SOMERSET NHS FOUNDATION TRUST
PUBLIC BOARD MEETING

A Public meeting of the Somerset NHS Foundation Trust Board will be held on **Tuesday 5 September 2023** at **9.00am** in the Moxon Suite at Frome Community Hospital, Enos Way, Frome BA11 2FH

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

Yours sincerely

COLIN DRUMMOND
CHAIRMAN

AGENDA

		Action	Presenter	Time	Enclosure
1.	**Welcome and Apologies for Absence**		Chairman	09:00	Verbal
2.	**Questions from Members of the Public and Governors**		Chairman		Verbal
3.	**Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 27 June 2023**	Approve	Chairman		Enclosure A
4.	**Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 4 July 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.	**Corporate Risk Register Report**	Receive	Phil Brice	09:20	Enclosure F

OBJECTIVE - tbc					
10.	**Patient Story and Clinical Topic – "Ronny's Story"**	Receive	Hayley Peters	09:30	Verbal
OBJECTIVE 2 – Provide the best care and support to people					
11.	**Assurance Report of the Quality and Governance Assurance Committee meeting held on 26 July 2023**	Receive	Jan Hull	10:00	Enclosure G
12.	**Learning from Deaths Framework: Mortality Review Progress Report**	Receive	Daniel Meron	10:05	Enclosure H
13.	**2022/23 Quality Accounts** • **YDH** • **SFT**	Approve	Phil Brice	10.15	Enclosure I Enclosure J
OBJECTIVE 6 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture					
14.	**Assurance Report of the People Committee meeting held on 25 July 2023**	Receive	Jan Hull	10:25	Enclosure K
15.	**Guardian of Safe Working for Postgraduate Doctors Reports**	Receive	Daniel Meron	10:30	Enclosure L
10:40 – 10:55 Coffee Break					
16.	**Six Monthly Freedom to Speak Up Guardian Progress Report**	Receive	Caroline Sealey	10:55	Enclosure M
17.	**Six Monthly Staffing Establishment Report**	Receive	Alison Wootton	11:05	Enclosure N
OBJECTIVE 8 – To develop a high performing organisation delivering the vision of the Trust					
18.	**Quality and Performance Exception Report**	Receive	Pippa Moger	11:15	Enclosure O
19.	**Merger Update**	Receive	David Shannon	11:25	Enclosure P
20.	**Elective Recovery Outpatient Checklist**	Approve	Andy Heron/ Xanthe Whittaker	11:35	Enclosure Q

OBJECTIVE 7: To live within our means and use our resources wisely					
21.	**Verbal report from the Finance Committee meeting held on 1 September 2023**	Receive	Martyn Scrivens	11:45	Verbal
22.	**Finance Report**	Receive	Pippa Moger	11:50	Enclosure R
23.	**Assurance Report from the Audit Committee:** • **Meetings held on 7 and 27 June 2023** • **Meeting held on 12 July 2023**	Receive	Paul Mapson	12:00	Enclosure S Enclosure T
24.	**Assurance Report from the Charitable Funds Committee meeting held on 12 July 2023**	Receive	Barbara Gregory	12:05	Enclosure U
OBJECTIVE 4 – Reduce Inequalities					
25.	**Assurance Report from the Mental Health Act Committee meeting held on 13 June 2023.**	Receive	|Alexander Priest	12:10	Enclosure V
FOR INFORMATION					
26.	**Follow up questions from the Public and Governors**		Chairman	12:15	Verbal
27.	**Any other Business**		All		Verbal
28.	**Risks Identified**		All		Verbal
29.	**Evaluation of the Effectiveness of the Meeting**		Chairman		Verbal
30.	**Items to be discussed at the Confidential Board Meetings** The items presented to the Confidential Board include: Chief Executive verbal report; colleague suspensions and exclusions report; Simply Serve Q1 2023/24 highlight report; Symphony Healthcare Services Q1 2023/24 report; medium term financial plan; minutes of the June and July 2023 Finance Committee meetings; acute bed reconfiguration – bed modelling plan; adult social care transformation – no criteria to reside; update on the New Hospital Programme.				
31.	**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.				

32.	**Date of Next Meeting** Tuesday 7 November 2023			12:20	

PUBLIC BOARD MEETING

MINUTES OF THE EXTRA ORDINARY SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 27 JUNE 2023 VIA TEAMS

Present:

Colin Drummond	Chairman
Barbara Gregory	Non-Executive Director
Alexander Priest	Non-Executive Director
Kate Fallon	Non-Executive Director
Jan Hull	Non-Executive Director
Graham Hughes	Non-Executive Director
Peter Lewis	Chief Executive
Phil Brice	Director of Corporate Services
Pippa Moger	Chief Finance Officer
Isobel Clements	Chief of People and Organisational Development

In Attendance

Ben Edgar-Attwell	Deputy Director of Corporate Services (minute taker)

No:	
1.	**WELCOME AND APOLOGIES**
1.1	The Chairman confirmed that apologies had been received from: Martyn Scrivens (Non-Executive Director); Sube Banerjee (Non-Executive Director); Paul Mapson (Non-Executive Director); Andy Heron (Chief Operating Officer); Hayley Peters (Chief Nurse); Daniel Meron (Chief Medical Officer); and David Shannon (Director of Strategy and Digital Development). The Chairman confirmed 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 Yeovil District Hospital NHS Foundation Trust and Somerset NHS Foundation Trust's annual accounts and accompanying reports. The Chairman advised that the accounts were included in the Confidential Board meeting as they cannot be publicly published until they have been approved and formally laid before Parliament.

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

PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 4 JULY 2023 IN THE HERRIDGE ROOM AT WINCANTON COMMUNITY HOSPITAL, WINCANTON

PRESENT

Colin Drummond	Chairman
Barbara Gregory	Non-Executive Director
Alexander Priest	Non-Executive Director
Martyn Scrivens	Non-Executive Director
Sube Banerjee	Non-Executive Director
Kate Fallon	Non-Executive Director (via Teams)
Jan Hull	Non-Executive Director (via Teams)
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
Daniel Meron	Chief Medical Officer
David Shannon	Director of Strategy and Digital Development
Isobel Clements	Chief of People and Organisational Development

IN ATTENDANCE

Fiona Reid	Director of Communications
Alison Wootton	Deputy Chief Nurse
Rebecca Furzer	Dementia and Delirium Trainee Advanced Clinical Practitioner (for item 10 only)
Rosemary Joseph	Dementia and Delirium Specialist Nurse (for item 10 only)
Xanthe Whittaker	Director of Elective Care (for items 14 and 15 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: Hayley Peters (Chief Nurse).
1.2	The Chairman welcomed all Board members and attendees to the 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 9 MAY 2023**
3.1	Alexander Priest proposed, Kate Fallon seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 9 May 2023 as a correct record.
4.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 6 JUNE 2023**
4.1	Barbara Gregory proposed, Sube Banerjee seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 6 June 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	In relation to the Board Assurance Framework discussion, it was clarified that the comments made related to the timescales covered by the Board Assurance Framework and not to the content.
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.	**CHAIRMAN'S REMARKS**
7.1	The Chairman provided an update on the recruitment of three Non-Executive Directors to replace the Non-Executive Directors whose term of office will come to an end in 2024. It was noted that high quality applications had been received. Interviews will be held on 11/ 12 July 2023 and 1 August 2023. Focus groups had been set up for 10 July 2023 and details of the focus groups and candidates will be circulated to the focus group participants within the next few days.
7.2	The Chairman highlighted the ongoing concerns in relation to the high number of patients in inpatient services with "no criteria to reside". A delay in discharge was not in the interest of the patient but also impacted on the elective care waiting list and, therefore, on other patients.

7.3	The Chairman further advised that the SFT annual accounts and annual report had been approved by the Audit Committee and Board. It was noted that the YDH annual accounts and annual report had now been finalised and updated versions will be emailed to Board members for their approval.
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 New Hospital Programme and the confirmation that the Musgrove Park Hospital scheme will remain on track for completion by 2030; the recognition of awards; the NHS75 celebrations; and media coverage.
8.3	The Chief Executive further advised that the national workforce plan had been published on 30 June 2023. The plan set out how the NHS will address existing vacancies and meet the challenges of a growing and aging population by recruiting and retaining more staff over the next 15 years and reforming the way the NHS works. The plan included a government funding commitment of more than £2.4 billion. Details of the plan will need to be explored to be able to assess the impact on the trust's and system wide workforce plan. It was noted that the funding commitment did not include the cost of employing extra colleagues and only covered training costs.
8.4	The Chief Executive provided an update on the industrial actions and advised that confirmation had been received that consultants will be taking industrial action from 18 to 21 July 2023. This will be in addition to the junior doctors' industrial action scheduled for 13 to 18 July 2023. The Chief Executive advised that the trust had a good track record of managing the impact of previous industrial actions on patient safety and the same approach will be used for further industrial actions. It was however recognised that colleagues who provided cover during the industrial actions were tired.
8.5	In relation to the consultant industrial actions, it was noted that some systems were struggling to fill rotas and one system had adopted BMA rate cards. It was further noted that the trust was in a good position in terms of managing the impact of industrial actions and Meridith Kane was thanked for her leadership in this respect. The Chief Executive set out the difference between the junior doctors and consultants' industrial actions and advised that whilst the former was a "walk out", the latter related to derogated actions which would result in a minimum level of services to be provided by a limited number of consultants. This will impact on activity levels, particularly elective care activity, and patient flows.
8.6	The Board discussed the report. The Board acknowledged the long list of awards and thanked all colleagues for managing the impact of the industrial actions.
9.	**BOARD ASSURANCE FRAMEWORK AND Q1 2023/24 CORPORATE RISK REGISTER**
9.1	**Board Assurance Framework (BAF)** The Director of Corporate Services presented the report which was received by the Board.

9.2	The Director of Corporate Services highlighted the key risks on the BAF and advised that the common areas of risk had remained unchanged. The aim of the format of the Board Assurance Framework was to ensure that the right conversations were taking place in the right places and that robust levels of assurance were received. Where appropriate, oversight of objectives had been assigned to committees to review the controls and assurances in place and to consider whether additional actions to strengthen controls will need to be implemented.
9.3	The Director of Corporate Services advised that the strategic objectives for 2022/23 had been carried forward into 2023/24 as they remained fit for purpose. Objectives two to five remained aligned with the system clinical aims and form the basis for the clinical model.
9.4	The Board discussed the report and commented/noted that: • Objective five – this objective covered a complex area and it will be important to focus on the areas which were in the control of the trust, e.g. making the best use of Symphony to improve primary care services. • Assurance could take the form of positive or negative assurance. In the case of neutral assurances, it will be the role of the relevant Committee or Board to determine whether additional assurance will need to be sought. • Population health – it was recognised that Board and Committee oversight arrangements to date had been limited and it was noted that a detailed update on the population health work taking place across the system was being prepared for the September 2023 strategic Board meeting. The update will include actions which are being taken by the trust; system work and data and how this fits into the wider population health work. The work on population health was based on a systemic approach and an ICS Data Development Group had been set up to analyse data across the system. • The new format and the detailed information were welcomed. • The impact of the pandemic had been highlighted as a key risk for objective five and it was queried whether this risk should be changed and made more specific as this was now a post pandemic risk. • The KPIs and the traffic lighting process for measuring performance was welcomed but it was felt that a narrative for some of the KPIs will be helpful, e.g. 285 suicide/self harm incidents.
9.5	The Chairman commented that the Board Assurance Framework will need to inform the Board agendas and noted that Board agendas will continue to be reviewed to ensure that they were aligned to the key strategic risks.
9.6	**Corporate Risk Register** The Director of Corporate Services presented the report which was received by the Board. The Director of Corporate Services highlighted the key risks on the risk register and advised that six risks had been scored at 20. These risks related to acute estate; demand;

	referral to treatment times; waiting times; Symphony Healthcare Services not becoming financially self-sustaining; and core numbers of Junior and Consultant medical workforce.
9.7	The Board discussed the report and commented/noted that: • A representative from the estate team will be attending the next Quality and Governance Assurance Committee meeting to provide an update on the acute estate risk. • The Quality and Governance Assurance Committee has oversight of the demand; referral to treatment times; and waiting times risks. • The Board was well sighted on the Symphony Healthcare Services risk. • It was encouraging to see how the risk register was evolving and it was felt that the information was easily accessible. • It will be important to also discuss whether or not to carry a risk.
9.8	The Chairman asked all Committee Chairs to ensure that the Committees keep oversight of the risks and strategic objectives allocated to the Committees.
10.	**PATIENT STORYR – "EVERYTHING IS 'FINE' – A STORY OF A MAN WHO LOVES SPUDS, TIDDY'S AND POTATOES"**
10.1	Rebecca Furzer and Rosemary Joseph joined the meeting for this agenda item.
10.2	Rebecca Furzer advised that it was the intention that Patrick, Frank's son, would be present at the meeting to tell Frank's story, but due to a deterioration of Frank's health, he was unable to do so. Rebecca Furzer and Rosemary Joseph set out the background to Frank's journey through both acute hospitals and community hospitals where he spent a total of 120 days as an inpatient. They read out the story as written by Patrick which highlighted: the impact on Frank; the challenges faced by the family; the lack of cohesive processes; and the impact on the family. The story recognised the sheer dedication and professionalism of the team to provide Frank with the appropriate care. Rebecca Furzer further set out what had gone well, areas for improvement and the actions taken to improve the issues identified and raise awareness of dementia and delirium.
10.3	Rebecca Furzer and Rosemary Joseph set out the role of the dementia and delirium team, the support provided and highlighted the difference the team made not only to the family but also in supporting colleagues with strategies and advice to help them understand their individual patient's needs.
10.4	The Board discussed the story and commented/noted that: • The Board thanked Rebecca and Rosemary and the wider team for their excellent work and their focus on personalised care and the wellbeing of the patient, the patient's family and colleagues.

- The story was very powerful and it was very moving to hear colleagues trying hard to provide good quality of care. Frank's multiple transfers across services had had a significant impact on him and the family and the transfers had worsened his condition. The significant work undertaken to mitigate harm to Frank was recognised.

- Especially patients with dementia should have a much shorter inpatient stay as an inpatient stay was more harmful to this group of patients. On average it was estimated that 25% of inpatients had dementia and this group of patients generally had poor outcomes. The involvement of the dementia and delirium team was therefore particularly welcomed.

- It was recognised that the team could not provide support to all dementia patients at all times and supporting patients with dementia and delirium was everyone's business. It was queried whether capacity of the team will be expanded or whether other support solutions were available. Rebecca Furzer commented that the service was a reactive service but with a vision to be proactive and try to reduce risks and distress as early as possible. A large part of the role of the team was therefore educating colleagues on how to support a patient with dementia. It was noted that funding had been received for one clinical nurse specialist as well as three Band 4 colleagues and an extensive education programme was being rolled out. The aim was to empower all colleagues to have the skills to provide individualised care to prevent some of the issues highlighted in Frank's story.

  Rebecca Furzer further advised that it was also important to raise awareness as dementia remained a stigma and this could result in wrong assumptions being made. It was noted that the aim was to include delirium screening on proformas to raise awareness of dementia and delirium.

- The receipt of education funding was welcomed and it was queried how long it will take to train a colleague to deliver training. Rebecca Furzer advised that four team members will be providing training to colleagues. The programme to deliver level one dementia training was a three year programme. A national training programme was currently not available. All colleagues will be required to undertake mandatory dementia awareness training and compliance was currently at 99%. The tier 2 training was a comprehensive programme and focussed on providing individualised care.

- Part of the story was painful to listen to and the story showed how much value the team added to patients and families. In addition, colleagues looked to the team for direction and patients with dementia and super imposed delirium were one of the most complex groups of patients. The team had made a significant impact on the quality of care provided to this group of patients.

- The work in acute hospitals and community hospitals was excellent but it will also be important to understand what support can be provided in the community and how to join this up with dementia services provided by the voluntary sector. One of the issues raised in Frank's story was the disconnect with therapy services and this disconnect could apply to a larger number of patients. It was noted that a number of

	assessments for therapy services had to be carried out and it was queried what assurance could be provided that the pathway issues had been addressed, especially as the disconnect between acute and therapy services was a longstanding issue. Rebacca Furzer commented that observations were carried out on the ward but there may not always be a need for therapy services and sometimes colleagues may be worried moving a patient without a therapy assessment. The dementia and delirium team had permission and the confidence to move patients without a therapy assessment. • It was queried to what extent the design of the new electronic patient record (EHR) will help the team to keep track of patients and ensure that they receive continuity of care and appropriate transfers. The Director of Strategy and Digital Services advised that having a single point for recording and accessing information was a key rationale for the EHR programme. Rebecca Furzer agreed that a single system will significantly help the team. Caution was expressed that the EHR programme in itself will not result in a change in services and how the system will be adopted across services will be key. This will be a significant programme of work and will need careful planning and take account of transformation and resources. • Reducing the need for multiple assessments and sharing of information were key benefits set out in the merger business case and also related to one of the core Board Assurance Framework strategic objectives.
10.5	The Board thanked Rebecca Furzer and Rosemary Joseph for sharing Frank's story and for their focus on personalised care and improving the patient experience. The Board also thanked Frank and Patrick for allowing their story to be heard. This topic was relevant in view of the wider discussions on acute and community interface. The Board asked for a progress report to be provided to a future meeting.
10.6	Rebecca Furzer and Rosemary Joseph left the meeting.
11.	**ASSURANCE REPORT OF THE GOVERNANCE AND QUALITY ASSURANCE COMMITTEE MEETING HELD ON 24 MAY 2023**
11.1	Jan Hull presented the report which was received by the Board. She highlighted the areas of assurance received and the areas to be reported to the Board. The area to be reported to the Board related to: • Assurance from Elective and Cancer Services update • Assurance from the Patient Experience and Engagement work programme • Concerns regarding Minehead MIU increase in activity.
11.2	The Board discussed the report and commented/noted that:

	• The majority of the risks overseen by the Committee had been rated "amber" or "green". The fire safety risk had been rated "red" and an update on the actions taken to mitigate this risk will be presented to the July or September 2023 Committee meeting.
11.3	The Committee provided the Board with assurance that the items discussed at the meeting provided assurance in relation to objectives two to five of the Board Assurance Framework.
12.	**ASSURANCE REPORT OF THE PEOPLE AND WORKFORCE COMMITTEE MEETINGS HELD ON 22 MAY 2023**
12.1	Kate Fallon presented the report which was received by the Board. She highlighted the areas of assurance received and advised that two areas for follow up had been identified. These related to the uptake of the Pulse survey and an update on the work of the colleague support team.
12.2	No issues have been identified to be followed up by other Committees or to be reported to the Board.
12.3	The topics discussed at the meeting provided significant assurance in relation to strategic objectives two to five of the Board Assurance Framework.
12.4	The Board discussed the report and commented/noted that: • There will need to be an increased focus on culture and the Committee's work plan may need to be reviewed accordingly. • Work was taking place across the Finance and People Committees to look at agency expenditure. The workforce model was being reviewed to ensure that it was fit for purpose and this work will be overseen by the People Committee.
13.	**ANNUAL FIT AND PROPER PERSON TEST DECLARATION**
13.1	The Secretary to the Trust presented the report which was received by the Board.
13.2	The Board noted the findings from the annual Fit and Proper Person Test exercise and accepted the assurance that all Board members and Directors as specified in the Fit and Proper Person Policy continued to meet the Fit and Proper Person Test requirements.
14.	**QUALITY AND PERFORMANCE REPORTS**
14.1	Xanthe Whittaker joined the meeting.
14.2	The Chief Finance Officer presented the first combined report which was received by the Board. She highlighted the areas of good performance and provided an overview of the key performance challenges across the trust.
14.3	The Board discussed the report and commented/noted:

- It was queried whether in view of the operational pressures, assurance could be provided that there was no emerging trend in relation to patient safety. The 102 ligature incidents were highlighted as an example, and although it was recognised that 65 of these incidents related to two patients at Rydon Ward, there remained a significant number of incidents relating to other patients. The Chief Medical Officer advised that he was satisfied that there was sufficient oversight of the ligature incidents and all incidents were reviewed to ensure that assessments and care plans accurately reflected observation levels and the management of identified risks. The Chief Medical Officer confirmed that he had no patient safety concerns.

  The Chief Executive advised that in terms of overall patient safety, there had been no change, although it was recognised that some environments were not as safe as desired. The Director of Corporate Services advised that service groups were developing their quality standards and performance against these standards will be monitored.

- Performance against the two week cancer target remained below the 90% target whilst performance against the 62 day cancer waiting time standard showed a sustained improvement over the last few months. It was queried whether this sustained improvement was an indication of a general recovery of cancer service performance. Xanthe Whittaker advised that there had been a reduction over the last few months in the number of patients waiting over 62 days but at the same time there had been high levels of referrals across the colorectal and urology specialties and, more recently, in gynaecology services. These increases could be attributed to an increase in awareness following celebrity deaths.

  Xanthe Whittaker advised that there had also been an improvement in performance against the cancer – 28 days Faster Diagnostic target. She advised that the two week target did not reflect the improvements being made and highlighted the establishment of one stop breast clinics. Whilst patients may need to wait longer than two weeks to be seen, all tests will be carried out on the same day and patients will receive a diagnosis at their first appointment. Previously patients may have been seen within two weeks but would have had to attend multiple appointments before receiving their diagnosis. Xanthe Whittaker concluded that a number of indicators were going in the right direction and she was confident that trajectory will stay on course. It will however be necessary to provide guidance and support referrals to be able to clearly distinguish between suspected cancer and HRT related referrals.

- Performance against the emergency department target was generally good but the overall figure was distorted by MIU performance and did not reflect the significant pressures in the acute emergency departments. The Chief Operating Officer highlighted the high emergency department attendance levels at Musgrove Park Hospital and the high conveyance levels, particularly of frail and elderly patients. A deep dive into the data was being undertaken by the Emergency Delivery Board to be able to identify the reasons for the high attendance and conveyance.

  The Chief Operating Officer advised that good progress was being made with the hospital at home service and the management of the ambulance stack but the underlying reasons for the high demand will need to be further explored.

