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 6 May 2025** at **9.30am** at Minehead Community Hospital, Luttrell Way, Minehead, Somerset, TA24 6DF

If you are unable to attend, would you please notify David Seabrooke, Interim Trust Secretary by email david.seabrooke@somersetft.nhs.uk

Yours sincerely

DR RIMA MAKAREM
CHAIR

AGENDA

		Action	Presenter	Time	Enclosure
1.	**Welcome and Apologies for Absence**		Chair	09:30	Verbal
2.	**Questions from Members of the Public and Governors**		Chair		Verbal
3.	**Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 4 March 2025**	Approve	Chair		Enclosure 01
4.	**Action Logs and Matters Arising**	Review	Chair		Enclosure 02
5.	**Registers of Directors' Interests and Receive any Declarations of Interests relating to items on the agenda**	Note and receive	Chair		Enclosure 03
6.	**Chair's Remarks**	Note	Chair	09.40	Verbal
7.	**Chief Executive and Executive Directors' Report**	Receive	Peter Lewis	09:50	Enclosure 04
8.	**Q4 Risk Management, Assurance Framework and Corporate Risk Register**	Receive	Jade Renville	10.10	Enclosure 05

		Action	Presenter	Time	Enclosure
OBJECTIVE 6 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture					
9.	**Freedom to Speak up Guardian**	Receive	Caroline Sealey	10.20	Enclosure 06
10.	**Assurance Report from the People Committee meetings held on 14 January, 12 February (deep dive) and 18 March 2025**	Receive	Jan Hull	10.45	Enclosure 07
OBJECTIVE 2 – Provide the best care and support to people					
11.	**Patient Story: Personalised Care – Maternity** ***A post birth self-check in that offers early identification of pelvic health dysfunction, birth trauma and mental health concerns***	Receive	Melanie Iles/ Hayley Peters	10.50	
12.	**Quality and Performance Exception Report**	Receive	Pippa Moger	11.20	Enclosure 08
	Coffee Break			11.15	
13.	**Wellbeing Champion Report**	Receive	Graham Hughes	11.35	Enclosure 09
14.	**Six Monthly Safe Staffing Establishment Report**	Receive	Hayley Peters	11.45	Enclosure 10
15.	**Q4 Learning from Deaths Framework: Mortality Review progress Report**	Receive	Melanie Iles	12.00	Enclosure 11
16.	**Guardian of Safe Working for Junior Doctors Report**	Receive	Melanie Iles	12.15	Enclosure 12
17.	**Assurance Report of the Mental Health Act Committee meeting held on 11 March 2025**	Receive	Alex Priest	12.30	Enclosure 13
18.	**Assurance Report of the Quality and Governance Assurance Committee meetings held on 26 February and 26 March 2025**	Receive	Inga Kennedy	12.40	Enclosure 14
Lunch Break - 12.50 – 13.30					

		Action	Presenter	Time	Enclosure
OBJECTIVE 7: To live within our means and use our resources wisely					
19.	**Finance Report (M12)**	Receive	Pippa Moger	13.30	Enclosure 15
20.	**Revenue Budget 2025/26**	Approve	Pippa Moger	13.45	Enclosure 16
21.	**Amendments to Standing Financial Instructions and Standing Orders**	Approve	Pippa Moger	14.00	Reading Room
22.	**Going Concern Statement**	Approve	Pippa Moger	14.10	Enclosure 18
23.	**Assurance Report of the Audit Committee – 17 April 2025**	Receive	Paul Mapson	14:16	Enclosure 19
24.	**Verbal report from the Finance Committee meetings held on 31 March and 28 April 2025**	Receive	Martyn Scrivens	14.20	Enclosure 20a and 20b
FOR INFORMATION					
25.	**Follow-up questions from the Public and Governors**		Chairman	14.30	Verbal
26.	**Any other Business**		All		Verbal
27.	**Risks Identified**		All		Verbal
28.	**Evaluation of the Effectiveness of the Meeting**		Chairman		Verbal
29.	**Items to be discussed at the Confidential Board Meeting** Suspension and exclusion report Staff survey report; Wells Priory Refurbishment Symphony Healthcare Services Highlight Report Minutes of the Finance Committee meeting held on 31 March 2025				
30.	**Withdrawal of Press and Public** To move that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.				
31.	**Date of Next Public Meeting** Tuesday 1 July 2025 – Yeovil District Hospital				

PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 4 MARCH 2025 AT THE BOARDROOM AT YEOVIL DISTRICT HOSPITAL, HIGHER KINGSTON, YEOVIL, BA21 4AT

PRESENT

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

IN ATTENDANCE

Katy Darvall	Consultant Vascular Surgeon and Learning from Deaths Lead (for item 10 only)
Fiona Reid	Director of Communications
Ria Zandvliet	Secretary to the Trust

1. WELCOME AND APOLOGIES FOR ABSENCE

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

1.2. It was noted that no apologies had been received.

1.3. The Board noted that the number of voting Executive and Non-Executive Directors was the same and agreed that, if a vote is required, the Chair will use their second vote to ensure that Non-Executive Directors have a majority vote.

2. QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS

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

3. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 4 FEBRUARY 2025

3.1. The Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 4 February 2025 as a true and accurate record.

4. ACTION LOGS AND MATTERS ARISING

4.1. The Board received the action log and noted the progress in relation to the actions to review the content of the Board Assurance Framework; and the involvement of Non-Executive Directors in board rounds.

4.2. There were no matters arising from the minutes.

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

5.1. The Board received the Register of Directors' interests and noted that two changes to the register had been received:

- Inga Kennedy – to add "'Trustee of the White Ensign Association' (A registered Charity)"
- Martyn Scrivens – to remove "a member of the board of Wesleyan Bank Limited"

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

6. CHAIR'S REMARKS

6.1. The Chair provided an update on the recruitment process for new Non-Executive Directors: following a procurement exercise, a recruitment company had been appointed to support the recruitment process. A review of the job description and person specification was taking place; the recruitment process will be launched following Council of Governors' approval.

6.2. The Chair highlighted the changes at NHS England and it was noted that Jim Mackey had been appointed as interim Chief Executive following Amanda Pritchard's departure. In addition, Dr Penny Dash had been appointed as the new Chair of NHS England from 1 April 2025. Penny Dash's key areas of focus were on data, driving best practices across systems to improve the quality of care, particularly in acute services, and productivity.

6.3. The Chair commented that it will be important to ensure that productivity and performance against all business as usual metrics will be as good as possible. From her perspective, she will continue to push for transformation and population health.

6.4. The Chair further commented that an announcement had been made on 28 February 2025 that negotiations in relation to the GP contract had been concluded and that, as a result, the GP collective actions had been stopped. As part of the contract, a number of measures had been negotiated, including a register for patients with depression and schizophrenia, and cancer measures but it will be important to check that these measures do not impact on the work of the Trust.

6.5. The Chair advised that she will continue to raise the Trust's profile nationally and it was noted that Melanie Iles will be speaking at the HSJ conference in April and at a further conference in the autumn. She advised that trusts had been requested to submit bids for HSJ awards and she encouraged teams to submit bids as it was important to recognise the excellent work taking place within the Trust.

7. CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT

7.1. The Chief Executive presented the report which was received by the Board. The Chief Executive particularly highlighted the submission of the draft 2025/26 system plan to NHS England on 27 February 2025 and the feedback session to be held on 12 March 2025.

7.2. The Chief Executive further highlighted the Modern Slavery statement which was approved by the Board.

7.3. The Chief Executive provided an update on the GP collective actions and advised that 32 QOF indicators income protected in 2024/25 had been removed and that this income will be redistributed to other areas. The impact of these changes on the wider system will be reviewed. The Chief Executive advised that, although the GP collective actions had been stopped, not all issues raised by GPs related to the contract and GPs may decide to continue to stop providing some services which had previously been provided.

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

- The impact of the GP contract in relation to the provision of primary care mental health services was a concern. The impact will need to be reviewed to assess whether mitigating actions will need to be put in place.

- The content of the report will be amended from May 2025 and the main focus will be on feedback from the Operational Leadership Team meetings and other key issues to be raised with the Board.

- Three 100-day discharge sprints had been launched and the key areas of focus of these sprints were on: seven day a week board rounds; role clarity; and personalised care. The sprints were now in their second week and early data indicated that the 100-day discharge sprints were the right improvement projects to address internal delays. It was recognised that there always be elements of external delays but every effort will need to be made to ensure that internal processes were as robust as possible. The Chief Nurse

highlighted the support arrangements put in place and advised that data from the sprints will be monitored through the Operational Leadership Team.

The Chief Nurse highlighted the action to involve Non-Executive Directors (NEDs) in the board rounds and advised that NEDs will be involved after the teams have had more time to settle into the new processes.

- It was too early to assess what impact the changes at NHS England will have on individual trusts. The key issue will be NHSE's relationship with the Department of Health and Social Care (DoH). There will not likely be any changes to legislation but working relationship will be different and discussions were taking place about combining some teams across NSHE and the DoH.

- The diabetes care initiatives were welcomed, but it was queried whether the position in relation to diabetes care for children had improved as a result of these initiatives. The Chief Medical Officer advised that the Trust was still an outlier in relation to children's diabetes care at Musgrove Park Hospital (MPH). She advised that there had been an under-investment in the provision of insulin pumps for children and business cases for pumps had been submitted. The key issues related to the lack of commissioning of insulin pumps and children not starting on insulin pumps early enough. Other factors included the need for staffing and training to be able to support patients on pumps.

  The Chief Medical Officer advised that there was a health inequality aspect to diabetes care and that it was important to recognise the needs of children and adults in deprived areas.

8. OUR INCLUSIVE ORGANISATION PROGRESS REPORT

8.1. The Chief Executive presented the report setting out progress and next steps which was received by the Board.

8.2. The Chief Executive advised that the focus on inclusion had mainly been from a colleague perspective but it was recognised that consideration also needs to be given to the Board's own role in leading on inclusion. It was noted that time will be allocated for a more in-depth discussion on inclusion at the April 2025 Board development day and questions to be considered include: whether the Board is having the right conversations; and whether we are engaging and working with managers to help them to create the right environment in their teams and to give them confidence to lead on inclusion.

8.3. The Chief Executive further advised that Phil Brice's role will be to take forward inclusion work from a population perspective.

8.4. The Chief of People and Organisational Development commented that some of the inclusion indicators were going in the right direction but there remained challenges in

relation to colleagues with long term disabilities. She reiterated the need to focus on inclusion as a Board and to consider what "good" will look like.

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

- A risk had been included on the risk register relating to discrimination.
- Feedback from governors indicated that colleagues had been abused by members of the public on their way to work. In addition, a clinician had been racially abused in ED and the way this had been responded to, from the clinician's perspective, could have been better. It was key that leadership was visible and that colleagues were supported.
- It was queried how many patients had received letters advising that they will not be treated because of their behaviour. The Chief Executive commented that treatment may be withdrawn for different reasons and notifying patients may not always be via letter.
- Mental health services had a well established approach of involving the Police as early as possible and seeking to support prosecution. Injunctions had previously been used but this was easier in mental health services in view of the longer term relationships with patients. The Chief Operating Officer encouraged the use of the Police in all services which would be in line with the Trust's zero tolerance approach. The Chief Medical Officer highlighted an example of the Police being called to manage an aggressive patient in ED and a letter being issued to the patient.
- A thematic review of incidents was being undertaken by the security team and, following the review, consideration can be given whether colleagues can be provided with confidence building training to help them to manage difficult situations.
- The development session was welcomed. It was suggested going back to basics and be clear about: the difference between diversity and inclusion; what an inclusive culture means; and what the broader picture is. It was noted that Deloitte had published a report on inclusion and the report provided a broader view and asked tough questions. Jan Hull encouraged Board members to read the report.
- Harriet Jones was meeting with individual Board members prior to the development session and Inga Kennedy recommended that Board members read their paperwork provided by Harriet Jones prior to the discussion.
- Harriet Jones was developing an inclusion governance and accountability framework.

8.6. The Board approved the proposed next steps as outlined in the report.

9. QUALITY AND PERFORMANCE EXCEPTION REPORT

9.1. The Chief Finance Officer presented the report which was received by the Board. She highlighted the areas of good performance and provided an overview of the key performance challenges across the Trust. The Chief Finance Officer particularly highlighted: the addition of inclusion data relating to mental health services; the increase in the number of patients in acute beds not meeting the criteria to reside; the percentage of people waiting under six weeks for a diagnostic test; ambulance handover times; and the number of patients waiting 18 weeks or more to be seen by our community dental service.

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

- All mental health providers were required to collect inclusion data following the Manchester incident and changes to community treatment orders and the Mental Health Act. The Chief Finance Officer advised that data collection will need to be further improved and that a review of the initial data set will be undertaken to look at the profile of the population and service users to identify areas of disparity.

- The Yeovil Diagnostic Centre will be opening later in March 2025.

- The Mental Health Legislation Committee will be reviewing the Use of Force Legislation at its next meeting and will further consider what metrics to be put in place to monitor the use of isolation and exclusion. It was recognised that one patient can significantly influence the number of isolations and exclusions and the metrics will need to take account of the number of patients as well as the number of isolations and exclusions.

  Alex Priest commented that mental health performance was generally very good and complimented the teams on this performance. In view of this excellent performance, he queried the future direction of mental health services as a fully integrated trust.

  The Chief Operating Officer advised that successes should be celebrated but, in view of the integrated nature and configuration of the Trust, not all waits were visible to the Board, e.g. waits in community mental health services. There was further work to be done in mental health services, including on multi-disciplinary working and decision-making and this was an area of focus. In addition, it was also important to measure the therapeutic experience of being an inpatient on a mental health ward. A further emerging area nationally was neurodiversity and mental health issues and the actions to be taken will be further reviewed by the incoming mental health and learning disabilities service group director.

  The Chief Medical Officer advised that mental health inpatient wards had long length of stay and this will be further impacted by the lack of access to dementia services and the low dementia diagnostic rate in the South West. She acknowledged the presence of serious mental health illness in the

community and the work required in relation to multi-disciplinary working and the need to be able to track and monitor patients in the community.

The Chief Executive advised that conversations were taking place with the service group triumvirate about service strategies which will be further discussed at a future Board development day.

- It was queried whether services were as productive as they could be, e.g. community diagnostic services and career conversations. The Chief Finance Officer advised that overall waiting times performance at the Taunton Diagnostic Centre was good. The Director of Strategy and Digital Development advised that, from a performance perspective, all three contracts used by the Trust performed well. There was currently an issue in relation to the capacity to carry out complex investigations. There was a high level volume of activities which meant that any staffing issues can significantly impact on waiting times.

  It was noted that the opening of the Yeovil Diagnostic Centre will provide opportunities for pathways, e.g. audiology, and the reduction of waits for patients on those pathways.

- Appraisal indicators only monitored compliance and not the quality of appraisals. The Chief of People and Organisational Development advised that the staff survey results will provide data in relation to the value of appraisals but suggested that consideration should be given as to whether these indicators were the right indicators. The Chief of People and Organisational Development further advised that a large amount of data was available for triangulation which enabled areas for future focus to be identified. There was a high focus on career conversations but it was recognised that the target of 90% was difficult to achieve.

  The Chief Operating Officer commented that career conversations in the private sector were often linked to pay and bonuses and compliance with appraisals/career conversations was consequently less of an issue.

  The Chief Nurse highlighted the need to modernise the appraisal/career conversation approach and advised that one approach may not suit all age groups. She advised that one option could be to have team appraisals which would fit in with the productivity agenda.

  Martyn Scrivens commented that the uptake of appraisals/career conversations was also challenging in the private sector. He commented that it was important to also know how the appraisal felt to colleagues and that the nature of the discussion should be tailored. He stressed the need for qualitative measures.

- The improvements in dental waiting times were welcomed and it was queried whether additional dentists had been recruited. It was noted that creative recruitment solutions had been identified by the service manager and that

interviews for dentists were taking place. The service manager was complimented on this excellent achievement.

- The report covered community service waiting times but it was queried whether information on wider community and primary care services was available. The Chief Executive advised that there were not many indicators covering community services but felt that it was not possible for the report to cover all indicators. The Chief Operating Officer advised that there had been concerns about Hospital@Home services' activity levels but the position had improved and good progress was being made. He further advised that there were some areas of concerns, e.g. sickness absence in urgent treatment centres and staffing issues and this was being monitored.

  The Chair queried whether the Trust had set its own targets, e.g. how many patients the Hospital@Home service was able to treat and their transfer to hospital rate. The Chief Operating Officer advised that a Programme Board had been established to monitor performance and a comprehensive data set was available and being reviewed by the Programme Board to identify areas for focus. It was noted that some service groups had their own scorecard.

  The Chair agreed that it was not the intention for the report to cover all details, but felt that the report currently did not show any details. She queried how the Board was alerted to areas of concern in community and primary care services. She further advised that national metrics were very much acute focussed and reiterated the need to see a small number of metrics for primary care. The Director of Strategy and Digital Development advised that primary care services did not have reporting mechanisms and that work on developing waiting times metrics was taking place.

  It was noted that conversations about the information to be presented by Symphony Health Services to the Board were taking place.

9.3. The Chief Executive commented that the Board received data but did not see triangulation and that consideration will need to be given as to what information to present to the Board. Committees also did not receive detailed performance data across all services and functions. It was agreed that it was difficult to determine what the report was telling the Board for individual services and functions and it was felt that the data should be triangulated and that the report should include a clear narrative as to the conclusions of the triangulation.

9.4. The Board agreed to carry out a deep dive of community and primary care service performance at a future Board development day.

10. LEARNING FROM DEATHS FRAMEWORK: MORTALITY REVIEW PROGRESS REPORT

10.1. Katy Darvall joined the meeting via Teams for this agenda item.

10.2. Katy Darvall 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. She highlighted the key findings of the reviews and learning and themes identified.

10.3. 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.

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

- The launch of a new End of Life care plan alongside a package of training.

- The higher number of observed deaths due to acute bronchitis and the planned review of both coding data and patient level data.

- It was queried whether work was taking place with local hospices to help identifying when a patient is at their end of life and to provide them with the right support either at a hospice or at home. The Chief Nurse advised that the end of life dashboard monitored patient choice in terms of where they wished to die. In addition, a small number of metrics had been set up to measure the time to transfer a patient to their place of choice. The Chief Nurse further advised that the team was working closely with St Margaret's Hospice. The bed base for hospice care was low but processes had been transformed and community teams, district nurses and other multi-disciplinary teams were working alongside St Margaret's Hospice to support patients in the community.

- Concerns had been raised about some elements of care of a patient with severe pneumonia who sadly passed away and it was noted that learning from the investigation was taken forward by matrons across the trust. It was queried how assurance will be received that the ward concerned had changed its practices. The Chief Nurse commented that, in principle, any learning from deaths should be taken forward through the service group's governance meeting and an action plan should be developed and monitored at the governance meetings.

  Katy Darvall also agreed that the learning from deaths team was a small team and did not follow up on the learning actions itself. Learning was devolved to service groups, wards or departments and each service group had their own governance lead alongside matrons and organisational learning was fed back to the Mortality Surveillance Group. She further advised that learning was drawn out by the care of the elderly team through the structured judgment review and feedback was shared across the department and fed back to the learning from deaths leads.

  It was queried whether the Patient Safety Board will be looking at learning from deaths and actions being taken. The Chief Medical Officer advised that

the Patient Safety Board looked at wider patient safety issues in line with the Health Foundation Framework and national strategy for patient safety, and further looked at data, some of the PSIRF elements, and historic serious incidents but did not look in more detail in individual cases and learning.

It was recognised that assurance processes had improved significantly but it was felt that assurance about some of the individual cases was not as strong. The Chief Nurse agreed to check the processes followed in this specific case. **Action: Chief Nurse.**

- PEWS performance had been rated red in the scorecard for the last year and it was queried whether there were issues about processes. The Chief Nurse commented that the issues were complex as there was no single explanation for every ward and the issues had also been raised in the PEWS internal audit report. It was key to have a consistent approach to live documentation in real time followed by the timely escalation of sepsis etc. Real time information was however not being provided due to a lack of access to equipment. The Chief Nurse acknowledged that considerable work still needs to take place with colleagues as to why real time observations were critical to time care. The Board agreed that processes should work correctly before IT systems can be put in place.

  The Chief Medical Officer commented that uploading real time observations onto a fully digitalised system will avoid the need for additional manual activities and will further create automatic alerts in case of a need for escalation. The Director of Strategy and Digital Development advised that having different systems across different sites was not helpful and this reiterated the need for a single electronic health record.

  It was noted that PEWS data had not been available for some time and was now pending a review of the digital forum. Concerns were expressed about the delay producing this data. The Chief Finance Officer advised that it was not possible to obtain data until the national system had been reconfigured. The Chief Finance Officer agreed to check whether data can be made available. **Action**: Chief Finance Officer.

10.5. Katy Darvall left the meeting.

11. ASSURANCE REPORT OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING HELD ON 29 JANUARY 2025

11.1. Inga Kennedy presented the report which was received by the Board. It was noted that verbal feedback had been presented to the February 2025 Board meeting. Inga Kennedy highlighted the areas of assurance received and the areas of concern and follow up by the Committee.

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

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

11.3. Inga Kenney highlighted the agenda item discussed at the meeting held on 26 February 2025 and advised that the assurance report from the February 2025 meeting will be presented to the May 2025 Board meeting.

12. FINANCE REPORT

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

- The in-month surplus of £2.185 million which was in line with the plan for the month.
- The year to date deficit of £5.992 million which was breakeven to the plan.
- The in-month agency expenditure of £2.219 million which was £1.210 million below the plan and £0.109 million below the cap.
- The in-month delivery of the cost improvement programme of £7.556 million which was consistent with the plan.
- The year to date delivery of £58.522 million capital expenditure against a plan of £72.912 million.
- The in-month workforce position – 5 WTE (whole time equivalent) above the workforce cap trajectory and the expectation that the cap will be delivered by year end.
- The receipt of £8.9 million New Hospital Programme funding to cover the costs incurred to develop the NPH scheme and wind down costs. It was noted that this funding will be transacted through the month 11 returns to NHS England.

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

- The Trust's off framework agency usage was the second highest nationally in January and controls and processes for off-framework agency usage had been strengthened.
- £8 million of the capital underspend related to delays to the Yeovil Diagnostic build programme but it was noted that it was expected that the lease will be signed on 17 March 2025.
- Any unused capital funding cannot be rolled over into the next financial year and additional capital schemes had been identified and approved at the Finance Committee.

- Although it was possible to improve internal capital management and contingency processes, a large part of the capital programme was linked to national programmes, guidance or approval processes and any national delays impacted on local capital programmes, e.g. the delays in relation to the new theatre and new inpatient ward. On behalf of the Finance Committee, Martyn Scrivens expressed concerns that the need, year on year, to identify additional schemes to be able to deliver the capital envelope could result in un-prioritised schemes being delivered at the expense of prioritised schemes. It was noted that the Director of Strategy and Digital Development will be presenting a comparison of original spend and actual spend to the next Finance Committee meeting to provide the Committee with assurance that capital spend was appropriately prioritised.

- The capital work on the tower block at Yeovil District Hospital had been delayed due to regulations put in place following the Grenfell fire and it was stressed that a contingency plan will need to be developed in case of any delays in capital projects. The Director of Strategy and Digital Development provided an update and advised that the Trust had appealed to the Secretary of State for Levelling Up, Housing and Communities about the delays and progress was being made. The Chief Finance Officer commented that the legislation required appropriate resourcing and this related to the need for people with relevant experience, skills and training in the new regulations.

13. VERBAL REPORT FROM THE FINANCE COMMITTEE MEETING HELD ON 24 FEBRUARY 2025

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

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

14.1. Graham Hughes, Chairman of the Charity Committee, presented the report which was received by the Board. He highlighted the areas of assurance received and particularly highlighted the meeting with the cardiology department about the intended use for their accrued funds.

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

14.3. The Board discussed the report and noted that proposals for the use of the cardiology funds were being developed and will be presented to the next Charity Committee meeting.

15. FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS

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

16. ANY OTHER BUSINESS

16.1. The Chair advised that Ria Zandvliet will be leaving the Trust on 10 March 2025 and this was her last Board meeting. On behalf of the Board she thanked Ria for her excellent support to the Board over many years.

17. RISKS IDENTIFIED

17.1. The Board did not identify any new risks but reiterated the risk relation to the impact of the 2025/26 planning guidance; and the ongoing financial and performance pressures.

18. EVALUATION OF THE EFFECTIVENESS OF THE MEETING

18.1. The Board agreed that the meeting had been efficient and effective with detailed discussions and challenges. The Chair highlighted the need to discuss the length and content of future Board papers.

19. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

19.1. 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.

20. WITHDRAWAL OF PRESS AND PUBLIC

20.1. 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.

21. DATE FOR NEXT MEETING

21.1. 6 May 2025 at Minehead Community Hospital

SOMERSET NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETING

HELD ON 4 MARCH 2025

MINUTE	ACTION	BY WHOM	DUE DATE	PROGRESS
10. Learning from Deaths Framework	Check and confirm assurance arising from the review of the pneumonia case discussed	Chief Nurse	May 2025	HP and MI have looked at the case discussed in Board with the service group, we have identified areas to strengthen in terms of learning within and cross service groups. HP and MI meeting with teams 14/4/25
10. Learning from Deaths Framework	Ascertain the availability of PEWS data from the national system	Chief Finance Officer	May 2025	Work is underway to re-instate access to this information

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:	David Seabrooke, Interim Trust Secretary
PRESENTED BY:	Rima Makarem, Chair
DATE:	6 May 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 24 April 2025. The report has been updated to remove interests that have expired.
Recommendation	The Board is asked to: • Note the Register of Interests. • Declare any changes to the Register of Interests. • Declare any conflict of interests in relation to the agenda items.

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

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

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

Details: N/A
Equality and Inclusion **The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.** **How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?**
No impact on people with protected characteristics has been identified as part of the attached report.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.
Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Public or staff involvement or engagement has not been required for the attached report.

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

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

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

REGISTERS OF DIRECTORS' INTERESTS

NON EXECUTIVE DIRECTORS	
Rima Makarem Chairman	• Chair, Sue Ryder – non-remunerated • Chair, Queen Square Enterprises – remunerated • Lay member, General Pharmaceutical Council – remunerated
Jan Hull Non-Executive Director	• Trustee of the Dulverton Abbeyfield Society.
Alexander Priest Non-Executive Director	• Chief Executive Mind in Somerset
Martyn Scrivens Non-Executive Director (Deputy Chairman)	• Non Executive Director and Chair of Audit Committee of Hampshire Trust Bank Limited • Wife works as a Bank Vaccinator for the Trust ▪ Member of the Boards of Directors of the Ardonagh Group – consisting of the following companies: - Ardonagh Holdco Limited (Jersey) - Ardonagh New Midco 1 Limited (Jersey) - Ardonagh Group Holdings Limited (UK) - Ardonagh New Midco 3 Limited (Jersey) - Ardonagh Midco 1 Limited (Jersey) - Ardonagh Midco 2 plc (UK) - Ardonagh Midco 3 plc (UK) - Ardonagh Finco plc (UK) • Director of Ardonagh International Limited
Graham Hughes Non-Executive Director	• Chairman of Simply Serve Limited • Parish Councillor of Babcary Parish Council
Paul Mapson Non-Executive Director	Nothing to declare.
Inga Kennedy Non-Executive Director	• IJKennedy Healthcare Consultancy - Position - Director (however this Ltd Company is registered as not trading at this time.) • Trustee of the White Ensign Association

EXECUTIVE DIRECTORS	
Peter Lewis Chief Executive (CEO)	• Management Board Member, Somerset Estates Partnership (SEP) Board • Director, Somerset Estates Partnership Project Co Limited
Jade Renville	• Executive Director of Corporate Services, Somerset ICB Board • Chair, Richard Huish Multi-Academy Trust (voluntary capacity) • Father is Director and owner of Renvilles Costs Lawyers
Isobel Clements Chief of People and Organisational Development	• Sister in law works in the pharmacy department at MPH • Nephew works as a physio assistant within MPH. • Governor at Weston College
Andy Heron Chief Operating Officer/Deputy Chief Executive	• Wife works for Avon and Wiltshire Mental Health Partnership NHS Trust (and is involved in a sub contract for liaison and diversion services) • Director of the Shepton Mallet Health Partnership • Executive Director for SHS
Pippa Moger Chief Finance Officer	• Stepdaughter works at Yeovil District Hospital • Son works for the Trust • Director of the Shepton Mallet Health Partnership • Director of Somerset Estates Partnership Project Co Limited • Member of the Southwest Pathology Services (SPS) Board • Shareholder Director for SSL
Hayley Peters Chief Nurse	None to declare
David Shannon Director of Strategy and Digital Development	• Member of the Southwest Pathology Services (SPS) Board • Daughter is employed as a healthcare assistant at Musgrove Park Hospital • Member of the Symphony Health Care Services (SHS) Board • Director of Symphony Health Services (SHS) • Wife works within the Neighbourhood's Directorate.

	• Management Board Member, Somerset Estates Partnership (SEP) Board • Director Predictive Health Intelligence Ltd • Shareholder Director of SSL
Melanie Iles Chief Medical Officer	None to declare

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Chief Executive/Executive Director Report
SPONSORING EXEC:	Peter Lewis, Chief Executive
REPORT BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
PRESENTED BY:	Peter Lewis, Chief Executive
DATE:	6 May 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 information on national, regional, and local issues impacting on the organisation. It also updates 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.
Recommendation	The Board is asked to note the report.

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

- ☒ Aim 1 Contribute to improving the health and wellbeing of population and reducing health inequalities
- ☐ Aim 2 Provide the best care and support to people
- ☐ Aim 3 Strengthen care and support in local communities
- ☐ Aim 4 Respond well to complex needs
- ☐ Aim 5 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
- ☐ Aim 6 Live within our means and use our resources wisely
- ☐ Aim 7 Deliver the vision of the trust by transforming our services through innovation, research and digital transformation

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.

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)
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 BACKGROUND AND PURPOSE

1.1 This report provides information on national, regional, and local issues impacting on the organisation.

1.2 It also updates 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.

1.3 The following items require Board approval:

- Amendments to Standing Financial Instructions and Standing Orders
- NHS England Annual Self-Declaration – Condition 7

2 NATIONAL AND REGIONAL DEVELOPMENTS/POLICY UPDATES

NHS Operating Model

2.1 Over recent weeks, there have been several national announcements. NHS England is undergoing a significant transformation, with its functions being integrated into the Department of Health and Social Care (DHSC). As described within the announcements, this strategic move aims to streamline operations, reduce duplication of efforts, and enhance the overall efficiency of healthcare delivery.

2.2 As part of this transition, a new executive team, known as the NHS Transformation Executive Team, has been appointed to oversee the integration process. This team will ensure continuity in business priorities and statutory functions during the transition period.

2.3 Details of the full team are available here NHS England » NHS England names new executive team to lead transition. This new team leads to the Regional Director for the South West Region, Elizabeth O'Mahony is to take up role as Interim Chief Finance Officer. Elizabeth's Regional Director responsibilities will be covered by the current Regional Chief Nursing Officer, Sue Doheny.

2.4 The integration will likely result in substantial job cuts, with estimates suggesting that up to 50% of NHS England roles could be affected. This reduction is part of a broader effort to make better use of taxpayers' money

and eliminate inefficiencies within the system. Additionally, the Cabinet Office has initiated a review of arm's-length bodies (ALBs), meaning that these bodies may also be closed, merged, or have their functions brought back into departments.

Update from Sir Jim Mackey

2.5 At the start of the 2025/26 financial year, Sir Jim Mackey, Chief Executive of NHS England, published a letter addressed to trust chief executives and chairs and ICB chief executives and chairs.

2.6 The letter:

- Provides an update on the NHS's overall financial position going into 2025/26 and some immediate priorities for trust and ICB leaders.
- Signals a shift towards medium-term planning and greater transparency, including with funding allocations.
- Sets out the critical role ICBs will play in the future as strategic commissioners.
- Sets out the need to manage the challenge of reducing ICB costs by 50% carefully including maintaining or investing in areas such as strategic commissioning functions and look carefully at areas where there is duplication
- Says that ICBs are expected to create bottom-up plans that are affordable within the reduced running cost envelope – for sign off by the end of May – and implement the plan during Quarter 3.

2.7 For providers, the letter sets out a requirement for us to reduce our corporate cost growth since 2018/19 by 50% during Quarter 3 of this financial year.

2.8 We are continuing to work across our clinical and corporate services to respond to these challenges.

Planning Submission for 2025/26

2.9 On 30 January 2025, NHS England published the 2025/26 Priorities and Operational Planning Guidance, together with the detailed financial allocations for each Integrated Care System.

2.10 This confirms the national priorities for 2025/26 which are:

- Reduce the time people wait for elective care.
- Improve A&E waiting times and ambulance response times.
- Improve patients' access to general practice and improve access to urgent dental care.
- Improve patient flow through mental health crisis and acute pathways and improve access to children and young people's mental health services.

2.11 In delivering the national priorities systems are expected to:

- Drive the reform that will support delivery of the immediate priorities and ensure the NHS is fit for the future.
- Live within the budget allocated, reducing waste and improving productivity.
- Maintain collective focus on the overall quality and safety of services.

2.12 As part of the national submission, both the Trust and Somerset ICB submitted balanced plans. To deliver a balanced plan, it has been necessary to set a challenging efficiency programme for both the Trust and ICB. With regard to the performance targets, the financial plan will support the delivery of all key targets with the exception of Referral to Treatment 52-week wait compliance.

2.13 Whilst the final plan delivers a balanced financial position and achieves the majority of the key planning objectives, the challenging operational and financial context mean there are inherent risks to delivery. The are a number of risks that will require ongoing management and mitigation where possible. These will be monitored by system partners and reported to the Finance Committee.

3 CORPORATE UPDATES

Looking back over two years as one organisation

3.1 In April, it was two years since Yeovil District Hospital and Somerset NHS Foundation Trust became one merged trust, providing services from across community, mental health and learning disability services in the county and into Dorset, and services from both Yeovil District Hospital and Musgrove Park Hospital, and a quarter of Somerset's GP practices.

3.2 Over the last two years, teams have been working hard to merge processes, systems, teams and expertise to build a better way of working across the county. It has come with challenges and hurdles to overcome, but alongside those challenges, there have many benefits for our patients and local communities, as well as for own teams.

3.3 From making care more accessible with new services for ophthalmology clinics across Somerset, and transforming dermatology care, to easily sharing best practice and improvements across our sites – for example, how the success of total hip operations done as a day case has been expanded to all operating lists for this procedure.

3.4 We've gone further than even our own sites, with new ways of working collaboratively with external partners across the Somerset system in our

new transfer of care hub and care coordination hub – all with the aim of improving patient care.

3.5 The NHS is in a time of change, and our trust is too. But with our diverse skills across acute, community and mental health care, there's no end to the opportunities we have to improve care for patients in Somerset.

Interim Chief Nurse Appointment

3.6 Following the recent news that Hayley Peters, our current Chief Nurse, is leaving her role and joining Portsmouth and the Isle of Wight as Group Chief Nurse at the end of June, we have appointed Dave Thomas to the Interim Chief Nurse role. We extend our heartfelt thanks to Hayley for her exceptional service and contributions to our organisation. While we will have further opportunities to express our gratitude before she leaves, we wish her all the best in her new position.

3.7 Dave is currently our Director of Nursing Strategy and Transformation and will take up his new role from Monday, 23 June. We are assuming that Dave will remain in the post for approximately six months whilst we manage the recruitment process for the substantive Chief Nurse.

Board Inclusion Workshop

3.8 On 1 April 2025, the Board of Directors completed an inclusion workshop focused on "How the Board Can Lead on Inclusion." This workshop was a pivotal step in our ongoing commitment to fostering an inclusive culture within our organisation. The primary objective of the workshop was to equip the Board with the knowledge and tools necessary to lead on inclusion effectively. The session emphasised the importance of the Board's role in driving inclusive practices and setting the tone for the entire organisation.

3.9 During the workshop, Board members engaged in comprehensive discussions and activities designed to deepen their understanding of inclusion and its impact on organisational success. The workshop provided a platform for the Board to explore various aspects of inclusion, including the challenges and opportunities it presents.

3.10 A number of themes and areas for action were identified from this workshop, as outlined within the Action Plan attached as **Appendix A** to this report.

3.11 In addition, an inclusion board framework is in development. This will enable the Board to focus on setting the vision, leadership, governance, and assurance relating to inclusion.

Review of Strategic Aims and Priorities for 2025/26

3.12 During a recent Board Development Day, the Board of Directors conducted a thorough review of the organisation's Strategic Aims and Objectives for the 2025/26 year. This review was essential to ensure that our strategic direction aligns with our long-term vision and goals.

3.13 As a result of the review, the Board decided to combine two of the previous Strategic Aims (previously called Strategic Objectives). This decision was made to streamline our focus and enhance the effectiveness of our strategic initiatives. The consolidation of these objectives will allow for a more cohesive approach to achieving our organisational goals.

3.14 The review process led to the establishment of seven overall Strategic Aims for 2025/26. Under each of these Strategic Aims, a number of Objectives have been identified. These will guide our efforts throughout the year, ensuring that we remain focused on our mission and values. Progress against these Aims and Objectives will be monitored via a newly redeveloped Board Assurance Framework, which will begin to be used during Quarter 1.

3.15 The revised Aims are:

1 Contribute to improving the physical health and wellbeing of the population and reducing health inequalities
2 Provide the best care and support to people
3 Strengthen care and support in local communities
4 Respond well to complex needs
5 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
6 Live within our means and use our resources wisely
7 Deliver the vision of the trust by transforming our services through innovation, research and digital transformation.

3.16 Further information on the proposed Objectives is outlined within **Appendix B**. These Objectives would be reviewed to ensure they are SMART (Specific, Measurable, Achievable, Relevant, Time-bound) and will be reported via the BAF. The Objectives will also be reviewed against the NHS 10 Year Plan when published.

Amendments to Standing Financial Instructions and Standing Orders

1.1 Amendments are required to both the SFT Standing Financial Instructions (last approved 2024) and the Trust Standing Orders (version 12) to incorporate changes as a result of new public procurement laws.

Amendments proposed to Standing Financial Instructions

1.2 Point 12.4 Prepayments (page 29), third bullet point, removal of EU public procurement rules. Replaced with public procurement law.

Amendments proposed to Standing Orders

1.3 Annex 3, 1.2.1 (page 57) paragraph amended to remove reference to EU law and instead detail the Procurement Act 2023, The Provider Selection Regime and The Public Contracts Regulations 2015.

1.4 Annex 3, 1.19.1.4 (page 68) amended to state statutory provisions, rather than statutory provisions including those giving effect to EU Directives.

1.5 The Trust Board is asked to discuss and **approve** the proposed amendments.

NHS England Annual Self-Declaration – Condition 7

1.6 As part of its Provider Licence, the Trust is required to make one of the following statements:

EITHER

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources.

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

1.7 It is proposed to declare compliance with statement 3a which is in line with the Going Concern statement as presented to this meeting. The Board will be required to **approve** this compliance statement.

Use of the Corporate Seal

1.8 As outlined in the Standing Orders, there is a requirement to produce a quarterly report of sealings made by the Trust. The seal register entries over

the period 25 January 2025 to 31 March 2025 are set out in the attached **Appendix C**.

2 BOARD ASSURANCE UPDATES/REPORTS

Future Reporting of Assurance Reports

2.1 It is proposed that the future reporting of assurance reports to the Board will be addressed via this Executive Director report, following the relevant review and discussion at the Board assurance committee meetings. This approach aims to streamline the reporting process, ensuring that the Board receives comprehensive and timely updates on key issues and developments.

2.2 Under this new reporting structure, assurance reports will be summarised within the Executive Director report, highlighting critical findings, actions taken, and any significant outcomes. This summary will provide the Board with a clear and concise overview of the assurance activities, enabling informed decision-making and effective governance.

2.3 In cases where concerns or issues are identified during the committee meetings, the full assurance report will be presented to the Board for detailed review and discussion. This ensures that the Board remains fully informed and can address any potential risks or challenges promptly.

2.4 The proposed approach is designed to enhance the efficiency and effectiveness of our reporting processes, while maintaining transparency and accountability. By integrating assurance reporting into the Executive Director report, we aim to provide a more cohesive and streamlined flow of information to the Board.

3 COMMUNICATIONS UPDATES

Somerset FT in the news

3.1 **Hypnopal study -** Following a briefing to media, there was coverage about our nurse researcher Ana Maria-Toth's Hypnopal study, which looks at the effect of hypnosis pre and post surgery. Both Ana and a patient who took part in the hypnosis gave excellent interviews – well worth a listen. You can listen here (Patient Matthew and Ana-Maria Toth's interviews are 1.09:10 into programme).

3.2 **Somerset stroke care colleagues test pioneering nerve stimulation therapy -** Following a press release issued by the trust, there was coverage in the West Somerset Free Press and Apple FM website about how care and research colleagues at our trust have teamed up to test a pioneering new nerve stimulation therapy, in a bid to improve hand and arm weakness in

stroke survivors. The West Somerset Free Press article is here and Apple FM here.

3.3 **Somerset FT shares ePMA rollout and impact -** The Health Tech Newspaper recently spoke with colleagues from our digital team about the deployment its electronic prescribing and medicines administration system (ePMA) at the trust, highlighting benefits around increased efficiency and patient safety. Read more here.

3.4 **Eczema -** We were contacted by BBC Radio Somerset to field an interviewee to talk about eczema. Professor Alex Anstey, one of our consultant dermatologists, gave an interview on BBC Radio Somerset's mid-morning Simon Parkin show about all things eczema, and the interview also touched on improvements in our dermatology service. You can listen here (15:55 into programme).

3.5 **£90,000 grant for eye care at Musgrove Park Hospital -** Following a joint press release from the League of Friends at Musgrove Park Hospital and the trust, there was further coverage on the Apple FM website about how the 'Friends has given a grant of close to £90,000 to improve and expand eye treatments at the hospital with two new camera slit lamps. Read more here.

3.6 **Taunton GPs offering the most same-day appointments -** Coverage in the Somerset County Gazette about how Taunton GP surgeries saw 45% of patients for same-day appointments in February, NHS England data reveals. The Taunton area GP practice which carried out the highest percentage of same-day appointments was Lister House Surgery in Wiveliscombe (run by Symphony Healthcare Services). In February 2025, it saw 58% of patients (2,920) on the same day, 5% the next day (248), and 15% between two and seven days later (773). Read more here.

3.7 **Crewkerne Timebank initiative celebrates hours exchanged -** Coverage in the Chard and Ilminster News about a new initiative that has seen more than 250 hours exchanged between Crewkerne residents. The timebank was started by a Crewkerne GP who was concerned about patients who may be lonely. Crewkerne Health Centre has helped with the development of the scheme and the social prescribing link worker is the coordinator. Read more here.

Appendix 1

BOARD INCLUSION WORKSHOP ACTION PLAN

Themes from conversation and areas for action:

- Definitions:
  - We aren't clear on what we're aiming for and why – we need a shared understanding.
  - We need to identify clear measures and data sets to track progress.
  - We need to communicate our inclusion aims with our colleagues and with leaders – this enables accountability.
- Improved data:
  - The Board need to be asking for diversity and inclusion data to set expectations.
  - The Board need to know what data they are looking for, why, and how to use it. Practice asking different questions of the papers and data they see.
  - The data we provide to service groups needs to improve so that they can meet expectations. We need to ensure they have easy access to diversity and inclusion data.
  - We may need to prioritise and invest in improving our data – e.g. demographic collection and analysis for colleagues and for patients.
- EQIA:
  - Discussion indicated current process is not fit for purpose and not having the desired impact.
  - Current process comes at the end, rather than the start of a change process.
  - Current process doesn't influence the design of a change or inform decision making and approval of changes.

Framework theme	Gap / issue	Action	Timeframe	Responsibility
Vision	We don't have a consistent understanding or definition of what inclusion means to us at SFT	Develop a Board-level definition: - 1 paragraph - Specific to SFT - Clearly articulates why inclusion is important		
	We don't have a clear set of measures to know if we're making progress on inclusion	Once we have a definition, identify a small number of measures to identify a baseline, and identify targets for improvement. *What are we aiming for? Particular consideration is needed for patient experience and outcome data.*		
	Inclusion needs to be a 'golden thread' – not a stand-alone action.	Ensure inclusion is threaded through all aims and objectives. *E.g. how we use data to understand the problem and how we will measure impact*		
Leading by Example	Board members need to be asking different questions to set expectations around inclusion	*Identify how to support Board to do this. Ideas discussed –* - *Head of Inclusion to shadow Board and sub committees and provide feedback* - *External coaching?*		

	We aren't sure what skills we have on the Board to progress inclusion. Current skills matrix is not meeting need.	*Head of Inclusion has drafted a skills matrix – Board could use this as somewhere to start and develop?* *Need a mechanisms to allow Board to have open and honest conversations about their skills, areas for development, and skills gaps on the Board that need filling.* *Free up the Board to challenge the status quo and do things differently.*		
	We aren't clearly communicating with the organisation that inclusion is important, what we think that means, and why. This means we aren't setting clear expectations.	*Identify steps to do this well – develop plan with Director of Communications. Agreed we need consistent, clear, and ongoing communications on inclusion.*		
Accountability	Diversity and inclusion data is not routinely being provided on diversity and inclusion in papers to Board.	Improve the quality of data available so that it is easily available to include in papers. - Identify routine papers that should embed diversity and inclusion data. Use these as a test case. - *Discussion about whether we need to invest to improve our data quality and accessibility of data.*		

		- *Discussion on how we hold ICB to account on providing population diversity data.* - *Be brave and move away from regulatory data reporting – identify meaningful measures that a relevant of our context.*		
Assurance	EQIA is not fit for purpose	Review and re-design the EQIA process. - Learn from what has/hasn't worked for new People Impact Assessment which has been used in people services. - *Board would need to hold colleagues to account on providing a meaningful EQIA at the right time.*		

Appendix B

Proposed Strategic Aims and Objectives for 2025/26

Strategic Aim	Specific Objectives for 2025/26
1. Contribute to improving the health and wellbeing of the population and reducing health inequalities	1. Improve the physical health of mental health inpatients and community MH patients with SMI 2. Increase opportunities for self-referral/early diagnosis with a focus on areas with current lower access rates 3. Develop an innovative service for assessment, treatment and monitoring of adults with ADHD 4.
2. Provide the best care and support to people	1. Delivery of 2025/26 national priorities and success measures 2. Reduce the number of patients who no longer have a reason to reside in an acute bed to no more than 15% of the bed base
3. Strengthen care and support in local communities	1. Developing community response including care-co, virtual ward and Call before Convey 2. Fully implement the model of care between Somerset FT and Symphony in South Somerset West; test the outcomes and spread to other services in the county (a key part of Symphony strategy). 3. Make a range of currently acute-based services available within more accessible neighbourhood settings
4. Respond well to complex needs	1. Develop pathway for C&YP with complex health and care needs to avoid CAMHS tier 4 admission and minimise paediatric in-patient LOS 2. Improve transition from children's to adult services 3. Convert all TEPS (Treatment Escalation Plans) to digital format and make them available across all information systems via SIDER
5. Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture	1. Year 3 People Strategy priorities (LET, ER improvement programme): a) Learning, Education and Training Programme b) Reductions in disciplinaries, grievances and employment tribunals c) Reductions in sickness absence 2. Implement new model for people services function, including cost reduction

	3. Implement Inclusive Board governance framework (embed all aspects of EDI into board decision making) and ensure the board has the skills and experience to understand and address the needs of diverse communities
6. Live within our means and use our resources wisely	1. Deliver the 2025/26 financial plan and deliver the financial strategy and reduction in recurrent deficit 2. Drive up productivity across all 6 service groups via the productive care programme, including transformation and the deployment of new digital/AI based technologies 3. Estates strategy review to ensure capital funds are prioritised and national funding sources utilised where applicable in the context of the changed operating environment
7. Deliver the vision of the trust by transforming our services through innovation, research and digital transformation	1. Level up digital offer across our services – Digital medicines management and electronic documentation. 2. Conclude Full Business case for Electronic Health Record and appoint the preferred provider. 3. Develop our relationships with Medical Schools specifically the Biomedical Research Centre with Exeter University

Appendix C

SOMERSET NHS FOUNDATION TRUST - SEAL REGISTER

1 November 2024 – 31 March 2025

Date of Sealing	No. of Seal	Nature of Document	First Signatory	Second Signatory
07/11/2024	10	Licence to Occupy and Licence for Works – First Floor of Yeovil Diagnostic Centre	David Shannon	N/A
14/01/2025	11	Leases at Bartec 4 • Unit 8 • Unit 10a • Unit 12	David Shannon	Peter Lewis
21/02/2025	12	SFT Trust Underlease, SFT Reversionary Lease, InHealth Underlease and Plans (YDC)	David Shannon	Peter Lewis
18/02/2025	13	Sale of 22-23a Market Place, Frome – Transfer of whole Land Registry and Contract	Isobel Clements	Melanie Iles
19/02/2025	14	South Petherton Medical Centre Lease	David Shannon	Melanie Iles
18/03/2025	15	Rooftop Underlease – EE Limited – YDH	Pippa Moger	David Shannon
26/03/2025	16	SFT and InHealth agreement	David Shannon	Peter Lewis

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	2024/25 Q4 Board Assurance Framework
SPONSORING EXEC:	Jade Renville, Director of Corporate Services
REPORT BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
PRESENTED BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
DATE:	6 May 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 strategic objectives, which remain the long term aims for the newly merged organisation. 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. **The Board Assurance Framework (BAF)** An Assurance Framework has been developed to clearly 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. There has been a recent review and update to the Trust's Aims and Objectives, with a new version of the BAF in development. This will be presented to the Board Assurances Committees during Q1 2025/26. The highest risks to the strategic objectives are currently: • Access to primary care / increasing ED demand (objective 2) – 20 • Workforce shortages (objectives 2) – 20 • Age of acute and community estates (objective 2) - 20 • Vacancy rates within senior doctor workforce (objective 6) – 20 • Risk of 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 is asked to: • Review the Board Assurance Framework, note the actions being taken to address the risks identified and the ongoing redevelopment of the BAF.

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	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 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

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

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The report is presented to 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 Q4 BOARD ASSURANCE FRAMEWORK

1. PURPOSE OF THE REPORT

1.1 To present the 2024/25 Q4 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 There has been a recent review and update to the Trust's Aims and Objectives. This review was conducted to ensure that our strategic direction remains aligned with our mission and the evolving needs of our organisation. As part of this process, a new version of the Board Assurance Framework (BAF) is currently in development.

2.2 The new BAF will provide a robust framework for monitoring and managing risks, ensuring that we maintain high standards of governance and accountability.

2.3 The revised Aims and Objectives, along with the new BAF, will be presented to the Board Assurance Committees during Q1 2025/26.

2.4 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

2.5 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
- Age of acute and community estates (objective 2) - 20
- Vacancy rates within senior doctor 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
- 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 The Committee received and completed its regular review of the BAF on 29 January 2025 and 26 March 2025. The Committee also undertook a deep dive of Objective 4 – Reduce Inequalities on 26 February 2025.

4.3 These reviews included an analysis of the status, challenges faced, and progress made towards achieving the objectives. In addition, the Committee reviewed its Risk Appetite at the February meeting.

Finance Committee

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

People Committee

4.5 The People Committee reviews Objective 6 at each bi-monthly meeting. A review was completed in January 2025 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. A further review was completed in March 2025 where the recent NHS England announcements and financial climate were noted; this may have an impact on the associated risks against this objective.

Audit Committee

4.6 The Audit Committee received the BAF at the April 2025 meeting, where the progress with the development of the new BAF was noted, along with a review of the assurance and governance processes in place for the oversight and management of the BAF.

5. CONCLUSION

5.1 The Trust continues to carry a significant number of high strategic risks that are over and above the level of risk it is willing accept within its Risk Appetite Statement. There are also a number of objectives operating within the Risk Appetite Level with good progress being made on identified actions.

5.2 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.

5.3 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.

5.4 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.

5.5 As referenced at the beginning of this report, a review of Trust Aims and Objectives has been completed, with future iterations of the BAF report to be provide additional narrative and context against the identified objectives.

6. RECOMMENDATION

6.1 The Board of Directors is asked to review the Board Assurance Framework, note the actions being taken to address the risks identified, and the future amendments to the report as presented to the April 2025 Board Development Day.

DEPUTY DIRECTOR OF CORPORATE SERVICES

BOARD ASSURANCE FRAMEWORK SUMMARY

Quarter 4 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 A	Financial Management Open 12 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	5 ⇧	Diabetes: pats on hybrid closed loops	152 ⇧	Smoking status: acute IP	41.0% ⇩
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 ⇔	Years in good health (females)	65.7	Years in good health (males)	64.1

	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 St	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	64 ⇩	Patient Initiated follow up (PIFU)	7.6% ⇧	Ambulance handover hrs lost >15m	15332 ⇩
CDiff cases in inpatient settings: YTD	84 ⇩	Falls per 1000 days	5.6 ⇧	Pressure ulcers per 1000 bed days	1.32 ⇩
End of Life pat discharges <24hrs	0 ⇔	Acute Home Treatment caseload	84 ⇧	No criteria to reside: % of acute beds	27.5% ⇩

	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	Access to primary care / increasing ED demand	2620, 2615, 673, 372, 551, 1709	4	5	20	2	4	8
2	Shortfalls in Social Care capacity	2273 & 1513	4	4	16	4	3	12
3	Age of acute and community estates	1789	5	4	20	4	2	8
4	Workforce shortages	2044, 1815, 1880, 1944, 2306, 2307, 2	5	4	20	4	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	On Plan
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	574 ⇧	Pats admitted to Acute Home Treatmt	227 ⇩	Increase Open MH attendances	21354 ⇩
Increase numbers of self-referrals	27788 ⇩	Urgent Community response <2hrs	90.9% ⇧	Treatmt Escalatn Plans -pat/fam involv	62.0% ⇩

	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 part/full	#### ⇔	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 issue	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	96.4% ⇧	Reduce time in ED: intensity users	78952 ⇧	Time to assessment in CYPNP	79 wks ⇩
Av wait for assessment: adults w/ASD	71 wks ⇩	Homeless service: annual referrals	802 ⇧	Personalised care planning tbc	⇔
Dementia diagnosis rate-Symphony	52.6% ⇩	No criteria to reside: % of acute beds	27.5% ⇩		

	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	3	12	4	2	8
2	Personalised care doesn't get required focus	1952	4	2	8	3	2	6
3	LOS > 21 days due to insufficient intermediate care capacity	2273	4	4	16	4	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	89.0% ⇧	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	4	20	4	3	12
2	Retention rate for some colleague groups	1880	2	3	6	2	3	6
3	Systemic Discrimination	2770	4	4	16	3	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 - origin	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 ext	IC	Mar-25	Complete
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	Complete

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	47% ⇔	Agency v plan (YTD)	8060k fav ⇧
No criteria to reside: % of acute beds	27.5% ⇩	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 4 =	12	

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	561 ⇧	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

GREEN	AMBER	RED
Well functioning controls in place to manage risks and deliver objective	Some key controls in place, but may not cover all risks or elements of objective	Clear gaps in controls for management of risks and delivery of objective
Assurance available for key controls	Some assurances available, but may not cover all controls	Limited or no assurance available
Assurance is overall **positive**	Assurance is overall **neutral**	Assurance is overall **negative**
	Clear actions to address gaps in controls and/or assurances	Plan not sufficient to address gaps in controls and/or assurances

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:	Trust Board
REPORT TITLE:	Freedom to Speak Up Report
SPONSORING EXEC:	Isobel Clements
REPORT BY:	Caroline Sealey
PRESENTED BY:	Caroline Sealey
DATE:	23.04.25 for May 2025 Board

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

Executive Summary and Reason for presentation to Committee/Board	All organisations which regulate or provide NHS healthcare should implement the principles and actions set out in the report Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. This paper provides an update regarding FTSU activity in Somerset Foundation Trust (SFT) covering an overview for the year 2024 – 2025 and then in further detail for the period October 2024 – March 2025. It informs the Trust Board about the number of concerns received, the categories of the concerns, the professional background of the colleagues contacting the service and their demographics. It also outlines the themes of the concerns, the service progress and planned actions. A total of 412 cases were raised in 2024 / 2025 – an increase of 22% compared to the previous year. For the period Q3 and Q4 2024/25 a total of 215 cases were raised. This is an increase of 11% compared to the same period in 2023/24. Data collected demonstrates that most concerns in this period were raised by Nursing and Midwifery colleagues admin & clerical colleagues. A significant number of concerns (39%) contained an element of working safety or wellbeing.
Recommendation	The Board is asked to note and discuss the report

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

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

Equality The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics
☒ This report has been assessed against the Trust's People Impact Assessment Tool and there are no proposals or matters which affect any persons with 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

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)
Colleagues who have used the FTSU service are asked to provide feedback via an MS Forms survey. In addition, since April 24, we have started to collect feedback from managers / leaders who were involve in supporting resolution of a concern to sense check we are offering an impartial service and look at service improvement.

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The previous FTSU six monthly progress report was presented at the November 2024 Board Meeting. This paper has been presented to the Operational Leadership Team in April 2025.

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

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

SOMERSET NHS FOUNDATION TRUST

FREEDOM TO SPEAK UP REPORT

1. PURPOSE

1.1 To present an overview of the work of the Freedom to Speak Up (FTSU) Guardians including high level detail of the number of cases raised, a thematic analysis and any learning from these cases.

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

1.3 This paper covers the period of Q3 and Q4 2024-2025 in detail with a summary of the full annual data for 2024-25.

2. BACKGROUND

2.1 Following the publication of Sir Robert Francis KC's Freedom to Speak Up Report into the failings in Mid Staffordshire NHS Foundation Trust, the National Guardian's Office (NGO) and the role of the FTSU Guardian were created. It is a requirement that all providers of NHS services, including primary care, secondary care, Integrated Care Systems and the private sector, employ a FTSU Guardian. Their role is to ensure patient safety and colleague wellbeing by providing a mechanism for colleagues to speak up when they see or hear something that is not right. The FTSU Guardian also provides support to colleagues who raise concerns and supports the Board to develop a 'positive, compassionate, and inclusive' workplace culture in line with the vision set out in the NHS People Plan.

2.2 In addition, while the mission of the National Guardian's Office is to make speaking up business as usual in the NHS, the broader strategy is to effect cultural change.

2.3 The National network of FTSU Guardians continues to grow with over 1,200 Guardians in post. In response, to the growth and success of the role, the NGO has strengthened the training and support it provides Guardians in order to ensure they meet the needs of the workforce in this complex and wide-ranging role.

2.4 The FTSU model within Somerset Foundation Trust (SFT) consists of a full-time lead guardian (band 8a), Caroline Sealey, and a full-time guardian (band 6), Sarah Kerrigan, who has been in post since March 2024.

3. NATIONAL GUARDIAN'S OFFICE (NGO) UPDATE

3.1 The NGO leads, trains and supports a network of Freedom to Speak Up Guardians in England and conducts speaking up reviews to identify learning and support improvement of the speaking up culture of the healthcare sector.

Our vision: that speaking up is business as usual in the healthcare sector in England.

Our mission: to improve workplace cultures, ensuring workers are confident to speak up, by providing expert support, guidance and challenge.

3.2 In September 24, Dr Jayne Chidgey-Clark, National Guardian for the NHS, responded to Lord Darzi's report into the NHS stating that "Lord Darzi's diagnosis of the NHS chimes with the feedback we have heard from Freedom to Speak Up guardians":

3.3 The Speak Up Review by the NGO to understand the speaking up experiences of overseas trained workers has been extended and the report is now expected in the spring / summer 2025. The National Guardian is becoming increasingly concerned that the voices of overseas trained workers are not always being heard, and in some cases, are being silenced. She reports it is vital that these workers are listened to. The aim is to develop actionable recommendations out of the review to improve policies and practices, fostering a more inclusive and supportive Speak Up culture throughout healthcare. SFT have expressed interested in participating in this review.
[Speak Up Review into experiences of overseas-trained workers - National Guardian's Office](#).

3.4 In October 2024, the Patient Safety Commissioner for England launched the seven Patient Safety Principles, and these have been welcomed and endorsed by the NGO. In doing so they recognised the key role leaders have in fostering the right environment to ensure patient safety, quality and equity is at the heart of all healthcare.

3.4 In January 2025, the NGO published [Detriment Guidance](#) the aim of which is to support FTSU guardians, their organisations, and their leadership, to make speaking up business as usual by ensuring those who have spoken up are supported and to remove the barrier of fear of detriment that may prevent speaking up. In addition, they published [Employment Tribunals Fact Sheet](#) which supports guardians in their response when they are approached for information or attendance as a witness in connection with employment tribunal claims or similar proceedings.

3.5 National engagements from the NGO in 2024-25 include:

3.6 The NGO has over the past year improved the support and development for all Guardians and have introduced a revised training programme for new guardians. This has now been awarded continuing professional development accreditation.

3.7 On 6th March 2025, the annual report, Making Speaking Up business as usual, was laid before parliament. It highlights the work of both the Guardians and NGO and also shares learning which indicates that more work is needed for speaking up to be described as business as usual in the healthcare sector in England. It outlines the following annual data:

4. SFT FREEDOM TO SPEAK UP GUARDIAN ACTIVITY

4.1 **National Work –** The FTSU service continues to actively engage with the National Guardian's Office, including responding to surveys, timely submission of quarterly data returns and putting forwards ideas for future development of the Guardian role.

The Lead FTSUG attended a Mentor and Network Chair Meeting in London in February 25 to support and plan future national work, support a review of the IT systems and development guide and to be updated regarding the planned Information Governance guidance. The lead Guardian continues to be a National mentor and has mentored approximately 30 new Guardians.

Both FTSUG's also attended the National NGO Conference in March 2025 'Speaking Up – Changing Organisational Culture'. The agenda included talks on empowering a culture of speaking up, a look at 'Does civility saves lives?', panel discussions on why good teams matter and building an open and honest reporting culture, and a working group reviewing overing coming barriers to speaking up.

4.2 **Regional Work -** The FTSUGs attend Regional Network meetings and actively participate in driving the FTSU agenda forward. As an established and experienced service, guardians at SFT are often asked to provide advice and share best practice across the region. The lead guardian links regularly with the regional lead in order to provide peer support.

The FTSUGs are in regular contact with the Guardians in Dorset including a monthly meeting for peer support, to review and learn from complex cases, share best practice, and benchmark the service in order to push the speaking up agenda forward.

4.3 **Local Work** – The team are continuing to build on the progress achieved to date supporting the creation of a culture where every colleague, irrespective of role, feels safe to speak up. This proactive work includes:

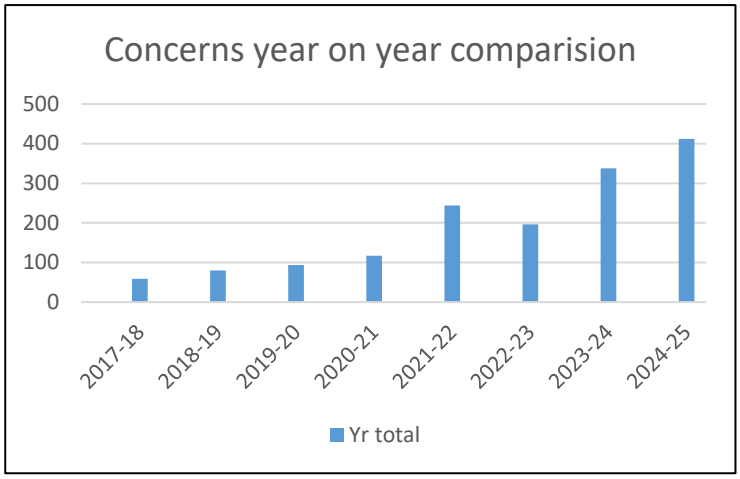
- Being visible in both acute hospitals and throughout the community sites as able, including supporting drop-in sessions and walkabouts.
- Triangulating information alongside HR Business partners, HR advisors, recruitment advisors and OD colleagues for each service group as well as liaising with senior leaders as appropriate. We are always reviewing and exploring ways to compare data sets to better understand if there are opportunities to improve colleague experiences.
- Review of the 'Champion' model that has seen recruitment of 10 FTSU Ambassadors within a voluntary role in line with the Freedom to Speak Up Champions and Ambassadors guidance. We continue to recruit to this role on a rolling basis.

- Continuing to develop our case management system hosted on Radar including an information dashboard. This work is now being recognised by other Trusts and we have been asked to 'showcase' the system on a number of occasions.
- Development and launch of the Speaking Up Exploration Tree - Our news - Introducing the Speaking Up Exploration Tree - the aim of which is to empower and encourage colleagues to voice their concerns and ideas at a local level initially whenever possible, which in turn often leads to a quicker and more effective solution.
- Ongoing delivery of training as part of various Trust programmes including Doctor Induction, Safety Days, Prepare to Care, Theatre Induction Programme and in response to local requests.
- Attending the Safety Action Group to allow triangulation of safety specific data and themes.
- Offering flexibility with our service hours to support colleagues working various shift patterns to speak up.
- Proactive working with services that have been identified as having challenges. This includes listening events and individual 'interviews' with information being shared back to the leadership team for review and action.
- Reaching out to areas of 'silence' and engaging with these colleagues to increase awareness and knowledge of the service.
- Attendance at the Patient Safey Roadshow in MPH and YDH.
- Review of the recommendations from the Too Hot to Handle? report.
- Supporting the CQC inspection of Children and Young People service group.
- Supporting a Schwartz round as a 'storyteller'.
- Continuous review and consideration of 'productivity and impact measures'.
- Review of the current intranet page in line with the Trusts implementation of a single intranet platform.

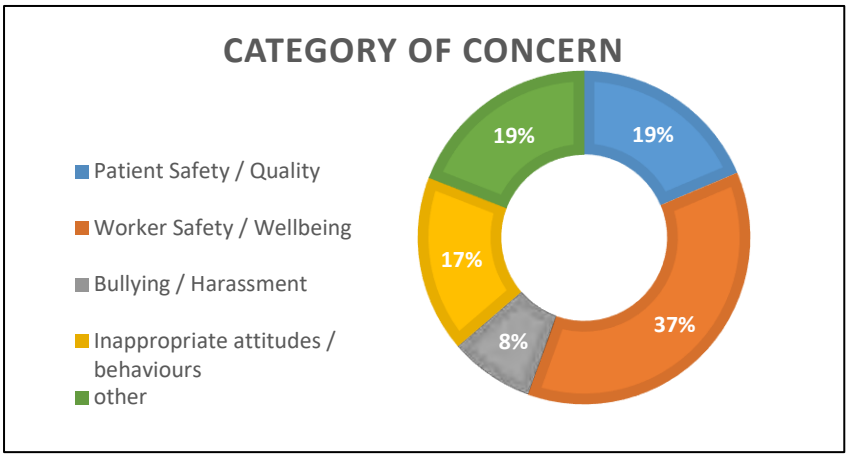
5 SUMMARY OF CONCERNS

5.1 Annual Data for 2024-25

The total number of concerns in 2024-25 was 412. This saw an increase of 22% compared to the previous year and a 252% increase over the past 5 years. The year-on-year comparison of total number of concerns is shown here:



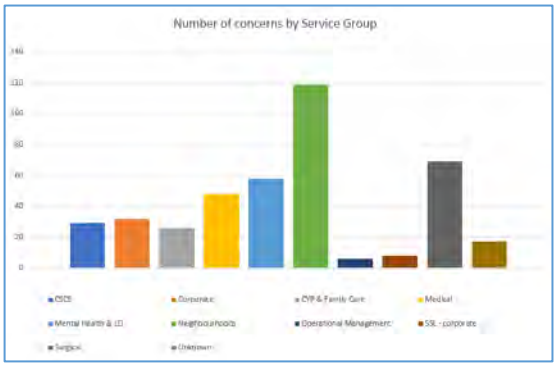
5.2 Concerns were recorded into the following categories as per [Recording Cases and Reporting Data (nationalguardian.org.uk)]:

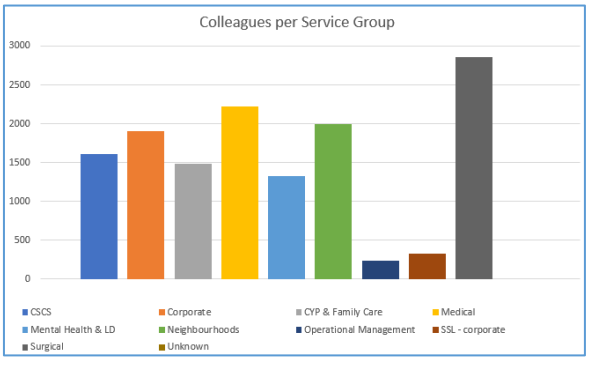


'Other' concerns include:

- Policy / procedure issues
- Lack of career progression
- Organisational change
- Contractual issues
- Car parking concerns
- Unfair recruitment
- Poor leadership
- Disparity in job role

5.3 The number of concerns raised per service group is shown below and, as a comparator, the number of colleagues per service group is as follows:





The apparent high number of concerns within the Neighbourhood service group is a result of the same concern being raised collectively by 35 colleagues and, in line with the NGO guidance, these have to be recorded as separate cases.

The number of concerns reported by the other services groups are in line with the headcount apart from both the Surgical and Mental Health / Learning Disability service groups where the numbers are lower than expected.

5.4 **Data for Q3 and Q4 2024/25** is detailed in the tables and graphs below. This data (excluding the service groups) has been mandated and submitted to the NGO in line with the reporting guidance Recording Cases and Reporting Data (nationalguardian.org.uk).

