE

20.1. James Sidney joined the meeting via Teams.

20.2. Jan Hull, Non-Executive Director lead for Organ Donation, advised that organ donation reports had previously not been presented to the Board on a regular basis, and it was felt helpful to raise the Board’s awareness of the organ donation

work. She advised that she had been privileged to chair the Organ Donation Committee over the last six months. The report provided assurance to the Board regarding organ donation performance within the trust; confirmed the reporting arrangements for the trust's Organ and Tissue Committee; and aimed to raise awareness and visibility of organ donation activity within the trust.

20.3. James Sidney presented the report which was received by the Board. He highlighted the excellent performance of the trust, which is categorised as an 'Exceptional' performer by NHS Blood and Transplant. During 2023/24 100% of potential organ donors were referred, and the specialist nurse was present in 100% of discussions with families: these are the two key criteria.

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

- Going forward the Committee will report to the Quality and Governance Assurance Committee with feedback to be provided to the Board via the Committee's assurance report to the Board.

- Discussions in relation to the future chair of the Committee were ongoing.

- key priority for 2025 will be the development of an integrated Standard Operating Procedure and policy.

The Board accepted the recommendations as set out in the report and thanked Jan Hull and James Sidney for the excellent report.

## 21. LEARNING FROM DEATHS FRAMEWORK: MORTALITY REVIEW PROGRESS REPORT

21.1. Paul Foster joined the meeting for this agenda item.

21.2. Paul Foster presented the report and advised that the report demonstrated the processes for learning from deaths and how this learning was shared and improvements made within the trust. He highlighted the key findings of the reviews and learning and themes identified.

21.3. The Board received the report and the issues identified as part of the investigations, the lessons learned, areas of improvement and actions taken were noted. It was noted that the report had been reviewed by the Quality and Governance Assurance Committee.

21.4. The Board discussed the reports and commented/noted:

- The previous report referred to a number of GP practices not referring deaths to the Medical Examiner service and it was noted that the referral process was now mandated and that there was no evidence of non compliance with this mandatory requirement.

- It was queried whether the introduction of the Medical Examiners (ME) process had resulted in an increase in coroner activity. Paul Foster advised that there was no evidence of a link between the introduction of the ME process and coroner activity levels. He highlighted the impact of an increase in coroner activity levels on clinicians.

- The Summary Hospital-level Mortality Indicator (SHMI) data showed a higher number of excess deaths compared to the number of expected deaths and it was noted that this increase corresponded with a backlog of uncoded records due to capacity challenges within the team. A plan was in place to address this backlog but further increases were expected in the coming months. It was noted that this will continue to be closely monitored.

- All community deaths were now reviewed by the ME and lessons learned will be identified and shared as part of the learning from deaths process. The System Mortality Review Group will discuss the learning from primary care related deaths but it will be important to make this a shared learning process across the wider system.

- An audit on the number of patients who choose to die at home as part of their palliative care pathway was being carried out to determine to what extent these deaths impacted on overall figures. It was noted that the number of unexpected deaths at home had significantly reduced.

21.5. The Board thanked the team for their excellent work.

21.6. Paul Foister left the meeting.

## 22. ASSURANCE REPORT FROM THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON 17 SEPTEMBER 2024

22.1. Alexander Priest, Chairman of the Mental Health Act 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.

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

- Ensuring the right people are informed when patients are in seclusion.

- The number of CAMHS out of area patients is higher than usual.

- The CQC action report.

- The updated and agreed Terms of Reference.

- Complaints slightly higher than usual.

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

- In response to a question from governors about smoking by patients admitted to mental health wards, Alexander Priest advised that the profile of nicotine use generally was changing to vapes and the proposed changes to the sale of cigarettes to anyone under the age of 15 provided a health management opportunity for an important group of the population. There was still a focus on the implementation of smoke free programmes and the change over to vapes was being trialled in Ash and Willow Wards. If successful, the trial will be rolled out to other wards.

22.4. The Board thanked the Committee for its hard work and noted that Paul Mapson will be joining the Committee from its next meeting.

## 23. REVIEW OF MENTAL HEALTH SERVICES AGAINST CQC FINDINGS RELATING TO NOTTINGHAMSHIRE HEALTHCARE TRUST

23.1. Jane Yeandle and Dr Andreas Papadopoulos joined the meeting for this agenda item and presented the report which was received by the Board.

23.2. Jane Yeandle set out the background and advised that the Care Quality Commission (CQC) had recently completed a final review of Nottinghamshire HealthCare Foundation Trust's mental health services. NHS England required all mental health providers to report against the final review findings at respective public trust boards and the Trust has undertaken an assurance review exercise against the findings and recommendations set out in the CQC report. The results of that review have been discussed at the Quality and Governance Committee meeting held on 30 October 2024 and are set out in the report presented to the Board.

23.3. Andreas Papadopoulos and Jane Yeandle set out the high level positive findings, the areas for improvement and the next steps in taking forward the governance and oversight, clinical pathways and delivery, and resources and operating structures related recommendations.

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

- One of the victims, Barnaby Webber, was from Somerset and it was highlighted that the review should also look retrospectively and provide a gap analysis. Jane Yeandle advised that the review had been approached with authenticity and the review included colleagues involved in improvement work and an expert by experience whose family member was killed by a patient with severe mental health illness in London.

- Jane Yeandle and Andreas Papadopoulos were complimented on how they had approached the review and the transparency of the review. The Chief Medical Officer advised that, from a national Chief Medical Officers meeting, it appeared that the trust had been more proactive in this review and the approach taken than the majority of other organisations who were still considering their approach.

- One of the recommendations related to collecting data which was currently not being collected and it was queried how this data, once available, will be used. Jane Yeandle advised that the data will be used as part of the wider work within service groups, including looking at access to services, especially for patients in crisis, and seeking assurance that services were as user friendly as possible.

- The Section 117 After Care responsibility was a joint responsibility with the Local Authority and the Trust had been encouraging the Local Authority to agree a strategy and a policy and procedures for after care for some time. Work had further taken place to encourage the Local Authority to increase the level of after care provided and it was queried what further work can be undertaken to improve after care services. Andreas Papadopoulos advised that the funding arrangements created a divide in terms of which organisation was responsible and accountability for which aspects of after care services. It was critical to move beyond that divide and work more closely together in the benefit of the patient. He welcomed any support the Board could provide taking this forward with the Local Authority.

- It was expected that serious mental illness will be included in the ten year health plan to be published in the spring and, if so, this will be linked to funding and a focus on joined up health and local authority services.

- Severe mental illness practices had not been audited for some time and it was queried what would have prompted the trust to audit this at an earlier stage and whether there was a check list or dashboard to prompt clinical audits for particular group of patients. The Chief Nurse advised that this question had also been raised at the Quality and Governance Assurance Committee meeting and she was not confident that the annual audit programme was still as effective as in previous years and robust audit plans may not be available for all specialties.

  It was suggested that a number of audit programmes were stopped during Covid and the Committee has asked for assurance that the programmes have been fully reinstated and that areas for improvements have been identified. This will be followed up by the Quality and Governance Assurance Committee.

23.5. The Board accepted the recommendations set out in the report and thanked Jane Yeandle and Andreas Papadopoulos for the detailed and excellent review.

## 24. FINANCE REPORT

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

- The in-month surplus of £0.739 million which was £1.184 million favourable compared with the plan for the month.

- The year to date deficit of £12.601 million which was breakeven to the plan.

- The in-month agency expenditure of £2.110 million which was £0.888 million below the plan and £0.152 million above the cap.

- The in-month delivery of the cost improvement programme of £4.563 million which was consistent with the plan.

- The year to date delivery of £30 million capital expenditure against a plan of £33 million.

- The in-month workforce position – 95.06 WTE (whole time equivalent) under the workforce cap trajectory.

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

- Additional income had been received to compensate for the direct costs of the postgraduate doctors in training industrial action in June and July 2024 and a one off HMRC bank interest payment had been received to compensate for a HMRC delay in repayment of recovered VAT.

- The key risk to deliver the cost improvement programme related to elective recovery funding income. Although data was encouraging, more up to date and accurate data will be required to receive assurance that this risk will not materialise.

- The majority of pay awards had been enacted in month six and the remainder will be enacted in month seven. It was noted that funding was below the full pay award costs and that this shortfall will need to be managed.

- The impact of the increase in National Insurance contributions was not yet known and further details will need to be awaited. Historically National Insurance increases have been covered through budgetary increases but no assurance has been received in relation to the impact on primary care services and this will impact on Symphony Healthcare Services.

- The level of unidentified savings had reduced to £4.9 million and the main challenges identifying cost savings were in clinical support, cancer and estate services.

## 25. VERBAL REPORT FROM THE FINANCE COMMITTEE MEETING HELD ON 28 OCTOBER 2024

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

## 26. ASSURANCE REPORT FROM THE AUDIT COMMITTEE MEETING HELD ON 10 OCTOBER 2024

26.1. The Board received the report and noted the areas of assurance received and the areas of concern and follow up by the Committee.

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

- The findings of the frailty internal audit report (Executive and Operational Leadership Team).
- The work in progress with the CRR and BAF.
- The concern about third-party suppliers and the additional request for a review of third-party management.

26.3. The Board thanked the Committee for its hard work.

## 27. ASSURANCE REPORT FROM THE CHARITY COMMITTEE MEETING HELD ON 22 JULY 2024

27.1. 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.

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

27.3. Graham Hughes further provided feedback from the meeting held on 21 October 2024 and highlighted the key items covered:

- The Trustee's annual report and financial statements prepared in accordance with FRS 102 for the year ended 31st March 2024. It was noted that the accounts were the first full year accounts of the merged charity and Graham Hughes set out the income and expenses details.
- The investment update.
- The fundraising report.
- The major donations and proposed projects.
- The charity risk register.
- The finance reports and approvals.

27.4. The Board thanked the Committee for its hard work.

## 28. FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS

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

## 29. ANY OTHER BUSINESS

29.1. The Chairman advised that Kate Fallon will be leaving her Non-Executive Director role from 30 November 2024. He advised that Kate had been a Non-Executive Director of 9.5 years and her knowledge and experience, particularly in the NHS, will be missed. Kate Fallon commented that she was proud to have been associated with the trust (and legacy Taunton and Somerset NHS Foundation Trust) from day one of her joining. The trust had delivered significant achievements, including two mergers, and had a great and committed workforce with a high level of imagination and drive. Kate Fallon commented that she felt privileged to have been part of the trust's journey. The strength of the candidates who applied for the chair position showed how well regarded the trust is nationally.

## 30. RISKS IDENTIFIED

30.1. The Board did not identify any new risks which had not already been identified.

## 31. EVALUATION OF THE EFFECTIVENESS OF THE MEETING

31.1. The Board agreed that the meeting had been productive with a large number of items covered effectively, and detailed challenging. The patient story had been very good with lengthy discussions.

## 32. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

32.1. 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.

## 33. WITHDRAWAL OF PRESS AND PUBLIC

33.1. 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.

## 34. DATE FOR NEXT MEETING

34.1. 4 February 2025

**SOMERSET NHS FOUNDATION TRUST**

**ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETINGS**

**HELD ON 5 NOVEMBER 2024**

| AGENDA ITEM | ACTION | BY WHOM | DUE DATE | PROGRESS |
|---|---|---|---|---|
| No actions were identified at the meeting held on 5 November 2024 | | | | |

| 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 February 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 28 January 2025. |
| **Recommendation** | The Board is asked to:<br>• note the Register of Interests;<br>• declare any changes to the Register of Interests;<br>• 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**<br>**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.**<br><br>**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**<br><br>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**<br>(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**<br>Chairman | • Chair, Sue Ryder – non-remunerated<br>• Chair, Queen Square Enterprises – remunerated<br>• Lay member, General Pharmaceutical Council – remunerated<br>• Trustee, LifeArc – non-remunerated |
| **Jan Hull**<br>Non-Executive Director | • Trustee of the Dulverton Abbeyfield Society.<br>• Formerly Managing Director of South, Central and West Commissioning Support Unit |
| **Alexander Priest**<br>Non-Executive Director | • Chief Executive Mind in Somerset |
| **Martyn Scrivens**<br>Non-Executive Director<br>(Deputy Chairman) | • Non Executive Director and Chair of Audit Committee of Hampshire Trust Bank Limited<br>• Wife works as a Bank Vaccinator for the Trust<br>• Non-Executive Director and Chairman of Wesleyan Bank Limited, a 100% subsidiary of Hampshire Trust Bank Limited" (with effect from 28 February 2022)<br>▪ Member of the Boards of Directors of the Ardonagh Group – consisting of the following companies:<br>- Ardonagh Holdco Limited (Jersey)<br>- Ardonagh New Midco 1 Limited (Jersey)<br>- Ardonagh Group Holdings Limited (UK)<br>- Ardonagh New Midco 3 Limited (Jersey)<br>- Ardonagh Midco 1 Limited (Jersey)<br>- Ardonagh Midco 2 plc (UK)<br>- Ardonagh Midco 3 plc (UK)<br>- Ardonagh Finco plc (UK)<br>• Director of Ardonagh International Limited |
| **Graham Hughes**<br>Non-Executive Director | • Chairman of Simply Serve Limited<br>• Parish Councillor of Babcary Parish Council |
| **Paul Mapson**<br>Non-Executive Director | Nothing to declare. |
| **Inga Kennedy**<br>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)<br>• Isle of Wight NHS Trust - Position - Non-Executive Director (end of term is Mar 24) |
| **EXECUTIVE DIRECTORS** | |
| **Peter Lewis**<br>Chief Executive (CEO) | • Management Board Member, Somerset Estates Partnership (SEP) Board<br>• Director, Somerset Estates Partnership Project Co Limited |
| **Jade Renville** | • Executive Director of Corporate Services, Somerset ICB Board<br>• Chair, Richard Huish Multi-Academy Trust (voluntary capacity)<br>• Father is Director and owner of Renvilles Costs Lawyers |
| **Isobel Clements**<br>Chief of People and Organisational Development | • Sister in law works in the pharmacy department at MPH<br>• Nephew works as a physio assistant within MPH. |
| **Andy Heron**<br>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)<br>• Director of the Shepton Mallet Health Partnership<br>• Executive Director for SHS |
| **Pippa Moger**<br>Chief Finance Officer | • Stepdaughter works at Yeovil District Hospital<br>• Son works for the Trust<br>• Director of the Shepton Mallet Health Partnership<br>• Director of Somerset Estates Partnership Project Co Limited<br>• Member of the Southwest Pathology Services (SPS) Board<br>• Shareholder Director for SSL |
| **Hayley Peters**<br>Chief Nurse | None to declare |
| **David Shannon**<br>Director of Strategy and Digital Development | • Member of the Southwest Pathology Services (SPS) Board<br>• Daughter is employed as a healthcare assistant at Musgrove Park Hospital |

| | |
|---|---|
| | • Member of the Symphony Health Care Services (SHS) Board<br>• Director of Symphony Health Services (SHS)<br>• Wife works within the Neighbourhood's Directorate.<br>• Management Board Member, Somerset Estates Partnership (SEP) Board<br>• Director Predictive Health Intelligence Ltd<br>• Shareholder Director of SSL |
| **Melanie Iles**<br><br>Chief Medical Officer | None to declare |

| 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 February 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.<br><br>The report covers the period 26 October 2024 to 24 January 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. DELAY TO OUR NEW HOSPITALS PROGRAMME SCHEME

1.1. The Department of Health and Social Care published its review of the New Hospitals Programme on 21 January 2025. The announcement was made by Secretary of State for Health and Social Care, Wes Streeting, in Parliament. Following that, each scheme received information about how it is affected by the review.

1.2. We estimate that our programme has been further delayed by at least another five years as a result of the review of the New Hospitals Programme. We further estimate that the build will take approximately seven years, and the whole programme will not be complete before 2040. Development of our NHP programme will now pause until 2030/1 and construction will not begin until 2033 - 2035.

1.3. This is bitterly disappointing for the patients and families we care for and for the colleagues who work in some buildings that are nearly 80 years old and not fit for a modern NHS. Parts of Musgrove Park Hospital were built in the 1940s. The roofs leak, the services infrastructure is woeful and needs significant upgrade, and we have concerns about our ability to keep those areas running and provide clinical services to vulnerable patients from them. The Care Quality Commission described the impact that our outdated maternity unit has on the privacy and dignity of the mothers, babies and families we care for.

1.4. This delay is a bitter blow. Our New Hospitals Programme is planned to replace our outdated women's (including maternity), children's and elective surgical facilities, and to expand urgent and emergency care. We will now spend some time reviewing what this delay means, and how we manage the parts of our hospital that are not fit for purpose for approximately 15 years before we are able to complete the build programme.

## 2. EXTREME PRESSURE ON OUR SERVICES

2.1. We are continuing to experience extreme demand across our services, particularly in our Emergency Departments at Yeovil Hospital and Musgrove Park Hospital and as a result of significant increase in the number of flu and respiratory illness cases.

2.2. Our colleagues continue to work incredibly hard during this period of huge demand, to see and treat our patients as quickly as possible and while our services continue to be extremely busy, we have seen a current improvement in the pressures we are experiencing.

2.3. We are very grateful to our colleagues, our patients and those that matter to them the most, our carers, our communities and our healthcare partners for their ongoing support.

2.4. Thank you for continuing to be patient and kind to our colleagues throughout this winter period - they are doing their very best to care for you, at times of extreme pressure.

**What actions are we taking**

2.5. Patient safety is our top priority and colleagues from across the trust are working together to ensure that we can continue to provide urgent and emergency care for all patients, and to keep as many routine services running as possible, during these increased winter pressures.

2.6. We are also working closely with our health and care partners across the county, to ensure that patients who are ready to leave hospital can be discharged, at the earliest opportunity.

2.7. Further information on what these pressures mean for patients and guidance on what services to visit is available on our internet Continued pressures on our services - Somerset NHS Foundation Trust

## 3. FAREWELL

3.1. Colin Drummond retired on 31 December after more than 10 years as chair of Somerset FT and its predecessor trusts. His farewell message is set out below.

"I want to express my thanks and admiration to all of you and wish you all the best for Christmas and the coming years. I have been privileged to have had the best job in Somerset. Over the past 10 years we have done so much together. Via our mergers we have created a unique, patient-centred organisation covering acute, mental health, and community services plus 25% of general practice in Somerset.

We recognised that our patients often require flexible access to a range of services and our structure minimises the handovers between separate organisations which can be so frustrating to all involved. Other parts of England are moving in similar directions, but no-one has yet delivered what we have. It is a great tribute to the openness, forward thinking and can-do attitude of all involved. Our first merger completed on 1 April 2020 just as Covid was striking and proved its worth and robustness throughout the pandemic.

What you have achieved over the past 10 years, and what I particularly admire and will remember, is much more than the mergers. The energy, commitment and inventiveness which you all show in providing the best care to our patients has struck me since the first day I joined. Historically the NHS

has seemed to me a very top-down and bureaucratic organisation; however, there is an increasing realisation that it is people at the sharp end who will deliver the new models of care that our patients need and expect - as you are doing. You are a model of the future for the NHS in what will be tough times financially; money will be tight and difficult decisions may have to made, but let's focus resources and decision-making as close to the patient as possible. I am convinced the NHS will survive and prosper but it requires genuine local empowerment to do so. You have shown you are up to the challenge and the opportunity.

I personally am very sad to be leaving, but I am not getting any younger and it is time to hand on the baton. You will always remain in my heart.

Colin"

## 4. FEEDBACK FROM THE CARE QUALITY COMMISSION'S (CQC) INSPECTION OF OUR ACUTE PAEDIATRIC SERVICES

4.1. The CQC recently visited our trust to inspect our acute paediatric services. They spent one day at YDH and MPH each and spoke to a wide variety of colleagues and to patients, families and carers.

4.2. Our teams did a lot of work to welcome the team of inspectors and to show them our services and describe their work, both what they are proud of and how we are tackling the challenges we face. The team of inspectors was warm, asked curious questions about our teams' work, the impact on children and families, and on our teams.

4.3. The CQC team thanked our colleagues who went above and beyond to facilitate a good, well organised and well attended inspection. The inspection report is awaited and will be uploaded onto the internet when available.

## 5. OUTCOME OF INQUEST INTO THE DEATH OF JESSICA POWELL

5.1. The jury inquest into the death of Jessica Powell recently concluded. The conclusion was that "Rowan Ward failed to adequately supervise and secure the therapy room which was fitted with windows that Jessica, a frequent absconder, might reasonably believe she could escape through. Jessica deliberately tried to climb through the window and it was not her intention to end her life by doing so."

5.2. Jessica was well known to our mental health services. When Jessica became an adult, she was admitted to Rowan ward whenever she needed inpatient care. On the evening of Wednesday 19 August 2020 Jessica tried to climb out of a window on the ground floor of Rowan ward. The ward window was secured with a restrictor, as is customary on windows across NHS mental

health services. Jessica suffered catastrophic injuries during the incident and died in the intensive care unit of Yeovil District Hospital four days later.

5.3. The trust commissioned Verita to conduct a root cause analysis that included questions from Jessica's family and focused on:

- Care and treatment from admission in September 2019 to the event on 19 August 2020, focussing on risk assessment and management.

- The layout, operation and safety of the ward environment, including matters to do with windows and restrictors.

5.4. The trust will review the inquest's conclusion to see if there are further actions we need to take.

## 6. SOMERSET MARKS HALF A MILLION PATIENT TESTS THROUGH COMMUNITY DIAGNOSTIC CENTRES

6.1. We have celebrated a huge milestone in January 2025 as the 500,000th patient received a diagnostic test at one of Somerset's community diagnostic centres.

6.2. The national community diagnostic centre programme began in August 2021 with the aim of reforming diagnostic pathways, offering patients a wide range of diagnostic tests closer to home, and a greater choice on where and how they are undertaken, reducing the need for hospital visits, and often leading to faster access to treatment.

6.3. Somerset's community diagnostic centre programme offers 21 different diagnostic tests across a number of sites throughout the county, and is run in a collaboration between our trust, GP practices, and organisations from the independent sector. The programme has created flagship diagnostic centres, including the Taunton Diagnostic Centre which was opened in September 2021 and was the first independent sector partnership of its kind in the UK. The programme has also developed and launched specialist ophthalmology diagnostic facilities.

6.4. An innovative partnership with Somerset's GP practices has been developed to provide a range of tests in the county's community diagnostic centres, which shows the Somerset Integrated Care System's commitment to investing in all partners within the health system, as well as using the experience, clinical skills and local knowledge they bring. We are now planning to open the largest community diagnostic centre, in Yeovil in March 2025, which will further expand diagnostic capacity in the east of Somerset and will provide the facilities to develop new ways of diagnosing and caring for patients.

6.5. Since the programme began, we have seen a 17.5% improvement in diagnostic waiting times and feedback from our patients is excellent. 98% of

patients have said they are either satisfied or very satisfied with their care. The next stage of the Somerset diagnostic programme is to transform our additional diagnostic capacity and excellent facilities, so patients can get everything they need at a single appointment. This is in line with the government's plans for reforming planned care in the NHS.

## 7. OUTCOME OF INQUEST INTO THE DEATH OF A 39 YEAR OLD PATIENT

7.1. In March 2023, the patient attended the Minor Injury Unit at West Mendip Community Hospital feeling generally unwell. After a wait of up to 80 minutes she was called through to be seen. It quickly became apparent to the assessor that the patient was very unwell with sepsis and needed ambulance transfer to YDH. A 999 call was made, and the patient was transferred to YDH, where she was stabilised, intubated and transferred to ITU.

7.2. Overnight she deteriorated further with a working diagnosis of overwhelming sepsis. A second line was inserted, and a chest x-ray was taken to check its placement. The film showed a tension pneumothorax had developed but this was not identified by the team. The patient continued to deteriorate and sadly died. It was unclear how much the untreated tension pneumothorax contributed to her death.

7.3. At the inquest two colleagues outlined the changes that we have made to the triage process for an Urgent Treatment Centre (the unit was a Minor Injury Unit in March 2023), which includes triage by a clinician within 15 minutes of booking in, the findings of our root cause analysis which focussed on the tension pneumothorax, and our subsequent action plan.

7.4. The inquest concluded with a narrative conclusion where it was found that the patient died of sepsis and an undiagnosed tension pneumothorax. However, the coroner was very critical of two witnesses from the West Mendip Community Hospital and identified delays in the community hospital waiting room and delays for an ambulance due to the wrong categorisation of the call based on the information shared. The coroner did not make a Prevention of Future Deaths report because she was satisfied that with the steps we have taken on triage in the UTC and communication with the ambulance service, and that the missed tension pneumothorax was not a system error. She is maintaining contact with us to further understand the work we are doing to change culture to improve patient safety.

7.5. The trust will look closely at the coroner's comments to understand what further steps we need to take.

## 8. STUDY AIMS TO FIND THE BEST WAY OF OFFERING CERVICAL SCREENING TESTS AFTER PREGNANCY

8.1. Clinicians 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.

8.2. As part of the study, people taking part would also be offered a urine self-testing for Human Papillomavirus (HPV), the virus that causes abnormal cells on the cervix, leading to cervical cancer. This type of cancer is common in young women and people with a cervix globally, which led the NHS to set up the National Cervical Screening Programme over 35 years ago to help prevent cervical cancer.

8.3. Since its introduction, the number of cases of cervical cancer have halved, but uptake of screening is at an all-time low, especially in younger women and people with young children, something that doctors in Somerset have set about trying to reverse.

8.4. The study, called Postnatal Instead of Normally-timed Cervical Screening (or PINCS for short), aims to find out whether cervical screening six weeks after childbirth is as accurate and acceptable as at 12 weeks after childbirth. If proven, it could lead to a major national policy change, which participants in their previous study, pre-PINCS, told them would be likely improve accessibility and uptake, and crucially, save many more lives of young people.

## 9. TIME TO TALK ABOUT MENTAL HEALTH AS INTERNATIONALLY-TRAINED NURSES

9.1. Sun Sander-Jackson, our inclusion lead, has written an incredibly moving and poignant article about the difficult experiences that both her, and her other internationally-trained colleagues, have faced. The article was also published in the widely-acclaimed Nursing Times publication and the link to the article is available **here.**

## 10. THE PRINCESS ROYAL VISITS MUSGROVE PARK HOSPITAL TO THANK THE LEAGUE OF FRIENDS

10.1. The Princess Royal visited Musgrove Park Hospital on 1 November 2024 to meet volunteers of the Musgrove Park League of Friends, which funded the hospital's first surgery robot.

10.2. The hospital's League of Friends and donated £1.5 million to buy the da Vinci Xi robot, which surgeons have used to operate on over 200 people in its first year.

10.3. During her visit, The Princess Royal visited the hospital's League of Friends shop, met volunteers who raise money for the League of Friends and trust colleagues who use the robot, as well as seeing first-hand the difference it makes for patients.

10.4. During the visit, upper GI surgeon Mr David Mahon, described the incredible benefits that robotic surgery is having on patient care across Somerset. Surgeons are now able to perform more intricate and less invasive surgery, across a variety of different disciplines within the hospital.

## 11. UPDATE ON OUR MATERNITY SERVICES

11.1. We welcomed senior clinicians to our maternity services as part of NHS England's Maternity Safety Support Programme (MSSP). On Monday 18 November, Somerset Maternity and Neonatal Voices Partnership (MNVP) published its 15 Steps report.

11.2. Both of these are supportive measures to help us with the work that we are doing to improve our maternity services. NHSE's MSSP is intended to provide support through mentoring, leadership development, and hands-on assistance and is a national programme to help maternity services improve the quality and safety of their services.

11.3. Following their visit, the team extended a heartfelt thank you to our teams for the warm welcome they received. They fed back some very useful insights and suggestions to support our improvements and we will be working with them in the future to develop this into our ongoing improvement plan.

11.4. Somerset MNVP's 15 Step report provides feedback from service users on the environment within our units at MPH and YDH. We have been working for a number of years to replace our maternity unit at MPH through the national New Hospitals Programme which has now been delayed. However, the report highlights the importance of some things that are within our control such as the importance of:

- Additional changes to make signage clearer.
- Work to make some environments more accessible, feel less clinical and support privacy.
- A need to review posters and information displays to avoid information overload and make information inclusive and accessible to all.
- The importance of ongoing maintenance and replacement of older fixtures and fittings and of making it clear when improvements are being made or are imminent.

11.5. We will go through the report in detail and incorporate the feedback into our action plan and have thanked Somerset MNVP and their volunteers who gave up their time to support us by giving this feedback.

## 12. VISIT BY MINISTER OF STATE FOR HEALTH (SECONDARY CARE) AT MUSGROVE PARK HOSPITAL ON 24 NOVEMBER 2024

12.1. We hosted a visit by Karin Smyth, Minister of State for Health (Secondary Care) to Musgrove Park Hospital (MPH) by Karin Smyth, Minister of State for Health (Secondary Care) on 24 November 2024. The minister was in Taunton for a public engagement event to help shape the 10- year plan and arranged a visit to MPH as part of her schedule.

12.2. The visit, led by Peter Lewis, consisted of two parts – a visit to the Emergency Department and a visit to Main Outpatients where dermatology minor operations will be taking place. While in the Emergency Department, we

- Introduced the front door of the hospital.
- Described how the demographic of Somerset influences the patients we care for.
- Described how our unique range of services helps our trust respond to the challenges.
- Gave an overview of the remaining challenges.

12.3. Within the main outpatient department, the team described the transformation of our dermatology service which has improved patient experience and reduced waiting times. The return of the service to Somerset from Bristol has enabled created an opportunity for us to completely re-design and transform dermatology services in Somerset.

12.4. The new clinical model, which is the result of collaboration between our trust, primary care and the ICB, demonstrates the use of digital technology and is resulting in patients now being seen locally in Somerset. All patients not referred on the suspected cancer pathway are triaged through teledermatology, with many being given advice and care management plans. Onward referrals are made where necessary, with up to 80% seen by the intermediate dermatology service, staffed by GPs trained in dermatology to become GPs with extended roles (GPwERs), nurse specialists, pharmacists, supported by specialist teams. Further skin cancer services are provided from Musgrove Park and Yeovil Hospitals. The trust's skin cancer team provides important care for patients, from the point of initial concern over a suspicious mole or lesion to referral into secondary care from their GP for diagnosis.

## 13. USE OF THE CORPORATE SEAL

13.1. As outlined in the Standing Orders, there is a requirement to produce a quarterly report of sealings made by the trust.

13.2. The seal register entries over the period 1 April 2024 to 24 January 2025 are set out in the attached appendix.

## 14. MEDIA COVERAGE

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

## 15. NATIONAL DEVELOPMENTS

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

**SOMERSET NHS FOUNDATION TRUST**

**SEAL REGISTER**

**1 APRIL 2024 – 24 JANUARY 2025**

| Date of Sealing | No. of Seal | Nature of Document | First Signatory | Second Signatory |
|---|---|---|---|---|
| 8 April 2024 | 01 | Burnham and Berrow Medical Centre, Deed of Guarantee and Indemnity and Release | David Shannon | Peter Lewis |
| 30 April 2024 | 02 | Deed of Termination of Deed of Guarantee and Indemnity – Lynton Health Centre | Peter Lewis | David Shannon |
| 3 May 2024 | 03 | Licence to alter Unit 5F, Courtlands | Phil Brice | Peter Lewis |
| 24 May 2024 | 04 | Substation Transfer | David Shannon | Pippa Moger |
| 6 June 2024 | 05 | ED CT Scanner contract with Harris Bros and Collard Ltd | David Shannon | Phil Brice |
| 17 June 2024 | 06 | Musgrove Park Hospital Retail leases with Compass Contract Services Ltd (trading as Medirest) – café in concourse; food store in concourse; and café in duchess | Peter Lewis | David Shannon |
| 21 June 2024 | 07 | Duty of Care Deed, residential accommodation, Goldcroft | David Shannon | Pippa Moger |
| 27 June 2024 | 08 | Compound licence and licence to carry out works – Yeovil Diagnostic Centre | Peter Lewis | David Shannon |
| 1 July 2024 | 09 | Deed of Grant – Wincanton Hospital | Isobel Clements | Phil Brice |
| 2025 | | | | |
| 14 January 2025 | 01 | Leases at Bartoc 4 – unit 8, unknit 10a, unit 12 | David Shannon | Peter Lewis |
| 24 January 2025 | 02 | SFT Trust underlease, SFT reversionary lease, Inhealth underlease and plans (YDC) | David Shannon | Peter Lewis |

**APPENDIX A**

## MEDIA COVERAGE

Over the period 26 October 2024 to 24 January 2025, there has been the following media coverage:

- **New Hospital Programme delay**
  There was lots of coverage across regional and national media outlets following the government's announcement of a delay to the New Hospital Programme scheme at Musgrove Park Hospital, which is in 'Wave 2'. The story was first featured on the BBC Radio Somerset breakfast show, including interviews with Gideon Amos MP and a mum who told of her experience of the maternity unit at MPH. The interviews are here (2.11:05 into programme). In addition, our director of midwifery Sally Bryant was interviewed by BBC Radio Somerset's drive programme – listen here (2.24:30 into programme). The BBC News Online coverage is here, West Somerset Free Press coverage here.

- **Somerset community diagnostic programme sees 500,000th patient**
  Following a proactive package of communications, local media covered the milestone for our community diagnostic centres, which have now seen 500,000 patients. The Somerset County Gazette Series coverage is here, and Apple FM coverage is here. We are also in talks with the Health Service Journal about a feature on the achievement.

- **Mental Health Carers Assessment Service**
  Coverage about the reduction in funding from Somerset Council for our mental health carers assessment service. The BBC Radio Somerset package is here (1.35:45 into programme) and BBC News Online article here.

- **Myeloma UK national award for Somerset FT**
  Further coverage on the BBC News Online website about how a Crewkerne man whose blood cancer caused his vertebrae to be crushed, leading him to lose three inches in height has thanked Somerset FT for his treatment at Musgrove Park Hospital, which led to the trust winning a national award. You can read the article here.

- **High Intensity Use service**
  On the back of a proactive package of communications about our high intensity use service, we invited BBC Points West to see the service in action as they met a patient under our care, the HIU service manager and an emergency department consultant. The BBC News Online article is here, BBC Radio Somerset interview here (Hear Patient Gayle at 1.07:40 into programme and service lead Neil Thomas at 2.10:55 into programme).

- **Improvement works at MPH's post-natal ward – Fern ward**
  Following a Facebook post by our maternity services and Somerset Maternity Voice Partnership, we were approached by BBC Radio Somerset for information about maintenance work being carried out on Fern ward

that aims to significantly cool the ward down in the event of extreme temperatures. The work has been carried out following various feedback and reports that covered the ageing maternity estate at MPH. The article is here. This story also ran on BBC Radio Somerset news bulletins.

- **NHS pressures**
  Following the extensive coverage of NHS pressures, there was an article on BBC News Online about how all south west NHS trusts had stood down their 'critical incident' status. Read the article here.

- **Post-menopausal bleeding self-referral service**
  Further coverage of the first year of our post-menopausal bleeding self-referral service across the BBC network, with BBC News Online publishing an article here.

- **Myeloma UK national award for Somerset FT**
  A Crewkerne man whose blood cancer caused his vertebrae to be crushed, leading him to lose three inches in height has thanked Somerset FT for his treatment at Musgrove Park Hospital Taunton, which led to the trust winning a national award. You can read the article here.

- **NHS pressures**
  Continued coverage across media outlets about pressures on the NHS, including an interview on BBC Radio Somerset with Dr Paul Foster, our medical director for Yeovil Hospital, which you can hear here (1.10:45 into programme). Much of the coverage in the region focused on whether trusts were in a 'critical incident', mask wearing advice and general updates on the situation. We are also in the planning stage for a piece with ITV Westcountry and potentially Channel 4 News about our Respiratory Hospital @ Home service and how it's helping with pressures. Further coverage in BBC News Online is here, Somerset Live is here and Somerset County Gazette here.

- **Post-menopausal bleeding self-referral service**
  We worked with the regional BBC on a package of communications around the first year of our post-menopausal bleeding self-referral service. The BBC Radio Somerset coverage, which includes an interview with consultant gynaecological-oncologist Mr David Milliken and patient Hazel, is here (Interview with Mr Milliken is 1.09:25 into programme and interview with patient Hazel is 2.11:15 into programme). Additional coverage in the National Health Executive is here, Somerset County Gazette is here, and West Somerset Free Press is here.

- **Awards success for our children's community nursing service colleagues**
  Coverage in Somerset Live about how three colleagues from our children's community and specialist nursing team have cause for celebration after they scooped special NHS England awards and recognition for showing fantastic leadership. The article is here.

- **MP challenging decision to close Yeovil Hospital hyper acute stroke unit**
  Coverage across Somerset's media about how Adam Dance, MP for Yeovil, is challenging a decision to close a hospital's hyper acute stroke unit. The Somerset County Gazette article is here and BBC News Online is here.

- **Inquest into death of Jessica Powell at Rowan ward**
  Coverage in many south west media outlets this week about the conclusion of an inquest into the death of Rowan ward patient Jessica Powell. We issued a statement following the inquest. The BBC News Online article is here and ITV Westcountry here.

- **Parkside promotion of bowel cancer screening**
  As part of regular promotion communications, the West Somerset Free Press ran an article about the private screening service offered at Musgrove Park Hospital, which can include a colonoscopy. Read the article here.

- **'Alice in Wonderland' style panto performed for Williton Hospital patients**
  Williton hospital was turned into a winter wonderland for a day as colleagues and volunteers performed a pantomime for current and past patients and their friends and family. This was covered on our trust social media channels and the West Somerset Free Press article is here.

- **Hippychick gives toy donation to Musgrove Park Hospital's paediatric diabetes department**
  Coverage on the Somerset Chamber of Commerce website about how, it's part of its ongoing commitment to Musgrove Hospital during its 25th anniversary year, Hippychick is donating a selection of toys to the diabetes department for a Christmas party. Read the article here.

- **Chemotherapy now available at Williton Hospital**
  Lots of coverage across Somerset's media about chemotherapy services now being made available at Williton Hospital for the first time. The West Somerset Free Press article is here, Somerset Live here, and Health Tech Newspaper here. Our lead nurse for chemotherapy, Emma Wells-Burr, was also interviewed by BBC Radio Somerset, along with a patient who has benefited. Listen back here (Emma Wells-Burr interview 1.07:25 into programme and Patient Stephen interview 2.08:10 into programme). The story also featured on our social media channels and Our News.

- **Mr Indy Sian helps to save the sight of people in rural Cambodia**
  Following a package of planned communications on this subject, our ophthalmology consultant Mr Indy Sian was interviewed by BBC Radio Somerset this week about the work he's been doing in rural Cambodia to help save the sight of people who've had almost no access to eye care over many years. The interview is here (2.16:30 into programme).

- **New bowel cancer self-referral launches in Bridgwater**
  Coverage in the Bridgwater Mercury about how a brand-new service that makes it easier for people to get checked for bowel cancer has launched in Bridgwater – article here.

- **Award for our cleaning team**
  Our cleaning team is celebrating success in the Cleaning Excellence Awards 2024. The trust's cleaning response team was a winner in the Outstanding Achievement in Infection Prevention and Control category. More here.

- **Distraction boxes helping people with a mental health crisis**
  Coverage on Heart FM about how all children and young people who attend our hospitals with mental health needs are being offered a distraction box to help them stay calm in the unfamiliar setting

- **10 years of the new Bridgwater Community Hospital**
  We celebrated 10 years of the current Bridgwater Community Hospital on Bower Lane. A reporter from the Bridgwater Mercury joined the celebrations and the resulting article is here.

- **Rise in HIV diagnoses in Somerset**
  We featured in the Pink News publication, along with the Somerset County Gazette, following contact from media who learned that the number of HIV diagnoses in Somerset has significantly increased over the last year. We issued a statement from our consultant physician Dr Sathish Thomas-William, who also gave important public health advice. The Pink News article is here and County Gazette here.

- **Mum "told to go private" by NHS colleagues**
  BBC News Online featured a story about a mum struggling with complications after giving birth said she begged to see a specialist – but was told to pay for private care. We issued a statement and you can see the coverage here.

- **Knife crime improvements needed**
  A story on the BBC News Online website about how work being done to prevent serious youth violence in Somerset is not good enough, according to inspectors. This included a note about how colleagues in ED at MPH and YDH are not 'professionally curious' enough. The article is here.

- ***Joyce Standring retires after 80-year NHS career***
  The story of our long-serving nurse-turned-volunteer Joyce Standring featured across national media this week after it was picked up by the South West News Service – a news agency that sends stories to popular news outlets. You can see the article here.

- **Charity campaign for Christmas donations**
  Our community fundraiser Amy Phelps was interviewed on the BBC Radio Somerset breakfast show about the Somerset NHS Charity's Christmas appeal. Listen here (2.08:30 into programme).

- **Fundraising story**
  A brief story about a café in North Curry that has fundraised for our Love Musgrove charity. The BBC News Online article is here.

- ***New bowel cancer self-referral service in Bridgwater***
  Following a press release and mini marketing campaign we received a lot of interest in the new bowel cancer self-referral service that specifically targets the Bridgwater area due to high rates there. The new service aims to make it easier for people in their 40s to get checked for bowel cancer and is open exclusively to people aged 40-49 who are registered with a GP in Somerset. The Bridgwater Mercury coverage is here.

- **Men's Health Month**
  In the second part of a series that came about on the back of our Men's Health Month campaign, Jon Staple, our fire safety advisor at Simply Serve Limited, shared his story on the BBC Radio Somerset Simon Parkin show. You can hear the interview here (2.20:13 into programme) and see an online written version here.

- **New operating theatre opens at Dorset County Hospital to treat our dental patients**
  Coverage in the New Blackmore Vale and various Dorset-based media about how a £2 million project to convert a procedure room at Dorset County Hospital into a full operating theatre has been completed. The new theatre will be used for special care dentistry, which is provided by Somerset FT, and other surgeries. The article is here.

- **New sexual health clinic at Wincanton Hospital**
  Coverage in the Somerset County Gazette about a new clinic run by Somerset-wide Integrated Sexual Health (SWISH) at Wincanton Hospital every Tuesday. We issued a statement to confirm and welcome the new clinic. The coverage is here.

- **Three year wait for patient needing orthopaedic surgery**
  There was coverage in The Guardian about how a Dorset-based patient was told she had to wait three years for hip and knee surgery. Our orthopaedic assessment service (OASIS) was mentioned in the story as the patient/GP approached the service for an assessment. We were unable to comment as the story related to a Dorset patient and the standard procedure would have been for the patient to access the Dorset equivalent assessment service. The article is here.

- **Health Minister visit to MPH**
  Last Sunday (24 November) Health Minister Karin Smyth MP visited Somerset as part of the government's public engagement on healthcare reform. As part of this she took part in an event at Somerset Cricket Club and also met our dermatology team at Musgrove Park Hospital. Coverage of the visit on Somerset Live is here and on the Health Business publication, here.

- **Somerset FT doctors visit Richard Huish College in recruitment education event**
  Coverage on the Somerset Chamber of Commerce website on how over 25 doctors from Musgrove Park Hospital recently visited Richard Huish College to host a special evening designed for young people who have made applications to study medicine at university. The article is here.

- **Death of woman with sepsis following visit to West Mendip Hospital's urgent treatment centre**
  Following contact from a news agency reporter who attended the inquest into the death of Kimberley Ball, there was coverage in the Daily Telegraph that gave a detailed account of the coroner's findings. The story is here and you can view our statement towards the end of the article.

- **ED waits over 12 hours**
  Coverage across local media outlets following a press release sent out by MP Gideon Amos about how over 500 patients in Somerset faced waits of 12 hours or more for A&E services in October, according to NHS England data. We clarified the data to ensure it was accurate and the resulting coverage is here.

- **Dietitian Leah Seamark wins award**
  Further coverage in the County Gazette series on how our dietitian Leah Seamark has won an award for the way her and the team have been giving dietary advice to patients with a wide range of gut conditions, including irritable bowel syndrome (IBS) and coeliac disease – all via a series of webinars and a website – read the article here.

- **Predictive Health Intelligence**
  Extensive coverage across the BBC regional network this week about our joint venture, Predictive Health Intelligence, which is a case-finding search engine that enables clinicians to easily identify people potentially at risk of chronic liver disease by analysing test results over time. Please see below links to the coverage that includes an interview with our gastroenterology consultant, Dr Tim Jobson, and patient Brian – both of which we facilitated at MPH and at Brian's home respectively.

  BBC Radio Somerset: Charlie Taylor - 13/11/2024 - BBC Sounds (1.08:25 into coverage – Dr Tim Jobson interview; 2.08:25 into coverage – Patient Brian interview + whole segment)
  BBC News Online: Liver disease patients with no symptoms diagnosed thanks to NHS first - BBC News

- **Men's Health Month**
  On the back of our Men's Health Month campaign, we pitched the story to BBC Radio Somerset, which is running a series of interviews with colleagues who've shared their personal and professional stories related to men's health. The first interview – with Dairin Keating, our electrical craftsperson – can be listened to here (20:45 into programme).

- **Dietitian Leah Seamark wins award**
  Following a press release we issued, there was coverage in the West Somerset Free Press about how our dietitian Leah Seamark has won an award for the way her and the team have been giving dietary advice to patients with a wide range of gut conditions, including irritable bowel syndrome (IBS) and coeliac disease – all via a series of webinars and a website. Coverage is here.

- **Remembrance Day coverage**
  The two minute silence at both Musgrove Park and Yeovil Hospitals appeared on Monday's editions of ITV Westcountry and BBC Points West as we proactively submitted footage of them taking place.

- **Patient death and mortuary wait**
  More coverage again on the sad death of a helicopter engineer, with a focus on the family being unhappy at the wait to see their loved one's body in the mortuary at MPH. The coverage last week was in the Shropshire Star, which is here. In addition, our understanding is that BBC Radio Somerset no longer plans to cover the story in the immediate future.

- **Behind the scenes at MPH's surgical centre build**
  We invited a reporter from Greatest Hits Radio for a behind the scenes tour of the surgical centre at MPH. During the tour she interviewed Dr Ruairi Moulding, one of our consultant anaesthetists, Charlotte Parkman, our lead nurse for general theatres, Jessin John, our endoscopy manager, and Fliss Chamberlain, our senior operational manager for endoscopy and gastroenterology. You can hear the interviews on Greatest Hits Radio today and the online coverage is here. Also, look out for some extra video clips across our communications channels in the coming weeks.

- **Seamstress Helen McDermaid turns 80**
  Listen to this really uplifting BBC Radio Somerset interview with Helen McDermaid, our seamstress at Williton Hospital, all about her job and recent 80th birthday, which aired this week – it's 1.07:40 into the programme. This follows a social media post on the trust's channels and also article on our public website and Our News.

- **Award for Amanda Vickery**
  Coverage in Somerset Live about how Amanda Vickery, our catering liaison manager at MPH, has been awarded for her dedication to her team's wellbeing, creating a supportive and open environment for colleagues – read here.

- **Retirement of Helen Parfitt**
  Coverage in Somerset Live about our nurse, Helen Parfitt, reflecting on nearly five decades at Musgrove Park, sharing memories of her journey from children's nursing to pharmacy support. This is also a story that we widely publicised across our communications channels over the last month.

- **Condom shortage in Somerset**
  We were contacted by the Somerset County Gazette who heard about a condom shortage in Somerset. We were able to clarify that this was a very short-term supply chain issue that only affected the Somerset-Wide Integrated Sexual Health (SWISH)'s 'Safer Sex packs', which are available on request from the SWISH website. The coverage is here…and it also reached the national Metro news outlet.

- **Trust AI policy**
  The Health Tech Newspaper ran a story about the publication of our new artificial intelligence (AI) story, which you can read here. We'll be covering the use of AI at the trust, and what it means for colleagues and patient care, in more detail over the coming months.

- **Patient death and mortuary wait**
  There was coverage on the sad death of a helicopter engineer, with a focus on the family being unhappy at the wait to see their loved one's body in the mortuary at MPH. It was covered on the breakfast programme of BBC Radio Shropshire and BBC Radio Hereford and Worcester. The online coverage is here.

- **Visit of The Princess Royal to Musgrove Park Hospital**
  Lots of coverage appeared across media outlets about the royal visit on 31 October 2024. The Princess Royal thanked League of Friends volunteers and also saw the robotic surgery console, which was purchased by the 'Friends. The Somerset County Gazette coverage is here.

- **80th birthday of Williton Hospital seamstress Helen McDermaid**
  Coverage across local media outlets about the 80th birthday of our seamstress at Williton Hospital, Helen McDermaid. The Somerset Live article is here.

- **Budget**
  Following the Budget announcement in October 2024 by the Chancellor, a number of our Somerset MPs issued press releases, much of which included information about our services, including the future of the Yeovil Hospital hyper-acute stroke unit and capital projects, cancer and elective waiting times and investments at Musgrove Park Hospital. The Somerset County Gazette coverage featuring Adam Dance, MP for Yeovil, is here, and Rachel Gilmour, MP for Tiverton and Minehead, about waiting times is here, and Gideon Amos, MP for Taunton and Wellington, about the New Hospitals Programme at MPH is here.

- **Podcast: Dr Michael Fernando's work in Afghanistan**
  Following widespread coverage over October 2024, the Blackmore Vale interviewed Dr Michael Fernando, one of our consultant paediatricians, about his Saving Babies Lives' work in Afghanistan. It was published as a podcast, which you can hear here.

- **Expansion of private GP service at Yeovil Hospital**
  There was additional coverage in November 2024 on the new private GP at Yeovil Hospital, which is run by our private patient services. The Somerset Live article is here.

- **Ophthalmology consultant's sight-saving trip to Cambodia**
  Further coverage of our consultant ophthalmologist Mr Sian Indy's trip to Cambodia, where he helped to improve the sight of people in rural communities. Somerset Live article here.

**APPENDIX B**

## NATIONAL DEVELOPMENTS

Over the period 26 October 2024 to 24 January 2025, there have been the following national developments:

- **Plan to reform elective care for patients**
  On Monday (6 January 2025) the prime minister announced a new national plan published by NHS England setting out how the NHS will reform elective care for patients in England.

  The government has pledged to recover the constitutional standard of 92% of patients receiving treatment within 18 weeks for planned care by March 2029. The plan not only commits to reducing waiting times but promises to build a sustainable NHS where 'elective care looks and feels different to patients and NHS staff'.

  In his speech to launch the plan, the prime minister committed to delivering 40,000 additional appointments a week within the first year of this Parliament. He touched on a few specific measures including expanding the number of surgical hubs, extending access to community diagnostic centres and reforming the NHS app.

  NHS England's press release dated 4 January is available on here. NHS Providers has published a briefing on the plan.

- **Launch of independent commission into adult social care**
  At the start of the year, the Department of Health and Social Care announced investment for social care and an independent commission into adult social care. The Department of Health and Social Care published a press release and multiple organisations and representative bodies responded. Responses included those from The King's Fund, The Health Foundation, ADASS, Somerset Council.

- **Our trust's response to the Department of Health and Social Care's engagement exercise that will inform the 10-year plan**
  The Department of Health and Social Care (DHSC) is conducting an engagement exercise that is harnessing the views of NHS colleagues, patients, families and carers, and the public, to inform the 10-year plan that is scheduled to be published in the spring.

  The plan will set out how we all can deliver an NHS fit for the future, creating a modern health service that is designed to meet the changing needs of our changing population.

  The engagement follows the publication in September of Lord Ara Darzi's independent investigation of the NHS in England. It outlined the need to make

three ‘strategic shifts’ - moving care from ‘hospital to community’, from ‘analogue to digital’ and from ‘treatment to prevention’. The engagement asks about these three shifts.

The DHSC required organisations to respond within a short timescale, by 2 December. Colleagues, patients, families and carers, and members of the public have longer to submit their views via the change.nhs.uk website.

Our trust’s response is below.

***Q1. What does your organisation want to see included in the 10-Year Health Plan and why?***
*Somerset NHS Foundation Trust wholly supports the three “shifts”, and our organisational form supports us to deliver the shifts locally. The aim to improve population health is set out in our mission “to improve the health and wellbeing of everyone in Somerset and to deliver outstanding integrated care by supporting our colleagues and nurturing an inclusive culture of kindness, respect and teamwork.*

*Our strategic objectives restate the objective to improve population health and include additional objectives about delivering care and support in local communities, reducing inequalities and responding well to people with complex needs.*

- *Improve the health and wellbeing of the population*
- *Provide the best care and support to people*
- *Strengthen care and support in local communities*
- *Reduce inequalities*
- *Respond well to complex needs.*

*Somerset NHS Foundation Trust provides primary care (general practice to circa 130,000), community services, services from community hospitals, mental health and learning disability services, and acute services (two district general hospitals). We are a unique organisation that was formed as a result of two mergers because of the opportunities our organisational form presents to integrate services where appropriate (for example physical and mental health services) and to provide care in the most appropriate place (for example providing care in communities rather than acute hospitals).*

*To support us to deliver the shifts effectively we would like to see the following in the 10-year plan:*

- *Parity between mental and physical health.*
- *Performance and financial mechanisms to support the delivery of the*

*three shifts. At present, the performance and financial frameworks in which we work focus primarily on acute care, which results in focus on acute hospitals at a time when we need community services and population health to be our focus. Without a supportive incentive framework, we will not be able to focus on addressing the causes of the current challenges.*

- *Plans to reform the provision and commissioning of primary care. We are seeing the challenges in primary care understandably resulting in a push from community to acute care.*

- *An overview of health and social care, shared performance with social care and mechanisms to look at the whole patient pathway including NHS and social care services.*

- *Links to the People Plan giving the NHS a framework in which to continue training, attracting and developing the colleagues with the skills, and in the required numbers, to work in the NHS of the future in which the three shifts are delivered.*

***Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?***
*While a shift from hospital to community is critical, this needs to be seen as more than services moving from an acute to a community setting. This can result in diseconomies of scale and cost growth, particularly in rural areas where the population is dispersed over a wide geographical area. So, while it will be right to "lift and shift" some services, we also need to focus on working differently and providing earlier, proactive care and support to help people remain healthier for longer, and to help them take responsibility for their own health.*

*The greatest challenges include:*

- *Performance framework: As detailed in response to Q1, a performance framework that focusses on acute performance and does not focus on care provided in the community in the same way.*

- *Fragmented provider landscape: In many ICBs, there will be a fragmented provider landscape, making it more challenging and complex to move care from acute hospitals into the community.*

- *Primary care: capacity in primary care to respond. In areas where primary care is more stretched, there is additional reliance on secondary care which risks pushing patients and activity in the wrong direction. Capacity in primary care in the future, and the capability and levers to transform a fragmented landscape, are both significant challenges.*

- *Cultural shift: A cultural shift for NHS colleagues and social care colleagues to look at the entire patient pathway, and to deliver that care in the most appropriate setting.*

- *Challenges in the VCSFE sector as a result of financial pressures in local authorities and the cost of living crisis: The NHS does not make it easy for VCSFE partners to maximise the contribution that they can make in local communities because of excessively burdensome processes.*

- *Practicalities presented by staffing models, availability of suitable space and travel times, which can take some time to work through.*

*Opportunities include:*

- *The creation of a holistic context and framework for NHS providers to operate within that includes:*

  - *an understanding of population health and how providers' services support and impact population health improvement*
  - *the whole patient pathway including health and social care*
  - *where those services are delivered*
  - *access to services, and*
  - *gaps in services and how those impact on their local populations.*

***Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?***
*Challenges include:*

- *Legacy of fragmented services and investment: Our trust is the product of two organisational mergers to bring acute services, community hospitals, community services, mental health and learning disability services and a quarter of the county's GP practices into one trust. Currently colleagues need to navigate multiple systems, and this has a significant impact on our productivity, ability to integrate services and staff morale.*

- *Investment to deliver an integrated care record: Investment in digital capacity and services has historically been fragmented and consisting of targeted often single year investment, delivering a sub optimal outcome. To deliver the core capability to allow this shift cannot be achieved in a single year and requires multi-year planning and implementation which the current financial framework does not support.*

- *Time, capacity and capability for implementations: Implementations can be very complex pieces of work that take time, require specialist skills and the engagement of clinical colleagues and services to ensure they deliver the anticipated improvements. Being able to recruit and retain a suitable workforce to enable this transformation is vital, however the*

*competition for roles is great. A large-scale shift in the NHS will require continued investment in those skills.*

- *Frameworks for use of new and emerging technologies such as AI: AI has the potential to support multiple provider processes, but it is essential that it is used safely, openly and in the right way and that public, patient and colleague confidence in NHS services and process is maintained. Currently the use of AI in a clinical setting is limited due to the approved use cases and the constraints placed by professional bodies (e.g. dual reporting in diagnostic imaging). Whilst these are important safeguards, they currently do not support the improved efficiency of systems*

- *Public and patient expectations: Patients and the public are used to using technology in their everyday lives and expect NHS systems, from notification of appointments to what information clinicians have at their fingertips, to be better than they currently are.*

*Many of our challenges are also our opportunities:*

- *Implementation of a unified electronic health record will potentially:*

  - *Place the information in the hand of the patient to enable them to support their own health and care whilst ensuring a clinician has the right information on which to base advice and decisions.*

  - *Transform how our colleagues work, enabling better management of care across traditional boundaries to patients.*

  - *Improved colleague experience as it enables them to work more efficiently and removes duplication and the complexity that comes with accessing multiple different legacy systems.*

  - *Ensure we better meet the expectations of patients and the public (and what they are used to in other aspects of their lives).*

  - *Monitoring technology assists in the delivery of care where people live and is a vital tool to help shift care from hospital into communities and to support people to stay well for longer.*

  - *New technologies such as AI have the potential to support with multiple provider processes if used safely, openly and in the right way. It could, in the future, improve the productivity of clinical and corporate services.*

***Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?***

*Challenges:*

- *Understanding of population health underpinned by data: A holistic and comprehensive understanding of population health at a system and provider level, underpinned by data, that supports targeted intervention to improve population health.*

- *Timeframes: Work to improve population health, spot illness earlier and tackle the causes of ill health will take time, potentially much longer than to bring down waiting times in a specialty for example, and this needs to be recognised and acknowledged.*

- *Partnership working and capacity within primary care and the third sector: Capacity in primary care and the third sector to work proactively in partnership to improve population health. This requires a change of approach and the levers, mechanisms and data to embed true partnership working, which needs ongoing work and support to be successful.*

- *Cultural shift: There needs to be a cultural shift that includes the political and societal landscape, delivery, performance and management framework to focus on population health and its improvement as a priority. Where the attention is predominantly on how we respond to sickness, it risks a short-term focus at the expense of addressing the causes of ill health and acute demand.*

*Opportunities:*

- *The use and leverage of providers' responsibilities as anchor institutions: A big determinant of good health is your life chances and good employment. One of the significant impacts that a large provider can have in their local area is the role that it can play in recruiting locally from deprived communities and the subsequent development of its staff.*

- *Mechanism to further embed partnership working at ICB level: This presents an opportunity to further embed partnership working with the long-term aim of improving population health looking at the health of the population, the wider determinants of health and the role that each partner plays to influence those, the services that are commissioned, how they are delivered and perform and the gaps in services.*

***Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:***

- ***Quick to do, that is in the next year or so***
- ***In the middle, that is in the next 2 to 5 years***
- ***Long term change, that will take more than 5 years***

*Next year or so*

- *Review and realign the formal and informal incentive structures (accountability arrangements, financial arrangements etc.) within*

*the NHS to support and enable the three shifts. This needs to take a population-based perspective, rather than be focused on sectors or specific services. As an example, the contractual framework for general practice, coupled with the business model, can work against the shift from hospital to community.*

*Short-term and middle*

- *Develop and implement a framework to support investment in and delivery of scaled up prevention activity, both primary and secondary. Without this, we will continually be responding to the short-term pressures, and we need to better support people to remain healthier for longer.*

- *Provide greater focus and attention on population-based data, in addition to performance and service productivity data. There is a wide variation in access data between different populations (either at PCN level or for specific cohorts of the population). More focus and a greater understanding of this will help support more targeted interventions and actions, that will in turn support the three shifts.*

*Middle to longer-term*

- *Incentivise others (other public services and employers) to take action to improve the health of the population. We know that circa 80% of health needs are driven by the wider determinants of health (for example, education, housing, early years support, employment)*

- *Invest in technology to enable remote monitoring and responses to peoples' health needs at scale. We have many local initiatives to do this, but unless we can impact at a population level, we will not make sufficient progress to impact acute demand and therefore the disproportionate investment into acute services.*

- *Review and transform the capital funding arrangements, to include alternative sources of investment and develop a longer-term capital investment programme for the NHS. We have a significant backlog maintenance issue as well as a constrained ability to invest in service development and transformation that would support the strategic direction and improve productivity.*

- **NHS Providers: State of the provider sector**
  NHS Providers has published its annual State of the provider sector report which provides a snapshot of the issues facing hospital, mental health, ambulance and community services across England.