14.4	The Board acknowledged the areas of good performance and recognised the challenges and the actions being taken to address them.
15.	**ELECTIVE CARE 2023/25 PRIORITIES – BOARD DECLARATION**
15.1	Xanthe Whittaker presented the report which was received by the Board. She highlighted the letter received from NHS England on 23 May 2023, setting out the priorities for delivering elective care, and the accompanying checklist of expectations on what trusts should do to support elective recovery.
15.2	Xanthe Whittaker highlighted the checklist and advised that the trust was largely compliant with the expectations set out in the checklist. Further work will need to be carried out in some areas and the actions to be taken to achieve compliance had been included in the checklist.
15.3	The Board discussed the report and commented/noted that: • NHS England does not expect detailed responses against each of the statements and it was not expected that NHS England will challenge the completed return. • The checklist will be shared with the ICB before submission to NHS England. • The elective recovery programme was a significant and intense programme of work and Xanthe Whittaker was thanked for her continued focus on elective recovery against many operational challenges. • The Quality and Governance Assurance Committee received regular presentations on the elective recovery programme and the Committee received significant assurance about the focus on elective recovery and progress made. • The waiting list included a complex group of patients in terms of co-morbidities and this impacted on the waiting list as these patients may require a longer hospital stay. It was noted that 172 surgical patients on the waiting list had been reviewed and 33 patients had been identified as suitable to be treated at the Shepton Mallet Treatment Centre. However, only three patients had accepted a transfer to the Shepton Mallet Treatment Centre. This review and contacting patients had taken up significant time and the low uptake showed the challenges in finding alternative options to reduce the waiting list. It was noted that patients can choose another provider through the national system but there was concern about suitability. Xanthe Whitaker confirmed that work was taking place alongside the ICB in relation to the relationship with the Shepton Mallett Treatment Centre and overall relationships were working well but there remained a number of constraints. • The Chief Executive advised that there were also structural independent provider capacity issues and, although the independent sector currently accepted referrals, the nature of patients accepted by the independent provider was limited and this impacted on the ability to reduce the cohort of long waiting patients which will need to be treated by the end of March 2024. The challenge transferring patients to the independent sector had been raised with the Prime Minister's Delivery Unit and the

	commissioning of the independent sector will need to change to be able to treat long waiting patients. • It was queried whether progress had been made in relation to the validation of the waiting list and whether this validation had made a significant impact on the waiting list. Xanthe Whittaker advised that the validation exercise had been launched a few months ago and the response to email or text messages had been excellent. Of the 85% of patients who responded, between 5-7% responded that they had been treated elsewhere or that their condition had improved. In view of the success of the exercise, a paper exercise was also being set up to be able to target patients without an email or telephone number on file. The validation exercise will continue on an ongoing basis.
15.4	The Board noted the assurance statement and levels of compliance.
15.5	The Board thanked Xanthe Whittaker for her excellent work and focus on elective recovery.
15.6	Xanthe Whittaker left the meeting.
16.	**MERGER UPDATE**
19.1	The Director of Strategy and Digital Development provided a verbal update and highlighted: • The progress made in relation to the 100 day project. It was noted that a quarterly update will be presented to the September 2023 Board meeting. • The clinical dashboard was being finalised and this dashboard will be linked to the key performance indicators as set out in the Board Assurance Framework. • Overall good progress was being made in terms of clinical integration, but progress varied across services. The audiology service will be one of the specialties taking part in the planning process for a shared waiting list. • Good progress was also being made in terms of close working arrangements between acute and mental health services.
19.2	The Board discussed the update and commented/noted that: • The Director of Strategy and Digital Development and the team was congratulated on the excellent progress made. • As there was a clear link between the quarterly update reports and wider strategies, it was queried when reports will be presented to the Board Committees. The Director of Strategy and Digital Development advised that clinical strategy updates to the Quality and Governance Assurance Committee had already been scheduled. The aim was to move away from a project approach and move to a business as usual approach. The 100 day report will be the last quarterly report to the Board and, going forward, regular reports will be presented to the relevant Board Committee.

	• A formal six monthly review of progress made, as well as a one and two year review, will need to be undertaken and feedback will be presented to the Board.
17.	**VERBAL REPORT FROM THE FINANCE COMMITTEE MEETING HELD ON 26 JUNE 2023**
17.1	Martyn Scrivens, Chairman of the Committee, provided feedback from the meeting held on 26 June 2023 and advised that the Committee reviewed the finance report for May 2023. The report showed a continuation of the key challenges experienced over the last year, particularly relating to agency spend and achievement of the cost improvement programme.
17.2	The Committee further reviewed progress against the capital plan and noted that a number of capital items scheduled for 2022/23 had been moved to the 2023/24 plan. It was felt that the overall plan provided sufficient flexibility to manage the additional pressures.
18.	**FINANCE REPORTS**
18.1	The Chief Finance Officer presented the financial report which was received by the Board. She particularly highlighted: • An in-month deficit of £1.781 million against an in-month deficit of £1.671 million. • A year to date deficit of £3.389 million against a planned deficit position of £2.841 million. • An in month agency spend of £3.917 million which was £1.778 million above the agency cap. • An agreed cost improvement plan of £33.8 million and the delivery of £1.242 million cost improvements in May 2023 against a forecast delivery of £1.352 million. • A year to date capital expenditure of £5.0 million against a plan of £5.7 million.
18.2	The Board discussed the report and commented/noted that: • The junior doctor industrial action had resulted in an additional £130,000 cost and costs for industrial actions were not funded. A further industrial action had taken place in June 2023 and the financial impact will be included in the month three report. Although the costs of the industrial actions were included in the overall finance figures, these figures did not take account of an additional loss in income of £1.1 million as a result of having to cancel surgery. The omission of this loss was in line with a national directive. As this was a national issue it was hoped that the additional financial pressures will not impact on the trust's eligibility for Elective Services Recovery Funding. • The achievement of the end of year cost improvement target was a concern and additional schemes were being identified. A deep dive into the cost improvement

	programme and schemes identified will be undertaken at the August 2023 Finance Committee meeting. • It was queried what the total cost of industrial actions which have taken place or planned over the first six months of the financial year will be. The Chief Finance Officer advised that the junior doctor industrial actions cost c£100,000 a day but it was too early to estimate the cost of the consultant industrial actions as planning was in its early stages. It was expected that the daily costs will be less but that the amount of lost income will be higher. • It was queried whether the industrial actions had an impact on the achievement of the cost improvement programme. It was noted that although there was no direct financial impact, there was an impact in terms of managers' focus. • The Finance Committee had discussed the reasons for agency expenditure and had queried how much of the agency expenditure was linked to the number of vacancies. This was an area of overlap between the Finance and People Committees and consideration will need to be given as to how to challenge the service groups on vacancies, agency expenditure and achievement of the cost improvement programme. It was noted that discussions on this joint work were taking place.
19.	**ASSURANCE REPORT FROM THE CHARITABLE FUNDS COMMITTEE MEETING HELD ON 15 MAY 2023**
19.1	Barbara Gregory presented the report which was received by the Board. She highlighted the areas of assurance received and advised that two areas for follow up had been identified. These related to the fundraising report and providing a break down of expenditure committed to projects from the 25th anniversary fundraising appeal; and the Charity's priorities.
19.2	No issues have been identified to be reported to the Board.
19.3	The Board discussed the report and commented/noted that: • A clean audit of the charities' accounts had been received and Barbara Gregory thanked the teams for their excellent work. • Donations for the YDH breast cancer unit had exceeded its target and this was an excellent achievement. • The launch of the new charity branding had taken place on 19 June 2023 and had been well received.
20.	**FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS**
20.1	There were no follow up questions from members of the public or, specifically, Governors.

21.	**ANY OTHER BUSINESS**
21.1	There was no other business.
22.	**RISKS IDENTIFIED**
22.1	The Board identified risks in relation to: the patient story – assessments, the sharing of information and carers/family support; the Board Assurance Framework; the clinical, financial, patient and colleague impact of the industrial actions; and the shortfall in the cost improvement programme. The Board noted that these risks had been included on the Corporate Risk Register.
23.	**EVALUATION OF THE EFFECTIVENESS OF THE MEETING**
23.1	The Board agreed that the meeting had been productive with a wide range of topics covered in detail, including the patient story.
23.2	The Board noted that the format of the meetings had been amended to include a strategic session after the Part B meeting to enable more timely strategic discussions.
24.	**ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING**
24.1	The Chairman highlighted the items for discussion at the confidential Board meeting and set out the reasons for including these items on the Confidential Board agenda.
25.	**WITHDRAWAL OF PRESS AND PUBLIC**
25.1	The Board moved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.
26.	**DATE FOR NEXT MEETING**
26.1	5 September 2023

SOMERSET NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETINGS HELD ON 4 JULY 2023

AGENDA ITEM	ACTION	BY WHOM	DUE DATE	PROGRESS
No actions to be followed up by the Board were identified at the 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:	5 September 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 30 August 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 and Inclusion
The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. **How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?**
No impact on people with protected characteristics has been identified as part of the attached report.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

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

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

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

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

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REGISTERS OF DIRECTORS' INTERESTS

NON EXECUTIVE DIRECTORS	
Colin Drummond Chairman	• Honorary Vice President of Calvert Trust Exmoor (outdoor holidays for people with disabilities) – current • President of Wadham College Oxford 1610 Society • Deputy Lieutenant for Somerset • Worshipful Company of Water Conservators – 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)

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	• 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 NHS Devon Health System
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

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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 within the Neighbourhood's Directorate. • Director of YEP Project Co Limited • Director Predictive Health Intelligence Ltd
Daniel Meron Chief Medical Officer	• Visiting Professor, Peninsula Medical School, University of Plymouth

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Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Chief Executive/Executive Director Report
SPONSORING EXEC:	Chief Executive
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Chief Executive
DATE:	5 September 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 July and August 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
☒bj 2 Provide the best care and support to children and adults
☒ Obj 3 Strengthen care and support in local communities
☒ Obj 4 Reduce inequalities
☒ Obj 5 Respond well to complex needs
☒ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☒ Obj 7 Live within our means and use our resources wisely
☒ Obj 8 Develop a high performing organisation delivering the vision of the Trust

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

Equality and Inclusion
The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
This report has not been assessed against the Trust's Equality Impact Assessment Tool.

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

Public/Staff Involvement History
How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
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. COMMUNITY DIAGNOSTIC CENTRE ANNOUNCEMENT

1.1. The health secretary Steve Barclay recently announced the launch of thirteen new community diagnostic centres across the country.

1.2. Thirteen new community diagnostic centres (CDCs) - including eight independently run CDCs - are being launched across the country as part of government plans to use the independent sector to cut NHS waiting lists.

1.3. It is hoped that nationally the new CDCs will deliver more than 742,000 additional scans, test and checks a year.

1.4. Following the announcement, as part of the programme, we have now shared our plans to develop a community diagnostic centre on the grounds of Yeovil District Hospital. NHS patients in Somerset and the north west of Dorset will benefit from quicker diagnoses thanks to the Yeovil Diagnostic Centre, which will be the second stand-alone diagnostic centre in our county and will open in winter 2024.

1.5. Pending approval from local planners, building for the Yeovil Diagnostic Centre is planned to begin in spring 2024 and the centre will open in winter 2024. People are now being encouraged to attend a local engagement drop-in session in Yeovil to support the planning process.

2. SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE VISIT TO MUSGROVE PARK HOSPITAL

2.1. The Secretary of State for Health and Social Care, the Rt Hon Steve Barclay MP, recently visited Musgrove Park Hospital. While he was at the hospital, he was given an overview of the following:

- Clinical areas that have benefitted from recent development and therefore support colleagues to deliver care differently
- The building site for our new surgical centre.
- Our maternity unit that is in desperate need of redevelopment and which will, along with other areas, benefit from the national New Hospitals Programme.

2.2. The Secretary of State was joined for his visit by the local MP for Taunton Deane, Rebecca Pow.

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2.3. This last-minute visit was a valuable opportunity for us to highlight to him the uniqueness of our trust which brings together acute, community, mental health and learning disability services and primary care – and how important continued investment in our infrastructure, including our digital programme, is. We took full opportunity to describe the uniqueness of our organisation, the work we are doing on Acute Home Treatment and how a single electronic health record is a key enabler to meeting our strategic plans and the challenges we currently have in achieving this.

2.4. The Secretary of State asked that we follow up his visit with a letter summarising the key points we made.

3. NATIONAL HOSPITALS PROGRAMME ROADSHOW

3.1. We were very pleased to host one of the national New Hospitals Programme roadshows at Musgrove Park Hospital on 3 August 2023.

3.2. Led by Lord Nick Markham CBE, Parliamentary Under Secretary of State at the Department of Health and Social Care, and trust chairman Colin Drummond, the event was an opportunity to share some of the challenges facing the trust, as well as the opportunities and importance of the future development that the New Hospitals Programme will bring.

3.3. A range of local stakeholders, partners and trust colleagues attended the informal round table sessions, including Rebecca Pow MP, Bill Revans, Leader of Somerset Council, and Paul Von Der Heyde, Chair of the ICB as well as importantly patients and patient representatives.

3.4. We had the opportunity to ask questions and share views on the programme development and roll out. There was unanimous support for our New Hospital Programme project to create a new maternity and paediatric centre (replacing the current one which is in buildings dating from the Second World War) and for our Integrated Patient Record project which will bring together the plethora of separate electronic systems in the trust and enable us to deliver the full benefits of recent mergers. We highlighted to Lord Markham barriers slowing down progress on these projects and agreed to work together to address them.

3.5. As part of the event, Lord Markham and the New Hospitals team were given a tour of the paediatrics and maternity buildings at Musgrove Park, to demonstrate the challenging estates environment that some teams are working within.

3.6. Lord Markham was very interested in the feedback and conversations that took place during the event.

4. WORK BEGINS ON £87 MILLION SURGICAL CENTRE AT MUSGROVE PARK HOSPITAL

4.1. Construction work has begun on the main build of the new £87 million surgical centre at Musgrove Park Hospital. The new surgical centre, which is scheduled to open in early summer 2025, will replace the current hospital theatres and critical care unit. It will also house a new endoscopy suite.

4.2. The hospital dates back to the Second World War, and some very old areas are still in clinical use. Our new surgical centre will mean we can continue to phase out the use of our older 1940s buildings for patient care and treatment. It is the latest in a series of transformative developments designed to give the people of Somerset and our colleagues the facilities and environment which they deserve. It will make a huge difference to the service we can offer and the experience of our patients.

4.3. The new surgical centre will include:

- Six endoscopy rooms, patient recovery and clinical support areas
- Eight operating theatres (including two state-of-the-art hybrid operating theatres that can be used for both surgery and interventional radiology), recovery areas and clinical support.
- 22 critical care beds, all specified for level 2 and 3 critical care patients.

4.4. Much building work and service moves have taken place over the last few years in preparation for the new surgical centre, including a new sterile services centre, relocated superficial x-ray department, and main hospital kitchen move, among others.

5. OPENING OF THE FIRST FLOOR OF THE TAUNTON DIAGNOSTIC CENTRE

5.1. Over the past few months, work has taken place to develop the first floor of the Taunton Diagnostic Centre at Blackbrook Business Park in Taunton – and patients are now able to access even more NHS care and treatment from the centre.

5.2. The centre opened in September 2021 as the first community diagnostic centre in England run by the independent sector in partnership with the NHS. Through this partnership, between our trust and Alliance Medical, a range of diagnostic imaging services, such as ultrasound, magnetic resonance imaging (MRI), computed tomography (CT) and X-Ray, are provided from the building's ground floor.

5.3. Two new services traditionally run by the NHS from hospital settings, have moved into the building's first floor and are now fully open.

5.4. The move means that patients can now visit the centre for an echocardiogram, commonly known as an echo scan, which is used to look at the heart and nearby blood vessels. And, in addition, part of our orthopaedic assessment service for Somerset – known as OASIS – has moved into the building so patients can get treatment for conditions that affect their joints, bones and muscles, and nerve tissue without visiting hospital.

6. UPDATE ON INDUSTRIAL ACTION

6.1. Consultants who are members of the British Medical Association (BMA) took 48 hours of national strike action from 7am on Thursday 24 August until 7am on Saturday 26 August 2023. A further strike action by consultants is scheduled for 19 and 20 September 2023.

6.2. Teams across the trust are worked together to ensure that we can continue to provide urgent and emergency care for all patients, and to keep as many of our services running as possible during the periods of industrial action.

6.3. A four-day period of industrial action by junior doctors took place from 7am on 11 August to 7am on Tuesday 15 August 2023. This was the fifth round of industrial action for junior doctors in England. Our trust has planned in the same way for this period of industrial action as before, but the combination of the ongoing industrial action, the time of the year when colleagues plan annual leave and a much-needed break, the influx of holiday makers to the South West, big events in the South West, a high number of people accessing some services as well as an increase in the number of patients with Covid-19, meant that our plans were not as robust as they have been during previous periods of industrial action.

7. RECRUITMENT FOR CHIEF MEDICAL OFFICER

7.1. Daniel Meron has decided to retire from his role as chief medical officer (CMO) in January 2024 but will continue to work clinically while enjoying travel and many adventures.

7.2. Daniel has provided medical leadership and been a key part of our executive team as we merged Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust to create one of the first integrated trusts in England, and subsequently as Yeovil District Hospital NHS Foundation Trust and our former Somerset FT worked together to merge in April 2023. We made these organisational changes because they were the right thing to do for our patients and our colleagues and Daniel has made a huge contribution to our vision of what we can achieve as an integrated trust and provided medical leadership through these changes and the pandemic.

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7.3. We have begun the process of finding a new CMO and have instructed recruitment agency GatenbySanderson to support us in the recruitment process.

8. INDEPENDENT INQUIRY AND AFTERMATH OF THE LUCY LETBY TRIAL

8.1. The country has been shocked and appalled by the events that came to light as a result, and in the aftermath, of Lucy Letby's trial and conviction.

8.2. Following her conviction, the Government announced an independent inquiry into the circumstances behind the horrific murders and attempted murders of babies at the Countess of Chester Hospital. The inquiry will investigate the wider circumstances around what happened at the hospital, including the handling of concerns and governance, and what actions were taken by regulators and the wider NHS.

8.3. On 18 August 2023, NHS England wrote to all Integrated Care Boards and NHS Trusts welcoming the independent inquiry and the steps that it is taking to prevent anything like this happening again, including the steps that are already in motion to strengthen patient safety and monitoring. These include:

1. The national roll-out of medical examiners since 2021.

2. The new Patient Safety Incident Response Framework which will be implemented across the NHS this autumn.

3. The launch of the strengthened Freedom to Speak Up policy which all NHS organisations are expected to adopt by January 2024.

4. The recently strengthened the Fit and Proper Person Framework which now includes additional background checks which also apply to board members taking on a non-board role. The Fit and Proper Person requirements prevent the appointment of any individual as a Board director unless they fully satisfy all FPP requirements, including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not).

8.4. The letter also emphasised the importance of NHS leaders listening to the concerns of patients, families and colleagues and following whistleblowing procedures alongside good governance, and the role of NHS leaders and Boards to ensure:

- All colleagues have easy access to information on how to speak up.

- Relevant departments are aware of the national Speaking Up Scheme and actively refer individuals to the scheme.

- Approaches or mechanisms are in place to support those colleagues who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

- Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.

- Boards are regularly reporting, reviewing and acting upon available data.

8.5. It is very important that all our colleagues feel comfortable and are supported to raise concerns and feel listened to, so that we can respond to concerns in the right way. In the last few weeks, I have emphasised how important it is that all colleagues feel comfortable to raise concerns and are listened to in all my trust-wide communications

8.6. We have:

- Launched a new series of posters promoting our Freedom to Speak up Guardians, Caroline Sealey and Stephanie Hayward, to raise the profile of the service.

- Reminded colleagues about the WorkInConfidence platform, a secure, independent platform where colleagues can raise any concern, day or night**,** anonymously, with a member of our Freedom to Speak Up Guardian team.

8.7. In addition, we are preparing communications for Freedom to Speak Up month in October which will be trailed through September, and planning communications about the Medical Examiners service.

9. OUR NATIONAL HEALTH STORIES LAUNCH

9.1. As part of the NHS75 birthday celebrations, a new national health stories campaign was launched across the NHS.

9.2. Somerset FT is one of 19 trusts to take part in the ‘Art for life – telling the story of the NHS’ project. The project, led by our Art for Life team, is part of a major national programme of artistic work in hospital settings, giving NHS staff a chance to tell their stories in the organisation’s 75th year.

9.3. A programme of engagement with NHS colleagues will take place in all 19 trusts over the coming weeks and months and will conclude with a finale

performance in November 2023, showcasing the work developed over the previous six months.

10. TWIN CLINIC CELEBRATES TWO YEARS…AND LOTS OF IMPROVEMENTS

10.1. Scores of parents of twins came together to celebrate the second birthday of our twin clinic, which is led by consultant gynaecologist and fetal medicine lead, Dr Kat Harrison-Tvarozkova.

10.2. The event, held at the Wombat Cricket Club just outside Taunton, included a fun-filled picnic with games and raffles taking place too...and there was even an appearance from BBC Points West's senior health reporter Matthew Hill, who found out from Kat all about the benefits of the twin clinic, as well as hearing first hand from families about their experiences.

10.3. Since the clinic launched in April 2021, the number of emergency c-sections for twin mothers at Musgrove has reduced significantly - just 9%, compared to the national average of over 30%.

10.4. Women expecting twins are at greater risk of complications and need close monitoring with additional scans and appointments, which is where our dedicated twin clinic comes in. The expectant mum’s care is monitored by the same team, which helps them to build up a strong relationship with their named midwife and consultant.

10.5. The concept and implementation of the clinic was led by Kat, Lorraine James, our antenatal clinic midwife, Julie Austin Thompson, Tracy Brick and Leanne Renhard, from our screening team, and Lynn Borthwick, our former antenatal clinic lead, who has now left the trust.

10.6. The number of twins who need further care at Musgrove Park Hospital’s neonatal unit has reduced to 11%, lower than the national average of 37%. This means more babies can go home with their mother and siblings earlier, ready to begin life at home.

10.7. The team’s work has been praised by the nationally accredited ‘Twins Trust’, which showed that the team's vision, hard work and dedication had paid off, with overwhelmingly positive feedback from parents.

11. ADDITIONAL HYSTERECTOMY OPTION NOW AVAILABLE AS A DAY SURGERY

11.1. Patients at Musgrove Park Hospital are now able to go home on the same day following a vaginal hysterectomy.

11.2. This type of hysterectomy provides relief from the distressing symptoms of

pelvic organ prolapse. It comes just weeks after surgeons performed Musgrove's first ever laparoscopic hysterectomy – more commonly known as keyhole surgery – as a day case procedure.

11.3. Prior to these developments, patients would have stayed an average of two to three days in hospital, which could affect their recovery time as we know people are more likely to recovery quicker in the comfort of their own home.

