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

NHS Somerset NHS Foundation Trust

SOMERSET NHS FOUNDATION TRUST
PUBLIC BOARD MEETING

A Public meeting of the Somerset NHS Foundation Trust Board will be held on **Tuesday 4 July 2023** at **9.00am** in the Herridge Room at Wincanton Community Hospital, Dancing Lane, Wincanton BA9 9DQ

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

Yours sincerely

COLIN DRUMMOND
CHAIRMAN

AGENDA

		Action	Presenter	Time	Enclosure
1.	**Welcome and Apologies for Absence**		Chairman	09:00	Verbal
2.	**Questions from Members of the Public and Governors**		Chairman		Verbal
3.	**Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 9 May 2023**	Approve	Chairman		Enclosure A
4.	**Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 6 June 2023**	Approve	Chairman		Enclosure B
5.	**Action Logs and Matters Arising**	Review	Chairman		Enclosure C
6.	**Registers of Directors' Interests and Receive any Declarations of Interests relating to items on the Agenda**	Note and Receive	Chairman		Enclosure D
7.	**Chairman's Remarks**	Note	Chairman		Verbal
8.	**Chief Executive and Executive Directors' Report**	Receive	Peter Lewis	09:10	Enclosure E
ALL OBJECTIVES					

9.	**Board Assurance Framework and Q1 2023/24 Corporate Risk Register Report** • **Board Assurance Framework** • **Corporate Risk Register**	Receive	Phil Brice	09:20	Enclosure F1 Enclosure F2
OBJECTIVE 5 – Respond well to complex needs					
10.	**Patient Story - "Everything is 'fine' – a story of a man who loves spuds, tiddy's and potatoes"**	Receive	Rebecca Furzer	09:40	Presentation
OBJECTIVE 2 – Provide the best care and support to people					
11.	**Assurance Report of the Quality and Governance Assurance Committee meeting held on 24 May 2023**	Receive	Jan Hull	10:10	Enclosure G
OBJECTIVE 6 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture					
12.	**Assurance Report of the People Committee meeting held on 22 May 2023**	Receive	Kate Fallon	10:20	Enclosure H
13.	**Annual Fit and Proper Person Test Declaration**	Approve	Phil Brice	10:25	Enclosure I
Coffee Break 10:30 – 10:40					
OBJECTIVE 8 – To develop a high performing organisation delivering the vision of the Trust					
14.	**Quality and Performance Exception Report**	Receive	Pippa Moger	10:40	Enclosure J
15.	**Elective Care 2023/24 priorities – Board Declaration**	Receive	Andy Heron/ Xanthe Whittaker	10:50	Enclosure K
16.	**Merger Update**	Receive	David Shannon	11:05	Verbal
OBJECTIVE 7: To live within our means and use our resources wisely					
17.	**Verbal report from the Finance Committee meeting held on 26 June 2023**	Receive	Martyn Scrivens	11:15	Verbal
18.	**Finance Report**	Receive	Pippa Moger	11:20	Enclosure L

19.	**Assurance Report from the Charitable Funds Committee meeting held on 15 May 2023**	Receive	Barbara Gregory	11:30	Enclosure M
FOR INFORMATION					
20.	**Follow up questions from the Public and Governors**		Chairman	11:35	Verbal
21.	**Any other Business**		All		Verbal
22.	**Risks Identified**		All		Verbal
23.	**Evaluation of the Effectiveness of the Meeting**		Chairman		Verbal
24.	**Items to be discussed at the Confidential Board Meetings** The items presented to the Confidential Board include: the Part B Chief Executive report; the Colleague Suspension and Exclusion report; the Group Corporate Governance Framework; Follow up to the National Discharge Team visit held on 5 June 2032; and minutes of the Finance Committee meetings held in April and June 2023.				
25.	**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.				
26.	**Date of Next Meeting** Tuesday 5 September 2023			11:45	

PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 9 MAY 2023 IN THE EDUCATION SUITE, SOUTH PETHERTON COMMUNITY HOSPITAL, SOUTH PETHERTON

PRESENT

Colin Drummond	Chairman
Barbara Gregory	Non-Executive Director (via Teams)
Alexander Priest	Non-Executive Director
Martyn Scrivens	Non-Executive Director
Sube Banerjee	Non-Executive Director
Kate Fallon	Non-Executive Director
Jan Hull	Non-Executive Director
Graham Hughes	Non-Executive Director
Paul Mapson	Non-Executive Director
Peter Lewis	Chief Executive
Phil Brice	Director of Corporate Services
Pippa Moger	Chief Finance Officer
Andy Heron	Chief Operating Officer
Hayley Peters	Chief Nurse
Daniel Meron	Chief Medical Officer
David Shannon	Director of Strategy and Digital Development

IN ATTENDANCE

Fiona Reid	Director of Communications
Kirstie Lord	Deputy Director of People Services
Fiona Green	Lead Advanced Care Practitioner for Frailty and Hospital@Home (for item 10 only)
Sue	(for item 10 only)
Paul Foster	Consultant Urologist/Clinical Director (for item 12 only)
Harriet Jones	Head of Inclusion (for item 17 only)
Ria Zandvliet	Secretary to the Trust (minute taker)

No:	
1.	**WELCOME AND APOLOGIES FOR ABSENCE**
1.1	It was noted that apologies had been received from: Isobel Clements (Chief of People and Organisational Development).

1.2	The Chairman welcomed all Board members and attendees to the first post merger Board meeting and confirmed that the meeting was quorate.
2.	**QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS**
2.1	No questions from members of the public or governors had been received.
3.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 7 MARCH 2023**
3.1	Jan Hull proposed, Kate Fallon seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 7 March 2023 as a correct record.
	MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 20 MARCH 2023
3.2	Barbara Gregory proposed, Alexander Priest seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 20 March 2023 as a correct record.
4.	**MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 7 MARCH 2023**
4.1	Martyn Scrivens proposed, Graham Hughes seconded and the Board approved the minutes of the Yeovil District Hospital NHS Foundation Trust Public Board meeting held on 7 March 2023 as a correct record.
	MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION PUBLIC BOARD MEETING HELD ON 20 MARCH 2023
4.2	Graham Hughes proposed, Paul Mapson seconded and the Board approved the minutes of the Yeovil District Hospital NHS Foundation Trust Public Board meeting held on 20 March 2023 as a correct record.
5.	**TO REVIEW THE ACTION LOGS AND MATTERS ARISING**
5.1	The Board received the action log and noted the progress made and completed actions.
5.2	There were no matters arising.
6.	**TO NOTE THE REGISTERS OF DIRECTORS' INTERESTS AND RECEIVE ANY DECLARATIONS OF INTERESTS RELATING TO ITEMS ON THE AGENDA**
6.1	The Board received the Register of Directors' interest. There were no changes to the register.
6.2	There were no declarations in relation to any of the agenda items and all Board members will be eligible to vote on any of the agenda items.

7.	**CHAIRMEN'S REMARKS**
7.1	The Chairman highlighted the completion of the merger and advised that an update on progress made in relation to the day one corporate actions and the integration of clinical services had been included as a separate agenda item.
7.2	The Chairman thanked the executive team and all colleagues for their excellent work and achievements especially in view of the significant operational challenges.
7.3	The Chairman advised that, at a recent Board Development Day, the Board had agreed the need for the Board to focus, to a greater extent, on the future strategy and strategic issues and to discuss some of the papers presented to the Board in more detail at Committee level prior to them being presented to the Board. This change in process will enable a more detailed discussion at Committee level and avoid duplication.
7.4	The Chairman further provided an update on the recruitment of three Non-Executive Directors and advised that the candidate information pack had been circulated to all Board members for information. He advised that the aim will be to phase in the three appointments from later this year so that they will have time to settle in prior to the three current Non-Executive Directors leaving in May and August 2024.
8.	**CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT**
8.1	The Chief Executive presented the report which set out a number of significant and positive developments. The report was received by the Board.
8.2	The Chief Executive specifically highlighted the merger from 1 April 2023; the impact from the industrial actions; and the construction of the new breast cancer unit. He further advised that operational performance during April 2023 had improved compared to March 2023 but patient flow remained challenging.
8.3	The Board discussed the report and commented/noted that: • The Somerset Discharge to Assess service had been very successful in helping patients to regain their independence at home and the service was congratulated on their success. It was however recognised that the service experienced significant challenges due to the high number of delayed discharges. One of the most significant challenges was access to sufficient intermediate care capacity. • The international recruitment team was congratulated on their excellent work. • The number of patients with "no criteria to reside" had reduced slightly to below 200 patients in the acute hospitals and 70 to 80 patients in community hospitals. There were further a number of patients waiting in intermediate care beds for onward placements or care packages. The Chief Operating Officer advised that the national discharge management team will be visiting the trust in June 2023 as the Somerset system was seen as an outlier in terms of patient flow. It was queried whether the trust was confident that it

had taken all actions that it could have taken to discharge patients and engage with family and carers. The Chief Executive explained that 85% of acute hospital patients were discharged to their home without support on what is known as "pathway zero". The key challenge related to "pathway one" – discharge to a patient's home but with a support package. The Rapid Response service was set up to provide additional capacity within the community but capacity was a real challenge.

The Chief Operating Officer commented that discharge was not a "just in time" system and the discharge process covered the period between admission and discharge. It will not be possible to fully eliminate the number of patients with "no criteria to reside" but he was confident that the trust was robustly challenging itself on actions taken. Further actions were being taken in relation to acute home treatment but home care will continue to be key. The general home care market had recovered significantly and, as at the end of April 2023, only four patients were waiting for general home care. Specialised community home care however continued to have a significant shortfall in capacity.

The social care capacity issues had not been highlighted in national communications since the start of the winter and it was expected that this was due to affordability and the need to offset savings. It was therefore suggested that consideration should be given as to how many beds could be closed to enable investment in social care. The Chief Executive commented that such a discussion had taken place on a system basis, but the high number of patients with "no criteria to reside" had a financial impact on both the Council and the Trust. The current cost to the trust was £15 million in lost bed capacity and new innovative solutions will need to be identified. As well as bed capacity costs, consideration should also be given to the missed costs of opportunities that cannot be utilised due to the lost bed capacity. Other factors to be taken into account were: quality of care, productivity efficiencies etc and all these factors will be used to inform the operating model.

The suggestion for the NHS to transfer funds to the Local Authority for investment into bed based care and home care was discussed and it was suggested that a national settlement should not be awaited and that a Somerset settlement will need to be identified which will need to include a review of bed capacity.

The Board discussed the transfer of funding to the Local Authority in more detail and comments made included: the cost of looking after patients in an acute or community hospital was higher than the cost of bedded or home based care; patients were admitted to the wrong place for their needs due to supply issues; the cost of prolonged hospital stays extended beyond the system and also affected patients and their families/carers; patients who wanted to stay in or be discharged to their home did not have a choice due to the lack of home based care capacity; and Local Authority data on the number of patients in care settings or receiving home base care was not being shared. Overall, there was no or little support for transferring funding to the Local Authority and one of the main reasons was that a bed based system was not the most effective system for patients. In addition, the home care market had improved and was expected to continue to improve. The number of patients admitted to bed base care pre Covid was 3% compared to 8%

	post Covid and this should be the area of focus. It was agreed that a longer term strategy and a new model of care for the next ten years will be required.
8.4	Reference was made to the NHS Provider Licence section of the report which asked the Board to agree to statement 3a which indicated that the trust had a reasonable expectation that the trust 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. It was suggested that it might be difficult to declare compliance with statement 3a in view of the patient flow and bed capacity risks. Following a discussion, the Board agreed that it will still be appropriate to declare compliance with statement 3a as it was expected that required resources will be available.
8.5	Colin Drummond proposed, Barbara Gregory seconded and the Board approved compliance with statement 3a.
9.	**BOARD ASSURANCE FRAMEWORK AND Q4 2022/23 CORPORATE RISK REGISTER**
9.1	The Director of Corporate Services presented the report which was received by the Board. The Director of Corporate services advised that the final version of the 2022/23 Board Assurance Framework (BAF) had been presented to the April 2023 Board Development Day and the Board agreed to retain the same strategic objectives for 2023/24. The final version of the BAF had also been formally signed off by the relevant Board Committees.
9.2	The Director of Corporate Services highlighted the key risks on the BAF and Corporate Risk Register.
9.3	The Board discussed the report and commented/noted that: • Oversight of the BAF through the Board Committees was excellent and provided a clear governance structure. • The Corporate Risk Register (CRR) had been discussed in detail at the Quality and Governance planning meeting. The new format of the CRR and the linkage to service groups was welcomed. The new format enabled easier navigation between the risks and the Committee will continue to review all risks but will particularly focus on new risks on the CRR. • The BAF was discussed in detail at the April 2023 Audit Committee meeting and the Committee agreed that, although the BAF reflected progress and assurances and controls on an in-year basis, the strategic objectives were longer term objectives. The Committee further discussed the need for clarity about the level of information below BAF level and how assurance was fed back to the Committees and Board. In relation to the CRR, the Committee agreed that the new format was robust but that not all risks were actual risks as some reflected problems or issues. The Director of Corporate Services agreed to consider these comments. It was noted that, going forward, the risks will be linked to risk appetite and work to align the risks to the agreed risk appetite statements was already taking place. **Action: Director of Corporate Services.**

	• The risks were a mixture of risks which were in control of the trust and risks which were not in control of the trust. In relation to the latter risks, it will be important for the Board to be informed what the real issues were and the actions which were being taken. The Director of Corporate Services advised that these discussions took place at Committee level and feedback, including the risks to be escalated to the Board, will be included in the assurance reports to the Board. Where appropriate, further Board discussions on the escalated risks can be set up.
11.	**ASSURANCE REPORT OF THE QUALITY AND PERFORMANCE/ GOVERNANCE AND QUALITY ASSURANCE COMMITTEE MEETING HELD ON 29 MARCH 2023**
11.1	This item was brought forward on the agenda.
11.2	Jan Hull presented the report which was received by the Board. She highlighted the areas of assurance received and the areas to be reported to the Board. These areas related to: • The issues raised as part of the Learning Disabilities Services review. • The suspension of SFT Home Birth Services. • The preparation for Junior Doctor Industrial Action. • The development and submission of the Care Quality Commission Action Plan following the inspection of SFT. • The post merger Major Incident Plan documentation and assurance of day one actions.
11.3	The Board discussed the report and commented/noted that: • Medical physics and radiation protection – it was queried whether an-inhouse solution will be a better longer term solution. The Chief Medical Officer advised that this service had been provided in-house but, due to an unexpected event, an interim solution had to be put in place whilst a recruitment campaign was being carried out. The intention was to bring this service back inhouse.
10.	**PATIENT STORY AND CLINICAL TOPIC – "a year in the life of Mike – a story of one man's journey through healthcare and challenging the norm"**
10.1	Fiona Green, Lead Advanced Care Practitioner for Frailty and Hospital@Home, and Sue, Mike's daughter, joined the meeting for this agenda item.
10.2	Fiona Green set out the background to Mike's frequent hospital admissions, long hospital stays, and the challenges of a "traditional" healthcare approach which was one of admission to hospital as the only option. She further highlighted the issues faced by Mike and Sue, as his principal carer.
10.3	Sue provided an overview of the impact of the hospital admissions on her and the wider family. She advised that the discharge process had been difficult and stressful and had

	resulted in a financial impact on her and her family as no guidance had been provided on how to access resources and equipment to enable her dad to be discharged to his home and they had funded the necessary equipment themselves. Sue mentioned that she had felt lonely and vulnerable and, due to the frequent hospital admissions and difficulties, her dad had changed and she was grieving for the dad she felt she had lost. Sue advised that before Fiona and the team became involved, her dad remained in hospital longer than needed and his notes were not always correct which meant that Sue did not always feel listened to as the nursing team just looked at the notes. Sue felt that she did not have a voice and having to repeat herself several times was stressful and dismissive. An example was that her dad had been able to feed himself at home, and, although Sue had indicated this to the nursing team, her dad continued to be fed by nursing staff. The involvement of Fiona and her team had had a positive impact on Sue and her family as a team member was always available to explain what was happening and she did not need to repeat herself and "fight" health professionals. She was respected as the daughter who knew her dad and was shown compassion. The team also followed up referrals which had previously been rejected, and someone from the team was available 24/7 for advice. The team was person centred and build a report with Mike and Sue and due to their work, Mike stopped being clinically vulnerable which allowed Sue to keep working.
10.4	Sue concluded by stating that without Fiona and her team, her dad would have had to go into a nursing home or, in the worst case, may not have survived his hospital stays. She was concerned that other families may not be listened to either and this impacted on patient care in the community.
10.5	Fiona Green provided an overview of the achievements since 2022 and advised that Mike had become more independent with only three hospital admissions since March 2022. The admissions had totalled eight days and this was a significant improvement from the length of Mike's previous admissions. A video was shown which showed the significant improvements Mike had made in his ability walk and live more independently.
10.6	The Board discussed the story and commented/noted that: • Sue was thanked for sharing her story with the Board and her story had been moving and compassionate. Sue was asked to thank her dad for allowing his story to be heard. • The story highlighted the best and worse scenarios and showed the need to recommit to Triangle of Care and the Carers Charter and scale up support for carers. • The story clearly reflected the challenges in how Sue was previously treated and setting up new services with an old hospital based model of care was culturally challenging. The story reflected basic principles of listening to family and carers which should be applied in all services and these cultural issues will need to be addressed. Sue commented that the hardest thing for her was that her dad's medical notes were not always accurate and that nursing and clinical staff did not listen to her and accept that the notes were not accurate. She further highlighted that she felt consultants were not willing to listen to her whilst this could have

	reduced her dad's previous hospital stays. Fiona Green confirmed that consultant engagement had significantly improved over the last year. • The story highlighted the enormous amount of time and effort put in by carers, families and the community team to make the system work as it was intended to work. As well as a focus on Triangle of Care there will also need to be a focus on the quality of care. It was queried why there had been a resistance to listening to the family and the community team and what changes Fiona suggested would help the system to function better. Fiona Green commented that there was now a two way line of communication with consultants, but previously there had been a lack of understanding about the clinical skills in community and specialist teams and the complex work taking place in community settings as well as a lack of recognition that these skills extended beyond hospital settings. Fiona Green further advised that the discharge process had improved and the community team was able to fully manage the discharge process. The link with carers in general could be further improved. • It was queried how Mike had come to the attention of the community team. Fiona Green advised that Mike had been highlighted as part of a daily multidisciplinary team call due to concerns by the rehabilitation team about Mike's care. Fiona was now the Lead Advanced Care Practitioner in the East and West of the county and the focus of the team was on joining up clinical services, including primary care services. The team had been able to make significant improvements but this required the right resources. • Kindness, respect and teamwork for everyone, everyday were the values of the organisation and, as evidenced by Mike and Sue's experiences, these aspirations have not always been met. This was disappointing and it was felt that the Board should take a leadership role and keep asking questions to ensure that the aspirations are met.
10.7	The Chief Medical Officer, on behalf of the Board, thanked Sue for sharing her story and offered his apologies to Sue and her dad about their difficult journey. He further thanked Fiona Green and the team for their excellent work and person centred care.
12.	**LEARNING FROM DEATHS FRAMEWORK: MORTALITY PROGRESS REPORTS**
12.1	Paul Foster joined the meeting for this agenda item.
12.2	The Chief Medical Officer advised that, in line with previous discussions, the reports will in future be discussed in detail at the Quality and Governance Committee meeting and shared with the Board with key issues highlighted.
12.3	**YDH** Paul Foster presented the report which demonstrated the processes for learning from deaths and how this learning was shared and improvements made within the former YDH.
12.4	Paul Foster advised that work had taken place over the last six months to align reporting across both acute hospitals and a single report will be presented to the Board from Q1

	onwards. It was noted that work was also taking place to align the 72 Hour Rapid Review Groups and Mortality Review Groups.
	SFT
12.5	Paul Foster presented the report which demonstrated the processes for learning from deaths and how this learning was shared and improvements made within the former SFT.
12.6	The Board received the reports covering YDH and SFT and the issues identified as part of the investigations; the lessons learned, areas of improvement and actions taken were noted.
12.7	The Board discussed the reports and commented/noted that: • The level of alignment was encouraging. • The reports will be discussed at the Quality and Governance Committee meeting and it was queried whether further information on the unexpected deaths on the "ready-to-go" wards can be presented to the meeting. Paul Foster advised that this will be covered as part of the deep dive into the issues raised in the reports but all unexpected deaths due to delays in discharge will need to be reviewed. • The serious incident review mentioned specifically in the report had taken a long time and it was queried whether this delay had been appropriate and whether it enabled learning to be implemented in a timely way. Paul Foster advised that learning from an incident was not only identified as part of the serious incident review but also as part of the "72 hour" rapid review and other processes. The serious incident review took a long time as it required input from a number of colleagues. The Chief Nurse commented that the need for input by colleagues was recognised but it was also important to manage the expectations of families waiting for a copy of the report, who may not understand the reasons for the time taken to produce a report. The Chief Medical Officer commented that the RCA methodology was used for the serious incident reviews but this methodology was never intended to be used for this purpose and was more intended for major incidents. The use of the RCA methodology had expanded over the years but was not the best tool for serious incidents. • The reason for the high HMSR at Musgrove Park Hospital was well understood and was due to the coding of palliative services.
12.8	Paul Foster left the meeting.
13.	**ASSURANCE REPORT OF THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON 14 MARCH 2023**
13.1	Alexander Priest, Chair of the Mental Health Act Committee, presented the report which was received by the Board.

13.2	Alexander Priest highlighted the areas of concern and follow up and particularly highlighted the Care Quality Commission's report from the Ash Ward compliance visit. The report had been very positive with positive feedback from carers and other stakeholders. Three areas for action had been identified and the implementation of these actions will be monitored by the Committee.
13.3	The Committee did not identify any specific issues or risks to be reported to the Board and/or Board Committees
14.	**ASSURANCE REPORT OF THE PEOPLE AND WORKFORCE COMMITTEE MEETINGS HELD ON 8 MARCH 2023**
14.1	Graham Hughes presented the report which was received by the Board. He advised that one area for follow up had been identified and this related to a national article covering the findings from a recent tribunal about racist discrimination through all internal processes of an organisation. Although the article did not relate to the trust, it did provide an opportunity for colleagues and the trust to reflect whether the same could happen in the trust.
14.2	No issues have been identified to be followed up by other Committees or to be reported to the Board.
14.3	The Committees were able to provide the Board with assurance that the items discussed at the meeting provided significant assurance in relation to addressing gaps in controls and assurances for objective six of the Board Assurance Framework.
15.	**GUARDIAN OF SAFE WORKING FOR POSTGRADUATE DOCTORS REPORTS**
15.1	The Chief Medical Officer presented the reports for YDH and SFT which were received by the Board. It was noted that, in line with previous discussions, the reports will in future be discussed in detail at the People Committee meeting and shared with the Board with key issues highlighted.
15.2	The Board discussed the report and commented/noted that: • The report provided evidence that the working hours for trainee doctors remained safe and that the process was working well. • An immediate safety concern had been raised due to junior doctors feeling unsafe in their practice due to an increased volume of work during the absence of a middle grade orthogeriatrician and it was queried whether support arrangements were in place. The Chief Medical Officer reassured the Board that all practitioners and junior doctors were supervised and worked within their competencies. The concern had been raised as part of an exception report and remedial actions had been taken. • It was queried whether concerns relating to rota gaps should not be raised directly with the relevant consultant. The Chief Medical Officer commented that concerns about rota gaps fell within the remit of exception reporting and it was helpful for the Board to see this information as sometimes structural remedies and financial investment may be required.

	• Rota management was a recurring theme and it was queried what actions were being taken. The Chief Medical Officer advised that a digital rota management system had been identified and this system was supported by clinicians. The system will be rolled out across the trust in a phased approach. The Chief Operating Officer highlighted the lack of flexibility of the current rota management system relating to provisions for maternity leave and sickness and advised that Janet Fallon had been invited to an operational team's meeting to discuss this in more detail. • Discussions about increasing the substantive workforce were taking place with the medical directorate and this was also part of the workforce planning process. • The focus on over-recruiting nurses to some of the wards to reduce agency spend had worked well and the same approach could also be considered for medical colleagues. It was suggested further discussing the people and finance elements at future People and Finance Committee meetings.
15.3	The Board accepted the recommendations as set out in the reports.
16.	**SIX-MONTHLY WELLBEING GUARDIAN REPORT**
16.1	Graham Hughes, Non-Executive Director Wellbeing Guardian lead, presented the report which was received by the Board.
16.2	Graham Hughes particularly highlighted: the excellent findings of the internal audit for health and wellbeing across both SFT and YDH; the work with the inclusion team to understand the experiences of diverse staff groups around wellbeing provision; the work of the Colleague Support service and the agreement of funding of the service to at least March 2024; the challenges – finding adequate rest spaces in bases and cost of living pressures; the future work.
16.3	The Chairman thanked Graham Hughes for his contributions to the wellbeing work and the focus on the health and wellbeing of colleagues.
17.	**SIX MONTHLY INCLUSION REPORT**
17.1	Harriet Jones (Head of Inclusion) joined the meeting (by Teams) for this agenda item.
17.2	Harriet Jones presented the report which set out progress against the strategic priorities for the inclusion team, as well as an overview of progress in implementing the inclusion roadmap The report was received by the Board.
17.3	Harriet Jones particularly highlighted: • The work with members of the executive team to identify personal inclusion priorities and objectives for the next 12 months.

	• The collaboration with the organisational development and leadership team to deliver inclusive leadership and allyship content to over 400 people art several senior leadership away days. • The focus on tailored development and up-skilling for colleagues across people services to increase capacity to support the organisation implement inclusive practice through local people plans, training delivery, and HR advice.
17.4	The Board discussed the report and commented/noted that: • The report clearly showed the excellent work taking place and Harriet Jones and the team were complimented on the progress made. • It was queried whether the allyship training for the senior leadership team will also be suitable for Non-Executive Directors. Harriet Jones commented that consideration could be given as to whether or not the allyship programme can be a stand alone programme and delivered to the Non-Executive Directors or whether a new programme will need to be developed specifically for Non-Executive Directors. Harriet Jones agreed to consider how best to deliver training to the Non-Executive Directors. **Action: Harriet Jones.** • A recent disability confident internal audit had been conducted and it was queried how the recommendations will be implemented and monitored. Harriet Jones advised that a Task and Finish Group has been set up to develop a detailed action plan and to monitor the implementation of the actions. • The progress made by the networks was excellent. • The front cover of the Board reports referred to equality and diversity and required confirmation whether an assessment had been carried out. For the majority of the reports an assessment had not been carried out and equality and diversity should be considered when writing a report. A formal Equality Impact Assessment should be carried out for each strategy, strategic service development and business case presented to the Board. The reasons for the equality and diversity section of the front cover of Board reports may not be understood by all relevant colleagues and it may be helpful to raise awareness. • Kirstie Lord commented that Harriet Jones was reviewing the Equality Impact Assessment as the current form was no longer fit for purpose. She advised that equality and diversity should be considered at the start of the development of a strategy and it was also important for executive directors to consider how they can drive inclusion forward and how to create a more lively approach to inclusion.
17.5	The Board thanked Harriet Jones for her excellent work.
17.6	Harriet Jones left the meeting.

18.	**QUALITY AND PERFORMANCE REPORTS** **Group Board Overview Quadrant – YDH** **Quality and Performance Report – SFT**
18.1	The Chief Finance Officer presented the reports which were received by the Board. She provided an overview of the key performance challenges across both trusts which covered: acute referral to treatment (RTT) times; diagnostics; cancer services; urgent care – A&E 4 hour performance; ambulance handover times; community physical health services waiting times and activity; mental health waiting times and activity; mental health talking therapies; children and young people's eating disorders; out of area placements; infection control; slips, trips and falls; mandatory training; sickness absence; turnover rates; career conversations.
18.2	The Board discussed the report and commented/noted: • The ongoing recovery of elective activity, especially in relation to 104 and 78 week waiters. • The improvements in diagnostic and cancer waiting times performance. • The improvement in mental health waiting times performance was excellent, especially in view of the increase in activity. Caution was however expressed that the service was still under significant pressure as demand continued to increase. • 2023/24 will be the last year of the mental health investment standard and no confirmation had as yet been received as to mental health investment from 2024/25 onwards. • Although improvements had been made in some areas, overall cancer waiting times performance continued to be an area of concern due to some capacity issues. The improvement in diagnostic performance will support cancer waiting times performance as diagnostics was the first step of the cancer pathway.
18.3	The Board acknowledged the areas of good performance and recognised the challenges and the actions being taken to address them.
19.	**MERGER UPDATE**
19.1	The Director of Strategy and Digital Development presented the merger update report and NHS England action plan, which were received by the Board.
19.2	The Board discussed the report and commented/noted that: • The key day one actions had been completed on 1 April 2023 and the strong day one actions and the actions identified as part of the merger plan were on track for delivery as per the milestones as set out in the Post Transaction Integration Plan. • Ongoing operational challenges, including the recent industrial action, had hindered the ability for clinical teams to come together and plan the integration of their

	services over the past few months. A full detailed update on the clinical integration programme as at the end of Q1 will be provided to the July 2023 Board meeting. • A serious IT related incident recently took place resulting in IT systems in Bridgwater being incapacitated for a 12 hour period. The incident was outside of the control of the trust, but concerns were expressed about the dependency on one N3 internet line for critical services. The Director of Strategy and Digital Development commented that continuity plans were put in place and learning in relation to where the plans could be further strengthened had been identified. The digital resilience plans will also support the continuity plans. • Good progress had been made in relation to the directorate and service group structures but integration work was still ongoing in some services.
20.	**VERBAL REPORT FROM THE FINANCE COMMITTEE MEETING HELD ON 24 APRIL 2023**
20.1	Kate Fallon, Chairman of the Committee, provided feedback from the meeting held on 24 April 2023 and advised that the end of year financial positions for both trusts were excellent in spite of the significant operational challenges.
20.2	She highlighted that the 2023/24 operational plan will be challenging to achieve especially in view of the significant agency costs. Discussions about how to manage agency demand and the process for Committee oversight were taking place.
20.3	Kate Fallon further highlighted the ambitious cost improvement requirements for 2023/24 and it was noted that the executive team were actively looking at opportunities for cash releasing savings.
20.4	The Chairman advised that, going forward, the Finance Committee will be chaired by Martyn Scrivens and thanked Kate Fallon for her leadership of the Committee over the last few years.
21.	**ASSURANCE REPORT OF THE AUDIT COMMITTEEE MEETING HELD ON 13 APRIL 2023**
21.1	Barbara Gregory presented the report which was received by the Board. Barbara Gregory highlighted the assurances received and the areas of concern or follow up. The committee did not identify any specific risks to be reported to the Board.
21.2	The Board discussed the report and commented/noted that: • Agency invoicing control - not every agency invoice was being checked in terms of rates charged due to resource issues and this was felt to be a weakness in control. The Chief Finance Officer advised that a new invoice checking process was being piloted in the mental health service group and, if successful, the pilot will be rolled out to all service groups. Kirstie Lord commented that the control issue had arisen due to a confusion about the role of the people service and managers but the change in working practices will strengthen the controls.

	Concern was expressed that this basic control was not in place and it was queried whether this could be part of a systemic control weakness. The Chief Finance Officer advised that there was a difference between checking shifts worked and the right rate being charged and the control issue related to the latter as shifts worked were checked. The new invoicing checking system was aimed at carrying out checks centrally. The Chief Finance Officer assured the Board that the control issue was not part of a systemic control weakness. Paul Mapson advised that central oversight will be the best option and this approach was supported by the Audit Committee. Progress will be monitored by the Audit Committee.
21.3	The Committee was able to provide the Board with assurance that the items discussed at the meeting provide significant assurance in relation to addressing gaps in controls and assurances for objective six of the Board Assurance Framework.
22.	**FINANCE REPORTS** **YDH/SFT**
22.1	The Chief Finance Officer presented the financial reports which were received by the Board. She particularly highlighted: • The significant impairments for both YDH and SFT due to the annual valuation undertaken by the valuers across land, buildings and dwellings. Although the impairments were classified as an operating expenditure, this expenditure was removed for the purpose of the overall financial performance. • The delivery of the forecast break even positions for both YDH and SFT. • The delivery of the full cost improvement programme for YDH and the delivery of a £13.330million cost improvement plan against an end of year plan of £14.181 million for SFT.
22.2	The Board congratulated the Chief Finance Officer and the wider executive team on the achievement of the forecast end of year financial position for both YDH and SFT, especially in view of the many challenges faced during the 2022/23 financial year.
23.	**GOING CONCERN STATEMENT**
23.1	The Chief Finance Officer presented the report which was received by the Board. It was noted that the single statement as proposed in the report will apply to both the Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust accounts.
23.2	The Board discussed the report and agreed that the cash flow statement for the next 12 months did not highlight any concerns.
23.3	Barbara Gregory proposed, Kate Fallon seconded and the Board approved the application of "Going Concern" for the Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust accounts for 2022/23.

24.	**2023/24 REVENUE BUDGET**
24.1	The Chief Finance Officer presented the report which was received by the Board. The Chief Finance Officer advised that the Board had delegated authority to approve the final version of the 2023/24 annual plan to the Finance Committee and the plan was approved at the March 2023 Committee meeting and submitted to NHS England on 30 March 2023.
24.2	The Chief Finance Officer highlighted the cost improvement programme; the breakdown by service group; and the discussions taking place with the service groups. One of the key challenges will be achieving the agency cap and progress will be included in the monthly finance reports and discussed at the monthly service group finance and performance meetings.
24.3	The Board discussed the report and commented/noted: • It was queried whether the agency savings for medical staff were realistic. The Chief Finance Officer advised that the submitted plan for 2023/24 was compliant with the agency cap, but in view of the high agency expenditure in 2022/23, the cap may be difficult to achieve. It was noted that a new system for onboarding agency doctors had been put in place and this system enabled a reduction in medical agency costs due to a change in tax treatment. In addition, options for international recruitment for different specialties were being explored. The Chief Medical Officer advised that processes for medical agency staff had been aligned across the trust and vacancies and the use of medical agency staff were discussed at the monthly service group meetings. It was felt that there was more visibility about the use of medical agency staff and this enabled closer monitoring. The Chief Medical Officer assured the Board that every possible action will be taken to achieve the agency cap. He added that the challenge did not just relate to recruiting new doctors but also related to the reshaping of the bed base post pandemic and the reshaping of the clinical workforce. It was queried whether medical staff were in agreement with the financial analysis of how much agency usage related to vacancies and escalation beds and whether they were aware of the financial implications of the different reasons for using agency staff. The Chief Medical Officer advised that the Medical Leadership Group was aware of the financial implications. • The cost improvement programme will be challenging to achieve and, in view of the high number of non recurrent schemes in previous years, it was queried whether the target will be achievable. The Chief Finance Officer advised that some of the service groups had made good progress identifying cost improvement schemes and discussions with other service groups were still taking place. She was as confident as she could be that the overall target will be achieved but the key question will be how many of the schemes will be recurrent and non recurrent. The target was that 75+% of new schemes should be recurrent and it was encouraging that more recurrent schemes were being identified.
24.4	Jan Hull proposed, Kate Fallon seconded and the Board approved the 2023/24 annual revenue budget as set out in the report.

25.	**FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS**
25.1	Ian Hawkins, Lead Governor, commented that it was reassuring to see the reaction of the Board members to the patient story and to hear the compassion. He felt that the meeting had been very productive with excellent discussions.
26.	**ANY OTHER BUSINESS**
26.1	There was no other business.
27.	**RISKS IDENTIFIED**
27.1	The Board identified risks in relation to: the delivery of the 2023/24 financial plan; the discharge arrangements and the carers support as outlined in the patient story; overall cancer and RTT performance; and agency invoicing controls.
28.	**EVALUATION OF THE EFFECTIVENESS OF THE MEETING**
28.1	The Board agreed that the meeting had been very effective with a wide range of topics covered. The patient story had been excellent but consideration should be given as to how to manage patient stories as today's patient story had raised a number of issues which required more detailed discussion and this was difficult to do in a public Board setting with limited time available for a detailed discussion. It was noted that there was a follow up discussion on Hospital@Home in the development session after the Board meeting which would allow for that further review.
28.2	It will be helpful for the sequencing between papers to be presented to a Committee and the Board to be closer aligned so that all papers to be presented to a Committee had been discussed by the Committee prior to them being presented to the Board.
29.	**ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING**
29.1	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.
30.	**WITHDRAWAL OF PRESS AND PUBLIC**
30.1	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.
31.	**DATE FOR NEXT MEETING**
31.1	4 July 2023

PUBLIC BOARD MEETING

MINUTES OF THE EXTRA ORDINARY SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 6 JUNE 2023 IN THE BOARDROOM AT YEOVIL DISTRICT HOSPITAL, YEOVIL

Present:

Colin Drummond	Chairman
Barbara Gregory	Non-Executive Director (via Teams)
Alexander Priest	Non-Executive Director
Martyn Scrivens	Non-Executive Director
Sube Banerjee	Non-Executive Director
Kate Fallon	Non-Executive Director
Jan Hull	Non-Executive Director
Graham Hughes	Non-Executive Director
Paul Mapson	Non-Executive Director
Peter Lewis	Chief Executive
Phil Brice	Director of Corporate Services
Pippa Moger	Chief Finance Officer
Andy Heron	Chief Operating Officer
Hayley Peters	Chief Nurse
Daniel Meron	Chief Medical Officer
David Shannon	Director of Strategy and Digital Development
Isobel Clements	Chief of People and Organisational Development

In Attendance

Ben Edgar-Attwell	Deputy Director of Corporate Services
David Craig	Directorate Manager
Ria Zandvliet	Secretary to the Trust (minute taker)

No:	
1.	**WELCOME AND APOLOGIES**
1.1	The Chairman confirmed that there were no apologies and that the meeting was quorate.
2.	**DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA**
2.1	There were no declarations of interest relating to items on the agenda.
3.	**ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING**
3.1	The Chairman advised that the focus of the Confidential Board meeting will be on the approval of the service contract for the Diagnostic Services Provider at the Yeovil

	Diagnostic Centre. The Chairman set out the reason for including this item on the Confidential Board agenda.
4.	**WITHDRAWAL OF PRESS AND PUBLIC**
4.1	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.
5.	**ANY OTHER BUSINESS**
5.1	There was no other business.
6.	**DATE OF NEXT MEETING**
6.1	4 July 2023

SOMERSET NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETINGS HELD ON 9 MAY 2023

AGENDA ITEM	ACTION	BY WHOM	DUE DATE	PROGRESS
9. Board Assurance Framework and Corporate Risk Register	To consider the comments from the Audit Committee in relation to the longer term nature of the strategic objectives and the description and nature of risks.	Phil Brice	July 2023	The comments have been taken into account in the development of the 2023/24 Board Assurance Framework (BAF). The revised BAF is included on the agenda.
17. Six Monthly Inclusion Report	To consider specific allyship training for Non-Executive Directors.	Harriet Jones	September 2023	Feedback on progress made will be reported to a future Board meeting.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Registers of Directors' Interests
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Chairman
DATE:	4 July 2023

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 27 June 2023.
Recommendation	The Board is asked to: • note the Register of Interests; • declare any changes to the Register of Interests; • declare any conflict of interests in relation to the agenda items.

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

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

Equality 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 not been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
☐ 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)
N/A

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

EXECUTIVE DIRECTORS	
Peter Lewis Chief Executive (CEO)	• Member of the NHS Confederation Community Network Board • Management Board Member, Yeovil Strategic Estates (YEP) Partner Board • Director, YEP Project Co. Limited
Phil Brice Director of Corporate Services	• Sister works for the Trust • Non-Executive Director of the Shepton Mallet Health Partnership • Non-Executive Director of SSL
Isobel Clements Chief of People and Organisational Development	None to declare
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 YEP Project Co Limited • Member of the Southwest Pathology Services (SPS) Board • Non-Executive 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 on a temporary contract within the recruitment department. • Director of YEP Project Co Limited • Director Predictive Health Intelligence Ltd
Daniel Meron Chief Medical Officer	None to declare

Somerset NHS Foundation Trust Non-Executive Directors	
Colin Drummond Chairman	• Honorary Vice President of Calvert Trust Exmoor (outdoor holidays for people with disabilities) – current • President of Wadham College Oxford 1610 Society • Deputy Lieutenant for Somerset • Worshipful Company of Water Conservators – Master
Jan Hull Non-Executive Director (Deputy Chairman)	• Trustee of the Dulverton Abbeyfield Society. • Formerly Managing Director of South, Central and West Commissioning Support Unit
Dr Kate Fallon Non-Executive Director (Senior Independent Director)	• Daughter is a Consultant at the Trust • Symphony Health Services Board member • Daughter has been appointed as the Guardian of Safe Working Hours for Junior Doctors • Non-Executive Director Symphony Health Services
Barbara Gregory Non-Executive Director	• RESEC Research into Elderly and Specialist Care Trustee. • Deloitte Associate – with effect from 6 February 2018. • Chair of the CNL (Chairs, Non Executive and Lay members) Faculty of HFMA • Director of AGRF

Alexander Priest Non-Executive Director	• Chief Executive Mind in Somerset
Sube Banerjee Non-Executive Director	• Executive Dean, Faculty of Health, University of Plymouth • Hon Consultant in Psychiatry, Plymouth University Hospitals NHS Trust (unremunerated) • Visiting Professor, Brighton and Sussex Medical School (unremunerated) • Trustee and Patron, Alzheimer's Society (unremunerated) • Editor-in-chief, The International Journal of Geriatric Psychiatry • Director Cognitive Agility Ltd (personal consulting to governments and industry) • Association Member BUPA (unremunerated) • Trustee and Executive Board Member Medical Schools Council (unremunerated) • Board member University of Plymouth Enterprise Limited (unremunerated)
Martyn Scrivens Non-Executive Director	• Non Executive Director and Chair of Audit Committee of Hampshire Trust Bank Limited • Wife works as a Bank Vaccinator for the Trust • Non-Executive Director and Chairman of Wesleyan Bank Limited, a 100% subsidiary of Hampshire Trust Bank Limited" (with effect from 28 February 2022) ▪ Member of the Boards of Directors of the Ardonagh Group – consisting of the following companies: – Ardonagh Holdco Limited (Jersey) – Ardonagh New Midco 1 Limited (Jersey) – Ardonagh Group Holdings Limited (UK) – Ardonagh New Midco 3 Limited (Jersey) – Ardonagh Midco 1 Limited (Jersey) – Ardonagh Midco 2 plc (UK) – Ardonagh Midco 3 plc (UK) – Ardonagh Finco plc (UK)
Graham Hughes Non-Executive Director	• Chairman of Simply Serve Limited • Parish Councillor of Babcary Parish Council
Paul Mapson Non-Executive Director	• Advisor to Swansea Bay University Health Board • Advisor to NHS Devon Health System

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Chief Executive/Executive Director Report
SPONSORING EXEC:	Chief Executive
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Chief Executive
DATE:	4 July 2023

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

Executive Summary and Reason for presentation to Committee/Board	The purpose of the report is to update the Board on the activities of the executive and senior leadership team and/or points of note which are not covered in the standing business and performance reports, including media coverage. The report covers the period May and June 2023.
Recommendation	The Board is asked to note the report.

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

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

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

Equality
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 not been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
☐ 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)
The report includes references to colleagues.

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. NHS OVERSIGHT FRAMEWORK QUARTER 4 – 2022/23 SEGMENTATION REVIEW OUTCOMES

1.1. We received the outcome of NHS England's quarterly segmentation reviews of both our legacy trusts as part of the NHS Oversight Framework. The aim is to identify where NHS providers may benefit from, or require, support to improve performance and quality of care outcomes for patients.