  The survey's finding includes:

  - Over 9 in 10 trust leaders (96%) raised concerns about the impact of seasonal pressures over winter on their trust and local area.

- Delayed discharge (57%), social care capacity (49%) and acute bed capacity (43%) were identified as the top three greatest risks to the provision of high-quality patient care over winter.
- Nearly three quarters of trust leaders (71%) and 100% of acute specialist trust and ambulance trust respondents thought it unlikely the NHS can meet the constitutional standards over the next five years.

- Most (79%) trust leaders were very worried or worried about whether their trusts have capacity to meet demand for services over the next 12 months.

- 98% of trust leaders expressed support for the national policy agenda to shift more care from acute services to community and move care closer to home for patients.

- When considering how patient care could be improved, the top three areas trust leaders would like the new government to prioritise are capital investment in estates (54%), capital investment in digital (48%) and social care (41%).

- **Publication of latest NHS performance data**
  This week NHS England published the latest NHS performance data. NHS England's press release to accompany the data highlights the fact that:

  - A&E and ambulance services experienced more pressure than any October on record

  - The overall waiting list fell for the first time since February, reducing by around 70,000 in September from 7.64 million to 7.57 million, with the estimated number of patients waiting down more than 77,000 from 6.42 million to 6.34 million. The waiting list is now down 195,000 on September 2023.

  - Freeing up space in emergency departments was impacted by delays discharging patients, including to social and community care, with an average of 12,340 beds taken up each day by people who no longer needed to be there.

  - The NHS missed its target to virtually eliminate waits of 65 weeks by September, with 22,903 patients still waiting that long. However, 65-week waits are down more than 90% on their peak (233,051 in June 2021), with just 12 providers accounting for over two fifths of the remaining waits.

  - It was a record September for diagnostic activity with 2.37 million tests and checks delivered, up a fifth on the same month pre-pandemic (1.95 million in September 2019).

- Every month so far this year has seen more than a quarter of a million people checked for cancer following an urgent referral, including 256,996 in September, with staff carrying out 53,861 cancer treatments.

- **Mental Health Bill introduced in Parliament**
  The new Mental Health Bill was introduced in Parliament in November 2024 by the government to reform the Mental Health Act 1983 (MHA). This following summary sets out NHS Providers' view and next steps.

  **Overview**
  The Bill is largely the same as the draft mental health bill 2022, however, it does include several changes further to the recommendations made by the parliamentary committee that scrutinised the earlier draft bill during the last Parliament. These updates include:

  - **Detention Criteria – 'how soon':** the proposed requirement for clinicians to consider 'how soon' a harm might occur has been removed from the detention criteria.

  - **Nominated Person:** the requirement for the Approved Mental Health Professional to see the Nominated Person in person has been removed.

  - **Advanced Choice Documents:** the Bill seeks to introduce duties on Integrated Care Boards (ICBs) and NHS England (NHSE) to make arrangements so that people at risk of detention are informed of their ability to make an Advance Choice Document and (if they accept) are supported to make one.

  - **Principles:** the Bill amends section 118, which makes requirements for the Code of Practice, to include the language of the four principles from the Independent Review.

  - **Discharge:** the Bill contains measures for a new requirement for a patient's responsible clinician (or the responsible authority for the patient) to consult with a second professional involved in the patient's care when taking the decision to discharge them from certain powers under the Act.

  **Update on financial implications**
  According to the explanatory notes, the overall cost of the reforms is now expected to be £169m. After that, there is expected to be an ongoing average annual cost of around £282m.

  Ongoing costs for resourcing the reforms and upfront training costs for existing staff are estimated to total £1.9 billion for the NHS; £78m for the Care Quality Commission (CQC); and £396m for local authorities. A further £2.5 billion is estimated to be required for housing and care costs for the reforms

relating to people with a learning disability and autistic people; and £287m for His Majesty's Courts and Tribunals Service and the Legal Aid Agency.

**Implementation**
Full implementation of these reforms once the Bill is passed – subject to future funding – is expected to occur in phases and take about ten years, largely due to the required training of additional clinical and judicial staff.

Next year's spending review will give clarity on the funding available up to 2027/28 and enable the Department for Health and Social Care (DHSC) to provide more clarity on implementation timeframes. Timeframes for the implementation of reforms introduced beyond 2027/28 will be contingent on future funding decisions.

**NHS Providers view**
NHS Providers welcomes this step to modernise the MHA and renew focus on improving mental health services. NHS Providers supports proposals to simplify the Act and make changes that maintain appropriate safeguards, while enabling greater individual rights and liberties, and ensuring service users can have a more active role in their care planning with a focus on recovery. It says it is vital the proposed reforms are accompanied by sufficient additional resources to ensure they can be implemented effectively in practice.

Although reform of the MHA is crucial, more needs to be done to improve how and where people access high-quality mental health services, and individual outcomes and experience. Sufficient funding and support for mental health and wider public services are crucial to addressing the underlying issues driving the pressures on mental health services and compounding the rising severity and complexity of people's needs. Children and young people's mental health, tackling racial inequality, and the care deficit experienced by people with learning disabilities and autism must be prioritised in particular. By doing so, we can ensure that all individuals receive the right care, at the right time on a long-term, sustainable basis.

**Next steps**
NHS Providers will be reviewing the Bill and accompanying documents in detail and working to brief MPs and Peers as the Bill progresses through Parliament, as well as engaging with government colleagues.

- **NHS Providers report – Providers Deliver: shifting care upstream**
  NHS Providers has launched a report in November 2024 which highlights how NHS trusts are leading new approaches to ensure patients get the care they need in the right place at the right time.

  The report shows how in the face of a very challenging environment trusts are innovating and adapting to deliver the three key shifts called for by the government:
  1. Moving from hospital to community-based care,

2. from analogue to digital technology, and
3. from a focus on treatment to prevention.

| Somerset NHS Foundation Trust | |
|---|---|
| **REPORT TO:** | Board of Directors |
| **REPORT TITLE:** | 2024/25 Q3 Board Assurance Framework |
| **SPONSORING EXEC:** | Jade Renville, Director of Corporate Services |
| **REPORT BY:** | Ben Edgar-Attwell, Deputy Director of Corporate Services |
| **PRESENTED BY:** | Jade Renville, Director of Corporate Services |
| **DATE:** | 4 February 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** | Somerset NHS Foundation Trust (SFT) has identified eight long term strategic objectives. The five clinical objectives are aligned with the system clinical aims which also form the basis for the clinical model. These sit alongside our financial, people and organisational objectives.<br><br>**The Board Assurance Framework (BAF)**<br>An Assurance Framework has been developed to outline the highest risks to the Trust in achieving these objectives; the plans in place to manage and mitigate these and to provide the Committees and Board with a summary of key plans and strategies supporting their delivery.<br><br>There was discussion at the Board meeting held in September 2024. Further refinement to the BAF following subsequent Committee and Board development sessions will be addressed within future quarterly reports.<br><br>The highest risks to the strategic objectives are currently:<br><br>• Access to primary care / increasing ED demand (objective 2) – 20<br><br>• Workforce shortages (objectives 2) – 20<br><br>• Vacancies within consultant workforce (objective 6) – 20<br><br>• Risk EHR business case is not approved or delays to process (objective 8) - 20 |

| | |
|---|---|
| | Further information on the current risk position is outlined below. |
| **Recommendation** | The Board of Directors is asked to:<br><br>• Review the Board Assurance Framework and note the actions being taken to address the risks identified.<br><br>• Consider the objectives reserved to the Board in respect of the key controls and assurances and any further assurances that may be required in respect of any individual areas of risk. |

| **Links to Joint Strategic Objectives**<br>(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 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**<br>**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.**<br><br>**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 impacts on people with protected characteristics have not been considered as part of this report but are considered as part of the mitigating actions taken at service group level. |

| 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<br><br>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<br>(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 on a quarterly basis. |

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

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

**SOMERSET NHS FOUNDATION TRUST**

**2024/25 Q3 BOARD ASSURANCE FRAMEWORK**

## 1. PURPOSE OF THE REPORT

1.1 To present the 2024/25 Q3 SFT Board Assurance Framework to the Board of Directors in line with the governance and monitoring arrangements outlined within Appendix 1 of this report.

## 2. CURRENT POSITION

2.1 The current risk profile against the eight objectives is as follows:

| Corporate Objective | Risk Appetite | | Highest Risk |
|---|---|---|---|
| 1. Improve the health and wellbeing of the population | G | Seek 15-16 | 12 |
| 2. Provide the best care and support to people | R | Open 12 | 20 |
| 3. Strengthen care and support in local communities | A | Seek 15-16 | 16 |
| 4. Reduce inequalities | G | Seek 15-16 | 12 |
| 5. Respond well to complex needs | A | Seek 15-16 | 16 |
| 6. Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture | R | Seek 15-16 | 20 |
| 7. Live within our means and use our resources wisely | R | Financial Manag – Open 12 | 16 |
| | A | Commercial – Seek 15-16 | |
| 8. Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies | R | Seek 15-16 | 20 |

2.2 The highest risks identified within the Assurance Framework across all objectives are:

- Access to primary care / increasing ED demand (objective 2) – 20
- Workforce shortages (objectives 2) – 20

- Vacancies within consultant workforce (objective 6) – 20
- Risk of EHR business case is not approved or delays to process (objective 8) – 20
- Shortfalls in Social Care capacity (objectives 2 and 3) – 16
- Fragility of Primary Care and possible impact of GP action (objective 3) – 16
- LOS > 21 days due to insufficient intermediate care capacity (objective 5) – 16
- Retention rate for some colleague groups (objective 6) – 16
- Systemic discrimination (objective 6) – 16
- Failure to identify & deliver sufficient recurrent CIP (objective 7) – 16
- Lack of pace of system-wide changes to address deficit (objective 7) – 16
- The Trust fails to deliver the elective activity trajectory (objective 7) - 16
- Unsafe premises and environment/fire compartmentalisation (objective 8) - 16

## 3. BOARD COMMITTEE REVIEWS/DEEP DIVES

3.1 The Board Assurance Committees are tasked with the regular review and in-depth analysis of the Strategic Objectives assigned to them. These reviews ensure that the objectives are being met and that any issues are promptly addressed. The committees also identify key priority areas for future focus.

**Quality and Governance Assurance Committee**

3.2 A comprehensive deep dive was undertaken on Objective 2 on 30 October 2024. This review included an analysis of the current status, challenges faced, and progress made towards achieving the objective. Another detailed deep dive was carried out into Objective 3 on 18 December 2024. The committee identified areas of success and those requiring further attention. The committee also received an updated BAF at the meeting held on 29 January 2025.

3.3 The Quality and Governance Assurance Committee will continue to review the objectives delegated to it in upcoming focus meetings. These sessions will provide an opportunity to assess the key priority areas.

**Finance Committee**

3.4 The Finance Committee conducts a thorough review of Objective 7 on a quarterly basis. The most recent reviews took place in September 2024 and January 2025.

**People Committee**

3.5 The People Committee reviews Objective 6 at each bi-monthly meeting. A detailed review was completed in December 2024 on the assurance ratings and actions identified with good progress made in a number of areas although some actions had been delayed, which would be monitored by the Committee.

**Audit Committee**

3.6 The Audit Committee reviewed the BAF and the wider arrangements at the meeting held on 15 January 2025.

## 4. CONCLUSION

4.1 The Trust continues to carry a significant number of high strategic risks that are over and above the level its Risk Appetite Statement.

4.2 Due to the nature of the wider NHS, a number of the highest rated risks are residual strategic or operational risks that the Trust may not be able to directly influence. Consideration should be made as to whether or not further mitigations can be identified.

4.3 There is a mixed level of assurance across the strategic objectives. Actions to improve controls and assurance has been reviewed and updated for 2024/25 and will be monitored throughout the year in the respective overseeing committee and/or Board.

4.4 The position around delivery of the core strategic objectives remains extremely challenging in the context of operational pressures within the Trust and in social care and primary care across the county; and increasingly, workforce issues in a number of core services.

## 5. RECOMMENDATION

5.1 The Board is asked to review the Board Assurance Framework, consider the objectives and risks reserved to the Board, and note the actions being taken to address the risks identified.

**DEPUTY DIRECTOR OF CORPORATE SERVICES**

# BOARD ASSURANCE FRAMEWORK SUMMARY

## Quarter 3 2024/25

| Ref | Executive Owner | Corporate Objective | | Aspirational Measure | Overseeing Committee | Risk Appetite | | Highest Risk | | Priority Programmes & Strategies | | Risk Controls | | Oversight Arrangements - Governance & Engagement | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1** | MI | **Improve the health and wellbeing of the population** | | **Healthy life expectancy** | Board | G | Seek 15-16 | 12 | ⇔ | A | ⇔ | G | ⇔ | A | ⇔ |
| **2** | HP | **Provide the best care and support to people** | | **Colleague engagement** | Quality & Governance Assurance Committee | R | Open 12 | 20 | ⇔ | A | ⇔ | A | ⇔ | G | ⇔ |
| **3** | AH | **Strengthen care and support in local communities** | | **Admissions prevented by Acute Home Treatment and Rapid Response** | Quality & Governance Assurance Committee | A | Seek 15-16 | 16 | ⇔ | G | ⇔ | G | ⇔ | A | ⇔ |
| **4** | HP | **Reduce inequalities** | | **TBC** | Quality & Governance Assurance Committee | G | Seek 15-16 | 12 | ⇔ | A | ⇔ | A | ⇔ | R | ⇔ |
| **5** | MI | **Respond well to complex needs** | | **Patients not meeting the Criteria to Reside in acute beds** | Quality & Governance Assurance Committee | A | Seek 15-16 | 16 | ⇔ | G | ⇔ | G | ⇔ | G | ⇔ |
| **6** | IC | **Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture** | | **Retention rate: rolling 12-months** | People Committee | R | Seek 15-16 | 20 | ⇔ | A | ⇔ | A | ⇔ | A | ⇔ |
| **7** | PM | **Live within our means and use our resources wisely** | | **Underlying deficit - year on year reduction** | Finance Committee | R<br>A | Financial Management Open 12<br>Commercial Seek 15-16 | 16 | ⇔ | A | ⇔ | A | ⇔ | A | ⇔ |
| **8** | DS | **Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies** | | **TBC** | Board | R | Seek 15-16 | 20 | ⇔ | R | ⇔ | A | ⇔ | A | ⇔ |

| | Highest Risk | Assurance ratings | | Risk Appetite |
|---|---|---|---|---|
| ⇧ | Highest risk rating increased | Assurance increased | G | Below risk appetite level |
| ⇔ | Highest risk rating remained the same | Assurance remained the same | A | Within risk appetite level |
| ⇩ | Highest risk rating decreased | Assurance decreased | R | Above risk appetite level |

| Exec Owner | Corporate Objective | Overseeing Committee |
|---|---|---|
| Mel Iles | **1. Improve the health and wellbeing of the population** | Board |

**Key Performance Indicators (those highlighted are linked to the Quality Strategy)**

| | | | | | |
|---|---|---|---|---|---|
| Peri-op anaemia:pats rec intravn iron | 10 ⇩ | Diabetes: pats on hybrid closed loops | 152 ⇧ | Smoking status: acute IP | 34.2% ⇩ |
| Smoking quit rates: Mental health IP | 42% ⇩ | 28 day cancer faster diagnostic | #### ⇩ | Suicide/Self harm prev: MH Staff | 385 ⇔ |
| Suicide/Self harm prev: non-MH | 222 ⇔ | | | | |

| | Key Risks (*High Consequence risks that may stop us achieving the objective*) | Risk Reference (*From corporate risk register*) | Current Risk Con | Lik | RS | Target Risk Con | Lik | RS |
|---|---|---|---|---|---|---|---|---|
| 1 | Population Health may not get the focus required | 1613 | 3 x 4 = | 12 | | 3 x 3 = | 9 | |
| 2 | Approach to Population Health may be uncoordinated | 1615 | 4 x 2 = | 8 | | 4 x 2 = | 8 | |
| 3 | Lack of analytic support and visibility of data | 1616 | 3 x 3 = | 9 | | 3 x 2 = | 6 | |

**Risk Appetite**

**Seek 15-16** — Green - below risk appetite level

| Controls (*What we have in place to support delivery of the objective*) | Assurance (*Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*) | Outcome of assurance | Assessment (*See assessment guidance*) |
|---|---|---|---|
| **Priority Programmes and Strategies** | | | |
| ICS Population Health Strategy | ICS System Assurance Forum | Positive | |
| Smoking Cessation and Perioperative care programme | Reporting framework for Tobacco Programme under development | Positive | Amber |
| Suicide prevention programme | Programme Board to be established | Neutral | |
| Somerset Liver Improvement Programme | NIHR Research overseen by SFT Research Department | Negative | |
| **Risk Controls** | | | |
| Digital Strategy Board | Reports to the Board | Positive | |
| Weekly / fortnightly reviews of Patient Tracking Lists for tumour sites | Cancer gov invol System Performance Group, Cancer Performance S | Positive | Green |
| **Oversight Arrangements for Governance & Engagement** | | | |
| ICS Population Health Transformation Board | Progress on KPIs presented to Board on regular basis | Positive | |
| ICS Data Development Group | Overview of Programme to Board Development Session | Neutral | Amber |
| Trust Information and Data Group | Oversight of flagship priorities & clinical strategy - QGAC | Positive | |
| Quality Assurance Group | Oversight of topic assurance | Neutral | |

| Actions to Improve Controls and Assurance (*Required for any areas assessed Amber or Red*) | Lead | Target Date | Progress Summary |
|---|---|---|---|
| Risk controls and oversight of priority programmes | MI | Apr-25 | On Plan |
| Embed improving health and tackling inequalities approaches in neighbourhood working | TE | Apr-25 | On Plan |
| Trust Support to ICS priorities | DS / MI | Apr-25 | On Plan |
| Trust involvement in development of population health dataset | DS | Apr-25 | On Plan |
| Develop and improve Healthcare Inequalities data and evidence eg ethnicity data. | DS / MI | Apr-25 | Behind Schedule |
| | | | |

| Exec Owner | Corporate Objective | Overseeing Committee |
|---|---|---|
| Hayley Peters | **2. Provide the best care and support to people** | Quality & Governance Assurance Committee |

**Key Performance Indicators (those highlighted are linked to the Quality Strategy)**

| | | | | | |
|---|---|---|---|---|---|
| Incidents involving ligatures | 42 ⇩ | Patient Initiated follow up (PIFU) | 7.9% ⇧ | Ambulance handover hrs lost >15m | 14562 ⇩ |
| CDiff cases in inpatient settings: YTD | 76 ⇩ | Falls per 1000 days | 5.65 ⇩ | Pressure ulcers per 1000 bed days | 1.28 ⇩ |
| End of Life pat discharges <24hrs | 0 ⇔ | Acute Home Treatment caseload | 68 ⇧ | No criteria to reside: % of acute beds | 21.8% ⇩ |

| | Key Risks (High Consequence risks that may stop us achieving the objective) | Risk Reference (From corporate risk register) | Current Risk Con | Lik | RS | Target Risk Con | Lik | RS |
|---|---|---|---|---|---|---|---|---|
| 1 | Access to primary care / increasing ED demand | 2620, 2615, 673, 372, 551, 1709 | 4 x | 5 = | 20 | 2 x | 4 = | 8 |
| 2 | Shortfalls in Social Care capacity | 2273 & 1513 | 4 x | 4 = | 16 | 4 x | 3 = | 12 |
| 3 | Age of acute and community estates | 1789 | 5 x | 3 = | 15 | 4 x | 2 = | 8 |
| 4 | Workforce shortages | 2044, 1815, 1880, 1944, 2306, 2307, 2 | 5 x | 4 = | 20 | 4 x | 3 = | 12 |

**Risk Appetite**

**Open 12** — Red - above risk appetite level

| Controls (What we have in place to support delivery of the objective) | Assurance (Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)) | Outcome of assurance | Assessment (See assessment guidance) |
|---|---|---|---|
| **Priority Programmes and Strategies** | | | |
| Clinical Strategy | CQC Inspection / Insight Reports / Royal College Outlier Status | Negative | |
| Digital and Estates Strategies | National Patient Surveys / Staff Survey | Positive | Amber |
| Recruitment and Retention Plans | Model Hospital/GIRFT/national benchmarking data | Neutral | |
| Hospital @ Home Programme | | | |
| **Risk Controls** | | | |
| Service Group Workforce Plans | People Committee | Neutral | |
| Risk assessed capital and backlog maintenance programmes | Internal audit programme | Neutral | Amber |
| | | | |
| **Oversight Arrangements for Governance & Engagement** | | | |
| Operational Leadership Team (Transformation) - Delivery of ClinStrat | Delivery of Transformation - Trust Board | Neutral | |
| Strategic Estates Group | Oversight of clinical strategy - QGAC | Positive | Green |
| | Governance assurance reports inc MSSP feedback | Neutral | |

| Actions to Improve Controls and Assurance (Required for any areas assessed Amber or Red) | Lead | Target Date | Progress Summary |
|---|---|---|---|
| Ward Accreditation programme - trial planned July 24, roll out autumn 24 | HP | Dec-24 | Behind Schedule |
| Delivery of Quality Strategy Work Plan - Year One, including measurement of delivery | HP/MI | Dec-24 | Behind Schedule |
| Delivery of the action plan following the internal audit for Personalised Care | CB-J | Dec-24 | Behind Schedule |
| Implementation of the UTC business case for YDH winter 2024/25 (and MPH 25/26) | AH | Dec-24 | Significantly Behind Schedule |
| Successful entry into the national 'culture of care' programme for MH wards | HP | Apr-25 | On Plan |
| Complex emotional needs strategy implementation | JY | Apr-25 | On Plan |
| 100 day discharge sprint | HP | May-25 | On Plan |

| Exec Owner | Corporate Objective | Overseeing Committee |
|---|---|---|
| Andy Heron | **3. Strengthen care and support in local communities** | Quality & Governance Assurance Committee |

**Key Performance Indicators (those highlighted are linked to the Quality Strategy)**

| | | | | | |
|---|---|---|---|---|---|
| Adm. Prevented by Rapid Resp/AHT | 499 ⇧ | Pats admitted to Acute Home Treatmt | 255 ⇧ | Increase Open MH attendances | 21912 ⇧ |
| Increase numbers of self-referrals | 22727 ⇩ | Urgent Community response <2hrs | 87.4% ⇧ | Treatmt Escalatn Plans -pat/fam involv | 66.6% ⇩ |
| | | | | | |

| | Key Risks (*High Consequence risks that may stop us achieving the objective*) | Risk Reference (*From corporate risk register*) | Current Risk Con | | Lik | | RS | Target Risk Con | | Lik | | RS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Workforce shortages - Primary Care | 2188 | 3 | x | 4 | = | 12 | 2 | x | 3 | = | 6 |
| 2 | Fragility of Primary Care & possible impact of GP action | 673 & 2884 | 4 | x | 4 | = | 16 | 4 | x | 3 | = | 12 |
| 3 | Shortfalls in Social Care capacity | 2273 & 1513 | 4 | x | 4 | = | 16 | 4 | x | 3 | = | 12 |

| Risk Appetite | |
|---|---|
| **Seek 15-16** | Amber - within risk appetite level |

| Controls (*What we have in place to support delivery of the objective*) | Assurance (*Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*) | Outcome of assurance | Assessment (*See assessment guidance*) |
|---|---|---|---|
| **Priority Programmes and Strategies** | | | |
| Trust/ICS workforce strategy and integration | ICS System Assurance Forum | Neutral | |
| Acute Home Treatment Reset | Regional and Executive Oversight | Negative | Green |
| Productive Care Programme | OLT (Transformation) | Positive | |
| Symphony Strategy | | | |
| **Risk Controls** | | | |
| Reports to OLT | Board Development Programme | Neutral | |
| Reports to QOFP | OLT | Positive | Green |
| Hospital @ Home Programme Board | Regional oversight of implementation and peformance | Negative | |
| **Oversight Arrangements for Governance & Engagement** | | | |
| Reports to QGAC | Trust Board Quadrant Report | Neutral | |
| Integrated Neighbourhood Working Steering Group | Intermediate Care performance report - weekly | Neutral | Amber |
| Urgent Emergency Care Delivery Group | Trust Board Quadrant Report | Neutral | |
| | QOFP | | |

| Actions to Improve Controls and Assurance (*Required for any areas assessed Amber or Red*) | Lead | Target Date | Progress Summary |
|---|---|---|---|
| Action plan to address low levels of referral activity into H@H - Care Co has now gone live 4/11/24 | TE | Apr-25 | Significantly Behind Schedule |
| North Sedgemoor Integration Programme | TE | Apr-25 | On Plan |
| South Somerset West PCN/Neighbourhood Collaboration | TE | Apr-25 | On Plan |
| NCTR Review | PL | Apr-25 | On Plan |
| UTCs for Yeovil and Taunton | AH | Apr-25 | On Plan |
| Delivery 2 year investment UTC workforce | AH | Apr-25 | On Plan |

| Exec Owner | Corporate Objective | Overseeing Committee |
|---|---|---|
| Hayley Peters | **4. Reduce inequalities** | Quality & Governance Assurance Committee |

**Key Performance Indicators (those highlighted are linked to the Quality Strategy)**

| | | | | | |
|---|---|---|---|---|---|
| Prot characteristics data completeness | 90.4% ⇧ | Maternity: continuity of care hi risk tbc | ⇔ | Ethnicity equity of access:acute RTT | Equit ⇔ |
| Ethnicity equity of access: cancer | Equit ⇔ | Ethnicity equity of access: MH | Equit ⇔ | Safeguarding children Level 3 training | #### ⇧ |
| | | | | | |

| | Key Risks (*High Consequence risks that may stop us achieving the objective*) | Risk Reference (*From corporate risk register*) | Current Risk Con | | Lik | | RS | Target Risk Con | | Lik | | RS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | System and Trust strategy not fully developed | 1620 | 5 | x | 2 | = | 10 | 4 | x | 2 | = | 8 |
| 2 | Data Team - Competing priorities and recruitment and retention issu | 1616 | 3 | x | 3 | = | 9 | 3 | x | 2 | = | 6 |
| 3 | Historical funding/resource gaps including in MH & LD | 1622 | 3 | x | 4 | = | 12 | 3 | x | 3 | = | 9 |

| Risk Appetite | |
|---|---|
| **Seek 15-16** | Green - below risk appetite level |

| Controls (*What we have in place to support delivery of the objective*) | Assurance (*Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*) | Outcome of assurance | Assessment (*See assessment guidance*) |
|---|---|---|---|
| **Priority Programmes and Strategies** | | | |
| Information on Health Inequalities - Trust Board Development | Internal Audit - Mental Health (January 2023) | Positive | |
| Digital Strategy - population health data | Digital Board/Board review | Neutral | Amber |
| Stolen Years / Deaths of Dispair Programme TBC | QGAC annual review | Positive | |
| Primary Care LD Screening Programme | LeDER Report | Neutral | |
| **Risk Controls** | | | |
| Equality Impact Assessments | None | Negative | |
| Master Patient Index - data quality review | Data Quality reports | Neutral | Amber |
| | Board reports | Positive | |
| **Oversight Arrangements for Governance & Engagement** | | | |
| Quality & Governance Assurance Committee | CQC Inspection/Insight | Negative | |
| Population Health Management Committee | Board Assurance Reports | Neutral | Red |
| | Board Reports | Neutral | |

| Actions to Improve Controls and Assurance (*Required for any areas assessed Amber or Red*) | Lead | Target Date | Progress Summary |
|---|---|---|---|
| Review Equality Impact assessment process and effective monitoring at all levels | PB | Apr-25 | On Plan |
| Development of strategy to incorporate of deprivation/exclusion markers into trust data | DS | Apr-25 | Behind Schedule |
| Meet requirements of NHSE Statement of Information on Health Inequalities | LC | Apr-25 | On Plan |
| Implement Patient Carer Race Equality Framework | PB | Apr-25 | On Plan |

| | | | |
|---|---|---|---|
| Embed improving health and tackling inequalities approaches in neighbourhood working | TE | Apr-25 | On Plan |
| Develop and improve Healthcare Inequalities data and evidence eg ethnicity data. | DS / MI | Apr-25 | Behind Schedule |

| Exec Owner | Corporate Objective | Overseeing Committee |
|---|---|---|
| Mel Iles | **5. Respond well to complex needs** | Quality & Governance Assurance Committee |

**Key Performance Indicators (those highlighted are linked to the Quality Strategy)**

| | | | | | |
|---|---|---|---|---|---|
| CYP Eating Disorders - Routine | 95.5% ⇔ | Reduce time in ED: intensity users | 78952 ⇧ | Time to assessment in CYPNP | 76 wks ⇧ |
| Av wait for assessment: adults w/ASD | 65 wks ⇩ | Homeless service: annual referrals | 795 ⇧ | Personalised care planning tbc | ⇔ |
| Dementia diagnosis rate-Symphony | 53.5% ⇩ | | | | |

| | Key Risks (*High Consequence risks that may stop us achieving the objective*) | Risk Reference (*From corporate risk register*) | Current Risk Con | Lik | RS | Target Risk Con | Lik | RS |
|---|---|---|---|---|---|---|---|---|
| 1 | Sub-optimal links between primary care & SFT services | 1951 | 4 x 3 = | 12 | | 4 x 2 = | 8 | |
| 2 | Personalised care doesn't get required focus | 1952 | 4 x 2 = | 8 | | 3 x 2 = | 6 | |
| 3 | LOS > 21 days due to insufficient intermediate care capacity | 2273 | 4 x 4 = | 16 | | 4 x 3 = | 12 | |

**Risk Appetite**

**Seek 15-16** — Amber - within risk appetite level

| Controls (*What we have in place to support delivery of the objective*) | Assurance (*Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*) | Outcome of assurance | Assessment (*See assessment guidance*) |
|---|---|---|---|
| **Priority Programmes and Strategies** | | | |
| Transition Complex CYP Programme | Internal monitoring | Positive | |
| Clinical Strategy | ICS System Assurance Forum | Neutral | Green |
| Personalised Care Strategy | Personalised Care Strategy Group. | Neutral | |
| **Risk Controls** | | | |
| Clinical priority prog. eg high service use, homeless, eating disorders | Compliance with national and regional programmes | Positive | |
| Support to ICS Personalised care strategy planning | Internal monitoring, audit | Positive | Green |
| Primary Care / SFT Interface Group | Reporting to GP Support Unit and OLT Transformation Group | Positive | |
| **Oversight Arrangements for Governance & Engagement** | | | |
| QGAC Assurance Reports | Reports to QGAC | Positive | |
| Symphony Board | Oversight reports for ICB, Primary Care Board etc. | Neutral | Green |
| Complex Care Board | Progress on KPIs presented to Board on regular basis | Neutral | |

| Actions to Improve Controls and Assurance (*Required for any areas assessed Amber or Red*) | Lead | Target Date | Progress Summary |
|---|---|---|---|
| SFT Personalised care improvement group established/milestones 24/25 | CBJ | Mar-25 | On Plan |
| Transitional Care System Case for Change | AH | Apr-25 | On Plan |
| South Somerset West PCN/Neighbourhood Collaboration | AH | Apr-25 | On Plan |
| | | | |
| | | | |
| | | | |

| Exec Owner | Corporate Objective | Overseeing Committee |
|---|---|---|
| Isobel Clements | **6. Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture** | People Committee |

**Key Performance Indicators (those highlighted are linked to the Quality Strategy)**

| | | | | | |
|---|---|---|---|---|---|
| Retention: rolling 12 months | 88.8% ⇧ | Pulse Engagement | 7.06 ⇧ | Pulse Advocacy | 7.12 ⇧ |
| | | Inclusion: % Band 8a+ who are female | 57.9% ⇩ | | ⇔ |
| | | | | | |

| | Key Risks (*High Consequence risks that may stop us achieving the objective*) | Risk Reference (*From corporate risk register*) | Current Risk Con | Lik | RS | Target Risk Con | Lik | RS |
|---|---|---|---|---|---|---|---|---|
| 1 | Vacancy rates within senior doctor workforce | 2044 | 5 x | 4 = | 20 | 4 x | 3 = | 12 |
| 2 | Retention rate for some colleague groups | 1880 | 4 x | 4 = | 16 | 3 x | 3 = | 9 |
| 3 | Systemic Discrimination | 2770 | 4 x | 4 = | 16 | 3 x | 3 = | 9 |

**Risk Appetite**

**Seek 15-16** — Red - above risk appetite level

| Controls (*What we have in place to support delivery of the objective*) | Assurance (*Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*) | Outcome of assurance | Assessment (*See assessment guidance*) |
|---|---|---|---|
| **Priority Programmes and Strategies** | | | |
| People Strategy 2023-2028 | People Strategy KPIs / retention data / NQPS | Positive | |
| Inclusion workforce plan | Internal audit / NHS Staff Survey / NQPS / WDES / WRES / Gender Pay | Negative | Amber |
| Listening roadmap | NHS Staff Survey / NQPS / People Impact Assessment | Neutral | |
| **Risk Controls** | | | |
| Service Group Workforce Plans | People Committee reports, QOFP reporting | Neutral | |
| Improved R&R implementation and review process | Colleague Experience Group reports to OLT, Board reports, scorecard | Positive | Amber |
| Workforce inclusion workplan | 6 monthly internal Board report and People Committee report | Negative | |
| **Oversight Arrangements for Governance & Engagement** | | | |
| Reports to People Committee | People Committee strategy commitments assurance deep dives | Neutral | |
| People Services Governance Committee | Deliverables highlight reports and project charters | Neutral | Amber |
| Colleague Experience Group | Cultural Maturity IA Review - Report to OLT/People Committee | Negative | |

| Actions to Improve Controls and Assurance (*Required for any areas assessed Amber or Red*) | Lead | Target Date | Progress Summary |
|---|---|---|---|
| Stengthen the link between colleague experience and learning through a revised learning strategy & KPI - origi | IC | Jun-25 | On Plan |
| Implement formal monitoring arrangements of the inclusion workforce plan and improve visibility | IC | Sep-24 | Complete |
| Explore colleague experience from different generational perspective & develop response plan | IC | Mar-25 | On Plan |
| Review next steps for retention focus now the exemplar programme has ended - orginal target date Sept 24 ex | IC | Mar-25 | On Plan |
| Add the measures of the people plan into QOFP reporting to improve assurance of progress | IC | Sep-24 | Complete |
| Explore how to measure leadership impact as part of the year 2 leadership expectations deliverable | IC | Mar-25 | On Plan |

| Exec Owner | Corporate Objective | Overseeing Committee |
|---|---|---|
| Pippa Moger | **7. Live within our means and use our resources wisely** | Finance Committee |

**Key Performance Indicators (those highlighted are linked to the Quality Strategy)**

| | | | | | |
|---|---|---|---|---|---|
| Financial position v plan (YTD) | B/even ⇧⇩ | % of CIP identified as recurrent | 49% ⇩ | Agency v plan (YTD) | 5759k fa ⇧ |
| No criteria to reside: % of acute beds | 21.8% ⇩ | Performance v workplan trajectory | 12561 ⇧⇩ | | |

| | Key Risks (*High Consequence risks that may stop us achieving the objective*) | Risk Reference (*From corporate risk register*) | Current Risk Con | | Lik | | RS | Target Risk Con | | Lik | | RS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Failure to identify & deliver sufficient recurrent CIP | 6 | 4 | x | 4 | = | 16 | 4 | x | 3 | = | 12 |
| 2 | Lack of pace of system-wide changes to address deficit | 960 | 4 | x | 4 | = | 16 | 4 | x | 3 | = | 12 |
| 3 | The Trust fails to deliver the elective activity trajectory | 1859 | 4 | x | 4 | = | 16 | 3 | x | 3 | = | 9 |

**Risk Appetite**

**Financial Management Open 12**
**Commercial Seek 15-16**

Red - above risk appetite level
Amber - within risk appetite level

| Controls (*What we have in place to support delivery of the objective*) | Assurance (*Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*) | Outcome of assurance | Assessment (*See assessment guidance*) |
|---|---|---|---|
| **Priority Programmes and Strategies** | | | |
| Finance Strategy - reduce underlying deficit to breakeven by 26/27 | Oversight of Strategy through Finance Committee | Neutral | |
| Financial Plans for 2024/25 | Financial oversight reports to Finance Committee | Neutral | Amber |
| Productive Care Programme | Reports to Operational Leadership Team (Transformation) | Neutral | |
| **Risk Controls** | | | |
| System wide discussions to manage available resources | Reports to Finance Committee | Positive | |
| Finance Committee oversight | Reports to Finance Committee | Neutral | Amber |
| System Triple Lock Process | Reports to System Finance Assurance Group and SAF | Neutral | |
| **Oversight Arrangements for Governance & Engagement** | | | |
| Control and oversight of CIP through Accountability Frameworks | Financial oversight reports to Finance Committee | Neutral | |
| System Finance Assurance Group | Key Financial Systems Internal Audit Report | Positive | Amber |
| Finance Committee | Reports to Board | Neutral | |

| Actions to Improve Controls and Assurance (*Required for any areas assessed Amber or Red*) | Lead | Target Date | Progress Summary |
|---|---|---|---|
| Challenge set to obtain 75% recurrent CIP in 24/25 planning | PM | Mar-25 | Significantly Behind Schedule |
| Productive Care Programme initial outputs reported on for 24/25 & 25/26 efficiencies | AH/PM | Jul-24 | Complete |
| Work with Social Care to increase capacity in care market to reduce delays and increased costs | PL | Mar-25 | On Plan |
| Quarterly review of underlying position to be presented to Finance Committee | PM | Quarterly | On Plan |
| Strengthen arrangement between People and Finance Committees regarding workforce reporting | PM / IC | May-24 | Complete |
| | | | |

| Exec Owner | Corporate Objective | Overseeing Committee |
|---|---|---|
| David Shannon | **8. Deliver the vision of the Trust by transforming our services through research, innovation and digital technologies** | Board |

**Key Performance Indicators (those highlighted are linked to the Quality Strategy)**

| | | | | | |
|---|---|---|---|---|---|
| Research: active trials / studies open | 231 ⇔ | Quality Improvmt: training packages | 507 ⇧ | Data Delivery Strategy on track | ⇔ |
| Patient interactions via Patient Hub | 4427 ⇩ | Electronic Health Record on track | Behind ⇧⇩ | WTEs freed up: Robotic Process Auto | 66 ⇩ |
| New Hospital Programme on Track | ⇩ | | | | |

| | Key Risks (*High Consequence risks that may stop us achieving the objective*) | Risk Reference (*From corporate risk register*) | Current Risk Con | Lik | RS | Target Risk Con | Lik | RS |
|---|---|---|---|---|---|---|---|---|
| 1 | Risk EHR business case is not approved or delays to process | 1840 | 5 x | 4 = | 20 | 5 x | 2 = | 10 |
| 2 | Failure to secure/implement necessary digital/data/technology | 1624, 2556 | 5 x | 3 = | 15 | 3 x | 3 = | 9 |
| 3 | Unsafe premises and environment/fire compartmentalisation | 1789, 1238 | 4 x | 4 = | 16 | 4 x | 2 = | 8 |

| Risk Appetite | |
|---|---|
| **Seek 15-16** | Red - above risk appetite level |

| Controls (*What we have in place to support delivery of the objective*) | Assurance (*Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*) | Outcome of assurance | Assessment (*See assessment guidance*) |
|---|---|---|---|
| **Priority Programmes and Strategies** | | | |
| Digital Strategy - Incl Joint Electronic Health Record Somerset & Dorset | Approval of Outline Business Case & NHSE Digital Maturity Assesment | Neutral | |
| Research Strategy - Year 1 priorities | Internal Audit Reports | Neutral | **Red** |
| Estates Strategy including New Hospital Programme | External Assurance reports - NHP Readiness Assesment | Negative | |
| | | | |
| **Risk Controls** | | | |
| Joint Electronic Health Record Prog Board across Somerset and Dorset | External Review of programme governance and FBC readiness | Neutral | |
| Somerset ICS Digital Strategy Implementation Group | NHSE Digital Maturity Assesment | Positive | **Amber** |
| Data Security and Protection Toolkit | Internal Audit Report | Positive | |
| **Oversight Arrangements for Governance & Engagement** | | | |
| Digital Strategy Board | Quarterly Report to Finance Committee | Positive | |
| Research Strategy Oversight Group | | Neutral | **Amber** |
| Strategic Estates Group and NHP Executive Group | Regular report to Finance Committee | Negative | |

| Actions to Improve Controls and Assurance (*Required for any areas assessed Amber or Red*) | Lead | Target Date | Progress Summary |
|---|---|---|---|
| NHSE Review of EHR Business Case | DS | Sep-24 | Significantly Behind Schedule |
| Identify and implement options for the use of the NHSE Federated Data Platform | SH | Dec-24 | Behind Schedule |
| Research Strategy Year 1 deliverables - governance arrangements and structure development | DS | Sep-24 | Complete |
| Align Improvement Programme with NHS Impact Framework | GC/RJ | Sep-24 | Complete |
| Development of Research Partnership with Universities | GC | Mar-24 | On Plan |
| New Hospital Programme Development of Strategic Outline Case | IB | Oct-24 | Significantly Behind Schedule |

**APPENDIX 1**

## 1. BOARD ASSURANCE FRAMEWORK

1.1 The Board Assurance Framework identifies which of the joint strategic objectives may be at risk because of inadequacies in the operation of controls, or where the Trust has insufficient assurance that the actions and mitigations will deliver the objectives. At the same time, it encompasses the control of risk, provides structured assurances about where risks are being managed and ensures that objectives are being delivered. This allows the Trust to determine how to make the most efficient use of resources and address the issues identified in order to improve the quality and safety of care.

1.2 The Assurance Framework is a key element of the governance documents used by the Trust to inform its declaration of compliance with the Essential Standards of Quality and Safety and the Annual Governance Statement. As part of the audit process both the external and internal auditors review the adequacy of the Assurance Framework. Each Trust is expected to have had a framework in place for each full year being reviewed.

## 2. ASSURANCE FRAMEWORK GOVERNANCE ARRANGEMENTS

2.1 The Audit Committee is responsible for reviewing the levels and effectiveness of the assurances that the Board received in respect of the risks identified, ensuring that these are relevant and timely, and that the overall system of internal control is effective. The Audit Committee oversee the effectiveness of the above processes at each of its meetings.

2.2 The Quality and Governance Committee has responsibility for oversight of the clinical strategy objectives (2, 3, 4 and 5). The People Committee has responsibility for oversight of the people objective (6) and the Finance Committee has responsibility for oversight of the finance objective (7). Objectives 1 and 8 are reserved to the Board. The Assurance Framework is also reviewed by the Executive Team on a regular basis.

2.3 The strategic objectives/BAF are reviewed and considered by the relevant committees on a regular basis.

| Somerset NHS Foundation Trust | |
|---|---|
| **REPORT TO:** | Board of Directors |
| **REPORT TITLE:** | Corporate Risk Register Report |
| **SPONSORING EXEC:** | Peter Lewis, Chief Executive |
| **REPORT BY:** | Samantha Hann, Deputy Director of Integrated Governance |
| **PRESENTED BY:** | Peter Lewis, Chief Executive |
| **DATE:** | 4 February 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 Board of Directors are ultimately responsible and accountable for the comprehensive management of risks faced by the Trust. They will: … ***receive and review the Corporate Risk Register via the Board Assurance Committees*** *and the Assurance Framework quarterly, which identify the principal risks and any gaps in assurance regarding those risks*. Each Board Assurance Committee will receive the Corporate Risk Register report with the specific risks assigned to them. The Committees will formally review and scrutinise the risks within their remit. These reports will be received at least once a quarter together with the Board Assurance Framework.<br><br>The highest areas of risk for the organisation are:<br><br>• Insufficient capacity to meet demand, deliver against referral to treatment times and reduce waiting lists<br><br>• Workforce recruitment and retention<br><br>• Financial position<br><br>• Aging estates - acute and community<br><br>• Pressures in social care; intermediate care; and primary care<br><br>• Delivery of digital transformation |
| **Recommendation** | The report covers those risks detailed on the Somerset Foundation Trust Corporate Risk Register. The report focuses on the high risks scoring 15+ on the risk matrix and includes corporate risks and service group risks. |

| | |
|---|---|
| | The Board are asked to review the report and the risks identified. |

| **Links to Joint Strategic Objectives**<br>(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**<br>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.<br>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 no proposals or matters which affect any persons with protected characteristics directly within this report. Any risks where there are proposals or matters which may affect any persons with protected characteristics would be included within the mitigating action plans held within the individual risk assessments referred to within this report. |
| All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate. |

| **Public/Staff Involvement History**<br>(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**<br>(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 Corporate Risk Register is presented to the Board and the Board Assurance Committees on a quarterly basis. |

| **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**

**CORPORATE RISK REGISTER REPORT 27 DECEMBER 2024**

## 1. INTRODUCTION

1.1 In line with the Trust's Risk Management Strategy, the Board will receive and review the Corporate Risk Register via the Board Assurance Committees, and the Assurance Framework quarterly. The Board Assurance Framework (BAF) forms part of the Trust's Risk Management Strategy and is the framework for identification and management of strategic risks. Further details can be found in Appendix 2.

## 2. PURPOSE OF THE REPORT

2.1 To present the Corporate Risk Register to the Board of Directors.

2.2 This risk report aims to provide details of the key risks detailed on the Trust's Corporate Risk Register on 27 December 2024 as shown within Appendix 1.

2.3 The risks recorded within this report including Appendix 1 only include the high-level summary title of the risks. The full description of the risks, which meet the minimum dataset requirements as outlined within the Risk Management Policy, are recorded within the risk register entries on Radar.

2.4 The validation process of risks within SFT has been included within Appendix 3.

2.5 The report also includes the corporate risks identified by Simply Serve Limited (SSL) and Symphony Healthcare Services (SHS) which are wholly owned subsidiary companies of SFT. These risks will either be shown as additional corporate risks for SFT (2191 & 2192) or mapped into existing SFT corporate risks (Risks 2409, 2423, 2456, 2467, 2627, 2683, 2692 & 2812).

## 3. CORPORATE RISK REGISTER

3.1 At the end of Quarter 3 2024/25, there are currently twenty-five risks on the Corporate Risk Register detailed within the circle heat map, five of which score 20 or 25:

- Risk 0004 Demand (20)
- Risk 0012 Waiting Times (20)
- Risk 2044 Vacancies within senior doctor workforce (20)
- Risk 2192 SHS not becoming self-sustaining (20)
- Risk 2923 Inability to isolate inpatients in accordance with national IPC requirements due to lack of capacity within Trust inpatient areas (20)

**New Risks**

3.2 There have been three new risks added to the Corporate Risk Register during Quarter 3 2024/25:

- Risk 2770 Inability to become the equitable and inclusive organisation we aspire to be for our colleagues and patients due to systemic discrimination
- Risk 2821 Inability to create a compassionate and inclusive culture where all colleagues can thrive due to discriminatory behaviour
- Risk 2923 Inability to isolate inpatients in accordance with national IPC requirements due to lack of capacity within Trust inpatient areas

**Increased Risks**

3.3 There have been two risks which have increased during Quarter 3, 2024/25 which have been included on the Corporate Risk Register:

- Risk 2191 Reduced colleague resilience due to workplace pressures and prolonged increased demand on services *(SHS Risk)*
- Risk 2728 Inability to monitor patient related service activity due to the lack of data integrity

**Risks which have Reduced**

3.4 There have been four risks which have reduced during Quarter 3, 2024/25 from the Corporate Risk Register:

- Risk 1827 Lack of unified policy and approach for the management of colleague personal files
- Risk 2584 Unauthorised merger of patient records in PACS system
- Risk 2728 Inability to monitor patient related service activity due to the lack of data integrity
- Risk 2821 Inability to create a compassionate and inclusive culture where all colleagues can thrive due to discriminatory behaviour

**Risks which have been Archived**

3.5 There have been two risks which have been archived from the Corporate Risk Register during Quarter 3, 2024/25:

- Risk 1852 Unsupported infection control electronic case management system
- Risk 2413 Inability to proceed with planned go live of new ordercomms system

**Risk Appetite & Risk Tolerance**

3.6 Each of the risks on the Corporate Risk Register have been assigned to the most relevant strategic objective for the organisation, including for SSL where relevant. The risk has then been RAG rated to demonstrate whether the risk is within or

outside of the agreed risk appetite level for the strategic objective the risk has been assigned to. This is shown within Appendix 1.

3.7 It is important for the Board and the Board Assurance Committees are aware of the risks that fall outside of the set risk appetite levels and to use this information to focus their discussions on these risks. Further information on risk appetite and risk tolerance can be found in Appendix 4.

**Emerging Risks**

3.8 Risk management activities must be dynamic and responsive to emerging risks. Horizon scanning is about identifying, evaluating, and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the organisation. Additionally, horizon scanning can identify positive areas for the Trust to develop its services, taking opportunities where these arise. By implementing mechanisms to horizon scan the Trust will be better able to respond to changes or emerging issues in a coordinated manner.

3.9 It is a responsibility of the Board to horizon scan and identify external risks that may impact on the delivery of its strategy. The Deputy Director Integrated Governance and the Trust's Risk Managers will monitor the emerging risks scoring 12 on the Service Group and Corporate services risk registers and highlight these within the report that is received by the Board Assurance Committees.

## 4. RISK MANAGEMENT ARRANGEMENTS UPDATE

4.1 Work continues to implement the aligned risk management processes with training and support being provided to individuals and teams across the organisation. The Audit Committee will be kept up-to-date on a regular basis through this report on the progress with the implementation plan included within the Trust's Risk Management Strategy and Policy.

4.2 Work continues with the intensive implementation programme across the organisation to develop Radar as the Trusts Risk Management System and train colleagues in the use of the Radar system. This covers all elements of the system including but not limited to; incident reporting; PALS and complaints; claims; etc.

4.3 Specifically in relation to the risk register element of the system, work remains underway to review all risks on Radar to ensure these meet the minimum standard as specified within the approved Risk Management Policy.

4.4 Progress reports against the Risk Management Strategy performance indicators are presented to the Audit Committee on a quarterly basis as part of the monitoring of the implementation of the Strategy. The Board Assurance Committees undertake deep dives into areas of significant risk that fall within the remit of the Committees and assurance is provided to the Audit Committee on a six monthly basis.

## 5 CONCLUSION

5.1 The Trust continues to respond and manage to an exceptionally high level of risk. There has been progress in mitigating a number of risks but the position remains

challenging due to workforce challenges; operational and financial pressures within the Trust and in social care and primary care across the County.

## 6 RECOMMENDATION

6.1 The Board of Directors is asked to review the Corporate Risk Register.

# Corporate Risk Register 27 December 2024

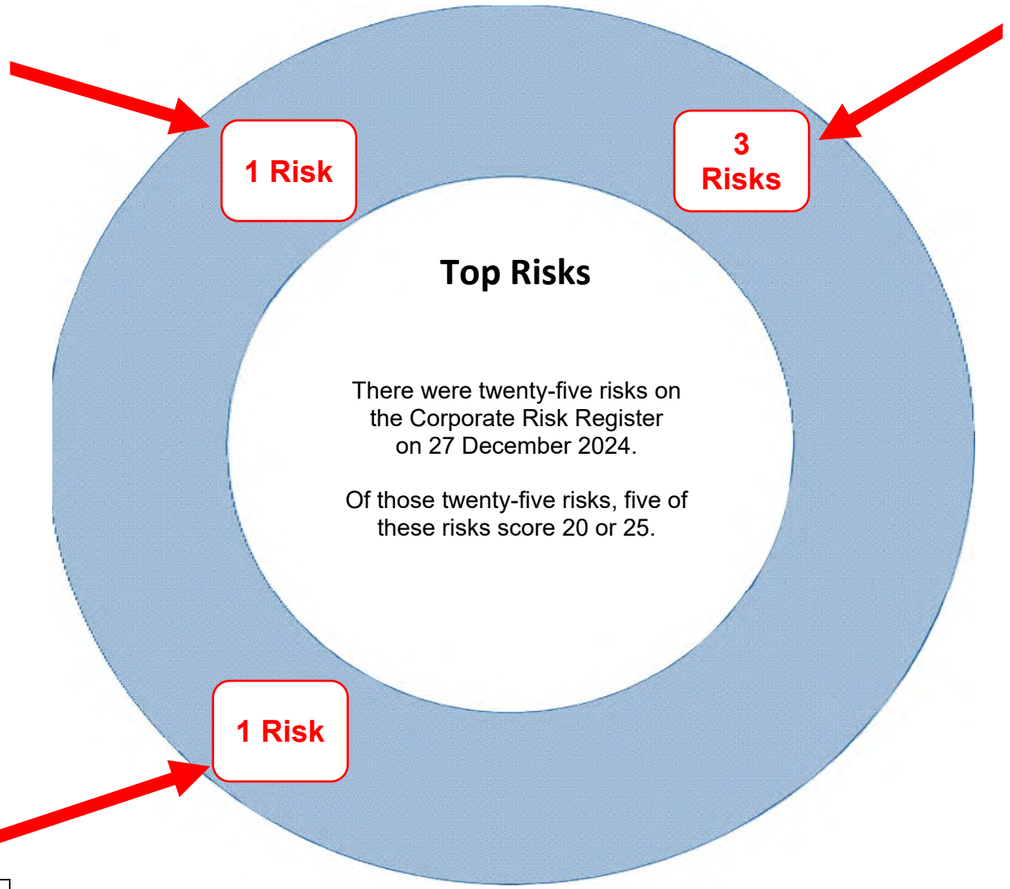
NHS Somerset NHS Foundation Trust

## People Committee

| | | |
|---|---|---|
| 20 | R2044 | Vacancies rates within senior doctor workforce |
| | SO6 | |
| 16 | R1880 | Retention and turnover of staff |
| | SO6 | |
| 16 | R2191 | Reduced colleague resilience due to workplace pressures and prolonged increased demand on services *(SHS Risk)* |
| | SO6 | |
| 16 | R2307 | Current medical workforce establishment not mapped to year on year increasing demand |
| | SO6 | |
| 16 | R2770 | Inability to become the equitable and inclusive organisation we aspire to be for our colleagues and patients due to systemic discrimination |
| NEW | SO6 | |
| 15 | R2306 | Vacancies rates within trainee doctor workforce as a result of national shortage of trainees; Deanery allocations; and the structure of run throughs |
| | SO6 | |
| 15 | R2556 | Failure to secure necessary digital, data and technology infrastructure due to inadequate investment in people, their digital skills and literacy impacting recruitment and retention |
| | SO6 | |

## Financial Committee

| | | |
|---|---|---|
| 20 | R2192 | SHS not becoming self-sustaining *(SHS Risk)* |
| | SO7 | |
| 16 | R0006 | Delivery of CIP 2024/25 |
| | SO7 | |
| 16 | R0960 | Failure to deliver financial plan |
| | SO7 | |
| 16 | R1611 | Failure to secure necessary infrastructure due to the assurance of availability of capital funding either locally or through national programmes |
| | SO7 | |
| 15 | R1624 | Failure to secure necessary digital, data and technology infrastructure due to inadequate investment and portfolio delivery |
| | SO7 | |




## Quality & Governance Committee

| | | |
|---|---|---|
| 20 | R0004 | Demand |
| | SO2 | |
| 20 | R0012 | Waiting Times |
| | SO2 | |
| 20 | R2923 | Inability to isolate inpatients in accordance with national IPC requirements due to lack of capacity within Trust inpatient areas |
| NEW | SO2 | |
| 16 | R0007 | Referral to Treatment Times |
| | SO2 | |
| 16 | R0673 | Current capacity and future resilience of primary care in Somerset |
| | SO3 | |
| 16 | R1238 | Fire Compartmentation |
| | SO8 | |
| 16 | R1878 | Inefficient use of Safeguarding resource due to the current need to develop workarounds for using the multiple systems to ensure delivery of a safe Safeguarding Service |
| | SO8 | |
| 16 | R2273 | Insufficient intermediate care capacity |
| | SO3 | |
| 15 | R0862 | Use of escalation beds across SFT |
| | SO2 | |
| 15 | R1789 | Unsafe premises and environment |
| | SO2 | |
| 15 | R2053 | Increased risk of harm due to development of episode of care pressure ulcers |
| | SO2 | |
| 15 | R2257 | Non-compliance with National Bed Rails Patient Safety Alert |
| | SO2 | |
| 15 | R2462 | Lack of knowledge, skill and resource to demonstrate compliance with national guidance and legislation for decontamination due to not having a dedicated decontamination lead in place |
| | SO2 | |

**Key:** Risk Score = 15-25 R = Risk 01 = Unique Risk Reference
**Risk Appetite:** Within Risk Appetite for the Strategic Objective (SO) risk is assigned to  Outside of Risk Appetite for the Strategic Objective (SO) risk is assigned to

## 7. BOARD ASSURANCE FRAMEWORK & CORPORATE RISK REGISTER

7.1 In line with the Trust's Risk Management Strategy, the Board will receive and review the Corporate Risk Register via the Board Assurance Committees, and the Assurance Framework quarterly. The Board Assurance Framework (BAF) forms part of the Trust's Risk Management Strategy and is the framework for identification and management of strategic risks.

### Board Assurance Framework

7.2 The Board Assurance Committees carry out detailed monitoring and review of the principal risks that relate to the organisation's strategic objectives and priorities. These risks will be proactively managed and reported on through the BAF. The Board Assurance Committees provide assurance to the Board with regard to the continued effectiveness of the Trust's system of integrated governance, risk management and internal control. Committees continue to review the extent to which they are assured by the evidence presented for each risk.