11.4. It is the latest example of how we're innovating and doing things differently to improve patients' care and experience in Somerset.

11.5. By helping patients to avoid a stay in hospital, their overall recovery and return to full fitness is greatly improved, and there is a reduction in the potential complications associated with an inpatient stay, such as hospital-acquired infection, thrombosis and loss of independence and muscle strength.

12. LAUNCHING LEGACY MENTORS TO SUPPORT NURSES IN THEIR EARLY CAREERS

12.1. For our colleagues in their early careers within the NHS, it can be an incredibly daunting time with steep learning curves, and often it's colleagues in the latter part of their careers who are able to offer sound advice and support to their fledging colleagues.

12.2. This has not just been noticed within our own services, but across the country, and so 'Legacy Mentoring' has officially been launched by NHS England.

12.3. Legacy mentors are experienced nurses who can offer mentoring to new nurses in the first two years of their NHS careers, supporting them to not only stay within the NHS, but to stay well and in the right roles for them, too.

12.4. The group is made up of six Somerset FT colleagues, who will be working as legacy mentors alongside their day-to-day nursing roles – lead legacy mentor, Nic Monteiro, clinical skills trainer, Nabegail Oronce, Kirsty Hambly, who has recently worked within the trust's testing team and nursing on wards at Musgrove Park, clinical nurse specialist for HIV, Karen Maddison, diabetes staff nurse, Momar Erolan, and clinical practitioner and pastoral care for mental health international nurses, Christine Picton.

12.5. The group will offer coaching both face to face and virtually, for any newly-registered nursing colleagues within the first 24 months of their careers.

12.6. Staffing levels within the NHS continue to be a challenge, and lead legacy mentor Nic explains why it is so important that we're working together across the Somerset healthcare system to keep colleagues working within the county.

12.7. NHS England has funded the legacy mentors in Somerset for one year through the legacy mentoring programme, which is one of the Chief Nursing Officer's High Impact actions to support nurse retention, and has been hailed as very successful in other trusts across the county.

13. USE OF THE CORPORATE SEAL

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

13.2. The seal register entries over the period 1 April 2023 to 1 September 2023 are set out in the attached appendix.

14. MEDIA COVERAGE

14.1. Over the period July to August 2023, there has been the following media coverage:

- BBC Radio Somerset interview with Jo Morrison, our consultant gynaecological oncologist, about a study being run at the trust about access to cervical screening after birth. This follows a package of comms over the last month that has included a social media post, web article and Our News article. The link is available here and the item is 2:09.55 into the programme.

- Coverage of the new alcohol care team at Musgrove Park Hospital on BBC Radio Somerset ((1:33.55, Part 1, and 2:24.25, Part 2, into programme) and in the Nursing Times.

- Widescale coverage of the start of the main building work on the surgical centre at Musgrove Park Hospital.

- Coverage on ITV Westcountry about the Voyage of Recovery, which was led by our early psychosis team. In the coverage, we hear from three of the participants on the voyage (three of our patients) and also our clinical psychologist Dr Estelle Rapsey. This was part of a package of communications on the Voyage of Recovery that included social media posts, as well as a feature with BBC Radio Somerset.

- Coverage on BBC Radio Somerset about the opening of the Taunton Diagnostic Centre First Floor with our echocardiogram and orthopaedic assessment services moving in from August 2023. The coverage includes an interview with Emily King, Cardiac Physiologist and service lead, and Carolyn Nation, our clinical service manager for the Orthopaedic Assessment Service in Somerset (OASIS).The coverage is here: https://www.bbc.co.uk/sounds/play/p0fwfnd1 (3:31.45 into programme).

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- Coverage on BBC Radio Somerset about our homeless and rough sleepers nursing service, centred around the NHS Parliamentary Award that the team won last week. The coverage includes an interview with service lead Karen George. Matt Faulkner - Charlie Taylor sits in (06/07/2023) - BBC Sounds (2:50.05 into programme). We are planning further communications in the coming week with broadcasters.

- NHS75 Celebrations - Our services, sites and colleagues were celebrated in a range of media as outlined below.

  - ***BBC Radio Somerset live broadcast at Yeovil District Hospital*** BBC Radio Somerset - Claire Carter, 05/07/2023

  - ***ITV Westcountry feature at Musgrove Park Hospital*:** ITV West Country ran a piece on its programme at 6pm on Wednesday 5 July 20923 with a number of interviews with patients and staff.

    The following piece appeared on their website.

  - ***Greatest Hits Radio features at Wincanton Hospital***
    A package of clips from Wincanton Hospital,
    (Sarah-Jayne Ayo – activities coordinator):
    Article - We meet the faces of Somerset's NHS as the service prepares to turn 75 | News - Greatest Hits Radio (Somerset) (planetradio.co.uk)

    (Chenise Newham – senior sister):
    Article - 'You want to care for people and make a difference' say NHS staff | News - Greatest Hits Radio (Somerset) (planetradio.co.uk)

    (Clare Ferguson – healthcare assistant):
    Social media
    https://twitter.com/ghrsouthwest/status/1676482788684357632?s=46&t=c3kwlFqcRusokq9puX9dow

    (Tania Collins – matron)
    Article - 'Our community hospitals help people get back on their feet' | News - Greatest Hits Radio (Somerset) (planetradio.co.uk)
    Friday (Katherine Evans - facilities services assistant)
    Article: 'We're like a family - we even go on holiday together' | News - Greatest Hits Radio (Somerset) (planetradio.co.uk)

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15. NATIONAL DEVELOPMENTS

NHS Long Term Workforce Plan Launched

15.1. NHS England published the first ever NHS long term workforce plan. The plan describes how the NHS will address existing vacancies and meet the challenges of a growing and ageing population by recruiting and retaining hundreds of thousands more staff over 15 years and working in new ways.

15.2. The plan sets out supply and demand scenarios and projections for key workforce groups and professions. The plan then focusses on the three areas where we will take action to ensure that the NHS has the workforce it needs for the future, including retaining existing talent and making the best use of new technology alongside the biggest recruitment drive in health service history to address the gap.

Recruit – grow the workforce:

- By significantly expanding domestic education, training and recruitment, we will have more doctors, nurses and other healthcare professionals working in the NHS.

Retain existing talent:

- Embed the right culture and improve retention.

- By improving culture, leadership, and wellbeing, we will ensure fewer staff leave the NHS over the next 15 years.

Reform: Working and training differently:

- Working differently means colleagues can spend more time with patients, harnesses digital innovations and enables new and innovative ways of working. Training will be reformed, to give learners a better experience.

15.3. The full press release is available to read on the NHS website.

15.4. We welcome the announcement of the plan and recognise that it will complement and align with our People Strategy commitments and ambitions for the trust.

15.5. A full workforce plan is in place for Somerset FT, where we are already developing a number of new initiatives to support recruitment and retention and career / training opportunities for colleagues as part of our People Promise, to ensure that we can attract and retain talent, and support our teams.

Announcements on Reform of Cancer Standards

15.6. NHS England announced that there will in the future be three cancer standards that combine all the previous ten standards and cover additional patients. The reform of the standards follows consultation and engagement

and is supported by clinical experts and leading cancer charities, according to NHS England.

15.7. The three standards are:

- The 28-Day Faster Diagnosis Standard (FDS) which means patients with suspected cancer who are referred for urgent cancer checks from a GP, screening programme or other route should be diagnosed or have cancer ruled out within 28 days.

- The 62-day referral to treatment standard which means patients who have been referred for suspected cancer from any source and go on to receive a diagnosis should start treatment within 62 days of their referral.

- Rhe 31-day decision to treat to treatment standard which means patients who have a cancer diagnosis, and who have had a decision made on their first or subsequent treatment, should then start that treatment within 31 days.

15.8. GPs will still refer people with suspected cancer in the same way, but the focus will be on getting people diagnosed or cancer ruled out within 28 days, rather than getting a first appointment – leading to quicker diagnosis.

New standards for NHS board members from the Department of Health and Social Care

15.9. The Kark review made recommendations on how to improve the operation and effectiveness of board directors, board members and individuals who perform equivalent functions, to ensure they are 'fit and proper' for their roles.

15.10. The letters introduce a new framework and set out a series of next steps for implementation, including a deadline of 30 September 2023 to use new board member reference templates and complete and retain new board member references.

15.11. The Framework responds to recommendations by introducing a means of retaining information relating to individual directors, and a new way of completing references with additional content whenever a director leaves an NHS board. It is supported by with:

- guidance for chairs on the implementation of the test
- guidance on updating the electronic staff record (ESR)
- directory of board level learning and development opportunities

NHS data shows the NHS is on track for busiest summer on record

15.12. NHS England published the latest NHS performance data. The media reported that the number of people waiting for hospital treatment in England has reached 7.5 million people for the first time. The number reached 7.57 million at the end of June – up by 100,000 on the previous month.

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15.13. The information released by NHS England shows that:

- Emergency departments experienced their second busiest July ever last month, with new data published today showing 2.1 million attendances.

- The data suggests this summer is currently on track to be the busiest ever for the NHS staff with 4.42 million attendances in A&E over June and July – 42,500 more than the previous high (4.37 million in 2022).

- Ambulances services faced their busiest month since May 2022, with 707,000 incidents last month.

- The NHS experienced another record month for cancer checks with over 261,000 urgent referrals in June and a near-record number of people starting treatment for cancer (29,479).

- A record number of tests and checks were carried out for the month of June (2.24 million), up 16% on the same month pre-pandemic (1.9 million).

- NHS staff continue to make progress on the longest waits for patients with the number of people waiting more than a year dropping in June, with year long waits reducing by almost 2,000 compared to May.

- Progress on the covid backlog came amid further strike action, with three days of junior doctor strikes in June leading to 106,120 postponed elective appointments and procedures. To date, around 778,000 hospital appointments across the NHS have been rescheduled due to strike action.

15.14. NHS Providers deputy chief executive Saffron Cordery has responded to the latest monthly performance figures from NHS England with the following statement:

"A perfect storm of squeezed funding in the NHS, the pandemic, the cost-of-living crisis, workforce shortages and now industrial action has pushed the waiting list to its highest point at 7.57 million.

"This will ring alarm bells for trust leaders up and down the country as mounting care backlogs inevitably pile more pressure onto an already overstretched NHS. Amid ongoing strikes, this is an extremely busy summer for A&E while ambulance services also face very high demand and more urgent calls.

"Trusts leaders' priority is delivering timely, high-quality patient care. They have made vital progress on this despite tough circumstances, including

delivering a record number of tests and checks in June and seeing cancer patient referrals more quickly.

"However, the pressure on urgent and emergency care is relentless. This is felt across the whole system in hospital, ambulance, mental health and community services.

"Trust leaders' efforts to recover urgent and emergency care – and to bring down the waiting list – must be backed nationally with proper support. This includes better government funding in workforce and capital, including beds and vital equipment, and a solution for the challenges in social care.

"The strikes divert trusts' resources from bearing down on backlogs to managing the disruption they cause. It's vital the government and unions talk to find a resolution to the pay dispute. There can be no delay."

NHS Providers report on the NHS productivity challenge

15.15. This week NHS Providers has launched a new report Stretched to the limit: tackling the NHS productivity challenge, which highlights the scale of the operational and financial ask facing trusts over the coming year, with a particular focus on boosting productivity across the NHS.

15.16. The report is based on a survey of trust chief executives and finance directors from across the provider sector. Its findings highlight the significant progress trusts from across hospital, community, mental health and ambulance services have made towards reducing care backlogs and delivering better outcomes for patients. However, the report warns that despite the progress made thus far, it will be challenging to meet the government's overall performance demand, deliver unprecedented efficiencies and continue to protect quality of care.

15.17. The report explores what trusts are already doing, both within their own organisations and in collaboration with system partners, to improve patient flow, deliver operational efficiencies and improve productivity.

15.18. However, while some productivity constraints are within trusts' gift to address, there are wider barriers relating to workforce, bed and service capacity, patient acuity, social care capacity and industrial action that are limiting trusts' capacity to improve productivity.

15.19. The report highlights what is needed from government and national bodies, in the short term and long term, to enable providers to deliver the level and quality of healthcare the public expects and deserves. This includes a step change in capital investment to provide more beds, more community care, a digital revolution, a safe and comfortable therapeutic environment, appropriate support for social care, and effective delivery of the NHS Long Term Workforce Plan.

General Medical Council publishes the results of the 2023 national training survey

15.20. This week the General Medical Council has published the 2023 national training survey results. The survey, completed by more than 70,000 doctors, gives a comprehensive picture of how workplace experiences are impacting those in training and their trainers.

15.21. Overall, the survey results show that the quality of UK postgraduate training remains high (86% of trainees were positive about their clinical supervision and 83% told us they had a good experience in their post). However, the data also shows negative trends in doctors' training experiences:

- Two thirds are at high or moderate risk of burn out.
- Doctors at the early stage of their careers are experiencing negative behaviours more than their senior colleagues, and
- Doctors' wellbeing is being impacted.

15.22. NHS Providers has responded to the findings of the national survey with this statement.

Skills for Care report *Size and Structure of the Adult Social Care Sector Workforce in England*

15.23. Skills for Care has published a report titled Size and Structure of the Adult Social Care Sector and Workforce in England which looks at the workforce supply and demand for 2022/3.

15.24. NHS Providers has responded to the report, emphasising the link between social care and the NHS and calls for better investment in adult social care to recruit and retain UK staff to put the sector on a sustainable footing. The statement is here.

NHS Providers guide to supporting the internationally educated workforce

15.25. NHS Providers titled A guide to supporting your internationally educated workforce provides practical advice and case studies that Board members can implement to address the challenges experienced by internationally educated colleagues as an essential part of promoting a more equitable, diverse and inclusive NHS.

SOMERSET NHS FOUNDATION TRUST

SEAL REGISTER

1 APRIL 2023 to 31 AUGUST 2023

Date of Sealing	No. of Seal	Nature of Document	First Signatory	Second Signatory
1 June 2023	54	Deed of Variation relating to a deed of variation and an agreement for lease of premises known as Rutherford Diagnostic Centre	David Shannon	Daniel Meron
29 June 2023	55	Lease of first floor of Taunton diagnostic Centre	David Shannon	Pippa Moger
12 July 2023	56	Yeovil Diagnostic Centre service contact	David Shannon	Peter Lewis
17 July 2023	57	Lease of car parking spaces at Victoria Gate	David Shannon	Isobel Clements
18 August 2023	58	Lease of first floor at Rutherfords Diagnostic Centre – deed of warranty	David Shannon	Peter Lewis

NHS England

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

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

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Corporate Risk Register Report
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:	5 September 2023

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

Executive Summary and Reason for presentation to Committee/Board	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: • 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 31 July 2023. The report focuses on the high risks scoring 15+ on the risk

	matrix and includes corporate risks and service group risks. The Board are asked to 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:

Equality

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

There are no proposals or matters which affect any persons with protected characteristics directly within this report. Any risks where there are proposals or matters which may affect any persons with protected characteristics would be included within the mitigating action plans held within the individual risk assessments referred to within this report.

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

Public/Staff Involvement History

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

Not applicable

Previous Consideration

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

The Corporate Risk Register is presented to the Board on a quarterly basis.

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

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

SOMERSET NHS FOUNDATION TRUST

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 31 July 2023.

2.3 The report also includes the corporate risks identified by Simply Serve Limited (SSL) which is a wholly owned subsidiary of SFT. These risks are either shown as additional corporate risks for SFT (Risks U1047 & U1056) or mapped into existing SFT corporate risks (Risks U1050 & U1051)

3. CORPORATE RISK REGISTER

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

- Risk 004 Demand
- Risk 0012 Waiting Times
- Risk 0497 Symphony Healthcare Services not becoming financially self-sustaining
- Risk 1329 Core numbers of Junior and Consultant medical workforce

- Risk 1799 Inability to fill vacancies organisationally

New Risks

3.2 There have been two new risks added to the Corporate Risk Register since the last report on 3 July 2023:

- Risk R1852 - Unsupported infection control electronic case management system

- Risk R1855 – Failure to deliver financial plan

Increased Risks

3.3 There have been no risks which have increased since the last report on 3 July 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 3 July 2023 and has been removed from the Corporate Risk Register:

- Risk R690/U728 – Ongoing unsustainable pressure to colleagues in the Trust / staff resilience

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 3 July 2023.

Service Group and 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 3 July 2023 has also been included within Appendix 1.

3.7 Since the last report on 3 July 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 U236	Reduced GP cover within SHS Practices	Reduced from 16 ⇨ 12
Risk R366	Ongoing shortfall in staffing levels within the District Nursing Teams	Reduced from 16 ⇨ 9
Risk U729	Violence & aggression towards Practice Staff	Reduced from 16 ⇨ 8
Risk R1134	Non-compliance with stroke standards due to increased demand	Reduced from 16 ⇨ 12
Risk R1422	Vacancies across clinical posts in children's therapy services	Reduced from 15 ⇨ 12
Risk R1662	Inability to provide consistent Consultant cover for Somerset Neuro Rehabilitation Unit	Risk 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 3 July 2023, there has been ten 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:

- U1066 – Reduced capacity for site specific cancers due to lack of consultant oncology cover - breast
- U1067 – Reduced capacity for site specific cancers due to lack of consultant oncology cover – colorectal and lung
- U1068 – Unable to access Mosaiq due to insufficient licenses available hindering the delivery of patient care
- U1071 – Lack of anaesthetic support for pre assessment clinics within paediatrics
- R1822 – Security risk to colleague due to outdated and poor condition of Shepton Mallet Community Hospital
- R1824 – Inability to evacuate staff from the District Nurses Office at Minehead Community Hospital
- R1828 – Insufficient nursing establishment for AMU
- R1842 – Patients with missed follow-ups due to failures in manual referral and follow up processes in Emergency Department
- R1844 – Lack of Standing Operating Procedure for confirming whether there is next of kin prior to undertaking hospital funerals
- R1851 – Inability to meet the Department of Health and Social Care fit testing principles due to the lack of resource available to have a designated Lead for Fit Testing

4. RISK MANAGEMENT ARRANGEMENTS UPDATE

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

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 Trusts and in social care and primary care across the County.

6. RECOMMENDATION

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

Corporate Risk Register 31 July 2023

People Committee

20 R1329 Core numbers of Junior and Consultant medical workforce

20 R1799/U1042 Inability to fill vacancies – organisationally

16 U0189 Failure to achieve mandatory training levels

16 U0925 Retention and turnover of staff

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

15 R1815 Vacancies and absence rates within nursing and AHP teams

Financial Committee

20 U0497 SHS not becoming self-sustaining

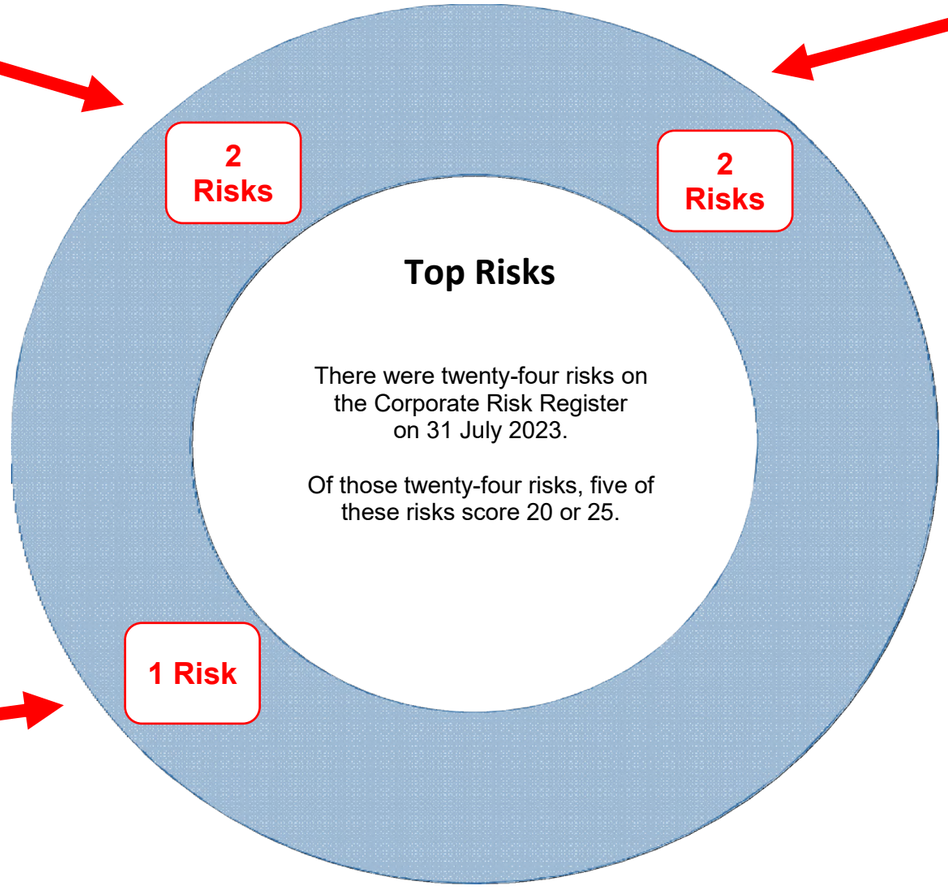
16 R1611/U0984 Failure to secure necessary infrastructure – physical & digital (funding)

16 U1056 Non-delivery of service provision KPIs by Contractor

15 R0006/U0738 Delivery of CIP 2023/24

15 U1047 Reduction of funding into SSL budget to meet service requirements

15 R1855 Failure to deliver financial plan



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

Quality & Governance Committee

20 R0004 Demand

20 R0012 Waiting Times

16 R0007/U100 Referral to Treatment 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 R1513 Community care and Adult Social Care provision for Learning Disability patients

16 R1852 Unsupported infection control electronic case management system

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

15 R1789 Unsafe premises and environment

Appendix 1

QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R0004	20	⇔	Demand

Service Group / Corporate Function Risks 15+

U21/ R1811	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
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
R1362	16	⇔	Insufficient theatre capacity for Urology cases to meet demand
R1504	16	⇔	Referral rates into Children & Young People's Neurodevelopment Service
R1597	16	↑	No dedicated theatre list for elective caesareans leading to delays and poor patient experience
R1709	16	⇔	Increase in Primary Care in Minehead sending patients with primary care conditions to Minehead MIU
R1830	16	NEW	Unprecedented levels of referrals into radiotherapy which cannot be met by treatment capacity
R0293	15	⇔	Insufficient capacity to meet demand for CT scanning
R0562	15	⇔	Insufficient capacity to meet demand in diabetes specialist podiatry service
U1023	15	⇔	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	⇔	Increase in acuity and demand of general medical and care of the elderly patients