1.2. During May 2023, NHS England and NHS Somerset undertook a detailed Quarter 4 review against the six themes in the framework, with the findings and recommendations being presented to NHS England Regional Support Group (RSG). The RSG agreed that the segment 2 assessment levels for both our legacy trusts remain in place for Quarter 4 2022/23. Our letters from NHS England note that:

- Overall, both trusts demonstrated sustained improvements in elective care and a positive position across all six themes, with most metrics rated individual segment 2 or 1.

- For YDH, there was a single individual segment 3 flagged, that was identified through the staff survey and related to the proportion of staff in senior leadership roles who are from a) a BME background or b) are women. We are looking closely at the overall position as a merged trust.

- The ICB, with support from NHS England, will continue to work with us to clarify next steps to potentially move our merged trust to segment 1.

2. NEW HOSPITAL PROGRAMME (NHP)

2.1. A team from the national NHP visited Musgrove Park Hospital on 11 May 2023 to find out more about our plans that include replacing our maternity unit and children's ward. The team had a walk around our site and an in-depth discussion with our programme team and spoke to clinicians working within our services. It was a very positive visit, with the NHP team keen to understand our plans and clearly understanding our need to replace these very outdated and not fit for purpose facilities.

2.2. The Secretary of State for Health and Social Care, Steve Barclay, announced at the end of May 2023 that five hospitals constructed mostly using reinforced autoclaved aerated concrete (RAAC) will be rebuilt by 2030 as part of the New Hospital Programme. As part of the announcement, he confirmed that the

national programme is now expected to be backed by over £20 billion of investment in hospital infrastructure.

2.3. In his address to Parliament, the Secretary of State, said that four hospitals in cohort 4, including Musgrove Park Hospital in Taunton, remain on track for completion by 2030.

3. UPDATE ON FUTURE CONFIGURATION OF STROKE SERVICES IN SOMERSET

3.1. NHS Somerset held a 12-week consultation on the future configuration of stroke services in Somerset that began on 30 January 2023 and closed on 24 April 2023. The Quicksilver Community Group handed over to a meeting of the Full Somerset Council on 24 May 2023, a petition, with over 5,000 signatures, calling for a stop to the closure of Yeovil Hospital's hyperacute and acute stroke services. The consultation process to date was then discussed at a meeting of the Scrutiny Committee for Adults and Health on 31 May 2023. That meeting agreed to set up an extraordinary meeting in September 2023 to review the consultation feedback and discuss the issues further. A date has not yet been set.

4. UPDATE ON INDUSTRIAL ACTION

4.1. The BMA announced on 23 June 2023 that a fourth round of industrial action is now planned for junior doctors across England. A five-day walkout is planned to take place between 7am on Thursday 13 July to 7am on Tuesday 18 July.

4.2. Our service groups and colleagues from corporate services will be regularly meeting during this period to monitor the impact on our clinical services and will submit regular returns to monitor the impact of the strike at a county, regional and national level.

Ballots for future industrial action

4.3. We are waiting to hear the outcome of a number of ballots to understand the potential impact of future industrial action, including The Royal College of Nursing (RCN), The British Medical Association (BMA Consultant members), Hospital Consultants and Specialists Association (HCSA), and The Society of Radiographers (SoR).

4.4. In addition, The British Medical Association have notified us that they are re-balloting junior doctors to understand their views on taking future industrial action. Ballots will close on 31 August 2023. If industrial action is voted for, this is expected to take place during the period 14 September 2023 to 28 February 2024.

5. PUBLICATION OF MONTHLY PERFORMANCE DATA

5.1. NHS England (NHSE) published its regular monthly performance statistics including waits for planned care, urgent community response data and community health service waiting lists.

5.2. NHSE's press release highlights a drop in the number of people waiting more than 18 months, improvements in ambulance response times, reductions in the 62-day cancer backlog, and progress on the NHS Elective Recovery Plan's target to virtually eliminate those waiting 18-months or more for elective treatment by April.

5.3. NHS Providers' response is here.

Our position with regard to patients who have waited longer than 78 weeks

5.4. Together, our legacy trusts, Somerset FT and YDH, started 2022/23 with a combined number of 541 patients waiting over 78-weeks for referral to treatment (RTT), but over the year we reduced this down to 68 patients at the end of March 2023. The trusts' year-end position for 78-week waiters meant we were the third best system within the south west.

5.5. This combined position was significantly better than our agreed trajectory of 300 for year-end, and even the stretch trajectory of 146 patients breaching the 78-week standard. This involved treating a cohort of just under 12,000 patients across the year, in addition to clinically prioritised patients needing urgent or cancer treatment.

5.6. The key challenge in 2023/24 is to treat all the remaining 78-week waiters by the end of June 2023, which will be very difficult with the activity lost due to industrial action and the recent Bank Holidays, and to then achieve a maximum wait of 65 weeks by March 2024; the latter will involve treating just over 15,500 more patients across the year than we treated in 2022/23.

6. LEARNING DISABILITY WEEK

6.1. The week of 19-25 June 2023 was Learning Disability week and Hayley Peters, our chief nurse, shared the announcement of three new developments that will help to improve the care for people with learning disabilities.

Across the trust you'll be able to see these new initiatives:

- We are introducing a brand new role into the LD specialist service that will help to ensure that people with a learning disability get the same level of access to cancer care as everyone else – something that traditionally has not been the case across the country.

- Oliver McGowan training - for the first time ever, we have introduced an e-learning module with a focus on learning disabilities that must be completed by every colleague at the trust.

- Following on from Lily, our learning disabilities volunteer at Musgrove Park, and her 'Word of the Week', we have brought all the words together onto a single poster that has QR codes to short clips of Lily and specialist nurse Louise Atkinson using Makaton to sign useful words – this will be displayed across our sites.

7. ADVANCE CARE PLANNING WEEK

7.1. Whether someone at end of life has had time to prepare, or if it has come all of a sudden, the main thing everyone wishes for is that their loved one has their wishes met and can die comfortably and at peace. As healthcare professionals we know that this cannot always be the case, but more often than not, we get the chance to ensure that someone is cared for in the way they would want through advance care planning.

7.2. Advance care planning (ACP) gives people a chance to think about, talk about, record, and share their priorities and wishes. This can be done at any age or stage of health, and can take different forms:

- For health and medical treatment decisions
- For after death
- Decision making for when you are unable
- For future care wishes.

7.3. Our unique end of life care service in Somerset spans multiple healthcare and voluntary organisations, and as such, it hosts its own unique Advance Care Planning Week, taking place this year from 26 to 30 June.

7.4. The aim of the week is to raise further awareness of advance care planning, and why it's so important that we all get it right. Our Somerset advance care planning lead and end of life care practice facilitator, Amy Giles, explains: "We started out as a specialist end of life care education team, set up in response to the pandemic, with the aim to collate all information and learning resources on end of life and palliative care into one place.

7.5. "We launched the Somerset End of Life Care and Bereavement Support website last year, which is a unique hub for all healthcare professionals and members of the public on end of life care, and have been growing the team to expand our remit. There are now five of us, all spanning different specialists from a paramedic to an occupational therapist, and we also have Gemma, our treatment escalation plan (TEP) lead.

7.6. "Advance care planning can give a patient a voice, even if they can't speak for themselves anymore. It helps family members to understand what their

loved one actually wanted from their care and after their death, and in turn that helps us as professionals, to deliver the wishes of the patient."

7.7. As part of the awareness raising throughout the week, Amy is using her own personal experience and reflections to encourage others to start thinking about their care at end of life.

8. FIRST SENIOR LEADERSHIP FORUM

8.1. During May 2023, over 70 of the senior leaders across our trust met for our first senior leadership forum. It was an incredibly valuable session which enabled leaders from all parts of our diverse trust to come together for a full day to discuss the challenges we face and the opportunities we have as a unique, merged trust. We explored both "what" we want to do and "how" we want to do it. This forum will form a regular part of our meeting structure.

We considered and discussed:

- The context in which we provide services. This includes the growing elderly population, differences in life and healthy life expectancy, the expected continued demand for NHS services and the wider determinants of health and how as a merged trust we could work differently.

- Our Acute Home Treatment Service, and the huge opportunity that it brings. This was followed by a presentation on our Mental Health Home Treatment service and a very lively discussion about what lessons this could provide for our physical health services.

- Inclusive leadership and creating the right environment for all colleagues and our trust to thrive.

9. CELEBRATING OUR COLLEAGUES

9.1. On 12 May 2023, we celebrated the thousands of nursing colleagues in Somerset, who work in a range of services – caring for our patients from the beginning to end of life. This year's theme is 'making a difference' and we asked our colleagues to share and reflect on the ways they make a difference, every day.

9.2. Teams from across our trust, including wards at our acute hospitals, our mental health units, community hospitals and services in the county and beyond, have shared their photos, stories and displays for International Nurses' Day. The day focused on celebrating all our nursing colleagues, and the wider teams they work within, recognising the brilliant work they do and the difference they make to our patients, and the support they provide to each other.

9.3. We celebrated International HR Day on 20 May 2023. This is an initiative led by the European Association for People Management (EAPM) to recognise the important role of the HR profession. This year's theme, HR shaping the new future, is about how the profession is leading change to improve working lives and sustainable success in the world of work.

9.4. International HR day provided an opportunity to reflect on the provision of services and all colleagues within the people profession have been encouraged to consider how we thrive through change and shape the future rather than react to it and to reflect on what's great about working within their teams and what would make their experience even better - and then make those improvements.

10. NATIONAL HEALTHCARE ESTATES AND FACILITIES DAY

10.1. On Wednesday 21 June, we celebrated the second annual National Healthcare Estates and Facilities Day – a chance to say a huge thank you to hundreds of our trust colleagues, including those within Simply Serve Limited (SSL), working in estates and facilities roles.

10.2. Across the trust we have cleaners, electricians, porters, fire officers, administrators, chefs – and that is to name just a few – that all play an important role in ensuring our patients have a comfortable and safe experience of our services, as well as ensuring we all have comfortable and safe environments to work in every day.

10.3. Teams celebrated across Somerset and into Dorset on the day, including displays from our estates, medical electronics, sustainability and soft facilities management teams in the entrance areas at Bridgwater, Burnham-on-Sea, Dene Barton, Wellington, West Mendip, Shepton Mallet, Chard, Crewkerne, South Petherton, Minehead and Frome community hospitals.

10.4. There were also guided tours of community plant rooms; a free BBQ at YDH for colleagues as a thanks from our estates and facilities management colleagues; and a display in the Jubilee Concourse at MPH displaying an array of service equipment (UV decontamination unit, Socamel Oven, (empty) oxygen bottles with practical valve fitting test/training, and EBME medical devices).

10.5. All of our estates and facilities teams make such a huge difference, and it was a privilege to say 'thank you' and wish them a very happy National EFM Day.

11. MBE AWARDED TO TRISH SPRUCE

11.1. Congratulations to Trish Spruce, our associate director of international recruitment, who was recognised in the King's Birthday Honours list, with an MBE for her work in supporting international NHS recruitment.

12. STAFF GOVERNOR ELECTIONS

12.1. Elections have begun for our future staff governors and will end at 5pm on Wednesday 28 June 2023. We received nominations from 13 colleagues. Four nominations were from previous YDH colleagues, and they will take up the four seats earmarked for former YDH colleagues.

12.2. A ballot is being undertaken for the remaining six staff governor seats on our Council of Governors.

13. PLATINUM AWARD FOR OUR NORTH SEDGEMOOR OCCUPATIONAL THERAPISTS

13.1. From November 2022 to April 2023, colleagues across the trust took part in the national reconditioning games – an initiative that aimed to prevent deconditioning by encouraging everyone to try innovative and fun ways to promote physical activity and emotional wellbeing.

13.2. Since the games ended, the national team has been awarding medals to teams across the country for the work they did during the games, and our occupational therapists based in North Sedgemoor, Hattie Stevens, Helen Rostron, and UWE students Jemma Parrott and Amelia Dent, have received a platinum medal!

13.3. As part of their roles working within primary care, Hattie, Helen, and students Jemma and Amelia have been championing the games within care homes. Care coordinators Lindsay Fear and Emma Jones were also pivotal in the coordination of the games, helping to maintain relationships with the care homes, as well as becoming part of the south west reconditioning ambassadors' network.

13.4. The platinum medal celebrates the efforts of the whole team, which included more than simply planning and hosting the games. As well as the various events put on over the few months, Helen presented at the Southwest Reconditioning Games learning and sharing event, while the team also created a podcast with support from NHS Regional Clinical Fellow, Joanna Jones, and Emergency Care Improvement Support Team (ECIST) advisor, Nick Holding. You can listen to the podcast here.

13.5. Providing an ongoing legacy, nine activity coordinators were also funded from the Sports England Together Fund, to attend Age UK 'flexercise' training. This training has been applied to a regular group and one-to-one seated movement sessions across the trust!

14. DR ZOE BAKEWELL WINS COVETED SILVER SCISSORS AWARD

14.1. Being recognised for outstanding practice by fellow professionals is always an amazing feeling, so Dr Zoe Bakewell was over the moon when she found out that she had won the national Silver Scissors award.

14.2. Zoe is one of our core surgical trainees in surgery and was nominated for the prestigious award by two of her fellow doctors – for her excellence in teaching.

14.3. The Silver Scissors is a junior teaching award from the Association for Surgeons in Training, sitting alongside the same family of awards as the Silver Scalpel – which our colorectal consultant surgeon Richard Bamford won back in 2019.

15. WESTON COLLEGE BUSINESS AWARD

15.1. Colleagues from our Sector Based Work Academy Programme – or SWAP – team are celebrating after they took home an award at this month's Weston College Business Awards.

15.2. Weston Super Mare's prestigious Winter Gardens venue played host to the highly anticipated awards on 15 June 2023, which brought together 250 distinguished guests for an inspiring celebration of learners and local employers, who've worked closely with the college to offer work-placed opportunities to people starting their career.

15.3. Our trust has been named as 'Pre-employment Employer of the Year', with judges saying they recognised our dedication to supporting unemployed people through SWAP, to gain employment in clinical and support roles within the NHS.

15.4. Nina Dawe, our SWAP team leader, said she was proud to work alongside some exceptional colleagues. "The hard work and passion for the programme that comes from our SWAP team is outstanding and to see that recognised is fantastic," she said.

15.5. "We were nominated last year, so to come back this year after significant changes across both our team and trust and get that win is an achievement we are delighted with."

16. CELEBRATING NHS75

16.1. The NHS turns 75 on 5 July 2023 and planning is in full swing to celebrate the NHS, our trust, sites and services now and in the future.

16.2. Glastonbury Festival unveiled a mural celebrating the NHS and NHS colleagues in Somerset, including some from our trust, joined a celebration on the Pyramid stage on Saturday 24 June.

16.3. Within our trust we are celebrating and showcasing many of our fantastic volunteers and colleagues, looking at how services and roles have changed over the years, and sharing profiles of colleagues and a photo gallery of our sites over the years. Many of our teams and ward areas will also be celebrating by taking part in the NHS Big Tea.

16.4. In addition, the communications team is planning media work and a live outside broadcast at Yeovil Hospital on 5 July 2023, featuring stories, updates and interviews about the past and future of the NHS in Somerset. Other planned media work includes a pre-record for Greatest Hits Radio from Wincanton Community Hospital and a pre-recorded piece for ITV West Country.

17. SOMERSET BOARD INTRODUCTORY WORKSHOP

17.1. The first meeting of the Somerset Board took place earlier in June 2023 with a workshop for members. This is the coming together of the Health and Wellbeing Board and the Integrated Care Partnership.

17.2. The Somerset Board is the single high-level strategic partnership board for the county: in essence the remit of the board is broad, considering all influences on what it is like to live, work and visit Somerset.

17.3. The purpose of the Board is:

- To understand the needs of the population.
- Collaboratively, with the community and all sectors in the county, determine and agree the longer-term strategic vision for the county.
- Push forward agreed priorities to improve the lives of the Somerset population.
- Direct how the assessed health and care needs for the population of Somerset are to be met.
- To provide strategic leadership and hold each other to account for delivery against the Improving Lives Strategy and the Integrated Care Strategy.

18. MEDIA COVERAGE

18.1. Below a link to the BBC Radio Somerset coverage on 2 June 2023 about our Discharge to Assess service. This was part of a planned package of communications with the BBC. We also posted the story on social media a couple of weeks ago and featured it in Our News and our public website. Simon Parkin - 27/05/2023 - BBC Sounds (Interviews with Clare Brolly from

the Discharge to Assess service and Mel Lock from Somerset Council are 2.12:25 into programme).

18.2. We have a full programme of media work, but the week of 19 May 2023 has been particularly busy with two stories gaining a lot of media coverage. The first was the opening of the day theatre at Yeovil District Hospital. Coverage included an interview with Paul Foster and coverage was gained on:

- BBC Radio Somerset (drive programme): Matt Faulkner - 15/05/2023 - BBC Sounds (Interview with Paul Foster is 3.19:55 into programme)
- BBC Somerset News Online: Yeovil Hospital's new operating theatre opens - BBC News
- Somerset Live Chard and Ilminster News: New operating theatre opens at Yeovil Hospital today | Chard & Ilminster News (chardandilminsternews.co.uk)

18.3. Somerset has become the first county in the south west to offer a ground-breaking treatment for severe depression on the NHS. A team of mental health clinicians have set up an NHS clinic in Taunton for the widely acclaimed repetitive Transcranial Magnetic Stimulation treatment – also known as rTMS. The coverage includes interviews with our consultant psychiatrist Dr Nathan Maynard, Cat Gullick, our neuromodulation team lead, and patient Mark.

- BBC Points West: BBC One - Points West, Evening News, 18/05/2023 (Features 9.05 into programme – only available to watch until about 6:30pm today)
- BBC Radio Somerset: BBC Radio Somerset - Claire Carter, 18/05/2023 (Features at 1.08:55 and 2.08:15 into programme – available to watch for 30 days)
- BBC News Online (was also on national BBC Health News page): West NHS clinic to offer depression magnet therapy - BBC News

18.4. Below are links to BBC Radio Somerset coverage about the fundraising and development of our breast care unit at Yeovil Hospital, which include interviews with two of our fundraising volunteers, our breast care surgeon, Caroline Osborne, and head of charity, James Kirton.

- Tuesday 23 May: https://www.bbc.co.uk/sounds/play/p0flbw08 (1.08:40 and 2.09:10 into programme – fundraising volunteers' interviews)
- Wednesday 24 May: https://www.bbc.co.uk/sounds/play/p0flbwpw (1.35:05 and 2.35:45 into programme – Caroline and James interviews).

19. NATIONAL DEVELOPMENTS

Department of Health and Social Care responds to Patricia Hewitt's review into Integrated Care Systems

19.1. The Department of Health and Social Care (DHSC) has published its response to the Rt Hon Patricia Hewitt's independent review into integrated care systems (ICSs), alongside their response to the Health and Care Select Committee inquiry 'Integrated care systems: autonomy and accountability'

19.2. The Hewitt review was commissioned by the chancellor, Rt Hon Jeremy Hunt, in November 2022 to look at the role and powers of ICSs. The review was conducted with significant engagement with leaders from across the health and care system. The government's response sets out its commitment to helping ICSs develop, to streamlining the number of national level targets and to reviewing the NHS capital regime, and covers a number of themes including:

- targets and priorities for ICSs
- autonomy and support for ICSs
- ICS governance, accountability and oversight
- assessment and review of ICSs
- prevention and promoting health
- finance and funding.

UK Covid-19 Inquiry

19.3. The UK Covid-19 Inquiry has held a third preliminary hearing to further examine the scope and procedures for the public hearings for module 2. This module will investigate core UK decision-making and political governance.

19.4. Within our trust we have notified colleagues that from 1 June 2023, all colleagues within our trust and our legacy organisations, including bank, contractors and those seconded, are required to make sure they have retained and continue to retain all documents; correspondence; notes; emails; and all other information, however held, which contain or may contain content relating directly or indirectly to our response to the COVID-19 pandemic and key decisions made as part of the recovery.

19.5. At the moment we do not know what level of involvement will be required from us. However, we want to work with any public inquiry openly and transparently. As the inquiry gets underway, it may be necessary to search for and identify relevant documents. It is therefore essential all documents are appropriately saved and will be available for access including after any colleagues who have left the trust.

19.6. The trust lead for the inquiry is Andrew Sinclair, associate director of resilience. The resilience team will be supporting colleagues and teams across our organisation as part of the management of this public inquiry process including information, advice and guidance in terms of the storage and preservation of data, records and documents, and what is needed to be

considered and actioned if our Trust and our services are called upon to give evidence and records.

Nuffield Trust's Report "Building Resilience in Social Care: Learning from the first wave of Covid"

19.7. The Nuffield Trust's report in collaboration with the Care Policy and Evaluation Centre, analyses the structural and systemic factors that affected the ability of the social care sector to respond to the first wave of the Covid-19 pandemic. The link to it is here. An accompanying piece by Natasha Curry, the Nuffield Trust's Deputy Director of Policy, describes the crucial lessons that must be learnt if social care is to better respond to the next crisis it faces. NHS Providers' response to the report is here.

NHS Providers Briefing on the UK Covid-19 Inquiry

19.8. The UK Covid-19 Inquiry's public hearings for module 1 commenced on 13 June 2023 and will conclude on 21 July 2023. This NHS Providers briefing summarises the proceedings most relevant to NHS trusts, and is the first in the series of weekly briefings on the Inquiry's public hearings.

19.9. Module 1 is investigating government planning and preparedness and will examine the period between June 2009, when the World Health Organisation (WHO) announced that scientific criteria for an influenza pandemic had been met, and 21 January 2020, when the WHO issued the first situation report on what would become the COVID-19 pandemic.

19.10. The Inquiry has been considering evidence on this module since on 21 July 2022 gathered through rule 9 requests under the Inquiries Rules 2006 and three preliminary hearings.

NHS Providers: Report on Patient Flow

19.11. NHS Providers has published a new report in its series Providers Deliver: Patient flow, which highlights practical steps and innovations introduced by trusts and their partners to improve patient flow.

19.12. The report presents a series of case studies where trusts have developed effective approaches to improve patient flow in the face of unparalleled pressures. It also sets out the wider context behind obstacles to patient flow that cause delays. Work to address them requires a joined up approach based on close partnerships between different types of providers.

19.13. NHS Providers chief executive Sir Julian Hartley said: "The case studies in this report show how trusts are working collaboratively to prevent avoidable admissions, manage demand more effectively… and deliver real improvements in the health of the populations they serve." Read the full statement.

Blog on how we can support the Physical Health of People with Severe Mental Illness

19.14. To mark Mental Health Awareness Week, Dr Jemma Kwint, senior research fellow at National Institute for Health and Care Research, discusses the ways we can support the physical health of people with severe mental illness. Read Dr Kwint's blog.

King's Fund Podcast "Love, Care and Hard Work: Life as an unpaid Carer"

19.15. In this podcast Jo Vigor, assistant director of leadership and organisational development, speaks to Karen and Yvette, a couple who demonstrate the varied and essential role that unpaid care work plays in many relationships. The podcast looks at what support they currently receive, and what could make a positive difference and looks at recent research in this area.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	2023/24 Q1 Board Assurance Framework
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Phil Brice, Director of Corporate Services Ben Edgar-Attwell, Deputy Director of Corporate Services Steve Thomson, Director of Integrated Governance
PRESENTED BY:	Phil Brice, Director of Corporate Services
DATE:	4 July 2023

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	A review of the Trust's strategic objectives was undertaken by the Board of Directors where it was agreed that the eight strategic objectives previous set 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)** A revised 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. Common areas of risk identified across objectives remain: • Pressures in social care and intermediate care • Insufficient capacity to meet demand • Infrastructure investment and ageing estate • Pressures in primary care • Workforce recruitment and retention • The impact of the pandemic • Delivery of financial plans

Recommendation	The Board is asked to: • Review the Board Assurance Framework and note the actions being taken to address the risks identified. • Consider the objectives reserved to the Board in respect of the key controls and assurances and any further assurances that may be required in respect of any individual areas of risk.

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

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

Implications/Requirements (Please select any which are relevant to this paper)

☒ Financial	☒Legislation	☒ Workforce	☒ Estates	☒ ICT	☒ Patient Safety/ Quality

Details: N/A

Equality
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 not been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics

☐ 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)

N/A

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

Quarterly 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

2023/24 Q1 BOARD ASSURANCE FRAMEWORK

1. PURPOSE OF THE REPORT

1.1 To present the 2023/24 Q1 SFT Board Assurance Framework to the Board.

2. BOARD ASSURANCE FRAMEWORK

2.1 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.

2.2 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.

2.3 Revisions have been made to the Assurance Framework for 2023/24 in order to focus the Committees and Board on the key risks, controls and assurance, and the plans in place to mitigate the risks. In addition, the Assurance Framework provides the Committees and Board with a summary of key plans and strategies supporting their delivery.

2.4 A review of the Trust's strategic objectives was undertaken by the Board of Directors at a Board Development Day in April 2023, where it was agreed that the eight strategic objectives previous set remain the long term aims for the newly merged organisation.

2.5 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.

2.6 They are supported by a range of supporting strategies and transformation plans that are also identified in the sections of the Assurance Framework.

3. ASSURANCE FRAMEWORK GOVERNANCE ARRANGEMENTS

3.1 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.

3.2 The Audit Committee oversee the effectiveness of the above processes at each of its meetings.

3.3 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 people objective (6) and the Finance Committee has responsibility for oversight of the finance objective (7). Objectives 1 and 8 are reserved to the Boards.

3.4 The Assurance Framework is also reviewed at the Executive Team meeting on a regular basis.

4. GAPS IN CONTROL AND ASSURANCE

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

- the impact of pressures and capacity shortfalls in social care and intermediate care (objectives 2 and 3)
- insufficient capacity to meet demand (objectives 7 and 8)
- infrastructure investment and ageing estate (objectives 2 and 8)
- the impact of pressures in primary care (objectives 2, 3 and 5)
- workforce recruitment and retention (objectives 3 and 6)
- the impact of the pandemic (objective 5)
- delivery of financial plans (objective 7)

4.2 The current level of activity being faced by the Trusts across all of their services continues to impact significantly the steps to deliver all objectives and mitigate the risks. Recent Board and system-level discussions on the pressures in primary care, social care and other providers and their impact on the Trusts' achievements of our clinical and corporate objectives will continue to be reviewed.

4.3 Gaps in controls and assurance are identified in a number of objectives and actions to address these are identified in some and in development for others. The Boards and their sub-committees should consider if there are any

further assurances that may be required in respect of any individual areas of risk.

4.4 Within the summary of each objective there is reference to key supporting strategies and transformation plans that are essential to the achievement of the objective. The Boards and their sub-committees should consider the progress against these strategies and plans as part of their assurance review of the objectives.

4.5 A summary of actions to address the key risks is set out in the Assurance Framework but each is supported by an action plan to address the issues raised and the response is co-ordinated by the nominated lead executive director.

4.6 All strategic risks have been reviewed by the Deputy Director of Integrated Governance and all risks are mapped to the risks on the Corporate Risk Register, in line with the findings from the CQC well led report.

5. CONCLUSION

5.1 The Quality and Governance Committee have reviewed objectives 2, 3, 4 and 5 within the Board Assurance Framework and considered the key controls and assurances in place and the gaps in controls and assurances.

5.2 Progress continues to be made identifying actions to address any gaps in controls and assurances but 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.

5.3 There has been some reduction in the highest risks across a small number of objectives as outlined within the report.

6. RECOMMENDATION

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

DEPUTY DIRECTOR OF CORPORATE SERVICES

BOARD ASSURANCE FRAMEWORK SUMMARY

Quarter 1 2023/24

	Highest Risk	Assurance ratings
⇧	Highest risk rating increased	Assurance increased
⇔	Highest risk rating remained the same	Assurance ramined the same
⇩	Highest risk rating decreased	Assurance decreased

Ref	Executive Owner	Corporate Objective	Overseeing Committee		Highest Risk		Plans & Strategies		Policies & Processes		Oversight Arrangements	
1	DS	**Improve the health and wellbeing of the population**	Board		16	⇔	A	⇔	G	⇧	A	⇔
2	HP	**Provide the best care and support to people**	Quality & Governance Assurance Committee		20	⇩	G	⇧	A	⇔	G	⇧
3	AH	**Strengthen care and support in local communities**	Quality & Governance Assurance Committee		20	⇩	G	⇧	G	⇔	A	⇔
4	PB	**Reduce inequalities**	Quality & Governance Assurance Committee		15	⇔	G	⇧	A	⇔	A	⇔
5	DM	**Respond well to complex needs**	Quality & Governance Assurance Committee		16	⇩	G	⇧	G	⇔	A	⇔
6	IC	**Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture**	People Committee		20	⇔	G	⇧	A	⇔	A	⇔
7	PM	**Live within our means and use our resources wisely**	Finance Committee		16	⇔	A	⇔	A	⇔	A	⇔
8	PL	**Develop a high performing organisation delivering the vision of the trust**	Board		20	⇩	G	⇔	G	⇧	A	⇔

Exec Owner	Corporate Objective	Overseeing Committee
David Shannon	**1. Improve the health and wellbeing of the population**	Board

Key Performance Indicators

Diabetes: HbA1C checks	100% ⇧	Addiction (smoking / Alcohol)	2% ⇔		Suicide/Self harm prev: MH Staff	285 ⇧	
Suicide/Self harm prev: non-MH	135 ⇧	28 day cancer faster diagnostic	Apr 73.6% ⇧		Number of pats enrolled to Periop		

	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	R1613/U986	3 x 4 =	12		3 x 3 =	9	
2	Approach to Population Health may be uncoordinated	R1615/U987	4 x 2 =	8		4 x 2 =	8	
3	Lack of understanding of shared accountability/resourcing	R1616/U988	4 x 4 =	16		4 x 2 =	8	

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)
Plans & Strategies			
Somerset Health and Care Strategy	ICS System Assurance Forum	Neutral	
ICS Population Health Strategy			Amber
Smoking Cessation and Perioperative care programme			
Processes for Delivering Plans			
ICS Action learning set to support PHM development completed	Priorities developed for ICS aligned with core20 plus 5	Positive	
Development of Pop Health integrated dataset data group	Compliance with regional and national programmes	Positive	Green
Flagship programme		Neutral	
Oversight Arrangements for Governance & Engagement			
ICS Health Transformation Board	Progress on KPIs presented to Board on regular basis	Positive	
ICS Data Development Group	Limited Board and Committee oversight to date	Negative	Amber
Trust Data and Population Health Insights Group	Oversight off flagship priorities & clinical strategy - QGAC	Positive	

Actions to Improve Controls and Assurance (Required for any areas assessed Amber or Red)	Lead	Target Date	Progress Summary
Oversight of current priority progammes - Smoking Cessation, Perioperative care and Suicide prevention	DS	Oct-23	On Plan
Insights group to focus on neighbourhood / PCN service access	DS	Jul-23	On Plan
Development and implementation of resource plan for SFT	DS	Apr-24	On Plan
Work with colleagues to develop ICS level programme	DS / DM	Apr-24	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

Ambulance handover hrs lost >15m	11565 ⇧	Cancelled operations		⇔	C.Diff year to date cases		18 ⇩
Patient Initiated follow up (PIFU)	8.2% ⇧	Falls resulting harm per 1000 days	Mar	0.34 ⇧	Pressure ulcers per 1000 bed days	Mar	0.96 ⇩
Acute Home Treatment caseload	32	Pats waiting social wk assessment		89 ⇩	End of Life pat discharges <24hrs		75.9% ⇩

	Key Risks (*High Consequence risks that may stop us achieving the objective*)	Risk Reference (*From corporate risk register*)	Current Risk Con	x	Lik	=	RS	Target Risk Con	x	Lik	=	RS
1	Access to primary care / increasing ED demand	R673	4	x	4	=	16	4	x	4	=	16
2	Shortfalls in Social Care capacity	R831/U331 & R1513	5	x	3	=	15	4	x	3	=	12
3	Age of acute and community estates	R3 & R1473	4	x	5	=	20	4	x	4	=	16

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*)
Plans & Strategies			
Clinical Strategy	CQC Inspection / Insight Reports	Positive	
Digital and Estates Strategies	National Patient Surveys / Staff Survey	Positive	Green
Recruitment and Retention Plans	Model Hospital/GIRFT/national benchmarking data	Neutral	
Processes for Delivering Plans			
Continued development and implementation of Clinical Strategy	Due diligence reports	Positive	
Risk assessed capital and backlog maintenance programmes	Internal audit programme	Neutral	Amber
Hospital @ Home Programme			
Oversight Arrangements for Governance & Engagement			
Integrated performance reporting	GST assurance processes (IQAB, Care Essentials etc.) QGAC	Neutral	
Strategic Estates Group	Oversight off flagship priorities & clinical strategy - QGAC	Positive	Green

Actions to Improve Controls and Assurance (*Required for any areas assessed Amber or Red*)	Lead	Target Date	Progress Summary
Launch programme to EPJP and prevent deconditioning across all sites	HP	Jul-23	On Plan
Development of Quality and Patient Strategy	HP	Oct-23	On Plan
Ward Accreditation - revised programme to be developed	HP	Jul-23	On Plan
Leadership quality walkarounds	PB/HP	Jul-23	On Plan
Development of the Chief Nurse Core Standards	HP	Jul-23	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

Pats ref to Acute Home Treatment	126 ⇧	Adm. Prevented by Rapid Resp/AHT	321 ⇧	Urgent Community response <2hrs	Apr	94.0% ⇧
PCNs with integrated models	1 ⇔	Psychiatric readmission rate	Apr 4.0% ⇧	Integrated family hub launch		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	Workforce shortages	1301, R1329, R1669, R1624/U994	4	5	20	3	4	12
2	Fragility of Primary Care	R673	4	4	16	4	4	16
3	Shortfalls in Social Care capacity	R831/U331 & R1513	5	3	15	4	3	12

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)
Plans & Strategies			
Trust/ICS workforce strategy and integration	ICS System Assurance Forum	Neutral	
Acute Home Treatment	Regional oversight of implementation and peformance	Positive	Green
Processes for Delivering Plans			
Integration pilot underway in North Sedgmoor - 2 more planned	SEND Improvement Board oversight of implementation	Neutral	
New Hospital@Home services under development	Deep Dive outcomes - YDH and MPH	Positive	Green
Oversight Arrangements for Governance & Engagement			
Regular Service Group F&P/QOFP meetings	Trust Board Quadrant Report	Neutral	
Intermediate Care Board with KPI monitoring	Intermediate Care performance report - weekly	Neutral	Amber
System Neighbourhood Board co-chaired by COO	Trust Board Quadrant Report		

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	AH/TE/CD	15.06.23	On Plan
Intermediate Care Strategy development reporting to Neighbourhood & PC Programme Board	PM/AH	12.07.23	Behind Schedule
KPIs/metrics monitored and actions taken via the QOFP process	PM/AH	01.03.23	On Plan

Exec Owner	Corporate Objective	Overseeing Committee
Phil Brice	**4. Reduce inequalities**	Quality & Governance Assurance Committee

Key Performance Indicators

Prot characteristics data complete	Nov	98.9% ⇔	Ethnicity equity of access:acute RTT		tbc	Ethnicity equity of access: cancer		tbc
Ethnicity equity of access: MH		tbc	Reduce elective waits - pats with LD	Mar	19w ⇧	Healthy life expect. gap: high-low	2020	13.3y

	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	R1620/U991	5	x	3	=	15	4	x	2	=	8
2	Data quality issues leading to poor information	R1621/U992	4	x	3	=	12	4	x	2	=	8
3	Historical funding/resource gaps including in MH & LD	R1622/U993	3	x	4	=	12	3	x	3	=	9

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)*
Plans & Strategies			
Open Mental Health	Internal Audit - Mental Health (January 2023)	Positive	
Digital Strategy - population health data	Digital Board/Board review	Neutral	Green
	CQC Inspection - (September 2022)	Positive	
Processes for Delivering Plans			
Equality Impact Assessment	None	Negative	
Master Patient Index programme	Data Quality reports	Positive	Amber
Elective Recovery inequalities programme	Board reports	Positive	
Oversight Arrangements for Governance & Engagement			
System Quality Governance Committee	CQC Inspection/Insight	Positive	
Quality & Governance Assurance Committee	Board Assurance Reports	Neutral	Amber
Population Health Management Committee		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	Jul-23	On Plan
Development of strategy to incorporate of deprivation/exclusion markers into trust data	DS	Mar-24	On Plan

Exec Owner	Corporate Objective	Overseeing Committee
Dan Meron	**5. Respond well to complex needs**	Quality & Governance Assurance Committee

Key Performance Indicators

CYP Eating Disorders - Urgent	100% ⇧	CYP Eating Disorders - Routine	96.2% ⇧	Reduce time in ED: intensity users	67,427 ⇩
Dementia diagnosis rate	53.7% ⇧	Persistent physical symptoms prog.	Yes ⇔	Time to assessment in CYPNP	69w ⇧
Homeless service: annual referrals	732 ⇧	Personalised convs/health coaching	115 ⇔		

	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 sufficiently deliver the clinical model	R1617/U989	4 x 3 =	12		4 x 2 =	8	
2	Insufficient capacity in primary care	R673	4 x 4 =	16		4 x 4 =	16	
3	Impact of post pandemic on our population and services	R7/U100	4 x 4 =	16		4 x 4 =	16	

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*)
Plans & Strategies			
Clinical care and support strategy	Internal monitoring	Positive	
Somerset Health and care strategy	ICS System Assurance Forum	Neutral	Green
Dementia and Delirium strategy	Internal monitoring	Positive	
Processes for Delivering Plans			
Homeless service priority programme	Compliance with national and regional programmes	Positive	
Representation at ICS Personalised care strategy planning			Green
High intensity users service development with ICS			
Oversight Arrangements for Governance & Engagement			
Accountabilty Framework process/meetings	Reports to QGAC	Positive	
	Oversight reports for ICB, Primary Care Board etc.	Neutral	Amber
	Progress on KPIs presented to Board on regular basis	Positive	

Actions to Improve Controls and Assurance (*Required for any areas assessed Amber or Red*)	Lead	Target Date	Progress Summary
Development of oversight and reporting governance with ICB/ICP	DM	Oct-23	Behind Schedule
Support prioritised to the ICS personalised care strategy	DM	Jul-23	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

Retention: % in post >12months	74.4% ⇔	Pulse Engagement	6.8/6.4 ⇔	Inclusion: % B8S reg.disabled	2.9% ⇔
Pulse Advocacy measure	6.8/6.5 ⇔	Inclusion: % B8s who are female	58.6% ⇧	Inclusion: % B8s ethnic minority	19.8% ⇔

	Key Risks (*High Consequence risks that may stop us achieving the objective*)	Risk Reference (*From corporate risk register*)	Current Risk Con	Lik	RS	Target Risk Con	Lik	RS
1	Inability to fill vacancies across organisation	R1799	4 x	5 =	20	4 x	3 =	12
2	Retention and turnover of colleagues	U925	4 x	4 =	16	3 x	3 =	9
3	Ongoing unsustainable pressure to colleagues in the Trusts / staff re	R690/U728	4 x	4 =	16	4 x	3 =	12

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*)
Plans & Strategies			
People Strategy 2023-2028 with defined year 1 deliverables	People Strategy KPIs	Positive	
People Promise Exemplar programme	National Staff survey results - people promise areas	Positive	Green
Inclusion Roadmap	WDES/WRES/gender pay gap/EDS	Positive	
Processes for Delivering Plans			
Year 1 deliverables charter	Highlight reports	Neutral	
Retention roadmap	Internal audit due Q3 23/24	Neutral	Amber
Values and behaviourial framework	Pulse survey/ FTSU, H&W, career conversation and absence interna	Positive	
Oversight Arrangements for Governance & Engagement			
People Committee	People Committee strategy commitments assurance deep dives	Positive	
People Governance Committee	Year 1 deliverables highlight reports and project charters	Neutral	Amber
Cultural Strategy Group	Cultural Maturity Review - internal audit	Positive	

Actions to Improve Controls and Assurance (*Required for any areas assessed Amber or Red*)	Lead	Target Date	Progress Summary
Implement governance arrangements for people strategy year 1 deliverables	IC	Jul-23	On Plan
Develop listening strategy to support an improvement in uptake rate of people pulse	IC	Sep-23	On Plan
Undertake retention internal audit	IC	Dec-23	On Plan
Strengthen the link between colleague experience and patient experience through intrinsically linking expe	IC	Dec-23	On Plan
Strengthen the link between colleague experience and learning	IC	Dec-23	On Plan

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

Key Performance Indicators

Financial position v plan (YTD)	(548) ⇔	% of CIP identified as recurrent	34% ⇩	Agency v plan (YTD)	1.7m ad ⇩

	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	R6/U738	5 x	3 =	15	5 x	2 =	10
2	Lack of pace of system-wide changes to address deficit	FIN001	4 x	4 =	16	3 x	3 =	9
3	The Trust fails to deliver the elective activity trajectory	FIN014	4 x	3 =	12	4 x	2 =	8

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)
Plans & Strategies			
Finance Strategy - reduce underlying deficit to breakeven by 26/27	Oversight of Strategy through Finance Committee	Neutral	
Financial Plans for 2023/24	Financial oversight reports to Finance Committee	Neutral	Amber
Processes for Delivering Plans			
System wide discussions to manage available resources	Internal and external audit programme	Positive	
	HFMA Financial Sustainbility Checklist results	Positive	Amber
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

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 23/24 planning	PM	Mar-24	Behind Schedule
Identify further efficiencies/improve productivity using available benchmarking, GIRFT etc.	PM	Dec-23	Behind Schedule
Work with Social Care to increase capacity in care market to reduce delays and increased costs	AH	Sep-23	Behind Schedule
Quarterly review of underlying position to be presented to Finance Committee	PM	Quarterly	On Plan

Exec Owner	Corporate Objective	Overseeing Committee
Peter Lewis	**8. Deliver a high performing organisation delivering the vision of the Trust**	Board

Key Performance Indicators

A&E 4-hour standard		78.7% ⇩	78 week acute RTT waiters		87 ⇩	6 week diagnostics		77.2% ⇧
62 day cancer waiting time	Apr	68.6% ⇧	Mental health 6 week waiting time		90.0% ⇩	Community waiters >18 weeks		4,052 ⇩

	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	Insufficient capacity to meet demand in all services	R4	5	x	4	=	20	4	x	4	=	16
2	Failure to secure the necessary infrastructure	R1611/U984 & R1624/U994	4	x	4	=	16	4	x	2	=	8
3	Failure to realise benefits of merger & service integration	R1612/U985	4	x	3	=	12	3	x	2	=	6

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*)
Plans & Strategies			
People Strategy	National Staff Survey results	Positive	
Inclusion Strategies	Cultural Maturity Internal Audit Report	Positive	Green
Digital Strategy	External Review through NHSE/CQC liaison meetings	Neutral	
Processes for Delivering Plans			
Colleague Health, Wellbeing and Resilience programmes			
Values into Action workshops			Green
Merger Integration Programme	Merger updates to Board/NHSE review and approval of plans	Positive	
Oversight Arrangements for Governance & Engagement			
Accountability Frameworks (QOFP) & System Performance Group	Quarterly Reports to Board (Finance, F2SU, GoSW, LfDs etc.)	Positive	
Covid Recovery Co-ordination Group	Performance as monitored by Accountability Framework	Neutral	Amber
Intermediate Care Programme Board	Board Quadrant Reports	Neutral	

Actions to Improve Controls and Assurance (*Required for any areas assessed Amber or Red*)	Lead	Target Date	Progress Summary
Development and delivery of system bed capacity review/plan	AH		
Seek additional elective capacity via insourcing and other system facilities	XW	Sep-23	On Plan
System to participate in Right Procedure Right Place (surgery) programme	FC	Mar-24	On Plan
Model/plan to address elective capacity shortfall (65 weeks)	XW	Sep-23	Behind Schedule
Develop and implement business case(s) for Community Diagnostic Programme	DS	Sep-23	On Plan

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	2023/24 Q1 Corporate Risk Register
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Samantha Hann, Deputy Director of Integrated Governance
PRESENTED BY:	Phil Brice, Director of Corporate Services
DATE:	4 July 2023

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

Executive Summary and Reason for presentation to Committee/Board	The Board of Directors are ultimately responsible and accountable for the comprehensive management of risks faced by the Trust. They will: … ***receive and review the Corporate Risk Register via the Board Assurance Committees*** *and the Assurance Framework quarterly, which identify the principal risks and any gaps in assurance regarding those risks.* Each Board Assurance Committee will receive the Corporate Risk Register report with the specific risks assigned to them. The Committees will formally review and scrutinise the risks within their remit. These reports will be received at least once a quarter together with the Board Assurance Framework. The highest areas of risk for the organisation are: • Pressures in social care; intermediate care; and primary care • Insufficient capacity to meet demand • Workforce recruitment and retention • Aging estates - acute and community • Financial position
Recommendation	The report covers those risks detailed on the Somerset Foundation Trust Corporate Risk Register on 12 June 2023. The report focuses on the high risks scoring 15+ on the risk matrix and includes corporate risks and service group risks. The Board is asked to note the report and the risks identified.