7.3 The BAF includes all principal risks that represent higher levels of opportunity or threat, which may have a major, or long-term impact on benefits realisation or organisation objectives and which may also impact upon the strategic objectives and outcomes positively or negatively.

7.4 The Board is required to review the risks that Board Assurance Committees have highlighted where further assurances may be required. This provides a filter mechanism that enables the Board to maintain a strategic focus.

7.5 One of the purposes of the BAF is to ensure that all principal risks are mitigated to an appropriate or acceptable level. It is expected that not all risks will be able to have mitigating controls that reduce the risk to the target level.

### Corporate Risk Register

7.6 The Corporate Risk Register is a central repository for the most significant operational risks scoring 15+ arising from the Service Group or departmental risk registers that cannot be controlled, or risks that have significant impact on the whole organisation and require Executive oversight and assurance on their management.

7.7 These risks represent the most significant risks impacting the Trust ability to execute its strategic objectives and therefore align with the principal strategic risks overseen by the Board. These risks may still be managed at Service Group or departmental level but require Executive oversight or will be managed by an Executive Director.

7.8 The Board sub-committees will review the Corporate Risk Register at least once a quarter to ensure that risks are being managed effectively and that lessons and risk information are being shared across the organisation. These reviews will inform the Audit Committee and Board of Directors decision in

respect of the recommendation to approve the Trust's Annual Report which contains the annual governance statement which provides assurance of the level at which the Trust's system of internal control is managing organisational.

7.9 Risks recorded on the Corporate Risk Register may also appear on the BAF if they have the potential to compromise delivery of strategic objectives. Not every high scoring risk on the Corporate Risk Register will appear on the BAF, and not all BAF entries will appear on the Corporate Risk Register, which is the tool for the management of operational risk.

7.10 The Board will use the BAF and the Corporate Risk Register to guide its agenda setting, further information and assurance requests and to inform key decision making, particularly about the allocation of financial and other resources. Through the Board sub-committees, the Board will receive assurance that the BAF and Corporate Risk Register has been used to:

- inform the planning of audit activity (Audit Committee)
- inform financial decision making and budget setting (Finance Committee)
- inform quality and governance decisions (Quality and Governance Assurance Committee)
- inform workforce; human resources; training and development decisions (People Committee)

## 8. VALIDATION OF RISKS

8.1 Risk will be managed through risk assessments and risk registers at all levels of the Trust, from "Ward to Board" with a clear escalation system and line of sight by the Board for those risks that cannot be managed at a Service Group or operational level.

8.2 By defining the level of risk that is to be managed at each tier of the organisation, risks can be managed by the correct level of seniority and each tier has oversight of risks managed in the tier below. The tiers within the organisation can be found in the Trust's Risk Management Strategy.

8.3 Every specialty/department within the organisation is responsible for maintaining its own local risk register, and departmental managers are authorised to manage all risks on their risk registers (i.e. risks rated up to, and including, 8).

8.4 Service Groups Triumvirates and Corporate Service Directors ensure the risk registers within their Service Group/Corporate Service are reviewed regularly (at least monthly) at the Service Group/Corporate Service governance meetings for risks scoring 8 or above.

8.5 Where a significant specialty/departmental risk scoring 12 or above is identified, following appropriate scrutiny from the risk owner, it will be reported into the Service Group/Corporate Service governance meeting and Quality, Outcomes, Finance and Performance (QOFP/F&P) meeting. The Service Group/Corporate Service will re-assess the risk in the context of the Service Group/Corporate Service and either agree to accept the risk or provide advice to the risk owner on the effective management.

8.6 The formal review of the risks scored between 12 and 25 at the monthly QOFP/F&P meetings is one mechanism by which significant operational risks will be escalated for inclusion on the corporate risk register and also where feedback will be provided by the Triumvirates regarding the status of previous escalations.

8.7 Service Group/Corporate Services risk registers are used by the Executive team to inform the discussions at QOFP/F&P meetings to ensure that risk is considered collectively and holistically, along with financial and operational performance. These meetings are the mechanism by which Service Groups and Corporate Services Management Teams are held to account for the management of all aspects of their services, including the management of service risks.

8.8 Risks on the Corporate Risk Register are discussed, monitored and reviewed at the monthly Board Assurance Committee Meetings and Operational Leadership Team meetings.

## 9. RISK APPETITE AND RISK TOLERANCE

9.1 Risk appetite is defined as the 'the amount and type of risk that an organisation is willing to take on in order to meet its strategic objectives'. It is the level at which the Trust Board determines whether an individual risk, or a specific category of risks are considered acceptable or unacceptable based upon the circumstances / situation facing the Trust, and the desired balance between the potential benefits of innovation and the threats.

9.2 The Trust Board are ultimately responsible for deciding the nature and extent of the risks it is prepared to take. The Trust's approach to risk appetite is a key element of the Board and the Board Assurance Committees strategic approach to risk management as it explicitly articulates their attitude to and boundaries of risk. When used effectively it is an aide to decision making and provides an audit trail in that it supports why a course of action was followed.

9.3 Risk tolerance reflects the boundaries within which the Executive management are willing to allow the true day-to-day risk profile of the organisation to fluctuate while they are executing strategic objectives in accordance with the Board's strategy and risk appetite. It is the application of risk appetite to specific objectives and is the level of risk within which the Board expects the Board Assurance Committees to operate, and management to manage. Risk tolerance is different to risk appetite in that it represents the *application of risk appetite* to specific objectives and refers to the acceptable level of variation relative to achievement of a specific objective.

9.4 The Trust expectation is that risks across the organisation will be managed within the Trust's risk appetite and tolerance. However, the Trust's Risk Appetite & Risk Tolerance Statement does not negate the opportunity to potentially make decisions that result in risk taking that is outside of the set risk appetite as some risks are unavoidable and outside of the Trust's ability to mitigate to an acceptable level. Where risks are identified that fall outside the risk appetite level these will be escalated through the Trust's governance structure, within the BAF, and through this report.

9.5 The BAF includes all principal risks that represent higher levels of opportunity or threat, which may have a major, or long-term impact on benefits realisation or organisation objectives and which may also impact upon the strategic objectives and outcomes positively or negatively. The Corporate Risk Register represents the most significant risks impacting the Trust's ability to execute its strategic objectives.

9.6 It is important for the Board and the Board Assurance Committees are aware of the risks that fall outside of the set risk appetite levels and to use this information to focus their discussions on these risks.

9.7 Each of the risks on the Corporate Risk Register have been assigned to the most relevant strategic objective (*figure 1*) for the organisation, including for SSL where relevant (*figure 2*). The risk has then been RAG rated to demonstrate whether the risk is within or outside of the agreed risk appetite

level for the strategic objective the risk has been assigned to. This is shown within Appendix 1.

*Figure 1*

| | Somerset NHS Foundation Trust Strategic Objectives | Risk Appetite |
|---|---|---|
| 1 | Improve the health and wellbeing of the population | **Seek (4)** |
| 2 | Provide the best care and support to people | **Open (3)** |
| 3 | Strengthen care and support in local communities | **Seek (4)** |
| 4 | Reduce inequalities | **Seek (4)** |
| 5 | Respond well to complex needs | **Seek (4)** |
| 6 | Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture | **Seek (4)** |
| 7 | Live within our means and use our resources wisely | **Financial Management - Open (3) Commercial – Seek (4)** |
| 8 | Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies | **Seek (4)** |

*Figure 2*

| | Simply Serve Limited Strategic Objectives | Risk Appetite |
|---|---|---|
| 1 | Support SFT to deliver the clinical strategy | **Seek (4)** |
| 2 | Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture | **Seek (4)** |
| 3 | Live within our means and use our resources wisely | **Financial Management - Open (3) Commercial - Seek (4)** |
| 4 | Develop a high performing organisation delivering the vision of the trust | **Seek (4)** |

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<br>Ian Clift, Senior Performance Manager<br>Isobel Clements, Chief of People and Organisational Development<br>Alison Wootton, Deputy Chief Nurse<br>Xanthe Whittaker, Director of Elective Care |
| **PRESENTED BY:** | Pippa Moger, Chief Finance Officer |
| **DATE:** | 4 February 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.<br><br>Areas in which performance has been sustained or has notably improved include:<br><br>• CAMHS Eating Disorders – Urgent and routine referrals seen within the required time periods remain above the national standards and the national averages.<br><br>• Access to our perinatal service was significantly above the 10% national standard.<br><br>• the number of patients waiting 52 weeks or more from referral to acute treatment reduced.<br><br>• the percentage of patients followed up within 72 hours of discharge from our adult mental health wards remained above 90%.<br><br>• 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:<br><br>• the numbers of patients in our acute beds not meeting the criteria to reside.<br><br>• the percentage of people waiting under six weeks for a diagnostic test.<br><br>• the percentage of ambulance handovers completed within 30 minutes of arrival at our Emergency Department.<br><br>• 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**<br>(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**<br>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<br><br>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**<br>(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**<br>(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: DECEMBER 2024**

## 1. BACKGROUND AND PURPOSE

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

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

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

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

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

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

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

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

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

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

**CHIEF FINANCE OFFICER**

# Overview

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

| **Successes** | **Priorities** |
|---|---|
| • our eating disorders service for children and young people continued to exceed the national waiting times standard for routine appointments.<br>• Talking Therapies achieved all nationally mandated standards.<br>• compliance remains high in respect of mental health inpatients receiving a follow-up within 72 hours of discharge.<br>• there was a reduction in the number of patients waiting over 52 weeks from referral to treatment.<br>• the compliance level in respect of mandatory training remains high despite the operational challenges faced by services.<br>• our mental health perinatal service continues to exceed the 10% national reporting standard.<br>• 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.<br>• continuing to restore and expand capacity above pre-COVID-19 levels, to address backlogs in routine elective work which has built-up.<br>• 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.<br>• continue with new ways of working, particularly through the use of technology.<br>• continue to adapt our recruitment practice, developing more innovative arrangements and reducing time to hire significantly.<br>• 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.<br>• 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.<br>• significantly increasing levels of demand, particularly for urgent care and mental health services, leading potentially to increased pressures on teams and longer waiting times.<br>• 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:** No Trust-attributed MRSA bloodstream infections (BSIs) were reported in December 2024, leaving the total for the year at two.
- **MSSA:** There were nine Trust-attributed MSSA BSIs reported in December 2024, bringing the total to 53.
- **E. coli**: There were seven Trust-attributed E. coli BSIs reported in December 2024, bringing the total to 87.
- **Klebsiella:** There were three Trust-attributed Klebsiella BSIs reported in December 2024, bringing the total to 28.
- **Pseudomonas:** There were three Trust-attributed Pseudomonas aeruginosa BSI reported in December 2024, bringing the total to 11.
- **C. diff**: There were five Trust-attributed cases reported in December 2024, bringing the total to 76.

**Respiratory Viral Infections**

- **COVID-19:** 108 inpatient cases of COVID-19 were identified during December 2024, of which 36 were healthcare-attributed.
- **Influenza:** 439 inpatient cases were identified during December 2024; the majority were 'Flu A.
- **Respiratory syncytial virus (RSV):** 166 inpatient cases of RSV were identified during December 2024.

**Outbreaks**

- During December 2024 a total of 20 outbreaks affected inpatient wards; four were due to COVID-19, 15 were due to influenza and one was due to norovirus.
- Carbapenemase-producing organism: the outbreak on the YDH site remains ongoing.

**Surgical Site Infections – Data as of November 2024 (the latest data available)**

Total Hip Replacement

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

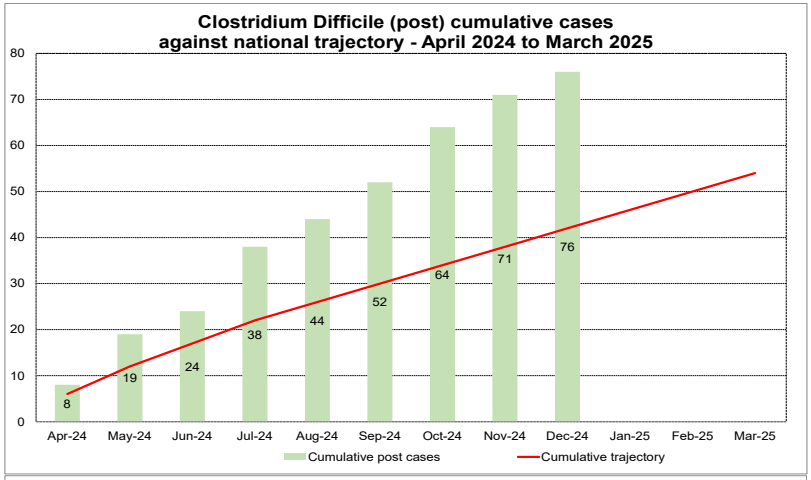
Total Knee Replacement

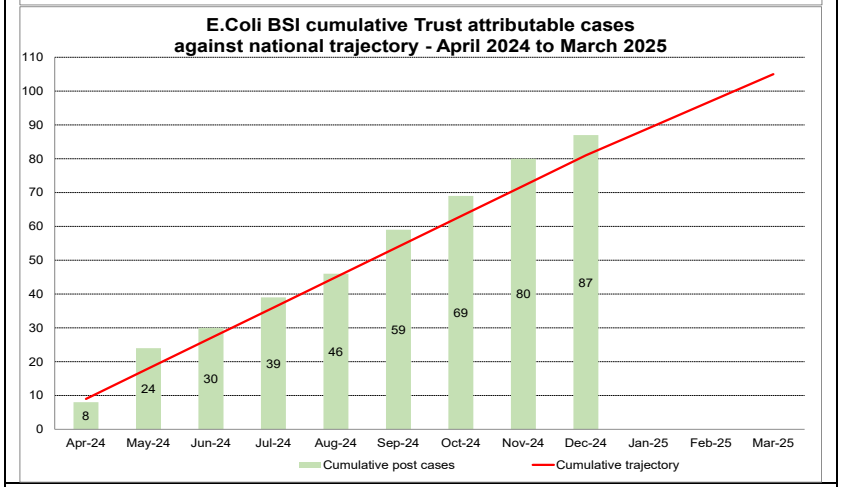
- MPH rate of infection = 0.46%
- YDH rate of infection = 0%

Spinal Surgery

MPH rate of infection = 1.47%

**Line/Bar Charts**




**Recent performance**

| Area | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|
| MRSA | 0 | 0 | 1 | 0 | 0 | 0 |
| C.Diff | 14 | 6 | 8 | 12 | 7 | 5 |
| MSSA | 4 | 9 | 4 | 7 | 4 | 9 |
| E.coli | 9 | 7 | 13 | 10 | 11 | 7 |

## 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.**

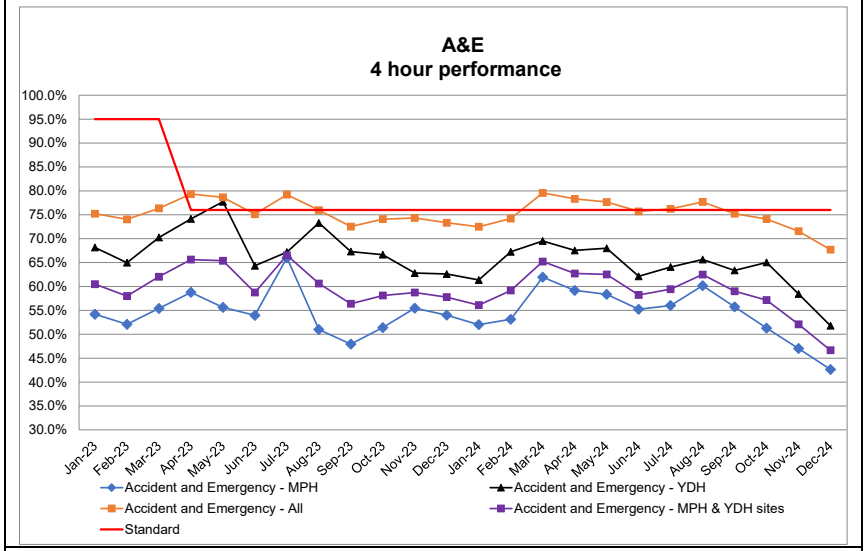
### Current performance (including factors affecting this)

- Trust-wide A&E 4-hour performance for our EDs was 46.6% during December 2024, down from 52.1% in November 2024. With Urgent Treatment Centres (UTCs) compliance included at 97.4%, overall compliance was 67.7%, down from 71.6% in November 2024, and 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): 42.6%.
    - Yeovil District Hospital (YDH): 51.8%.
- Combined rolling 12-month A&E attendances at MPH and YDH, for the period from 1 January to 31 December 2024, were 5.8% higher than the same months of 2023. Since 1 January 2024, the average number of attendances has increased to 425 patients per day, compared to 408 per day between 1 April and 31 December 2023, which has affected performance against the four-hour standard.
- The number of patients spending more than 12 hours in the departments in December 2024 was 10.8% at MPH.

### Focus of improvement work

- Urgent Treatment Rooms at YDH are working well and are significantly improving time to ED doctors.
- An analysis of the impact of the front door scanner is under way at MPH ED.
- An analysis of the use of Minor Injury and Ailment (MIA) chairs and corridor spaces is under way to support staffing reviews. A new middle grade rota is to be launched in April 2024, which increases overnight cover.
- A meeting was held with the acute medicine team on 6 January 2025, to explore options for front door patient pathways (including Same Day Emergency Care) at MPH.
- Work is progressing on the Transfer team pilot at MPH ED to reduce delays in the movement of patients to wards.
- At YDH, GP interviews are due to take place on 7 February 2025. Two YDH ED Consultant posts remain out for advert – support has been secured from recruitment teams for 'hard to fill' posts, and approval has been provided to seek agency support.
- Two fixed term ST3 posts have been offered at MPH.
- A 0.5 whole time equivalent consultant post has been accepted for MPH ED.

### Line Chart




### How do we compare

In December 2024, the national average performance for Trusts with a major Emergency Department was 55.3%. Our performance was 46.6%. We were ranked 99 out of 122 trusts. With Urgent Treatment Centre attendances included, we were ranked 63, with performance of 67.7%. National average performance was 68.3%.

### Recent performance

| Area | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|
| A&E only | 59.4% | 62.5% | 59.0% | 57.1% | 52.1% | 46.6% |
| Including MIU | 76.2% | 77.7% | 75.2% | 74.1% | 71.6% | 67.7% |

## 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.**

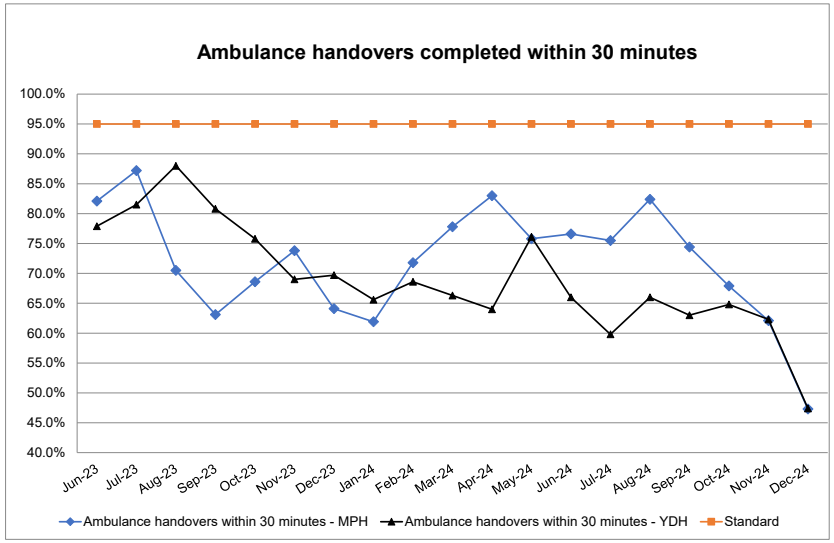
### Current performance (including factors affecting this)

- During December 2024, performance for the handover within 30 minutes of patient arrivals by ambulance decreased at Musgrove Park Hospital (MPH) and at Yeovil District Hospital (YDH) when compared to November 2024. Compliance in December 2024 was:
  - MPH: 47.3% (1,353 out of 2,565 handovers were within 30 minutes).
  - YDH: 47.4% (715 out of 1,360 handovers were within 30 minutes).
- The average performance across all hospitals served by South Western Ambulance Service NHS Foundation Trust (SWAST) in November 2024 was 48.7%.

### Focus of improvement work

- Work is ongoing with the ICB and SWASFT regarding the alignment of processes at both sites. A meeting has been arranged with department clinical leads in February 2025 to support this.
- An additional 288 patients were seen in MPH in December 2024 compared to December 2023. This includes an additional 142 ambulance arrivals, and 44 'majors' patients within that month.
- The length of stay in MPH ED for admitted patients has increased from an average of 7 hours 16 mins in 2023, to 10 hours in 2024. Work is ongoing with site and discharge teams to improve flow into inpatient areas, including the 100-day discharge sprint.
- At YDH, operational plans for the use of the current Acute Assessment Unit to be converted to greater rapid assessment and cycling space are being finalised, with aim to go live in February 2025, which will support earlier clinical assessment and treatment, and ambulance offload.
- The YDH Urgent Treatment Centre launch has been delayed due to building works and subsequent departmental moves. The aim is now to launch in April 2025.
- Plans for the SWASFT 'Timely Handover' time to be reduced to 45 minutes from 90 minutes are being presented to the Urgent Care Board on 28 January 2025.

### Line Chart




### How do we compare

In December 2024, 47.3% of all ambulance handovers at Musgrove Park Hospital and 47.4% of all ambulance handovers at Yeovil District Hospital were completed within 30 minutes. The average performance across all hospitals served by SWAST was 48.7%.

### Recent performance

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

| Area | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|
| MPH | 75.5% | 82.4% | 74.4% | 67.9% | 62.1% | 47.3% |
| YDH | 59.8% | 66.0% | 63.0% | 64.8% | 62.3% | 47.4% |

## Responsive

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

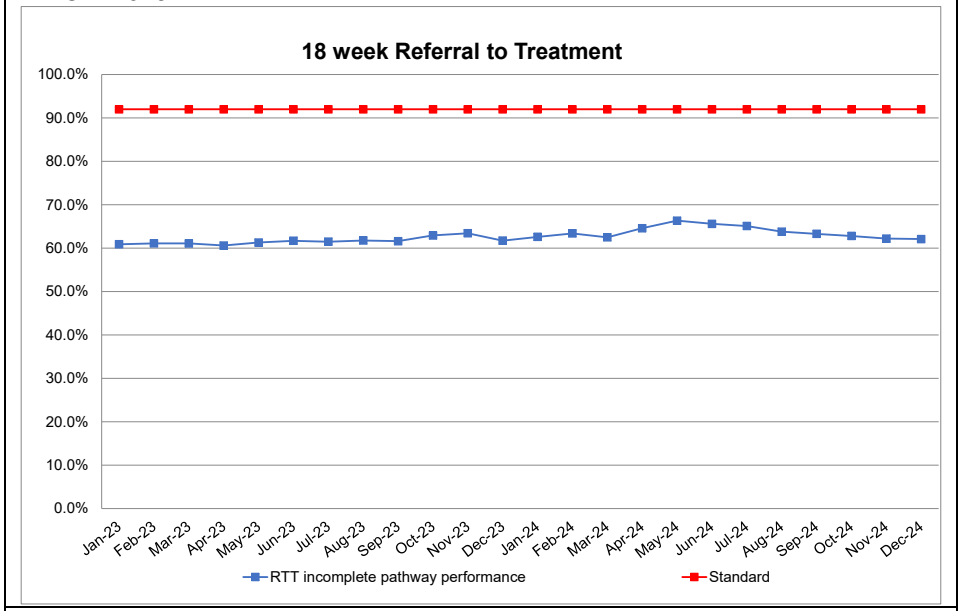
### Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT was 62.1% (combined acutes + community) in December 2024, down by 0.1% from the November 2024 position.
- The total waiting list size increased by 491 pathways, and was 8,713 higher (i.e., worse) than the planning trajectory (60,076 actual vs. 51,363); this is due in part to the Dermatology service transfer, not fully accounted for in the planning trajectory, but also to a recent growth in referrals which may be linked to GP Collective Action.
- The number of patients waiting over 52 weeks decreased by seven in December to 1,364 pathways, 588 lower (i.e. better) than the planning trajectory of 1,952.
- The number of patients waiting over 65 weeks reduced by two to 142 at month-end, against a trajectory of zero.
- The number of patients waiting 78+ weeks increased to six in December 2024 from five in November 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 59.1% in November 2024, the latest data available; our performance was 62.2%. National performance improved by 0.2% between October and November 2024; our performance reduced by 0.6%. The number of patients waiting over 52 weeks across the country decreased by 12,996 to 221,889 (3.0% of the national waiting list compared with 2.3% for the Trust). The number of patients waiting over 78 weeks nationally decreased by 395 to 2,051.

### Performance trajectory: 78 week and 65 week wait performance

| Area | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|
| 78-week trajectory | 0 | 0 | 0 | 0 | 0 | 0 |
| 78-week actual | 15 | 19 | 11 | 10 | 5 | 6 |
| 65-week trajectory | 178 | 125 | 0 | 0 | 0 | 0 |
| 65-week actual | 426 | 370 | 247 | 198 | 144 | 142 |

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.**

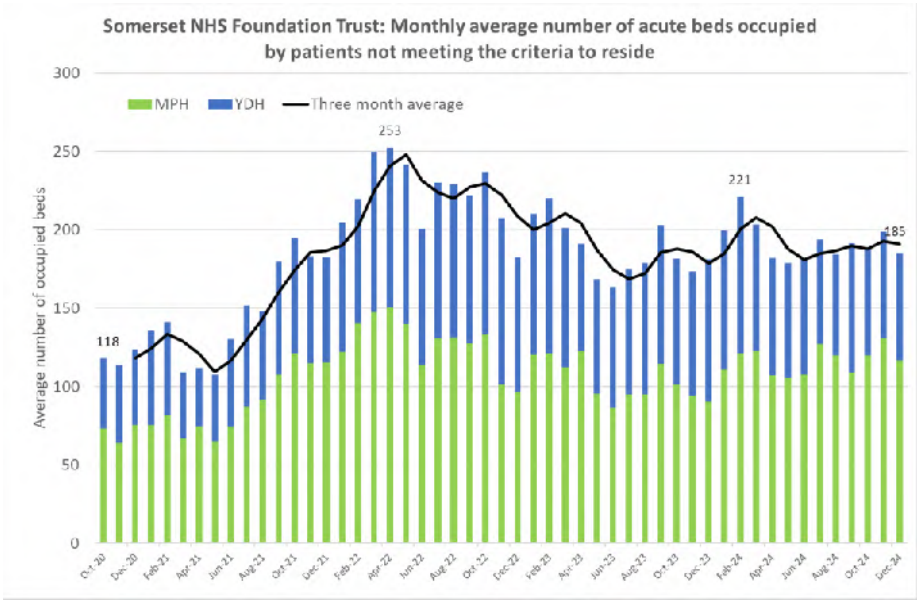
**Current performance (including factors affecting this)**

- During December 2024, the Trust-wide number of acute bed days occupied by patients not meeting the criteria to reside was 5,744 (3,620 at MPH and 2,124 at YDH), down from 5,961 in November 2024. This equates to 185 fully occupied beds for the month of December 2024, down from 199 in November 2024.
- In our community hospitals, the number of patients not meeting the criteria to reside as at 31 December 2024 was 44, unchanged from the number as at 30 November 2024.
- Of the 1,666 acute inpatients discharged during December 2024 who had a Discharge Ready Date recorded, the average duration between the Discharge Ready Date and the actual date of discharge was 2.7 days, up from 2.6 days during November 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 52.0%, down from 52.2% achieved during November 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 December 2024, national best-quartile performance was that 8.3% 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 21.4% of beds. We were ranked 107 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 | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|
| MPH | 3,939 | 3,719 | 3,269 | 3,721 | 3,930 | 3,620 |
| YDH | 2,070 | 1,991 | 2,475 | 2,122 | 2,031 | 2,124 |
| Total | 6,009 | 5,710 | 5,744 | 5,843 | 5,961 | 5,744 |

**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 ensure that at least 90% of people are seen by our adult mental health and learning disabilities services within six weeks of being referred.**

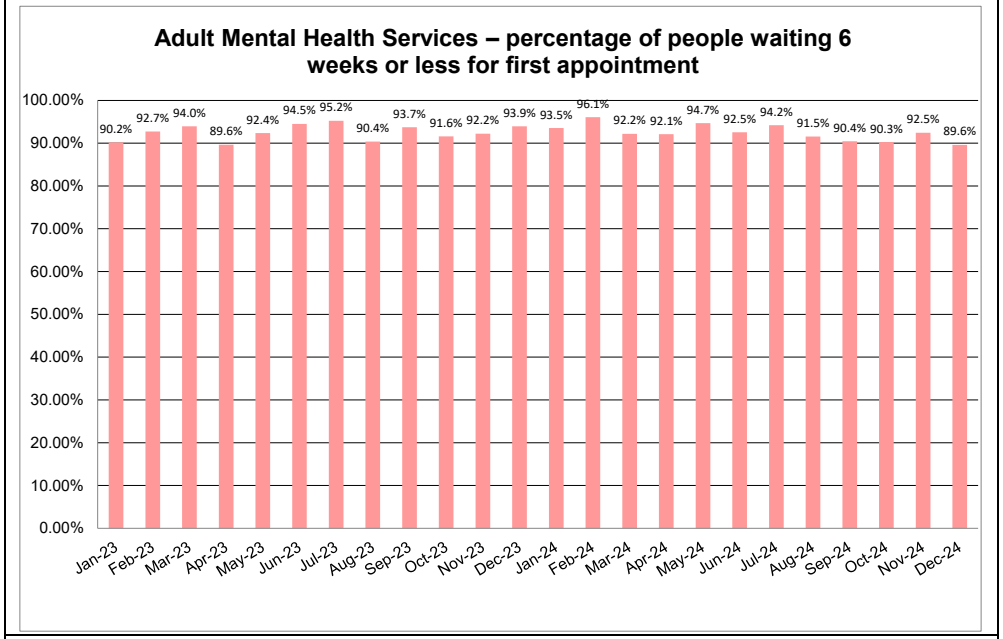
**Current performance (including factors affecting this)**

- As at 31 December 2024, of 48 people waiting, 43 had waited under six weeks (89.6%).
- Of the five patients waiting six weeks or longer, three have since attended appointments in January 2025.

**Focus of improvement work**

- Regular waiting list reports are circulated to managers within all services to identify and respond appropriately to potential breaches of the six week waiting times.
- As at 12 January 2025, performance in respect of patients waiting under six weeks had risen back above the compliance standard, at 92.2%.

**Bar Chart**




**How do we compare**

The latest report from the NHS Benchmarking Network, on Adult and Older People's Mental Health Services, shows that our waiting times for first and second appointments for adult mental health services are in the lowest (i.e. best) quartile nationally.

**Recent performance**

The numbers and percentages of people waiting six weeks or more at the month end in recent months were as follows:

| Area | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|
| Number waiting | 12 | 5 | 4 | 4 | 2 | 3 |
| % < 6 weeks | 94.2% | 91.5% | 90.4% | 90.3% | 92.5% | 89.6% |

## 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.**

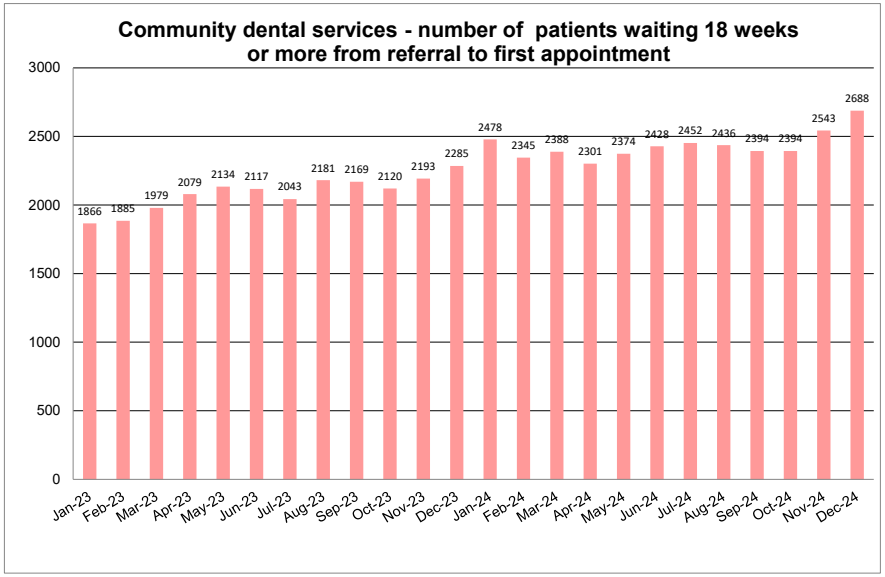
### Current performance (including factors affecting this)

- As at 31 December 2024, the number of patients waiting 18 weeks or more totalled 2,688 an increase of 145 compared to numbers as at 30 November 2024.
- Of the patients waiting 18 weeks or more to be seen, 1,947 were waiting within Somerset up from 1,869 as at 30 November 2024), and 741 were waiting within Dorset (up from 674 as at 30 November 2024).
- The number of people waiting 52 weeks or more increased from 491 as at 30 November 2024 to 540 as at 31 December 2024.

**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 will experience a significant change in activity levels due to successful recruitment. The service continues its recruitment and is positive about a Consultant recruitment drive for the county.
- 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.

### Bar Chart




### How do we compare

The number of patients waiting 18 weeks or more as at 31 December 2024 increased compared to numbers as at 30 November 2024.

### Recent performance

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

| Area | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|
| Number waiting | 2,452 | 2,436 | 2,394 | 2,394 | 2,543 | 2,688 |

**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).**

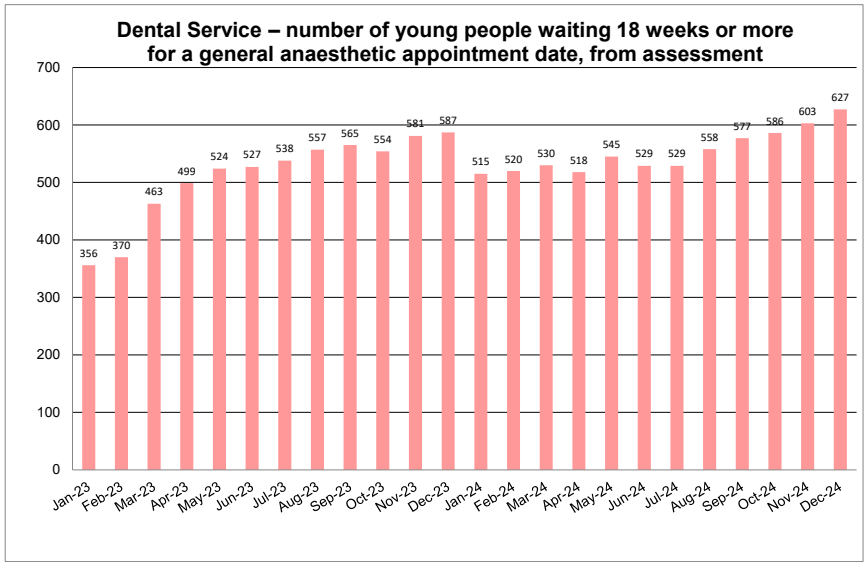
**Current performance (including factors affecting this)**

- As at 31 December 2024, 627 patients had waited 18 weeks or more, up from 603 at the end of November 2024. Of these, 564 related to our Dorset service (up from 537 as at 30 November 2024), and 63 related to our Somerset service (down from 66 as at 30 November 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**

- 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 advertisements which are out.
- There has been a positive impact from the number of patients on the majority of morning lists at YDH increasing to six. Improving ward capacity and Pre-Operative Assessment Clinic (POAC) limitations remain works in progress.
- Musgrove Park Hospital has agreed to double the children's GA theatre sessions from autumn 2025.
- The approval of a business case by Dorset Integrated Care Board, means there will be additional theatre slots throughout 2024/25. 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. Consultant advert out will look to counter this risk of reduced GA provision. Risk assessment submitted and mitigation on-going.

**Bar Chart**




**How do we compare**

The number of young people waiting 18 weeks or more as at 31 December 2024 increased when compared to numbers reported as at 30 November 2024.

**Recent Performance**

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

| Area | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|
| Number waiting | 529 | 558 | 577 | 586 | 603 | 627 |
| % > 18 weeks | 60.9% | 61.6% | 66.6% | 68.8% | 73.3% | 77.7% |

**Responsive**

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

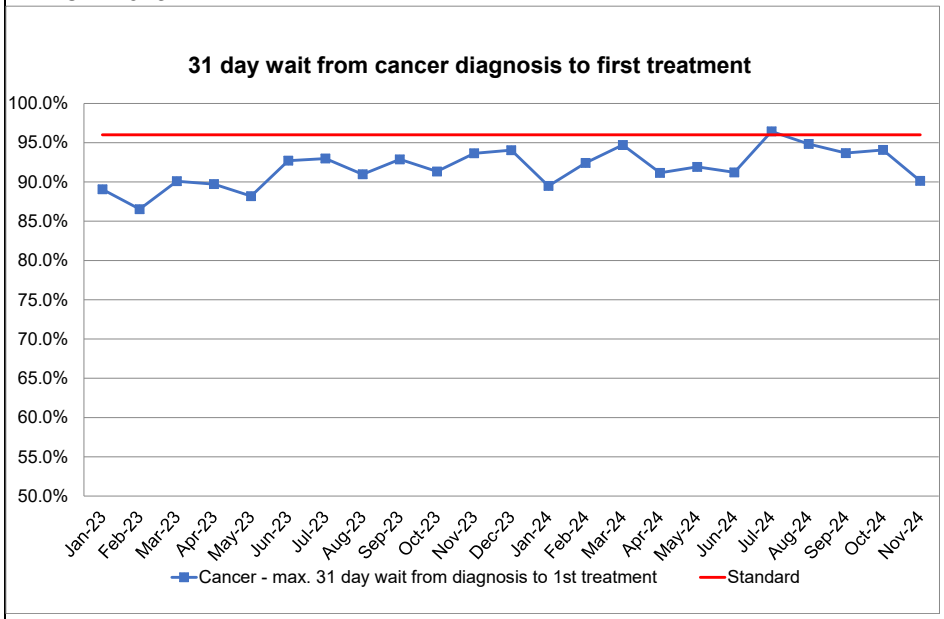
## Current performance (including factors affecting this)

- Performance against the 31-day first combined treatment standard was 90.1% in November 2024, below the 96% national standard and slightly below the national average performance.
- There were 66 breaches of the standard, 36 (55% of breaches) for skin and 10 for breast (15%). 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.
- 74% 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 62-day cancer standard report 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 September 2025, 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 91.0% in November 2024, the latest data available. Our performance was 90.1%. We ranked 106 out of 140 providers.

## Recent performance

**31-day diagnosis to first treatment performance**

| Area | Jun | Jul | Aug | Sep | Oct | Nov |
|---|---|---|---|---|---|---|
| % Compliance | 91.2% | 96.4% | 94.8% | 93.7% | 94.1% | 90.1% |

## 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.**

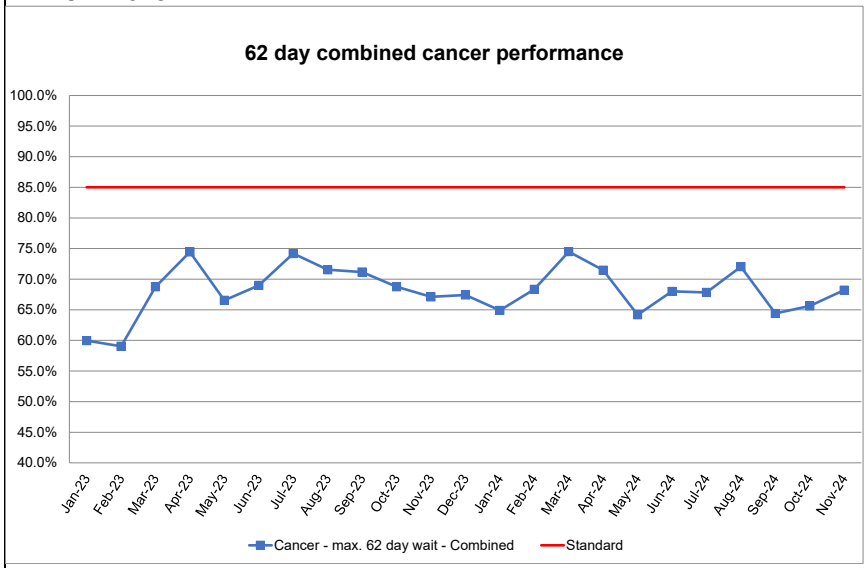
### Current performance (including factors affecting this)

- The percentage of patients treated for a cancer within 62 days of referral was 68.2% in November 2024, which is below national average performance and marginally below the planning trajectory.
- The main breaches of the 62-day combined cancer standard were in urology (36% of breaches) and skin (23%).
- 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.
- Although the current 62-day standard of 70% is not being met, patients are being diagnosed within 28 days of referral, with the 28-day Faster Diagnosis Standard being met for 76.5% of patients in November 2024 against the current national target of 75%.
- Twenty-three GP referred patients were treated in November 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 69.4% in November 2024, the latest data available. Our performance was 68.2%. We were ranked 99 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 | Jun | Jul | Aug | Sep | Oct | Dec |
|---|---|---|---|---|---|---|
| % Compliance | 68.0% | 67.8% | 72.0% | 64.4% | 65.6% | 68.2% |
| Trajectory | 65.9% | 66.5% | 67.1% | 66.5% | 66.4% | 68.8% |

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.**

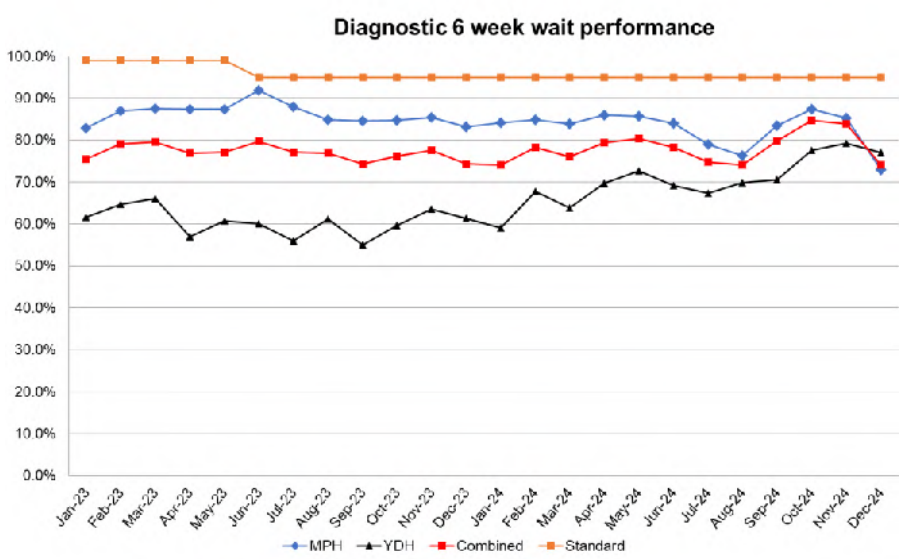
**Current performance (including factors affecting this)**

- The percentage of patients waiting under six weeks for their diagnostic test decreased to 74.1% in December 2024 from 83.8% in November 2024 and remains below the planning trajectory.
- The number of patients waiting over six weeks in December 2024 increased by 1,367 in the month; the highest numbers of patients waiting over six weeks were waiting for the following diagnostic tests:
  - Echo (up from 578 to 706; 23% of over six-week waiters).
  - CT (up from 246 to 648; 21% of over six-week waiters).
  - MRI (up from 343 to 640; 21% of over six-week waiters).
- The total waiting list size increased by just over 13% (1,392 patients); most of this increase was in CT and ultrasound.
- The deterioration in performance reflects the loss of capacity over the bank holiday period, in addition to the staffing issues in CT.
- A CT scanner has been partially closed due to staffing issues, including long-term sickness and insufficient cover for maternity leave, which has increased the number of over six week waits for CT scans.
- The echo backlog reflects staff departures on both hospital sites over the last three months; the MRI backlog relates to continued high demand for scans.

**Focus of improvement work**

- Additional echo capacity has been established through additional insourcing, and weekend waiting list initiatives.
- A further echo physiologist had been appointed (0.4 WTE) but has now withdrawn.
- 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 from early February 2025.

**Line Chart**




**How do we compare**

National average performance for NHS providers (i.e. excluding Independent Sector providers) was 79.5% in November 2024, the latest data available. Our performance was 83.8%. We were ranked 94 out of 157 trusts for the 15 high-volume diagnostic tests.

**Recent performance**

| Area | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|
| Musgrove Park Hospital (MPH) | 78.9% | 76.3% | 83.5% | 87.4% | 85.2% | 72.9% |
| Yeovil District Hospital (YDH) | 67.3% | 69.9% | 70.6% | 77.6% | 79.3% | 77.0% |
| Combined | 74.8% | 74.0% | 79.8% | 84.7% | 83.8% | 74.1% |
| Trajectory | 83.3% | 84.7% | 86.6% | 88.6% | 90.3% | 89.4% |

## Responsive

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

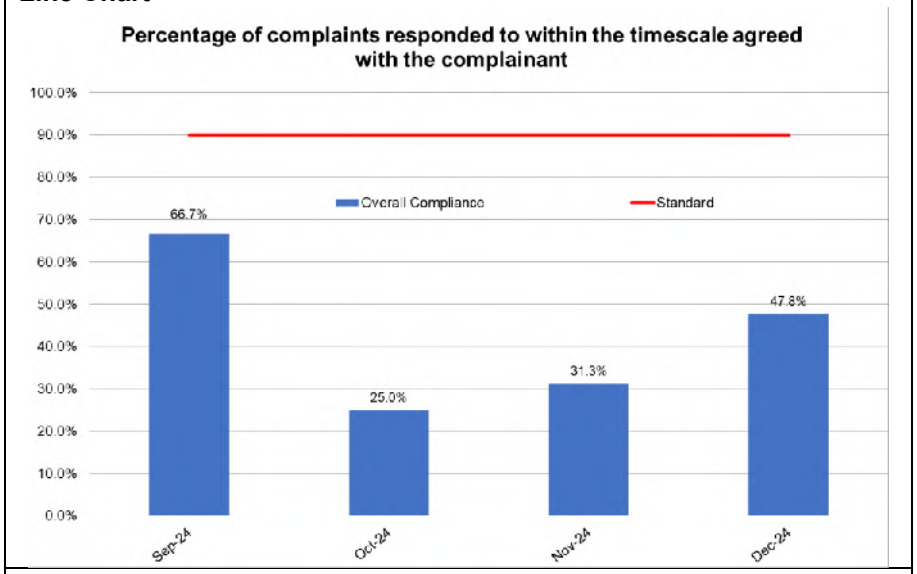
**Current performance (including factors affecting this)**

- Of 23 complaints responded to during December 2024, a total of eleven (48.7%) were responded to within the timescales agreed with the complainants.
- Delays occurred due to a combination of reasons including:
    - Reduced workforce within the complaints team leading to a slight delay in quality assuring letters and returning queries for consideration to the service groups. This is already mitigated by requesting that service groups return responses within 30 days to ensure adequate time for this.
    - 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 and 13 December 2024. The next meeting, scheduled for February 2025, will begin to focus on the development of an action plan.

**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 | 4 | 4 |
| CYP & Families | 2 | 3 | 9 | 14 |
| Medical Services | 4 | 8 | 9 | 21 |
| Mental Health & LD | 0 | 4 | 3 | 7 |
| Neighbourhoods | 1 | 0 | 0 | 1 |
| Surgical Services | 3 | 4 | 12 | 19 |
| Corporate | 0 | 0 | 1 | 1 |
| **Totals:** | **10** | **19** | **38** | **67** |

## Well Led

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

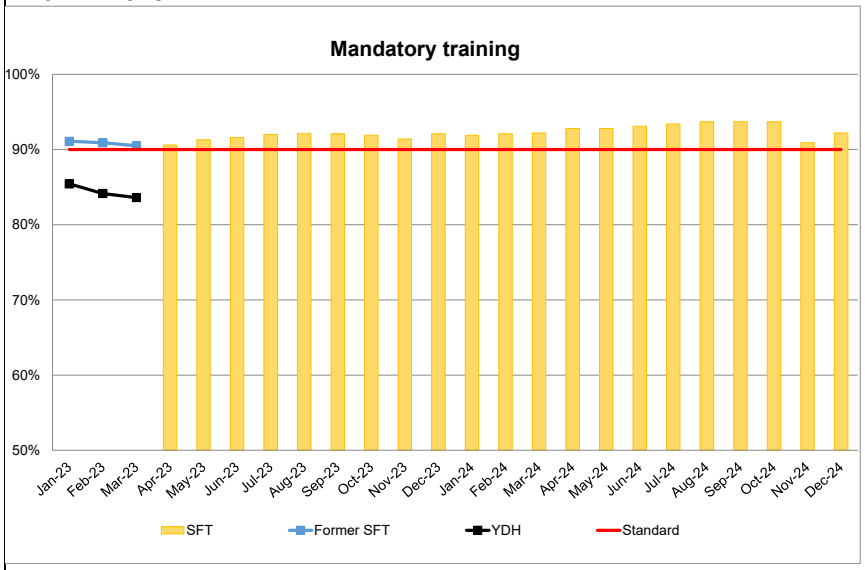
### Current performance (including factors affecting this)

- As at 31 December 2024, our overall mandatory training rate was 92.2%, up by 1.3% from the rate as at 30 November 2024.
- Apart from Symphony Health Service (SHS), all colleagues moved to the new Trust training system, LEAP, on 1 April 2023. As at 30 November 2024, compliance reported from the two separate systems was as follows:
  - LEAP: 92.2% (90.9% as at 30 November 2024)
  - SHS: 79.0% (79.0% as at 30 November 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 69.6% as at 30 November 2024 to 82.9% as at 31 December 2024. 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.
- Capacity for Basic Life Support (BLS) at MPH will increase by 20% by the end of the year because venepuncture and cannulation are moving into the Skills Hub, freeing up the training room. Monthly Sunday BLS sessions at MPH are popular, as are evening sessions. A review of data for September 2024 indicated that one-fifth of all resuscitation training spaces were lost to DNAs (this does not include late cancellations).
- The resuscitation team continues to run with a high level of sickness absence; however, an additional whole time equivalent (WTE) Resuscitation Officer has been recruited and will start in January 2025 on the YDH site, and funding for a further 0.8 WTE has been agreed to expand the team on the MPH site.

### Run Chart




### How do we compare

Compliance as at 31 December 2024 increased from the rate reported as at 30 November 2024.

### Recent Performance

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

| Area | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|
| % Compliance | 93.3% | 93.7% | 93.7% | 93.7% | 90.9% | 92.2% |

**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)**

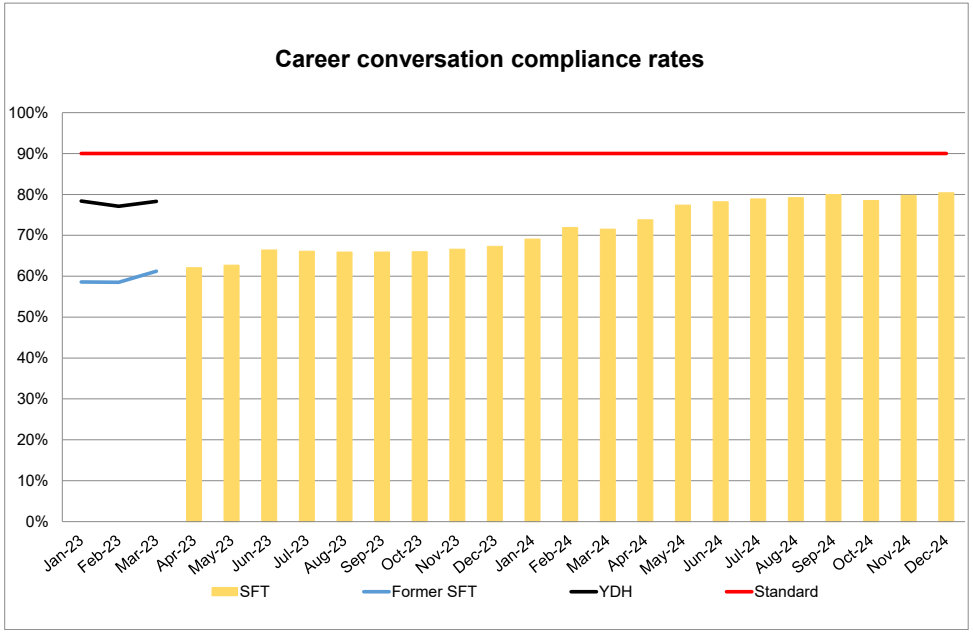
- Compliance as at 31 December 2024, in respect of appraisals being undertaken at least annually was 80.4%, an increase from 79.8% reported as at 30 November 2024
- Estates and Facilities are the best performing area, with a rate of 84.9%, followed by Neighbourhoods at 84.8% and Medical services with 84.3%.

**Focus of improvement work**

All areas of focus presented previously are continuing including:

- Service groups identifying trajectories for improvement and presenting this 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**




**How do we compare**

Compliance as at 31 December 2024 increased by 0.6% compared to the position as at 30 November 2024.

**Recent performance**

The compliance rates in recent months were as follows:

| Area | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|
| % compliance | 78.9% | 79.2% | 80.0% | 78.5% | 79.8% | 80.4% |

**Well Led**

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

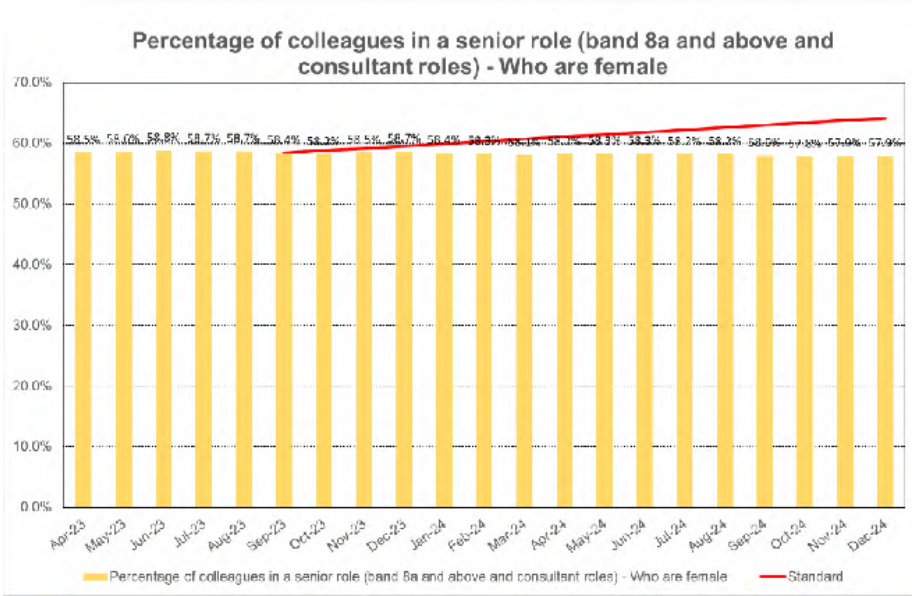
**Current performance (including factors affecting this)**

- Across Somerset NHS Foundation Trust as a whole, 79% of colleagues (excluding bank, locums and those on secondment) identify as female. There is a lower representation of women in senior roles, which influences our organisational-wide pay gap.
- As at 31 December 2024, a total of 57.9% of colleagues at Band 8a or above identify as female, the same percentage as at 30 November 2024, and behind the target trajectory of 63.0% identified to achieve equitable representation by March 2028.
- There was no significant movement within this measure during 2023/24.

**Focus of improvement work**

- The inclusion workforce plan sets out several actions to understand and address the gender pay gap. Service groups are responsible for understanding their data and developing plans to address at a local level. This is captured on the scorecard and addressed through Quality, Outcomes, Finance and Performance meetings.

**Run Chart**




**How do we compare**

- 51.1% of Somerset residents identify as female.
- 77% of the NHS workforce identify as female.
- 79% of colleagues at Somerset NHS Foundation Trust identify as female.
- 57.9% of senior roles (Band 8a or above) identify as female.
- 50% of medical and dental colleagues identify as female.

**Recent performance**

Compliance over recent months were as follows:

| Area | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|
| Monthly rate | 58.2% | 58.2% | 58.0% | 57.8% | 57.9% | 57.9% |

## 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.**

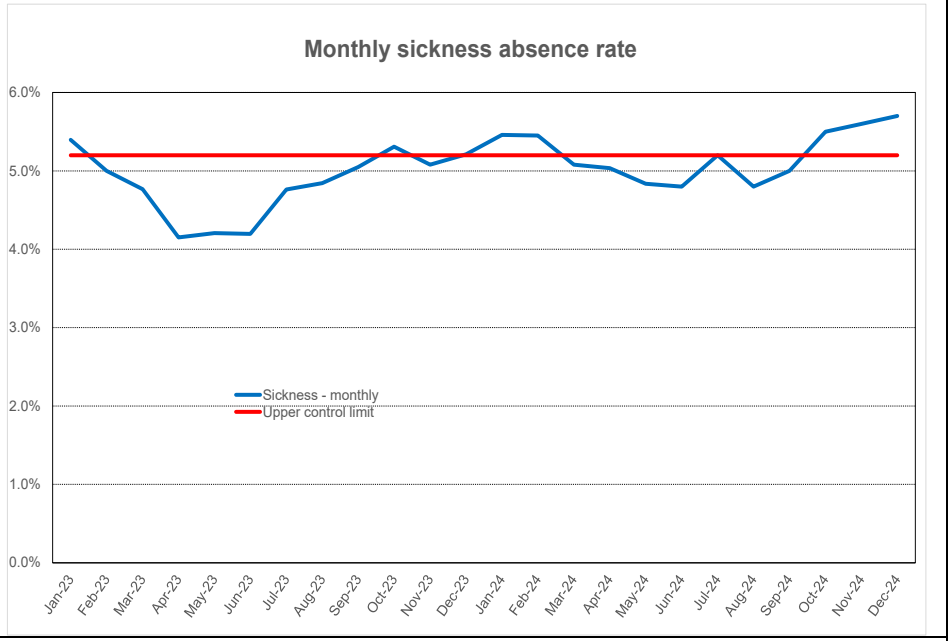
### Current performance (including factors affecting this)

- The monthly sickness absence rate for December 2024 was 5.7%, up from 5.6% in November 2024. This was the highest rate recorded since the formation of the new Trust in April 2023 and 0.5% higher than the rate in December 2023.
- The 12-month rolling sickness absence rate for the period ending 31 December 2024 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 increases in absence were estates and ancillary colleagues and healthcare scientists.
- Estates & Facilities had the greatest monthly increase, from 8.9% in November 2024 to 9.8% in 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 | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|
| 12-month rolling rate | 5.2% | 5.1% | 5.1% | 5.1% | 5.2% | 5.2% |
| Monthly rate | 5.2% | 4.8% | 5.0% | 5.5% | 5.6% | 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.**

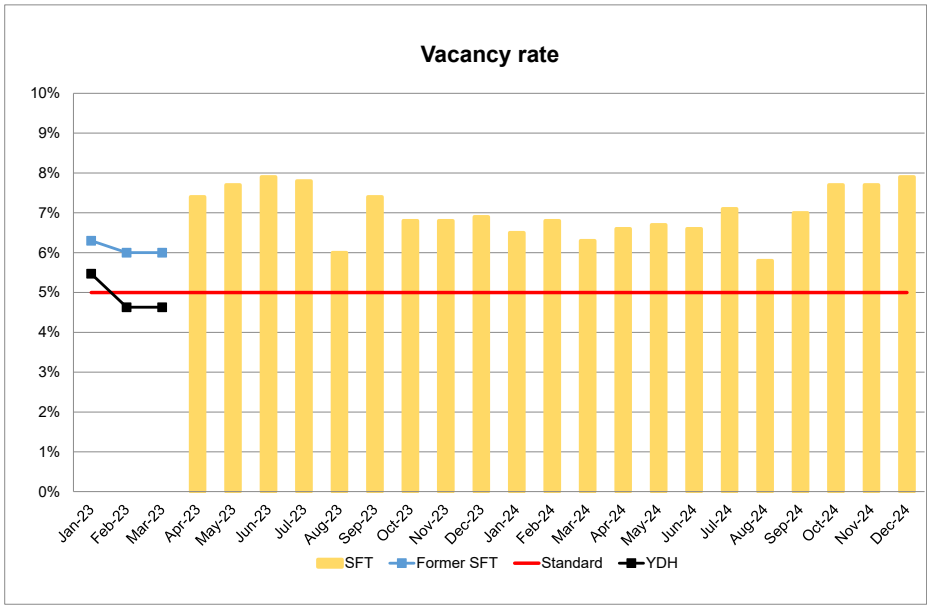
**Current performance (including factors affecting this)**

- Our vacancy rate as at 31 December 2024 was 7.9%, an increase of 0.2% compared to the rate reported as at 30 November 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 will improve visibility of vacancies and how these are being managed. This was presented to the January 2025 meeting of our People Committee.