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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
R1813	15	NEW	Lack of service contract leading to increase in waiting times – Neurophysiology
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	⇔	Evacuation of patients - SNICU
R1820	20	NEW	Evacuation of patients – Maternity (MPH)
R1694	16	⇔	Evacuation of patients – TOR Ward
U45	15	⇔	Evacuation of patients - Wards 6 to 9
R1746	15	⇔	Evacuation of patients – lack of appropriate equipment to support vertical evacuation in community hospitals

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QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R1513	16	⇔	Community & Adult Social Care provision for mental health and learning disability patients
R1852	16	NEW	Unsupported infection control electronic case management system
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+

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QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R1789	15	⇔	Unsafe premises and environment

Service Group / Corporate Function Risks 15+

R0890	20	⇔	Inability to convert model box room to provide required clinical space to meet service needs
R1849	20	NEW	Outbreak of Carbapenemase-producing organisms (CPO) due to an environmental reservoir of CPO
U1031/ R1808	16	⇔	Lack of cell salvage equipment in maternity
R1256	16	⇔	Contamination 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/ R1809	15	⇔	Lack of outpatient room availability for patients within Dietetic Services
U1029/ R1810	15	⇔	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
U1063	15	NEW	Inability to place PICC/midlines for outpatients and hospital at home patients due to lack of clinic space
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	⇔	Inability for nursing staff to hear patient call bells
R0534	15	⇔	Poor condition of Shepton Mallet Community Hospital Portakabin Units
R0654	15	⇔	Ligature Points on the ward pose a risk to patients

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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	⇔	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
R0530	16	⇔	Somerset Lipid Service is not adequately developed and resourced
R0956	16	⇔	Rheumatology medical staffing
U1025	16	⇔	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
R1505	16	⇔	Dental workforce challenges
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	⇔	Lack of out of hours medical cover at SNRC
R1819	16	NEW	Significant shortages in the sonographer work force impacting on the obstetric service
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

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Appendix 1

PEOPLE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R1799	20	⇔	Inability to fill vacancies – organisationally
U189	16	⇔	Failure to achieve mandatory training levels
U925	16	⇔	Retention and turnover of staff
R1624 / U994	16	⇔	Failure to secure necessary infrastructure – physical and digital (workforce)

Service Group / Corporate Function Risks 15+

R0131	16	⇔	Training and validation of pressure ulcers acquired in the Community
R0564	16	↑	Inequitable service provision to teams/localities across Somerset - Physiologists
U1051	16	⇔	Lack of skilled and unskilled colleagues to deliver services
R1295	16	⇔	Insufficient numbers of skilled personnel in Estates to maintain 24/7 response
R1812	16	⇔	Inability to recruit Sterile Services Technicians
R1616 / U988	16	⇔	Lack of analytic support and visibility of data to manage population health
U1073	15	NEW	Inability to audit and review Sepsis and deteriorating patient records due to lack of resource
R1389	15	↑	Backlog of clinical correspondence - Neurology admin team

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PEOPLE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

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

Service Group / Corporate Function Risks 15+

R0440	20	⇔	Inability to provide a robust, continuous streamlined service for direct current cardioversion patients
R1396	20	↑	Insufficient nursing establishment in cardiac cath lab
R0306	16	⇔	Lower Paediatric Diabetic Senior Nurse to patient ratio in comparison to other SouthWest regional Units
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
U0868	16	⇔	Insufficient Clinical Nurse Specialist cover for gynaecology cancer patients
U0886	16	↑	Lack of radiology nursing cover
U1070	16	NEW	Lack of funding for Paediatric physiotherapy out of hours
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
R1625	16	⇔	Paediatric high dependency unit staffing
R1679	16	⇔	Weight Management Service staffing
R1706	16	⇔	Cath Lab staffing establishment
R1755	16	⇔	Insufficient Clinical Nurse Specialist cover – Gynaecology oncology
R1798	16	⇔	Insufficient Weight Management Dietitian staffing due to vacancies
U772 / R1759	15	⇔	Anaesthetic Practitioner on Call Service Provision
U1022/ R1758	15	⇔	Significant staffing vacancies in the Emergency Department - nursing and ENPs
U1040	15	⇔	Lack of Occupational Therapy staffing causing delays in patients receiving timing treatment
R1301	15	⇔	Wards under resourced and insufficient skill mix of staff – Nurses & HCAs
R1856	15	NEW	Staffing challenges within the Interventional radiology nursing team

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FINANCE COMMITTEE

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)
U1056	16	⇔	Non-delivery of service provision KPIs by Contractor

Service Group / Corporate Function Risks 15+

R1310	20	⇔	No automated and cross organisation treatment escalation plans process
R1343	20	⇔	Quality of Discharge Summaries
R1840	20	NEW	Inability to fund new electronic health record with shortfall in national allocation
R0003	16	⇔	Insufficient investment to reduce levels of backlog maintenance
R0336	16	⇔	Replacement Viewpoint (Colposcopy system) across Grace and Gynae Oncology Services
U1050	16	⇔	Insufficient investment from main contractor to reduce levels of backlog maintenance
R1419	16	⇔	Inability to financially support Yeovil Dental Access Centre
R1482	16	⇔	End of Life Pharmacy Robot
R0421	15	⇔	End of life overhead hoist

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Appendix 1

FINANCE COMMITTEE

Somerset NHS Foundation Trust

Corporate Risks 15+

R0006 / U738	15	⇔	Delivery of CIP
U1047	15	⇔	Reduction of funding into SSL budget to meet service requirements
R1855	15	NEW	Failure to deliver financial plan

Service Group / Corporate Function Risks 15+

R1785	15	⇔	Inflated agency rates leading to overcharges to the Trust
R1787	15	⇔	Inaccurate agency invoices being paid due to lack of process between temporary staffing and wards

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Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 26 July 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:	5 September 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 26 July 2023. The Committee received assurance in relation to: • The Care Quality Commission Action Plan Update • The update from the Service Group Assurance Group – Family Care • The update in relation to Acute Home Treatment Services/Hospital at Home • The Corporate Risk Register and the correlation of risks across the Committees • The update in relation to the Maternity Incentive Scheme The Committee identified the following areas of concern or for follow up: • The update on the implementation of the internal audit recommendation to be provided to the October 2023 meeting. • Service Group Assurance report – Family Care - the condition of the maternity and paediatric estate and the impact on clinical pathways and colleagues.

	• The fire safety risks and in particular the risk in relation to the standards of fire safety of the building housing the Somerset Neonatal ICU. The Committee identified the following area to be reported to the Board: • The summary of the families and young people service group report including the excellent joint leadership between CAMHS and Paediatrics. • The estates and fire risks. • The work of the Acute Home Treatment Team and the importance of the service as we move towards winter. • The correlation of workforce and infrastructure risks across the three committees. • The assurance in relation to the maternity Incentive Scheme.
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Quality and Governance Assurance Committee. The Board is further asked to note the areas to be reported to the Board.

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

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

Equality and Inclusion **The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.** **How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?**
The needs and potential impacts on people with protected characteristics are considered by each individual service group as part of their update to the Committee. The Committee reviews data presented to the Committee and will raise any queries if required.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Staff involvement takes place through the regular service group and topic updates.

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING HELD ON 26 JULY 2023

1. PURPOSE

1.1. The report sets out the items discussed at the formal meeting held on 26 July 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

Care Quality Commission (CQC) Action Plan Update

2.1. The Committee received an update on the implementation of the CQC action plan. The Committee agreed that good progress was being made and noted the outstanding actions. The Committee received assurance that the action plan was reviewed by the Mental Health and Learning Disability Service Group on a fortnightly basis.

Service Group Assurance Report – Family Care

2.2. The Committee received the assurance report from the Children, Young People and Family Service Group and noted the key highlights from the report, including the integration of governance processes and the establishment of a clear governance structure for the monthly governance meetings across all services.

2.3. The Committee also noted the very diverse range of services within the Service Group, and the geographical breadth within the dental service; their proactive approach to complaints and PALS; the work of the paediatric diabetes service; the positive outcomes of the joint leadership across CAMHS and Paediatrics; the impact of the new post to support Transition from children's to adult services, and the success of the new Health and Wellbeing hub in Bridgwater.

2.4. The Committee welcomed the focus on patient, family and colleague feedback; identifying and sharing learning and best practice.

2.5. The Committee agreed that the report provided significant assurance about the work and areas of focus of the Group, including the excellent joint leadership between CAMHS and Paediatrics.

Acute Home Treatment Services/Hospital at Home

2.6. The Committee received an update on the Acute Home Treatment Service and the progress made in relation to moving to the next phase of the service model.

2.7. The Committee noted the work with the Medical Leadership Team and Executive colleagues to rebrand the service and build the model based on the ethos to treat people at home, as much as possible, and bringing the hospital level of care and expertise to their doorstep.

2.8. The Committee further noted: the development of delivery and working groups and the purpose of these groups; the work with the new out of hours service provider in relation to the development of a referral hub; the increase in activity; the development of multiple pathways; the work in relation to the surgical out of hospital programme; the actions being taken to expand the service and pathways.

2.9. The Committee received a patient story and noted how much of a positive difference the service had made to the patient.

2.10. The Committee noted the next steps and the linkages between the rapid response service, district nursing service and the acute home treatment service. The Committee recognised the strategic importance of the programme of work both in terms of driving the clinical strategy and mitigating the winter pressures. The Committee further recognised the need to support carers and noted that patient and carer representatives will be invited to the Programme Board to share their experience and identify areas for improvement.

Corporate Risk Register

2.11. The Committee received the up-to-date combined Corporate Risk Register report and noted that there were currently 23 corporate risks on the risk registers of which five scored 20 or above. The Committee noted the progress made in mitigating a number of risks but recognised that the overall position remained challenging due to the workforce risks and operational pressures within the trust, social care and primary care services across the county.

2.12. The Committee discussed the procurement process and timeline for a single risk management system and agreed that a full tender competition will not be required and that, in view of the lower risk, the two current providers will be asked to tender for a single system.

2.13. The Committee noted that workforce risks had been discussed at the People Committee meeting and infrastructure related risks at the Finance Committee meeting. The Committee agreed that the correlation of risks across the three Committees provided significant assurance.

2.14. The Committee agreed to discuss the risks relating to tackling inequalities at a future meeting.

Maternity Incentive Scheme (MIS)

2.15. The Committee received an update on progress made in relation to achieving the year five requirements of the MIS.

2.16. The committee noted the progress in relation to safety actions 1 (Perinatal Mortality Review Tool) and 5 (Midwifery Staffing report) and in particular the treatment delays due to acuity and activity on the labour ward; and staffing shortages which had been mitigated through the use of staff deployment from specialist roles and will be further mitigated by recent recruitment.

2.17. The Committee agreed that the report provided significant assurance.

Any Other Business

2.18. The Committee discussed whether risks relating to the level of restructuring post merger should be moved from the Integration Risk Register to the Corporate Risk Register. The Committee noted that this had not been identified as a significant risk through the Service Groups and it was therefore agreed to follow this up through the Integration Programme Board which monitored progress against each individual team.

2.19. The Committee noted that the arrangements to mitigate the impact of the industrial actions had worked well and this provided the Committee with significant assurance.

3. AREAS OF CONCERN OR FOLLOW UP

Deteriorating Patients

3.1. The Committee received an update on the implementation of the internal audit recommendations and noted that one recommendation in relation to a revised training package remained outstanding. The Committee noted that an update will be presented to the October 2023 planning meeting.

Service Group Assurance Report – Family Care

3.2. The Committee noted that the condition of the maternity and paediatric estate, and the impact this had on the clinical pathways as well as on colleagues' wellbeing, was a key area of concern. The Committee further noted that the condition of the estate had been observed as part of a recent National Hospital Programme (NHP) visit, and that three clinical options to improve the estate had been submitted as part of the NHP programme.

Fire Safety

3.3. The Committee received an update on fire safety and noted the historic arrangements across all services.

3.4. The Committee noted that a gap analysis had been carried out which had identified high fire safety risks across Musgrove Park Hospital and community and mental health services and moderate risks at Yeovil Park Hospital. The

Committee noted details of these risks and the actions already being taken to improve fire safety processes.

3.5. The Committee further noted the concerns in relation to the standards of fire safety of the building housing the Somerset Neonatal ICU; noted the reasons for these concerns; and noted the need to develop short, medium and long term mitigation measures and set up a task and finish group to monitor the implementation of these actions.

3.6. The Committee asked for the overall actions to be prioritised and ensure that a fire safety culture was promoted across the trust. The Committee further asked for a progress report to be presented to the September 2023 Committee meeting.

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

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

- The summary of the families and young people service group report including the excellent joint leadership between CAMHS and Paediatrics.
- The estates and fire risks.
- The work of the Acute Home Treatment Team and the importance of the service as we move towards winter.
- The correlation of workforce and infrastructure risks across the three committees.
- The assurance in relation to the maternity Incentive Scheme.

5. BOARD ASSURANCE FRAMEWORK (BAF)

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

- **Objective 2** – CQC action plan.
- Negative assurance regarding estates and facilities management – **objective 2**
- **Objectives 2, 3 and 5** – Acute Home Treatment Service/Hospital at Home Service
- Children and young people service group assurance report provided assurance against all objectives.

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:	Operational Leadership Team
REPORT TITLE:	Learning from Deaths Framework: Mortality Review Progress Report
SPONSORING EXEC:	Daniel Meron, Chief Medical Officer
REPORT BY:	Claire Bailey, Learning from Deaths Lead Laura Walker, Head of Patient Safety and Learning Gary Filer, Quality and Safety Lead Analyst
PRESENTED BY:	Paul Foster, Medical Director, Learning from Deaths Medical Lead
DATE:	5 September 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 National Guidance on Learning from Deaths (National Quality Board, March 2017) and the Implementing Learning from Deaths framework, key requirements for Trust Boards (NHS Improvement, July 2017), places a number of requirements on NHS Trusts. This includes the need to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public Board meetings. This report also demonstrates the processes in place for how Somerset FT learn from deaths and how this learning is shared and improvements are made.
Recommendation	The Board is asked to discuss this report.

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

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

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

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

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

Equality and Inclusion

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

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

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

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

Public/Staff Involvement History

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

The views of service users and/or the public have not been explicitly considered in the report but their views may have been sought as part of reviews covered in 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 has been presented to the Quality Governance and Assurance Committee and Operational Leadership Meeting and is presented to the Board on a quarterly basis.

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

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

SOMERSET NHS FOUNDATION TRUST

LEARNING FROM DEATHS REPORT – QUARTER 1 2023-2024

1. BACKGROUND AND PURPOSE

1.1. In December 2016 the CQC report Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England, identified that learning from deaths was not given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. In March 2017 the National Quality Board published national guidance on learning from deaths to initiate a standardised approach to learning which includes several recommendations to be included into Trust's governance frameworks. These recommendations included having a Director responsible for the learning from deaths agenda, a Non-Executive Director to take oversight of progress and implementing a systematic approach to identifying the deaths requiring review, with a robust methodology for case record reviews. Ongoing developments included specific guidance for NHS Trusts in working with families, published in July 2018 and the introduction of Medical Examiners who commenced their role in the Trust on 1 July 2020. The intention is to make sure that all deaths not investigated through the coronial process are subject to a degree of independent scrutiny, with increased transparency for the bereaved and an opportunity for them to raise concerns.

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

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

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

2. UPDATE ON THE MORTALITY REVIEW PROCESS

2.1. Since merger, we have continued to focus on aligning the Learning from Deaths pathway across the organisation. We have made progress in the following areas:

- Working closely with Helen Gilliland, the Lead Bereavement and Medical Examiner Officer, we have now agreed a single referral process from their service to Learning from Deaths. Prior to January 2023, the Medical Examiner service at legacy SFT used a fully paper-based system for recording their scrutiny and referring cases to Learning from Deaths. The Medical Examiner service at legacy YDH recorded their scrutiny on a form hosted on the Electronic Patient Record, TrakCare. A subset of the data captured on these forms was imported on to an Excel spreadsheet, and this was used to identify cases for further review.

  A new digital platform, that was initially developed for the Medical Examiner service at YDH to replace the TrakCare form, was introduced across the whole of the Medical Examiner service in Somerset in January 2023. The platform was intended to automatically notify the Learning from Deaths Lead when referral triggers were met, however it quickly became apparent that this function was not working. This created an issue at legacy YDH as there was no process for sharing referrals once the TrakCare form was discontinued. As an interim measure, the paper referral form, which legacy SFT had continued to use, was introduced at YDH. We also retrospectively reviewed all the deaths scrutinised by the ME service to ensure that any missed referrals were accounted for. We have met with Helen Gilliland and a colleague from IT to discuss further developing the Medical Examiner platform to improve its functionality.

- We have identified that there are times when the Medical Examiner has referred to Learning from Deaths due to concerns raised by the family of the deceased, but that those concerns would not be well served by a Structured Judgement Review (SJR). We have met with Caroline Taylor, the Head of Patient Experience to agree a pathway from Learning from Deaths to PALS and Complaints. Further work is needed to firm up this pathway with our Bereavement Team so that families are clearly made aware of the potential avenues that their concerns can take.

- We had hoped to have made more progress towards rolling out the updated versions of the SJR tools (developed by Better Tomorrow, a national Learning from Deaths forum). The intention remains to host these on a single digital platform. The Radar system Lead had built the acute trust SJR form and the associated workflows, however we agreed to pause further development of this until we had confirmation that YDH clinical areas could also be included. Alongside colleagues in our bereavement team, who wanted to extend their existing Radar workstreams to include YDH, we met with the Director of Integrated Governance. Various options were considered, but it has since been confirmed that using Radar would be the most prudent solution until a decision has been reached about which Risk Management platform will be in use across the whole organisation. It was agreed that this

project would start with the Bereavement data. This has been in the testing phase and will soon be implemented. We remain committed to this project as currently SJR's are recording in different ways across the organisation. In some areas, an online tool is used, in others this is recorded on a paper template, Word document or PowerPoint presentation. This leads to inconsistencies which make it challenging to centrally collate and review the data.

- We have continued to develop consistent processes for the completion of SJRs. Whilst SJRs have been completed at our YDH site for a long time, these had historically fallen within the remit of the Mortality Review Group. Whilst we have made significant progress towards moving these out to clinical teams to complete and manage any learning through their M&M processes, this still needs to be embedded as core work. We are encouraged by the response of colleagues within the Medical Service Group, who have engaged with significantly reducing the number of outstanding cases that needed review. Going forwards, the Clinical Director for Medicine at our YDH site has established a rota for allocating reviews to colleagues. It is hoped that it will be possible for a similar or equivalent solution to be implemented at our MPH site.

- Over the last year, we have been working with colleagues in our Mental Health and Learning Disability Service Group to develop and streamline their process for investigating and reviewing deaths. It has been agreed that a rapid review report will be completed for all unexpected deaths, however these will only proceed to a meeting where there is potential for the Serious Incident process to be triggered. The inclusion criteria for what should be considered as in scope for an SJR has also been reviewed. Clearer parameters have now been set which are more in line with national guidance.

  We anticipate that in the next quarter, the output of SJRs will no longer be considered by the Mental Health Serious Incident Review Group (MH SIRG) and a separate meeting, broadly like the Mortality and Morbidity (M&M) meeting model, will be established. Local teams will undertake reviews of any other deaths and have access to the Local Service Review or After Action Review templates to support this as appropriate.

  This is a significant change from previous practice. Almost all unexpected deaths were, as a minimum, discussed at a rapid review meeting, subject to an SJR, which was overseen by MH SIRG. By removing ambiguity, we expect that there will be a reduction in the numbers of deaths subject to these processes. We have also met with LeDeR and colleagues who support patients with Learning Disability to clarify the review process when a death occurs in one of our acute hospital bedded areas. The Learning Disability Liaison team will continue to complete the notification to LeDeR and support any review processes. The rapid review process will only be initiated where there are concerns highlighted (either by staff via an incident report or the Medical Examiner). The Learning from Deaths team will request SJRs from the relevant clinical team, link in with the Liaison team, and then share all relevant review documentation with

LeDeR. The Learning from Deaths team will also co-ordinate the sharing of any outcomes from the review completed by LeDeR.

- We have reviewed our governance arrangements for ensuring that we have strategic level oversight. This is to provide assurance that our processes maximise learning from the deaths of people in our care. At legacy YDH, analysis of SMR data was the responsibility of the Clinical Outcomes Committee (CLOC) and monitoring the mortality review process and its outcomes was a key task of the Mortality Review Group (MRG). At legacy SFT, scrutiny of SMR data and the output from mortality reviews was the core function of the Mortality Surveillance Group (MSG). CLOC and MRG have now ceased to exist as active forums and MSG will be the sole strategic level mortality overview group. Discussions with key stakeholders are still ongoing as to how SMR data will be harnessed in the future. Until this has been agreed, we will continue to have a mixture of data from Telstra and HED.

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

3.1. Examples of learning:

- A Structured Judgement Review completed by our cardiology team identified issues with the appropriateness of undertaking certain procedures in patients with known co-morbidities. In this case, the patient was sent for an angiogram as work up for a TAVI procedure. This has led to the team agreeing to write a new protocol recommending that angiograms are not routinely done on patients awaiting TAVI unless they have angina.

- An external review by Niche on behalf of NHS England identified gaps in the Duty of Candour process where there has been a homicide committed by a patient known to our Mental Health and Learning Disabilities Service Group. This led us to complete a joint process review with Devon Partnership NHS Trust and has resulted in changes to our Duty of Candour policy in terms of how we support the families of both the victims and perpetrators of homicide.

- A patient known to our haematology department was admitted to hospital following experiencing a relapse of lymphoma. Sadly, it was recognised early that this patient was palliative. A Structured Judgement Review identified that communication around planning for end of life was confusing. This added stress to the patient and their family, which may have been reduced if there had been more effective liaison between teams. As a result of this, teaching has been provided to the ward team to raise awareness of end-of-life processes and pathways.

- The ME raised concerns about the management of a patient's pressure ulcer, which had rapidly deteriorated ahead of their death. Our District Nurse service was asked to complete an SJR and identified that

the patient received good care overall. Of note, the team were supportive of the patient's preferences for care and took all reasonable actions to mitigate any risks, for instance in response to the patient declining to use pressure relieving equipment. This review has identified incidental learning concerning delays to documentation, although these were not thought to have negatively impacted the patient's care. This has been shared with the team to highlight the importance of completing initial assessments at the point of acceptance on to caseload.