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

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

Equality 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 not been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
☐ 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)
N/A

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The Corporate Risk Register is presented to the Board and the Board Assurance Committees on a quarterly basis.

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

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

SOMERSET NHS FOUNDATION TRUST

CORPORATE RISK REGISTER REPORT

1. INTRODUCTION

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

Board Assurance Framework

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

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

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

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

Corporate Risk Register

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

1.7. These risks represent the most significant risks impacting the Trust ability to execute its strategic objectives and therefore align with the principal strategic risks overseen by the Board. These risks may still be managed at Service

Group or departmental level but require Executive oversight or will be managed by an Executive Director.

1.8. The Board sub-committees will review the Corporate Risk Register at least once a quarter to ensure that risks are being managed effectively and that lessons and risk information are being shared across the organisation. These reviews will inform the Audit Committee and Board of Directors decision in respect of the recommendation to approve the Trust's Annual Report which contains the annual governance statement which provides assurance of the level at which the Trust's system of internal control is managing organisational.

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

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

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

2. PURPOSE OF THE REPORT

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

2.2 This risk report aims to provide details of the key risks detailed on the Trust's Corporate Risk Register on 12 June 2023.

3. CORPORATE RISK REGISTER

3.1 There are currently twenty-three risks on the Corporate Risk Register detailed within the circle heat map, six of which score 20 or 25:

- Risk 003 Estate - Acute
- Risk 004 Demand
- Risk 007/100 Referral to Treatment Times
- Risk 0012 Waiting Times
- Risk 0497 Symphony Healthcare Services not becoming financially self-sustaining

- Risk 1329 Core numbers of Junior and Consultant medical workforce

New Risks

3.2 There has been one new risk added to the Corporate Risk Register since the last report on 10 May 2023:

- Risk 1769 - Inpatient service temporarily restricted due to acute dietitian workforce challenges

Increased Risks

3.3 There have been no risks which have increased since the last report on 10 May 2023 which have been included on the Corporate Risk Register.

Risks which have Reduced

3.4 There has been one risk which has reduced since the last report on 10 May 2023. This risk however still remains on the Corporate Risk Register. There have been no risks which have reduced since the last report which have been removed from the Corporate Risk Register.

- Risk U331/R831 - Insufficient intermediate care capacity

Risks which have been Archived

3.5 There have been no risks which have been archived from the Corporate Risk Register since the last report on 10 May 2023.

Service Group & Corporate Function Risks

3.6 A number of additional risks scoring 15 or more continue to be identified at Service Group and departmental levels. These risks have been linked to risks on the Corporate Risk Register as shown in Appendix 1. The movement of these risks since the last report on 10 May 2023 has also been included within Appendix 1.

3.7 Since the last report on 10 May 2023, there have been a number of risks at Service Group and departmental levels which have reduced or been archived:

Risk Number	Risk Description	Reduced / Archived
Risk U49	Increased demand – opening of escalation areas	Reduced from 20 → 12
Risk R343	Inability to recruit to vacant Neurology Consultant posts	Reduced from 16 → 12
Risk R644	Reduced echocardiography service due to staffing issues	Reduced from 20 → 9
Risk R1653	Loss of therapy colleagues due to Athena Therapy contract ending	Reduced from 16 → 8

Risk R847	Increased bed capacity - doubling up beds in single rooms	Archived
Risk R1046	Rio disaggregation (separation of systems)	Archived
Risk R1512	Lack of qualified Resuscitation Team staff	Archived

Emerging Risks

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

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

3.10 Since the last report on 10 May 2023, there has been thirteen emerging risks which have been added to the service group and departmental risk registers with a score of 12 which will be closely monitored and mitigating action plans developed:

- U1020 – Inability to appropriately support children and young people with eating disorders admitted to ward 10 due to lack of funding for paediatric dietetic staff
- U1027 – Inadequate staffing for main outpatient clinics
- U1028 – Delay in Urodynamics testing due to lack of workforce with required specialists skills
- U1030 – Lack of space in Radiology to support growth of department
- U1034 – Health and wellbeing of staff and patients in the paediatric outpatients department due to lack of ventilation and intense heat in the area
- U1038 – Unavailability of a range of Endotracheal tubes across all theatre areas
- U1039 – Missed recurrent upper or lower GI cancers due to back log of overdue patients requiring an endoscopy surveillance procedure
- R1738 – Risk losing the steam supply for heating and hot water to Queens and Duchess Buildings due to steam leak on the Main Steam Line
- R1754 – Impact on nursing staff working on Barrington ward which is dedicated to looking after patients with Covid19

- R1756 – Impact on the Tissue Viability Team and service whilst the team continue to supplement the depleted Podiatry inpatient provision
- R1760 – Increased delays and length of stay at West Mendip Community Hospital
- R1762 – Difficulty recruiting to medical vacancies within Mental Health and Learning Disabilities service group
- R1773 – Recruitment challenges in Yeovil Home Treatment Team resulting in low staffing numbers.

4. RISK MANAGEMENT ARRANGEMENTS UPDATE

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

4.2 The Risk Management Policy is under development with key stakeholders across the Trust with input from the Service Groups and Corporate Teams. This will be finalised over the summer.

4.3 The Trust continues to manage two Risk Management Systems – RADAR and Ulysses. During 2023/24, the Trust will undertake a review of the systems and their functionality and a decision will be made on the system that will be in sole use by the Trust for 2024/25. A review of the risks on the two risk registers on these systems remains ongoing as part of the alignment work.

5. CONCLUSION

5.1 There has been progress in mitigating a number of risks but the position remains challenging due to workforce challenges and operational pressures within the Trust.

6. RECOMMENDATION

6.1 The Board is asked to note the Corporate Risk Register

Corporate Risk Register 12 June 2023

NHS Somerset NHS Foundation Trust

People Committee

20 R1329 Core numbers of Junior and Consultant medical workforce

16 U0189 Failure to achieve mandatory training levels

16 R0690/U0728 Ongoing unsustainable pressure to colleagues in the Trust

16 U0925 Retention and turnover of staff

16 R1624/U994 Failure to secure necessary infrastructure (workforce)

15 R1301 Wards under resourced and insufficient skill mix of staff – Nurses & HCAs

15 R1669 Clinical Pharmacy Service Workforce Challenge

15 R1769 Inpatient service temporarily restricted due to dietitian workforce challenges

Financial Committee

20 U0497 SHS not becoming self-sustaining

16 R1611/U0984 Failure to secure necessary infrastructure – physical & digital (funding)

15 R0006/U0738 Delivery of CIP 2022/23

Quality & Governance Committee

20 R0003 Estate – Acute

20 R0004 Demand

20 R0007/U100 Referral to Treatment Times

20 R0012 Waiting Times

16 U083 Product shortages and/or significant delays of supply due to unpredictable market

16 R0673 Current capacity and future resilience of primary care in Somerset

16 R1238 Fire Compartmentation

16 R1473 Estate – Community

16 R1513 Community care and Adult Social Care provision for Learning Disability patients

15 R0326 No coordinated approach to the transition of children and young people with complex care needs

15 R0831/U331 Insufficient intermediate care capacity

15 R1620/U0991 Failure to achieve our objective of reducing healthcare inequalities

Key: Risk Score = 15-25 R = RADAR U = ULYSSES 01 = Unique Risk Reference

Appendix 1

QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R0003	20	⇔	Estate - Acute

Service Group / Corporate Function Risks 15+

R0890	20	⇔	Inability to convert model box room to provide required clinical space to meet service requirements
R1548	20	⇔	End of life aspect isolators and air handling units
U1031	16	NEW	Lack of cell salvage equipment in maternity
R1256	16	⇔	Staff and areas becoming contaminated due to water droplets/aerosols from toilets, macerators, drains due to poor ventilation
R1297	16	⇔	Lack of safe access to steam control valves serving the heating & hot water heat exchangers for the day surgery building
R1562	16	⇔	Non-compliance of statutory maintenance of thermostatic mixing values
R1570	16	⇔	Management of the Asbestos Register
R1648	16	⇔	Poor water quality and potentially unsafe water systems at project handovers
R1668	16	⇔	Cath lab cardiac arrest call bell system not fit for purpose
R0170	15	↑	Insufficient clinic space availability for the Trauma & Orthopaedic service
U1013	15	⇔	Lack of outpatient room availability for patients within Dietetic Services
U1029	15	NEW	Lack of ability to manage US waiting list and support clinical specialties with service developments/improvement due to reduction of US rooms as a result of reconfiguration
R1299	15	⇔	Loss of high voltage supply and resilience due to additional load for new surgical centre
R1300	15	⇔	Air conditioning maintenance not undertaken to the correct legislative standards
R1346	15	⇔	Inability to develop support site development due to electrical supplier unable to increase our maximum demand for a long period of time
R1567	15	⇔	Helipad barriers - non-compliance with current electrical regulations
R1670	15	⇔	Lack of physical space within the department to accommodate clinical functions
R1686	15	⇔	Treatment room on Blake Ward is no longer fit for purpose for ENT emergencies
R1741	15	NEW	Inability for nursing staff to hear patient call bells
R1744	15	NEW	Security, energy loss and patient satisfaction risk due to inadequate doors to the physiotherapy outpatient department

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

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

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

Appendix 1

QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R0004	20	⇔	Demand

Service Group / Corporate Function Risks 15+

U21	25	⇔	Unsafe numbers of attendances in Emergency Department
R1077	20	⇔	Cancellation of elective activity due to insufficient number of theatre slots for trauma lists to meet demand
R1649	20	⇔	Insufficient capacity to meet demand in heart failure nurse led service
R0293	16	⇔	Insufficient capacity to meet demand for CT scanning
R0372	16	⇔	Overcrowding in Emergency Department
R0551	16	⇔	Overcrowding in Acute Medical Unit
R0560	16	↑	Insufficient capacity to meet demand for Endocrine weight management service
R0887	16	⇔	Increased demand for inpatient and outpatient complex wound care together with continued deficit in vascular nursing resource
R0953	16	⇔	Increased demand impacting on patient flow within the Trust
R1134	16	⇔	Non-compliance with stroke standards due to increased demand
R1362	16	⇔	Insufficient theatre capacity for Urology cases to meet demand
R1504	16	⇔	Referral rates into Children & Young People's Neurodevelopment Service
R1709	16	⇔	Increase in Primary Care in Minehead sending patients with primary care conditions to Minehead MIU
R1735	16	NEW	Insufficient capacity to meet demand in Home Enteral Tube Feeding service
R0562	15	↑	Insufficient capacity to meet demand in diabetes specialist podiatry service
U1023	15	NEW	Inability to meet demand for immunotherapy
R1450	15	⇔	Significant and continuous growth in demand for Ultrasound services
R1587	15	⇔	Super surge additional beds being set up in medical wards
R1745	15	NEW	Increase in acuity and demand of general medical and care of the elderly patients

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

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

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

Appendix 1

QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R0012	20	⇔	Waiting Times
R0007 / U100	16	⇔	Referral to Treatment Times
U83	16	⇔	Product shortages and/or significant delays of supply due to unpredictable market
R0673	16	⇔	Impact of the current capacity and future resilience of Primary Care in Somerset on the Trust
R1238	16	⇔	Fire Compartmentation

Service Group / Corporate Function Risks 15+

R0009	16	⇔	Diagnostic Waiting Times Performance
R1731	16	⇔	Failure to meet both National Cervical Screening Program and National Cancer Waiting Times standards within Grace Centre
R0008 / U652	15	⇔	Deteriorating cancer performance & inability to meet cancer standards
R1664	20	⇔	Evacuation of patients - Jubilee Building
R1774	20	NEW	Evacuation of patients - SNICU
R1694	16	⇔	Evacuation of patients – TOR Ward
U45	15	⇔	Evacuation of patients - Wards 6 to 9
R1746	15	NEW	Evacuation of patients – lack of appropriate equipment to support vertical evacuation in community hospitals

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

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

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

Appendix 1

QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R1473	16	⇔	Estate - Community
R1513	16	⇔	Community & Adult Social Care provision for mental health and learning disability patients
R0326	15	⇔	No coordinated approach to the transition of children and young people with complex care needs
R1620 / U991	15	⇔	Failure to achieve our objective of reducing healthcare inequalities
R0831 / U331	15	↓	Insufficient intermediate care capacity

Service Group / Corporate Function Risks 15+

R0534	15	⇔	Poor condition of Shepton Mallet Community Hospital Portakabin Units
R0654	15	⇔	Ligature Points on the ward pose a risk to patients

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

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

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

Appendix 1

PEOPLE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R1329	20	⇔	Core numbers of Junior and Consultant medical workforce

Service Group / Corporate Function Risks 15+

R0497	20	↑	Lack of continuity within medical team on Barrington Ward
U1024	20	NEW	Patient pre-assessments and treatments being delayed on a regular basis or stopped due to no Dr cover on the St Margarets hospice site
R1150	20	⇔	Orthogeriatric medical staffing
U236	16	⇔	Reduced GP cover within SHS Practices
R0530	16	⇔	Somerset Lipid Service is not adequately developed and resourced
R0956	16	↑	Rheumatology medical staffing
U1025	16	NEW	Reduced capacity for specialist site specific cancers service due to lack of Dr cover
R1413	16	⇔	Multiple longstanding vacancies within the Clinical and Medical Consultant oncology service
R1491	16	⇔	Inability to provide endoscopists to meet capacity for colonoscopy lists
R1662	16	⇔	Inability to provide consistent Consultant cover for Somerset Neuro Rehabilitation Unit
R1700	16	⇔	Need to recruit and train a further Consultant in ERCP (Endoscopic Retrograde Cholangiopancreatography)
R1701	16	⇔	Increased risk of amputation for patients with Diabetic Foot due to delays in identification or management of ulceration
R1749	16	NEW	Lack of out of hours medical cover at SNRC
U515	15	⇔	Inability to retain and recruit critical care consultant intensivists
U864	15	⇔	Inability to support the additional 10 escalation beds at La Fontana Care Home in Martock (SHS)
R0999	15	⇔	Inability to recruit substantive Orthodontic consultant

U189	16	⇔	Failure to achieve mandatory training levels

R0131	16	⇔	Training and validation of pressure ulcers acquired in the Community

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

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

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

Appendix 1

PEOPLE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R0690 / U728	16	⇔	Ongoing unsustainable pressure to colleagues in the Trust / staff resilience
U925	16	⇔	Retention and turnover of staff
R1624 / U994	16	⇔	Failure to secure necessary infrastructure – physical and digital (workforce)
R1669	15	⇔	Clinical Pharmacy Service Workforce Challenge
R1769	15	NEW	Inpatient service temporarily restricted due to dietitian workforce challenges

Service Group / Corporate Function Risks 15+

U729	16	⇔	Violence & aggression towards Practice Staff
R1581	16	⇔	Clinical Coding backlog due to loss of qualified and experienced colleagues
R1295	16	⇔	Insufficient numbers of skilled personnel in Estates to maintain 24/7 response
R1616 / U988	16	⇔	Lack of analytic support and visibility of data to manage population health

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

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

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

Appendix 1

PEOPLE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R1301	15	⇔	Wards under resourced and insufficient skill mix of staff – Nurses & HCAs

Service Group / Corporate Function Risks 15+

R0399	20	⇔	Increased vacancy rate in Occupational Therapy across the organisation
R0440	20	⇔	Inability to provide a robust, continuous streamlined service for direct current cardioversion patients
R0306	16	↑	Lower Paediatric Diabetic Senior Nurse to patient ratio in comparison to other SouthWest regional Units
R0366	16	⇔	Ongoing shortfall in staffing levels within the District Nursing Teams
R0513	16	⇔	Limited provision of specialist neurological rehabilitation and neuropsychiatry service
R0781	16	⇔	High staffing vacancy percentage and shortfall of therapy staff for the stroke rehab units and community stroke rehab service
U868	16	⇔	Insufficient Clinical Nurse Specialist cover for gynaecology cancer patients
R0969	16	⇔	Speech and language therapy input in our Stroke Rehabilitation Centres are well below the national average
R1112	16	⇔	Insufficient Orthotist cover
R1148	16	⇔	Theatres do not have the required safe staffing numbers in the establishment to deliver the service
R1400	16	⇔	Significant nursing and support staff vacancies on the Paediatric ward
R1520	16	⇔	Inability to recruit into staff vacancies - midwifery
R1625	16	⇔	Paediatric high dependency unit staffing
R1679	16	⇔	Weight Management Service staffing
R1706	16	⇔	Cath Lab staffing establishment
R1755	16	NEW	Insufficient Clinical Nurse Specialist cover – Gynaecology oncology
U772 / R1759	15	⇔	Anaesthetic Practitioner on Call Service Provision
U1022/ R1758	15	⇔	Significant staffing vacancies in the Emergency Department - nursing and ENPs
R1422	15	⇔	Vacancies across clinical posts in children's therapy services

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

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

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

Appendix 1

FINANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

U497	20	⇔	SHS not becoming self-sustaining
R1611 / U984	16	⇔	Failure to secure necessary infrastructure – physical & digital (funding)
R0006 / U738	15	⇔	Delivery of CIP

Service Group / Corporate Function Risks 15+

R1310	20	⇔	No automated and cross organisation treatment escalation plans process
R1343	20	⇔	Quality of Discharge Summaries
R0336	16	⇔	Replacement Viewpoint (Colposcopy system) across Grace and Gynae Oncology Services
R1016	16	⇔	Clinical Coding backlog – loss of income
R1482	16	⇔	End of Life Pharmacy Robot
R0421	15	⇔	End of life overhead hoist
R1215	15	⇔	Pharmacy Worksheet and labelling system does not link to either Mosaiq ePrescribing or Trust PAS systems and is non-compliant with guidance

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

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

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

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 24 May 2023
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Jan Hull, Chairman of the Quality and Governance Assurance Committee
DATE:	4 July 2023

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the Quality and Governance Assurance Committee meeting held on 24 May 2023. The Committee received assurance in relation to: • The Corporate Risk Register and the alignment of risk management across the trust. • The 2022/23 Q4 update of strategic objectives 2 to 5 and the work in relation to the development of the 2023/24 Board Assurance Framework. • The elective and cancer services update. • The patient experience and engagement update. • The neighbourhoods and communities service group assurance report. • The Patient Safety Incident Response Framework (PSIRF) update. The Committee identified the following areas of concern or for follow up: • The increase of activity and complexity of presentation at Minehead MIU as reported in the Service Group report.

	The Committee identified the following area to be reported to the Board: • Assurance from Elective and Cancer Services update. • Assurance from the Patient Experience and Engagement work programme. • Concerns regarding Minehead MIU increase in activity.
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Quality and Governance Assurance Committee. The Board is further asked to note the area to be reported to the Board.

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

Implications/Requirements (Please select any which are relevant to this paper)					
Financial	x Legislation	☐ Workforce	☐ Estates	☐ ICT	x 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
☐ 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)
N/A

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING HELD ON 24 MAY 2023

1. PURPOSE

1.1. The report sets out the items discussed at the formal meeting held on 24 May 2023, along with the assurance received by the Committee and any areas of concern identified. The meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

Corporate Risk Register

2.1. The Committee received the up-to-date combined Corporate Risk Register report and noted that there were currently 22 corporate risks on the risk registers of which seven scored 20 or above. The Committee noted that the number of risks had reduced due to the consolidation or aggregation of thematic risks and the removal of duplicate risks that covered the two legacy trusts. The Committee noted that two risk management recording systems will remain in place for 2023/24.

2.2. The Committee received an update on the alignment of risk management across the trust and noted the work taking place with service groups, clinical teams, corporate functions and SSL. The Committee noted that the SSL Board had adopted the SFT risk Management Strategy and had agreed their risk appetite and risk tolerance approach.

2.3. The Committee received feedback on the development of a system wide risk register but noted the concerns in relation to the misalignment of risk maturity with the ICB which may impact on the ability to assess and manage more strategic system risks.

2.4. The risk register had been reconfigured to support our principle of ensuring that the right conversations were taking place in the right places. Some of the risks assigned to the Committee for oversight had not yet been reviewed through the Committee and these included transition from children to adult services and reducing inequalities. Consideration will need to be given as to how to gain assurance about these risks.

Quality and Governance Assurance Committee Strategic Objectives Review

2.5. The Committee noted the final update on the four 2022/23 strategic objectives falling under the remit of the Committee.

2.6. In relation to the 2023/24 strategic objectives, the Committee noted that the objectives will be developed to focus on long term delivery of the strategy and objectives rather than in-year delivery.

2.7. The Committee further noted the new system governance arrangements and the system level groups set up to review population health management, complex personalised care and neighbourhoods and communities. Consideration will need to be given how these groups can provide a level of assurance against some of the strategic objectives.

Elective and Cancer Services Update

2.8. The Committee received an update regarding elective and cancer services performance and noted the focus during 2022/23 on reducing the number of patients waiting over 78 weeks. Although the trust had not been able to reduce 78 week waiting times to zero by 31 March 2023, considerable reductions had been made. The focus for 2023/24 will be on reducing waiting times for patients waiting over 65 weeks. The Committee received an overview of the plan to achieve the 65 week wait target and noted the capacity and demand modelling approach and the scale of the challenges achieving the target of zero patients waiting over 65 weeks by 31 March 2024.

2.9. The Committee noted the focus on specific targets: theatre utilisation; 62 day cancer pathway; 28 day faster diagnosis; diagnostics; activity levels; and outpatient flow; and the review of the cohort of patients due to breach 65 weeks by March 2024 to understand the underlying activity run rate of treating these patients.

2.10. The Committee received an overview of the plan for outpatient transformation and noted the details of the plan, including the clinical and digital validation processes and the focus on health inequalities and DNAs.

2.11. The Committee received an update on the 2023/24 Cancer Operating Plan Priorities and noted the three high priority areas and performance against these priorities. The Committee further noted the plan to speed up the diagnostic phase of the cancer pathways.

2.12. The Committee noted the elective care priorities Board Checklist which will need to be completed and which will be presented to the July 2023 Board meeting.

2.13. The Committee agreed that the presentation provided significant assurance about the work taking place in relation to elective and cancer services.

Patient Experience and Engagement

2.14. The Committee received an update on the integration of the patient experience and engagement teams and noted that the teams were at the early stages of transformation and change. The aim was to have a new team structure and underpinning processes in place by 1 October 2023.

2.15. The Committee received an update on the engagement sessions with service groups to explore the impact of the patient engagement service on the service groups and noted the key points from these sessions.

2.16. The Committee noted details of the service review which was being undertaken and the engagement with service users and their families about their experience of the service and what they feel the service should provide.

2.17. The Committee received the PALS and complaints performance data for the period 1 April 2022 to 31 March 2023 and noted the reporting challenges due to the two different risk management systems and the aim to develop a Quality Assurance report by October.

2.18. The Committee received an overview of the workstreams that the patient experience and engagement team were involved in: expansion of the use of Care Opinion; supporting the development of the Quality Strategy; collaborating with the inclusion and culture strategy workstreams; increasing the number of patient engagement and experience volunteers; and the expansion of Triangle of Care.

2.19. The Committee agreed that good progress was being made and noted the responsibility of the Committee, the Trust Board and People Committee to ensure that the patient and carer voice is part of everything that we do and to seek engagement and involvement wherever it is relevant and appropriate.

2.20. The Committee agreed that the presentation and the value-based approach to the restructuring provided significant assurance in terms of methodology and agreed a further update on progress and impact of the changes should be scheduled.

Service Group Assurance Report – Neighbourhoods and Communities

2.21. The Committee received the assurance report and noted the key highlights from the report.

2.22. The Committee noted the challenges in relation to: care/nursing home settings which are unable to provide their regulatory activity, often leading to community services being required to provide care and training; patients from one particular GP practice presenting at the Minehead MIU as they are unable to access primary care services locally; and care homes in east Mendip not purchasing new syringe drivers.

2.23. The Committee noted the key priorities for the Service Group and the links to the Minehead MIU risks; workforce challenges; quality and safety aspects for the patient experience; and co-production and working with colleagues.

2.24. The Committee noted the work taking place at Integrated Commissioning Board (ICB) level to understand and address the issues in relation to primary care and same day urgent care in Minehead.

2.25. The Committee agreed that the report provided assurance that a well-developed governance structure is in place in this service group.

Patient Safety Incident Response Framework (PSIRF)

2.26. The Committee received an update in relation to PSIRF which is due to be rolled out across all trusts later in 2023 and which replaces the Serious Incident Framework.

2.27. The Committee noted the main focus and details of the PSIRF and changes in processes and the anticipated resource requirements.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. The Committee identified the increase of activity and complexity of presentation at Minehead MIU, as reported in the Service Group report, as an area of concern for follow up through the Board.

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

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

- Assurance from Elective and Cancer Services update.
- Assurance from the Patient Experience and Engagement work programme.
- Concerns regarding Minehead MIU increase in activity.

5. BOARD ASSURANCE FRAMEWORK (BAF)

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

- Positive assurance around control of elective care against **Objectives 2** and **4** around reducing inequalities.
- Neighbourhoods and Communities report provided assurance around **Objective 3** regarding supporting communities and **Objective 5** re complex care linked to Homeless and Rough Sleepers and Acute Home Treatment.

5.2 The Board is asked to direct the Committee as to any future areas of deep dives relating to the above objectives.

Jan Hull
CHAIRMAN OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the People Committee meeting held on 22 May 2023
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Graham Hughes, Chairman of the People Committee
DATE:	4 July 2023

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the People Committee meeting held on 22 May 2023 and the assurance received by the Committee. The meeting was conducted as a video conference call. The Committee received assurance in relation to: • The work of the Colleague Support Team. • The review of objective six of the Board Assurance. • The work in relation to the People Strategy. • The clinical supervision programme. • The learning item on flexible working. • The Electronic Health Records Update. • The Director report. • The workforce corporate risk register. • The work in relation to the implementation of recommendations from the wellbeing, career conversations and sickness internal audit reports. The Committee identified the following aeras for follow up: • The Colleague Support Team – a further update to be

	presented to the November 2023 meeting. • The Director report – the uptake of the Pulse Survey. No issues have been identified to be followed up by other Committees or to be reported to the Board. The Committee is able to provide the Board with assurance that the items discussed at the meeting provide significant assurance in relation to addressing gaps in controls and assurances for objective six of the Board Assurance Framework.
Recommendation	The Board is asked to discuss the report and note the areas of assurance and follow up.

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

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

Equality 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 not been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
☐ 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)
N/A

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

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

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

SOMERSET NHS FOUNDATION TRUST (SFT)

ASSURANCE REPORT FROM THE PEOPLE COMMITTEE

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 22 May 2023, the assurance received by the Committee and any areas of concern identified.

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

2. ASSURANCE RECEIVED

Colleague Story – Colleague Support Team

2.1. The Committee received an update on the work taking place within the Colleague Support Team, and particularly within the Intensive Therapy Unit (ITU), where the need for dedicated support had led to the commencement of the ITU Colleague Support Project.

2.2. The Committee received an overview of the Colleague Support Project and noted that ITU colleagues were at higher risk of sickness and absence for longer periods due to the emotional nature of their work. The aim of the project was to offer targeted support and early intervention.

2.3. The Committee noted the increase in the number of colleague referrals; the total number of colleagues who have received support; and the positive impact of the support as evidenced by a reduction in the Colleagues General Anxiety Disorders score.

2.4. The Committee discussed the impact of the pandemic on colleagues and noted the presentation of colleagues with severe levels of post-traumatic stress disorder linked to events on the ITU during the pandemic and the decision to support a substantive full time Colleague Wellbeing Practitioner within the ITU.

2.5. The Committee further discussed the support available to other colleagues and noted that some of the support, e.g. compassion circles, was available to all colleagues but the Practitioner will be able to reach out to colleagues who would not necessarily contact the generic service.

Review of the Board Assurance Framework

2.6. The Committee reviewed strategic objective six of the Board Assurance Framework (BAF) and agreed that the actions to deliver the objective will need to be updated to reflect the progress made in relation to the People Strategy. The Committee noted that the format of the BAF and Key Performance Indicators (KPIs) was being reviewed to move from an in-year to

a longer term monitoring approach. The Committee agreed that the links between the Finance and People Committees will need to be strengthened.

People Strategy

2.7. The Committee received the People Strategy report and noted the update on the measures and year one deliverables which will provide a baseline position from which progress can be monitored.

2.8. The Committee noted that the measures have been developed to reflect the culture and the use of expected ranges rather than targets. The Committee further noted that nine deliverables had been identified for year one and that the aim will be to turn the deliverables into business as usual and monitor progress on a regular basis.

2.9. The Committee discussed the need for an overall measure to determine the impact of the strategy and the difficulty of evidencing improvement and noted that data will be collected and reviewed by the Culture Strategy Group.

2.10. The Committee agreed the need for the Committee to regularly focus on a certain aspect of the People Strategy to be able to obtain assurance about the implementation of the People Strategy.

Clinical Supervision

2.11. The Committee received an update on clinical supervision and noted the key highlights, including the introduction of the Professional Nurse Advocate (PNA) roles; the clinical supervision workshops; the PNA training requirements; the need to focus on Quality Impact (QI) projects due to the low level of QI activity; and the need for Trainee Nurse Associates (TNA) to be included in the Research Fellowship Programme.

2.12. The Committee noted the need for quality supervision which will allow colleagues to thrive in the workplace and improve retention; and the actions to be taken to raise the importance of releasing colleagues for quality supervision.

2.13. The Committee noted that this was a new programme and will require continued reflection and learning and dedicated time in the roster for colleagues to undertake the required training.

Learning item – Flexible Working

2.14. The Committee received an update on flexible working which was a key priority under the people promise exemplar project and which will help colleagues to maintain a good work/life balance.

2.15. The Committee noted the benefits of flexible working; the need to make flexible working easier for all colleagues, including clinical colleagues; and the trial of self-rostering on wards.

2.16. The Committee discussed the difficulty implementing this within clinical teams due to their historic focus on set shift patterns and recognised that this will be challenging and will require levels of compromise. The Committee noted that a flexible working dashboard was being developed to monitor progress and that the dashboard will be shared with the Committee on a regular basis.

Electronic Health Records Progress Update

2.17. The Committee received an update on the Electronic Health Record (EHR) programme and noted the emphasis in the trust's digital strategy on both patient and colleague empowerment and the procurement of a new electronic health record which will provide an opportunity to work differently, review pathways of care across the integrated organisation and give more time back to colleagues to complete their work and spend time with patients.

2.18. The Committee noted the link in the digital strategy to the Electronic Staff Record (ESR); the need to cleanse data to ensure the accuracy of the data; and the need to transfer to a new digital workforce solution in a few years' time.

2.19. The Committee noted that: it was expected that the outline EHR business case will be approved by the regional team by mid July 2023 after which a full business case will be developed; market engagement with vendors has taken place to understand available solutions; discussions with colleagues were taking place.

2.20. The Committee noted the actions in relation to preparing colleagues with the digital skills and digital literacy required and the development of a digital people roadmap to be able to assess the baseline position and develop improvement plans.

2.21. The Committee recognised the challenges delivering a new electronic health record and noted that examples of where a new system has been implemented showed the need to focus on people and change alongside the technology. The Committee was assured that the right conversations are taking place in the right way.

Director Report

2.22. The Committee received the report and noted the completion of the senior people team consultation; the retention position; and the progress in relation to the Sector Based Work Academy Programme (SWAP) initiative.

Workforce Corporate Risk Register

2.23. The Committee discussed the workforce risks and noted the alignment of risks and the removal of duplicate risks. The Committee noted that there were currently 22 risks on the Corporate Risk Register, seven of which scored 20 or 25 and that a review of the risks associated with the People Committee was taking place.

2.24. The Committee noted that a large number of risks were allocated to service groups and it was suggested inviting service groups to the People Committee meeting to provide assurance about the mitigation of people risks.

2.25. The Committee welcome the new format of the report which clearly showed the contributing and emerging risks and which will help to ensure that the right conversations were taking place in the right place.

2.26. The Committee noted that a single risk management system will be in place by the end of the financial year.

Internal Audit Plans 2022/23

2.27. The Committee received the report and noted that audits on wellbeing, career conversations and sickness had been carried out in 2022.

2.28. The Committee noted that the sickness audit had identified a number of high priority recommendations and the Committee received assurance that actions plans to implement the recommendations had been developed and that progress will continue to be monitored at the weekly business planning meetings.

2.29. The Committee noted that the wellbeing audit had highlighted medium priority recommendations and the implementation of the actions was noted.

2.30. The Committee further noted that an action plan and work group had been set up to implement the actions from the career conversation audit. The progress made was noted.

3. AREAS OF CONCERNS/FOLLOW UP

Colleague Story – Colleague Support Team

3.1. The Committee asked for a further update on the work of the Colleague Support Team to be presented to the November 2023 Committee meeting.

Director Report

3.2. The Committee discussed the uptake of the Pulse Survey and the actions to be taken to incentivise colleagues to complete the survey, which includes a targeted approach with some teams; raising awareness of the reasons for the survey; and the development of an improvement trajectory.

4. ISSUES REQUESTED TO BE FOLLOWED UP BY OTHER COMMITTEES

4.1. No issues had been requested to be followed up by the People Committee.

5. ASSURANCE FRAMEWORK

5.1. The Committee received the assurance on strategic objective six in the following areas:

- The colleague story provided assurance around caring for our people with the focused work on ITU and retention of colleagues.

- Assurance was given on planning from the discussion around the People Strategy deliverables and measures which will develop over the coming months.

- The clinical supervision focus for organisation was very strong and the Committee heard about investment from CPD funding.

- The importance of flexible working going forward was noted in line with the People Promise Exemplar work.

- The digital plan update detailed the breadth of the challenge over the coming weeks and months. There was assurance that the right conversations are taking place in the right way.

- The 2023/24 Internal Audit Plan evidenced links to risks in the organisation.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Fit and Proper Person Test Declaration
SPONSORING EXEC:	Colin Drummond, Chairman
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Colin Drummond, Chairman
DATE:	4 July 2023

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

Executive Summary and Reason for presentation to Committee/Board	The purpose of this report is to set out the actions taken to ensure that Board and Director level appointments, as set out in the Fit and Proper Person Policy, meet the CQC 'Fit and Proper Persons' Regulations.
Recommendation	The Board is asked to accept the assurance that all Board members and Directors as specified in the Fit and Proper Policy meet the Fit and Proper Persons 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 Develop a high performing organisation delivering the vision of the Trust

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

Equality
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 not been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
☐ 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)
N/A

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

FIT AND PROPER PERSONS TEST

1. INTRODUCTION

1.1 The Care Quality Commission's (CQC) registration requirements include the need for trusts to be able to demonstrate that all Board members are of good character and meet the CQC's fit and proper persons regulation.

1.2 A report on the Fit and Proper Persons requirements was presented to the Board in 2014/15 and the Board approved the Fit and Proper Persons Toolkit for new appointments and ongoing compliance developed by NHS Providers and NHS Employers.

1.3 The Board also agreed that the Toolkit applied to all Board members and other relevant Directors as set out in the Fit and Proper Person Policy. The Policy was last reviewed and approved in 2020.

1.4 As part of the CQC requirements, all Board members and Directors specified in the Fit and Proper Policy are required to submit an annual self-declaration stating that they continue to meet the Fit and Proper Persons requirements.

2. COMPLIANCE

2.1 The Chairman is ultimately responsible for discharging the requirements placed on the trusts to ensure that all Directors meet the fitness test and do not meet any of the "unfit" criteria.

2.2 Thorough reviews of personnel files have previously been undertaken and these reviews provided assurance that all Board members and Deputy Directors met the Fit and Proper Person requirements.

2.3 The annual checks against the Insolvency Register and the Disqualified Directors list have been conducted and all those to whom the Fit and Proper Persons requirements apply have completed an annual self-declaration confirming that they have read and understood the Fit and Proper Person Regulations and that they meet the required standards.

2.4 No concerns about relevant Directors' fitness or ability to carry out their duties or information about a director not being of good character have been identified or brought to the attention of the Chairman.

2.5 The Chairman therefore provide the Board with assurance that all relevant Directors continue to meet the Fit and Proper Persons requirements.

3. RECOMMENDATION

3.1 The Board is asked to accept the assurance that all Board members and Directors as specified in the Fit and Proper Person Policy continue to meet the Fit and Proper Persons requirements.

CHAIRMAN

Somerset NHS Foundation Trust	
REPORT TO:	The Trust Board
REPORT TITLE:	Quality and Performance Exception Report
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Associate Director – Planning and Performance Senior Performance Manager Chief of People and Organisational Development Deputy Chief Nurse Director of Elective Care
PRESENTED BY:	Chief Finance Officer
DATE:	4 July 2023

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. Covid-19 continues to have a significant impact on a range of access standards, whilst restoration work is being undertaken to reduce the number of patients waiting and to shorten waiting times. As referrals recover to pre-Covid-19 levels this will also have an impact on services and numbers waiting. Urgent and emergency patients continue to be prioritised, to receive the treatments they need. Areas in which performance has been sustained or has notably improved include: • CAMHS Eating Disorders - Urgent referrals to be seen within one week and Routine referrals to be seen within four weeks, both of which are now above the national standard. • The percentage of Talking Therapies patients moving to recovery. • Patients followed up within 72 hours of discharge from an adult mental ward.

	Areas in respect of which the contributory causes of, and actions to address, underperformance are set out in greater detail in this report include: • the percentage of patients seen within four hours and spending longer than 12 hours, in our accident and emergency department and minor injury units. • Talking Therapies, percentage of people waiting under six weeks for their first therapy session. • the percentage of people waiting under six weeks for a diagnostic test. • the numbers of people waiting 18 weeks or more to be seen by our community physical health services, including 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	Develop a high performing organisation delivering the vision of the Trust

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

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

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

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

J

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 not been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
☐ 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)
No recommendations are being made, other than to ask the Board to discuss and note the 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

J

SOMERSET NHS FOUNDATION TRUST

QUALITY AND PERFORMANCE EXCEPTION REPORT: MAY 2023

1. 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 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.

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

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

1.6 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.

1.7 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.

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

CHIEF FINANCE OFFICER

J

Overview

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

Successes	Priorities
• our eating disorders service for children and young people exceeded the national waiting times standards for both urgent and routine appointments. • our performance improved in respect of the four-hour waiting time standard for Accident & Emergency, and also for ambulance turnaround times. • compliance remains high in respect of mental health inpatients receiving a follow-up within 72 hours of discharge. • our Talking Therapies service continues to maintain recovery rates which are above the national standard. • the compliance level in respect of mandatory training remains high despite the operational challenges faced by services.	• continue to maintain a safe service and making sure urgent patients are treated as quickly as possible within the context of the challenges the current coronavirus outbreak brings. • continue to support the health and wellbeing, both physically and psychologically, of colleagues across the Trust, as they continue to deliver high quality care to patients whilst managing significant and ongoing pressures associated with COVID-19 and rising levels of demand. • continue to restore and expand capacity above pre-COVID-19 levels, to address backlogs in routine elective work. • work with the Somerset system to encourage continued referrals and presentations at hospital where needed and appropriate, especially in respect of urgent or emergency care.
Opportunities	**Risks and Threats**
• continue to progress the health and wellbeing plans for our colleagues at pace; this includes the psychological support offered alongside practical aspects of support such as accommodation provision and nutrition. • continue with new ways of working, particularly through the use of technology. • continue to adapt our recruitment practice, developing more innovative arrangements and reducing time to hire significantly. • develop reporting solutions to improve robustness of recording and reporting.	• COVID-19 continues to have a significant impact on clinical capacity and the Trust's ability to recover elective activity, which will continue to have a negative impact on waiting times for some time to come. • delays in discharging medically fit patients needing domiciliary care will result in further cancellations of surgery which will reduce our capacity to treat long waiting patients. • significantly increasing levels of demand, particularly for urgent care and mental health services, leading potentially to increased pressures on teams and longer waiting times. • nursing vacancy levels remain challenging. Sickness / absence also presents a challenge for colleagues within some critical areas, and we need to ensure that we continue to support colleagues accordingly.

Safe

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

Current performance (including factors affecting this)

The internal threshold for MSSA bloodstream infections was agreed at the May 2023 Infection Control Committee, at 64 cases.

- **MRSA:** There was one Trust-attributed MRSA bloodstream infection (BSI) reported during May 2023. The total since 1 April 2023 was one.
- **C. diff**: There were 11 Trust-attributed cases in May 2023. The total since 1 April 2023 was 18 against a threshold for the year of 54.
- **MSSA:** Six Trust-attributed MSSA BSIs were reported during May 2023. The total since 1 April 2023 was 12 against an internal threshold for the year of 64.
- **E. coli**: 15 Trust-attributed E. coli BSIs were reported in May 2023. The total since 1 April 2023 was 33, against a threshold of 105.
- **Klebsiella:** Five Trust-attributed Klebsiella BSIs were reported in May 2023. The total since 1 April 2023 was six against a threshold of 31.
- **Pseudomonas:** No Trust-attributed Pseudomonas aeruginosa BSI were reported in May 2023. The total reported since 1 April 2023 was two against a threshold of 15.

Appendix 6 provides further details.

Respiratory Viral Infections

- **COVID-19:** 164 inpatient cases of COVID-19 were identified during May 2023, of which 63 were healthcare-attributed.
- **Influenza:** four inpatient cases were identified during May 2023.
- **Respiratory Syncytial Virus (RSV):** two inpatient cases of RSV were identified during May 2023.

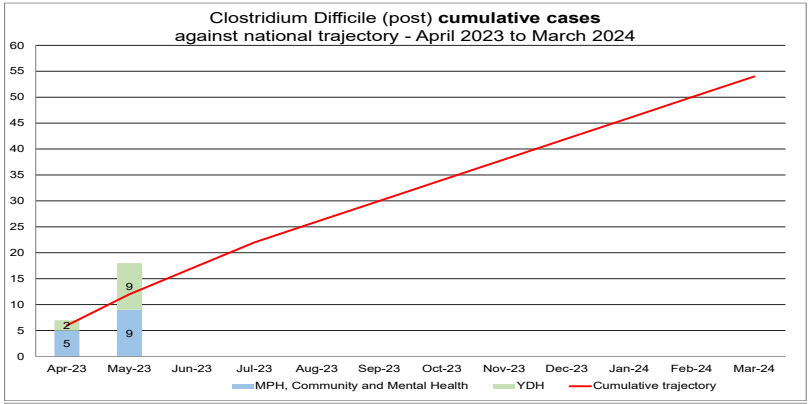
Outbreaks

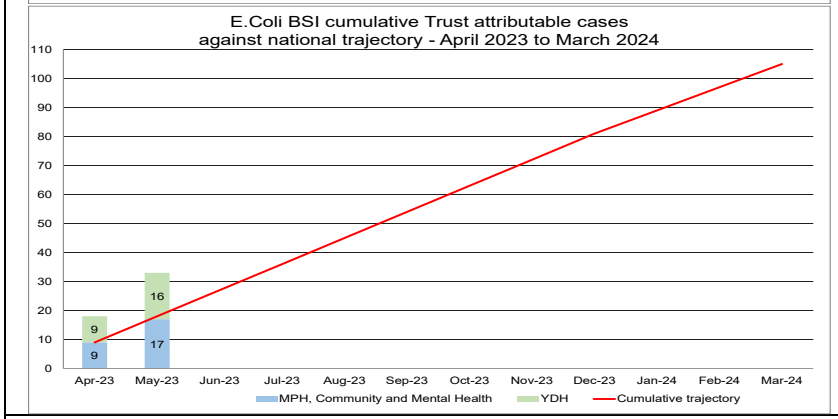
- During May 2023 there a total of 13 outbreaks affecting inpatient wards, all due to COVID-19.