Table 1 Overview of Concerns

Quarter	Number of concerns raised	Number of concerns raise anonymously	Disadvantageous and / or demeaning treatment
Q3	89	6	3*
Q4	126	16	1**

*colleagues have not provided any further information and have not requested that this is reviewed
** this colleague suffered no detriment at the time of completing the survey but felt they might in the future

Table 2 Category of Concerns

Quarter	Number with an element of patient safety/ Quality*	Number of concerns with an element of worker safety or wellbeing*	Number with an element of bullying or Harassment*	Number with an element of inappropriate attitudes / behaviours*	Number of other concerns*
Q3	22	61	12**	27	23
Q4	55	97	11***	35	57

* Some concerns have elements that span multiple categories
**includes 2 sexual safety concerns
*** includes 1 sexual safety concern

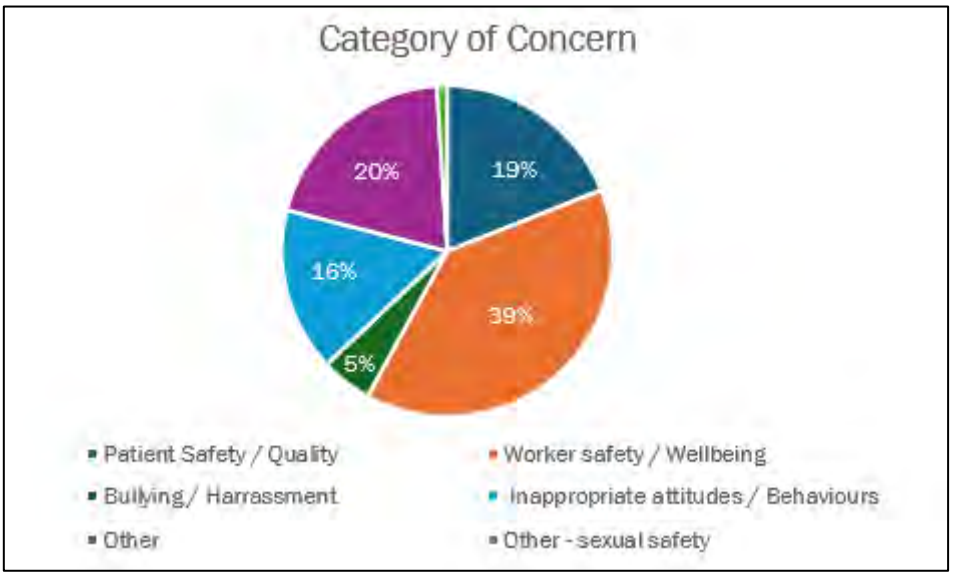
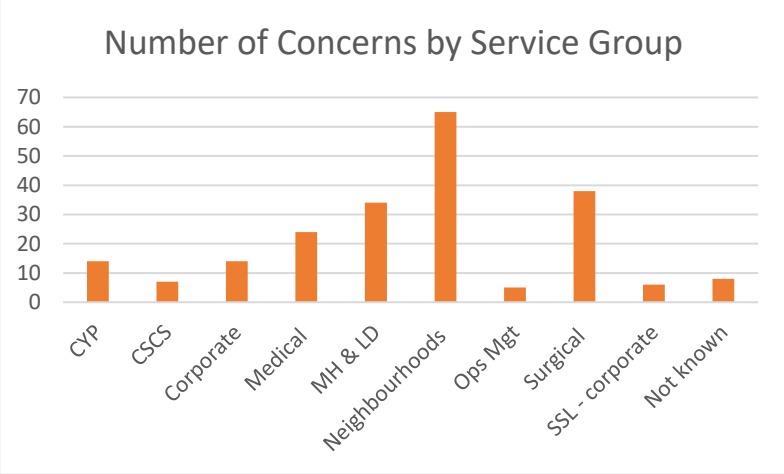


Table 3 Professional / Worker Group of colleagues speaking up:

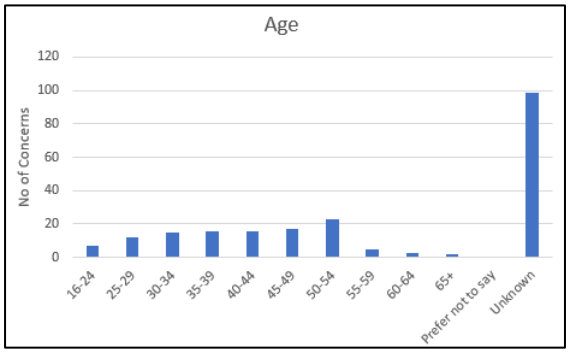
Professional / Worker Group	Q3	Q4	Totals
Additional clinical services	15	12	27
Additional professional scientific & technical	6	7	13
Admin and clerical	18	17	35
AHP's	4	7	11
Estates and ancillary	5	6	11
Healthcare scientists	1	3	4
Medical and dental	9	4	13
Nursing and midwifery - registered	28	58	86
Students	0	3	3
Other	0	0	0
Not Known	3	9	12
Totals	**89**	**126**	**215**

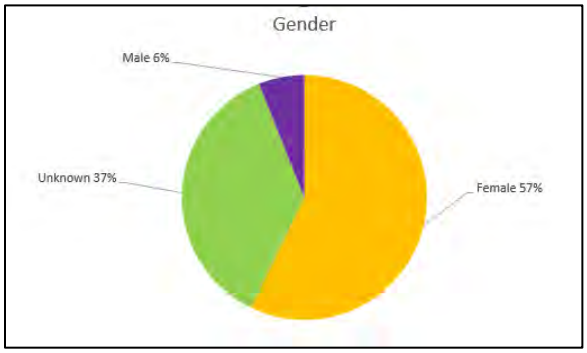
Number of concerns by service group:

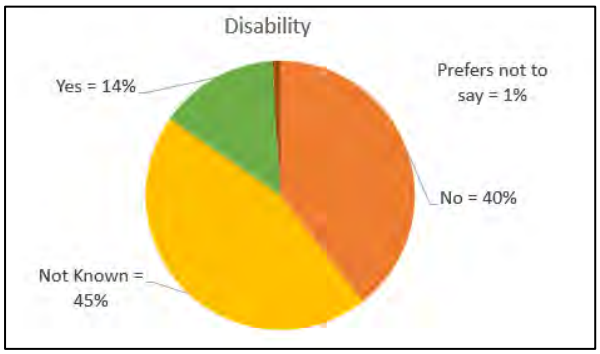
In Q3 and Q4, the reporting has increased within the Mental Health / Learning Disability service group and is in line with the headcount. Reporting within the Surgical directorate remains lower than expected and the spike in Neighbourhoods is as a result of the 'collective' concern outline in 5.3.

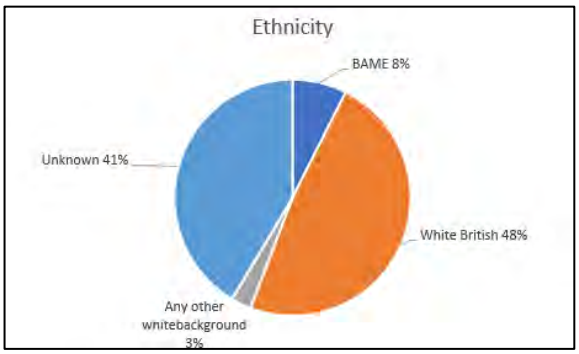


5.5 Demographic information of colleagues who raised concerns in Q3 and Q4 is as follows: NB the gaps in the data are largely attributed to the 'collective' concern raised by colleagues in the Neighbourhood service group who sadly failed to respond to requests for the information.

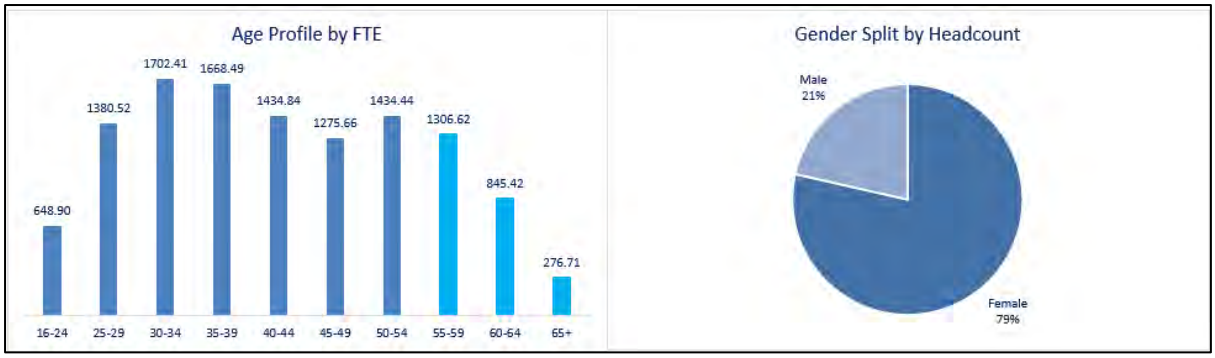




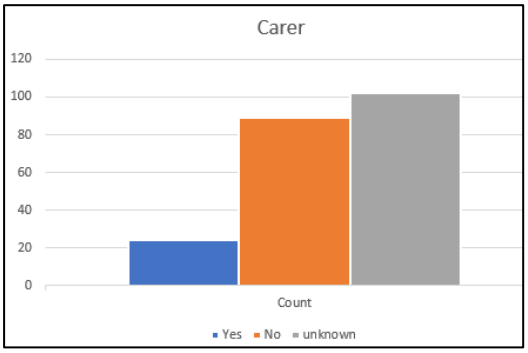


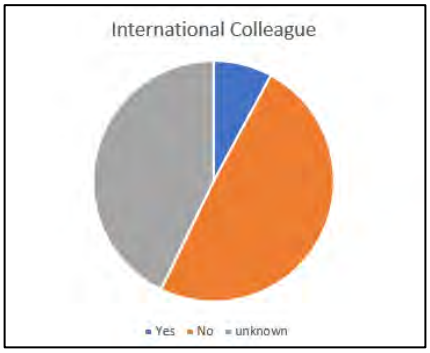


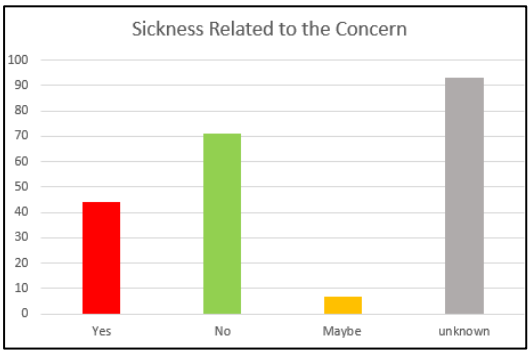
As a comparator, the SFT demographic information from the workforce statistics is as follows:

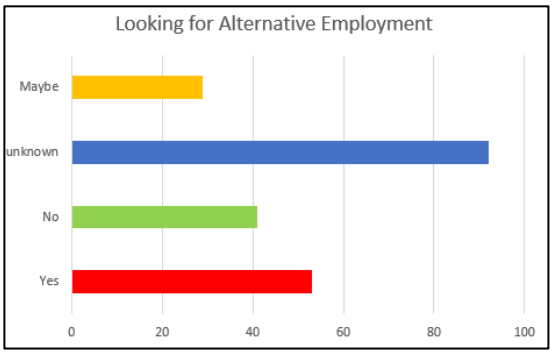


Additional demographic data collection is as follows:

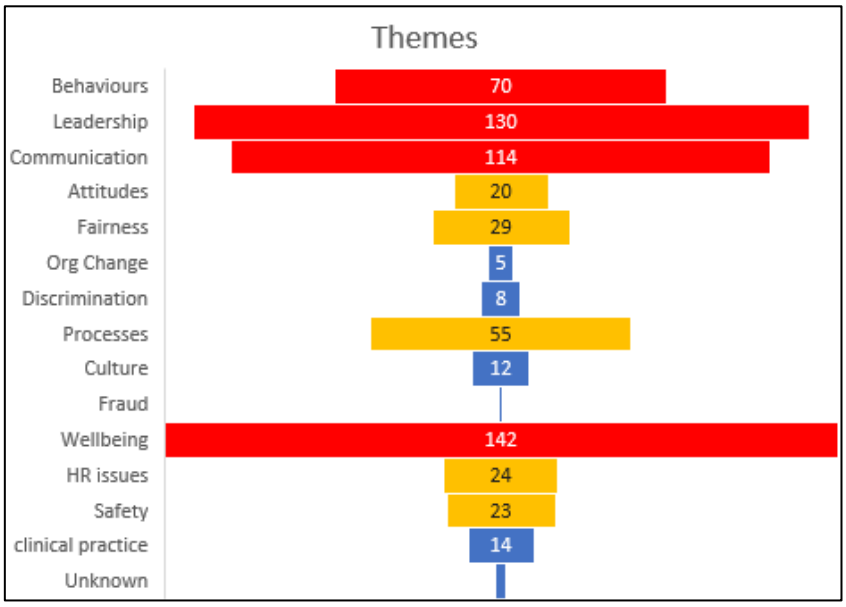








5.6 Themes from Q3 and Q4 are as follows:



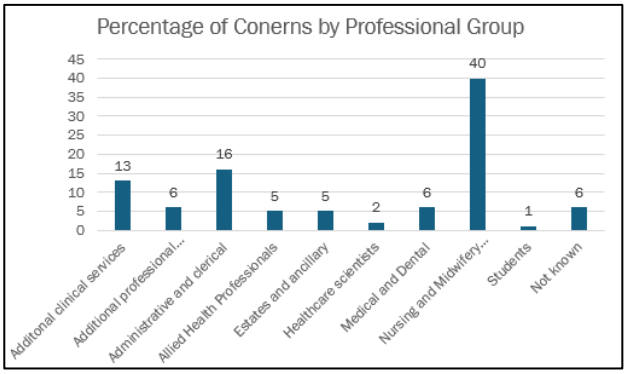
5.7 In line with service monitoring and standards, an audit of response times from point of first contact has been undertaken. The target is to respond to all concerns within 3 working days.

Quarter	Working Days taken to respond				
	0	1	2	3	3+
3 (89 concerns)	89 (100%)	-	-	-	-
4 (126 concerns)	126(100%)	-	-	-	-

6.0 ANALYSIS OF THE DATA

Local Data for Q3 and Q4 has shown:

- 9% increase in total reported cases from Q1- Q2 (2024-25) and an 11% increase in total reported cases from Q3 – Q4 (2023-24)
- 19% of cases raised this period contained an element of patient safety / quality compared to a total of 18% in Q1 – Q2 (2024-25)
- 5% of cases raised this period contained and element of bullying and harassment compared to a total of 11% in Q1 – Q2 (2024-25)
- 16% of cases raised in this period contained an element of inappropriate attitudes and behaviours compared to a total of 19% in Q1 – Q2 (2024-25).
- Combining concerns with an element of bullying and harassment with those containing an element of inappropriate attitudes and behaviours gives a total of 21% in this reporting period, a reduction of 9% compared to Q1-Q2 2024-25.
- 39% of concerns contained an element of worker safety or wellbeing compared to a total of 33% Q1-Q2 (2024-25).
- 1% of concerns raised related to sexual safety.
- 9% of cases were raised anonymously compared to a total of 13% in Q1– Q2 (2024-25).
- Wellbeing, (poor) leadership, communication and behaviours were the most common themes
- Disadvantageous and / or demeaning treatment as a result of speaking up has risen to almost 2%. No colleagues who claim such detriment have provided details to allow further investigation.
- 40% of concerns raised came from Nursing and Midwifery colleagues, 16% from Admin and Clerical, 15% from Additional Clinical Services, and 6% from both Allied Health Professionals and Medical & Dental Colleagues. 6% of concerns this period were raised by colleagues of unknown professional group.



7.0 TRAINING

7.1 'Speak Up' training has been mandated across the organisation for all colleagues since August 2021. Compliance up to end of Q4 2024/25 is as follows:

Service Group	Number to be Trained	Certified	Expiring	Percentage Trained Q4 Jan-Mar 2025	Percentage Trained Q3 Oct-Dec 2024	Increased/ Decreased from last report	Expired/ Training Required
Simply Serve	310	285	15	96.8%	98.4%	-1.6%	10
Corporate Support Services	1831	1630	112	95.1%	95.0%	0.1%	89
Neighbourhood Services	1866	1650	110	94.3%	95.4%	-1.1%	106
Clinical Support and Cancer Services	1498	1327	82	94.1%	93.2%	0.9%	89
Mental Health and Learning Disabilities	1234	1080	76	93.7%	93.8%	-0.1%	78
CYP & Families Services	1349	1187	68	93.0%	93.3%	-0.3%	94
Medical Services	2073	1843	84	93.0%	92.4%	0.6%	146
Surgical Services	2680	2331	146	92.4%	92.9%	-0.5%	203
Operational Management	220	186	12	90.0%	90.3%	-0.3%	22
Freedom to Speak Up for Quarter 4 January - March 2025 by Service Group (Excludes Bank and New Starters)	**13061**	**11519**	**705**	**93.6%**	**93.7%**	**-0.1%**	**837**
Freedom to Speak Up for Quarter 4 January - March 2025 by Service Group BANK STAFF (Excludes New Starters) ONLY	**2344**	**1151**	**91**	**53.0%**	**55.1%**	**-2.1%**	**1102**
Freedom to Speak Up for Quarter 4 January - March 2025 by Service Group ALL STAFF (Substantive, Bank and New Starters)	**15909**	**13050**	**808**	**87.1%**	**87.6%**	**-0.5%**	**2051**

Compliance rates for substantive colleagues is excellent at 93.6%. Apparent compliance rates for bank colleagues is significantly lower at 53.0% but this is in part due to incorrect mapping and the data cleanse with payroll is an ongoing process to address this.

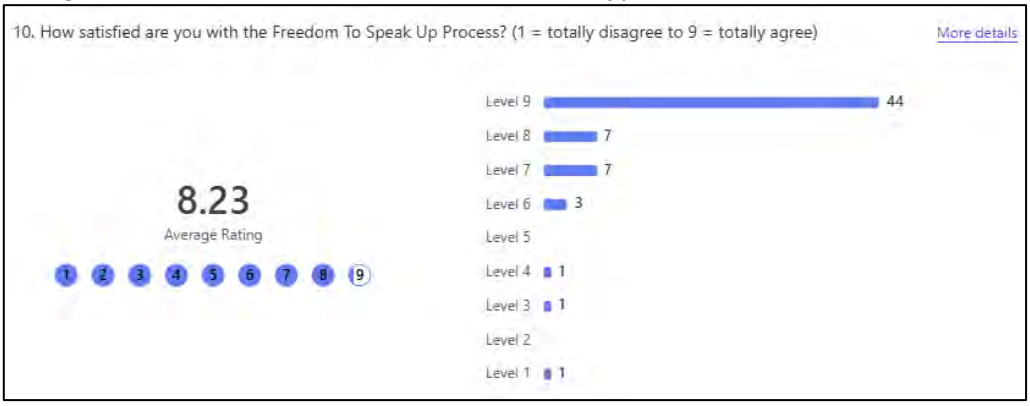
7.2 The 'Follow Up' module for colleagues at band 8a and above was launched in May 2023 for former SFT colleagues and July 2024 for former YDH colleagues and compliance as of end of Q4 2024/25 is as follows:

Service Group	Number to be Trained	Certified	Percentage Trained Q4 Jan-Mar 2025	Percentage Trained Q3 Oct-Dec 2024	Increased/ Decreased from last report	Expired/ Training Required
SSL Corporate	2	2	100.0%	100.0%	0.0%	
Corporate Support Services	207	192	92.8%	91.3%	1.5%	15
Neighbourhood Services	95	84	88.4%	88.3%	0.1%	11
Clinical Support and Cancer Services	207	179	86.5%	81.3%	5.2%	28
CYP & Families Services	143	120	83.9%	81.3%	2.6%	23
Surgical Services	265	218	82.3%	76.5%	5.8%	47
Mental Health and Learning Disabilities	106	87	82.1%	82.9%	-0.8%	19
Medical Services	144	114	79.2%	77.5%	1.7%	30
Operational Management	22	16	72.7%	75.0%	-2.3%	6
Freedom to Speak Up Follow Up Module for Quarter 4 January - March 2025 by Service Group (Excludes Bank and New Starters)	**1191**	**1012**	**85.0%**	**82.1%**	**2.9%**	**179**
Freedom to Speak Up Follow Up Module for Quarter 4 January - March 2025 by Service Group BANK STAFF (Excludes New Starters) ONLY	**85**	**17**	**20.0%**	**19.2%**	**0.8%**	**68**
Freedom to Speak Up Follow Up Module for Quarter 4 January - March 2025 by Service Group ALL STAFF (Substantive, Bank and New Starters)	**1304**	**1042**	**79.9%**	**77.5%**	**2.4%**	**262**

The later launch of the training for former YDH colleagues has resulted in compliance for this module currently being lower than the 'Speak Up' module.

8.0 FEEDBACK

8.1 Colleague satisfaction with the FTSU service for Q3 and Q4 is 8.23 out of 9. (This is a slight decrease from 8.39 reported previously):



Some colleagues who left a score of 6 and below are those who have been unhappy with the outcome (despite being coached that the outcome they were seeking was unrealistic). Some colleagues have provided (negative) feedback related to other services (including HR and recruitment) via the FTSU survey. One colleague left poor feedback after being advised we did not have availability to attend a team meeting with less than 72 hours notice.

8.2 The service collates feedback from service users and some of the feedback received is detailed below:

- Its great to have another persons point of view, as when confronted with situations, there is only so much that a person can take in.
- Helpful, approachable and confidential throughout. Not afraid to ask the questions needed.
- They gave me confidence that my concerns are actioned in a very professional manner.
- Although impartial, the guardian was very supportive, arranged meetings promptly, listened and always followed up after a meeting.
- They have been amazingly supportive and informative, which gave me the knowledge to be able to raise my concerns in a way that I was being listened to as opposed to it being brushed under the carpet again.
- I found the team to be fast, effective and professional. The concern was resolved in a satisfactory manner.
- Freedom to Speak up Guardian was so patient, kind, and really helped me through my concerns.
- More helpful than I was hoping for, lots of ideas... EMPATHY!!!!!... knowing I was being listened to and given the right things for ME not just my workplace issue "fixit"
- Very helpful. Felt listened to. Good to be able to raise concerns anonymously.
- I received a very prompt reply with helpful guidance on the next step I should take and the offer of support at the time and then a follow up to see if I needed anything else.
- Helpful and non judgemental, not afraid to ask the difficult questions.
- Having someone listen with no preconceptions about me has really helped me and improve my mood / wellbeing and given me back a little bit of self worth
- I felt well supported & that the guardians listened to my concerns, provided support & were very professional. A great asset to the Trust. Thank you.

8.3 Since the start of 2024/25, the service has been collecting feedback from leaders who have been involved in resolving a concern. Comments from Q3 – Q4 include:

- (The guardians) feedback has generated actions and learning for the team. I think the approach used at this site could be adapted across other sites
- Keen to sort out the problem, kind and reflective - recognised both sides of issue.
- Excellent communication and able to understand the nuances of the situation.
- (The guardian) provided a very balanced and supportive approach to concerns raised. She was great to work with, so a solution could be found, in this case it will take a while to see if this was effective. 'Your involvement certainly aided conversation and healthy challenge'.
- Thank you for all your support. You have really helped to identify some difficult issues and have been a pillar of support.
- Hugely impressed with the way that (the guardian) supported us all. It was a challenging situation but (the guardians) excellent communication skills, really helped.
- I have always found the team to be extremely supportive to all parties ensuring they listening equally to all. Having a neutral representative at conflict resolution meetings is helpful in the support and balance for all parties. I have always found the level of involvement from the team to be just right, so from my experience, I'm not sure there is anything to improve on.
- The FTSU Guardian approached me from a neutral perspective to discuss and understand issues that had been raised by a member of my team. In these circumstances I may have felt threatened as I was the one that the initial complaint was about. However, the FTSU Guardian actively sought to understand my perspective and explore any issues I may have, having already done the same with my team member. During our subsequent joint meeting with all

parties she managed to achieve a constant sense of neutrality whilst supporting and being actively helpful to all parties. As a result, we have found a way forward and tackled in the meeting some tricky issues that I was wary of tackling without a witness. She also helped me challenge my own practice leading me to reflect that going forward I would distinguish between a welfare meeting focussed on wellbeing alone and a supervision meeting which covered wellbeing, as this may help the other person understand the purpose of the meetings better and avoid misunderstanding.

8.4 Service improvement suggestions from colleagues include (FTSU response is outlined in green):

- I think there are lots of different ways to raise a concern. Potentially having a flow chart of 'have you tried' might be a helpful option. We have now developed and launched the Speaking Up Exploration Tree.
- More face to face availability. With 2 guardians covering the entire county this is an ongoing challenge but we remain as flexible as possible.
- It's slightly frustrating that once you've replied to a response (on the anonymous platform) that you can no longer see it / read it again. But this is very minor. We have worked with the developers to resolve this and made some other improvements to enhance the colleagues experience.
- Be more visible to managers so they know you are standing up for use Spicies (this is how a colleague with ADHD describes their condition) With 2 guardians covering the entire county this is an ongoing challenge but we remain as visible as possible.

9. SUMMARY OF LEARNING FROM SPEAKING UP

The majority of the concerns raised have resulted in some learning either on an individual, local or Trust level. A summary of this learning is described below:

- Trust process / guidance is not always followed, and it can be difficult to interpret. In addition, 'managers discretion' is open to interpretation and needs to be applied fairly.
- Clear, transparent and timely communication is vital.
- At times, incident reports need to be reviewed sooner, and actions completed.
- Apparent poor local leadership can result in concerns not being addressed and colleagues coming to FTSU.
- Some colleagues need to have their expectations managed earlier and at a local level
- Leadership needs to be consistent and collaborative.
- Leaders working with complex colleagues often need support themselves.
- Timely feedback to 'close the loop' is essential.
- Some colleagues still remain fearful of potential consequences to speaking up.
- Colleagues need to be aware of all routes to speaking up and consider local resolution initially.

11. RECOMMENDATION

11.1 The Board is asked to:

- Discuss for assurance trends and themes and approve this report
- Note the feedback that has been given from colleagues

Caroline Sealey, Lead FTSU Guardian

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the People Committee held on 14 January and 28 March 2025
SPONSORING EXEC:	Isobel Clements, Director of People and Organisational Development
REPORT BY:	David Seabrooke, Interim Trust Secretary
PRESENTED BY:	Jan Hull, Chair of People Committee
DATE:	6 May 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 Committee has discussed the challenge of meeting the national targets around agency use and job planning.
Recommendation	That the report be noted.

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

- ☒ Obj 1 Improve health and wellbeing of population
- ☒ Obj 2 Provide the best care and support to children and adults
- ☒ Obj 3 Strengthen care and support in local communities
- ☒ Obj 4 Reduce inequalities
- ☒ Obj 5 Respond well to complex needs
- ☒ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
- ☒ Obj 7 **Live within our means and use our resources wisely**
- ☒ Obj 8 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

Equality and Inclusion

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

How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
The needs and potential impacts on people with protected characteristics are considered by each individual service group as part of their update to the Committee. The Committee reviews data presented to the Committee and will raise any queries if required.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.
Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Staff involvement takes place through the regular service group and topic updates.

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

ASSURANCE REPORT FROM THE PEOPLE COMMITTEE MEETINGS HELD ON 14 JANUARY, 12 FEBRUARY, AND 28 MARCH 2025

1. PURPOSE

To advise the Board of the principal items considered by the Committee at its recent meetings, decisions made and actions initiated.

2. ASSURANCE RECEIVED

The recruitment team is transitioning to a managed service model, where the recruitment team will handle most of the administrative tasks, reducing the burden on hiring managers. This model is expected to improve efficiency and candidate experience.

The February meeting was principally a deep dive on consultant job planning and the staff survey results. Staff survey results have been analysed and work will continue to feedback to all staff groups alongside the national position comparisons.

The March meeting heard a positive staff story from a new starter from overseas.

On medical workforce the committee noted:

- The key areas of concern include Rheumatology, Gastroenterology, and Mental Health. There is the difficulty in attracting candidates and sometimes inflexible requirements from Trust departments
- The reduction in medical vacancies from 2024 vs 2025, showed an overall reduction from 93 to 65. Microbiology and Haematology have reduced the vacancies. Ongoing challenges are in specialties such as Rheumatology and Gastroenterology. There has also been positive work in Dentistry where there is significant recruitment issue nationally and currently the organisation doesn't have any vacancies.
- The GMC Sponsorship Scheme has been successful, particularly in Mental Health, with several Israeli Psychiatrists relocating. Dermatology has also benefited from the scheme, with a Dermatologist and their partner (a stroke consultant) relocating.
- The risk around senior doctors and long-standing vacancies was discussed, with a suggestion to review and potentially reduce the risk score as this is no longer a trust wide risk and sits within certain service groups.
- The risk related to trainee doctor vacancies has improved, with nearly 500 trainee doctors now in the Trust.
- In the year ahead, there is a target to reduce agency spend by 40%. Somerset does not use off framework agency for medical. Currently the Trust is just over the trajectory to meet the target, and it is an ambitious plan. Bank spend also needs to be reduced by 10%

Off Framework Agency

The areas with the highest off framework agency usage were Paediatrics, Neonates, A&E, and Critical Care. The Neonatal Unit at Musgrove is particularly affected, with a 25% vacancy level and high occupancy rates. It was noted that there is currently serious challenge within neonatal care and that significant creativity needs to be applied to the workplan.

People Strategy

Assurance was received on the progress of deliverables for year one and year two. The committee agreed on the proposed approach for year three, focusing on consolidation and measurement of current initiatives.

Recruitment

The committee received assurance on the significant improvements in recruitment systems and processes, including the alignment of the ledger, ESR, and recruitment systems.
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 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.

Other Assurances received

- The progress in reducing medical workforce agency spend, although there is still more work to be done.
- favourable medical education outcomes
- Off framework agency and assurance around the process applied and authorisation

3. AREAS OF CONCERN OR FOLLOW UP

There will be further consideration at the Operational Leadership Team meeting (OLT) going into 2025/26 of risks in the context of the financial framework and how to address issues particularly around the workforce cap. Further consideration will also be required from the Board sub committees.

Concerns were raised about the substantial number of medical vacancies and the effectiveness of recruitment strategies. It was noted that some vacancies are hard to fill, and there is a need to understand the short to medium-term impact on services. The committee acknowledged the ongoing risk related to medical recruitment and workforce.

NHS England have set out the following priorities for job planning:

- Year 1 - 95% of job plans signed off-by April 2025.
- Year 2 – Identify the variance between planned and actual activity. Job plans built on capacity and demand analysis.
- Year 3 – Multi-professional and multi-disciplinary service level job planning

It was noted that the Trust is currently at 50% compliance for job plans so the target will not be achieved by April 2025. The committee received assurance on the job planning platform which was included in the Chief of People Officer's report.

The Committee noted the need for the Board to become more engaged with the job planning process with an update to the Board later in the year.

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

The corporate risk register currently has 24 risks, with five scoring over 20. There has been discussion on the strategic and system-wide risk of a diminishing workforce against a rapidly growing population and this issue will be raised in the quarterly risk system meeting with the Integrated Care Board (ICB) and the Council. The retirement risk including the risk around retention is being reviewed and the organisation's appetite needs to be confirmed to score the risks and assess.

The Committee reviewed the risk appetite around Objective 6 and **recommends** that this be changed to "significant". The committee emphasises the need to continue robust management in this area.

The Committee **approved** the Fit & Proper Persons Policy and the Knowledge and Library Service Strategy.

5. BOARD ASSURANCE FRAMEWORK (BAF)

The Committee has conducted its Q3 and Q4 reviews of the Board Assurance Framework. There are no matters to bring to the Board's attention.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Quality and Performance Exception Report
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Lee Cornell, Associate Director – Planning and Performance Ian Clift, Senior Performance Manager Isobel Clements, Chief of People and Organisational Development Alison Wootton, Deputy Chief Nurse Xanthe Whittaker, Director of Elective Care
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	6 May 2025

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

Executive Summary and Reason for presentation to Committee/Board	Our Quality and Performance Exception Report sets out the key exceptions across a range of quality and performance measures, and the reasons for any significant changes or trends. Areas in which performance has been sustained or has notably improved include: • access to our perinatal service was significantly above the 10% national standard. • the percentage of patients followed up within 72 hours of discharge from our adult mental health wards remained above 90%. • the number of patients waiting 18 weeks or more from referral to be seen by our community services reduced. • compliance in respect of patients seen within two hours by our urgent community response service remained significantly above the national reporting standard.

	Areas in respect of which the contributory causes of, and actions to address, underperformance are set out in greater detail in this report include: • the percentage of people waiting under six weeks for a diagnostic test. • the percentage of ambulance handovers completed within 30 minutes of arrival at our Emergency Department. • the number of patients waiting 18 weeks or more to be seen by our community dental service.
Recommendation	The Board is asked to discuss and note the report.

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

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

Equality The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics
This report has been assessed against the Trust's People Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planned to mitigate any identified inequalities A range of key indicators, relating to waiting times for treatment including acute hospital services, cancer services, and mental health services, are routinely monitored to provide assurance that there is equity of provision and access in relation to people with protected characteristics. This includes standards delivered according to recorded ethnicity and learning disability. Our workforce measures also include indicators relating to ethnicity, gender and disability.

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
Not Applicable.

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

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

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	

SOMERSET NHS FOUNDATION TRUST

QUALITY AND PERFORMANCE EXCEPTION REPORT: MARCH 2025

1. BACKGROUND AND PURPOSE

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

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

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

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

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

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

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

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

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

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

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
• compliance remains high in respect of mental health inpatients receiving a follow-up within 72 hours of discharge. • the compliance level in respect of mandatory training remains high despite the operational challenges faced by services. • our mental health perinatal service continues to exceed the 10% national reporting standard. • patients waiting 18 weeks or more for one of our community services decreased. • compliance in respect of patient seen within two hours by our urgent community response team remained significantly above the national reporting standard.	• continue to support the health and wellbeing, both physically and psychologically, of colleagues across the Trust, as they continue to deliver high quality care to patients whilst managing significant and ongoing pressures associated backlogs arising from the time of the COVID-19 pandemic, and rising levels of demand. • continuing to restore and expand capacity above pre-COVID-19 levels, to address backlogs in routine elective work which has built-up. • work with the Somerset system to encourage continued referrals and presentations at hospital where needed and appropriate, especially in respect of urgent or emergency care.
Opportunities	**Risks and Threats**
• continue to progress the health and wellbeing plans for our colleagues at pace; this includes the psychological support offered alongside practical aspects of support such as accommodation provision and nutrition. • continue with new ways of working, particularly through the use of technology. • continue to adapt our recruitment practice, developing more innovative arrangements and reducing time to hire significantly. • develop reporting solutions to improve robustness of recording and reporting.	• delays in discharge of inpatients not meeting the criteria to reside and needing domiciliary care will result in further cancellations of surgery which will reduce our capacity to treat long waiting patients. • significantly increasing levels of demand, particularly for urgent care and mental health services, leading potentially to increased pressures on teams and longer waiting times. • sickness / absence presents a challenge for colleagues within some critical areas, and we need to ensure that we continue to support colleagues accordingly.

Safe

Infection Prevention and Control (IPC) performance is assessed by means of the numbers of key healthcare associated infections (HCAI) (Trust apportioned) against agreed thresholds. These are: MRSA bloodstream infections (BSI): zero tolerance, Clostridioides difficile (C. diff) infection (CDI): 91 cases, MSSA BSIs: 64, E. coli BSIs: 127 cases, Klebsiella BSIs: 51 Pseudomonas aeruginosa BSIs: 17.

Current performance (including factors affecting this)

- **MRSA:** No Trust-attributed MRSA bloodstream infections (BSIs) were reported in March 2025. The total number of cases for 2024/25 was four.
- **MSSA:** There were seven Trust-attributed MSSA BSIs reported in March 2025, bringing the total for 2024/25 to 77 against the internal threshold of 64.
- **E. coli**: There were 14 Trust-attributed E. coli BSIs reported in March 2025, bringing the total for 2024/25 to 124 against the threshold of 127.
- **Klebsiella:** There were seven Trust-attributed Klebsiella BSIs reported in March 2025, bringing the total for 2024/25 to 46 against the threshold of 51.
- **Pseudomonas:** There were no Trust-attributed Pseudomonas aeruginosa BSI reported in March 2025, bringing the total for 2024/25 to 14 against the threshold of 17.
- **C. diff**: There were four Trust-attributed cases reported in March 2025, bringing the total for 2024/25 to 90 against the threshold of 54.

Respiratory Viral Infections

- **COVID-19:** 43 inpatient cases of COVID-19 were identified during March 2025, of which 13 were healthcare-attributed.
- **Influenza:** 72 inpatient cases were identified during March 2025; the majority were 'Flu A.
- **Respiratory syncytial virus (RSV):** 30 inpatient cases of RSV were identified during March 2025.

Outbreaks

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

Surgical Site Infections – Data as of February 2025 (the latest data available)

Hip Replacement

- MPH rate of infection = 0%
- YDH rate of infection = 0.53%

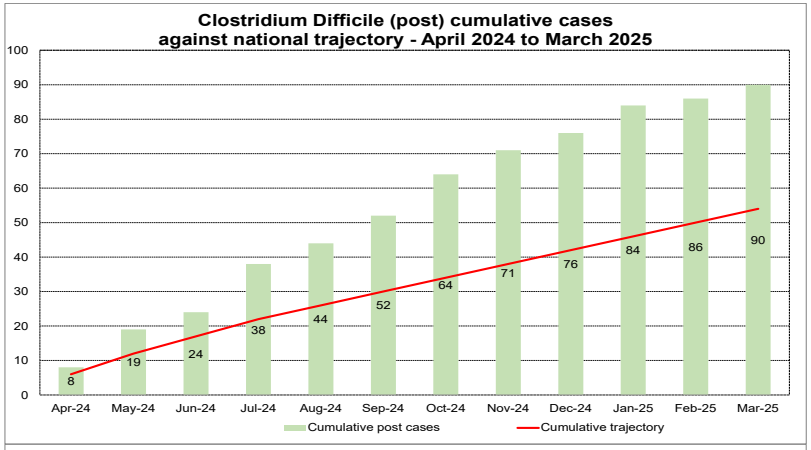
Knee Replacement

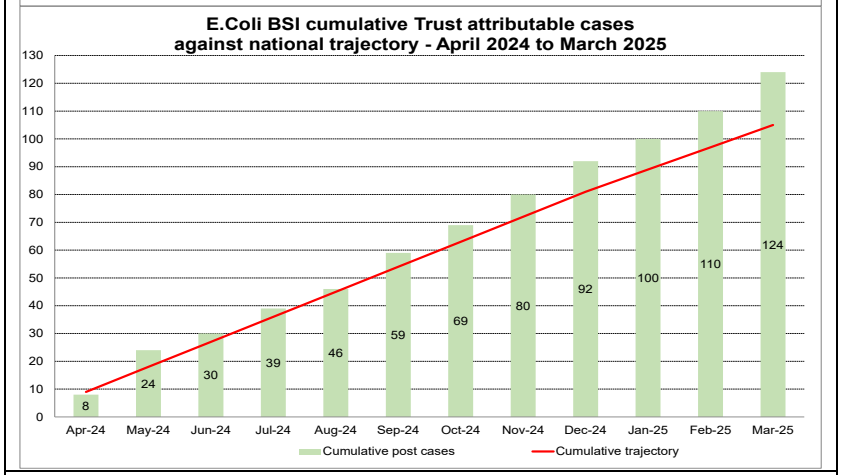
- MPH rate of infection = 0.41%
- YDH rate of infection = 0%

Spinal Surgery

- MPH rate of infection = 1.52%

Line/Bar Charts





Recent performance

Area	Oct	Nov	Dec	Jan	Feb	Mar
MRSA	0	0	0	2	0	0
C.Diff	12	7	5	8	2	4
MSSA	7	4	9	7	7	7
E.coli	10	11	7	7	10	14

Safe

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

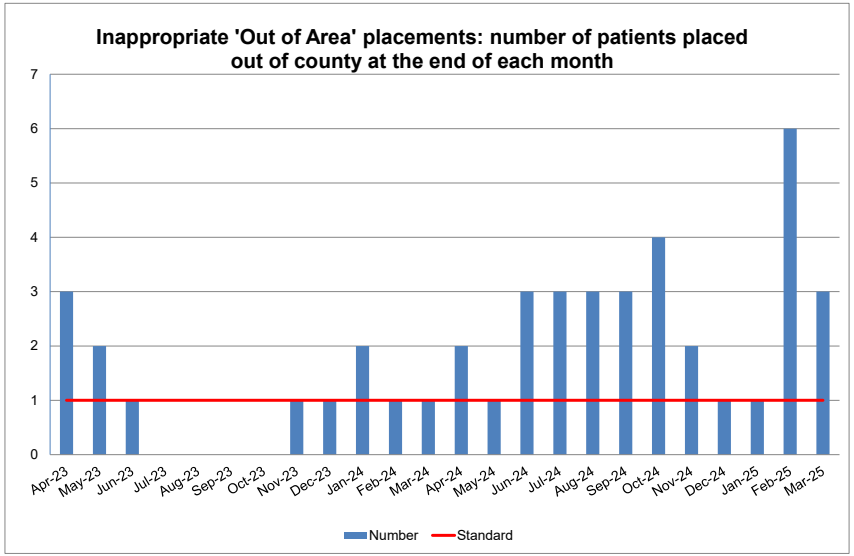
Current performance (including factors affecting this)

- As at 31 March 2025 three patients remained placed out of area. The noted significant increase in use of out of area (OOA) beds in February 2025 was due primarily to a lack of available beds and the availability of the Extra Care Area, associated with the delay to discharge of a Holford ward patient to a secure bed.
- One of the patients who was placed out of area on 27 February 2025 was discharged to their home on 4 April 2025.
- The other two patients who were placed out of area of 29 and 31 March 2025 remain so placed.

Focus of improvement work

- A review over the period 1 March 2024 to 28 February 2025 showed that 81.8% of innappropriate out of area admissions were due to the need for PICU and 18.2% for acute beds. Of these figures, 45.5% were a requirement for a gender specific ward, 18.2% were due to inaccessibility of seclusion at Holford ward and 36.3% were due to a lack of available beds. With only ten PICU beds available there are occasions when, due to clinical acuity or gender, it would be unsafe to admit a patient. A review of the increase in demand for gender-specific beds and the correlation in OOA admissions is in progress.
- When a patient is placed out of area, the Urgent Care Hub and/or Holford Ward maintains regular contact with the patient until the patient is either transferred back to our wards, discharged, or moved to secure services. Every effort is made to place people as close to Somerset as possible.
- At times, episodes relate to patients awaiting transfer to secure services. We work closely with other NHS providers, to facilitate such transfers and closely monitor processes to minimise risk.
- An out of area esclation proccess is in place to ensure that barriers to repatriation and/or discharge of patients are minimised and escalated with system partners where appropriate.

Bar Chart



How do we compare

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

Recent Performance

The numbers of patients who were on out of area placements as at the last day of each month were as follows:

Area	Oct	Nov	Dec	Jan	Feb	Mar
Number of patients out of area on last day of month	4	2	1	1	6	3

Safe

Restraints and prone restraint incidents – monthly numbers of incidents reported via our RADAR reporting system. Our aims are to maintain high rates of reporting, have a low proportion of incidents which result in harm, and minimise where possible the use of restraints.

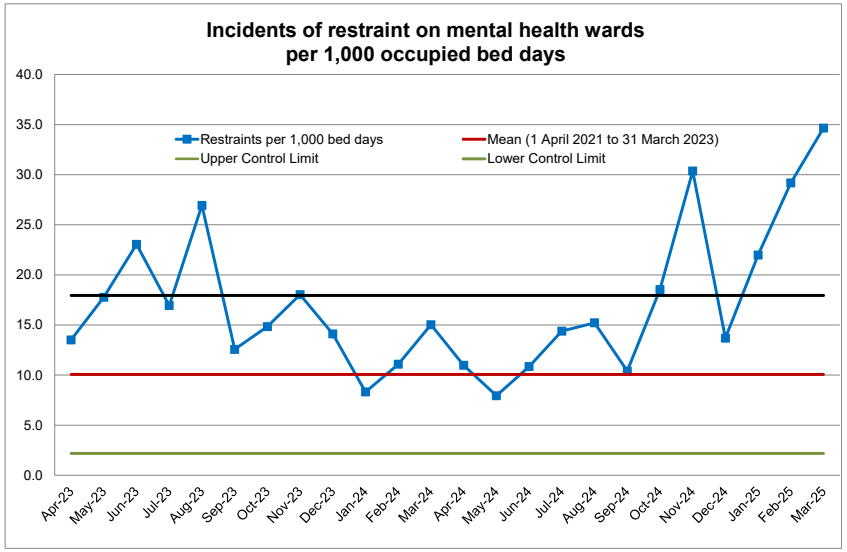
Current performance (including factors affecting this)

- During March 2025 there were 119 Restrictive Interventions (RIs) reported with our mental health wards, at a rate of 34.7 per 1,000 occupied bed days, above the Upper Control Limit of 17.95.
- Six of the interventions resulted in a prone restraint, a rate of 1.7 per 1,000 occupied bed days.
- Of the 119 interventions reported, 93 occurred on Rowan Ward 1, one of our adult mental health wards, and 12 occurred on Rowan Ward 2.
- The reported reasons for RIs were: 75 to facilitate nasogastric (NG) feeding, 13 to enforce medication, 12 to prevent serious intentional harm, five to prevent violence to others, five to prevent dangerous behaviours, three to prevent the patient exhibiting extreme and prolonged over-activity, three to prevent the patient absconding, two to deliver personal care and one to prevent a patient causing serious physical injury to themselves by accident.

Focus of improvement work: Restraint - Prone Position

- One patient detained on Rowan Ward 1 had 83 RI events to facilitate NG tube feeding/prevention of self-harm, which is primarily required as a lifesaving intervention due to a very low BMI.
- To support the implementation of Safety Pods, further funding has been secured that will enable the purchase of 20 additional Safety Pods. Safety Pods are an evidence-based intervention and are now recommended for use to reduce incidences of floor and prone position restraints. Safety Pods are endorsed by the Care Quality Commission and some of the country's foremost experts in this field.
- Reducing RIs forms one of the four main workstreams of the Inpatient Quality Transformation programme and aims to support models of care which reduce the use of force and restriction, supports research and seeks to identify ways to stop mechanical restraint, long-term segregation and other harmful forms of restrictive practice.
- This work also ensures that the recording of restrictive practice data has a focus on protected characteristics, including ethnicity and gender to help identify areas for more targeted intervention and ensure that all forms of restrictive practices are understood, appropriately captured and acted upon.

SPC Chart



How do we compare

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

Recent Performance

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

Area	Oct	Nov	Dec	Jan	Feb	Mar
Number of incidents	63	98	45	77	90	119
Rate per 1,000 bed days	18.5	30.4	13.7	22.0	29.2	34.7

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.

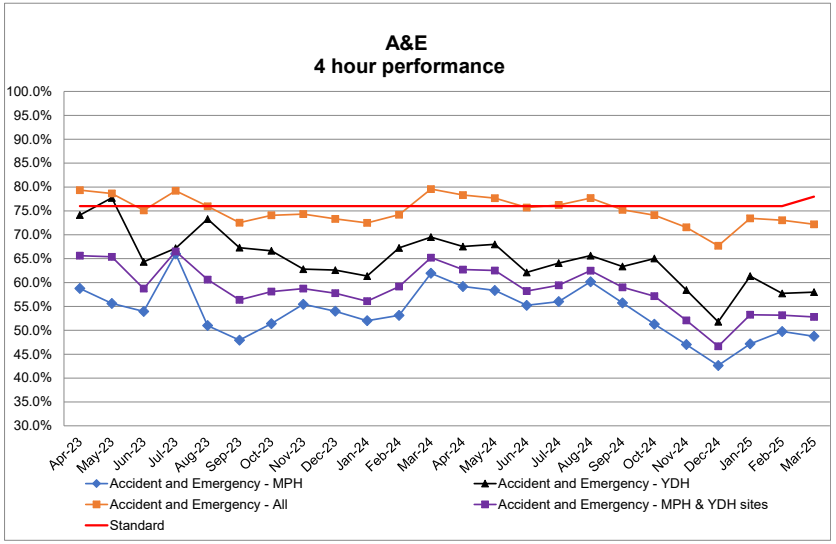
Current performance (including factors affecting this)

- Trust-wide A&E 4-hour performance for our EDs was 52.8% during March 2025, down slightly from 53.2% in February 2025. With Urgent Treatment Centres (UTCs) compliance included at 97.7%, overall compliance was 72.2%, down from 73.0% in February 2025, and below the 78% national standard to be achieved in March 2025.
- Compliance in respect of our two A&E departments was:
    - Musgrove Park Hospital (MPH): 48.7%.
    - Yeovil District Hospital (YDH): 58.0%.
- Combined rolling 12-month A&E attendances at MPH and YDH, for the period from 1 April 2024 to 31 March 2025, were 1.4% higher than the same months of 2023/24.
- The number of patients spending more than 12 hours in the departments in March 2025 was 3.3% at MPH and 4.3% at YDH, the best performance at both sites since October 2024.

Focus of improvement work

- A total of four consultant posts have now been offered at YDH (three fixed term pending specialist registration and one substantive). One SAS post has been offered and accepted and four further interviews are scheduled for late April 2025.
- The Tortus (Ambient voice technology) trial has been extended and a working group has been set up.
- A mapping workshop for middle grade rota options at MPH is planned for late April 2025.
- A workstream has been launched to align 'clinically ready to proceed' definitions.
- Visits have been undertaken to the care co-ordination hub, and a steering group has been set up from 23 April 2025.
- "Call before convey" is aimed for launch in June 2025, and ED engagement meetings began on 22 April 2025. A further meeting is planned with the ICB, specifically to review opportunities for ED clinician expertise for the Care Co-ordination hub to support potential call before conveying models.
- Data to enable an analysis of the impact of the front door scanner has been reviewed – patient-level data has been received and is being analysed.
- Transfer team pilot weeks have been completed at MPH. Evaluation is to be completed by the end of April 2025.

Line Chart



How do we compare

In March 2025, the national average performance for Trusts with a major Emergency Department was 60.9%. Our performance was 52.8%. We were ranked 95 out of 121 trusts. With Urgent Treatment Centre attendances included, we were ranked 57, with performance of 72.2%. National average performance was 72.5%.

Recent performance

Area	Oct	Nov	Dec	Jan	Feb	Mar
A&E only	57.1%	52.1%	46.6%	53.3%	53.2%	52.8%
Including UTC	74.1%	71.6%	67.7%	73.4%	73.0%	72.2%

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.

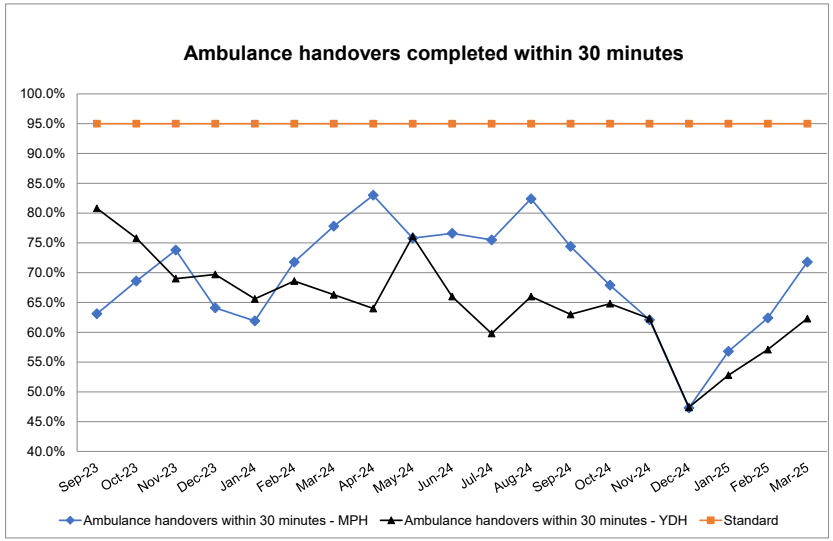
Current performance (including factors affecting this)

- During March 2025, performance for the handover within 30 minutes of patient arrivals by ambulance increased at Musgrove Park Hospital (MPH) and also at Yeovil District Hospital (YDH) when compared to February 2025. Compliance in March 2025 was:
  - MPH: 71.8% (1,808 out of 2,519 handovers were within 30 minutes).
  - YDH: 62.3% (813 out of 1,304 handovers were within 30 minutes).
- The average performance across all hospitals served by South Western Ambulance Service NHS Foundation Trust (SWAST) in March 2025 was 54.5%. The national average was 72.1%.

Focus of improvement work

- SWAST are now attending site team bed meetings to improve communications and understanding of factors affecting flow.
- "Call before convey" work is due to start in June 2025 to support in reducing attendances where there may be alternatives to attendance in the community.
- Visits to the care co-ordination hub are planned for April 2025.
- A rating and cycling review meeting was undertaken in April 2025, with input from our Improvement Team, who undertook an objective review of processes on both sites. Due to current floor plan and staffing limitations, it is not presently possible to align processes between sites more fully.
- The YDH Urgent Treatment Centre (UTC) has unfortunately been delayed due to water damage in the diagnostics centre, delaying the movements of departments. However, a soft launch of UTC operations at weekends is being developed for June 2025 to support handover.

Line Chart



How do we compare

In March 2025, 71.8% of all ambulance handovers at Musgrove Park Hospital and 62.3% of all ambulance handovers at Yeovil District Hospital were completed within 30 minutes, above the regional average performance across all hospitals served by SWAST of 54.5%, but below the national average of 72.1%.

Recent performance

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

Area	Oct	Nov	Dec	Jan	Feb	Mar
MPH	67.9%	62.1%	47.3%	56.8%	62.4%	71.8%
YDH	64.8%	62.3%	47.4%	52.8%	57.1%	62.3%

Responsive

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

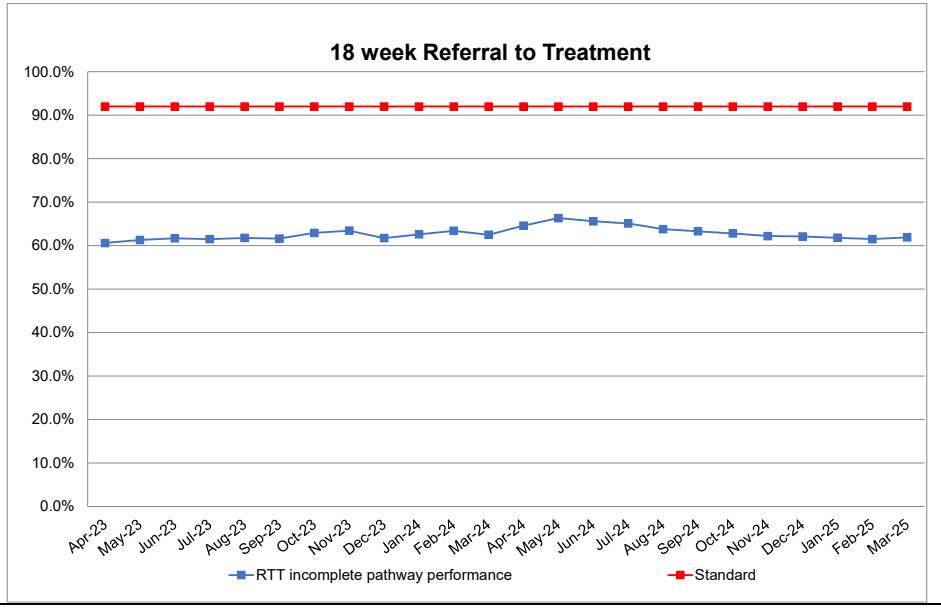
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT was 61.9% (combined acutes + community) in March 2025, up by 0.4% on the February 2025 position.
- The total waiting list size increased by 311 pathways, and was 8,720 higher (i.e. worse) than the planning trajectory (59,621 actual vs. 50,901 plan); this is due in part to the Dermatology service transfer, not fully accounted for in the planning trajectory.
- The number of patients waiting over 52 weeks decreased by 149 in March 2025 to 1,257 pathways, 585 lower (i.e. better) than the planning trajectory of 1,842. The 52-week waiters represent 2.1% of the waiting list against a target for March 2026 of no more than 1.0%.
- The number of patients waiting over 65 weeks decreased by 36 to 81 at month-end, against a trajectory of zero.
- Four patients had waited over 78 weeks, against a trajectory of zero.

Focus of improvement work

- A specialty-level RTT planning model has been developed for 2025/26, which takes account of the impact of productivity opportunities and quantifies the level of activity needed to meet the two new national targets of a 5% improvement in performance against the 18-week RTT and first appointment within 18 weeks.
- Productivity plans have been developed, and specialties are working on their activity delivery plans, including insourcing contracts where required.
- Monitoring reports for the new RTT standards are being established, along with reports to monitor the delivery against the core productivity measures, such as Advice & Guidance, Patient Initiated Follow-ups (PIFU), Did Not Attend (DNA rates) and capped theatre utilisation.
- A significant programme of improvement work to support elective care recovery in the medium and long-term remains in place.

Line Chart



How do we compare

The national average performance against the 18-week RTT standard was 59.2% in February 2025, the latest data available; our performance was 61.5%. National performance stayed the same between January and February 2025; our performance reduced by 0.3%. The number of patients waiting over 52 weeks across the country decreased by 5,352 to 193,516 (2.6% of the national waiting list compared with 2.1% for the Trust). The number of patients waiting over 78 weeks nationally decreased by 314 to 1,691.

Performance trajectory: 78 week and 65 week wait performance

Area	Oct	Nov	Dec	Jan	Feb	Mar
78-week trajectory	0	0	0	0	0	0
78-week actual	10	5	6	4	4	4
65-week trajectory	0	0	0	0	0	0
65-week actual	198	144	142	146	117	81

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.

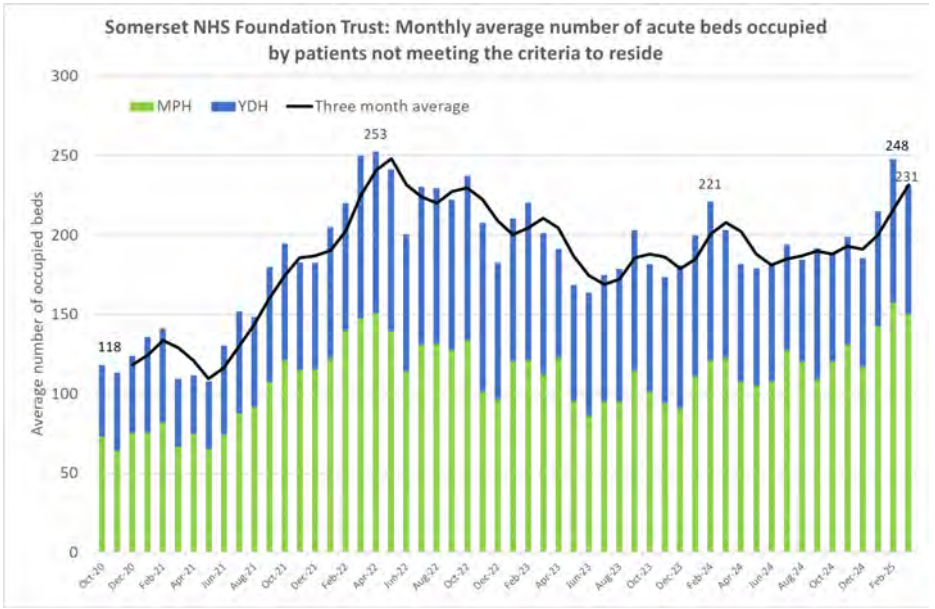
Current performance (including factors affecting this)

- During March 2025, the Trust-wide number of acute bed days occupied by patients not meeting the criteria to reside was 7,168 (4,652 at MPH and 2,516 at YDH), up from 6,941 in February 2025. This equates to 231 fully occupied beds for the month of March 2025, down from 248 in February 2025.
- In our community hospitals, the number of patients not meeting the criteria to reside as at 31 March 2025 was 57, up from 56 as at 28 February 2025.
- Of the 1,818 acute inpatients discharged during March 2025 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, down from 3.0 during February 2025. 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 52.6%, down from 54.9% achieved during February 2025.

Focus of improvement work

- A range of actions continue to be undertaken 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 appropriate and timely.
- The trial undertaken at YDH by selected wards to test a solution to enable Discharge Ready Dates to be recorded for Pathway 0 patients is being reviewed to ascertain the viability of rolling it out.

Trend Chart



How do we compare

As at 31 March 2025, national best-quartile performance was that 9.5% 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 23.8% of beds. We were ranked 114 of 118 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	Oct	Nov	Dec	Jan	Feb	Mar
MPH	3,721	3,930	3,620	4,413	4,412	4,652
YDH	2,122	2,031	2,124	2,254	2,529	2,516
Total	5,843	5,961	5,744	6,667	6,941	7,168

Responsive

Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) service – Beginning treatment within six weeks of referral. The target is for at least 75% of patients who are discharged during the reporting month to have had their first treatment within six weeks of referral.

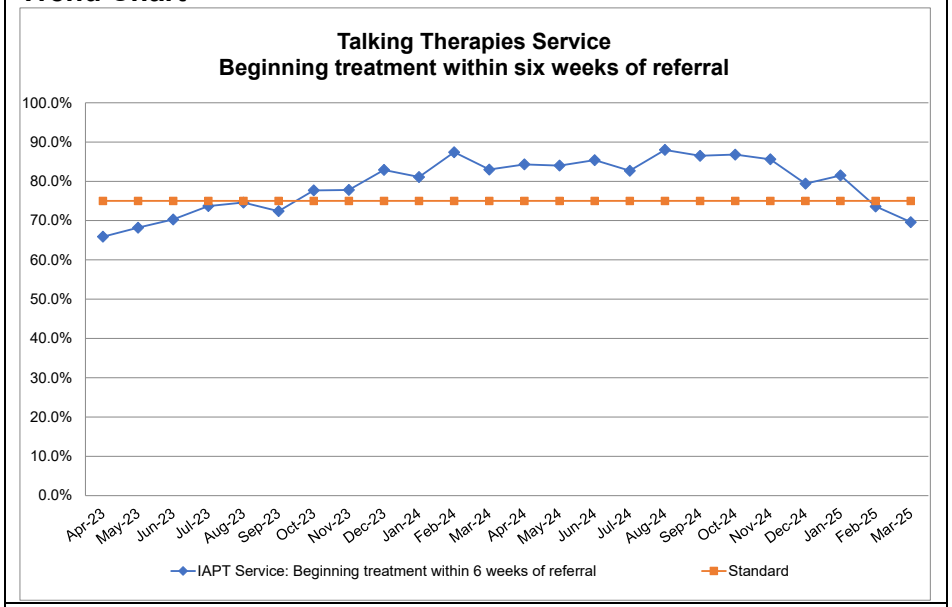
Current performance (including factors affecting this)

- During March 2025, compliance was 69.6%, down from 73.6% in February 2025.
- The reported performance reflects the length of wait between referral and when therapy commences. However, compliance is reported at point of discharge, and therefore reflects the challenges faced by the service around a year ago when there was a significant shortage of assessment workers. The service is now reporting that they are back on track, but it may take several months for compliance to return back above the 75% level.
- Between 1 April 2024 and 31 March 2025 referrals had decreased by 3.0% when compared to the same months of 2023/24. This has reduced the pressures on capacity and demand.
- Although vacancies are currently low, with 3.0 whole time equivalent (WTE) vacancies at Step 3 and 3.0 WTE vacancies at Step 2, there is a high level of absence due to maternity leave, for which there is insufficient cover.

Focus of improvement work

- Work continues to be undertaken by the service manager to increase clinical patient-facing time, which will have a positive impact on the numbers waiting.
- The service operates a countywide waiting list protocol whereby referrals are solely dealt with by length of wait rather by than team base and then length of wait. This has a significant impact on the management of the waiting lists.

Trend Chart



How do we compare

In February 2025, the latest published data available, the national average performance was that 90.8% of patients who were discharged during the month had their first treatment within six weeks of referral. Our performance was 73.6%.

Recent Performance

Area	Oct	Nov	Dec	Jan	Feb	Mar`
Total Discharges	465	411	369	417	428	438
First treatment inside of six weeks	404	352	293	340	315	305
Compliance %	86.9%	85.6%	79.4%	81.5%	73.6%	69.6%

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.

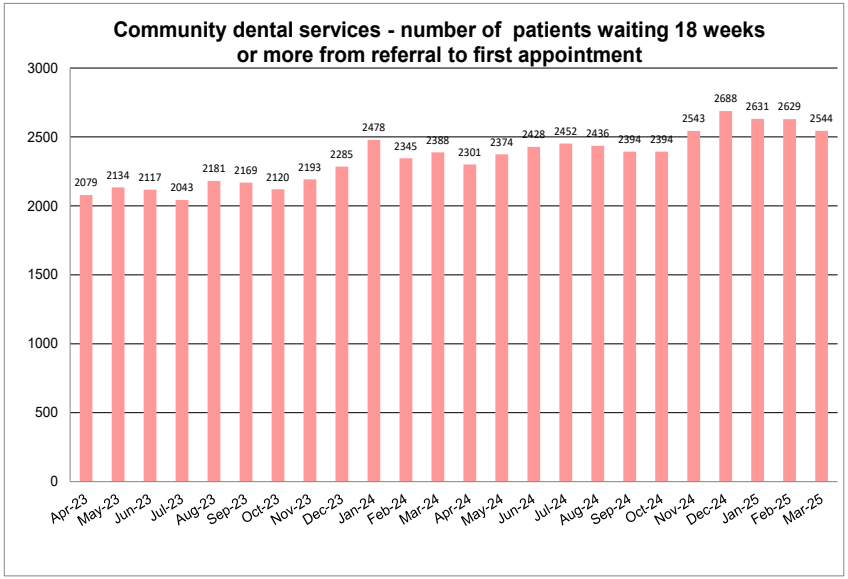
Current performance (including factors affecting this)

- As at 31 March 2025, the number of patients waiting 18 weeks or more totalled 2,544 a decrease of 85 compared to numbers as at 28 February 2025.
- Of the patients waiting 18 weeks or more to be seen, 1,772 were waiting within Somerset (down from 1,892 as at 28 February 2025), and 772 were within Dorset (up from 737 as at 28 February 2025).
- The number of people waiting 52 weeks or more decreased from 571 as at 28 February 2025 to 538 as at 31 March 2025.

Focus of improvement work

- The Somerset service is in a better position and is at full establishment of clinicians. The Dorset service continues to face considerable challenges due to vacancies and sickness absence. The service was successful with recent Consultant interviews, appointing one per county with a year delay in the start of Dorset consultant due to maternity leave.
- 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 previously 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.
- Teams are involved in AI pilots, with a view to supporting productivity gains and efficiencies although it is recognised that the impact of this will be longer term.

Bar Chart



How do we compare

The number of patients waiting 18 weeks or more as at 31 March 2025 decreased by 85, compared to numbers as at 28 February 2025.

Recent performance

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

Area	Oct	Nov	Dec	Jan	Feb	Mar
Number waiting	2,394	2,543	2,688	2,631	2,629	2,544

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).

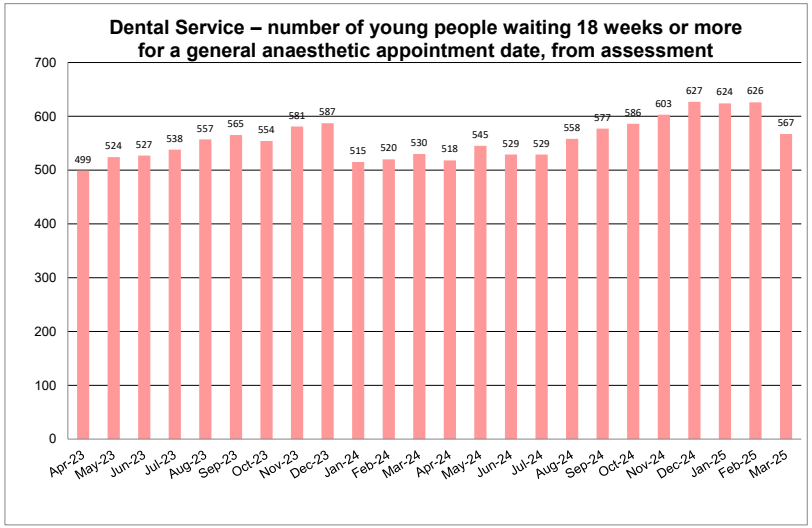
Current performance (including factors affecting this)

- As at 31 March 2025, a total of 567 patients had waited 18 weeks or more, down from 626 at the end of February 2025. Of these, 553 related to our Dorset service (down from 577 as at 28 February 2025), and 14 related to our Somerset service (down from 49 as at 28 February 2025).
- The Dorset service continues to have significant levels of vacancies, which is a national issue, exacerbated by two whole time equivalent (WTE) senior GA dentists retiring at the end of April 2025, for whom there is insufficient cover.
- Winter pressures in Somerset have seen multiple paediatric lists cancelled at Yeovil District Hospital (YDH) due bed availability.

Focus of improvement work

- The recruitment of dentists in Somerset is an improved picture, and our GA pool for adults in Somerset should also be improved with the return of colleagues currently on maternity leave and the successful appointment of a special care Consultant due to start with the service in June/July 2025.
- Multiple scheduled lists have been stood down at YDH due to winter pressures on the paediatric ward. The service is working with the team at YDH to assess the suitability of holding GA sessions in the modular theatre to support more robust capacity.
- The approval of a business case by Dorset Integrated Care Board, means there will be additional theatre slots throughout 2025/26. This will have a positive impact on reducing the GA waiting list; although - as stated above - two whole time equivalent dentists in the GA pool will shortly be retiring. The successful recruitment of a consultant and the return of a specialist on a career break will aim to counter this risk of reduced GA provision, but not until the Spring of 2026.
- One WTE junior dentist has accepted a position in Dorset but has had a delayed start due to personal reasons and will join us in June 2025.

Bar Chart



How do we compare

The number of young people waiting 18 weeks or more as at 31 March 2025 decreased by 59 when compared to numbers reported as at 28 February 2025.