- The impact of poor communication was noted in a complaint from the family of a patient who died on one of our medical wards. The family described fearing that they could see their loved one deteriorating but were left hoping for a positive outcome because they trusted that they would be kept informed by staff. This left the family feeling frustrated and confused. They felt that they had to repeatedly ask for updates and were not given information that conveyed the seriousness of the situation until they directly asked about the prognosis. It was acknowledged that at many points during the patient's admission, communication with their family fell short of the expected standards, and learning has been identified from this. As well as additional training for staff around effective and timely communication, a new communication sheet for family members has been implemented to ensure that contact is made daily or if there is a decline in the patient's condition.

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

Scrutiny through the ME service

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

3.4. The Medical Examiner's office had 647 deaths of patients under the care of SFT reported to them between April and June 2023. Of these, 587 were within the acute hospital, 60 were within our community hospitals, and 0 deaths were in our mental health inpatient settings. 97% of the 647 deaths were scrutinized by the Medical Examiner team. In total, 68 deaths were highlighted to Learning from Deaths.

Structured Judgement Reviews

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

3.6. During Quarter 4 of 2022/2023 and Quarter 1 of 2023/2024, the Medical Examiner service have highlighted a potential theme around deaths on the Ready to Go wards and referred 9 deaths in line with this theme. We have requested SJR's for all of these deaths. We are in the process of collating the data and will report on any outcomes in due course.

3.7. We are additionally seeing a potential theme from the Medical Examiner referrals and completed SJR's concerning Treatment Escalation Plans. We will continue to monitor this.

LeDeR review

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

3.9. During this reporting period 5 inpatient deaths meet the criteria for SJR. 2 SJRs have been completed and shared with LeDeR. There were no deaths that met the Serious Incident threshold.

Serious Incident process

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

3.11. Within this reporting period, 8 deaths have been discussed at a rapid review meeting. None of these deaths required further investigation under the serious incident process. However, 2 will be subject to a Structured Judgement

Review and 4 will be reviewed locally by the specialty teams. In the remaining cases, no further review was required and any learning that was identified during the meeting was shared with the clinical teams.

PALS and complaints

3.12. During this quarter, 14 PALS queries and 2 formal complaints have been raised concerning the deaths of patients in our care. All PALS queries have been resolved and there is 1 outstanding formal complaint.

Perinatal Deaths

3.13. All perinatal deaths are reviewed using the Perinatal Mortality Review Tool (PMRT). This tool facilitates a standardised and robust review of all eligible perinatal deaths. A monthly PMRT meeting is held to enable regular review of cases with the multidisciplinary team (MDT) and an external representative, allowing for a 'fresh eyes' perspective. A joint action plan for each month's review of cases (unless being managed as a serious incident) enables the maternity governance team to highlight any common actions and identify themes from reviews. All finalised reports and subsequent action plans are shared with the parents according to their wishes.

3.14. In this reporting period, there were 3 perinatal deaths eligible to be notified to MBRRACE-UK, 1 of which met the criteria for PMRT review. This concerned an intrauterine death. An initial review meeting has been held, with plans for a further review following expert opinion. This is within expected timescales. Further details of any reviews undertaken, as well as any findings and subsequent action plans, are held within the quarterly report provided to the Trust Board by maternity services.

Paediatric Deaths

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

3.16. During this reporting period, there have been 0 paediatric deaths.

Coronial activity

3.17. During this reporting period, there were 56 new enquiries from the coroner concerning the deaths of patients known to SFT. Formal statements have been requested for all cases.

3.18. Several inquests pending from previous reporting periods have been concluded during this quarter. This includes 40 read-only inquests, 5 inquests heard with witnesses called and 1 inquest with a jury present.

Standardised mortality

Summary Hospital-level Mortality Indicator (SHMI), March 2022 – February 2023

Source: NHS England (July 2023)

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

Trust level

Trust	Provider spells	Observed deaths	Expected deaths	SHMI value
Somerset NHS FT	75,160	2,905	2,910	0.9976 As expected

Site level *Acute hospitals and exceptions*

Site	Provider spells	Observed deaths	Expected deaths	SHMI value
Musgrove Park Hospital	46,650	1,785	1,710	1.0420 As expected
Yeovil District Hospital	26,525	980	1,085	0.9061 As expected
South Petherton Hospital	235	10	25	0.4473 **Lower than expected**
Crewkerne Hospital	75	15	10	2.1268 **Higher than expected**

Diagnosis group *Reported groups by exception*

Diagnosis group	Provider spells	Observed deaths	Expected deaths	SHMI value
Septicaemia (except in labour), Shock	1,360	275	335	0.8261 **Lower than expected**

Visual life adjusted display (VLAD) – recent alerts

No recent alerts

Standard mortality ratios from HED, April 2022 to March 2023

Source: HED.nhs.uk - SHMI HES and HSMR HES modules (20th July 2023)

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

Trust level

Trust	SHMI (Apr 22 – Mar 23)	HSMR (Apr 22 – Mar 23)
Somerset NHS FT	99.4 (As expected) 95% CI: 95.7 - 103.1 Observed: 2,780 Expected: 2,797 Spells: 71,436	107.5 **(Above expected)** 95% CI: 102.9 - 112.2 Observed: 2,065 Expected: 1,921 Spells: 55,138

Site level *Acute hospitals and exceptions*

Trust	SHMI (Apr 22 – Mar 23)	HSMR (Apr 22 – Mar 23)
Musgrove Park Hospital	103.9 (As expected) 95% CI: 99.1 - 109.0 Observed: 1,721 Expected: 1,656 Spells: 44,974	119.0 **(Above expected)** 95% CI: 112.4 - 126.0 Observed: 1,203 Expected: 1,011 Spells: 33,727
Yeovil District Hospital	89.7 **(Below expected)** 95% CI: 84.0 - 95.7 Observed: 921 Expected: 1,027 Spells: 24,628	88.5 **(Below expected)** 95% CI: 82.3 - 95.2 Observed: 736 Expected: 831 Spells: 19,222
Crewkerne Hospital	208.3 **(Above expected)** 95% CI: 119.0 - 338.3 Observed: 16 Expected: 8 Spells: 73	167.6 (As expected) 95% CI: 93.7 - 276.4 Observed: 15 Expected: 9 Spells: 50
Frome Community Hospital	152.7 **(Above expected)** 95% CI: 100.6 - 222.2 Observed: 27 Expected: 18 Spells: 154	162.9 **(Above expected)** 95% CI: 105.4 - 240.4 Observed: 25 Expected: 15 Spells: 95
Minehead Community Hospital	179.4 (As expected) 95% CI: 48.3 - 459.2 Observed: 4 Expected: 2 Spells: 30	512.8 **(Above expected)** 95% CI: 138.0 - 1,312.9 Observed: 4 Expected: 1 Spells: 32
South Petherton Hospital	51.9 **(Below expected)** 95% CI: 26.8 - 90.6 Observed: 12 Expected: 23 Spells: 230	95.0 (As expected) 95% CI: 43.4 - 180.4 Observed: 9 Expected: 9 Spells: 88
West Mendip Community Hospital	163.8 **(Above expected)** 95% CI: 103.8 - 245.8 Observed: 23 Expected: 14 Spells: 128	171.0 **(Above expected)** 95% CI: 108.4 - 256.6 Observed: 23 Expected: 13 Spells: 83

Trust	SHMI (Apr 22 – Mar 23)	HSMR (Apr 22 – Mar 23)
Unknown (a small number of spells with invalid site codes, related to merger)	178.6 (As expected) 95% CI: 2.3 - 993.5 Observed: 1 Expected: 1 Spells: 36	1428.6 **(Above expected)** 95% CI: 287.1 - 4,174.0 Observed: 3 Expected: 0 Spells: 32

Plans for reviews in response to Standardised Mortality Data:

3.19. As shown above, we continue to see above expected numbers of deaths at some of our community hospitals. This has been a consistent trend. We have previously co-ordinated reviews into these deaths which provided assurance that there were no clinical concerns with the care that the patients received. As part of our ongoing monitoring, we will conduct a further review.

3.20. Whilst not listed as an exception in this report, Katy Darvall, our Trust Mortality Lead has identified that there is a need to review deaths within the diagnosis group of influenza. We are in the process of extracting the relevant data and will report on the findings of this review in due course.

Appendix 1

		2022/2023												2023/2024							
		April	May	June	Q1 total	July	Aug	Sept	Q2 total	Oct	Nov	Dec	Q3 total	Jan	Feb	Mar	Q4 total	April	May	June	Q1 total
ACUTE INPATIENTS*	Total deaths (including ED)	235	197	172	604	188	198	170	556	187	183	275	645	275	227	223	725	182	203	202	587
	Total Scrutinised by ME	181	155	145	481	179	171	156	506	180	164	215	559	264	221	213	699	182	199	190	571
	SJR's requested by LfD	7	15	7	29	18	6	11	35	14	12	13	39	24	12	16	52	12	9	7	28
	SJR's completed	22	17	11	50	28	10	19	57	26	15	16	57	26	10	13	49	8	5	6	19
	Problems in care**	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	1	0	2
	Serious Incident process initiated	0	1	1	2	2	2	3	7	1	0	0	1	0	1	0	1	1	0	0	1
	Learning Disabilities: internally all deaths in acute inpatient settings are subject to review or investigation																				
	Total deaths	3	1	1	5	4	1	3	8	2	1	5	8	3	1	3	7	3	0	2	5
	Review/investigation completed	3	1	1	5	4	1	3	8	2	1	2	5	1	1	3	5	1	0	1	2
COMMUNITY HOSPITAL	Total deaths	13	24	18	55	13	28	21	62	14	22	28	64	16	16	21	53	22	22	16	60
	Total scrutinised by ME	12	23	19	54	8	23	15	46	11	17	15	43	8	11	18	37	22	19	15	56
	SJR's requested by LfD	0	0	1	1	1	0	0	1	0	0	1	1	0	0	1	1	0	1	1	2
	SJR's completed	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Problems in care**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incident process initiated	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0
MENTAL HEALTH	Total deaths (reported as incident)	4	9	4	17	8	1	8	17	3	7	4	14	6	9	9	24	2	9	5	16
	Total scrutinised by ME	1	0	0	1	0	0	1	1	0	0	1	1	0	0	1	1	0	0	0	0
	SJR's requested by LfD	1	5	1	7	6	1	6	13	1	4	3	8	4	6	7	17	1	7	4	12
	SJR's completed	1	5	1	7	6	1	4	11	1	3	1	5	1	2	2	5	0	0	0	0
	Problems in care**	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0
	Serious Incident process initiated	1	1	2	4	2	0	0	2	0	1	1	2	0	1	0	1	0	1	0	1
COMMUNITY SERVICES	SJR's requested by LfD	1	1	0	2	0	0	0	0	0	0	1	1	0	0	0	0	0	1	1	2
	SJR's completed	8	3	4	15	2	4	5	11	3	1	3	7	2	2	1	5	0	0	1	1
	Problems in care**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incident process initiated	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total deaths subject to Coroner's Inquests		7	12	12	31	24	16	18	58	15	16	11	42	17	17	27	61	16	27	13	56

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

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	YDH Quality Account
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Steve Thomson, Director of Integrated Governance
PRESENTED BY:	Phil Brice, Director of Corporate Services
DATE:	5 September 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 YDH Quality Report – incorporating the Quality Account – is a report about the quality of services provided by Yeovil District Hospital NHS Foundation Trust in 2022/23. The Quality Account is a requirement as set out in the Health Act 2009 with amendments made in 2012, such as the inclusion of quality indicators. Guidance for 2022/23 once again confirmed that there was no requirement for an external audit opinion on the Quality Account. For 2022/23, the Trust focussed on six flagships - the priority programmes for delivering the five clinical care and support strategy aims: • Aim 1: Improving the health of our population • Aim 2: Best care • Aim 3: Local communities, • Aim 4: Value all people alike • Aim 5: Personalised, coordinated care The flagship projects and programmes were delivered at team and / or service group level and monitored within the Board Assurance Framework. The report has been shared with Healthwatch, the Oversight and Scrutiny Committee, Governors and the Integrated Care Board for Somerset and Dorset. Feedback from these stakeholders is expected imminently.
Recommendation	The Board is asked to discuss the Quality Reports/Quality Accounts and agree that the reports accurately reflect performance against the objectives.

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

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

Equality and Inclusion
The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
The Trust is committed to reducing inequalities across all services provided. The priorities as described and addressed in the Quality Account align to the NHS priorities set out in the NHS Long Term Plan and Operational Planning Guidance and have specific focus on reducing inequalities. The merger with Somerset NHS Foundation Trust was planned to provide better care for our patients and ensure that everyone in the county enjoys consistent access to high quality services. The merger eliminates organisational boundaries and puts us in a better position to support people to stay well, give equal opportunity to mental and physical health and delivery services in the most appropriate setting. As services have been and are integrated, the potential impact on individuals with protected characteristics is considered in the planning and implementation phases. This will include wider engagement with various stakeholders. A number of specific initiatives have been implemented within the year to address inequalities as detailed within the report.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History
How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
The Quality Account has been drafted within wider engagement and involvement of colleagues. In addition, the reports have been shared with external agencies as described above and their stakeholder statements will be included within the final published 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 Quality Accounts are published annually. Oversight of delivery of the objectives is delegated to the Quality and Governance Committee and within the Board Assurance Framework as reported to the Board Assurance Committees and directly to the Board.

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

Quality Account
Yeovil District Hospital
2022/23

Yeovil Hospital Healthcare

Our year 2022/23

47,697
patients admitted

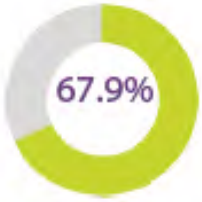
159,915
radiology tests

66,479
ED attendances

2,688
children admitted

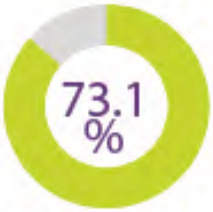
1,253
babies born

1,817
patients treated for cancer



referral to treatment within 18 weeks
(Target 92%)
up to March 2023

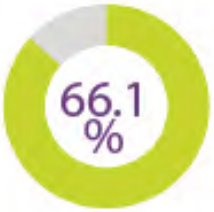
410
stroke patients treated



ED patients seen within 4 hours
(Target 95%)

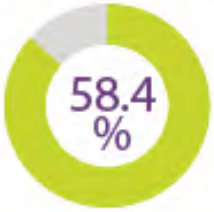
353
fractured hips mended

543
patients assessed by the frailty team



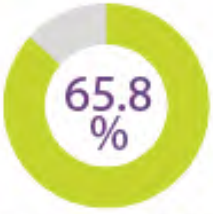
Diagnostic six week performance
(Target 99%)

4,460
admissions avoided through AEC



Cancer 2 Week Wait
(Target 93%)

Cancer 31 Day First
(Target 96%)



Cancer 62 Day Standard
(Target 85%)

27
new doctors

23
new nurses inc. unregistered & students

3,008 treated for COVID-19

2,833 recovered from COVID-19

Contents

Part 1: Statement on quality from the chief executive of Yeovil District Hospital

1.1 Our commitment to quality, Statement from the Chief Executive

Welcome to the annual quality account and report for Yeovil District Hospital NHS Foundation Trust, for the financial year 2022/23.

This quality account sets out how we performed against the quality improvements that we set ourselves. It also provides an opportunity for us to reflect on our achievements and challenges during, what has been, an extremely important year.

During 2022/23, we prepared to merge Yeovil District Hospital NHS Foundation Trust and Somerset NHS Foundation Trust, as well as focussing on providing care and support for those who needed it and support those patients and service users who care was delayed as a result of the Covid-19 pandemic. Like other NHS providers across England, we saw record numbers of patients (66,479), many of them with complex care needs, attend the Emergency Department at Yeovil District Hospital compared to the previous year (60,009). At the same time, we provided treatment for those patients whose planned treatment had been delayed and reduced the number of long waiting patients, with 369 pathways waiting over 52 weeks compared to 756 in March 2022.

We merged with Somerset NHS Foundation Trust on 1 April 2023 because we want to provide better care for our patients and ensure that everyone in the county enjoys consistent access to high quality services irrespective of where they live. Working as one organisation, and therefore eliminating organisational boundaries, puts us in a better position to support people to stay well, give equal priority to mental and physical health, deliver services in the most appropriate setting, help us to further improve care for our patients and service users, and make better use of our resources.

We are now a unique organisation that provides community, mental health and learning disability services throughout the county and into Dorset, along with acute services from both Yeovil Hospital and Musgrove Park Hospital, our 13 community hospitals in Somerset, and a quarter of Somerset's GP practices through our subsidiary Symphony Healthcare Services.

During 2022/23, our clinical and corporate services worked towards integrating and planning single countywide services and looked afresh at our existing clinical strategy, engaging our colleagues, services and partners, to ensure it remained relevant. The aims of our refreshed clinical strategy form part of our organisational strategic objectives, are shared with our partners on the Somerset Integrated Care Board, and are to:

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

It is also very important that we have facilities that support us to deliver the best care to our patients. In 2022/23 Yeovil District Hospital received £15m for a new ward and fifth operating theatre that will help us reduce waiting times for patients. The building work is split into two parts. The first part, which we expect to open in autumn 2024, will see Yeovil District Hospital's main theatre suite receive a significant refurbishment and the addition of a fifth operating theatre. The second part of the project is the addition of a new 20-bed ward which we expect to open a little earlier in spring 2024.

These facilities are in addition to a new £5m day theatre which will also help us to significantly reduce waiting times which grew during the pandemic. Work is already underway on the unit which uses funding from the Government's 'Targeted Investment Fund'. The new building will include a theatre suite with recovery rooms, reception and waiting areas, office space and a dedicated facility for colleagues.

2022/23 was undoubtedly a challenging year for the NHS but one in which we made significant steps to put us on a good footing for the future. However, it is important to note that we faced operational challenges as we sought to care for those patients who needed urgent treatment - and treat those who had waited a long time for treatment - while we faced continued difficulty to discharge patients when they were medically fit.

I want to end by thanking all my colleagues within the trust, our partners, our volunteers, our charities and the families and carers who support our patients. Without their hard work, dedication and commitment, we would not have been able to make the progress we have. Thank you once again for all that you do for the people and patients of Somerset and the services that we provide.

Peter Lewis

Chief Executive

1.2 Our vision, values and strategy

For 2022/23, the Trust focussed on six flagships - the priority programmes for delivering the five clinical care and support strategy aims:

Aim 1: Improving the health of our population,

Aim 2: Best care,

Aim 3: Local communities,

Aim 4: Value all people alike,

Aim 5: Personalised, coordinated care.

There was one flagship for aims 1-4 with aim 5 having one flagship programme for adults and a second for children and young people. Progress of flagships over the last year has been variable. This is partly due to teams having to reset priorities across the system, establish new relationships and the impact of operational pressures and leadership changes. The intention of the flagships was to set ambitions together and develop joint working with Somerset NHS Foundation Trust (SFT) colleagues and teams ahead of the merger.

How they were measured, monitored and reported?

The flagship projects and programmes were delivered at team and / or service group level and monitored within the Board Assurance Framework.

Here is how the Trust performed in these areas in 2022/23:

PRIORITY 1 - POSITIVE STEPS: USING THE TIME WAITING FOR SURGERY TO OPTIMISE PEOPLE'S HEALTH AND WELLBEING BOTH NOW AND FOR THE FUTURE

Why was it important?

This was a new flagship programme of work in 2022, to support the Trusts' ambition to play our part in improving the health of the population. Peri-operative care is the comprehensive management of patients before, during and after surgery, from the moment surgery is contemplated right through to recovery and long-term follow-up. It is understood that the fitter a patient is, the better they can cope with surgery, enabling a quicker recovery and improved outcomes. It is also known that the earlier teams understand the health requirements of patients, the more time there is to support healthy lifestyle change, which not only supports improved outcomes from surgery but may avoid the need altogether. Peri-operative care enables better outcomes from surgery such as reduced length of stay, speedier recovery, reduced re-admissions plus better long-term outcomes.

The aims of the peri-operative service are to:

- optimise the health of patients who need surgery.
- turn 'Waiting time' into 'Preparation time' prior to surgery.
- establish patients as partners in their own health management to positively impact their long-term health and wellbeing.

What was achieved during the year?

Prior to this work being adopted as a flagship programme, the peri-operative programme team agreed the scope of their current improvement. This was a focus on the pre-surgical period to optimise patients prior to surgery i.e., by improving mobility, cardiovascular and fitness levels, stopping or reducing smoking or helping patients to control their diabetes prior to surgery.

A core team was established, which developed 14 workstreams with leads. The programme has members from both YDH and SFT and is working to develop the Somerset Peri-operative service, building on existing services, learning from each other and taking forward the most beneficial options. Bi-weekly steering group meetings were implemented and over this time commenced c. 55+ tests of change.

Examples of workstreams developed are:

- identifying and taking action with patients as soon as the GP decides surgery may be an option i.e., diabetes pilot. This team works with GP surgeries to identify patients with diabetes, referred for elective surgery, to optimise and maintain their condition prior to their pre-operative assessment.
- targeting modifiable risk factors i.e., smoking cessation services with public health.
- working with and developing services currently available within the community to optimise health i.e., exercise pilot with Somerset Activity and Sports Partnership (SASP), the Home-based Older People's Exercise (HOPE) trial exercise programme with NHS England (NHSE) and emotional support through the talking therapies service.
- understanding how the patient can best prepare for surgery utilising services i.e., health coaches based within primary care networks.

QIP 2022/23 - PRIORITY 2 - INDEPENDENT LIVES: HELPING OLDER PEOPLE TO LIVE AS THEY WISH, GIVING THEM TIME TO DO WHAT IS IMPORTANT TO THEM

Why was it important?

Nationally an increasing number of people are at risk of developing frailty. Somerset has a higher than average elderly population with 24.8% aged 65 and over. Frailty is a clinically recognised state of increased vulnerability resulting from ageing; associated with a decline in the body's physical and psychological reserves. A person living with frailty has twice the mortality risk of a fit older person and increasing frailty is associated with substantial increases in healthcare costs. They are more likely to attend emergency departments and experience delayed transfers of care. People living with mild, moderate, or severe frailty could often have their needs best met in settings outside of acute hospital care. This flagship's ambition is to ensure quick and accurate identification of vulnerable people and to provide alternatives to hospital admission that are more responsive and better able to meet the needs of the frail person.