**Run Chart**




**How do we compare**

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

**Recent performance**

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

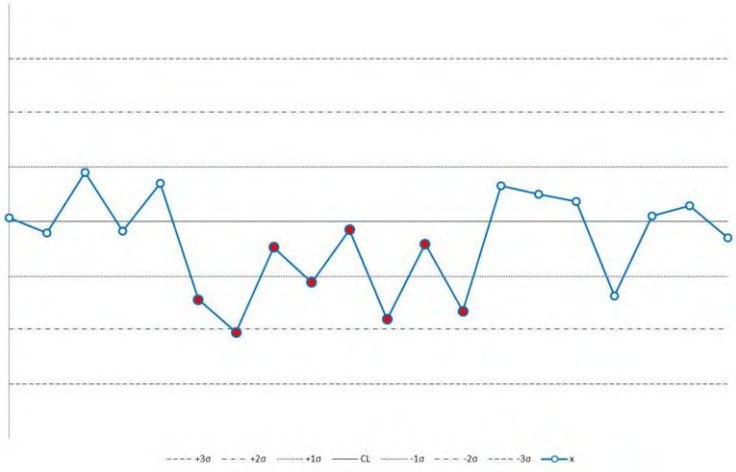
| Dec | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|
| Vacancy rate | 7.1% | 5.8% | 7.0% | 7.7% | 7.7% | 7.9% |

# Appendix 1 - Procedure for Interpreting Run Charts

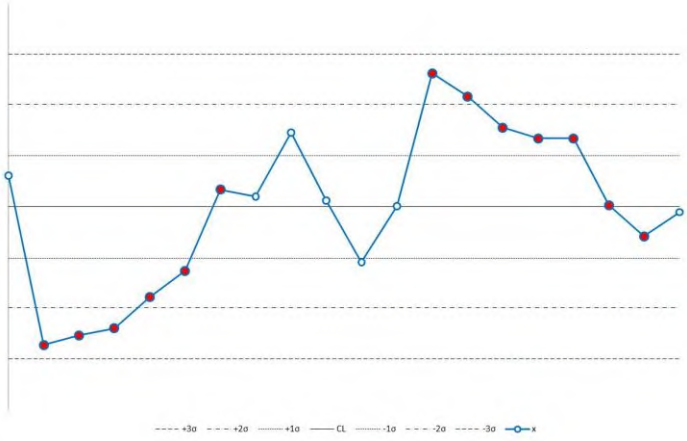
**Special Cause Variation Rules**

1. A single point outside the control limits

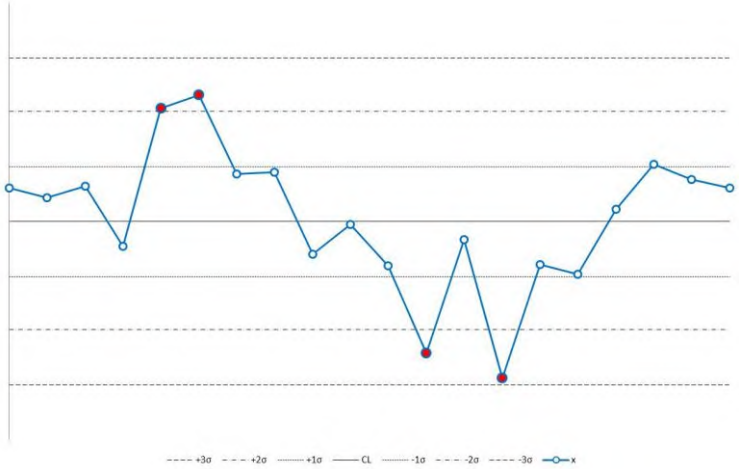

2. A run of eight or more points in a row above (or below) the centreline



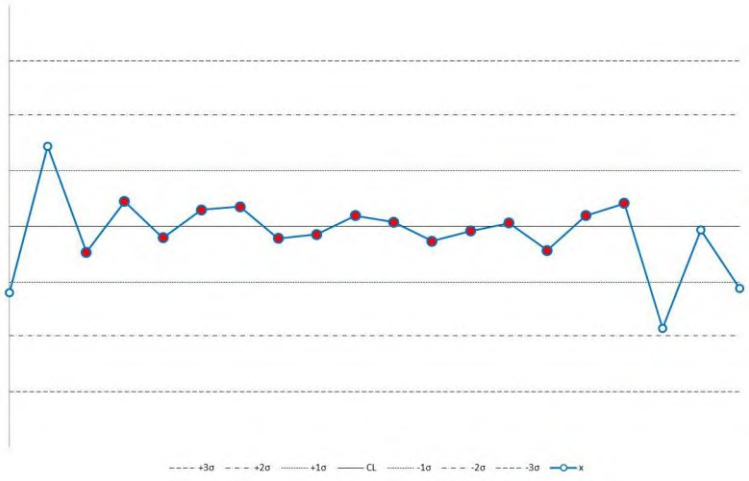

3. Six consecutive points increasing (trend up) or decreasing (trend down)



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

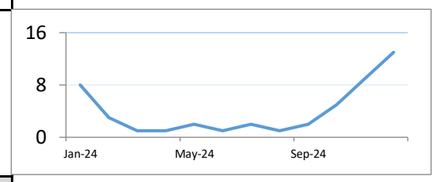
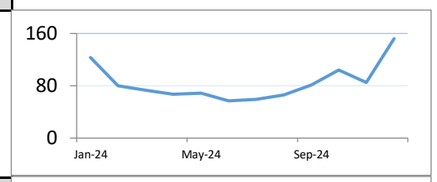
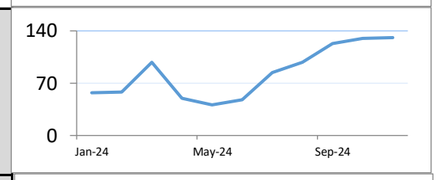
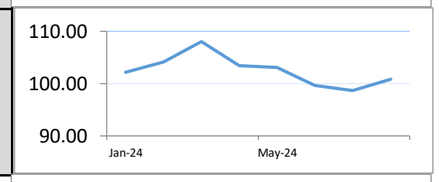
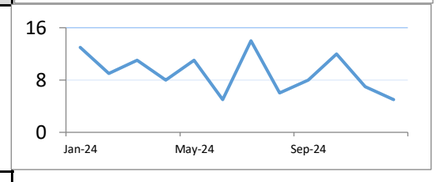
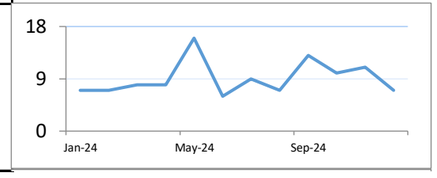
**Our current Care Quality Commission ratings are as follows:**

| | 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** |

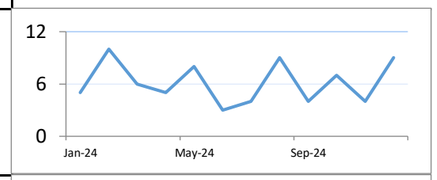
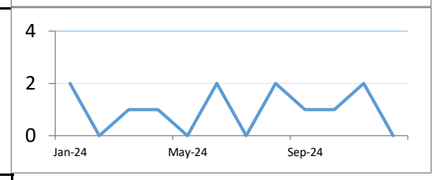
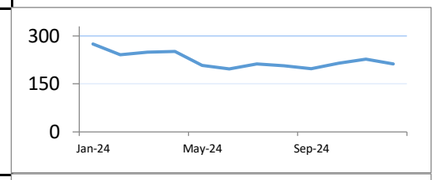
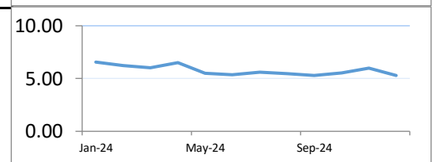
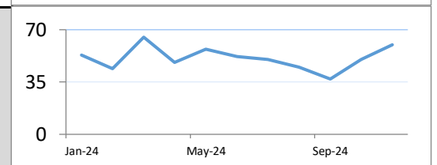
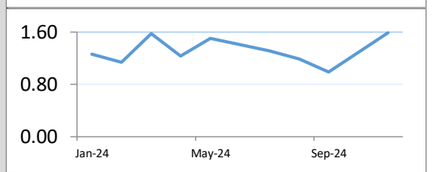
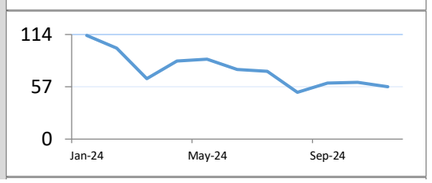
**SOMERSET NHS FOUNDATION TRUST**

**QUALITY MEASURES - 2024/25**

| Area | Ref | Measure | | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Admissions | 1 | Average daily number of medical and surgical outliers in acute wards during the month | MPH | 8 | 3 | 1 | 1 | 2 | 1 | 2 | 1 | 2 | 5 | 9 | 13 |   |
| | 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 | 123 | 80 | 73 | 67 | 69 | 57 | 59 | 66 | 81 | 104 | 85 | 152 |   |
| | 4 | | YDH | 57 | 58 | 98 | 50 | 41 | 48 | 84 | 98 | 123 | 130 | 131 | Data awaited |   |
| Mortality (acute services) | 5 | Summary Hospital-level Mortality Indicator (SHMI) | | 102.14 | 104.12 | 108.03 | 103.41 | 103.09 | 99.67 | 98.67 | 100.86 | Data not yet due - September 2024 to be reported after January 2025 | | | |   |
| Infection Control | 6 | Clostridium Difficile cases<br>HOHA cases (Hospital Onset Hospital Acquired) and<br>COHA cases (Community Onset Hospital Acquired) | | 13 | 9 | 11 | 8 | 11 | 5 | 14 | 6 | 8 | 12 | 7 | 5 |   |
| | 7 | MRSA bacteraemias (post) | | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | |
| | 8 | E. coli bacteraemia | | 7 | 7 | 8 | 8 | 16 | 6 | 9 | 7 | 13 | 10 | 11 | 7 |   |

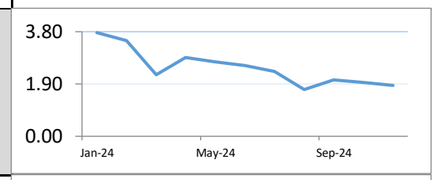
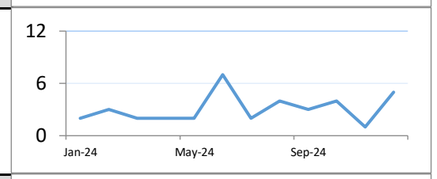
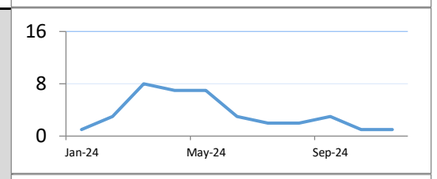
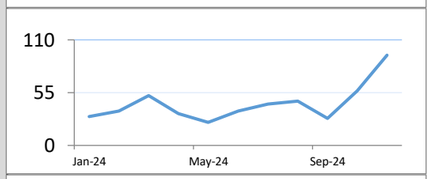
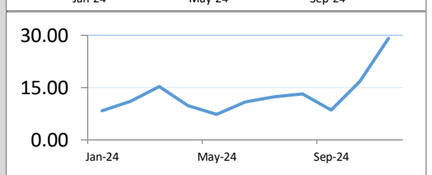
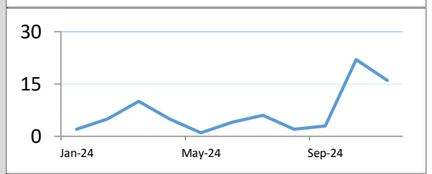
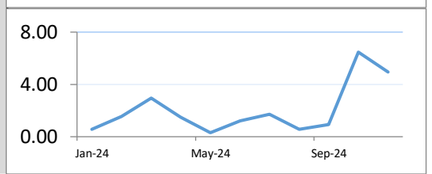
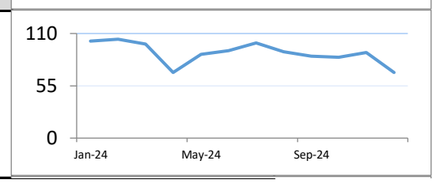
**SOMERSET NHS FOUNDATION TRUST**

**QUALITY MEASURES - 2024/25**

| Area | Ref | Measure | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Infection Control | 9 | Methicillin-sensitive staphylococcus aureus | 5 | 10 | 6 | 5 | 8 | 3 | 4 | 9 | 4 | 7 | 4 | 9 |   |
| Maternity | 10 | No. of still births | 2 | 0 | 1 | 1 | 0 | 2 | 0 | 2 | 1 | 1 | 2 | 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 | 275 | 241 | 249 | 252 | 208 | 197 | 213 | 207 | 198 | 215 | 227 | 213 |   |
| | 13 | Rate of falls per 1,000 occupied bed days - all services | 6.56 | 6.25 | 6.04 | 6.49 | 5.48 | 5.35 | 5.60 | 5.46 | 5.29 | 5.55 | 6.00 | 5.30 |   |
| Pressure ulcer damage | 14 | Inpatient wards - number of incidents | 53 | 44 | 65 | 48 | 57 | 52 | 50 | 45 | 37 | 50 | 60 | Data not yet due |   |
| | 15 | Rate of pressure ulcer damage per 1,000 inpatient ward occupied bed days | 1.26 | 1.14 | 1.58 | 1.24 | 1.50 | 1.41 | 1.31 | 1.19 | 0.99 | 1.29 | 1.59 | |   |
| | 16 | District nursing - number of incidents | 113 | 99 | 66 | 85 | 87 | 76 | 74 | 51 | 61 | 62 | 57 | |   |

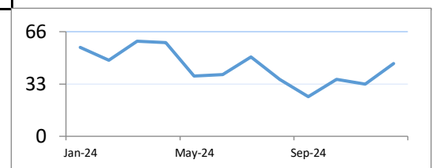
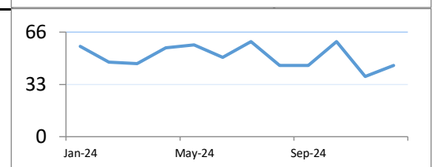
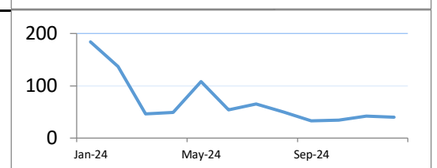
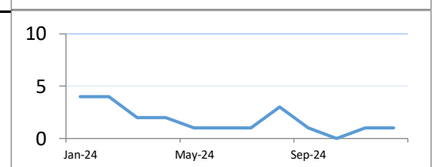
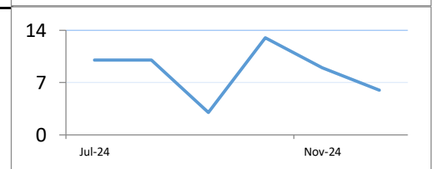
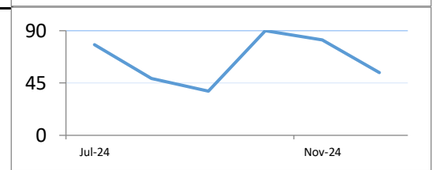
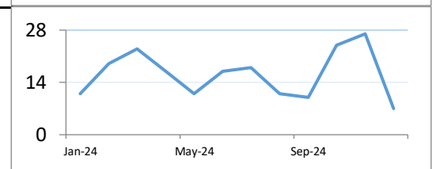
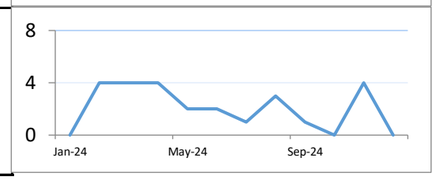
**SOMERSET NHS FOUNDATION TRUST**

**QUALITY MEASURES - 2024/25**

| Area | Ref | Measure | | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 17 | Rate of pressure ulcer damage per 1,000 district nursing contacts | | 3.77 | 3.47 | 2.24 | 2.87 | 2.71 | 2.56 | 2.36 | 1.70 | 2.05 | 1.96 | 1.85 | |  |
| Cardiac Arrests | 18 | No. ward-based cardiac arrests - acute wards | MPH | 2 | 3 | 2 | 2 | 2 | 7 | 2 | 4 | 3 | 4 | 1 | 5 |  |
| Cardiac Arrests | 19 | No. ward-based cardiac arrests - acute wards | YDH | 1 | 3 | 8 | 7 | 7 | 3 | 2 | 2 | 3 | 1 | 1 | |  |
| Restraints (mental health wards) | 20 | Total number of incidents | Mental Health Wards | 30 | 36 | 52 | 33 | 24 | 36 | 43 | 46 | 28 | 57 | 94 | |  |
| | 21 | Restraints per 1,000 occupied bed days | Mental Health Wards | 8.32 | 11.08 | 15.32 | 9.79 | 7.33 | 10.85 | 12.37 | 13.20 | 8.57 | 16.76 | 29.13 | Data awaited |  |
| | 22 | Number of prone restraints | Mental Health Wards | 2 | 5 | 10 | 5 | 1 | 4 | 6 | 2 | 3 | 22 | 16 | |  |
| | 23 | Prone restraints per 1,000 occupied bed days | Mental Health Wards | 0.55 | 1.54 | 2.95 | 1.48 | 0.31 | 1.21 | 1.73 | 0.57 | 0.92 | 6.47 | 4.96 | |  |
| nts | 24 | Total number of medication incidents | MPH | 102 | 104 | 99 | 69 | 88 | 92 | 100 | 91 | 86 | 85 | 90 | 69 |  |

**SOMERSET NHS FOUNDATION TRUST**

**QUALITY MEASURES - 2024/25**

| Area | Ref | Measure | | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medication incider | 24 | Total number of medication incidents | YDH | 56 | 48 | 60 | 59 | 38 | 39 | 50 | 36 | 25 | 36 | 33 | 46 |  |
| | 24 | Total number of medication incidents | Community & Mental Health | 57 | 47 | 46 | 56 | 58 | 50 | 60 | 45 | 45 | 60 | 38 | 45 |  |
| Ligatures and ligature points | 25 | Ligatures: Total number of incidents | Mental Health Wards | 184 | 137 | 46 | 49 | 108 | 54 | 65 | 50 | 33 | 34 | 42 | 40 |  |
| Ligatures and ligature points | 26 | Number of ligature point incidents | Mental Health Wards | 4 | 4 | 2 | 2 | 1 | 1 | 1 | 3 | 1 | 0 | 1 | 1 |  |
| 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 |  |
| | 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 |  |
| Seclusion | 29 | Number of Type 1 -Traditional Seclusion | Mental Health Wards | 11 | 19 | 23 | 17 | 11 | 17 | 18 | 11 | 10 | 24 | 27 | 7 |  |
| | 30 | Number of Type 2 -Short term Segregation | Mental Health Wards | 0 | 4 | 4 | 4 | 2 | 2 | 1 | 3 | 1 | 0 | 4 | 0 |  |

**SOMERSET NHS FOUNDATION TRUST**

**CORPORATE SCORECARD 2024/25**

| No. | Description | | Links to corporate objectives | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Thresholds |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Accident and Emergency / Urgent Treatment Centre 4-hour performance | Accident & Emergency department (ED) - MPH | 2 | 52.0% | 53.1% | 61.9% | 59.2% | 58.4% | 55.2% | 56.0% | 60.2% | 55.7% | 51.3% | 47.0% | 42.6% | From April 2024<br>>=76%= Green<br>>=66% - <76% =Amber<br><66% =Red<br><br>(the standard will rise to 78% in March 2025) |
| 2 | | Accident & Emergency department (ED) - YDH | | 61.4% | 67.3% | 69.5% | 67.5% | 68.0% | 62.1% | 64.1% | 65.6% | 63.4% | 65.0% | 58.4% | 51.8% | |
| 3 | | Accident & Emergency department (ED) - Combined | | 56.1% | 59.2% | 65.2% | 62.7% | 62.5% | 58.2% | 59.4% | 62.5% | 59.0% | 57.1% | 52.1% | 46.6% | |
| 4 | | Urgent Treatment Centres (formerly Minor Injury Units) | | 96.0% | 95.1% | 97.9% | 98.9% | 97.3% | 98.1% | 98.3% | 98.5% | 97.8% | 97.5% | 98.4% | 97.4% | |
| 5 | | Trust-wide | | 72.5% | 74.2% | 79.6% | 78.3% | 77.7% | 75.7% | 76.2% | 77.7% | 75.2% | 74.1% | 71.6% | 67.7% | |
| 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 | 6.2% | 3.3% | 2.4% | 1.1% | 1.4% | 1.3% | 2.1% | 1.4% | 2.5% | 4.3% | 6.1% | 10.8% | <=2%= Green<br>>2% - <=5% =Amber<br>>5% =Red |
| 7 | | Accident and Emergency department (ED) - YDH | | 7.6% | 3.6% | 5.1% | 4.7% | 2.3% | 3.3% | 5.9% | 5.2% | 5.0% | 4.4% | 4.4% | Data awaited | |
| 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 | 61.9% | 71.8% | 77.8% | 83.0% | 75.8% | 76.6% | 75.5% | 82.4% | 74.4% | 67.9% | 62.1% | 47.3% | >=95%= Green<br>>=85% - <95% =Amber<br><85% =Red |
| 10 | Ambulance handovers waiting less than 30 minutes: YDH | | | 65.6% | 68.6% | 66.3% | 64.0% | 76.1% | 66.0% | 59.8% | 66.0% | 63.0% | 64.8% | 62.3% | 47.4% | |
| 11 | Cancer - 28 days Faster Diagnosis All Cancers | | 1,2 | 70.8% | 84.7% | 84.1% | 78.6% | 80.6% | 75.0% | 70.0% | 70.9% | 75.4% | 79.0% | 76.5% | Data not yet due | >=75%= Green<br><75% =Red<br>(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 | | | 89.5% | 92.4% | 94.7% | 91.2% | 91.9% | 91.2% | 96.4% | 94.8% | 93.7% | 94.1% | 90.1% | Data not yet due | >=96%= Green<br><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 | | | 64.9% | 68.3% | 74.5% | 71.5% | 64.2% | 68.0% | 67.8% | 72.0% | 64.4% | 65.6% | 68.2% | Data not yet due | >=85%= Green<br>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 | | | 19 | 22 | 29 | 21 | 20 | 23 | 21 | 19 | 22 | 33 | 23 | Data not yet due | 0= Green<br>>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% | >=95%= Green<br>>=85% - <95% =Amber<br><85% =Red |
| 16 | CAMHS Eating Disorders - Routine referrals to be seen within 4 weeks - (rolling 3 months) | | 1,2,5 | 100.0% | 96.9% | 96.9% | 97.1% | 97.3% | 97.1% | 96.6% | 100.0% | 95.7% | 95.7% | 95.5% | 95.5% | >=95%= Green<br>>=85% - <95% =Amber<br><85% =Red |

**SOMERSET NHS FOUNDATION TRUST**

**CORPORATE SCORECARD 2024/25**

| No. | Description | | Links to corporate objectives | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Thresholds |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 17 | Mental health referrals offered first appointments within 6 weeks | All mental health services | 1,2,3 | 94.2% | 96.8% | 92.8% | 93.0% | 95.7% | 95.7% | 96.2% | 93.5% | 93.9% | 94.9% | 94.4% | 96.2% | >=90%= Green<br>>=80% - <90% =Amber<br><80% =Red |
| 18 | Mental health referrals offered first appointments within 6 weeks | Adult mental health services | | 93.5% | 96.1% | 92.2% | 92.1% | 94.7% | 92.5% | 94.2% | 91.5% | 90.4% | 90.3% | 92.5% | 89.6% | >=90%= Green<br>>=80% - <90% =Amber<br><80% =Red |
| 19 | | Older Persons mental health services | | 93.7% | 96.0% | 90.3% | 93.8% | 97.0% | 100.0% | 97.2% | 93.8% | 93.4% | 97.8% | 94.7% | 97.7% | |
| 20 | | Learning disabilities service | | 100.0% | 100.0% | 100.0% | 83.3% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 66.7% | 100.0% | |
| 21 | | Children and young people's mental health services | | 96.1% | 100.0% | 100.0% | 95.0% | 95.4% | 95.3% | 98.5% | 97.8% | 98.8% | 97.8% | 96.3% | 97.5% | |
| 22 | Percentage of women accessing specialist community Perinatal MH service - 12 month rolling reporting | | 1,2 | 12.2% | 12.4% | 12.6% | 12.9% | 13.0% | 13.1% | 13.3% | 13.8% | 13.7% | 14.2% | 14.1% | 14.4% | >=10%= Green<br>>=7.5% - <10% =Amber<br><7.5% =Red |
| 23 | Diagnostic 6-week wait - acute services | MPH | 1,2 | 84.1% | 84.8% | 83.9% | 86.0% | 85.7% | 84.0% | 78.9% | 76.3% | 83.5% | 87.4% | 85.2% | 72.9% | From March 2024<br>At or above regional ambition 85% = Green<br>Above trajectory = Amber<br>Below trajectory = Red |
| 24 | | YDH | | 59.0% | 67.8% | 63.8% | 59.4% | 72.7% | 69.2% | 67.3% | 69.9% | 70.6% | 77.6% | 79.3% | 77.0% | |
| 25 | | Combined | | 74.1% | 78.2% | 76.0% | 79.4% | 80.4% | 78.3% | 74.8% | 74.0% | 79.8% | 84.7% | 83.8% | 74.1% | |
| 26 | RTT incomplete pathway performance: percentage of people waiting under 18 weeks | | 1,2,4 | 62.6% | 63.4% | 62.5% | 64.6% | 66.3% | 65.6% | 65.1% | 63.8% | 63.3% | 62.8% | 62.2% | 62.1% | >=92%= Green<br><92% =Red |
| 27 | 52 week RTT breaches - Patients of all ages | | | 2,252 | 2,158 | 2,270 | 1,969 | 1,871 | 1,873 | 1,842 | 1,769 | 1,536 | 1,445 | 1,371 | 1,364 | From April 2023<br>At or below trajectory = Green<br>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 | |
| 29 | 65 week RTT breaches - Patients of all ages | | | 605 | 538 | 434 | 463 | 484 | 493 | 426 | 370 | 247 | 198 | 144 | 142 | |
| 30 | Referral to Treatment (RTT) incomplete pathway waiting list size | | | 53,787 | 53,800 | 53,524 | 54,625 | 55,014 | 56,599 | 57,442 | 57,619 | 58,112 | 58,725 | 59,585 | 60,076 | |

**SOMERSET NHS FOUNDATION TRUST**

**CORPORATE SCORECARD 2024/25**

| No. | Description | | Links to corporate objectives | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | 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 | 6.4 | 6.0 | 5.9 | 5.8 | 5.8 | 5.8 | 5.9 | 6.0 | 5.8 | 6.2 | 6.5 | Monitored using Special Cause Variation Rules. Report by exception. |
| 32 | | YDH | | 7.7 | 6.9 | 7.1 | 7.0 | 6.7 | 6.3 | 5.5 | 6.4 | 5.7 | 6.2 | 5.8 | Data awaited | |
| 33 | Patients not meeting the criteria to reside: % of occupied bed days lost | MPH | 2,7 | 18.4% | 20.5% | 21.0% | 18.9% | 19.2% | 19.4% | 23.2% | 22.4% | 19.6% | 19.0% | 22.7% | 20.0% | <=9.8%= Green >15% =Red |
| 34 | | YDH | | 25.7% | 29.5% | 23.0% | 21.8% | 23.4% | 23.0% | 21.0% | 19.9% | 26.4% | 21.3% | 20.8% | 20.2% | |
| 35 | Acute bed days lost due to patients not meeting the criteria to reside | MPH | 2,7 | 3,435 | 3,516 | 3,805 | 3,215 | 3,267 | 3,230 | 3,939 | 3,719 | 3,269 | 3,721 | 3,930 | 3,620 | TBC |
| 36 | | YDH | | 2,756 | 2,891 | 2,495 | 2,238 | 2,284 | 2,230 | 2,070 | 1,991 | 2,475 | 2,122 | 2,031 | 2,124 | |
| 37 | Community service waiting times: number of people waiting over 18 weeks from referral to first appointment (excluding dental) | | 1,2,3 | 1,164 | 1,107 | 1,399 | 1,590 | 1,712 | 1,870 | 1,944 | 1,937 | 1,736 | 1,426 | 1,061 | 768 | 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) | | | 232 | 229 | 264 | 257 | 259 | 280 | 277 | 277 | 263 | 240 | 95 | 26 | |
| 39 | Community service waiting times: number of people waiting over 104 weeks from referral to first appointment (excluding dental) | | | 34 | 35 | 45 | 45 | 49 | 57 | 73 | 88 | 93 | 86 | 25 | 7 | |
| 40 | Community dental services - General, Dominciliary or Minor Oral surgery waiting 18 weeks or more | | 1,2,3 | 2,478 | 2,345 | 2,388 | 2,301 | 2,374 | 2,428 | 2,452 | 2,436 | 2,394 | 2,394 | 2,543 | 2,688 | From April 2024 <1,979 = Green >=1,979 = Red |
| 41 | Community dental services - General, Dominciliary or Minor Oral surgery waiting 52 weeks or more | | | 584 | 575 | 574 | 531 | 584 | 620 | 600 | 538 | 533 | 489 | 491 | 540 | From April 2024 <574 = Green >=574 = Red |
| 42 | Community dental services - Child GA waiters waiting 18 weeks or more | | 1,2,3 | 515 | 520 | 530 | 518 | 545 | 529 | 529 | 558 | 577 | 586 | 603 | 627 | 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 | 89.5% | 93.3% | 87.5% | 86.7% | 73.7% | 77.8% | 70.6% | 84.6% | 87.5% | 100.0% | 100.0% | 91.7% | >=60%= Green <60% =Red |
| 44 | Talking Therapies RTT : percentage of people waiting under 6 weeks | | 1,2,3 | 81.1% | 78.4% | 83.0% | 84.3% | 84.0% | 85.4% | 82.7% | 88.0% | 86.5% | 86.8% | 85.6% | 79.3% | >=75%= Green <75% =Red |
| 45 | Talking Therapies RTT: percentage of people waiting under 18 weeks | | 1,2,3 | 99.4% | 99.2% | 98.9% | 99.0% | 98.9% | 98.7% | 98.2% | 99.6% | 98.9% | 98.3% | 97.8% | 98.0% | >=95%= Green <95% =Red |
| 46 | Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) Recovery Rates | | 1,2,3 | 57.5% | 60.7% | 56.6% | 58.6% | 60.2% | 59.6% | 58.9% | 61.2% | 54.8% | 53.0% | 57.0% | 57.5% | >=50%= Green <50% =Red |

**SOMERSET NHS FOUNDATION TRUST**

**CORPORATE SCORECARD 2024/25**

| No. | Description | | Links to corporate objectives | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Thresholds |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 47 | Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Improvement | | 1,2,3 | 74.7% | 74.1% | 75.9% | 69.7% | 78.5% | 72.3% | 74.3% | 77.8% | 76.5% | 73.8% | 75.9% | 71.2% | >=67%= Green<br><67% =Red |
| 48 | Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Recovery | | 1,2,3 | 55.5% | 57.0% | 54.8% | 54.9% | 57.9% | 56.0% | 55.4% | 58.7% | 53.3% | 52.6% | 52.7% | 50.6% | >=48%= Green<br><48% =Red |
| 49 | Adult mental health inpatients receiving a follow up within 72 hrs of discharge | | 1,2 | 100.0% | 100.0% | 92.9% | 97.6% | 90.9% | 90.5% | 100.0% | 96.2% | 97.4% | 96.9% | 100.0% | 97.1% | >=80%= Green<br><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 | 2 | 1 | 1 | 2 | 1 | 3 | 3 | 3 | 3 | 4 | 2 | 1 | 1= Green<br>>1 = Red |
| 51 | Intermediate Care - Patients aged 65+ discharged home from acute hospital beds on pathway 0 or 1 | | 1,2,3 | 94.6% | 96.1% | 93.3% | 95.1% | 94.1% | 94.3% | 94.7% | 93.8% | 94.9% | 94.8% | 94.8% | Data awaited | >=95%= Green<br>>=85% - <95% =Amber<br><85% =Red |
| 52 | Urgent Community Response: percentage of patients seen within two hours | | 1,2,3 | 91.1% | 91.6% | 95.9% | 90.5% | 87.8% | 87.5% | 87.4% | 89.5% | 85.8% | 87.4% | 87.1% | Data not yet due | >=70%= Green<br>>=60% - <70% =Amber<br><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% | Issues have been encountered with the reporting system, which are being worked on by our Data Insight Team. | | | >=90%= Green<br>>=75% - <90% =Amber<br><75% =Red |
| 54 | | YDH | | | | | 17.4% | 47.5% | 25.9% | 27.3% | 42.9% | 47.1% | | | | |
| 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<br>>=70% - <80% =Amber<br><70% =Red |
| 56 | | YDH | | | | | 82.3% | 90.7% | 86.5% | 92.4% | Issues encountered with the reporting system, as mentioned above. | | | | | |
| 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 | Changes from 1 January 2024 to include both acute sites and communit | 76.0% | | 72.5% | | 75.6% | | 79.2% | | 63.0% | | Bi-monthly reporting | >=90%= Green<br>>=80% - <90% =Amber<br><80% =Red |
| 58 | Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services | MPH | 1,2,5 | 78.8% | 77.8% | 95.3% | 94.4% | 91.9% | 83.3% | 100.0% | 90.9% | 87.1% | 92.3% | 90.6% | Data awaited | |
| 59 | Percentage of emergency patients screened for sepsis - Emergency Departments | | | 97.8% | 100.0% | 96.6% | 87.5% | 96.2% | 90.9% | 77.8% | 91.0% | 90.7% | 92.8% | 94.2% | Data awaited | |
| 60 | National paediatric early warning system (PEWS) | MPH | 1,2,5 | 66.7% | 80.0% | 100.0% | 64.3% | 87.5% | Reporting has been moved from a paper method to a digital solution. This will improve robustness of recording. Planned that reporting will commence from February 2025 covering January 2025. | | | | | | | |

**SOMERSET NHS FOUNDATION TRUST**

**CORPORATE SCORECARD 2024/25**

| No. | Description | | Links to corporate objectives | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | 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% | >=90%= Green<br>>=80% - <90% =Amber<br><80% =Red |
| 62 | Mandatory training: percentage completed | Combined | 6 | 91.9% | 92.1% | 92.2% | 92.8% | 92.8% | 93.1% | 93.3% | 93.7% | 93.7% | 93.7% | 90.9% | 92.2% | All courses >=90%= Green<br>Overall rate <80% =Red<br>Any other position = Amber |
| 63 | Monthly percentage of days lost due to sickness | | 6 | 5.5% | 5.5% | 5.1% | 5.0% | 4.8% | 4.8% | 5.2% | 4.8% | 5.0% | 5.5% | 5.6% | 5.7% | SPC<br>(Upper Control Limit 5.2%) |
| 64 | Sickness absence levels - rolling 12 month average (Trust-wide) | | 6 | 4.9% | 5.3% | 5.3% | 5.2% | 5.2% | 5.2% | 5.2% | 5.1% | 5.1% | 5.1% | 5.2% | 5.2% | SPC<br>(Upper Control Limit 5.4%) |
| 65 | Career conversations (12 months) - formerly 'Performance review (12-month)' | | 6 | 69.1% | 71.9% | 71.5% | 73.8% | 77.4% | 78.2% | 78.9% | 79.2% | 80.0% | 78.5% | 79.8% | 80.4% | >=90%= Green<br>>=80% - <90% =Amber<br><80% =Red |
| 66 | Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide) | | 6 | 6.5% | 6.8% | 6.3% | 6.6% | 6.7% | 6.6% | 7.1% | 5.8% | 7.0% | 7.7% | 7.7% | 7.9% | <=5%= Green<br>>5% to <=7.5% =Amber<br>>7.5% =Red |
| 67 | Retention rate – rolling 12 months percentage of colleagues in post | | 6 | 88.9% | 89.0% | 89.2% | 89.1% | 89.0% | 89.2% | 89.0% | 88.8% | 88.3% | 88.7% | 88.7% | 88.8% | >=88.3%= Green<br>>=80% to <88.3% =Amber<br><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% | | | >=Trajectory = Green<br><=10% below trajectory = Amber<br>>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 | 38 | 33 | 38 | 62 | 62 | 53 | 59 | 49 | 62 | 47 | SPC<br>(Upper Control Limit 78 |

**Appendix 5a – Specialty and tumour-site level performance**

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

| RTT specialty | Over 18-week waiters | Over 52-week waiters | Incomplete pathways | Incomplete pathways performance |
|---|---|---|---|---|
| General Surgery | 706 | 52 | 2030 | 65.2% |
| Urology | 1557 | 138 | 3575 | 56.4% |
| Trauma & Orthopaedics | 3371 | 461 | 8452 | 60.1% |
| Ear, Nose & Throat (ENT) | 2491 | 171 | 5165 | 51.8% |
| Ophthalmology | 1637 | 32 | 4949 | 66.9% |
| Oral Surgery | 1224 | 30 | 2920 | 58.1% |
| Plastic Surgery | 73 | 2 | 198 | 63.1% |
| Cardiothoracic Surgery | 20 | | 41 | 51.2% |
| General Medicine | 23 | | 56 | 58.9% |
| Gastroenterology | 1367 | 73 | 3047 | 55.1% |
| Cardiology | 1092 | 5 | 3709 | 70.6% |
| Dermatology | 874 | 10 | 3133 | 72.1% |
| Thoracic Medicine | 643 | 5 | 1919 | 66.5% |
| Neurology | 915 | 17 | 2072 | 55.8% |
| Rheumatology | 275 | 2 | 909 | 69.7% |
| Geriatric Medicine | 173 | 4 | 601 | 71.2% |
| Gynaecology | 1923 | 65 | 4733 | 59.4% |
| Other – Medical Services | 1009 | 7 | 3262 | 69.1% |
| Other - Paediatric Services | 558 | 7 | 1652 | 66.2% |
| Other - Surgical Services | 2450 | 273 | 6375 | 61.6% |
| Other – Other Services | 408 | 10 | 1278 | 68.1% |
| **Total** | **22789** | **1364** | **60076** | **62.1%** |

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

| Tumour site | No of breaches | Trust performance |
|---|---|---|
| Brain | 0 | 100% |
| Breast | 6.0 | 82.9% |
| Colorectal | 10.5 | 57.1% |
| Gynaecology | 3.0 | 82.4% |
| Haematology | 0.0 | 100.0% |
| Head & Neck | 4.5 | 47.1% |
| Lung | 12.5 | 53.7% |
| Other | 4.0 | 72.4% |
| Skin | 24.0 | 75.5% |
| Upper GI | 3.5 | 80.0% |
| **Urology** | **38.5** | **51.6%** |

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

- Twelve 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.
- Eleven patient pathways had internal delays mainly related to a lack of capacity. Some of these pathways also had elements of unavoidable delays, due to additional investigations, medical complexity, waiting times at other organisations and periods of patient choice.

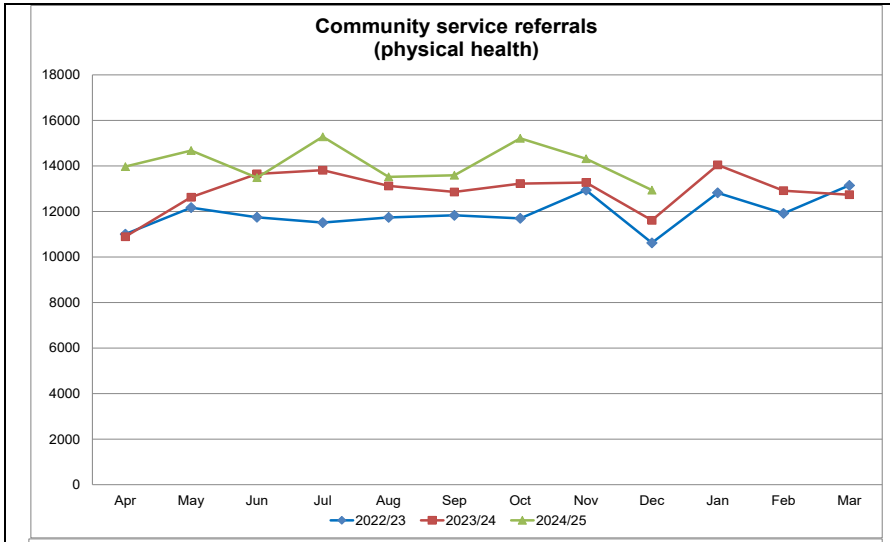
**Appendix 2 – RTT validation progress**

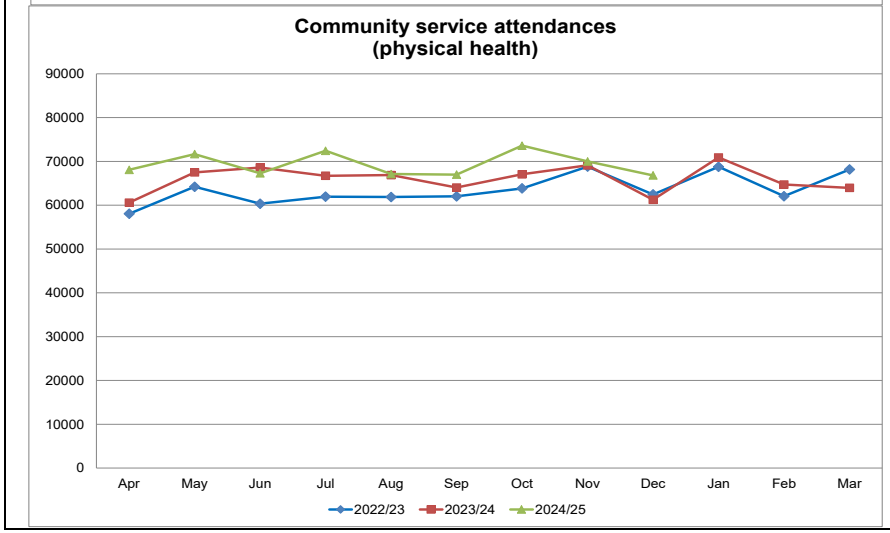
The national target is to reach a level of 90% validation of patients waiting 12 weeks and over from Referral to Treatment (RTT) by the 31 of October 2023. Validation includes both the administrative/technical validation and also contacting the patient to confirm they still wish to be seen.

| RTT waiting times bands | Week ending 14th Apr | 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 12 weeks and over | 77% | 75% | 76% | 69% | 67% | 70% | 69% | 74% | 55% | 54% |
| 26 weeks and over | 77% | 77% | 76% | 77% | 76% | 77% | 76% | 72% | 57% | 57% |
| 52 weeks and over | 93% | 97% | 99% | 99% | 95% | 100% | 99% | 99% | 92% | 85% |

## Operational context

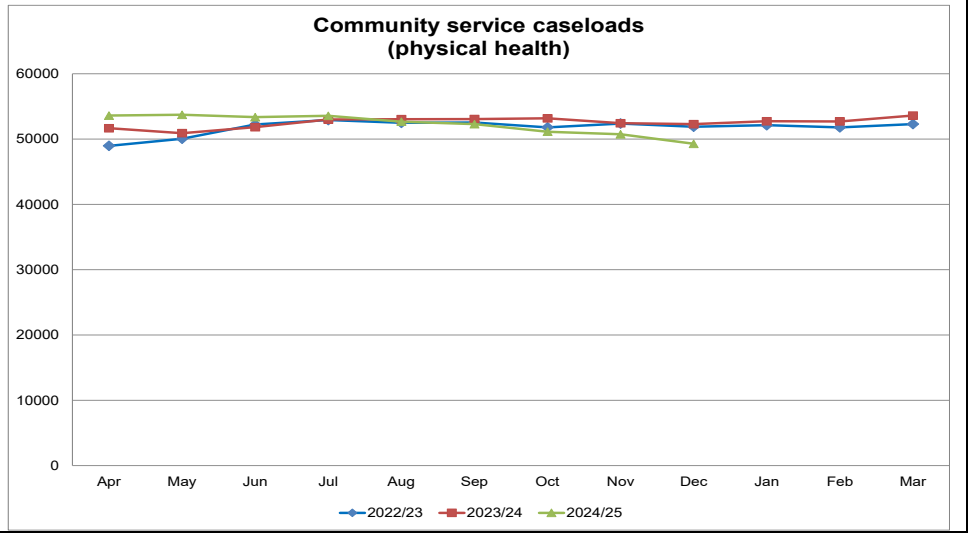
**Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.**



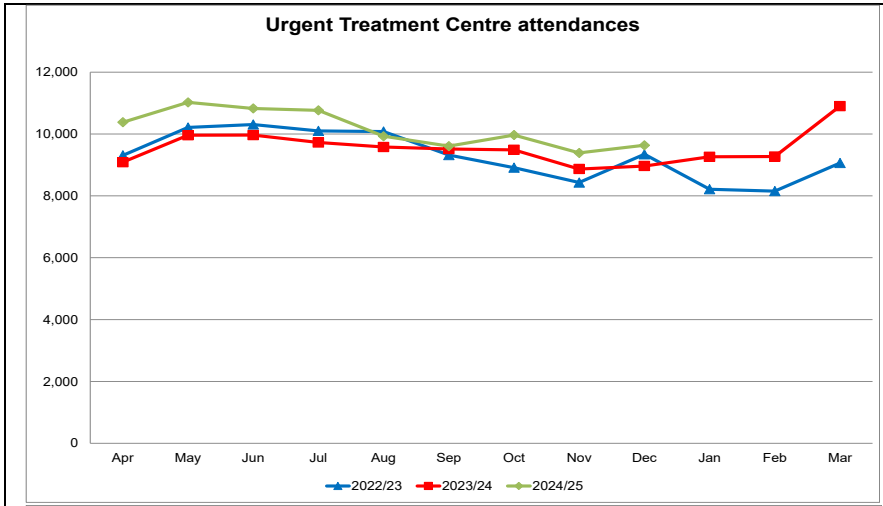

Summary:

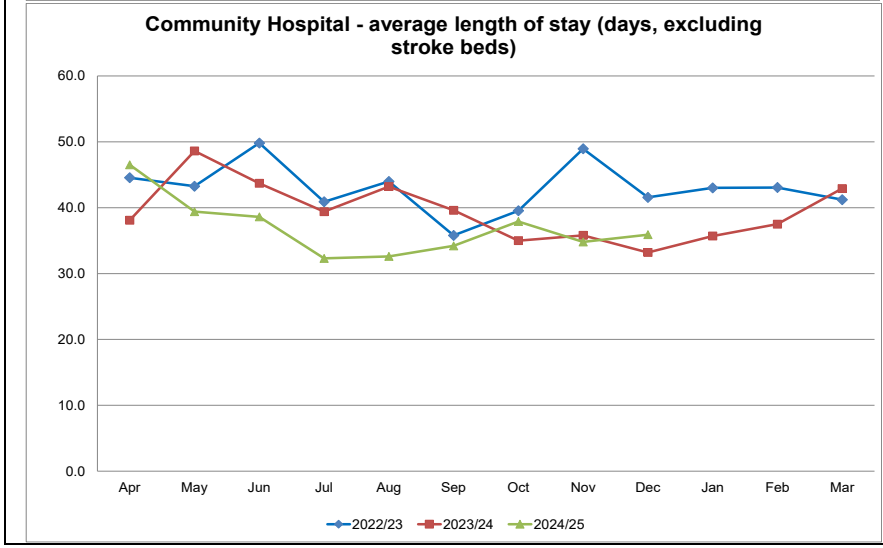
- Direct referrals to our community physical health services between 1 April and 31 December 2024 were 10.4% higher than the same months of 2023 and 20.6% higher than the same months of 2022. Services with the highest increases include Rapid Response, Diabetes Integrated Care and District Nursing.
- Attendances for the same reporting period were 5.5% higher than the same months of 2023 and 10.7% higher than the months of 2022.
- Community service caseload levels as at 31 December 2024 were 5.8% lower than as at 31 December 2023, and 5.0% lower than 31 December 2022 levels.



## Operational context

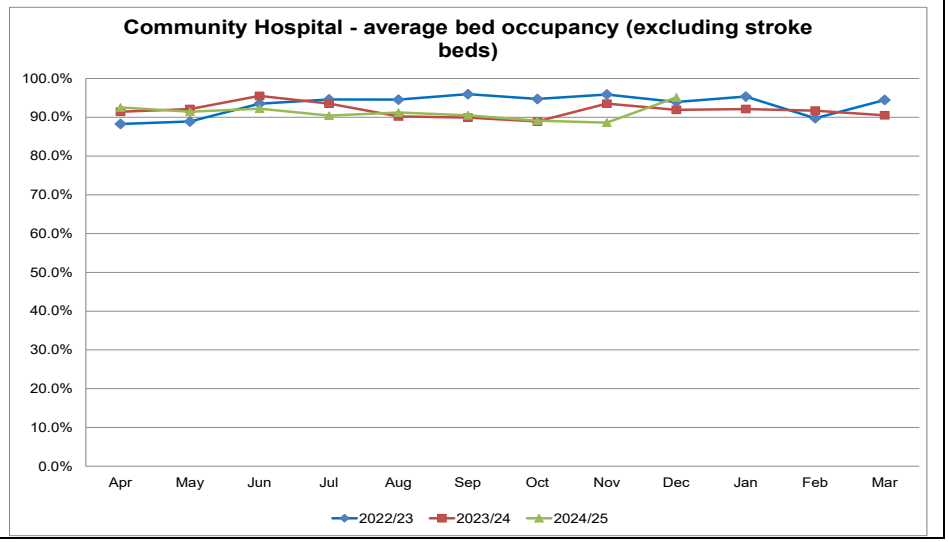
**Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.**



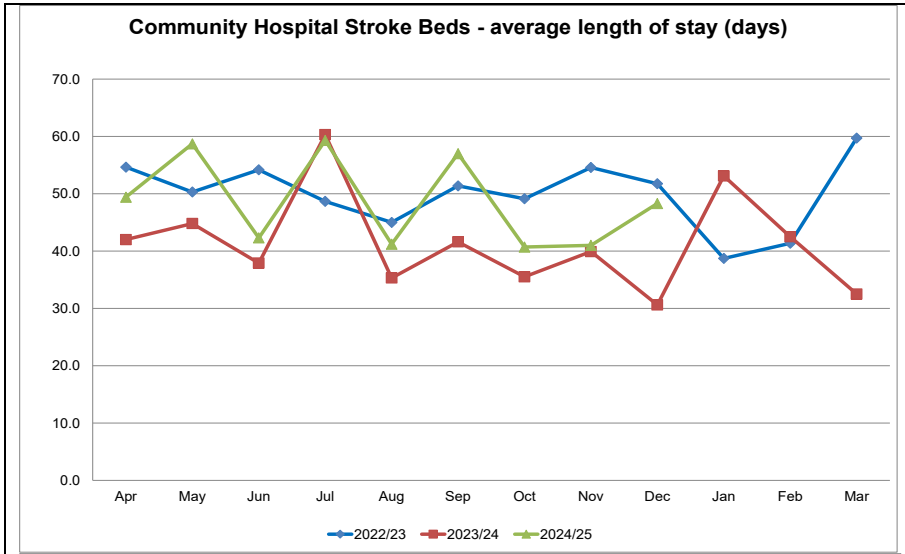

Summary:

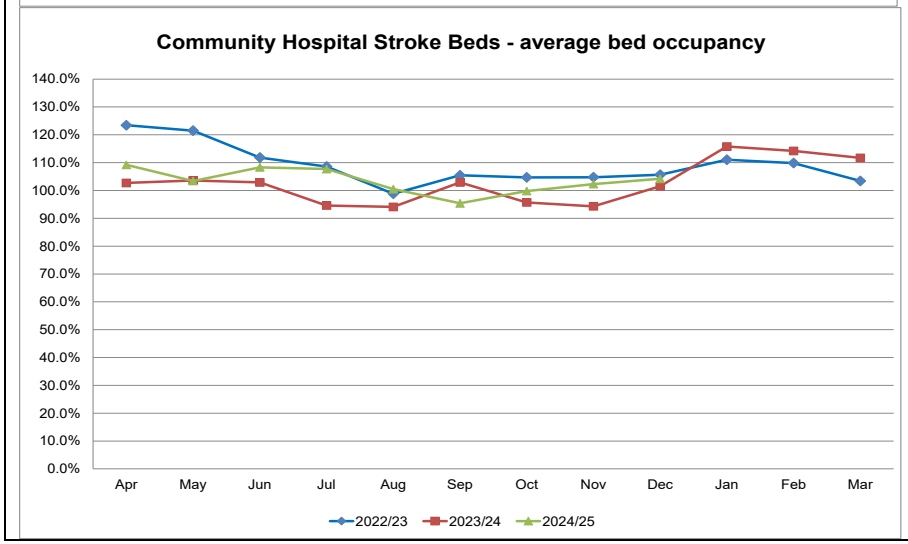
- Between 1 April and 31 December 2024, the number of Urgent Treatment Centre attendances was 7.5% higher than the same months of 2023, and 6.4% higher than the same months of 2022. During December 2024, 97.4% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 76%.
- The average length of stay for non-stroke patients in our community hospitals in December 2024 was 35.9 days, an increase compared to November 2024. The year-to-date average length of stay for non-stroke patients was 36.9 days, compared to 39.5 days in the same months of 2023. The community hospital bed occupancy rate for non-stroke patients in December 2024 increased to 95.1%, from 88.6% in November 2024.



## Operational context

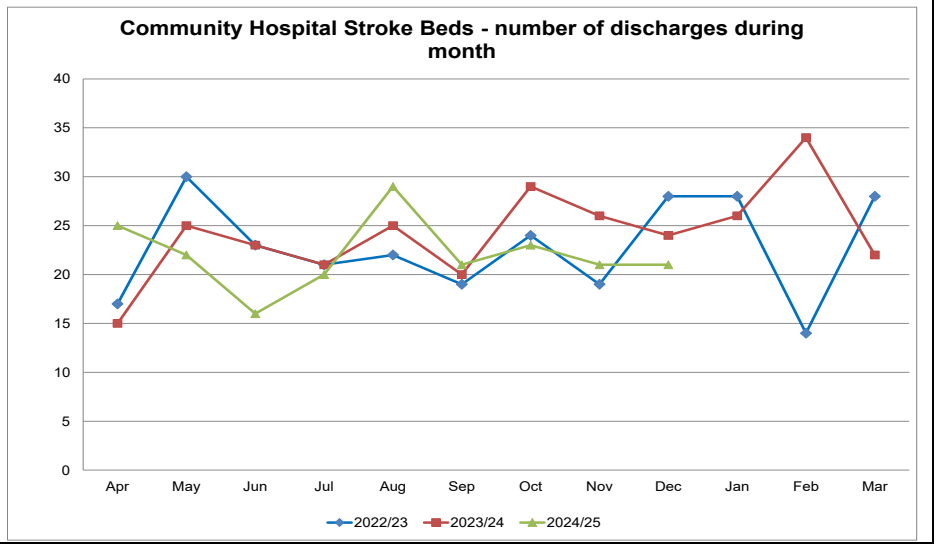
**This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.**



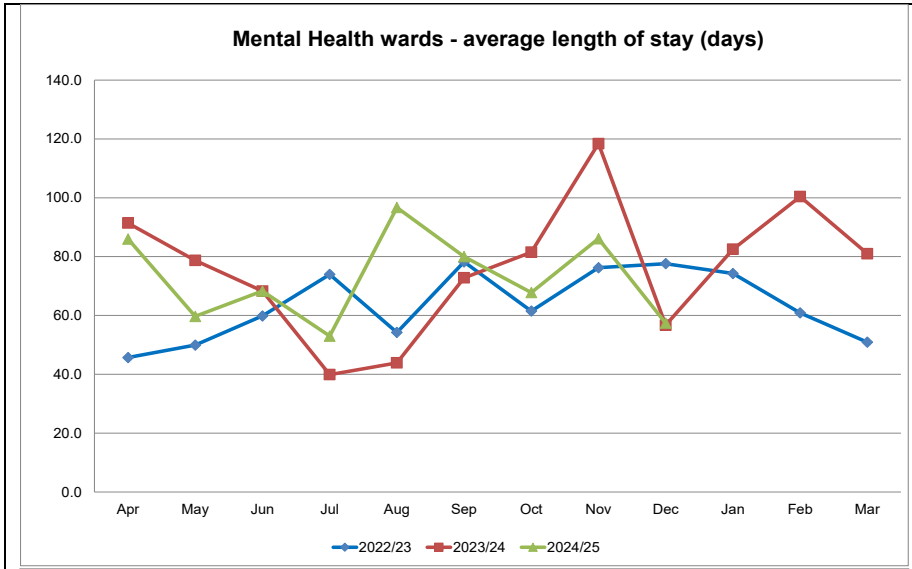

Summary:

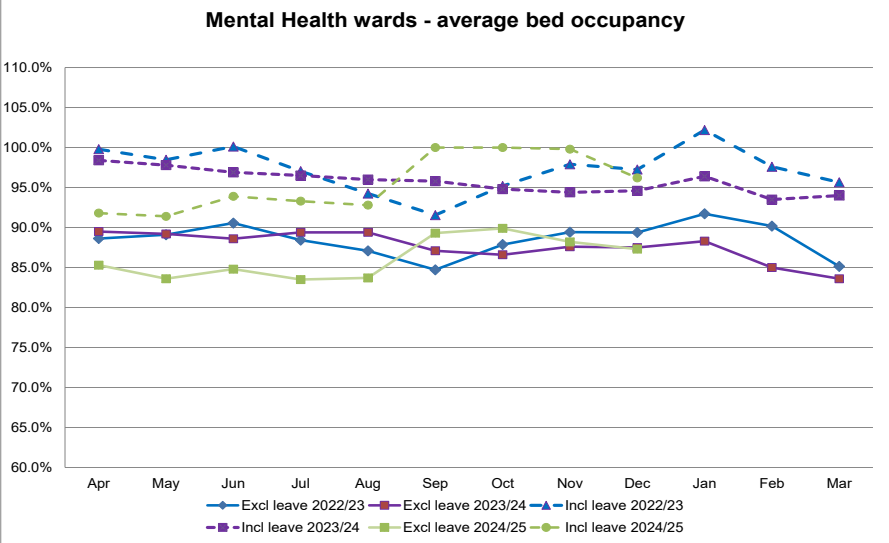
- The average length of stay for stroke patients in our community hospitals in December 2024 increased to 48.3 days, from 41.0 days in November 2024. Three patients discharged during December 2024 had a length of stay exceeding 100 days, with one South Petherton patient having a length of stay of 123 days.
- The year-to-date average length of stay for stroke patients was 48.4 days, up from 40.3 days in the same months of 2023. This is due principally to an increase in the numbers of patients discharged with very long lengths of stay.
- Stroke bed occupancy in December 2024 increased compared to November 2024.
- During December 2024 there were 21 discharges of stroke patients, the same as during November 2024.