Recent Performance

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

Area	Oct	Nov	Dec	Jan	Feb	Mar
Number waiting	586	603	627	624	626	567
% > 18 weeks	68.8%	73.3%	77.7%	77.3%	75.6%	76.7%

Responsive

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

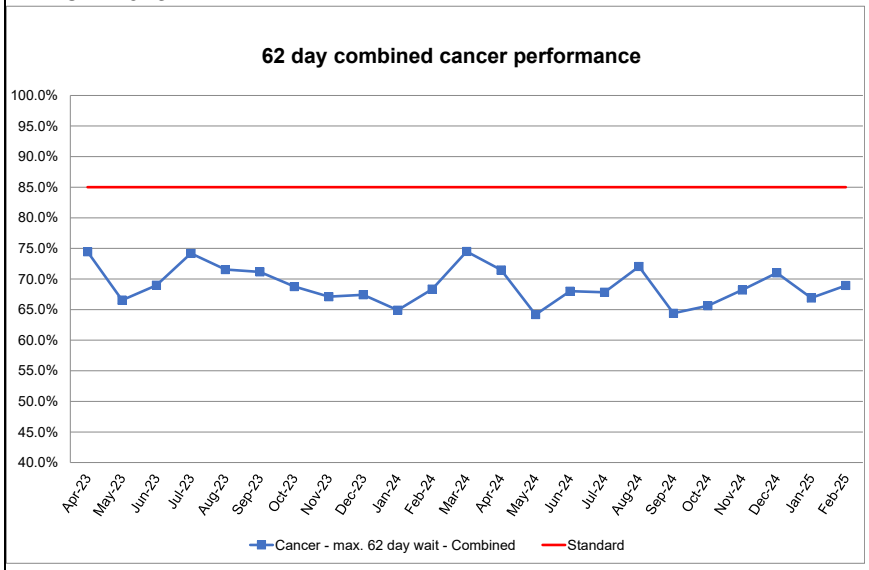
Current performance (including factors affecting this)

- The percentage of patients treated for a cancer within 62 days of referral was 68.9% in February 2025, which is above the national average performance but below the planning trajectory.
- The main breaches of the 62-day combined cancer standard were in urology (33% of breaches), lower gastrointestinal (22%) and skin (12%).
- 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. The 28-day Faster Diagnosis Standard (FDS) was met for 78.6% of patients in February 2025, above the current national target of 75%.
- Twenty-eight GP referred patients were treated in February 2025 on or after day 104 (the national 'backstop'); please see Appendix 5a.

Focus of improvement work

- A new cancer 'front door' is now in place for most tumour sites; 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.
- With the delayed opening of the Yeovil Diagnostic Centre, options are being explored for putting in place additional endoscopy and CT colon capacity, to reduce diagnostic waits within the lower gastrointestinal pathway; this is likely to involve insourcing and waiting list initiatives. This should be in place by the end of April 2025.
- Additional capacity remains in place for the skin cancer service.

Line Chart



How do we compare

National average performance for providers was 67.0% in February 2025, the latest data available. Our performance was 68.9%. We were ranked 81 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	Sep	Oct	Nov	Dec	Jan	Feb
% Compliance	64.4%	65.6%	68.2%	71.0%	66.9%	68.9%
Trajectory	66.5%	66.4%	68.8%	70.2%	71.3%	71.5%

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.

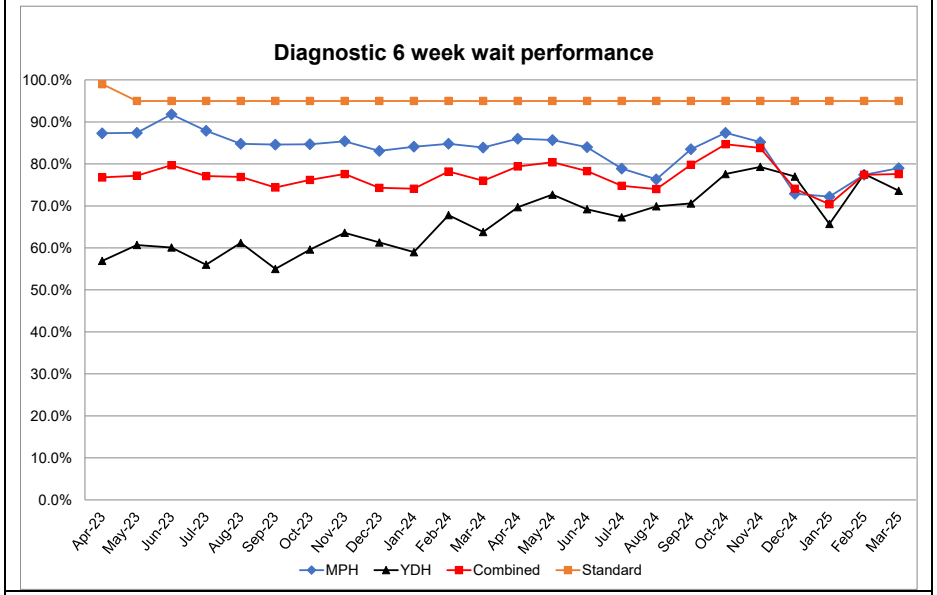
Current performance (including factors affecting this)

- The percentage of patients waiting under six weeks for their diagnostic test was 77.6% in March 2025, similar to performance in February 2025 (77.4%).
- The number of patients waiting over six weeks at the end of March 2025 increased by 83 patients in the month; the highest numbers of patients waiting over six weeks were waiting for the following diagnostic tests:
    - CT (down from 837 to 590, 19% of over six-week waiters).
    - Echo (down from 606 to 570, 18%).
    - MRI (down from 499 to 461, 15%).
    - Ultrasound (up from 251 to 429, 14%).
- The total waiting list size increased by just over 3% (453 patients).
- The high volume of CT and ultrasound over six-week waiters reflects the loss of capacity over the Christmas and New Year bank holiday, in addition to current staffing challenges due to sickness and departures.
- The echo backlog reflects staff departures over the last six months.
- The MRI backlog relates to continued high demand for scans.

Focus of improvement work

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

Line Chart



How do we compare

National average performance for NHS providers (i.e. excluding Independent Sector providers) was 81.9% in February 2025, the latest data available. Our performance was 77.4%. We were ranked 113 out of 155 trusts for the 15 high-volume diagnostic tests.

Recent performance

Area	Oct	Nov	Dec	Jan	Feb	Mar
Musgrove Park Hospital (MPH)	87.4%	85.2%	72.9%	72.2%	77.4%	79.0%
Yeovil District Hospital (YDH)	77.6%	79.3%	77.0%	67.7%	77.6%	73.6%
Combined	84.7%	83.8%	74.1%	70.4%	77.4%	77.6%
Trajectory	88.6%	90.3%	89.4%	92.0%	93.8%	95.0%

Responsive

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

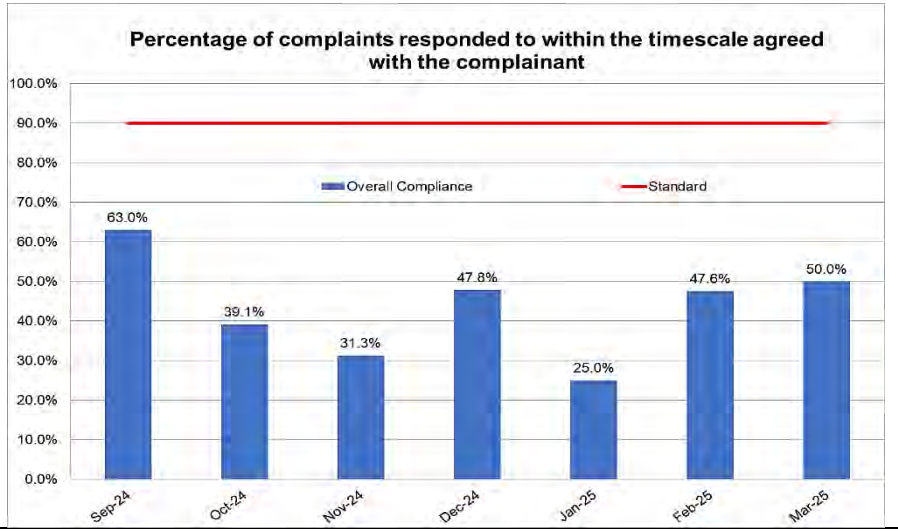
Current performance (including factors affecting this)

- Of 28 complaints responded to during March 2025, a total of 14 (50.0%) were responded to within the timescales agreed with the complainants.
- Delays occurred due to a combination of reasons including:
  - Ongoing operational and workforce challenges across all areas to be able to review, prioritise and respond to complaints.
  - A change in process, resulting in clinicians not previously involved in handling complaints now taking on this responsibility.
  - Continued complexity, with a large proportion of complaints overlapping teams and service groups, and challenges with service groups identifying a lead for the review and ongoing management of a complaint.
  - The timely availability of paper medical notes when multiple teams are involved across service groups.

Focus of improvement work.

- A weekly sitrep of service group positions regarding formal complaints is provided to the Director of Patient Experience and Engagement and the Chief Nurse. This report aims to provide senior leadership with oversight, particularly focusing on complaints that are 'at risk' (between 30 and 40 days old), to facilitate a more efficient escalation process.
- Regular meetings between Associate Directors of Patient Care and the Head of Patient Experience to identify causes of delays and potential solutions.
- 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 enables the identification of where delays have occurred and will help inform service improvement.
- Regular tracker meetings between complaint co-ordinators and service groups to identify potential delays and escalate concerns.
- A 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, and 14 February 2025. The next meeting, scheduled for September 2025, will review progress against the NHS Complaint Standards action plan.
- Development of an interactive dashboard to increase visibility and timeframes of complaints.

Trend Chart



How do we compare

Performance improved slightly, from 47.6% in February 2025, to 50% in March 2025.

Recent Performance

Complaints open:

Directorate	Numbers waiting <=20 days	Numbers waiting >20 and <=40 days	Numbers waiting >40 days	Total
Clinical Support	0	2	3	5
CYP & Families	1	0	16	17
Medical Services	12	6	6	24
Mental Health & LD	1	1	1	3
Neighbourhoods	2	3	2	7
Surgical Services	5	5	19	29
Corporate	1	0	0	1
Totals:	**22**	**17**	**47**	**86**

Well Led

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

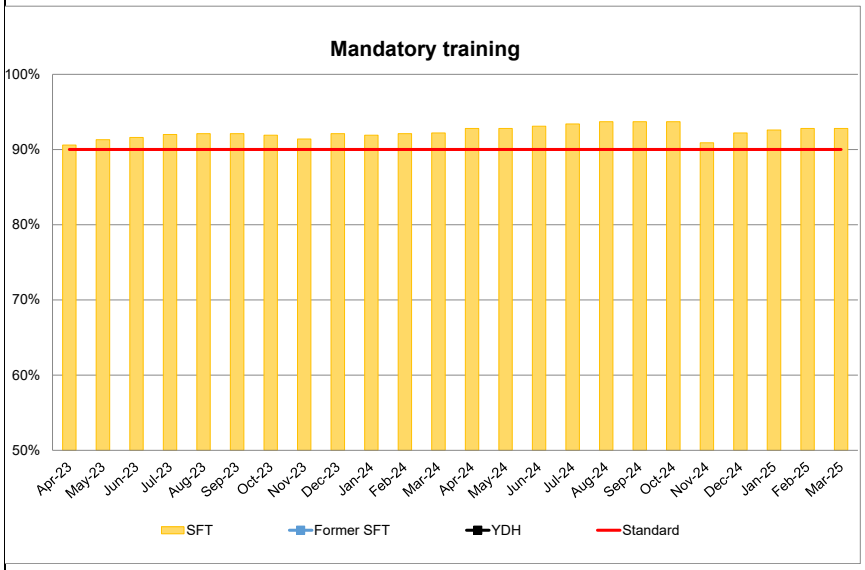
Current performance (including factors affecting this)

- As at 31 March 2025, our overall mandatory training rate was 92.8%, unchanged from the rate as at 28 February 2025.
- Apart from Symphony Health Service (SHS), all colleagues moved to the new Trust training system, LEAP, on 1 April 2023. As at 31 March 2025, compliance reported from the two separate systems was as follows:
  - LEAP: 92.8% (92.8% as at 28 February 2025)
  - SHS: 75.8% (71.9% as at 28 February 2025)
- 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

- Remapping of over 1,000 colleagues in respect of Level 3 Safeguarding is planned to be undertaken over the coming 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.
- During March 2025, 27% of resuscitation course spaces remained unused (not booked / cancelled / did not attend). Clinical pressures continue to have a significant impact on colleagues' ability to attend resuscitation training. Compliance increased by 0.1% compared to February 2025. A recent investigation showed more than 80 colleagues were booked onto multiple courses; all have all been contacted to remove their duplicate bookings.
- Staffing challenges continue within the resuscitation teaching team, with 25% of those currently absent on long term sickness.

Run Chart



How do we compare

Compliance as at 31 March 2025 remained the same as the rate reported as at 28 February 2025.

Recent Performance

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

Area	Oct	Nov	Dec	Jan	Feb	Mar
% Compliance	93.7%	90.9%	92.2%	92.6%	92.8%	92.8%

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)

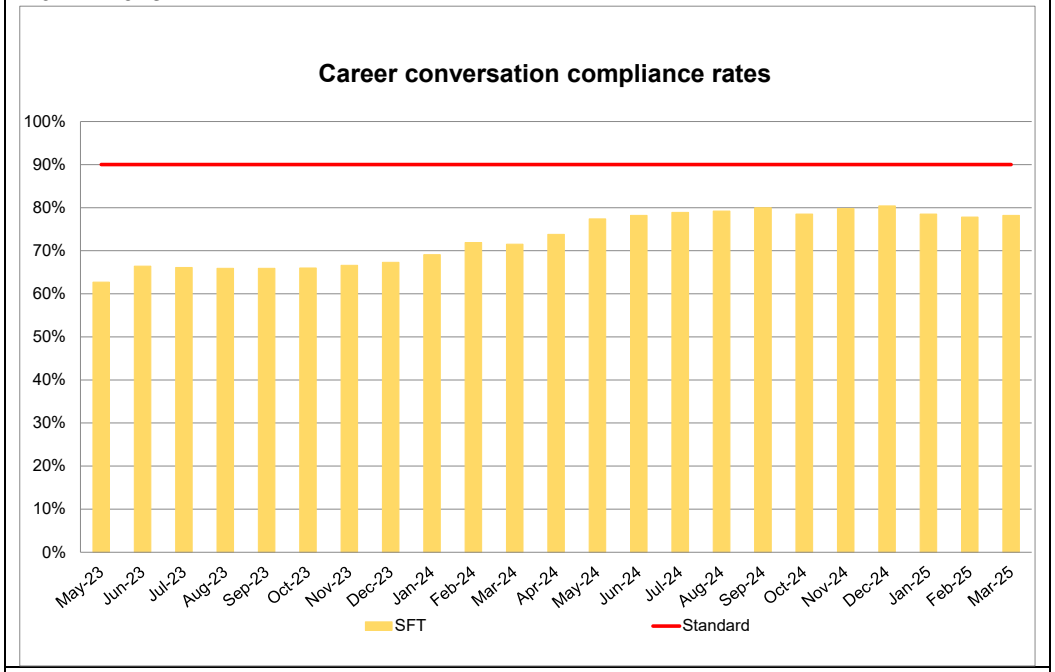
- Compliance as at 31 March 2025, in respect of appraisals being undertaken at least annually was 78.2%, up slightly from 77.8% reported as at 28 February 2025.
- Estates and Facilities are the best performing area, with a rate of 88.0%, followed by Surgical Services at 79.0% and Medical Services at 78.1%.

Focus of improvement work

All areas of focus outlined previously are continuing, including:

- Service groups continue to report actions to improve compliance through the Quality, Outcome, Performance and Finance meetings.
- The appraisal people strategy deliverable is focused on identifying and understanding the barriers preventing effective appraisals. The deliverable has completed the initial data gathering and analysis stage.

Run Chart



How do we compare

Compliance as at 31 March 2025 increased by 0.4% compared to the position as at 28 February 2025.

Recent performance

The compliance rates in recent months were as follows:

Area	Oct	Nov	Dec	Jan	Feb	Mar
% compliance	78.5%	79.8%	80.4%	78.5%	77.8%	78.2%

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.

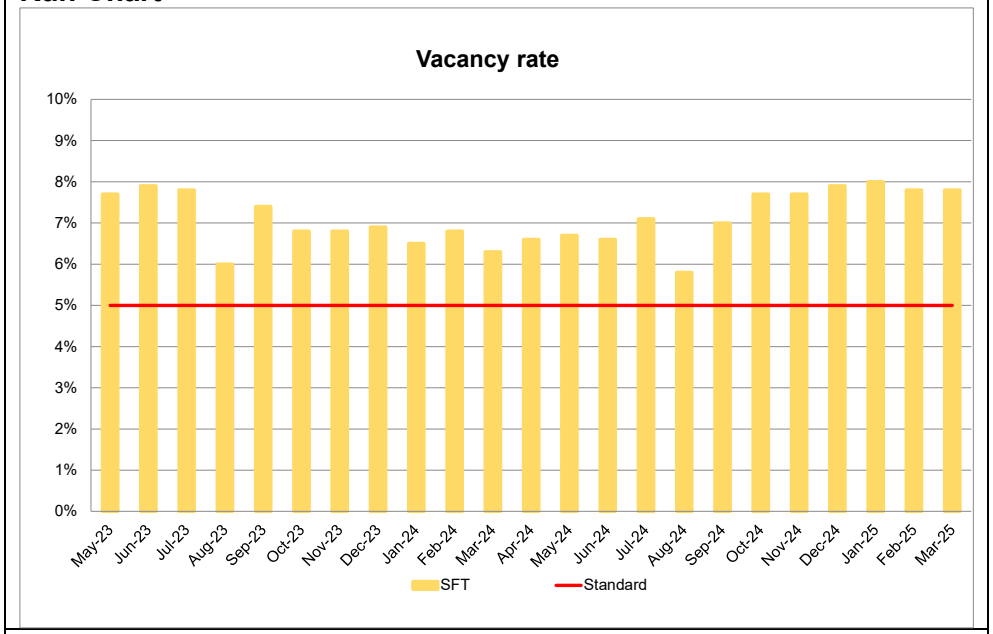
Current performance (including factors affecting this)

- Our vacancy rate as at 31 March 2025 was 7.8%, the same as at 28 February 2025.
- The areas with the highest vacancy rates are:
  - Mental Health and Learning Disabilities: 12.2%
  - Neighbourhood Services: 11.4%
  - Estates and Facilities: 10.6%
- 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.

Focus of improvement work

- The vacancy tracker went live at the beginning of April 2025. This provides services with detailed information on vacancy information to support action planning. The tracker highlights hard to fill roles and roles which are relisted due to unsuccessful recruitment.
- Services are working on workforce plans to ensure improved planning to respond to hard to fill roles and to support redesigning roles to meet future clinical strategy plans.

Run Chart



How do we compare

The vacancy rate within the Trust in March 2025 was unchanged from February 2025.

Recent performance

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

Dec	Oct	Nov	Dec	Jan	Feb	Mar
Vacancy rate	7.7%	7.7%	7.9%	8.0%	7.8%	7.8%

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.

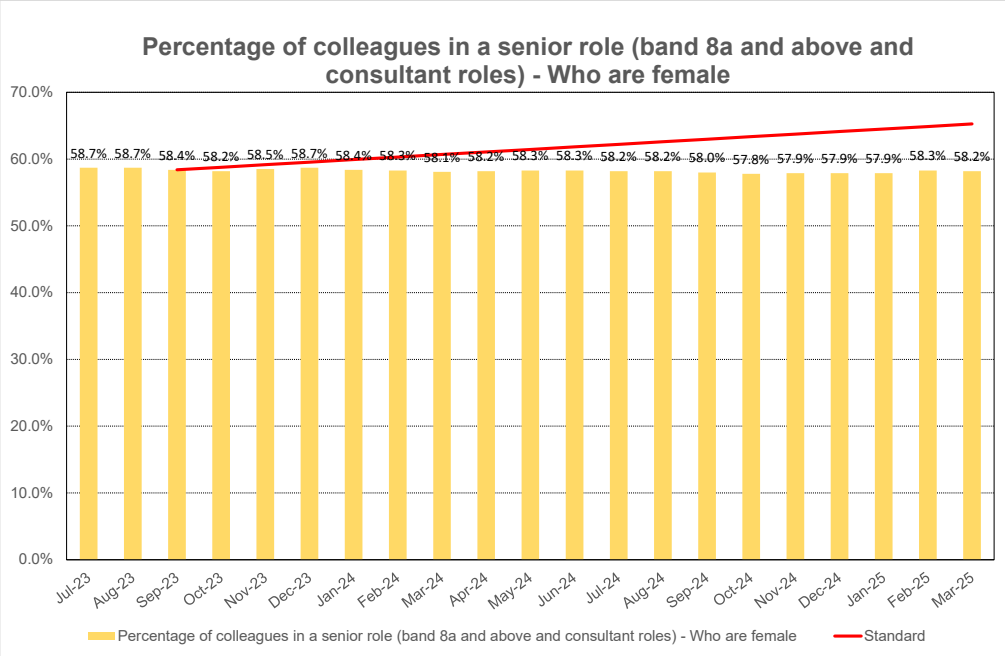
Current performance (including factors affecting this)

- 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 March 2025, a total of 58.2% of colleagues at Band 8a or above identify as female, a slight decrease from 58.3% reported as at 28 February 2025, and behind the target trajectory of 65.3% identified to achieve equitable representation by March 2028.
- There was no significant movement within this measure during 2024/25.

Focus of improvement work

- A priority for 2025/26 is supporting an inclusive Board; key to this is ensuring the Board are clearly communicating with the organisation that inclusion is important and setting an expectation that services are addressing areas of disadvantage.

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

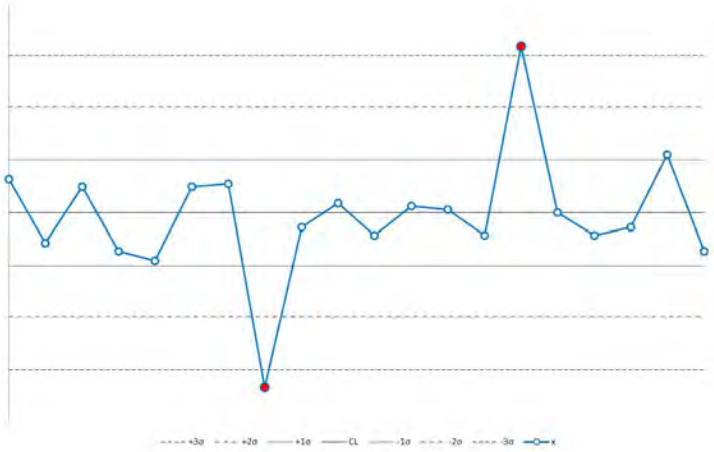
Compliance over recent months were as follows:

Area	Oct	Nov	Dec	Jan	Feb	Mar
Monthly rate	57.8%	57.9%	57.9%	57.9%	58.3%	58.2%

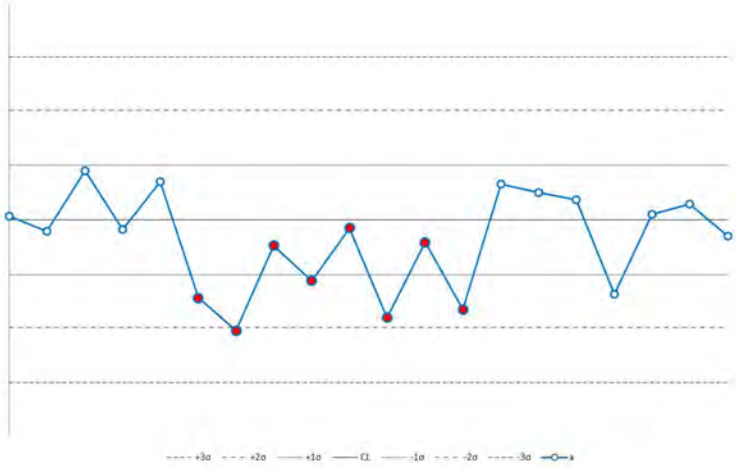
Appendix 1 - Procedure for Interpreting Run Charts

Special Cause Variation Rules

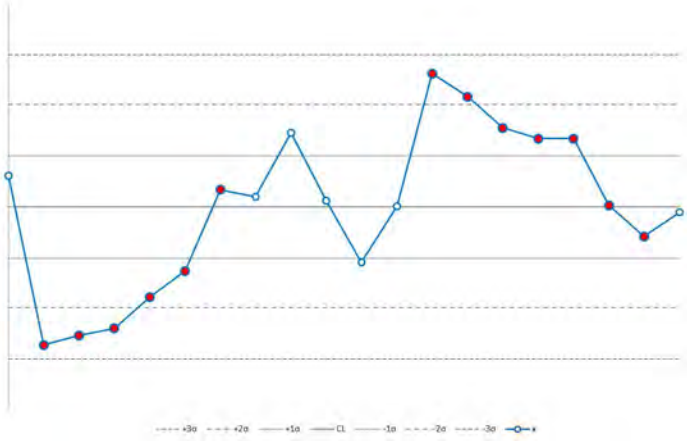
1. A single point outside the control limits



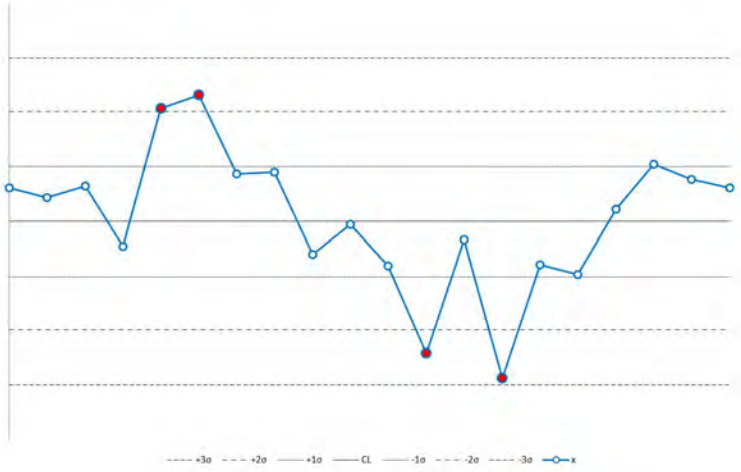
2. A run of eight or more points in a row above (or below) the centreline



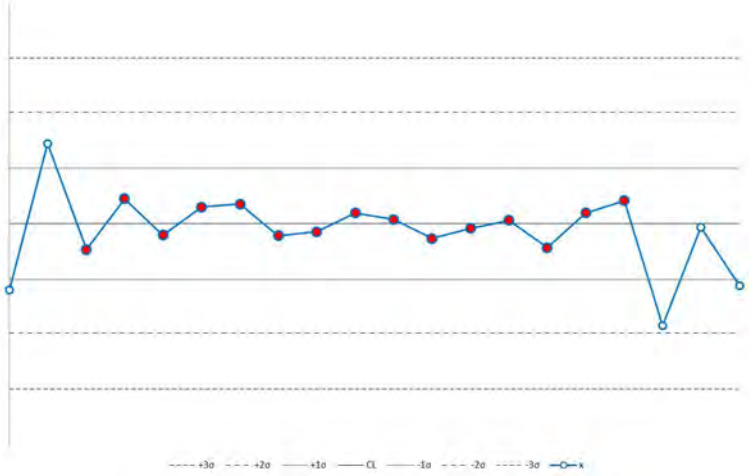
3. Six consecutive points increasing (trend up) or decreasing (trend down)



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

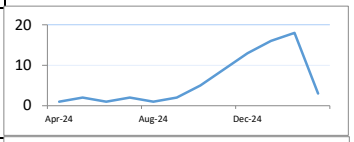
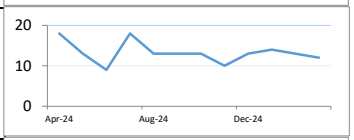
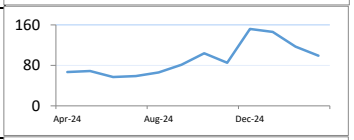
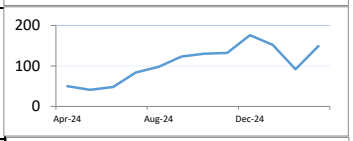
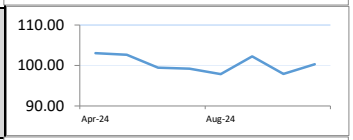
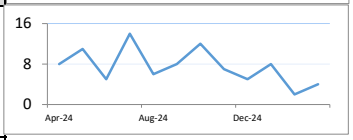
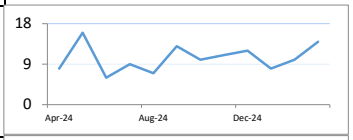
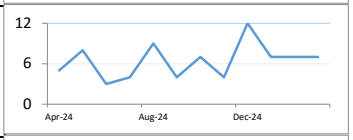
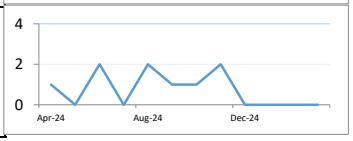
Our current Care Quality Commission ratings are as follows:

	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**

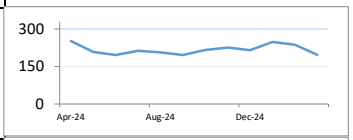
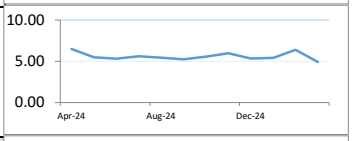
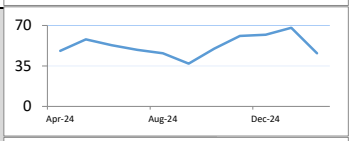
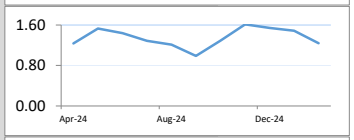
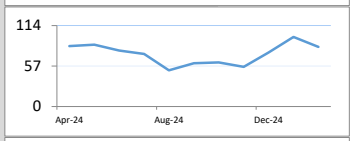
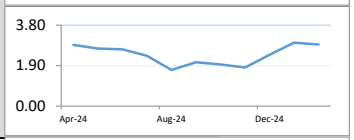
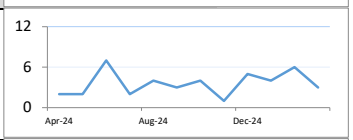
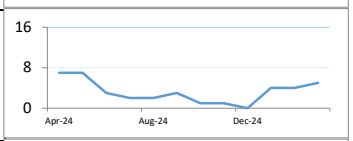
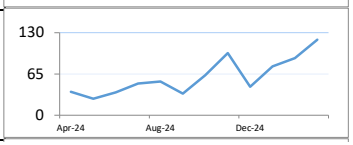
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2024/25

Area	Ref	Measure		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	
Admissions	1	Average daily number of medical and surgical outliers in acute wards during the month	MPH	1	2	1	2	1	2	5	9	13	16	18	3	
	2		YDH	18	13	9	18	13	13	13	10	13	14	13	12	
	3	Number of patients transferred between acute wards after 10pm	MPH	67	69	57	59	66	81	104	85	152	146	117	99	
	4		YDH	50	41	48	84	98	123	130	132	176	152	92	149	
Mortality (acute services)	5	Summary Hospital-level Mortality Indicator (SHMI)		103.05	102.64	99.48	99.23	97.87	102.24	97.91	100.31	Data not yet due - December 2024 to be reported after April 2025				
Infection Control	6	Clostridium Difficile cases HOHA cases (Hospital Onset Hospital Acquired) and COHA cases (Community Onset Hospital Acquired)		8	11	5	14	6	8	12	7	5	8	2	4	
	7	MRSA bacteraemias (post)		0	1	0	0	0	1	0	0	0	2	0	0	
	8	E. coli bacteraemia		8	16	6	9	7	13	10	11	12	8	10	14	
Infection Control	9	Methicillin-sensitive staphylococcus aureus		5	8	3	4	9	4	7	4	12	7	7	7	
arnity	10	No. of still births		1	0	2	0	2	1	1	2	0	0	0	0	

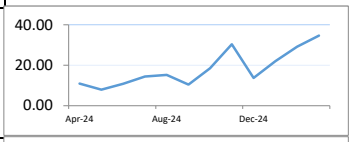
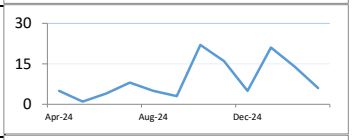
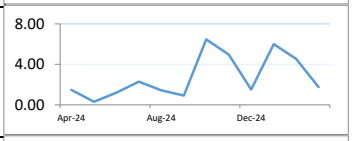
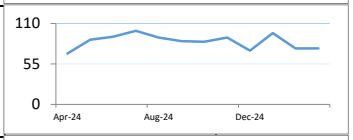
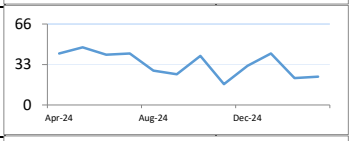
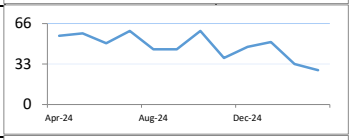
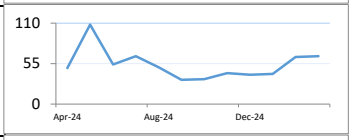
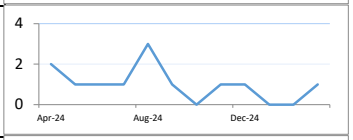
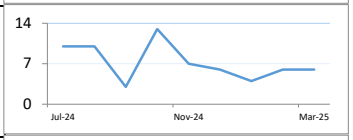
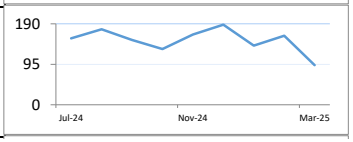
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2024/25

Area	Ref	Measure		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	
Mate	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		252	208	196	213	206	196	216	226	215	248	237	197	
	13	Rate of falls per 1,000 occupied bed days - all services		6.49	5.48	5.32	5.60	5.43	5.24	5.57	5.98	5.35	5.42	6.39	4.92	
Pressure ulcer damage	14	Inpatient wards - number of incidents		48	58	53	49	46	37	50	61	62	68	46	Data not yet due	
	15	Rate of pressure ulcer damage per 1,000 inpatient ward occupied bed days		1.24	1.53	1.44	1.29	1.21	0.99	1.29	1.61	1.54	1.49	1.24		
	16	District nursing - number of incidents		85	87	79	74	51	61	62	56	76	98	84		
Pressure ulcer damage	17	Rate of pressure ulcer damage per 1,000 district nursing contacts		2.87	2.71	2.66	2.36	1.70	2.05	1.95	1.82	2.41	2.98	2.89		
Cardiac Arrests	18	No. ward-based cardiac arrests - acute wards	MPH	2	2	7	2	4	3	4	1	5	4	6	3	
	19	No. ward-based cardiac arrests - acute wards	YDH	7	7	3	2	2	3	1	1	0	4	4	5	
)	20	Total number of incidents	Mental Health Wards	37	26	36	50	53	34	63	98	45	77	90	119	

SOMERSET NHS FOUNDATION TRUST

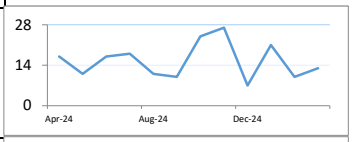
QUALITY MEASURES - 2024/25

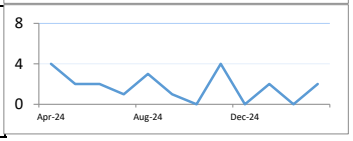
Area	Ref	Measure		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	
Restraints (mental health wards	21	Restraints per 1,000 occupied bed days	Mental Health Wards	11.0	7.9	10.8	14.4	15.2	10.4	18.5	30.4	13.7	22.0	29.2	34.7	
	22	Number of prone restraints	Mental Health Wards	5	1	4	8	5	3	22	16	5	21	14	6	
	23	Prone restraints per 1,000 occupied bed days	Mental Health Wards	1.48	0.31	1.21	2.30	1.44	0.92	6.47	4.96	1.52	5.99	4.54	1.75	
Medication incidents	24	Total number of medication incidents	MPH	69	88	92	100	91	86	85	91	73	97	76	76	
Medication incidents	24	Total number of medication incidents	YDH	42	47	41	42	28	25	40	17	32	42	22	23	
	24	Total number of medication incidents	Community & Mental Health	56	58	50	60	45	45	60	38	47	51	33	28	
Ligatures and ligature points	25	Ligatures: Total number of incidents	Mental Health Wards	49	108	54	65	50	33	34	42	40	41	64	65	
	26	Number of ligature point incidents	Mental Health Wards	2	1	1	1	3	1	0	1	1	0	0	1	
Violence and Aggression	27	Violence and Aggression: Number of incidents patient on patient (inpatients only)	Acute, Community Hospitals and Mental Health wards	New reporting	4	10	10	10	3	13	7	6	4	6	6	
	28	Violence and Aggression: Number of incidents patient on staff	Acute, Community Hospitals and Mental Health wards		22	133	156	177	152	131	165	188	139	162	93	

SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2024/25

Area	Ref	Measure		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Seclusion	29	Number of Type 1 -Traditional Seclusion	Mental Health Wards	17	11	17	18	11	10	24	27	7	21	10	13
	30	Number of Type 2 -Short term Segregation	Mental Health Wards	4	2	2	1	3	1	0	4	0	2	0	2





SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Thresholds
1	Accident and Emergency / Urgent Treatment Centre 4-hour performance	Accident & Emergency department (ED) - MPH	2	59.2%	58.4%	55.2%	56.0%	60.2%	55.7%	51.3%	47.0%	42.6%	47.2%	49.8%	48.7%	From April 2024 >=76%= Green >=66% - <76% =Amber <66% =Red (the standard will rise to 78% in March 2025)
2		Accident & Emergency department (ED) - YDH		67.5%	68.0%	62.1%	64.1%	65.6%	63.4%	65.0%	58.4%	51.8%	61.3%	57.7%	58.0%	
3		Accident & Emergency department (ED) - Combined		62.7%	62.5%	58.2%	59.4%	62.5%	59.0%	57.1%	52.1%	46.6%	53.3%	53.2%	52.8%	
4		Urgent Treatment Centres (formerly Minor Injury Units)		98.9%	97.3%	98.1%	98.3%	98.5%	97.8%	97.5%	98.4%	97.4%	98.6%	98.0%	97.7%	
5		Trust-wide		78.3%	77.7%	75.7%	76.2%	77.7%	75.2%	74.1%	71.6%	67.7%	73.4%	73.0%	72.2%	
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	1.1%	1.4%	1.3%	2.1%	1.4%	2.5%	4.3%	6.1%	10.8%	10.4%	9.1%	3.3%	<=2%= Green >2% - <=5% =Amber >5% =Red
7		Accident and Emergency department (ED) - YDH		4.7%	2.3%	3.3%	5.9%	5.2%	5.0%	4.4%	4.4%	8.5%	8.9%	7.9%	4.3%	
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	83.0%	75.8%	76.6%	75.5%	82.4%	74.4%	67.9%	62.1%	47.3%	56.8%	62.4%	71.8%	>=95%= Green >=85% - <95% =Amber <85% =Red
10	Ambulance handovers waiting less than 30 minutes: YDH			64.0%	76.1%	66.0%	59.8%	66.0%	63.0%	64.8%	62.3%	47.4%	52.8%	57.1%	62.3%	
11	Cancer - 28 days Faster Diagnosis All Cancers		1,2	78.6%	80.6%	75.0%	70.0%	70.9%	75.4%	79.0%	76.5%	75.8%	72.0%	78.6%	Data not yet due	>=75%= Green <75% =Red (the standard will rise to 77% in March 2025)
12	31 day wait - from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment			91.2%	91.9%	91.2%	96.4%	94.8%	93.7%	94.1%	90.1%	93.7%	93.7%	97.1%	Data not yet due	>=96%= Green <96% =Red
13	Cancer - 62 day wait - from an Urgent Suspected Cancer or Breast Symptomatic Referral, or Urgent Screening Referral, or Consultant Upgrade to a First Definitive Treatment			71.5%	64.2%	68.0%	67.8%	72.0%	64.4%	65.6%	68.2%	71.0%	66.9%	68.9%	Data not yet due	>=85%= Green From April 2024 at or above trajectory =Amber and below trajectory =Red
14	Cancer: 62-day wait from referral to treatment for urgent referrals – number of patients treated on or after day 104			21	20	23	21	19	22	33	23	13	17	28	Data not yet due	0= Green >0 = Red
15	CAMHS Eating Disorders - Urgent referrals to be seen within 1 week - (rolling 3 months)		1,2,5	100.0%	100.0%	100.0%	-	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	Data being validated	>=95%= Green >=85% - <95% =Amber <85% =Red
16	CAMHS Eating Disorders - Routine referrals to be seen within 4 weeks - (rolling 3 months)		1,2,5	97.1%	97.3%	97.1%	96.6%	100.0%	95.7%	95.7%	95.5%	95.5%	96.4%	96.2%		>=95%= Green >=85% - <95% =Amber <85% =Red
17	Mental health referrals offered first appointments within 6 weeks	All mental health services		93.0%	95.7%	95.7%	96.2%	93.5%	93.9%	94.9%	94.4%	96.2%	94.5%	97.4%	96.0%	>=90%= Green >=80% - <90% =Amber <80% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Thresholds
18	Mental health referrals offered first appointments within 6 weeks	Adult mental health services	1,2,3	92.1%	94.7%	92.5%	94.2%	91.5%	90.4%	90.3%	92.5%	89.6%	92.9%	96.4%	91.0%	>=90%= Green >=80% - <90% =Amber <80% =Red
19		Older Persons mental health services		93.8%	97.0%	100.0%	97.2%	93.8%	93.4%	97.8%	94.7%	97.7%	91.1%	96.2%	96.2%	
20		Learning disabilities service		83.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	
21		Children and young people's mental health services		95.0%	95.4%	95.3%	98.5%	97.8%	98.8%	97.8%	96.3%	97.5%	97.3%	98.8%	99.0%	
22	Percentage of women accessing specialist community Perinatal MH service - 12 month rolling reporting		1,2	12.9%	13.0%	13.1%	13.1%	13.2%	13.1%	13.2%	13.0%	13.1%	12.9%	12.9%	13.0%	>=10%= Green >=7.5% - <10% =Amber <7.5% =Red
23	Diagnostic 6-week wait - acute services	MPH	1,2	86.0%	85.7%	84.0%	78.9%	76.3%	83.5%	87.4%	85.2%	72.9%	72.2%	77.4%	79.0%	From March 2024 At or above regional ambition 85% = Green Above trajectory = Amber Below trajectory = Red
24		YDH		59.4%	72.7%	69.2%	67.3%	69.9%	70.6%	77.6%	79.3%	77.0%	65.7%	77.6%	73.6%	
25		Combined		79.4%	80.4%	78.3%	74.8%	74.0%	79.8%	84.7%	83.8%	74.1%	70.4%	77.4%	77.6%	
26	RTT incomplete pathway performance: percentage of people waiting under 18 weeks		1,2,4	64.6%	66.3%	65.6%	65.1%	63.8%	63.3%	62.8%	62.2%	62.1%	61.8%	61.5%	61.9%	>=92%= Green <92% =Red
27	52 week RTT breaches - Patients of all ages			1,969	1,871	1,873	1,842	1,769	1,536	1,445	1,371	1,364	1,388	1,406	1,257	From April 2023 At or below trajectory = Green Above trajectory = Red
28	52 week RTT breaches - Patients aged 18 or under			New reporting	185	168	165	162	115	91	86	87	104	108	116	
29	65 week RTT breaches - Patients of all ages			463	484	493	426	370	247	198	144	142	146	117	81	
30	Referral to Treatment (RTT) incomplete pathway waiting list size			54,625	55,014	56,599	57,442	57,619	58,112	58,725	59,585	60,076	59,061	59,310	59,621	

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Thresholds
31	Average length of stay of patients discharged from acute wards - (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).	MPH	2,7	5.9	5.9	5.8	5.9	6.0	6.1	5.9	6.3	6.6	6.7	7.1	6.4	Monitored using Special Cause Variation Rules. Report by exception.
32		YDH		7.6	7.5	7.0	6.3	7.3	7.0	7.3	6.7	7.2	8.3	7.7	7.5	
33	Patients not meeting the criteria to reside: % of occupied bed days lost	MPH	2,7	18.9%	19.2%	19.4%	23.2%	22.4%	19.6%	19.0%	22.7%	20.0%	19.5%	26.4%	26.0%	<=9.8%= Green >15% =Red
34		YDH		21.8%	23.4%	23.0%	21.0%	19.9%	26.4%	21.3%	20.8%	20.2%	20.9%	26.2%	24.4%	
35	Acute bed days lost due to patients not meeting the criteria to reside	MPH	2,7	3,215	3,267	3,230	3,939	3,719	3,269	3,721	3,930	3,620	4,413	4,412	4,652	TBC
36		YDH		2,238	2,284	2,230	2,070	1,991	2,475	2,122	2,031	2,124	2,254	2,529	2,516	
37	Community service waiting times: number of people waiting over 18 weeks from referral to first appointment (excluding dental)		1,2,3	1,590	1,712	1,870	1,944	1,937	1,736	1,426	1,061	768	592	576	589	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)			257	259	280	277	277	263	240	95	26	9	5	4	
39	Community service waiting times: number of people waiting over 104 weeks from referral to first appointment (excluding dental)			45	49	57	73	88	93	86	25	7	1	0	0	
40	Community dental services - General, Domiciliary or Minor Oral surgery waiting 18 weeks or more		1,2,3	2,301	2,374	2,428	2,452	2,436	2,394	2,394	2,543	2,688	2,631	2,629	2,544	From April 2024 <1,979 = Green >=1,979 = Red
41	Community dental services - General, Domiciliary or Minor Oral surgery waiting 52 weeks or more			531	584	620	600	538	533	489	491	540	559	571	538	From April 2024 <574 = Green >=574 = Red
42	Community dental services - Child GA waiters waiting 18 weeks or more		1,2,3	518	545	529	529	558	577	586	603	627	624	626	567	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	86.7%	73.7%	77.8%	70.6%	84.6%	87.5%	100.0%	100.0%	91.7%	94.4%	94.1%	88.9%	>=60%= Green <60% =Red
44	Talking Therapies RTT : percentage of people waiting under 6 weeks		1,2,3	84.3%	84.0%	85.4%	82.7%	88.0%	86.5%	86.9%	85.6%	79.4%	81.5%	73.6%	69.6%	>=75%= Green <75% =Red
45	Talking Therapies RTT: percentage of people waiting under 18 weeks		1,2,3	99.0%	98.9%	98.7%	98.2%	99.6%	98.9%	98.3%	97.8%	98.4%	99.0%	98.4%	99.3%	>=95%= Green <95% =Red
46	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) Recovery Rates		1,2,3	58.6%	60.2%	59.6%	58.9%	61.2%	54.8%	53.0%	56.9%	56.3%	56.3%	55.6%	58.4%	>=50%= Green <50% =Red
47	Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Improvement		1,2,3	69.7%	78.5%	72.3%	74.3%	77.8%	76.5%	73.6%	75.9%	70.7%	75.8%	72.4%	70.4%	>=67%= Green <67% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Thresholds
48	Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Recovery		1,2,3	54.9%	57.9%	56.0%	55.4%	58.7%	53.3%	52.6%	52.6%	49.6%	54.3%	51.2%	54.5%	>=48%= Green <48% =Red
49	Adult mental health inpatients receiving a follow up within 72 hrs of discharge		1,2	97.6%	90.9%	90.5%	100.0%	96.2%	97.4%	96.9%	100.0%	97.1%	100.0%	94.6%	97.5%	>=80%= Green <80% =Red
50	Inappropriate Out of Area Placements for non-specialist mental health inpatient care. Number of 'active' out of area placements at the month-end		1,2	2	1	3	3	3	3	4	2	1	1	6	3	1= Green >1 = Red
51	Intermediate Care - Patients aged 65+ discharged home from acute hospital beds on pathway 0 or 1		1,2,3	95.1%	94.1%	94.3%	94.7%	93.8%	94.9%	94.8%	94.8%	93.2%	95.9%	Data awaited	Data awaited	>=95%= Green >=85% - <95% =Amber <85% =Red
52	Urgent Community Response: percentage of patients seen within two hours		1,2,3	90.5%	87.8%	87.5%	87.4%	89.5%	85.8%	87.4%	87.1%	93.4%	92.6%	92.7%	Data not yet due	>=70%= Green >=60% - <70% =Amber <60% =Red
53	% Stroke Patients direct admission to stroke ward in 4 hours	MPH	1,2,5	38.3%	49.1%	50.0%	52.4%	54.3%	34.9%	The provider of the software system used to record all stroke activity implemented changes to the dataset in October 2024 which resulted in reports currently being inaccessible nationally. Our Data Analytics Team have been awaiting patch updates from software provider to enable reporting to recommence. It is planned that reporting will recommence by April 2025.						>=90%= Green >=75% - <90% =Amber <75% =Red
54		YDH		15.2%	50.0%	27.6%	35.6%	40.0%	41.2%							
55	Patients spending >90% of time in stroke unit - acute services	MPH	1,2,5	85.0%	80.2%	88.5%	94.1%	94.0%	98.2%							>=80%= Green >=70% - <80% =Amber <70% =Red
56		YDH		50.0%	54.6%	67.7%	70.3%	56.3%	74.2%							
57	Percentage of patients with a National Early Warning Score (NEWS) of 5 or more acted upon appropriately - The registered nurse should immediately inform the medical team caring for the patient	MPH, YDH, Community Hospitals and Mental Health wards	1,2,5	72.5%		75.6%		79.2%		63.0%		A review of the audit form is being undertaken, deferring the audit until April 2025.				>=90%= Green >=80% - <90% =Amber <80% =Red
58	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services	MPH	1,2,5	94.4%	91.9%	83.3%	100.0%	90.9%	87.1%	92.3%	90.6%					
59	Percentage of emergency patients screened for sepsis - Emergency Departments			87.5%	96.2%	90.9%	77.8%	91.0%	90.7%	92.8%	94.2%					
60	National paediatric early warning system (PEWS)	MPH	1,2,5	64.3%	87.5%	Reporting has been moved from a paper method to a digital solution, which will improve the robustness of recording. It was planned that reporting would commence from April 2025 but a review of all questions is now being undertaken.										
61	Percentage of complaints responded to within the timescale agreed with the complainant		6	New reporting - to					63.0%	39.1%	31.3%	47.8%	25.0%	47.6%	50.0%	>=90%= Green >=80% - <90% =Amber <80% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Thresholds
62	Mandatory training: percentage completed	Combined	6	92.8%	92.8%	93.1%	93.3%	93.7%	93.7%	93.7%	90.9%	92.2%	92.6%	92.8%	92.8%	All courses >=90%= Green Overall rate <80% =Red Any other position = Amber
63	Monthly percentage of days lost due to sickness		6	5.0%	4.8%	4.8%	5.2%	4.8%	5.0%	5.5%	5.6%	5.8%	5.7%	5.3%	4.8%	SPC (Upper Control Limit 5.4%)
64	Sickness absence levels - rolling 12 month average (Trust-wide)		6	5.2%	5.2%	5.2%	5.2%	5.1%	5.1%	5.1%	5.2%	5.2%	5.2%	5.2%	5.2%	SPC (Upper Control Limit 5.2%)
65	Career conversations (12 months)		6	73.8%	77.4%	78.2%	78.9%	79.2%	80.0%	78.5%	79.8%	80.4%	78.5%	77.8%	78.2%	>=90%= Green >=80% - <90% =Amber <80% =Red
66	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)		6	6.6%	6.7%	6.6%	7.1%	5.8%	7.0%	7.7%	7.7%	7.9%	8.0%	7.8%	7.8%	<=5%= Green >5% to <=7.5% =Amber >7.5% =Red
67	Retention rate – rolling 12 months percentage of colleagues in post		6	89.1%	89.0%	89.2%	89.0%	88.8%	88.7%	88.7%	88.7%	88.8%	88.8%	89.0%	89.1%	>=88.3%= Green >=80% to <88.3% =Amber <80% =Red
68	Percentage of colleagues in a senior role (band 8a and above and consultant roles):	Who are of an ethnic minority	4,6	21.8%			21.0%			21.6%			22.5%			>=Trajectory = Green <=10% below trajectory = Amber >10% below trajectory = Red
69		Who are female	4,6	58.3%			58.0%			57.9%			58.2%			
70		With a recorded disability	4,6	3.0%			3.4%			3.9%			4.0%			
71	Number of formal HR case works (disciplinary, grievance and capability).		6	33	38	62	62	53	59	49	62	47	50	50	63	SPC (Upper Control Limit 78

SOMERSET NHS FOUNDATION TRUST

OUR CORPORATE OBJECTIVES

1 Improve the health and wellbeing of the population
2 Provide the best care and support to people
3 Strengthen care and support in local communities
4 Reduce inequalities
5 Respond well to complex needs
6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
7 Live within our means and use our resources wisely
8 Deliver the vision of the Trust by transforming our services through research, innovation and digital technologies

Appendix 5a – Specialty and tumour-site level performance

Table 1 – Performance against the RTT performance standard in March 2025, including the number of patients waiting over 18 weeks, the number of patients waiting over 52 weeks, and the average (mean) number of weeks patients have waited on the Trust's waiting list.

RTT specialty	Over 18-week waiters	Over 52-week waiters	Incomplete pathways	Incomplete pathways performance
General Surgery	598	25	1983	69.8%
Urology	1734	187	3736	53.6%
Trauma & Orthopaedics	3506	380	8421	58.4%
Ear, Nose & Throat (ENT)	2218	185	5084	56.4%
Ophthalmology	1426	7	4323	67.0%
Oral Surgery	1388	33	3017	54.0%
Plastic Surgery	43	1	139	69.1%
Cardiothoracic Surgery	15		40	62.5%
General Medicine	36		69	47.8%
Gastroenterology	1220	26	2861	57.4%
Cardiology	1036	8	3933	73.7%
Dermatology	913	17	2882	68.3%
Thoracic Medicine	650	12	2050	68.3%
Neurology	878	19	1975	55.5%
Rheumatology	273	3	801	65.9%
Geriatric Medicine	155	2	554	72.0%
Gynaecology	2036	92	4707	56.7%
Other – Medical Services	1184	3	3295	64.1%
Other - Paediatric Services	562	9	1692	66.8%
Other - Surgical Services	2464	241	6667	63.0%
Other – Other Services	405	7	1392	70.9%
Total	**22740**	**1257**	**59621**	**61.9%**

Table 2 – Performance against the 62-day GP cancer standard in February 2025.

Tumour site	No of breaches	Trust performance
Brain	0.0	100%
Breast	6.0	80.0%
Colorectal	21.0	46.2%
Gynaecology	2.0	75.0%
Haematology	1.0	93.8%
Head & Neck	8.5	34.6%
Lung	7.5	71.2%
Other	2.0	33.3%
Skin	11.5	85.9%
Upper GI	5.0	80.8%
Urology	32.0	51.5%
Total	**96.5**	**68.8%**

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

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

Seven patients of the above patients were treated at a tertiary centre, with the several being referred late by us for a range of reasons including capacity but also factors outside of our control. There were also delays for some pathways at the tertiary centre including changes of treatment plan due to further diagnostic tests revealing more advanced disease, and capacity shortfalls.

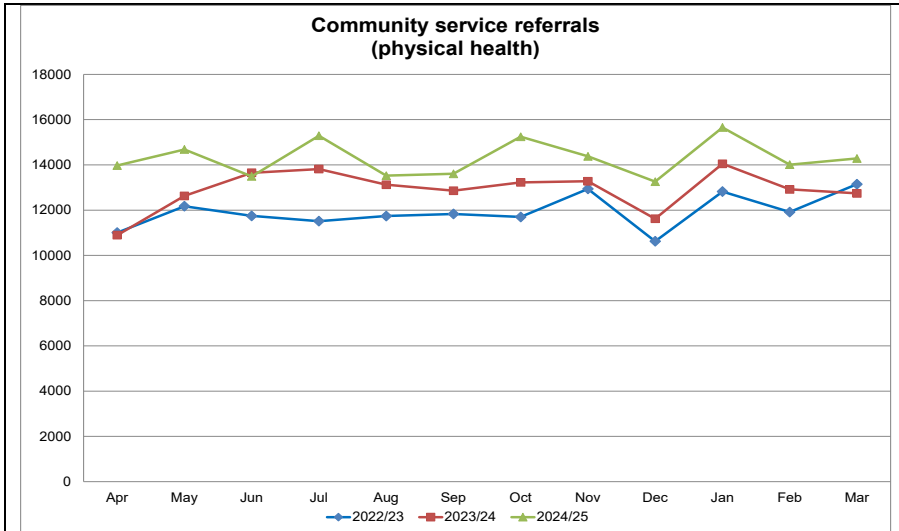
Appendix 2 – RTT validation progress

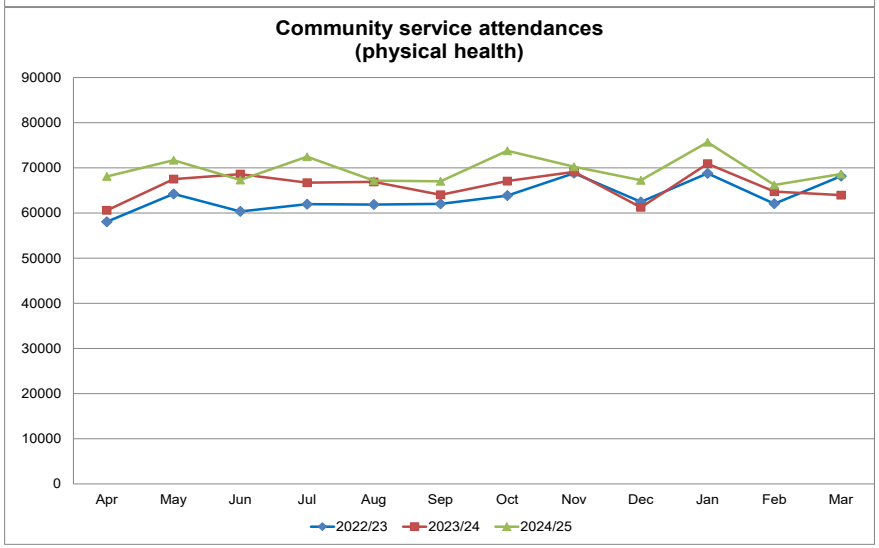
The national target is to reach a level of 90% validation of patients waiting 12 weeks and over from Referral to Treatment (RTT) by 31 October 2023. Validation includes both the administrative/technical validation and also contacting the patient to confirm they still wish to be seen.

RTT waiting times bands	Week ending 14th Jul	Week ending 11th Aug	Week ending 8th Sep	Week ending 13th Oct	Week ending 10th Nov	Week ending 15th Dec	Week ending 12th Jan	Week ending 16th Feb	Week ending 9th Mar	Week ending 13th Apr
12 weeks and over	69%	67%	70%	69%	74%	55%	54%	69%	71%	705
26 weeks and over	77%	76%	77%	76%	72%	57%	57%	69%	72%	71%
52 weeks and over	99%	95%	100%	99%	99%	92%	85%	95%	96%	98%

Operational context

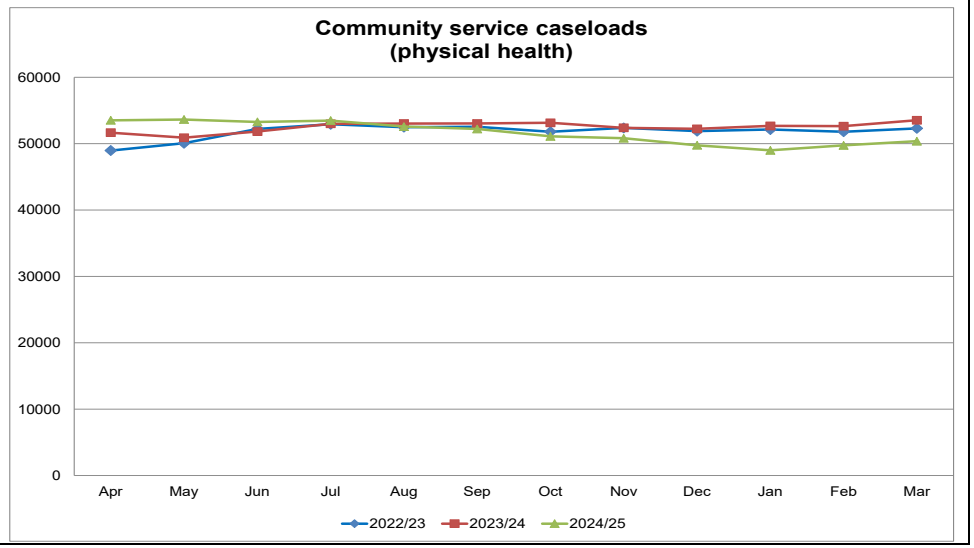
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





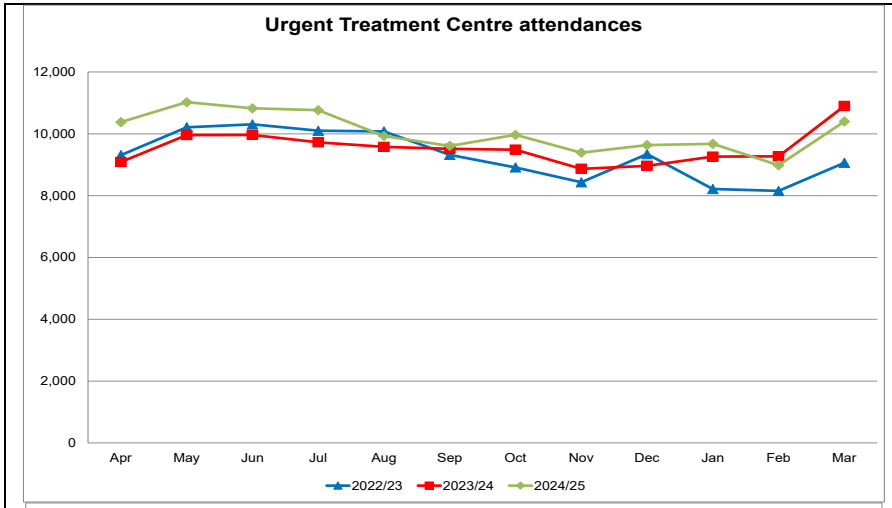
Summary:

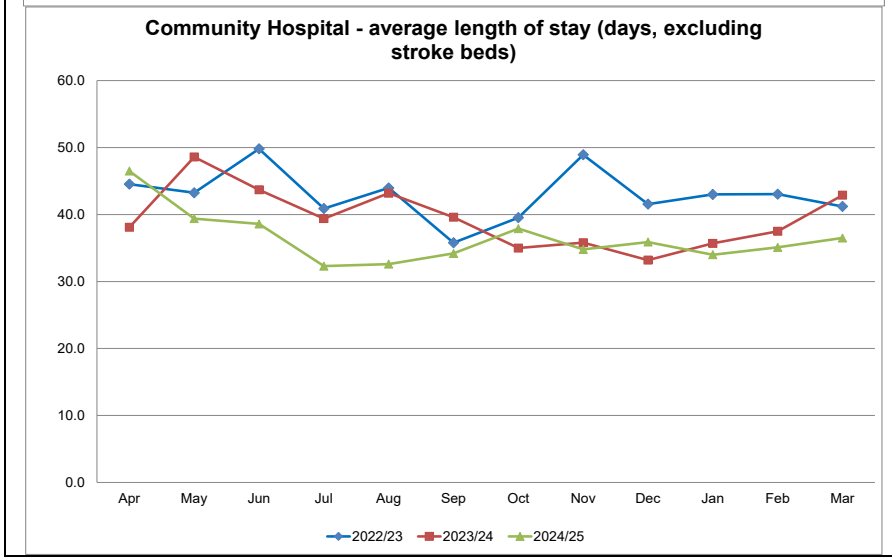
- Direct referrals to our community physical health services between 1 April 2024 and 31 March 2025 were 10.7% higher than the same months of 2023/24 and 19.7% higher than the same months of 2022/23. Services with the highest increases include Rapid Response, Diabetes Integrated Care and District Nursing.
- Attendances in 2024/25 were 5.6% higher than in 2023/24 and 9.6% higher than in 2022/23.
- Community service caseload levels as at 31 March 2025 were 5.9% lower than as at 31 March 2024, and 2.8% lower than 31 March 2023 levels.



Operational context

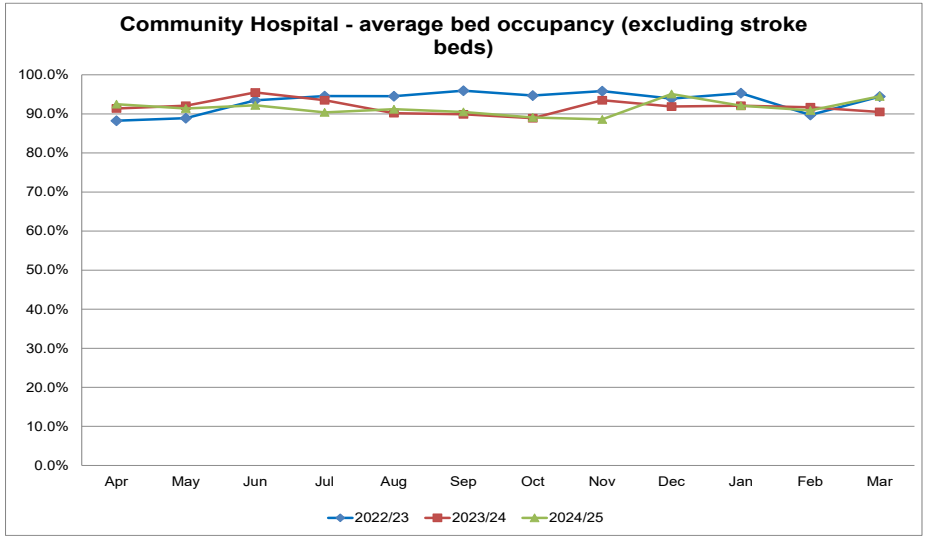
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





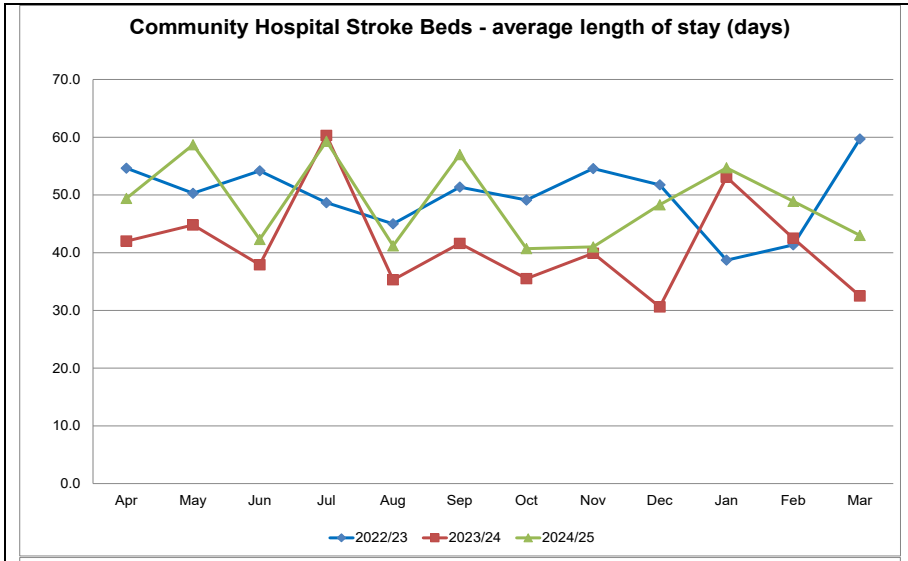
Summary:

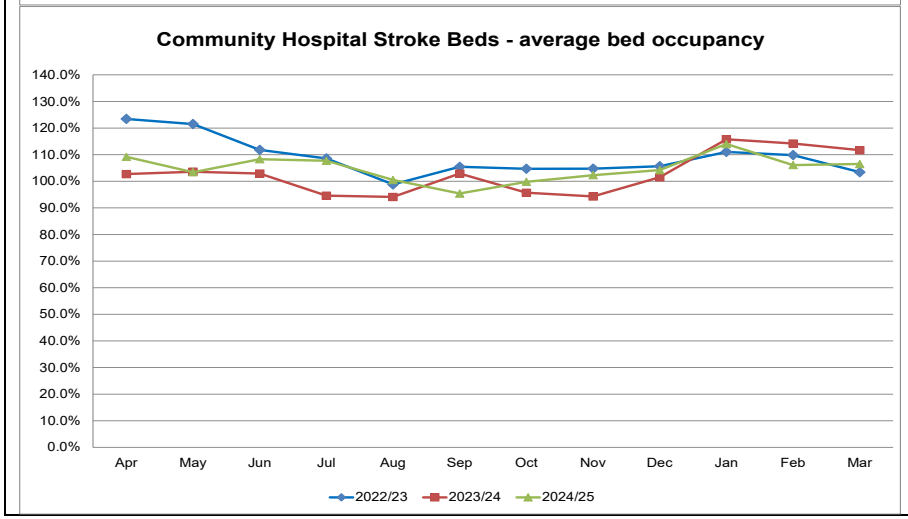
- Between 1 April 2024 and 31 March 2025, the number of Urgent Treatment Centre attendances was 5.2% higher than the same months of 2023/24, and 8.2% higher than the same months of 2022/23. During March 2025, 97.7% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 78%.
- The average length of stay for non-stroke patients in our community hospitals in March 2025 was 36.5 days, an increase compared to February 2025. The overall average length of stay for non-stroke patients in 2024/25 was 36.5 days, compared to 39.4 days in 2023/24. The community hospital bed occupancy rate for non-stroke patients in March 2025 increased to 94.5%, from 90.9% in February 2025.