Challenges

- The main challenge for the year ahead remains the same, to implement improvement strategies to reduce the gram-negative and MSSA bloodstream infections.

Line/Bar Charts





Recent performance

Area	Dec	Jan	Feb	Mar	Apr	May
MRSA	0	0	0	1	0	1
C.Diff	2	7	4	3	7	11
MSSA	6	7	5	6	6	6
E.coli	12	13	10	12	18	15

Safe

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

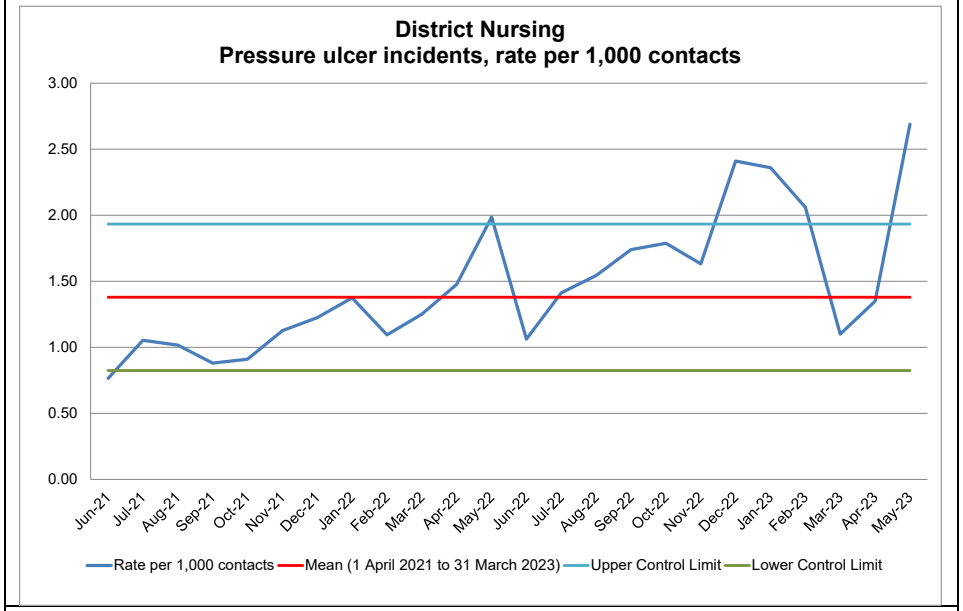
Current performance (including factors affecting this)

- During May 2023 a total of 80 incidents were reported within the District Nursing Service. There are 21 cases yet to be validated, as they are being monitored (unstageable or deep tissue injuries cases). There were no pressure ulcers reported at Category 4 (the most severe).
- Incident data demonstrates that the larger proportion of cases reported (56 cases out of 80) are in situations where the patient is not having routine nursing care provided (i.e. there was no planned care in the preceding seven days). This reflects the fact that the District Nurses are reliant on external agencies to support ongoing pressure ulcer prevention care (i.e. care homes, private care or domiciliary care providers). The district nurses work with these teams to identify people at risk and ensure a care plan is in place but when busy this can be more difficult for them to complete.
- During the period of this report the District Nursing service was not experiencing high levels of pressures due to staffing shortages or high workloads. It is possible that this enabled them to be more proactive in their assessments and care, and identify more people with damage.

Focus of improvement work

- A Trust Pressure Ulcer Reduction Strategy is being developed via the Pressure Ulcer Steering Group, to include patient education, staff education, documentation, assurance and pressure relieving equipment workstreams.
- An advertisement is currently out for Pressure Ulcer Educator and Quality Improvement roles, a 12-month secondment project to support the Pressure Ulcer Strategy.
- Pressure Ulcer Prevention and Management eLearning (via LEAP) for all clinical/patient-facing colleagues is mandated from 1 June 2023.

SPC Chart



How do we compare

During May 2023, the number of incidents and rate per 1,000 contacts increased compared to April 2023.

Recent Performance

Area	Dec	Jan	Feb	Mar	Apr	May
Number of reported incidents	70	70	56	58	37	80
Rate per 1,000 contacts	2.41	2.36	2.06	1.91	1.35	2.69

Safe

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

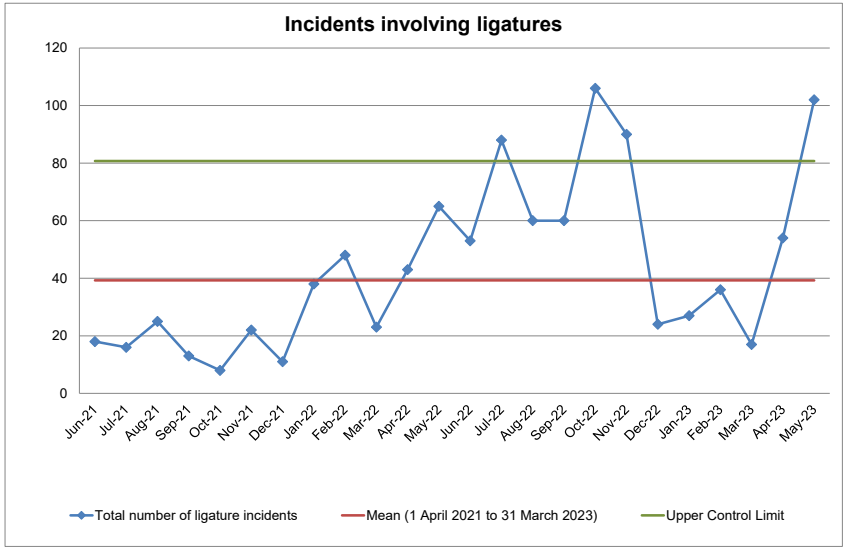
Current performance (including factors affecting this)

- During May 2023 a total of 102 ligature incidents were reported, plus two ligature point incidents.
- Of the 102 ligature incidents, 72 occurred at Rydon Ward 1, with 65 relating to two patients. Rowan Ward reported 18 incidents, with ten relating to one patient.
- Of the 102 ligature incidents, 13 resulted in minor harm. No harm above minor was recorded.
- No harm was recorded in respect of the two ligature point incidents, which involved a branch in a bush and a wired fence enclosing the garden. The two incidents occurred at Rydon Ward 1, one relating to one of the patients with multiple incidents recorded, as mentioned above.

Focus of improvement work

- All incidents involving ligatures are reviewed to ensure that assessments and care plans accurately reflect observation levels and the management of identified risk. A review of risks and observation levels is also undertaken at all handovers for each individual patient.
- The pronounced increase in ligature incidents on Rydon Ward 1 relates primarily to two patients diagnosed with an Emotionally Unstable Personality Disorder, who are using clothing or bed linen to tie non-fixed ligatures, where either no actual harm or minor harm occurred to the patients. A risk management plan is in place, which is being carefully managed in order not to adopt an overly restrictive approach, which would severely impact on the patients' privacy and dignity.
- Potential technological solutions are currently available including door-top alarms, and room monitors which will continue to be evaluated as part of this working group, to be used as an addition to evidenced-based risk assessment and appropriate observation and engagement. The Deputy Service Director and Head of Inpatient and Urgent Care have undertaken a review of all door alarms/door sets, which are currently available on the market, and this will be presented as a business case to the Trust Board, for their consideration.

SPC Chart



How do we compare

The latest NHS Benchmarking Network report, covering the year 2021/22, showed that Somerset NHS Foundation Trust had comparatively lower levels of ligature incidents than peer providers nationally.

Recent Performance

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

Area	Dec	Jan	Feb	Mar	Apr	May
Number of Ligature incidents	24	27	36	17	54	102
Number resulting in harm	8	3	5	1	8	13

Safe

Patients with a National Early Warning Score (NEWS2) score of 5 or 6 acted upon appropriately - we are committed to improving and maintaining high rates of compliance across all services and to reduce the number of incidents not responded to in a timely manner.

Current performance (including factors affecting this)

- During April/May 2023, an audit was undertaken on every Thursday, of all the Trust's adult inpatient wards (acute, community and mental health), excluding maternity.
- During the audits, 60 patients were identified as having a NEWS2 score of five or more, of whom 40 were recorded as being acted upon appropriately by both nursing and medical colleagues. The other 20 were missing part of the escalation documentation but had elements of escalation noted.

Focus of improvement work

- The Deteriorating Patient and Sepsis nurse shares the weekly audit results with the ward managers and matrons via an infographics poster. They also work alongside ward staff clinically each month with a focus on staff fully understanding the significance of a NEWS2-importance of escalation.
- A Sepsis Awareness Nurse works 12 hours per week and provides 1-2-1 teaching of the digital Sepsis screening and the Sepsis 6 tool. Any issues identified are escalated.
- Monthly Sepsis awareness training is available for all staff.
- The Deteriorating Patient and Sepsis nurse works with the digital team on the sepsis screening tool, Sepsis 6 and patientrack, ensuring the programs and devices are suitable for use. A trial of a visible screen at the front desk on Conservators ward is to be conducted. This will make viewing the NEWS2 5 easier for all staff and will support senior nurses, doctors and allied health professionals to recognise and prioritise sick patients.
- A full programme of work is underway with ownership by the Service Groups to heighten awareness of the full standard.
- We continue to see an increase in the number of overseas nurses and are aware that there is a junior workforce, targeted training and 1:1 support is being provided.

How do we compare

Compliance in full for the bi-monthly audit covering April/May 2023 decreased slightly compared to the audit covering February/March 2023.

Recent Performance

Area	Feb/Mar	Apr/May
Number of fully compliant to standard	39	40
Records audited	58	60
Compliance	67.2%	66.7%

Although not a large number, there is an improvement on last year. Please note the standards are worded slightly differently which will affect the results:

- Feb/ Mar 2022: 56%
- April May 2022: 50%

Questions from the audit tool

Standards 3a
The registered nurse should immediately inform the nurse in charge.

Standards 3b
The registered nurse should immediately inform the medical team caring for the patient.

responsive

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

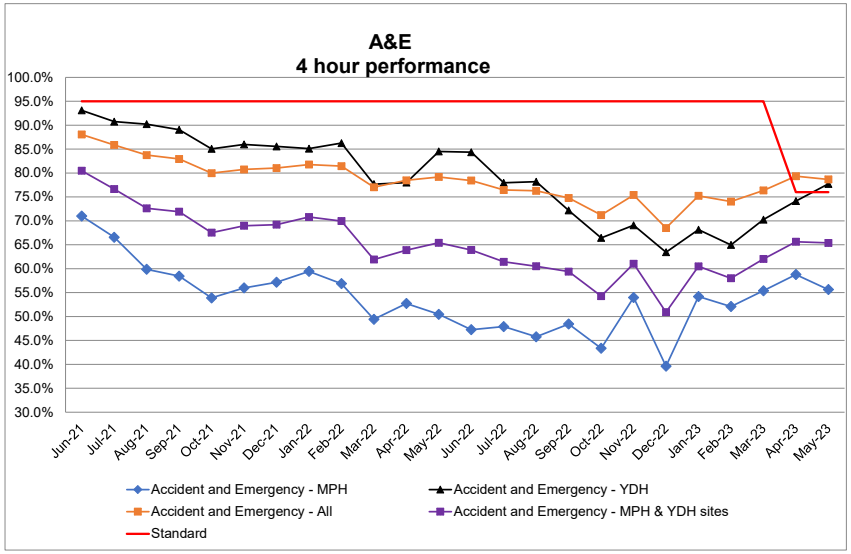
Current performance (including factors affecting this)

- Trust-wide A&E 4-hour performance for May 2023 was 65.4%, almost unchanged from April 2023. Compliance within our Minor Injury Units (MIUs) was 97.1%. Overall compliance across all attendance types was 78.7%, remaining above the revised national standard of 76%.
- Compliance in respect of our two A&E departments was:
  - Musgrove Park Hospital (MPH): 55.6%.
  - Yeovil District Hospital (YDH): 77.7%.
- Combined A&E attendances at MPH and YDH in May 2023 were 12.0% higher than May 2022 levels. The daily average number of attendances across both sites was 423 during May 2023, compared to 390 during April 2023.
- The number of patients spending more than 12 hours in the departments was 2.1% at MPH and 1.1% at YDH. The rates at both sites have improved for the last four months in a row.

Focus of improvement work

- An ED performance trajectory is in development, with an associated action plan for both sites.
- An audit of cases is undertaken when the standard operating procedure is not followed for failed GP and health professional referrals, to support direct admission to specialist teams.
- In June 2023, the successful electronic referral to the MPH Acute Medical Unit medical team was extended to nursing handovers as a 'test of change' and will be monitored and reviewed.
- There is a continued focus on embedding new Surgical Decision Unit (SDU) pathways including surgical and orthopaedic GP "expected" being streamed directly to SDU.
- Same Day Emergency Care (SDEC) completed a 'YES day' at the Musgrove site on 20 June 2023 to increase referrals seen in SDEC. The SDEC team will review the outcome of day and develop the service from learning. Both SDEC sites will review activity, pathways, staffing, and opening hours to develop both services and further support urgent Care pathways

Line Chart



How do we compare

In May 2023, the national average performance for Trusts with a major Emergency Department was 60.9%. Our performance was 65.4%. We were ranked 31 out of 109 trusts. With Minor Injury Unit attendances included, we were ranked 15, with performance of 78.7%.

Recent performance

Area	Dec	Jan	Feb	Mar	Apr	May
A&E only	50.9%	60.5%	58.0%	62.0%	65.6%	65.4%
Including MIU	68.5%	75.2%	74.0%	76.3%	79.3%	78.7%

Responsive

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

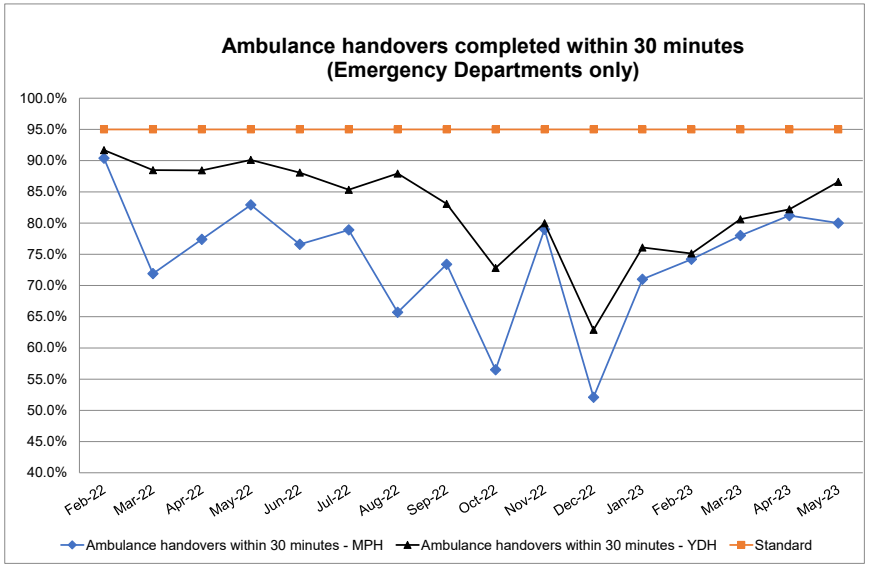
Current performance (including factors affecting this)

- During May 2023, the handover of patient arrivals by ambulance received into our Emergency Departments (EDs) at both Musgrove Park Hospital (MPH) and Yeovil District Hospital (YDH) further improved:
  - MPH: 80.0% (1,840 out of 2,301 handovers were within 30 minutes).
  - YDH: 86.6% (1,160 out of 1,340 handovers were within 30 minutes).
- The average performance across all hospitals served by SWAST in May 2023 was 63.4%.
- During May 2023, arrivals by ambulance accounted for 31.5% of all patients attending the MPH ED, down from 33.3% in April 2023. The percentage of arrivals by ambulance at our YDH ED was 23.2%, down from 25.5% in April 2023.

Focus of improvement work

- The South Western Ambulance Service NHS Foundation Trust (SWAST), Hospital Ambulance Liaison Officer (HALO) role has been implemented across the Trust, to support ambulance flow and handovers. Both acute sites and the HALO team will review role and refine processes.
- The HALO team is now fully recruited.
- Acute sites are working with SWAST and community partners to look at alternative pathways for patients to follow. An audit has been completed for the hours of 0800-2000 and will be repeated for out of hours. The results will inform a system-wide action plan.
- The ED improvement plan continues to test new ways of working to maximise flow within ED, supporting ambulance handovers.
- Bi-monthly meetings are held with the Integrated Care Board (ICB), and system providers, supporting improvement work.

Line Chart



How do we compare

In May 2023, 80.0% of all ambulance handovers at Musgrove Park Hospital and 86.6% of all ambulance handovers at Yeovil District Hospital were completed within 30 minutes. The average performance across all hospitals served by SWAST was 63.4%.

Recent performance

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

Area	Dec	Jan	Feb	Mar	Apr	May
MPH	52.1%	71.0%	74.2%	78.0%	81.2%	80.0%
YDH	62.9%	76.1%	75.1%	80.6%	82.2%	86.6%

Responsive

Referral to Treatment Time (RTT) is a measure of the length of time a patient waits from the point of referral through to receiving treatment. The target is for at least 92% of patients, who have not yet received treatment, to have been waiting less than 18 weeks at the month-end. Trusts should have no patients waiting over 52 weeks for treatment.

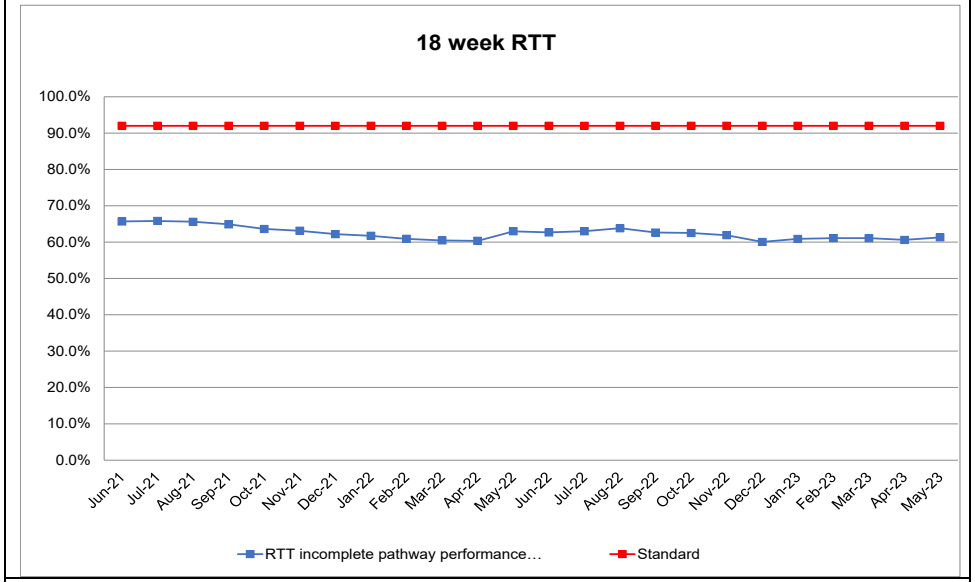
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT was 61.3% (combined acute + community) in May 2023, up slightly from 60.6% in April 2023.
- The total waiting list size increased by 506 pathways in May 2023, but was 405 lower (i.e. better than) trajectory (53,856 actual vs. 54,261). The number of patients waiting over 52 weeks increased by 93 pathways in May 2023 to 2,340 pathways, against a trajectory of 2,618 or fewer. The number of patients waiting over 65 weeks was 712 at month-end, 642 better than trajectory (1,352). The number of patients waiting 78+ weeks increased by three to 87. We reported three patients waiting over 104 weeks (all due to clinical complexity).
- Until November 2021 Musgrove remained one inpatient theatre's worth of capacity down due to the conversion of a theatre into critical care capacity. This along with other factors has resulted in a backlog of more complex, longer routine cases on the waiting list.
- Bed pressures, and to a lesser extent, theatre staff shortages continue to limit full restoration of inpatient activity, along with other factors such as increasing patient complexity, although the impact has reduced over the past two months.

Focus of improvement work

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

Line Chart



How do we compare

The national average performance against the 18-week RTT standard was 58.3% in April 2023, the latest data available; our performance was 60.6%. National performance deteriorated by 0.3% between March and April 2023. The number of 52-week waiters nationally increased by 11,313 to 371,111 (representing 5.0% of the national waiting list compared with 4.3% for the Trust).

Performance trajectory: 78week and 65 week wait performance

Area	Nov	Jan	Feb	Mar	Apr	May
78-week trajectory	499	595	440	300	0	0
78-week actual	281	252	179	68	84	87
65-week trajectory	N/A	N/A	N/A	N/A	1,105	1,352
65-week actual					714	710

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

Responsive

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

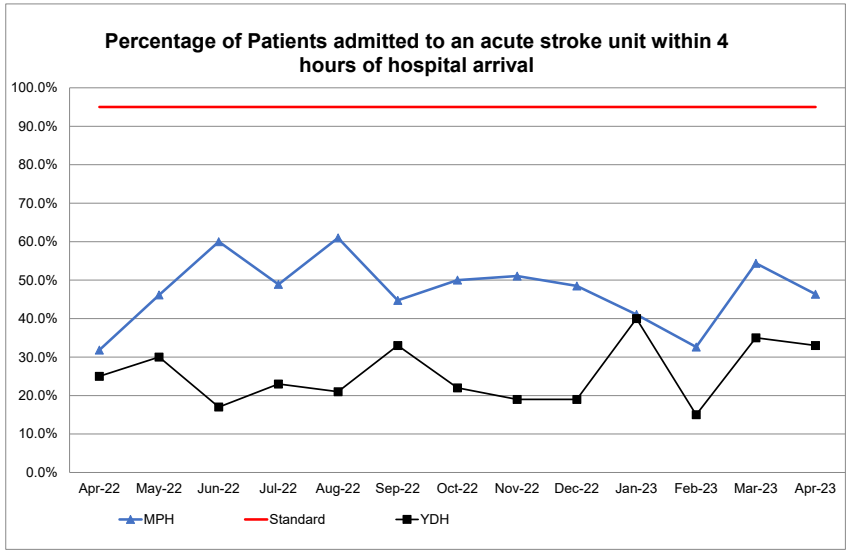
Current performance (including factors affecting this)

- During April 2023, the latest validated information, both acute hospital sites were outside of the four-hour direct admission standard. Performance at the two sites was as follows:
  - Musgrove Park Hospital (MPH): 46.3%
  - Yeovil District Hospital (YDH): 33.0%
- Performance is heavily influenced by bed availability (i.e. no stroke beds being available at the time), and also clinical presentation that may not immediately suggest stroke on admission, and medical decisions as when appropriate to move/transfer patients from the emergency departments to the wards.

Focus of improvement work

- The Stroke team are proactive in aiming to identify patients who present to ED with stroke symptoms promptly, to ensure that any delays to transferring to a stroke unit are minimised.
- Current performance levels are reflective of wider pressures on the hospital rather than a disjointed pathway of treatment for patients and when bed availability and flow are favourable, the four-hour target is achieved in the majority of cases. On review, the majority of those who are not admitted to a stroke bed within the four-hour standard transpire to be patients with stroke-like symptoms who have not actually had a stroke.
- Workforce review plans are in progress to ensure that vacant posts are appointed to and two specialist grade doctors have been appointed within the last month, with start dates of September and October 2023.
- A recruitment plan is in place for a specialist grade at Yeovil District Hospital – with interviews completed and terms being agreed.

Line Chart



How do we compare

During April 2023 compliance decreased in both hospital sites compared to March 2023.

Performance over the last six months

Area	Nov	Dec	Jan	Feb	Mar	Apr
% compliance MPH	51.1%	48.5%	51.1%	32.6%	54.4%	46.3%
% compliance YDH	19.0%	19.0%	40.0%	15.0%	35.0%	33.0%

Responsive

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

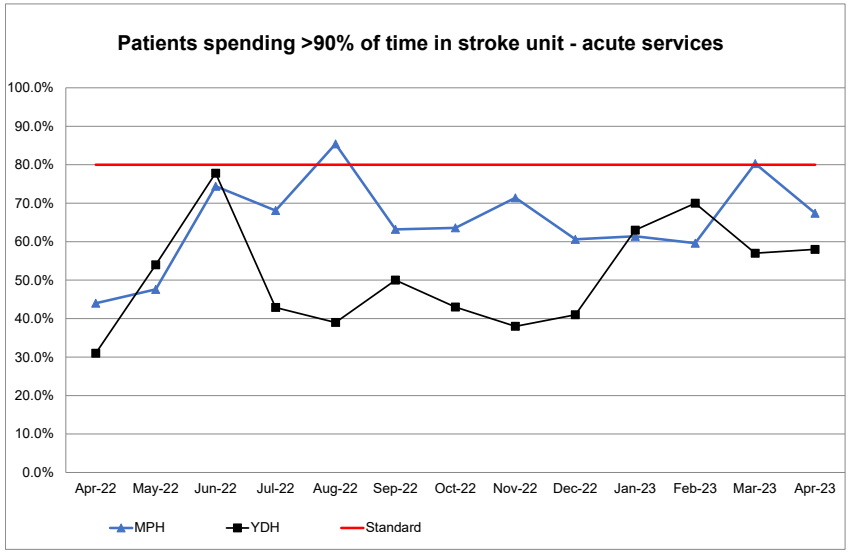
Current performance (including factors affecting this)

- During April 2023, the latest validated information, compliance at both Musgrove Park Hospital and Yeovil District Hospital was below the 80% standard. Performance at the two sites was as follows:
  - Musgrove Park Hospital (MPH): 67.4%
  - Yeovil District Hospital (YDH): 58.0%
- As is the case with the four-hour standard, performance in respect of this reporting standard is heavily influenced by the availability of stroke beds.

Focus of improvement work

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

Line Chart



How do we compare

During April 2023 compliance decreased in respect of Musgrove Park Hospital compared to March 2023, but slightly increased at Yeovil District Hospital.

Performance over the last six months

Area	Nov	Dec	Jan	Feb	Mar	Apr
% compliance MPH	71.4%	60.6%	61.4%	59.6%	80.3%	67.4%
% compliance YDH	46.0%	53.0%	60.0%	61.0%	54.0%	58.0%

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.

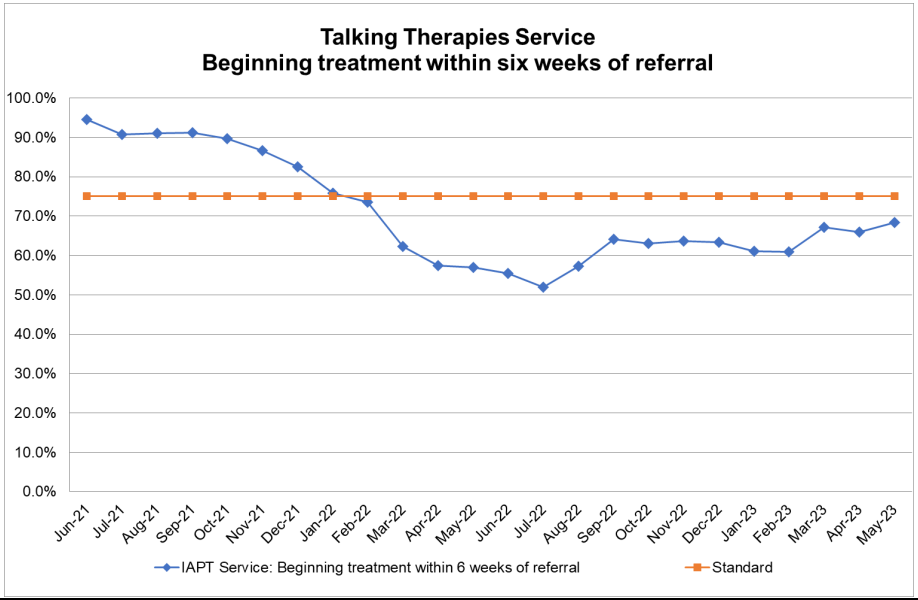
Current performance (including factors affecting this)

- During May 2023, compliance was 68.4%, up from 65.9% in April 2023 and the highest rate recorded since February 2022.
- The fall in compliance that has occurred since February 2022 has been primarily due to rising levels of demand and a shortfall in capacity within the service. Between 1 April 2021 and 31 March 2022 referrals into the service increased by 26.7% compared to the same months of 2020/21 and by 17.1% compared to same months of 2019/20.
- Referrals between 1 April 2022 and 31 March 2023 were 2.6% lower than the same months of 2021/22, but 14.0% higher than the same months of 2019/20.
- The position was being exacerbated by vacancy levels, long term sickness and maternity leave. However, in the last month there have been successes in appointing new staff.

Focus of improvement work

- Although there have been successes in recruitment with varying commencement dates there remain several posts vacant and recruiting continues to be challenging, which is reflected nationally.
- Once new colleagues commence in post, their contribution will be gradual until they are fully up to speed.
- The service has reasserted the commissioned eight-session treatment model, to offset against too many extensions to treatment.
- The service continues to employ locums and is continuing to use external online providers creatively.

Trend Chart



How do we compare

National average performance against the six-week standard in March 2023 (the latest published data) was 90.2%; our performance was 67.2%.

Recent Performance

Area	Dec	Jan	Feb	Mar	Apr	May
Total Discharges	379	411	468	528	487	582
First treatment inside of six weeks	240	251	285	355	321	398
Compliance %	63.3%	61.1%	60.9%	67.2%	65.9%	68.4%

Safe

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

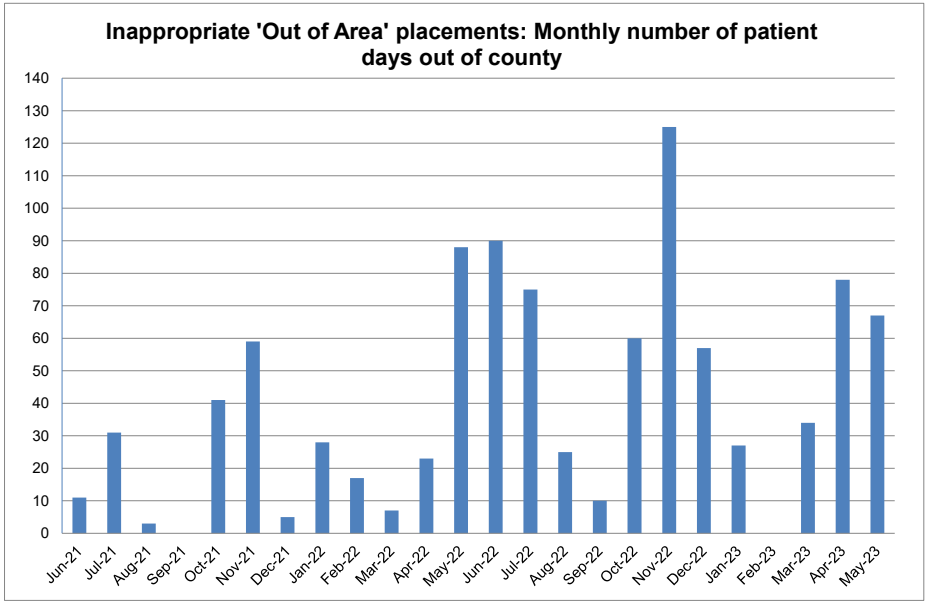
Current performance (including factors affecting this)

- During May 2023, three patients were placed out of area, for a total of 67 days.
- Two patients, who were both placed out of county during March 2023, remain so placed. One of the two patients has now been accepted by secure services and awaits a bed to become available. The other was not accepted by secure services and a meeting is due to take place to assess possible options for the patient to return to Somerset.
- The third patient, who was placed out of county on 13 April 2023, returned to Somerset on 6 May 2023.

Focus of improvement work

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

Bar Chart



How do we compare

Data published by NHS Digital shows that we continue have amongst the lowest levels of inappropriate out of area placements of all providers of mental health services nationally.

Recent Performance

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

Area	Dec	Jan	Feb	Mar	Apr	May
Number of Days	57	27	0	34	78	67
Number of patients	4	1	0	2	3	3

Responsive

Older Persons Mental Health Waiting Times – One of our key priorities is to ensure that patients are able to access our services in as timely a manner as possible, and without unnecessary delays. Our aim is to ensure that at least 90% of people are seen by our mental health services within six weeks of being referred. The data shown relates to our mental health services for children & young people, adults and older persons.

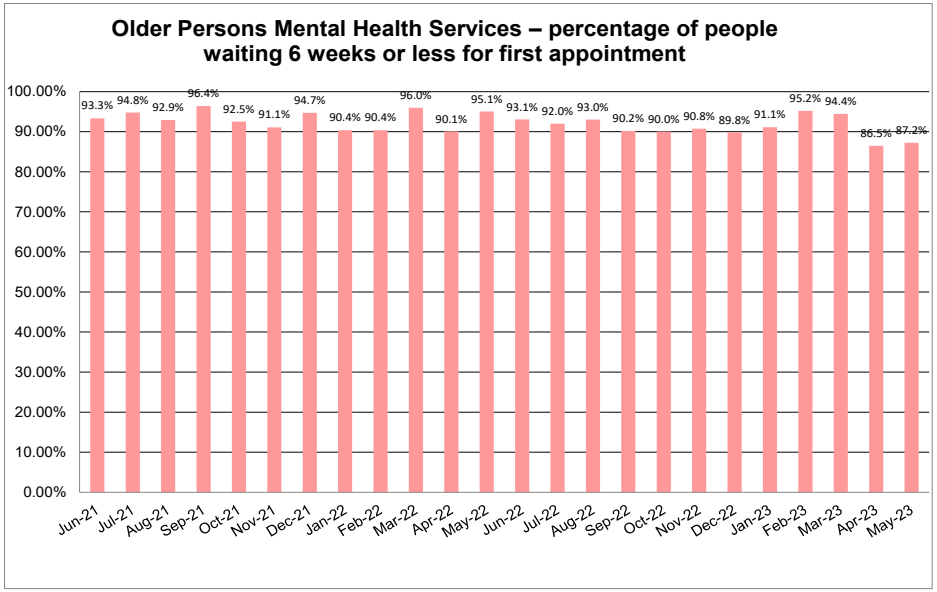
Current performance (including factors affecting this)

- As at 31 May 2023, 239 out of 274 people waiting (87.2%) were reported as waiting under six weeks. Although a slight improvement compared to 30 April 2023, compliance was still below the 90% standard.
- The performance of older persons mental health services has been particularly affected by the continued level of vacancies which significantly impacts on the capacity of the services to meet levels of presenting demand.

Focus of improvement work

- Services continue to work on recruitment to fill vacancies, and review skill mixing where appropriate. Bank and agencies have also been engaged with, to look at providing cover until posts can be recruited to.
- Reviews have been undertaken of the efficiency of processes, ensuring that patients are contacted prior to their appointments to discuss the appointment with them, and also to advise that families and friends may also attend, if the person is happy for them to do so.
- The services continue to review caseloads and activity schedules for clinicians and are appointing engagement workers who will work closely with patients, families and carers to improve engagement and attendance at initial appointments (thereby reducing the rates of patients not attending their appointments).

Run Chart



How do we compare

The latest NHS Benchmarking Network data shows our older people's median waiting time is near the best quartile.

Recent performance

The performance against the waiting time standard in recent months was as follows:

Area	Dec	Jan	Feb	Mar	Apr	May
All mental health services	89.8%	91.1%	95.2%	94.4%	86.5%	87.2%

Responsive

Perinatal and Maternal services – 12 month rolling number of women accessing services. The aim is to ensure that the number of women accessing services equates to at least 10% of the number of live births in Somerset in 2016.

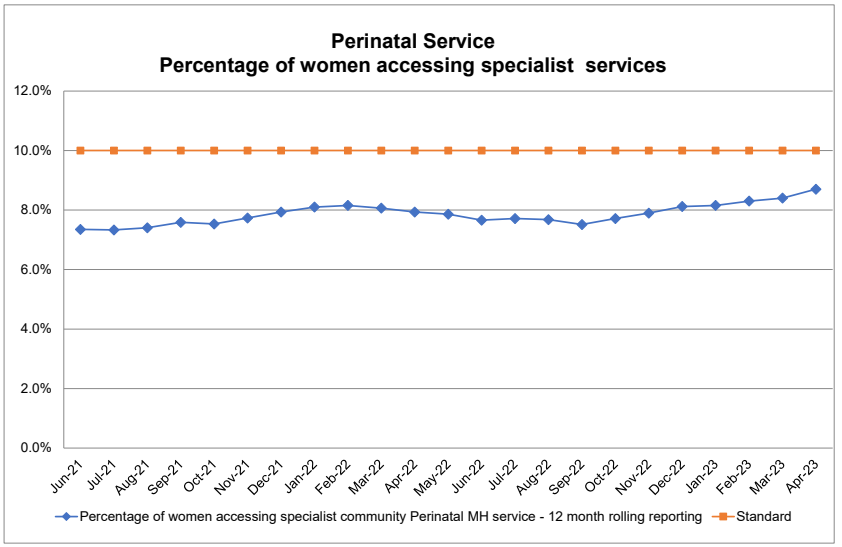
Current performance (including factors affecting this)

- Between 1 May 2022 and 30 April 2023, the latest data available, a total of 478 women accessed the service, which equates to 8.7% of the Somerset 2016 birth rate.
- The reported rate has increased for the last seven months in a row.
- Achieving the 10% standard is made more challenging by the fact that compliance is based upon the number women accessing services in the last 12 months, expressed as a percentage of the number of live births in Somerset in 2016, since when the number of live births has fallen by 7.4%. Performance based on the Somerset birth rate for 2021 was 9.4%

Focus of improvement work

- Work has been undertaken to increase the number of Attend Anywhere (AA) appointments, rather than telephone appointments, which are not counted as a contact. In cases where patients prefer to have a telephone call rather than an AA appointment, these wishes are respected.
- For referrals where an assessment is needed, the assessment is carried out face-to-face.
- The service has taken steps to improve data quality and ensure that all team members are recording all appointments with patients, in order to ensure that the numbers reported are accurate.

SPC Chart



How do we compare

Our current access rate is the second-highest in the South West region, and is around 2% higher than the national average.

Recent Performance

The 12-month rolling access rates in recent months were as follows:

Area	Nov	Dec	Jan	Feb	Mar	Apr
% compliance	7.9 %	8.1 %	8.2 %	8.3 %	8.4 %	8.7 %

Responsive

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

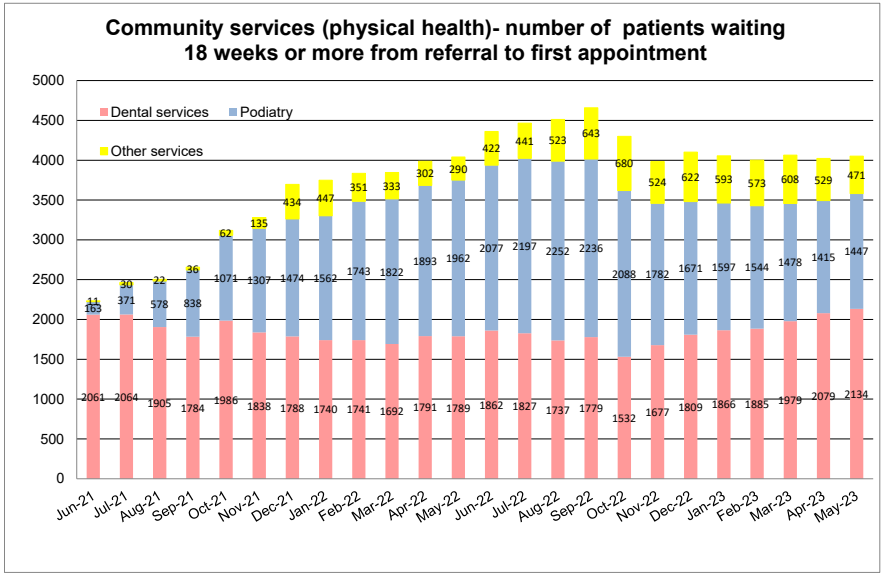
Current performance (including factors affecting this)

- As at 31 May 2023, the number of patients waiting 18 weeks or more totalled 4,052, an increase of 29 patients compared to the position as at 30 April 2023.
- Our Somerset and Dorset dental service had 2,134 patients waiting 18 weeks or more to be seen, up from 2,079 as at 30 April 2023 (Somerset: 1,850 patients, up from 1,804 and Dorset: 284 patients, up from 275), the sixth month in a row that the number has increased.
- The number of people waiting 18 weeks or more to be seen by our Podiatry service increased to 1,447 patients, from 1,415 as at 30 April 2023. This was the first monthly increase after eight consecutive months of the numbers reducing. The Podiatry service continues to have significant levels of vacancies, which is a national issue.
- Of the numbers within 'Others', 65% related to our Children and Young People Therapy Service, which increased from 273 as at 30 April 2023 to 306 as at 31 May 2023.

Focus of improvement work

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

Bar Chart



How do we compare

The number of patients waiting 18 weeks or more as at 31 May 2023 increased by 29 when compared to 30 April 2023.

Recent performance

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

Area	Dec	Jan	Feb	Mar	Apr	May
Number waiting	4,102	4,056	4,002	4,065	4,023	4,052

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).

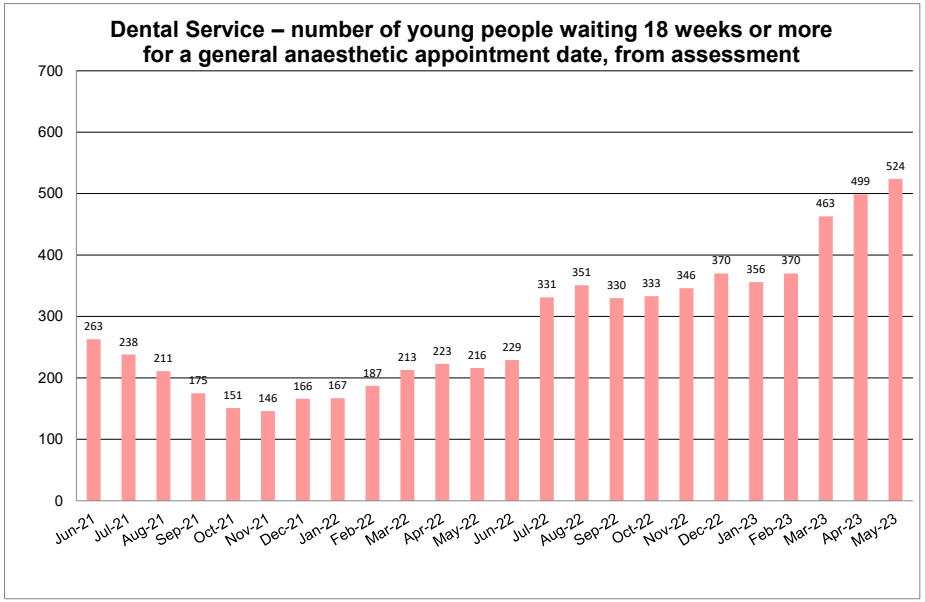
Current performance (including factors affecting this)

- As at 31 May 2023, 524 young people had waited 18 weeks or more, an increase of 25 compared to 30 April 2023.
- Of the 524 patients waiting, 439 related to our Dorset service (up from 413 as at 30 April 2023), and 85 related to our Somerset service (down from 86 as at 30 April 2023).
- The service continues to have significant levels of vacancies, which is a national issue, exacerbated by sickness/absence that affects capacity within the service, as well as the loss of some theatre slots.