## Assurance and Leading Indicators

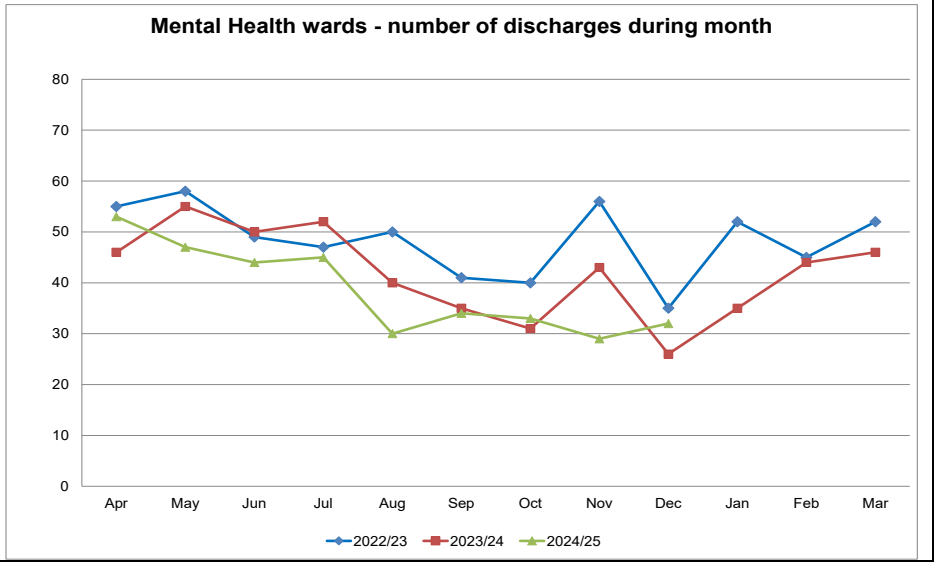
**This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.**



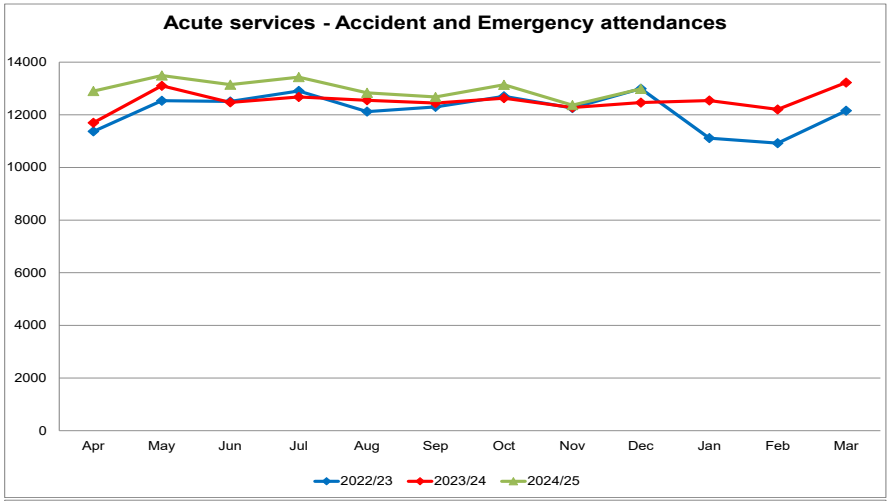

Summary:

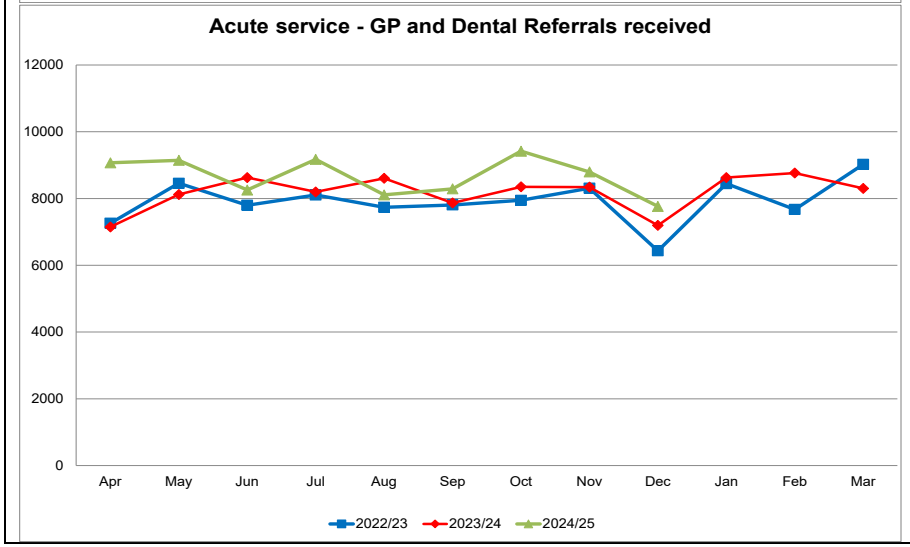
- The average length of stay across all of our mental health wards in December 2024 was 57.4 days, down from 86.1 days in November 2024. During December 2024, four patients were discharged with lengths of stay of 100 days or more, including one patient discharged from Willow Ward our rehabilitation ward, who had a length of stay of 421 days.
- The average length of stay across all of our mental health wards for the year to date was 71.9 days, compared to 73.4 days in the same months of 2023.
- The mental health bed occupancy rates, on the basis of excluding and including leave, decreased in December 2024 compared to November 2024. A total of 32 patients were discharged in December 2024, up from 29 in November 2024.



## Operational context

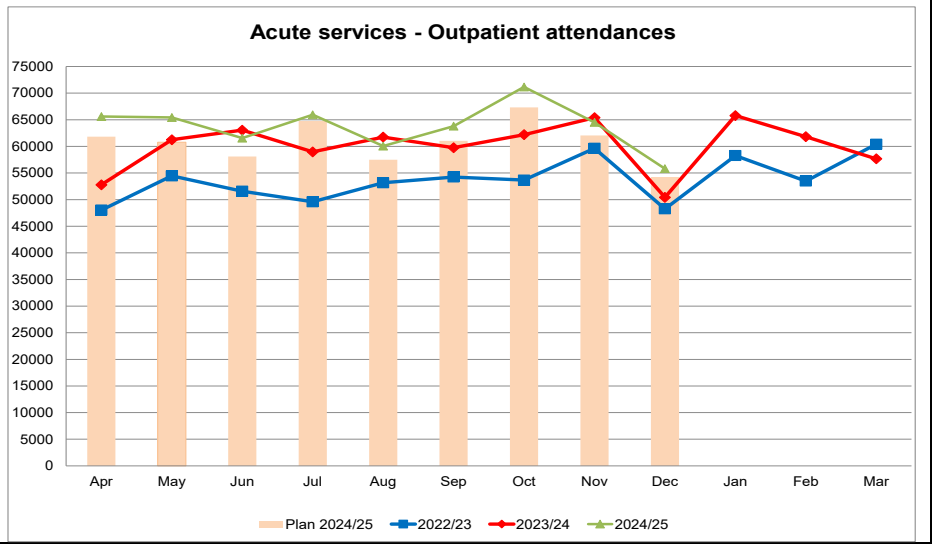
**Acute services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior years.**



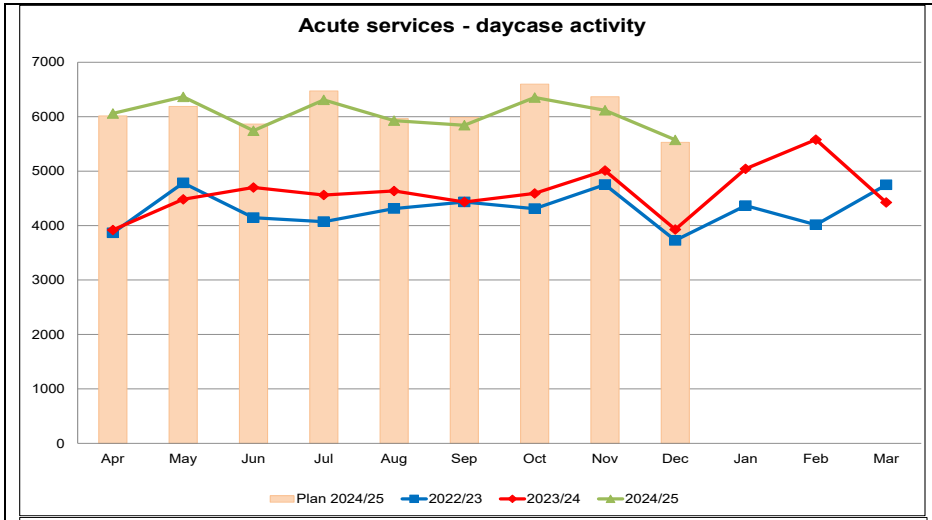

Summary:

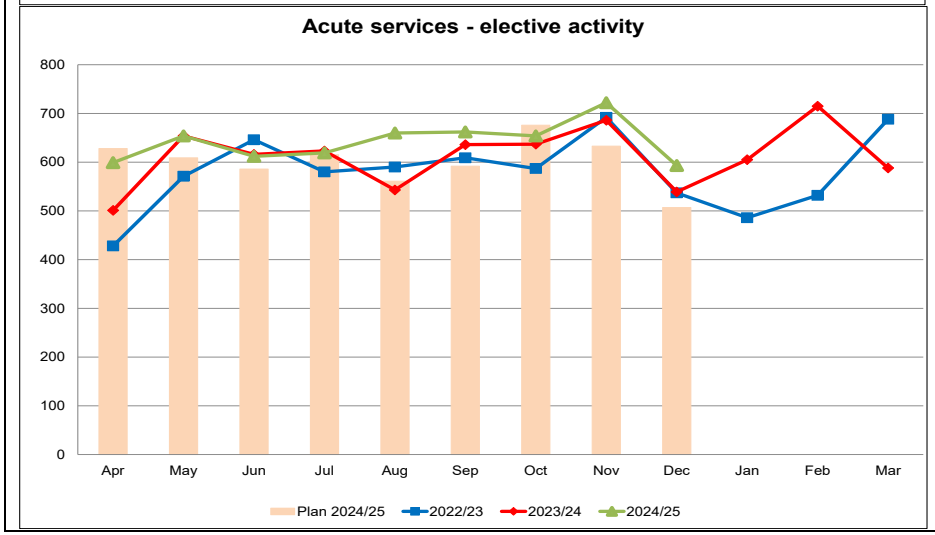
- Between 1 April and 31 December 2024 attendances to Accident and Emergency were 4.1% higher than the same months of 2023 and 4.7% higher than the same months of 2022. In December 2024, 46.6% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 76%.
- GP and Dental referrals between 1 April and 31 December 2024 were 7.7% higher than the same months of 2023 and 11.7% higher than the same months of 2022.
- Outpatient attendances for the same period were 7.1% higher than the corresponding months of 2023 and 21.4% higher than the same months of 2022. Attendances for the year to date are currently 4.8% above the interim plan for 2024/25.



## Operational context

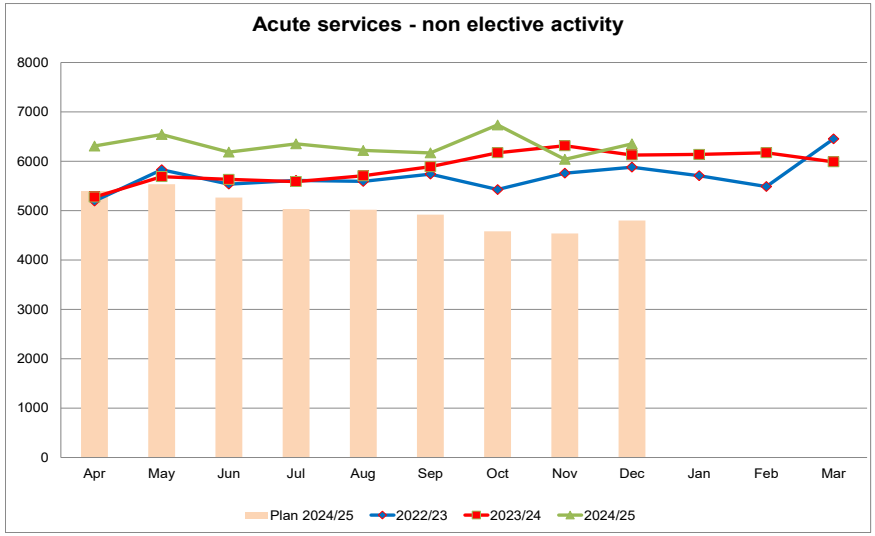
**Acute services: This section of the report provides a summary of the levels of day case, elective, and non elective activity during the reporting period, compared to the previous months and prior years.**




Summary:

- The number of day cases undertaken by our acute services between 1 April and 31 December 2024 increased by 34.8% compared to the same months of 2023 and by 41.4% compared to the same months of 2022. Activity for the year to date was 1.3% below the current year plan.
- Over the same period, elective admissions were 6.8% higher than the corresponding months of 2023 and 10.2% higher compared to the same months of 2022. Activity for the year to date was 6.8% above the current year plan.
- Non elective admissions also saw increases, of 8.6% compared to 2023 and 12.5% compared to 2022. Activity for the year to date was 26.2% above the current year plan.



**Appendix 6 – Infection Control and Prevention – December 2024**

| MRSA bloodstream infections | Commentary on MRSA / MSSA BSIs |
|---|---|
| Musgrove Park Hospital = 0<br>Yeovil District Hospital = 0<br>Community Hospitals / Mental Health = 0 | Case numbers of MSSA doubled in December in comparison to last month and we remain slightly over our internal trajectory. In comparison with other trusts our MSSA rate per 100,000 occupied bed days places us in the middle regionally and slightly below the Southwest rate. |
| **MSSA Bloodstream Infections** | |
| Musgrove Park Hospital = 6<br>Yeovil District Hospital = 3<br>Community Hospitals / Mental Health = 0 | |
| **E. coli bloodstream infections** | **Commentary on Gram-negative bloodstream infections** |
| Musgrove Park Hospital = 4<br>Yeovil District Hospital = 3<br>Community Hospitals / Mental Health = 0 | Case numbers for all the Gram-negative bloodstream infections remain relatively stable. Case numbers of Klebsiella have reduced this month back to an expected level. As a trust we remain under trajectory for all gram-negative bloodstream infections and have some of the lowest rates in comparison with the rest of the region. |
| **Klebsiella bloodstream infections** | |
| Musgrove Park Hospital = 3<br>Yeovil District Hospital = 0<br>Community Hospitals / Mental Health = 0 | |
| **Pseudomonas bloodstream infections** | |
| Musgrove Park Hospital = 2<br>Yeovil District Hospital = 1<br>Community Hospitals / Mental Health = 0 | |
| **C. difficile** | **Commentary on C. difficile** |
| Musgrove Park Hospital = 3<br>Yeovil District Hospital = 2<br>Community Hospitals / Mental Health = 0 | Case numbers of C. difficile reduced slightly again in December 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) = 36**<br>Musgrove Park Hospital = 27<br>Yeovil District Hospital = 7<br>Community Hospitals / Mental Health = 2<br><br>**Influenza = 449 (Inpatients)**<br>Musgrove Park Hospital = 292<br>Yeovil District Hospital = 139<br>Community Hospitals / Mental Health = 8<br><br>**Respiratory Syncytial Virus (RSV) = 166 (Inpatients)**<br>Musgrove Park Hospital = 103<br>Yeovil District Hospital = 60<br>Community Hospitals = 3 | **Respiratory Viruses**<br>Whilst COVID cases decreased during December (almost halved) cases of 'Flu A significantly increased from 41 cases in November to over 400 in December. This is likely to be due to the high numbers of 'Flu A circulating across the population which have outcompeted COVID.<br><br>'Flu often infects people alone, i.e. if a patient has 'Flu, they are less likely to have another respiratory virus such as COVID at the same time. As a result, if more people are infected with 'Flu at one time, less will be infected with another respiratory virus such as COVID or RSV. From the early data, the fact that this has been a comparatively bad year for 'Flu may mean case numbers of COVID and RSV are lower than previous years. |
| **Outbreaks** | **Commentary on outbreaks** |
| **COVID = 4**<br>Musgrove Park Hospital = 4<br><br>**Influenza = 15**<br>Musgrove Park Hospital = 5<br>Yeovil District Hospital = 8<br>Community / Mental Health = 2<br><br>**Carbapenemase Producing Organism (CPO)**<br>• **YDH -** Since January 2022 there have been 72 cases of CPO identified on the YDH site. | **Respiratory Outbreaks**<br>In line with respiratory virus case numbers, outbreaks of COVID have reduced and been replaced with outbreaks of 'Flu A. It is rare that 'Flu B causes outbreaks.<br><br>**Carbapenemase Producing Organism (CPO) - YDH**<br>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. During December, more cases of IMP resistance have been identified. This was the original resistance mechanism when the outbreak began and there have not been many cases for some time. This needs a deeper review but is likely to be significant. |

| Surgical Site Infections | Commentary on Surgical Site Infections |
|---|---|
| Surgical Site Infection Surveillance enables early recognition of infections to inform remedial and improvement actions.<br><br>**Musgrove Park Hospital Site**<br>Continuous surveillance for Total Hip Replacement (THR), Total Knee Replacement (TKR) and Spinal Surgery has been in place on the MPH site since 2009.<br><br>**Yeovil District Hospital Site**<br>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**<br>• **Hip Replacement**<br>Within the last year (December 2023 to November 2024) a total of 357 operations have been undertaken with no infections identified.<br><br>• **Knee Replacement**<br>Within the last year (December 2023 to November 2024) a total of 216 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% but has reduced from last month.<br><br>• **Spinal Surgery**<br>Within the last year (December 2023 to November 2024) a total of 341 operations have been undertaken and 5 infections identified giving an infection rate of 1.47%. This is a little above the national benchmark of 1.2%.<br><br>**Yeovil District Hospital Site**<br>• **Hip Replacement**<br>Within the last year (December 2023 to November 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.<br><br>• **Knee Replacement**<br>Surveillance began in January 2024 therefore between January and November 2024, a total of 384 operations have been undertaken with no infections identified.<br><br>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. |

NHS
Somerset
NHS Foundation Trust

| Somerset NHS Foundation Trust | |
|---|---|
| **REPORT TO:** | Board of Directors |
| **REPORT TITLE:** | Quality Strategy 2024 - 2027 |
| **SPONSORING EXEC:** | Hayley Peters, Chief Nurse |
| **REPORT BY:** | Hayley Peters, Chief Nurse<br>Melanie Iles, Chief Medical Officer |
| **PRESENTED BY:** | Hayley Peters, Chief Nurse<br>Melanie Iles, Chief Medical Officer |
| **DATE:** | 4 February 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 Quality Strategy sets out our Trust's approach to delivering safe, effective, high-quality care that ensures a positive experience and is safe, for our patients, colleagues and all those who receive our support<br><br>The Quality Strategy is a vital framework to enhance the standards of care we provide. Our core principles of Patient Safety, Patient Experience, and Clinical Effectiveness are the platform to fostering a culture that prioritises high-quality care for those we serve.<br><br>The strategy outlines our intent to review within the next six months our quality governance framework, which will enable us to monitor progress against our strategic and service group priorities, uphold our core standards, and improve the quality of care and support, based on the insights gathered from our assurance and from patient and colleague feedback. The journey towards improving quality is ongoing and requires concerted efforts from all levels of our organisation.<br><br>Our year one priorities will be subject to ongoing review and through active engagement with our Service Group colleagues, patients, and the wider community, we will ensure that our quality priorities are not only relevant but also responsive to evolving healthcare needs.<br><br>As we embark on this ambitious plan, we remain dedicated to continuous improvement, accountability, and transparency.<br><br>Together, we will not only meet the challenges ahead but will also set a benchmark for quality care that inspires trust and |

| | |
|---|---|
| | confidence in our services and supports our colleagues to provide the highest standards of care and support.<br><br>Our next steps will be the development of a Quality Plan for the next three years and the Quality Plan will contain measurable targets around governance and co-production, as well as including targets from existing strategies. |
| **Recommendation** | The Board is asked to approve the Quality Strategy and note the ongoing work and the development of a Quality Plan. |

**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

The needs of people with protected characteristics have been considered as part of the development of the strategy and the patient benefits case is included in the strategy. Their needs will be further considered as part of the development of the quality plan.

**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)

Extensive engagement has taken place with service groups and the draft strategy has been discussed by the Quality and Governance Assurance Committee and was presented to the joint Board/Governors meeting.

**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]

| |
|---|
| N/A |

| **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 | |

# Our Quality Strategy 2024-2027

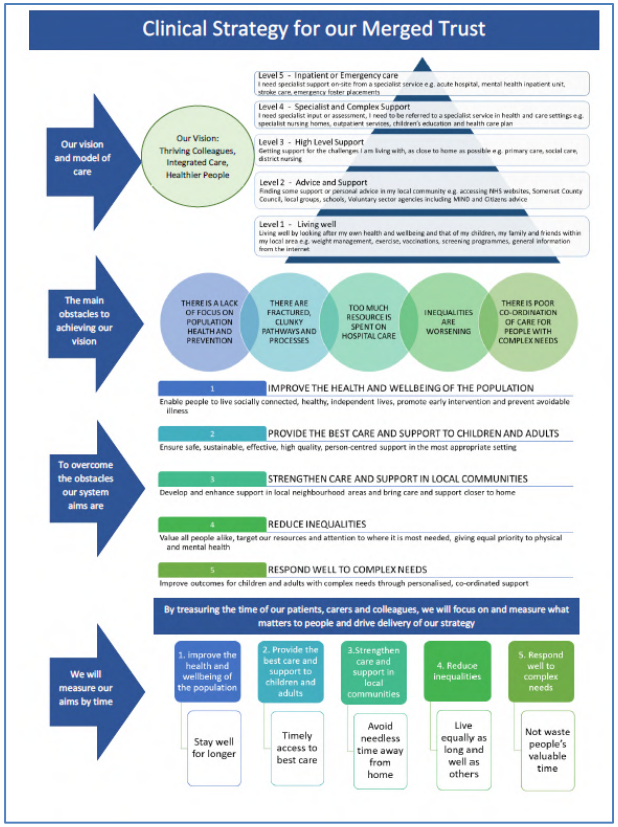
Kindness, Respect, Teamwork
Everyone, Every day

Melanie Iles, Chief Medical Officer
Hayley Peters, Chief Nurse

3rd December 2024

# Our Trust

Somerset NHS Foundation Trust brings together community services, mental health and learning disability services, hospital and primary care services in one trust. We aim to transform care for our patients and the people of Somerset and beyond.



# Our mission, vision and values

**Our mission** is to improve the health and wellbeing of everyone in Somerset and to deliver outstanding integrated care by supporting our colleagues and nurturing an inclusive culture of kindness, respect and teamwork.

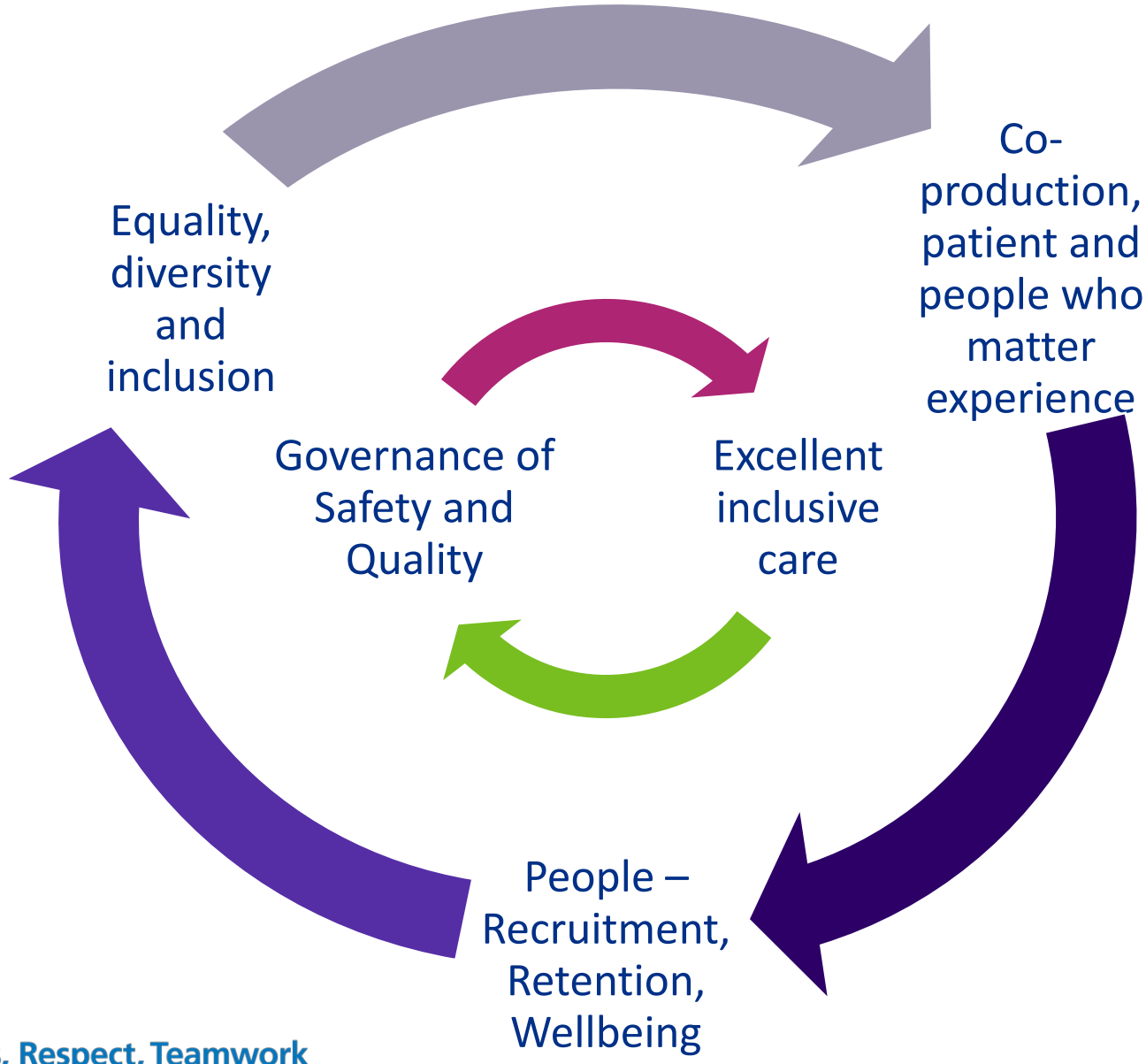
**Our vision** is  thriving colleagues, integrated care, healthier people.

**Our values** are kindness, respect and teamwork.

# Supporting strategies to achieve our Strategic Objectives

| | | | |
|---|---|---|---|
| Improve the health and wellbeing of the population | Provide the best care and support to people | Strengthen care and support in local communities | Reduce inequalities |
| Respond well to complex needs | Support our colleagues | Live within our means | Deliver the vision of the Trust by transforming our services through research, innovation and digital technologies |
| Clinical Strategy | **Quality Strategy** | Finance Strategy | Digital Strategy |
| People Strategy | Comms and Engagement Strategy | Estates, Facilities and Capital Development Strategy. | Research Strategy, Green Plan and others |

# What did the Service Groups say?




Kindness, Respect, Teamwork
Everyone, Every day

# What is our quality strategy?

The Quality Strategy sets out our Trust's approach to delivering safe, effective, high-quality care that ensures a positive experience and is safe, for our patients, colleagues and all those who receive our support

Our priorities take into account national strategic priorities, including the NHS National Patient Safety Strategy; and are focused around four thematic principles which are key to our quality agenda. These are:

a. **Personalised Care**
**b. Patient Involvement and Experience, and Co-Production**
**c. Right Care, Right Bed**
**d. Colleague Engagement and Wellbeing**

We are developing our approach to the Patient Safety Incident Response Framework (PSIRF) and have identified our principal themes under this framework which form our safety priorities for the next 12-18mths

# What do we mean by quality

we have adopted the definition given in **“ gh Q l y C f All” (2008)**, following the NHS Next Stage Review led by Lord Darzi.

It sets out three dimensions to quality, all three of which must be present to provide a high-quality service:

**Patient safety** – quality care is care which is delivered to reduce avoidable harm to patients. It encourages a culture of support, openness and honesty around care to ensure the system learns and adapts from safety events.

**Patient experience** – quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect. The patient experience domain of quality also embraces accessibility, understood in the sense that we must provide services in an inclusive way that recognises the diversity of our population.

**Clinical effectiveness** – quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual’s health outcomes.

# Where are we now?

| CQC domain | SFT's predecessor Trusts | | Somerset FT | Yeovil District Hospital FT |
|---|---|---|---|---|
| | Taunton & Somerset FT | Somerset Partnership FT | | |
| Safe | Requires improvement | Requires improvement | Requires improvement | Requires improvement |
| Effective | Good | Good | Good | Good |
| Caring | Outstanding | Good | Good | Good |
| Responsive | Good | Good | Good | Good |
| Well-led | Good | Good | Good | Good |
| Use of resources | Good | n/a | n/a | Inadequate |
| **Overall Trust rating** | **Good** | **Good** | **Good** | **Requires improvement** |
| **Acute hospital overall rating** | Requires Improvement (Musgrove Park Hospital) | n/a | n/a | Requires Improvement (Yeovil District Hospital) |

*"a comprehensive review of the Trust's Quality Governance Framework has been completed.*

*This review was conducted as part of the Trust's regular corporate governance processes to ensure it remains effective and fit for purpose.*

*The findings were presented to the Board in May 2024, and this paper had been made available to us in NHSE.*

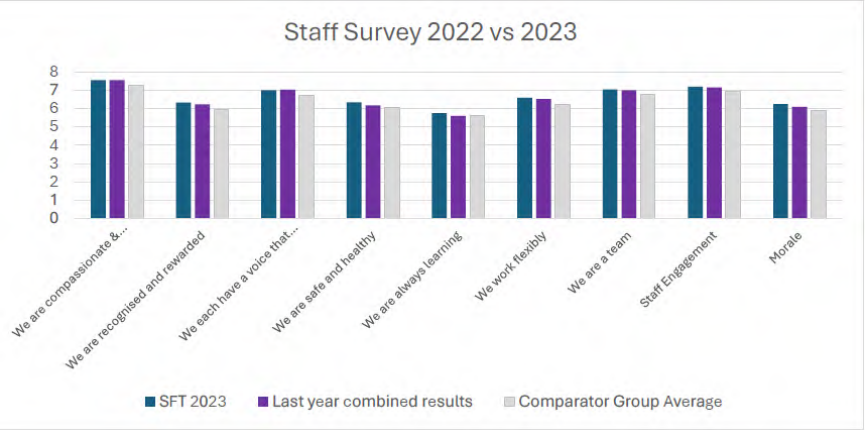
*We were able to discuss with you how the Board will maintain oversight and responsibility for patient safety under a 'devolved' governance structure, and you explained the process and routes for escalation. We briefly reflected on the most recent CQC Maternity inspection report and concerns raised at the System Quality Group in relation to paediatric services; although this meeting was not specifically in relation to those, you were able to explain the mechanisms for those concerns to be raised, and how those were being progressed. "*

# Where are we now?

1. **Patient Safety**
- Patient safety board
- Review of governance
- PSIRF, LFD, Martha's rule

2. **Patient experience**
- Formal patient experience & engagement group
- Build on excellence

3. **Clinical effectiveness**
- Provision of direction and support for colleagues to deliver their governance responsibilities
- Development of effective frameworks that meet requirements, but are simple for front line colleagues
- Provision of training and guidance
- QAG and data review group



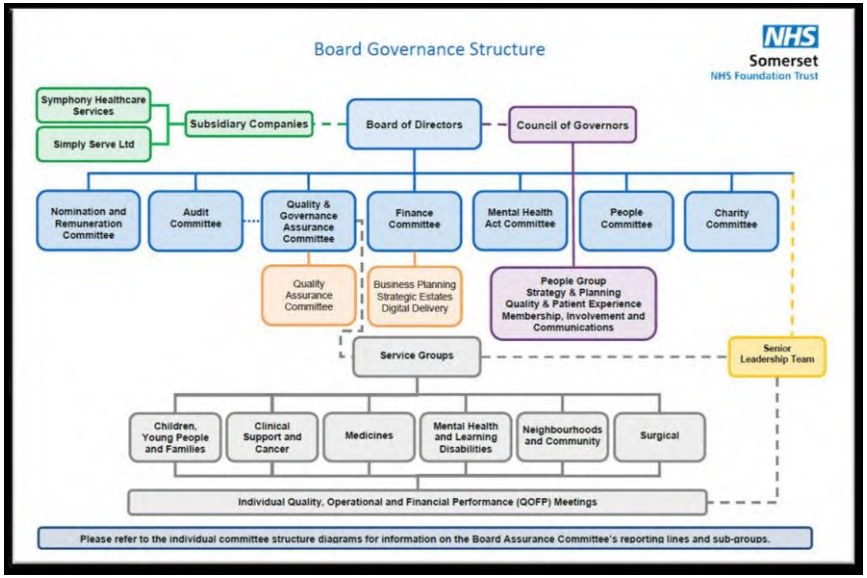

Strongest themes: compassionate and inclusive and staff engagement

# Where do we want to be?

- Trust level and service group level priorities
- Patient engagement and experience strategy
- Service transformation and integration
- Productive care
- Strategic quality improvement priorities
  - Personalised Care
  - Patient Involvement and Experience, and Co-Production
  - Right Care, Right Bed
  - Colleague Engagement and Wellbeing
- PSIRF priorities: deteriorating patient, TEPS, people who matter
- National strategies

# How do we get there?

- Reviewing the quality governance – put good governance in place
- LFPSE
- Data to drive Quality improvement
- Development and approval of policies
- Trust QGAC
- Service groups & QOFP



# Conclusion

- Our Quality Strategy is as a vital framework to enhance the standards of care we provide.
- Our core principles of Patient Safety, Patient Experience, and Clinical Effectiveness are the platform to fostering a culture that prioritises high-quality care for those we serve.
- The strategy outlines our intent to review within the next six months our quality governance framework, which will enable us to monitor progress against our strategic and service group priorities, uphold our core standards, and improve the quality of care and support, based on the insights gathered from our assurance and from patient and colleague feedback.
- The journey towards improving quality is ongoing and requires concerted efforts from all levels of our organisation.
- Our year one priorities, will be subject to ongoing review and through active engagement with our Service Group colleagues, patients, and the wider community, we will ensure that our quality priorities are not only relevant but also responsive to evolving healthcare needs.
- As we embark on this ambitious plan, we remain dedicated to continuous improvement, accountability, and transparency.
- Together, we will not only meet the challenges ahead but will also set a benchmark for quality care that inspires trust and confidence in our services and supports our colleagues to provide the highest standards of care and support.

# Discussion - Moving from Strategy to Plan

- The achievement of the Quality Strategy will be overseen by QGAC. The Quality Strategy also aligns to the BAF
- Our next steps will be the development of a **Quality Plan** for the next 3 years
- The Quality Plan will contain measurable targets around governance and co-production, as well as including targets from existing strategies
- How do we do this as a large complex organisation?
- How do we bring the strategy to life?

NHS

Kindness, Respect, Teamwork
Everyone, Every day

NHS
Somerset
NHS Foundation Trust

# Quality Strategy

# 2024-2027

# Contents

# 1 Introduction

## What is our Quality Strategy?

1.1 This Quality Strategy sets out our Trust's approach to delivering safe, effective, high quality care that ensures a positive experience and is safe, for our patients, colleagues and all those who receive support from Somerset NHS Foundation Trust.

1.2 It is one of several strategies that the Trust has to help it deliver its mission, vision and objectives. It supports our three core strategies: Clinical Care and Support; People and Finance; and it sits alongside other enabling strategies such as our Digital, Estates and Research Strategies which run through everything that we deliver.

1.3 We have engaged extensively with our Service Groups (the Groups responsible for the operational delivery of our clinical services) to establish a range of specific quality priorities which they will work to deliver. Some of these are medium- and long-term goals, but some will be delivered quickly, and we will make progress against them all in the first year. We have sought to do this in conjunction with our patients and service users, and their carers but recognise there is more work we need to do to involve our communities in developing this work in the coming years.

1.4 Our Service Group priorities take into account national strategic priorities, including the NHS National Patient Safety Strategy; and are focused around four thematic principles which are key to our quality agenda. These are:

a. Personalised Care
b. Patient Involvement and Experience, and Co-Production
c. Right Care, Right Bed
d. Colleague Engagement and Wellbeing

1.5 In addition, we are developing our approach to the Patient Safety Incident Response Framework (PSIRF) and have identified our principal themes under this framework which form our safety priorities for the next 12-18 months

1.6 To deliver these priorities, we recognise the need to review our quality governance framework around the three pillars of quality – patient safety, patient experience and clinical effectiveness. The strategy includes a description of how we will review quality, and the governance arrangements in place across the trust to ensure that standards are met, performance is improved, and quality measures are reported at all levels of the organisation to the Board. This includes a reflection on how we can deliver the improvements to quality in the NHS set out by Lord Darzi in his *Independent Investigation of the National Health Service in England* report, published in September 2024.

1.7 In the appendices to the strategy, we set out the year one priorities for our:

- Quality Governance Framework reviews
- Strategic quality priorities (including PSIRF)
- Service Group quality priorities

## What we mean by Quality

1.8 When we talk about quality, for the purposes of this strategy, we have adopted the definition given in "High Quality Care for All" (2008), following the NHS Next Stage Review led by Lord Darzi. This definition has largely been embraced throughout the NHS. It sets out three dimensions to quality, all three of which must be present to provide a high-quality service:

- **Patient safety** – quality care is care which is delivered to reduce avoidable harm to patients. It encourages a culture of support, openness and honesty around care to ensure the system learns and adapts from safety events.
- **Patient experience** – quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect. The patient experience domain of quality also embraces accessibility, understood in the sense that we must provide services in an inclusive way that recognises the diversity of our population.
- **Clinical effectiveness** – quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes.

1.7 At Somerset NHS Foundation Trust, we believe that this continues to be the best way of explaining what we mean by quality, to both colleagues and patients. We talk about Patient Safety, Patient Experience and Clinical Effectiveness in all of our supporting strategies, not just the Quality Strategy, and we judge all of our service changes against those criteria. They are at the heart of how we develop our services, and of how we have developed this Quality Strategy.

1.8 We also know that improving quality brings wider benefits that will help us navigate the challenges faced by the NHS. For example, we are working under significant financial strain, but we know that delivering high quality services that get care right first time means that we can save money as well as delivering better care for patients. Quality delivers value for money, which will better preserve the Somerset pound and make sure that we use our limited financial resources in the best way.

1.9 Our approach to quality has paid particular attention to the national NHS Patient Safety Strategy (2019, revised 2021), and the Digital Clinical Safety Strategy (2021). As we have developed our approach to quality and our priorities, we have sought to embed the principles of these national strategies into our work. We have referenced below how we have tried to achieve this.

# 2. Vision and objectives

2.1 We want our approach to quality to be rooted in our mission, vision and values. SFT brings together community services, mental health and learning disability services, hospital and primary care services in one trust for the whole county, as well as providing some services into neighbouring counties. We want to transform care for our patients and the people of Somerset and beyond. Our Quality Strategy seeks to deliver on our Mission, Vision and Values, enabling us to deliver care of the highest quality for local people.

2.2 Our **mission** is to improve the health and wellbeing of everyone in Somerset and to deliver outstanding integrated care by supporting our colleagues and nurturing an inclusive culture of kindness, respect and teamwork.

2.3 Our **vision** is – thriving colleagues, integrated care, healthier people.

2.4 Our vision is supported by shared **values** that were developed by our colleagues across our range of services. They are kindness, respect and teamwork. We strive to use them in our work every day, to develop a compassionate, inclusive and learning culture and put our values at the heart of our service planning, recruitment and the operational running of services for patients.

**Our Strategic Objectives**

2.5 Our trust's Strategic Objectives support the achievement of the aims we share with health and social care partners in Somerset.

They are to:

- Improve the health and wellbeing of the population
- Provide the best care and support to people
- Strengthen care and support in local communities
- Reduce inequalities
- Respond well to complex needs
- Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning cultures
- Live within our means and use our resources wisely
- Deliver the vision of our Trust by transforming our service through research, innovation and digital technologies

2.6 Our Quality Strategy is aligned to these Strategic Objectives, showing how they link through to the quality priorities we are delivering. It supports our three core strategies: Clinical Care and Support; People and Finance; and sits alongside others such as our Digital, Estates and Research Strategies which run through everything that we deliver.

2.7 As we developed this Quality Strategy, we wanted to engage directly with our Service Groups to establish Quality Priorities, and make sure that not only did the Quality Strategy deliver on the trust's Strategic Objectives, but also helped to deliver the specific priorities of the Service Groups directly delivering care and support to patients and service users every day.

## 3. Where are we now?

3.1 Somerset NHS Foundation Trust (SFT) in its current form was established on 1 April 2023, following the merger of the former Somerset NHS Foundation Trust (created by the merger of Somerset Partnership, and Taunton and Somerset NHS Foundation Trusts in April 2020) and Yeovil District Hospital NHS Foundation Trust (YDH). We created this unique NHS Trust because we want to provide better care for our patients and ensure that everyone in the county enjoys consistent access to high quality services irrespective of where they live. Working as one organisation, and therefore eliminating organisational boundaries, puts us in a better position to support people to stay well, give equal priority to mental and physical health, deliver services in the most appropriate setting, help us to further improve care for our patients and service users, and make better use of our resources.

### Care Quality Commission ratings

3.2 The current Trust has not been subject to formal overall inspection by the Care Quality Commission (CQC) but both predecessor trusts were rated Good overall by the CQC. However, there were some areas of our services which were rated as "Requires Improvement", in particular within the Safe domain, and we were conscious of the need to ensure that our services met all of the CQC's domains as we developed this strategy so that we can demonstrate that our services are safe, effective, caring, responsive and well-led.

3.3 The CQC inspected our maternity services at Musgrove Park Hospital, Yeovil District Hospital and Bridgwater Community Hospital in November 2023 and those reports were published in May 2024. The services at the two acute hospitals were rated as Inadequate overall and the service at Bridgwater Community Hospital was rated as Requires Improvement overall. Following the maternity services inspection, the overall rating for both our acute hospital sites decreased from Good to Requires Improvement. The inspection report highlighted for us the need to strengthen our processes to provide ongoing review of quality, performance and governance including developed a strong audit and policy programme to drive continual improvements in our services, not only in maternity but across all of our services.

3.4 Our CQC current and historic ratings can be seen in Figure 1 below:

| CQC domain | SFT's predecessor Trusts | | Somerset FT | Yeovil District Hospital FT |
|---|---|---|---|---|
| | Taunton & Somerset FT | Somerset Partnership FT | | |
| Safe | Requires improvement | Requires improvement | Requires improvement | Requires improvement |
| Effective | Good | Good | Good | Good |
| Caring | Outstanding | Good | Good | Good |
| Responsive | Good | Good | Good | Good |
| Well-led | Good | Good | Good | Good |
| Use of resources | Good | n/a | n/a | Inadequate |
| **Overall Trust rating** | **Good** | **Good** | **Good** | **Requires improvement** |
| **Acute hospital overall rating** | Requires Improvement (Musgrove Park Hospital) | n/a | n/a | Requires Improvement (Yeovil District Hospital) |

**Figure 1: CQC ratings**

### NHS England Post-Merger Review

3.5 As part of the assurance process for the merger of SFT and YDH, the Trust was subject to extensive review of its quality governance framework, alongside other aspects of its strategic and operational functions. The due diligence and external reviews supported the trusts to proceed to merger and the quality governance framework was reviewed by NHS England in a targeted post-merger review in June 2024. The review found that:

*"a comprehensive review of the Trust's Quality Governance Framework has been completed. This review was conducted as part of the Trust's regular corporate*

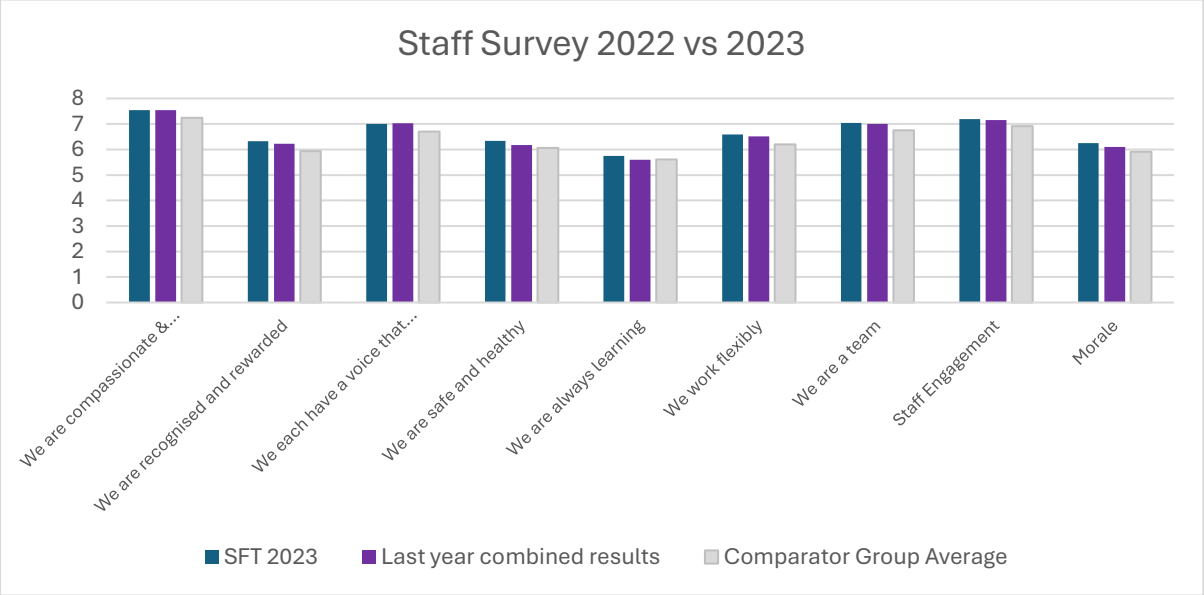
*governance processes to ensure it remains effective and fit for purpose. The findings were presented to the Board in May 2024, and this paper had been made available to us in NHSE. We were able to discuss with you how the Board will maintain oversight and responsibility for patient safety under a 'devolved' governance structure, and you explained the process and routes for escalation. We briefly reflected on the most recent CQC Maternity inspection report and concerns raised at the System Quality Group in relation to paediatric services; although this meeting was not specifically in relation to those, you were able to explain the mechanisms for those concerns to be raised, and how those were being progressed. "*

**NHS Staff Survey**

3.6 A lot of work goes into ensuring that we create the right climate for our colleagues and each of our service groups looks very closely at the results of the NHS Staff Survey in their areas to improve their colleagues' experience, spread good practice and implement improvements where needed. This was the first time that we were able to participate in the survey as one organisation. Both legacy Trusts started from good bases with high results, but this year's results surpassed the combined results of the previous year.

3.7 There is overwhelming evidence that positive staff engagement is a key to delivering and improving high quality care. The 2023 NHS Staff Survey was completed during October and November 2023 with a 53% response rate.

3.8 The table below highlights the overwhelmingly positive feedback from our people and in every theme the Trust scored higher than the benchmark group average. We are really encouraged that our results have remained so positive despite so many challenges, however the promise of 'we each have a voice that counts' fell slightly compared to the 2022 survey.




3.9 The strongest themes for the Trust in 2023 remain the People Promises of:

- We are compassionate and inclusive
- Staff engagement

**Patient Safety**

3.10 The NHS Patient Safety Strategy (July 2019) describes the national approach to Patient Safety as a core part of delivering quality. It describes Patient Safety starting with a safe culture and requiring a safe structure. The NHS National Patient Safety Strategy has three aims which guide organisations to increase safety and foster a culture of insight, involvement and improvement. Specifically, the National Patient Safety Strategy calls on trusts to:

- Improve understanding of safety by drawing insight from multiple sources of patient safety information (**Insight**)
- Equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system **(Involvement)**
- Design and support programmes that deliver effective and sustainable change in the most important areas (**Improvement**)

3.11 The Trust's Patient Safety Board is responsible for overseeing this approach and sets the structure for patient safety with openness, listening and learning at the centre. The Patient Safety Board should act to draw together threads of patient safety work, data, insights and learning with a core aim of being able to understand the patient safety culture of the organisation.

3.12 The Board receives regular insight reports, highlighting areas where the Trust is an outlier in patient safety to inform further review and learning. Patient Safety Partners and Patient Safety Specialists both within SFT and in partner organisations are included, though we recognise there is more to do to support and develop these roles across the organisation.

3.13 Learning from patient safety is defined through the Patient Safety Incident Response Framework (PSIRF), which focuses on learning and improvement with an emphasis on the complex systems and cultures that support continuous improvement in patient safety. This plan is underpinned by the new Trust Patient Safety Incident Response Policy which will be reviewed every 12-18 months. This approach will enable the Trust to remain flexible and consider the specific circumstances in which patient safety events occurred and ensure the needs of those affected are met.

3.14 To provide a clear Patient Safety structure from floor to Board, patient safety work and culture is frequently highlighted through colleague communications and safety teaching and roadshows. Reporting and raising concerns are encouraged and reporting structures for patient safety match the organisation structure at SFT with involvement from services, service groups, and Trust-wide support all feeding into the Patient Safety Board, chaired by the Chief Medical Officer and reporting directly to the Quality and Governance Assurance Committee.

3.15 The structures and roles supporting patient safety in the Trust require further review to ensure they are meeting the needs of the new organisation. This will form part of the year one priorities for this strategy.

3.16 In aligning to the National Patient Safety Strategy we have outlined patient safety workstreams with support from Patient Safety Partners and Patient Safety Specialists such as those around implementing Martha's Rule, supporting PSIRF and LFPSE implementation and responding to National Patient Safety Alerts which feed into the Patient Safety Board.

**Patient Experience**

3.17 Our vision for Patient Experience as described in our merger business case and patient benefits case is to monitor and promote excellent experience of care for all patients, carers, and families; encourage meaningful patient and public involvement in developments, improvement and co-design and support learning from feedback across the trust; inform and influence organisational priorities relating to improving patient experience and patient outcomes; and provide assurance that we have the systems and processes to learn from feedback from patients, their families and carers.

3.18 While there are well-developed structures for patient experience and engagement in some services and Service Groups – particularly within mental health and learning disabilities - this is an inconsistent picture across the trust at present. In September 2024, we established a formal Patient Experience and Engagement Group which reports regularly to the Quality & Governance Assurance Committee.

3.19 We are developing a patient experience and engagement strategy which will support the delivery of our strategic objectives and be core to the delivery of this Quality Strategy, the People Strategy - particularly the culture strategy - and the equality, diversity, and inclusion (EDI) agenda. This will set out how we will fulfil our ambition to work in partnership with our patients, service users, carers, and communities to develop and improve our services in line with the requirements of *Working in Partnership with People and Communities* across the whole Trust.

**Clinical Effectiveness**

3.20 Arrangements for clinical effectiveness in the Trust are overseen as part of the overall approach to governance, integrated with other key elements including risk management, compliance with regulation, and assurance.

3.21 Accountabilities for clinical effectiveness are devolved via the operational structure of the organisation, with a central Governance Support Team providing three key support functions:

- Provision of direction and support for colleagues to deliver their governance responsibilities
- Development of effective frameworks that meet requirements, but are simple for front line colleagues
- Provision of training and guidance

3.22 Oversight of clinical effectiveness is provided by a clear assurance structure (see Section 5), with several key committees reporting to the Quality and Governance Assurance Committee, including:

- The Quality Assurance Group, which receives regular reports on organisational wide “topics”, covering a comprehensive range of clinical and non-clinical requirements
- The Data review Group, which monitors the Trust’s benchmarked performance against nationally reported quality indicators and ensures that an appropriate response is in place to address any outliers

3.23 Although the structures for clinical effectiveness have been regularly reviewed, a more comprehensive review is now required to align with changes to patient safety arrangements and meet the requirements of the new organisation.

**SWOT Analysis**

3.24 Our current ability to deliver high quality services shows that we have some strengths and some weaknesses. We also see some opportunities to deliver services of higher quality, as well as some threats which might make this more difficult. Some of these are summarised in the SWOT analysis below.

| **Strengths** | **Weaknesses** |
|---|---|
| i. Strong history of good quality care across both legacy trusts, built upon during the merger.<br>ii. Working as part of regional structures and collaborative arrangements which are well established and successful.<br>iii. Good links with regional and national networks across many clinical and non-clinical teams.<br>iv. Organisational commitment to quality, including a nationally recognised high quality QI team/programme which has delivered training to thousands of colleagues.<br>v. Availability of high-quality data to inform decision making.<br>vi. Quality focused scrutiny from Non-Executive Directors and Governors<br>vii. Cultural focus on quality, starting at Board level. | viii. New integrated approach not yet fully embedded across both legacy trusts.<br>ix. Some single points of failure remain.<br>x. Vulnerable to loss of "institutional memory" as older staff retire or other experienced colleagues leave.<br>xi. Some issues are too difficult to solve alone, with limited regional / national options to resolve.<br>xii. Capacity difficulties to resolve strategic quality issues in addition to "business as usual". |
| **Opportunities** | **Threats** |
| xiii. Merger gives both trusts the opportunity to learn from the other<br>xiv. Merger allows for staffing gaps etc to be more easily and flexibly filled.<br>xv. Current national commitment to, and focus on, quality, will mean that it is easier to prioritise quality initiatives.<br>xvi. Size and scope of new organisation might make it easier for us to forge links with national and regional partners to further the quality agenda. | vii. Tendence towards risk aversion, especially in the current financial climate.<br>viii. Uncertainty over priorities given potential focus on Covid recovery and waiting list reduction over other things.<br>ix. Further impact of cost savings targets on quality.<br>xx. Further operational pressures making it even more difficult to focus on quality improvement alongside day to day operational delivery |

# 4. Where do we want to be – developing our Quality Priorities

4.1 When the former SFT and YDH merged on 1 April 2023 to become the new Somerset NHS Foundation Trust, we did not have a written strategy for quality, so this is the first such document covering the newly established organisation. We wanted it to be informed not only by the strategic considerations which led us to merge, but also by the improvements our patients told us that they want.

4.2 As we developed our Quality Strategy, we wanted to engage directly with our Service Groups to establish Quality Priorities, and make sure that not only would the Quality

Strategy deliver on the Trust's Corporate Objectives, but also help to deliver the specific priorities of the Service Groups directly caring for patients every day.

4.3 We have developed our Quality Priorities at both the strategic / Trust-wide level, and from below via the Service Groups and the patients we directly serve. We have also developed our priorities as a result of developing national guidance.

4.4 We asked Service Groups to work directly with colleagues, service users and others to develop their quality priorities. To do this well, we knew that this needed to be a collaborative approach, focusing on the needs and wishes of the people who use our services, and the people who matter to them.

4.5 Good governance is also vital to making sure that we deliver our priorities. With this in mind, we are committed to reviewing our governance processes for each of the three pillars of quality.

4.6 We are also committed to developing and improving the engagement and involvement of our patients, service users and our communities in all our quality and governance processes. In particular, we aim to improve our ability to:

- monitor and promote excellent experience of care for all patients, carers, and families
- encourage meaningful patient and public involvement in developments, improvements and co-design and support learning from feedback across the organisation
- inform and influence organisational priorities relating to improving patient experience and patient outcomes
- provide assurance that we have the systems and processes to learn from feedback from patients, their families, and carers

These commitments will form part of our Patient Experience and Engagement Strategy to be published in 2024/25.

**Service transformation priorities**

4.7 As part of our business case for merger, we developed a Business Case and a Patient Benefits Case to show how the merger would deliver high quality services in a different way. We set out the desired quality improvements that will transform the organisation for our patients in the merger business case. These were:

- Earlier intervention meaning illness is less likely to escalate to crisis or emergency
- Quicker access to diagnosis and treatment, including specialist care
- Improved access to holistic care which meets both physical and mental health needs
- Improved patient safety from simpler, quicker pathways and shared patient record systems
- Better health outcomes as colleagues see wider range of clinical cases, share knowledge & best practice
- Unwarranted variation reduced through consistent county-wide pathways
- Ready access to patients' full clinical history via shared IT systems which increases patient safety and good clinical outcomes
- Equity of care across the county from consistent approach

- Improved patient experience from streamlined pathways, and in some cases less travel for care

4.8 The Patient Benefits Case set out six case studies explaining how these benefits would develop and be delivered at a service level, details of which are set out in Appendix 1.

**Productive Care**

4.9 As the next phase of integration, following our merger, we have launched our productive care programme. The aim of productive care is to build on our successful start on merging by benchmarking all our services to inform future transformation plans to increase our productivity resulting in better patient experience. The programme is data driven and built on four areas of integration and development:

- quality and safety
- workforce
- activity and performance
- finance

4.10 We will use the information from the programme to inform quality and safety performance, future priorities and will continue to use equality and quality impact assessment processes to understand and assure the impacts of any service changes on the quality of care we provide.