Operational context

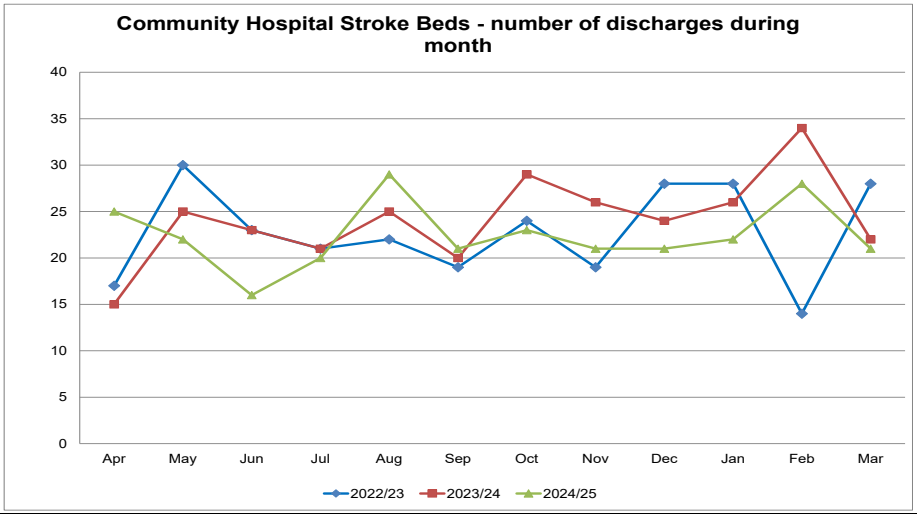
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





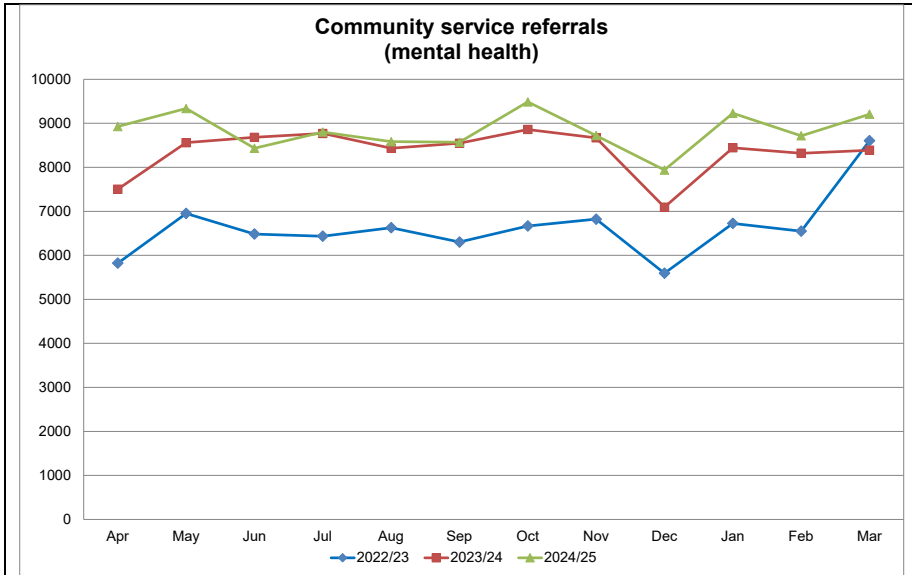
Summary:

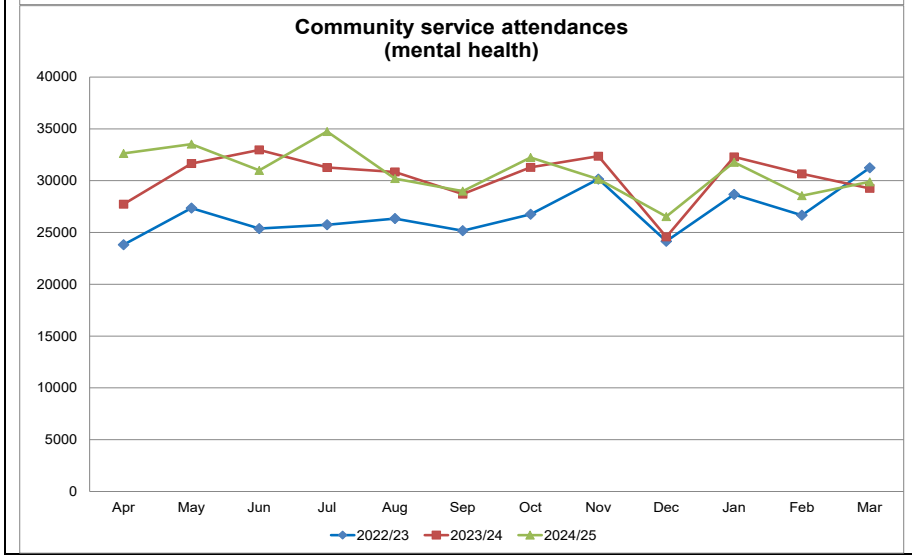
- The average length of stay for stroke patients in our community hospitals in March 2025 decreased to 43.0 days, from 48.9 days in February 2025. No patients discharged during March 2025 had a length of stay exceeding 100 days
- The average length of stay for stroke patients in 2024/25 was 48.6 days, up from 41.1 days in 2023/24. This is due principally to an increase in the numbers of patients discharged with very long lengths of stay.
- Stroke bed occupancy in March 2025 slightly increased compared to February 2025.
- During March 2025 there were 21 discharges of stroke patients, compared to 28 during February 2025.



Operational context

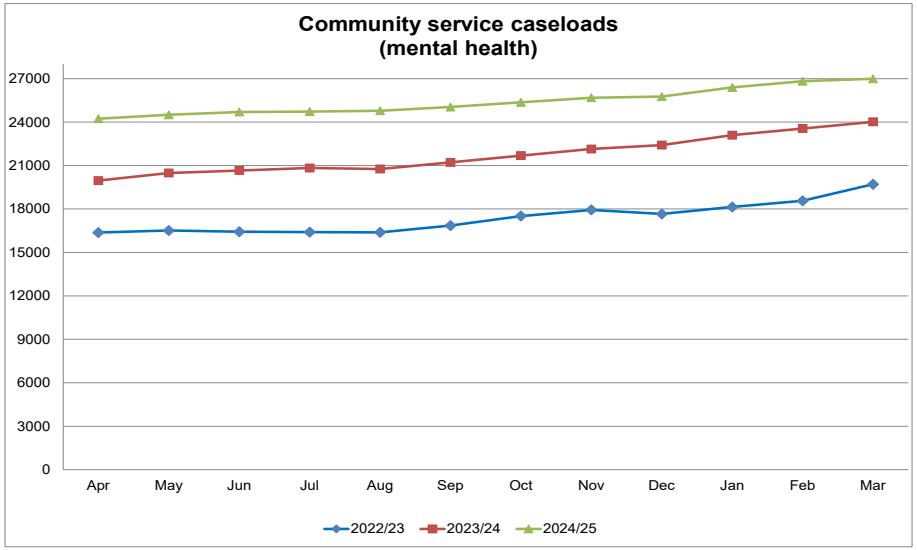
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





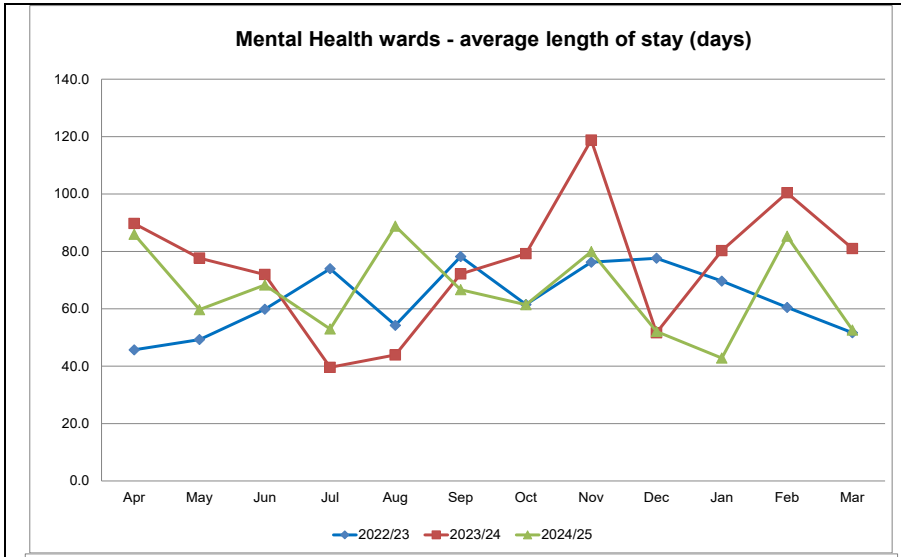
Summary:

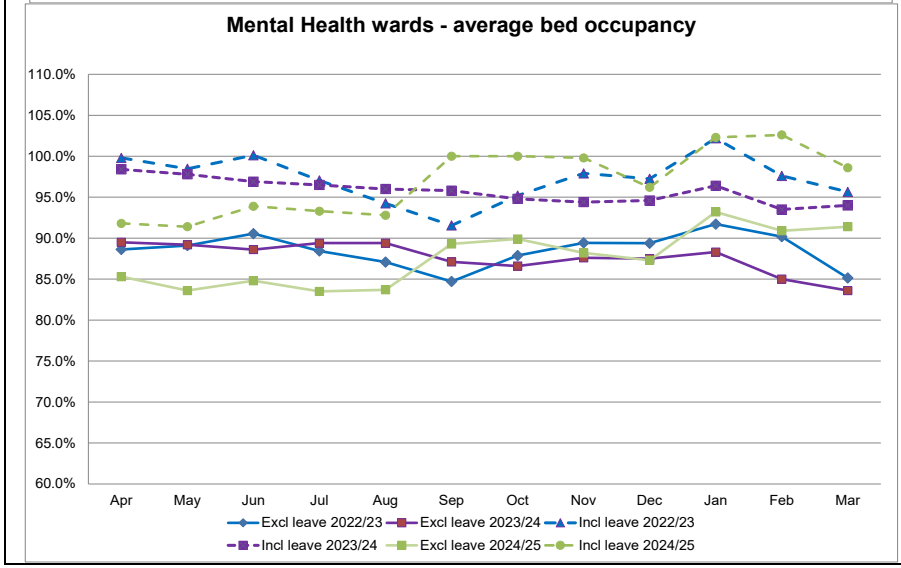
- Direct referrals to our community mental health services between 1 April 2024 and 31 March 2025 were 5.7% higher than the same months of 2023/24 and 33.1% higher than the same months of 2022/23.
- Attendances in 2024/25 were 1.8% higher than in 2023/24 and 15.2% higher than in 2022/23. Services which have seen significant increases in recorded activity include Primary Care Mental Health Services (Open Mental Health), Home Treatment, and Older People's Community Mental Health services.
- Community mental health service caseloads as at 31 March 2025 increased by 12.4% when compared to 31 March 2024 and were 45.4% higher than as at 31 March 2023. It should be noted that investment has facilitated the expansion of some community mental health services.



Assurance and Leading Indicators

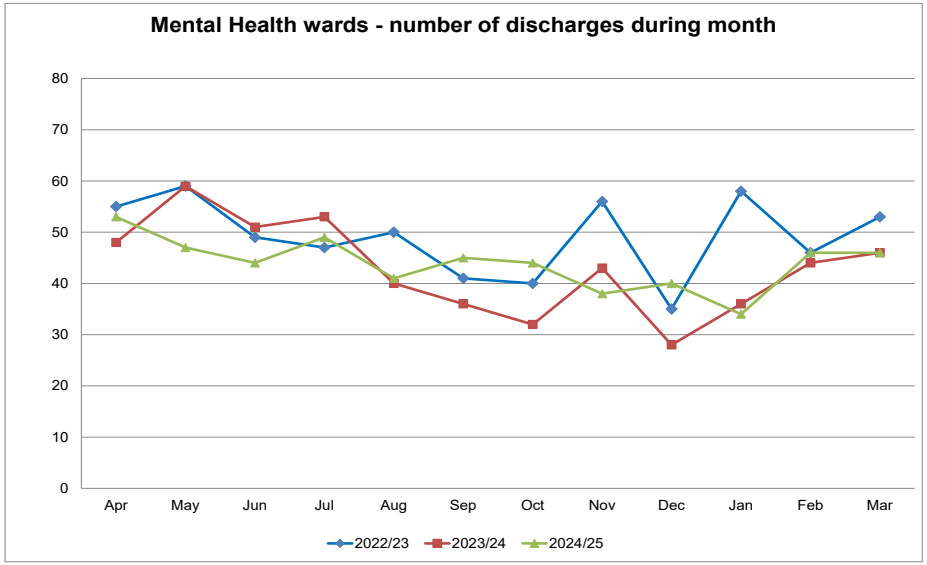
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





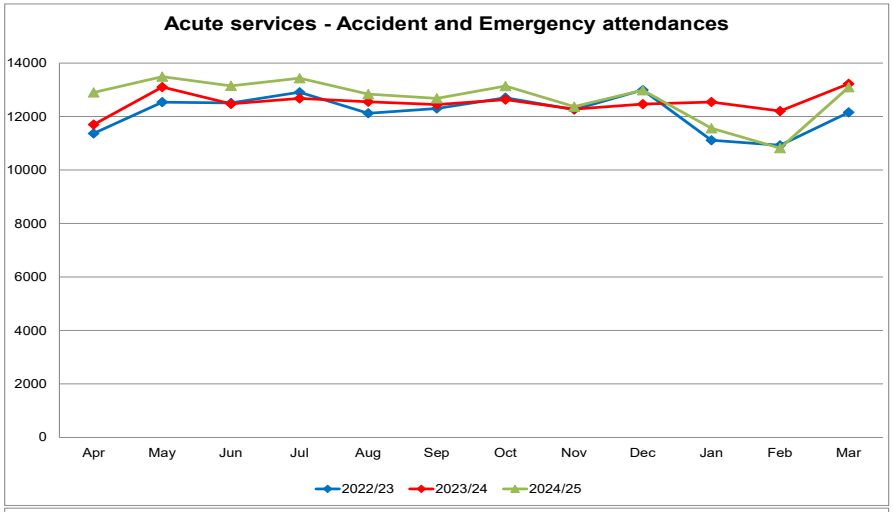
Summary:

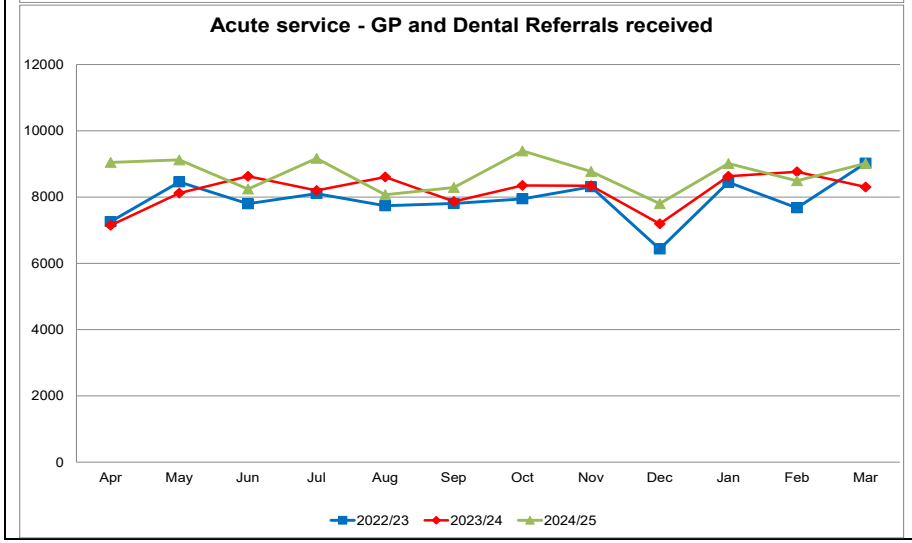
- The average length of stay across all of our mental health wards in March 2025 was 52.6 days, down from 85.3 days February 2025. During March 2025, 10 patients were discharged with lengths of stay of 100 days or more, including one patient discharged from Ash Ward, our low secure ward, who had a length of stay of 391 days.
- The average length of stay across all of our mental health wards in 2024/25 was 66.8 days, compared to 75.4 days in 2023/24.
- The mental health bed occupancy rates, on the basis of excluding leave increased in March 2025 compared to February 2025 but decreased when including leave. A total of 46 patients were discharged in March 2025, the same as during February 2025.



Operational context

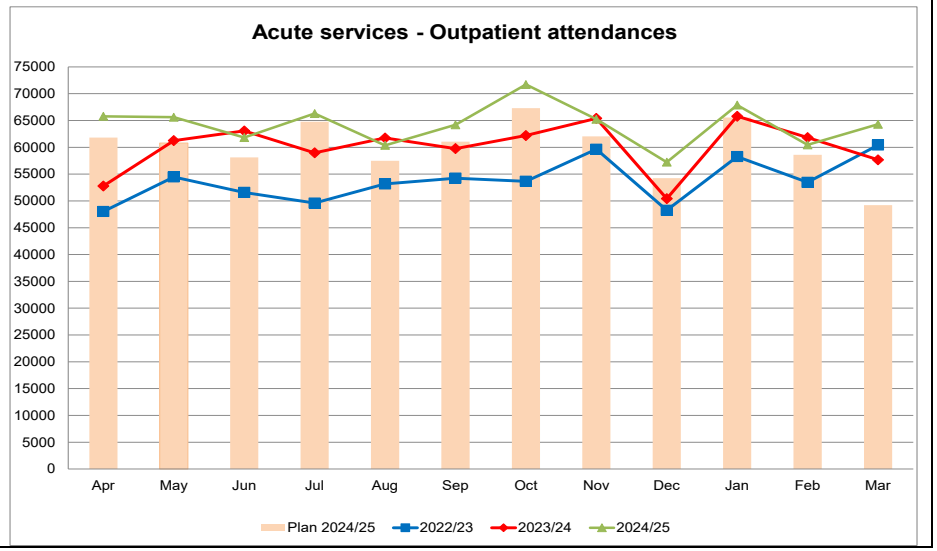
Acute services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior years.





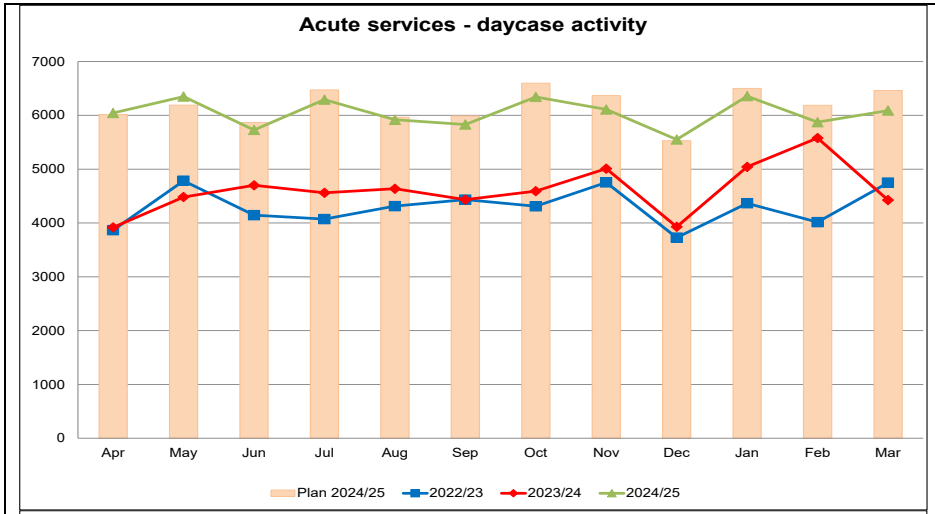
Summary:

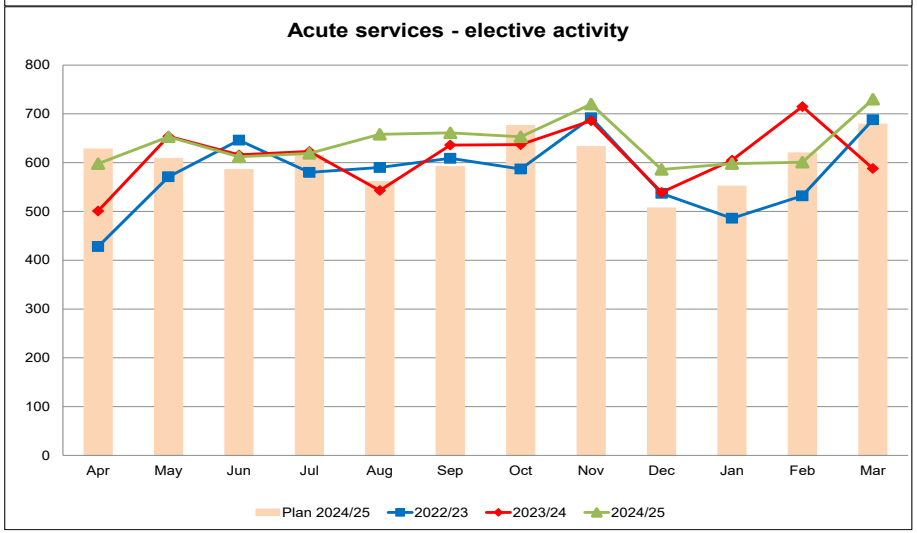
- Between 1 April 2024 and 31 March 2025 attendances to Accident and Emergency were 1.4% higher than the same months of 2023/24 and 4.5% higher than the same months of 2022/23. In March 2025, 52.8% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 78%.
- GP and Dental referrals between 1 April 2024 and 31 March 2025 were 6.4% higher than the same months of 2023/24 and 9.9% higher than the same months of 2022/23.
- Outpatient attendances for the same period were 6.9% higher than the corresponding months of 2023/24 and 19.6% higher than the same months of 2022/23. Attendances during 2024/25 were 6.9% above the interim plan for the year.



Operational context

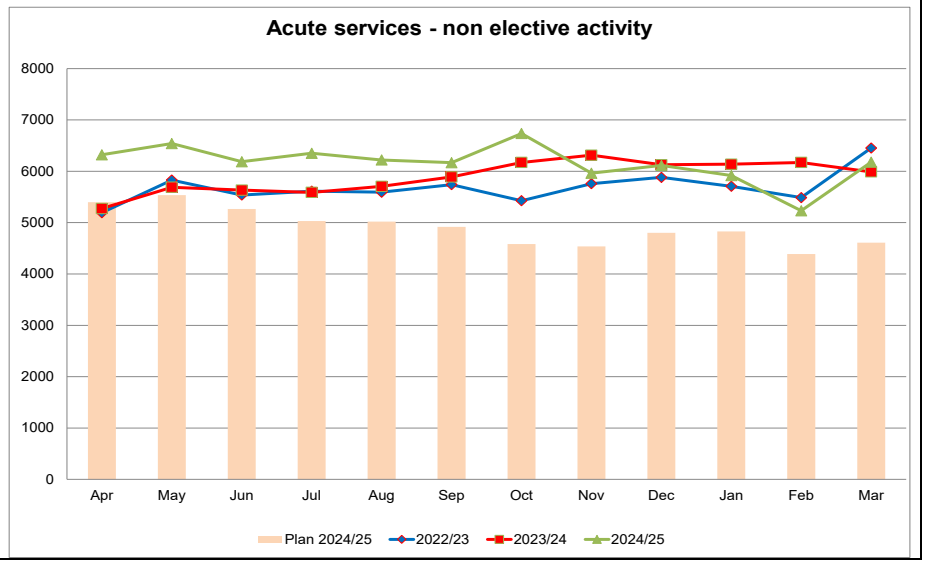
Acute services: This section of the report provides a summary of the levels of day case, elective, and non elective activity during the reporting period, compared to the previous months and prior years.





Summary:

- The number of day cases undertaken by our acute services between 1 April 2024 and 31 March 2025 increased by 31.1% compared to the same months of 2023/24 and by 40.7% compared to the same months of 2022/23. Activity for the year to date was 2.2% below the current year plan.
- Over the same period, elective admissions were 4.7% higher than the corresponding months of 2023/24 and 10.7% higher compared to the same months of 2022/23. Activity for the year to date was 5.9% above the current year plan.
- Non elective admissions also saw increases, of 4.6% compared to 2023/24 and 8.4% compared to 2022/23. Activity for 2024/25 was 25.5% above the plan.



Appendix 6 – Infection Control and Prevention – March 2025

MRSA bloodstream infections	Commentary on MRSA /MSSA BSIs
Musgrove Park Hospital = 0 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **End of year total = 4**	There are no national thresholds assigned to MRSA or MSSA bloodstream infections (BSI). However, there is a zero tolerance of MRSA BSIs and as a Trust we assign an internal threshold for MSSA. At the end of this financial year, the Trust is above threshold for both MRSA and MSSA bloodstream infections. **MRSA –** Case numbers remain stable. Although there was one more case than the previous year, this was a contaminant. **MSSA –** Overall case numbers of MSSA bloodstream infections have increased this year in comparison with the previous year; 152 cases in 2023/24 and 162 cases in 2024/25. Whilst the number of cases that are community associated remains the same, the proportion of Trust attributable cases has increased from 43% to 48%. The sources are varied but the most common remains peripheral vascular cannulae (28%). This year the national definitions of PVC related BSIs were applied to our post infection reviews of cases: • **PVC Related BSI –** the PVC is definitely the source of the infection • **PVC Associated BSI –** the PVC is probably the source of the infection This has increased the accuracy of identifying those that are linked to PVCs which could account for some of the increase in numbers, however, it does not explain all cases. Some of the patients had poor venous access and had difficult or multiple cannulations. Recent reviews of practice have highlighted issues with cleaning of cannula ports and with use of ultrasound guidance. A joint monthly audit between Matrons and IPC will commence the end of April to understand these issues further and implement improvements. Progress will be monitored via the Infection Control Committee.
MSSA Bloodstream Infections	
Musgrove Park Hospital = 4 Yeovil District Hospital = 3 Community Hospitals / Mental Health = 0 **End of year total = 77**	
E. coli bloodstream infections	**Commentary on Gram-negative bloodstream infections**
Musgrove Park Hospital = 9 Yeovil District Hospital = 5 Community Hospitals / Mental Health = 0 **End of year total = 124**	The number of Trust apportioned cases of Gram-negative bloodstream infections has slightly reduced this year (184 cases) in comparison to last year (202 cases). As a result, the Trust ends the financial year below the thresholds for all Gram-negative bloodstream infections.

Klebsiella bloodstream infections	Whilst the sources of the Trust apportioned Gram-negative BSIs are varied, two sources dominate, urine (39% of cases) and biliary / hepatobiliary (29% of cases). The focus has been on reducing the number of Gram-negative BSIs linked to urethral urinary catheters. Improvements are being sustained with only 17% of Gram-negative BSIs linked to urethral urinary catheters this year. However, overall numbers of Gram-negative bloodstream infections have slightly increased this year from 623 in 2023/24 to 648 in 2024/25. The proportion of these infections that are Trust attributable has reduced from 32% last year to 28% this year. This may be due to natural variation of disease but in part could be a response to the improvement work. It is clear, there is a significant burden of disease in community cases that are admitted to the Trust, several of which are due to a urinary source (not CAUTI). Work in community has focused on some strategies such as hydration, but further work is needed to determine if there are other opportunities to prevent these infections and resulting admissions. A joint venture is being discussed with the ICB.
Musgrove Park Hospital = 5 Yeovil District Hospital = 2 Community Hospitals / Mental Health = 0 **End of year total = 46**	
Pseudomonas bloodstream infections	
Musgrove Park Hospital = 0 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **End of year total = 14**	
C. difficile	**Commentary on C. difficile**
Musgrove Park Hospital = 4 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **End of year total = 90**	The Trust ends the financial year in line with the assigned threshold, although case numbers are increasing year on year. This is a national picture and is being reviewed by experts in the field. No clear drivers have been identified yet. Previously, increases have been associated with certain virulent strains of C diff such as 027. Additionally, the impact of certain antibiotics has driven case numbers. There are no obvious changes to antibiotic usage and there are no emerging strains of concern to explain the current national increases. As a Trust we have not had outbreaks or direct transmission between patients. Our focus continues to be on practice particularly around equipment and environmental cleanliness until further guidance is issued.

Respiratory Viral Infections - inpatients	Commentary on Respiratory Viral Infections
COVID (Trust Cases) = 13 Musgrove Park Hospital = 9 Yeovil District Hospital = 4 **Influenza = 72 (Inpatients)** Musgrove Park Hospital = 55 Yeovil District Hospital = 17 **Respiratory Syncytial Virus (RSV) = 30 (Inpatients)** Musgrove Park Hospital = 7 Yeovil District Hospital = 23	**Respiratory Viruses** Overall, respiratory virus case numbers have significantly reduced during March which is following a more normal seasonal pattern for the first time since the beginning of the pandemic.
Outbreaks	**Commentary on outbreaks**
COVID = 3 Musgrove Park Hospital = 2 Yeovil District Hospital = 1 **Influenza = 2** All Musgrove Park Hospital **RSV = 3** All Yeovil District Hospital **Carbapenemase Producing Organism (CPO)** • **YDH -** Since January 2022 there have been 82 cases of CPO identified on the YDH site.	Outbreaks decreased significantly in March. This has been another challenging year, with high numbers of outbreaks across all sites, spanning the whole financial year, with no break in occurrences. This has been further complicated with several wards affected by simultaneous outbreaks of more than one respiratory virus. However, at the end of the financial year outbreaks are settling, mirrored with a similar reduction in respiratory virus case numbers. This may be an indication that they are changing to a more seasonal pattern for the first time since the COVID pandemic began. **Carbapenemase Producing Organism (CPO) - YDH** This has been managed as a Trustwide outbreak which has spanned two key time periods, January 2022 to August 2023 and December 2023 to the current time. There are two different resistance mechanisms involved. The genes that encode for these resistance mechanisms can move between different species of bacteria which makes the linking of cases in the outbreak more challenging. This is the reason that more specialist testing has been required from UKHSA. A new testing strategy is being introduced that means all admissions to Yeovil will be screened for CPO on admission, this will help determine if new cases are due to acquisition in hospital or if CPO is now endemic in our community population. A deep clean of the wards is planned for Spring and Summer which proved effective previously in reducing cases.

Surgical Site Infections	Commentary on Surgical Site Infections
Surgical Site Infection Surveillance enables early recognition of infections to inform remedial and improvement actions. **Musgrove Park Hospital Site** Continuous surveillance for Total Hip Replacement (THR), Total Knee Replacement (TKR) and Spinal Surgery has been in place on the MPH site since 2009. **Yeovil District Hospital Site** Continuous surveillance on total hip replacement surgery has been in place on the YDH site since April 2022 and continuous surveillance was commenced on total knee replacement surgery from January 2024.	**Musgrove Park Hospital Site** • **Hip Replacement** Within the last year (March 2024 to February 2025) a total of 363 operations have been undertaken with no infections identified. • **Knee Replacement** Within the last year (March 2024 to February 2025) a total of 242 operations have been undertaken and 1 infection identified giving an infection rate of 0.41% which is in line with the national benchmark of 0.4%. • **Spinal Surgery** Within the last year (March 2024 to February 2025) a total of 329 operations have been undertaken and 5 infections identified giving an infection rate of 1.52%. This is a little above the national benchmark of 1.2%. **Yeovil District Hospital Site** • **Hip Replacement** Within the last year (March 2024 to February 2025) a total of 376 operations have been undertaken and 2 infections identified giving an infection rate of 0.53%. The infection rate has reduced and is now in line with the national benchmark of 0.5%. • **Knee Replacement** Within the last year (March 2024 to February 2025) a total of 417 operations have been undertaken with no infections identified. The national rate is calculated over the period April 2018 to March 2023 and therefore not directly comparable to trust infection rates. However, as a trust the national benchmark is always used as a guide. A task group is in place, led by the Surgical Service Group but working with infection control to identify any areas for improvement that might reduce the risk of infections. Expansion of the surveillance programme is planned for the next financial year.

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Wellbeing Guardian Report
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Louise Netto, Deputy Director of Experience and Learning
PRESENTED BY:	Graham Hughes, Non-Executive Director (Wellbeing Guardian)
DATE:	06/05/2025

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

Executive Summary and Reason for presentation to Committee/Board	This report outlines the health & wellbeing work undertaken since the last submission. It highlights areas of current work, future work streams, key challenges, and risks. It is set in the context of several key strategies that underpin endeavours relating to colleague health and wellbeing.
Recommendation	For the Board to be aware of the ongoing work, understand the challenges, risks and support the future work.

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

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

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

Equality and Inclusion The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
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.

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]

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

1. Introduction

1.1 This report outlines the health & wellbeing work undertaken since the last submission. It highlights areas of current work, future work streams, key challenges, and risks. Several key strategies set the context.

1.2 Appendix 1 provides additional detail in terms of data to support this report.

2. Background

2.1 Model Hospital Data suggests a strong trust performance on all indicators including Support and Compassion in comparison with median scores for regional peers.

2.2 **NHS Staff Survey** data suggests a consistent and sustained overall score for the 'We are Safe and Healthy' element of the people promise, however, there has been a significant drop in the perceived positive action on health and wellbeing by the organisation. This may be reflective of renewed focus on systemic interventions and the impact of subsequent changes to the approach, as well as internal team pressures preventing promotional activity.

2.3 **Proactive and preventative wellbeing strategies** are vital in creating and facilitating an organisational culture where the workforce is supported to prioritise their individual and collective physical and emotional wellbeing, in order to enhance their ability to sustain high levels of compassionate care in the face of high emotional and physical challenges (High Challenge / High Support model of workforce wellbeing).

3. Update from previous report

3.1 **Reactive and Responsive Support:** In June 2024 the Colleague Support and Wellbeing Services integrated into a single service. The purpose of the integration was to enhance the physical wellbeing offer in the trust alongside the existing emotional and psychological support for a more equitable wellbeing offer in line with trauma informed approaches which take into account the inextricable link between physical and mental health. The opportunities created by this integration have reduced silo working and duplication and presented a range of opportunities for integrated service development.

3.2 The **Wellbeing Action Group** (WAG) has provided a networking, learning, dissemination and escalation space for ongoing wellbeing activities and challenges from across the trust. It has served as a conduit between the Colleague Experience group, and Service Directors, as well as a space for colleagues from all service groups and levels of the trust to share best practice and learning in relation to local projects in order to enhance colleague wellbeing as a priority into 'business as usual'. This is significant since the opportunities for co-production serve to ensure meaningful and sustainable changes and developments, that best fit the

populations they are designed to serve. Themes which have been raised in the space include: Creative Break Taking, Physical Break Spaces and impact of

3.3 working environments, Violence and Aggression, Organisational Anxiety, trust wide/ partnership physical health projects, team development interventions etc. We will be reviewing the effectiveness of this space as part of the overall colleague experience portfolio review.

3.4 **A new Occupational Health provider (People Asset Management, PAM)** began in role on 1st January 2025. Transition has been more complicated than hoped but early feedback from colleagues who have used the service has been positive. Improvements in data analysis under the new contract have enabled us to calculate the cost impact of wasted appointments. This is significant at £13,170 in the first quarter and work is underway to understand what improvements can be made to avoid costs in the future There may also be further opportunities to explore preventative measures through their online offerings included in the contract. This work is ongoing.

3.5 **Trust data analysis regarding MSK and Stress** highlighted specific colleague groups at greater risk of absence/impact which has informed a number of developing projects (details below in **Future Developments**).

4. Further Developments

4.1 There is growing recognition that **systemic solutions** are required to address systems and relational issues which contribute to challenges to workforce wellbeing. The scope of control and influence of the organisation for some challenges may be limited (e.g. demand outweighing capacity, increased acuity, external resourcing and physical footprint etc). However, aspects of colleague experience and wellbeing at work can be enhanced by practical changes at service level, additional support and training for leaders across the trust, as well as access to preventative, proactive and responsive wellbeing interventions. Retention data shows a significant proportion of leavers have been more experienced colleagues in positions of leadership. Supporting our new generation of leaders to develop and thrive under the compassionate leadership framework will support, embed and infuse compassionate, inclusive and trauma informed care into the operational foundations of the organisation (in line with trust values). Research tells us that this will have a significant positive impact on colleagues' experiences and wellbeing at work, as well as supporting and sustaining compassionate care for patients, which in turn improves patient outcomes, patient experience and overall costs. Implementation costs to do this in a meaningful way may be a challenge, but we are exploring whether the recently announced NHS charities together transformation grant application process may support a time limited solution to develop a meaningful and sustainable approach.

4.2 **The Wellbeing portfolio** has been reorganised to include Colleague Support and Wellbeing Services, and Mediation, resolution and coaching services. This reflects the relational aspects of working in health care that have a direct impact on colleague experience and wellbeing, aligning with Trauma Informed principles which recognise that 'every interaction is an intervention'.

4.3 **Physical Environment:** The Health and Wellbeing Framework identifies the need for a healthy working environment. Data sources continue to indicate a lack of a space for breaks away from service areas and/or access to safe spaces during times of high pressure. Options vary depending on locations, and solutions may also depend on personal preferences. There remains a demand for multipurpose spaces across the Trust, not just limited to the two acute sites. There is a continued risk that support functions (CSS, PNA, HRA, FSUG, Managers etc) cannot find appropriate spaces to hold confidential 1:1's which impacts on service delivery and opportunities to support colleagues in compassionate, inclusive and trauma sensitive ways. We now have an agreement at exec level that any new buildings should consider rest spaces for colleagues as a matter of course, although it is not clear if this includes existing development projects and will not address existing limitations in the short term and remains a risk. This will be discussed further at the next people governance meeting on 15th May 2025.

4.4 **Colleague Support Service** tiered intervention structure continues to offer a range of universal, primary prevention, rapid response and complex support interventions at individual, team and organisational levels. Appendix 1 shows activity and impact data. Referral rates for the CSL have been sustained at around 50 new referrals every month, however the level of acuity and complexity (e.g. safeguarding, risk levels) have risen in the same time period. Colleague changes, planned absence and trust directives have contributed to the challenges of sustaining the service. The team have explored and implemented alternative ways of working to ensure continuity (e.g. stepping down new webinar projects) but an unintentional consequence of this is a lower public profile of wellbeing activity across the trust.

5. Level 5 (**specialist intervention**) individual referrals for work related difficulties have risen by 13% over last 12 months. This is likely to be an underestimate in terms of need due to alternative statutory/privately sourced routes available for specialist support and strict internal referral criteria. The service is reviewing internal resource allocation to build a more sustainable model to meet future demand, but an unintentional consequence of this is a lower public profile of wellbeing activity across the trust.

5.1 **Team interventions** have increased overall by 24% year on year (2023/24 - 24/25). To increase consistent and best practice access to trauma informed Post

Incident Support across the trust, two 2-day training sessions have been delivered in **Staff Support Post Incident and Post Incident Reflective Conversations (PIRC)** with colleagues who are already skilled in psychological practice and experience in facilitating therapeutic groups. Approximately 30 colleagues have been trained across multiple service groups to date. This is supported by a community of praxis structure to support and sustain the approach across the trust

5.2 in future. This has a benefit of reducing operational pressure on colleague support and spreads an evidence based, best practice approach to psychological first aid and trauma informed approach on an organisational level. Further training and community of praxis sessions are planned for next year following the success of the initial training.

5.3 Musculo Skeletal issues are often one of the top reasons for absence within the Trust. **The Physio4U service** has been redesigned to manage the increasing demand and since 1st January is now a manager referral only offer. Sixty slots have been allocated proportionately to the service groups. Close monitoring has been put in place to establish if this model is working. Demand is regularly still exceeding the quota in some service groups and will be reviewed on a quarterly basis.

6. Future Developments for 2025/26

- **Compassionate Leadership Training with Leadership and Organisational Development**

This project aims to embed compassionate leadership at the heart of our organisational culture and aligns with our strategic objectives. The training will be for individual leaders to orientate and enhance their understanding of the concepts within a compassionate leadership framework, develop their skills in how to embody, model and sustain this approach in their own areas of influence. Meaningful application and cultivation of compassionate leadership approaches across the workplace will encourage innovation and improvement in service delivery. The intention will be to align the training with existing projects to enhance an inclusive, compassionate and collaborative culture across the trust in accordance with the trust leadership framework.

- **Somerset Activity Sports Partnership (SASP) project**

Guided by population and staff survey data, this project with SASP will focus on HCA's and those with long term conditions focussing on increasing physical activity levels for physical and mental health benefits. In its infancy, the project team are drawing together the QI methodology and measures.

- **Health Fair Pilot**

This will follow on from the collaborative project with Somerset Council earlier in the year at MPH, where different aspects of healthy lifestyles such as blood pressure

screening, stop smoking, healthy weight, health checks were offered to colleagues. The pilot also provides an opportunity to canvas colleagues' opinion to understand more about the needs and wishes of the workforce when it comes to employer interventions for physical health.

- **Mediation, Resolution and Coaching Relaunch**

Our colleagues need to have access to psychologically safe spaces to develop and learn, particularly when traditional management spaces may not always be able to provide the necessary conditions or opportunities. Our internal coaching offer provides expert coaching to colleagues on a short-term basis. New support structures and CPD opportunities for existing and new coaches will enhance the offer within the trust, creating a cost effective, sustainable, supportive community of practice to ensure a consistent and evidence based coaching offer.

Ongoing Collaborations with organisational and external stakeholders:
Sexual Safety Committee
Violence and Aggression Working Group
Leadership and Organisational Development
Preceptorship
Observation and Support Training
F1 Training

Somerset Activities Sports Partnership
Somerset Council Public Health Team
University of Exeter

Research Contributions and National Representation
CUP3 Study involvement https://sites.exeter.ac.uk/careunderpressure/care-under-pressure-3/
Association for Clinical Psychology Staff Health and Wellbeing Advisory Group
Menopause Special Interest Group (National)
Trauma Informed Care SW Group

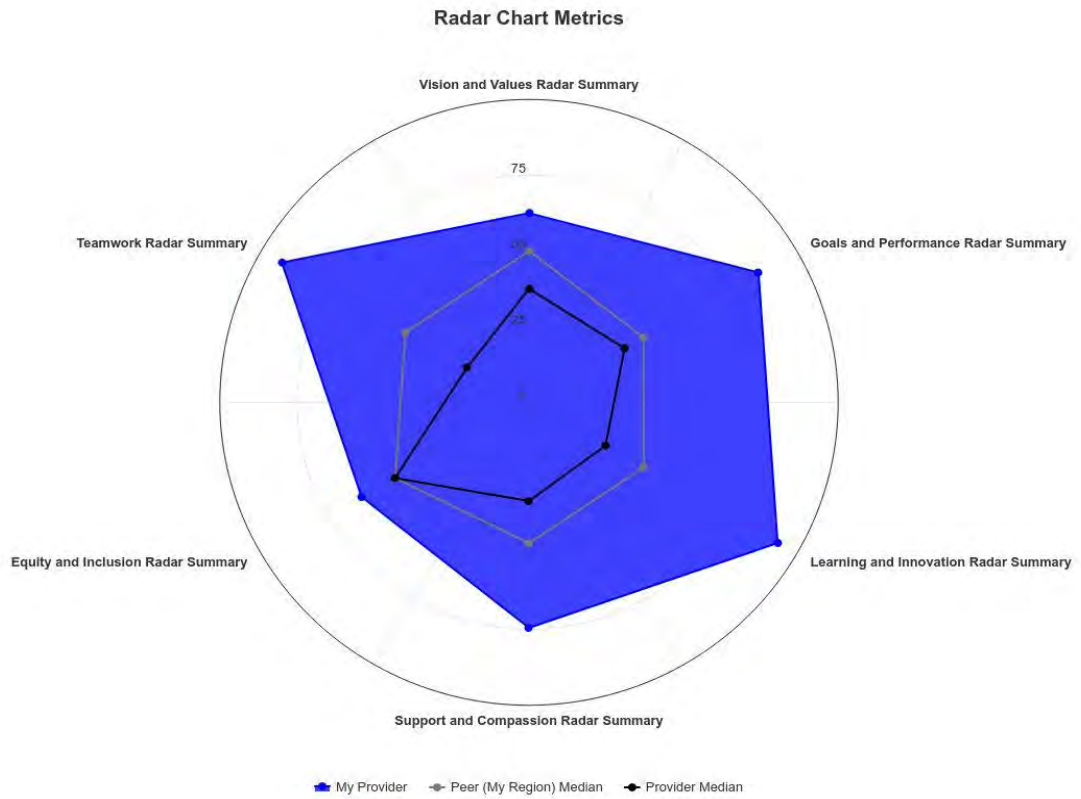
Kindness, Respect, Teamwork
Everyone, Every day

Wellbeing Guardian Report
May 25 : Appendix 1

Model hospital data

How we currently compare nationally:

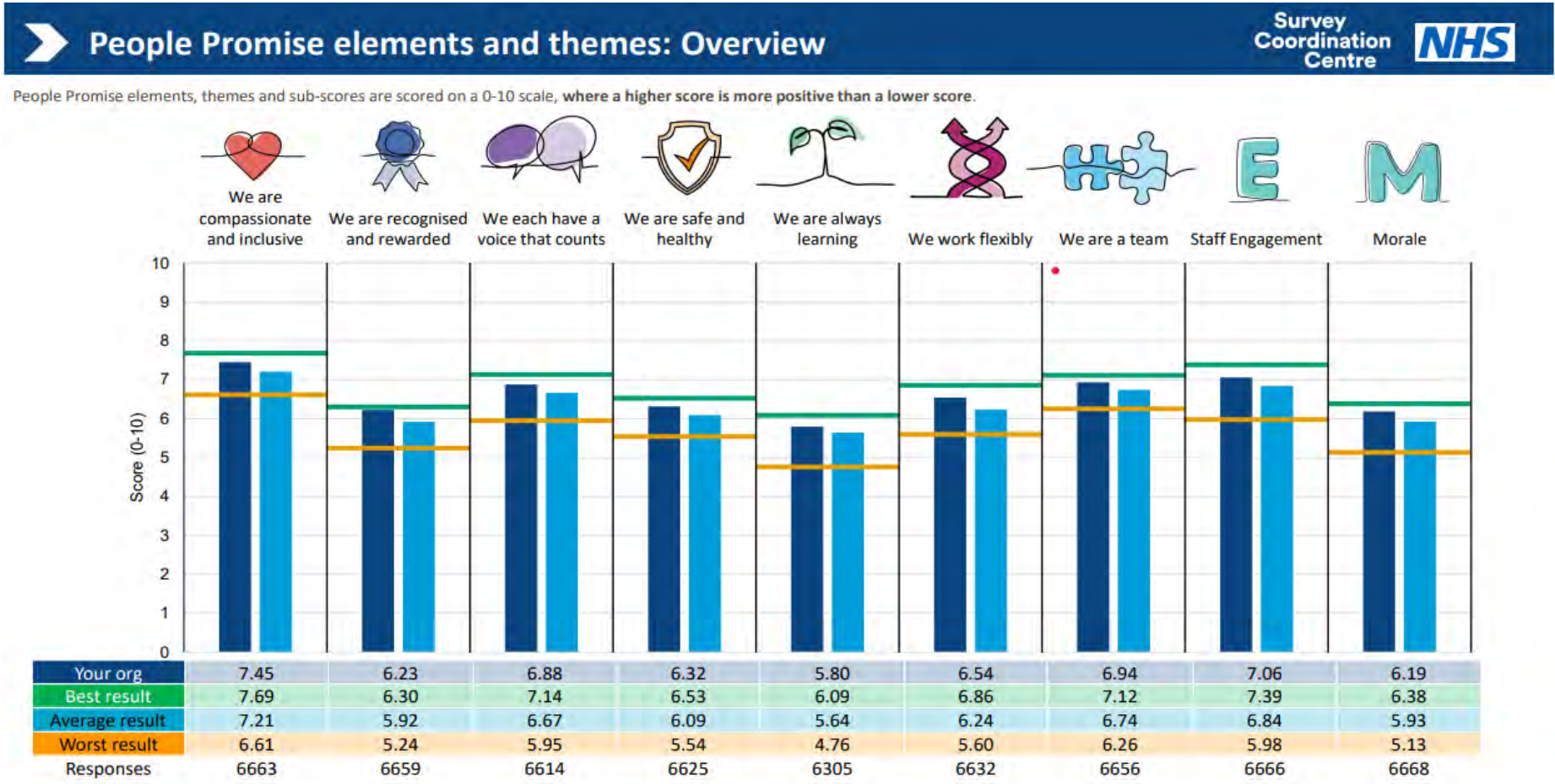
- Strong performance indicators across all metrics in relation to peers.
- No National Comparators with same level of integration as a provider: Somerset Foundation Trust (Mental Health, Acute & Community).



Staff Survey 2024

Overall Staff Survey results show above average scores for elements which impact directly on Colleague Wellbeing:

- We Are Safe And Healthy
- We are Compassionate and Inclusive
- Staff Morale



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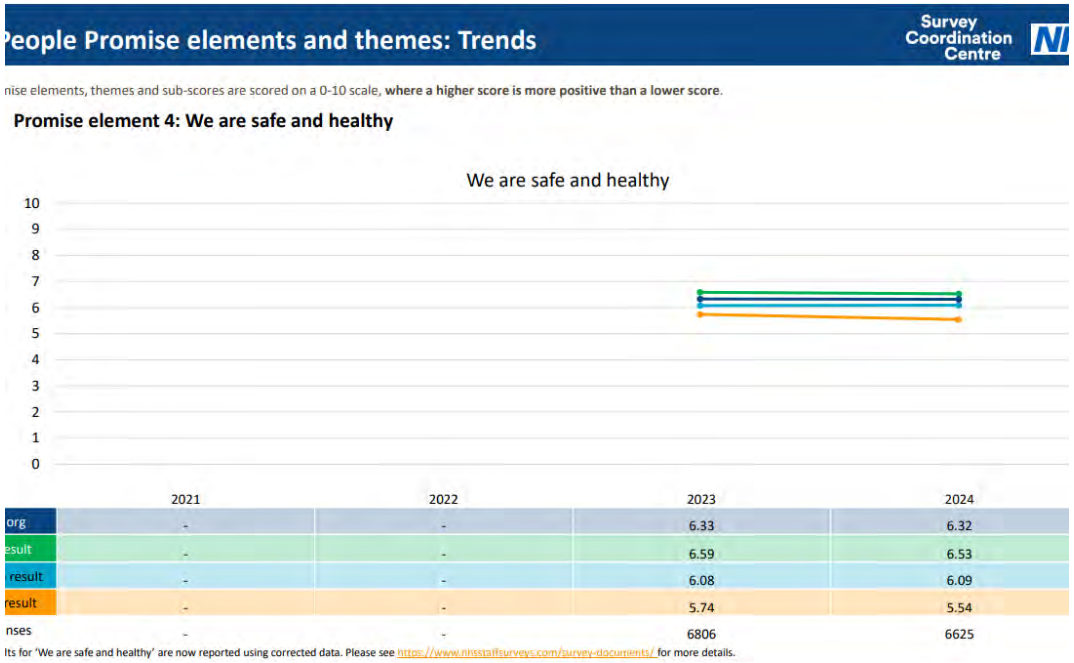
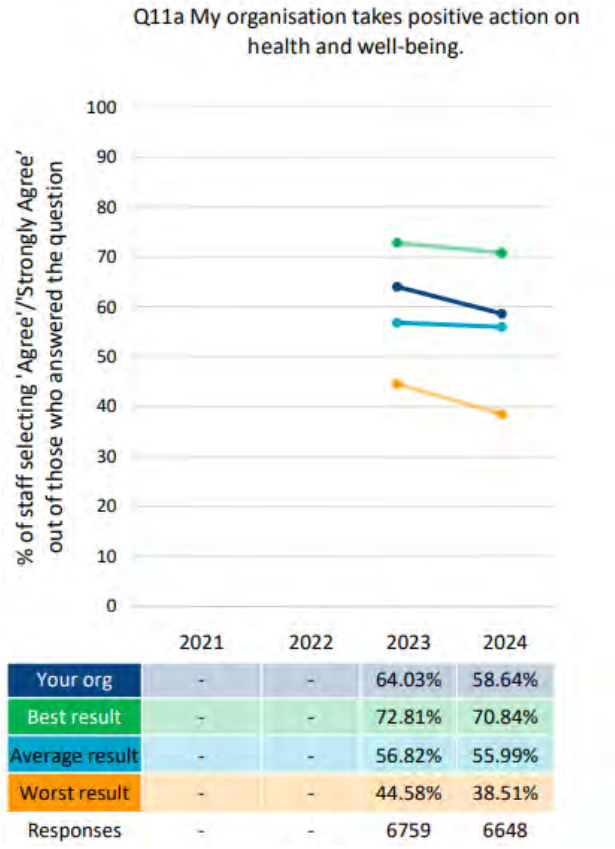
Staff Survey (2) – themes and sub-scores



Consistent and sustained overall result with previous year but……

….significant decline in perceived positive action on health and wellbeing by organisation



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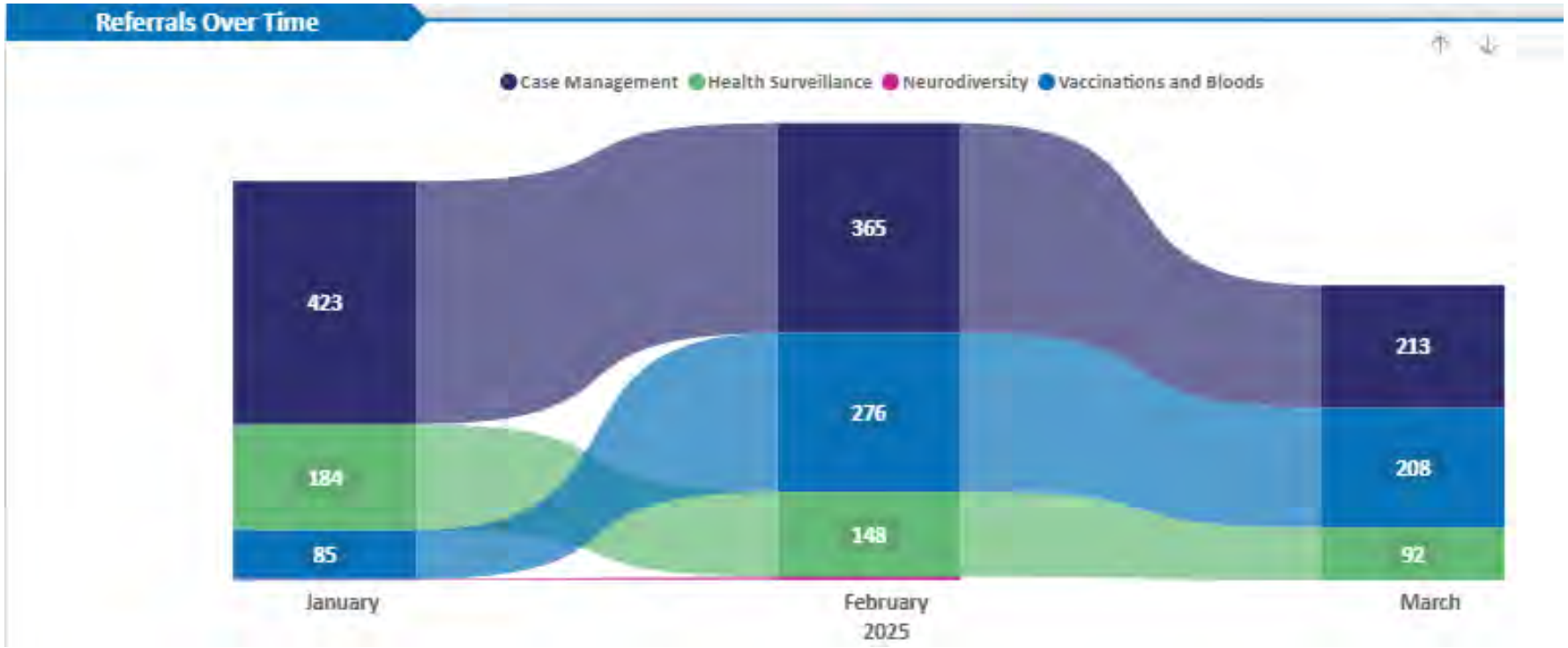
Everyone, Every day

Occupational Health Data - PAM

Kindness, Respect, Teamwork
Everyone, Every day

Referrals Made

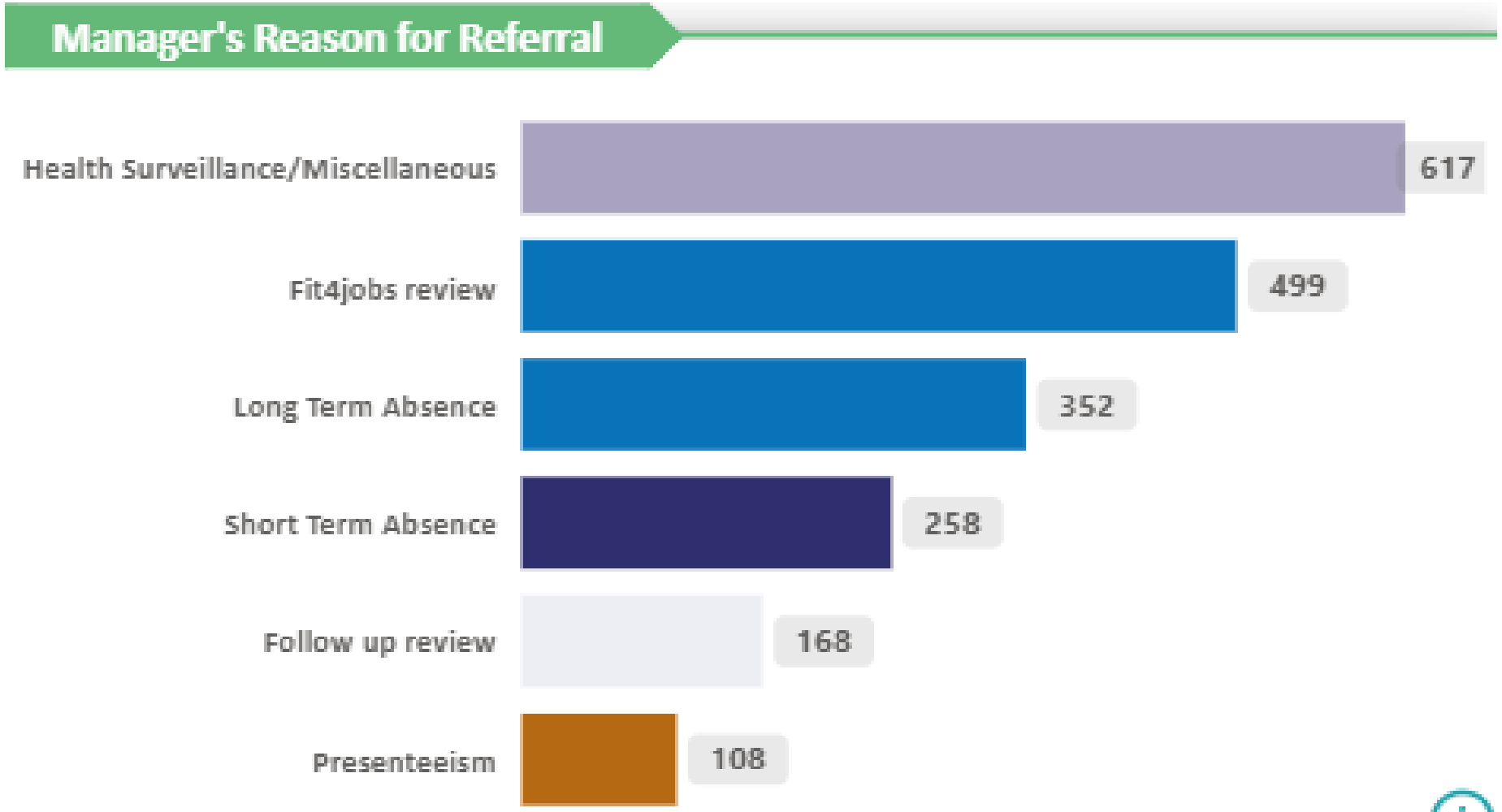


Steady build over time.

Most were for management referrals

Work In Progress List now means vaccinations and other processes can be started.

Referrals Made Continued



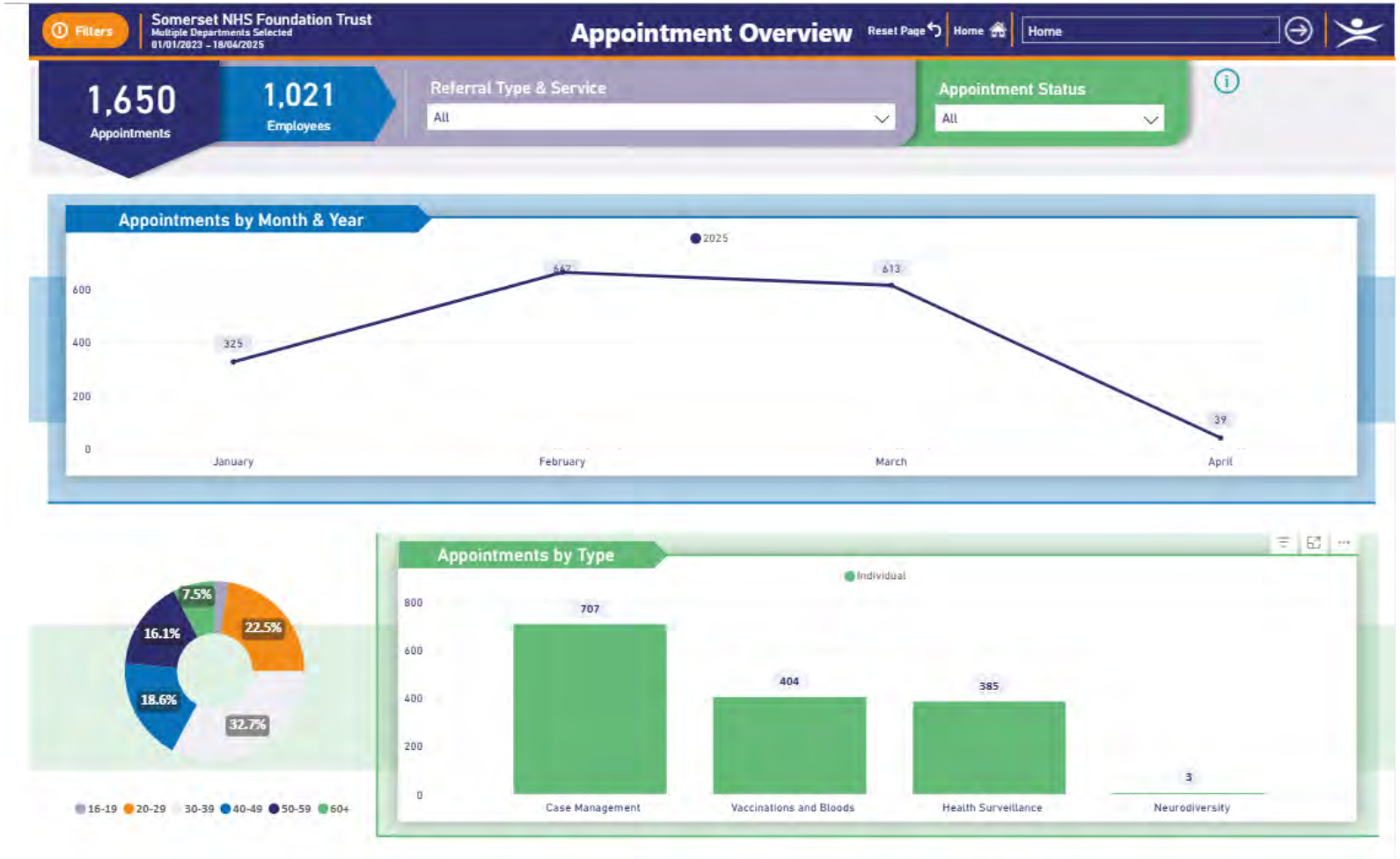
Time to Refer

Time to Refer	ERTW	Fit	Further Intervention Required	Unfit
In Work	3%	94%	1%	1%
0-1 Week	34%	34%	24%	8%
1-4 Weeks	34%	41%	20%	5%
4-8 Weeks	28%	22%	41%	9%
8-16 Weeks	36%	40%	20%	4%
16+ Weeks	19%	25%	53%	3%

Tier 2 Department	In Work	0-1 Week	1-4 Weeks	4-8 Weeks	8-16 Weeks	16+ Weeks
Somerset NHS Surgical Services	102	8	20	10	11	9
Somerset NHS Neighbourhood Services	75	6	14	16	10	13
Somerset NHS Corporate Support Services	72	5	7	6	6	5
Somerset NHS Clinical Support and Cancer Services	53	6	4	5	4	3
Somerset NHS Mental Health and Learning Disabilities	47	4	8	4	7	3
Somerset NHS Medical Services	38	3	5	7	12	5
Somerset NHS CYP & Families Services	52	2	6	5	4	
Somerset NHS SSL Corporate	8	2	1	2	1	

Main illnesses for colleagues not in work:
Mental Health, MSK, Gastro, GU/Gynae and other known causes.

Appointment Overview



Over 1,000 colleagues have been seen in 12 weeks.

Wasted Appointments

Top Locations by Cost

- Fit4Jobs recruits
- Beacon Physicists
- South Petherton Wards

Top Locations by missed appointments

- Recruitment Medical Fit4Jobs Recruits

Occupational Health Services Feedback

"The system was easy to use and making the referral was straightforward. The colleague was seen promptly."

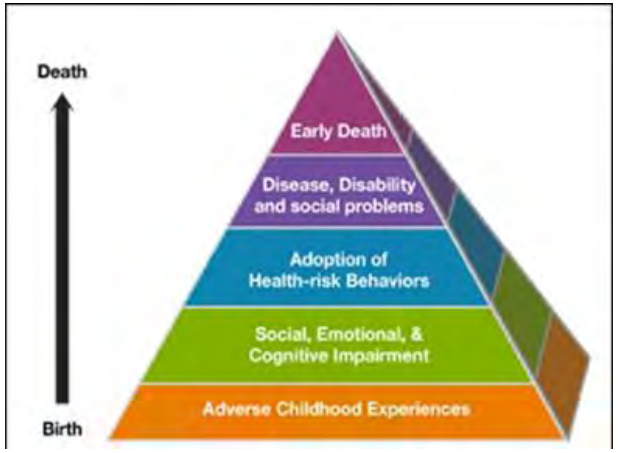
"The process was good and the report was helpful in supporting my colleague".