Focus of improvement work

- The service continually reviews its recruitment programme and clinical delivery structure and other initiatives in an endeavour to encourage applicants. Although recent appointments have been made with varying start dates, a number of colleagues have also recently left the service. Once new colleagues commence in post, their contribution will be gradual until they are fully up to speed. A recruitment campaign for senior specialist posts is underway.
- Following active engagement, and the development of an options appraisal to which the service contributed, the Dorset Integrated Care Board (ICB) has allocated funding for Paediatric GAs, as an active intervention to start in the Autumn of 2023, to try to clear nearly 400 patients from the wait list, as well as additional ongoing capacity.
- The Somerset service continues to engage with the theatre teams to identify and support better theatre list utilisation and additional lists. With current Trust-wide issues relating to demand and capacity, along with the complexity of anaesthetics and the number of available beds, this continues to prove challenging. However, once resolved the service will be able to return to levels of capacity that were halved about 12-18 months ago due to changes in theatre requirements.

Bar Chart



How do we compare

The number of young people waiting 18 weeks or more as at 31 May 2023 increased by 25 compared to 30 April 2023.

Recent Performance

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

Area	Dec	Jan	Feb	Mar	Apr	May
Number waiting	370	356	370	463	499	524
% > 18 weeks	51.7%	48.2%	51.4%	59.7%	63.4%	66.4%

Responsive

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

Current performance (including factors affecting this)

- During May 2023, 93.2% of patients aged 65 or over who were discharged from acute hospital beds within Somerset were transferred onto Pathway 0 or Pathway 1.

Pathway 0

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

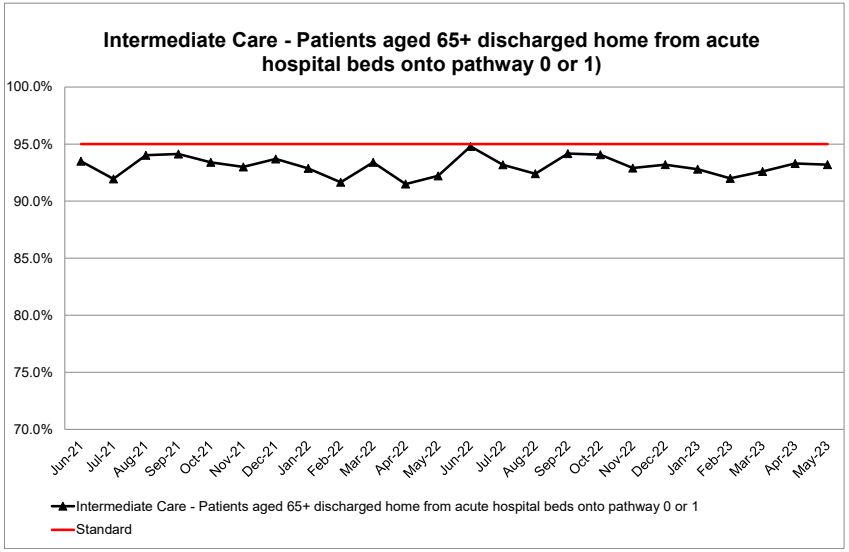
Pathway 1

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

Focus of improvement work

1. **Increase Pathway 0 discharges** - acute teams working on this.
2. **Short Term Intermediate Care Improvement Plan** – five workstreams are exploring opportunities to reduce the intermediate care No Reason to Reside (NCTR) figures – as a result, intermediate care NCTR stretch targets have been met.
3. **De-escalation of escalation beds** – admissions have ceased to 77 intermediate care beds over the last five weeks. This includes the closure of all community hospital surge and super surge beds.
4. **End of pathway delays** – good progress has been made in the sourcing of packages of care and a gradual reduction in care home delays. More focus is now needed on reducing outstanding social work assessment delays – one of the five improvement workstreams. A trajectory has been set by Adult Social Care to reduce to zero by the end of June 2023. Currently off target.
5. **Community Hospital length of stay** – overall length of stay has reduced to 38 days. A working group is to be established.
6. **Streamlining the transfer of care hub -** the next milestone is the introduction of telephone call referrals to the bedded care pathway (already operational for Pathway 1).

Line Chart



How do we compare

The percentage of patients aged 65 or more transferred onto pathway 0 or 1 during May 2023 compliance was almost unchanged from April 2023.

Performance over the last six months

Area	Dec	Jan	Feb	Mar	Apr	May
Total Discharges	2,799	2,713	2,632	2,937	2,790	2,851
Pathway 0	2,443	2,302	2,267	2,557	2,416	2,445
Pathway 1	166	216	155	163	188	213
% onto P0 or P1	93.2%	92.8%	92.0%	92.6%	93.3%	93.2%

Responsive

The two-week wait for suspected cancer is a measure of the length of wait to see a specialist following urgent referral for suspected cancer. The target is for at least 93% of patients to be seen within 14 days of referral. This standard is the first step in the 62-day GP cancer pathway standard.

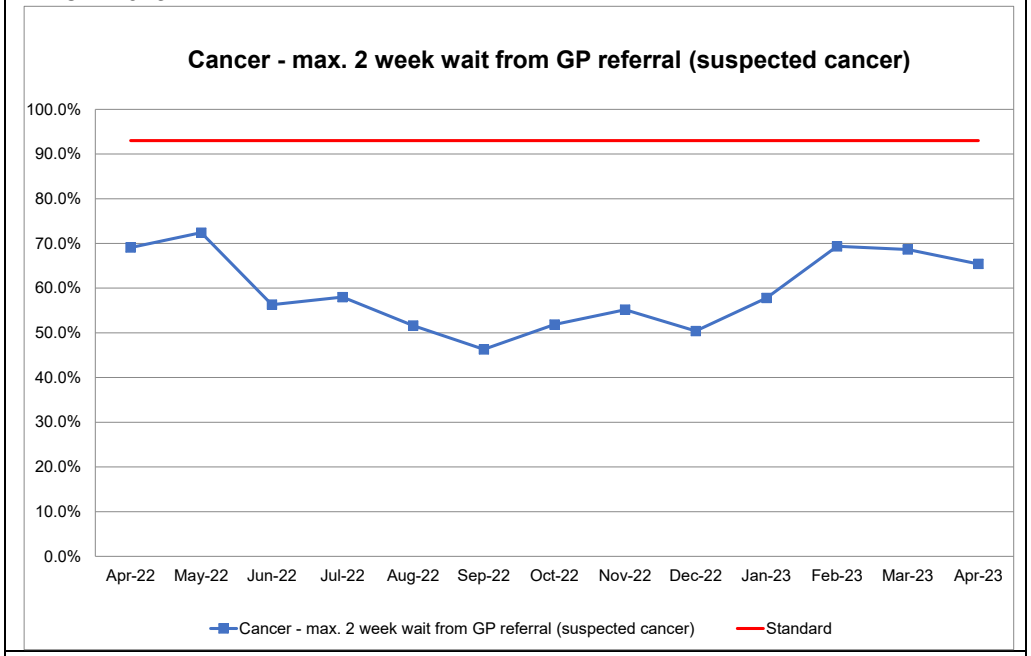
Current performance (including factors affecting this)

- The percentage of patients seen within 14 days of referral by their GP for a suspected cancer was 65.4% in April 2023, down from 68.6% in March 2023, and below both the 93% national standard and the national average.
- Lower GI (Gastrointestinal) pathways made-up 35% of breaches of the two-week wait standard, breast 24% and gynaecology 15%.
- Gynaecology referrals are currently 56% higher than pre-COVID levels, which appears to be related to the continued increase in Hormone Replacement Therapy (HRT) use. This is because a change in HRT, or dosage not being correct, may lead to bleeding which also can be a symptom of cancer. More GPs are also referring patients without a physical examination.
- Changes to the Musgrove breast service capacity due to a departure from the team last year has limited the ability of the service to meet demand and keep waits within two weeks, although the national 28-day Faster Diagnosis Standard is now being consistently met.
- Keeping pace with demand for colonoscopy and CT colon tests, which are the first step in the pathway for two-thirds of all Lower GI two-week wait referrals, remains a challenge, with further spikes in demand being seen in May 2023, following the Dame Deborah James documentary.
- The breast symptomatic (cancer not suspected) 93% two-week wait standard was not achieved in April 2023, with performance of 46.8% and 50 breaches, the majority related to the Musgrove capacity problems described above.

Focus of improvement work

- Please refer to the exception reports provided for the 28-day Faster Diagnosis Standard (Lower GI and gynaecology pathway redesign) and the Diagnostic six-week wait standard (Lower GI - colonoscopy waits) for further information on the actions being taken.

Line Chart



How do we compare

National average performance in April 2023, the latest data available, was 77.8%. Our combined performance was 65.4%. We were ranked 118 out of 141 providers.

Recent Performance

Area	Nov	Dec	Jan	Feb	Mar	Apr
% Compliance	55.2%	50.4%	57.8%	69.4%	68.6%	65.4%

Responsive

28 Day Faster Diagnosis Cancer Standard is a measure of the length of wait from referral through to diagnosis (benign or cancer). The target is for at least 75% of patients to be diagnosed within 28 days of referral. The first step in a 62-day cancer pathway.

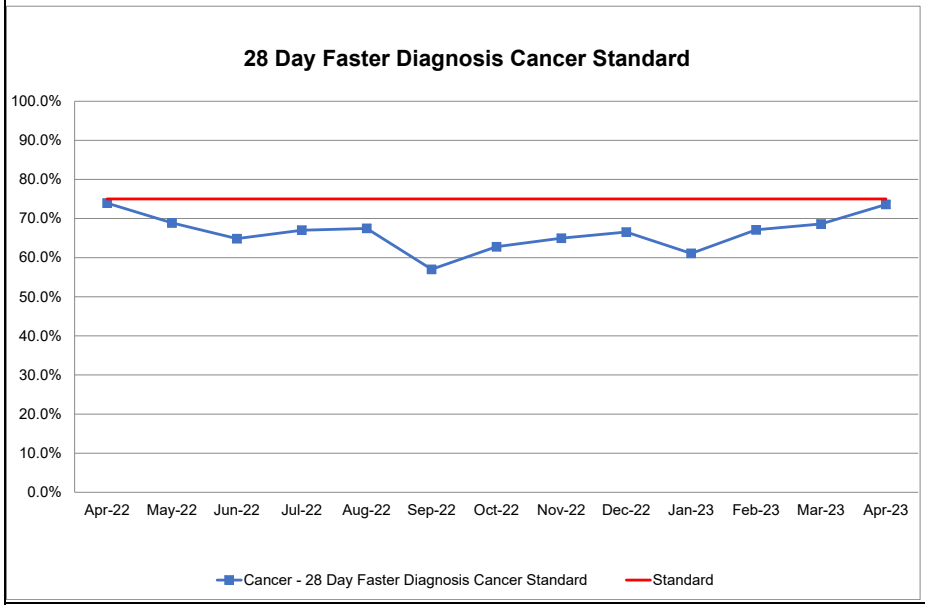
Current performance (including factors affecting this)

- The percentage of patients diagnosed with a cancer or given a benign diagnosis within 28 days of referral increased from 68.6% in March 2023 to 73.6% in April 2023, higher than the national average, but below the national 75% standard.
- The higher-volume tumour sites not meeting the 75% national standard in April 2023 were: colorectal (44.2%), urology (64.7%) and gynaecology (41.2%). Colorectal made up 43% of all the breaches of the 28-day standard and gynaecology 23%. Colorectal and gynaecology have again shown growth in referrals in recent months, relative to pre-COVID levels.
- The recent improvement in performance against the 28-day Faster Diagnosis Standard has in part been a result of breast at Musgrove Park Hospital (MPH) achieving the standard again. Breast achieved the 28-day standard in November 2022, for the first time since last achieving in April 2022, following the additional capacity put in place with GPs recruited and trained to run two-week wait clinics, support provided by Yeovil District Hospital (YDH), and evening clinics established by the team.

Focus of improvement work

- A new lead nurse post has been introduced within the Faster Diagnosis Team, to bring together and streamline the processes across the MPH and YDH sites. This should help to speed up the management of colorectal patients for this phase of their pathway.
- A new community-based/self-referral gynaecology pathway for post-menopausal bleed patients will commence over the summer. This will comprise a one-stop clinic appointment and ultrasound scan. Patients for whom a benign cause of their bleeding cannot be identified, and those requiring additional investigations, will be referred to secondary care. Women will be able to self-refer to the clinic from September 2023

Line Chart



How do we compare

National average performance for providers was 71.3% in April 2023, the latest data available. Our Trust-wide performance was 73.6%. We ranked 74 out of 141 providers.

Recent performance

Performance in recent months was as follows:

28-day Faster Diagnosis performance

Area	Nov	Dec	Jan	Feb	Mar	Apr
% Compliance	65.0%	66.5%	61.1%	67.1%	68.6%	73.6%

Responsive

31 day waiting times standard is a measure of the length of wait between diagnosis and first treatment. The standard requires at least 96% of patients are treated within 31 days diagnosis, the second step in a 62-day cancer pathway.

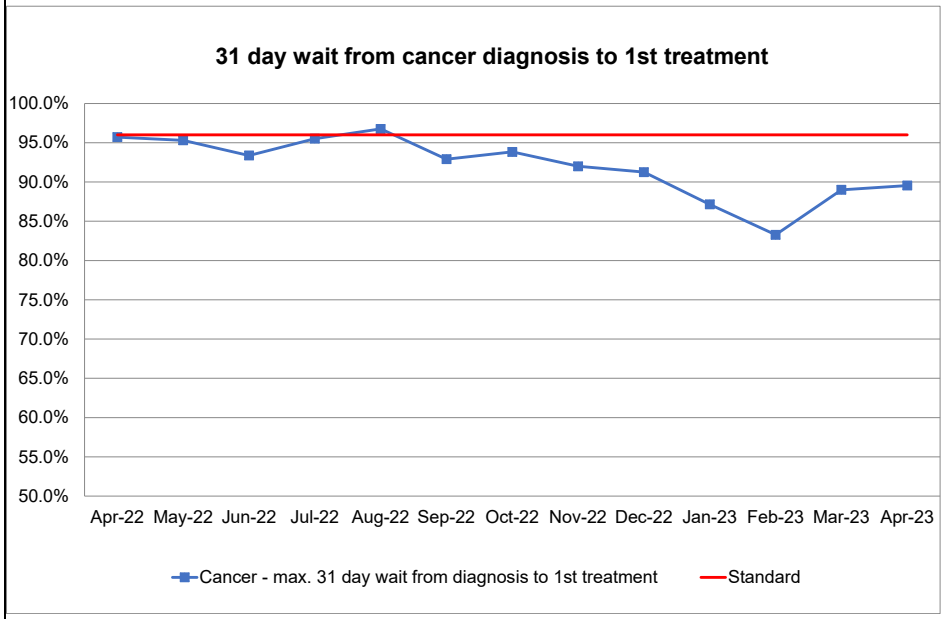
Current performance (including factors affecting this)

- Performance against the 31-day first definitive treatment standard was 89.5% in April 2023, below the 96% national standard and slightly below the national average performance.
- There were 33 breaches of the first definitive treatment standard, 16 of which were for breast pathways. This represents an unusually high number of breaches of the 31-day standard for breast patients. It relates to a bulge in the Musgrove Park Hospital waiting list as a result of additional capacity being put into the diagnostic phase of the pathway two to three months ago, which has led to more patients needing treatment at the same time.
- There were nine breaches for lower GI (gastrointestinal) pathways, also related to a bulge in demand for surgical treatment.
- There were smaller numbers of breaches of the 31-day standard across a range of tumour sites. In most cases these breaches also related to surgical capacity. Industrial action and bed pressures have had a minimal impact on planned cancer treatments. However, any delays or cancellations of surgery are clinically risk-assessed on a case-by-case basis by the operating surgeon.

Focus of improvement work

- Cancer and other urgent surgical patients continue to be prioritised for access to beds.
- The allocation of theatre lists to specialties/surgeons continues to be monitored and discussed with clinical teams on a week-to-week basis.
- The Trust has a wide-ranging plan to improve bed availability including greater use of home-based, monitored care.
- The work outlined in the other cancer exception reports (two-week wait, 28-day Faster Diagnosis Standard and 62-day GP) will also help to reduce delays in cancer pathways which will also help to smooth bulges in demand for cancer surgery.

Line Chart



How do we compare

National average performance for providers was 90.5% in April 2023, the latest data available. Our Trust-wide performance was 89.5%. We ranked 102 out of 140 providers.

Recent performance

31-day diagnosis to first treatment performance

Area	Nov	Dec	Jan	Feb	Mar	Apr
% Compliance	92.0%	91.3%	87.1%	83.3%	89.0%	89.5%

Responsive

The 62-day cancer waiting time standard is a measure of the length of wait from urgent referral by a GP for suspected cancer, to the start of first definitive treatment. The target is for at least 85% of patients to be treated within 62 days of referral.

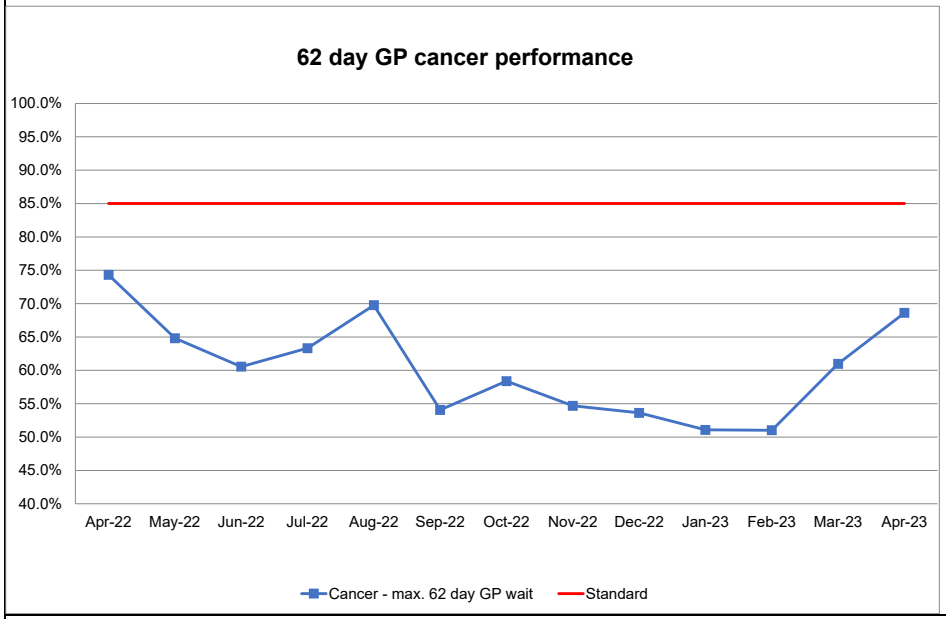
Current performance (including factors affecting this)

- The percentage of cancer patients treated within 62 days of referral by their GP improved from 61.0% in March 2023 to 68.6% in April 2023, below the national standard of 85%, but above the national average of 61.0%.
- The main breaches of the 62-day GP standards were in urology (38% of breaches) and colorectal (22%). The main causes of the breaches were very high growth in demand in urology (up 19% over the last three months, relative to same pre-COVID period) and an associated increase in diagnostic waiting times. There are also delays in patients undergoing prostate surgery at another provider due to the high demand.
- Fourteen patients were treated in April 2023 on or after day 104 (the national 'backstop'). For further details please see Appendix 5a.
- The number of patients waiting over 62 days at the end of May 2023 was one patient above (i.e. worse than) the recovery trajectory (204 against a plan of 203).

Focus of improvement work

- Additional prostate biopsy sessions continue to be run to reduce the waits for this step in the pathway. Capacity and Demand modelling will be undertaken to understand a potential recurrent shortfall in capacity.
- Pathways redesign work is continuing for prostate, across both Musgrove Park and Yeovil District Hospitals.
- The colorectal improvement group continues to meet weekly to redesign the diagnostic part of the colorectal cancer pathway.
- Please also see the 28-day Faster Diagnosis exception report for details of the gynaecology post-menopausal bleed pathway, which should help to reduce inappropriate referrals into the service and speed-up the diagnostic phase of the pathway for remaining patients.

Line Chart



How do we compare

National average performance for providers was 61.0% in April 2023, the latest data available. Our Trust-wide performance was 68.6%. We were ranked 43 out of 139 trusts.

Recent performance

62-day GP cancer performance

Area	Nov	Dec	Jan	Feb	Mar	Apr
% Compliance	54.7%	53.6%	51.1%	51.0%	61.0%	68.6%

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.

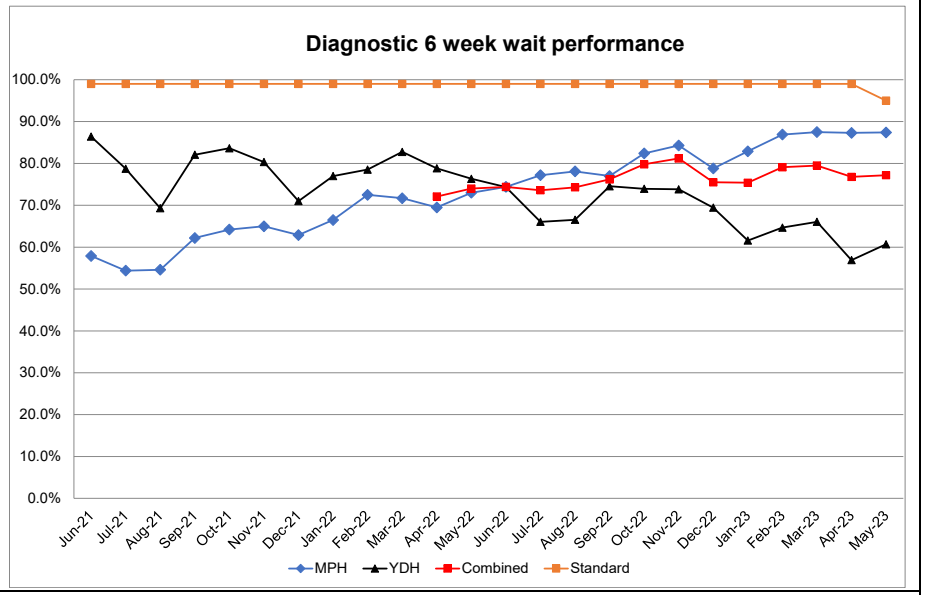
Current performance (including factors affecting this)

- The Trust-wide percentage of patients waiting under six weeks for their diagnostic test increased from 76.8% in April 2023 to 77.2% in May 2023.
- The number of patients waiting over six weeks increased by 231; the highest numbers of patients were waiting for an Echo (up from 636 to 736, 28% of over six-week waiters), Audiology (up from 358 to 428, 16%), and Colonoscopy (down from 358 to 264, 10%), together making up 54% of the long waiters.
- The total waiting list size increased by 11%, largely due to an increase in the longer-waiting Echo and, to a lesser extent, Audiology patients at the Yeovil site, because of an ongoing capacity shortfall.
- The number of patients waiting over six weeks for a colonoscopy has continued to reduce but remains high due to the very high cancer referral demand in recent months, which has pushed-out routine waits. Demand for audiology appointments also remains high.

Focus of improvement work

- An additional Echo room is being established on the Yeovil site, which is nearing completion. The clinical reporting system is also being changed to bring it in-line with the Musgrove system. This will allow image sharing across sites and more flexible use of capacity. An insourcing contract is in place, which will commence once the additional room and reporting system works are completed.
- Funding has been agreed to support the recruitment of a nurse endoscopist, which will increase colonoscopy capacity.
- Additional in-house clinics are being run in audiology, to support backlog clearance, on top of the existing outsourcing contract. The Musgrove site is out to advertisement to increase staffing levels to provide additional in-house capacity later in the year. Additional capacity is also planned on the Yeovil site as part of the Community Diagnostic Centre (East) business case.

Line Chart



How do we compare

National average performance for NHS providers (i.e. excluding Independent Sector providers) was 71.5% in April 2023, the latest data available. Our performance was 76.8%. We were ranked 89 out of 159 trusts for the 15 high-volume diagnostic tests.

Recent performance

Area	Dec	Jan	Feb	Mar	Apr	May
Musgrove Park Hospital (MPH)	78.8%	82.9%	86.9%	87.5%	87.3%	87.4%
Yeovil District Hospital (YDH)	69.4%	61.6%	64.7%	66.1%	56.9%	60.7%
Combined	75.5%	75.4%	79.1%	79.5%	76.8%	77.2%

Responsive

Our aim is to ensure that at least 90% of the complaints we receive are responded to within 40 working days.

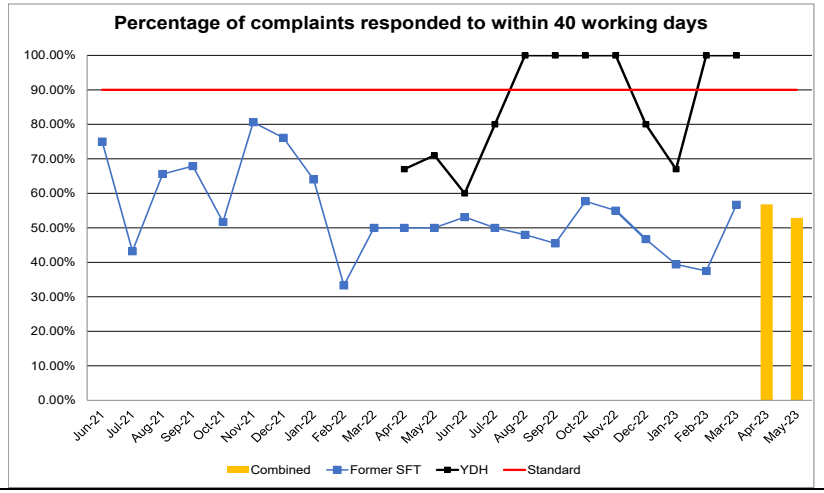
Current performance (including factors affecting this)

- In May 2023, 52.9% of complaints were responded to within 40 working days, down from 56.8% in April 2023. Production of the Trust-wide data continues to present challenges, associated with the merging of the teams, processes and systems used in the predecessor organisations (Radar and Ulysses).
- During May 2023 a total of 34 complaints were closed, and 24 new complaints were received.
- For the 'test of change' process, incorporating both the Neighbourhood and Medicine service groups, 14 complaints are going through the test of change process, of which one is overdue.
- Of the 14 active complaints, 12 complainants have requested written responses and two would like a meeting.

Focus of improvement work.

- Work continues within the Patient Experience team to develop and implement key indicators, with a timescale for completion of Autumn 2023.
- A test of change process commenced within the Medicines service group in April 2023. As this was working well, it was rolled out to the Neighbourhood service group. The Surgical services group is scheduled to follow in July 2023.
- Process mapping sessions continue with PALS and complaints to understand the similarities and differences between the two teams.
- The Director and Head for Patient Experience continue to review resources and processes including interaction with the service groups to understand their expectations and support required from the team.
- The Surgical services group has a new governance team in place. Open complaints have reduced from approximately 50 at its peak to 16 as at 31 May 2023..

Line Chart



How do we compare

Compliance during May 2023 decreased compared to April 2023.

Recent Performance

Our performance in recent months is as follows:

Area	Dec	Jan	Feb	Mar	Apr	May
% within 40 working days					56.8%	52.9%

Current open complaints:

Service Group	Within date	Late	Total
Surgical	8	8	16
Medical	11	4	15
Children & Young Persons & Families	3	1	4
Mental Health & Learning Disabilities	15	1	16
Neighbourhoods	3	0	3
Clinical Support & Cancer Services	2	3	5
Centrally Coordinated	2	0	2
Totals:	**44**	**17**	**61**

Well Led

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

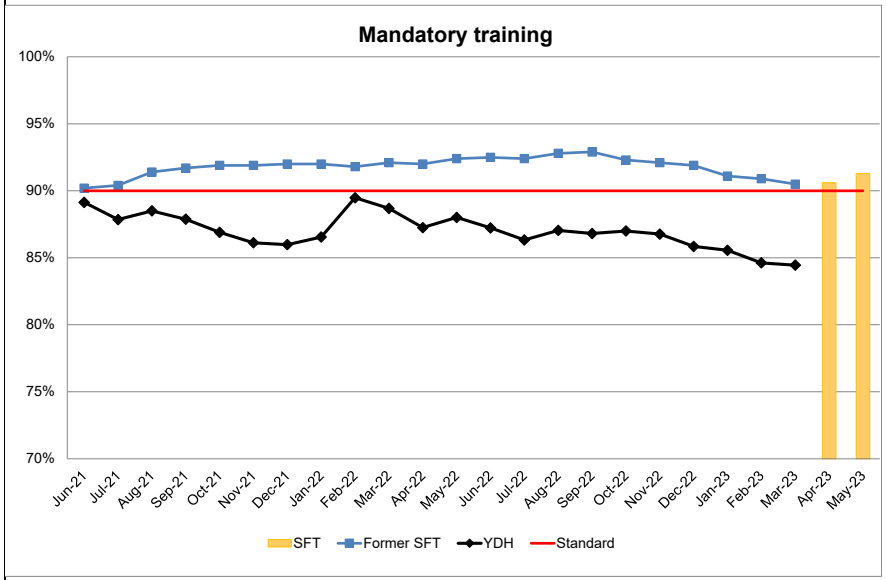
Current performance (including factors affecting this)

- As at 31 May 2023, our overall mandatory training rate as a merged Trust was 91.3%.
- Apart from Symphony Health Service (SHS), all colleagues moved to the newly-commissioned Trust training system, LEAP, on 1 April 2023. As at 31 May 2023, compliance reported from the two separate systems was as follows:
  - LEAP: 91.4% (90.7% as at 30 April 2023)
  - SHS: 74.6% (79.2% as at 30 April 2023)
- Operational pressures, and limited capacity for areas with large backlogs such as life support and safeguarding continue to remain a challenge to full recovery.

Focus of improvement work

- Work is ongoing to improve reporting, through combining information from the Trust's LEAP system and also from SHS.
- The Resuscitation team continues to create additional curriculum and training opportunities to target those who will become out of date now that the reversion to a 12-month training cycle has been applied.
- Service Groups and Corporate Directorates continue to receive tailored reports via their People Business Partners and have real-time access via the learning management system to data on their teams, to help identify areas which need action.
- Action continues, to support re-mapping in service groups for Level 3 safeguarding, where teams indicate that they may be incorrectly mapped.
- The Safeguarding Team are undertaking a review to consider moving a risk-based solution to cover periods when operational pressures occur.
- The Deputy Chief People Officer and members of their senior management team are following up reported compliance of SHS to ascertain actions being undertaken to improve uptake.

Run Chart



How do we compare

Compliance as at 31 May 2023 increased compared to 30 April 2023.

Recent Performance

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

Area	Dec	Jan	Feb	Mar	Apr	May
Former SFT	91.9%	91.1%	90.9%	90.5%		
YDH	85.2%	85.4%	84.1%	83.6%		
Merged Trust					90.6%	91.3%

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.

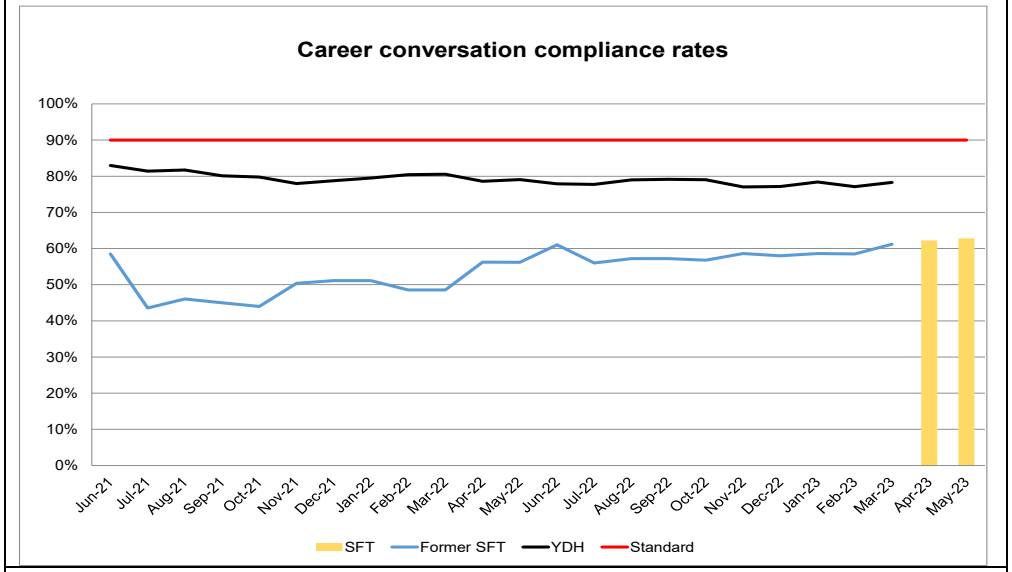
Current performance (including factors affecting this)

- Compliance as at 31 May 2023, in respect of career conversation reviews being undertaken at least annually, was 62.7%, up from 62.1% as at 30 April 2023, but below the standard of 90%.
- Operational pressures continue to affect compliance.

Focus of improvement work

- Work is currently in progress to merge the workforce information of both predecessor Trusts, to enable retrospective analysis to be undertaken and presented.
- Conversations continue between People Business Partners and Leadership and service group leads, with a more focused approach with directorates to support teams in identifying and removing barriers to improving performance.
- Career conversations continue to be a key area of discussion in directorate and service group meetings to ensure this is reviewed at every opportunity and given the right level of focus.
- People Business Partners now have access to information relating to colleagues who are due an increment award this year and whose review is currently out of date. This informs the monthly conversations held with service managers and assists with highlighting the importance of ensuring that career conversations for all colleagues are in date.
- The accessibility and functionality of the recording system is being reviewed, with feedback from focus groups being collated with a view to possible adjustments of the system and support within the leadership development programme. The review also forms part of a comprehensive review of career conversations and the alignment of processes across the Trust.

Run Chart



How do we compare

Compliance as at 31 May 2023 increased slightly compared to position as at 30 April 2023

Recent performance

The compliance rates in recent months were as follows:

Area	Dec	Jan	Feb	Mar	Apr	May
Former SFT	58.0%	58.6%	58.5%	61.2%		
YDH	77.1%	78.4%	77.1%	78.3%		
Merged Trust					62.1%	62.7%

Well Led

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

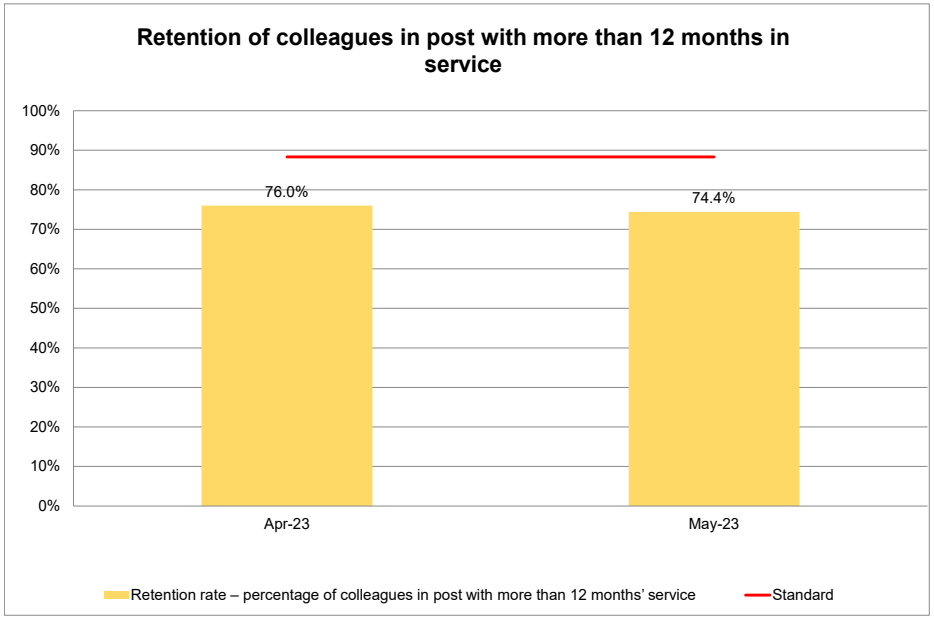
Current performance (including factors affecting this)

- Of 172 colleagues who had commenced employment on or after 1 June 2022, a total of 128 (74.4%) were still with the Trust as at 31 May 2023.
- As at 30 April 2023 the number was 117 out of 154 (76.0%) who had commenced employment on or after 1 May 2022.

Focus of improvement work

- As one of 23 NHS People Promise Exemplar sites, we have a detailed action plan in place to improve retention across the Trust. This has been in place for 12 months and has already demonstrated some small improvements in retention. The aim of the exemplar sites is to test the assumption that optimum delivery of all NHS People Promise interventions delivered in one place simultaneously can deliver improved colleague experience and retention outcomes - beyond the sum of the individual components.
- Key areas of focus for the people promise work includes, local induction improvement project, stay conversation pilots, implementing legacy mentoring and developing a detailed flexible working improvement project.
- Retention is a key element of the People Strategy 2023 to 2028, and one of the nine year-one deliverables focuses on implementing a talent management framework in line with the Future of the NHS Human Resources and Organisational Development priorities. This will include agreeing formal governance arrangements to provide oversight of talent management, succession planning and will link with partners across the system and will be a key element of improving retention within the organisation.

Trend Chart



How do we compare

The retention rate decreased slightly during May 2023 compared to April 2023.

Recent performance

The retention rates in recent months were as follows:

Area	Dec	Jan	Feb	Mar	Apr	May
Monthly rate					76.0%	74.4%

Well Led

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

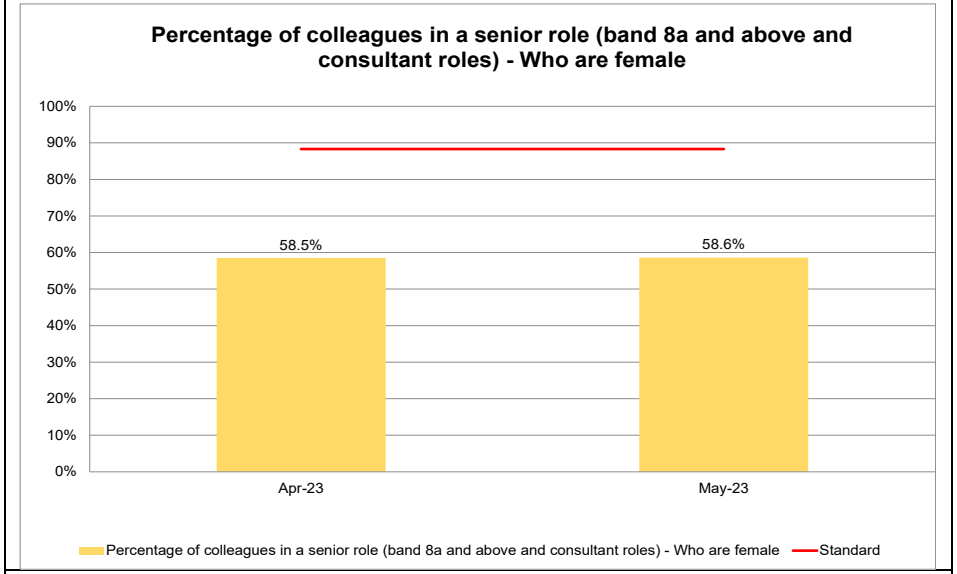
Current performance (including factors affecting this)

- Across Somerset NHS Foundation Trust as a whole, 79% of colleagues (excluding bank, locum and those on secondment) are female. Even though our organisation is female-dominated, there is a lower representation of women in senior roles, which influences our organisational wide pay gap.
- As at 31 May 2023, of 1,800 colleagues employed at Band 8a or above, a total of 1,055 identified as female, a rate of 58.6%. This is a slight increase from the rate reported as at 30 April 2023.
- Our mean gender pay gap is 20% (female colleagues on average paid less than male colleagues). When looking at role-type and pay bands, pay gaps within agenda for change bands are relatively low. However, there are much larger pay gaps within our medical and dental workforce.
- Analysis of the Clinical Excellence Awards identified inequalities in relation to race and gender, with women and BAME colleagues being less likely to apply and being awarded lower value awards.

Focus of improvement work

- Based on our analysis, we have identified the need to focus on the Clinical Excellence Award, to understand how we make this national scheme as inclusive as possible locally.
- We plan to complete a more detailed analysis to understand why we are seeing larger pay gaps within medical roles and within consultant positions in particular.
- Service groups will be able to review their own gender representation and identify actions to address this.
- Two year-one key deliverables for the People Strategy 2023 to 2028 will support this work, one on talent management and another on inclusive, skills-based recruitment practices.

Run Chart



How do we compare

Nationally:

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

Recent performance

Compliance over recent months were as follows:

Area	Dec	Jan	Feb	Mar	Apr	May
Monthly rate					58.5%	58.6%

Well Led

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

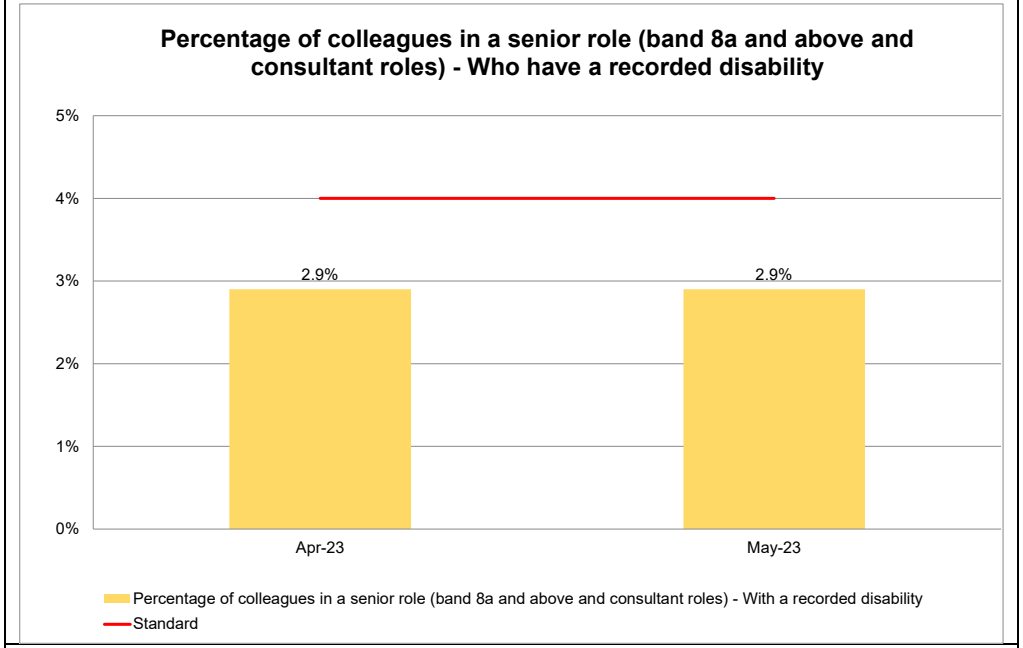
Current performance (including factors affecting this)

- Within Somerset NHS Foundation Trust, 4% of colleagues are recorded as having a disability.
- As at 31 May 2023, of 1,800 colleagues employed at Band 8a or above, a total of just 53 (2.9%) were recorded as having a disability. This rate was unchanged from the rate reported as at 30 April 2023.
- Disabled colleagues are under-represented when compared to the general population and under-represented at senior levels.
- Our data indicates the proportion of colleagues who have not completed their data in ESR increases with seniority.

Focus of improvement work

- Improving declaration rates will afford the ability to build a better picture of representation. Understanding why ESR declaration rates are low is key to improving this.
- Service groups will be able to review their own disability representation and identify actions to address this as part of the revised scorecard.
- Two year-one key deliverables for the People Strategy 2023 to 2028 will support this work, one on talent management and another on inclusive, skills-based recruitment practices.