**Strategic Quality Improvement priorities**

4.11 When we asked Service Groups to work with colleagues, service users and others to develop their local quality priorities, a number of key themes became apparent in the process. We considered these alongside the priorities identified through our patient safety, patient experience and clinical effectiveness governance processes; national priority schemes and the next phase of our integration programme – productive care. This review culminated in four over-arching strategic themes:

- Personalised Care
- Patient Involvement and Experience, and Co-Production
- Right Care, Right Bed
- Colleague Engagement and Wellbeing

**PSIRF priorities**

4.12 As part of the implementation of PSIRF, organisations were required to identify local priorities based on an understanding of their incident profile and safety culture. As locally defined priorities, PSIRF enables organisations to focus on those areas for improvement by undertaking several patient safety incident investigations (PSIIs) for each priority. This allows application of a systems-based approach to learning from these incidents exploring multiple interacting contributory factors. The outcomes of the PSIIs can then be thematically analysed to inform our patient safety improvement planning and work. Within SFT, the safety improvement plans and workstreams will be overseen by Patient Safety Board.

4.13 The work to describe the patient safety incident profile at SFT was undertaken between June and November 2023 and was conducted by the Quality & Safety Analysts and PSIRF implementation teams within the Governance Support Team, in conjunction with a wide range of stakeholders including medical directors, safety teams and topic specialists.

4.14 A detailed summary of this work was shared with key stakeholders, both internal and external, in advance of a planning session to choose the Trust's priorities. Following detailed discussions at this session, the final three priorities were chosen by consensus as:

- Deteriorating patient (including sepsis)
- Treatment escalation planning
- Engaging with people who matter to the patient (particularly those who cannot advocate for themselves).

4.15 To deliver PSIRF learning responses we have recruited and trained a number of frontline colleagues from across the organisation to provide systems-based learning through a range of tools. We continue to train colleagues and support the wider uptake of the national safety syllabus through our LEAP platform.

4.16 At the end of the 12-18months, the Patient Safety Board will be well placed to draw together themes and learning from PSIIs and will have a deep understanding of our safety culture and therefore be able to establish the learning priorities for the next 12-18 month cycle.

The details of the strategic priorities, including PSIRF, and the monitoring processes are set out in Appendix 2.

**Service Group priorities**

4.17 We asked our Service Groups to develop their quality priorities were developed in line with principles to, where possible, make sure they:

- took into account the views and priorities of patient and carer groups and service users, reflecting the diversity of our population and our staff.
- mapped across to the CQC essential standards
- aligned with the ICB quality strategy
- aligned with other trust supporting strategies, e.g. digital, estates, research etc

4.18 We sought to reflect national priorities in our work. For example, we considered the NHS National Patient Safety Strategy, Working in Partnership with People and Communities and other documents to inform our approach.

4.19 We recognise that our Service Groups tackled this in different ways and achieved a range of engagement and feedback in establishing their priorities. We know that we did not hear from all the diverse voices of our communities in this and we will need to do more work in the future iterations of this strategy, to inform our future priorities. However, from this initial work, a variety of areas of focus emerged, although there were some ideas which were more frequently expressed by participants. Figure 6 below is a "thought cloud", showing some of the words used by participants.


4.20 Each of the Service Groups developed their priorities against the foundations of our Quality Strategy. These priorities are set out in Appendix 3

## 5. How do we get there? - reviewing the Quality Governance Framework

5.1 We know that in order to achieve the Quality Priorities that we have set ourselves in this Quality Strategy, we will need to review progress and put in place good governance to gain assurance that all our services are of high quality, regardless of their inclusion within this document.

**Learning and support**

5.2 We know what we want to achieve but we also know that sometimes there will be incidents or difficulties, and we want to put in place a system of learning and support which means that colleagues are confident to report issues and learn from them so that we achieve as best we can. The new PSIRF and Learning from Patient Safety Events (LFPSE) reporting systems allow for the further embedding of learning and review into our reporting and monitoring processes, and our newly-enlarged trust now means that there is cross-county consistency in how we are trying to deliver quality.

5.3 We will enhance the opportunities of our new structures by using data more in our attempts to drive Quality Improvement. This will include the use of internal and clinical audit and oversight of best practice guidance to support implementation of our quality priorities.

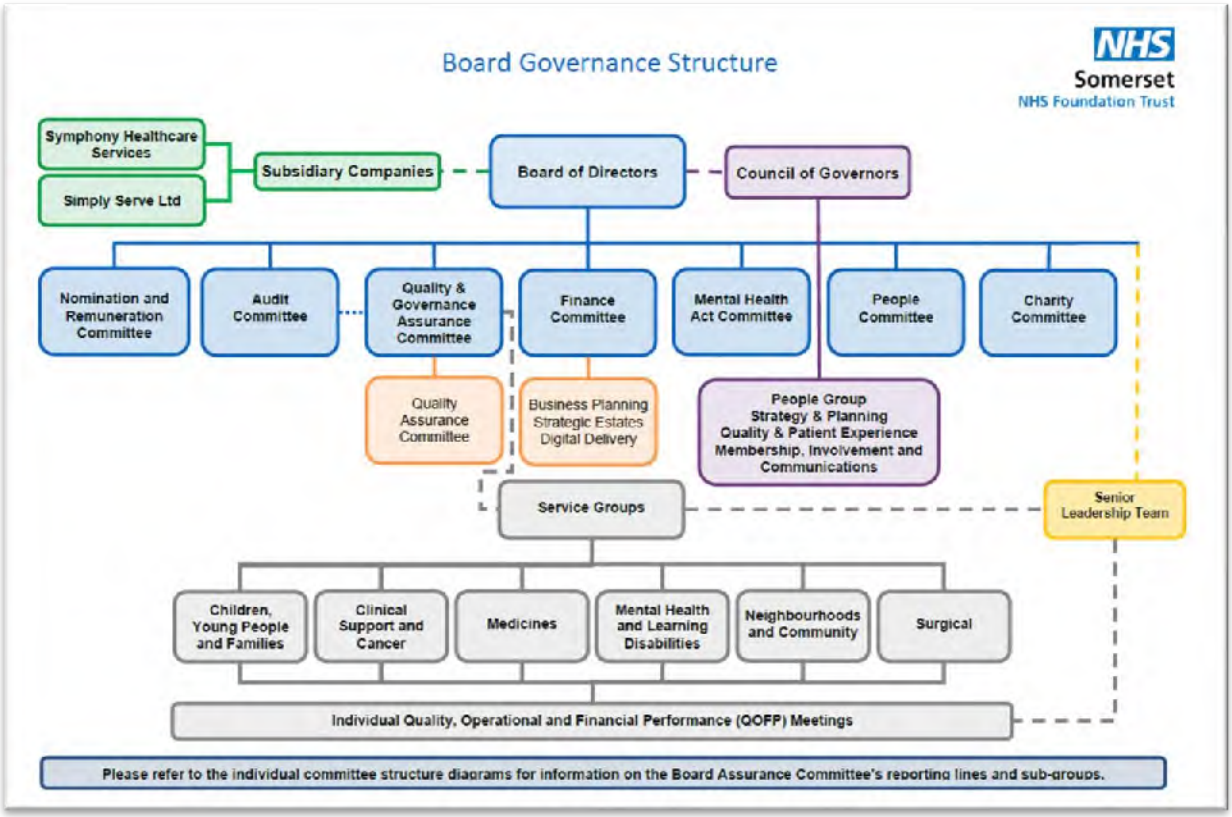
5.4 We will ensure that processes for the development and approval of policy and guidance documents support our aim of codesign and inclusion, helping us to achieve our stated Quality goals.

**Trust-level oversight and governance structure**

5.5 At a trust level, we have established devolved governance arrangements so that oversight is held at Service or Service Group level where appropriate and escalated to organisation and board level where required.

5.6 The Quality & Governance Assurance Committee is the Board committee with responsibility for seeking assurance on the delivery of the quality strategy. A programme of updates will be scheduled for discussion with the Committee. Its place

in the wider trust governance structure, including its links to the Service Groups, is shown below.

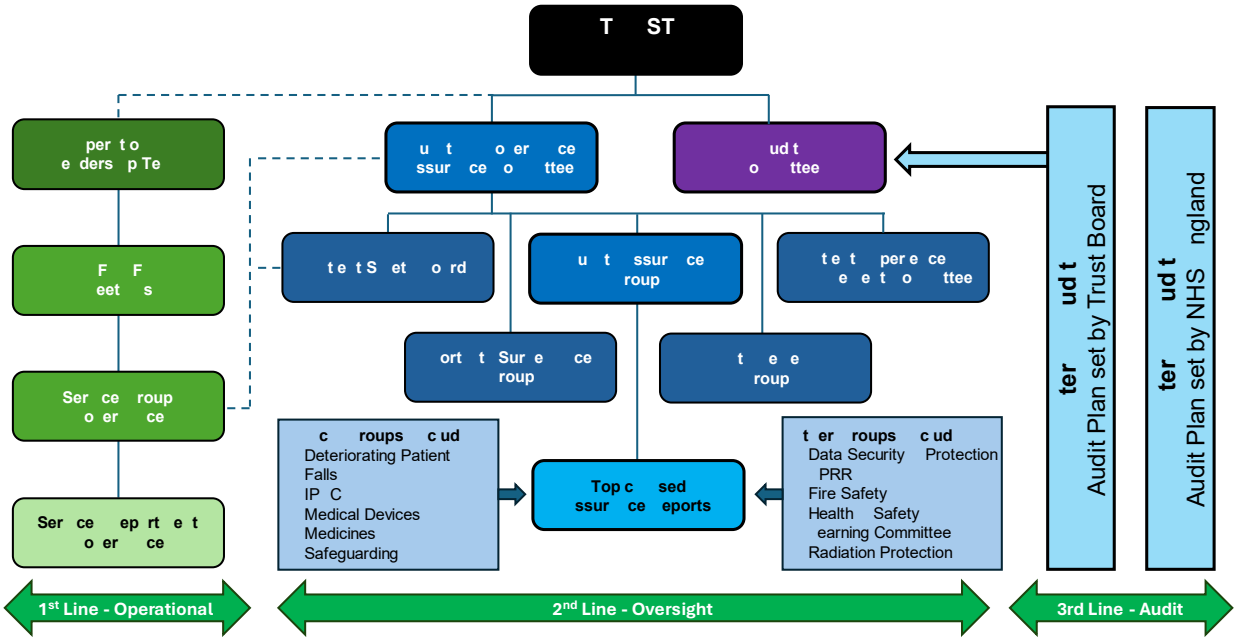



5.7 The strategic Quality Priorities will be overseen and monitored through the Quality & Governance Assurance Committee and reported on annually through our Quality Report and Account. Specific key quality indicators will be included in the Board Assurance Framework (BAF) and overseen by the relevant board assurance committee and progress reported quarterly to the Trust Board.

5.8 Service Group Quality Priorities will be overseen through their Quality Outcomes Finance and Performance meetings (QOFPs) and reported on annually by the Service Groups in their reports to the Quality & Governance Assurance Committee.

5.9 Our trust assurance reporting structure, showing how the various strands of quality governance come together to inform the Board, is shown below:

**Assurance Reporting Structure**




5.10 Following the feedback from our maternity CQC inspection reports, our learning from implementation of PSIRF and LfPSE and the post-merger review process, we will be reviewing our overall governance structure and processes to ensure they are fit for purpose to deliver effective governance and assurance and oversee deliver of our strategic objectives. We will complete this work by 1 April 2025.

**Patient Safety**

5.11 As part of the governance review, we will look again at our structures and resource to support patient safety, including the role of the Patient Safety Board, the effective delivery of PSIRF and LfPSE, and the roles in central and Service Group structures to deliver the aims of the national Patient Safety Strategy. This will include the role of Patient Safety Partners to inform and shape our learning and improvement. We will also complete this work by 1 April 2025.

5.12 The Patient Safety Board will report quarterly on its progress to the Quality & Governance Assurance Committee who will provide assurance, in turn, to the Trust Board.

**Patient Experience**

5.13 We will develop a Patient Experience and Engagement Strategy by 31 December 2024, which will set out how the Trust will meet the standards and requirements of *Working in Partnership with People and Communities* across the whole Trust and deliver our vision for Patient Experience, as described in our merger business case and patient benefits case, to:

- monitor and promote excellent experience of care for all patients, carers, and families
- encourage meaningful patient and public involvement in developments, improvement and co-design
- support learning from feedback across the trust
- inform and influence organisational priorities relating to improving patient experience and patient outcomes; and

- provide assurance that we have the systems and processes to learn from feedback from patients, their families and carers.

.

5.14 The Patient Experience and Engagement Group will report quarterly on its progress to the Quality & Governance Assurance Committee who will provide assurance, in turn, to the Trust Board.

**Clinical Effectiveness**

5.15 As outlined above, although the structures for clinical effectiveness have been regularly reviewed, a more comprehensive review is now required to align with changes to patient safety arrangements and meet the requirements of the new organisation. This will form part of the overall governance review and will be completed by 1 April 2025.

# 6 Conclusion

6.1 Our Quality Strategy for 2024-2027 serves as a vital framework for Somerset NHS Foundation Trust to enhance the standards of care we provide.

6.2 We have defined our core principles of Patient Safety, Patient Experience, and Clinical Effectiveness as the platform to fostering a culture that prioritises high-quality care for all those we serve.

6.3 The strategy outlines our intent to review within the next six months our quality governance framework, which will enable us to monitor progress against our strategic and service group priorities, uphold our core standards, and improve the quality of care and support, based on the insights gathered from our assurance and from patient and colleague feedback.

6.4 We recognise that the journey towards improving quality is ongoing and requires concerted efforts from all levels of our organisation. Our year one priorities, set out in the appendices, will be subject to ongoing review and through active engagement with our Service Group colleagues, patients, and the wider community, we will ensure that our quality priorities are not only relevant but also responsive to evolving healthcare needs.

6.5 As we embark on this ambitious plan, we remain dedicated to continuous improvement, accountability, and transparency. Together, we will not only meet the challenges ahead but will also set a benchmark for quality care that inspires trust and confidence in our services and supports our colleagues to provide the highest standards of care and support.

**Appendix 1: Patient Benefits Cases**

When we wrote our business case, we summarised the desired benefits across those case study areas, and the number of patients benefitting, as set out below:

| Change | Benefit to patients | No. of patients benefitting a year |
|---|---|---|
| **Maternity** | | |
| Combining our maternity teams, including WREN team | • Increased scale and ability to implement national requirements (including personalised care) | c. 4,300 |
| | • Improved maternity care and experience for women living in the 'corridor' in the middle of the county, especially those with complex pregnancies or with additional needs | c. 600 |
| **Oncology** | | |
| Overhaul of psychological support offer | • Better care for the psychological aspects of cancer | c. 550 |
| Improved access to clinical trials | • Earlier access to innovative drugs, closer monitoring during treatment, and improved patient outcomes from trial participation<br>• Enhanced colleague knowledge of leading-edge treatments | c. 100-150 |
| Fewer inter-site transfers | • Reduced clinical risk from site transfers<br>• Less discomfort & inconvenience from being transported between sites<br>• Less colleague time spent administrating patient transfers which frees up time for front line care | c. 5 |
| **Cardiology** | | |
| Amended acute NSTEMI pathway | • Quicker patient access to diagnostics and specialist care leading to improved patient outcomes<br>• Reduced clinical risk from fewer inter-site patient transfers<br>• Less patient time waiting for specialist care and feeling anxious.<br>• Eliminate duplicate investigations which will reduce patient waiting and free up clinical time<br>• Improved use of combined diagnostic capacity, which reduces patient waits<br>• Less patient time (and less discomfort) from being transported between sites<br>• Reduced administrative work associated with inter-site transfers, which frees up colleague time to care for other patients | c. 200 |
| Amended pacemaker pathway, and remote monitoring county-wide | • Right pacemaker first time which reduces risk of heart failure<br>• Quicker identification of deteriorating heart function, which supports early intervention<br>• Fewer pacemaker upgrades which frees up clinical time and catheterisation lab capacity for other patients<br>• Greater patient convenience from not having to attend as many face to face appointments<br>• Greater patient peace of mind from continuous heart monitoring | c. 690 |

| | | |
|---|---|---|
| County-wide clinics | • Improved access to care for heart failure patients for mental health aspects of their condition<br>• Improved access to cardiac rehabilitation<br>• Improved access to care which meets both physical and mental health needs | c. 150 for patients with heart failure and angina<br>+<br>c. 50 for patients benefitting from emotional health checks |
| **Stroke** | | |
| Combined patient and carer education and support programmes | • Equity of provision of support leading to improved health outcomes<br>• Care better tailored to individuals' needs<br>• Increased patient confidence to self-manage<br>• Healthcare workers' time focused on what only they can do (rather than taking on tasks better done by others) | c. 1,100-1,400 patients<br>+ 700-800 carers |
| Improved use of physical capacity | • More care provided closer to home<br>• Rehabilitation support less likely to be stood down | c. 1,100-1,400 |
| **Peri-operative care** | | |
| Introduction of a county-wide approach to peri-operative care | • Quicker recovery and fewer complications post-surgery<br>• Better patient experience<br>• Lasting lifestyle improvements which benefit long-term health | c. 24,850 |
| **Homelessness** | | |
| Introduction of a county-wide approach to care of homeless people | • Intervene early to prevent escalation of health need<br>• Address a significant health inequality in our county<br>• Provide coordinated care which is tailored to the complex needs of this patient cohort | up to c.300-400 |

**Appendix 2: Strategic Quality Improvement Priorities**

## QIP 2024/25 - Priority 1 – Personalised Care

### Why is this important?

Personalised Care according to the NHS England long term plan will benefit people by giving them the same choice and control over their mental and physical health that they have come to expect in every other aspect of their life.

A one-size-fits-all health and care system simply cannot meet the increasing complexity of people's needs and expectations.

Personalised care and support planning is a series of facilitated conversations in which the person, or those who know them well, actively participates to explore the management of their health and wellbeing within the context of their whole life and family situation.

Personalised care and support planning is key for people receiving health and social care services. It is an essential tool to integrate the person's experience of all the services they access so they have one joined-up plan that covers their health and wellbeing needs.

The process recognises the person's skills and strengths, as well as their experiences and the things that matter the most to them. It addresses the things that are not working in the person's life and identifies outcomes or goals and actions to resolve these.

Through ensuring people are active participants and experts in the planning and management of their own health and wellbeing, ensures that the outcomes and solutions have meaning to that person in the context of their whole life and therefore leading to improved changes of successfully supporting them.

The personalised care and support plan is developed following an initial holistic assessment about the person's health and wellbeing needs. There is no set template for what a personalised care and support plan should look like, but it should reflect the following:

- A way of capturing and recording conversations, decisions and agreed outcomes or goals in a way that makes sense to the person
- Should be proportionate, flexible and coordinated and adaptable to a person's health condition, situation and care and support needs
- Should include a description of the person, what matters to them and all the necessary elements that would make the plan achievable and effective.

An internal audit was completed in 2023, the purpose of the audit was to provide assurance on whether the Trust completes personalised care plans within existing patient documentation. The audit showed areas of good practice but in most areas, it was difficult to demonstrate that people had been give choice and control and actively participated in their treatment plans.

Following the audit, the Trust has established a co-produced personalised care improvement group. This is co-chaired by Healthwatch and has three public/patient partners to ensure we are involving the voice of our population.

### What do we want to achieve?

An action plan was developed following the audit report and recommendations which will:

- Collate the results of the survey that was developed to gain awareness of our colleagues understanding of what personalised care is, whether we deliver personalised care, what stops us and what would help us to deliver care in a personalised way.
- Produce a personalised care policy.
- Develop a multi-faceted audit programme that will enable the organisation to gain assurance that personalised care is being delivered.
- Launch a training programme for colleagues

In addition to the corporate actions informed by the internal audit, Service Groups have identified a number of specific actions related to personalised care. These include, but are not limited to:

- Implement GP & nurse led clinics, supported by tele-derm solutions, to provide a more personalised and responsive dermatology service.
- Pilot a frailty nurse for SDEC at YDH
- Develop pre-surgery optimisation across 14 identified workstreams (anaemia, smoking, diabetes, frailty, nutrition/dietetics, alcohol, weight management, advance care planning, exercise, emotional support, pain management, cancer, health coaches, departmental process) to prevent deconditioning in surgical patients.
- Empower people living with cancer in care planning & delivery
- Help our PCNs and teams to embed proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions, as per the Fuller report recommendations.
- Prioritise End-of-Life Care planning for last few days of life.
- Support initiatives in the care of those with learning disabilities, recognising individualised care for this specific group will establish a model to spread personalised care to children and young people and their families.

## QIP 2024/25 - Priority 2 – Patient Involvement & Co-Production

**Why is this important?**

In 2022, the health and care act introduced significant reforms to the organisation and delivery of health and care services in England. At the heart of the changes was the need to establish a framework that supports collaboration and partnership working across a system to make it easier to deliver joined up care for our patients which is grounded in listening to what really matters to our patients and the public we serve.

As an NHS Foundation Trust we are subject to the triple aim duty which requires us to have regard to all likely effects of our decisions in relation to 3 areas:

- Health and wellbeing for people including its effects in relation to inequalities.
- Quality of health services for all individuals including the effects of inequalities in relation to the benefits people get from these services.
- The sustainable use of NHS resources.

In addition, Section 242 (Duty to Involve) of the NHS Act defines how, by law, NHS Trusts must ensure that patients and / or the public are in involved in certain decisions that affect the planning and delivery of NHS services.

Central to our responsibility to deliver against the triple aim duty, is how we work in partnership with people and communities to truly design and deliver a healthcare service which is meaningful and prioritises and delivers against what matters most to our local community. Working in partnership is delivered through a variety of approaches such as engagement, participation, involvement, consultation and co-production and has a golden thread of listening to, and responding to, feedback. These terms often overlap but also mean different things to different people and occasionally, they have a legal or technical definition.

Our organisational approach to engagement and involvement approach needs to help all colleagues understand that engaging with our communities is not seen as an obstacle to overcome on the way to achieving a pre-determined outcome.

**What do we want to achieve?**

By working in collaboration with people across our local communities we have an opportunity to better tailor services to meet needs and preferences unique to that community. Working in partnership enables us to design and deliver care more effectively and will help us to prioritise our resources to have the greatest impact and to support senior managers with making informed decisions about any potential service changes. Working in partnership will help us to address health inequalities by understanding local communities needs and to develop solutions **with** them.

Each service group will be working on delivering their own engagement and involvement plan utilising the NHS ngland resource 'Planning ngagement – a step-by-step guide'. This will enable each service group to shape a plan which is meaningful to the needs of the population they serve, to recognise that each service group is at different stages of their engagement and involvement journey and to enable all colleagues to build confidence with understanding why this is important.

We aspire to embed engagement and involvement and responding to feedback so that it is at the heart of all we do; to hardwire this across the organisation.

This work will underpin the Trust Patient Engagement and Involvement Strategy 2024 – 2027.

## QIP 2024/25 - Priority 3 – Right Care, Right Bed

**Why is this important?**

It is crucial to ensure that patients are cared for in the most appropriate care setting, by staff with the skills to provide this care.

When healthcare services are under pressure due to excessive demand and system issues, including delayed transfers of care, patients can come to harm and in addition this creates massive increased and avoidable costs for both the NHS and social services, as well as the wider public sector. Much serious avoidable harm to patients, such as hospital acquired infection and injurious falls, occurs when patients are cared for in the wrong setting.

**What do we want to achieve?**

Along with embedding the recent acute ward reconfiguration at MPH and YDH and building on the early successes of Hospital at Home, the Trust is focussing on a wide range of initiatives to support care in the right place. This includes system-wide work to address delayed transfers of care along with projects aimed at improving specific patient pathways within specialties.

Service Groups have identified a number of specific actions related to right care, right bed. These include, but are not limited to:

- Embedding the 20 min transfer policy across the sites to further improve the flow out of ED.
- Reducing length of stay by improving pathways, focussing on eight identified strategies.
- Using digital technology to improve dermatology pathways.
- Optimising pre-surgery to prevent deconditioning in surgical patients, with fourteen identified workstreams: Anaemia, Smoking, Diabetes, Frailty, Nutrition/dietetics, Alcohol, Weight management, Advance Care Planning, Exercise, Emotional Support, Pain Management, Cancer, Health Coaches, Departmental Process.
- Further development of Hospital at Home to understand the demand and capacity of for the service, including paediatric pilot.
- Further development of criteria led discharge
- Review of physiotherapy demand and capacity work to minimise inequity in waiting times.
- Reviewing reporting turnaround times for Radiology.
- Development of a 7-day paediatric assessment service

## QIP 2024/25 - Priority 4 – Colleague Health and Wellbeing

**Why is this important?**

Colleague health and wellbeing is central in supporting our colleagues to deliver the best care and support through a compassionate, inclusive, and learning culture. Wellbeing demands a holistic approach, applied in different ways at multiple levels (individual, managerial, team, strategic and organisational). Wellbeing is sometimes positioned as an afterthought when something difficult happens rather than underpinning and contributing to high quality ‘business as usual’ which everyone must take ownership of.

Basic physical wellbeing needs are not always met successfully across the whole of the organisation (e.g. hydration, toilet breaks, rest breaks etc). Research evidence identifies this leads to reduced cognitive capacity, impacting on decision making, patient care/outcomes and potentially short term and long-term health outcomes for staff. The culture and structure of the team plays a significant role in enabling these behaviours. The tone for the organisation can be set by responsive and attuned support from senior leaders and managers across the organisation, as well as in the way colleagues work together. Ongoing Service Pressures can make releasing colleagues to attend formal wellbeing interventions challenging. There is a risk that interventions may be perceived as not an effective use of resources if colleagues are not enabled to make use of them – there is a difficult balance to strike.

Educating senior managers with regards to best practice, available support and existing protocols may help managers feel more informed and supported thereby enabling them to support teams more effectively.

**What do we want to achieve?**

A range of preventative strategies and responsive interventions are required at each level of ownership (individual, managerial, team, strategic and organisational) to ensure the organisation nurtures a commonplace culture of wellbeing, and to reduce the frequency and impact of events which significantly challenge the wellbeing of colleagues.

The strategic and organisational focus for 2024/25 is on consolidating the "Care for Our People" Year 1 deliverables of the People Strategy (focussed on violence and aggression, and a just and restorative culture) and moving on to Year 2 deliverables (focussing on stress and burn out). These include:

- Supporting delivery of the Trust's violence reduction and prevention action plan
- Rolling out training for staff support post incident, linked to ongoing PSIRF implementation work
- Launching the Team Immediate Meet (TIM) tool, a communication tool designed to facilitate a hot debrief following events which cause distress, across inpatient environments
- Implementing a new Occupational Health contract with clearer guidance on heath and wellbeing support
- Gathering and reviewing information and key data to identify key priorities for reducing stress and burnout

Service Groups have identified a number of specific actions related to supporting colleagues. These include, but are not limited to:

- Improved facilities for colleague wellbeing
- Protected time for wellbeing interventions
- Focus on flexible working
- Senior leadership drop-ins
- Culture and emotional support

## QIP 2024/25 - Priority 5 – Patient Safety Incident Response Framework Themes

**Why is this important?**

The Patient Safety Incident Response Framework (PSIRF) advocates a coordinated and data-driven response to patient safety incidents. It embeds a response into a broader system of improvement and promotes a significant cultural shift towards systematic patient safety management.

PSIRF supports the creation of much stronger links between incidents and learning and improvement. We aim to work in collaboration with those affected by incidents – colleagues, patients, families, and carers – to improve learning opportunities and subsequent quality improvement work, leading to effective change. This approach will continue to increase

transparency and openness amongst our colleagues in reporting incidents and engagement in establishing learning and improvements that follow.

We are committed to learning from incidents and continuously improving the care and services we provide. We recognise and acknowledge the significant impact incidents can have on colleagues, patients, their families, and carers. Patient, family, and colleague engagement and involvement in responding to incidents is crucial to safe delivery of care and service improvement.

PSIRF allows organisations to explore patient safety incidents that are relevant to the organisational context and the populations served. It also supports a proportionate response, enabling a focus on incidents where there are real opportunities for learning and improvement.

Following detailed analysis and stakeholder engagement, the Trust identified a number of safety concerns contributing to incidents across the Trust. Further exploration of these concerns identified some areas where, although there were ongoing safety issues, these were well understood, and work was already underway to address them. However, there were some key themes where further exploration was required and could help identify significant safety improvements.

The three key themes selected by the Trust for further exploration are:

- **Recognition, escalation and response to deterioration of patients** within maternity, neonates, paediatrics, acute medical admissions, surgical decisions unit and emergency admissions unit.
- **Involving people who matter** (families, friends, carers and loved ones) in patient care.
- **TEP decision making, documentation and communication issues** with patients and families that impact on discharge and transfers across SFT locations.

**What do we want to achieve?**

The key aim of reviewing the identified themes is to support the creation local organisational recommendations and actions to feed into new or existing patient safety priorities and improvement programmes. Due to the nature of these themes and the fact that they were chosen because they are not fully understood, although there is a clear plan for review, it is not possible to set out clear improvement goals that will come out of the review.

In line with national guidance, the Trust will conduct out 3-6 learning responses per priority per year. Attempting to do more than this will impede our ability to adopt a systems-based learning approach from thematic analysis and learning from excellence. The outcomes of these learning responses will be thematically analysed and will inform our patient safety improvement planning and work.

# Appendix 3: Service Group Quality Improvement Priorities

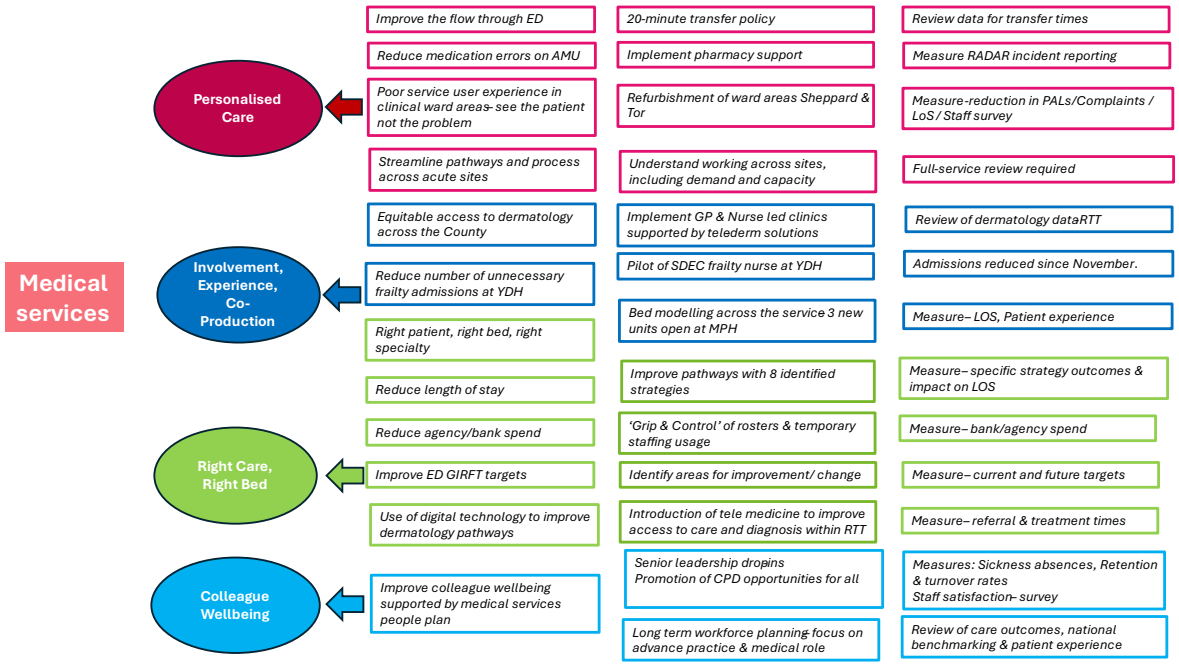



**Figure 7: Medical Service Group priorities**

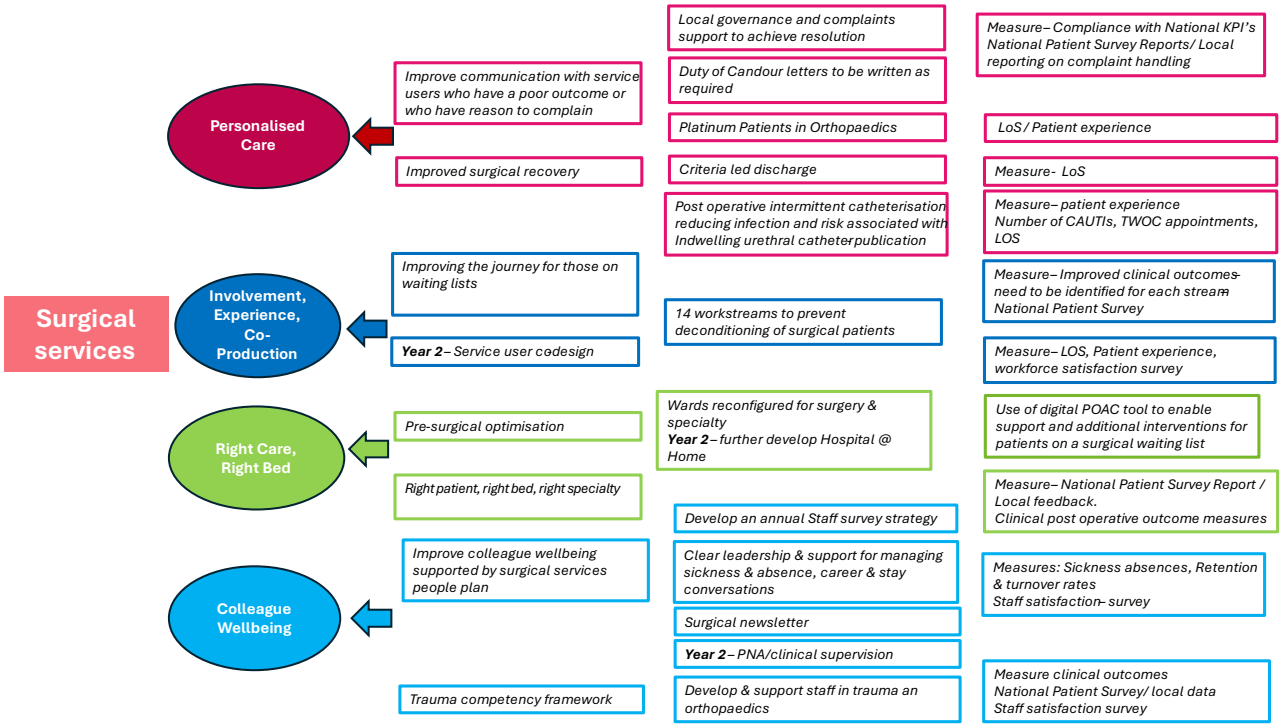



**Figure 8: Surgical Service Group priorities**

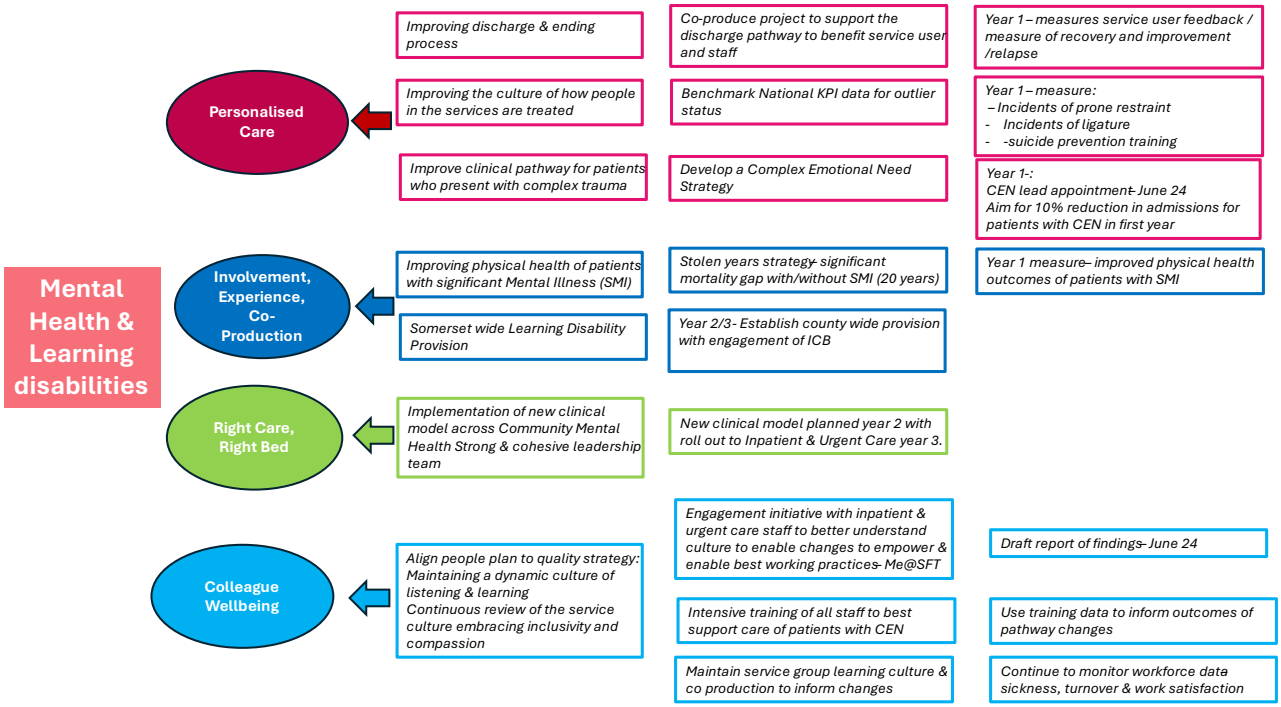



**Figure 9: Mental Health & Learning Disabilities Service Group priorities**

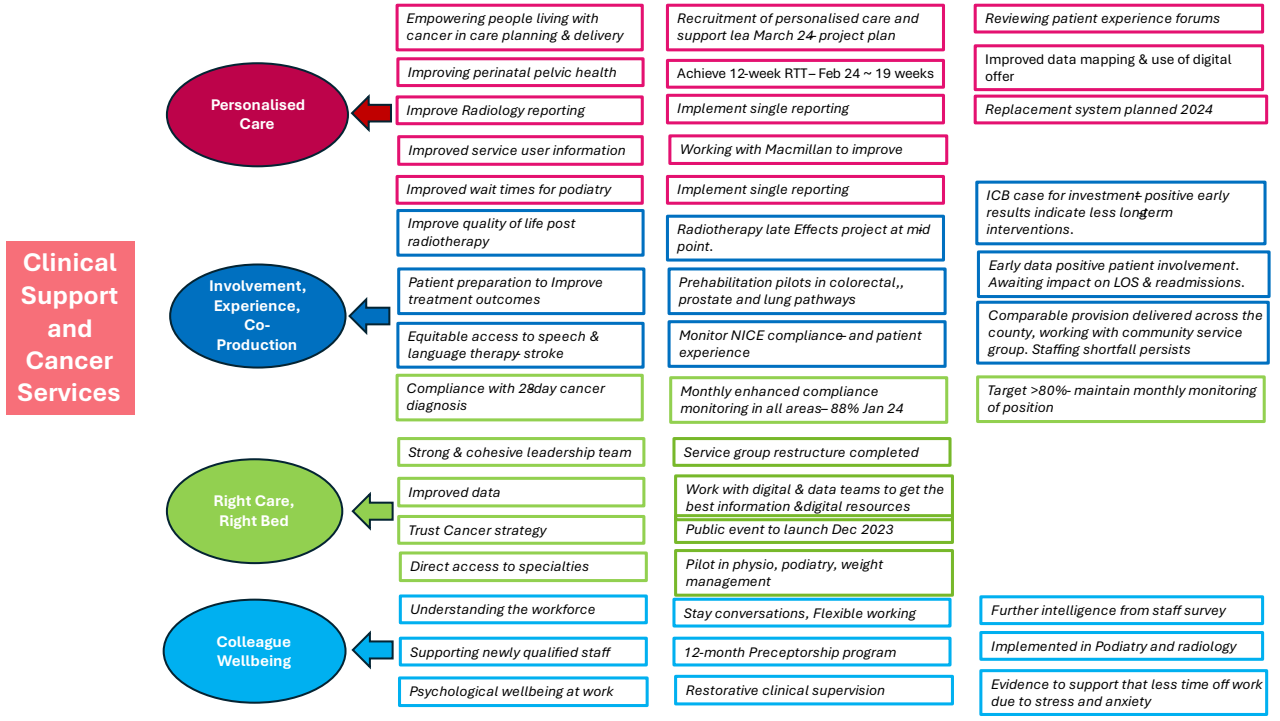



**Figure 10: Clinical Support and Cancer Service Group priorities**

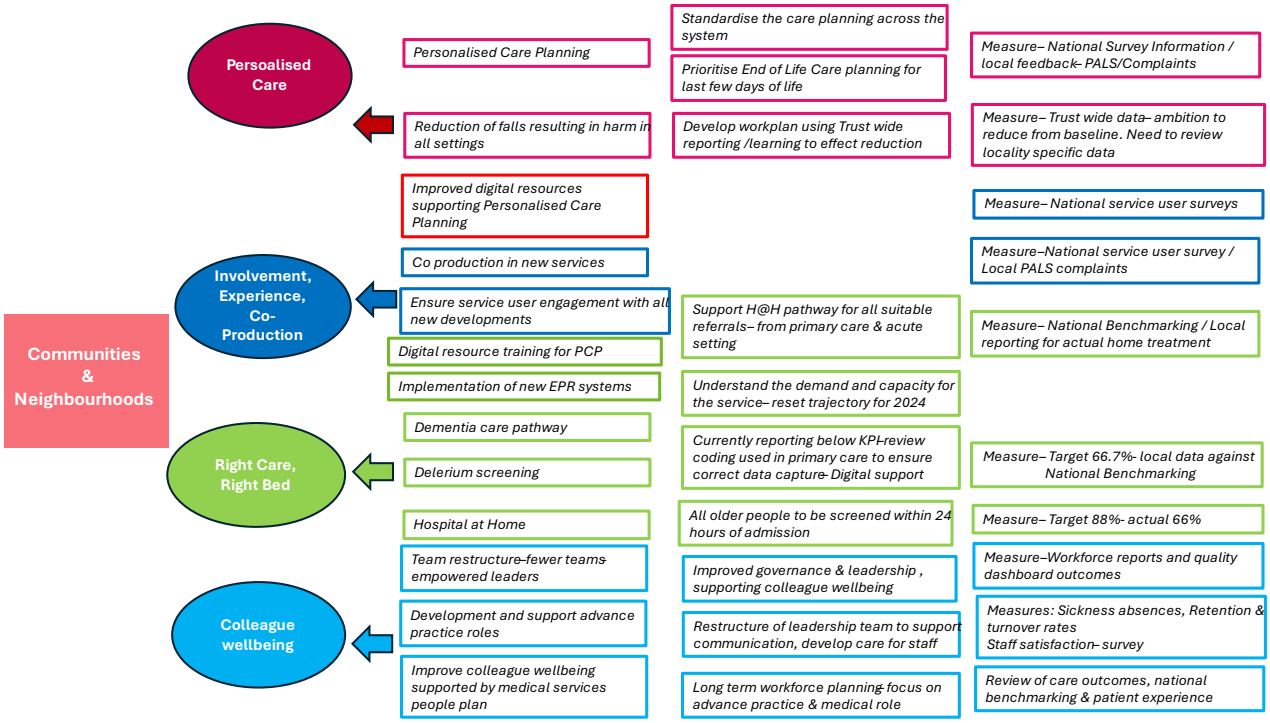



**Figure 11: Communities and Neighbourhoods Service Group priorities**

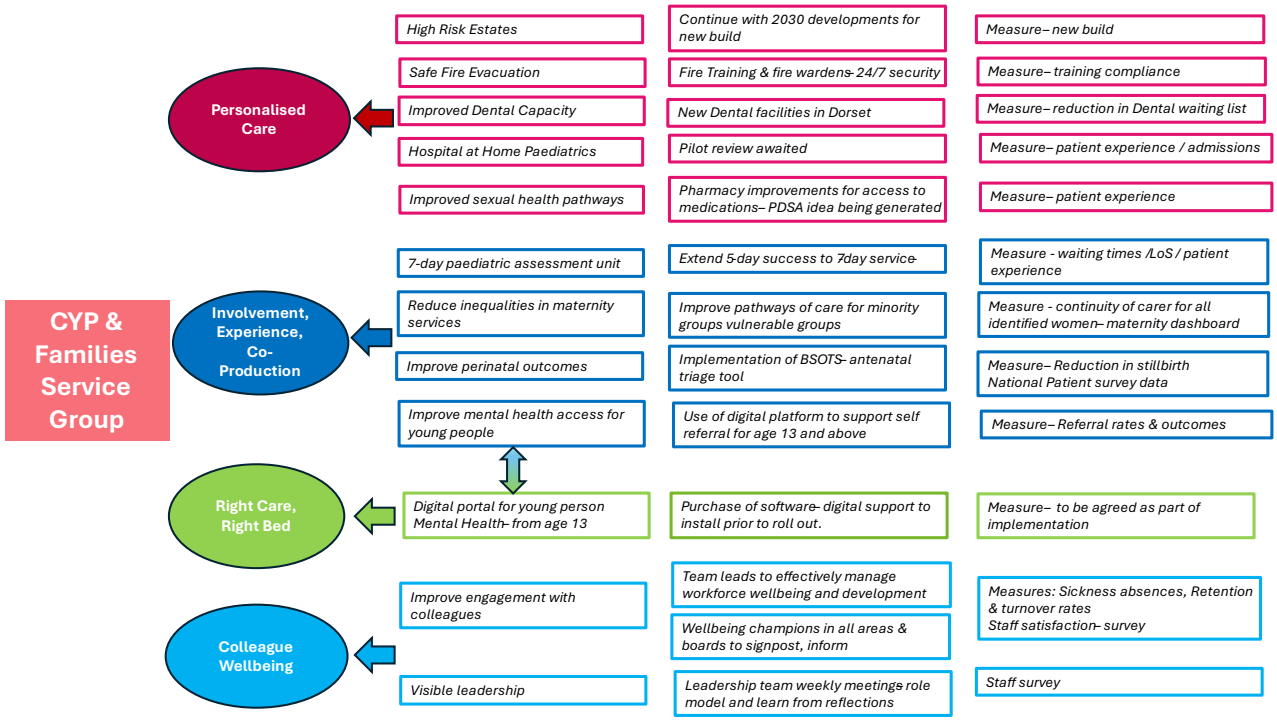



**Figure12: Children, Young People and Families Service Group priorities**

| Somerset NHS Foundation Trust | |
|---|---|
| **REPORT TO:** | Board of Directors |
| **REPORT TITLE:** | Assurance Report from the Quality and Governance Assurance Committee focus meeting held on 30 October 2024 |
| **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 February 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 focus meeting held on 30 October 2024.<br><br>The Committee received assurance in relation to:<br><br>• The Board Assurance Framework.<br><br>• The Corporate Risk Register<br><br>• The work in relation to objective 2 – provide the best care and support to people<br><br>• The Quality Strategy<br><br>• The actions taken in response to the report regarding the Nottingham Healthcare Care Quality Commission (CQC) Findings<br><br>• The Maternity and Neonatal Safety and Quality Quarterly report (MNIS)<br><br>• The Learning from Deaths Quarter 2 Report<br><br>• The Policies and procedures Status Report<br><br>The Committee identified the following areas of concern or for follow up: |

| | |
|---|---|
| | • The Corporate Risk Register – digital risk<br><br>The Committee identified the following areas to be reported to the Board:<br><br>• The digital risk due to the ongoing delay of securing the unified EHR. |
| **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**<br>(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**<br>**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.**<br><br>**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**<br><br>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**<br>(Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B] |
|---|
| The report is presented to the Board after every formal meeting. |

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

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

**SOMERSET NHS FOUNDATION TRUST**

**ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING HELD ON 30 OCTOBER 2024**

## 1. PURPOSE

1.1. The report sets out the items discussed at the business meeting held on 30 October 2024, along with the assurance received by the Committee and any areas of concern identified. The meeting was conducted by MS Teams.

## 2. ASSURANCE RECEIVED

**Board Assurance Framework (BAF)**

2.1. The Committee received and noted the quarter 2 BAF report.

**Corporate Risk Register (CRR)**

2.2. The Committee received the CRR and considered the key areas of risk for follow up by the Committee or Board.

2.3. The Committee further discussed: the EFM estates and infrastructure risk – the premises assurance model report will be presented to the December 2024 meeting; the need for a deep dive on the discharge arrangements, no criteria to reside, and personalised care – which was agreed to be discussed at the December 2024 meeting; the risk in relation to the unauthorised merger of patient records – the merger of data had been carried out by the external supplier and the impact of this risk was overseen by the Data Security and Protection Group; and the increase in the Symphony Healthcare Services sustainability risk following a review of this risk by the Finance Committee.

2.4. The Committee further received an update on the bed rails safety alert risk; and the elective recovery/activity risk.

**Objective 2 – provide the best care and support to people**

2.5. The Committee received an update on:

- The KPIs for this objective and the Committee noted that, due to the diversity of services, it was difficult to measure absolute quality across all services. Specific service group metrics will be reported through the service group's quality and operational finance and performance meetings, with exceptions to be reported to the Quality and Governance Assurance Committee.

- The key risks – the new risk relating to workforce shortages and the link to the productive care and transformation work was noted.

- The actions to improve controls and assurance relating to ward accreditation and the management of the delay in the implementation of urgent treatment centres (UTCs).

- The completion of “heat maps” by each service group and the discussions to be arranged with each service group to discuss the “heat maps” and areas of concern.

2.6. The Committee noted that the ward accreditation process will go live shortly and further noted the suggestion to present an update to non-executive directors and governors.

**Quality Strategy**

2.7. The Committee received the draft Quality Strategy and noted the three pillars of the strategy – patient safety, patient experience and clinical effectiveness; and the four strategic priorities – personalised care, patient involvement and experience and co-production, right care right bed, and colleague engagement and wellbeing.

2.8. The Committed noted: the proposal to develop a strategy for patient experience and engagement; the review of the governance arrangements and the approaches to patient safety; oversight of the strategic priorities by the Committee (priorities 1 to 3) and the People Committee (priority 4); the link to objective 2 and the range of measurables and deliverables; and the need to consider the impact of the 10-year plan once published.

2.9. The Committee noted the reporting arrangements: Patient Safety Group in respect of patient safety; governance support in respect of clinical effectiveness; reporting on relevant aspects by the newly established Patient Experience and Engagement Group; and reporting by each service group as part of their assurance reports to the Committee. The Committee noted that the reporting structure of the quality and operational finance and performance groups will need to be further discussed.

2.10. The Committee noted that the strategy will be shared with relevant stakeholders, including governors and that an annexe will be added to the strategy providing details on the expected impact on patients, with key deliverables and measurements.

**Report regarding the Nottingham Healthcare Care Quality Commission (CQC) Findings**

2.11. The Committee received an overview of the work undertaken following the publication of the CQC report and noted that the desktop review by the mental health team of the trust’s position against the findings and recommendations set out in the report had highlighted: a need to strengthen some aspects of governance, assurance and how caseloads are managed, incorporating staffing and the clinical officer to patient needs. In addition, the service group

had highlighted a need to strengthen multi-disciplinary working between doctors and community mental health teams.

2.12. The Committee further noted: that the annual audit programme for mental health services will be reviewed to include a focus on the whole clinical pathway for patients; that oversight of the implementation of the findings in the report will be reviewed following receipt of national guidance on monitoring processes; that a summarised version of the report was presented to the Board at its public meeting held on 4 November 2024.

**Maternity Incentive Scheme (MIS)**

2.13. The Committee received an update on the progress against the safety actions and noted: the development of an action plan to meet the BAPM standards for neonatal medical and nursing staffing (safety action 4); the data, including the impact and associated actions in place in response to themes identified; the work in relation to personalised care and homebirth service provision; the position in relation to compliance with the training element of safety action 8 and the expectation that compliance with this safety action can be declared by year end; the claims scorecard and targeted interventions.

2.14. The Committee further noted: the estates work required to room 9 – second emergency theatre; the recruitment of staffing for this emergency theatre; and the support to the team in terms of culture and multi-disciplinary working.

**Learning from Deaths Quarter 2 Report**

2.15. The Committee received the quarterly report and noted the key findings of the report. The Committee noted that the report had not identified any concerns to be brought to the attention of the Committee. This report had also been presented to the November 2024 public Board meeting.

**Policies and Procedure Status Report**

2.16. The Committee received an update on the management of policies and procedures and noted that all policies and procedures had been uploaded onto Radar which allowed clear oversight of the policies and procedures and review dates.

2.17. The Committee: noted the position and the steps being taken to address the overall position; supported the six overall goals set out in the report and the single main system approach through Radar; and recognised the risks associated with procedural documents and the context of organisational change. The Committee felt assured that the risks were being managed and that work on the review of policies and procedures was taking place.

## 3. AREAS OF CONCERN OR FOLLOW UP

**Corporate Risk Register (CRR)**

3.1. The Committee discussed the increase in the digital risk due to the ongoing delay of securing the unified EHR and agreed that, due to its impact, this risk will need to be reviewed by the Board.

3.2. The Committee asked for an update on the histopathology consultant shortage risk and actions taken to be presented to a future meeting.

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

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

- The digital risk due to the ongoing delay of securing the unified EHR.

## 5. BOARD ASSURANCE FRAMEWORK (BAF)

5.1 The Committee agreed that the reports provided assurance in respect of objective 2, the maternity and neonatal update and the MIS position.

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

**Inga Kennedy**
**CHAIRMAN OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE**

| Somerset NHS Foundation Trust | |
|---|---|
| **REPORT TO:** | Board of Directors |
| **REPORT TITLE:** | Assurance Report from the Quality and Governance Assurance Committee Business meeting held on 27 November 2024 |
| **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 February 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 27 November 2024.<br><br>The Committee received assurance in relation to:<br><br>• The progress made in relation to the MHRA bed rails alert<br><br>• The Board Assurance Framework update<br><br>• The Corporate Risk Register update<br><br>• The Quality and Performance exception Report<br><br>• The Patient Safety Board update<br><br>• The Patient Experience and engagement assurance report<br><br>• The Mental Health and Learning Disabilities Service Group assurance report<br><br>• The Independent Investigation and Mental Health Homicide Decision letter<br><br>• The feedback from the Maternity Safety Support programme visit |

| | |
|---|---|
| | • The oversight of the Maternity and Perinatal Incentive Scheme Year 6<br><br>The Committee identified the following areas of concern or for follow up:<br><br>• The Governance Support Summary – the lack of assurances for some of the topics<br><br>The Committee identified the following areas to be reported to the Board:<br><br>• The overlap between the People Committee and the Quality and Governance Assurance Committee in relation to culture and workforce shortages.<br><br>• The need for a Board level update on no criteria to reside.<br><br>• 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. |
| **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**<br>(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<br>**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.**<br><br>**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**<br><br>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**<br>(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 BUSINESS MEETING HELD ON 27 NOVEMBER 2024**

## 1. PURPOSE

1.1. The report sets out the items discussed at the formal meeting held on 27 November 2024, along with the assurance received by the Committee and any areas of concern identified. The meeting was conducted by MS Teams.

## 2. ASSURANCE RECEIVED

### MHRA Bed Rails Alert

2.1. The Committee received an update on the progress made actioning the alert and noted that training had been rolled out but that it will take approximately six months to ensure that all colleagues will be trained. The outstanding action related to the risk assessment of equipment in community settings, particularly linked to adult social care. The Committee noted that discussions will continue to take place with the ICB about progressing this action with regional support.

2.2. The Committee observed that all actions, which were in control of the trust, had been completed but that the outstanding action was not in direct control of the trust.

### Board Assurance Framework

2.3. The Committee received the Board Assurance Framework and noted that a review of the governance elements of the BAF will be undertaken in 2025 and that therefore the BAF had been updated based on the current arrangements.

2.4. The Committee received an update on the following objectives: objective 2 – the identification of an aspirational measure relating to improved colleague engagement and the delay in relation to the implementation of the urgent treatment centre business case for YDH; objective 3 – the identification of aspirational measures relating to increasing the number of admissions prevented by Acute Home Treatment and Rapid Response services; objective 4 – further work required to identify the aspirational measure for this objective; the need to capture deprivation and exclusion data; and the need to discuss objective 4 and its link to objective 1 at a future Board Development Day; and objective 5 – the identification of an aspirational measure relating to reducing the number of patient not meeting the “criteria to reside” in acute beds.

2.5. The Committee noted the following high level risks: access to primary care; increase in emergency department demand; fragility of primary care; possible impact of GP action; shortfalls in social care capacity; and length of stay.

2.6. The Committee further noted that actions plans were in place to address the low levels of referral activity into Hospital@Home.

**Corporate Risk Register**

2.7. The Committee received the up-to-date combined Corporate Risk Register report and noted that there were currently 30 corporate risks on the risk register of which six scored 20 or above. The Committee noted the details of these risks and noted the new risk in relation to data integrity in respect of mental health services. The Committee was advised that this new risk will be reviewed to take account of the shift to Learning from Patient Safety Events (LFPSE).

2.8. The Committee further noted the new risks regarding discrimination – the inability to become the equitable and inclusive organisation we aspire to be for our colleagues and patients due to systemic discrimination; and the inability to create a compassionate and inclusive culture where all colleagues can thrive due to discriminatory behaviour.

2.9. The Committee was advised of a new emerging risk regarding the impact of GPs taking collective action on the trust's services. This risk was currently being reviewed at service group level and will be reviewed from an organisational perspective.

**Quality and Performance Exception Report**

2.10. The Committee received the report and noted that the report had been presented to the November 2024 Board meeting.

2.11. The Committee discussed the following areas*:* the emerging concern regarding the long delays in terms of Ministry of Justice cases and the impact of the delays on individual patients which will be discussed by the Mental Health Legislation Committee; the strong and consistent performance from mental health services; the work to understand the increase in the use of prone restraints; the successful implementation of the ICE pathology system and the actions being taken to address concerns about historic results; and the no criteria to reside position.

2.12. The Committee particularly discussed the increase in the number of referrals for ADHD and autism spectrum disorders. The Committee noted that innovative ways in which the ADHD service can be provided, e.g. digital assessments prior to face-to-face appointments, are being considered. The Committee further noted: that a group of people have been referred from the private sector to the NHS to restart their treatment; the need to consider patients transitioning from children to adult services; and the establishment of a steering group to look at working practices to ensure that the service was as effective as possible.

2.13. The Committee was provided with feedback from the NHS England Workforce and Education virtual visit which took place mid November 2024. The national team had reviewed the whole training programme and feedback indicated that the visit had been very positive, with positive feedback about the trust itself but also about the trust's response to issues which were not going as well.