"It's frustrating that all colleagues aren't yet uploaded to the system"

Colleague Support and Wellbeing Service Data

Kindness, Respect, Teamwork
Everyone, Every day

Recognising the inextricable link between Physical, Psychological and Emotional wellbeing and ensuring an equitable approach

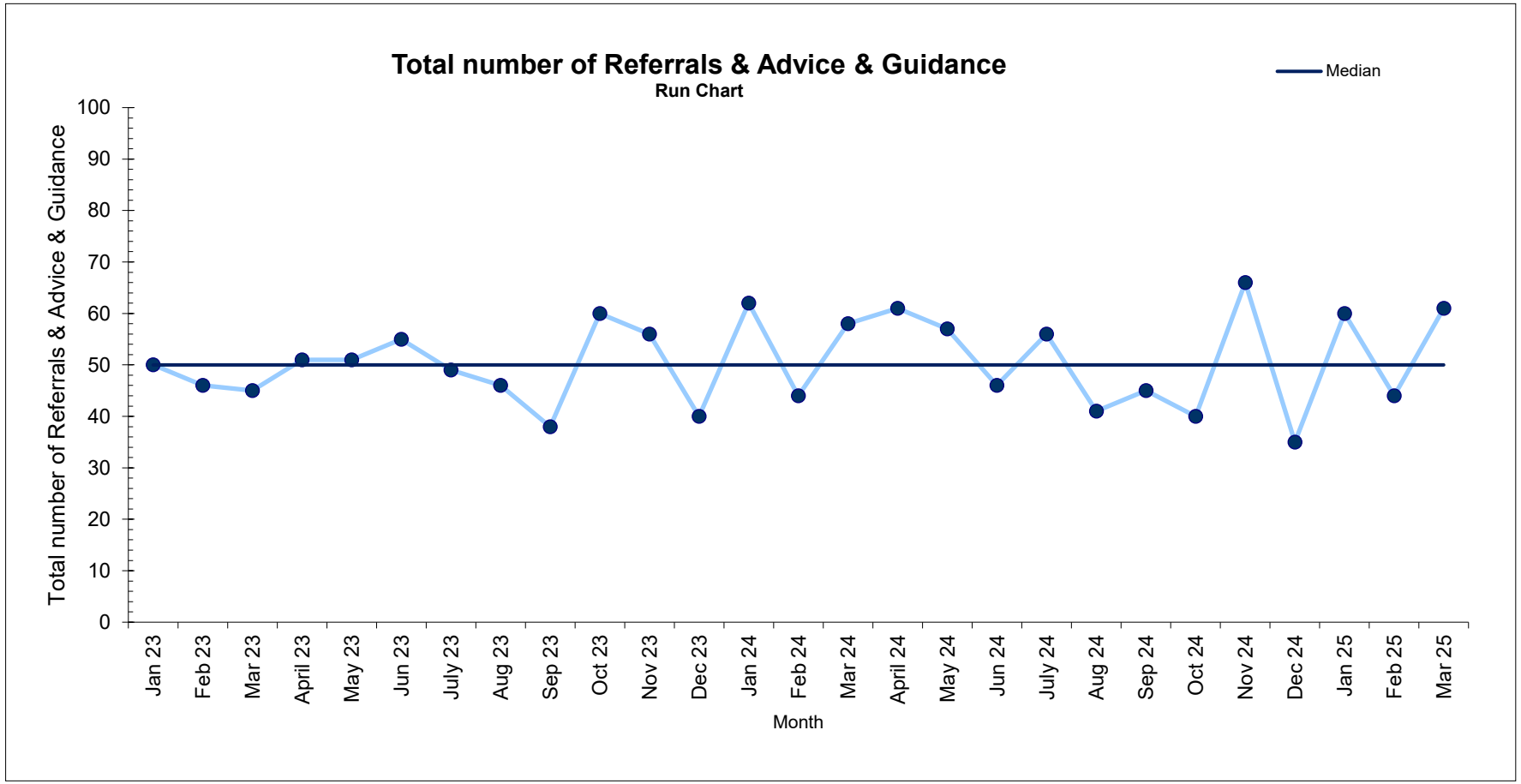


Physio for you: Referrals Made

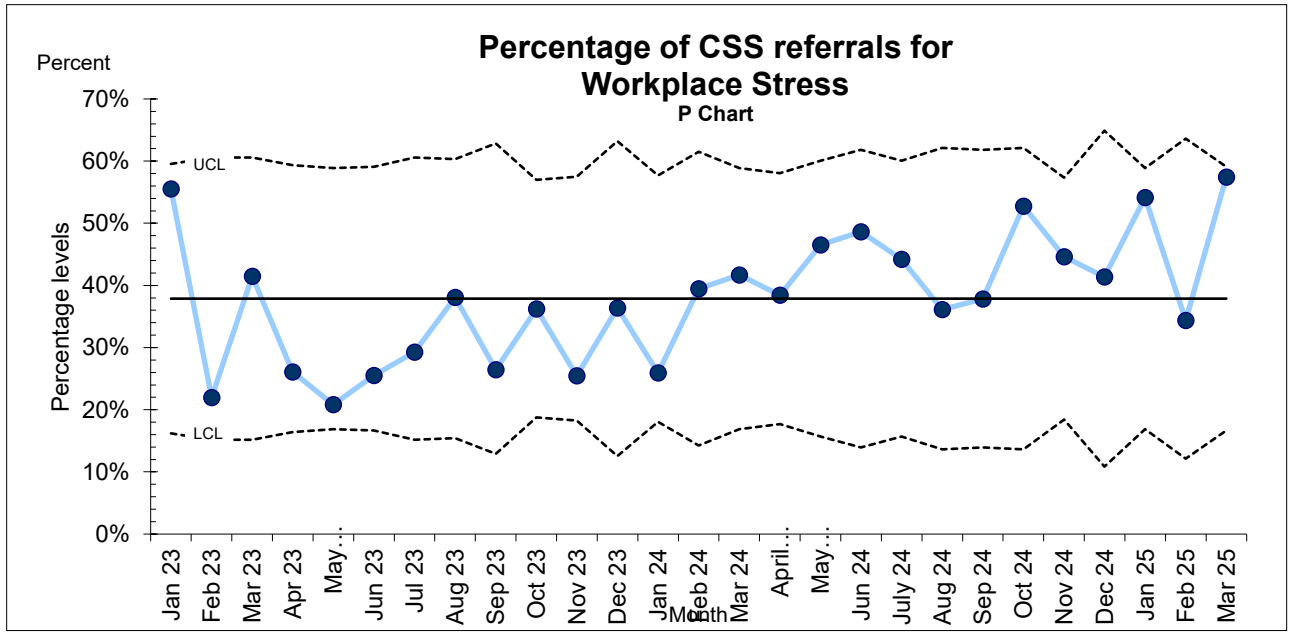
	Jan-25	Feb-25	Year total	Total since Sept 21 launch		Sept 21-Dec 24
Number of P4U self/manager referrals	61	64	125	**2753**		2628
Number of Colleagues who received an appointment within 5 working days	58	52	110	**2052**		1942
Percentage appointment within 5 working days	95%	81%				
Number of face to face follow ups	48	42	90	**1611**		1521
Percent requiring face to face follow up following initial consultation	79%	66%				

Colleague Support Service Support Line: Total Number of Referrals and Advice & Guidance

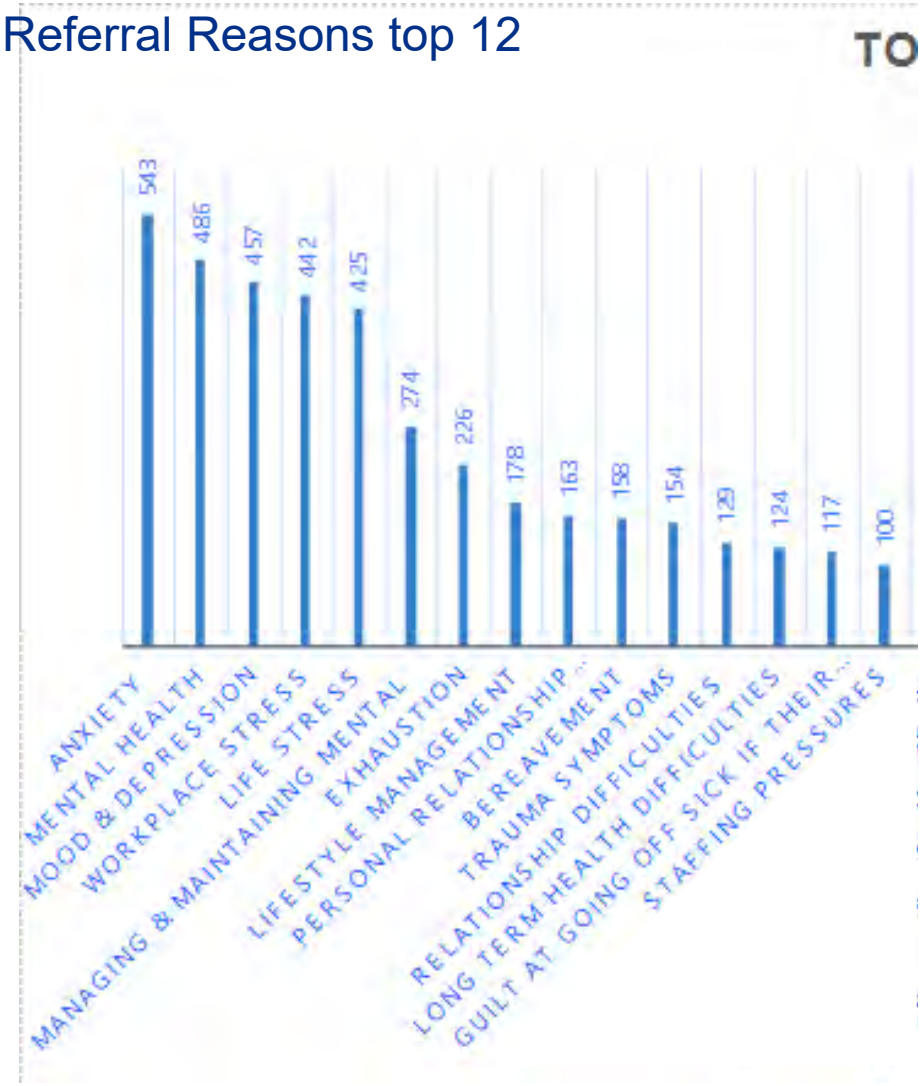
Date	Number of referrals per month
Jan 23	50
Feb 23	46
Mar 23	45
April 23	51
May 23	51
Jun 23	55
July 23	49
Aug 23	46
Sep 23	38
Oct 23	60
Nov 23	56
Dec 23	40
Jan 24	62
Feb 24	44
Mar 24	58
April 24	61
May 24	57
Jun 24	46
July 24	56
Aug 24	41
Sep 24	45
Oct 24	40
Nov 24	66
Dec 24	35
Jan 25	60
Feb 25	44
Mar 25	61
Total	1363



Referral Reasons



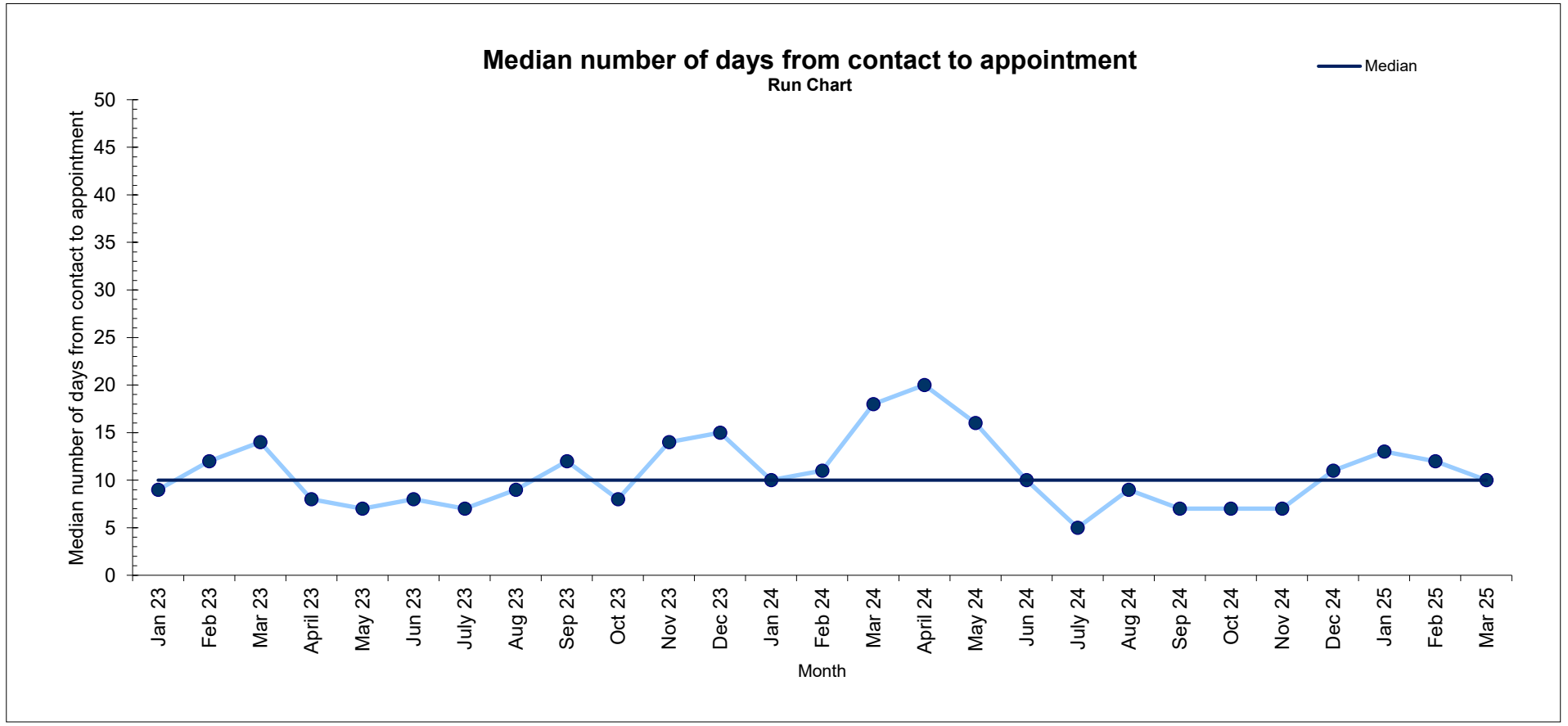
Referral Reasons top 12



Contact to Appointment Data

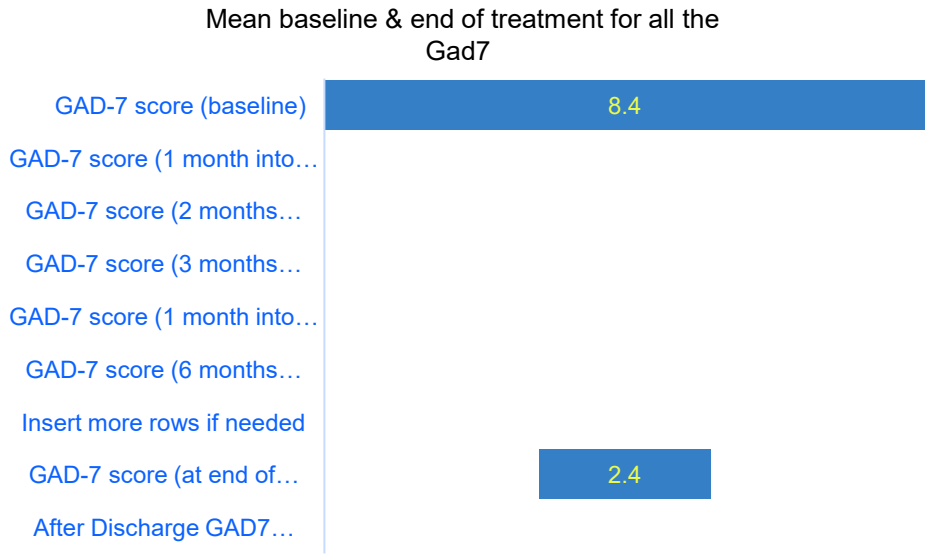
Monthly calls to the Colleague support Telephone Line

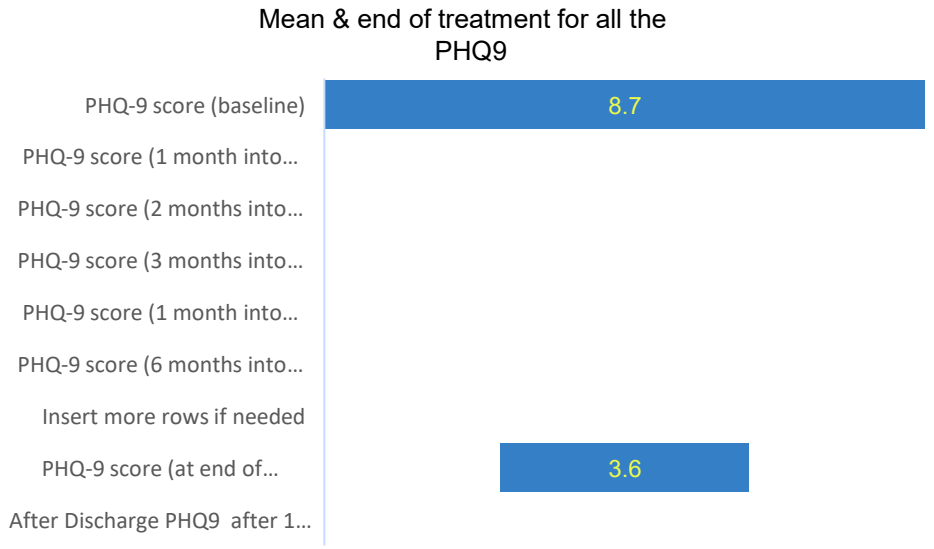
Month	Median number of days from contact to appointment
Jan 23	9
Feb 23	12
Mar 23	14
April 23	8
May 23	7
Jun 23	8
July 23	7
Aug 23	9
Sep 23	12
Oct 23	8
Nov 23	14
Dec 23	15
Jan 24	10
Feb 24	11
Mar 24	18
April 24	20
May 24	16
Jun 24	10
July 24	5
Aug 24	9
Sep 24	7
Oct 24	7
Nov 24	7
Dec 24	11
Jan 25	13
Feb 25	12
Mar 25	10
Total	289



GAD & PHQ9 data

Monthly calls to the Colleague support Telephone Line





Feedback – Colleague Support Line

March 2025

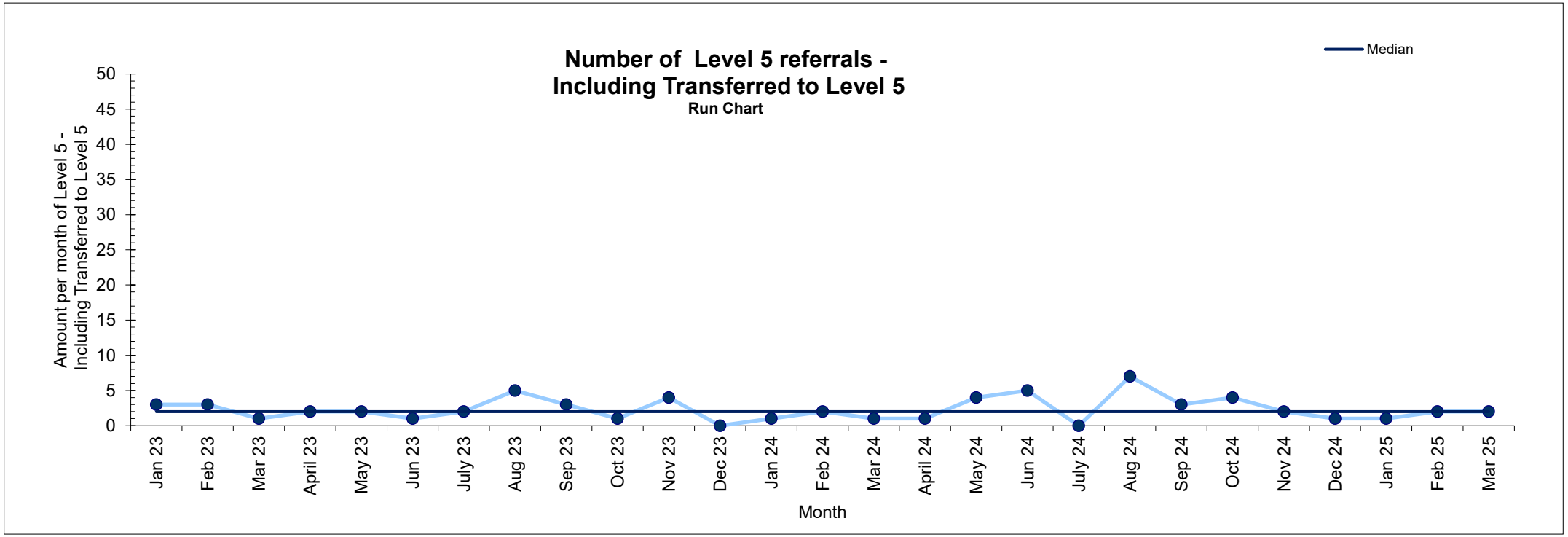
I want to say a huge thank you for your support at a time when I was processing the events that happened. You gave me the space to process and also the validation of my feelings about what happened. Thank you again for being so easy to talk with.

If I'm honest, I did not think this service was going to be of much help, but i can honestly say it has helped me a lot and i finished with the reassurance that if I have a blip, I can call the colleague support line for a one-off chat.

Amazing service, essential given the pressures on staff, really helped me to stay in work and manage work and home life during a difficult time in my life.

This service and the ladies I spoke to on my initial call and then my 2nd call made a big difference to how I was feeling - sometimes it's nice just to talk about things that are making you anxious at work and be listened to because it does not matter how small or large the issue is , it causes anxiety/ stress and a simply conversation with an independent person can really help .

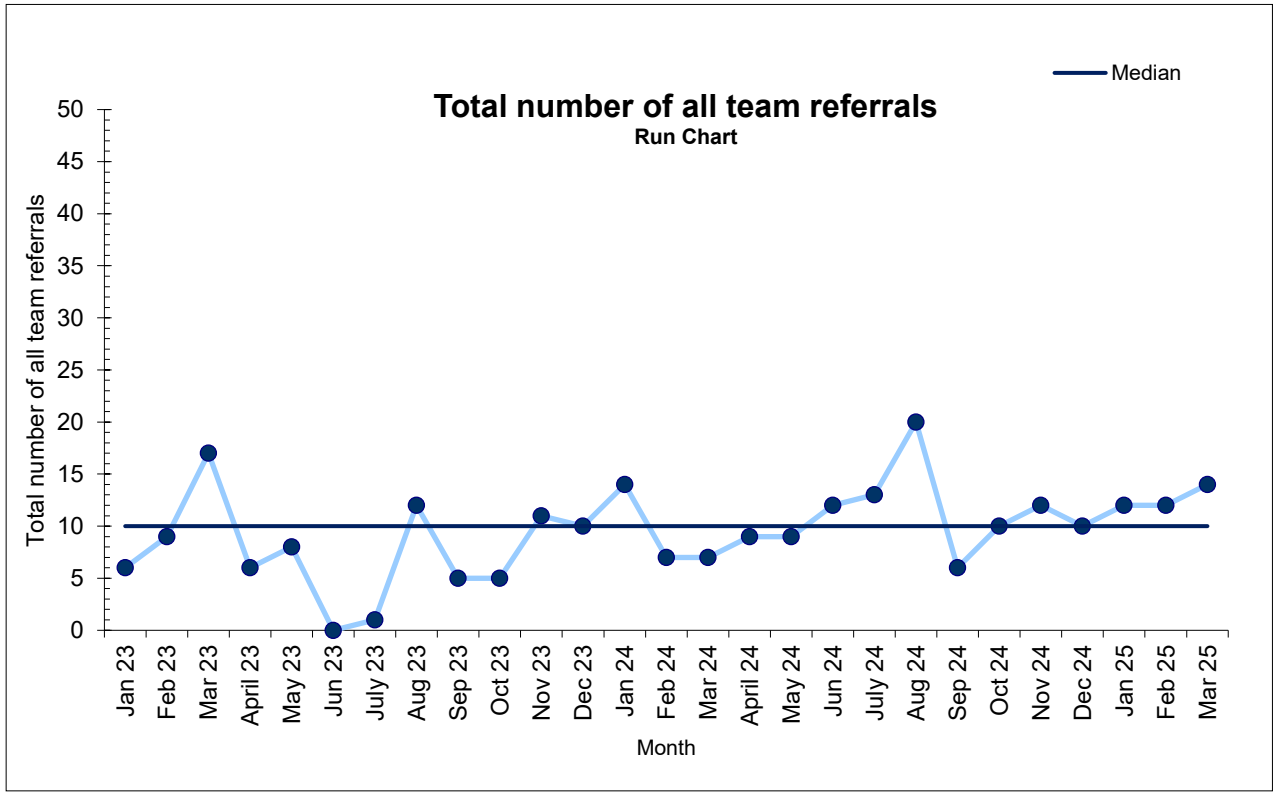
Number of Level 5 (Specialist) Referrals



There has been a 13% increase in level 5 referrals between 2023/24 and 2024/25 financial year

Team Intervention Referrals

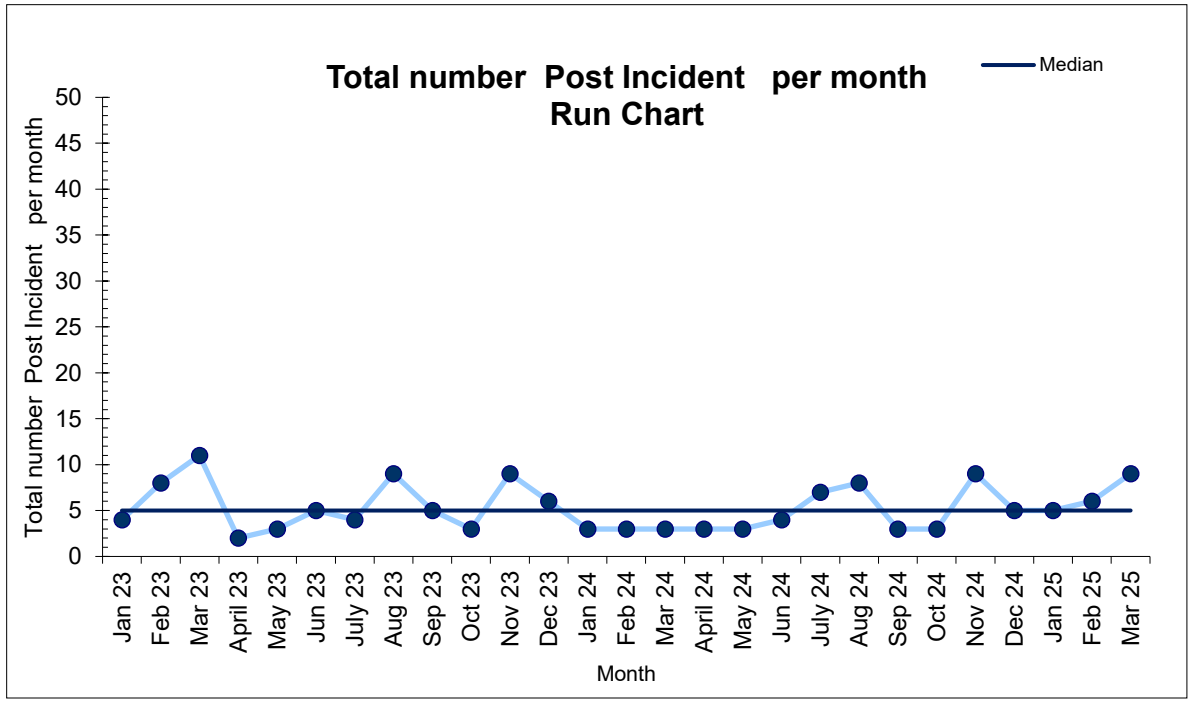
- Referral reasons:
  - Consultation
  - PIRC
  - Supervision
  - Team Support
  - Compassion Circle
- Upward trend
- Increasing demand:
  - Longer response times
  - Stricter Criteria
  - Prioritisation of resources



24% increase in team referrals year on year (2023/24 – 24/25)

Feedback:

'Thank you for all the sessions you have done with our team recently. We are very grateful for your time and for the kind, caring and compassion that you have given us throughout this difficult period for our team. We all feel that you have really listened to us and helped guide us where to go next…'


Total number Post Incident per month
Run Chart
Median
Total number Post Incident per month
50
45
40
35
30
25
20
15
10
5
0
Jan 23
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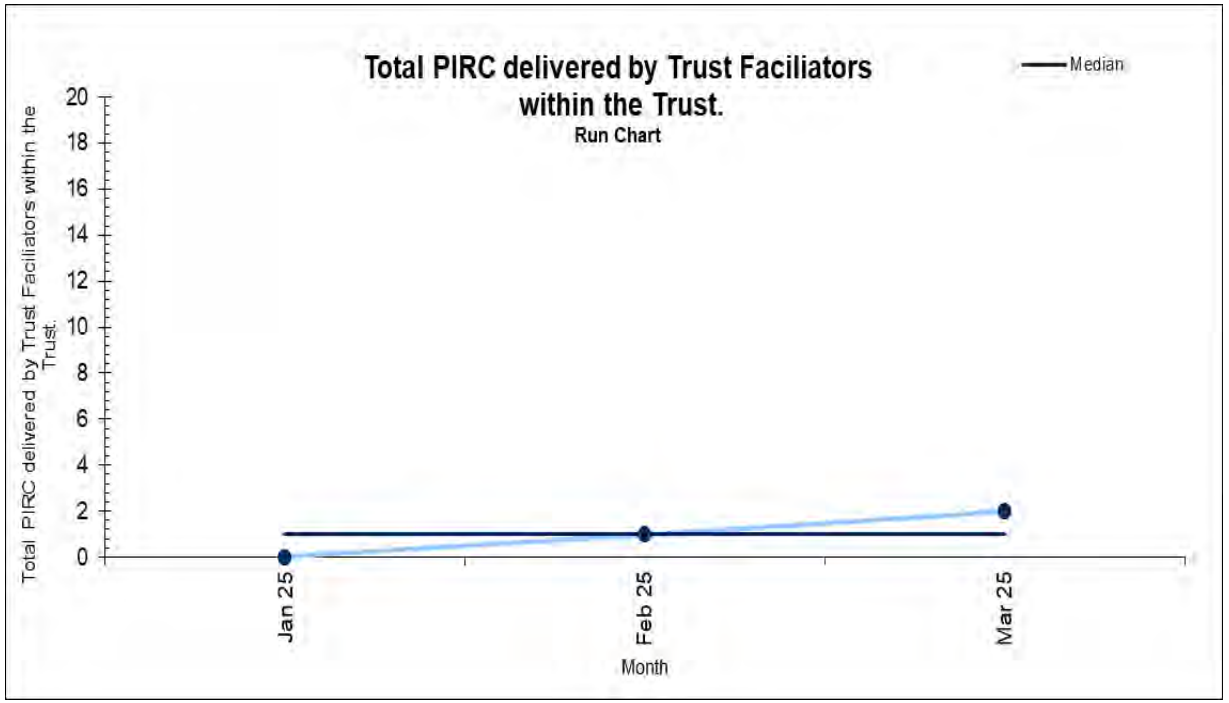
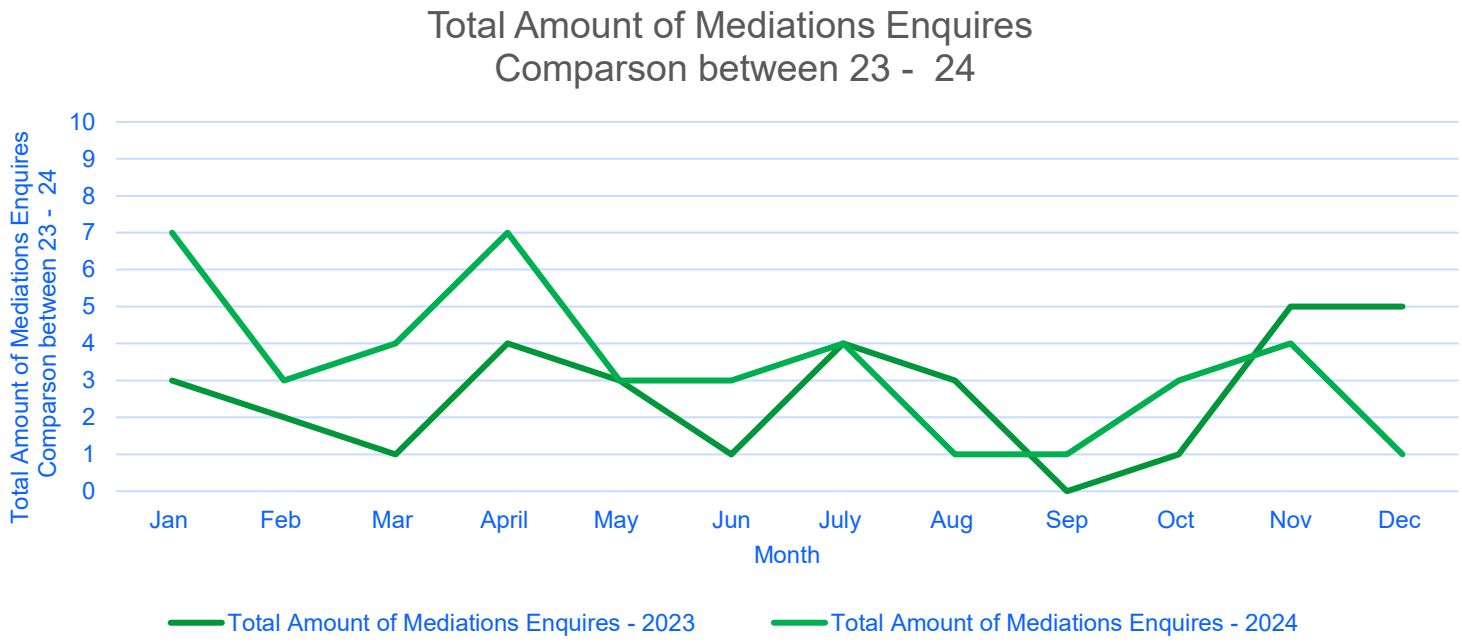
Month


Total PIRC delivered by Trust Faciliators within the Trust.
Run Chart
Median
Total PIRC delivered by Trust Faciliators within the Trust.
20
18
16
14
12
10
8
6
4
2
0
Jan 25
Feb 25
Mar 25
Month

Mediation, resolution and Coaching

Mediation Enquiries 2023/24

Date	Total Amount of Mediations Enquires - 2023	Total Amount of Mediations Enquires - 2024
Jan	3	7
Feb	2	3
Mar	1	4
April	4	7
May	3	3
Jun	1	3
July	4	4
Aug	3	1
Sep	0	1
Oct	1	3
Nov	5	4
Dec	5	1
Total	32	41

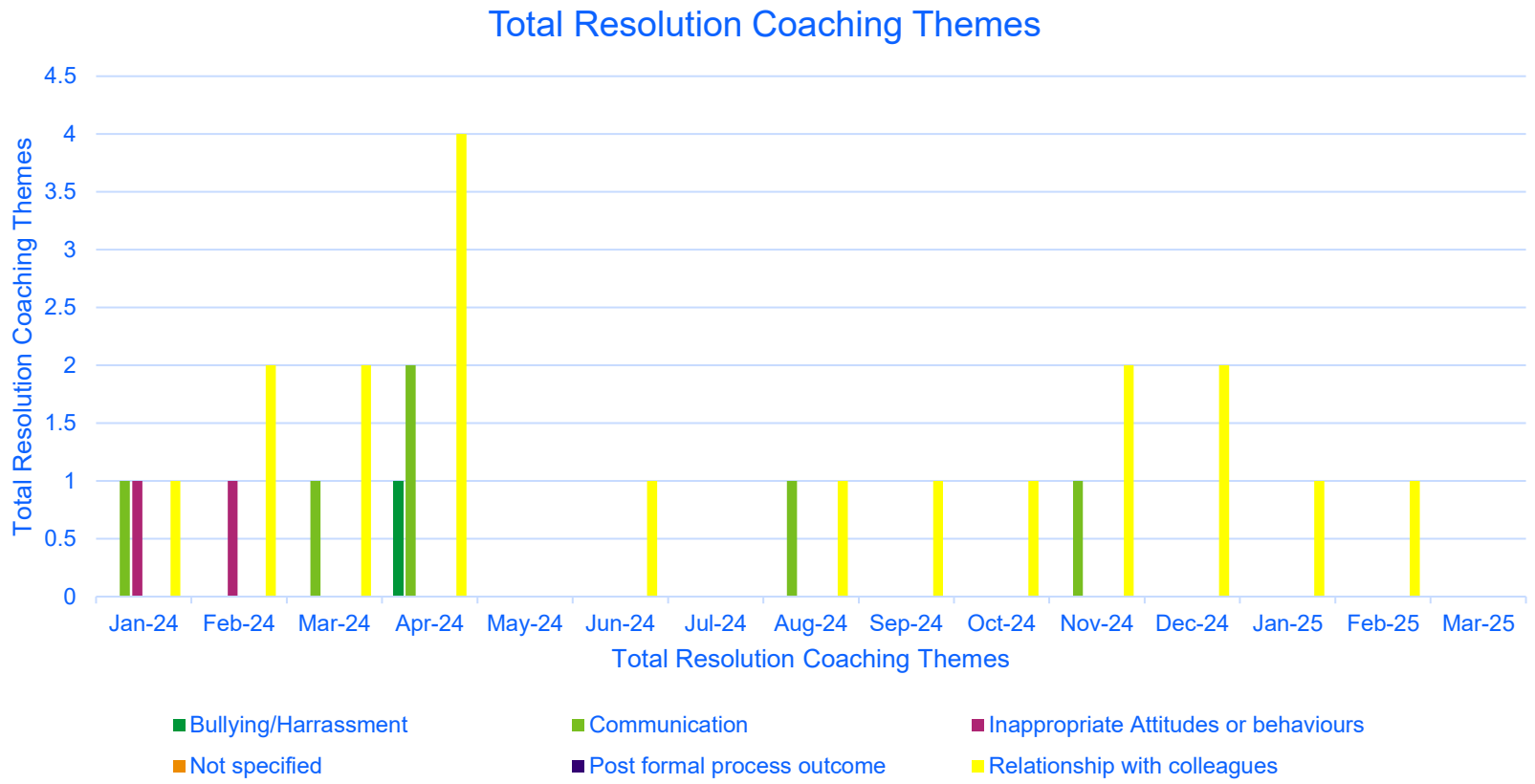


12% year on year increase of mediation requests

Resolution Coaching Themes

- Yellow indicates themes relating to relationship with colleagues
- Green reflects theme of communication

Both reflect relational aspect of difficulties



Mediation and resolution services Feedback – ‘Soothing the System’

“I found the facilitators very helpful. They were able to interpret my thoughts that were heightened and confused by emotion and present them back in a clearer and constructive way”.

“Facilitated conversion made me listen and be listened appropriately and a clearer idea of the other party point of view”

“Very Helpful, thought provoking and helped to resolve some of our issues”

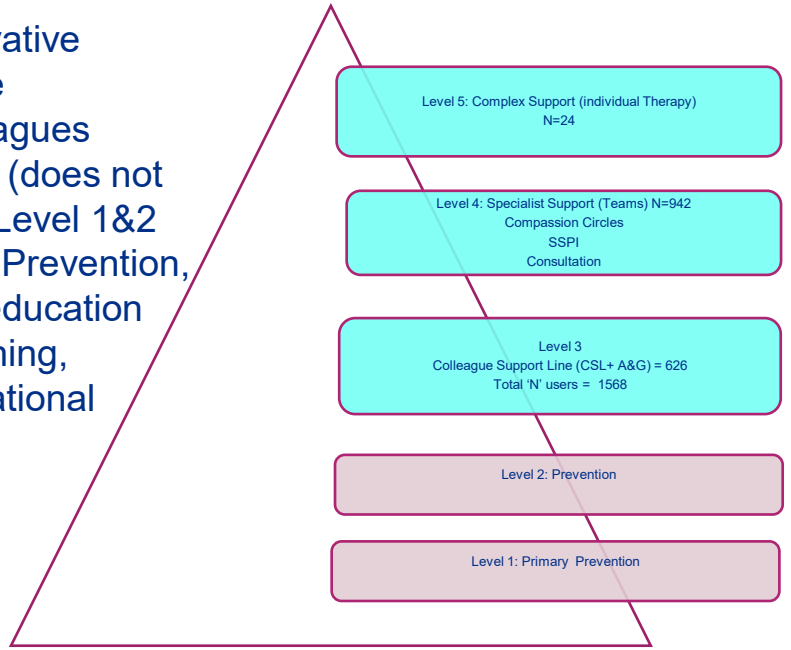
Impact and costs

Benefits Realisation SFT Colleague Support Service April 24 – March 25

Apr 2024 – March 25
High level assumptions:

- Percentage benefit derived based on hierarchy of need
- There may be duplication in colleagues accessing support offerings
- Average colleague salary – mid-point B6 (NHS A4C) – £37,361.72 /year - £19.16/hour - £143.69/day (7.5hrs)
- Average colleague sickness – 16 days in rolling 12-month period (i.e. no increase since 2022)
- Based on agency bookings data - £47.22 per hour estimation for a Band 6 agency level, which, in terms of annual cost, equates to about the cost of a top of scale Band 8a when considering we don't pay for annual leave
- 1 person being sick for 16 days @ mid-point B6 = £2,299.04 (minus agency backfill)
- 1 person being sick for 10 days @ mid-point B6 = £1,436.90 (minus agency backfill)
- 1 person being sick for 5 days @ mid-point B6 = £718.45 (minus agency backfill)
- Not factored into calculations: retention, increase in agency costs, backfill
- Unknown savings in reduction in colleague A&E attendances, use of mental health crisis services, use of secondary mental health services, use of primary care

Conservative estimate N=colleagues reached (does not include Level 1&2 Primary Prevention, psychoeducation and training, organisational impact)



2023 – 2024 NHS funding - £334,139 **Trust commitment to funding 2024-2025**	**Estimate 1 assumptions** • Maximum benefit across all interventions CSL 100% 670 Team interventions 100% 806 Individual therapy 100% 32 Total N= 1508 • 16 days sickness (average) **£2,292**	**Estimate 2 assumptions** • Medium benefit across all interventions CSL 75% 502.5 Team interventions 75% 604.5 Individual therapy 75% 24 TOTAL 'n' = **1131** • 10 days sickness (2 weeks) **£1,436.90**	**Estimate 3 assumptions** • Low benefit across all interventions CSL 50% 335 Team interventions 50% 403 Individual therapy 50% 16 TOTAL 'n' = 754 • 5 days sickness (1 week) **£718.45**	**Estimate 4 assumptions** • Extremely low benefit across all interventions CSL 25% 167.5 Team interventions 25% 201.5 Individual therapy 25% 8 TOTAL 'n' = **377** • 1 day sickness **£143.25**
Approx cost avoidance	1508 x £2,292 = **£3456336**	1194 x £1,432.50 = **£1620157.5**	754 x £718.45 = 541711.30	377 x £143.25 = **54005.25**
Approx Return on Investment (ROI) **For every £1 spent: X £'s avoided**	£334,000 : £**3593856** **£1 : £10.35**	£334,000 : £**1620157.5** **£1 : £4.85**	£334,000 : £541711.3 **£1 : £1.62**	£334,000 : 54005.25 **£1 : 0.16**

Ambitions

Plans for 2025/26

Colleague Support and wellbeing: continue integration work to develop integrated aims, reporting profiles and maximise benefits of approach

Continue to develop OH offer under new contract

Continue to build on physical health projects (SASP, Health Fair Pilot), identify and collate relevant measures and set timeline for anticipated progress.

Coaching, Mediation and Resolution: Relaunch internal offers with new support structures to enhance offer for all colleagues

Develop and deliver Compassionate Leadership training in conjunction with L&OD to operationalise, embed and infuse compassion through practice, policy and organisational approach.

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Six Monthly Safe Staffing Establishment Report
SPONSORING EXEC:	Hayley Peters, Chief Nurse
REPORT BY:	Alison Wootton, Deputy Chief Nurse, SFT (Development of report informed by Associate Directors of Patient Care in Service Groups)
PRESENTED BY:	Hayley Peters, Chief Nurse Alison Wootton, Deputy Chief Nurse
DATE:	

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

Executive Summary and Reason for presentation to Committee/Board	This report provides a six-monthly update, July 2024 – December 2024, of safer staffing assurance for all Somerset NHS Foundation Trust (SFT) inpatient wards, critical care, and emergency departments. Maternity safe staffing is not covered in this paper as it is presented separately to the Quality and Governance Assurance Committee as part of the Maternity Incentive Scheme and issues escalated to the Board if required. The paper provides an overview on associated safer staffing risks and the controls and mitigations in place for these risks. This report offers high level assurance that safe staffing is reviewed formally every six months and that it is also reviewed on a dynamic basis so that appropriate action is in place to support safest and best possible quality of care. The paper provides assurance that safe staffing is reviewed holistically considering a variety of metrics, data, and professional opinion to ensure that we are anticipating seasonal flux or changes in case mix that may require alterations in staffing ratios or professions. Over the last six months we have experienced continued pressures from:

	• Delays to discharge with high numbers of people who are medically fit for discharge, many who still have complex nursing needs. • High pressures in emergency care. • On going use of escalation beds including the reopening of the community escalation beds towards the later end of the report period. • High levels of respiratory illness causing both increased bed pressures in the acute hospitals due to higher admissions, higher level of acuity in patient mix, ward restrictions due to IPC and a higher level of colleague sickness causing compromised levels of staffing. The Board are asked to note the following: • Safe staffing levels have been reviewed as detailed in this report. Every effort has been taken to mitigate the risks and where this isn't possible, positive adjustments to establishments are recommended. • There remain challenges to service delivery requiring a dynamic approach to monitor and adjust safe staffing. • There is service group level ownership and oversight of safe staffing risks and issues and there is a clear and accessible escalation process to raise concern if the risk is considered inadequately managed or mitigated. • The board is offered assurance that the Trust is taking all reasonable and available measures to ensure safe staffing levels in ward areas and where this is not possible, escalation and actions are followed to try and mitigate the risks of working with a compromised level of staffing.
Recommendation	• The Board is asked to consider the report and the recommendations. • The Board is asked to note that positive adjustments to establishments have been robustly validated and the costs associated are being found internally by the service groups. • The Board are asked to approve this report for publication on the public website as per requirements.

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

☒ Obj 4 Reduce inequalities. ☒ Obj 5 Respond well to complex needs. ☒ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive, and learning culture. ☒ Obj 7 Live within our means and use our resources wisely. ☒ Obj 8 Delivering the vision of the Trust by transforming our services through research, innovation, and digital technologies.

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

Equality The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics
☒ This report has been assessed against the Trust's People Impact Assessment Tool and there are no proposals or matters which affect any persons with 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.

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

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The six-monthly review was last presented to the Board in November 2024 covering the period of December 2023-June 2024

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

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

Somerset NHS Foundation Trust
Six Monthly Staffing Establishment Report

1. BACKGROUND AND PURPOSE

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

1.2. The intention of this report is to provide data, thematic issues, risks, and mitigations that allow the Board to be assured that Somerset NHS Foundation Trust (SFT) have planned core safe nurse staffing levels across all in-patient ward areas, and that we respond to changes in care requirements in our ward areas. This report covers the reporting period for June 2024 to the end of December 2024.

2. METHOD OF REVIEW

2.1 In line with national recommendations, a triangulated review of each ward area has been undertaken. We have reviewed the following:

- Quality, safety and performance information
- The recommendations of the safer nursing care tool (SNCT)
- The model hospital benchmarking
- We have used a professional judgement, challenge session for each in patient ward area.

For the acute and community hospital wards these meetings were overseen by the Deputy Chief Nurse and attended by the Associate Directors of Patient Care, Matrons and Ward Managers. In Mental Health these reviews were supported by the Associate Director, senior clinical management colleagues and unit leadership teams.

3. RECOMMENDED CHANGES

3.1. Following the ward reconfigurations in YDH, two wards did not have the correct budget to match the required staffing level, this was 6b (increase in beds) as it moved from 4a, and 6a after it was changed from a ‘ready to go unit’ back to a general medical unit. Following review of all the ward budgets funding has been moved within the service group to correct these two areas to match the required, planned establishments.

3.2. Within medical services changes in establishments have been required to maintain safe staffing levels over the period of reporting. Some of the increased staffing levels have been due to use of escalation beds due to winter pressures and excess patients with no criteria to reside creating flow problems from our ED.

3.3. These areas include both emergency departments who have had extended periods of escalation and are holding significant numbers of patients above their core establishments. The other area also affected by escalation beds is the acute frailty unit on the MPH site increasing the bed base by three patients. These are seasonal escalation beds managed and mitigated with extra staffing levels as required.

3.4. Fielding Ward - MPH is a 27 bedded (plus two escalation beds) cardiology ward has been repeatedly raised as a concern at night. On review of the ward metrics, we have seen increased falls at night, deep tissue injury, increased complaints around care concerns, and staff reporting stress, burnout and moral injury due to the increasing workload and feeling that they are giving sub-standard care on the night shift. The night shift is currently running on a ratio of 1:13 for HCAs, and this prevents us from being able to provide bay nursing over the 24/7 period and not able to respond to call bells in prompt and timely way. The service group had initially increased to a third HCA using some flexibility in the cardiology budget, despite this, the area requires a 4th HCA to meet the care needs of the patients. With this in place there has been an improvement in ward safety and quality metrics. The service group are aware of this cost pressure and are working on a longer-term plan to mitigate this within the service group budget.

3.5. Portman Ward - MPH is a 27 bedded area, as part of the ward reconfiguration it was changed from general medical to the 'care of older people' speciality. The staffing level was not adjusted at the time and there has been an increase in dependency with the night staffing level being a concern. Again, we have seen increased falls at night, increased tissue injury, increased complaints and concerns around care at night, and staff reporting stress, burnout and moral injury due to the increasing workload and feeling that they are giving substandard care on the night shift. The night shift plan is currently running on a ratio of 1:9 for HCAs, and this prevents us from being able to provide bay nursing over the 24/7 period and not able to respond to call bells in prompt and timely way.

Increasing the night HCAs to 4 would align with Eliot, Shepherd, Exmoor, Conservators (other care of older persons wards) who all have 4 HCAs which allows for bay (one HCA per bay of patients) nursing on a night shift. The service group are managing this as a cost pressure and aim to resolve through redesign of other establishments or increase the amount of savings achieved across the service group.

3.6. Following review of the safer staffing data and professional judgement, two areas within surgery also require an uplift in establishment. These changes are required due to ward reconfiguration that has adjusted size of wards but also intensified the number of surgical specialities in areas. With a move of lower-level surgical cases to day case procedures this has meant that those requiring hospital stay have a higher level of care needs and staffing levels have needed adjusting.

3.7. 7B - YDH – mixed surgical ward including trauma and orthopaedics, colorectal, urology, gynaecology and breast. This area had been flagged in previous safe staffing papers due to the lower nurse to patient ratio (9-10 patients per registrant) and that we were a data outlier for mortality post-surgery for fractured neck of femur This was part of the action plan to enhance the post operative care for this group of patients, but this required a higher registered nursing ratio. Mitigating action was to put in a registered nurse 24/7 and it is recommended that this is continued substantively.

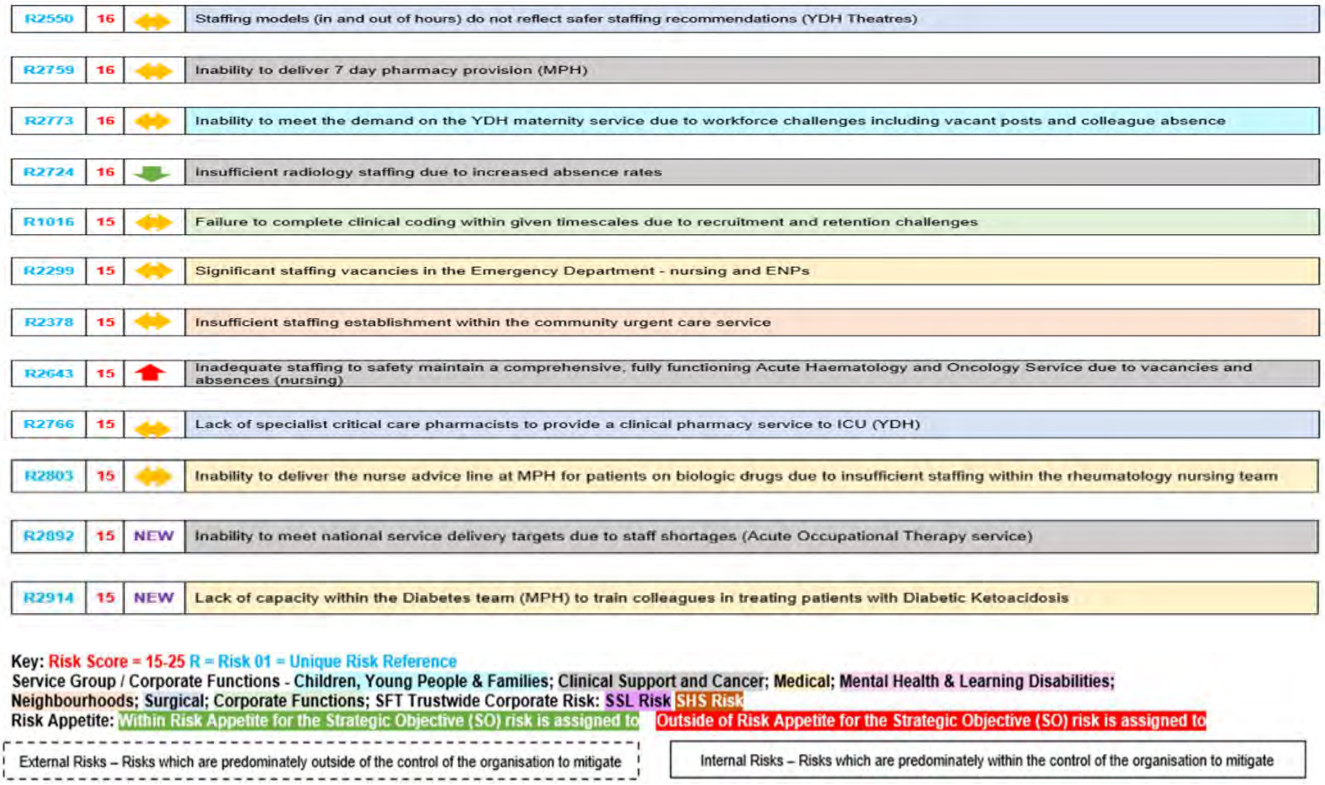
3.8. 4A - YDH - Planned elective, gastroenterology, urology, - Surgical Ward.
Following ward moves to reconfigure the bed stock at YDH 4a is now a surgical ward (previously on 7a, previous team and establishment moved) – the changed layout of this ward and increased complexity of surgical patients has meant that the planned staffing level was quickly noted to be inadequate and an increase in one HCA 24/7 was required to maintain safe care within the ward and it is recommended that this is continued substantively.

Within surgical services the required changes to establishments have been achieved by moving ward based nurse funding within the service group to cover the costs of the changes that are required.

4. **RISKS - Nursing, HCA & AHP Risks 15+ (extract taken from Corporate Risk Register Report – 27 December 2024)**

The risks below are a headline of risks that are nursing and AHP based and are not solely linked to the ward-based nursing covered in this paper. Each service group holds local risks that fall below 15 and these are reviewed as part of regular monthly governance meetings.

R2342	20	⇔	Insufficient staffing resource within speech and language therapy service on Acute Stroke unit (YDH)
R2886	20	NEW	Depleted level of practitioner cover due to hard to fill vacancies and leave (maternity and sick) – Neurology service
R0513	16	⇔	Limited provision of specialist neurological rehabilitation and neuropsychiatry service
R0916	16	⇔	Insufficient critical care rehabilitation establishment
R2064	16	⇔	Inability to staff theatre services on the YDH site due to registered and non-registered staffing vacancies
R2227	16	⇔	Insufficient staffing resource within the Adult Speech and Language service to meet demand on the general medical wards in both acute hospitals
R2255	16	⇔	Insufficient staffing levels across the Stroke Rehabilitation units at Williton and South Petherton
R2491	16	⇔	Inability to meet NICE guidelines and roll out hybrid closed loop technology within paediatric diabetes due to current staffing levels and skill mix



5. FILL RATES & ESCALATION

5.1. The six months of this report show fill rates at a combined, high level for registered nurses is comparable to the previous period but that over several months we have lower levels of registered staff than our core plan. Daily this will have been reviewed in each area and mitigating actions implemented. When the data is looked at by each area there are some areas of concern that are not seen in this aggregate position (see service group data in appendix). Fill rates for HCA appears very good but these shifts are often used to offer extra support to areas where core numbers have been compromised (for example having an extra unregistered nurse when to backfill an unfillable registrant shift).

5.2. MPH has used less escalation capacity since the reconfiguration of beds in August 2023. This improvement has led to less medical outliers, and reduced lengths of stay, this has also had a significant positive impact on the number of reported incidents linked to issues such as falls and pressure areas in both the medical and surgical service groups, we are also hearing of better colleague experience and enjoyment of role. Both acute hospitals have had escalation beds in use over the period of this report and at times these have extended into the community hospitals. The use of escalation has been continuously high at YDH with most of the possible planned escalation in use and on a few occasions, we have extended to the limits of the possible plan. This has meant that both YDH and MPH have had patients held in non-care areas such as corridors in both emergency departments, or discharge areas, this has happened on a daily basis with large numbers of patients waiting for extended periods for admission to normal care areas.

5.3. In January 2025 the RCN published 'On the frontline of the UK's corridor care crisis' (Corridor care crisis | Publications | Royal College of Nursing), this was published to highlight the ongoing concern of patients being cared for in areas that were not

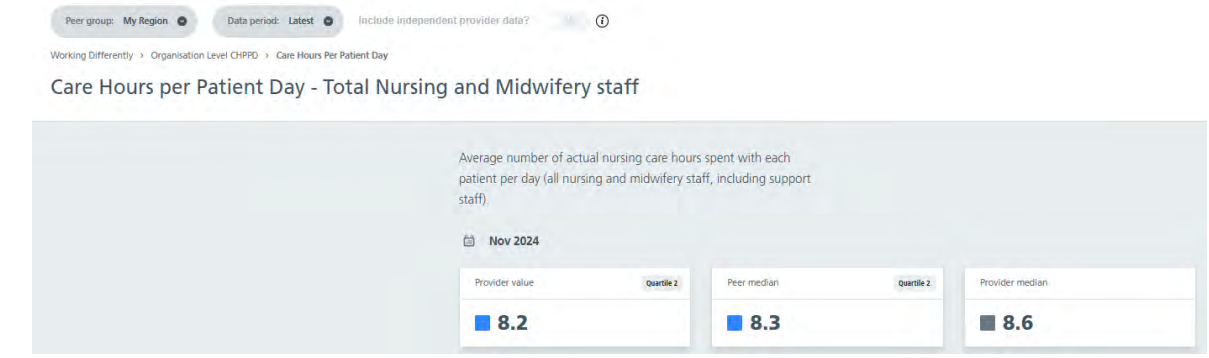
usually care areas such as corridors or waiting areas. At that point there was no official data to say how many patients experienced care in this way. Within SFT we provide care in two ways that would meet this definition of corridor care, firstly in our emergency departments where we hold more patients than we have bed spaces any escalation bed in our ward areas or planned escalation that does not have 'bed head facilities' (e.g a space used that does not have a call bell, oxygen and suction and is not in a defined bedspace). Since early 2025 we have been required to submit this data nationally. Where we have any extra patients or escalation beds in use we have standard operating procedures in place that have a staffing plan so that we can provide nursing care.

6. MODEL HOSPITALS

6.1. Data of care hours per patient day are submitted nationally and uploaded for comparison via the model hospital system. The high-level data also combines nursing and midwifery which is not the same as our local data, but the charts below are provided as a benchmark.

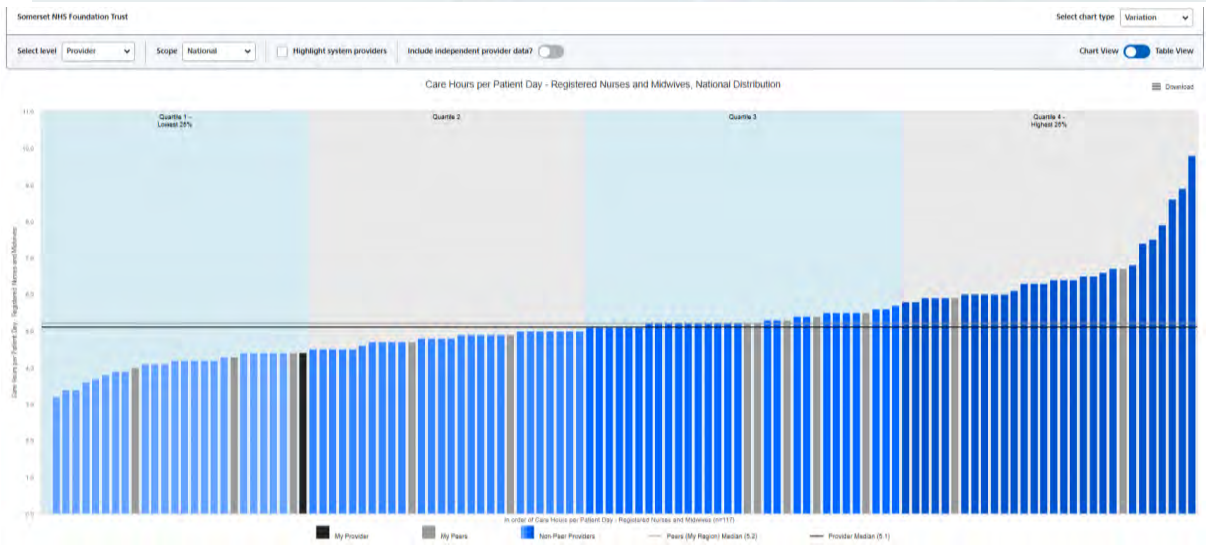
6.2. Review of the model hospital data would indicate that our total staffing level is below but close to our region and national averages but that our skill mix is more weighted towards unregistered colleagues than in other areas.

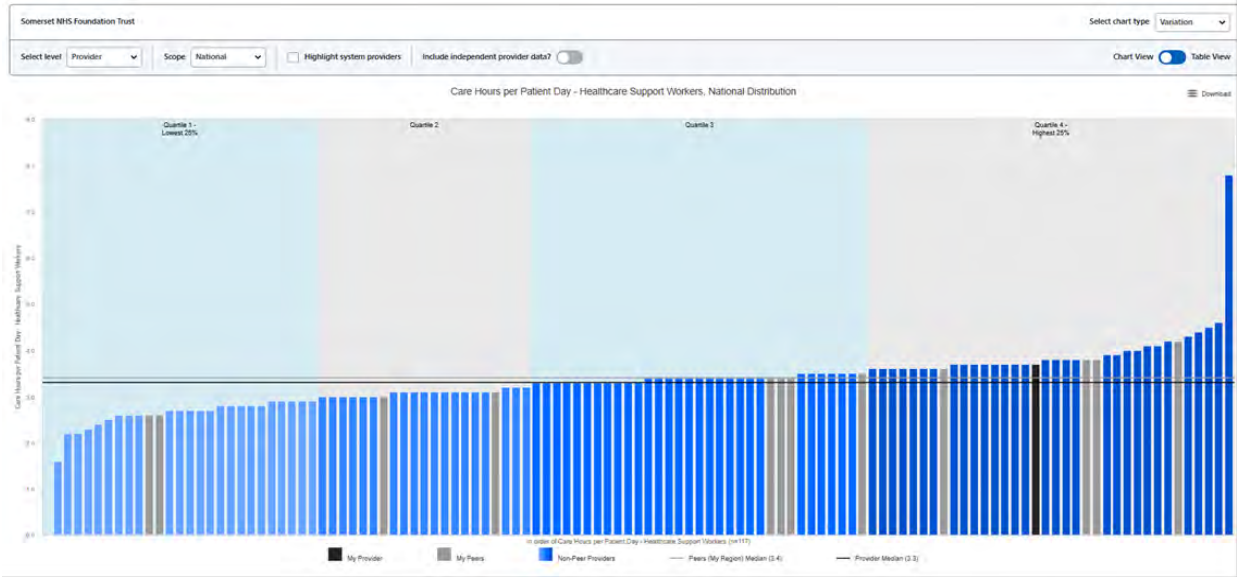
6.3. In the last update in Model Health (Nov 24) our overall position has dropped from 8.3 Care Hours per Patient Day in May 24 to 8.2. National average has remained the same at 8.6, but our regional peers have also dropped from 8.5 to 8.3. Registered Nurses and Midwives improved from 4.3 to 4.4 but is still lower than regional peers at 5.2 and national position of 5.1. Care provided by healthcare support workers remains higher than national and regional average at 3.7 hours, but this is a drop from 3.9 hours in May.



Working Differently › Organisation Level CHPPD › Care Hours Per Patient Day

Care Hours per Patient Day - Registered Nurses and Midwives





7. **SAFER NURSING CARE TOOL (SNCT):**
A review of the accumulative data from the first nursing establishment audit using the Safer Nursing Staffing Tool (Version-2023).

7.1. In 2023, the Chief Nurse commissioned a full review of establishments on inpatient wards, National Care Board guidance recommend the use of a recognised tool and the main tool in use is the Safer Nursing Care Tool (SNCT). The first audit was performed in March 2024 of all most general inpatient wards in YDH, MPH and the community hospitals and the second round of data was collected in July 2024. This audit will be performed a minimum of twice a year, ideally in January and July to review for any seasonal differences. Reliability and usefulness of these audits is likely to build over time. Analysis of this can be found in appendix 1.

8. **RECOMMENDATIONS**

1. The Board is asked to note that positive adjustments to establishments have been robustly validated (outcome data, model hospital, SNCT and professional judgement) and the costs associated are being found internally by the service groups.

2. There is a requirement for this report to be published on our public website once it is approved.

3. The Board is asked to note the areas for concern raised particularly around corridor care in our emergency departments and ward escalation beds.

Appendix 1

SAFER NURSING CARE TOOL (SNCT): ***A review of the accumulative data from the first nursing establishment audit using the Safer Nursing Staffing Tool (Version-2023).***

Background

8.1. The Safer Nursing Care Tool (SNCT) is the output of work undertaken by the Shelford Group (collaboration of 10 of the largest NHS Trusts in England) and over the last 20 years has undergone extensive academic and statistical analysis, to validate the algorithms that support the calculation of accurate nursing numbers to patient acuity and dependency. Links between patient acuity and dependency, workload, staffing and quality are well established and conclude that low staffing numbers contribute to poorer outcomes for patients. Consequently, there is a need to always consider and recognise the importance of professional judgement – described as the application of clinical judgment, when making decisions based on nursing knowledge (evidence, theories, ways/patterns of knowing), other disciplinary knowledge, critical thinking, and clinical reasoning. Additionally, when reviewing the outputs of the SNCT, teams must also consider nurse sensitive indicators such as infection rates, pressure ulcers, falls and complaints. The tool has been through several revision and refreshes and has been modified to recognise the changing demographic and needs of patients who are accessing healthcare. (Levels of care descriptors SNCT Adults 2023 & Paediatrics 2022 – please see below)

Care level	Descriptor *Care requirements may include the following:*
Level 0 Hospital Inpatient Needs met by provision of normal ward cares.	• Underlying medical condition requiring on-going treatment. • Post-operative / post-procedure care - observations recorded as per local policy. • National Early Warning Score (NEWS) is within normal threshold. • Patients requiring oxygen therapy. • Patients not requiring enhanced therapeutic observations (according to local policy). • Patients requiring assistance of one with some activities of daily living.
Level 1a Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	• Step down from Level 2 care. • Requiring continual observation / invasive monitoring/physiological assessment. • NEWS local trigger point reached and requiring intervention/action/review. • Pre-operative optimisation/post-operative care for complex surgery. • Requiring additional monitoring/clinical interventions/clinical input including: - Patients at risk of a compromised airway - Oxygen therapy greater than 35%, + / - chest physiotherapy 2–6 hourly or intermittent arterial blood gas analysis - Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest drains - Severe infection or sepsis - New spinal injury/cord compression
Level 1b Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of their care needs.	• Complex wound management requiring more than one nurse or takes more than one hour to complete. • Patients with stable Spinal/Spinal Cord Injury. • Patients who consistently require the assistance of two or more people with mobility or repositioning. • Requires assistance with most or all care needs. • Complex Intravenous Drug Regimes – (including those requiring prolonged preparatory/administration/post-administration care). • Patient and/or carer's requiring enhanced psychological support owing to poor disease prognosis or clinical outcome. • Patients requiring intermittent or within eyesight observations according to local policy. • Facilitating a complex discharge where this is the responsibility of the ward-based nurse.
Level 1c Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• Patients requiring arm's length or continuous observation as per local policy.

Care level	Descriptor *Care requirements may include the following:*
Level 1d Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	- Patients requiring arm's length or continuous observation by 2 or more members of staff (provided from within ward budget) as per local policy.

Level 2
Patients who may be managed within clearly identified, designated beds with the resources, expertise and staffing levels required OR may require transfer to or be cared for in a dedicated Level 2 facility/unit.
	- Deteriorating / compromised single organ system.
	- Step down from Level 3 care or step up from Level 1a.
	- Post-operative optimisation/ extended post-op care.
	- Cardiovascular, renal or respiratory optimization requiring invasive monitoring.
	- Patients requiring non-invasive ventilation/respiratory support; CPAP/BiPAP in acute respiratory failure.
	- First 24-hours following tracheostomy insertion or patients post 24-hours requiring 2-hourly suction.
	- CNS depression of airway and protective reflexes.
	- Patients with burns where more than 30% body surface area is affected or requiring conscious sedation for dressing changes.
	- Requires a range of therapeutic interventions which may include:
	  - Greater than 50% oxygen continuously
	  - Requiring close observation due to acute deterioration and needing advanced organ support
	  - Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium
	  - CNS depression of airway and protective reflexes
	  - Invasive neurological monitoring including ICP, external ventricular drains and lumbar drains

Level 3 Patients needing advanced respiratory support and/ or therapeutic support of multiple organs.	- Monitoring and supportive therapy for compromised/collapse of two or more organ/ systems. - Respiratory or CNS depression/compromise requires mechanical/invasive ventilation. - Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/ sepsis or neuro protection.

Published October 2023

8.2. The first full SNCT audit was undertaken in March 2024 and included most acute wards on the MPH and YDH site including paediatric wards and EDs, as well as wards located in Community hospitals. Data was collected on acuity and dependency for a period of 20 days excluding weekends. This audit was completed for a second time in July 2024

8.3. The ambition is to run a minimum of two SNCT audits each year during the summer and winter periods currently it has been agreed that this will happen during July and January. The data from January 2025 has been completed but will be reported on in the next board report.

8.4. This report provides some high-level analysis of combined results for MPH, YDH, Paediatrics and Community Hospitals following the July 2024 audit. Both EDs have taken part in the SNCT audit for both periods but further work was undertaken prior to the 2025 audit to try and ensure the audits were being completed in the same way as the data did have some anomalies and needed further work.

The completion of ward audits for the July period was much improved with all wards submitting some data. Some audits submitted did not have all 20 days completed so data was completed using a best fit approach which was based on data collected.

8.5. The areas that weren't included during the July review were maternity, community nursing teams and mental health inpatient wards. Our mental health wards contribute to Mental Health Optimal Staffing Tool (MHOST), nationally it is recognised that this tool needs updating and this work is being commissioned in 2025. Our local mental health teams have undertaken a review of data and professional review in each in patient area to check that establishments are meeting patients needs.

8.6. Maternity continues to use BadgerNet which does collect data on activity and workload and is included as part of the Maternity reporting through the Quality and Governance Committee.

8.7. Our community nursing teams have been beta testing as a pilot site the Community Nursing Safer Staffing Tool (CNSST), this pilot has paused whilst NHSE review outputs and consider future recommendations. This review has concluded and it is planned to restart this audit in the coming months and hopefully the next report will include CNSST.

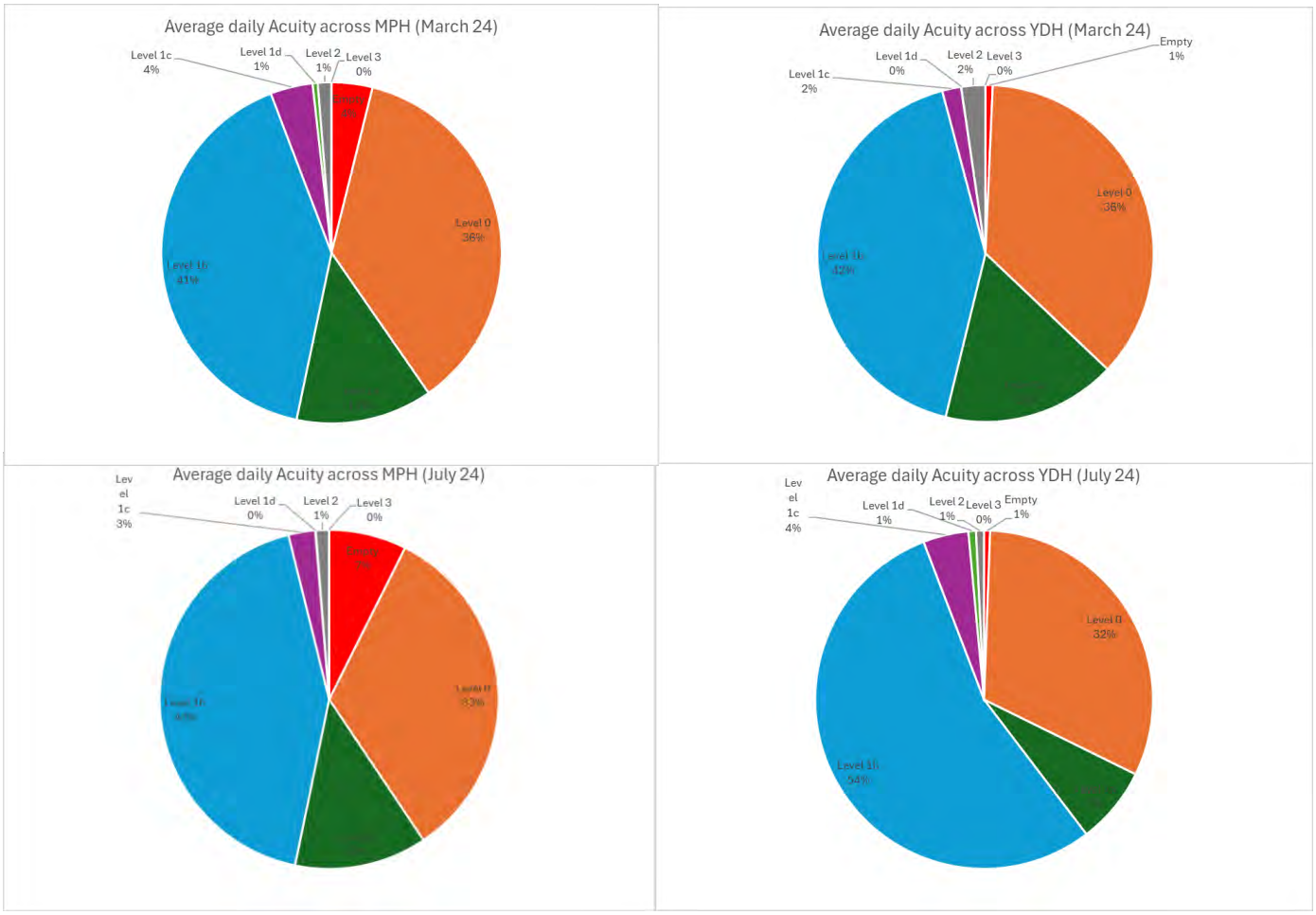
8.8. The latest versions of the adult inpatient ward areas SNCT (2023) now includes provision for providing additional supervision needs for patients who need closer observation because of cognitive concerns e.g. dementia/delirium. There is also a version of the tool that supports the determination of appropriate establishments for inpatient areas with predominately side rooms. This version of the tool also advocates that data is collected for a period of 30 days and should include weekends. However, following discussions with the Deputy Chief Nurse, whilst we are still developing our confidence in the use of the SNCT we will continue to collect for 20 days and exclude weekends.