Run Chart



How do we compare

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

Recent performance

Compliance over recent months were as follows:

Area	Dec	Jan	Feb	Mar	Apr	May
Monthly rate					2.9%	2.9%

Well Led

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

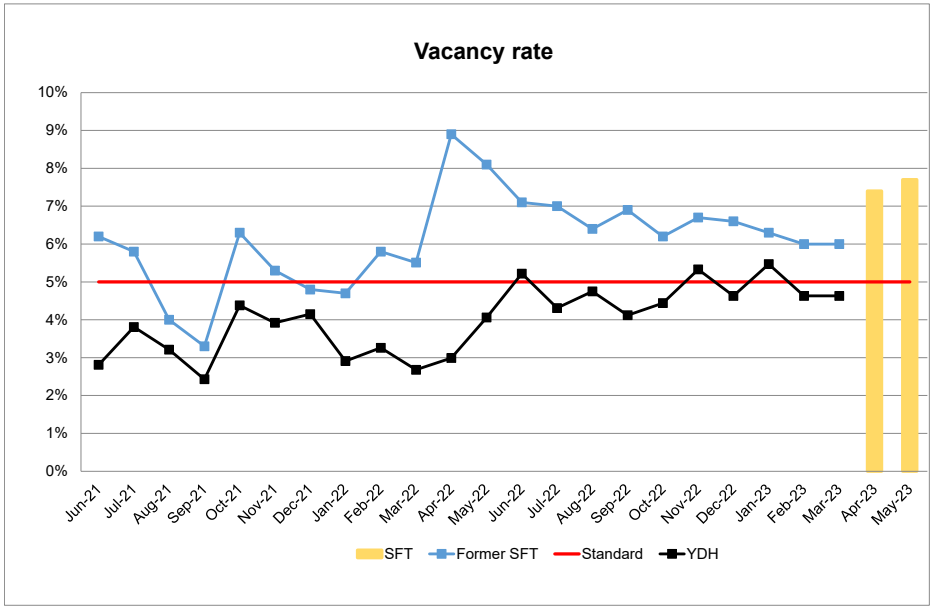
Current performance (including factors affecting this)

- The vacancy rate as at 31 May 2023 was 7.7%, 2.7% above the 5% compliance standard.
- The reported vacancy rate increased, mainly due to additional funding being received across operational and corporate areas prior to recruitment to new posts being undertaken.
- There are also many areas where vacancies are of particular concern, and are recognised nationally as areas of shortage, including psychologists, podiatrists, registered mental health nurses, theatres, and a range of medical staffing including orthogeriatric, orthodontic, endoscopy, cardiology and respiratory consultants. These gaps are reflected on the risk register both corporately and at service level.
- Retaining healthcare support workers also continues to be a challenge.

Focus of improvement work

- Continuing to deliver and monitor the impact of the People Promise Exemplar work.
- Reviewing our workforce plans and approach with service groups to ensure that the focus on addressing vacancies remains a priority.
- The focus on reducing agency spend to achieve the NHS England agency cap will support improvements in the vacancy position.
- Delivery of the Somerset system multi-year plan to address staffing challenges collaboratively.

Run Chart



How do we compare

The vacancy rate within the Trust increased during May 2023 compared to April 2023.

Recent performance

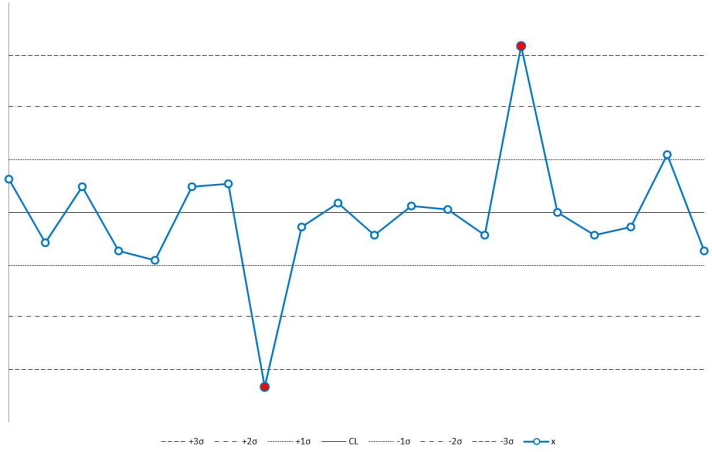
The performance against the vacancy rate standard in recent months was as follows:

Dec	Dec	Jan	Feb	Mar	Apr	May
Vacancy rate					7.4%	7.7%

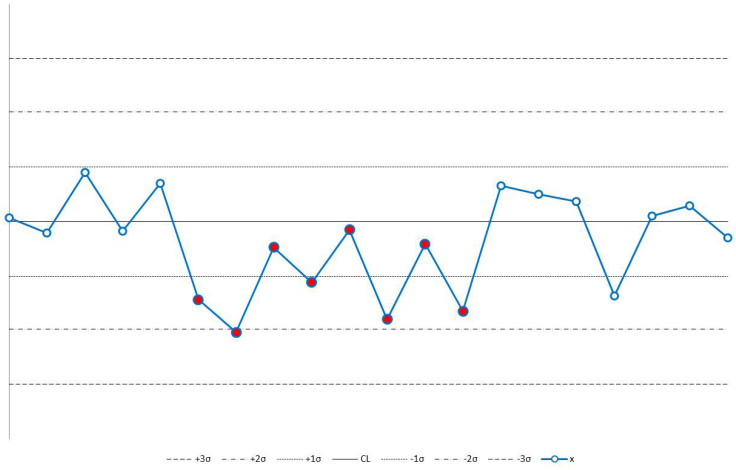
Appendix 1 - Procedure for Interpreting Run Charts

Special Cause Variation Rules

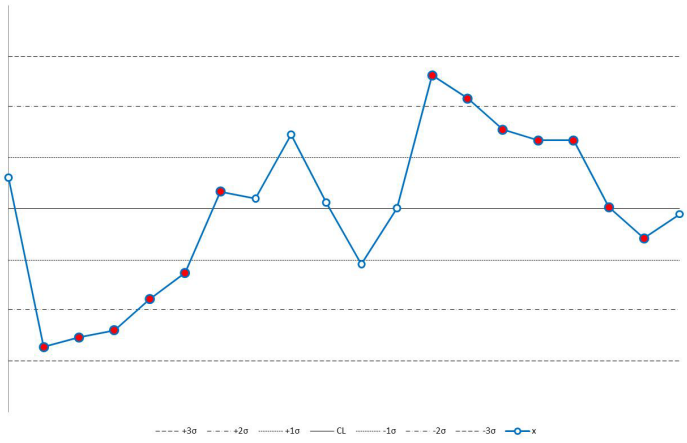
1. A single point outside the control limits



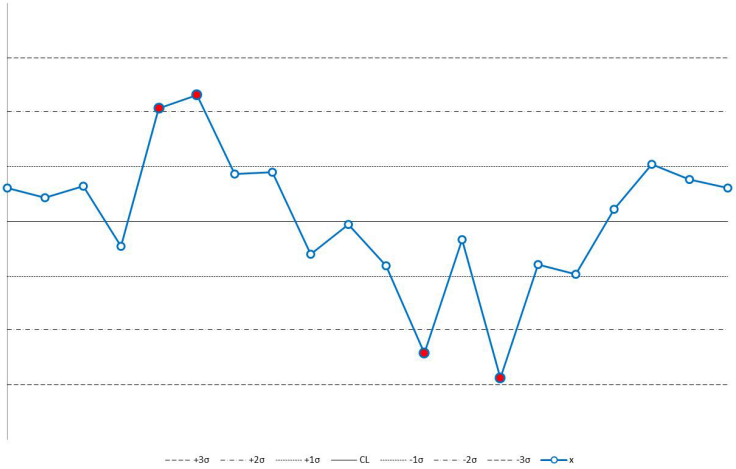
2. A run of eight or more points in a row above (or below) the centreline



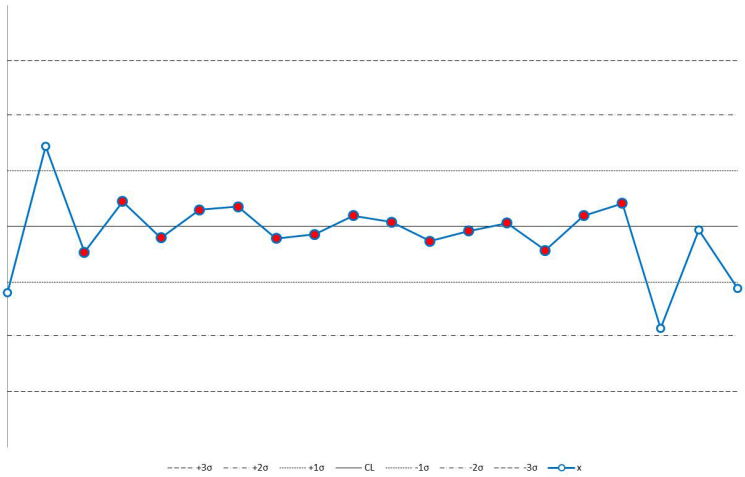
3. Six consecutive points increasing (trend up) or decreasing (trend down)



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



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



APPENDIX 2

OUR CARE QUALITY COMMISSION RATINGS

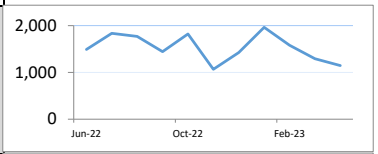
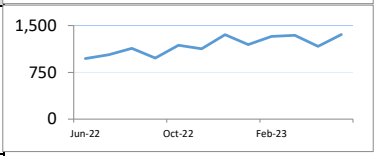
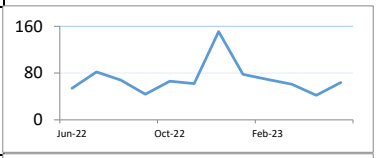
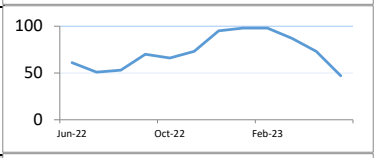
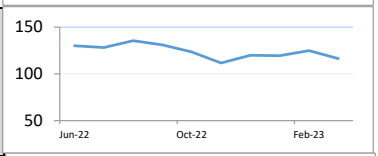
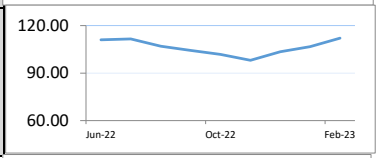
Our current Care Quality Commission ratings are as follows:

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

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

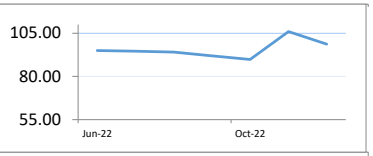
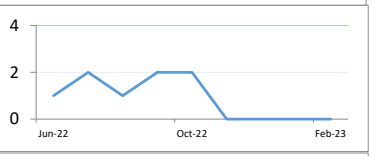
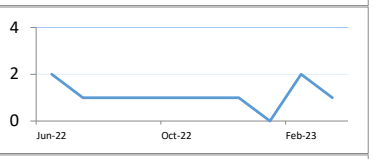
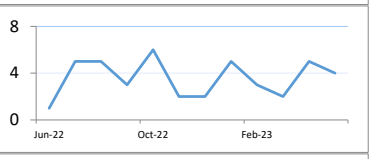
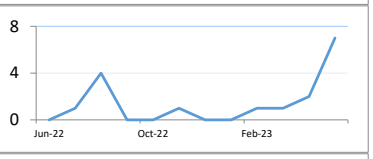
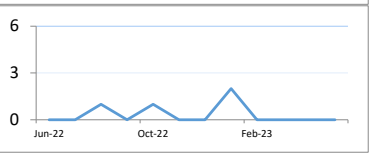
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	
Admissions	1	Number of medical and surgical outliers in acute wards	MPH	1,489	1,835	1,770	1,442	1,824	1,067	1,424	1,964	1,579	1,293	1,145	Data awaited	
	2		YDH	971	1,033	1,134	978	1,183	1,126	1,354	1,196	1,326	1,344	1,168	1,356	
	3	Admissions of under 16 year olds to adult mental health wards		0	0	0	0	0	0	0	0	0	0	0	0	
	4	Mixed sex accommodation breaches	Acute wards	0	0	0	0	0	0	0	0	0	0	0	0	
	5	Number of patients transferred between acute wards after 10pm	MPH	54	82	68	44	66	62	151	78	69	61	42	64	
	6		YDH	61	51	53	70	66	73	95	98	98	87	73	47	
tality (acute services)	7	Hospital Standardised Mortality Ratio (HSMR)	MPH and Community Hospitals	130.15	128.23	135.50	131.01	123.38	111.66	119.98	119.34	124.90	116.36	April 2023 to be reported after May 2023		
	8	Summary Hospital-level	MPH and Community Hospitals	111.07	111.57	106.95	104.28	101.81	98.08	103.43	106.72	112.07	March 2023 to be reported after May 2023			

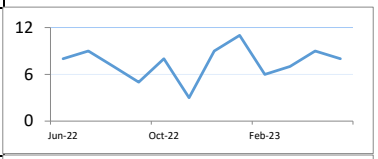
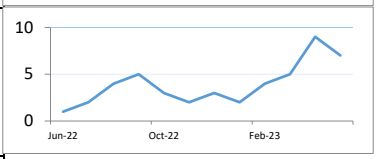
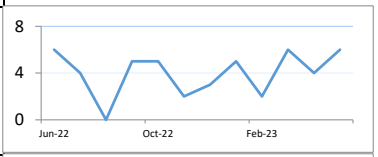
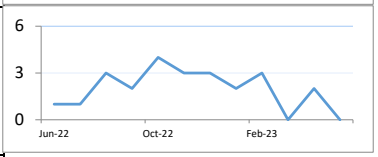
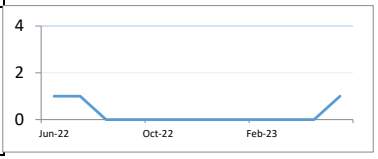
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	
Mort	9	Mortality Indicator (SHMI)	YDH	95.00	94.59	94.11	91.92	89.84	105.98	98.70	January 2023 to be reported after May 2023					
Incident reporting	10	No of Serious Incidents Requiring Investigation (SIRIs)/Never Events - acute services		1	2	1	2	2	0	0	0	0	Data awaited	Data awaited	Data awaited	
	11	Number of recorded Serious Incidents Requiring Investigation - community and mental health services		2	1	1	1	1	1	1	0	2	1	Data awaited	Data awaited	
	12	Clostridium Difficile cases HOHA cases (Hospital Onset Hospital Acquired) and COHA cases (Community Onset Hospital Acquired)	MPH,	1	5	5	3	6	2	2	5	3	2	5	4	
	13		YDH	0	1	4	0	0	1	0	0	1	1	2	7	
	14		Community Hospitals and Mental Health wards	0	0	1	0	1	0	0	2	0	0	0	0	
	15	MRSA bacteraemias (post)	MPH,	0	0	0	0	0	0	0	0	0	0	0	1	
	16		YDH	0	0	0	0	0	0	0	0	0	0	0	0	

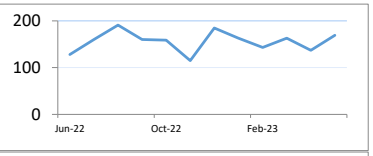
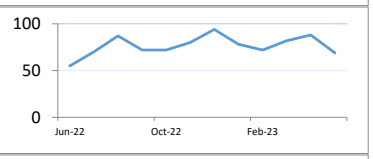
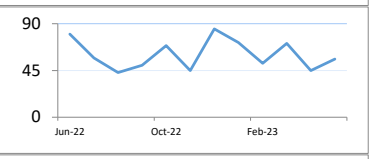
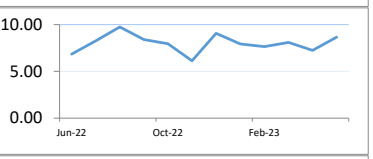
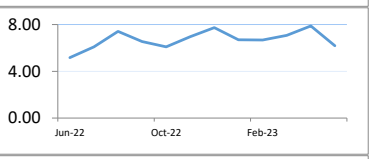
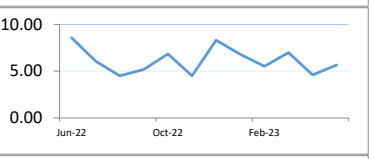
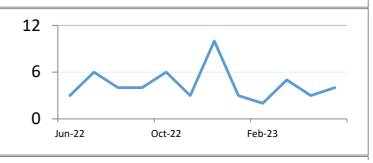
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	
Infection Control	17		Community Hospitals and Mental Health wards	0	0	0	1	0	0	0	0	0	1	0	0	
	18	E. coli bacteraemia	MPH,	8	9	7	5	8	3	9	11	6	7	9	8	
	19		YDH	1	2	4	5	3	2	3	2	4	5	9	7	
	20	E. coli bacteraemia	Community Hospitals and Mental Health wards	0	0	0	0	0	0	0	0	0	0	0	0	
	21		MPH,	6	4	0	5	5	2	3	5	2	6	4	6	
	22	Methicillin-sensitive staphylococcus aureus	YDH	1	1	3	2	4	3	3	2	3	0	2	0	
	23		Community Hospitals and Mental Health wards	0	0	0	0	0	0	0	0	0	0	0	0	
ernity	24	No. of still births		1	1	0	0	0	0	0	0	0	0	0	1	

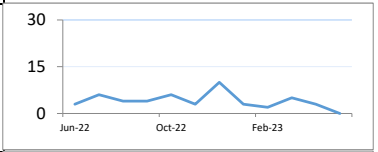
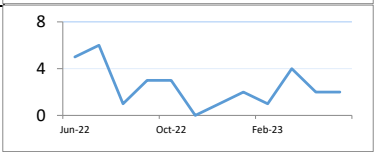
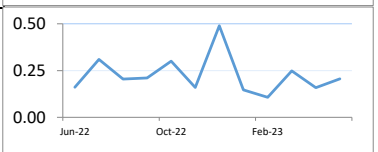
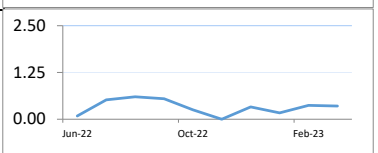
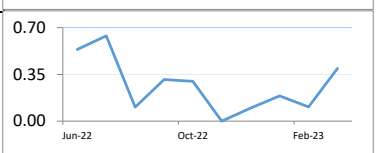
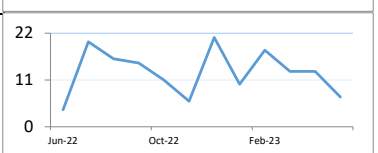
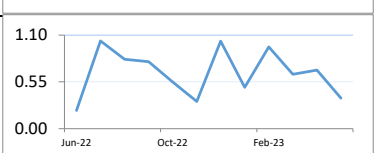
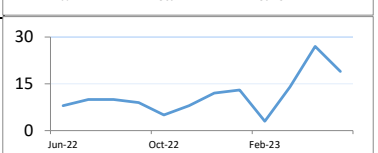
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	
Mate	25	No. of babies born in unexpectedly poor condition		0	0	0	0	0	0	0	0	0	0	0	0	
Falls	26	Total number of patient falls	MPH	128	160	191	160	159	115	185	163	143	163	137	169	
	27		YDH	55	70	87	72	72	80	94	78	72	82	88	69	
Falls	28	Total number of patient falls	Community Hospitals and Mental Health wards	80	57	43	50	69	45	85	72	52	71	45	56	
	29	Rate of falls per 1,000 occupied bed days - all services	MPH	6.86	8.25	9.75	8.40	7.95	6.13	9.06	7.94	7.65	8.09	7.24	8.67	
	30		YDH	5.17	6.10	7.42	6.54	6.09	6.96	7.74	6.69	6.67	7.08	7.88	6.19	
	31		Community Hospitals and Mental Health wards	8.57	6.07	4.50	5.19	6.84	4.51	8.32	6.80	5.53	7.00	4.60	5.68	
Falls	32		MPH	3	6	4	4	6	3	10	3	2	5	3	4	

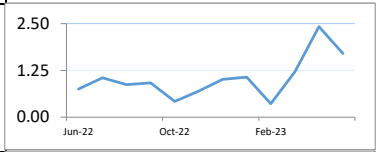
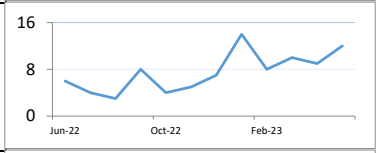
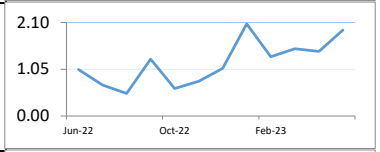
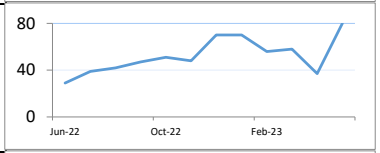
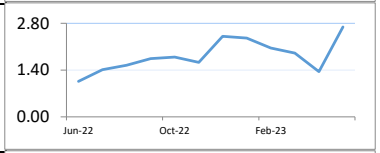
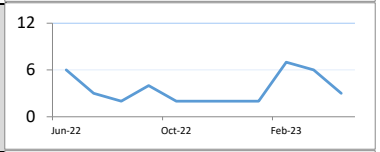
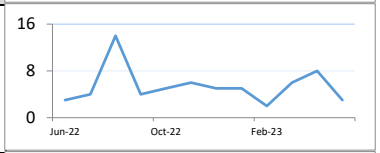
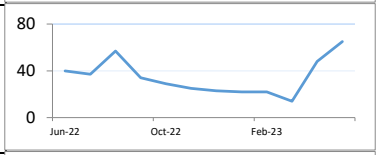
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	
	33	Moderate Harm - Number of falls resulting in moderate harm - all services	YDH	3	6	4	4	6	3	10	3	2	5	3	0	
	34		Community Hospitals and Mental Health wards	5	6	1	3	3	0	1	2	1	4	2	2	
	35	Moderate Harm - Rate of falls resulting in moderate harm per 1,000 occupied bed days - all services	MPH	0.16	0.31	0.20	0.21	0.30	0.16	0.49	0.15	0.11	0.25	0.16	0.21	
	36		YDH	0.09	0.52	0.60	0.55	0.25	0.00	0.33	0.17	0.37	0.35	0.27	0.00	
Falls	37	Moderate Harm - Rate of falls resulting in moderate harm per 1,000 occupied bed days - all services	Community Hospitals and Mental Health wards	0.54	0.64	0.10	0.31	0.30	0.00	0.10	0.19	0.11	0.39	0.39	0.39	
	38	Acute wards - number of incidents	MPH	4	20	16	15	11	6	21	10	18	13	13	7	
	39	Rate of pressure ulcer damage per 1,000 acute ward occupied bed days	MPH	0.21	1.03	0.82	0.79	0.55	0.32	1.03	0.49	0.96	0.64	0.69	0.36	
	40	Acute wards - number of incidents	YDH	8	10	10	9	5	8	12	13	3	14	27	19	

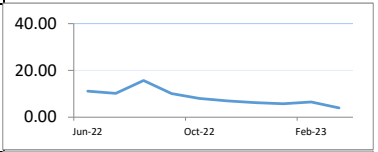
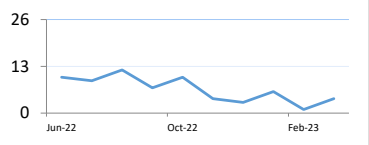
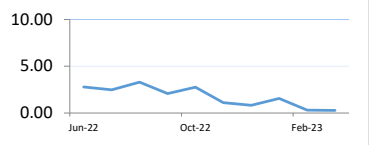
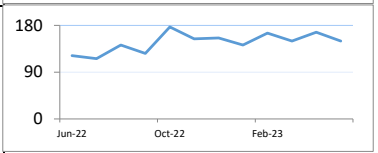
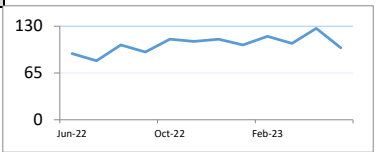
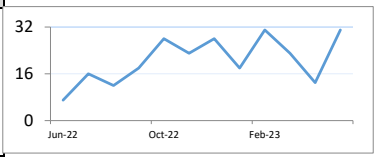
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	
Pressure ulcer damage	41	Rate of pressure ulcer damage per 1,000 acute ward occupied bed days	YDH	0.75	1.05	0.87	0.92	0.42	0.70	1.01	1.07	0.36	1.21	2.42	1.70	
	42	Community hospitals - number of incidents		6	4	3	8	4	5	7	14	8	10	9	12	
	43	Rate of pressure ulcer damage per 1,000 community hospital occupied bed days		1.05	0.70	0.51	1.28	0.62	0.78	1.07	2.07	1.33	1.51	1.45	1.93	
	44	District nursing - number of incidents		29	39	42	47	51	48	70	70	56	58	37	80	
	45	Rate of pressure ulcer damage per 1,000 district nursing contacts		1.06	1.41	1.54	1.74	1.79	1.63	2.41	2.36	2.06	1.91	1.35	2.69	
Cardiac Arrests	46	No. ward-based cardiac arrests - acute wards	MPH	6	3	2	4	2	2	2	2	7	6	3	Data awaited	
	47		YDH	3	4	14	4	5	6	5	5	2	6	8	3	
	48	Total number of incidents	Mental Health Wards	40	37	57	34	29	25	23	22	22	14	48	65	

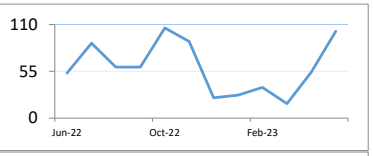
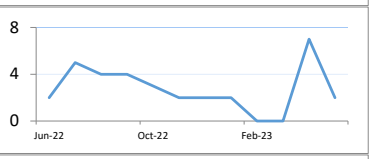
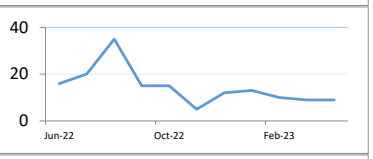
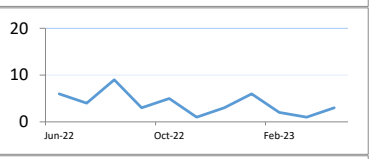
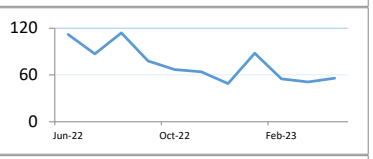
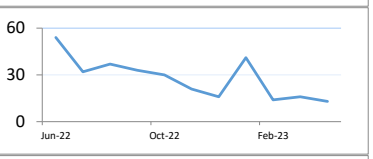
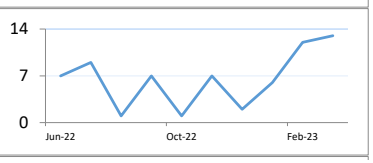
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	
Restraints (mental health wards)	49	Restraints per 1,000 occupied bed days	Mental Health Wards	11.13	10.15	15.69	10.06	8.00	7.02	6.25	5.77	6.49	3.97	13.51	17.77	
	50	Number of prone restraints	Mental Health Wards	10	9	12	7	10	4	3	6	1	4	4	4	
	51	Prone restraints per 1,000 occupied bed days	Mental Health Wards	2.78	2.47	3.30	2.07	2.76	1.12	0.82	1.57	0.30	0.28	1.13	1.09	
Medication incidents	52	Total number of medication incidents	MPH, Community Hospitals and Mental Health wards	122	116	142	126	177	154	156	142	165	150	167	150	
	53		YDH	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	
	54	Medication incidents - drug errors	MPH, Community Hospitals and Mental Health wards	92	82	104	94	112	109	112	104	116	106	127	100	
edication incidents	55	Medication incidents - drug errors	YDH	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	
	56	Medication incidents -	MPH, Community Hospitals and Mental Health wards	7	16	12	18	28	23	28	18	31	23	13	31	

SOMERSET NHS FOUNDATION TRUST

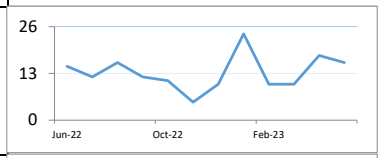
QUALITY MEASURES - 2023/24

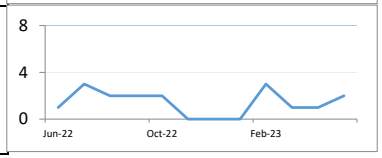
Area	Ref	Measure		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	
M	57	incorrect storage	YDH	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	
Ligatures and ligature points	58	Ligatures: Total number of incidents	Mental Health Wards	53	88	60	60	106	90	24	27	36	17	54	102	
	59	Number of ligature point incidents	Mental Health Wards	2	5	4	4	3	2	2	2	0	0	7	2	
Violence and Aggression	60	Violence and Aggression: Number of incidents patient on patient (inpatients only)	MPH, Community Hospitals and Mental Health wards	16	20	35	15	15	5	12	13	10	9	9	Data awaited	
	61	Violence and Aggression: Incidents resulting in harm - patient on patient (inpatient only)	MPH, Community Hospitals and Mental Health wards	6	4	9	3	5	1	3	6	2	1	3	Data awaited	
	62	Violence and Aggression: Number of incidents patient on staff	MPH, Community Hospitals and Mental Health wards	112	87	114	78	67	64	49	88	55	51	56	Data awaited	
	63	Violence and Aggression: Incidents resulting in harm - patient on staff	MPH, Community Hospitals and Mental Health wards	54	32	37	33	30	21	16	41	14	16	13	Data awaited	
Unexpected deaths	64	Unexpected Deaths: Total number of incidents to be investigated	Community and mental health services	7	9	1	7	1	7	2	6	12	13	Data awaited	Data awaited	

SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Seclusion	65	Number of Type 1 -Traditional Seclusion	Mental Health Wards	15	12	16	12	11	5	10	24	10	10	18	16
	66	Number of Type 2 -Short term Segregation	Mental Health Wards	1	3	2	2	2	0	0	0	3	1	1	2





SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Thresholds
1	Accident and Emergency / Minor Injury Unit 4-hour performance	Accident & Emergency department (ED) - MPH	4, 6, 9	47.3%	47.9%	45.8%	48.4%	43.4%	54.0%	39.6%	54.2%	52.1%	55.4%	58.8%	55.6%	From April 2023 >=76%= Green >=66% - <76% =Amber <66% =Red
2		Accident & Emergency department (ED) - YDH		84.4%	78.0%	78.2%	72.2%	66.4%	69.1%	63.4%	68.2%	65.0%	70.3%	74.1%	77.7%	
3		Accident & Emergency department (ED) - Combined		63.9%	61.4%	60.5%	59.4%	54.3%	61.0%	50.9%	60.5%	58.0%	62.0%	65.6%	65.4%	
4		Minor Injury Units		97.4%	97.1%	96.9%	96.8%	97.0%	97.6%	93.9%	96.3%	96.8%	96.7%	98.1%	97.1%	
5		Trust-wide		78.4%	76.5%	76.3%	74.8%	71.2%	75.4%	68.5%	75.2%	74.0%	76.3%	79.3%	78.7%	
6	Accident and Emergency / Minor Injury Units: percentage of patients spending more than 12-hours in the department	Accident and Emergency department (ED) - MPH	4, 6, 9	4.1%	4.7%	8.8%	4.2%	8.4%	2.9%	10.2%	7.1%	5.3%	2.6%	2.3%	2.1%	<=2%= Green >2% - <=5% =Amber >5% =Red
7		Accident and Emergency department (ED) - YDH		0.8%	2.6%	2.2%	3.3%	5.8%	3.8%	7.4%	7.5%	6.2%	4.4%	3.0%	1.1%	
8		Minor Injury Units		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
9	Ambulance handovers waiting less than 30 minutes - Emergency Department only (MPH)		4, 6, 9	76.6%	78.9%	65.7%	73.4%	56.5%	79.0%	52.1%	71.0%	74.2%	78.0%	81.2%	80.0%	>=95%= Green >=85% - <95% =Amber <85% =Red
	Ambulance handovers waiting less than 30 minutes - Emergency Department only (YDH)			88.1%	85.3%	87.9%	83.1%	72.8%	80.0%	62.9%	76.1%	75.1%	80.6%	82.2%	86.6%	
10	Cancer - maximum 2-week wait from GP referral (suspected cancer)		3, 4, 9	56.3%	58.0%	51.6%	46.3%	51.9%	55.2%	50.4%	57.8%	69.4%	68.6%	65.4%	Data awaited	>=93%= Green <93% =Red
11	Cancer - 28 days Faster Diagnosis All Cancers			64.9%	67.0%	67.5%	57.0%	62.8%	65.0%	66.5%	61.1%	67.1%	68.6%	73.6%	Data awaited	>=75%= Green <75% =Red
12	Cancer - maximum 31 day wait from diagnosis to first treatment			93.4%	95.5%	96.8%	92.9%	93.8%	92.0%	91.3%	87.1%	83.3%	89.0%	89.5%	Data awaited	>=96%= Green <96% =Red
13	Cancer - maximum 62 day wait from urgent GP referral			60.6%	63.3%	69.8%	54.1%	58.4%	54.7%	53.6%	51.1%	51.0%	61.0%	68.6%	Data awaited	>=85%= Green <85% =Red
14	Cancer: 62-day wait from referral to treatment for urgent GP referrals – number of patients treated on or after day 104			24	18	17	19	16	21	22	20	29	20	14	Data awaited	0= Green >0 = Red
15	CAMHS Eating Disorders - Urgent referrals to be seen within 1 week - (rolling 12 months)		3, 4, 9	83.3%	82.6%	80.0%	80.0%	80.0%	85.0%	84.2%	88.9%	93.5%	100.0%	100.0%	100.0%	>=95%= Green >=85% - <95% =Amber <85% =Red
16	CAMHS Eating Disorders - Routine referrals to be seen within 4 weeks - (rolling 12 months)			79.0%	80.4%	84.7%	85.4%	90.2%	91.5%	91.1%	91.4%	92.5%	95.4%	95.2%	96.2%	>=95%= Green >=85% - <95% =Amber <85% =Red
17	Diagnostic 6-week wait - acute services	MPH	4, 9	74.4%	77.2%	78.1%	77.0%	82.4%	84.3%	78.8%	82.9%	86.9%	87.5%	87.3%	87.4%	From April 2023 >=95%= Green >=90% - <95% =Amber <90% =Red
		YDH		74.4%	66.1%	66.5%	74.5%	74.1%	73.8%	69.4%	61.6%	64.7%	66.1%	56.9%	60.7%	

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Thresholds
		Combined		74.4%	73.6%	74.3%	76.2%	79.8%	81.2%	75.5%	75.4%	79.1%	79.5%	76.8%	77.2%	
18	RTT incomplete pathway performance: percentage of people waiting under 18 weeks		4, 6, 9	62.7%	63.0%	63.8%	62.6%	62.5%	61.9%	60.0%	60.9%	61.1%	61.1%	60.6%	61.3%	>=92%= Green <92% =Red
19	40 week RTT breaches			New reporting					5,128	5,495	5,036	5,015	4,975	5,359	5,524	TBC
20	52 week RTT breaches			2,789	2,779	2,714	2,695	2,601	2,405	2,418	2,298	2,216	2,187	2,247	2,340	From April 2023 At or below trajectory = Green Above trajectory = Red
21	65 week RTT breaches			New reporting										714	710	
22	78 week RTT breaches		4, 6, 9	503	463	422	393	334	281	315	252	179	68	84	87	From April 2023 At or below trajectory = Green Above trajectory = Red
23	Referral to Treatment (RTT) incomplete pathway waiting list size			47,230	46,677	47,214	48,294	49,404	50,412	50,705	51,244	51,542	52,869	53,351	53,856	
24	Mental health referrals offered first appointments within 6 weeks	All mental health services	4, 6, 9	91.9%	93.2%	93.8%	90.4%	90.8%	91.9%	89.0%	91.3%	94.6%	94.4%	88.2%	90.0%	>=90%= Green >=80% - <90% =Amber <80% =Red
25		Adult mental health services		87.9%	94.7%	93.6%	87.4%	89.2%	90.0%	86.3%	90.2%	92.7%	94.0%	89.6%	92.4%	
26		Older Persons mental health services		93.1%	92.0%	93.0%	90.2%	90.0%	90.8%	89.8%	91.1%	95.2%	94.4%	86.5%	87.2%	
27		Learning disabilities service		100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	88.9%	92.3%	100.0%	92.9%	88.9%	100.0%	
28		Children and young people's mental health services		98.9%	91.9%	100.0%	100.0%	97.3%	100.0%	95.9%	95.1%	96.5%	95.4%	93.6%	95.1%	
29	Percentage of women accessing specialist community Perinatal MH service - 12 month rolling reporting		4, 6, 9	7.7%	7.7%	7.7%	7.5%	7.7%	7.9%	8.1%	8.2%	8.3%	8.4%	8.7%	Data awaited	>=10%= Green >=7.5% - <10% =Amber <7.5% =Red
30	Average length of stay of patients on wards (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).	MPH	4, 9	6.5	6.5	7.0	6.6	6.6	6.9	6.6	7.2	6.8	6.2	6.5	6.2	Monitored using Special Cause Variation Rules. Report by exception.
31		YDH		Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	
32	Patients not meeting the criteria to reside: % of occupied bed days lost	MPH	4, 9	19.7%	22.8%	22.6%	21.7%	22.5%	17.6%	16.0%	19.6%	19.8%	19.1%	22.6%	17.2%	SPC (Upper Control Limit 25.1%)
33		YDH		24.3%	26.6%	26.2%	25.5%	26.7%	27.5%	22.3%	23.0%	25.0%	23.2%	20.4%	Data awaited	SPC (Upper Control Limit 28.1%)
34	Waiting times: number of people waiting over 18 weeks from referral to first appointment - community services including dental		4, 6, 9	4,361	4,465	4,512	4,658	4,881	3,983	4,102	4,056	4,002	4,065	4,023	4,052	< 82 patients = Green >=82 - <86 = Amber >86 = Red
35	Community dental services - Child GA waiters waiting 18 weeks or more		4, 6, 9	229	331	351	330	333	346	370	356	370	463	499	524	0 = Green >=0 - =<50 =Amber >50 =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Thresholds
36	Early Intervention In Psychosis: people to begin treatment with a NICE-recommended care package within 2 weeks of referral (rolling three month rate)		4, 6, 9	76.9%	63.6%	69.2%	66.7%	75.0%	58.8%	61.9%	60.9%	68.8%	83.3%	88.2%	Data awaited	>=60%= Green <60% =Red
37	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) RTT : percentage of people waiting under 6 weeks		4, 6, 9	55.5%	51.9%	57.3%	64.1%	63.1%	63.6%	63.3%	61.1%	60.9%	67.2%	65.9%	68.4%	>=75%= Green <75% =Red
38	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) RTT: percentage of people waiting under 18 weeks		4, 6, 9	98.3%	98.6%	98.6%	98.0%	97.5%	98.1%	98.7%	98.5%	97.6%	98.9%	98.0%	98.5%	>=95%= Green <95% =Red
39	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) Recovery Rates		4, 7, 9	62.8%	58.7%	59.9%	64.5%	56.5%	61.0%	58.4%	62.1%	59.2%	64.3%	60.3%	59.6%	>=50%= Green <50% =Red
40	Adult mental health inpatients receiving a follow up within 72 hrs of discharge		4, 9	97.2%	91.4%	100.0%	96.6%	100.0%	97.4%	100.0%	93.9%	90.3%	100.0%	98.7%	100.0%	>=80%= Green <80% =Red
41	Inappropriate Out of Area Placements for non-specialist mental health inpatient care (monthly number of patient days)		4, 5, 9	90	75	25	10	60	125	57	27	0	34	78	67	0= Green >0 = Red
42	Intermediate Care - Patients aged 65+ discharged home from acute hospital beds on pathway 0 or 1		4, 5, 9	94.8%	93.2%	92.4%	94.2%	94.1%	92.9%	93.2%	92.8%	92.0%	92.6%	93.3%	93.2%	>=95%= Green >=85% - <95% =Amber <85% =Red
43	Urgent Community Response: percentage of patients seen within two hours		4, 5, 9	New reporting						84.4%	84.5%	79.0%	92.0%	94.0%	Data awaited	>=70%= Green >=60% - <70% =Amber <60% =Red
44	% Stroke Patients direct admission to stroke ward in 4 hours	MPH	4, 6, 9	60.0%	48.9%	61.0%	44.7%	50.0%	51.1%	48.5%	41.1%	32.6%	54.4%	46.3%	Data awaited	>=90%= Green >=75% - <90% =Amber <75% =Red
45		YDH		17.0%	23.0%	21.0%	33.0%	22.0%	19.0%	19.0%	40.0%	15.0%	35.0%	33.0%	Data awaited	
46	Patients spending >90% of time in stroke unit - acute services	MPH	4, 6, 9	74.4%	68.1%	85.4%	63.2%	63.6%	71.4%	60.6%	61.4%	59.6%	80.3%	67.4%	Data awaited	>=80%= Green >=70% - <80% =Amber <70% =Red
47		YDH		72.0%	52.4%	41.0%	57.0%	53.0%	46.0%	53.0%	60.0%	51.0%	54.0%	58.0%	Data awaited	
48	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services	MPH	4, 9	86.0%			Due to capacity within the Governance Team required audits have been delayed. A reporting solution using electronic forms is currently being tested by the Trust's Digital Team.									>=90%= Green >=49% - <90% =Amber <49% =Red
49	Percentage of emergency patients screened for sepsis - acute services	MPH		75.0%												
50	Percentage of patients with a NEWS of 5 or more acted upon appropriately - The registered nurse should immediately inform the medical team caring for the patient	MPH, community hospitals and mental health wards	4, 9	Reporting criteria reviewed and updated. Bi-monthly reporting will recommence from April 2023 and will cover February/March 2023								67.2%		66.7%		>=90%= Green >=80% - <90% =Amber <80% =Red
51	Percentage of complaints responded to within 40 working days - Trust-wide	Former SFT	9	53.1%	50.0%	48.0%	45.5%	57.7%	55.0%	46.7%	39.4%	37.5%	56.7%	51.5%	48.4%	>=90%= Green >=75% - <90% =Amber >75% =Red
52		YDH		60.0%	80.0%	100.0%	100.0%	100.0%	100.0%	80.0%	67.0%	100.0%	100.0%	100.0%	100.0%	
53		Combined		New reporting										56.8%	52.9%	

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Thresholds
54	Mandatory training: percentage completed	Former SFT	1, 8, 9	92.5%	92.4%	92.8%	92.9%	92.3%	92.1%	91.9%	91.1%	90.9%	90.5%	Post merger		All courses >=90%= Green Overall rate <80% =Red Any other position = Amber
55		YDH		87.2%	86.3%	87.0%	86.8%	87.7%	86.8%	85.9%	85.6%	84.6%	84.5%			
56		Combined		New reporting										90.6%	91.3%	
57	Proportion of days lost due to sickness		1,8,9	5.5%	6.6%	5.0%	4.9%	5.8%	5.5%	6.3%	5.4%	5.0%	4.8%	4.2%	4.2%	SPC
58	Sickness absence levels - rolling 12 month average (Trust-wide)		8, 9	5.9%	6.0%	6.0%	6.0%	5.9%	5.9%	5.9%	5.8%	5.8%	5.6%	5.2%	5.1%	SPC
59	Career conversations (12 months) - formerly 'Performance review (12-month)'		1,8,9	New reporting										62.1%	62.7%	>=90%= Green >=80% - <90% =Amber <80% =Red
60	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)		8, 9											7.4%	7.7%	<=5%= Green >5% to <=7.5% =Amber >7.5% =Red
61	Retention rate – percentage of colleagues in post with more than 12 months' service		8, 9											76.0%	74.4%	>=88.3%= Green >=80% to <88.3% =Amber <80% =Red
62	Percentage of colleagues in a senior role (band 8a and above and consultant roles):	Who are of an ethnic minority	1,8,9											19.8%	19.8%	>=17%= Green >=14% to <17% =Amber <14% =Red
63		Who are female	1,8,9											58.5%	58.6%	>=79%= Green >=70% to <79% =Amber <70% =Red
64		With a recorded disability	1,8,9											2.9%	2.9%	>=4%= Green >=2% to <4% =Amber <2% =Red
65	Number of formal HR case works (disciplinary, grievance and capability).		1,8,9											166	Data awaited	TBC