**Patient Safety Board Report (PSB)**

2.14. The Committee received a report on the work of the Patient Safety Board and noted that the PSB was working well across the trust to bring together the safety culture of the trust. The first learning responses from the Patient Serious Incident Response Framework (PSIRF) had been produced and the trust had been able to sign off four patient safety incident investigations.

2.15. The Committee discussed the work of the PSB and noted: the wider concerns regarding the structure and roles within patient safety due to the departure of key colleagues; the discussion about the future approach to safety in line with the quality strategy; the process of scoping current work and identify gaps and opportunities aligned to similar work across governance; the regular review of the membership and terms of reference of the PSB; and the good engagement with service groups and service group reporting to the PSB.

2.16. The Committee discussed the publication of signed off patient safety incident investigations as, at the request of family, not all reports were anonymised. The Committee agreed that it was important to get the balance right and that the aim should be to be open and transparent about the publication of the reports. In addition, the Committee noted that other processes such as sharing reports with the coroner will need to be considered.

2.17. The Committee noted: the work required regarding people who matter (including carers) which will need to include: a deep dive to explore areas of concern and actions to be taken to address these concerns; the system level support for carers including carers in the community; and the support for colleagues in managing these relationships. The Committee further noted the progress in relation to the implementation of Martha's rule, including the ongoing engagement and preparation work, the simulation testing of the phone line and electronic referral form; and the expectation that live testing will start on wards at MPH and YDH by December 2024 with roll out across the acute sites by April/May 2025.

**Patient Experience and Engagement Assurance Report**

2.18. The Committee received the first report and the purpose of the report was to provide a summary and analysis of patient experience and engagement activity across the trust, including PALS, complaints, feedback from Healthwatch and National Survey results.

2.19. The Committee noted: the number of second letters received and the action being taken to understand the drivers for second letters, including the analysis of themes; the commencement of an NHS complaints standards diagnostic

focussing on resolution meetings; the training provided with a focus on compassionate engagement and early and timely resolution; the decrease in the number of new complaints; performance in relation to resolving complaints within an agreed timeframe and the process for monitoring and reporting exceptions; and the completed risk assessment for formal complaints, including identified mitigations.

2.20. The Committee further noted: the work undertaken over the last six months to develop the Radar system to be able to manage complaints; the service areas with the highest proportion of complaints; the work in the emergency department to triangulate complaints information and to put the information into context with the number of concerns and the high levels of demand; the thematic analysis by AI technology as part of the Copilot trial to help to identify trends; details of the closed Parliamentary and Health Service Ombudsman (PHSO) case; the ongoing use of Care Opinion as a platform for obtaining patient feedback and the work taking place to increase the use of Care Opinion to obtain patient feedback; the interpretation and translation service trial and its positive impact to date within maternity services; the engagement work taking place with less heard communities; and the impact of vacancies within the complaints team on response times' performance.

**Service Group Assurance Report – Mental Health and Learning Disabilities**

2.21. The Committee received the assurance report from the mental health and learning disabilities service group and noted the key highlights from the report, including: the significant improvements in the service group's governance arrangements; the implementation of the learning from patient safety events (LfPSE) and patient safety incident response framework (PSIRF) systems within the service group and the data challenges faced by the service group; the need for designated spaces for colleagues to discuss HR issues and concerns; and the successful establishment of HR groups for colleagues to be able to resolve longstanding issues more efficiently.

2.22. Committee further noted: the me@SFT interviews held as part of the Joy at Work programme, the roll out of this process within community services, and the reporting arrangements; the establishment of an overarching group at executive level, including the ICB, to explore the concerns in relation to ADHD demand and capacity; the positive feedback from the Leadership Quality Walkround particularly in relation to visibility of the senior leadership team; the increase in the number of PALS enquiries for the South Somerset team, the development of an improvement plan to address any concerns and the senior support provided to the team; the national accreditation of Holford Ward by the Royal College of Psychiatrists; and the progress made in relation to the carers assessment service, including the establishment of a Carers Group to explore opportunities to bring carers into services.

2.23. The Committee received an update on the ongoing NHS England project across all mental health wards regarding inpatient transformation and noted:

the different workstreams, including on culture of care; and the positive feedback by colleagues on the programme.

2.24. The Committee discussed the definition of mental health homicides and noted that the traditional definition had been clear, but that in the light of the PSIRF process, the national definition has been reviewed and changed to “anyone who has had any contact with mental health services”. Discussion on the implications of this new definition were taking place with NHS England’s regional Independent Investigation Review Team and the ICB. The Committee noted that the new and more generalised definition may result in an increase in the number of homicide reviews.

2.25. The Committee agreed that the report provided good assurance about the service group’s approach to governance.

**Independent Investigation and Mental Health Homicide Decision Letter**

2.26. The Committee received an overview of the incident that led to the homicide investigation in March 2023 and noted that the report was positive, that the Homicide Group will continue to monitor the action plan, and that an assurance visit to the ward by the senior leadership team will be undertaken in 2025. In addition, the ICB and the regional Independent Investigation Review Team (IIRT) will also be visiting the ward in 2025.

**Maternity Safety Support Programme (MSSP) Visit**

2.27. The Committee received feedback from the visit and noted that the visit had been positive. Feedback had highlighted areas for improvement and, with the exception of the availability of blood products on the labour wards, these areas were as expected. The Committee noted that two blood fridges had been ordered and that the factual accuracy report was expected in December 2024.

2.28. The Committee further noted that: the team had found the visit really positive and that the MSSP team will continue to provide support to the team with useful tools and resources.

**Maternity and Incentive Scheme (MIS) Year 6**

2.29. The Committee received the quarterly maternity and perinatal safety and quality report and noted that an audit on the evidence against six of the ten safety actions was being undertaken by internal auditors.

2.30. The Committee received an update on the following areas of concern:

- Safety action 9 – demonstrating clear oversight to the Board on maternity and neonatal safety and quality issues – regular briefings reports have been presented to the Quality and Governance Assurance Committee alongside briefings on transitional care (safety action 3), the anaesthetic workforce (safety action 4) and Saving Babies Lives care bundle implementation (safety action 6). The Committee has provided the Board with regular assurance reports.

- Safety action 8 – training – compliance will be reported to the Committee in December 2024 but work was ongoing to ensure that all required colleagues attend fetal monitoring and maternity emergencies training.

- Safety action 5 – data relating to the percentage of specialist midwives employed and mitigation to cover any inconsistencies still have to be reported to the Board. The Committee noted that the percentage of specialist midwives, at 9.78%, was compliant with the 2021 Birthrate + workforce recommendations but that a new midwifery workforce assessment recommended a percentage of 15%. This uplift amounted to 10.62 wte and the service was looking at actions to be taken to address this shortfall.

- Safety action 6 – the requirement to demonstrate that best endeavours, and sufficient progress, had been made towards full implementation of version 3 of the Saving Babies Lives care bundle. A review by the LMNS Programme Board meeting concluded that best endeavours had been made, but that further progress was required. The Committee noted that progress against this safety action will be reported to the December Committee meeting.

  The Committee noted: the progress in relation to the implementation of the culture improvement plan; and that the Chief Nurse will continue to meet with the Perinatal Leadership team bi-monthly.

- Safety action 9 – evidence that a review of maternity and neonatal quality and safety was undertaken by the Board or an appropriate Committee – further work will be required as the service had only presented one thematic review to the Committee to date. The Committee noted that the team was still adjusting to the new PSIRF reporting framework and embedding the concept.

- Safety action 3 – the Committee reviewed and accepted the action plan.

2.31. The Committee acknowledged that this process had been difficult for the service and thanked the team for their dedication and commitment.

## 3. AREAS OF CONCERN OR FOLLOW UP

**Governance Support Summary**

3.1. The Committee received feedback from the Quality Assurance Group and the Data Review Group meetings. In relation to the Quality Assurance Group, the Committee noted the discussion in relation to the topic reports, including the red rating for the introduction of New Clinical Procedures topic due to the lack of assurance that appropriate processes were being followed, and the amber

rating for six topics due to limited levels of assurance available for elements of the topics and/or parts of the trust.

3.2. In relation to the Data Review Group, the Committee noted the discussion in relation to: a wide range of data, including Care Quality Commission patient surveys; a new potential outlier alert in respect of the National Bowel Cancer Audit adjusted 18-month unclosed ileostomy after anterior resection and the review by the team to ensure that this was an outlier and to identify any follow up actions.

3.3. The Committee further noted the receipt of 15 national audit reports with potential areas for improvement identified in seven of the reports.

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

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

- The 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.

## 5. BOARD ASSURANCE FRAMEWORK (BAF)

5.1 The Committee agreed that it had received both positive and negative assurance for the various objectives that this Committee is responsible for.

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

**Inga Kennedy**
**CHAIRMAN OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE**

| Somerset NHS Foundation Trust | |
|---|---|
| **REPORT TO:** | Board of Directors |
| **REPORT TITLE:** | Assurance Report from the Quality and Governance Assurance Committee business meeting held on 18 December 2024 |
| **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 February 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 18 December 2024.<br><br>The Committee received assurance in relation to:<br><br>• Strategic objective 5 – respond well to complex needs<br><br>• The Leadership quality Walkround 20024 Report<br><br>• The Premises Assurance Report<br><br>• The Sustainability Update<br><br>• The Maternity and Perinatal Incentive Scheme (MPIS) Year 6<br><br>• Care Quality Commission Action Plan<br><br>• Management of Colleague Personal Files<br><br>The Committee identified the following areas of concern or for follow up:<br><br>• Personalised Care – update to be provided to a future meeting<br><br>• Premise Assurance Report – update to be presented to a future meeting. |

| | |
|---|---|
| | • Inquest regarding a mental health inpatient death in 2020<br><br>The Committee did not identify any areas to be reported to the Board. |
| **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<br><br>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<br>(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 18 DECEMBER 2024**

## 1. PURPOSE

1.1. The report sets out the items discussed at the business meeting held on 18 December 2024, along with the assurance received by the Committee and any areas of concern identified. The meeting was conducted by MS Teams.

## 2. ASSURANCE RECEIVED

**Strategic Objective 5 – respond well to complex needs**

2.1. The Committee received a presentation on the work in relation to this objective and noted the aspirational measures relating to no criteria to reside and further noted the additional measures on "monitoring the length of wait to date for assessment for adults with ADHD/ASD" and "the number of young people with a transition plan".

2.2. The Committee received an update on the work in relation to the system wide work on patient flow, and particularly on the five key areas of focus: admission to being medically fit; transfer of care hub – decision making and enabling discharges; pathway 1 (discharge to asses) – capacity by geography and effective provision; pathway 2 delays with pathway 2 beds, effectiveness of reablement, future bed requirements and access criteria; and pathway 3 – new service model.

2.3. The Committee noted the challenges for each of these area of focus and the work taking place to improve processes and reduce delays in the pathways.

2.4. The Committee noted the establishment and the success of the multi-disciplinary and multi-professional services set up to manage high intensity adults (2 services) and young people (one service) users in the community. The Committee noted the positive impact of these services on ED attendances by these group of patients.

2.5. The Committee recognised that although assurances for this objective had been rated as positive, and actions had been rated as green, the majority of the KPIs continued to be rated red and it was therefore essential to consider whether the focus was on the right actions or whether additional actions will be required. The Committee noted that work on reviewing actions was taking place.

**Leadership Quality Walkround 2024 Report**

2.6. The Committee received a report on the Leadership Quality Walkrounds undertaken in 2024 and noted that 32 visits across mental health, community services and acute services had been undertaken during 2024.

2.7. The Committee noted: that the findings of the walkrounds provided assurance that the key themes from the visits were already areas of focus; that overall feedback from the visits had portrayed a positive, engaged leadership and compassionate and dedicated colleagues, experiencing challenging levels of demand and expectation through a period of change; the common theme around lack of appropriate or sufficient clinical and resting space and the longstanding issue in relation to the suitability of some of the estate. The committee observed that the key theme had not changed from the previous year and that consideration may need to be given as to whether the focus was on the right areas of improvement or whether the themes related to the risks held by the trust as it is difficult to mitigate these risks to drive the improvement that the trust would like to see.

2.8. The Committee noted: the main themes relating to workforce/recruitment, estates and facilities, and digital systems; and the need to consider how to capture feedback from other visits. The Committee noted the consensus about how much people value the process and the ability to be able to engage with colleagues and patients.

**Premises Assurance Report**

2.9. The Committee received an overview of the Premises Assurance Model (PAM) submitted for the trust.

2.10. The Committee noted: the background to the PAM; the “good” or “minimal improvement required” level of assurance for many aspects of estates and facilities related compliance; the areas where moderate levels of improvement are required; areas of inadequate compliance; the development of mitigation plans for each area of improvement or inadequate compliance; the implementation of the Quick Solutions software to support the collection of evidence for the PAM submission; the overview of the PAM submission for each domain and the work required to achieve full compliance; the introduction of a new domain relating to helipads and the work required to achieve compliance with this domain; the discussion in relation to the costed action plans for all domains to be able to make informed decisions as to the prioritisation of improvement work; and the work required regarding the triangulation of information from the PAM submission, the leadership quality walkrounds and patient and colleague feedback.

**Sustainability Update**

2.11. The Committee received an update on the progress made in relation to the implementation of the strategic aims set out in the Green Plan.

2.12. The Committee noted: the oversight by the Strategic Sustainability Group; the review of the Green Plan in 2025 following the receipt of guidance from Greener NHS; the updating of the objectives to include specific timeframes and milestones; the risks to implementing a number of the objectives, e.g. funding for decarbonising the existing estate, reducing omissions from travel by moving to EVs and implementing a number of digital programmes; the challenges in relation to reducing food waste and changing the content of meals provided; the limitations in the available data to determine the trust's carbon footprint and the work with the supply chain and other external organisations to understand how to use established method to overcome these challenges.

2.13. The Committee noted that adaptation to the impact of climate change and the risk related to digital resilience were areas where least progress had been made. In relation to the impact of climate change, the Committee asked Richard Harper to liaise with other rural organisations to check what discussions are taking place in other organisations.

2.14. The Committee agreed that the report provided assurance in terms of proper leadership and oversight for taking this work forward, and the implementation plan provided a set of milestones and evidenced the progress made. The Committee observed that a number of actions had a deadline of March 2025 and noted that the aim was to complete these actions by the deadline but, if not fully completed, some improvements will have been made. The Committee further noted that the majority of the actions from the internal audit had been addressed.

**Maternity Incentive Scheme (MIS) Year 6**

2.15. The Committee received an update of the current position regarding compliance with the MIS year 6 since the September 2024 meeting.

2.16. The Committee noted the internal audit on the evidence available to support the trust's position against six of the ten safety actions and the conclusion that the evidence indicated non-compliance with safety action 6 (implementing version 3 of the Savings Babies Lives care bundle) and safety action 9 (having clear oversight in place to provide the Board with assurance on maternity and neonatal safety and quality issues). The Committee noted the reasons for this non-compliance and the work taking place to support the implementation of the audit recommendations. The Committee noted that, although the remaining audited safety actions had been assessed as compliant, internal audit had identified opportunities to enhance the quality of the evidence provided to demonstrate compliance with the safety action.

2.17. The Committee received the report regarding safety action 1 quarterly perinatal mortality review and noted the two themes identified during the quarter: triage provision; and a number of cases where the baby had a known congenital anomaly. The Committee noted the work taking place to address these findings and further noted that the Board declaration will be presented to the January 2025 Committee meeting.

2.18. The Committee recognised the challenges and noted that discussions were taking place on how to improve governance, assurance and reporting to the Board; and that a virtual meeting had been set up with the national team to share learning and areas of best practice.

**Care Quality Commission Action Plan**

2.19. The Committee received the updated action plan and agreed: that the action plan provided assurance about the review process; and that appropriate support was in place to consider the evidence required to demonstrate delivery of the improvements made.

2.20. The Committee noted that four actions had been completed and closed and that a number of actions remained open pending the outcome of audits to test the actions.

**Management of colleague personal files**

2.21. The Committee received an update on the risk relating to colleague record keeping and noted that the risk was proactively managed and that a report on potential next steps in support of the overarching record keeping policy will be presented to the People Committee meeting and shared with the Quality and Governance Assurance Committee.

## 3. AREAS OF CONCERN OR FOLLOW UP

**Personalised Care**

3.1. The Committee received an update on the personalised care work programme and noted the findings of the personalised care internal audit undertaken in 2023 which related to: a lack of an organisational focus on personalised care; the lack of consistent personalised care plans; the low uptake of training; and the lack of sharing areas of good practice.

3.2. The Committee noted the actions taken to address the findings, including: a dedicated lead role to focus on personalised care; the establishment of a personalised care improvement group jointly with Healthwatch Somerset and other stakeholders, including two patient voice partners and colleagues; engagement with colleagues about their understanding of personalised care, to identify barriers to personalised care and to share ideas.

3.3. The Committee noted that the findings of the engagement exercise had highlighted a strong consensus of the definition of personalised care and its benefits but had also highlighted challenges such as time constraints, limited resources, cultural and attitudinal barriers and communication difficulties. Areas for improvement included: increased staffing and time allocation; enhanced communication and training; and the need to foster a patient-centred culture.

3.4. The Committee further noted: the key enablers for the delivery of personalised care – leadership behaviours and fostering trust, compassion, equality,

respect and innovation; the productive care project in Mendip; the work with the ICB to create a shared agenda to address the challenges and opportunities for embedding personalised care and providing support with developing plans through an improvement approach; collaboration with the patient experience and engagement team to utilise feedback from patients and carers; the development of a set of co-produced aims and measures; the next steps, including seeking leaders to develop workstreams of the test and learn cycles, the sharing of learning, and the development of a campaign for staff to think about personalised care in an active way. The Committee noted that the timeframe was to start work on 1 January 2025 and to have a personalised care plan in place for piloting by the end of March 2025 in Mendip.

3.5. The Committee asked for a further update to be provided to a future meeting.

**Premises Assurance Report**

3.6. The Committee recognised the value of the PAM self assessment and agreed that it will be important to triangulate and cross reference the PAM data with other sources of information such as the Care Quality Commission reports, patient feedback and other sources. The need for external assurance had been raised at the Audit Committee and it had been agreed to ask for a follow up report to be presented to a future Quality and Governance Assurance Committee meeting.

**Inquest regarding a mental health inpatient death in 2020**

3.7. The Committee received an update on the findings of the inquest and noted that a narrative verdict had been recorded. The issues identified related to supervision and the lack of securing the therapy room. The Coroner recognised the significant changes made to Rowan Ward since the incident in 2020.

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

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

## 5. BOARD ASSURANCE FRAMEWORK (BAF)

5.1 The Committee agreed that the reports have enabled the triangulation of a number of topics relating to the Board Assurance Framework and provided both positive and negative assurance about objectives assigned to the Committee.

5.2 The Committee agreed that it had received positive assurance in terms of objective 5 – the development of the personalised care approach and the

current work in relation to no criteria to reside; and objective 2 – the condition of the estate and the maternity services update.

5.3 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**

| Somerset NHS Foundation Trust | |
|---|---|
| **REPORT TO:** | Board of Directors |
| **REPORT TITLE:** | New Hospital Programme (NHP) Review and Implications for Somerset Foundation Trust |
| **SPONSORING EXEC:** | David Shannon, Director of Strategy and Digital Development |
| **REPORT BY:** | David Shannon, Director of Strategy and Digital Development<br>Ian Boswall, Director of Redevelopment |
| **PRESENTED BY:** | David Shannon, Director of Strategy and Digital Development |
| **DATE:** | 4 February 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 provides and update on the NHP Review and the implications for services provided on the Musgrove Park Hospital site. The announcement of the revised schedule for the New Hospital Programme has delayed the start date for any works on the Musgrove Park Hospital Site by at least 5 years, with a start date for construction set at 2033. This increases the risk of being able to deliver services for the medium to long term in buildings – specifically the maternity and Paediatric building. |
| **Recommendation** | To note the update and the revised timeline for the inclusion of Musgrove Park Hospital in the new hospital programme.<br><br>To discuss the next steps in reviewing the continuity of service delivery with the new timeline and mitigations required during this period.<br><br>To note the financial risk as a result of write off of previous investment in the programme. |

| **Links to Joint Strategic Objectives**<br>(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 |

**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?

An EQIA and impact assessment has been completed for the Scheme, this has been updated as the plans developed. This will now need to be updated as a result of the change in programme timescales. The programme has completed an overarching EQIA https://www.gov.uk/government/publications/new-hospital-programme-review-outcome/new-hospital-programme-equality-impact-assessment

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.

Colleague and patient involvement and engagement has been undertaken over the five years of the programme. Following the recent announcement, meetings have been held with impacted services and communicated to all of the Trust.

**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 –

The Board has previously received updates on the programme and associated business cases.

| **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**

**OUTCOME OF THE NATIONAL NEW HOSPITAL REVIEW AND THE IMPACT ON THE MUSGROVE PARK HOSPITAL SCHEME AND CLINICAL SERVICES**

## 1. NATIONAL NHP REVIEW

1.1. In September 2024, the New Government stated that the current New Hospital Programme (NHP) is 'unaffordable and undeliverable' and announced that there would be a review of the Programme to ensure there was a realistic and deliverable timetable of schemes that are appropriately funded.

1.2. The outcome of the national review commits £15bn over next 5 years. This has reduced the number schemes proceeding to complete broadly by 2030 to 22. A number of those schemes are historic schemes that have either completed or are due for completion shortly. The schemes proceeding for completion by 2030 are now classified as 'Wave 1' schemes.

1.3. There were 22 schemes in scope of the review and 18 of those have been delayed. Of the 18 schemes that are delayed 9 are expected to be completed between 2030 and 2035, with the remaining 9 scheduled for construction between 2035 and 2040.

1.4. The evaluation process used in the review to profile schemes was based on key assessment criteria (multi criteria decision support analysis).

This included

- NHS England Estate Return Information Collection (ERIC) and Patient-Led Assessments of the Care Environment (PLACE) - this data is collated and submitted by trusts for their sites, then consolidated by NHS England

- Office for National Statistics (ONS) who maintain relevant statistics on a local authority basis

Some data was generated by NHP, including:

- Scheme deliverability which has been evaluated by scheme leads within the NHP team

- Data on the impact of estate condition. This had previously been completed by the NHP clinical team in conjunction with trusts, as part of site inspections

1.5. The outputs of the review model have not been shared with Trusts to date. The specific detail of the review the criteria and output can be found in the link below. New Hospital Programme: plan for implementation - GOV.UK

1.6. Through discussion between Department and Health and Social Care and Treasury Ministers the scheme phasing is based on a funding envelope of £3bn per year.

## 2. MUSGROVE PARK HOSPITAL SCHEME

2.1. The NHP Scheme at MPH consisted of 3 main parts:

- Replacement of the Maternity, Gynae and Pediatric department from the 1940s buildings
- Development of an elective care center replacing the theatres and wards in Queen Building and day surgery unit
- Redevelopment of Queens building to provide updated emergency services

2.2. The MPH is part of wave 2. Specifically, the expectation is that a restart of planning will happen in the financial year 2030/31, and to commence construction between 2033 and 2035 Based on the current 7-year construction programme, this would mean construction completion around 2040. The scheme has already been delayed for over 3 years so cumulatively this would be a 10-year delay assuming a restart to the programme in 2030/31.

2.3. Two business cases had been approved by the Trust Board and submitted to the Department of Health and Social care to support early enabling works for the scheme, this included a new multi-story car park and electrical infrastructure improvements. These projects will now be paused as funding is unlikely to be available until after 2030, although this will be reviewed in the context of the next round of capital allocations.

## 3. CRITICAL INFRASTRUCTURE INVESTMENT ASSESSMENT

3.1. In recognition of impact of delays on the 18 wave 2 and 3 schemes NHP have stated that they will working closely with NHSE to support Trusts to fund critical infrastructure investment to sustain services for the next 10 years. The recent 2025/26 capital allocations support this intention and NHP intend to initiate a data collection process to assess the extent of this requirement and that will inform capital allocations between 2026 and 2030.

3.2. Information is being gathered on the anticipated costs for bringing the accommodation in the scope of the scheme up to Condition B (sound and operationally safe estate) and maintain that status over 10 years. The assessment will also include the provision of a 2nd maternity theatre and replacement of the existing end of life modular maternity theatre, paediatrics

condition improvements, the replacement of the ventilation systems for day surgery unit and roof replacement to enable that upgrade. This cost over the next 10 years has been estimated at £98m which is in excess of the ability to fund from within normal system capital allocations. Support from the national team will be required to progress this level of development.

3.3. The ability to be able to undertake this maintenance and provide the upgrades is high risk. There is limited ability within the current site footprint to enable the decant of existing facilities. To provide a level of context the current maternity and neonates building is approximately 3000m sqm, more than a single floor of the Duchess building on the Site.

## 4. IMPACT OF PAUSING THE NHP SCHEME

4.1. NHP has requested that wave 2 schemes wind down their programme teams by end of March and will support with redeployment across the Programme where possible. An assessment of the implications of the redeployment of the current NHP is currently being made.

4.2. The expenditure on programme development to date since 2020 will need to be treated as a revenue cost in 2024/25 as the scheme delivery is several years away. NHP have advised they are working with Treasury to provide resource cover for these costs, this has yet to be confirmed, however will be impacting all schemes included in wave 2 and wave 3.

**Impact on current and future service provision**

4.3. The most significant risk from the scheme delay is the ability to sustain delivery of maternity services. However there are risks to sustain a suitable estate to maintain and improve the quality of other services including paediatrics, gynae services and the elective and emergency services provided from the Queens building.

4.4. The estate condition is currently recorded as a risk of 16 on the corporate risk register, this assumed that the new hospital programme would resolve a number of the issues in a timely way. This assessment will now need to be reviewed, and it is likely that without alternative mitigation, the risk will increase. There are a number of other risks on the risk register associated with fire safety and compartmentation and service impact of poor infrastructure that will need to be reviewed accordingly.

4.5. A detailed review of these continuity and estate risks will be undertaken over the next few weeks alongside next steps for mitigation

## 5. NEXT STEPS

5.1. There a several immediate and medium-term steps that will be undertaken as a result of the announcement.

- Manage the impact of the pause in the national programme and funding on the programme infrastructure. This will include ensuring financial support is received to manage the transition period and other revenue consequences in 2024/2025.

- Review and update the risk assessments relating to the estate and service continuity resulting from the new timeline.

- Assess the options for medium term investment into the estate to maintain services until the development of the new build. This will include a review of enabling works and short-term redevelopment options to inform a critical infrastructure bid.

- Continue to work with New Hospital Programme to understand the ongoing interaction and programme governance.

5.2. The specific timescale for the actions will need to be developed over the coming weeks, with priority to advise the Board on the first two actions at its next meeting.

NHS
Somerset
NHS Foundation Trust

| Somerset NHS Foundation Trust | |
|---|---|
| **REPORT TO:** | Board of Directors |
| **REPORT TITLE:** | Guardian of Safe Working for Postgraduate Doctors<br>Quarterly Report – Q3 2024/25 |
| **SPONSORING EXEC:** | Melanie Iles, Chief Medical Officer |
| **REPORT BY:** | Tom Rees (TST) and John McFarlane (YDH), Guardian of Safe Working; Lee-Ann Toogood, Medical Workforce Manager |
| **PRESENTED BY:** | Melanie Iles, Chief Medical Officer |
| **DATE:** | 4 February 2025 |

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

| | |
|---|---|
| **Executive Summary and Reason for presentation to Committee/Board** | This report covers quantitative and qualitative summary of exception report data generated between 17 October 2024 and 24 January across Somerset NHS Foundation Trust.<br><br>The key findings from the report are:<br><br>• The downtrend in exception reporting (ERs) this quarter from YDH, but numbers are still higher than historical averages. ERs from MPH are comparable to previous quarters. We have seen a spike in ERs from Ophthalmology and DCT trainees at MPH which requires further investigation.<br><br>• Both the GoSW and individual supervisors have found the current method of ER and actioning difficult to navigate and use. We anticipate further issues may arise from this in the future and would advocate for a better interim solution.<br><br>The recommendations from the report are:<br><br>• We continue to recommend that an interim solution is found to the current method of exception reporting across the trust.<br><br>• We continue to be concerned that exception reporting may be under reported as a consequence and have found OOH exception reports to be minimal. We understand an interim solution is in the pipeline and would support expediting its implementation. |

| Recommendations | 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)

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?

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

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

**Public/Staff Involvement History**

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

Not applicable for this report.

**Previous Consideration**

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

| **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 |

| CONTENTS | |
|---|---|

## QUARTERLY REPORT ON SAFE WORKING HOURS:

## DOCTORS AND DENTISTS IN TRAINING

### 1. EXECUTIVE SUMMARY

1.1. We have seen a downtrend in ERs this quarter from YDH, but numbers are still higher than historical averages. ERs from MPH are comparable to previous quarters. We have seen a spike in ERs from Ophthalmology and DCT trainees at MPH which requires further investigation.

### 2. INTRODUCTION

2.1. This report covers and comprises quantitative and qualitative data on working patterns and associated exception reports for postgraduate doctors in training across the Trust.

2.2. Exception reports are a mandatory requirement of the 2016 Junior Doctor Contract. All doctors on this contract should report any hours worked above their standard contract via the software provided by the hospital in order to be awarded time off in lieu (TOIL) or additional payment where TOIL cannot be accommodated.

### 3. EXCEPTION REPORT DATA:

| | |
|---|---|
| Number of doctors/dentists in training on 2016 TCS (total): | 424 |
| Job plan allocation for Guardian of Safe Working: (1.5 legacy SFT, 1 YDH) | 2.5 PAs |
| Job plan allocation for Educational Supervisors per trainee: | 0.125 PAs |

3.1. **Exception reporting since the introduction of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016**
As of 24/01/2025 - Total of exception reports since implementation of 2016 TCS (December 2016). 3494 for Taunton and for Yeovil 1636. The overall cost of exception report overtime is £93,426.17

**Figure 1 Quarterly total for exception reporting**

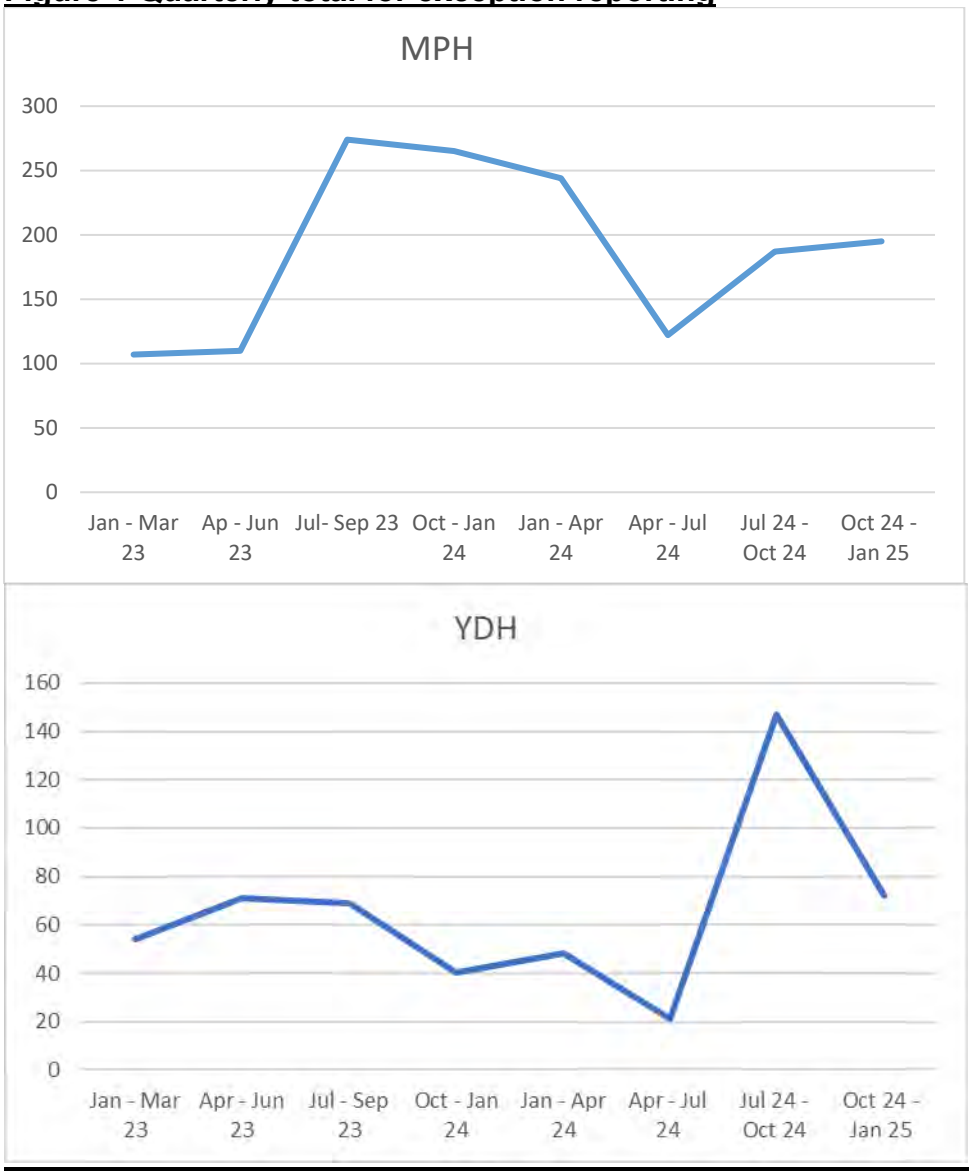
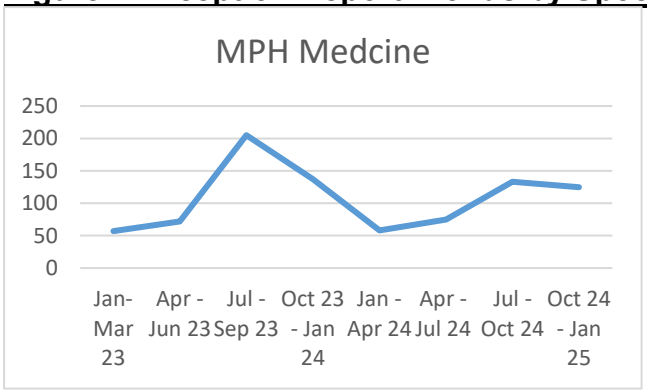
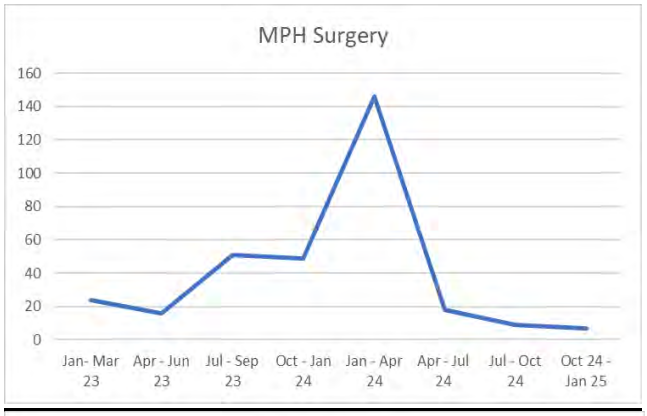
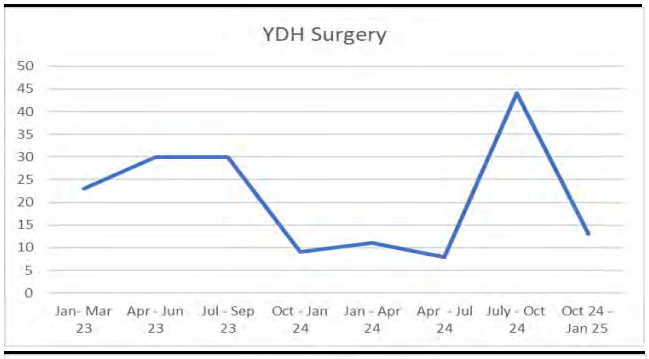
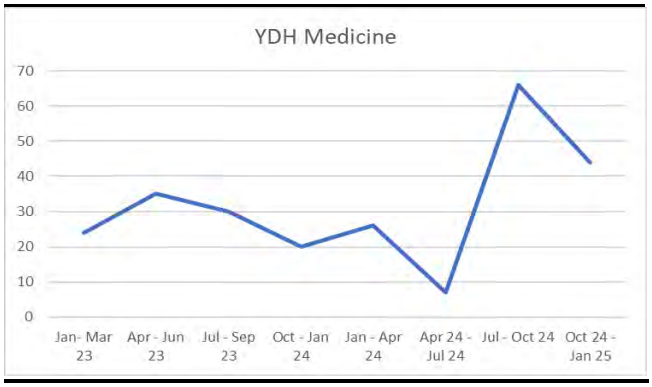



**Figure 2 Exception Report Trends by Specialty**






3.2. **Exception reports this quarter** - please find the information in brackets from the previous quarterly report for comparison:

***Table 1: Exception reports per specialty***

| **Specialty** | **No. exceptions raised** | **No. exceptions closed** | **No. exceptions outstanding** | **Type** |
|---|---|---|---|---|
| Acute & General Medicine | MPH 125 (133)<br>YDH 44 (66) | 48<br>44 | 77<br>0 | Hours MPH 116 YDH 43<br>Educational MPH 7<br>Pattern YDH 1<br>Support MPH 1 |
| Anaesthetics | 0 *(0)* | 0 | 0 | |
| DCT Trainees | 23 *(0)* | 0 | 23 | Hours 23 |
| Emergency Medicine | MPH 3 (1)<br>YDH 5 (1) | 2<br>0 | 1<br>5 | Hours MPH 3 YDH 5 |

| Specialty | No. exceptions raised | No. exceptions closed | No. exceptions outstanding | Type |
|---|---|---|---|---|
| ENT | 1 *(0)* | 0 | 1 | Hours MPH 1 |
| General Surgery | MPH 6 *(9)*<br>YDH 13 (44) | 6<br>0 | 0<br>13 | Hours MPH 6 YDH 10<br>Pattern 1 YDH<br>Support 2 YDH |
| O&G | MPH 1 (13)<br>YDH 1 *(1)* | 1<br>0 | 0<br>1 | Hours MPH 1 YDH 1 |
| Oncology/ Haematology/Palliative Care | MPH 4 *(0)*<br>*YDH 3 (0)* | 3<br>1 | 1<br>2 | Breaks YDH 3<br>Hours MPH 4 |
| Ophthalmology | MPH 19 (0) | 19 | 0 | Hours 15<br>Education 2<br>Pattern 2 |
| Paediatrics | MPH 0 *(0)* | 0 | 0 | |
| Psychiatry | MPH 10 *(12)* | 1 | 9 | Hours MPH 10 |
| Trauma & Ortho | MPH 1 *(1)*<br>YDH 5 (9) | 0<br>0 | 1<br>5 | Hours 5 YDH 1 MPH |
| Urology | MPH 0*(1)*<br>*YDH 0 (2)* | 0<br>0 | 0<br>0 | Hours 1 MPH |
| Vascular | 1 *(4)* | 0 | 1 | Hours 1 MPH |
| **Total** | **265** | **126** | **139** | |

***Table 2: Exception reports per trainee grade***

| Grade of trainee | No. exceptions raised Taunton | No. exceptions raised Yeovil |
|---|---|---|
| F1 | 65 | 40 |
| F2 | 58 | 21 |
| CT1-2 / ST1-2 | 66 | 9 |
| ST3+ | 4 | 2 |
| **Total** | **193** | **72** |

## Locum Agency and Bank Spend to cover Post Graduate Doctors in Training

| Division | Pay Gross (No VAT) | Commission Gross (No VAT) | VAT | Booking Gross (No VAT) |
|---|---|---|---|---|
| Clinical Support & Cancer Services | £401,204.37 | £41,801.22 | £24,176.00 | £482,924.46 |
| CYP & Families Services | £688,387.18 | £40,564.85 | £51,008.91 | £800,863.13 |
| Medical Services | £2,945,780.82 | £164,139.65 | £76,775.85 | £3,479,745.16 |
| Mental Health and LD | £1,031,155.76 | £78,460.56 | £83,347.72 | £1,204,314.76 |
| Neighbourhood Services | £115,119.02 | £11,751.54 | £1,450.98 | £142,329.62 |
| Operational Management | £63,437.50 | £666.40 | £183.20 | £72,742.35 |
| OPMH Sedgemoor | £12,920.00 | £1,064.00 | £0.00 | £15,766.96 |
| OPMH Taunton | £42,318.88 | £3,268.00 | £10,285.17 | £51,426.71 |

| | | | | |
|---|---|---|---|---|
| Surgical Services | £450,601.04 | £21,097.32 | £8,977.20 | £533,880.36 |
| Grand Total | £5,750,924.57 | £362,813.54 | £256,205.03 | £6,783,993.51 |

3.3. **Qualitative summary of exception reports**
At MPH we have seen a spike in the number of ERs generated from DCT trainees due to NROC work and Ophthalmology due to overrun clinics. TR due to meet DCT trainees and CSL, and meet Ophthalmology supervisors. Other ER numbers in line with previous Qs. However, we have seen an increase in missed educational opportunities at MPH, particularly from foundation trainees, mainly generated due to ward work load in medical specialities.

3.4. **Immediate safety concerns (ISCs)**
No ISCs have been reported this quarter at Yeovil. There was a single immediate safety concern raised at MPH generated on 20 January which was due to a deteriorating patient who was not transferred to an acute ward, despite escalation. I am awaiting further information from the Resident doctor and supervisor and will provide an update at the next Q report. Another ISC raised at MPH was misclassified.

3.5. **Fines**
No fines were issued during this quarter.

3.6. **Work schedule reviews**
There were no work schedule reviews this quarter.

## 4. ISSUES ARISING

4.1. **Postgraduate Doctor Forum (PDF)**
Yeovil continue to hold regular well attended PDFs, and hopefully these have helped to reduce the spike to exception reporting from last quarter.
PDF was held at MPH. Number of attendees was lower than previous forums. We will attempt to encourage attendance at next PDF.

4.2. **Rota management**
At MPH there have been concerns raised regarding the issuance of the O&G rota, which was not allocated within the 6 week time window, but has now been resolved. There were also concerns regarding the Psychiatry rota which was not reflective of the work schedule (more OOH work) and has required change to the resident doctors pay.

4.3. **Weekend working/ Out of Hours Issues**
We continue to see few numbers of ERs raised from weekend working. No themes were raised this Q regarding OOH issues.

## 5. SUMMARY

5.1. At Yeovil the trend is downwards following the big spike in exception reports in both general surgery and medicine last quarter. The number of reports has

now fallen to 75 still above the average quarterly figure of 50. All supervisors at Yeovil struggle to use the current reporting system which makes monitoring and feedback to exception reports difficult. At MPH we have seen ER numbers comparable to previous quarters. However, we have seen a spike in ERs from Ophthalmology and DCT trainees, which require further investigation.

## 6. RECOMMENDATIONS

6.1. We continue to recommend that an interim solution is found to the current method of exception reporting across the trust. As one resident doctor wrote:

*'The removal of the Allocate exception reporting system has severely hampered my ability to submit exception reports on time - previously they could be completed from home and the system would track them automatically, which was straightforward enough to do on a NWD or weekend. The new system cannot be accessed outside of the trust to my knowledge, and I have to track submissions manually, via a spreadsheet, and send the updated version to myself. Extrapolated, I suspect this results in significant underreporting at a trust level, although data, if available, may show otherwise.'*

6.2. We continue to be concerned that exception reporting may be under reported as a consequence and have found OOH exception reports to be minimal. We understand an interim solution is in the pipeline and would support expediting its implementation.

Tom Rees and John McFarlane Guardian of Safe Working

| Somerset NHS Foundation Trust | |
|---|---|
| **REPORT TO:** | Board of Directors |
| **REPORT TITLE:** | Assurance Report from the People Committee meeting held on 4 December 2024 |
| **SPONSORING EXEC:** | Isobel Clements, Chief of People and Organisational Development |
| **REPORT BY:** | Ria Zandvliet, Secretary to the Trust |
| **PRESENTED BY:** | Graham Hughes, Chairman of the People Committee meeting held on 4 December 2024 |
| **DATE:** | 4 February 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 People Committee meeting held on 4 December 2024 and the assurance received and areas of concern or for follow up identified. The meeting was conducted as a video call.<br><br>The Committee received assurance in relation to:<br><br>• Colleague story – the programmes offered to individuals within services.<br><br>• The review of the Board Assurance Framework – strategic objective six - and Corporate Risk Register.<br><br>• Colleague Experience Group progress report - the ongoing work of the Employee Experience Group and the ambition to bring colleague experience alongside patient experience and performance elements.<br><br>• Both negative and positive assurance from the flexible working learning item.<br><br>• Director report - the positive progress with the workforce plan and controls in place and the positive assurance form NHS England.<br><br>The Committee identified the following areas for follow up: |

| | |
|---|---|
| | • The Corporate Risk Register – follow up report on the "collective action by GPs" risk.<br><br>• Colleague Experience Group progress report - follow up report to be provided to a future meeting.<br><br>• Director Report - update on the workforce plan will be presented to the January 2025 Committee meeting.<br><br>• Director Report – deep dive into the new workforce at a future meeting.<br><br>• Director Report - update on the demand on the workforce data team to be provided to a future meeting.<br><br>The Committee did not identify any issues to be reported to the Board.<br><br>The Committee is able to provide the Board with assurance that the items discussed at the meeting provide significant assurance in relation to addressing gaps in controls and assurances for objective six of the Board Assurance Framework. |
| **Recommendation** | The Board is asked to discuss the report and note the areas of assurance and follow up. |

| **Links to Joint Strategic Objectives**<br>(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.<br><br>How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report? |
| The colleague story and learning item are ways of identifying potential impacts on colleagues with protected characteristics and any lessons learned will be followed up. |
| 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 views from colleagues have been considered through the colleague story and learning item. |

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

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

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

**SOMERSET NHS FOUNDATION TRUST (SFT)**

**ASSURANCE REPORT FROM THE PEOPLE COMMITTEE**

## 1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 4 December 2024, the assurance received by the Committee and any areas of concern or for follow up identified.

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

## 2. ASSURANCE RECEIVED

**Colleague story – Rising Star Programme**

2.1. The Committee received the colleague story which focussed on a colleague's journey from a healthcare assistant (HCA) to a deputy ward manager.

2.2. The Committee noted that the colleague had worked in the Intensive Care Unit for 18 years, 16 years as a Band 5 Staff Nurse and the last two years as a Band 6. The colleague shared her lack of confidence and self-belief and her decision to take part in the Leadership Development programme. The Committee noted the benefits of the leadership development programme and in particular the colleague's development of her self-awareness, and the increase in her confidence and self-belief.

2.3. The Committee further noted: the supportive team environment during the course and the ongoing peer support and networking; the colleague's successful application for a Band 6 post; the successful application of the skills learned during the course, especially shift leading, role modelling, handling of difficult situations and supporting junior colleagues; the use of the team engagement and development tool to gain colleague opinions and understand their needs, resulting in improved communication and recognition within the ICU team; the survey to be undertaken in June 2025, involving the team, allied health professionals and medical professionals, to improve teamwork across the wider team.

2.4. The Committee agreed that the story was an excellent example of the return on investment in people development and noted the need to encourage all colleagues to access the available development programmes to progress in their careers.

**Review of Board Assurance Framework (BAF)**

2.5. The Committee received the updated Board Assurance Framework in relation to strategic objective six.

2.6. The Committee noted: the improvement in the retention rates across the trust and the concerns in relation to nursing and midwifery colleague retention; the reconvened Retention Action Group with the aim to develop a retention dashboard to strengthen oversight; the improvement in the National Pulse Survey response rates and the ongoing efforts to further increase the response rate to be able to better understand colleague experiences; the challenges in relation to the inclusion measures, the negative rating for these measures and the long period of time required for the inclusion workforce plan to deliver the necessary cultural change; the two risks related to discrimination; the review of the listening roadmap; and the delays in strengthening controls relating to links between colleague experience and learning; and the implementation of the retention action plan.

2.7. The Committee noted that the workforce planning audit report will be presented to the January 2025 Audit Committee meeting.

2.8. The Committee discussed revised target dates whilst stressing the importance of retaining the original target dates to acknowledge implementation delays.

**Corporate Risk Register**

2.9. The Committee received the updated corporate risk register relating to the People Committee and noted that there had not been any significant changes since the last report. The Committee noted the following key points: the correction of the incorrectly rated discriminatory behaviour risk from 16 to 12; the ongoing risk around substandard multi-disciplinary teams (MDT) working and the mitigating actions being taken; the analysis of the workforce demographics to understand the risk of losing colleagues due to retirement; the work to assess the short and long-term impact of potential collective action by GPs on services, including exploring alternative service delivery models; the review of nurse staffing risks; and the review of the survey results for risk training .

2.10. The Committee received an update on the senior operational team meeting discussions on cultural indicators and noted: the need to identify red flags that could indicate service or cultural issues within teams; the need to make information more widely available; the need to consider concerns about managers not addressing workforce related issues as part of the process of developing the year 3 people strategy deliverables.

2.11. The Committee noted the review of the reward and recognition process and the need to ensure that unregistered colleagues have the ability to feel recognised as part of the wider organisation.

**Colleague Experience Group progress report**

2.12. The Committee received an update on the work of the Colleague Experience Group and noted that the group was still evolving and focussing on integrating data sources to measure colleague experience effectively. The Committee noted that assurance will be obtained from colleague experience, patient

feedback and activity and performance data to understand what is contributing to a positive workplace culture.

2.13. The Committee noted: the key objective to triangulate the intelligence relating to culture from colleague experience to be able to understand and assess how actions are aligning with the ambition; the works of the key action groups to break data down by services and review HR data against formal and informal complaints, Freedom to Speak Up concerns and the national quarterly Pulse survey results; the increase in the Pulse survey response rates; the opportunity for the Colleague Experience Group to influence additional questions in the survey to measure the impact; the Gold quality improvement process to be undertaken over the next 12 months to ensure that the aims and objectives of the group were the right aims and objectives; and that the operational leadership group meetings will be used to triangulate patient and colleague experience and performance to be able to understand the culture of the organisation.

2.14. The Committee further noted: the objective to support colleagues through wellbeing support and coaching and mentoring provided by the leadership and organisational development team; and that measures are being considered for the newly developed multi-disciplinary working for leadership and leadership programme.

**Learning Item – Flexible Working Programme**

2.15. The Committee received an update on the flexible working programme and learning from the last 18 to 24 months and noted that flexible working was a key focus within the People Promise.

2.16. The Committee noted: the increase in the number of colleagues who felt that the trust championed flexible working; that 61% of colleagues felt that they had a good work/life balance; the decrease in the number of colleagues leaving due to work-life balance issues; the development of a dashboard providing insight into key areas including colleagues working less than full time hours; the breakdown of information relating to colleagues working less than full time hours and the need to focus on the reasons why colleagues at band 7 and above were less likely to work less than full time hours; and the introduction of a self-service flexible working application to be able to provide a better oversight of flexible working arrangements.

2.17. The Committee further noted: the participation in the Timewise Flexible Working Programme focussing on leadership and supporting and managing the flexible working process; the positive progress made and the challenges in relation to generational differences and reluctance from managers; the need for continued education on flexible working; the need to advertise flexible working options more consistently to attract a broader candidate pool and reduce post-hire flexible working requests; the ongoing work with the Electronic Staff Record (ESR) in relation to team-based rostering; and the launch of a national policy around flexible working which will be implemented within the trust.

2.18. The Committee discussed the flexibility of work locations, especially the balance between home-based and office-based working and noted that there had been a shift in expectations post covid and that there was now more flexibility in terms of work location than pre covid. There was variation within services and some colleagues have left due to more rigid office-based work. The Committee recognised the importance of balancing team dynamics with individual flexibility and further recognised the ongoing challenge of managing these expectations.

2.19. The Committee noted that medical and nursing colleagues already work flexibly by providing cover seven days a week and through extended hours; and that the adaptation of the self-rostering system in several organisations had made a significant difference in terms of colleague satisfaction.

**Director Report**

2.20. The Committee received the report and received an update on the Somerset Workforce Plan. The Committee noted: the trajectory to deliver a workforce cap by the end of March 2025 in line with a national mandate to reduce the growth in workforce; the over-achievement against trajectory by 17 wte; the increase in workforce where appropriate, e.g. dermatology services; the year to date agency spend and the significant reduction in agency spend compared to the previous year; the under-delivery against the national agency cap due to gaps in primary care and mental health services; the plan to review the workforce plan following the receipt of national guidance; the aim to have a draft workforce, finance and activity plan by mid February 2025.

2.21. The Committee received an update on the collaborative work taking place across the system; the success from the service groups owning the recruitment control process; the positive feedback received from NHS England about finance and workforce management as part of the quarterly review meeting.

2.22. The Committee further noted: the significant work carried out to ensure that ESR was fit for purpose and ready for the new workforce solution expected in the next two years; the use of workforce data and the demand on the workforce data team; the transformation programme for people services planned for 2025 and the aim of the programme to streamline processes, improve digital capabilities, and reduce costs; the need to consider the Equality Impact Assessment process for large transformational change; and the work in relation to the use of AI and process automation to improve efficiency.

## 3. AREAS OF CONCERNS/FOLLOW UP

**Corporate Risk Register**

3.1. The Committee noted that a further update on the “collective action by GPs” risk will be presented to the January 2025 Committee meeting.

**Colleague Experience Group progress report**

3.2. The Committee asked for a further update to be provided to a future meeting.

**Director Report**

3.3. The Committee noted that an update on the workforce plan will be presented to the January 2025 Committee meeting.

3.4. The Committee agreed to undertake a deep dive into the new workforce solution at a future meeting.

3.5. The Committee further discussed the demand on the workforce data team and whether there were opportunities to reduce the reliance on the workforce data team. The Committee agreed to ask for an update to be provided to a future meeting.

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

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

## 5. ASSURANCE FRAMEWORK

5.1. The Committee received assurance on strategic objective six in the following areas:

- Colleague story – the programmes offered to individuals within services.
- The review of the Board Assurance Framework – strategic objective six - and Corporate Risk Register.
- The ongoing work of the Employee Experience Group and the ambition to bring colleague experience alongside patient experience and performance elements.
- Both negative and positive assurance from the flexible working learning item.
- The positive progress with the workforce plan and controls in place and the positive assurance form NHS England.

| Somerset NHS Foundation Trust | |
|---|---|
| **REPORT TO:** | Board of Directors |
| **REPORT TITLE:** | Assurance Report from the People Committee meeting held on 14 January 2025 |
| **SPONSORING EXEC:** | Isobel Clements, Chief of People and Organisational Development |
| **REPORT BY:** | Ria Zandvliet, Secretary to the Trust |
| **PRESENTED BY:** | Graham Hughes |
| **DATE:** | 4 February 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 People Committee meeting held on 14 January 2025 and the assurance received and areas for concern or follow up identified. The meeting was conducted as a video call.<br><br>The Committee received assurance in relation to:<br><br>• The review of the board Assurance Framework – the action plans to mitigate the areas of negative assurance.<br><br>• The Corporate Risk Register<br><br>• The People Strategy update - the progress of deliverables for year one and year two of the People Strategy. The Committee agreed the proposed approach for year three, focusing on consolidation and measurement of current initiatives.<br><br>• The Approach to Recruitment<br>- the significant improvements in recruitment systems and processes, including the alignment of the ledger, ESR, and recruitment systems. This alignment provides valuable insights into workforce management and control.<br><br>- The Committee acknowledged the tremendous contribution of volunteers to the organisation. |

| | |
|---|---|
| | - The positive developments in AI applications for recruitment and the implementation of the vacancy tracker, which provides accurate and real-time data on vacancies and recruitment progress.<br><br>• Director report - the job planning platform<br><br>The Committee identified the following areas for follow up:<br><br>• The Corporate Risk Register – a follow up on the senior medical workforce risk.<br><br>• People Strategy – a table with RAG ratings to be developed to show progress against each of the people strategy initiatives<br><br>• Terms of Reference and Planner - the terms of reference to be checked against the new Care Quality Commission framework and a new deputy chair to be appointed.<br><br>• Frequency of meetings – *follow up on* the suggestion to change the frequency from monthly to bi-monthly<br><br>• Approach to recruitment – achievement of the time to hire target.<br><br>The Committee did not identify any issues to be reported to the Board.<br><br>The Committee is able to provide the Board with assurance that the items discussed at the meeting provide significant assurance in relation to addressing gaps in controls and assurances for objective six of the Board Assurance Framework. |
| **Recommendation** | The Board is asked to discuss the report and note the areas of assurance and follow up. |

| **Links to Joint Strategic Objectives**<br>(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 needs and impacts on people with protected characteristics are considered as part of the wide recruitment process.

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 views from colleagues have been considered through people strategy adnd apporach to recruitment agenda items.

**Previous Consideration**

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

The assurance report is presented to the Board after each meeting.

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

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

**SOMERSET NHS FOUNDATION TRUST (SFT)**

**ASSURANCE REPORT FROM THE PEOPLE COMMITTEE**

## 1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 14 January 2025, and the assurance received by the Committee and areas of concern or for follow up identified..

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

## 2. ASSURANCE RECEIVED

**Review of Board Assurance Framework**

2.1. The Committee received the updated Board Assurance Framework in relation to strategic objective six. The Committee noted that: the target dates for colleague experience and learning had been extended to June 2025 but that the original target date was still noted; the review of the next steps for retention focus had been moved from December 2024 to March 2025; and that the Retention Action Group was up and running with progress being monitored.

2.2. The Committee further noted that actions plans were in place to mitigate the areas of negative assurance.

**Corporate Risk Register**

2.3. The Committee received the updated corporate risk register relating to the People Committee and noted the reduction in the number of risks on the corporate risk register. The Committee noted the key highlights: five of the 25 risks were scored 20; the vacancies within the senior clinical workforce were a significant risk which may benefit from a further deep dive session; the new risk in relation to the inability to isolate patients in accordance with infection prevention and control requirements due to a lack of capacity within trust inpatient areas; and the emerging risk in relation to increased levels of colleague sickness due to respiratory illnesses.

2.4. The Committee noted: that 40 risks were held at service group level with an increase in workforce related risks; the decrease in the risk relating to the lack of an unified policy and approach for the management of colleague personal files and the oversight of the impact of this risk by the Quality and Governance Assurance Committee; the further consideration of the risks in the context of the 2025/26 financial framework and the workforce cap at the Operational Leadership Team meeting.

**People Strategy**

2.5. The Committee received the people strategy update report and noted that the strategy included 24 ambitions to be delivered over a five year period and that

consideration will need to be given to the year three deliverables. It was noted that 13 of the deliverables had been completed.

2.6. The Committee further noted: the challenge to measure the impact of the deliverables as the results of the National Staff Survey and Quarterly Pulse surveys did not provide a clear indication of the tangible improvements for colleagues; the proposal to take a pause in year three to consolidate the work done so far, ensuring clear and measurable Key Performance Indicators (KPIs) for each deliverable; that the staff survey findings were still awaited; that the people services function was embarking on a significant transformation programme to support the organisation and its future needs, including a focus on supporting the Board and subcommittees in understanding and embedding inclusion into their leadership; that performance against the retention measure had reduced slightly but continued to be within the expected parameters and that, overall, the trust was performing well.