9. Findings

9.1. This report seeks to share some early indicators of current acuity and dependency vs staffing levels, one of the fundamental tenets when using this tool is that any decision to change nurse establishments must only be considered when a minimum of two

data set have been collected. In addition, when reviewing this data, it should not be undertaken in isolation and must recognise professional judgement, nurse sensitive indicators and outcomes. Following the second cycle of audits in July meetings have taken place with ward managers, matrons and ADPCs to review SNCT output, local quality and safety data, patient experience feedback and any other concerns that have been raised (for example through freedom to speak).

9.2. Acuity Inpatient Adult Wards – MPH and YDH



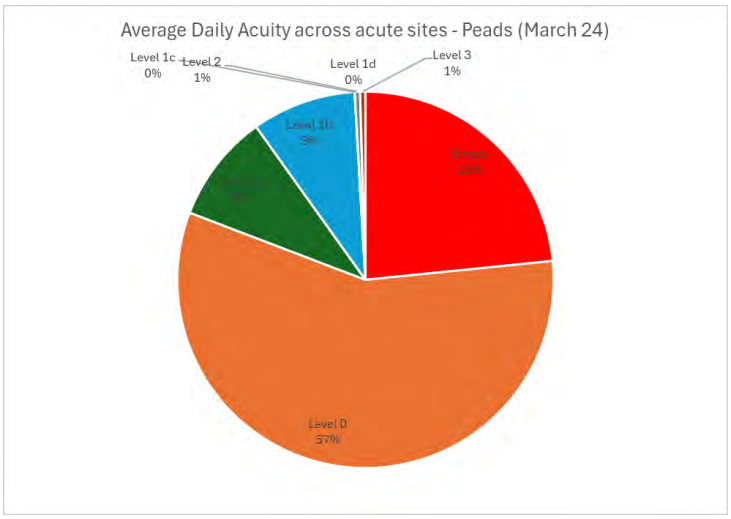
As can be seen the above profile for each of the acute sites is consistent with what would be expected with a high proportion of patients still being scored as level 1b, patients who are in a stable condition but are dependent on nursing care to meet their needs. There has been an increase on both sites during July but more significantly on the YDH site with a corresponding fall in patients being scored 1a.

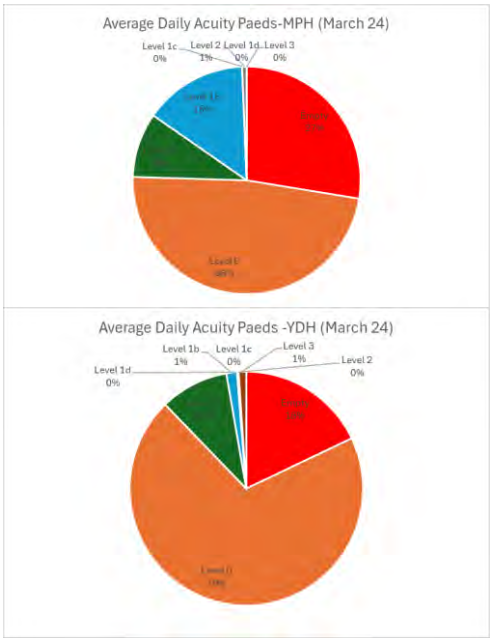
The patients scoring level 2, a high dependency level of care should only be seen in Acute Coronary Care Unit (YDH, cardiac and hyperacute strokes), Coronary Care Unit, Coleridge (respiratory high dependency area) and Dunkery (MPH, hyper-acute strokes), and the intensive care units. This is possibly still lower than would be expected but there is little change between March and July. The medical service group will need to keep this under review to optimise requirement verses acuity.

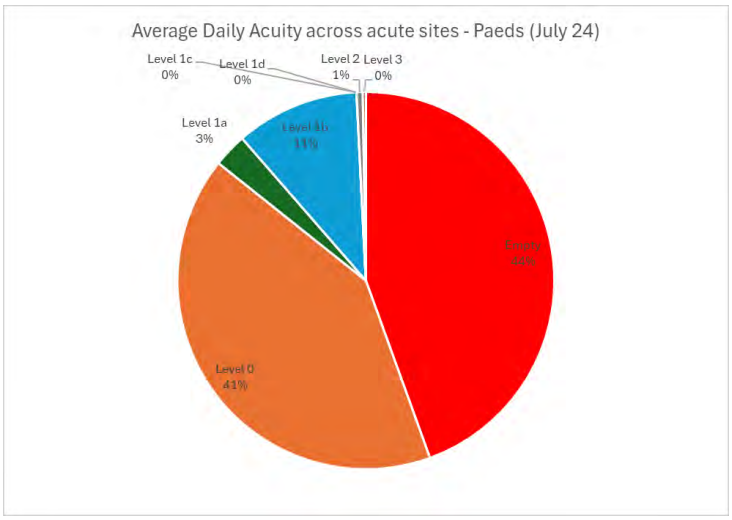
The patients scoring level 1C is probably proportionate for each site and in many cases is being managed without additional resources as teams are using Bay/Tag nursing approaches to continuously observe patients.

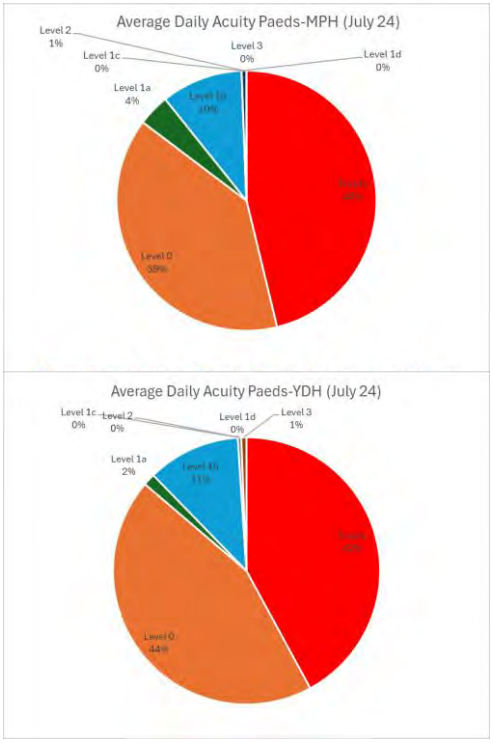
Ward configurations across both acute sites have been completed and early feedback from teams on the MPH site had been positive and perhaps this could account for the slight increase in empty beds on the MPH site. Unfortunately, this increase in bed availability has not been seen on the YDH site. Work continues on improving patient flow pathways across the organisation and the ongoing work with social care and other partners we would expect to see this profile changing during 2025.

9.3. **Acuity Inpatient Paediatric Wards – MPH and YDH**

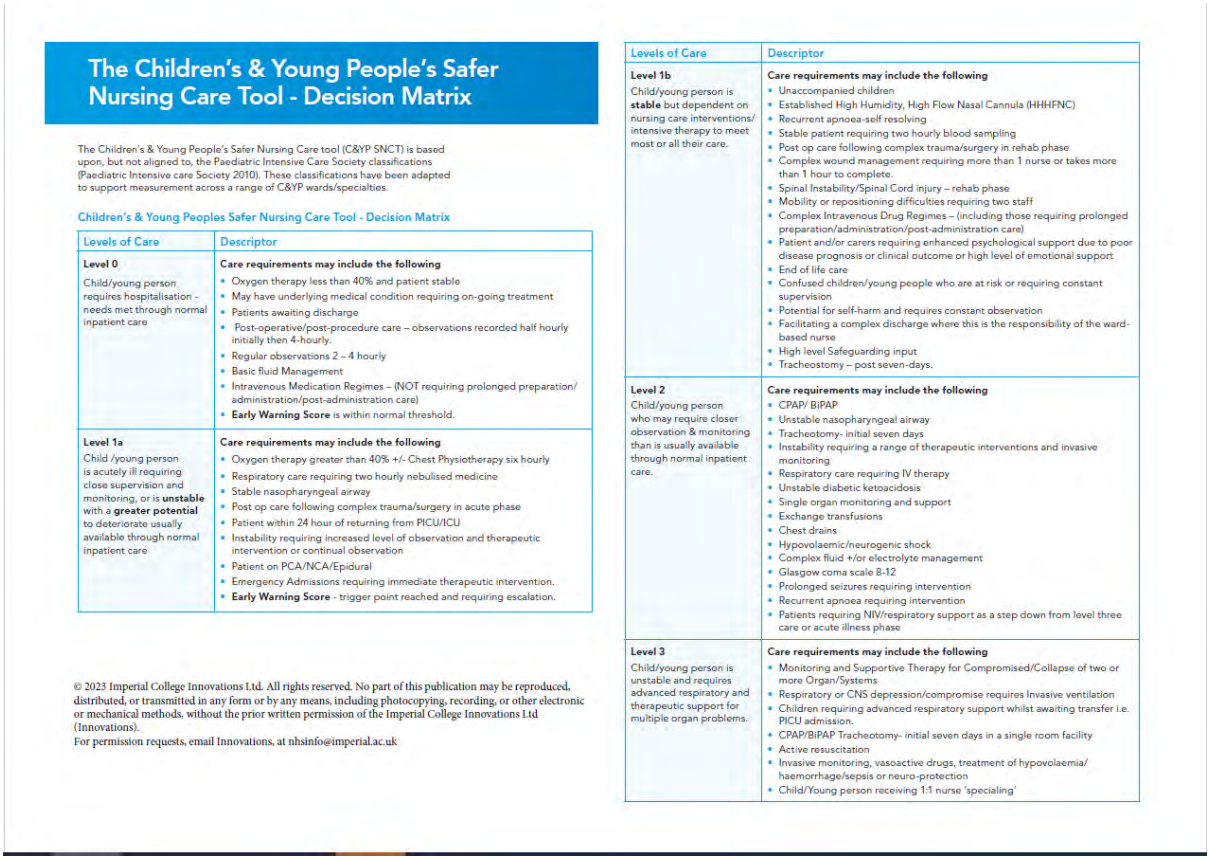








During the July 2024 audit MPH reported 33 beds in use this included the 2 escalation beds (which on reviewing the audit data for July were occupied, even though other beds on the unit were vacant). Removing the escalation beds changes the percentages marginally between 1-2% across acuity levels and reduces the number of empty beds during the period to 43%. YDH reported 24 beds in use during both audit cycles. During the July audit cycle the data would suggest that acuity across the 2 sites was very similar and as expected conversely acuity during the March audit did suggest that YDH had proportionally more patients than MPH. The most significant factor to influence the differences during the 2 audit cycles is likely to be seasonal variation.



The Children's & Young People's Safer Nursing Care Tool - Decision Matrix

The Children's & Young People's Safer Nursing Care tool (C&YP SNCT) is based upon, but not aligned to, the Paediatric Intensive Care Society classifications (Paediatric Intensive care Society 2010). These classifications have been adapted to support measurement across a range of C&YP wards/specialties.

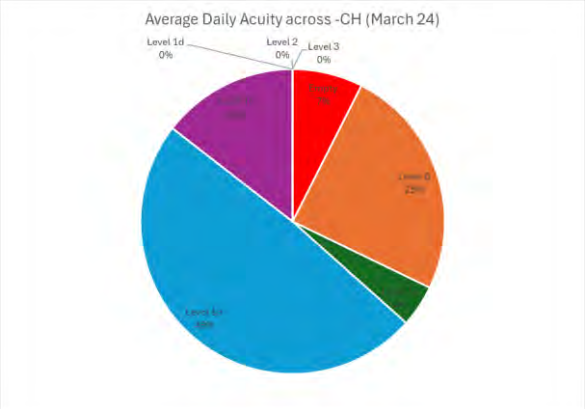
Children's & Young Peoples Safer Nursing Care Tool - Decision Matrix

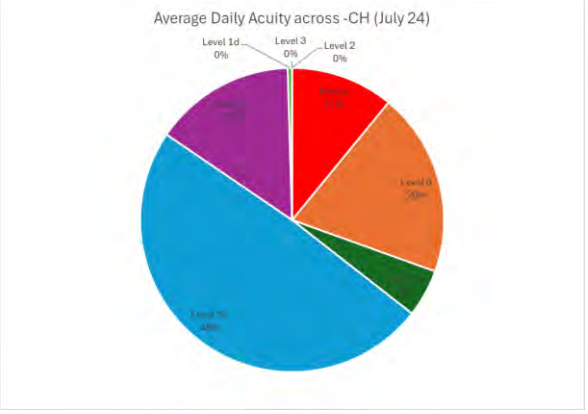
Levels of Care	Descriptor
Level 0 Child/young person requires hospitalisation - needs met through normal inpatient care	**Care requirements may include the following** • Oxygen therapy less than 40% and patient stable • May have underlying medical condition requiring on-going treatment • Patients awaiting discharge • Post-operative/post-procedure care – observations recorded half hourly initially then 4-hourly. • Regular observations 2 – 4 hourly • Basic fluid Management • Intravenous Medication Regimes – (NOT requiring prolonged preparation/ administration/post-administration care) • **Early Warning Score** is within normal threshold.
Level 1a Child /young person is acutely ill requiring close supervision and monitoring, or is **unstable** with a **greater potential** to deteriorate usually available through normal inpatient care	**Care requirements may include the following** • Oxygen therapy greater than 40% +/- Chest Physiotherapy six hourly • Respiratory care requiring two hourly nebulised medicine • Stable nasopharyngeal airway • Post op care following complex trauma/surgery in acute phase • Patient within 24 hour of returning from PICU/ICU • Instability requiring increased level of observation and therapeutic intervention or continual observation • Patient on PCA/NCA/Epidural • Emergency Admissions requiring immediate therapeutic intervention. • **Early Warning Score** - trigger point reached and requiring escalation.

Levels of Care	Descriptor
Level 1b Child/young person is **stable** but dependent on nursing care interventions/ intensive therapy to meet most or all their care.	**Care requirements may include the following** • Unaccompanied children • Established High Humidity, High Flow Nasal Cannula (HHHFNC) • Recurrent apnoea-self resolving • Stable patient requiring two hourly blood sampling • Post op care following complex trauma/surgery in rehab phase • Complex wound management requiring more than 1 nurse or takes more than 1 hour to complete. • Spinal Instability/Spinal Cord injury – rehab phase • Mobility or repositioning difficulties requiring two staff • Complex Intravenous Drug Regimes – (including those requiring prolonged preparation/administration/post-administration care) • Patient and/or carers requiring enhanced psychological support due to poor disease prognosis or clinical outcome or high level of emotional support • End of life care • Confused children/young people who are at risk or requiring constant supervision • Potential for self-harm and requires constant observation • Facilitating a complex discharge where this is the responsibility of the ward-based nurse • High level Safeguarding input • Tracheostomy – post seven-days.
Level 2 Child/young person who may require closer observation & monitoring than is usually available through normal inpatient care.	**Care requirements may include the following** • CPAP/ BiPAP • Unstable nasopharyngeal airway • Tracheotomy- initial seven days • Instability requiring a range of therapeutic interventions and invasive monitoring • Respiratory care requiring IV therapy • Unstable diabetic ketoacidosis • Single organ monitoring and support • Exchange transfusions • Chest drains • Hypovolaemic/neurogenic shock • Complex fluid +/or electrolyte management • Glasgow coma scale 8-12 • Prolonged seizures requiring intervention • Recurrent apnoea requiring intervention • Patients requiring NIV/respiratory support as a step down from level three care or acute illness phase
Level 3 Child/young person is unstable and requires advanced respiratory and therapeutic support for multiple organ problems.	**Care requirements may include the following** • Monitoring and Supportive Therapy for Compromised/Collapse of two or more Organ/Systems • Respiratory or CNS depression/compromise requires Invasive ventilation • Children requiring advanced respiratory support whilst awaiting transfer i.e. PICU admission. • CPAP/BiPAP Tracheotomy- initial seven days in a single room facility • Active resuscitation • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/ haemorrhage/sepsis or neuro-protection • Child/Young person receiving 1:1 nurse 'specialing'

The descriptors used for children are individual to this area and demonstrated in chart above.

9.4. **Acuity Inpatient Adult Wards – Community Hospitals**





The acuity profile has essentially remained unchanged when comparing the 2 audits cycles with many of the patients being scored as level 1b which is as expected. Work is still ongoing with social care and other partners, and it is still anticipated that during 2025 there will be a change in the profile as more patients will return home quicker with a reduced requirement for ongoing care in the community. Additionally, this would release capacity and support a reduction in acuity levels across acute sites.

Interestingly the percentage of patients being scored as 1a remains unchanged and although the number of patients scoring 1a is relatively low, it would not necessarily have been expected with 3 out the 9 CH reporting this level of acuity, interestingly it is not the same CH reporting this level of acuity. The ADPC and matrons should review and confirm that scoring is reflecting acuity appropriately.

9.5. **Staffing-Inpatient Wards – MPH**

Budget Day	SNCT Day	Actual Day
233.53	223.37	224.11
Budget Night	SNCT Night	Actual Night
145.53	135.37	136.11
Total budget	Total SNCT	Total 24 hrs
379.06	358.74	360.22

March 24 for comparison (some wards were missing from March data so unfortunately this is not a like for like comparison)

Total budget	Total SNCT	Total 24 hrs
339.66	314.42	331.02

When reviewing the above data there are several caveats:

a. All open wards were included in the July 2024 audit. Shepperd ward at the time of the audit was relocated to Tor for refurbishment, and there was a reduction in planned roster with some staff being redeployed to other areas. However, overall, it is believed that the data submitted is sufficiently robust to confirm that budgets do have sufficient provision to support safe and effective care.
b. The SNCT does not include the supervisory/clinical role of the ward manager. The SNCT only includes a 20% average for management, with all other time be allocated for direct patient care and activities associated with the delivery of care. Therefore 0.8wte per ward is not included for MPH wards, if this was included this could equal an additional 17.4wte (22 open wards) However, this would need to be part of the review process which includes professional judgement and outcomes.
c. There are several areas across MPH (CCU, Dunkery and Coleridge) where there is provision for level 2 care which requires a higher number of registered nurses. During this audit the acuity scoring for level 2 was relatively low and consequently that has lowered the SNCT score.
d. The role of the coordinator is also not included, and this would need to be factored in where teams adopt this role and would be part of the review process which includes professional judgement and outcomes for areas where there is a coordinator.
e. Some of the ward areas included have a smaller number of beds. The total number of beds per ward is used in the SNCT algorithm, along with the acuity score to calculate the number of staff required. In some instances, this would take the number of staff down per shift to an unsafe level. Consequently, the establishments for these wards are higher than SNCT would recommend because of the need to have a minimum number of nurses on a ward.
f. The SNCT does not differentiate between registered or non-registered it will simply produce a number, which can then be split once the preferred registered to non-registered ratio is confirmed. Across all the included wards at MPH this averages at 55% registered nurses per shift.

In summary: comparing the March and July audit results there is a difference between the total numbers of staff, however, this is attributable to data being submitted by all wards in July. Reassuringly there has not been a significant change in the ratio of registrant to patients overall. The evidence from the July audit continues to support the assumption that wards are managing rosters within budget and staffing wards to the agreed number of staff. There was some evidence that wards did run below core numbers on some shifts, but this was not the norm and generally any sickness or vacancy is covered by temporary staffing. There needs to be some additional work done in each of the service groups to understand the impact of the supervisory ward manager and coordinator roles being include in roster numbers when covering sickness or vacancy and consider if this is impacting on the provision of safe care. Currently the results show that MPH is break even when comparing the SNCT calculated establishments against budgeted establishments. However, the wards where level 2 care is provided will need to ensure that establishments are able to support the provision of Level 2 care as if all available beds were occupied with Level 2 patients. It is likely that this would result in a significant shortfall been what the SNCT calculated establishments would need to be when compared to what is currently budgeted.

9.6. **Staffing-Inpatient Wards – YDH**

July 2024

Budget Day	SNCT Day	Actual Day
100.62	127.96	90.68
Budget Night	SNCT Night	Actual Night
56.62	83.96	52.68
Total budget	Total SNCT	Total 24 hrs
157.24	211.92	143.36

March 2024 for comparison

Total budget	Total SNCT	Actual total
147.76	172.36	143.38

When reviewing the above data there are several caveats:

a. All wards were included during the July audit except Jasmine because it was closed during July.

b. The SNCT does not include the supervisory/clinical role of the ward manager. The SNCT only includes a 20% average for management, with all other time be allocated for direct patient care and activities associated with the delivery of care. Therefore 0.8wte per ward is not included for YDH wards, if this was included this would equal an additional 8.8 wte.

c. There is one area at YDH (ACCU) where there is provision for level 2 care which requires a higher number of registered nurses. During this audit the acuity scoring for level 2 was relatively low and consequently this has lowered the SNCT score.

d. The role of the coordinator is also not included, and this would need to be factored in where teams adopt this role and would be part of the review process which includes professional judgement and outcomes for areas where there is a coordinator.

e. Some of the ward areas included have a smaller number of beds. The total number of beds per ward is used in the SNCT algorithm, along with the acuity score to calculate the number of staff required. In some instances, this would take the number of staff down per shift to an unsafe level. Consequently, the establishments for these wards are higher than SNCT would estimate because of the need to have a minimum number of nurses on a ward.

f. The SNCT does not differentiate between registered or non-registered it will simply produce a number, which can then be split once the preferred registered to non-registered ratio is confirmed. Across all the included wards at YDH this averages at 55.61% registered nurses per shift.

g. There was one ward (6A) were numbers appeared to be consistently lower than the planned rota and were running at least 2 staff down each day.

In summary: Overall, there is good evidence that wards are managing rosters within budget and staffing wards to the agreed number of staff. Teams are supported to fill gaps in their rota using temporary staffing and/or backfilling with the supervisory ward manager however, although there seemed to be an increase in the number of occasions that a ward would run below core numbers. This in the main seems to be attributable to one area (ward 6A) which on average was consistently running 2 wte down each day. During this audit the gap between SNCT recommendation and budget establishments has grown with an average 26 shifts not being covered across days and nights. There needs to be some additional work done in each of the service groups to understand the impact of the supervisory ward manager and coordinator roles being include in roster numbers when covering sickness or vacancy and consider if this is impacting on the provision of safe care. Finally, ACCU where level 2 care is provided for will need to ensure that establishments are able to support the provision of Level 2 care as if all available beds were occupied with Level 2 patients.

9.7. **Staffing-Inpatient Wards – Paediatrics**

The descriptors used for children are similar to adults but are specific to this area so the listing

Paediatrics MPH March 24 and July 24

Budget Day		SNCT Day		Actual Day		Planned
March 24	July 24	March 24	July 24	March 24	July 24	
10.8	10.8	10.2	8.3	9.3	8.5	8
Budget Night		SNCT Night		Actual Night		
March 24	July 24	March 24	July 24	March 24	July 24	
6.8	6.8	6.2	6.3	5.3	6.5	7
Total budget		Total SNCT		Total 24 hrs		
March 24	July 24	March 24	July 24	March 24	July 24	
17.6	17.6	16.4	14.6	14.6	15	15

Paediatrics YDH March 24 and July 24

Budget Day		SNCT Day		Actual Day		Planned
March 24	July 24	March 24	July 24	March 24	July 24	
6.4	6.4	8.8	7.1	6.3	5.9	5
Budget Night		SNCT Night		Actual Night		
March 24	July 24	March 24	July 24	March 24	July 24	
2.4	4.4	4.8	5.1	2.3	3.9	4
Total budget		Total SNCT		Total 24 hrs		
March 24	July 24	March 24	July 24	March 24	July 24	
8.8	10.8	13.6	12.2	6.6	9.8	9

When reviewing the above data there are several caveats:

a. Unlike the adult version of the SNCT (2023) the Paediatric SNCT (2022) does **not** include empty beds and consequently these are not factored into the algorithm. Therefore, the total number of staff would be higher if at the time of the audit all beds were occupied.
b. The SNCT does not include the supervisory/clinical role of the ward manager. The SNCT only includes a 20% average for management, with all other time being allocated for direct patient care and activities associated with the delivery of care. Therefore 0.8wte per ward is not included for the 2 paediatric areas across the acute sites, if this was included this would equal an additional 1.6wte.
c. There is an expectation that both paediatric units on each of our acute sites will manage the care of the child requiring level 2 care, during this audit there was very little level 2 care scored and this has lowered the SNCT score and would need to be considered when setting establishments and would be part of the professional judgement, nurse sensitive indicators and outcome review.
d. The role of the coordinator is also not included, and again this would need to be considered, if teams have adopted this role, during the review process as described above.
e. The SNCT does not differentiate between registered or non-registered staff it will simply produce a number, which can then be split once the preferred registered to non-registered ratio is confirmed. Across both acute sites this averages at 76.81% registered nurses per shift.
f. The individual result for both paediatric units are also shown above in the table. When comparing the 2 units there is a discrepancy in the number of staff available to care for children with YDH still reporting staffing below the recommended SNCT numbers. This could be the result of lower admission numbers; a decision was made following the March audit to increase the number of staff on the night to 4 registrants. There has also been a business case which has been supported in principle increasing the number of band 6 staff so that every shift now has a band 6 rostered. There was also a proposal to increase the number of registrants on the day shift, how this is achieved consistently is still being explored.

9.8. **Staffing-Inpatient Wards – Community Hospitals**

July 2024

Budget Day	SNCT Day	Actual Day
77	94.5	76
Budget Night	SNCT Night	Actual Night
41	58.5	40
Total budget	Total SNCT	Total 24 hrs
118	153	116

March 2024 for comparison

Total budget	Total SNCT	Actual total
105.6	129.4	98.4

When reviewing the above data there are several caveats:

a. Two community hospital were not able to submit a completed data set for July, therefore for these sites the March data has been used to support analysis.
b. The SNCT does not include the supervisory/clinical role of the ward manager. The SNCT only includes a 20% average for management, with all other time be allocated for direct patient care and activities associated with the delivery of care. Therefore 0.8wte per ward is not included for Community Hospital wards, if this this was included this would equal an additional 6.4wte.
c. Some of the ward areas included have a smaller number of beds. The total number of beds per ward is used in the SNCT algorithm, along with the acuity score to calculate the number of staff required. In some instances, this would take the number of staff down per shift to an unsafe level. Consequently, the establishments for these wards are higher than SNCT would estimate because of the need to have a minimum number of nurses on a ward. There is also a requirement to consider the reablement requirement of these patients who may have limited access to ongoing therapy from AHP colleagues.
d. The SNCT does not differentiate between registered or non-registered it will simply produce a number, which can then be split once the preferred registered to non-registered ratio is confirmed. Across all the community hospital wards this averages at 43.1% registrants per shift.

In summary: Overall, there is good evidence that teams are managing rosters within budget and staffing wards to the agreed number of staff. When comparing the March and July audit results there is a slight difference between the total numbers of staff, however, this is attributable to a complete data set being available. There was some evidence that wards did run below core numbers on some shifts, but this was not the norm and generally any sickness or vacancy is covered by temporary staffing. During this audit the gap between SNCT recommendation and budget establishments has grown with an average 22 shifts not being covered across days and nights. There needs to be some additional work done in the service group to understand the impact of the supervisory ward manager and coordinator roles being include in roster numbers when covering sickness or vacancy and consider if this is impacting on the provision of safe care.

9.9. **Analysis**

10.9a. Service groups are now able to start to consider if establishments are set appropriately, although this still needs to be done cautiously as not all areas submitted data for March and some audits submitted for July had data missing and/or had not been validated (the missing data was rectified by using data that was available to complete from other days). There are a few wards that do need to be reviewed singularly by the service group and decide if there are any interim measure that need to be put in place. There are some differences between what is budgeted vs the number of staff that the SNCT calculator suggests are required for the number

and acuity of patients during the audit period. There are a variety of reasons that could explain this and some of these have been identified above as:

A. The supervisory/clinical role of the ward manager
B. The role of the coordinator
C. The low number of level 2 acuity during the audit
D. The lower number of beds in some wards

Other factors which would need to be consider are:

A. The requirement to split some of the bigger wards in the Jubilee building which has required additional coordinator roles to safely manage care.
B. The number of staff calculated for the AMU at MPH is lower than would be expected for an acute assessment unit that is a single side room ward. Having spoken to the national team we have been advised that the Acute Assessment Unit algorithm has been adjusted to reflect the higher acuity of this patient group and there will not be an additional SNCT calculator for side rooms and therefore any recommendations to be made should be through a review of outcomes, nurse indicators and professional judgment.
C. The Deputy Chief Nurse has met with service groups, matrons and ward managers to talk through their audit results and areas of concern are highlighted in the main part of the report with actions taken.

10. **Recommunication's from SNCT**

10.1. The January data capture has been completed, and analysis is underway.

10.2. Undertake further training on the use of the SNCT tool and how to apply professional judgement and understand the importance of looking for themes, and the interpretation of nurse sensitive indicators and other outcome data.

10.3. Consider the registered to non-registered ratio and benchmark with other organisations.

10.4. Consider looking at areas that have provision to manage level 2 care separately along with wards that have less than 16 beds.

10.5. Consider increasing the number of days audited in each cycle up to 30 and include weekends in July 2025.

10.6. Continue to work on a PowerBI application so that data can be reviewed over time and more usefully displayed.

Staffing Numbers by area July 2024

	Budget		SNCT		Planned		Actual (rounded up to nearest whole number)	
	day	night	day	night	day	night	day	night
MPH (Acc)	233.53	145.53	224.5	136.5	201	170	195	169
Beacon	5.8	1.8	6.3	2.3	6	3	5	3
Ward 9	6	2	5.5	1.5	6	3	5	3
Portman	9	5	10.3	6.3	8	7	9	5
Triscombe	17.6	13.6	15.7	11.7	17	14	17	13
Parkside	6.3	2.3	5.8	1.8	4	3	4	3
SDU	12.2	8.2	7.5	3.5	10	9	9	9
Shepperd (currently TOR)	9.7	5.7	7.5	3.5	8	7	6	5
Mont South	10.9	6.9	11.4	7.4	9	8	9	8
Mont North	8.4	4.4	10.5	6.5	7	6	6	6
Eliot	9.8	5.8	11.7	7.7	9	8	8	8
Blake	7.9	3.9	6.7	2.7	7	4	6	4
Hest South	11.3	7.3	14	10	9	8	9	9
Hest North	8.8	4.8	10.6	6.6	6	6	7	7
Gould	9.9	5.9	11.8	7.8	8	7	8	8
Fielding	9.2	5.2	9.3	5.3	8	5	8	5
Exmoor	9.6	5.6	9.4	5.4	8	7	9	7
Dunkery	20.1	16.1	15.8	11.8	20	16	19	17
AMU	20	16	16.2	12.2	17	17	17	17
AFU	7.6	3.6	8.3	4.3	6	5	6	5
Coleridge	17.8	13.8	14.5	10.5	17	16	17	17
CCU	5.6	1.6	4.2	0.2	3	3	3	3
Conservators	10	6	11.5	7.5	8	7	8	7
YDH (Acc)	101.9	57.9	130.5	86.4	90	68	89	72
ACCU	5.1	1.1	6.2	2.2	3	3	3	3
AMU 6B	9.3	5.3	14.8	10.8	12	10	14	14
9B	11.5	7.5	14	10	9	6	10	8
9A	9.6	5.6	9.9	5.9	9	6	9	6
8B	9.1	5.1	12	8	8	6	8	7
8A	8.8	4.8	13.7	9.6	8	6	8	6.0
7B	11.4	7.4	15.1	11.1	10	8	10	8

	Budget		SNCT		Planned		Actual (rounded up to nearest whole number)	
	day	night	day	night	day	night	day	night
7A	10.7	6.7	11.4	7.4	9	6	9	5
4A	10.1	6.1	12	8	9	7	8	7
6A	7.5	3.5	10.8	6.8	8	6	5	4
KW	6.6	2.6	8	4	5	4	5	4
Paeds (Accu)	17.2	9.2	15.4	7.4	13	11	13	10
Paeds MPH	10.8	6.8	8.3	4.3	8	7	8	7
Paeds YDH	6.4	2.4	7.1	3.1	5	4	5	3
Community (Accu)	77	41	94.5	58.7	66	45	66	50
West Mendip	11.5	7.5	15.3	11.3	10	7	12	10
Frome	8.5	4.5	10.5	6.5	8	5	7	5
Crewkerne	7.1	3.1	8	4	5	4	5	5
Wincanton	7.4	3.4	8.4	4.4	6	4	5	4
Burnham	6.9	2.9	9.4	5.4	5	4	5	4
Williton	9	5	7.8	4	9	5	8	5
Bridgewater	10.1	6.1	13.2	9.2	9	6	10	7
Minehead	7.2	3.2	8	4	5	4	5	4
South Petherton	9.3	5.3	13.9	9.9	9	6	9	6

Service Group and Inpatient Level Data
(Minus numbers in red indicate over recruitment; numbers in black are vacancy levels)

11. **Clinical Support & Cancer Services, narrative from the Associate Director of**

CSCS MPH

Measure	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Trend
Registered Nursing Fill Rate	97.5%	98.0%	100.3%	102.5%	102.9%	103.3%	
Unregistered Nursing Fill Rate	97.2%	90.7%	91.1%	94.6%	90.0%	86.4%	
All Staff Fill Rate - Day	93.4%	92.7%	95.2%	97.6%	97.2%	95.1%	
All Staff Fill Rate - Night	104.3%	100.0%	100.0%	102.7%	99.4%	100.0%	
All Staff Fill Rate - Overall	97.4%	95.3%	96.9%	99.5%	98.0%	97.0%	
Care Hours per Patient Day	7.4	7.4	7.4	7.1	6.7	6.6	
Registered Hours per Patient Day	4.7	4.8	4.9	4.6	4.4	4.4	
Completing Safer Staffing Measures	87%	58%	44%	52%	74%	81%	
Sickness	4.3%	6.2%	3.2%	5.6%	6.8%	3.7%	
Labour Turnover Rate	2.8%	2.9%	2.0%	3.9%	4.0%	3.9%	
Registered Nurse Vacancy Rate	-4.2%	-4.2%	-4.2%	-3.9%	-3.4%	-3.2%	
Unregistered Nurse Vacancy Rate	5.4%	5.4%	5.9%	5.9%	11.9%	12.0%	
All Clinical Staff Vacancy Rate	-4.2%	-4.2%	-4.2%	-3.9%	-3.4%	-3.2%	

Patient Care:

11.1. The data above covers two inpatient areas so the over recruitment (negative vacancy position) will represent one nurse who will be in training to achieve full chemotherapy administration competency. Fill rates for both units are good.

11.2. Turnover at YDH out-patient chemo department has slowed, though we remain under pressure from multiple long-term sickness absences and colleagues with reasonable adjustments to duties.

11.3. Ward 9 nursing establishment has been increased and substantiated to facilitate ambulatory care.

11.4. We have a high risk regarding provision of the Acute Haematology Oncology Service, including provision of the Cancer helpline. Controls are in place but the impact on the health and wellbeing of the team is great, this is due to some vacancy and long term staff absences. A support plan is being put in place to manage the risk but it remains vulnerable.

11.5. We hold numerous risks and vulnerabilities relating to AHP and Clinical Scientist staffing levels across multiple professions and services. Many of these will be impacting on patient care (inpatient and outpatient) and resulting in pathway delays and suboptimal care.

Toni Hall, Associate Director of Patient Care

12. **Family Services, narrative from the Associate Director of Patient Care**:

CYP & Families Services MPH

Measure	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Trend
Registered Nursing Fill Rate	93.7%	88.1%	88.9%	93.2%	92.4%	90.5%	
Unregistered Nursing Fill Rate	99.4%	71.9%	70.6%	66.6%	68.8%	64.1%	
All Staff Fill Rate - Day	96.5%	87.6%	88.2%	91.9%	91.0%	88.6%	
All Staff Fill Rate - Night	102.8%	86.4%	88.6%	90.2%	89.7%	88.0%	
All Staff Fill Rate - Overall	99.2%	87.0%	88.4%	91.1%	90.4%	88.4%	
Care Hours per Patient Day	5.5	9.7	8.9	9.8	9.7	9.9	
Registered Hours per Patient Day	3.5	8.3	7.7	8.6	8.4	8.6	
Completing Safer Staffing Measures	82%	54%	56%	59%	73%	76%	
Sickness	5.3%	5.6%	5.2%	4.1%	6.2%	5.4%	
Labour Turnover Rate	12.7%	13.8%	12.9%	12.8%	13.2%	11.9%	
Registered Nurse Vacancy Rate	5.9%	4.7%	4.0%	6.0%	0.7%	1.0%	
Unregistered Nurse Vacancy Rate	-5.1%	-1.7%	-0.9%	2.3%	5.1%	13.0%	
All Clinical Staff Vacancy Rate	5.4%	4.2%	3.9%	5.9%	0.6%	1.0%	

CYP & Families Services YDH

Measure	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Trend
Registered Nursing Fill Rate	89.7%	84.6%	88.7%	87.0%	92.3%	86.1%	
Unregistered Nursing Fill Rate	75.1%	86.0%	82.1%	83.7%	88.0%	88.4%	
All Staff Fill Rate - Day	82.3%	79.2%	83.8%	83.8%	89.2%	81.1%	
All Staff Fill Rate - Night	93.9%	97.2%	94.8%	91.6%	95.9%	98.5%	
All Staff Fill Rate - Overall	86.0%	84.9%	87.2%	86.2%	91.3%	86.6%	
Care Hours per Patient Day	25.4	19.0	22.1	26.9	27.1	26.7	
Registered Hours per Patient Day	19.8	14.6	17.5	21.1	21.2	20.5	
Completing Safer Staffing Measures							
Sickness	8.8%	8.3%	7.9%	9.1%	7.8%	7.5%	
Labour Turnover Rate	18.9%	16.6%	15.1%	16.9%	15.4%	15.1%	
Registered Nurse Vacancy Rate	8.1%	3.6%	-1.3%	11.3%	2.2%	1.7%	
Unregistered Nurse Vacancy Rate	-18.7%	-4.7%	-8.4%	5.5%	2.7%	-0.8%	
All Clinical Staff Vacancy Rate	8.1%	3.6%	-1.3%	11.3%	2.2%	1.7%	

12.1. The staffing levels on the children's ward at YDH did not meet the recommended guidelines for safe staff-to-bed ratios when the ward is at full capacity and patient acuity is high. Long-term efforts to improve staffing are in progress, the funding has been agreed by the Trust and recruitment is ongoing.

12.2. The data for the CYP and Families service group encompasses the children's wards and the neonatal units at both sites both of which experience fluctuating occupancy levels around the clock. We strive to adjust staffing ratios based on occupied beds rather than funded beds. Therefore, although the fill rate figures may not always appear optimal, they are usually aligned with actual occupancy. A weekly review of data on patient acuity and bed occupancy rates is ongoing.

12.3. Over the past two years, to ensure safe staffing on Ward 10, it has been necessary to use agency staff at short notice to supplement the core team. This approach is costly and disrupts continuity of care for patients and the nursing team. We are now avoiding the use of agency staff unless patient safety is a concern- we then use lower

tier agencies if at all possible. This has been supported by the business case agreed last year and recruitment against this.

12.4. Concerns about staffing levels on both Paediatric wards have been ongoing and are regularly reviewed by the leadership team in the CYP and Families service group, as well as discussed with our Executive team.

12.5. Currently, safe staffing levels are maintained using agency staff. However, we have significantly dropped our dependence on this source. Recruitment efforts are underway. Preceptee nurses are joining the teams at both sites following the completion of their training. This is a testament to both teams' support throughout their colleagues' training, leading these nurses to choose to join the teams permanently. We anticipate that the two paediatric teams will achieve a fully established staffing team by April 2025.

12.6. Recruitment of paediatric nurses has been challenging for several years. Recruitment efforts are ongoing, but due to a shortage of UK-based paediatric nurses and therapists, we must rely on international recruitment to fill this gap. This process has been very successful with three previous cohort. To support the successful integration of these nurses, the teams have introduced a settling-in period, an induction plan, and a clear mentorship programme to ensure support and training are available, competencies can be adequately reached, and the new recruits can settle into the team appropriately.

12.7. Skill mix is considered at every opportunity, and a bespoke team to support CAMHS patients has been recruited within both sites. This team provides therapeutic support alongside nursing support to vulnerable patients when they need hospitalisation due to a deterioration in their physical health. The team receives training and supervision from our CAMHS colleagues and offers educational bite-size training to nursing colleagues during their daily shifts. Feedback from our CAMHS patients and the CQC team within a recent inspection has been very positive about this added support and education opportunity.

12.8. The opening of our Paediatric Assessment Unit 7 days a week in MPH has been very welcomed by the paediatric teams and we have received positive feedback from Families. This service ensures that all admissions are appropriate. The model of PAU in YDH is different because it sits within ED and Paediatricians are called to assess and review patients from the ward, this can lead to delays. Ideally, we would like to integrate the model and have permanent paediatric staff supporting patients in PAU YDH, but this would require additional funding however would reduce admissions long term

12.9. Children requiring high dependency unit (HDU) level care at YDH are treated within the general Paediatric ward unless their condition worsens. In such cases, they may be transferred to the ITU, where a Paediatric Nurse will transition to provide necessary care. Alternatively, adult nurses may be utilised, and in some instances, it is necessary to transfer patients to Bristol or Southampton. This situation poses risks

to the patients, incurs additional staffing costs, and strains service provision. Additionally, the overall wellbeing and stress levels among staff are heightened due to these challenges.

12.10. Unfortunately, there is no child-friendly environment available for paediatric high dependency patients at YDH.

Suki Norris, Associate Director of Patient Care

13. **Medical Services, narrative from the Associate Director of Patient Care.**

Medical Services	MPH						
Measure	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Trend**
Registered Nursing Fill Rate	97.5%	95.6%	95.6%	94.2%	95.0%	95.4%	
Unregistered Nursing Fill Rate	101.7%	97.1%	101.9%	99.6%	96.5%	95.0%	
All Staff Fill Rate - Day	98.9%	95.1%	95.7%	92.9%	93.0%	93.2%	
All Staff Fill Rate - Night	103.1%	102.3%	104.9%	103.9%	101.0%	100.1%	
All Staff Fill Rate - Overall	100.8%	98.4%	99.9%	97.8%	96.6%	96.3%	
Care Hours per Patient Day	8.3	7.9	7.8	7.6	7.3	7.1	
Registered Hours per Patient Day	4.5	4.0	3.9	3.9	3.8	3.7	
Completing Safer Staffing Measures	90%	60%	43%	59%	87%	86%	
Sickness	6.1%	5.2%	5.7%	6.5%	7.6%	7.4%	
Labour Turnover Rate	11.0%	11.8%	10.7%	11.1%	10.2%	10.7%	
Registered Nurse Vacancy Rate	2.6%	3.2%	3.4%	1.2%	2.6%	1.5%	
Unregistered Nurse Vacancy Rate	-3.1%	1.5%	3.7%	4.3%	6.0%	7.6%	
All Clinical Staff Vacancy Rate	2.6%	3.2%	3.4%	1.2%	2.6%	1.5%	

Medical Services	YDH						
Measure	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Trend**
Registered Nursing Fill Rate	101.5%	98.4%	99.8%	101.7%	99.0%	99.1%	
Unregistered Nursing Fill Rate	98.8%	99.1%	96.3%	95.4%	98.2%	91.3%	
All Staff Fill Rate - Day	101.4%	98.5%	97.4%	99.2%	99.5%	95.7%	
All Staff Fill Rate - Night	104.1%	105.5%	104.3%	101.4%	100.8%	98.8%	
All Staff Fill Rate - Overall	102.5%	101.5%	100.4%	100.1%	100.1%	97.1%	
Care Hours per Patient Day	6.4	5.6	6.3	5.9	6.2	7.9	
Registered Hours per Patient Day	3.5	3.0	3.4	3.2	3.3	4.3	
Completing Safer Staffing Measures	95%	95%	51%	0%	0%	55%	
Sickness	5.2%	5.8%	5.4%	4.9%	4.6%	6.0%	
Labour Turnover Rate	9.7%	8.6%	9.4%	9.1%	8.8%	8.8%	
Registered Nurse Vacancy Rate	-15.1%	-14.7%	-14.7%	-14.9%	-13.0%	-11.3%	
Unregistered Nurse Vacancy Rate	-11.5%	-8.7%	-7.2%	-1.4%	0.7%	1.6%	
All Clinical Staff Vacancy Rate	-15.1%	-14.7%	-14.7%	-14.9%	-13.0%	-11.3%	

13.1. In summary, the last 6 months with nurse staffing in the Medical Service Group, we have continued to remain in a positive position with over established registered nurses. These extra staff were partly from closure of extra escalation wards and also due to improved retention rates last year that lead to over recruitment through the international pipeline. These colleagues are part of teams but the extra shifts are used to minimise use of temporary staffing due to sickness and have been used to support the large number of extra patients being cared for in the emergency departments and escalation beds on wards.

13.2. We have seen a larger deficit of healthcare assistants compared to this time 12 months ago. Recently this has posed some challenges for us with recruiting into the healthcare assistant positions, due to the changes in the recruitment process, which

has caused delays in applicants starting and withdrawing from the job offer due to delays with checks. This has been escalated to our senior recruitment advisor.

13.3. Over the last 3 months we have seen an increase in the need to support extra staffing number, this has mainly been due to the increased flow and bed pressures. We have needed to support the re-opening of Jasmine Ward, and there has been a high use of our escalation beds open, alongside supporting staffing both ED departments to support patients delayed for admission due to lack of beds. Alongside this we have seen very high levels ongoing levels of colleague absence, mainly due to respiratory conditions with a peak of Flu, Covid and Norovirus coinciding. Sickness levels have increased from June 2024 from 4% for our nursing workforce compared to 5.7% for the month of December 2024.

13.4. Our observation and support requests are decreasing within the service group, due to specialist training ongoing with our healthcare assistant workforce, and to date we have trained up to 50 healthcare assistants. We have already started to see a reduction in incidents of falls and violence and aggression where staff work who have received the training.

13.5. Our RN forecast vacancy position continues to remain positive, and ongoing scrutiny continues with our vacancy trackers and any gaps on our wards are supported and backfilled from over established areas. We are working closely with other service groups to support filling any RN vacancy from our over established numbers. The overseas pipeline is still currently switched off on both sites, and all newly qualified and overseas nurses are now mapped into all our trackers, with the last cohort of overseas arriving at the end of July 2025. There is a student nurse open day February 2025, and lots of interest has already been made from students due to qualify in the next 6 – 12 months to try and maintain and improve our local pipeline. We have 10 registered nurse apprentices due to qualify in the next 9 months, and all these recruitment schemes give reassurances that we will remain in a positive position moving forward in terms of registered nurse vacancies. Ongoing recruitment is managed at individual ward/ department areas and all vacancies will be approved through our vacancy recruitment panel. We are supporting growing our own and have seen a high number of staff move into more senior roles. The OD team and our HR support has been invaluable to offer advice and to help us understand how we can improve retention, and this is something that aligns with our medical service group quality strategy. The ADPC and the people's business partner have been working alongside the ward leads and matrons for all wards and departments reviewing and aligning ESR, trackers and roster templates to offer assurances of our good housekeeping processes, and this is a continued ongoing piece of work.

13.6. Skill mixes on our wards has improved over the last 6 months, and this has been helped and supported by our matrons now working 20% clinical time on their wards. We continue to have a focused piece of work on skills training gap analysis across all our wards, and support training and education needs where identified, with the support from our two clinical skills facilitators and the patient safety team, and we will continue, with our ongoing projects currently in place, however we recognise that

there is still a lot of work to do. We have had a change in 6 ward areas over the last 6 months of ward managers, due to promotions within the organisation or relocating overseas.

13.7. The ward managers have been pulled into the numbers more recently over the last 2 months, due to the continued challenges with increased sickness across the service group, but this is being closely monitored and recorded on the health roster. The KPIs continue to be a key area of focus, as during the last 2 months we have seen a few areas of concern with a drop in ward KPIs and increased care concerns. These areas are being monitored and each have an individual plan in place to support and review.

13.8. The bed and ward re configuration work has nearly been completed across both sites. The last move will be a swap of base between Elliot Ward (care of older people) and Sheppard Ward (general medical). This will happen after some works are completed on Sheppard Ward that were not done in the recent refurbishment. This move co-locates more of the care of older people in one part of the building to assist the medical team. There will be a slight change in the bed numbers with the Shappard base dropping 4 beds. Their will be a slight reduction in establishment and the funding released is being put forward for the increase in other areas (as described in main body of report).

13.9. The matrons/ ADPCs have good oversight and good grip and control over our over established areas, drilling down rosters day by day and plans are made to cover the gaps and move staff should this be required. They also review each request that comes in for enhanced care or observation/ support to ensure that those patients that require a higher level of support are prioritised, and staff that have received the training are moved to support.

Jacqueline Phillips, Associate Director of Patient Care

14. **Mental Health and Learning Disabilities, narrative from the Associate Director of Patient Care.**

Mental Health and Learning Disabilities MH wards

Measure	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Trend
Registered Nursing Fill Rate	99.7%	91.0%	92.1%	105.2%	103.3%	104.3%	
Unregistered Nursing Fill Rate	114.4%	99.3%	90.9%	117.1%	121.9%	118.2%	
All Staff Fill Rate - Day	99.1%	84.1%	83.8%	101.2%	99.8%	98.4%	
All Staff Fill Rate - Night	110.1%	97.5%	95.7%	111.7%	116.1%	111.7%	
All Staff Fill Rate - Overall	103.0%	88.9%	88.1%	105.0%	105.7%	103.3%	
Care Hours per Patient Day	14.3	12.9	13.1	13.4	13.6	14.8	
Registered Hours per Patient Day	5.5	4.8	4.9	5.2	5.1	5.7	
Completing Safer Staffing Measures	89%	56%	39%	52%	89%	91%	
Sickness	7.1%	5.4%	6.6%	6.7%	8.2%	7.3%	
Labour Turnover Rate	8.1%	8.5%	10.2%	10.1%	11.2%	12.2%	
Registered Nurse Vacancy Rate	14.5%	12.7%	18.5%	19.1%	18.9%	20.1%	
Unregistered Nurse Vacancy Rate	3.9%	5.7%	7.9%	7.9%	10.6%	9.6%	
All Clinical Staff Vacancy Rate	17.4%	15.6%	20.3%	19.2%	19.0%	19.6%	

14.1. We are in the process of conducting safer staffing surgeries across all the wards to give the ward managers the opportunity to review the required numbers of staff and the management of temporary staffing. We hope to have these completed by mid-February 2025.

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

14.3. Wards, including Holford, Rydon and Rowan are areas where we frequently need to have additional staffing to support the acuity of their patient groups, including when they need to be seen in the Acute Hospitals. The Service Group are planning to review the observation policy to provide greater clarity which may reduce the need for additional staffing to complete observations.

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

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

14.6. The ward nursing fill rate levels fluctuate when managing complex and vulnerable patients requiring additional 1:1, 2:1 or 3:1 staffing, sometimes for lengthy periods,

especially on the Psychiatric Intensive Care Unit (PICU) when vulnerable females need to be supported on a mainly male ward or where is a significant risk to others identified.

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

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

14.9. Wessex Ward has been temporarily closed since August 2024 due to staff shortages, with the remaining staff being redeployed across our other services whilst Tier 4 inpatient provision is reviewed with the South West Provider Collaborative.

14.10. There is currently a low vacancy rate across the mental health wards. Figures shown below suggests more vacancies than there actually are due to the way ESR reports leavers and starters. There are also newly qualified B5 nurses employed throughout the year who have accepted substantive posts but haven't actually started yet.

Inpatient

	Band 3	Band 5	Band 6	Band 7
Vacancies	17.23	21.96	20.59	4.72
Pipeline	6.53	13.00	7.44	1.00
Total	10.70	8.96	13.15	3.72

Community

	Band 3	Band 5	Band 6	Band 7
Vacancies	8.38	8.80	8.76	7.90
Pipeline	4.40	0.00	5.55	4.00
Total	3.98	8.80	3.21	3.90

a) The ward teams aim to complete twice daily patient acuity and dependency scoring using the Mental Health Optimisation Staffing Tool (MHOST). Alongside professional judgment, this tool supports ward clinicians to assess staffing requirements based on the presenting levels of patient acuity and dependency. MHOST incorporates a staffing multiplier to ensure that ward establishments are able to safely and effectively meet patient needs.

b) The wards continue to manage daily challenges through their capacity meetings and continue to strive to reduce reliance on temporary and agency staffing. This has resulted in a significant reduction in the use of agency.

c) We have three trainee Advanced Nurse Practitioners who are working well across Rydon Wards, Rowan and Pyrland Wards, which enhances the clinical support available to the wards. All 3 trainees are due to complete their studies in summer 2025.

d) All ward managers use the risk register to reflect where concerns are raised around staffing and recruitment to the service group, which are reviewed within the regular governance meeting and operational management meeting.

14.11. **Sickness**

During this period the rolling sickness rate has remained between 6.6% - 6.9%, with the reason for absence attributed to stress/anxiety/depression. Some of these are due to bereavement however this cannot be captured with the current options within ESR.

Date	Turnover	Sickness (In Month)	Sickness (Rolling)	Top Absence Reason
July 2024	8.6%	7.4%	6.7%	S10
August 2024	9.1%	5.5%	6.6%	S10
September 2024	10.9%	7.1%	6.6%	S10
October 2024	10.7%	8.1%	6.6%	S10
November 2024	11.4%	8.1%	6.7%	S10
December 2024	12.3%	7.5%	6.9%	S10

S10 = Stress/Anxiety/Depression

Holford

14.12. Due to the acuity over the past few months, and management of a number of high-risk patients on a mixed sex PICU with only one extra care area, this has required additional staffing to support patients on 1:1, 2:1 and 3:1. This has been managed primarily using bank staff and using agency HCA staff where bank staff have not been available to maintain safety and due to the high level of observations. As part of the safer staffing surgeries, we are reviewing substantive staff. We will also be completing an optional appraisal for managing the mixed-sex PICU.

Rowan 1 & 2

14.13. The wards need to have staff available to cover the two health-based places of safety on site 24/7.

14.14. The two wards are now established, and staff have settled in well. Each ward takes responsibility for one of the health-based places of safety and use staff flexibly across the site, especially when there are challenging periods.

14.15. Staffing may need to be increased to escort patients to YDH, if and when required.

Ali van Laar, ADPC

15. **Neighbourhoods and Community Services, narrative from the Associate Director of Patient Care.**

Neighbourhood Services	Community						
Measure	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Trend**
Registered Nursing Fill Rate	102.9%	96.7%	94.7%	96.9%	97.3%	97.9%	
Unregistered Nursing Fill Rate	110.1%	101.0%	89.5%	97.3%	96.3%	100.3%	
All Staff Fill Rate - Day	102.3%	97.4%	90.5%	95.7%	94.9%	96.6%	
All Staff Fill Rate - Night	106.2%	103.5%	95.6%	101.1%	101.3%	106.0%	
All Staff Fill Rate - Overall	103.8%	99.8%	92.5%	97.8%	97.4%	100.2%	
Care Hours per Patient Day	7.2	7.6	7.5	7.5	6.8	7.2	
Registered Hours per Patient Day	2.9	3.1	3.2	3.2	2.9	3.0	
Completing Safer Staffing Measures	88%	57%	42%	59%	87%	93%	
Sickness	6.6%	6.8%	8.1%	7.0%	7.1%	7.1%	
Labour Turnover Rate	13.7%	13.4%	13.5%	14.8%	14.2%	12.9%	
Registered Nurse Vacancy Rate	10.4%	10.2%	9.5%	9.1%	9.1%	6.9%	
Unregistered Nurse Vacancy Rate	4.4%	3.6%	3.2%	6.2%	8.2%	7.3%	
All Clinical Staff Vacancy Rate	10.4%	10.2%	9.5%	9.1%	9.1%	6.9%	

15.1. The overall landscape for community hospitals continues to improve with an overall average shift fill rate of registered nurses 96.9% and healthcare assistants 98.5%, The current vacancy rate is registered nurse 6.3wte and HCA 11.85wte. However we face the below challenges:

a. Recruitment to the more geographically isolated hospitals remains a challenge, resulting in long term vacancy which then impacts on agency usage. Working with the Talent Acquisition Specialist to look at different ways of recruiting and a more targeted approach in these areas. Minehead and Frome are hot spot areas and have been exploring overseas recruitment however sponsorship criteria and costs are a concern. Sponsorship needs to be at a B3 and a lot of candidates are not meeting the essential criteria. We are currently working with the Recruitment team to see if we can recruit to a B3 with a 3-6 month training programme for the hard to fill areas however this could be perceived as discriminatory against other colleagues who do not require sponsorship so does pose a risk.

b. High age profile across service group, with significant potential for retirement to impact.

c. Sickness rates are higher than Trust average at 7.11% in 2024. Majority of wards that have high sickness rates also have a high age profile with the average age profile for 55+ being 30%. Sickness audits and ward walk rounds are also being carried out by the HR team to support leaders in managing sickness and identify any

support that they may need. Flexible working is also being offered to all colleagues to support wellbeing and retention.

d. Succession planning and investment in leadership capacity is one of the service group's people priorities which will help ensure optimum succession planning in view of age profile as well as optimum use of flexible working and retire and return options. We have had successful recruitment to matron roles within community hospitals.

15.2. A full roster review has been completed as part of productive care programme which will optimise staffing resource. This has identified the need for a consistent approach to allocation and shift patterns across the community hospitals. Ward managers will become supernumerary and there has been uplift in deputy ward managers in some community hospital sites to reflect service need, within the constraints of the financial envelope. A case for change and consultation to implement changes to rostering pattern are next steps.

15.3. Safe staffing audit work commences again in January for community hospitals, which will capture the perceived increased acuity and dependency in all the Community Hospitals.

15.4. There has been success with nurses recruited via global recruitment campaigns to community hospitals who have been inducted to their identified roles.

Safer Staffing Community

15.5. District nursing had previously participated in the community nursing safer staffing tool (CNSST). This was paused nationally due to data collection discrepancies. This tool is expected to be relaunched in January 2025 with a longer data collection period of two weeks.

15.6. Activities co-ordinators across the Trust have moved into the Dementia and Delerium team, except for those in the Surgical Service group. It is anticipated that this will improve knowledge and skills on ward areas in managing and engaging patients with dementia and delirium and reduce the need for 1:1 supervision and maintain patient safety. This has already been realised at some community hospital sites.

John Sutton, Service Group Lead for Safety & Clinical Governance – Neighbourhoods & Community Services Group.

16. **Surgical Care narrative, from the Associate Director of Patient Care.**

Surgical	MPH						
Measure	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Trend**
Registered Nursing Fill Rate	83.7%	88.2%	85.5%	86.8%	88.2%	84.6%	
Unregistered Nursing Fill Rate	91.2%	94.9%	98.3%	96.5%	95.7%	95.7%	
All Staff Fill Rate - Day	88.0%	90.3%	89.7%	88.8%	89.6%	88.5%	
All Staff Fill Rate - Night	90.4%	95.1%	97.0%	96.9%	98.0%	98.1%	
All Staff Fill Rate - Overall	89.1%	92.5%	93.0%	92.4%	93.3%	92.7%	
Care Hours per Patient Day	10.2	10.1	9.7	9.6	9.5	9.4	
Registered Hours per Patient Day	5.6	5.7	5.3	5.4	5.5	5.4	
Completing Safer Staffing Measures	82%	54%	39%	55%	83%	79%	
Sickness	5.6%	6.0%	6.5%	6.9%	6.8%	6.4%	
Labour Turnover Rate	11.0%	10.3%	10.7%	10.4%	11.4%	11.2%	
Registered Nurse Vacancy Rate	20.9%	21.2%	21.1%	19.2%	18.5%	20.4%	
Unregistered Nurse Vacancy Rate	6.5%	6.7%	5.7%	9.6%	9.4%	10.6%	
All Clinical Staff Vacancy Rate	20.6%	21.0%	20.8%	18.9%	18.3%	20.1%	

Surgical	YDH						
Measure	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Trend**
Registered Nursing Fill Rate	89.2%	92.6%	94.8%	97.8%	96.8%	99.0%	
Unregistered Nursing Fill Rate	88.8%	88.6%	89.1%	87.5%	91.8%	86.9%	
All Staff Fill Rate - Day	90.7%	93.4%	94.7%	94.9%	95.1%	96.8%	
All Staff Fill Rate - Night	91.1%	92.8%	94.8%	99.5%	100.1%	101.0%	
All Staff Fill Rate - Overall	90.9%	93.1%	94.7%	97.0%	97.3%	98.7%	
Care Hours per Patient Day	8.3	7.9	7.9	7.9	7.8	8.2	
Registered Hours per Patient Day	5.4	5.2	5.2	5.2	5.1	5.4	
Completing Safer Staffing Measures	99%	97%	51%	0%	0%	0%	
Sickness	3.8%	3.6%	3.5%	4.8%	4.9%	3.2%	
Labour Turnover Rate	11.5%	11.1%	11.3%	10.9%	11.0%	9.7%	
Registered Nurse Vacancy Rate	7.6%	5.8%	6.7%	6.7%	5.5%	5.7%	
Unregistered Nurse Vacancy Rate	1.9%	6.0%	1.6%	6.2%	6.4%	9.7%	
All Clinical Staff Vacancy Rate	7.6%	5.8%	6.7%	6.7%	5.5%	5.7%	

16.1. The data presented provides a clear representation of the fill rate across our wards, with most wards consistently maintaining rates above 90%. While there is some missing data for MPH wards that may slightly impact the overall figures, a closer examination at the ward level confirms the accuracy of the reported numbers. ICU's lower fill rate is attributed to the fluctuating number of occupied beds and corresponding staffing adjustments, which means we do not always need to meet the full fill rate. This dynamic approach allows us to efficiently allocate resources based on real-time needs.

16.2. The sickness summary indicates a mix of short-term and long-term absences across various wards, primarily due to seasonal illnesses such as coughs, colds, and viruses. Several staff members are on long-term sick leave due to more serious health conditions, including mental health issues and post-surgery recovery. Some staff have since returned or transitioned to maternity leave. The overall trend shows that while short-term sickness is prevalent due to viral infections, long-term cases are being actively managed, with HR involvement where necessary. There are no significant patterns, and most absences appear to be individual cases rather than systemic issues.

16.3. The turnover across the wards has been minimal, with most departures attributed to staff seeking development opportunities or relocations. No significant concerns have been raised regarding retention, as the reasons for leaving are generally positive and related to career progression.

16.4. Regarding vacancies, RN positions are mostly filled, with new staff set to join in the coming months. However, there are some ongoing challenges with HCA vacancies, though recruitment efforts are underway, and many positions are expected to be filled soon. Temporary gaps are being managed through fixed-term contracts and secondments, ensuring that staffing levels remain stable despite maternity leaves and other long-term absences. Overall, the vacancy rates are being actively addressed through staggered recruitment and internal adjustments.

16.5. To improve staffing levels and ensure optimal fill rates, we plan to conduct regular deep dives into rosters and consistently review and refine staffing templates. This will help us identify any discrepancies and adjust rosters to align with actual ward needs. By maintaining a continuous cycle of review and feedback, we can ensure that staffing templates are accurate and effectively implemented. Additionally, this proactive approach will allow us to anticipate and address potential staffing challenges more efficiently, thereby improving overall resource allocation and ward performance.

16.6. MPH ICU Fill Rate: The current fill rate is lower due to our existing vacancy rate. We have ongoing recruitment efforts in place, which should gradually improve this metric. Staffing levels are flexed to match the number of beds in use, it can be challenging as this can fluctuate very quickly.

16.7. Vacancy: The vacancy rate is likely accurate. However, as with the fill rate, we expect improvements with new staff starting in January and April. Additionally, several staff members work exclusively on a permanent bank basis due to childcare or work-life balance considerations, which bolsters our staffing numbers.

16.8. Following review of the safer staffing data and areas where concern has been raised, two areas within surgery require an alteration in establishment. These changes are required due to ward reconfiguration that has adjusted size of wards but also intensified the number of surgical specialities in areas. With a move of lower level surgical cases to day case procedures this has meant that those requiring hospital stay have a higher level of care needs and staffing levels have needed adjusting.

16.9. 4A - YDH - Planned elective, gastroenterology, urology, - Surgical Ward.
Following ward moves to reconfigure the bed stock at YDH 4a is now a surgical ward (previously on 7a, previous team and establishment moved) – the changed layout of this ward and increased complexity of surgical patients has meant that the planned staffing level was quickly noted to be inadequate and an increase in one. HCA 24/7 was required to maintain safe care within the ward and it is recommended that this is continued substantively.

16.10. 7B YDH – mixed surgical ward including trauma and orthopaedics, colorectal, urology, gynaecology and breast.
This area had been flagged in previous safe staffing papers due to the poorer nurse to patient ratio (9-10 patients per registrant) and that we were a data outlier for mortality post-surgery for fractured neck of femur and it was part of the action plan to enhance the post operative care for this group of patients, but this required a higher registered nursing ratio. Mitigating action was to put in a registered nurse 24/7 and it is recommended that this is continued substantively.

16.11. Within surgical services the required changes to establishments have been achieved by moving ward based nurse funding within the service group to cover the costs of the changes that are required.

Kelly Hutchins, Associate Director of Patient Care

END

Somerset NHS Foundation Trust	
REPORT TO:	OLT
REPORT TITLE:	Learning from Deaths Report
SPONSORING EXEC:	Mel Iles, Chief Medical Officer
REPORT BY:	Claire Bailey, Learning from Deaths Lead Laura Walker, Head of Patient Safety and Learning Gary Filer, Quality and Safety Analyst
PRESENTED BY:	Paul Foster
DATE:	April 2025

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

Executive Summary and Reason for presentation to Committee/Board	This report is a requirement of the *National Guidance on Learning from Deaths* (National Quality Board, March 2017) and the *Implementing Learning from Deaths framework, key requirements for Trust Boards* (NHS Improvement, July 2017). Executive Summary and highlights from this report: Learning from the ***Deaths*** Our learning appears to be aligned with our PSIRF priorities, themes of TEP, managing the deteriorating patient and communication with people who matter continue to be seen. We are also seeing themes around transfers of care. Learning from the ***Detail*** Medical examiners are reviewing 100% of SFT deaths, totalling 612 in Quarter 4, with feedback being cascaded for 90 of these deaths. The Learning from Deaths team co-ordinate the triage of these so an agreement can be reached on a proportionate response. Learning from the ***Data*** Our overall Trust Mortality Rate continues to be as expected – SHMI **1.00.**
Recommendation	The group is asked to discuss this report.

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

☒ Obj 1 Improve health and wellbeing of population
☒ Obj 2 Provide the best care and support to children and adults
☐ Obj 3 Strengthen care and support in local communities
☒ Obj 4 Reduce inequalities
☒ Obj 5 Respond well to complex needs
☒ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☐ Obj 7 Live within our means and use our resources wisely
☒ Obj 8 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

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

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

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

Equality
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 Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics

☐ This report has been assessed against the Trust's Equality 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

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)

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

LEARNING FROM DEATHS REPORT – QUARTER 4 2024-2025

1. BACKGROUND AND PURPOSE

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

1.2 The Learning from Deaths report confirms our progress with the evolving systems used to identify and learn from a patient's death. The way we review a patient's death can take many forms with learning identified through several processes. Appendix 1 provides a summary of the reviews undertaken with comparative data from the previous year. These figures are updated at each subsequent Quarterly review period.

2. UPDATE ON THE MORTALITY REVIEW PROCESS

2.1 The Mortality Surveillance Group (MSG) met on 26th March 2025. Colleagues from the Medical Service Group shared an update on actions that are being taken to ensure that they have robust processes for oversight of the learning outcomes from any mortality reviews. Through accessing the centrally held SJR database, they have extracted reviews where poor care had been noted in order to follow up on any identified learning. All speciality Mortality Leads have been asked to share minutes from their M&M or equivalent departmental governance meeting with the service group governance team. A 'Learning from Events' meeting has also been established as a service group level forum for sharing and escalating learning. It was acknowledged that there is ongoing work to further embed the Learning from Deaths process across the whole trust.

2.2 On 24th March 2025, Paul Foster and Katy Darvall attended a system wide mortality group meeting chaired by the ICB. The 2023-2024 LeDeR annual report was shared with the group. During the reporting period, 35 reviews, of which 17 were more in-depth 'focused' reviews, were completed. Most deaths happened within a hospital setting, which is in line with the national findings for people with Learning Disability but is higher than in the general population. The most common causes of death related to diseases of the respiratory system. This was the same as for the previous reporting year, for which the findings from a deep dive review reported common themes:

- Challenges with the use of Treatment Escalation Plans (TEPs) and Advanced Care Plans.
- Lack of recognition of patient deterioration and the appropriate use of patient deterioration tools.

Both themes feature in the priorities for service improvement work for 2024-2025, in addition to a deep dive review of deaths related to sepsis from 2023-2024, and work to promote access to pneumococcal and influenza vaccinations in eligible groups.