Appendix 5a – Specialty and tumour-site level performance

Table 1 – Performance against the RTT performance standard in May 2023, 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	763	55	2,478	69.2%
Urology	1,276	209	2,867	55.5%
Trauma & Orthopaedics	2,754	534	6,404	57.0%
Ear, Nose & Throat (ENT)	2,381	136	5,153	53.8%
Ophthalmology	2,439	312	5,602	56.5%
Oral Surgery	1,103	124	2,540	56.6%
Plastic Surgery	123	17	252	51.2%
Cardiothoracic Surgery	4	0	14	71.4%
General Medicine	8	0	20	60.0%
Gastroenterology	1,239	37	2,625	52.8%
Cardiology	738	15	3,491	78.9%
Dermatology	315	6	1,427	77.9%
Thoracic Medicine	488	0	1,746	72.1%
Neurology	541	8	1,548	65.1%
Rheumatology	364	9	1,031	64.7%
Care of the Elderly	126	1	552	77.2%
Gynaecology	1,481	149	4,185	64.6%
Other – Medical Services	1,179	193	2,873	59.0%
Other - Paediatric Services	450	18	1,669	73.0%
Other - Surgical Services	2,814	511	6,548	57.0%
Other – Other Services	236	6	831	71.6%
Total	**20,822**	**2,340**	**53,856**	**61.3%**

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

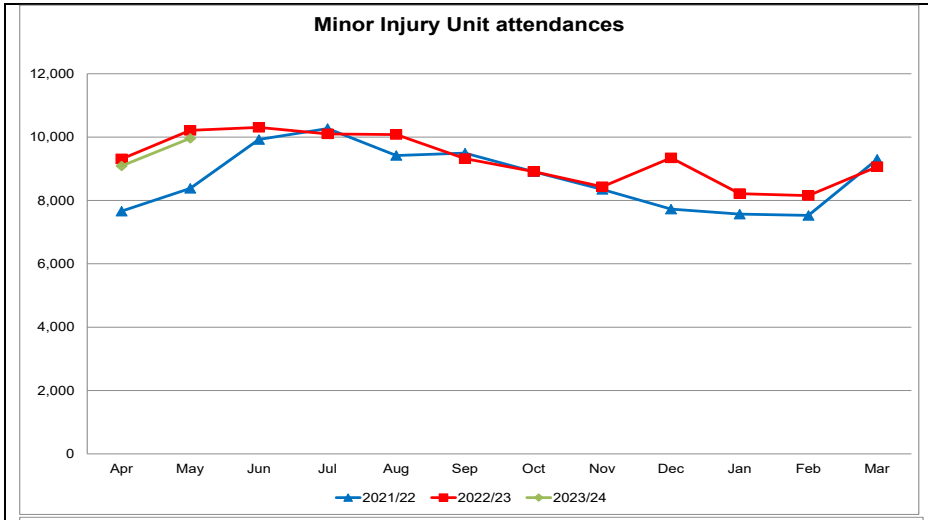
Tumour site	No of breaches	Trust performance
Breast	0	100.0%
Colorectal	11	35.3%
Gynaecology	4	66.7%
Haematology	5	28.6%
Head & Neck	1	50.0%
Lung	2.5	44.4%
Other	1	66.7%
Skin	5	87.0%
Upper GI	2	73.3%
Urology	19.5	57.1%
Total	**51.0**	**68.6%**

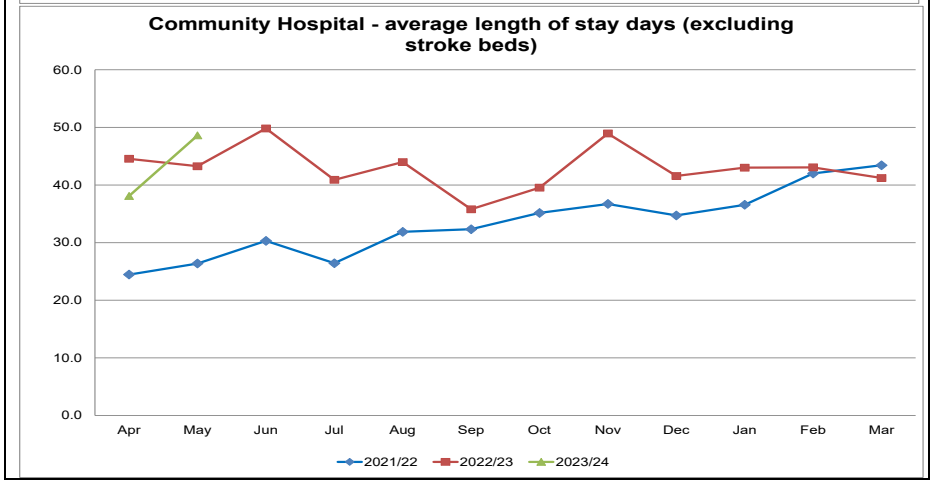
Fourteen patients were treated in April on or after day 104 (the national 'backstop'). Twelve were assessed as having unavoidable delays, with two pathways having been impacted largely by internal capacity problems. A breakdown of the unavoidable breaches is as follows:

- Six patient pathways had some internal delays, but pathways were further delayed for unavoidable reasons, including: the patient declining offered dates for investigations, the patient not attending their booked investigation and patient choice to delay appointments to discuss the treatment plan. One patient also transferred to us late for treatment from a Bristol hospital due to outpatient capacity problems at that trust.
- Three patients had a complex pathway, including patients requiring additional diagnostics, requesting second opinion, transferring from a different cancer pathway and the treatment plan changing.
- One patient pathway was delayed due to medical complexity with the patient being admitted and having complications, delaying planned investigations.
- Two patients significantly delayed their pathway by choosing to wait longer.

perational context

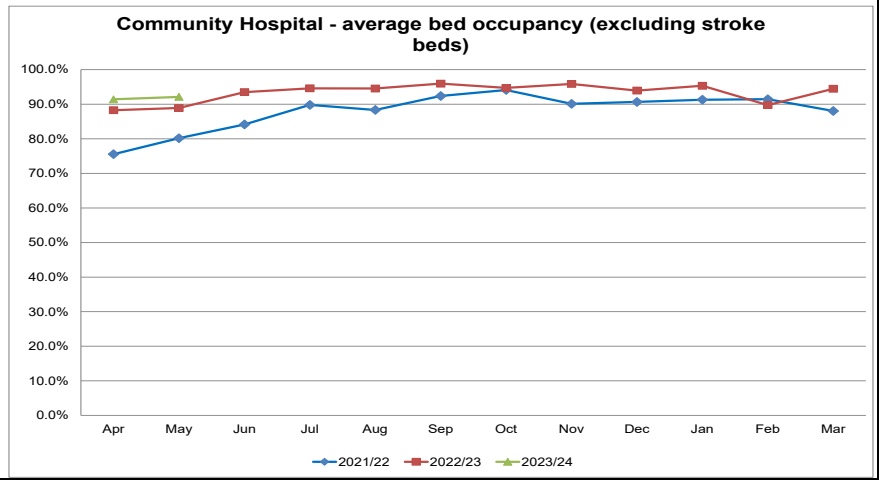
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





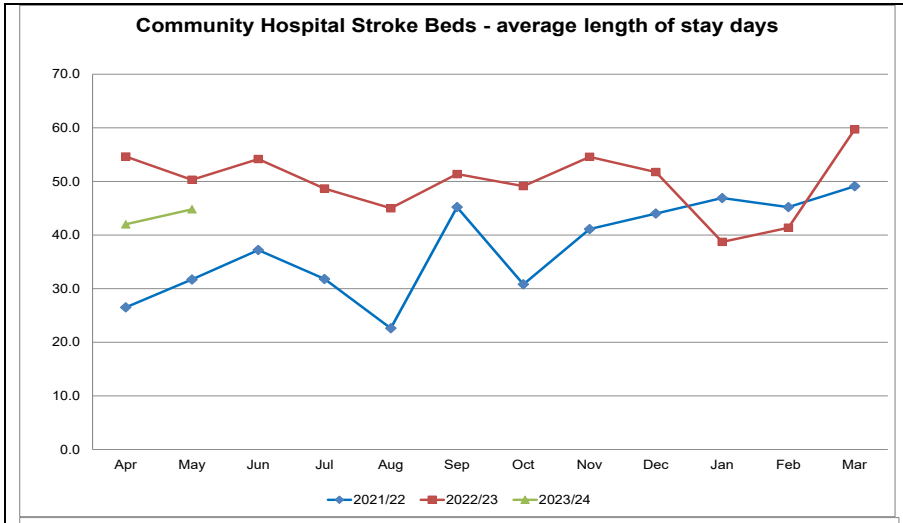
Summary:

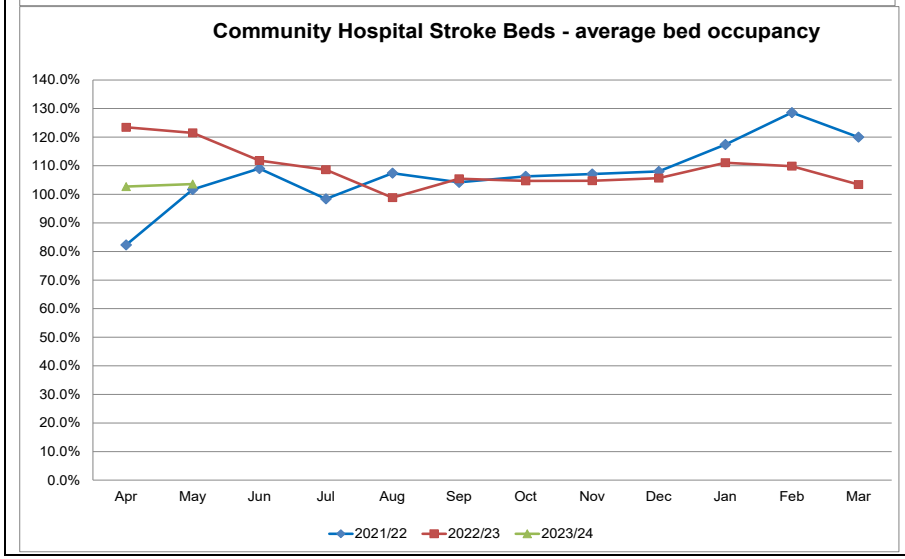
- Between 1 April and 31 May 2023 the number of Minor Injury Unit attendances was 2.4% lower than the same months of 2022/23, but 18.7% higher than same months of 2021/22. During May 2023, 97.1% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 76%, to be achieved by March 2024.
- The average length of stay for non-stroke patients in our community hospitals in May 2023 was 48.6 days, an increase compared to April 2023. Eight patients were discharged with lengths of stay longer than 100 days; the longest was 505 days for a patient at Bridgwater community hospital.
- The community hospital bed occupancy rate for non-stroke patients in May 2023 decreased to 91.4%, from 94.4% in April 2023.



Operational context

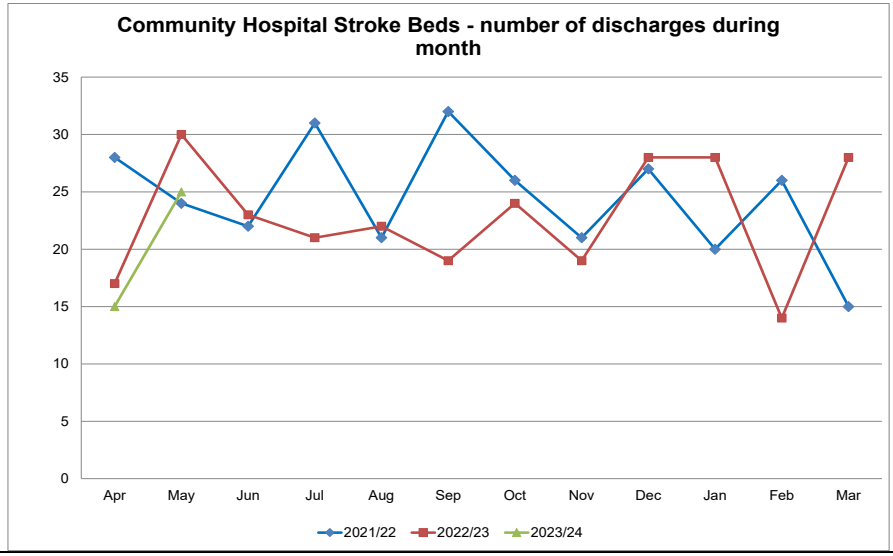
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





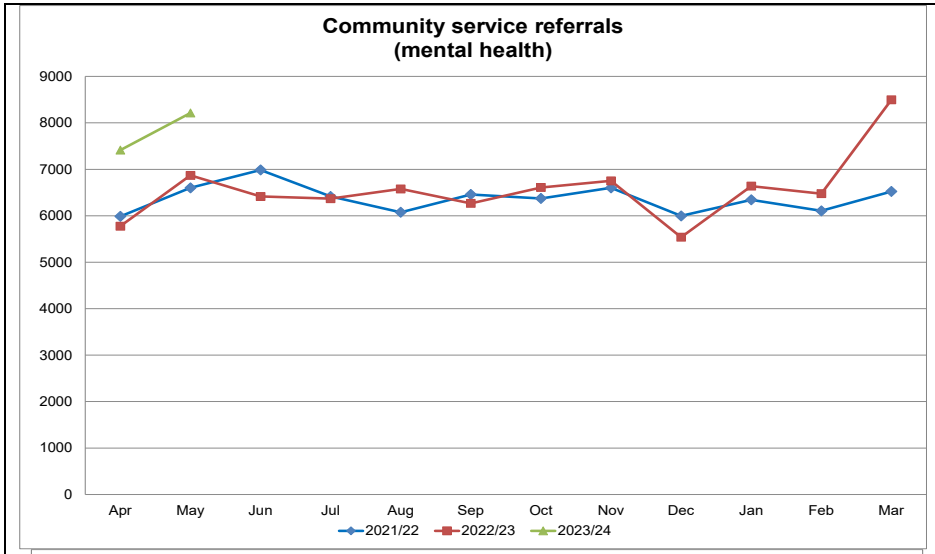
Summary:

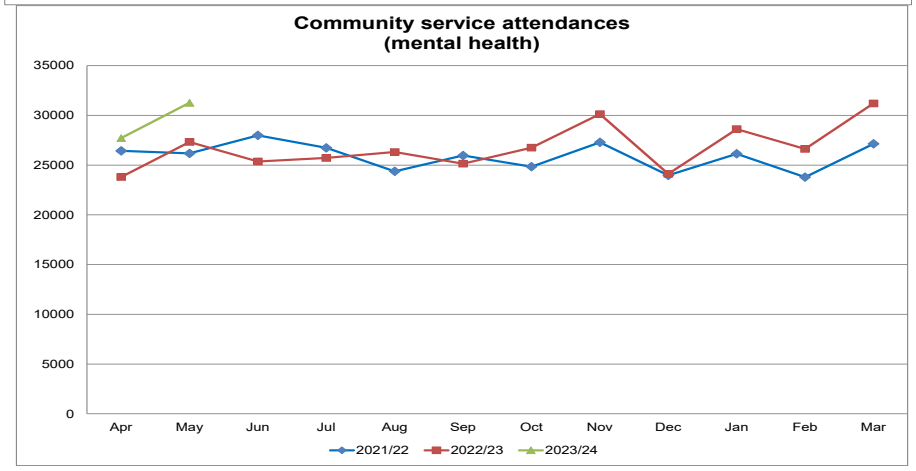
- The average length of stay for stroke patients in our community hospitals in May 2023 increased to 44.8 days, from 42.0 days in April 2023. No patients discharged in May 2023 had a length of stay longer than 100 days.
- Stroke bed occupancy in May 2023 decreased compared to April 2023.
- During May 2023 there were 25 discharges of stroke patients, up from 15 discharged during April 2023. The monthly average number of stroke patients discharged from our community hospitals in 2022/23 was 23.



Operational context

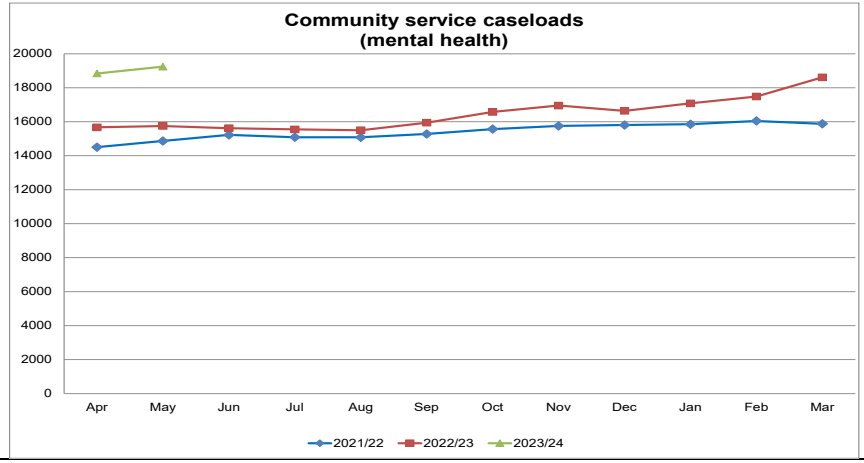
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





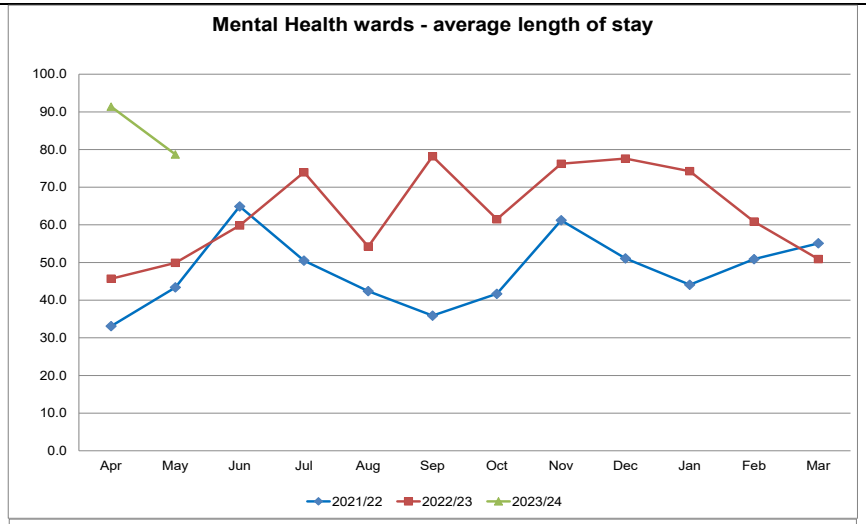
Summary:

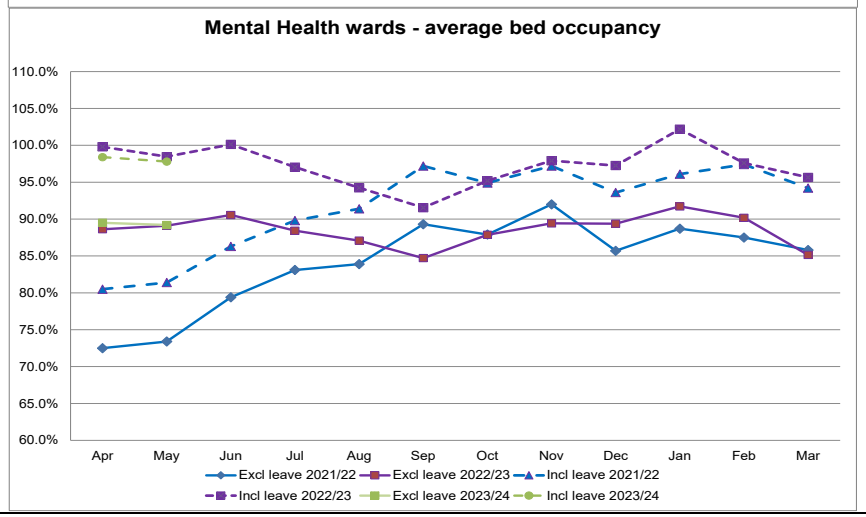
- Referrals to our community mental health services between 1 April and 31 May 2023 were 23.6% higher than the same months of 2022/23 and 24.1% higher than the same months of 2021/22.
- Attendances for the same reporting period were 15.4% higher than the same months of 2022/23 and 12.1% higher than the months of 2021/22. Services which have seen significant increases in recorded activity include Primary Care Mental Health Services (Open Mental Health), Home Treatment, and Psychological Therapies.
- Community mental health service caseloads as at 31 May 2023 increased by 22.2% when compared to 31 May 2022 and were 29.4% higher than as at 31 May 2021. It should be noted that investment facilitated the expansion of some community mental health services.



Assurance and Leading Indicators

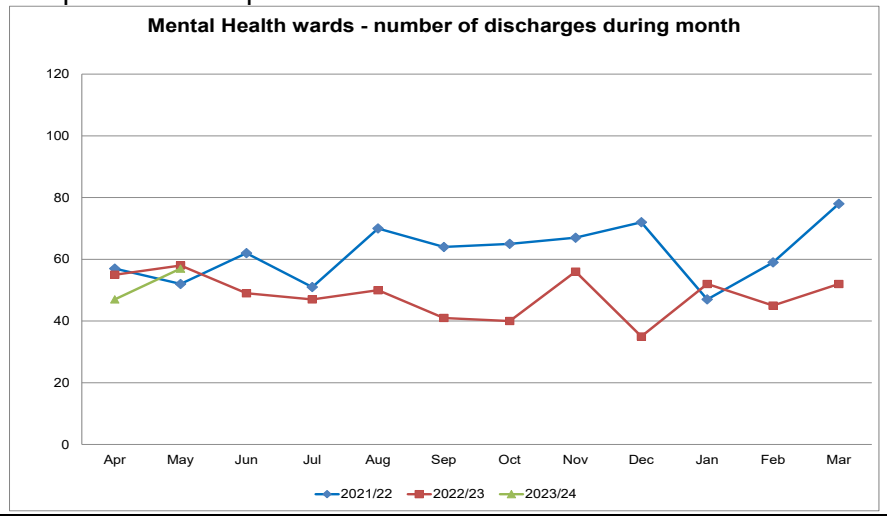
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





Summary:

- The average length of stay in our mental health wards in May 2023 decreased to 78.7 days from 91.4 reported for April 2023. The average lengths of stay in the last two months have been significantly affected by the discharge of individual patients with very long lengths of stay. Nine patients discharged in April 2023 had lengths of stay of 100 days or more. One patient discharged from Rydon ward 1 had a length of stay of 562 days. Increases in delayed transfers of care and the responsiveness / availability of step-down options have also resulted in longer lengths of stay.
- The mental health bed occupancy rate May 2023, based on excluding and including leave, slightly decreased compared to April 2023. A total of 57 patients were discharged in May 2023, up from 47 in April 2023.



Appendix 6 – Infection Control and Prevention

MRSA bloodstream infections	Commentary on MRSA / MSSA BSIs
Musgrove Park Hospital = 1 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0	During May the Southwest Infection Control Network set up a regional improvement group which the Trust is involved in. The aim of the group is: • To produce an assessment tool that organisations can use to identify areas for improvement • To bring together strategies for improvement in a single place, a menu for improvements depending on where the problem may lie in the organisation Locally our area of improvement into June 2023 is to start the campaign on avoiding the use of the ante-cubital fossa (elbow) where possible for the siting of peripheral vascular cannulae. This site is known to increase the risk of bloodstream infection.
MSSA Bloodstream Infections	
Musgrove Park Hospital = 6 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0	
E. coli bloodstream infections	**Commentary on Gram-negative bloodstream infections**
Musgrove Park Hospital = 8 Yeovil District Hospital = 7 Community Hospitals / Mental Health = 0	The Trustwide (all sites) catheter care improvement group is now established. There are three workstreams focusing on different aspects of catheter care: • Insertion of catheters (type of catheter, technique, training) • Care of catheters (daily care, removal when no longer required) • Long-term catheters (communication between healthcare settings and home)
Klebsiella bloodstream infections	
Musgrove Park Hospital = 5 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0	
Pseudomonas bloodstream infections	
None reported	
C. difficile	**Commentary on C. difficile**
Musgrove Park Hospital = 4 Yeovil District Hospital = 7 Community Hospitals / Mental Health = 0	Whilst case numbers are increasing both legacy Trusts had the lowest rates of C. difficile infection in the region (legacy Yeovil District Hospital were the lowest and legacy Somerset Foundation Trust the second-lowest). Antibiotics continue to drive our cases but we remain low antibiotic prescribers.

Respiratory Viral Infections - inpatients	Commentary on Respiratory Viral Infections
COVID Musgrove Park Hospital = 121 Yeovil District Hospital = 39 Community Hospitals / Mental Health = 4 **Influenza** Musgrove Park Hospital = 3 Yeovil District Hospital = 1 **Respiratory syncytial virus (RSV)** Musgrove Park Hospital = 1 Community Hospitals / Mental Health = 1	**COVID** COVID cases have reduced since March and are continuing to fall. Symptom severity appears to have reduced again with some presenting with very mild symptoms. This is being monitored closely to ensure the correct balance between reducing transmission and maintaining bed capacity is achieved. **Influenza** Levels of influenza remain low, and the season has been nationally classed as over. **RSV** Levels of RSV remain low, and the season can be regarded as over.
Outbreaks	**Commentary on outbreaks**
COVID Musgrove Park Hospital = 9 Yeovil District Hospital = 3 Community Hospitals / Mental Health = 1	**COVID** Outbreaks due to COVID remained stable in May 2023 in comparison to April 2023. As Summer approaches these are likely to reduce in number but will probably continue to occur.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Elective Care 2023/24 Priorities - Board Declaration
SPONSORING EXEC:	Andy Heron, Chief Operating Officer
REPORT BY:	Xanthe Whittaker, Director of Elective Care
PRESENTED BY:	Andy Heron, Chief Operating Officer
DATE:	4 July 2023

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	On 23 of May 2023, trusts were sent a letter (PRN00496; attached Appendix 1) from the NHS England team, setting-out the priorities for delivering elective care. This letter, whilst acknowledging the progress made over the last year, also set-out a checklist of expectations as to what trusts should be doing to support elective recovery, covering priority actions for improving referral to treatment times (RTT), cancer and how diagnostic services can support this. A checklist for trust boards, in the form of twenty-two assurance statements, was included in Annex 1 of the letter. The attached table sets out the Trust's position against these assurance statements in the checklist. Additional information is contained in the table, which includes next steps where the requirement is not currently being met, context and governance arrangements, as appropriate.
Recommendation	The Board is asked to note the Trust's position against the items in the checklist and the actions being taken to improve compliance where appropriate.

Links to Joint Strategic Objectives (Please select any which are impacted on / relevant to this paper)
✓ Obj 1 Improve health and wellbeing of population
✓ Obj 2 Provide the best care and support to children and adults
✓ Obj 3 Strengthen care and support in local communities
✓ Obj 4 Reduce inequalities
✓ Obj 5 Respond well to complex needs
✓Obj 6 Support our colleagues to deliver the best care and support through a compassionate,

inclusive and learning culture ✓ Obj 7 Live within our means and use our resources wisely ✓ Obj 8 Develop a high performing organisation delivering the vision of the Trust

Implications/Requirements (Please select any which are relevant to this paper)					
✓ Financial	☐ Legislation	✓ Workforce	☐ Estates	☐ ICT	✓ Patient Safety/ Quality
Details: N/A					
Equality 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 not been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics					
☐ 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)
N/A

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
A report was previously presented to the July 2022 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

K

Classification: Official

Publication reference: PRN00496

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS regional directors
- Cancer alliance managing directors
- ICB chief executives

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

23 May 2023

Dear Colleagues,

Elective care 2023/24 priorities

Thanks to your continued focus and effort on elective care and cancer recovery we have managed, through the exceptional efforts of your teams, to drive a significant reduction in the number of long waiting patients over recent months.

Despite a very challenging environment, where ongoing industrial action has seen planned care particularly hard hit, the number of patients waiting over 78 weeks has decreased from 124,911 in September 2021 to 10,737 at the end of March 2023, and the number of patients with urgent suspected cancer waiting longer than 62 days has decreased from a peak of 33,950 last summer to 19,023 at the end of March 2023.

We now look ahead to further reduction in 78 week waits, following the disruption from industrial action and delivering our next ambitions, as set out in Operational Planning Guidance, of virtually eliminating 65 week waits, reducing the 62-day backlog further, and meeting the Faster Diagnosis Standard, by March 2024. This letter sets out our priorities, oversight and support for the year ahead as well as including a checklist for trust boards to assure themselves across the key priorities (annex 1).

First, we should acknowledge the progress made over the last year or so:

- Since the beginning of February 2022, the NHS has treated more than 2m people who would otherwise have been waiting 78 weeks by the end of March 2023 (ie: the “cohort”).
- The number of patients waiting 65 weeks has reduced from 165,885 in September 2021 to 95,001 in March 2023.

- The cancer 62 day backlog has reduced year-on-year for the first time since 2017.
- The NHS has seen a record 2.8 million referrals for urgent suspected cancer, with the early diagnosis rate now higher than before the pandemic.
- In February 2023, the NHS achieved the faster diagnosis standard (FDS) for the first time since it was created.

Your leadership, collaboration with colleagues and across providers, innovation and tenacity has led to these improvements for patients and should give confidence for the future, despite the continued complexity of the environment that we are all working in.

Recognising the challenges and the complexity you are all dealing with, we thought it would help to set out the key priorities for the year ahead:

1. **Excellence in basics**
   - Maintaining a strong focus on data quality, validation, clinical prioritisation and maximising booking rates have contributed massively to our progress. We need to retain a clear focus on these things.

2. **Performance and long waits**
   - Continue to reduce waits of over 78 weeks and those waiting over 65 weeks.
   - Make further progress on the 62-day backlog where this is still required in individual providers, whilst pivoting towards a primary focus on achieving the Faster Diagnosis Standard.
   - To support this, we have reviewed and refreshed our tiering approach to oversight, so that we can be sure that we are focusing on those providers most in need of support. This refresh has been communicated to tiered providers.

3. **Outpatients (productivity actions annex 2)**
   - We know there is massive potential in our outpatient system to adjust the approach, engage patients more actively and significantly re-focus capacity towards new patients.

4. **Cancer pathway redesign**
   - In 2023/24 Cancer Alliances have received a funding increase to support implementation of priority changes for lower GI, skin and prostate pathways (included in annex 1). All trusts should now have clear, funded plans in place with their Alliance for implementation.

5. **Activity**

- Ensure that the increasing volume of diagnostic capacity now coming online is supporting your most pressured cancer pathways. ICBs have been asked to prioritise CDC and acute diagnostic capacity to reduce cancer backlogs and improve the FDS standard, as set out in the letter from Dame Cally Palmer and Dr Vin Diwakar.
- Generally, we all need to see a step up in activity over the coming months, as we recover from the ongoing impact of industrial action.

6. **Choice**

- A major contributor to our collective progress over this last year has been the way organisations and systems have worked together to accelerate treatment for long waiting patients. This includes work with the Independent Sector (IS) who have stepped up to help in this endeavour. We know this will continue to be important this year and we encourage all systems and providers to crystalise their plans to work together (including IS) early in the financial year to give us the best chance of success.
- We expect that patient choice will be an increasingly important factor this year, as set out in the Elective Recovery Plan, with some technological advances to support this. We will communicate this more fully when plans have been finalised.

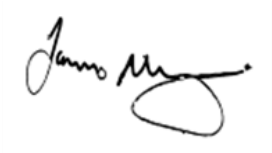
Moreover, it is crucial that we continue to recover elective services inclusively and equitably.

- Systems are expected to outline health inequality actions put in place and the evidence and impact of the interventions as part of their planning returns. Disaggregated elective recovery data should support the development of these plans.
- A collective effort is needed to continue to address the recovery of paediatric services. Provider, system, and regional-level elective recovery plans should set out actions that will be put in place to accelerate CYP recovery and ensure that elective activity gap between CYP and adults is reduced, a best practice toolkit has now been published to help achieve this.
- Systems are expected to continue to recover specialised service activity at an equitable rate to that of less complex procedures, ensuring a balance between high volume and complex patient care requirements.

Included with this letter is the board checklist (annex 1). This tool has been designed to be the practical guide for boards to ensure they are delivering against the ambitious objectives set out in the letter above.

Thank you again for all your efforts since the Elective Recovery Plan was published. Together, we have made laudable progress in reducing long waits and transforming services, as set out in the plan. We can all take confidence in this as we move on to the next stages of the recovery plan and continue to improve care for patients. If any support is required with these actions, please let us know.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

Dame Cally Palmer
National Cancer Director
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
NHS England

Chair
Getting It Right First Time (GIRFT) programme

Annex 1: Board checklist

We ask that boards review the checklist below to assure plans to deliver our elective and cancer recovery objectives over the coming year. There is national support available in each of these areas, please contact england.electiverecoverypmo@nhs.net to discuss any support needs.

The three key performance deliverables and metrics we need to focus on are:

- Virtually eliminate waits of >65w by March 2024
- Continue to reduce the number of cancer patients waiting over 62d
- Meet the 75% cancer FDS ambition by March 2024

	Assurance statement	Support/materials
1	**Excellence in basics**	
	Has any patient waiting over 26 weeks on an RTT pathway (as at 31 March 2023) not been validated in the previous 12 weeks? Has the 'Date of Last PAS validation' been recorded within the Waiting List Minimum Data Set?	
	Are referrals for any Evidence Based Interventions still being made to the waiting list?	Release 3 will be published on 28 May. It focuses on the following specialties: breast surgery, ophthalmology, vascular, upper gastrointestinal surgery, cardiology, urology, and paediatric urology
2	**Performance and long waits**	
	Are plans in place to virtually eliminate RTT waits of over 104w and 78w (if applicable in your organisation)?	
	Do your plans support the national ambition to virtually eliminate RTT waits of over 65 weeks by March 2024?	
3	**Outpatients**	
	Are clear system plans in place to achieve 25% OPFU reduction, enabling more outpatient first activity to take place?	NHSE GIRFT guidance

	Assurance statement	Support/materials
	Do you validate and book patients in for their appointments well ahead of time, focussing on completing first outpatient appointments in a timely way, to support with diagnostic flow and treatment pathways?	Validation toolkit and guidance NHS England » Validation toolkit and guidance published on 1st December 2022
4	**Cancer pathway re-design**	
	Where is the trust against full implementation of FIT testing in primary care in line with BSG/ACPGBI guidance, and the stepping down of FIT negative (<10) patients who have a normal examination and full blood count from the urgent colorectal cancer pathway in secondary care?	Using FIT in the Lower GI pathway published on 7*th* October 2022 BSG/ACPGBI FIT guideline and supporting webinar
	Where is the trust against full roll-out of teledermatology?	Suspected skin cancer two week wait pathway optimisation guidance
	Where is the trust against full implementation of sufficient mpMRI and biopsy capacity to meet the best practice timed pathway for prostate pathways?	Best Practice Timed Pathway for Prostate Cancer
5	**Activity**	
	Are clear system plans in place to prioritise existing diagnostic capacity for urgent suspected cancer activity?	Letter from Dame Cally Palmer and Dr Vin Diwakar dated 26 April 23.
	Is there agreement between the Trust, ICB and Cancer Alliance on how best to ensure newly opening CDC capacity can support 62 day backlog reductions and FDS performance?	
	How does the Trust compare to the benchmark of a 10-day turnaround from referral to test for all urgent suspected cancer diagnostics?	

	Assurance statement	Support/materials
	Are plans in place to implement a system of early screening, risk assessment and health optimisation for anyone waiting for inpatient surgery? Are patients supported to optimise their health where they are not yet fit for surgery? Are the core five requirements for all patients waiting for inpatient surgery by 31 March 2024 being met? 1. Patients should be screened for perioperative risk factors as early as possible in their pathway. 2. Patients identified through screening as having perioperative risk factors should receive proactive, personalised support to optimise their health before surgery. 3. All patients waiting for inpatient procedures should be contacted by their provider at least every three months. 4. Patients waiting for inpatient procedures should only be given a date to come in for surgery after they have had a preliminary perioperative screening assessment and been confirmed as fit or ready for surgery. 5. Patients must be involved in shared decision-making conversations.	NHS England » 2023/24 priorities and operational planning guidance NHS England » Revenue finance a contracting guidance for 2023/24 Perioperative care pathways guidance
	Where is the trust/system against the standards of 85% capped Theatre Utilisation and 85% day case rate?	
	Is full use being made of protected capacity in Elective Surgical Hubs?	
	Do diagnostic services meet the national optimal utilisation standards set for CT, MRI, Ultrasound, Echo and Endoscopy?	https://future.nhs.uk/NationalCommunityDiagnostics/groupHome
	Are any new Community Diagnostic Centres (CDCs) on track to open on agreed dates, reducing DNAs to under 3% and ensuring that they have the workforce in place to provide the expected 12 hours a day, 7 day a week service? Are Elective Surgical Hub patients able to make full use of their nearest CDC for all their pre and post-op tests where this offers the fastest route for those patients??	

	Assurance statement	Support/materials
6	**Choice**	
	Are you releasing any Mutual Aid capacity which may ordinarily have been utilised to treat non-urgent patients to treat clinically urgent and long-waiting patients from other providers? Is DMAS being used to offer or request support which cannot be realised within the ICB or region?	www.dmas.nhs.uk
	Has Independent Sector capacity been secured with longevity of contract? Has this capacity formed a core part of planning for 2023/24?	
7	**Inclusive recovery**	
	Do recovery plans and trajectories ensure specialised commissioned services are enabled to recover at an equitable rate to non-specialised services? Do system plans balance high volume procedures and lower volume, more complex patient care	
	Have you agreed the health inequality actions put in place and the evidence and impact of the interventions as part of your operational planning return? Was this supported by disaggregated elective recovery data?	
	Are children and young people explicitly included in elective recovery plans and actions in place to accelerate progress to tackle CYP elective waiting lists?	CYP elective recovery toolkit

Supporting guidance and materials are available on the Elective Recovery Futures site: https://future.nhs.uk/ElectiveRecovery

Annex 2: Outpatients (OP) productivity action

As set out in the 2023/24 Priorities and Operational Planning Guidance, systems are expected to deliver in line with the national ambition to reduce follow-ups by 25% against the 2019/20 baseline by March 2024. To note this excludes appointments where a procedure takes place. Further technical guidance (that covers other exclusions) is here.

Expected actions

In order to work towards achieving the 25% follow-up reduction target, trusts are expected to focus on the following within the first quarter of the year:

- Embed OP follow-up reduction in trust governance mechanisms
- Engage with clinical leads for specialties about the significance of the 25% follow-up reduction target, building on GIRFT guidance
- Review clinic templates to ensure they are set up to enable a 25% reduction in follow-up appointments
- Validate patients waiting for follow-ups to identify any who do not need to be seen
- Ensure continued and expanded delivery of patient initiated follow up (PIFU) in all major OP specialties, particularly accelerating uptake in specialties with the longest waits (ENT, gynaecology, gastroenterology and dermatology)
- Ensure patients who no longer need to be seen in secondary care are appropriately discharged, in line with clinical guidelines
- Work to reduce appointments that are missed by patients (DNAs), in line with NHS England guidance, including by:
  - Understanding the most common reasons why patients miss appointments, building on available national support
  - Making it easier for patients to cancel or reschedule appointments they don't need eg through sending a response to an appointment reminder
- Local analysis of patients on multiple pathways or those with multiple follow-ups.
- Consider conducting a retrospective clinical review of a sample of OP follow-up activity in at least two specialties with the longest waits, to identify where an alternative pathway of care could have been used (eg discharge, PIFU, appointment met through alternate means).

Payment

Reducing OP follow-ups is incentivised by the NHS payment scheme, where follow-up appointments are covered by a fixed payment element, and first appointments are covered by a variable element.

Support available

Competing priorities will always make it difficult to focus on making these changes. Continued support will be available through:

- Data packs for each tiered trust, and top ten other trusts with high OP follow up reduction opportunity
- Clinically-led conversations with tiered trusts from National Clinical Directors, GIRFT clinical leads, and OP clinical leads
- Operational support to amend clinic templates
- Support to improve equity of access through the national Action on Outpatients programme.

Elective Care 2023/24 Priorities – Board Declaration

Assurance statement	Current position	Additional information, including next steps
Excellence in basics		
1. Has any patient waiting over 26 weeks on an RTT pathway (as at 31 March 2023) not been validated in the previous 12 weeks? Has the 'Date of Last PAS validation' been recorded within the Waiting List Minimum Data Set (WLMDS)?	The Taunton and Yeovil sites currently have different approaches to validating RTT pathways. On the Yeovil site, 91% of patients who have reached a 26-week wait have been technically (i.e., administratively) validated within the past 12 weeks. Patients are, however, not currently being contacted, to confirm they still wish to be seen. On the Taunton site, where the volumes of patients waiting over 26 weeks is significantly higher, 63% of patients have been validated in the past 12 weeks, by either a technical validation and/or having been contacted digitally (i.e., via a text message or e-mail address), to check they still wish to remain on the waiting list. A process is currently being put in place to send letters to those patients without digital contacts. A process is in place to record the 'date of last PAS validation' in the WLMDS (weekly data-set submission) for both sites.	The two RTT validation teams will come together under a single management structure from the 1st August 2023. The two site teams will sit within the Operational Management team (Director of Elective Care's team within the Chief Operating Officer's Department). As part of unifying the management of the teams, the aim will be to: 1) even-out the RTT validation efforts across sites, 2) establish the same digital approach to contacting patients, on the Yeovil site and 3) to routinely, on a rolling basis, contact all patients reaching a 26-week wait.
2. Are referrals for any Evidence Based Interventions (EBI) still being made to the waiting list?	The Trust has historically performed well against the national EBI requirements. The latest report for the Somerset ICB system for 22/23, suggests that across all providers (including those treating Somerset patients but based outside of Somerset), 34 category 1 procedures were undertaken (against a target of zero), and 2402 category 2 procedures against a goal of 1889. Almost all of the 'excess' EBI procedures are hand procedures and there is a known data quality issue affecting these. SFT records these hand procedures as day-cases, due to the administrative processes, waiting list management and physical location (i.e., Procedure	The Trust continues to work with Somerset ICB on the management of EBIs. This includes an agreed programme of audits where exceptions to the EBI management process has been identified. EBI management and performance is reported via the Somerset Elective Care Board. It should be noted that the latest EBI national guidance (EBI list 3) takes a more holistic view of interventions. The number of interventions undertaken should increase rather than decrease. This is because, even with the pressures the NHS

	Room in Day Surgery or Minehead Hospital 'theatre') these procedures are managed through, when in practice the clinical procedure is undertaken as an outpatient procedure, and hence meets the EBI category 2 criteria.	is under following the pandemic, it is recognised it is right that we take a long-term view of a patient's care needs. If a relatively straightforward and low-cost medical intervention can be made now which will alleviate or reduce the need for other potentially more expensive interventions further down the line, then we should take that opportunity.
Performance and long waiters		
3. Are plans in place to virtually eliminate RTT waits of over 104w and 78w (if applicable in your organisation)?	The Trust is expecting to report one exceptional 104-week waiter at the end of June, but none at the end of July (subject to there being no patients who are unfit for their planned treatment). The number of 78-week waiters is forecast to reduce at the end of June (from 87 in May to circa 68), with all remaining patients due to breach 78 weeks in June or July being dated by the end of June. At present circa 30 patients still need to receive dates in order to clear in full the 78-week wait backlog by the end of July.	
4. Do your plans support the national ambition to virtually eliminate RTT waits of over 65 weeks by March 2024?	Our ambition is to treat all patients who will otherwise breach 65 weeks by the end of March 24. Our plans currently leave us with a capacity gap of 848 long waiters, once all currently available mitigations are applied. Weekly specialty, site and pathway-level monitoring is in place, which provides a forecast of the March 24 capacity gaps. Specialties continue to work towards reducing this gap to zero by year-end. The Quality & Governance Committee on 24th May received a briefing on the Trust's overarching 65-week wait plans and approach. Outsourcing options have been identified for T&O, general surgery, colorectal, upper GI, urology and ENT, through local Independent Sector providers.	The Trust is conscious it is currently unable to commit to delivering a maximum wait of 65 weeks at the end of March 2024. The number of patients needing to be treated by year-end is 15,364 higher than we needed to treat in 22/23 in order to achieve a maximum 78-week wait in March 23. However, the Trust believes the plans that are in place are a stretching but realistic view of what can be delivered. Additional plans to reduce the remaining year-end cohort of long waiters continue to be sought.