2.7. The Committee accepted the proposal to consolidate work in year three, focussing on measuring the impact of deliverables and ensuring realistic targets. In response to a question, the Committee noted that work on tracking internal career development opportunities and movement from service to service was taking place.

**Approach to Recruitment**

2.8. The Committee received an update on the recruitment work and the Committee noted: the vacancy cap position – 55 whole time equivalent (wte) above the cap as at December 2024, but 11.99 wte above the planned target in terms of the workforce plan; the significant reduction in the use of temporary staffing.

2.9. The Committee noted the following key points:

- The significant demand on the recruitment team in 2024 with a peak of 259 vacancies in October 2024; and the increase in demand from 2023.
- The efficiency gains from the implementation of the Oleeo recruitment system and the challenges with system integration and communication issues.
- The improved quality and inclusion data with an increasing number of applicants declaring disabilities and other demographic information.
- The number of colleagues who have moved around the organisation via the recruitment pathway.
- The successful but challenging implementation of the Oleeo system in view of the management of a high demand whilst learning a new system; and the roll out of the system to cover medical and international recruitment towards the end of this financial year.

- The consideration of the use of AI for some of the recruitment tasks.

- The transition to a managed service model to improve efficiency and candidate experience by quarter four of this financial year.

- The successful implementation of the managed service by the medical recruitment team in December 2024.

- The development of central training for recruitment to support hiring managers with the process and ensure inclusivity.

- Details of the new vacancy tracker, the opportunity to view data by staff group and the role out of the tracker to hiring managers in February 2025.

2.10. The Committee discussed the use of AI in recruitment to improve inclusivity as part of the shortlisting process and noted: that previous experience had shown that the AI process had produced the same shortlist as the manual shortlisting process; the need to constantly monitor the basis on which AI models are trained; the importance of being clear to candidates if AI was being used; the need to monitor the use of AI by candidates; and the concerns in relation to the use of AI in agenda for change job descriptions matching and the request to involve staff side in the AI work.

2.11. The Committee further discussed: the further work to be carried out to ensure that the process for internal movements within the organisation is streamlined and consistent across the organisation; that additional resources may be required for the transformation to a managed service; the progress made in aligning the ledger, ESR and recruitment systems; the measurement of the effectiveness of recruitment decisions and the ongoing focus of the Retention Group on this area.

2.12. The Committee recognised: the excellent work to improve the recruitment process; the need to continue to focus on productivity and reducing agency and locum staffing costs; the resources required to deliver the transformation of the recruitment service.

**Director Report**

2.13. The Committee received the report and noted the following additional updates: the opportunity to obtain learning from a trust in the Midlands on the introduction of a virtual assistant to handle low-level queries and casework within the people services department and the opportunity to trial the virtual system; the need to review the state of employee relations across the organisation and the areas of focus - capability of managers and colleagues to handle casework, the efficiency of investigations, and the overall handling of grievances and sickness absence; the importance of reviewing the current learning and education offer within the organisation with the goal to ensure that the training and education provided are fit for purpose, effective, and aligned with the organisation's needs.

2.14. The Committee acknowledged the significant contributions of volunteers to the organisation, particularly highlighting their role in the smooth running of the trust and the opening of the Maple unit.

## 3. AREAS OF CONCERNS/FOLLOW UP

**Corporate Risk Register**

3.1. The Committee further discussed the concerns about the substantial number of medical vacancies and the effectiveness of recruitment strategies. The Committee noted that some vacancies are hard to fill and that there was a need to understand the short to medium-term impact on services. The Committee agreed to ask for an update on the senior medical workforce risk to be presented to a future meeting.

**People Strategy**

3.2. The Committee asked for a table with RAG ratings to be developed to show progress against each of the people strategy initiatives

**Terms of Reference and Planner**

3.3. The Committee discussed its terms of reference and asked for the terms of reference to be checked against the new Care Quality Commission framework. The Committee noted the need to appoint a deputy chair.

**Frequency of meetings**

3.4. The Committee discussed the frequency of the People Committee meetings and noted the suggestion to change the frequency from monthly to bi-monthly to be able to better manage the workload and focus on essential business. Feedback on this proposal was requested and this will be followed up at the February 2025 meeting.

**Approach to Recruitment**

3.5. The Committee noted:

- The time to hire of 73.2 days with a target to achieve a 45-day time to hire by April 2025 and the challenges to achieve this new target. In response to a question, the Committee noted that if this target was not achieved by April 2025, detailed plans to work towards achieving this target as soon as possible will be put in place.

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

4.1 The Committee did not identify any issue to be reported to the Board at this meeting.

## 5. ASSURANCE FRAMEWORK

5.1. The Committee received assurance on strategic objective six in the following areas:

- The Committee acknowledged the ongoing risk related to medical recruitment and workforce.

- Assurance was received on the progress of deliverables for year one and year two of the People Strategy. The Committee agreed the proposed approach for year three, focusing on consolidation and measurement of current initiatives.

- The significant improvements in recruitment systems and processes, including the alignment of the ledger, ESR, and recruitment systems. This alignment provides valuable insights into workforce management and control.

- The Committee noted that the current time to hire is still too long and emphasised the importance of keeping this KPI highly visible.

- The Committee acknowledged the tremendous contribution of volunteers to the organisation.

- The Committee was assured of the positive developments in AI applications for recruitment and the implementation of the vacancy tracker, which provides accurate and real-time data on vacancies and recruitment progress.

- The Committee received assurance on the job planning platform which was included in the Chief People Officer report.

| Somerset NHS Foundation Trust | |
|---|---|
| **REPORT TO:** | Board of Directors |
| **REPORT TITLE:** | Assurance Report from the Mental Health Legislation Committee meeting held on 10 December 2024 |
| **SPONSORING EXEC:** | Jade Renville, Director of Corporate Services |
| **REPORT BY:** | Ria Zandvliet, Secretary to the Trust |
| **PRESENTED BY:** | Ben Edgar-Attwell, Deputy Director of Corporate Services |
| **DATE:** | 4 February 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 Mental Health Legislation Committee meeting held on 10 December 2024 and the assurance received by the Committee. The meeting was conducted as a video conference call.<br><br>The Committees received assurance in relation to:<br><br>• The Section 117 Update<br><br>• The Patient and Carer Race Equality Framework update<br><br>• The Mental Health Act Lead report<br><br>• The MCA, DoLs and LPS update<br><br>• The ICB commissioning update<br><br>• The update from the children and adolescent mental health services (CAMHS)<br><br>• The forensic progress report<br><br>• The out of Area Treatment Somerset (OATS) progress report<br><br>• The Care Quality Commission report for Holford Ward<br><br>• The position in relation to complaints and other issues |

| | |
|---|---|
| | • The progress made in relation to the management of risks<br><br>The following areas of concern or for follow up were identified:<br><br>• Section 117 – business case<br><br>• The Mental Health Lead Report – the lack of progress with the Mental Health Act assessment Standing Operating Procedure (SOP)<br><br>• The Mental Health Lead Report – the relationship with the police<br><br>• The MCA, DoLS and LPS update - training compliance for medical and dental colleagues<br><br>• Approved Mental Health Professional Services – the lack of representation at the meeting<br><br>• Complaints and issues – the review of the access to services<br><br>The Committee identified the following areas to be reported to the Board:<br><br>• The positive feedback from the CQC report for Holford Ward<br><br>• The progress in relation to Section 117<br><br>• The ongoing demand on the mental health administration team<br><br>• The lack of overall engagement from the police |
| **Recommendation** | The Board is asked to note the assurance and areas of concern or follow up identified by the Mental Health Act 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 with the mental health teams. 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.

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 MENTAL HEALTH LEGISLATION COMMITTEE MEETING HELD ON 10 DECEMBER 2024**

## 1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 10 December 2024, the assurance received by the Committee and any areas of concern identified.

## 2. ASSURANCE AND UPDATES RECEIVED

### Section 117

2.1. The Committee noted the longstanding Section 117 Aftercare challenges due to the shared responsibility arrangements between the Local Authority and the ICB and further noted: the changes in government policy in relation to funded nursing care for Section 117 patients and the necessary adjustments in funding allocations; the management of high-cost packages by an integrated panel and the streamlining of decision-making; the benefits of a single decision-making panel.

2.2. The Committee noted that a working group, involving the trust, local authority and the ICB will meet in 2025 to agree a unified Section 117 policy for Somerset.

2.3. The Committee noted that work on discharge planning for Section 117 patients and the recording of discharge planning was taking place and that guidance and training will be provided.

2.4. The Committee received the findings of a Parliamentary Health Service Ombudsman (PHSO) and Local Government Ombudsman (LGO) investigation into a complaint regarding Section 117 Aftercare. The Committee noted that some areas of improvement had been identified for both the local authority and the trust and that a response action plan will be prepared to implement the report's recommendations.

### Patient and Carer Race Equality Framework

2.5. The Committee received an update on the Patient and Carer Race Equality Framework and noted: that the framework was a mandated framework; that the framework was designed to support mental health providers to improve access, experiences and outcomes for racialised and ethnically and culturally diverse communities; that providers will be required to produce actions to reduce racial inequalities and that progress will be monitored by the Care Quality Commission (CQC). The Committee noted the actions to be taken

and further noted that a report will be presented to the February 2025 Quality and Governance Assurance Committee.

**Mental Health Act Lead Report**

2.6. The Committee received the Mental Health Act Lead report and noted the following highlights from the report: the increase in the number of tribunals since the summer and the positive feedback from tribunal members; the staffing changes; the increase in training requests, including further requests from Musgrove Park Hospital clinicians and Rowan/Rydon clinicians for S52s (holding powers); the requests for CTO training and the intention to roll this training out to the wider community teams; the advocacy activities; the reduction in the percentage of lapsed detentions.

The Committee received an update from a CTO recall in January 2024 involving a patient from Wessex House and noted the circumstances and details of the recall and the placement of the patient at Sevenoaks. The Committee noted that lessons had been learned; that a clear process for managing such future situations was in place; that discussions about the next steps around duty of care were taking place; and that the patient was making progress in Sevenoaks.

The Committee received the statutory guidance on discharge from mental health inpatient settings.

The Committee further noted: that the implementation of Right Care Right Person was ongoing; the increase in the number of patients taken to the place of safety; the reduction in the number of patients taken to YDH; the increase in the number of patients discharged after admission to a place of safety to 76% with either ongoing or no further support; the good working relationship with the police to roll out Right Care Right Person.

**MCA, DoLs and LPS updates**

2.7. The Committee received a verbal update in relation to the MCA, DoLs and LPS work and noted the following key highlights: the refresh of the Mental Capacity Act Policy which included engagement with patients and families with experience to ensure a person-centred approach; the work taking place on Consent to Share and the launch of the Standard Operating Procedure in 2025; the differing approaches by local authorities regarding the intersection of DoLS and the Mental Health Act and the need to continue to monitor the difference in approaches; the increase in level 2 training and the excellent compliance levels at YDH.

**ICB Commissioning**

2.8. The Committee received an update and noted that: the ICB had received a court order to convene a multi-agency meeting to provide information to a patient tribunal; the right staff to take part in this meeting had been identified.

**CAMHS**

2.9. The Committee received an update on child and adolescent mental health services (CAMHS) out of area placements and noted*:* that currently three young people had been placed out of area; the work taking place to repatriate or discharge two of these patients; that Wessex House remained closed and was expected to re-open in March with a new staffing team.

**Forensic Report**

2.10. The Committee received a progress report and noted the report.

**Out of Area Treatment Somerset (OATS) patients**

2.11. The Committee received the report and noted that planned admissions remained at ten and the details of some of these patients were noted. The Committee noted that there was one inappropriate out of area placement and the reason for this placement was noted.

**Care Quality Commission (CQC) Report – Holford Ward**

2.12. The Committee received feedback from the CQC visit to Holford Ward on 11 September 2024 and noted the positive feedback with good feedback from patients, carers and the IMHA service. The Committee noted the two concerns raised and further noted that the concerns raised in the previous report had been resolved.

2.13. The Committee noted the reason for the late presentation of the report to the Committee and agreed that the report provided excellent assurance about the positive environment. The Committee complimented the Holford Ward team on the excellent report.

**Complaints and Issues**

2.14. The Committee received the report and noted that six new complaints had been received via the Care Quality Commission or through the Trust's complaints process. The Committee noted the details of the complaints and agreed that it was assuring that no common themes or areas of concern had been identified.

2.15. The Committee noted that the use of AI was being trialled within the patient experience team to help with thematic analysis of formal complaints.

**Risk Register**

2.16. The Committee received the Mental Health and Learning Disability service group risk register and noted the high rated risks and actions taken to mitigate risks. The Committee discussed the following risks*:* the introduction of Dialogue Plus had been an improvement but had created challenges for medical recording on RiO – a review of all patients with a diagnosis of schizophrenia was taken place to ensure that proper documentation was recorded; the risk relating to the safeguarding concerns about a residential supported living facility in Somerset – the learning disability team continued to actively monitor and review trust patients in residence at the facility; the ADHD risk – which was being managed by the Chief Medical Officer and the ICB.

**Internal Audit Requests**

2.17. The Committee asked for audits to be carried out on Section 17 Leave; and Section 136.

## 3. AREAS OF CONCERN OR FOR FOLOW UP

**Section 117**

3.1. The Committee received an update on the Section 117 proposal and noted that the business case for a small project team had not been successful due to resource implications. The Committee asked for this to be raised with the executive team.

**Mental Health Act Lead Report**

3.2. The Committee noted the lack of progress in relation to the Mental Health Act assessment Standing Operating Procedure (SOP) due to the concerns about additional paperwork for clinicians.

The Committee further noted the challenges in bridging the gap between health, mental health and the police in certain areas. The Committee agreed to explore the opportunities to improve the overall relationship with the police.

**MCA, DoLs and LPS updates**

3.3. The Committee noted the concerns in relation to medical and dental staff training levels. The Committee agreed to raise the training levels for medical and dental staff with the Chief Medical Officer and noted the offer from Emma Lawton to consider how best to deliver the training to suit the needs of the team.

**AMHP (Approved Mental Health Professional) Services**

3.4. The Committee noted that there was no representation from the local authority at the meeting and the local authority will be requested to nominate a deputy.

**Complaints and Issues**

3.5. The Committee noted that a further complaint may be received via the CQC regarding care provided by community mental health services, access to these services and care provided by the home treatment team. The Committee asked for access to services to be reviewed.

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

4.1. The Committee identified the following areas to be reported to the Board:

- 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

**Alexander Priest**
**CHAIRMAN OF THE MENTAL HEALTH LEGISLATION 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 February 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 the financial position. |
| **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**<br><br>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**<br>(Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B] |
|---|
| Monthly report |

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

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

# SOMERSET NHS FOUNDATION TRUST

# FINANCE REPORT

## 1. SUMMARY

1.1 In December, the Trust recorded a surplus of £1.517m, this was in line with the planned position for the month. Cumulatively, the Trust is £8.177m in deficit, which is also breakeven to plan.

1.2 The main December headlines are:-

- Agency expenditure in month totalled £2.169m, this was £1.073m below the plan for the month. It was also £0.065m below the ceiling for the month and £0.259m below November expenditure. Cumulatively, the Trust has spent £4.7m less than in the equivalent 2023/24 period.
- CIP of £6.359m was delivered in December, in line with plan. Of this, recurrent savings were £2.433m (38% of total). Cumulatively, total efficiencies of £41.071m have been delivered which is on plan, of these, £14.449m (35%) are recurrent. The unidentified gap has reduced again this month and is now c£2m.
- Total whole time equivalents for all staff groups were 12,561 in December 30 below the expected trajectory for the month and 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 31 December 2024:

Table 1: Income and Expenditure Summary December

| Statement of Comprehensive Income | Annual Plan £000 | Current Month 9 | | | Year to date | | |
|---|---|---|---|---|---|---|---|
| | | Plan £000 | Actual £000 | Fav./ (Adv.) Variance £000 | Plan £000 | Actual £000 | Fav./ (Adv.) Variance £000 |
| **Income** | | | | | | | |
| Patient Care Income | 998,488 | 83,087 | 85,277 | 2,190 | 750,225 | 766,562 | 16,338 |
| Other Operating Income | 72,568 | 6,732 | 6,644 | (88) | 51,970 | 58,141 | 6,171 |
| **Total operating income** | **1,071,056** | **89,819** | **91,921** | **2,102** | **802,195** | **824,703** | **22,508** |
| **Operating expenses** | | | | | | | |
| Employee Operating Expenses | (739,748) | (60,801) | (63,057) | (2,257) | (557,036) | (567,904) | (10,869) |
| Drugs Cost: Consumed/Purchased | (93,421) | (8,035) | (7,965) | 70 | (71,546) | (71,642) | (95) |
| Clinical Supp & Serv Exc-Drugs | (32,992) | (2,379) | (5,573) | (3,195) | (27,998) | (48,602) | (20,604) |
| Supplies & Services - General | (35,549) | (2,962) | (2,669) | 293 | (26,662) | (25,945) | 717 |
| Other Operating Expenses | (158,268) | (13,203) | (11,036) | 2,168 | (118,819) | (114,307) | 4,512 |
| **Total operating expenses** | **(1,059,978)** | **(87,380)** | **(90,300)** | **(2,920)** | **(802,062)** | **(828,400)** | **(26,338)** |
| **Operating Surplus/Deficit** | 11,078 | 2,439 | 1,621 | (818) | 133 | (3,697) | (3,830) |
| Finance Expense | (13,070) | (1,089) | (331) | 759 | (9,805) | (7,983) | 1,821 |
| Finance Income | 2,424 | 202 | 285 | 83 | 1,818 | 3,156 | 1,338 |
| Other | 0 | 0 | 0 | (0) | (1) | 0 | 1 |
| **Overall Surplus/(Deficit)** | 432 | 1,552 | 1,575 | 24 | (7,855) | (8,524) | (669) |
| Depr On Donated Assets | 1,397 | 116 | 81 | (35) | 1,047 | 740 | (308) |
| Donated Assets Income | (2,591) | (216) | (102) | 114 | (1,943) | (1,682) | 261 |
| Amortisation | 9 | 1 | 1 | (0) | 7 | 7 | (0) |
| Impairments (Reversals) | 0 | 0 | 0 | 0 | 0 | 1,039 | 1,039 |
| Other | 753 | 63 | (36) | (99) | 567 | 246 | (321) |
| **Adjustments to control total** | (432) | (36) | (57) | (21) | (322) | 349 | 671 |
| **Adjusted Financial Performance** | 0 | 1,517 | 1,517 | 0 | (8,177) | (8,177) | 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 December, overall staffing levels were 30 wte below the workforce cap trajectory for the month: -

- Substantive staff were 36 wte over plan
- Bank staff were 39 wte under plan
- Agency staff were 37 wte under &
- Locums were 10 wte over the planned cap

2.4 The Trust continues to operate effective processes to manage and review our workforce. 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 and we remain on track to deliver this.

2.5 Overall temporary staffing numbers were under plan in month and December's wte's decreased by 35.4 wte when compared with November. The agency decrease was 3.22 wte.

Table 2: Pay expenditure information

| 2024/25 Monthly Pay Expenditure analysis | Mar-24 £000 | 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 | 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 | 3,554 | 2,090 | 1,927 | 1,894 | 1,882 | 1,975 | 1,826 | 2,767 | 2,064 | 1,977 | 2,033 | 56 | 18,401 | 19,362 | 961 |
| Medical Agency | 1,819 | 1,830 | 1,685 | 1,275 | 1,411 | 1,779 | 1,424 | 1,865 | 1,722 | 1,418 | 2,087 | 669 | 14,409 | 16,861 | 2,452 |
| Medical Locums | 1,409 | 1,152 | 1,032 | 938 | 1,159 | 818 | 1,000 | 908 | 1,023 | 995 | 503 | (492) | 9,026 | 4,531 | (4,496) |
| Nursing Agency | 966 | 771 | 618 | 547 | 547 | 486 | 369 | 501 | 384 | 441 | 888 | 447 | 4,663 | 8,825 | 4,162 |
| Other Agency | 466 | 484 | 497 | 391 | 405 | 331 | 317 | 331 | 323 | 311 | 269 | (42) | 3,388 | 2,533 | (855) |
| **Total Temporary Staff** | **8,214** | **6,326** | **5,759** | **5,044** | **5,404** | **5,388** | **4,936** | **6,372** | **5,516** | **5,142** | **5,779** | **637** | **49,887** | **52,111** | **2,224** |
| Nursing | 21,933 | 15,075 | 14,998 | 15,079 | 14,949 | 14,854 | 14,993 | 18,511 | 15,649 | 15,664 | 16,631 | 967 | 139,772 | 149,634 | 9,861 |
| Support to Nursing | 8,300 | 6,307 | 6,229 | 6,256 | 6,106 | 5,999 | 6,061 | 7,302 | 6,082 | 5,967 | 5,528 | (440) | 56,310 | 49,478 | (6,832) |
| Medical | 15,301 | 12,773 | 10,722 | 11,723 | 12,261 | 12,263 | 12,138 | 15,250 | 16,541 | 13,071 | 12,041 | (1,031) | 116,743 | 111,847 | (4,896) |
| AHP's | 13,095 | 8,615 | 8,680 | 8,658 | 8,656 | 8,616 | 8,646 | 11,165 | 9,279 | 9,360 | 9,699 | 339 | 81,675 | 87,653 | 5,978 |
| Infrastructure Support | 10,612 | 9,657 | 9,326 | 9,461 | 9,302 | 9,599 | 9,355 | 11,518 | 9,686 | 9,662 | 7,903 | (1,759) | 87,567 | 77,143 | (10,423) |
| Other | 5,196 | 3,191 | 4,956 | 3,611 | 4,026 | 3,845 | 4,164 | 3,955 | 4,012 | 4,190 | 3,220 | (970) | 35,950 | 29,169 | (6,781) |
| **Substantive Staff** | **74,437** | **55,618** | **54,912** | **54,789** | **55,300** | **55,176** | **55,357** | **67,701** | **61,250** | **57,915** | **55,021** | **(2,894)** | **518,017** | **504,925** | **(13,093)** |
| **Total All Staff** | **82,651** | **61,943** | **60,671** | **59,833** | **60,704** | **60,565** | **60,293** | **74,073** | **66,765** | **63,057** | **60,801** | **(2,257)** | **567,904** | **557,036** | **(10,869)** |
| **% Temporary** | 9.94% | 10.21% | 9.49% | 8.43% | 8.90% | 8.90% | 8.19% | 8.60% | 8.26% | 8.15% | 9.51% | | 8.78% | 9.36% | |

Table 3: WTE information

| 2024/25 Monthly Workforce analysis | Planning Month WTE | 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 | In Month WTE | In Month Plan WTE | F/(A) Variance WTE | Plan | F/(A) Variance WTE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Temporary staff | | | | | | | | | | | | | | | |
| Bank Staff | 611.40 | 588.90 | 493.89 | 493.02 | 516.60 | 518.54 | 487.53 | 554.72 | 519.78 | 498.22 | 498.22 | 537.31 | 39.09 | 539.24 | 41.02 |
| Medical Agency | 73.21 | 74.57 | 67.68 | 59.07 | 68.38 | 69.16 | 62.13 | 76.13 | 68.32 | 63.53 | 63.53 | 67.47 | 3.94 | 60.16 | (3.37) |
| Medical Locums | 22.40 | 31.19 | 25.72 | 26.61 | 33.27 | 32.54 | 29.98 | 28.65 | 29.85 | 29.25 | 29.25 | 19.69 | (9.56) | 19.76 | (9.49) |
| Nursing Agency | 93.45 | 94.58 | 69.57 | 64.96 | 70.88 | 67.02 | 46.30 | 47.29 | 48.55 | 59.27 | 59.27 | 86.12 | 26.85 | 76.79 | 17.52 |
| Other Agency | 53.61 | 67.26 | 77.61 | 59.76 | 58.10 | 58.65 | 55.32 | 52.70 | 45.45 | 42.74 | 42.74 | 49.41 | 6.67 | 44.05 | 1.31 |
| **Total Temporary Staff** | **854.07** | **856.50** | **734.47** | **703.42** | **747.23** | **745.91** | **681.26** | **759.49** | **711.95** | **693.01** | **693.01** | **760.00** | **66.99** | **740.00** | **46.99** |
| Nursing | 3,428.00 | 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 | 3,460.86 | 3,438.78 | (22.08) | 3,419.62 | (41.24) |
| Support to Nursing | 2,179.48 | 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 | 2,014.00 | 2,109.09 | 95.09 | 2,097.34 | 83.34 |
| Medical | 1,090.19 | 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 | 1,121.14 | 1,096.11 | (25.02) | 1,090.01 | (31.13) |
| AHP's | 1,663.11 | 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 | 1,658.43 | 1,602.99 | (55.44) | 1,594.06 | (64.37) |
| Infrastructure Support | 2,501.85 | 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 | 2,473.16 | 2,521.14 | 47.98 | 2,507.10 | 33.94 |
| Other | 1,080.51 | 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 | 1,140.14 | 1,062.79 | (77.35) | 1,056.87 | (83.27) |
| **Substantive Staff** | **11,943.12** | **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** | **11,867.73** | **11,830.90** | **(36.83)** | **11,765.00** | **(102.73)** |
| **Total All Staff** | **12,797.19** | **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** | **12,560.74** | **12,590.90** | **30.16** | **12,505.00** | **(55.74)** |
| **% Temporary** | 6.67% | 6.74% | 5.83% | 5.60% | 5.94% | 5.89% | 5.42% | 6.00% | 5.65% | 5.52% | 5.52% | 6.04% | | 5.92% | |

2.6 December agency expenditure was £2.169m. This was £0.259m lower than November and £0.831m lower than in the equivalent period in 2023/24. It should be noted that when compared to the same period last year, the Trust has spent £4.7m less on agency to date and remains on course to deliver £6.8m of recurrent cip.

2.7 Medical agency in December was £1.418m (£0.304m lower than November). Vacancies continue to be the largest driver of agency usage and accounted for £1.141m (66%) 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 December, we are £2.209m above the cap. This variance has decreased by £0.065 in December. Clinical service groups continue to exercise rigorous controls on their agency use and usage is reviewed regularly by senior colleagues on a regular basis.

2.9 In addition to the effective controls in place to manage agency 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

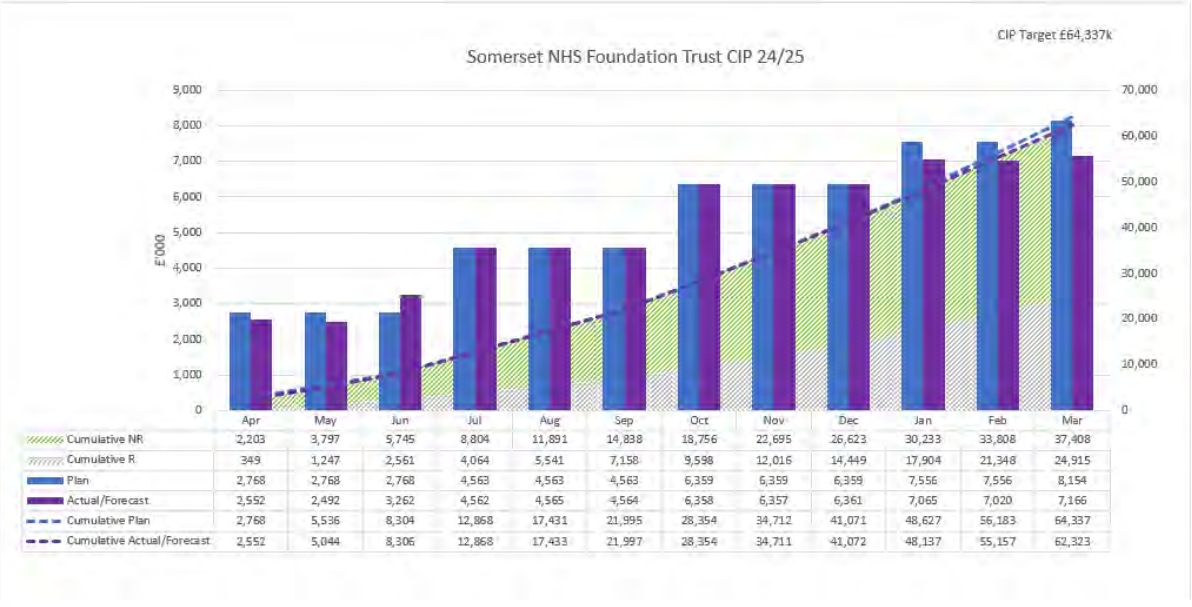
3.1 In December, savings of £6.359m were delivered. This was breakeven to plan. Recurrent savings formed £2.433m of the savings achieved (38%).

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 5% (November 6%) with a risk rating of red are largely all currently classified as non-recurring schemes. Low risk schemes are 87% (November 86%) and the remaining 8% medium (November 8%).

3.3 The level of savings achieved in month is reassuring, particularly as December 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

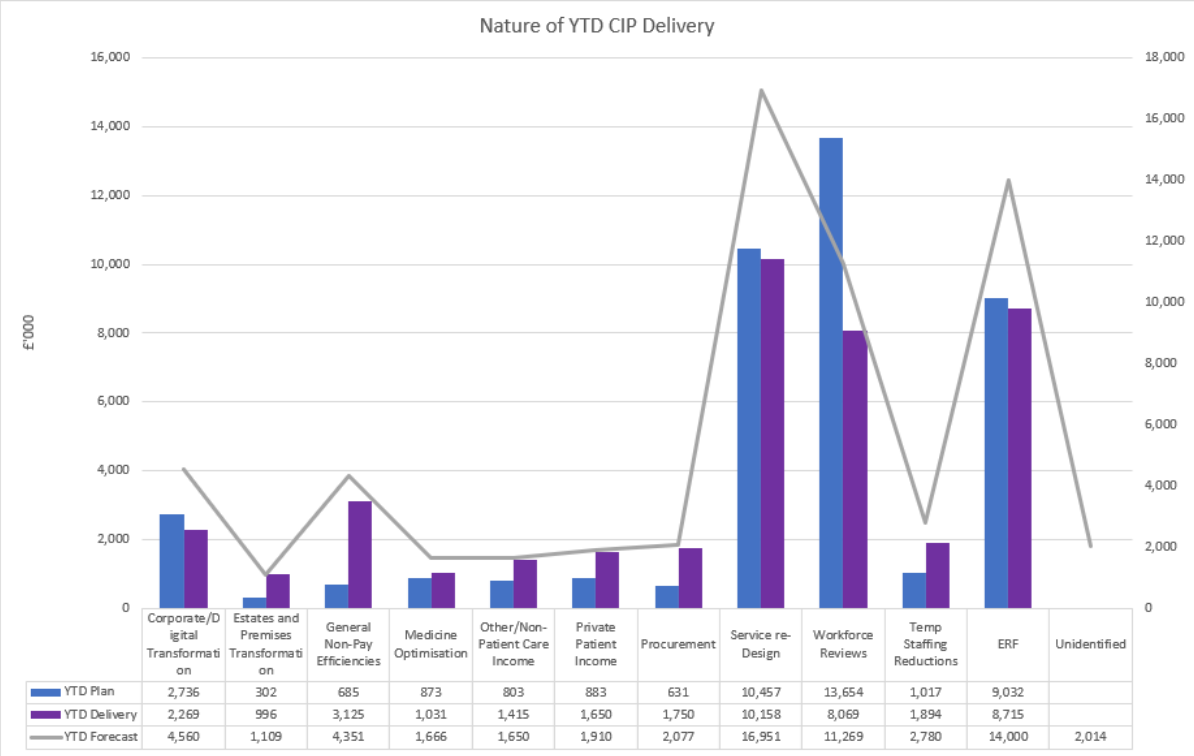



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cumulative NR | 2,203 | 3,797 | 5,745 | 8,804 | 11,891 | 14,838 | 18,756 | 22,695 | 26,623 | 30,233 | 33,808 | 37,408 |
| Cumulative R | 349 | 1,247 | 2,561 | 4,064 | 5,541 | 7,158 | 9,598 | 12,016 | 14,449 | 17,904 | 21,348 | 24,915 |
| 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 | 7,065 | 7,020 | 7,166 |
| 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 | 21,997 | 28,354 | 34,711 | 41,072 | 48,137 | 55,157 | 62,323 |

3.5 The nature of the efficiencies delivered through our cost improvement programme to date are summarised in the chart 2 below. A large element of the forecast savings are classified as service redesign; £16.951m.

Workforce reviews; £11.269m and general non-pay efficiencies; £4.351m are 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 | 2,736 | 302 | 685 | 873 | 803 | 883 | 631 | 10,457 | 13,654 | 1,017 | 9,032 | |
| YTD Delivery | 2,269 | 996 | 3,125 | 1,031 | 1,415 | 1,650 | 1,750 | 10,158 | 8,069 | 1,894 | 8,715 | |
| YTD Forecast | 4,560 | 1,109 | 4,351 | 1,666 | 1,650 | 1,910 | 2,077 | 16,951 | 11,269 | 2,780 | 14,000 | 2,014 |

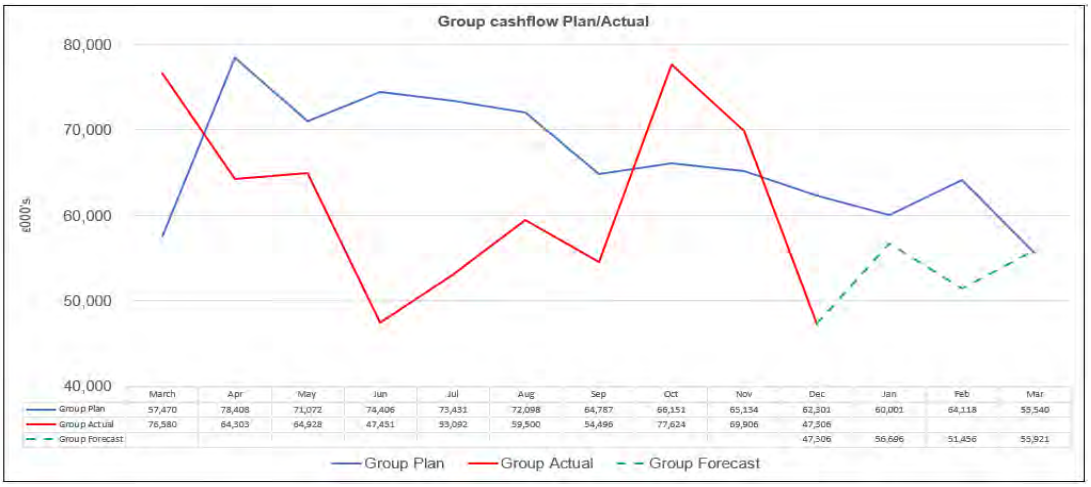
3.6 We continue to scope and identify further opportunities to close the gap, recognising also that the schemes already identified may not deliver in full. The level of unidentified savings has reduced again in December and is now c£2.0m an improvement of £0.3m since November.

## 4. CASH

4.1 Cash balances at 31 December were £47.306m; £14.995m lower than plan, this is primarily due to capital expenditure incurred in advance of PDC drawdown (£7.907m scheduled to be drawn down in January), £9.928m contract variations awaiting finalisation (including £8.82m for Elective recovery fund income) and timing differences in trade and other payables.

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

Chart 3: Cash flow Actual/Plan




## 5. STATEMENT OF FINANCIAL POSITION (BALANCE SHEET)

5.1 The movement in cash balances is due to capital expenditure incurred in advance of PDC drawdown (£7.907m scheduled to be drawn down in January), £9.928m contract variations awaiting finalisation (including £8.82m for Elective recovery fund) and timing differences in trade and other payables: non-capital.

5.2 Deferred income in-month movement is driven by £4.334m education income (including psychology students).

| Nov-24 | Dec-24 | Movement | | Mar-24 | Dec-24 | Movement in Year |
|---|---|---|---|---|---|---|
| £000 | £000 | £'000 | | £000 | £000 | £000 |
| 40,999 | 41,507 | 508 | Intangible Assets | 37,954 | 41,507 | 3,554 |
| 411,631 | 412,189 | 558 | Property, plant and equipment, other | 390,563 | 412,189 | 21,626 |
| 27,797 | 26,759 | (1,038) | On SoFP PFI assets | 28,360 | 26,759 | (1,602) |
| 81,903 | 81,232 | (671) | Right of use assets | 83,020 | 81,232 | (1,788) |
| 14 | 14 | 0 | Investments | 14 | 14 | (0) |
| 14 | 14 | 0 | Other investments/financial assets | 14 | 14 | 0 |
| 3,200 | 3,132 | (68) | Trade & other receivables >1yr | 2,957 | 3,132 | 175 |
| 565,559 | 564,847 | (712) | Non-current assets | 542,883 | 564,847 | 21,965 |
| 11,129 | 11,682 | 554 | Inventories | 11,005 | 11,682 | 677 |
| 24,994 | 24,586 | (408) | Trade and other receivables: NHS receivables | 7,081 | 24,586 | 17,505 |
| 25,980 | 29,080 | 3,100 | Trade and other receivables: non-NHS receivables | 24,932 | 29,080 | 4,148 |
| 466 | 466 | 0 | Non current assets held for sale | 466 | 466 | 0 |
| 69,906 | 47,306 | (22,600) | Cash | 76,580 | 47,306 | (29,274) |
| 132,475 | 113,120 | (19,355) | Total current assets | 120,064 | 113,120 | (6,943) |
| (110,598) | (101,231) | 9,366 | Trade and other payables: non-capital | (96,052) | (101,231) | (5,179) |
| (13,868) | (11,213) | 2,655 | Trade and other payables: capital | (14,419) | (11,213) | 3,207 |
| (30,045) | (25,009) | 5,037 | Deferred income | (16,340) | (25,009) | (8,669) |
| (17,427) | (17,050) | 376 | Borrowings | (14,364) | (17,050) | (2,687) |
| (5,292) | (4,706) | 587 | Provisions <1yr | (7,805) | (4,706) | 3,099 |
| (177,230) | (159,208) | 18,021 | Current liabilities | (148,980) | (159,208) | (10,228) |
| (44,756) | (46,088) | (1,334) | Net current assets | (28,916) | (46,088) | (17,172) |
| (107,406) | (104,412) | 2,994 | Borrowings >1yr | (111,977) | (104,412) | 7,565 |
| (4,607) | (4,607) | 0 | Provisions >1yr | (3,073) | (4,607) | (1,534) |
| (1,509) | (1,488) | 22 | Deferred income >1yr | (1,682) | (1,488) | 194 |
| (113,523) | (110,507) | 3,016 | Total long-term liabilities | (116,732) | (110,507) | 6,225 |
| 407,280 | 408,252 | 971 | Net assets employed | 397,234 | 408,252 | 11,018 |
| | | | **Financed by:** | | | |
| 383,329 | 383,329 | 0 | Public dividend capital | 363,752 | 383,329 | 19,577 |
| 77,897 | 77,897 | 0 | Revaluation reserve | 77,897 | 77,897 | 0 |
| 186 | (4,434) | (4,620) | Other reserves | (4,441) | (4,434) | 8 |
| (2,471) | (2,471) | 0 | Financial assets at FV through OCI reserve | (2,471) | (2,471) | 0 |
| (52,058) | (46,575) | 5,483 | I&E reserve | (38,050) | (46,575) | (8,524) |
| | | | **Other's equity** | | | |
| 397 | 505 | 109 | Non-controlling Interest | 548 | 505 | (42) |
| 407,280 | 408,252 | 971 | Total financed | 397,234 | 408,252 | 11,018 |

## 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 around backlog maintenance and IT (including digital and EHR) that continue to be reviewed ensuring spend is considered later in the programme.

6.2 Year to date, capital expenditure is £51.292m compared with the plan of £63.672m, resulting in an underspend of £12.381m, £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 as we are now in the winter period and may hinder the progress of 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** | **6,168** | **2,707** | **(3,460)** | **7,607** | **(1,006)** |
| **Essential Facilities Improvement Works** | **1,450** | **1,662** | **948** | **1,211** | **263** | **1,993** | **331** |
| **Service Redesign Enabling Works** | **3,920** | **3,983** | **2,673** | **3,023** | **351** | **5,184** | **1,201** |
| **Service Redesign Enabling Works - Major** | **8,660** | **7,660** | **3,028** | **554** | **(2,474)** | **7,426** | **(234)** |
| **Infrastructure** | **906** | **906** | **168** | **67** | **(101)** | **1,012** | **106** |
| **Rolling IT & Digital Development** | **13,519** | **13,202** | **9,566** | **5,494** | **(4,072)** | **12,148** | **(1,054)** |
| **Replacement Medical Equipment** | **5,550** | **5,550** | **3,898** | **1,632** | **(2,266)** | **6,195** | **645** |
| **Other** | **410** | **530** | **375** | **290** | **(85)** | **542** | **12** |
| **Total Internal Capital Envelope** | **43,523** | **42,106** | **26,823** | **14,978** | **(11,844)** | **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 | 17,261 | 22,774 | 5,513 | 24,631 | 0 |
| PDC NHP - MPH | 900 | 1,040 | 665 | 721 | 56 | 1,040 | 0 |
| PDC NHP Enabling | 1,137 | 1,137 | 1,137 | 848 | (289) | 1,137 | 0 |
| PDC Pathology Network | 222 | 100 | 82 | 77 | (5) | 200 | 100 |
| PDC Diagnostic Network | 733 | 855 | 478 | 74 | (404) | 0 | (855) |
| PDC Endoscopy - MPH | 549 | 549 | 139 | 352 | 213 | 549 | 0 |
| PDC Cyber Security | 0 | 55 | 0 | 0 | 0 | 55 | 0 |
| PFI Funded IFRIC 12 - SFT MES | 424 | 424 | 212 | 220 | 8 | 424 | 0 |
| Donated Acute MPH | 50 | 56 | 41 | 56 | 15 | 56 | 0 |
| PDC Tif - Elective Recovery/Theatre expansion | 4,076 | 4,076 | 2,275 | 3,455 | 1,180 | 4,076 | 0 |
| PFI Funded IFRIC 12 - YDH MES | 333 | 641 | 166 | 641 | 475 | 641 | 0 |
| Donated Salix (Slippage) | 0 | 1,777 | 0 | 328 | 328 | 2,000 | 223 |
| Donated Acute YDH Breast Unit | 1,000 | 1,256 | 887 | 1,266 | 379 | 1,265 | 9 |
| Donated YDH | 0 | 32 | 0 | 32 | 32 | 32 | 0 |
| PDC Yeovil CDC | 1,292 | 1,292 | 1,292 | 408 | (884) | 1,292 | 0 |
| PDC Somerset CYP Safe Spaces | 275 | 275 | 110 | 36 | (74) | 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 | 0 | 0 | 945 | (511) |
| **Total Additional Schemes** | **35,732** | **38,306** | **24,882** | **31,288** | **6,406** | **38,904** | **(523)** |
| IFRS Leases | 14,523 | 14,523 | 11,968 | 5,026 | (6,942) | 14,523 | 0 |
| **TOTAL TRUST PROGRAMME** | **93,778** | **94,935** | **63,672** | **51,292** | **(12,381)** | **95,533** | **(523)** |

6.5 The Board will be aware of the recent announcement following the review of the New Hospital Programme (NHP) to place the Musgrove Park Hospital scheme into Wave 2. This means that we would now expect to commence on-site construction between 2033 and 2035 and that we will need to pause further development of our scheme until 2030/31. At this point we will receive the necessary programme funding and support to enable us to develop a compliant scheme and the Strategic Outline Case. We are currently waiting for further clarity on how the costs incurred to date and any wind down costs will be managed.

## 7. CONCLUSION & 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 recent announcement to the delay to the Musgrove Park Hospital redevelopment to wave 2 of the NHP programme will be managed and the potential impact this may have on the financial performance of the Trust.

- Continue to close the 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. This now includes ensuring we can remain within the fixed ERF income envelope recently announced by NHSE.
- 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 December.

**CHIEF FINANCE OFFICER**

| Somerset NHS Foundation Trust | |
|---|---|
| **REPORT TO:** | Board of Directors |
| **REPORT TITLE:** | Assurance report from the Audit Committee meeting held on 15 January 2025 |
| **SPONSORING EXEC:** | Jade Renville, Director of Corporate Services |
| **REPORT BY:** | Ria Zandvliet, Secretary to the Trust |
| **PRESENTED BY:** | Paul Mapson, Chairman of the Audit Committee |
| **DATE:** | 4 February 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 Audit Committee meeting held on 15 January 2025 and the assurance received by the Committee. The meeting was conducted as a video conference call.<br><br>The Committee received assurance in relation to:<br><br>• Matters Arising – Terms of Reference discussion<br><br>• Internal Audit Escalation Assurance Report<br><br>• The Board Assurance Framework discussion<br><br>• The Corporate Risk Register, Risk Management Update and Risk Management Policy<br><br>• The Counter Fraud Progress Report and Recommendation Tracker<br><br>• The Internal Audit Progress Report<br><br>• The findings of the Capital Projects (Estates) Planning Audit<br><br>• The findings of the KFS – Charitable Funds Audit<br><br>• The findings of the People Strategy – Future Workforce Audit<br><br>• Positive and negative assurance in relation to the MIS Year 6 Review |

| | |
|---|---|
| | • The findings of the Procurement Audit follow up report<br>• The Internal Audit Follow Up report<br>• The discussion on the draft Internal Audit Plan 2025/26<br>• The External Audit Progress Report – planning for the 2024/26 accounts audit<br>• Losses and Special Payments<br>• Single Quotation/Tender Waiver Action Report<br>• The Terms of Reference Report<br><br>The Committee identified the following areas for follow up:<br><br>• The Corporate Risk Register – presentation of the 2025/26 risk appetite statement to the April 2025 Committee meeting and the outstanding decision in relation to mandating risk management training<br>• The Corporate Risk Register – the need for a strategic risk relating to the Somerset demographics<br>• The Counter Fraud Progress Report – the investigation into the validity of CVS by two colleagues<br>• People Strategy – Future Workforce Audit Report – the need for a Board level workforce discussion<br>• The findings of the Deterioration Patients (PEWS) Audit report<br><br>The Committee identified the following area to be reported to the Board or other committees:<br><br>• The Corporate Risk Register – the need for a strategic risk relating to the Somerset demographics<br>• People Strategy – Future Workforce Audit Report – the need for a Board level workforce discussion |

| Recommendation | The Board is asked to note the assurance and areas of concern identified by the Audit Committee. The Board is further asked to note the areas to be reported to the Board or to Committees. |
|---|---|

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

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

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<br><br>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<br>(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**

**AUDIT COMMITTEE MEETING HELD ON 15 JANUARY 2025**

## 1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 15 January 2025.

## 2. ASSURANCE RECEIVED

**Matter Arising - Terms of Reference**

2.1. The Committee discussed the reference to inviting senior officers to attend meetings as directed by the Audit Committee in view of the implementation of the escalation process. The Committee agreed to retain the authority of the Audit Committee to invite senior officers to the meetings and further agreed that duplication should be avoided as much as possible and that this reference was more relevant to inviting senior officers to meetings in the case of significant delays in implementing audit recommendations.

**Internal Audit Escalation Assurance Report**

2.2. The Committee received the report and noted that the escalation process had been initiated for the following audits: Frailty in Older People; Capital Projects (Estates) Planning; Deteriorating Patients – Paediatrics (PEWS); and Procurement Follow Up.

2.3. The Committee particularly discussed the frailty in older people report and noted the considerable pressure on the service, which had been further impacted by the bed and winter pressures. The Committee agreed that the underlying issues will need to be better understood and noted that the frailty service challenges will be raised at the Quality and Governance Assurance Committee.

**Board Assurance Framework**

2.4. The Committee discussed the Board Assurance Frameworks (BAF) and noted that the BAF will be presented to the November 2024 Board meeting.

2.5. The Committee recognised that the BAF was a high level document, that the strategic risks were unlikely to move significantly during the year and that it will be helpful to consider how to provide more information on actions being taken at lower levels.

2.6. The Committee noted that: recent deep dive into objectives had been undertaken at Committee level; some of the strategic objectives were wider system risks and mitigations actions were therefore limited to actions which could be taken by the trust; there was a need to differentiate between

risks to strategy and risk to current operations; the majority of controls and assurance levels had been rated green or amber whilst risk levels had remained red and that it was important to understand whether the actions had an impact on the risks, whether the actions were the right actions and whether further actions could be taken to mitigate the risk; system work was taking place but this work was not reflected in the BAF.

2.7. The Committee noted that risks were raised at service group level and that, in view of the scoring of the risk, the risk was not escalated to the corporate risk register. The concern was that if similar risks were raised in other service groups, there was no corporate oversight of these risks and the need for a compound higher scoring risk for escalation to the corporate risk register could be missed. The Committee further noted the work taking place with teams on risk profiling their service to be able to identify gaps in risks compared to central and corporate risks.

**Corporate Risk Register (CRR)**

2.8. The Committee received and discussed the report. The Committee noted the key themes; the high scoring corporate risk; and the mitigating actions taken.

2.9. The Committee further noted: the ongoing work with the subsidiaries; the work with GP practices to identify practice risks and uploading their risks onto Radar; the system work in relation to the development of a system risk management framework; the work with stakeholders on the development of the 2026/29 risk management strategy; and the need to ensure that the risk description reflected the actual risk.

**Risk Management Update**

2.10. The Committee noted that all risks had been transferred onto Radar and that a review of risks will be undertaken to ensure consistency and to avoid duplication.

2.11. The Committee received and noted the annual update and progress made.

**Risk Management Policy**

2.12. The Committee received the draft risk management policy which had previously been circulated for virtual approval. The Committee noted the changes to the policy.

**Counter Fraud Progress Report**

2.13. The Committee received the counter fraud progress report and noted the proactive work, investigations and performance against the functional standards.

2.14. The Committee noted the national recognition of the work of the Counter Fraud Manager on mandate invoicing fraud and the presentation of this work to a national fraud webinar.

2.15. The Committee noted the investigation into the attempt to divert a supplier payment of £3.2 million to a different bank account and complimented the finance team on the actions taken to avoid this fraud.

2.16. The Committee agreed that the report provided significant assurance about the work of the counter fraud service.

**Counter Fraud Recommendations Tracker**

2.17. The Committee received the counter fraud recommendations follow up report and the Committee agreed that the report provided significant assurance about the implementation of the recommendations. The Committee noted that there were no overdue recommendations.

**Internal Audit progress report**

2.18. The Committee received the internal audit progress report and agreed that good progress was being made implementing the internal audit plan with the field work underway for a further four reports and field work for three final audits commencing in January 2025.

**Capital Projects (Estates) Planning Audit Report**

2.19. The Committee received the audit report and noted the moderate opinion for design and a limited opinion for design effectiveness. The Committee noted that the report had been presented to the January 2025 Operational Leadership Team meeting. The Committee will monitor the implementation of the recommendations as part of the internal audit follow up report and progress will also be monitored by the Finance Committee.

**KFS – Charitable Funds Audit Report**

2.20. The Committee received the audit report and noted the moderate opinion for both design and design effectiveness. The Committee agreed that the report provided a good level of assurance.

**People Strategy – Future Workforce Audit Report**

2.21. The Committee received the audit report and noted the substantial opinion for design and a moderate opinion for design effectiveness. The Committee noted that workforce planning had been discussed in detail at the January 2025 People Committee meeting.

**MIS Year 6 Review**

2.22. The Committee received the audit report and noted that the audit did not provide an audit opinion. The Committee noted that the audit focussed on reviewing evidence for six out of the ten safety actions, in preparation for the annual submission, with t findings showing that the evidence for two of the safety actions did not meet the requirements. The Committee noted the findings and further noted that the report will be shared with the Quality and Governance Assurance Committee for further review and follow up.

**Procurement Audit Follow up Report**

2.23. The Committee received the audit report and noted that the audit was a follow up from a previous audit. The Committee noted that the findings showed significant progress made in relation to the implementation of the two high priority recommendations and the Audit Committee agreed to close the recommendations as having been completed.

**Follow up Report**

2.24. The Committee received the follow up report and noted the position in relation to the implementation of the 2023/24 and 2024/25 audit recommendations. The Committee noted that the implementation of two recommendations from 2023/24 were overdue and the details of these recommendations were noted.

2.25. The Committee agreed that there were no areas of significant concern.

**Draft Internal Audit Plan 2025/26 and Charter**

2.26. The Committee received the draft internal audit plan for 2025/26 and the internal audit charter.

2.27. The Committee discussed the report and recommended including an audit on the management of annual leave and sickness for medical staff in the audit plan. The Committee noted that the final version of the internal audit plan will be presented to the April 2025 Committee meeting.

**External Audit Progress Report – Initial Audit Consideration and Approach**

2.28. The Committee received the report and noted the work to date and the work scheduled over the next quarter, including the areas of focus for the 2024/25 accounts audit. The Committee noted that the land and building evaluation was due and that details of the valuation model and assumptions made will be shared with the Operational Leadership Team and the Finance Committee.

2.29. The Committee noted that the final external audit plan will be presented to the April 2025 Committee meeting.

**Losses and Special Payments**

2.30. The Committee received the losses and special payments report and noted the reasons for the losses and special payments.

2.31. The Committee agreed that the report did not highlight any areas of concern.

**Single Quotation/Tender Waiver Action report**

2.32. The Committee received the single quotation/tender waiver action report for the trust and for Simply Serve Limited and noted the single quotation and tender waiver actions and the reasons for these actions.

**Policy Changes/Updates/Statutory requirements**

2.33. The Committee noted that no policy changes or updates were to be brought to

the attention of the Committee. The Committee noted that the planning guidance for 2025/26 was still awaited.

**Terms of Reference Progress Report**

2.34. The Committee received the report which monitored progress against the Committee's Terms of Reference.

2.35. The Committee agreed that the report provided significant assurance about the work of the Committee but noted the need to consider including cyber security in the term of reference.

## 3. AREAS FOR FOLLOW UP

**Corporate Risk Register (CRR)**

3.1. The Committee received and discussed the report. The Committee noted the review of the 2025/26 risk appetite statement for discussion at the April 2025 Committee meeting.

3.2. The Committee received an update on risk management training and noted that approval from the Learning Committee about risk management training being assigned as mandated training was still awaited; that the delay in this approval had impacted on the delivery of the risk management strategy; and that it was expected that a decision will be made by the Learning Committee in February 2025.

3.3. The Committee discussed the frequent risk references over the last few years to an increase in demand and the need for additional staffing. The Committee highlighted the need to consider these risks in the context of demand and transformation and increasing productivity and noted that staffing establishment reviews were carried out for nursing and midwifery staff; that workforce planning took account of changing landscapes, including productivity requirements; that workforce numbers had flattened compared to the last few years; and that services were working on aligning workforce and adjusting roles in hard to recruit areas. The Committee further noted the need to reflect a strategic risk relating to the unique demographics of the population in Somerset and the impact on services and workforce.

**Counter Fraud Progress Report**

3.4. The Committee particularly discussed details of the investigation into the validity of CVs presented by two colleagues; the investigation findings; the management response; and noted the development of a Standard Operating Procedure setting out how individuals will be managed in these kinds of circumstances. The Committee asked for an update on the process and actions to be presented to the April 2025 Committee meeting.

**People Strategy – Future Workforce Audit Report**

3.5. The Committee highlighted the need for a strategic Board level discussion on the link between workforce and productivity but also on the wider

workforce planning in view of integration and transformation and agreed to escalate this to the Board as part of the assurance report.

**Deterioration Patients (PEWS) Audit Report**

3.6. The Committee received the audit report and noted the moderate opinion for design and a limited opinion for design effectiveness. The Committee expressed concern about the high priority risk, including the management response, and the Committee agreed to share the audit report with the Quality and Governance Assurance Committee for follow up.

3.7. The Committee further agreed to ask the Digital Committee to review the system issues.

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

4.1. The Committee identified the following issues to be reported to the Executive Team or other committees:

- 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

**CHAIRMAN OF THE AUDIT COMMITTEE**

| Somerset NHS Foundation Trust | |
|---|---|
| **REPORT TO:** | Board of Directors |
| **REPORT TITLE:** | Assurance Report from the Charity Committee meeting held on 21 October 2024 |
| **SPONSORING EXEC:** | David Shannon, Director of Strategy and Digital Development |
| **REPORT BY:** | Katie Fry, Executive PA |
| **PRESENTED BY:** | Graham Hughes, Chairman of the Charity Committee |
| **DATE:** | 4 February 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 21 October 2024.<br><br>The Committee received assurance in relation to:<br><br>• Annual accounts<br><br>• CCLA Investment Update<br><br>• Major donation and proposed projects<br><br>• Business cases 164, 171, 172, 173 and 175.<br><br>The Committee did not identify any areas of follow up.<br><br>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**<br>(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 21 OCTOBER 2024**

## 1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 21 October 2024, 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

### Annual Accounts

2.1. Fiona Westwood provided feedback on Monahans audit of the charities accounts.

2.2. Adjustments were identified and made to the initial draft of the accounts including correcting an error where income and expenditure were grossed up due to a billing mistake by SFT.

2.3. Adjustments were made to correctly identify and treat certain funds as restricted.

2.4. Full benefits of key management personnel must be disclosed. Graham Hughes asked to group additional personnel in this disclosure to avoid transparency issues.

2.5. The accounts were adopted as drawn, subject to the discussed adjustment regarding key management personnel.

### CCLA Investment Update

2.6. Daisy Mannifield attended for this item and provided an update.

2.7. Global equity markets have increased by 20% driven by factors such as artificial intelligence and technology.

2.8. The investment fund returned 12.55% for the year end to September with income around 2.7%.

2.9. There was a discussion regarding moving from the Investment Fund to the Ethical Investment Fund. This has more restricts but performance is slightly higher. There are 12 stocks difference, mainly relating to alcohol restriction.

### Major Donation

2.10. Potential projects to be funded by the major donation are still being proposed.

**Fundraising Report**

2.11. The Breast Cancer (Maple) Unit opening was a well-attended success.

2.12. There have been several successful fundraising events such as the first fire walk at Bridgwater Community Hospital and Cycle 42.

**Major Donation and Proposed Projects**

2.13. The charity has worked with the donors to determine how to use the funds. The donation will be allocated to four main parts:

- Wells Site Renovation
- Urology Project
- Gardens and Mental Health
- Flexible Allocation

2.14. The Committee supported the proposed allocation.

2.15. James Kirton introduced the idea of using part of the donation for small grants to support mental health initiatives.

2.16. The plans for the major donation will be discussed with ICB colleagues in the future.

**Finance Report and Approvals**

2.17. Income for quarter two was reported at £833,000. Expenditure for the quarter was £353,000.

2.18. The total funds in the charity now stand at £9.6m. £3.5m of this is committed, with another £2.4m allocated to the breast unit. This leaves £6.1m available, including the major donation of £2m previously mentioned.

2.19. Five business cases were reviewed and ratified (BC164, BC171, BC172, BC173, BC175).

## 3. AREAS OF CONCERN OR FOLLOW UP

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

## 4. 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**