The frailty work is linked to Somerset system projects including the community hospital transformational work and the local delivery of the Ageing Well programme. This focuses on delivering integrated personalised care in communities and addresses the needs of older people through the inter-related service models of community multi-disciplinary teams (MDT's), urgent community response, enhanced care in care homes and anticipatory care.

What was achieved during the year?

In this last year there has been a focus on how services can more effectively manage frailer individuals at home to reduce potentially harmful lengthy hospital stays. This was achieved through early identification, provision of community alternatives and robust training and support for colleagues.

- **Identification of frailty:** Previous work within the Emergency Department (ED) continued throughout the year, linked into wider work across Somerset.

- **Hospital at Home:** Frailty and Respiratory Hospital at Home pathways commenced late in 2022. To date the service has supported 452 patients saving in excess of 3000 acute bed days. The service runs 7 days a week, 12 hours a day. The service operates with a 'team of teams' model linking closely with neighbourhood teams, primary care networks, acute hospitals and care of the elderly services. The merger has enabled Hospital at Home to integrate arrangements with SFT to support the service and provide consistent cover across Somerset.

- **Frailty Advanced Clinical Practitioners** (ACP's) have been employed across ED and community services. These community roles sit primarily within the Hospital at Home team but are closely aligned with the neighbourhood teams. Close working between the teams has been established to support the training and supervision of the new appointments.

QIP 2022/23 – PRIORITY 3 – STOLEN YEARS: HELPING PEOPLE WITH MENTAL HEALTH CONDITIONS TO LIVE LONGER LIVES

Why was this important?

People with severe mental illness (SMI) struggle to live independently, are at greater risk of developing health problems and are less equipped to recognise when and how to respond to worsening health signs. People living with SMI often live with poor physical health and on average die 15 – 20 years earlier than other people. It is estimated two out of three people, with a diagnosis of SMI, die from physical illnesses that can be prevented. The main causes of death being circulatory disease, diabetes and obesity.

What was achieved during the year?

The majority of work in this area was linked to SFT services, but YDH linked on a number of the projects. The stolen years flagship pledged to co-produce projects with 'Experts by Experience', building on work already done. There were two main areas of focus in year. Firstly, the uptake and quality of physical health checks for patients with SMI, Secondly, growing collaborative relationships between mental health and physical health colleagues, to improve care for patients with mental ill-health when accessing physical health services.

- **Tobacco reduction programme**: Smoking is the largest avoidable cause of premature death, with more than 40% of adults with SMI smoking. The Trust's Tobacco Harm Reduction Service supports those with severe mental health conditions and/or learning disabilities, as well as acute hospital inpatients and maternity services and staff to stop smoking or to reduce the amount they smoke. It is also the lead on developing smoke free sites within the Trust, promoting the smoke free message across the grounds and providing training to staff on tobacco harm reduction / smoking cessation. In June 2022, SFT appointed a Tobacco Reduction Programme (TRP) manager to lead on this work which will contribute to a reduction in health inequalities. The TRP fully mobilised its' inpatient acute and mental health pathways across all sites in March 2023 and is utilising Quality Improvement (QI) methodology to inform training needs and enable wards to become smokefree by the end of 2023/24.
- **Colleagues working together**: Physical and mental health colleagues have worked together to support mental health patients when they become physically unwell in inpatient settings. This project was started after a patient was transferred by ambulance twice from a mental health ward to an acute site for assessment of a physical issue. Recognising this was not a good experience for this patient and to further improve patient care and safety, the teams worked together to develop advice and guidance for patients who become physically unwell on mental health wards, so they can remain there wherever possible. This is planned to go live across both EDs and mental health wards from Summer 2023.

  A further example of physical and mental health colleagues' collaboration was to support mental health inpatients when identified as end of life. Palliative care and bereavement colleagues provided support and training to staff so they could care for patients in familiar surroundings rather than moving to the acute trust. Simple measures such as sending beds for relatives to be able to sleep close by and providing staff with bereavement support has improved the confidence and skills of staff when caring for patients who are end of life. Staff feel energised as they can provide a holistic approach and improve patient care and experience.
- **Widening the focus:** In September 2022, Dr Katalin Fernando, Associate Medical Director for unplanned care, YDH, took on an additional portfolio role looking at the interface between acute medical and mental health services across YDH and SFT to better address the unmet physical healthcare needs of patients with mental health problems.

QIP 2022/23 – PRIORITY 4 – LAST 1,000 DAYS: VALUING PEOPLE'S PREVIOUS TIME IN THE LAST CHAPTER OF LIFE

Why was this important?

The last 1000 days flagship ambition is to identify and appropriately support patients to ensure they maximise the time they have, doing what is important to them in a place they want to be. This includes the needs of relatives and friends during life and after the death of their loved one has occurred. End of life care (EOLC) encompasses all stages of care and experience for patients and their families with a life-

limiting illness. It is not confined to the last days of life and can be measured many years prior to the death of a person. This flagship supports patients, family and carers to plan their last chapter of life and enables colleagues to provide high quality, compassionate EOLC. It seeks to ensure that those patients who die in hospital have the best care possible and that those patients, who wish to die at home, or elsewhere, are enabled to do so by supportive discharge arrangements which may include partnership working with other agencies and which respects an individual's choices, values, and beliefs.

What was achieved during the year?

The Last 1000 days flagship has been pivotal in the way EOLC is viewed countywide, with multi-agency colleagues coming together to do the right thing for patients who are at the end of their life. The Last 1000 days governance structure is well embedded with a steering group to which three subgroups report: operational, governance and education. Work has already begun to formally bring the two legacy EOLC teams together who have already worked on many of the projects together. The focus of many of the projects within the Last 1000 days flagship arise from colleagues themselves and/or learning from events which trigger them to work together to improve service provision.

Examples of work achieved are:

- **An EOL Homecare pilot:** commenced in November 2022 to bring about rapid discharge of EOL patients with days to short weeks to live from the acute trust. Previous data showed 29% of patients when identified as EOL die in hospital awaiting discharge and the process can take on average 6.3 days for a package of care to be set up and funding to be approved. For many patients this means they often become too unwell and one in three die in hospital and not in their place of choosing. The pilot explored the reasons why delays occurred, and teams have worked together to bridge gaps and to work differently to bring about prompt discharge. In February 2023, this moved to the project phase and to date 36 patients have been discharged home, with 68% getting home same day or next day. The teams are reviewing the data ahead of refining the pathways and considering spread to YDH and the community.
- **Packages of care audit:** Alongside the above project, colleagues were keen to understand if packages of care (POC) set up at the time of discharge met the needs of patients and families. This study reviewed POC set up in November and December 2022 and found colleagues were accurately requesting the level of care, support and equipment needed.
- **Ascites management:** Patients receiving palliative care often need abdominal drains due to a build-up of fluid (ascites) but are too unwell to come into hospital. A pilot to reduce the need of a hospital visit by using portable ultrasound scanners was undertaken – meaning consultant sonographers can visit a patient's home to perform the drain. Around three patients a month across Somerset may require this kind of service who would otherwise struggle to get to hospital. Previously an unwell patient receiving palliative care comes into hospital for drainage; this requires ambulance transport, a porter, then after waiting in the hospital while in pain, they need an ambulance to return home. By a sonographer going to the patient's house and working with colleagues in community services, it means that they can receive care in their own home. This helps to reduce hospital admissions, supporting patients to stay at home when they near the end of their life, and improving the quality of life for patients. This service is being trialled in the east of Somerset with plans to expand it county-wide.
- **Website**: The Somerset End of Life Care and Bereavement Support website was launched in March 2022. A care home roadshow was completed in year where 49 care homes were visited in person to present the website and the range of courses and services available.
- **Conference**: An inaugural EOLC conference was held in May 2022 to 200 delegates across 14 different organisations. The next conference is planned for September 2023.
- **'Patient Stories' project**: This seeks to put the patient and carer voice at the heart of the EOLC education delivered. So far two short films, one about care after death, one about Treatment Escalation Plans (TEP) have been made using families who were willing to share their experiences and from which learning opportunities exist.

- **Care of the Dying person:** a continued audit of practice in care for those in the last days of life has commenced. An action plan is being delivered by specialist palliative care teams supported by the EOLC education team.

- **The 'Talk About Project'**: advance care planning (ACP) project across Somerset used volunteers to help people personalise their care and legacy through an advance care plan. Unfortunately, the funding for this has been ceased and there is no resource in place to support advance care planning going forward.

- **A poor prognosis letter:** has been designed to help sign-post patients with a life-limiting diagnosis to resources, to help them consider things they may want to plan for, outside of their immediate medical needs. A draft letter is being adapted after feedback from a patient cohort. This will be trialled in a cancer-patient cohort with the help of the Lung cancer team.

QIP 2022/23 – PRIORITY 5 – CONNECTING US: USING TIME WELL BY GETTING TOGETHER TO FOCUS ON WHAT MATTERS TO PEOPLE WITH COMPLEX NEEDS

Why was this important?

A growing number of people are living with complex needs including chronic or long-term health conditions, often with physical and mental health needs as well as social deprivation challenges. Meeting the needs of this population requires anticipatory not reactive care, time to develop trusting relationships, broadening the membership of the care team and communicating across different specialties and agencies. Developing advanced and personalised models of care is essential to meet the challenge of complex care for our population.

What was achieved during the year?

- **Improvements in the support for those identified as high-intensity service users:** At the beginning of the year, colleagues worked with the Integrated Care Board (ICB) to develop a business case to establish a high-intensity service within Somerset. This was based on the national right-care model, built on the Ubuntu project (below), the developments in the ED high intensity user multi-agency group and the roles being created in the PCNs. The business case was approved; the two new posts are being hosted by SFT and are in the recruitment stage.

- **Ubuntu Project:** This partnership project between SFT and the Community Council for Somerset (CCS) supports high-intensity users referred with a focus on what is important to the individual, whilst developing self-activation and a subsequent reduction in health service use. The project team has finalised the service offer; accepting referrals from: SFT and YDH ED high-intensity user groups, primary care, South Western Ambulance Service NHS Foundation Trust (SWAST) and other partners. Sustainable funding for the Ubuntu service has been agreed as part of the development of a High-Intensity service for Somerset.

- **Functional Neurological Disorders (FND) improvements:** A working group was set up to discuss the existing services, and skills in teams across Somerset. The group have set a vision and drafted a future service model ready for consultation with stakeholders. Currently, the group are reviewing what improvement projects can be piloted within existing resources. Links have been made with the Regional FND network to share good practice. The FND need is being raised as part of the Neurological Rehabilitation case for change being prepared for the Integrated Care System (ICS) and there is wider colleague, patient and third sector engagement for the full case for change. The plan is to submit this at the end of June 2023.

QIP 2022/23 – PRIORITY 5 – FUNCTION FIRST – IMPROVING LIFE CHANCES FOR CHILDREN BY INCREASING THEIR TIME IN SCHOOL

Why was this important?

Children with complex needs, including those with persistent physical symptoms where no organic cause can be found, risk over-investigation and treatment. This includes frequent medical appointments, multiple

emergency department attendances and prolonged hospital stays. They are often functionally impaired, with schooling and home life negatively affected. Sadly, this frequently continues into adulthood drastically reducing life chances.

What was achieved during the year?

- **Out-patients service strategy:** The team have developed the strategy and have achieved the following:
    - ongoing senior doctor triage of referrals to ensure the right children are safely being seen in the right clinics.
    - prospective clinical and managerial monitoring of referrals and capacity to ensure waiting lists are well managed and capacity is maintained for urgent referrals.
    - utilising non-acute sites (community hospitals and schools) for clinics where possible to ensure there are opportunities for care closer to home.
    - commenced Darzi fellowship pilot project to provide joint primary/secondary care triage of referrals in West Somerset. This project will evaluate if Children and Young People (CYP) can be managed primarily in the community with specialist paediatric advice.

Part 2: Priorities for improvement and statements of assurance from the board

2.1 Quality Improvement Priorities

In this section we set out our priorities for the merged Trust for this year. It has been agreed to continue with the current priorities giving an opportunity to reset and refresh as the new service groups, operational and clinical leads are in place. The flagships will seek out opportunities to work across the wider health and social care system in Somerset.

How they will be measured, monitored and reported.

The flagship projects and programmes will be delivered at team and/or service group level and monitored within the Board Assurance Framework. The flagships have been realigned to better fit with the clinical care and support strategy.

QIP 2023/24 - PRIORITY 1 - POSITIVE STEPS: USING THE TIME WAITING FOR SURGERY TO OPTIMISE PEOPLE'S HEALTH AND WELLBEING BOTH NOW AND FOR THE FUTURE

Why is this important?

Peri-operative care is the comprehensive management of patients before, during and after surgery, from the moment surgery is contemplated right through to recovery and long-term follow-up. It is understood that the fitter a patient is, the better they can cope with surgery enabling a quicker recovery and improved outcomes. It is also known that the earlier our teams understand the health requirements of our patients, the more time there is to support healthy lifestyle change which not only supports improved outcomes from surgery but may avoid the need altogether. Peri-operative care enables better outcomes from surgery such as reduced length of stay, speedier recovery, reduced re-admissions plus better long-term outcomes.

The aims of the peri-operative service are to:

- optimise the health of patients who need surgery.
- turn 'Waiting time' into 'Preparation time' prior to surgery.
- establish patients as partners in their own health management to positively impact their long-term health and wellbeing.

What do we want to achieve?

- To embed new services / pathways for the Peri-operative management of frailty, anaemia, exercise and smoking. To achieve this, the team will further utilise excellent pre-existing services within Public Health and our community partners (Smoke Free Somerset, Turning Point, SASP, HOPE Social Enterprise, Talking Therapies etc).

- Drawing upon the successes of the Peri-Operative Diabetes Pilot pathway, the ambition is to on-board all GP surgeries across Somerset to identify surgical elective patients with diabetes at the point of GP referral, to maximise the best outcome for diabetes optimisation prior to surgery.

- The team will work further with Primary Care network colleagues to understand the role and opportunity of the Health Coaches, to support increased mobility, exercise, emotional wellbeing and weight management for patients prior to surgery.

- Peri-operative assessment clinics will be embedded further upstream from the existing Pre-Operative Assessment Clinics, to assess and work with our patients to identify surgical optimisation

goals. Patients will be regularly contacted by Care Co-ordinators to enable pre-existing conditions to be monitored and pre-surgical goals achieved.

- There will be collaborative working with our Primary and Secondary Care colleagues to understand each of these pathways to develop a service which is synonymous with the aims of the Elective Care Recovery Programme, improved surgical outcomes and patient care.

QIP 2023/24– PRIORITY 2 – LAST 1,000 DAYS: VALUING PEOPLE'S PREVIOUS TIME IN THE LAST CHAPTER OF LIFE

Why is it important?

The last 1000 days flagship ambition is to identify and appropriately support patients to ensure they maximise the time they have, doing what is important to them in a place they want to be. This includes the needs of relatives and friends during life and after the death of their loved one has occurred. End of life care (EOLC) encompasses all stages of care and experience for patients and their families with a life-limiting illness. It is not confined to the last days of life and can be measured many years prior to the death of a person. This flagship supports patients, family and carers to plan their last chapter of life and enables colleagues to provide high quality, compassionate EOLC. It seeks to ensure that those patients who die in hospital have the best care possible and that those patients, who wish to die at home, or elsewhere, are enabled to do so by supportive discharge arrangements which may include partnership working with other agencies and which respects an individual's choices, values, and beliefs.

What do we want to achieve?

In the year ahead, many of the projects will be continuing with an emphasis on ensuring patients who are identified as EOL with days or short weeks to live will be able to go home promptly which will improve hospital flow:

- The learning from the EOL homecare project which aims to take patients home from hospital within 24 hours, will inform wider rollout across the county. This will be supported by F1 quality improvement work looking at the completion of continuing healthcare fast track (CHCFT) applications to increase the approval rates of applications for funding.

- Review of current discharge pathways with consideration of EOL provision will be undertaken.

- Design of an education prospectus with the wider Somerset End of Life Care Education Network featuring all the courses and content available for all staff across Somerset working with those with life-limiting conditions.

- Following Care Quality Commission (CQC) feedback, a QI project to assess the impact of mandatory EOLC education on care outcomes will be undertaken to consider whether this has a positive impact on the experience of patients and carers.

- The appointment of a Somerset Treatment Escalation Plan (STEP) lead will enable coordinated improvement and monitoring of TEPs in the county.

- A local version of the NACEL audit, which is not running nationally this year, will be undertaken; through a case note review, staff survey and quality survey (bereavement survey).

- The merging of governance structures for the Last 1000 days flagship with one steering group to oversee the subgroups will be conducted: education, governance and operational. Many of the projects within the Last 1000 days flagship will arise from colleagues themselves and/or learning from events which trigger them to work together to improve service provision which will be captured.

QIP 2023/24 - PRIORITY 3 - INDEPENDENT LIVES: HELPING OLDER PEOPLE TO LIVE AS THEY WISH, GIVING THEM TIME TO DO WHAT IS IMPORTANT TO THEM

Why is this important?

Nationally an increasing number of people are at risk of developing frailty. Somerset has a higher than average elderly population with 24.8% aged 65 and over. Frailty is a clinically recognised state of increased vulnerability resulting from ageing; associated with a decline in the body's physical and psychological reserves. A person living with frailty has twice the mortality risk of a fit older person and increasing frailty is associated with substantial increases in healthcare costs. They are more likely to attend emergency departments and experience delayed transfers of care. People living with mild, moderate, or severe frailty could often have their needs best met in settings outside of acute hospital care. This flagship's ambition is to ensure quick and accurate identification of vulnerable people and to provide alternatives to hospital admission that are more responsive and better able to meet the needs of the frail person.

What do we want to achieve?

- The identification of frailty at the front door is now part of the Trust Commissioning for Quality and Innovation (CQUIN) for 2023-4. The Trust will be assessed on its' ability to produce a frailty assessment for over 65-year-olds presenting to ED and initiating an appropriate response for those who are frail using the CFS scale.
- Wider rollout of CFS within countywide teams e.g., hospital at home, CRS, rapid response for those aged 65+. This will ensure a common way of identifying frailty and monitoring deterioration to aid rapid intervention.
- Expansion of the hospital at home service, with the introduction of remote monitoring for frailty patients i.e., clinical observations and subjective patient questionnaires. The results can be viewed remotely by a dedicated team of clinicians and administrators.
- A review to look at the integration of frailty services across the acute hospitals to establish current and future provision in line with national guidance and local population needs.
- Explore further opportunities to roll out community falls and frailty clinic e.g., West Mendip hospital and South Somerset areas.
- Expand links with domically care agencies to enable the agency workers to call the Urgent Community Response team initially for a review rather than the GP and Ambulance service.
- Further roll out of the tiered education programme to the whole Trust and wider community. The intention is to embed this training as a requirement for all relevant Trust colleagues.

Work in collaboration with informatics to ensure that the right data is collected to enable us to review the services.

QIP 2023/24 – PRIORITY 4 – STOLEN YEARS: HELPING PEOPLE WITH MENTAL HEALTH CONDITIONS TO LIVE LONGER LIVES

Why is it important?

People with SMI (severe mental illness) struggle to live independently, are at greater risk of developing health problems and are less equipped to recognise when and how to respond to worsening health signs. People living with severe mental illness (SMI) often live with poor physical health and on average die 15 – 20 years earlier than other people. The main causes of death being circulatory disease, diabetes and obesity. It is estimated two out of three people, with a diagnosis of SMI, die from physical illnesses that can be prevented.

What do we want to achieve?

The stolen years programme remains committed to improving the physical health of patients with SMI. Areas of work planned for the year ahead are:

- Further workshops looking at improving the physical health of patients with mental ill-health across a number of physical health settings, targeting key areas such as diabetes, dietetics and surgery. A repository of 'pledges' will be collated to show where colleagues in physical health settings will have made changes to systems to improve access and care.

- The 'Healthy Living on Clozapine' project which was halted previously due to the pandemic and operational pressures will be restarted. The aim of the project is to support patients to lose weight and increase activity to achieve personalised activity goals.

- Embedding the wellbeing project RiO report within specialist outpatient clinics to increase the timeliness of physical health checks to improve identification of risk factors and offer interventions. The next stages of the project will also look at opportunities for spread where antipsychotic medication is prescribed.

- Adopting a county wide approach to ECG interpretation. Current provision of ECG interpretation does not allow for prompt, safe management of medical interpretation. After considering options, it has been agreed ECGs will be sent externally for interpreting and flagging which will ensure patients are followed up quickly and timely management plans are put in place where appropriate.

- SFT is participating in a randomised controlled trial to investigate the clinical and cost-effectiveness of the DIAMONDS diabetes self-management intervention for people with a severe mental illness. The DIAMONDS intervention involves one-to-one sessions with a trained coach over a six-month period. The coach will provide information and help support healthy lifestyle choices.

- In 2023/24 the Trust's Tobacco Harm Reduction Service will mobilise its High Dependency Service, specifically aimed at supporting mental health discharged patients, and outpatients, with an enhanced harm reduction and smoking cessation offer. In addition to offering Nicotine Replacement Therapy (NRT), patients on the outpatient pilot pathway will be able to access e-cigarettes and up to 16-weeks Specialist Practitioner support.

QIP 2023/24 – PRIORITY 5 – CONNECTING US: USING TIME WELL BY GETTING TOGETHER TO FOCUS ON WHAT MATTERS TO PEOPLE WITH COMPLEX NEEDS

Why is this important?

A growing number of people are living with complex needs including chronic or long-term health conditions, often with physical and mental health needs as well as social deprivation challenges. It's important that we understand the health of our population and how we can meet their needs through: anticipatory, proactive not reactive care; developing trusted relationships; broadening the membership of the care team and communicating across different specialties and agencies. Developing advanced and personalised models of care is essential to meet the challenge of complex care for our population.

What do we want to achieve?

- **High intensity user service for Somerset:** With the funding in place, the Somerset high-intensity user service will be established. The new post-holders will be tasked with understanding the current service offer in Somerset and what's required for the future, before implementing the right-care model. They will work with the established HIUGs in EDs, the PCN services and the Ubuntu coaches to ensure joined up working for the individuals identified and monitor the impact of the changes made.

- **Establishment of a persistent unexplained physical symptoms (PUPS) clinic (adults):** By the end of June, a full review of the clinic will be completed including cost of the service and benefits analysis. The evaluation will be made available to allow a decision about continuation of the clinic.

- **Personalised care approach:** To play our part in supporting the work of the Somerset ICB personalised care steering group, to develop the actions to embed the personalised care model across the ICS. To support the roll-out of personalised care training and education programme to

colleagues. Help our PCNs and teams to embed proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions, as per the Fuller report recommendations.