2.3 The Mental Health Homicide sub-group, which oversees the reviews and action plans for deaths that meet the definition of a Mental Health Homicide, will be chaired by Chloe Stepney, the Head on Forensics Services, upon the retirement of Jane Yeandle, the Service Group Director, at the end of April 2025. Jane has been integral to the development of robust processes for this pathway that ensures there is a strong focus on learning from these tragic events in a way that retains compassion for those involved. An update concerning a homicide that took place in 2024 was shared by the sub-group during the quarter. The trust was initially directed by NHSE to undertake an investigation through the Mental Health Homicide pathway, but after further consideration it has now been agreed that this event meets the criteria for a Domestic Homicide Review. This will be led by the Safer Somerset Partnership and the trust will contribute as appropriate. The sub-group have updated that there are ongoing discussions with the Independent Incident Review Group (NHSE/ICB). This is to look at the pathway for when Mental Health Homicides have occurred to ensure that all appropriate stakeholders are involved.

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

3.1 Examples of learning:

- A patient with known cardiac amyloid and multiple myeloma was admitted to one of our medical wards due to an exacerbation of symptoms associated with severe cardiac failure. Whilst their symptoms were starting to improve, they were sadly found in cardiac arrest and died. Our haematology team completed an SJR and found that whilst the death was sudden, it was unavoidable due to the patients known poor cardiac status. The care of the patient was reported to be good overall. Whilst not thought to be significant in this case, there was a learning point highlighted when the case was discussed by the team. It was noted that the haematologist had asked for the involvement of the heart failure nurses. Although the patient had a normal ejection fraction, they were known to be in heart failure with massive oedema, however the heat failure nurses only saw patients with an ejection fraction of less than 50%. This has since been discussed and it has been agreed that they will see patients with amyloidosis.

- A patient was transferred from a non-SFT hospital to one of our acute hospitals for emergency surgical intervention for a severe diabetic foot infection according to the Somerset and North Devon Vascular Network pathways. Sadly, they continued to decline due to a systemic infection and the focus of care was switched to palliation. The vascular team completed an SJR which found that the patient's death was unlikely to have been avoidable due to their pre-existing frailty and extensive infection at presentation. There were however issues with the quality of care which may have contributed to their death as there were delays with transferring the patient for surgery – this was not in accordance with the agreed pathways. When discussed at the departmental Mortality and Morbidity (M&M) meeting it was agreed that there was learning from this case. Ongoing vascular and diabetic foot teaching has taken place across the Vascular Network with a rolling programme being established. Non-compliance with the diabetic foot pathway will be incident reported to provide continued assurance.

- A Root Cause Analysis was completed by colleagues in our Mental Health and Learning Disability service group following the sad suicide of a patient who was known to services within one of our community teams. The investigation reported that there had been a significant period of stability in the patient's mental health. This led to a 'step-down' of care during the months preceding the death. Good practice was identified during this transfer of care, with a noted review of the escalation plan and dialog + (an intervention that structures conversations to explore patient needs and wishes, support care planning, and encourages active problem solving) which was appropriately shared with support agencies and people who matter. However, following this death the Community Mental Health Service (CMHS) have reviewed their processes and, whilst thought unlikely to have had an impact on the outcome in this case, improvements have been made. A Standard Operating Procedure has been produced to clarify the minimum expectations for the role of the keyworker within medication monitoring clinics. This includes a requirement to meet with the patient outside of their clinic appointments in order to build therapeutic rapport and review mental state and risk.

- A patient was admitted under the care of our respiratory team due to progression of known Interstitial Lung Disease. Sadly, despite treatment, the patient rapidly declined and died. Concerns were shared by the Medical Examiner service on behalf of the bereaved family highlighting poor communication from the ward. They described not being prepared for the likelihood that the patient was at the end of their life and felt they were given false hope. Our respiratory team completed an SJR. They found that the management of the patient's acute presentation was appropriate and comprehensive, and their death was unavoidable. Whilst their final deterioration was rapid and difficult to predict, it was acknowledged that documentation of any communication with the patient and their family was poor, so it was unclear whether the severity of deterioration and prognosis was fully explained. To improve this, a Quality Improvement project is

underway to implementing a communication sheet to support these significant conversations.

- A Patient Safety Incident Investigation (PSII) concerning a patient who died whilst an inpatient in one of our acute hospitals was discussed at Patient Safety Board during this quarter. The PSII made several safety recommendations in line with the trust's Patient Safety Priority of deteriorating patients. It was acknowledged that considerable changes have already taken place within our acute medical services which would be in line with some of these recommendations. This includes a ward moving to a larger area of the hospital, giving the staff an improved space to manage the acuity of the patients in their care. Alongside this, it was identified that there was a need to upskill staff working in this area and training has been provided.

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

- **Scrutiny through the Medical Examiner service**

  Since 09/09/24, all non-coronial deaths will have a proportionate review of their medical records completed by a Medical Examiner. Whilst the Medical Examiner service is independent of SFT, this initial scrutiny enables early identification of any case where a potential problem exists, for example where a potential omission in care or poor management is identified, or where the bereaved raise a significant concern. These are then referred to Learning from Deaths for consideration for further review. The Medical Examiner also ensures the appropriate direction of deaths to the coroner. Medical practitioners have a duty to report deaths to a coroner for which they are unable to ascertain the cause of death, the cause of death is unnatural, or the death occurred in custody or state detention, e.g., whilst under a section of the Mental Health Act.

  The Medical Examiner's office had 612 deaths of patients under the care of SFT reported to them between January and March 2025. Of these, 557 were within our acute hospitals, 53 were within our community hospitals and 2 patients were under the care of Hospital @ Home. The Medical Examiner team have scrutinised 100% of these deaths and shared feedback on 90 deaths to Learning from Deaths. This feedback is triaged and shared as appropriate for instance by a review methodology such as an SJR, PALS or Complaint response, or PSIRF learning response.

- **Structured Judgement Reviews**

  Structured Judgement Reviews (SJR's) are carried out by clinicians using adapted versions of the tools developed by the Royal College of Physicians and the Royal College of Psychiatrists. There is a mandatory requirement for SJR's to be completed on cases where concerns exist, in

accordance with the automatic inclusion criteria as described in the trust's Learning from Deaths Policy. These cases are identified via the Medical Examiner service or the incident reporting system, and completion of these reviews is overseen by the Learning from Deaths Lead. During this reporting period, 42 SJR's were requested through this pathway. In addition to these reviews, specialities should also routinely undertake SJR's on a sample of cases in the absence of any particular concern about care. The output from all completed reviews is collated so that common themes and trends can be seen from looking at good practice as well as problems with quality of care. This can then inform the trust's quality improvement work.

- **LeDeR review**

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

  During this reporting period there were 5 inpatient deaths of a person with Learning Disability. Concerns were raised by the Medical Examiner service about the care of three of these patients, which will be considered within an SJR.

- **Incident process**

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

  Within this reporting period, 3 deaths have been discussed at rapid review meetings. As a result, 1 of these deaths was deemed to meet the criteria for a Patient Safety Incident Investigation, and the other deaths will be subject to alternative PSIRF learning responses.

- **PALS and complaints**

  During this quarter, 34 PALS queries and 6 formal complaints have been raised concerning the deaths of patients in our care. Common themes are around:

- Poor communication. An example being of a patient with dementia, whose family felt that they were not included in care.
- Discharge arrangements. An example being of a family who reported that they were not involved in discharge planning, resulting in unsafe plans being made.
- Concerns about care and treatment at the end of life. An example being of a family who were concerned that the patient had been left in pain and distress after removing their syringe driver.
- Concerns about transfers of care. An example being of a family who reported that care was disjointed due to ward moves.

- **Maternity Deaths**

  In this reporting period there were 0 perinatal deaths eligible for notification to MBRRACE-UK by SFT or for local review using the Perinatal Mortality Review Tool (PMRT).

  There were 5 perinatal deaths at other trusts that are eligible for notification to MBRRACE-UK where we will contribute to the PMRT process as we provided antenatal care.

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

  There have been no maternal deaths during this reporting period.

- **Paediatric Deaths**

  Reviews of these deaths are mandatory and undertaken by the Child Death Overview Panel (CDOP). Notification of a child death to the local Safeguarding Children Board is made at the time of any agency becoming aware of the death of a child. Where the death occurs within the hospital, responsibility for completing this notification is usually undertaken by the paediatrician managing the case. We were made aware of 3 paediatric deaths during this quarter. There were 2 deaths of infants, one of which we will contribute to the PMRT being led by another trust, and the other was an expected death. There was an unexpected death of a young person in the community who was known to our services due to their complex medical needs.

- **Coronial activity**

  During this reporting period, there were 52 new enquiries from the coroner concerning the deaths of patients known to SFT. Formal statements have been requested for all cases.

  Several inquests pending from previous reporting periods have been concluded during this quarter. This includes 68 read-only inquests and 12

inquests heard with witnesses called. A further 2 pre inquest review hearings have been heard.

During this quarter, the trust has been issued with a regulation 28 prevention of future deaths report concerning a patient who sadly died at one of our acute hospitals. The inquest concluded that the patient died as a result of natural causes contributed to by gaps in the implementation of the pressure ulcer care plan. A range of projects are underway to address this, including the development of a new tool for Intentional Rounding and improvements to education and training to support the management of vulnerable patients. In addition, there are plans to standardise and align the pressure relieving equipment as well as the care plan documents across the inpatient areas.

- **Standardised mortality**

3.3.1 Summary Hospital-level Mortality Indicator (SHMI), November 2023 - October 2024

Source: NHS England (March 2025)

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

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

Trust level

Trust	Provider spells	Observed deaths	Expected deaths	SHMI value
Somerset NHS FT	86,785	3,170	3,155	1.00 As expected

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

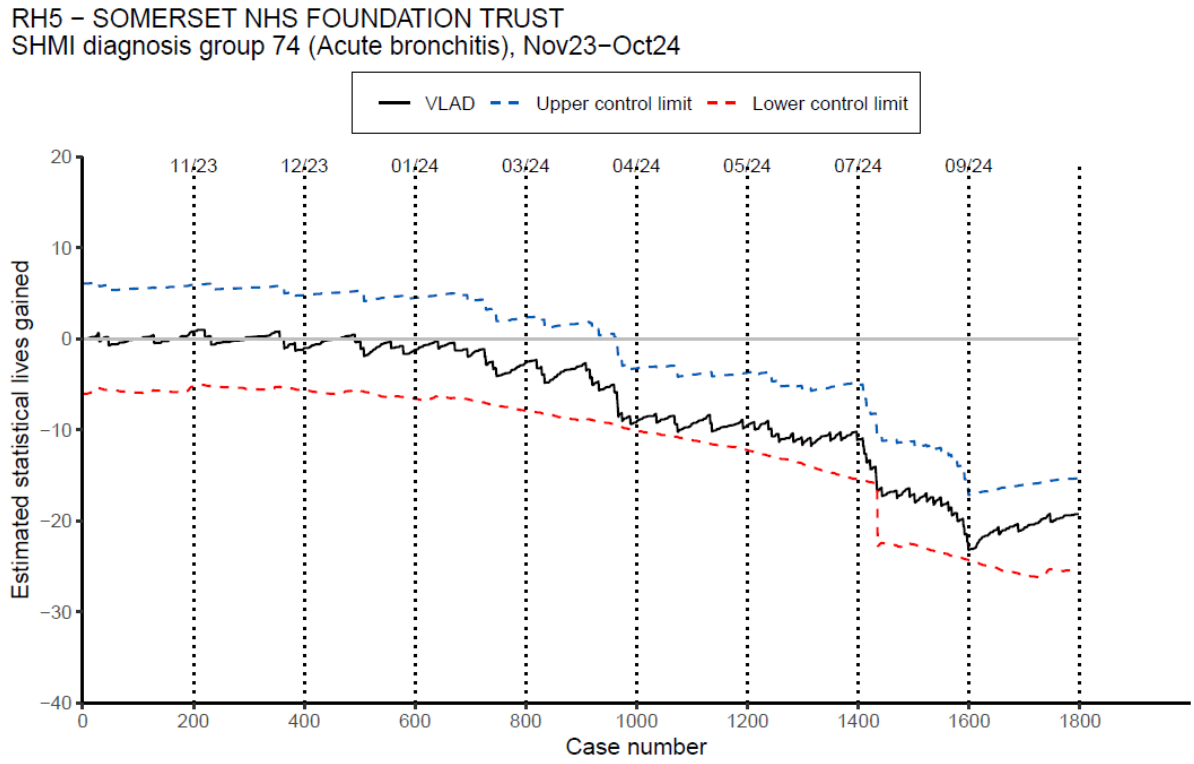
Site	Provider spells	Observed deaths	Expected deaths	SHMI value
Musgrove Park Hospital	62,475	1,945	1,975	0.98 As expected
Yeovil District Hospital	22,680	1,075	1,075	1.00 As expected

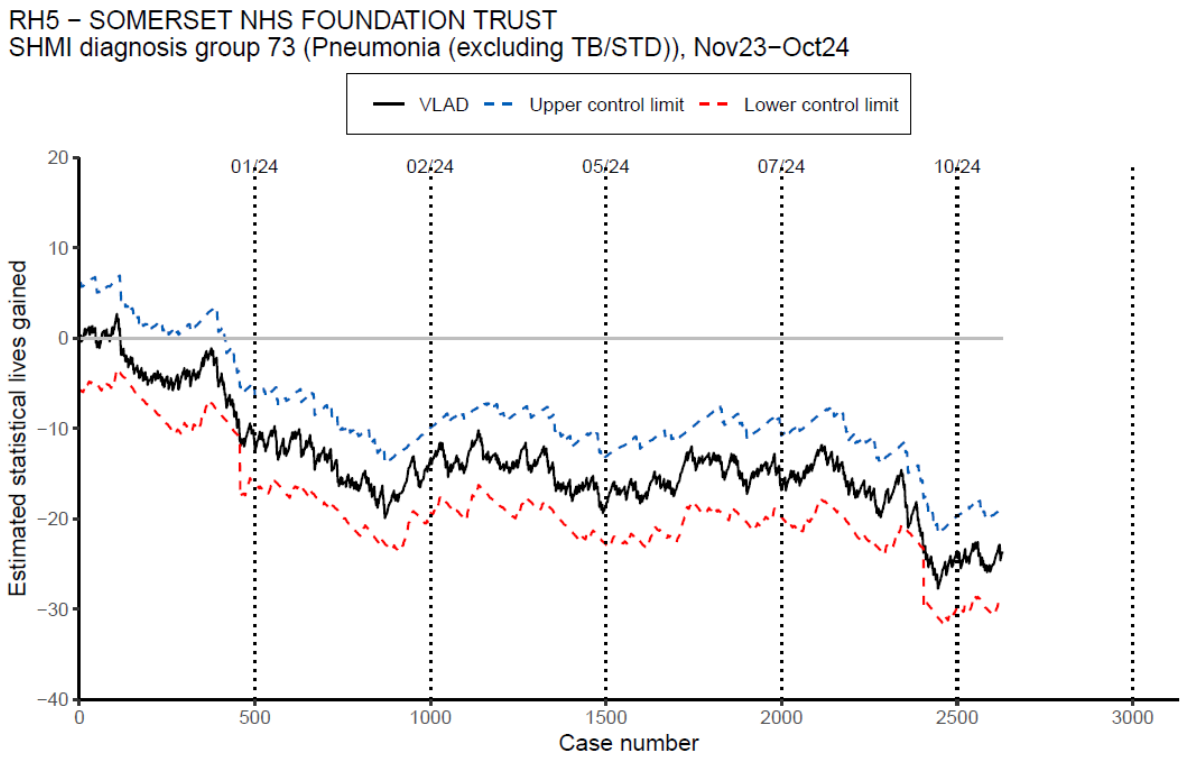
Diagnosis group ***Reported groups by exception***

Diagnosis group	Provider spells	Observed deaths	Expected deaths	SHMI value
All banded diagnosis groups are reported as within the ‘as expected’ banding.				

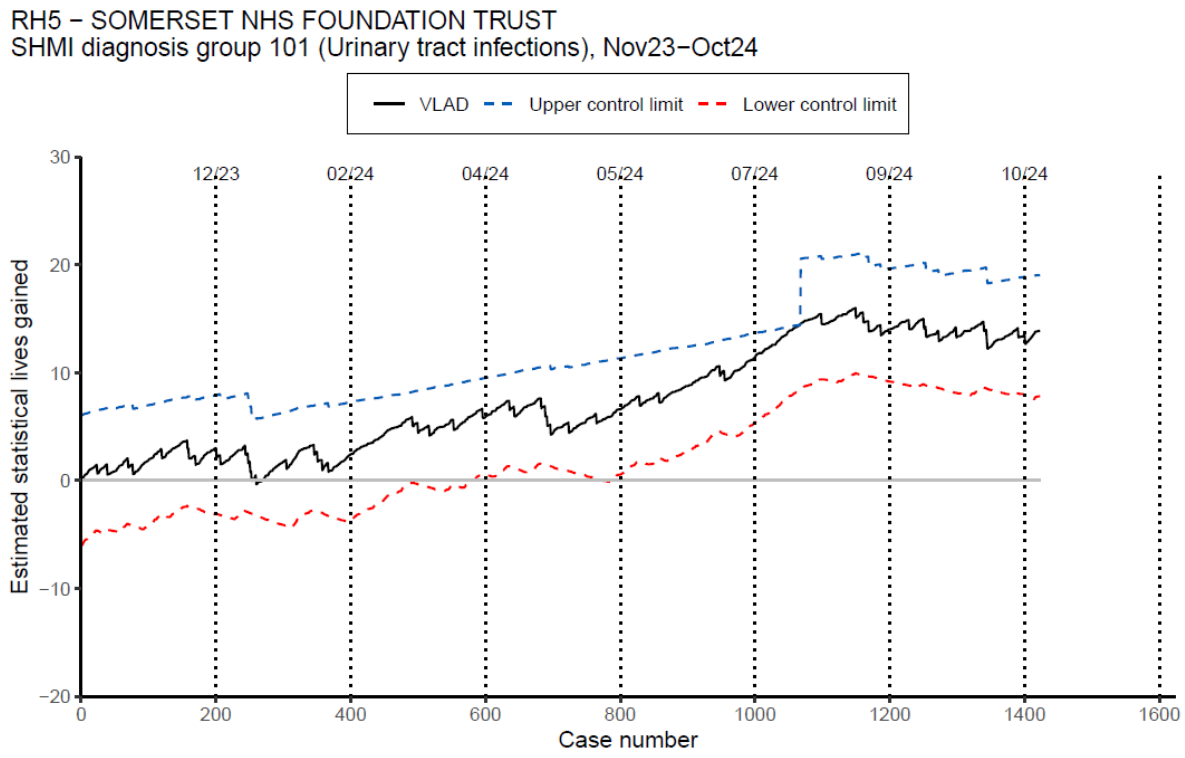
Visual life adjusted display (VLAD) – recent alerts

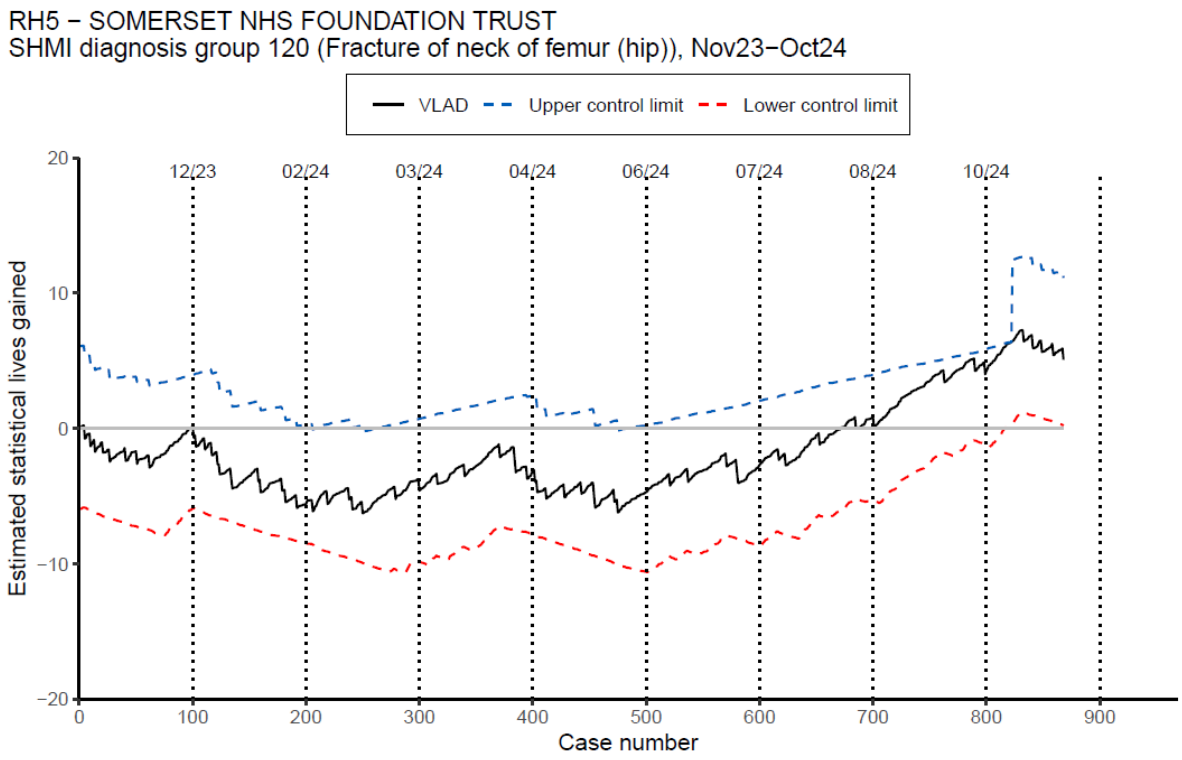
There were negative VLAD alerts (suggesting more deaths than would be expected) for acute bronchitis and pneumonia diagnosis groups.

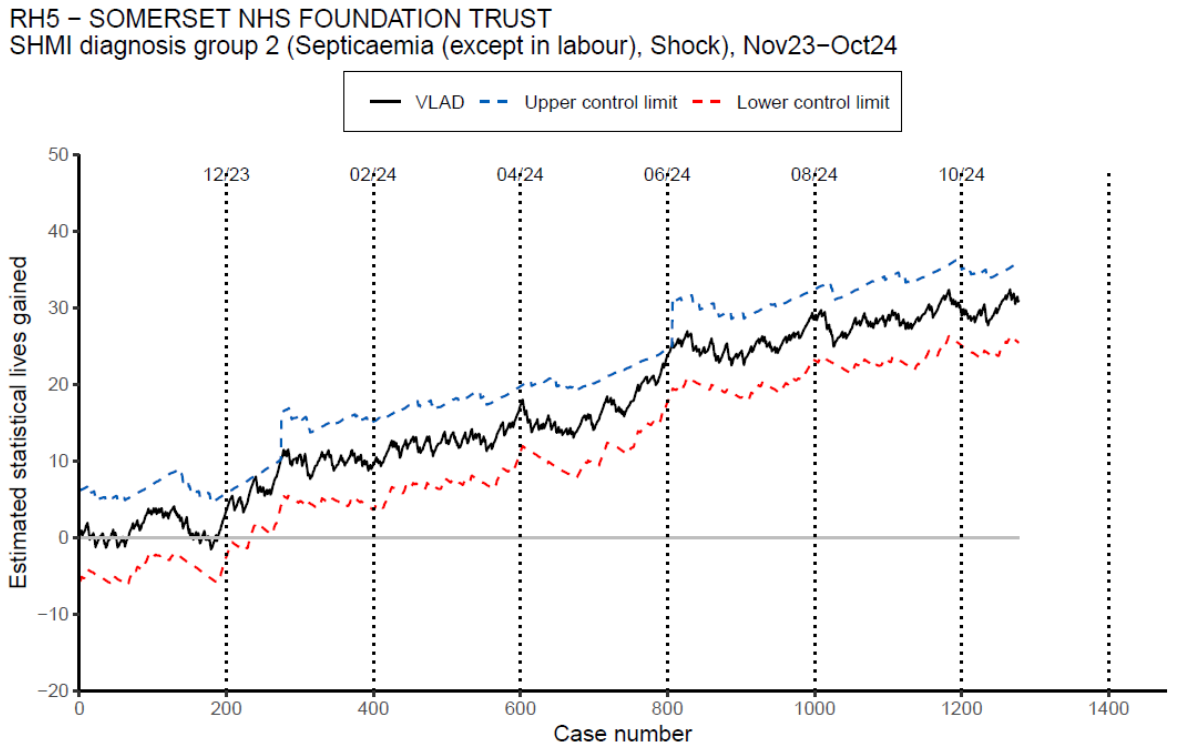




There was also a positive alert (suggesting fewer deaths than expected) for the urinary tract infection, fracture neck of femur and septicaemia diagnosis groups.







3.3.2 **Standard mortality ratios from HED**

At the time of writing this report, we had been made aware of an error with the data submission to HED for Quarter 3. We have been assured that this has been corrected, however we will not be able to produce a report that includes the missing

data until the system refreshes after the next data submission deadline. The below has been taken from an earlier report that was produced in March 2025 for MSG.

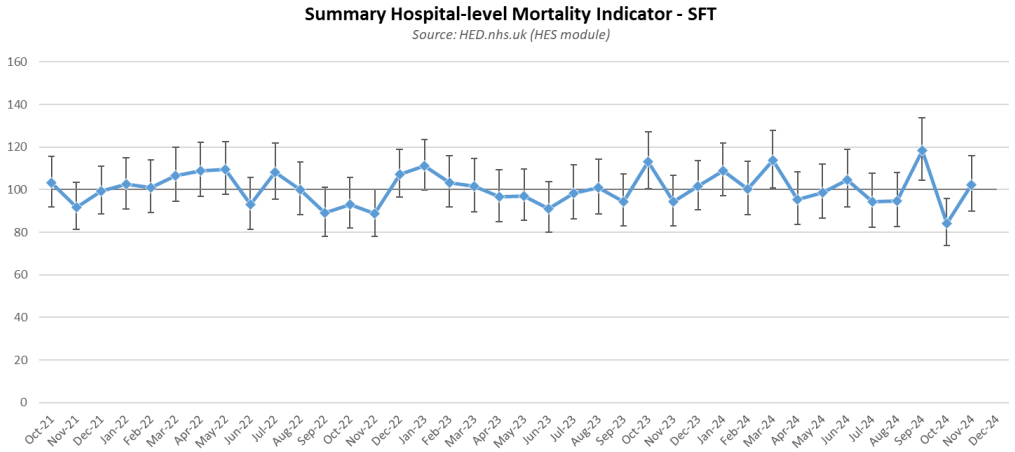
Source: HED.nhs.uk - SHMI HES and HSMR HES modules (12th March 2025)

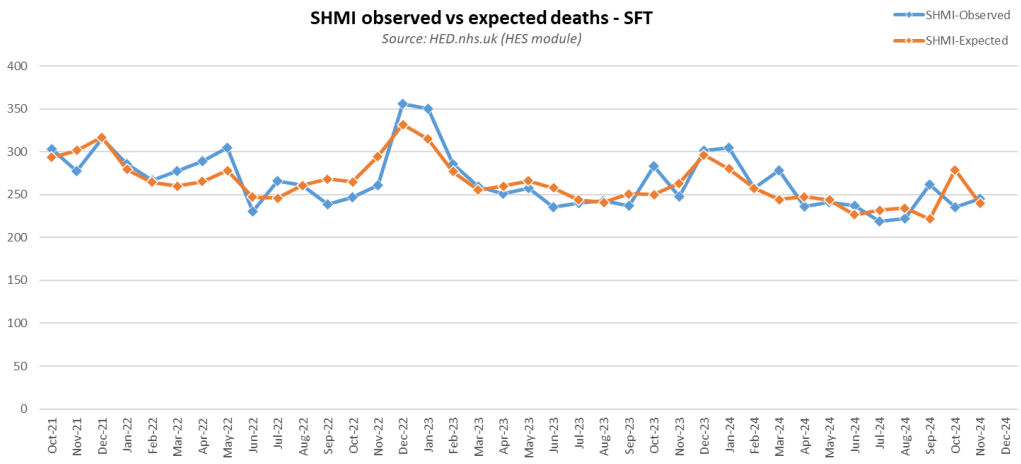
This report refers to two measures of standardised mortality: summary hospital-level mortality index (SHMI) and hospital standardised mortality ratio (HSMR).

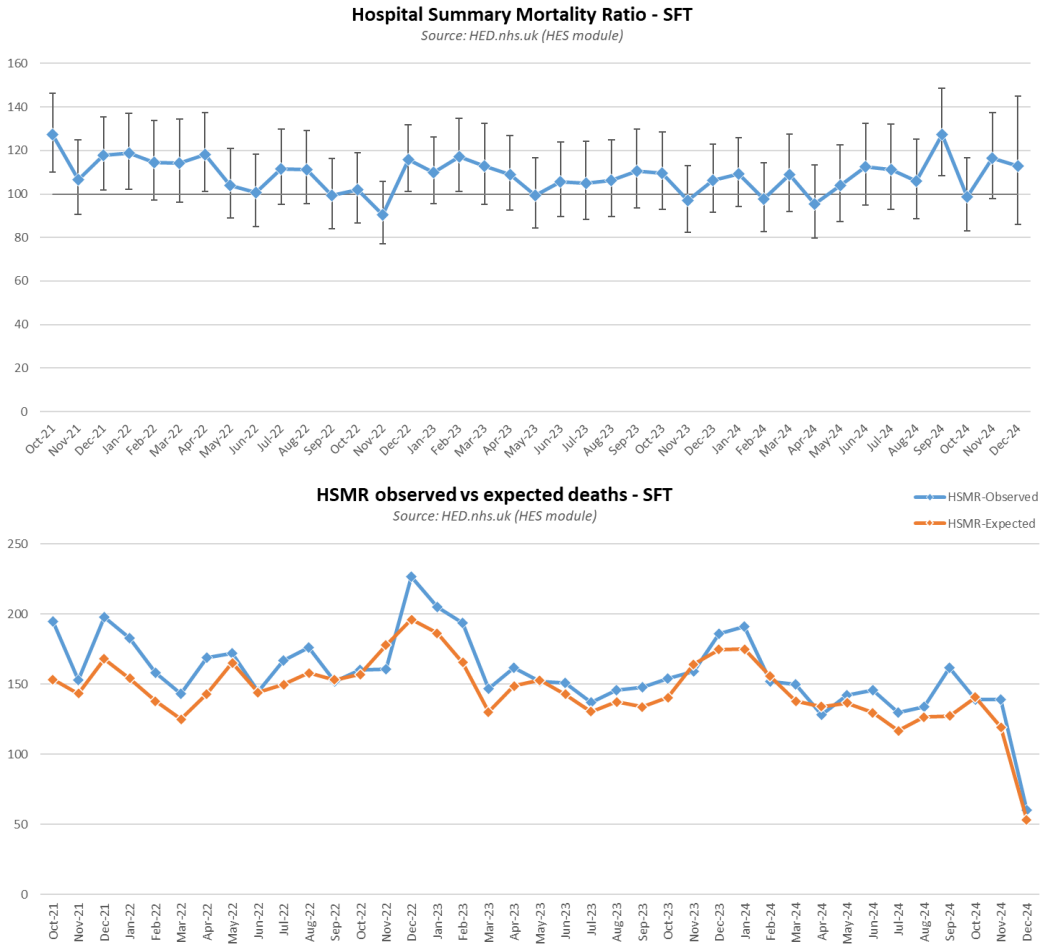
The following alerts are based on confidence intervals to allow for earlier identification of possible differences.

Trust level

Trust	SHMI (Dec 23 to Nov 24)	HSMR (Jan 24 to Dec 24)
Somerset NHS FT	99.6 (As expected) 95% CI: 96.0 - 103.3 Observed: 2,889 Expected: 2,901 Spells: 828	107.7 (Above expected) 95% CI: 102.6 - 113.0 Observed: 1,673 Expected: 1,553 Spells: 54,527







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

Trust	SHMI (Dec 23 to Nov 24)	HSMR (Jan 24 to Dec 24)
Musgrove Park Hospital	98.9 (As expected) 95% CI: 94.4 - 103.5 Observed: 1,849 Expected: 1,870 Spells: 548	115.0 (Above expected) 95% CI: 107.9 - 122.5 Observed: 962 Expected: 836 Spells: 33,460
Yeovil District Hospital	100.9 (As expected) 95% CI: 94.8 - 107.2 Observed: 1,040 Expected: 1,031 Spells: 280	94.3 (As expected) 95% CI: 87.2 - 102.0 Observed: 638 Expected: 676 Spells: 19,113

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

Diagnosis group (CCS)	SHMI (Dec 23 to Nov 24)	HSMR (Jan 24 to Dec 24)
7 - Viral infection	0.0 (Below expected) 95% CI: 0.0 - 73.6 O: 0 E: 5 S: 988	
11 - Cancer of head and neck	216.2 (Above expected) 95% CI: 118.1 - 362.8 O: 14 E: 6 S: 125	
64 - Other hematologic conditions	1128.0 (Above expected) 95% CI: 126.7 - 4,072.7 O: 2 E: 0 S: 5	
68 - Senility and organic mental disorders	134.8 (Above expected) 95% CI: 109.1 - 164.8 O: 95 E: 70 S: 636	143.2 (Above expected) 95% CI: 109.0 - 184.7 O: 59 E: 41 S: 44
71 - Other psychoses	306.7 (Above expected) 95% CI: 132.1 - 604.4 O: 8 E: 3 S: 164	
99 - Hypertension with complications and secondary hypertension	575.1 (Above expected) 95% CI: 210.0 - 1,251.8 O: 6 E: 1 S: 25	
125 - Acute bronchitis	134.2 (Above expected) 95% CI: 104.6 - 169.5 O: 70 E: 52 S: 1,630	163.8 (Above expected) 95% CI: 121.2 - 216.6 O: 49 E: 30 S: 37
127 - Chronic obstructive pulmonary disease and bronchiectasis	118.4 (As expected) 95% CI: 95.1 - 145.7 O: 89 E: 75 S: 1,213	140.6 (Above expected) 95% CI: 108.7 - 178.9 O: 66 E: 47 S: 53
175 - Other female genital disorders	960.8 (Above expected) 95% CI: 193.1 - 2,807.4 O: 3 E: 0 S: 205	
199 - Chronic ulcer of skin	183.7 (Above expected) 95% CI: 112.2 - 283.8 O: 20 E: 11 S: 177	152.4 (As expected) 95% CI: 87.1 - 247.5 O: 16 E: 11 S: 10
200 - Other skin disorders	0.0 (Below expected) 95% CI: 0.0 - 89.2 O: 0 E: 4 S: 388	
219 - Short gestation; low birth weight; and fetal growth retardation	9.5 (Below expected) 95% CI: 1.1 - 34.2 O: 2 E: 21 S: 184 VLAD alerts in last 3 months: 1	
245 - Syncope	296.6 (Above expected) 95% CI: 142.0 - 545.6 O: 10 E: 3 S: 528	203.7 (As expected) 95% CI: 74.4 - 443.3 O: 6 E: 3 S: 5

3.3.1 Reviews in response to alerts from the Standardised Mortality Report:

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

At MSG on 26/03/25, it was agreed that the following diagnosis groups would be reviewed:

- 11 – Cancer of head and neck
- 71 – Other psychoses
- 99 – Hypertension
- 199 – Chronic ulcer of skin
- 73 – Pneumonia

There is an ongoing review for Bronchitis. We hope to report the outcome from this in due course.

During the quarter, Katy Darvall has completed reviews on Frome and West Mendip Community Hospitals. Please see appendix 2 and 3 for the executive summaries from these reports. In both reviews, the overall quality of care was found to be very good or excellent and there was no evidence of avoidability for any of the deaths reviewed. The full reviews have been shared with colleagues in our Neighbourhoods service group, who will use the findings of these reviews alongside the SJR’s that they have been completing in a thematic analysis.

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

Appendix 1

NHS Somerset NHS Foundation Trust

		2023/2024				2024/2025															
		Jan	Feb	Mar	Q4 total	April	May	June	Q1 total	July	Aug	Sept	Q2 total	Oct	Nov	Dec	Q3 total	Jan	Feb	Mar	Q4 total
ACUTE INPATIENTS	Total deaths (including ED)	236	195	201	632	163	179	153	495	150	147	182	479	170	176	201	547	236	180	141	557
	Total Scrutinised by ME	231	193	195	619	156	179	153	488	150	147	182	479	170	176	201	547	236	180	141	557
	SJR's requested by LfD	10	9	8	27	10	8	13	31	10	12	12	34	10	8	12	30	18	4	10	32
	SJR's completed	31	20	27	78	24	23	24	71	20	21	21	62	20	15	21	56	16	3	1	20
	Problems in care*	2	0	1	3	0	1	0	1	1	0	0	1	0	0	2	2	0	0	0	0
	PSIRF	1	1	1	3	2	4	3	9	1	0	1	2	0	0	1	1	1	0	1	2
	Learning Disabilities: internally all deaths in acute inpatient settings are subject to review or investigation																				
	Total deaths	3	2	5	10	0	0	2	2	1	0	0	1	1	0	3	4	3	0	2	5
	Review/investigation completed	2	2	4	8	0	0	2	2	1	0	0	1	1	0	3	4	2	0	0	2
COMMUNITY HOSPITAL	Total deaths	19	15	20	54	19	18	22	59	25	23	22	70	20	26	22	68	20	17	16	53
	Total scrutinised by ME	19	15	20	54	19	18	22	59	25	23	22	70	20	26	22	68	20	17	16	53
	SJR's requested by LfD	0	0	0	0	0	0	1	1	0	1	0	1	0	0	2	2	3	0	0	3
	SJR's completed	0	0	0	0	0	0	3	3	2	3	2	5	2	2	1	5	0	0	0	0
	Problems in care*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	PSIRF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
MENTAL HEALTH	Total deaths (reported as incident)	10	4	9	23	3	5	5	13	10	8	4	22	6	3	7	16	11	8	4	23
	Total scrutinised by ME	0	0	0	0	0	0	0	0	0	0	1	1	0	0	1	1	1	0	0	1
	SJR's requested by LfD	3	0	2	5	1	2	3	6	5	2	2	9	0	1	0	1	1	0	0	1
	SJR's completed	2	0	2	4	1	2	3	6	5	2	2	9	0	0	0	0	0	0	0	0
	Problems in care*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	PSIRF	2	0	1	3	1	1	2	4	2	1	0	3	2	1	1	4	0	1	0	1
COMMUNITY SERVICES	SJR's requested by LfD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	4
	SJR's completed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2
	Problems in care*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	PSIRF process initiated	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	3	0	0	0	0
Total deaths subject to Coroner's Inquests		24	19	23	66	13	21	21	55	21	18	17	56	18	26	31	75	22	15	15	52

*Where SJR has identified that a death was thought more likely than not to be related to problems with care

Appendix 2

PATIENT LEVEL CLINICAL REVIEW – 'Excess' deaths in Frome Community Hospital: EXECUTIVE SUMMARY

Concern

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

Figures from July 2023 shown here:

SHMI for April 2022 – Mar 2023: 152.7 (100.6 – 222.2), Observed deaths 27, Expected deaths 18.

HSMR for April 2022 – Mar 2023: 162.9 (105.4 – 240.4), Observed deaths 25, Expected deaths 15.

Likely explanation

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

Aim of report

To review the deaths of patients who died in Frome Community Hospital or within 30 days of discharge between May 2022 and May 2023 to provide assurance and/or to identify areas of concern for further review.

Further aims were to assess the quality of care provided, identify any positive or negative learning to be shared, and, assuming no significant concerns were raised by the review, to recommend a more responsive and appropriate range of triggers for mortality review and assurance in our community hospitals.

Findings

37 patients, with a mean age of 80.8 years, were included in the review and 15 (41%) were admitted specifically for end-of-life care and a further 5 (14%) with advanced malignancy or "end-stage" disease. Most patients were admitted from

Royal United Hospital Bath (17) or Yeovil Hospital (9), but over a quarter (10) were admitted directly from home. For patients who died having been admitted for rehab (Pathway 2; 16 patients), that decision was appropriate in at least 15 cases.

Both mortality risk scores (SHMI and HSMR) did not adequately reflect patients admitted for end-of-life care – when this was taken into account, there was no excess mortality using SHMI, and only 3.7 “excess deaths” using HSMR. Palliative care coding (which has a significant impact on HSMR) is low in (legacy) SFT and high in YDH mainly due to different models of palliative care delivery.

26 of 31 patients who died in hospital underwent scrutiny by the Medical Examiner service. Concerns were raised in 2 cases, one for SJR and one referred to the coroner: the SJR was completed and found no care concerns or avoidability and the inquest found that the patient died of urosepsis following self-removal of his catheter. Two further cases were discussed with the coroner, but not taken forward for inquest. There was 1 complaint from a family regarding communication.

5 patients died within 3 days of admission to Frome; all were admitted for end-of-life care. There was no evidence of avoidability in any of these deaths.

16 patients who were admitted on Pathway 2 died. There was no clear evidence of avoidability in any of these deaths. This is not as clear for two of the patients who died in RUH as the cause of death is unknown, but there were no care concerns found with the care received in Frome. One patient died of hospital acquired COVID and a further patient died at home after discharge from a ruptured abdominal aortic aneurysm, but these deaths were not felt to be avoidable.

There was no evidence of avoidability in the deaths of the remaining 16 patients.

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

Overall, quality of care provided after death was also excellent.

Suggestions/Actions

At Trust level:

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

At Service Group level:

1. Agree upon a new set of triggers for mortality review in CHs in conjunction with the Learning from Deaths team. Possible triggers could include: patients who are escalated from a CH to an acute and die within 1 week (in

conjunction with acute teams), patients who weren't expected to die (such as those on PW2), those who die within 3 days of admission (if for EOL bed, only review EOL care and decision around transfer). Aiming to review around 15% of deaths.

2. Continue discussions with teams about earlier recognition of patients being in the dying phase and instituting a "care of the dying patient" plan, rather than continuing observations and unnecessary therapies – this is a theme that we see across all areas of the trust.

At Site level:

1. Discuss monitoring of BP in patients where the arms cannot be used, in light of the case of the patient with the large leg haematoma as a result of BP measurement from the leg.

Appendix 3

PATIENT LEVEL CLINICAL REVIEW – 'Excess' deaths in West Mendip Community Hospital – EXECUTIVE SUMMARY

Concern

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

Figures from July 2023 shown here:

SHMI for April 2022 – Mar 2023: 163.8 (103.8 – 245.8), Observed deaths 23, Expected deaths 14.

HSMR for April 2022 – Mar 2023: 171.0 (108.4 – 256.6), Observed deaths 23, Expected deaths 13.

Likely explanation

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

Aim of report

To review the deaths of patients who died in West Mendip Community Hospital or within 30 days of discharge between May 2022 and May 2023 to provide assurance and/or to identify areas of concern for further review.

Further aims were to assess the quality of care provided, identify any positive or negative learning to be shared, and, assuming no significant concerns were raised by the review, to recommend a more responsive and appropriate range of triggers for mortality review and assurance in our community hospitals.

Findings

28 patients, with a mean age of 84 years, were included in the review and 18 (64%) were admitted specifically for end-of-life care. Most patients were admitted from Yeovil Hospital (14) or Royal United Hospital Bath (6), and a quarter were admitted directly from home. For patients who died having been admitted for rehab (Pathway 2; 9 patients), that decision was appropriate at the time.

Both mortality risk scores (SHMI and HSMR) did not adequately reflect patients admitted for end-of-life care – when this was taken into account, there was no excess mortality using SHMI, and only 3 “excess deaths” using HSMR. Palliative care coding (which has a significant impact on HSMR) is low in (legacy) SFT and high in YDH mainly due to different models of palliative care delivery. Three patients were not coded for palliative care involvement when they should have been.

14 of 24 patients who died in hospital underwent scrutiny by the Medical Examiner service. No concerns regarding care relating to death were raised by either Medical Examiners or families, but there was 1 complaint from a family regarding communication.

7 patients died within 3 days of admission to West Mendip Community Hospital; all were admitted for end-of-life care. There was no evidence of avoidability in any of these deaths. There were no specific learning points to raise with the clinical team. There was 1 patient who should have had palliative care coding on their record but did not – having that code can increase the predicted mortality risk in HSMR by approximately 50%.

9 patients who were admitted on Pathway 2 died. There was no clear evidence of avoidability in any of these deaths. There were no specific areas of learning for the community hospital teams – there was prompt recognition and escalation when there was patient deterioration and good evidence of patient-centred decision-making and multidisciplinary working.

There was no evidence of avoidability in the deaths of the remaining 12 patients. There are multiple examples of excellent care included in the full review. There were 2 patients who should have had palliative care coding on their record but did not.

Overall, quality of care provided before death was very good or excellent and many examples are given in the main text of this review. All efforts were made to predict and control symptoms and care planning was clearly patient-centred and families were included.

Overall, quality of care provided after death was also excellent. The Verification of Expected Death policy was used appropriately.

Suggestions/Actions

At Trust level:

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

At Service Group level:

1. Agree upon a new set of triggers for mortality review in CHs in conjunction with the Learning from Deaths team. Possible triggers could include: patients who are escalated from a CH to an acute and die within 1 week (in conjunction with acute teams), patients who weren't expected to die (such as those on PW2), those who die within 3 days of admission (if for EOL bed, only review EOL care and decision around transfer). Aiming to review around 15% of deaths.

At Site level:

2. No specific actions.

Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Guardian of Safe Working for Postgraduate Doctors Quarterly Report – Q1 2025/26
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:	6 May 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 25 January 2025 and 17 April 2025 across Somerset NHS Foundation Trust. The recommendations from the report are: • We would welcome a new exception reporting system in order to capture the data effectively and work efficiently. • We will expand the next report to include rota gaps across the trust for visibility.
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. Overall, exception reporting numbers are in line, or below, previous equivalent Qs.

2. Problem areas have been highlighted.

3. We have made recommendations to improve both the exception reporting process and quarterly reports going forward.

2. INTRODUCTION

This report covers and comprises quantitative and qualitative data on working patterns and associated exception reports for postgraduate doctors in training across the Trust.

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.

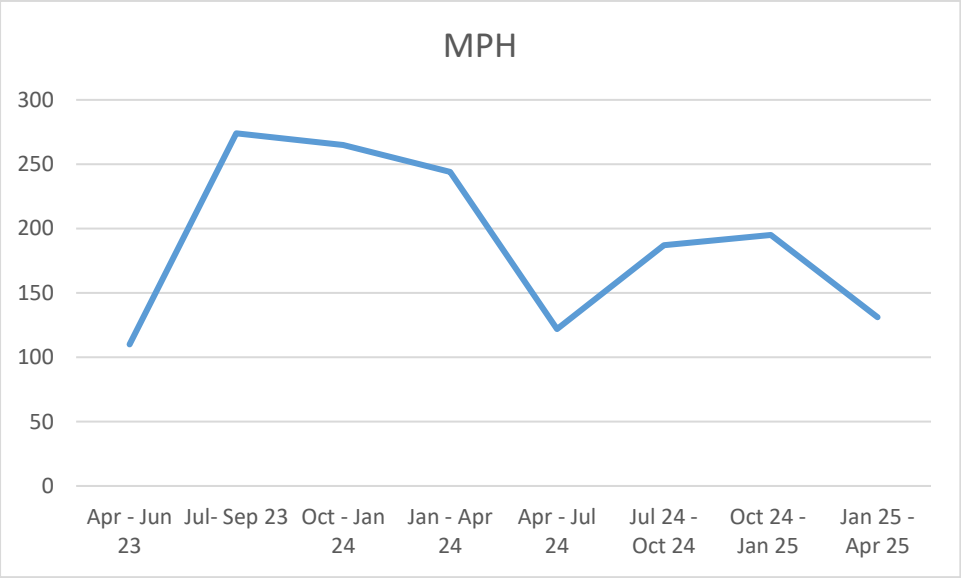
3. EXCEPTION REPORT DATA:

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). 3625 for Taunton and for Yeovil 1692.

Figure 1 Quarterly total for exception reporting



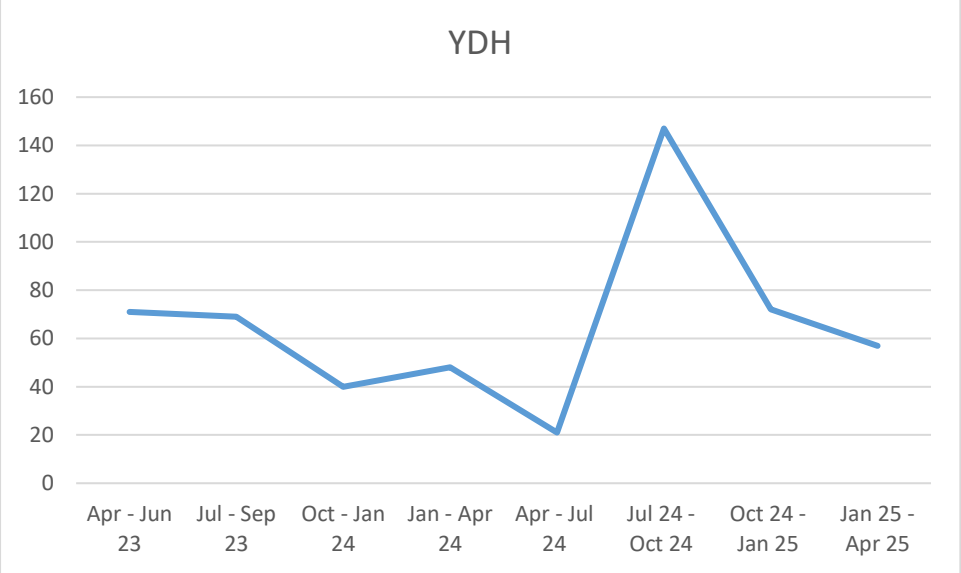
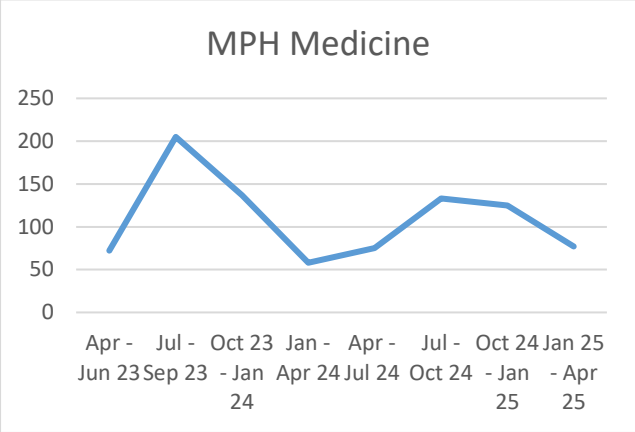
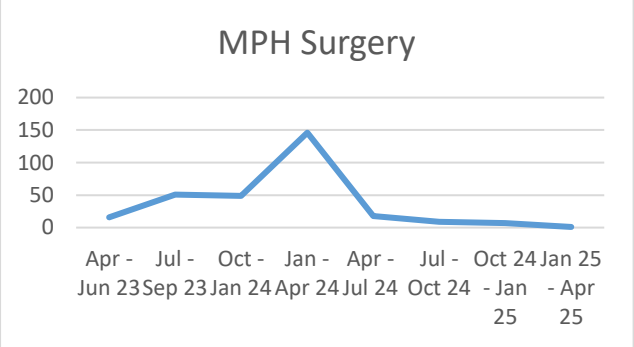
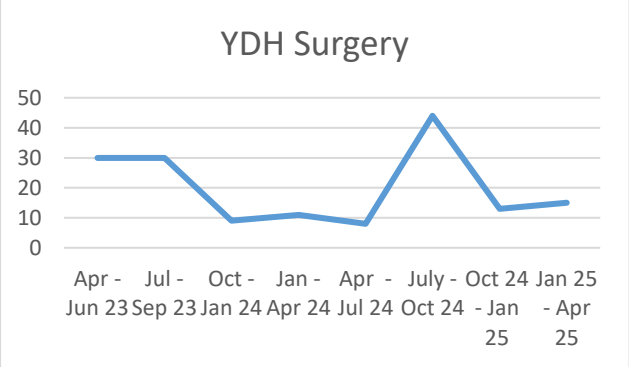
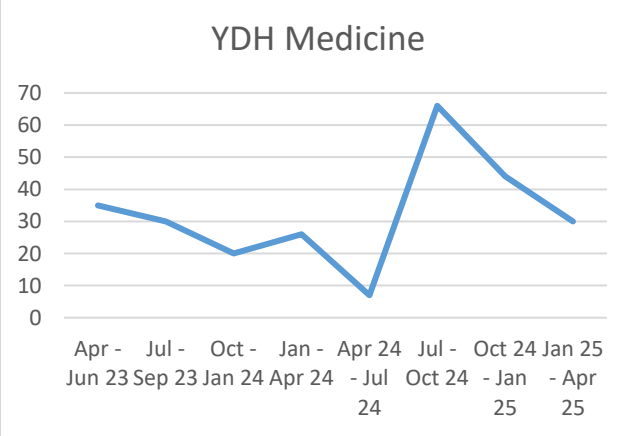


Figure 2 Exception Report Trends by Specialty









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 77 (125)** AMU 4 Cardiology 13 Care of Elderly 27 Endocrine 9 General Medicine 19 Respiratory 2 Stroke 3 **YDH 26 (44)** AMU 12 Cardiology 1 Endocrine 4 General Medicine 6 Stroke 3	46 26	31 0	Hours MPH 75 YDH 31 Educational MPH 1 YDH 4 Pattern MPH 1 Support MPH 1 YDH 4
Anaesthetics	0 *(0)*	0	0	
DCT Trainees	21 *(23)*	0	21	Hours 21
Emergency Medicine	MPH 0 (3) YDH 6 (5)	2 0	1 6	Hours MPH 0 YDH 6
ENT	0 *(1)*	0	0	
General Surgery	MPH 1 (*6)* YDH 13 (13)	0 4	1 9	Hours MPH 1 YDH 7 Education YDH 3 Support 3 YDH
O&G	MPH 2 (1) YDH 2 *(1)*	2 0	0 2	Hours MPH 2 YDH 2
Oncology/ Haematology/Palliative Care	MPH 1 *(4)* *YDH 0 (3)*	1 1	0 2	Hours MPH 1
Ophthalmology	MPH 8 (19)	0	8	Hours 15
Paediatrics	MPH 0 *(4)*	0	0	

Specialty	No. exceptions raised	No. exceptions closed	No. exceptions outstanding	Type
Psychiatry	MPH 0 *(10)*	1	9	
Trauma & Ortho	MPH 17 *(1)* YDH 2 (5)	17 0	0 2	Hours 1 YDH 17 MPH Support YDH 1
Urology	MPH 0*(0)* *YDH 2 (0)*	0 0	0 2	Hours 2
Vascular	0*(0)*	0	0	
Total	**178**	**72**	**106**	

Table 2: Exception reports per trainee grade

Grade of trainee	No. exceptions raised Taunton	No. exceptions raised Yeovil
F1	36	35
F2	50	15
CT1-2 / ST1-2	37	5
ST3+	6	1
Total	**129**	**56**

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	£220,653.50	£18,492.00	£8,370.40	£264,725.88
CYP & Families Services	£577,007.41	£36,829.22	£40,913.70	£676,349.26
Medical Services	£2,080,772.11	£90,947.81	£55,014.30	£2,451,355.84
Mental Health and LD	£692,079.58	£49,724.28	£34,333.40	£817,157.29
Neighbourhood Services	£160,409.00	£14,534.88	£7,216.97	£197,761.05
Operational Management	£103,635.00	£2,916.48	£0.00	£121,204.25
OPMH Taunton	£56,097.12	£4,332.00	£13,685.97	£68,430.11
Surgical Services	£476,595.44	£18,794.40	£35,831.31	£563,391.29
Grand Total	**£4,367,437.07**	**£236,571.06**	**£195,366.05**	**£5,160,591.07**

Qualitative summary of exception reports

Overall total number of ERs are in line, or below historical averages.

We have seen an increase in the number of exception reports from T&O this quarter which was due to a variation in working hours compared to work schedule. L-AT to look into this and consider a work schedule review if appropriate. We continue to see a high number of ERs from DCTs due to NROC shifts. We have subsequently met with the trainees and are hopeful that the numbers will be lower next Q.

We have broken down the ERs into individual medical specialities this Q for visibility.

3.2. Immediate safety concerns (ISCs)

2 ISCS for Yeovil which were misclassified and required over-payment

ISC generated from MPH due to FY1 gap on rota requiring SPR to act down as FY1 as well as carry SPR bleep.

ISC generated from OMFS due to breach in non-resident on call hours. Subsequently given time off following ward round as compensation and in line with contract. TR and L-AT have subsequently met with OMFS trainees to explain contact.

3 further ISCs generated at MPH – misclassified as overtime.

3.3. Fines

No fines were issued during this quarter.

3.4. Work schedule reviews

Work schedule reviews were performed in psychiatry this Q as issues were raised regarding rota patterns. Affected doctors had their work schedules updated to reflect an increase in anti-social hours worked and therefore an increase in pay.

4 ISSUES ARISING

4.2 Postgraduate Doctor Forum (PDF)

Yeovil continue to have monthly PDF meetings which are helping flag up and address any arising issues. The concerns in general surgery staffing are

improving. Concerns over lack of teaching space in the Academy are hopefully going to be resolved.

MPH had a well attended PDF this Quarter. Multiple issues discussed including rota, work schedules, teaching and training. One issue that arose was the current method of exception reporting and the difficulties that doctors are having in navigating the reporting process.

4.3 Rota management

Previous rota issue from psychiatry has now been resolved and there is a plan for implementation of a separate rota management team from August changeover to prevent recurrence.

We are concerned by the effects that rota gaps have on the wellbeing of doctors, particularly OOH. For transparency and visibility we will ask that further GoSW quarterly reports include rota gaps delineated by specialty (both short term and long term) so that we have an oversight of the issue including trends.

4.4 Weekend working

We continue to see low numbers of ERs generated from weekend working.

.

4.5 Out of Hours Issues

ER raised at MPH regarding gaps on medical rota during OOH work (between 17:00 and 21:00) requiring SPR to cover 2 roles.

We will monitor the effect that Martha's Rule may have on OOH work, particularly for more senior resident doctors, going forward.

4. SUMMARY

Overall, exception reporting numbers are in line, or below, previous equivalent Qs. Problem areas have been highlighted and we have made recommendations to improve both the exception reporting process and quarterly reports going forward.

5. RECOMMENDATIONS

1. We would welcome a new exception reporting system in order to capture the data effectively and work efficiently.

2. We will expand the next report to include rota gaps across the trust for visibility.

Tom Rees and John McFarlane Guardian of Safe Working

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Mental Health Legislation Committee held on 11 March 2025
SPONSORING EXEC:	Jade Renville, Director of Corporate Services
REPORT BY:	David Seabrooke, Interim Trust Secretary
PRESENTED BY:	Alex Priest, Chair of the Mental Health Legislation Committee
DATE:	6 May 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 Committee has continued to discuss section 136 arrangements with partner agencies.
Recommendation	That the report be noted.

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

- ☒ Obj 1 Improve health and wellbeing of population
- ☒ Obj 2 Provide the best care and support to children and adults
- ☒ Obj 3 Strengthen care and support in local communities
- ☒ Obj 4 Reduce inequalities
- ☒ Obj 5 Respond well to complex needs
- ☒ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
- ☒ Obj 7 **Live within our means and use our resources wisely**
- ☒ Obj 8 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

Equality and Inclusion

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

How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
The needs and potential impacts on people with protected characteristics are considered by each individual service group as part of their update to the Committee. The Committee reviews data presented to the Committee and will raise any queries if required.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.
Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Staff involvement takes place through the regular service group and topic updates.

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

ASSURANCE REPORT FROM THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON 11 MARCH 2025

1. PURPOSE

1.1. To advise the Board of the principal matters discussed by the Mental Health Act Committee.

2. ASSURANCE RECEIVED

2.1. A positive report from SWAN Advocacy was reviewed, which highlighted good engagement and communication across the wards. from 1 July 2025.

2.2. The Complaints and issues report to 1 December had two complaints regarding communication and unprofessional behaviour in community mental health teams.

2.3. Holford Ward action statement: the report had very positive feedback from the inspector. There are a couple of specific issues which require a response, but good progress has already been made on the actions.

2.4. It was noted that Somerset has very low numbers of out of area patients both for CAMHS and adults, so thanks were expressed to the teams for their hard work in maintaining these low numbers and enabling Somerset patients to be cared for within Somerset.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. The Committee continues to discuss the appropriate use of Section 136 and lines of communication with the police are open.

3.2. The Committee has requested a presentation on restrictive intervention/culture of care programme to the next meeting to provide assurance that the Trust is complying with its obligations.

3.3. The Committee will continue to engage with SCC on the Approved Mental Health Professional (AMHP) service.

3.4. New Mental Health Bill*:* The report is being presented to the House of Lords. A link was included within the papers for Committee members

3.5. The Patient and Carer Race Equality Framework considered the ethnicity and racialised profile against a number of measures, the majority of which were linked to the Mental Health Act, including detentions under the Act, restrictive interventions, physical health checks, CTOs and access to young people, services as well as adults and older adult. That there was a low representation of Asian and British Asian communities accessing children, adult and older adult services. It is not known if this is a coding issue or an actual issue, however it was confirmed that there are still numbers not recorded.

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

4.1. Temporary closure of Wessex House – this risk is being reviewed and it is anticipated that it will either be removed or the score reduced.

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee held on 26 February and 26 March 2025
SPONSORING EXEC:	Melanie Isles, Chief Medical Officer
REPORT BY:	David Seabrooke, Interim Trust Secretary
PRESENTED BY:	Inga Kennedy, Chair of the Quality and Governance Assurance Committee
DATE:	6 May 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 Committee has continued to discuss the Trust's response to matters raised by the Care Quality Commission
Recommendation	That the report be noted.

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

- ☒ Obj 1 Improve health and wellbeing of population
- ☒ Obj 2 Provide the best care and support to children and adults
- ☒ Obj 3 Strengthen care and support in local communities
- ☒ Obj 4 Reduce inequalities
- ☒ Obj 5 Respond well to complex needs
- ☒ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
- ☒ Obj 7 **Live within our means and use our resources wisely**
- ☒ Obj 8 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. **How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?**
The needs and potential impacts on people with protected characteristics are considered by each individual service group as part of their update to the Committee. The Committee reviews data presented to the Committee and will raise any queries if required.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.
Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Staff involvement takes place through the regular service group and topic updates.

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

ASSURANCE REPORT FROM THE QUALITY GOVERNANCE AND ASSURANCE COMMITTEE MEETINGS HELD ON 26 FEBRUARY (FOCUS) AND 26 MARCH (BUSINESS) 2025

1. PURPOSE

To advise the Board on the decisions arrived at and principal areas reviewed by the Quality Governance and Assurance Committee. The February meeting focused on Objective 4, reducing inequalities.

2. ASSURANCE RECEIVED

2.1. The business case for the electronic healthcare records has been signed off at regional level; it will now require national sign-off.

2.2. The internal Health & Safety report shows mandatory training compliance is positive and there has been good progress around safer sharps management, which had been subject to an HSE inspection report.

2.3. Surgical Care Group - during the last year there has been significant progress in streamlining the leadership structure; this has enhanced the accountability via weekly huddles. The new perioperative assessment has reduced cancellations and improved patients' readiness for surgery. JAG accreditation has been achieved for the Bridgwater endoscopy unit and incident reporting has improved.

2.4. Maternity CQC improvement actions: 10 actions have been completed; 12 actions have been completed pending assurance review, and 7 actions remain in progress and open. The plan is 76% completed. The CQC action planner will become the maternity improvement plan and follows normal business.

2.5. Patient Safety Board - the Patient Safety Board (PSB) is setting its priorities, reviewing the PSIRF report, reviewing conversations around patient safety responses and how the PSB works with the service groups. The Patient Safety Faculty will include a full-time head of patient safety who will coordinate all elements of the national strategy and priorities as well as the Trust's internal priorities and strategic aims. Medical leadership will provide leadership for the patient safety clinical directors and link into each service group; each group will have a patient safety lead.

2.6. An update was received on the Patient and Carer Race Equality Framework (PCREF). It is a mandatory framework for all mental health providers, with an aim that they become actively anti-racist organisations by ensuring that they are responsible for co-producing and implementing concrete actions to reduce racial inequalities within their services. Acquiring data to support this framework was a significant task and challenge. The Framework needed to be implemented by the end of March 2025. The performance reporting from April 2025 will be included as part of quarterly report and there needs to be a regular check-point for Board or this Committee, depending on what the Board agree, about progress with the PCREF.

2.7. Committee has taken some assurance on the valuable pockets of work that have been done so far but the objective will need to be discussed further at the Trust Board as part of the review of the BAF and the review of the objectives themselves.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. The 26 March Committee was advised that the Trust had received a Section 29A CQC Warning Notice following the inspection of our acute Paediatric Services. A meeting is being arranged with the Paediatricians at YDH to discuss. The Notice highlights the issues that we were already aware of before the inspection and have been working to address, specifically related to the paediatricians and the support provided to junior doctors, out of hours support and the culture of learning. We will then have 3 months to address the concerns and evidence significant improvement in the service.

3.2. In relation to Maternity Safety Action 9 a new Safety Champion Board has been convened, and membership will consist of the most senior clinical leads in midwifery, neonate and obstetrics and anaesthetics. The Board level safety champion will be Hayley Peters and non-executive directors, Inga Kennedy and Alex Priest.

3.3. An update on the ward accreditation programme was requested: the first piece of work, to standardise metrics across the acute and community hospitals in-patient beds, has been completed.

3.4. The unsafe premises risk has increased from 15 to 20; the Board will be asked to consider the vulnerabilities within SFT estates and what this might mean for future strategic priorities and decisions.

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

4.1 The exec team continue to work with the paediatric team at YDH to review ways to provide out of hours cover. Neonatal staffing capacity has improved and there has been no further increase in the number of Radar incidents.

Risk Appetite

4.2 Following discussion, the Committee agreed to **recommend** to the Trust Board that the Risk Appetite levels remain set as they were last year:

Strategic Objective 2: Open

Strategic Objective 3: Seek

Strategic Objective 4: Seek

Strategic Objective 5: Seek

5. BOARD ASSURANCE FRAMEWORK (BAF)

The Committee has conducted its Q4 review of the BAF (objectives 2-5) and reported to Audit Committee thereon.

Report to:	**Quality & Governance Assurance Committee**	**Agenda item no:**	
Date of Meeting:			
Title of Report:	**Maternity & Neonatal safety & quality quarterly report Q4 2025**		
Author (s):	**S. Bryant Director of Midwifery**		
Appendices	**Appendix 1: Safety Champion Walkabout Posters**		

1.0 Executive Summary

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

Complaints, PALS, and Quality Improvement Activity

During Q4, Maternity & Neonatal services received a total of three formal complaints and 17 PALS enquiries. While the number of formal complaints has decreased month-on-month, they continue to reflect recurrent themes that are being closely monitored and addressed.

In response to insights gathered through this and other feedback channels, several Quality Improvement (QI) projects are currently in development to support service enhancement.

Additionally, the service received multiple compliments via MNVP feedback, which highlighted positive aspects of care. These compliments will be shared with staff to support ongoing learning and boost morale.

Co-Production with Service Users

Maternity and Neonatal services continue to work closely with the MNVP to co-produce service improvements and ensure service user voices shape care at every level. This partnership supports delivery of national requirements, including the Maternity (and perinatal) incentive Scheme (MIS) Safety Action 7.

Key collaborative work in Q4 included the CQC maternity survey analysis, Review of the findings from the 15 Steps exercise, review of risks held on the risk register associated with theatre and procedure rooms, a triage improvements walkthrough, co-production of the MatNeo Improvement Plan, and MSSP report review.

Maternity & Neonatal Safety Champions

The Maternity and Neonatal Safety Champions continue to promote a strong safety culture through regular safety walkabouts, leadership, and data-driven action. In line with MIS Safety Action 9, bi-monthly walkabouts are held at each acute site, led by senior leaders and involving staff, MNVP reps, and service users.

Feedback is triangulated with other safety data through the quarterly Safety Intelligence Triangulation meetings and informs improvement plans. Actions are shared with staff and service users through posters and digital channels.

To strengthen this work, a new Safety Champions Board (SCB) was established in Q4 to oversee safety intelligence, co-produce improvements, and support harm reduction initiatives. The SCB ensures effective data use and integrates insights from incidents, workforce culture, and service user feedback, without duplicating existing governance structures.

CQC Action Plan & Re-Inspection Preparation

Regular liaison meetings continue with the CQC to monitor and report on progress. These will continue until all actions are completed or a further inspection occurs.

As of Q4, 87% of actions (81 of 93) have been delivered. The service is now prioritising staff feedback and engagement as part of its ongoing improvement work.

Active preparations are underway for a potential CQC re-inspection, with a target to fully complete and close the action plan by June 2025

MIS Year 7 Preparation

The service has been actively preparing for MIS Year 7, focusing on governance review and aligning reporting structures to minimise the risk of non-compliance. Safety leadership and meeting schedules have been refreshed to strengthen oversight, assurance, and to support timely escalation.

Somerset NHS Foundation Trust submitted its Board declaration of final compliance for MIS Year 6 (March 2025) under the Clinical Negligence Scheme for Trusts (CNST). The Trust is currently awaiting confirmation of funding to support delivery of related action plans, expected in April 2025.

Perinatal Quality Surveillance Tool

The Perinatal Quality Surveillance Tool (PQST) continues to be submitted monthly to NHS England, providing assurance on maternity and neonatal safety, staffing, and service quality. The tool supports early identification of risk and triangulates data from multiple sources, including incident reporting, workforce metrics, and service user feedback.

The service has been unable to evidence minimum obstetric cover on the delivery suite for this quarter.

Perinatal Mortality & Safety

In 2023, Somerset NHS Foundation Trust (SFT) reported an average stillbirth rate of 3.9 per 1,000 births, closely aligned with the national average of 4.0 per 1,000 births (2022). This marks a slight decrease from SFT's 2022 rate of 4.01, with a stabilised and adjusted figure of 3.5 per 1,000 births.

During Q4: One new referral was made to the Maternity and Neonatal Safety Investigations (MNSI) programme. A planned Quality Review Meeting (QRM) was held with MNSI, discussing case themes and learning, and reviewing Trust recommendations over time. Shared insights echoed national and regional trends. These areas align with themes triangulated across incidents, complaints/PALS, and claims data, and will be embedded within the Maternity and Neonatal Improvement Plan.

There were no MBRRACE-reportable neonatal deaths and no stillbirths over 24 weeks' gestation in Q4.