	Patient lists are now being reviewed to establish patient suitability to transfer, following which patients will be contacted to seek permission to transfer their care. Mutual aid will also be sought for T&O and spinal, and a number of other specialties which have long waits for first outpatient appointments, via the national mutual aid system. An approach to contacting large cohorts of patients in one go, is being developed.	
Outpatients		
5. Are clear system plans in place to achieve 25% OPFU reduction, enabling more outpatient first activity to take place?	A reduction in follow-up activity by 25% is not currently being delivered and remains a challenge in 23/24. SFT is currently delivering 110% of pre-COVID levels of follow-up activity. This level of activity is being undertaken to reduce a backlog of overdue follow-up. In addition, there are over 15,000 more patients (compared with 22/23) who will be long waiters by March 24 unless treated before, most of which will require a follow-up appointment as part of their pathway and treatment.	NHSE has set-out a number of actions to support the delivery of a 25% reduction in follow-up demand. Through the Somerset Transformation of Outpatient Care (STOC) programme, which the Board is due to receive an update on, actions will be taken to deliver a reduction in follow-up activity. These actions include the following: • Clinical template reviews, looking at the balance of new and follow-up appointments. • Engagement with clinical leads, to review opportunities for reducing follow-up demand, including increasing the use of Patient Initiated Follow-ups (PIFU). • Follow-up validation to reduce demand. • Interventions to reduce missed appointments (DNAs), including understanding why patients are not attending their appointments. • Clinical patient digital questionnaires, to identify patients needing to be expedited and those suitable for PIFU.

		A Trust Outpatient Board is being established to provider oversight and leadership to outpatient services. The remit of this Outpatient Board will cover transformation of outpatient services (including STOC), but also support the day-to-day operational management of outpatient services, from policy through to resolution of space requirements.
6. Do you validate and book patients in for their appointments well ahead of time, focussing on completing first outpatient appointments in a timely way, to support with diagnostic flow and treatment pathways?	The Taunton site has implemented a digital validation programme for our non-admitted patients that starts at week 26 and is repeated every 3 months. This focuses primarily on new patients waiting for their first appointment and includes all three recommended stages of validation (technical, administrative and clinical (where required)). This ensures that when our outpatient booking teams contact patients to book their first appointments, we can be sure that they are showing the correct clinical priority and wish to go ahead. The next stage of this digital validation programme will be to focus on patients whose follow-up appointments appear to be overdue, to identify those patients needed a more urgent follow-up and also those patients who potentially could be offered a Patient Initiated Follow-up (PIFU). Digital validation will also be rolled-out to the Yeovil site.	Please see response to 1.
Cancer pathway re-design		
7. Where is the trust against full implementation of FIT testing in primary care in line with BSG/ACPGBI guidance, and the stepping down of FIT negative (<10) patients who have a normal examination and full blood count from	Through the trust's colorectal referral hub, which supports Primary Care's implementation of the national guidance, the Trust and Somerset ICS has implemented in full the FIT testing guidance. 71% of all lower GI 2-week wait referrals in April and May were accompanied by a positive fit test (> 10 FIT score). With the exception	Monthly monitoring is in place, to identify any dips in compliance, and any reasons behind this. It should be noted that SFT and Somerset ICB does not meet the 80% national requirements for the level of Fit testing. This is because circa 30%

the urgent colorectal cancer pathway in secondary care?	of 1 referral (which was an exceptional case) the remaining patients referred without a positive FIT test fell in to the national clinical exclusion categories of having iron deficiency anaemia or a palpable mass.	of patients are being referred, clinically do not require a FIT test to be undertaken.
8. Where is the trust against full roll-out of teledermatology?	The Somerset System will be implementing teledermatology on the newly procured system, by October 23. The scope of the referrals to be managed through teledermatology is still to be confirmed as part of the development of the future and transitional clinical model.	The next steps for teledermatology is to finalise the care pathway, signing of the contract with the IT provider and an expected 8-12 week mobilisation period during which GP practices will be set-up on the system. The Trust has in place an active programme of dermatology transformation work, which has dedicated programme management support, executive sponsorship and an agreed governance structure. It reports in to the ICB via the Elective Care Board.
9. Where is the trust against full implementation of sufficient mpMRI and biopsy capacity to meet the best practice timed pathway for prostate pathways?	In March 23 the Yeovil Urology team began to implement the triaging of patients referred as a 2-week wait with a suspected prostates to MRI. This is ongoing and each month the percentage triaged direct to MRI is increasing. At the Taunton site, triage to MRI already takes place. The current wait for prostate biopsies (Local Anaesthetic Trans Perineal - LATP) is just over 3 weeks in Musgrove and 4 weeks in Yeovil. There has been a significant increase in 2-week wait referrals following Bill Turnbull's death from the condition, in August 22. The main reason for the longer than optimal waits currently seen is annual leave and Junior Doctor Industrial Action. The Yeovil team is considering options for converting some flexi-cystoscopy lists to prostate biopsy lists, to increase capacity. The Taunton team continues to build LATPs into job plans where possible and move the timing of	There is now a single Clinical Specialty Lead for urology across the two sites. Work is underway to continue to streamline and align pathways across sites. We will be undertaking capacity & demand modelling for prostate biopsies, to make sure we can provide as much flexibility as possible to meet further surges in demand.

	biopsy lists across the week to fit with pathology reporting times. This reduces the chance of patients needing to wait a further week to be discussed at the Multi-Disciplinary Team meeting.	
Activity		
10. Are clear system plans in place to prioritise existing diagnostic capacity for urgent suspected cancer activity?	All suspected cancer requests are clearly identifiable on our Patient Administration Systems (PASs), radiology and endoscopy clinical/booking systems and are prioritised in terms of vetting, booking, scanning and reporting. These processes are supported by an agreed escalation process for patients being tracked by the Multi-Disciplinary Team (MDT) co-ordinators who diagnostic test has been delayed.	
11. Is there agreement between the Trust, ICB and Cancer Alliance on how best to ensure newly opening CDC capacity can support 62-day backlog reductions and FDS performance?	The Community Diagnostic Centre (Taunton) has been open since September 21, providing additional MRI, CT and to a lesser extent ultrasound scanning capacity. This capacity continues to be used to support the management of cancer diagnostics, mainly by freeing-up capacity on the Trust based scanners where more complex scans are undertaken. The Trust's Faster Diagnostic Standard performance is not driven by longer than optimal waiting times for imaging, but instead by a shortfall of capacity for gynaecology outpatients, endoscopy and prostate biopsies as a result of very high levels of growth in demand. The factors affecting performance against the 28-day Faster Diagnosis Standard (FDS) and the numbers of patients waiting over 62 days on a 62-day pathway, are well understood. These and the associated plans were presented to the Quality & Governance Committee in May 23. The System Assurance Forum (SAF) will receive a similar update in July.	28-day FDS performance in April was 73.6% and well above the planning trajectory which was submitted as part of the 23/24 operational plan. May and June's performance is also forecast to be above trajectory. An action plan is in place and continues to be implemented.

<table>
<tr>
<td>12. How does the Trust compare to the benchmark of a 10- day turnaround from referral to test for all urgent suspected cancer diagnostics?</td>
<td>The turn-around times for cancer imaging is shown below for the Musgrove and Yeovil sites:
<table>
<tr><th></th><th>CT</th><th>MRI</th><th>US</th></tr>
<tr><td>Scanned within 10 days (Musgrove)</td><td>70%</td><td>24%</td><td>86%</td></tr>
<tr><td>Scanned within 10 days (Yeovil)</td><td>70%</td><td>60%</td><td>84%</td></tr>
<tr><td>Scanned within 14 days (Musgrove)</td><td>84%</td><td>56%</td><td>96%</td></tr>
<tr><td>Scanned within 14 days (Yeovil)</td><td>84%</td><td>82%</td><td>91%</td></tr>
</table>
Turn-around times for other key diagnostics, such as colonoscopies and prostate biopsies, are in excess of 10 days for most patients. The constraint is primarily workforce. Waiting times for gastroscopies differ across the two sites, with waits at Taunton being typically under 10 days and Yeovil, over 10 days. As for imaging, work in underway to try to use available capacity flexibly, across both sides of the county, to meet cancer but also non-urgent demand.</td>
<td>With the exception of colonoscopy and specialist CT colon scans, turn-around times for the high-volume cancer diagnostics are not a key driver for Faster Diagnosis Standard performance.

The Trust has submitted a business case for a Community Diagnostic Centre in Yeovil, which will provide additional imaging and endoscopy capacity for the Somerset system.</td>
</tr>
<tr>
<td>13. Are plans in place to implement a system of early screening, risk assessment and health optimisation for anyone waiting for inpatient surgery?
Are patients supported to optimise their health where they are not yet fit for surgery?
Are the core five requirements for all patients waiting for inpatient surgery by 31 March 2024 being met?</td>
<td>Plans are in place to begin implementing early screening and risk assessment and health optimisation for patients awaiting elective inpatient surgery in September 23. This service will not initially be county-wide but will be rolled-out.

The plans in place to optimise patients' health, covering anaemia, diabetes and smoking and there is also a digital weight management pilot program for some specialities. We are working on pathways for other</td>
<td>The Peri-Op pathways project continues to report progress via the Somerset Elective Care Board.</td>
</tr>
</table>

1) Patients should be screened for perioperative risk factors as early as possible in their pathway. 2) Patients identified through screening as having perioperative risk factors should receive proactive, personalised support to optimise their health before surgery. 3) All patients waiting for inpatient procedures should be contacted by their provider at least every three months. 4) Patients waiting for inpatient procedures should only be given a date to come in for surgery after they have had a preliminary perioperative screening assessment and been confirmed as fit or ready for surgery. 5) Patients must be involved in shared decision-making conversations.	workstreams (i.e., alcohol, emotional support), and can signpost to other services as needed. 1 & 2) Our aim is to achieve pre-operative screening for risk factors, optimisation and personalised support for diabetes and anaemia by 31st March 24, across the county. It will only be possible to identify other risk factors for patients being added to the waiting list at Musgrove using Pathpoint (digital Pre-Operative Assessment system). This will be achievable at Yeovil once Pathpoint is embedded there. The aim is for this to be in place from mid-2024 and further funding in 2024 will enable staff to be employed for screening, optimisation and personalised support at Yeovil. 3) Funding from the recently approved business will enable the service to employ Care Co-ordinators for 3-monthly surveillance of the patients being added to the Musgrove surgical waiting list. 4) This is our aim by March 2024. 5) This is our aim by March 2024. Part of the business case funding will be a pilot using a palliative care consultant to find out how we roll-out this education to all clinical colleagues along the elective surgical patients pathway.	
14. Where is the trust/system against the standards of 85% capped Theatre Utilisation and 85% day case rate?	Please see the Appendix 2. The Trust's performance against the two standards is as follows: • Capped theatre utilisation (85% standard) median 71% for the rolling 13-week period ending 4th June; rank 6 out of 7 systems in the South West (top performance 78%)	A theatre steering group for each of the two sites (chaired by the Director of Elective Care) is now in place oversee the programme of work to deliver improvements in theatre efficiency. Projects include:

	• Day-case rate (85% standard) median 83%; rank 1 out of 7 systems within the South West.	• Right Procedure Right Place (moving appropriate inpatient procedures to day-case, and day-case to outpatient). • 'Golden patient' (to start lists off on time). • Specialty reviews where utilisation is below optimal, to understand the drivers and what we can do to address these. • Theatre session template review (to ensure the correct length of session is planned, to then enable the appropriate booking of lists). • Appropriate reporting of allowable 'lunch break' in an all-day theatre session (which currently the Trust is not reporting). • Review of safety reviews/processes, to ensure they meet safety needs but do not duplicate or go beyond what is required to keep patients safe. • Actions to avoid cancellations on the day due to a lack of beds, which continue to impact on theatre utilisation, especially at the Yeovil site.
15. Is full use being made of protected capacity in Elective Surgical Hubs?	According to the national definitions, the Trust doesn't currently have an Elective Surgical Hub. However, the Trust bed-base has been reconfigured to enable surgical throughput to be protected as far as possible, by consolidating down the surgical inpatient bed numbers and using escalation capacity that does not impact on the surgical bed-base. Maximising the use of acute home treatments (i.e., virtual wards) and delivering more ambulatory / day-case care is going to be critical to chieving the modelled bed numbers and new care model.	

16. Do diagnostic services meet the national optimal utilisation standards set for CT, MRI, Ultrasound, Echo and Endoscopy?	At present we cannot centrally report against the national optimal utilisation standards. Session usage and slot bookings are reported on different clinical and administrative systems across.	Further work needs to be undertaken to understand the Trust's position against the optimal utilisation standards.
17. Are any new Community Diagnostic Centres (CDCs) on track to open on agreed dates, reducing DNAs to under 3% and ensuring that they have the workforce in place to provide the expected 12 hours a day, 7 day a week service? Are Elective Surgical Hub patients able to make full use of their nearest CDC for all their pre and post-op tests where this offers the fastest route for those patients??	Somerset has a clear Diagnostic strategy supported by key partners in Somerset. This strategy includes a 'diagnostic delivery model' which sets out the structure of diagnostic delivery so that targeted investment can be made in the right areas linked to the strategy. Somerset opened the Community Diagnostic Centre (Taunton) in September 21, providing additional MRI, CT and to a lesser extent ultrasound scanning capacity. This capacity continues to be used to support the management of cancer diagnostics, mainly by freeing-up capacity on the Trust based scanners where more complex scans are undertaken. Somerset has a business case for a second Community Diagnostic Centre (Yeovil) going through the final stages of approval. This centre will provide the same imaging modalities as the Taunton CDC, but will additionally provide Endoscopy, Audiology, outpatient capacity. This business case approval from the Trust, ICB, Cancer Alliance and networks. This will ensure equal access to facilities and capacity across Somerset. The additional capacity created has improved waiting times in Somerset. The Trust's Faster Diagnostic Standard performance as a result, is not driven by longer than optimal waiting times for imaging, but instead by a shortfall of capacity for gynaecology outpatients, endoscopy and prostate biopsies as a result of very high levels of growth in demand.	

	The new CDC in Yeovil will improve the Endoscopy capacity and provide additional outpatient space to enable Somerset to further expand its services which are constrained by the existing estate.	
Choice		
18. Are you releasing any Mutual Aid capacity which may ordinarily have been utilised to treat non-urgent patients to treat clinically urgent and long-waiting patients from other providers? Is DMAS being used to offer or request support which cannot be realised within the ICB or region?	We have not yet requested or offered mutual aid through DMAS, but nominated Trust colleagues have been trained on the system and are ready to use it. Our focus to date has been on use of independent sector (IS) capacity more locally (but including capacity beyond the Somerset boundaries) because of the rural nature of our population and the distances required to travel to other centres. Specialties are starting to identify patients who could be referred further afield, for which the DMAS system will now be used. However, it is recognised that uptake is likely to be low, as it is for patients being offered IS providers within Somerset.	See the response to 4.
19. Has Independent Sector capacity been secured with longevity of contract? Has this capacity formed a core part of planning for 2023/24?	Somerset ICB has contracts in place with a range of Independent Sector providers. The length of these contracts and where we are in that contract varies from provider to provider. The contract with the main Somerset IS provider has a year to go, with an option of a 2-year extension. IS capacity is being used to support elective recovery including the treatment of long waiters.	
Inclusive Recovery		
20. Do recovery plans and trajectories ensure specialised commissioned services are enabled to recover at an equitable rate to non-specialised services? Do system plans balance high volume procedures and lower volume, more complex patient care	Recovery plans have been developed reflecting the level of demand for individual services (i.e., the cohort of long waiters needing to be treated) and the capacity that has been identified to set against this. The cohort of patients needing to be treated includes a mixture of high volume and more complex / specialist patients. Specialty plans seek to address this balance, for	

	example converting inpatient theatre capacity to day-case where appropriate.	
21. Have you agreed the health inequality actions put in place and the evidence and impact of the interventions as part of your operational planning return? Was this supported by disaggregated elective recovery data?	The Somerset ICB has a programme of work targeted at reducing health inequalities for access to elective care. This includes interventions to try to reduce DNAs (did not attends), which have been demonstrated from commissioned analysis of our data, to be significantly higher for people from the more socially deprived areas of Somerset, to help them attend appointments. The Trust is also addressing health inequalities by prioritising appointments and surgery for patients with learning disabilities, and those patients with open mental health referrals who come from the most socially deprived areas of Somerset. The effectiveness of these interventions are being monitored. Work is also underway to understand differences between different Primary Care Networks and more/less socially deprived areas, in the rate of cancer 2-week wait referrals and the level of patients being diagnosed with a late-stage cancer. There are interventions planned to improve early diagnosis from these areas, which will include self-referral options for symptomatic patients and/or targeted additional local screening programmes.	The work on elective care health inequalities continues to be reported to and overseen by the Somerset Elective Care Board.
22. Are children and young people explicitly included in elective recovery plans and actions in place to accelerate progress to tackle CYP elective waiting lists?	SFT has a small number of Children and Young People (CYP) waiting over 52 weeks for treatment (as of the 18th June, 157 patients out of 4588 pathways were waiting over 52 weeks, 40 waiting over 65 weeks, and 5 waiting over 78 weeks). CYP day-case and inpatient activity is lower than pre-COVID. But this largely reflects the competing demand of very long adult waits versus CYP waits in combined adult/CYP services. The Taunton and Yeovil sites have flags on the waiting list that allow	There is work underway within the highest volume CYP surgical services (i.e., Dental and ENT), which together make-up 49% of the over 52-week waiting CYP patients, to find ways to maximise activity and the use of available theatre sessions. Individual long-wait CYP patients will continue to be focused on as part of our plans to deliver a 65-week maximum wait by March 24.

	operational managers to identify individual long-waiting CYP patients.	A new part of the Board Report is being developed to provide assurance for, and visibility of, CYP waiting times.

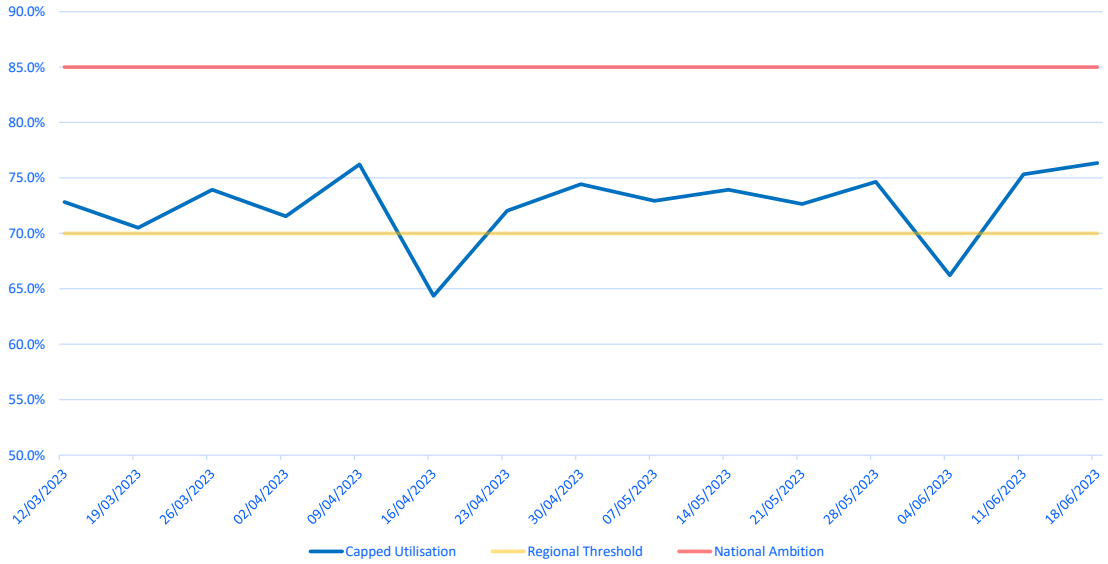
Appendix 1 – Elective Care 23/24 priorities letter

PRN00496_Elective care 2023-24 prioriti

Appendix 2 – Theatre Productivity 85% national standards

NHS
Somerset
NHS Foundation Trust

Capped Theatre Utilisation



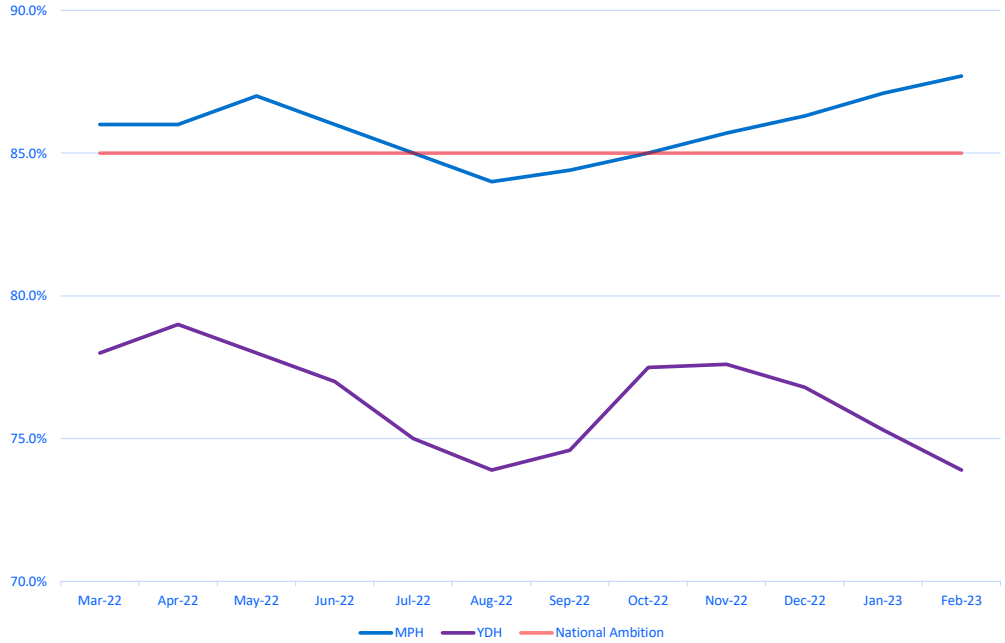
*N.b. weeks ending 11/06 and 18/06 YDH Site only

Kindness, Respect, Teamwork
Everyone, Every day

20/06/23

Day Case Rates for BADS Procedures

Somerset NHS Foundation Trust



Kindness, Respect, Teamwork
Everyone, Every day

20/06/23

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Somerset NHS Foundation Trust Finance Report – Month 2
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Deputy Chief Finance Officer
PRESENTED BY:	Chief Finance Officer
DATE:	4 July 2023

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

Executive Summary and Reason for presentation to Committee/Board	The Finance report sets out the overall income and expenditure position for the Trust. It includes commentary on the key issues, risks, and variances, which are affecting the financial position.
Recommendation	The Board is requested to discuss the report**.**

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

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

Implications/Requirements (Please select any which are relevant to this paper)					
☒ Financial	☐ Legislation	☐ Workforce	☐ Estates	☐ ICT	☐ Patient Safety/ Quality
Details: 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 not been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics

☐ 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)
N/A

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – 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 TO 31 MAY 2023

1. SUMMARY

1.1 In May the Trust recorded a deficit of £1.781m, which was £0.110m adverse compared with the plan for the month. Cumulatively, the Trust is £3.389m in deficit, this is £0.548m adverse to the planned position.

1.2 CIP achievement improved in May but remained below the planned level.

2. INCOME AND EXPENDITURE

2.1 Table 1 below sets out the summary income and expenditure account to 31 May 2023: -

Table 1: Income and Expenditure Summary

Statement of Comprehensive Income	Annual Plan	Current Month 2			Year to date		
		Plan	Actual	Fav./ (Adv.) Variance	Plan	Actual	Fav./ (Adv.) Variance
	£000	£000	£000	£000	£000	£000	£000
Income							
Patient Care Income	911,692	75,954	75,411	(543)	151,763	150,047	(1,717)
Other Operating Income	54,102	4,338	6,106	1,768	8,723	10,930	2,207
Total operating income	**965,794**	**80,292**	**81,517**	**1,225**	**160,487**	**160,977**	**490**
Operating expenses							
Employee Operating Expenses	(657,427)	(55,413)	(57,569)	(2,156)	(110,513)	(113,049)	(2,536)
Drugs Cost: Consumed/Purchased	(71,060)	(5,990)	(5,636)	355	(11,792)	(10,711)	1,081
Clinical Supp & Serv Exc-Drugs	(45,272)	(4,543)	(4,516)	27	(8,988)	(9,902)	(914)
Supplies & Services - General	(27,780)	(2,315)	(2,774)	(459)	(4,630)	(5,517)	(887)
Other Operating Expenses	(151,017)	(12,597)	(11,905)	691	(25,194)	(23,685)	1,510
Total operating expenses	**(952,556)**	**(80,858)**	**(82,400)**	**(1,542)**	**(161,117)**	**(162,863)**	**(1,746)**
Operating Surplus/Deficit	13,239	(567)	(884)	(317)	(630)	(1,886)	(1,256)
Finance Expense	(12,651)	(1,054)	(1,073)	(18)	(2,108)	(2,103)	6
Finance Income	613	51	252	201	102	405	303
Other	0	(1)	(2)	(1)	(4)	(4)	(0)
Overall Surplus/(Deficit)	1,200	(1,571)	(1,706)	(135)	(2,641)	(3,588)	(947)
Depr On Donated Assets	1,386	115	97	(18)	231	198	(33)
Donated Assets Income	(2,591)	(216)	(173)	43	(432)	0	432
Amortisation	9	1	1	(0)	2	1	(0)
Impairments (Reversals)	0	0	0	0	0	0	0
Other	(4)	(0)	0	0	(1)	0	1
Adjustments to control total	(1,200)	(100)	(75)	25	(200)	199	399
Adjusted Financial Performance	0	(1,671)	(1,781)	(110)	(2,841)	(3,389)	(548)

2.2 Agency expenditure was £3.917m in May (April 2023 £3.064m), which was £1.778m above the cap. The cap (c£30m for the year) is profiled pro-rata to 2022/23 actual expenditure. Escalation pressures and vacancies continue to be the primary drivers of agency usage. The Trust is continuing to review all agency usage to ensure it is essential and that effective controls are in place to authorise its use.

2.3 There are a number of income and expenditure variances which are largely neutral (i.e., pass through drugs and devices). There is an overall underspend on substantive pay costs year to date due to vacancies, but this does not fully offset the agency overspend.

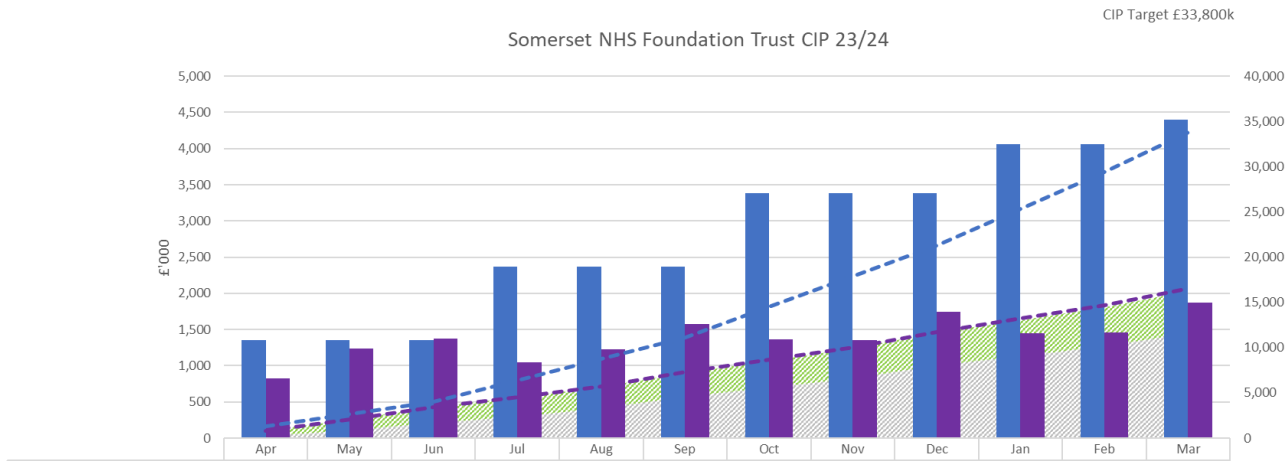
3. COST IMPROVEMENT PROGRAMME

3.1 The Trust has an agreed CIP plan of £33.8m for the year, this represents c3.4% of planned turnover.

3.2 In May, savings of £1.242m were delivered which is a shortfall of £0.110m against the plan. Recurrent savings formed £0.542m of the savings achieved (44%). Both of these were lower than planned and are an indicator of the challenging target. Services continue to be supported in their work to identify opportunities and progress is being made.

3.3 Further analysis is shown in the chart below: -

Chart 1: CIP Plan 23/24



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumlative NR	546	1,246	1,735	2,062	2,388	2,685	3,003	3,320	3,641	3,974	4,308	4,658
Cumlative R	277	819	1,710	2,405	3,286	4,543	5,570	6,594	7,998	9,062	10,135	11,608
Plan	1,352	1,352	1,352	2,366	2,366	2,366	3,380	3,380	3,380	4,056	4,056	4,394
Actual/Forecast	823	1,242	1,380	1,044	1,229	1,576	1,359	1,356	1,750	1,445	1,456	1,871
Cumlative Plan	1,352	2,704	4,056	6,422	8,788	11,154	14,534	17,914	21,294	25,350	29,406	33,800
Cumulative Actual/Forecast	823	2,065	3,445	4,490	5,719	7,295	8,654	10,010	11,760	13,205	14,661	16,531

3.4 The Board will be aware of the challenges services continue to face in the identification of schemes; however, service groups continue to invest considerable time and effort to strengthen their programmes and reduce the risk profile. Corporate teams are providing support where possible to help services to identify, secure and track savings.

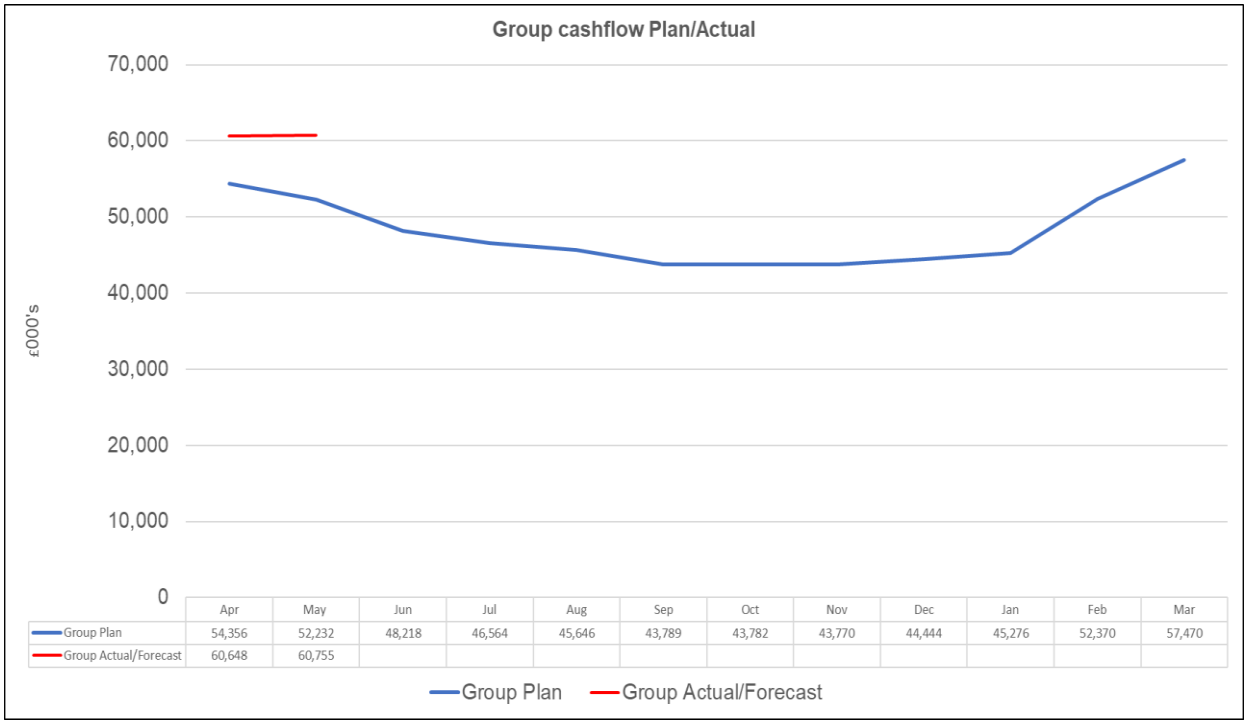
4. CASH

4.1 Cash balances as at 31 May were £60.8m which is higher than planned.

4.2 Our cashflow plan is based on the final 2023/34 plan is based on an assessment of the impact of number of factors which drive cash utilisation, these include, I&E performance against budget, CIP delivery, capital expenditure being incurred in line with the agreed capital programme and normal movements in working capital.

4.3 The actual/plan forecast cash flow for the year is shown in Chart 2 below: -

Chart 2: Cash flow Actual/Plan



5. CAPITAL

5.1 Schemes are being progressed in accordance with the agreed programme for the year. Even at this early stage there are a number of risks/issues including the additional costs of the modular theatre in Yeovil that will need to be managed within the overall envelope.

5.2 Year to date, capital expenditure is £5.0m compared with the plan of £5.7m, resulting in slippage of £0.7m. Further details are shown in Table 2 below:

Table 2: Capital Programme monitoring

Acute Programme MPH	Plan £000	YTD Plan £000	YTD Actual £000	Variance Act v plan YTD £000
Total MPH Site Risks / Plant & Equipment	480	0	(11)	(11)
MPH Site and Service Development	2,048	307	(0)	(307)
Acute Programme YDH	**Plan £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
Total YDH Main Site Budgets	3,800	140	523	383
Total - YDH Site and Service Development	6,091	382	117	(265)
Total - YDH Site Risks / Plant and equipment Replacement	370	0	153	153
Total Acute	**12,789**	**829**	**782**	**(47)**
Community/Mental Health Programme	**Plan £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
Total Community / Mental Health Site and Service Development	6,320	466	604	138
Total Community / Mental Health - Site Risks / Plant & Equipment	300	0	40	40
Total Community/Mental Health	**6,620**	**466**	**644**	**178**
Trustwide	**Plan £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
Trustwide	**13,650**	**971**	**1,620**	**649**
Total Internal Capital Envelope	**33,059**	**2,266**	**3,047**	**781**
Additional Capital Schemes	**Plan £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
PDC Digital - EHR - Trustwide	6,668	496	159	(337)
PDC STP 3 - MPH Surgical Centre	21,967	2,196	1,489	(707)
PDC NHP - MPH	1,060	150	107	(43)
PDC Pathology Network SFT	715	0	0	0
PDC Diagnostic Network SFT	374	0	0	0
PDC Endoscopy - MPH	358	0	0	0
PFI Funded IFRIC 12 - SFT MES	85	0	0	0
Beacon PFI Additions	626	0	0	0
Donated Acute MPH	600	0	11	11
PDC Tif - Elective Recovery/Theatre expansion - YDH	10,323	200	80	(120)
PDC Pathology Network YDH	115	0	0	0
PDC Diagnostic Network YDH	524	0	0	0
PFI Funded IFRIC 12 - YDH MES	382	0	0	0
Donated Acute YDH Breast Unit	2,750	0	58	58
PDC Yeovil CDC	796	0	0	0
PDC Somerset CYP Safe Spaces	368	60	58	(2)
Donated Community	110	0	0	0
Total Additional Schemes	**47,821**	**3,102**	**1,963**	**(1,139)**
IFRS Leases	3,781	324	0	(324)
TOTAL TRUST PROGRAMME	**84,661**	**5,692**	**5,009**	**(683)**

6. STATEMENT OF FINANCIAL POSITION (BALANCE SHEET)

Apr-23	May-23	Movement		Mar-23	May-23	Movement in Year
£000	£000	£'000		£000	£000	£000
22,995	24,353	1,358	Intangible Assets	25,142	24,353	(789)
353,505	355,274	1,770	Property, Plant and Equipment, Other	356,521	355,274	(1,247)
26,326	26,034	(292)	On SoFP PFI Assets	24,654	26,034	1,380
84,336	83,678	(657)	Right of Use Assets	82,143	83,678	1,535
296	205	(91)	Investments	296	205	(91)
14	14	0	Other investments/financial assets	14	14	0
2,894	2,929	35	Trade & other Receivables >1Yr	3,113	2,929	(184)
490,366	**492,488**	**2,123**	**Non Current Assets**	**491,883**	**492,488**	**605**
10,938	11,098	160	Inventories	10,833	11,098	265
29,737	36,765	7,028	Trade and other receivables: NHS receivables	39,244	36,765	(2,479)
22,785	26,571	3,786	Trade and other receivables: non-NHS receivables	22,158	26,571	4,413
60,648	60,755	107	Cash	64,388	60,755	(3,633)
124,108	**135,189**	**11,081**	**Total Current Assets**	**136,623**	**135,189**	**(1,434)**
(113,115)	(115,176)	(2,061)	Trade and other payables: non-capital	(124,670)	(115,176)	9,494
(3,968)	(21,156)	(17,188)	Trade and other payables: capital	(10,942)	(21,156)	(10,214)
(15,884)	(12,333)	3,550	Deferred Income	(8,524)	(12,333)	(3,809)
(4,957)	(4,953)	4	Borrowings	(6,210)	(4,953)	1,257
(4,873)	(4,880)	(8)	Provisions <1yr	(4,893)	(4,880)	13
(142,797)	**(158,498)**	**(15,702)**	**Current Liabilities**	**(155,239)**	**(158,498)**	**(3,259)**
(18,689)	**(23,309)**	**(4,621)**	**Net Current Assets**	**(18,616)**	**(23,309)**	**(4,693)**
(101,825)	(101,120)	705	Borrowings >1yr	(103,041)	(101,120)	1,921
(4,015)	(4,015)	0	Provisions >1yr	(4,034)	(4,015)	19
(1,919)	(1,898)	22	Deferred Income >1yr	(1,941)	(1,898)	43
(107,759)	**(107,033)**	**726**	**Total Long Term Liabilities**	**(109,016)**	**(107,033)**	**1,983**
363,918	**362,146**	**(1,772)**	**Net Assets Employed**	**364,251**	**362,146**	**(2,105)**
			Financed by:			
322,062	322,064	2	Public Dividend Capital	322,064	322,064	(0)
76,092	76,094	2	Revaluation Reserve	76,094	76,094	0
(2,471)	(2,471)	0	Other Reserves	(2,472)	(2,471)	1
(31,765)	(33,540)	(1,776)	I&E Reserve	(31,435)	(33,540)	(2,105)
363,918	**362,146**	**(1,772)**	**Total Financed**	**364,251**	**362,146**	**(2,105)**

7. CONCLUSION AND RECOMMENDATION

7.1 Performance in month was off plan as a result of the shortfall in CIP delivery. Services continue to work hard to identify schemes to fulfil their targets but in some areas progress continues to be difficult and the gap in plans has increased this month. We will continue to support and work with service groups.

7.2 Agency and locum costs are exceeding the cap and year date are £7m (22/23 £6.4m). We will continue to review usage and controls with services through their monthly oversight process.

7.3 Further industrial action is planned for the post graduate doctors in training and there are ballots underway in a number of other staff groups. There is currently no indication central funding to support the impact of these will be made available.

7.4 The Board are asked to note the financial performance for May.

CHIEF FINANCE OFFICER

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Charities Committee meeting held on 15 May 2023
SPONSORING EXEC:	Director of Strategy and Digital Development
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Barbara Gregory, Chairman of the Charities Committee
DATE:	4 July 2023

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the Charities Committee meeting held on 15 May 2023. The Committee received assurance in relation to: • The progress on merging the charities and the launch of Somerset NHS Charity. • The fundraising appeals for the Yeovil Breast Care Unit and Somerset 25th anniversary appeal. • Draft Annual accounts and Annual report. • Charity and fundraising priorities. The Committee identified the following areas for follow up: • Fundraising report – to present a breakdown of expenditure committed to projects from the 25th anniversary fundraising appeal to the next Committee meeting. • Charity priorities - to present a detailed report to the next Committee meeting. The Committee did not identify any issues to be reported to the Board.

Recommendation	The Board is asked to note the assurance and areas for follow up identified by the Charities Committee. The Board is further asked to note the areas to be reported to the Board.

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

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

Equality 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)
N/A

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE CHARITIES COMMITTEE MEETING HELD ON 15 MAY 2023

1. PURPOSE

1.1. The report sets out the items discussed at the formal meeting held on 15 May 2023, along with the assurance received by the Committee and any areas for follow up identified. The meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

Branding

2.1. The Committee received an update on charity branding and noted that the consultation on the branding had been completed and the new charity branding will be launched on 19 June 2023. The Committee recognised the need to be cautious about the cost of changing the branding.

Fundraising Report

2.2. The Committee received the fundraising report and noted that permission had been granted to link the charities. The Committee noted the appointment of two new community fundraisers; the meeting with a Rotary representative to try to secure ongoing support; and the first overseas Camino trek.

2.3. The Committee noted that the new Somerset NHS Charity branding was well received by colleagues not based on acute sites.

2.4. The Committee noted the start of the construction of the new Breast Care Unit in Yeovil; the levels of donations received for the Breast Care Unit, the 25th anniversary and the jewellery fundraising appeals; and the general increase in donations at both acute sites.

2.5. The Committee further noted: the concerns in relation to the garden project, and the need for ongoing maintenance; the positive impact of the two new fundraisers; the reasons for not being able to fund the Barton House shelter; the work to buy t-shirts and fleeces for volunteers; the suggestion to create a wish list of items to buy when sufficient funding is available; and the use of volunteers, particularly for the maintenance of gardens.

Charity Priorities

2.6. The Committee received an overview of the priorities and the different phases for the implementation of the priorities; the launch phase; consolidation phase; and the development phase. The Committee further noted the review of the website and the work in relation to identifying areas of good practice across all sites.

Finance Reports

2.7. The Committee received an update on the financial end of year positions and noted that an audit of the two accounts was currently taking place.

2.8. The Committee noted the work to consolidate approval procedures across all sites.

2.9. The Committee approved three business cases for funding.

3. AREAS OF CONCERN OR FOLLOW UP

Fundraising Report

3.1. The Committee asked for a breakdown of expenditure committed to projects from the 25th anniversary fundraising appeal to be presented to its next meeting.

Charity Priorities

3.2. The Committee noted that a detailed report will be presented to its next meeting.

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

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

Barbara Gregory
CHAIRMAN OF THE CHARITIES COMMITTEE