- **Proactive care**: the national framework for proactive care is due to be published this year. Once available, leads will review the recommendations and influence as a joint community, mental health and acute Trust to develop proactive care along our pathways. It is anticipated this will build on the one team approach developed in Burnham and the complex care team approach in South Somerset.

- **Dementia and Delirium care:** Somerset currently has a low diagnosis rate (53.8% compared to a national target of 66.7%); the aim going forward will be to improve diagnosis rates and associated care. Building on the work started, it is planned to further recruit to the care home liaison team and expand the benefits already seen.

  To ensure good care and prevent deterioration in older patients admitted for an emergency, the plan is to assess for the presence of delirium and if present to follow the Trust delirium guidelines. Results will be evaluated to measure the success with achieving this. Further, it is intended to develop a follow-up specialist clinic for those that have been admitted to our acute settings. All in-patient discharge summaries will clearly document the patients plan and this will be agreed with their carers.

QIP 2023/24 – PRIORITY 5 – FUNCTION FIRST – IMPROVING LIFE CHANCES FOR CHILDREN BY INCREASING THEIR TIME IN SCHOOL

Why is this important?

With the merger of SFT and YDH there has been change within the service group structures. With a new leadership team (service group director, associate medical director, and joint roles from CAMHS across paediatrics) there is a fantastic opportunity to review and reset the flagship, bringing in colleagues with their ideas, creativity and best practice from across the new SFT.

What do we want to achieve during the year?

Our priority is to address the key issues facing young people across Somerset. As such the focus will be to improve the clarity and responsiveness along our pathways caring for adolescents. There is potential to build on developments such as care closer to home through acute home treatment services. This reduces the requirement for hospital admission and improves transitions across different care environments and as young people move into adult services. The plan is to support initiatives in the care of those with learning disabilities, recognising individualised care for this specific group will establish a model to spread personalised care to CYP and their families. First steps will be to relaunch the flagship to encompass the ambitions agreed and to garner support across the service group and beyond.

2.2 Statements of assurance from the board

Service Income

Information on participation in clinical audits and national confidential enquiries

During 22/23 37 national clinical audit programmes and 4 national confidential enquiry studies covered relevant health services that the Trust provides. During that period the Trust participated in 91% of the national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate during 22/23 are shown in table 2.

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during the 21/22, are listed in table 2 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the teams of that audit or enquiry.

The responsibility and ownership for reviewing of the national clinical audit reports published sits within the speciality teams that submitted the data. 40 national clinical audit reports have been published in 22/23. Examples of actions under specific audits are detailed in Table 3.

The reports of 24 local clinical audits were reviewed by the Trust in 22/23. The actions that the Trust intends to take to improve the quality of health provided are detailed in Part 3.

National audit YDH eligible to participate in	YDH participation 22/23	Percentage of required number of cases submitted
Breast and Cosmetic Implant Registry	Yes	Continuous audit of all eligible patients
Case Mix Programme	Yes	Continuous audit of all eligible patients
Child Health Clinical Outcome Review Programme	N/A	No projects during period
Cleft Registry and Audit NEtwork Database	No	N/A to our Trust
Elective Surgery: National PROMs Programme	Yes	Continuous audit of all eligible patients
Emergency Medicine QIPs:	Yes	
> Pain in children	Yes	Continuous audit of all eligible patients
> Infection prevention and control	Yes	Continuous audit of all eligible patients
> Consultant sign off	Yes	Continuous audit of all eligible patients
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	Continuous audit of all eligible patients
Falls and Fragility Fracture Audit Programme:	Yes	
> Fracture Liaison Service Database	Yes	Continuous audit of all eligible patients
> National Audit of Inpatient Falls	Yes	Continuous audit of all eligible patients
> National Hip Fracture Database	Yes	Continuous audit of all eligible patients
Gastro-intestinal Cancer Audit Programme:	Yes	
> National Bowel Cancer Audit	Yes	Continuous audit of all eligible patients

> National Oesophago-gastric Cancer	Yes	Continuous audit of all eligible patients
Inflammatory Bowel Disease Audit	Yes	Continuous audit of all eligible patients
LeDeR - learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disability Mortality Review Programme)	Yes	Continuous audit of all eligible patients
Maternal and Newborn Infant Clinical Outcome Review Programme	Yes	Continuous audit of all eligible patients
Medical and Surgical Clinical Outcome Review Programme	Yes	Continuous audit of all eligible patients
> Testicular Torsion	Yes	All selected cases were completed
> Community Acquired Pneumonia	Yes	All selected cases were completed
> Endometriosis	Yes	All selected cases were completed
> Transition for child to adult health services	Yes	All selected cases were completed
Mental Health Clinical Outcome Review Programme	No	N/A to our Trust
Muscle Invasive Bladder Cancer Audit	No	*Not participated (very low numbers)
National Adult Diabetes Audit:	Yes	
> National Diabetes Core Audit	Yes	Continuous audit of all eligible patients
> National Diabetes Foot care Audit	Yes	Continuous audit
> National Diabetes Inpatient Safety Audit	Yes	Continuous audit of all eligible patients
> National Pregnancy in Diabetes Audit	Yes	Continuous audit of all eligible patients
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme:	Yes	
> Adult Asthma Secondary Care	Yes	Continuous audit of all eligible patients
> Chronic Obstructive Pulmonary Disease Secondary Care	Yes	Continuous audit of all eligible patients
> Paediatric Asthma Secondary Care	Yes	Continuous audit of all eligible patients
> Pulmonary Rehabilitation-Organisational and Clinical Audit	No	N/A to our Trust
National Audit of Breast Cancer in Older Patients	Yes	Continuous audit of all eligible patients
National Audit of Cardiac Rehabilitation	Yes	Continuous audit of all eligible patients
National Audit of Cardiovascular Disease Prevention (Primary Care)	No	N/A to our Trust
National Audit of Care at the End of Life	*No	Non-participation formally agreed via governance meetings.
National Audit of Dementia	Yes	80 pts / 100% of sample

National Audit of Pulmonary Hypertension	No	N/A to our Trust
National Bariatric Surgery Registry	No	N/A to our Trust
National Cardiac Arrest Audit	Yes	Continuous audit of all eligible patients
National Cardiac Audit Programme:	Yes	
> National Congenital Heart Disease	No	N/A to our Trust
> Myocardial Ischaemia National Audit Project	Yes	Continuous audit of all eligible patients
> National Adult Cardiac Surgery Audit	No	N/A to our Trust
> National Audit of Cardiac Rhythm Management	Yes	Continuous audit of all eligible patients
> National Audit of Percutaneous Coronary Interventions	No	N/A to our Trust
> National Heart Failure Audit	Yes	Continuous audit of all eligible patients
National Child Mortality Database	Yes	Continuous audit of all eligible patients
National Clinical Audit of Psychosis	No	N/A to our Trust
National Early Inflammatory Arthritis Audit	Yes	Continuous audit of all eligible patients
National Emergency Laparotomy Audit	Yes	Continuous audit of all eligible patients
National Joint Registry	Yes	Continuous audit of all eligible patients
National Lung Cancer Audit	Yes	Continuous audit of all eligible patients
National Maternity and Perinatal Audit	Yes	Continuous audit of all eligible patients
National Neonatal Audit Programme	Yes	Continuous audit of all eligible patients
National Ophthalmology Audit Database	Yes	Continuous audit of all eligible patients
National Paediatric Diabetes Audit	Yes	Continuous audit of all eligible patients
National Perinatal Mortality Review Tool	Yes	Continuous audit of all eligible patients
National Prostate Cancer Audit	Yes	Continuous audit of all eligible patients
National Vascular Registry	No	N/A to our Trust
Neurosurgical National Audit Programme	No	N/A to our Trust
Out-of-Hospital Cardiac Arrest Outcomes	No	N/A to our Trust
Paediatric Intensive Care Audit	No	N/A to our Trust
Perioperative Quality Improvement Programme	No	N/A to our Trust
Prescribing Observatory for Mental Health:	No	
> Improving the quality of valproate prescribing in adult mental health services	No	N/A to our Trust
> The use of melatonin	No	N/A to our Trust
Renal Audits:	No	
> National Acute Kidney Injury Audit	No	N/A to our Trust
> UK Renal Registry Chronic Kidney Disease Audit	No	N/A to our Trust

Respiratory Audits		
> Adult Respiratory Support Audit	*No	Not participated - difficulties in early stages
> Smoking Cessation Audit- Maternity and Mental Health Services	N/A	Postponed by provider
Sentinel Stroke National Audit Programme	Yes	Continuous audit of all eligible patients
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Yes	All incidents reported
Society for Acute Medicine Benchmarking Audit	No	Not participated
The Trauma Audit & Research Network (TARN)	Yes	Continuous audit of all eligible patients
UK Cystic Fibrosis Registry	Yes	Continuous audit of all eligible patients
UK Parkinson's Audit	Yes	100% of sample

Table 1

Information on Participation in Clinical Research

The conduct of clinical research has never been more important to the UK Government, NHS and the Life Sciences industry. The UK is a Global leader in delivering innovative research with medicinal and pharmaceutical products in the top 3 goods exported from the UK. The government is keen to maintain the UK's global ranking and reputation for high quality research. The life science industry in the UK turns over £89 billion annually. Much of this work is conducted in partnership or close collaboration with universities and the NHS.

Research is core business of the NHS, and this is demonstrated by the recent publishing of a series of key strategies. The Health and Care Act (2022) placed new legal duties on Integrated Care Boards around the facilitation and promotion of health research and the use of evidence obtained from research in the delivery and development of health services. Integrated Care Systems have been encouraged to develop a research strategy and strategic development work has commenced in the South West with collaboration across Somerset, Devon and Cornwall along with the Academic Health Science Network. Additionally, implementation of the Chief Nursing Officer for England's strategic plan for research has commenced and Health Education England has published its' research and innovation strategy for Allied Health Professionals. All of this makes a rich background and culture for research and development to thrive.

Information on the use of Commissioning for Quality and Innovation (CQUIN) payment framework

Somerset Integrated Care Board, our principal commissioner of services, sets annual targets under the framework for Commissioning for Quality and Innovation (CQUIN), the aim of which is to improve the quality of services delivered to patients. The achievement of the CQUIN standards generates additional income for the Trust, of up to 1.25%.
In 2022/23 the five CQUIN indicators selected for the contract were:

- CCG1: Staff flu vaccinations
- CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+
- CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions
- CCG6: Anaemia screening and treatment for all patients undergoing major elective surgery
- CCG7: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service

The financial risk associated with performance of the CQUIN indicators was removed during 2022/23 due the CQUIN income being included in the block contract value.

Information relating to registration with the Care Quality Commission (CQC) and special reviews / investigations

The Trust was registered with the Care Quality Commission (CQC), with no conditions on registrations. This registration has now been merged with Somerset NHS Foundation Trust.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period. The Care Quality Commission has not taken enforcement action against the Trust during 2022/23.

Information on the quality of data

Secondary Uses Service Data

The Secondary Uses Services (SUS) is the single comprehensive repository for healthcare data in England which enables a range of reporting and analysis to support the NHS in the delivery of healthcare services. SUS is a secure data warehouse that stores this patient level information in line with national standards.

The Trust submitted records during 2022/23 to SUS for inclusion in the Hospital Episode Statistics which are included in the latest published data, see table below.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.9% for admitted patient care;
- 100% for outpatient care; and
- 99.5% for accident and emergency care.

The percentage of records in the published data which included a valid General Medical Practice code was:

- 100% for admitted patient care;
- 99.9% for outpatient care; and
- 100% for accident and emergency care.

Secondary Uses Service Data

Information Governance Assessment Report / Data Security & Protection Toolkit

The Trust recognises data security and information governance as a high priority and continues to ensure that high standards are met throughout the organisation. The NHS Digital Data Security & Protection Toolkit (DSPT) is an annual self-assessment tool that requires the Trust to provide evidence of compliance with the standards laid down by the National Data Guardian's (NDG) review published in 2016.

Somerset FT Data Security and Protection Toolkit submission for 2022/23 will be completed in June 2023. It is expected that all mandatory evidence items will be reached, with an assessment status of 'standards exceeded'.

In line with the DSPT reporting tool, two incidents were reported to the ICO in 2022/23. Both incidents related to information being shared in error.

All incidents were fully investigated; action plans created where appropriate and additional targeted IG training sessions made available. The ICO was notified, and no further action was required. Data security and information governance breaches were reported and monitored through the Data Security and Protection Group, which, in turn, reports to the Quality and Governance Assurance Committee.

Payment by Results Clinical Coding Audit

The Trust was not subject to a Payment by Results clinical coding audit during by NHS Improvement in 2022/23.

Actions to improve data quality

A series of Clinical Coding audits were undertaken by an NHS Digital Approved Clinical Coding Auditor on behalf of the Trust. This examined the clinical coding accuracy of 200 Finished Consultant Episodes (FCEs) for activity between 1 April 2022 and 31 March 2023.

Spells tested	%of HRG changes	Pre-audit value	Post-audit value	Net change	Net change %
200	6.5%	£467,257	£460,371	-£6,886	1.5%

Clinical coding audits summary of results

The areas reviewed were a random sample covering, but not limited to, the following core specialities: general medicine, general surgery, trauma and orthopaedics, paediatrics, obstetrics, gynaecology and day theatre activity.

The coding accuracy achieved the highest Standards Exceeded Data Security and Protection Toolkit attainment level. Compared to the 2021/22 audit this has highlighted the Trust has maintained the highest Standards Exceeded DSPT attainment level. Of note, the auditor identified that all but 1 error were coder errors indicating that source material, both full paper case notes and electronic patient records, are of good quality and fit for purpose.

Acute Trust	Primary diagnosis correct	Secondary diagnosis correct	Primary procedure correct	Secondary procedure correct
Standards exceeded	>=95%	>=90%	>=95%	>=90%
Standards met	>=90%	>=80%	>=90%	>=80%
Yeovil District Hospital	**97%**	**95%**	**97%**	**96%**

Summary of coding accuracy

The joint largest sources of error identified from the audit stemmed from the ‘Secondary Diagnosis Omitted’ and Secondary Diagnosis Not Required’ error keys, these accounted for 40 errors each for a total of 80 errors. Despite the Trust achieving the highest Standards Exceeded attainment level these error keys can be indicative of a difficulty in extracting the salient information without straying over into “over coding” incidental or irrelevant conditions.

The error rate resulted in a potential net financial overcharge of £6,886 (1.5%) to the commissioners for the sample audited. This was the result of 13 Healthcare Resource Group (HRG) changes (6.5%) with a gross change totalling £14,100 (3.1%). However, this financial analysis is not a true representation of the financial impact on the trust as the majority of activity is billed as per local agreements rather than National Tariff and the results should not be extrapolated further than the actual sample audited.

The Trust will be taking the following actions to improve data quality:

- Clinical Coding Audit findings will be fed back to the Clinical Coders both on an individual basis as well as a group session highlighting all sources of coder error with all required post audit training implemented/scheduled in a timely manner as per each audit’s action plan.
- Particular focus will be given to secondary diagnosis assignment training.
- In line with the YDH Data Quality policy we have identified roles and responsibilities across the hospital to achieve good data quality. To assist in this the YDH Data Quality Steering Group is responsible for monitoring and compliance of coding standards with a particular focus on reporting. It also monitors the Trust Risk Register and reports on the standards of Data Quality, and monitors the implementation of any recommendations from both internal and external authorities in the Trust to the Information Governance Steering Group.
- Utilise healthcare intelligence from Dr Foster and Summary Hospital Level Mortality Indicator (SHMI) in addition to key external performance frameworks such as the model hospital and more specifically the Data Quality Maturity Index (DQMI) to help both monitor and improve data quality at source.

> The latest DQMI score for YDH as of January 2023 was 88.6% against the National Average score for the same time period of 74.0%

2.3 Performance against national core set of quality indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by NHS Digital. There is currently a review of the existing Operating Framework Indicators and this has meant that the March 23 publication of these metrics has been delayed and has not subsequently been made available.

The Trust's performance against these indicators is shown below. For each indicator, the Trust is also required to make an assurance statement.

Organisational health indicators

Indicator	Source	Latest date range	21/22 value	20/21 value	Best performance (national)	Worst performance (national)	National average	National target
Staff sickness	NHS Digital	Apr 22 to Mar 23	4.4%	4.2%	0.5%	9.6%	5.1%	3.8%
Staff turnover	Trust	Apr 22 to Mar 23	18.7%	16.4%	8.6%	21.8%	15.0%	15%
NHS staff survey response rate	NHS Digital	Mar 22	49%	57%	68.8%	26.2%	44.5%	-

The Trust considers that this data is as described as this is the latest available on the NHS Digital website and where necessary our internal data intelligence. Trust's response rate for the national staff survey has decreased but the response rate across all Acute Trusts in the last year.

Effective Indicators

Indicator	Source	Latest date range	21/22 value	20/21 value	Best performance (national)	Worst performance (national)	National average	National target
Palliative care coding	NHS Digital	Dec21-Nov22	64.0%	64.0%	64.0%	11.0%	39.5%	-
SHMI	NHS Digital	Dec21-Nov22	0.90	0.95	0.72	1.19	1.00	1.00
PROMS: Hip replacement EQ VAS	NHS Digital	Apr 21 to Mar 22	No data	No data	-	-	69.7%	-
PROMS: Hip replacement EQ 5D index	NHS Digital	Apr 21 to Mar 22	No data	No data	-	-	89.9%	-
PROMS: Hip replacement Oxford Hip Score	NHS Digital	Apr 21 to Mar 22	No data	No data	-	-	97.3%	-
PROMS: Knee replacement EQ VAS	NHS Digital	Apr 21 to Mar 22	No data	No data	-	-	59.3%	-
PROMS: Knee replacement EQ 5D index	NHS Digital	Apr 21 to Mar 22	No data	No data	-	-	82.1%	-
PROMS: Knee replacement Oxford Knee Score	NHS Digital	Apr 21 to Mar 22	No data	No data	-	-	94.6%	-

The Trust considers that this data is as described as this is the latest available on the NHS Digital website. There has been no data for the PROMS programme due to the reduction in the number of elective surgeries during the COVID-19 pandemic and this continues to affect this year's figures with surgery levels and responses below minimum reporting levels. Both SHMI and Palliative Care coding remain consistent with previous years and the Trust continues to perform well in these indicators.

Caring indicators

Indicator	Source	Latest date range	21/22 value	20/21 value	Best performance (national)	Worst performance (national)	National average	National target

MSA breaches	NHS Digital	Apr22-Mar23	0.0	0.0	0.0	0.4	0.0	-
Complaints rate	Trust	Apr22-Mar23	0.68	0.49	-	-	-	-
Staff: friends and family test	NHS Digital	Feb-23	6.40	-	-	-	6.60	-
Maternity: friends and family test	Trust	Apr22-Feb23	100.0%	100.0%	100.0%	64.0%	91.8%	-
Inpatients and day cases: friends and family test	Trust	Feb-23	95.0%	98.4%	100.0%	77.0%	94.0%	-
Emergency Department: friends and family test	Trust	Feb-23	93.0%	98.3%	100.0%	49.0%	80.0%	-

The Trust considers that this data is as described as this is the latest available on the NHS Digital (HSCIC) website and where necessary our internal data intelligence. All caring indicators are in line with expectations.

Safe indicators

Indicator	Source	Latest date range	21/22 value	20/21 value	Best performance (national)	Worst performance (national)	National average	National target
VTE risk assessment	NHS Digital	Apr22-Mar23	83.3%	95.8%	-	-	-	95.0%
Percentage of Patient Safety Alerts (PSA) completed within the required timeframe	NHS Digital	Apr22-Feb23	-	-	-	-	-	-
Never events	NHS Digital	Apr22-Mar23	3	2	0	10	-	-
Emergency C-section rates	Trust	Apr22-Mar23	31.6%	32.9%	7.1%	38.7%	37.7%	-
Rate of C.diff infection per 100,000 bed days	NHS Digital	Apr22-Mar23	9	12	-	-	-	-
MRSA bacteraemias	NHS Digital	Apr22-Mar23	83.3%	95.8%	-	-	-	95.0%
Rate per 1000 bed days: patient safety incidents	Trust	Apr 22 to Mar 23	52.7	54.3	-	-	-	-
Percentage of patient safety incidents that resulted in severe harm or death	Trust	Apr 22 to Mar 23	0.180%	0.120%	-	-	-	-

The Trust considers that this data is as described as this is the latest available on the NHS Digital (HSCIC) website and where necessary our internal data intelligence. The Trust intends to take the following actions to improve the following indicators, and so the quality of its services:

The maternity team undertake a review of every non-elective caesarean section to assess the clinical appropriateness of the decision making; and also recognise that an emergency caesarean section is always done in the best interests of mother and baby. The appropriateness of this target is an area of both national and local discussion.

Risk assessment framework indicators

Indicator	Source	Latest date range	20/21 value	19/20 value	Best performance (national)	Worst performance (national)	National average	National target
C.diff meeting the C.diff objective (all)	NHS Digital	Apr22-Feb23	9	12	-	-	-	-
Certification against compliance with requirements regarding access to health care for people with a learning disability	Trust Board Declaration	Apr22-Mar23	Compliant	Compliant	-	-	-	-
62 day wait for first treatment from urgent GP referral: all cancers	CWT return	Apr22-Feb23	65.8%	81.0%	100.0%	33.3%	75.9%	85.0%

62 day wait for first treatment from consultant screening service referral: all cancers	CWT return	Apr22-Feb23	61.6%	71.4%	100.0%	20.0%	64.5%	90.0%
31 day wait from diagnosis to first treatment: all cancers	CWT return	Apr22-Feb23	91.3%	95.1%	100.0%	52.6%	93.7%	96.0%
31 day wait for second or subsequent treatment: surgery	CWT return	Apr22-Feb23	84.7%	92.4%	100.0%	48.1%	84.3%	94.0%
31 day wait for second or subsequent treatment: anti-cancer drug	CWT return	Apr22-Feb23	97.8%	99.1%	100.0%	85.7%	99.0%	98.0%
Two week wait from referral to date first seen: all cancers	CWT return	Apr22-Feb23	58.4%	84.8%	100.0%	41.7%	80.7%	93.0%
Two week wait from referrals to date first seen: breast symptoms	CWT return	Apr22-Feb23	95.6%	91.4%	99.7%	4.0%	54.8%	93.0%
18 week maximum wait from point of referral to treatment (incomplete pathways)	NHSI return	Apr22-Feb23	67.9%	65.6%	100.0%	0.6%	65.7%	92.0%
Maximum 6 week wait for diagnostic procedures	NHSI return	Apr22-Feb23	70.2%	80.7%	100.0%	32.1%	74.6%	99.0%
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	NHSI return	Apr22-Mar23	73.0%	88.1%	100.0%	57.0%	68.3%	95.0%

The Trust considers that this data is as described as this is the latest available. All waiting times performances continue to be a challenge due to the post-Covid pandemic backlog and increased levels of activity in primary care and emergency departments, resulting in more admissions to hospital. The organisation is working collaboratively with system partners to address challenges in both bedded, and workforce, capacity which has and continues to impact on the Trust's ability to discharge patients in a timely way.