No Patient Safety Incident Investigations (PSII) were commissioned in Q4, though one case from Q3 remains open. Under the Patient Safety Incident Response Framework (PSIRF), six learning responses commissioned in Q4, four After Action Reviews (AAR) and two multidisciplinary team (MDT) reviews.

Review of PMRT cases in 2024/25 has identified a disproportionate representation of perinatal deaths among individuals from the global majority. As part of its equity focus, the service is prioritising ongoing work to review outcomes within the local Core20PLUS5 population, with a focus on stillbirth and neonatal death. Insights from this work will inform targeted improvements

Saving Babies Lives V3

While progress is ongoing across all elements, full implementation remains a challenge, as reflected in the MIS Year 6 declaration. In response, SFT is strengthening its action plan in collaboration with the LMNS, including recruitment to a 12-month Band 8a role to support delivery and oversight.

Birthrate Plus, Workforce & Staffing Acuity

The Birthrate Plus assessment is completed and final approval given, the service is actively recruiting in advance of the process to strengthen workforce capacity and ensure safe staffing levels in line with projected demand. However, staffing shortfalls persist, particularly in meeting ward acuity. In 25% of Q4, staffing fell short of acuity levels due to workforce gaps and limited room/staff availability for labour ward transfers.

Recruitment for obstetric posts remains a challenge. To mitigate this, the service has implemented workforce planning, rota redesign, and escalation protocols to maintain safety and service continuity.

In neonatal services, staffing currently does not meet BAPM standards due to challenges in recruiting Band 6 QIS nurses. Actions underway include block booking agency staff, recruiting for Band 5 posts, and developing a neonatal nursing review and workforce plan.

To address broader staffing concerns, the service continues to implement the staffing escalation policy, including staff redeployment, use of bank staff, daily safety huddles, and alignment with Birthrate Plus recommendations. These actions aim to reduce safety risks, support resilience, and maintain high-quality care during pressure periods.

Training Compliance

The report outlines training compliance across all staff groups, including both core competency and essential training. While overall compliance is maintained, areas of concern have been identified in midwifery-specific training.

To address this, the service has developed a new Training Needs Analysis, outlining actions to improve training uptake, ensure role-specific competence, and support safe, effective care delivery.

Risk Management

As of Q4, there are sixteen open risks related to Maternity and Neonatal services, all scoring 12 or above.

No new risks were added to the register during the quarter. However, two risk assessments were completed to update Risk 001597 (no dedicated theatre for elective C-sections), which led to the risk being closed and split into two separate risks (003032 & 003033) for more targeted management.

Additionally, Risk 000266 was reviewed, and the risk score was increased to sixteen, reflecting heightened concern and the need for ongoing mitigation and oversight.

Patient Safety Incidents

Between 1 January and 31 March 2025, a total of 207 events were reported via the LFPSE system. Of these, 47 incidents resulted in physical harm and 63 involved psychological harm.

Incidents were reviewed by setting, challenge, and outcome. The top Q4 safety themes were unselected challenge (63), clinical care concerns (46), communication/documentation/IG (42), infrastructure (16), and medications (14).

The high number of reports listed under ‘No safety challenge selected’ likely reflects colleagues’ ongoing familiarisation with the LFPSE system. To support improved reporting accuracy and insight, the governance team is addressing this through targeted education under the ‘Knowledge Nuggets’ initiative.

Claims Scorecard

The Claims Scorecard provides insight into trends, themes, and risks associated with maternity and neonatal services by analysing both open and closed claims, enabling the service to focus improvement efforts where they are most needed.

Examining claim trends supports targeted action, which will be reflected in the Maternity and Neonatal Improvement Plan. Current workstreams aligned to key claims themes include embedding the Operational Pressures Escalation Level (OPPEL) tool and escalation of clinical concerns charter within maternity and neonatal services and strengthening maternity triage services.

Improvement Planning

While clinical outcomes remain stable and positive, the service recognises ongoing concerns raised through multiple feedback and safety intelligence routes, particularly around communication, being listened to, and personalisation of care.

Addressing these issues is a top priority and forms a core workstream within the Single SFT Maternity and Neonatal Improvement Plan. This comprehensive plan aligns all national and local improvement drivers.

The draft plan has been co-produced with the MNVP and was launched at a multidisciplinary stakeholder workshop in March, where workstream leads and priority projects were agreed.

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:	6 May 2025

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

Executive Summary and Reason for presentation to Committee/Board	The Finance report sets out the overall income and expenditure position for the Group. It includes commentary on the key issues, risks, and variances, which are affecting financial performance.
Recommendation	The Board is requested to discuss and note the report.

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

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

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

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

FINANCE REPORT

1. SUMMARY

1.1 In March, the Trust recorded a surplus of £2.985m, this was £0.003m favourable to plan for the month. The Trust ended the year with a small surplus of £0.003m.

1.2 The main March headlines are:-

- Agency expenditure was £2.131m, this was £1.252m below the plan for the month. It was also £0.290m below the ceiling for the month, however it was £0.020m above February expenditure. Cumulatively, the Trust spent £7.9m less on all agency that it did in the equivalent 2023/24 period.
- CIP delivery was £8.154m in month and in line with plan. March recurrent savings were £2.980m (37% of total). In total, the planned level of savings were delivered.
- an impairment of £18.2m in the month resulting from the full valuation of the Trust's land and buildings as part of the year end accounts process. This is below the line and therefore disregarded in the assessment of financial performance by NHSE.

2. INCOME AND EXPENDITURE

2.1 Table 1 below sets out the summary income and expenditure account to 31 March 2025:

Table 1: Income and Expenditure Summary March

Statement of Comprehensive Income	Annual Plan £000	Current Month 12 Plan £000	Current Month 12 Actual £000	Current Month 12 Fav./ (Adv.) Variance £000	Year to date Plan £000	Year to date Actual £000	Year to date Fav./ (Adv.) Variance £000
Income							
Patient Care Income	1,002,205	84,821	90,764	5,943	1,002,205	1,037,399	35,195
Other Operating Income	72,568	6,923	52,163	45,240	72,568	126,148	53,579
Total operating income	**1,074,773**	**91,745**	**142,927**	**51,182**	**1,074,773**	**1,163,547**	**88,774**
Operating expenses							
Employee Operating Expenses	(741,179)	(62,086)	(110,518)	(48,432)	(741,179)	(798,523)	(57,344)
Drugs Cost: Consumed/Purchased	(95,707)	(8,068)	(8,379)	(311)	(95,707)	(95,779)	(72)
Clinical Supp & Serv Exc-Drugs	(32,992)	(1,599)	(6,384)	(4,786)	(32,992)	(70,060)	(37,068)
Supplies & Services - General	(35,549)	(2,962)	(3,756)	(793)	(35,549)	(37,455)	(1,906)
Other Operating Expenses	(158,268)	(13,123)	(27,862)	(14,740)	(158,268)	(179,269)	(21,001)
Total operating expenses	**(1,063,695)**	**(87,838)**	**(156,899)**	**(69,062)**	**(1,063,695)**	**(1,181,086)**	**(117,391)**
Operating Surplus/Deficit	11,078	3,907	(13,973)	(17,879)	11,078	(17,539)	(28,617)
Finance Expense	(13,070)	(1,086)	(3,091)	(2,005)	(13,070)	(13,827)	(758)
Finance Income	2,424	202	252	50	2,424	3,801	1,377
Other	0	(1)	0	1	1	(1,041)	(1,042)
Overall Surplus/(Deficit)	432	3,022	(16,812)	(19,833)	432	(28,606)	(29,039)
Depr On Donated Assets	1,397	116	93	(23)	1,397	1,005	(392)
Donated Assets Income	(2,591)	(216)	(225)	(9)	(2,591)	(2,538)	53
Amortisation	9	1	3	2	9	79	70
Impairments (Reversals)	0	0	18,234	18,234	0	27,209	27,209
Other	753	60	1,692	1,632	753	2,854	2,101
Adjustments to control total	(432)	(39)	19,797	19,835	(432)	28,609	29,041
Adjusted Financial Performance	0	2,982	2,985	3	0	3	3

2.2 The tables below set out pay expenditure and whole time equivalent (wte) information by month.

2.3 In March, total staffing was 12,531 WTE, 26 WTE over the planned cap trajectory for the month of 12,505 WTE with the following variances: -

- Substantive staffing was 28 WTE under plan
- Bank 72 WTE over plan
- Agency 23 WTE under &
- Locums 6 WTE over the planned cap.

2.4 The trust were 26 WTE short of the workforce CAP imposed at the start of the year of 12,505. The slight under achievement was the result of an increase in temporary staffing used in March to support escalation capacity.

2.5 Overall temporary staffing numbers were over plan in month and March's wte's increased by 24.65 wte when compared with February. The agency decrease was 4.24 wte.

Table 2: Pay expenditure information

2024/25 Monthly Pay Expenditure analysis	Apr-24 £000	May-24 £000	Jun-24 £000	Jul-24 £000	Aug-24 £000	Sep-24 £000	Oct-24 £000	Nov-24 £000	Dec-24 £000	Jan-25 £000	Feb-25 £000	Mar-25 £000	2024/25 In Month Plan £000	F/(A) Variance £000	2024/25 Total £000
Temporary staff															
Bank Staff	2,090	1,927	1,894	1,882	1,975	1,826	2,767	2,064	1,977	2,116	2,547	3,042	2,292	(750)	26,105
Medical Agency	1,830	1,685	1,275	1,411	1,779	1,424	1,865	1,722	1,418	1,535	1,512	1,339	2,087	747	18,796
Medical Locums	1,152	1,032	938	1,159	818	1,000	908	1,023	995	881	859	1,218	504	(714)	11,985
Nursing Agency	771	618	547	547	486	369	501	384	441	490	474	542	1,000	458	6,169
Other Agency	484	497	391	405	331	317	331	323	311	194	125	250	297	47	3,956
Total Temporary Staff	**6,326**	**5,759**	**5,044**	**5,404**	**5,388**	**4,936**	**6,372**	**5,516**	**5,142**	**5,216**	**5,517**	**6,391**	**6,180**	**(212)**	**67,011**
Nursing	15,075	14,998	15,079	14,949	14,854	14,993	18,511	15,649	15,664	15,862	15,778	15,962	17,060	1,097	187,374
Support to Nursing	6,307	6,229	6,256	6,106	5,999	6,061	7,302	6,082	5,967	6,084	6,079	5,819	5,589	(231)	74,292
Medical	12,773	10,722	11,723	12,261	12,263	12,138	15,250	16,541	13,071	13,642	13,033	14,366	12,466	(1,900)	157,784
AHP's	8,615	8,680	8,658	8,656	8,616	8,646	11,165	9,279	9,360	9,238	9,390	9,498	9,940	442	109,800
Infrastructure Support	9,657	9,326	9,461	9,302	9,599	9,355	11,518	9,686	9,662	9,842	9,518	10,648	7,530	(3,119)	117,575
Other	3,191	4,956	3,611	4,026	3,845	4,164	3,955	4,012	4,190	(2,359)	3,261	47,833	3,322	(44,511)	84,685
Substantive Staff	**55,618**	**54,912**	**54,789**	**55,300**	**55,176**	**55,357**	**67,701**	**61,250**	**57,915**	**52,309**	**57,059**	**104,127**	**55,906**	**(48,221)**	**731,512**
Total All Staff	**61,943**	**60,671**	**59,833**	**60,704**	**60,565**	**60,293**	**74,073**	**66,765**	**63,057**	**57,525**	**62,576**	**110,518**	**62,086**	**(48,432)**	**798,523**
% Temporary	10.21%	9.49%	8.43%	8.90%	8.90%	8.19%	8.60%	8.26%	8.15%	9.07%	8.82%	5.78%	9.95%		8.39%

Table 3: WTE information

2024/25 Monthly Workforce analysis	Apr-24 WTE	May-24 WTE	Jun-24 WTE	Jul-24 WTE	Aug-24 WTE	Sep-24 WTE	Oct-24 WTE	Nov-24 WTE	Dec-24 WTE	Jan-25 WTE	Feb-25 WTE	Mar-25 WTE	In Month CAP WTE	In Month Plan WTE	F/(A) Variance WTE
Temporary staff															
Bank Staff	588.90	493.89	493.02	516.60	518.54	487.53	554.72	519.78	498.22	524.28	584.42	611.09	611.09	539.24	(71.85)
Medical Agency	74.57	67.68	59.07	68.38	69.16	62.13	76.13	68.32	63.53	71.21	60.18	54.37	54.37	60.16	5.79
Medical Locums	31.19	25.72	26.61	33.27	32.54	29.98	28.65	29.85	29.25	30.16	28.84	25.31	25.31	19.76	(5.55)
Nursing Agency	94.58	69.57	64.96	70.88	67.02	46.30	47.29	48.55	59.27	67.91	59.47	62.60	62.60	76.79	14.19
Other Agency	67.26	77.61	59.76	58.10	58.65	55.32	52.70	45.45	42.74	49.33	39.55	41.52	41.52	44.05	2.53
Total Temporary Staff	**856.50**	**734.47**	**703.42**	**747.23**	**745.91**	**681.26**	**759.49**	**711.95**	**693.01**	**742.89**	**772.46**	**794.89**	**794.89**	**740.00**	**(54.89)**
Nursing	3,380.35	3,402.66	3,406.98	3,419.94	3,422.15	3,422.59	3,467.42	3,457.94	3,460.86	3,469.54	3,475.22	3,406.96	3,406.96	3,419.62	12.66
Support to Nursing	2,171.87	2,153.16	2,159.23	2,138.57	2,097.38	2,088.21	2,067.51	2,031.07	2,014.00	2,013.29	2,016.31	2,012.48	2,012.48	2,097.34	84.86
Medical	1,079.95	1,084.89	1,079.97	1,074.69	1,205.17	1,142.05	1,137.58	1,131.15	1,121.14	1,127.30	1,153.52	1,135.17	1,135.17	1,090.01	(45.16)
AHP's	1,590.04	1,589.92	1,586.06	1,600.67	1,607.25	1,626.72	1,653.37	1,649.77	1,658.43	1,656.14	1,666.44	1,676.82	1,676.82	1,594.06	(82.77)
Infrastructure Support	2,484.95	2,470.55	2,477.64	2,471.69	2,465.93	2,465.71	2,462.85	2,483.64	2,473.16	2,464.88	2,460.79	2,421.67	2,421.67	2,507.10	85.43
Other	1,136.01	1,161.37	1,145.51	1,126.36	1,127.82	1,134.55	1,113.43	1,130.66	1,140.14	1,140.80	1,133.98	1,083.37	1,083.37	1,056.87	(26.50)
Substantive Staff	**11,843.17**	**11,862.55**	**11,855.39**	**11,831.92**	**11,925.70**	**11,879.82**	**11,902.15**	**11,884.23**	**11,867.73**	**11,871.94**	**11,906.26**	**11,736.48**	**11,736.48**	**11,765.00**	**28.52**
Total All Staff	**12,699.67**	**12,597.02**	**12,558.81**	**12,579.15**	**12,671.61**	**12,561.08**	**12,661.64**	**12,596.18**	**12,560.74**	**12,614.83**	**12,678.72**	**12,531.37**	**12,531.37**	**12,505.00**	**(26.37)**
% Temporary	6.74%	5.83%	5.60%	5.94%	5.89%	5.42%	6.00%	5.65%	5.52%	5.89%	6.09%	6.34%	6.34%	5.92%	

2.6 March's agency expenditure was £2.131m, £1.120m lower than in the equivalent period in 2023/24 and £0.020m lower than February. When compared to the same period last year, the Trust has spent £7.9m less on agency to date and has delivered £6.8m of recurrent CIP. Nursing agency has seen the largest reduction in 2024/25, £3.3m less than last year, with medical agency £2.0m less and other agency £2.6m less than in 2023/24.

2.7 This reduction in expenditure is a considerable achievement and the result of a sustained focus by services on their agency usage. The Trust will need to go further again in 2025/26 as the national focus means a further 40% reduction in agency use and additionally, a reduction in bank spend of 10%. This will be extremely challenging to deliver.

2.8 Total medical agency in March was £1.339m (£0.173m lower than February). Vacancies continue to be the largest driver of agency usage and accounted for £1.119m (74% of the total SFT agency spend in month).

2.9 The Trust agency cap is £27.390m and is based on a 3.2% of planned pay spend. At the end of March, we are £1.531m above the cap. This variance has decreased by £0.290m in March. Services continue to exercise rigorous controls on their agency use and usage is reviewed regularly by senior colleagues.

2.10 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

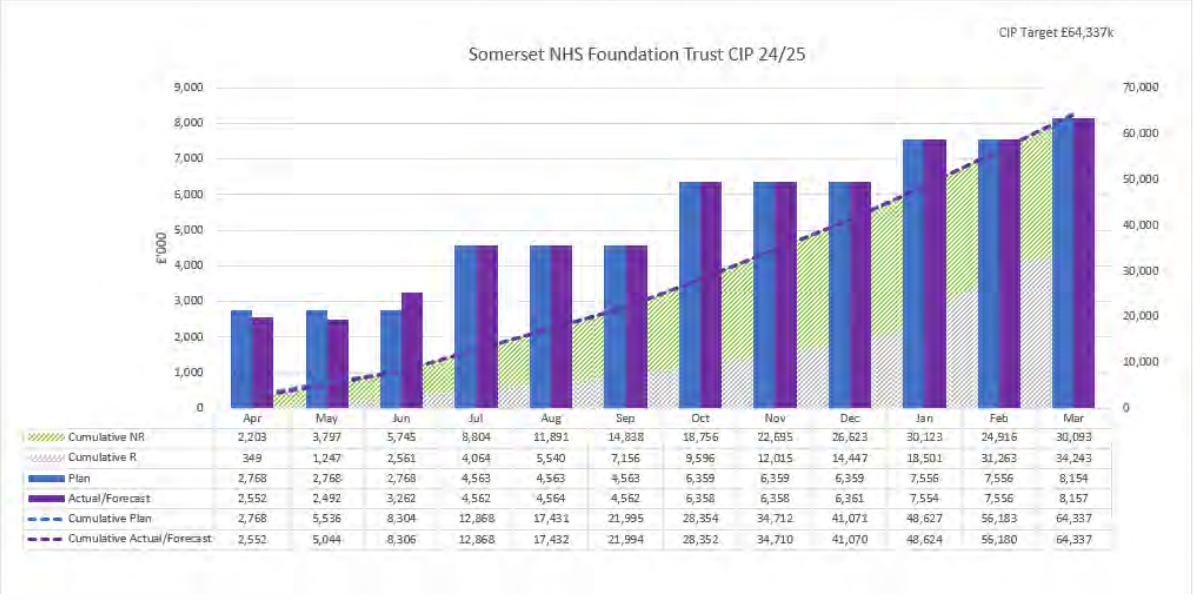
3.1 In March, savings of £8.154m were delivered. Total delivery was consistent with the plan for the month. Cumulative savings of £64.377m have been delivered which is also on plan. Recurrent savings were £2.980m (37% of total).

3.2 In total, recurrent savings of £34.243m were delivered, representing 53% of the overall achievement. This is a small improvement compared with 2023/24 (recurrent achievement of 51%). The Board are aware of the challenging

2025/26 plan. This will require a step change in recurrent delivery if we are to meet the 65% planning assumption.

3.3 Further analysis is shown in the charts below: -

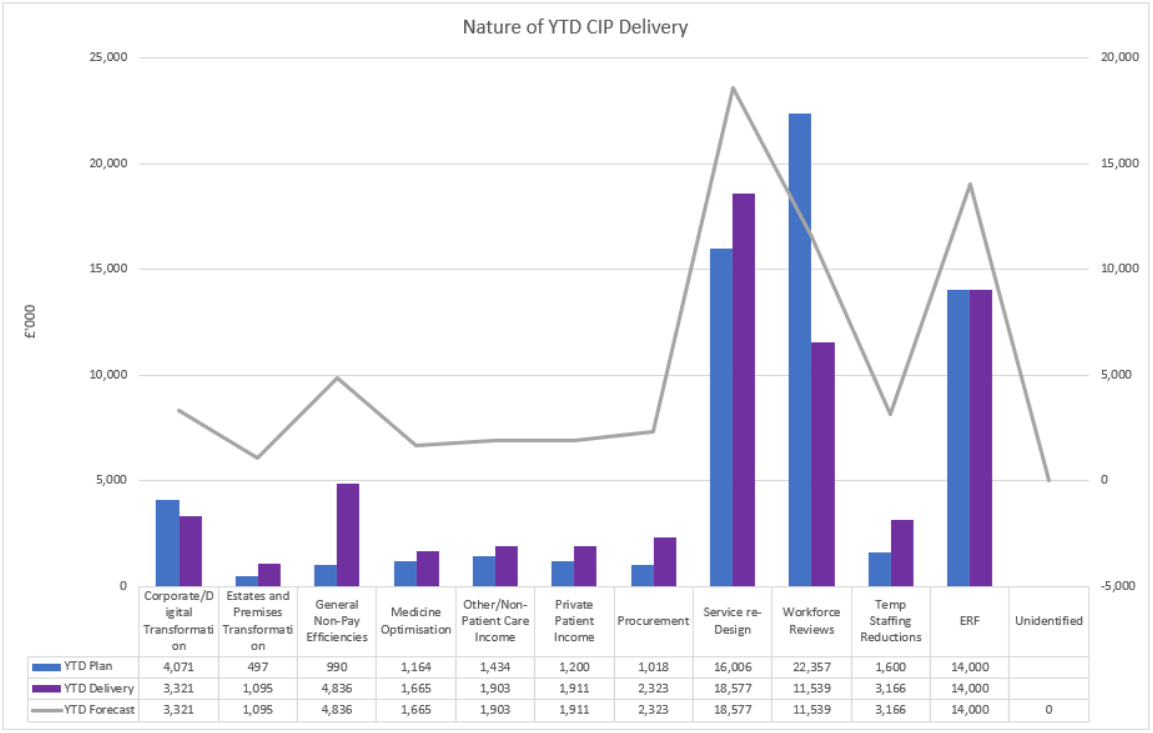
Chart 1: CIP Plan 2024/25



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative NR	2,203	3,797	5,745	8,804	11,891	14,838	18,756	22,695	26,623	30,123	24,916	30,093
Cumulative R	349	1,247	2,561	4,064	5,540	7,156	9,596	12,015	14,447	18,501	31,263	34,243
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	4,564	4,562	6,358	6,358	6,361	7,554	7,556	8,157
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	17,432	21,994	28,352	34,710	41,070	48,624	56,180	64,337

3.4 The nature of the schemes within the cost improvement plan year to date have been summarised and categorised below. The most significant area of delivery is classified as service redesign; £18.577m. Workforce reviews; £11.539m and general non-pay efficiencies; £4.836m being the two next largest contributors, respectively.

Chart 2: Nature of CIP delivery



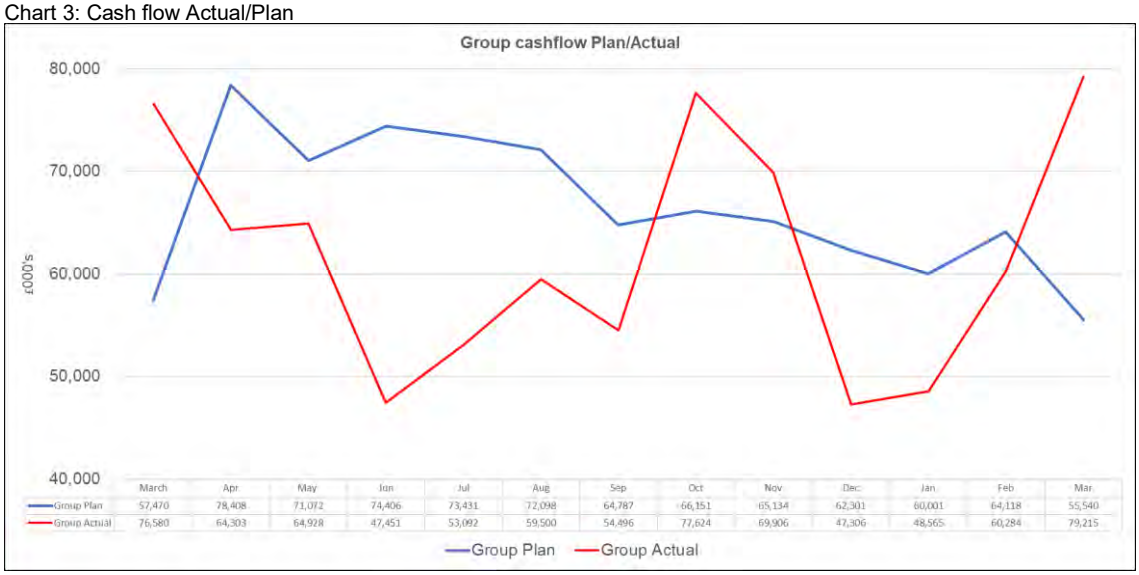
	Corporate/Digital Transformation	Estates and Premises Transformation	General Non-Pay Efficiencies	Medicine Optimisation	Other/Non-Patient Care Income	Private Patient Income	Procurement	Service re-Design	Workforce Reviews	Temp Staffing Reductions	ERF	Unidentified
YTD Plan	4,071	497	990	1,164	1,434	1,200	1,018	16,006	22,357	1,600	14,000	
YTD Delivery	3,321	1,095	4,836	1,665	1,903	1,911	2,323	18,577	11,539	3,166	14,000	
YTD Forecast	3,321	1,095	4,836	1,665	1,903	1,911	2,323	18,577	11,539	3,166	14,000	0

4. CASH

4.1 Cash balances at 31 March were £79.215m; this is primarily due to £17,772m of contract variations; (£15.826m of elective recovery funding) which come with corresponding cash (received in March).

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

Chart 3: Cash flow Actual/Plan



	March	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Group Plan	57,470	78,408	71,072	74,406	73,431	72,098	64,787	66,151	65,134	62,301	60,001	64,118	55,540
Group Actual	76,580	64,303	64,928	47,451	53,092	59,500	54,496	77,624	69,906	47,306	48,565	60,284	79,215

5. STATEMENT OF FINANCIAL POSITION

5.1 Trade and other receivables movement include £4m recovery of sales ledger debts and £12.7m accrued income release including £8.1m elective recovery funding.

5.2 Long-term liability in month movement is driven by £7.5m IFRS16 addition for the Yeovil Diagnostic Centre lease.

5.3 Income & expenditure reserve and revaluation reserve in month movements are driven by £18.2m impairment and £4.3m revaluation decrease resulting from a full valuation of the Trusts' land and buildings by our external valuer.

Feb-25	Mar-25	Movement		Mar-24	Mar-25	Movement in Year
£000	£000	£'000		£000	£000	£000
44,256	46,142	1,886	Intangible Assets	37,954	46,142	8,189
408,402	407,877	(525)	Property, plant and equipment, other	390,563	407,877	17,314
27,920	27,624	(296)	On SoFP PFI assets	28,360	27,624	(736)
82,084	82,758	674	Right of use assets	83,020	82,758	(262)
14	14	(0)	Investments	14	14	0
14	14	0	Other investments/financial assets	14	14	0
3,003	3,063	60	Trade & other receivables >1yr	2,957	3,063	106
565,694	**567,493**	**1,800**	**Non-current assets**	**542,883**	**567,493**	**24,611**
11,460	11,281	(180)	Inventories	11,005	11,281	276
12,064	5,338	(6,726)	Trade and other receivables: NHS receivables	7,081	5,338	(1,743)
43,117	18,796	(24,321)	Trade and other receivables: non-NHS receivables	24,890	18,796	(6,094)
466	496	31	Non current assets held for sale	466	496	31
60,337	79,215	18,878	Cash	76,622	79,215	2,593
127,444	**115,126**	**(12,318)**	**Total current assets**	**120,064**	**115,126**	**(4,938)**
(101,213)	(103,067)	(1,854)	Trade and other payables: non-capital	(96,052)	(103,067)	(7,015)
(10,825)	(18,207)	(7,382)	Trade and other payables: capital	(14,419)	(18,207)	(3,787)
(29,997)	(18,455)	11,542	Deferred income	(16,340)	(18,455)	(2,115)
(15,988)	(11,426)	4,562	Borrowings	(14,364)	(11,426)	2,937
(9,013)	(9,522)	(509)	Provisions <1yr	(7,805)	(9,522)	(1,716)
(167,036)	**(160,676)**	**6,360**	**Current liabilities**	**(148,980)**	**(160,676)**	**(11,696)**
(39,592)	**(45,550)**	**(5,958)**	**Net current assets**	**(28,916)**	**(45,550)**	**(16,633)**
(105,770)	(117,611)	(11,841)	Borrowings >1yr	(111,977)	(117,611)	(5,633)
(2,818)	(2,790)	28	Provisions >1yr	(3,073)	(2,790)	283
(1,445)	(1,423)	22	Deferred income >1yr	(1,682)	(1,423)	259
(110,032)	**(121,823)**	**(11,791)**	**Total long-term liabilities**	**(116,732)**	**(121,823)**	**(5,091)**
416,070	**400,120**	**(15,950)**	**Net assets employed**	**397,234**	**400,120**	**2,887**
			Financed by:			
394,396	399,414	5,018	Public dividend capital	363,752	399,414	35,662
77,897	73,581	(4,316)	Revaluation reserve	77,897	73,581	(4,316)
(354)	(354)	0	Other reserves	(4,441)	(354)	4,088
(2,471)	(2,471)	0	Financial assets at FV through OCI reserve	(2,471)	(2,471)	0
(53,923)	(70,733)	(16,810)	I&E reserve	(38,050)	(70,733)	(32,682)
			Other's equity			
525	683	159	Non-controlling Interest	548	683	136
416,070	**400,120**	**(15,950)**	**Total financed**	**397,234**	**400,120**	**2,887**

6. CAPITAL

6.1 Total capital expenditure was £96.145m at the end of March against a revised plan of £96.145m. There have been significant changes over the course of the year as a result of a combination of approving new areas of expenditure as schemes slipped and in response to additional funding allocations.

6.2 Detailed monitoring is reported regularly to the Finance Committee and oversight is through the Strategic Estates and Capital Delivery Groups. The successful delivery of a complex programme such as this is another huge achievement and the result of significant amount of planning and hard work of many colleagues.

6.3 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
Backlog Maintenance	**9,108**	**8,613**	**9,108**	**8,938**	**(170)**
Essential Facilities Improvement Works	**1,450**	**1,622**	**1,450**	**1,852**	**402**
Service Redesign Enabling Works	**3,920**	**4,565**	**3,920**	**5,374**	**1,454**
Service Redesign Enabling Works - Major	**8,660**	**7,618**	**8,660**	**3,847**	**(4,813)**
Infrastructure	**906**	**906**	**906**	**1,648**	**742**
Rolling IT & Digital Development	**13,365**	**12,103**	**13,365**	**12,672**	**(772)**
Replacement Medical Equipment	**5,550**	**5,995**	**5,550**	**6,687**	**1,137**
Other	**410**	**530**	**410**	**995**	**512**
Total Internal Capital Envelope	**43,369**	**41,952**	**43,369**	**42,015**	**(1,506)**
Externally Funded Capital Schemes	**Plan £000**	**Revised Budget £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
PDC STP 3 - MPH Surgical Centre	24,631	24,631	24,631	24,631	0
PDC NHP - MPH	900	1,040	900	1,040	140
PDC NHP Enabling	1,137	1,137	1,137	1,137	(0)
PDC Pathology Network	222	100	222	100	(122)
PDC Diagnostic Network	733	715	733	715	(18)
PDC Endoscopy - MPH	549	549	549	549	0
PDC Cyber Security	0	55	0	55	55
PFI Funded IFRIC 12 - SFT MES	424	876	424	876	452
Donated Acute MPH	50	67	50	67	17
PDC Tif - Elective Recovery/Theatre expansion	4,076	4,076	4,076	4,076	(0)
PFI Funded IFRIC 12 - YDH MES	333	641	333	641	308
Donated Salix (Slippage)	0	954	0	954	954
Donated Acute YDH Breast Unit	1,000	1,285	1,000	1,285	285
Donated YDH	0	32	0	32	32
PDC Yeovil CDC	1,292	1,292	1,292	1,292	(0)
PDC Somerset CYP Safe Spaces	275	275	275	275	(0)
Donated Community	110	0	110	0	(110)
PDC Diagnostic Screening-Colposcopy	0	176	0	176	176
PDC Critical Infrastructure	0	1,456	0	1,456	1,456
PDC LED Lighting	0	160	0	160	160
Total Additional Schemes	**35,732**	**39,517**	**35,732**	**39,516**	**3,784**
IFRS Leases	14,523	14,523	14,523	14,614	91
TOTAL TRUST PROGRAMME	**93,624**	**95,992**	**93,624**	**96,145**	**2,369**

6.4 We have received central “impairment” budget cover for the New Hospital Programme’s costs incurred to date. These costs have therefore not scored against the Trust adjusted financial performance.

7. CONCLUSION & RECOMMENDATION

7.1 The Board are asked to note the financial performance in March and that the Trust has achieved the planned position for 2024/25.

CHIEF FINANCE OFFICER

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Approval of 2025/26 Revenue budget
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Mark Hocking, Deputy Chief Finance Officer
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	6 May 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 presents the Board with the 2025/26 annual revenue budget including information on the cost improvement programme, forecast cashflow and statement of financial position.
Recommendation	The Board is requested to approve the 2025/26 annual revenue budget.

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

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

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

Equality and Inclusion

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

How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
The report itself has not been assessed against the Trust's Equality Impact Assessment Tool but the impact on protected characteristics will be considered as part of the overall financial plan.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

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

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

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

APPROVAL OF 2025/26 REVENUE BUDGET

1. INTRODUCTION

1.1 The Board approved the final version of the 2025/26 financial plan at its meeting on 25 March 2025 and this was submitted to NHSE on 27 March 2025 in accordance with the national timescale. The submission included: -

i) The financial plan – detailed profiled plans for I&E, capital, cash and efficiencies

ii) Workforce plans – setting out demand, supply, efficiency and skill mix information

iii) Activity plans - which set out trajectories for key performance areas

1.2 In addition, the Somerset ICB submitted a system wide plan which is a consolidation of the ICB and SFT plans for 2025/26. There have been some minor amendments in respect of additional capital schemes notified during April that will be incorporated into a final version which is required to be submitted on 30 April 2025.

1.3 This paper is a summary of the final plan and proposes the annual revenue budget for agreement.

2. SUMMARY

2.1 The financial plan was developed with reference to the national planning guidance and locally determined priorities. A detailed business planning process was undertaken internally and the overall plan was developed collaboratively with ICB colleagues.

2.2 The Trust and system plans are both breakeven. There is a clear expectation that all systems will live within their means and therefore set plans that are affordable but allow continued progress on the delivery of a core set of targets.

2.3 The Board have been regularly updated on the evolution of 2025/26 plans. This paper sets out how the revenue funding is allocated within the Trust, together with information on how the plan impacts cashflow and the Statement of Financial Position.

3. INCOME AND EXPENDITURE

3.1 The summary level Statement of Comprehensive Income (SOCI) budget at Group level is shown below: -

Group Statement of comprehensive income	Annual Budget £000
Operating income from patient care activities	1,021,445
Other operating income	71,151
Employee expenses	(754,193)
Operating expenses excluding employee expenses	(330,014)
Operating Surplus/(Deficit)	**8,389**
Finance Costs	(10,296)
Corporation Tax	(476)
Surplus/(Deficit) 2025/26	**(2,383)**
Adjustments to Financial Performance	2,383
Adjusted Financial Performance Surplus/(Deficit)	**0**

3.2 Service group, corporate services and other budgets are set out below. These are net of the agreed cost improvement targets. Corporate includes the corporate support service departments and other central budgets such as CNST, capital charges and depreciation is shown in the table below: -

SERVICE GROUP	EMPLOYEE BENEFITS £000	NON CLINICAL SUPPLIES £000	OTHER INCOME £000	CLINICAL SUPPLIES £000	DRUGS £000	FINANCING COSTS £000	NHS CLINICAL INCOME £000	NON NHS CLINICAL INCOME £000	25/26 TOTAL PLAN £000
SURGICAL SERVICES	155,053	2,686	(5,810)	23,480	17,021	0	0	(7,703)	184,728
MEDICAL SERVICES	125,665	2,890	(472)	12,902	17,418	0	0	(35)	158,368
CLIN SUPP & CANCER SERVS	80,987	12,962	(3,288)	9,525	33,614	2,328	0	(1,838)	134,291
NEIGHBOURHOOD SERVICES	80,242	7,892	(730)	1,326	946	0	0	(2,704)	86,972
MENTAL HEALTH AND LD	70,660	11,971	(932)	(483)	798	0	0	(70)	81,944
CYP & FAMILIES SERVICES	73,469	3,189	(1,572)	2,651	2,821	0	(131)	(2,017)	78,410
TOTAL OPERATIONAL	**586,076**	**41,591**	**(12,804)**	**49,401**	**72,618**	**2,328**	**(131)**	**(14,367)**	**724,713**
CORPORATE & OTHER SERVICES									
RESERVES	23,949	(8,758)	(1,700)	376	0	3,418	0	7,994	25,280
OPERATIONAL MANAGEMENT	9,356	4,254	(84)	(134)	44	0	0	0	13,437
CHIEF OF PEOPLE & OD	15,603	6,122	(18,820)	(75)	39	0	0	(38)	2,832
CHIEF FINANCE OFFICER	10,227	2,707	(5,711)	367	0	106	0	0	7,695
DIRECTOR OF STRATEGY & DIGITAL	18,986	26,296	(5,908)	(675)	0	3	0	0	38,701
DIRECTOR OF CORPORATE SERVICES	6,648	25,393	(175)	(297)	0	57	0	0	31,626
CHIEF NURSE	3,582	213	(15)	(34)	0	0	0	0	3,746
CHIEF MEDICAL OFFICER	2,911	50	(54)	(84)	0	0	0	0	2,823
CENTRAL BUDGETS	17,879	2,146	(29,650)	(391)	0	44,528	0	(1,304)	33,208
CLINICAL INCOME	0	40	0	0	0	0	(974,851)	(1,879)	(976,690)
ESTATES AND FACILITIES	33,221	28,267	(31,766)	1,809	0	77	(381)	(38)	31,189
TOTAL CORPORATE & OTHER	**142,362**	**86,730**	**(93,884)**	**864**	**83**	**48,189**	**(975,232)**	**4,735**	**(786,152)**
SUBSIDARIES									
SIMPLY SERVE LIMITED	12,710	12,821	(473)	7,867	5,037	511	0	0	38,473
SHS	25,926	3,319	(167)	452	2,068	2,300	(33,882)	(152)	(136)
SPS	0	6,677	0	7,584	0	0	0	(963)	13,299
SPSF	0	5,821	0	7,822	0	0	0	(1,457)	12,186
TOTAL SUBSIDARIES	**38,636**	**28,638**	**(640)**	**23,725**	**7,105**	**2,811**	**(33,882)**	**(2,572)**	**63,822**
GROUP TOTAL	**767,074**	**156,960**	**(107,328)**	**73,990**	**79,806**	**53,328**	**(1,009,244)**	**(12,204)**	**2,383**
LESS CONTROL TOTAL ADJUST	**0**	**0**	**0**	**0**	**0**	**(2,383)**	**0**	**0**	**(2,383)**
ADJUSTED FINANCIAL PERFORMANCE	**767,074**	**156,960**	**(107,328)**	**73,990**	**79,806**	**50,945**	**(1,009,244)**	**(12,204)**	**0**

Inter-company transactions have been excluded

3.3 A more granular income and expenditure position is set out in the table below. This is net of the £50m efficiency programme.

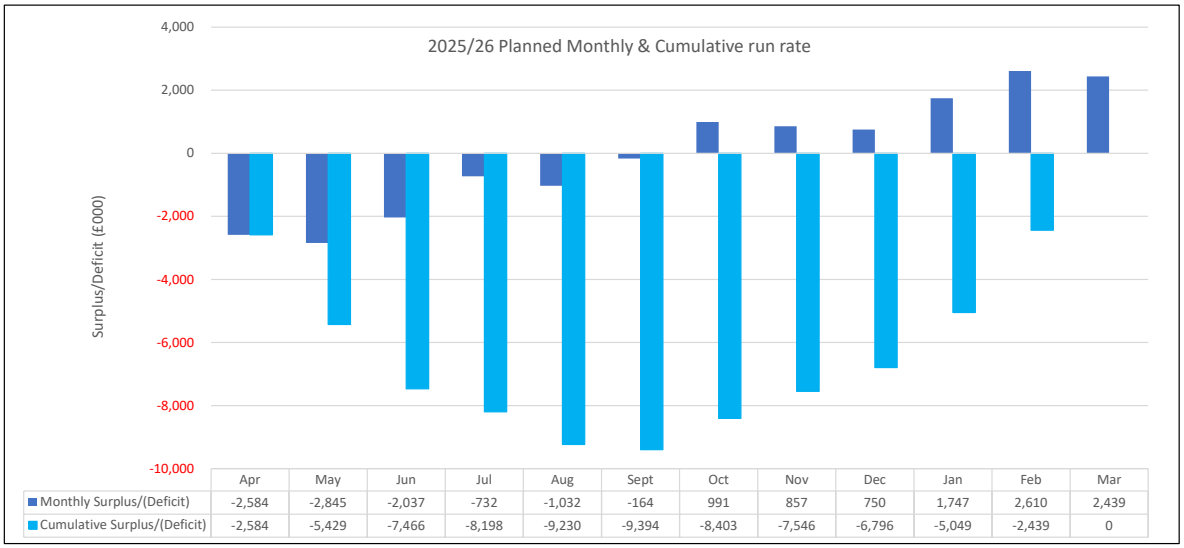
Statement of comprehensive income	Annual Budget £'000	2024/25 Outturn £'000
Income from patient care activities		
Integrated Care Boards	891,183	888,321
NHS England	106,253	156,504
Local Authorities	2,376	2,330
NHS Trusts//overseas/other/non NHS	14,004	26,452
Private patients	7,629	7,909
sub-total	**1,021,445**	**1,081,516**
Other operating income		
Research & Development	3,048	4,199
Education & Training	39,420	52,234
Car Parking, catering & staff accommodation	4,860	4,757
Donations	11,351	2,538
Other	12,472	18,302
sub-total	**71,151**	**82,030**
Total operating income	**1,092,596**	**1,163,546**
Operating expenditure		
Staff costs – substantive	(703,943)	(693,667)
Staff costs – agency	(17,739)	(28,921)
Staff costs – bank/locum	(32,511)	(38,089)
Additional superannuation	-	(44,117)
Supplies & services - clinical	(66,124)	(70,060)
Supplies & services - general	(33,876)	(37,029)
Drug costs	(74,770)	(95,779)
Establishment & premises costs	(37,964)	(36,152)
Purchase of healthcare	(20,208)	(13,466)
Depreciation & amortisation	(42,343)	(40,271)
Impairments	-	(27,208)
Clinical negligence	(22,728)	(22.083)
Other	(32,001)	(56,179)
sub-total	**(1,084,207)**	**(1,180,960)**
Operating Surplus/(Deficit)	**8,389**	**(17,414)**
Finance Costs		
Interest receivable	3,420	3,801
Interest payable	(4,332)	(5,190)
PDC dividends payable	(9,384)	(8,005)
Losses from disposal of assets	-	(1,039)
Corporation Tax	(476)	(758)
Surplus/(Deficit) 2025/26	**(2,383)**	**(28,605)**
Remove capital donations	(196)	(1,454)
Add back all I&E impairments	-	27,208
Impact of DEL impairment	-	(8,975)
Remove IFRIC12 finance costs	13,091	11,026
Add back IFRIC12 interest on IAS17 basis	(10,512)	(8,172)
DEL impairment adjustment	-	8,975
Adjusted Financial Performance Surplus/(Deficit)	**0**	**3**

3.4 Total staff costs are £759.193m and represent c70% of the Group operating expenses. The agency budget is c2.4% of total pay expenditure and represents a material and planned reduction on the actual spend in 2024/25.

3.5 A breakdown of the total staffing budget by staff type including whole time equivalent information (planned as 31 March 2026) is shown in the table below: -

Staff costs detail	Annual Budget £'000	WTE (SIP)
Clinical substantive staff (non-medical)		
Registered nursing & midwifery staff	(216,851)	3,599.16
Registered/ Qualified Scientific, Therapeutic and Technical	(119,672)	1,730.32
Support to nursing, AHP & clinical staff	(111,832)	2,522.02
	(400,026)	**7,851.50**
Medical & dental substantive staff		
Consultants	(80,897)	456.10
Career/Staff grades/Trainees	(78,803)	801.79
	(159,700)	**1,257.89**
Non-medical/non-clinical substantive staff		
NHS infrastructure support & others	**(95,888)**	**3,228.92**
Total substantive staff costs	**(703,943)**	**12,338.30**
Bank/Locum staff		
Registered nursing & midwifery staff	(7,395)	147.93
Registered/ Qualified Scientific, Therapeutic and Technical	(1,540)	21.27
Support to nursing, AHP & clinical staff	(10,039)	202.23
Medical staff	(11,238)	77.14
NHS infrastructure support & others	(2,299)	98.12
Total bank staff costs	**(32,511)**	**546.69**
Agency staff		
Registered nursing & midwifery staff	(3,272)	30.48
Registered/ Qualified Scientific, Therapeutic and Technical	(1,620)	12.42
Support to nursing, AHP & clinical staff	(648)	11.33
Medical staff	(11,635)	39.14
NHS infrastructure support & others	(564)	16.89
Total agency staff costs	**(17,739)**	**110.26**
Total staff costs	**(759,193)**	**12,995.25**

3.6 All budgets are profiled according to the expected pattern of monthly income, expenditure and efficiency savings delivery. Due primarily to the way that the efficiency programme is phased (i.e. a greater level of savings in the second part of the financial year) the Group will run deficits in the first six months and recover this through increase efficiency savings in the second six months. The monthly and cumulative phased budget is shown below :-



4. CIP

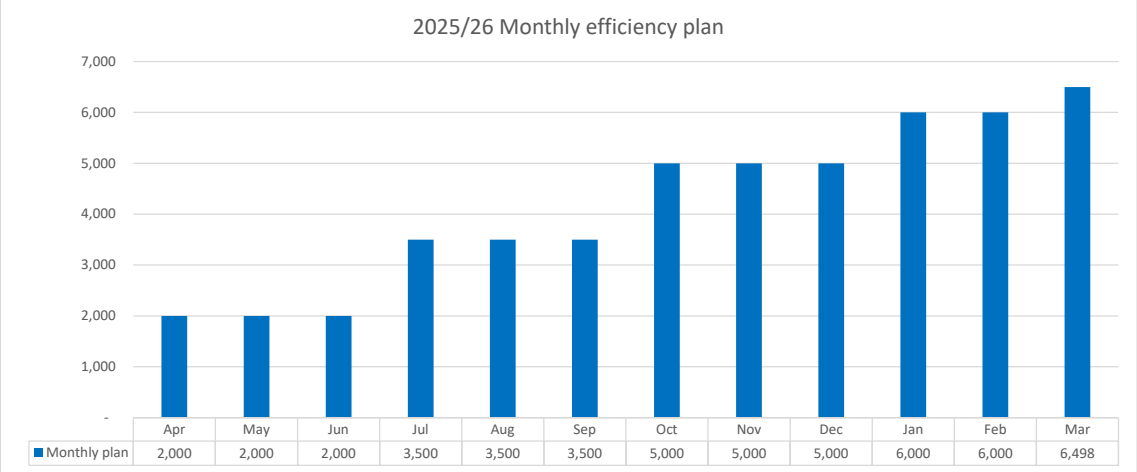
4.1 The total savings programme is £49.998m in 2025/26. The full programme has been allocated to clinical and non-clinical services on an agreed methodology that takes into account a baseline level of expected efficiency for all services, the level of cip achieved non-recurrently in the previous year and the budget deemed influence in the service.

4.2 The programme by area is set out below:-

Service Group/Corporate Team/Area	2025/26 CIP Target £m	% of Total Budget	% of Spend*
Clinical Support & Cancer Services Group	4.1	2.8%	5.9%
Medical Services Group	9.0	5.2%	5.7%
Surgical Services Group	8.5	4.3%	4.7%
Mental Health & LD Services Group	2.7	3.2%	3.7%
CYP & Families Services Group	4.7	5.4%	5.8%
Neighbourhood Services Group	8.1	6.4%	6.6%
Operational Management	0.9	6.2%	6.2%
Estates	2.7	6.0%	6.2%
Director of Corporate Services	0.9	2.9%	9.7%
Chief Finance Officer	0.5	3.4%	3.5%
Chief Nurse	0.1	3.5%	3.5%
Chief of People and OD#	2.0	9.5%	9.6%
Chief Medical Officer	0.3	8.8%	8.8%
Director of Strategy and Digital	2.3	5.0%	5.0%
SSL	1.4	3.9%	5.9%
SHS	1.8	4.9%	5.6%
TOTAL	**50.0**	**4.7%**	**5.6%**

** Influenceable spend (excl drug costs, cnst, depreciation etc)*
 # Includes £1.2m merger saving

4.3 Efficiency savings represent c4.4% of operating expenses (2024/25 c5.4%) and planned delivery is 65.9% recurrent, 34.1% non-recurrent. The plan is phased based on the expected delivery trajectory of individual schemes and increases from 12% in quarter 1 to 37% in quarter four. The monthly trajectory is shown below: -



4.4 There is a focus on pay related schemes which make up 85% of the planned savings. A summary of is shown below:-

Efficiency Plan Summary	Recurrent £m	Non Recurrent £m	Total £m
Pay	25.5	17.0	42.5
Non-pay	7.2	0	7.2
Income	0.3	0	0.3
TOTAL	**33.0**	**17.0**	**50.0**

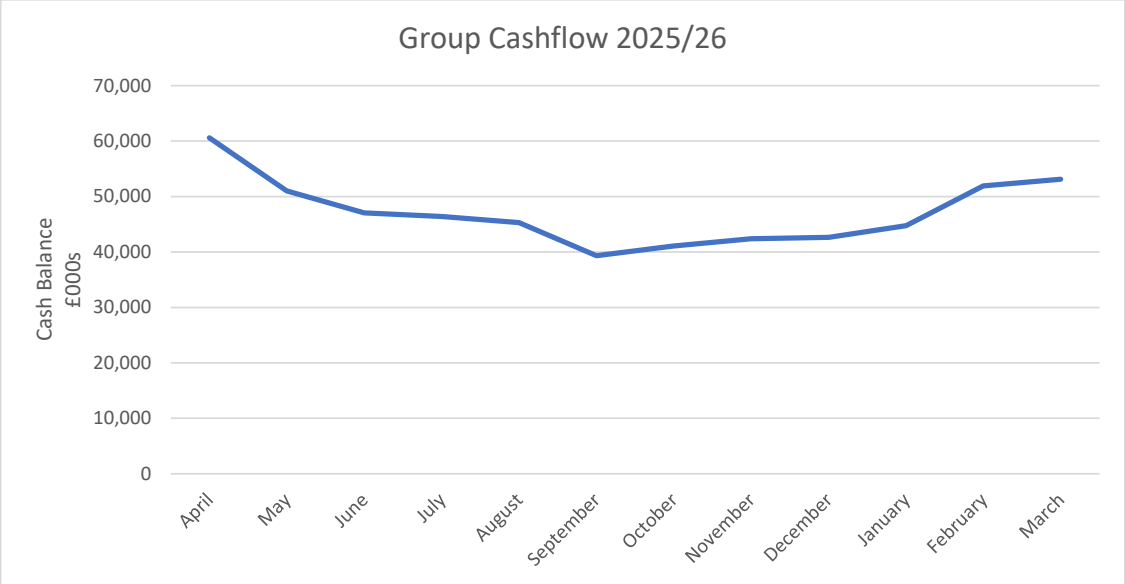
4.5 Services are continuing to develop their CIP plans using a combination of traditional CIP schemes and productivity and transformational opportunities identified as part their individual Productive Care Programmes (PCP).

4.6 We continue to work with the ICB to identify wider opportunities to secure recurrent benefits through strategic changes; through improved system flow, integrated neighbourhood working and population health management. Real progress in these areas will be crucial to enable our services to realise the full potential of their opportunities.

5. CASH

5.1 The cash flow statement is driven by the planned operating surplus/(deficit), the impact of non-cash transactions such as depreciation and movements in working capital and the impact of investment activities, namely the Group capital programme expenditure both in terms of capital expenditure and capital funding (PDC) received.

5.2 The level of cash retained by month is shown in the table below. The year-end balance is projected to be c£53m.



5.3 The Group cash flow statement is set out in the table below and is based on the final income and expenditure plan and capital programme for the year: -

Statement of Cash flows	Plan for y/e 31/03/26 £'000
Operating surplus/(deficit)	**8,389**
Non-cash income & expense	
Depreciation/amortisation	42,343
Income in respect of capital donations	(1,412)
Amortisation of PFI credit	(1,716)
Increase/(decrease) in trade/other payables/liabilities	(7,356)
Net cash generated/(used in) operations	**40,248**
Cash flows from investing activities	
Interest received	3,420
Purchase of intangible assets	(20,926)
Purchase of property, plant & equipment	(76,221)
Proceeds of sale of property, plant & equipment	466
Receipt of cash donations to purchase capital assets	1,412
Net cash used in investing activities	**(91,849)**
Cash flows from financing activities	
Public dividend capital received	56,593
Loans from DH/Other repaid	(708)
Capital element of lease payments & PFI	(10,266)
Interest paid/ Interest element of lease payments/PFI	(683)
PDC dividend (paid)/refunded	(9,384)
Net cash generated from/(used in) financing activities	**35,553**
Increase/(decrease) in cash & cash equivalents	**(16,049)**
Cash & cash equivalents at start of period	**69,150**
Cash & cash equivalents at end of period	**53,102**

5.4 The cash flow statement demonstrates that the Group will have sufficient cash available to meet its obligations and planned commitments and there is no planned additional borrowing in the period.

6. STATEMENT OF FINANCIAL POSITION

6.1 The statement of financial position (balance sheet) is derived principally from the final revenue plans set out above and planned capital expenditure programme and is shown below:-

Statement of Financial Position	Plan for y/e 31/03/26 £'000
Non-current assets	
Intangible assets	56.653
On-SoFP IFRIC 12 assets	26,928
Other property, plant and equipment (excludes leases)	477,322
Right of use assets - leased assets for lessee (excluding PFI/LIFT)	87,896
Other investments/financial assets	28
Receivables: due from NHS/DHSC & non-NHS/DHSC bodies	4,000
Credit loss allowance	(625)
Total non-current assets	**652,202**
Current assets	
Inventories	11,800
Receivables: due from NHS and DHSC group bodies	16,806
Receivables: due from non-NHS/DHSC Group bodies	24,586
Credit loss allowance	(895)
Cash and cash equivalents	53,102
Total current assets	**105,399**
Current liabilities	
Trade and other payables: capital	(19,500)
Trade and other payables: non-capital	(99,940)
Borrowings	(10,981)
Provisions	(8,450)
Other liabilities: other	(15,259)
Total current liabilities	**(154,130)**
Total assets less current liabilities	**603,471**
Non-current liabilities	
Trade and other payables: non-capital	(119,589)
Other liabilities: deferred income/other	(4,801)
Total non-current liabilities	**(124,390)**
Total net assets employed	**479,082**
Financed by:	
Public dividend capital	456,007
Revaluation reserve	77,987
Other reserves	(2,871)
Income and expenditure reserve	(52,581)
Non-controlling interest	540
Total taxpayers' and others' equity	**479,082**

6.2 The SOFP sets out the assets owned by the Group and liabilities which it owes. These sum to the total net assets of the organisation and in the case of NHS bodies, are funded by the taxpayers' equity. The movement in current assets and liabilities and other working capital are based on the business as usual activities of the Group

7. RECOMMENDATION

7.1 The Board is asked to note and approve the Trust's 2025/26 annual revenue budget as set out above.

CHIEF FINANCE OFFICER

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Going Concern Statement
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Chris Upham, Assistant Director - Financial Services
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	6 May 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	International Accounting Standard 1 Presentation of financial statements (IAS 1) requires management to make an assessment of an entity's ability to continue as a going concern when preparing that entity's financial statements. This report provides the Board with an overview of their responsibilities and evidence to support the going concern assessment in respect of Somerset NHS Foundation Trust.
Recommendation	The Audit Committee have reviewed and recommended approval to the Board of the application of the Going Concern concept to the preparation of the Somerset NHS Foundation Trust 2024/25 accounts.

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
- ☐ Obj8 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

Equality The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics
This report has been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics

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]
None.

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

Kindness, Respect, Teamwork
Everyone, Every day

SOMERSET NHS FOUNDATION TRUST

GOING CONCERN REPORT

1. INTRODUCTION

1.1 International Accounting Standards (IAS1) require the directors to assess, as part of the account's preparation process, the Foundation Trust's ability to continue as a going concern. In accordance with the NHS Foundation Trust Annual Reporting Manual paragraph 2.14:

"The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern."

1.2 Whilst it is unlikely that an NHS body will be determined not to be a going concern, this interpretation does not exempt the management of NHS bodies from undertaking a going concern review.

1.3 The Trust's external auditors will seek evidence to support their evaluation of management's going concern assessment and any disclosures in the financial statements. They need to conclude whether there is material uncertainty relating to the entity's ability to continue as a going concern. Where the auditor concludes that they are satisfied that the accounts should be prepared on a going concern basis but there are material uncertainties relating to the entity's ability to continue as such then they will report this using an emphasis of matter paragraph in their audit report.

2. GOING CONCERN ASSESSMENT

2.1 IAS 1 states the review should consider as much information about the future as possible but should look ahead at least 12 months from the end of the reporting period. In practice our auditors like the review to consider at least 12 months from the signing of the accounts, scheduled for 18 June 2025.

2.2 The going concern assessment should include a review of:

Financial Conditions	• inability to meet the planned annual financial targets • the need to use a working capital facility to meet future obligations when they fall due • any necessary working capital/loan facilities have not been agreed • existence of significant operating losses, historical and projected • anticipated or actual major loss of commissioner income • major cost improvement programme with high risk of non-achievement • major losses or cash flow problems which have arisen since the balance sheet date
Operating Conditions	• loss of key management without replacement • loss of key staff without replacement and/or industrial relation difficulties • significant failure to achieve Care Quality Commission standards resulting in any restrictions on services provided

	• fundamental changes in the market or technology to which the Trust is unable to adapt adequately
Other Conditions	• serious non-compliance with regulatory or statutory requirements • pending legal or regulatory proceedings against the Trust that may, if successful, result in claims that are unlikely to be satisfied • changes in legislation or government policy expected to adversely affect the Trust • issues which involve a range of possible outcomes so wide that an unfavourable result could affect the appropriateness of the going concern basis • significant concerns about finance or quality raised by regulators

2.3 Directors should request and consider evidence to support their assessment including identifying any potential remedial actions that may need to be addressed, to support their conclusion prior to their approval of financial statements. Evidence to consider may include:

Forecasts & budgets	• budget covering at least up to 12 months from the date of the approval of the financial statements • cash flow forecasts covering at least up to 12 months from the date of the approval of the financial statements and providing monthly balances for the period to the end of the financial year, reflecting agreed commissioning contracts • critical assumptions underlying forecasts and budgets • commissioning intentions, agreement of contract activity • CIP risk rating • capital programme cash flow forecasts and financing sources • an adequate matching of projected cash inflows with projected cash outflows including all liabilities and other commitments
Access to funding	• availability of an agreed financing facility if required • cash resources available to the Trust compared to the Trust's expected cash requirements
Medium & long-term plans	• medium or long-term plans that give an indication in general terms of how the directors expect the Trust's business to fare
Health services & markets	• the economic environment within which the Trust operates & any economic, political or other factors which may cause the health market to change
Contingent liabilities	• potential cash outflows during the review period relating to legal proceedings, environmental costs and service liability
Financial & operational risk management	• key risks identified by the Trust in its Risk Register • counterparty risks that arise from concentration on key suppliers or commissioners who may themselves be facing financial difficulty

Sensitivity analysis & stress testing	• critical assumptions that underlie the budgets and forecasts • the extent to which cash flows vary with changes in assumptions
Systems Controls	• Head of Internal Audit Opinion

2.4 The evidence considered has been contained within the monthly finance reporting to Finance Committee and Board. The Trust 2025/26 Financial Plan was approved by the Board on 25 March 2025 which encompassed guidance from NHS England for 2025/26.

2.5 Having due consideration to the relevant conditions and having performed the assessment utilising the evidence outlined above, the Directors need to evaluate which one of three potential conclusions is appropriate to the specific circumstances of the Trust. The Directors may conclude one of the following:

i) there are no material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern;

ii) there are material uncertainties related to events or conditions that may cast significant doubt about the Trust's ability to continue as a going concern, but the going concern basis remains appropriate;

iii) use of the going concern basis is not appropriate.

2.6 Directors should request and consider evidence to support their assessment including identifying any potential remedial actions that may need to be addressed, to support their conclusion prior to their approval of financial statements. Evidence to consider may include:

2024/25 Going Concern Assessment

Conditions	Criteria	Evidence
Financial	1. meeting the planned annual financial targets	1. Financial performance achieved during 2024/25 in line with plan.
	2. any necessary interim financing facilities are agreed	2. None required.
	3. existence of significant operating losses, historical and projected	3. None.
	4. anticipated or actual major loss of commissioner income	4. Nothing anticipated outside of plan.
	5. major cost improvement programme with high risk of non-achievement	5. CIP plans in progress and confident of plan delivery.
	6. major losses or cash flow problems which have arisen since the balance sheet date	6. Not anticipated.
Operating	7. loss of key management without replacement	7. None anticipated.
	8. loss of key staff without replacement and/or industrial relation difficulties	8. Not expected.
	9. significant failure to achieve Care Quality Commission standards resulting in any restrictions on services provided	9. S29A letter from CQC in relation to Paediatrics service, (awaiting impact on overall Trust rating).
	10. fundamental changes in the market or technology to which the Trust is unable to adapt adequately	10. Not anticipated.
Other	11. serious non-compliance with regulatory or statutory requirements	11. None.
	12. pending legal or regulatory proceedings against the Trust that may, if successful, result in claims that are unlikely to be satisfied	12. None.
	13. changes in legislation or government policy expected to adversely affect the Trust	13. None expected.
	14. issues which involve a range of possible outcomes so wide that an unfavourable result could affect the appropriateness of the going concern basis	14. None expected.
	15. significant concerns about finance or quality raised by regulators	15. None.

3. CONCLUSION & RECOMMENDATION

3.1 The Trust has submitted detailed financial plans for the financial year to NHS England to the end of March 2026 (Appendix 1: showing significant cash reserves available to support the Trust's continued activities). Based on current assumptions, it is unlikely that the Trust will require additional cash support in the form of interim revenue loan support from the Department of Health and Social Care.

3.2 For these reasons and based on the assessment above, the Directors consider it appropriate to continue to adopt the going concern basis in preparing the accounts.

3.3 The Trust Board is requested to review the report and approve the application of Going Concern in preparation of the accounts for 2024/25.

CHIEF FINANCE OFFICER

Appendix 1

Monthly cash flow forecast	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
Opening Cash Balance	69,150	60,578	51,017	47,073	46,396	45,304	39,308	41,066	42,374	42,637	44,743	51,918	53,102	60,177	67,145
Surplus/(Deficit) from operations	(2,014)	(2,275)	(1,111)	(158)	(458)	762	1,533	1,428	1,727	2,349	3,212	3,394	3,394	3,394	3,394
Non-cash flows in operating surplus/(deficit)	3,506	3,484	3,110	3,440	3,418	3,044	3,374	3,352	2,978	3,308	3,286	2,915	2,915	2,915	2,915
Operating cash flows before movements in working capital	**1,492**	**1,209**	**1,999**	**3,282**	**2,960**	**3,806**	**4,907**	**4,780**	**4,705**	**5,657**	**6,498**	**6,309**	**6,309**	**6,309**	**6,309**
Increase/(decrease) in working capital	(6,241)	(6,374)	1,253	(1,030)	(1,212)	1,033	(923)	(1,247)	817	(1,305)	3,167	4,703	4,703	4,703	4,703
Net cash inflow/(outflow) from operating activities	**(4,749)**	**(5,165)**	**3,252**	**2,253**	**1,749**	**4,839**	**3,985**	**3,534**	**5,522**	**4,353**	**9,665**	**11,012**	**11,012**	**11,012**	**11,012**
Capital expenditure	(4,296)	(4,399)	(5,728)	(2,938)	(2,858)	(5,048)	(2,744)	(2,744)	(4,294)	(20,598)	(20,842)	(37,994)	(4,296)	(4,399)	(5,728)
Investing activities	751	285	638	285	285	638	285	285	638	285	285	638	638	638	638
Net cash inflow/(outflow) before financing	**(8,294)**	**(9,279)**	**(1,838)**	**(401)**	**(825)**	**429**	**1,526**	**1,075**	**1,866**	**(15,961)**	**(10,893)**	**(26,344)**	**7,354**	**7,251**	**5,922**
Net cash inflow/(outflow) from financing activities	(279)	(283)	(2,106)	(276)	(268)	(6,425)	233	234	(1,603)	18,067	18,067	27,528	(279)	(283)	(2,106)
Net increase/(decrease) in cash and cash equivalents	(8,572)	(9,561)	(3,944)	(677)	(1,092)	(5,996)	1,758	1,309	263	2,107	7,175	1,184	7,076	6,968	3,816
Closing cash balance	**60,578**	**51,017**	**47,073**	**46,396**	**45,304**	**39,308**	**41,066**	**42,374**	**42,637**	**44,743**	**51,918**	**53,102**	**60,177**	**67,145**	**70,962**

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Audit Committee held on 16 April 2025
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	David Seabrooke, Interim Trust Secretary
PRESENTED BY:	Paul Mapson, Chair of Audit Committee
DATE:	6 May 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 Committee has reviewed the Going Concern statement elsewhere on the Board's agenda and supports the recommendation. The Committee has requested that the People Committee follow up the limited assurance internal audit report on the Patient Safety Incidents (PSIRF) system. Arising from the Counter Fraud report, members of the committee were very concerned about the position reported to us around the application of HR procedures where there is evidence of fraud and theft by individual staff. The internal auditor opinion for this year is likely to be Moderate, which the Committee has discussed and accepted. In other respects, the internal audit programme 2024/25 has made acceptable progress. The internal audit programme 2025/26 has been approved. Further details are given below – the committee asks that other committees familiarise themselves with this. The effectiveness of the board assurance framework review by committees for Q4 was reviewed and is considered to be operating effectively. The Conflicts of Interests policy was renewed.
Recommendation	That the report be noted.

Links to Joint Strategic Objectives (Please select any which are impacted on / relevant to this paper)
☒ Obj 7 **Live within our means and use our resources wisely**

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

Equality and Inclusion **The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.** **How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?**
The needs and potential impacts on people with protected characteristics are considered by each individual service group as part of their update to the Committee. The Committee reviews data presented to the Committee and will raise any queries if required.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Staff involvement takes place through the regular service group and topic updates.

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

ASSURANCE REPORT FROM THE AUDIT COMMITTEE MEETING HELD ON 16 APRIL 2025

1. PURPOSE

1.1. To advise the Board of a recommendation regarding Going Concern and to highlight the range of matters considered by the Committee.

1.2. The Committee meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

Internal audit programme 2024/25 – completed reviews reported

Internal audit review	Design	Effectiveness
Temporary Medical Workforce	Moderate	Moderate
Health and Safety Management	Moderate	Moderate
Clinical Supervision	Moderate	Limited
Patient Safety Incidents (PSIRF)	Limited	Limited
Non-Medical Prescribing	Substantial	Moderate

There are five more reviews in the 2024/25 programme that will be reported to the Committee at a future meeting:

In draft awaiting management comments:

- Temporary Staffing & Rostering (draft released 27 March 2025)
- Discharge Processes (Community) (draft planned w/c 7 April 2025).

Fieldwork is underway for the following audits:

- Use of Temporary Staffing (observation and support)
- Data Security and Protection Toolkit
- Agency – ID checks (due to start April)

Counter Fraud

The regular report from the Local Counter Fraud Specialist was received. The Counter Fraud proactive programme for 2025/26 was approved.

External Audit

KPMG reported approach to the audit of the Trust and its subsidiaries for 2024/25 and on the approach to value for money.

3.
4.
5.

6. AREAS OF CONCERN OR FOLLOW UP

In addition to matters described in the Executive Summary, the Committee noted that earlier limited assurance reports in 2024/25 had been escalated to the Operational Leadership Team. These were:

- Frailty in Older People
- Capital Projects (Estates) Planning
- Deteriorating Patients – Paediatric (PEWS)

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

Internal audit Programme 2025/26
The Committee highlights the programme to all committees. Based on the Trust's risk profile, 20 internal audit days have been allocated to each of:

IT Third Party Supplier Management
Service Group Governance - Mental Health & Learning Disabilities
Overseas Medical Recruitment
Data Quality – ESR
Infection Prevention and Control
SHS - Quality & Performance
Key Financial Systems - Payroll
Mental Health Act Compliance
Application of Medical Terms and Conditions
Procurement Compliance - Provider Selection Regime & Procurement Act
Data Security & Protection Toolkit

8. BOARD ASSURANCE FRAMEWORK (BAF)

The committee was assured that the Q4 BAF reviews by committees had been completed satisfactorily.

The committee noted the following BAF risks scored at 20:

- Access to primary care / increasing ED demand (objective 2)
- Workforce shortages (objective 2)
- Age of acute and community estates (objective 2)
- Vacancy rates within senior doctor workforce (objective 6)
- Risk of EHR business case is not approved or delays to process (objective 8)

A summary of the Board Assurance Framework is set out below:

Quarter 4 2024/25

Ref	Executive Owner	Corporate Objective		Aspirational Measure	Overseeing Committee		Risk Appetite
1	MI	Improve the health and wellbeing of the population		Healthy life expectancy	Board	G	Seek 15-16
2	HP	Provide the best care and support to people		Colleague engagement	Quality & Governance Assurance Committee	R	Open 12
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
4	HP	Reduce inequalities		TBC	Quality & Governance Assurance Committee	G	Seek 15-16
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
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
7	PM	Live within our means and use our resources wisely		Underlying deficit - year on year reduction	Finance Committee	R A	Financial Management Open 12 Commercial Seek 15-16
8	DS	Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies		TBC	Board	R	Seek 15-16

Paul Mapson
CHAIRMAN OF THE AUDIT COMMITTEE