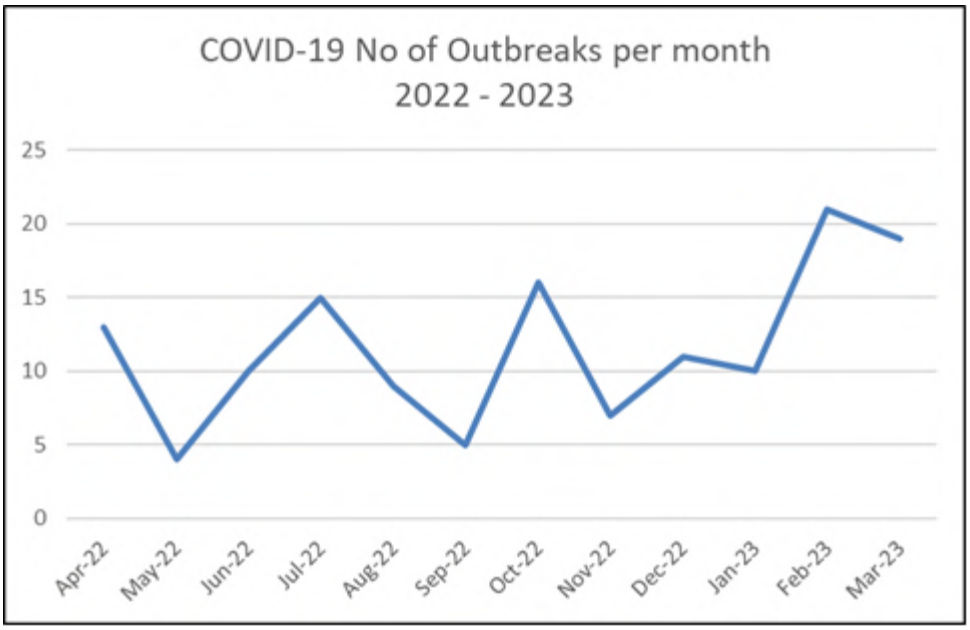
Part 3: Other information

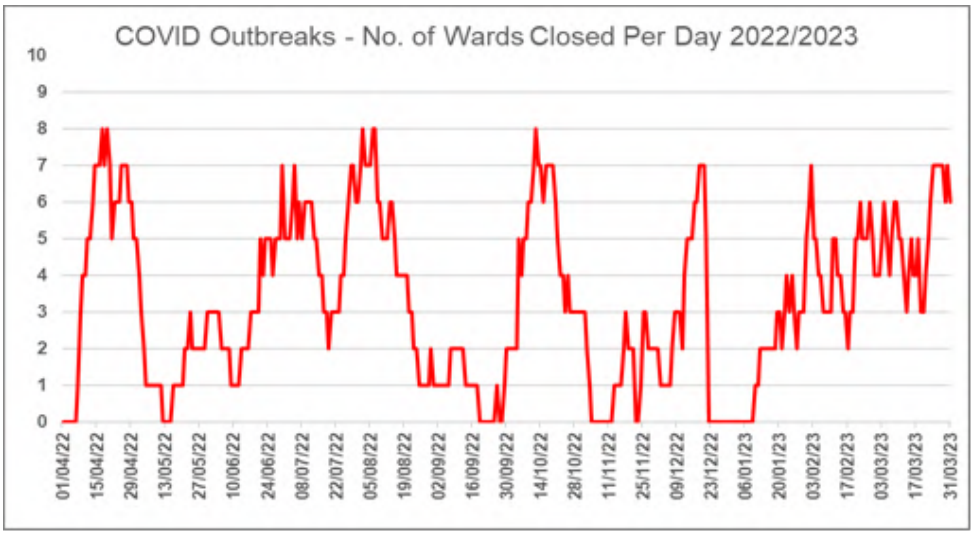
3.1 Patient Safety

- **INFECTION PREVENTION AND CONTROL DURING COVID-19**

Coronavirus disease (COVID-19) is caused by SARS-CoV-2, a newly emergent coronavirus first identified in December 2019. Cases are apportioned to trusts depending on the timeframe between first positive specimen and admission date:

- **Community** onset, positive specimen date ≥ 2 days after admission or hospital attendance (CO)
- Hospital-onset **Indeterminate** healthcare-associated, positive specimen date 3-7 days after admission (HO**I**HA)
- Hospital-onset **Probable** healthcare- associated, positive specimen date 8-14 days after admission (HO**P**HA)
- Hospital-onset **Definite** healthcare-associated, positive specimen date 15 days or more after hospital admission (HO**D**HA)





Outbreaks were managed in line with the Trust Management of COVID-19, Standard Operating Procedure. Key controls included isolation of all confirmed cases either in side-rooms or cohorted in bays and closing affected areas to new admissions. A total of 990 patients were affected, restrictions were in place for a total of 1,315 days with 1,253 bed days lost. By 21 December an unprecedented decision was taken to stop closing inpatient wards due to COVID-19 outbreaks. At this point, every effort was made to isolate confirmed COVID cases, but it became impossible to achieve due to the extreme pressure the Trust and the NHS was under at this period of the winter. As pressures eased by the end of January the usual management of outbreaks was reinstated.

Whilst the Trust was responding to the COVID-19 pandemic, it was still concentrating on other infection control priorities. It is a mandatory requirement for English NHS Acute Trusts to report Methicillin Resistant *Staphylococcus aureus* (MRSA), Methicillin Sensitive *Staphylococcus aureus* (MSSA), *Escherichia coli* (E.coli), *Klebsiella, Pseudomonas aeruginosa* bloodstream infections and *Clostridioides difficile* Infections (CDI) to the Department of Health via the HCAI Data Capture System, hosted by UK Health Security Agency. Case numbers of these infections are increasing nationally, and the reasons are not currently clear.

Traditionally, those infections that are Trust apportioned have been investigated using a recognised national process known as post infection review. This process was introduced during the mid-2000s in

response to high levels of MRSA bloodstream infections in the UK. In partnership with other strategies this was successful in driving down case numbers of this infection. As a result, this method has gradually spread to include other infections. However, over the last few years, this process has become more time consuming and is no longer proving effective in terms of infection reduction. Similar themes are identified and despite actions, overall case numbers are not reducing.

In August 2022, it was agreed to stop post infection reviews as there was no longer a national mandate to undertake them. The process was replaced locally with a shortened, targeted review. This aims to identify the source (where possible) and collect wider information that led to the infection. Rather than focusing on every infection, this information is thematically analysed to inform improvements. Although this process is still new several key themes have been identified:

- Previous colonisation with MSSA and presence of a peripheral vascular cannula (PVC) are strongly linked to the development of a *Staphylococcus aureus (*MRSA or MSSA) bloodstream infection.
- The presence of a urinary catheter is strongly associated with gram-negative bloodstream infections, in particular E. coli.

Relevant improvements have been commenced during the period of this report which include:

- MSSA screening, decolonisation and MSSA suppression in critical care which has significantly reduced their MSSA bloodstream infections
- A change to the skin cleansing product used prior to the insertion of a PVC has been implemented in all inpatient areas. Whilst it is early days since the change, signs of improvement are being seen.
- Trustwide improvement project on urinary catheter has commenced. This project is focussing on insertion, ongoing care and timely removal when no longer required. It is too early in the project to attribute success.

There is still significant progress to be made but the new process has allowed a change in focus away from the investigation to improvement.

Details of our response to Clostridioides difficile infection are included within the national indicator section.

3.2 Clinical effectiveness

Clinical audit

Clinical audit is a quality improvement and assurance tool, when carried out in accordance with best practice it:

- improves the quality of care and patient outcomes;
- provides assurance of compliance with standards; and
- identifies and minimises risk, waste and inefficiencies.

All clinical audit activity in YDH must be carried out with an explicit intention to improve, or assure, quality of care delivery. The Clinical Governance Team support all local and national clinical audit activity. Clinical audit activity is overseen by the Clinical Outcomes Committee. The tables below outline the recommendations and any action taken as a result of a selection of the local clinical audits undertaken during the reporting period.

National clinical audit

The following details the learning and outcomes from a selection of the national clinical audits during the reporting period.

NACAP COPD 2022

Audit Aim: The National Asthma and COPD (chronic obstructive pulmonary disease) Audit Programme (NACAP) is a collection of projects created with patients and designed to support improvements in the quality of care, services and outcomes for people with asthma and COPD. It includes collecting information from hospitals across England, Scotland and Wales to show which parts of asthma and COPD care are good and which parts could be better.

Report findings:

On review of publicly available data from the National Asthma and COPD Audit (NACAP), our Trust were consistently underperforming on some important metrics of Asthma and COPD care, NACAP wrote to us and wanted to understand the reasons for this. Specifically, the standard of care is for patients with asthma or COPD to be reviewed by a respiratory healthcare professional within 24 hours of admission and to receive a discharge bundle of interventions, which have been shown to improve their long-term care and prevent readmissions.

Compliance with both of these elements in more than 60% of patients for COPD and more than 50% for asthma leads to eligibility for the Best Practice Tariff or Aligned Payment and Incentive. Our recent records for Yeovil Hospital showed around 50% of our COPD patients have a specialist respiratory review within 24 hours and around 90% of our COPD patients receive a care bundle on discharge. For asthma, the figures have not been submitted.

The reason there were issues with review within 24 hours were due to us having a lot of patients who were staying down in ED for longer. We are not alerted to these patients until the day after or when they have been referred on the wards. We also had a lot of staff sickness and staff change over during this period. This will now be helped by the guidelines changing; we now have a 48-hour window to see COPD patients from time of admission.

Regarding the care bundle for COPD patients, we found a few that did not have the correct pieces signed, which would have caused a short fall in the data. Again, we had some patients we were unable to see, due to being admitted on the weekend or Friday evening and being discharged before Monday. This has been discussed and actioned now the team are back up to being fully staffed, this might enable us to cover Saturday shifts mitigate this.

We also found some patients were added onto the audit that were not appropriate, this has since been rectified going forward.

The Trauma Audit & Research Network 2022/23

Audit Aim: The Severn Major Trauma ODN was set up between 2010 and 2012 and launched in April 2012 along with over 20 other trauma networks in England. The purpose of the Networks was to improve the outcomes from major trauma. A number of national reports had demonstrated that outcomes could be improved and had made recommendations about how this could be achieved. The structure, function and service specification for the networks were based on successful systems elsewhere and the pilot networks in the UK.

Report findings: YDH is the best performing Trauma unit in the Severn Trauma Network.

There are no actions required for data quality/data completeness as per continues above national average Key Performance Indicators and engagement with the Severn Major Trauma Network via review of quarterly dashboard as well as Injury Severity Score >15 validation and discussion at Clinical Advisory Group meeting.
YDH data accreditation (quality) has been above national average >95% and
YDH data completeness at 100% for consecutive years up to mid-2022.

However, due to multifactor delays caused in receiving Trauma monthly list from information department between Aug, Sep and Oct 2022, Data reliability index page 8 report should be viewed with caution in March 2023 report, likelihood as per above delays and await response from TARN analyst. These issues are now rectified, and backlog submissions are now completed.

Areas for improvement:

Based on March/April 2023 reporting YDH is at great position in comparison to Somerset participating Trauma Units, no new SMART action plan is needed. YDH key performance indicators are above national targets, in line with NICE recommendations and standards. However, if Trauma mortality (Rate of Survivals) trending outside the normal lower limits (-2SD) values (i.e. - 3 SD from the mean (negative) then mortality auditing is recommended.

Local clinical audits

The following details the learning and outcomes from a selection of the local clinical audits during the reporting period.

Technical patient safety solutions for medicines reconciliation on admission of adults to hospital

Aim:

- To measure current practice in medicines reconciliation on admission of adults to inpatient settings as part of a continuous improvement programme. The NPSA released an alert in 2007 (Technical patient safety solutions for medicines reconciliation on admission of adults to hospital - NICE/NPSA/2007/PSG001) which lead to the Trust putting a policy in place to ensure all patients admitted to an acute adult ward received a full medicines reconciliation within 24 hours of admission. There is already a monthly rolling audit undertaken by the Trust to monitor the adherence to this and this audit is to establish the conformance in more detail and to identify the causes of the results.

Conclusion:

- The sources of information, Identification and Resolution of Discrepancies and documentation of Medicines Reconciliation at Admission standards are currently being met.
- The compliance to the standard of carrying out medicines reconciliation within 24 hours of admission did not reach the target compliance of 100% due to a number of patients taking non-conventional routes through the hospital to become inpatients (for example, through CDUP and FAU escalation bays).

Recommendations:

- A discussion whether the target compliance should be adjusted as it is not always feasible to reach 100%.
- Educate all pharmacy and medical staff the importance of documentation.

	> To re-audit once recommendations have been put in place.

Neuromuscular monitoring	
Aim: > To re-evaluate the compliance of Anaesthesia Doctors with documentation of use of nerve stimulator during anaesthesia and in reversing the Neuromuscular blocking agents. > To re-evaluate the documentation of the reverse medication agent used in reverse and its dose	Conclusion: > Compliance with documentation of the use of NMB monitors improved from 63.89% to 78.9%. (15% increase) > Compliance With Documentation of Reversing agent in notes improved from 58.33% to 73.6% (15.2% increase) Recommendations: > After arrival of new Quantitative neuromuscular monitors, teaching and training on these monitors to be arranged 1- Adding the guide of use of Quantitative neuromuscular monitors to the card/poster before attaching it to the anaesthesia machine. > Reaudit after 6 months

EPAC (Early Pregnancy Assessment Clinic) review of Beta-Human Chorionic Gonadotrophin (BHCG) when more than two are performed.	
> Aim: To assess if more than two BHCGs have been agreed by consultant as per EPAC guideline.	Conclusion: > In the one year snap shot, EPAC are not following the guideline. > 34% of clinical decisions to perform more than two BHCGs were not consultant decision. Recommendations: > Encourage EPAC nurses to challenge and remind. > To Incident report if more than two BHCGs are performed without consultant input. This will raise timely discussion and learning for clinician involved.

Summary Hospital-level Mortality Indicator (SHMI)

The number of deaths in hospital is captured through the Summary Hospital-level Mortality Indicator (SHMI). This reports mortality at trust level using a standard and transparent methodology which is published quarterly as a National Statistic by NHS Digital.

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. Data includes hospital deaths and those occurring 30 days after discharge. Our latest published SHMI covering 12 months December 2021 to January 2022 is 89.7, with 100 being the expected norm.

Hospital Standardised Mortality Rate (HSMR)

The trust uses Dr Foster to support analytical review of outcomes data. This includes reporting of the Hospital Standardised Mortality Ratio (HSMR), which reviews a set number of indicators to inform understanding of quality and improvements in clinical care.

The HSMR complements the SHMI by: focussing on deaths while in the care of the hospital, using more sophisticated risk models for individual diagnoses and providing more timely information than the SHMI.

Taken together, the HSMR and SHMI provide a powerful insight into hospital mortality. HMSR data is based on summary indicators using strict definitions which encompass a basket of 56 diagnosis groups, (made up of high-volume procedures and conditions) that account for around 85% of in-hospital deaths. The SHMI includes all diagnosis groups accounting for 100% of deaths.

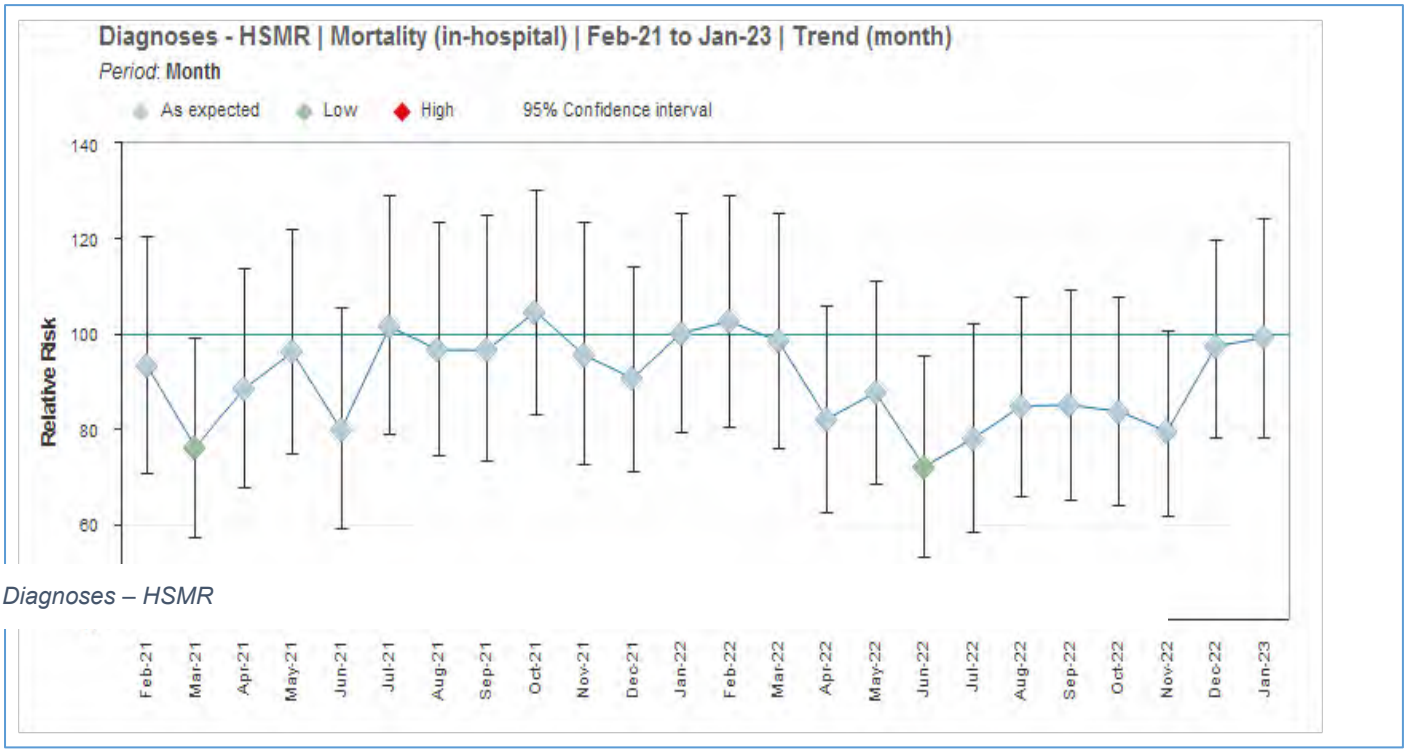
Other key differences in methodology include: HSMR is adjusted for more factors than the SHMI, most significantly patients receiving palliative care being excluded from the HSMR calculations. A further difference is seen in the fact that SHMI data includes post-discharge deaths, up to 30 days after discharge while the HSMR focuses on in-hospital deaths. The SHMI attributes a death to the last spell within an acute non-specialist trust, whereas the HSMR attributes a death across a continuous in-patient spell.

Both the HSMR and SHMI are reported with a significant data time lag allowing for analysis.

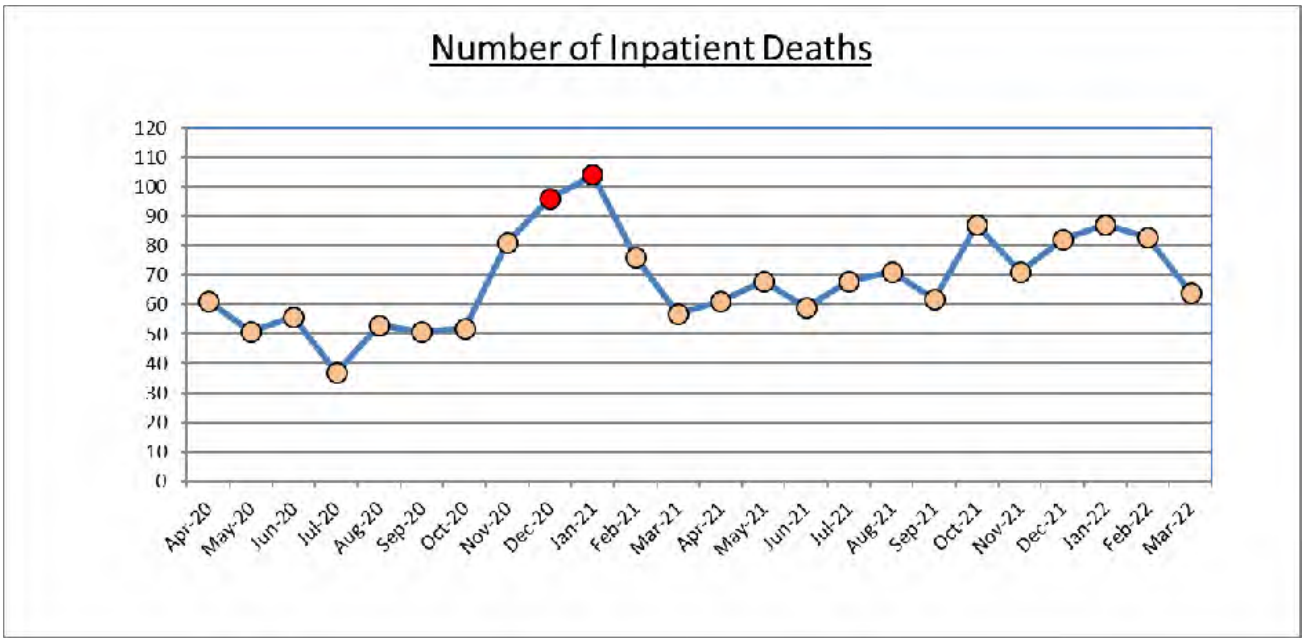
The trust HSMR is reported at 87.2, rolling year as at Jan 2023, which is a positive outcome and statistically lower than anticipated. This favourable position has been ratified and monitored throughout the year and it is believed to be due to a combination of factors including the good practice of identification and management of patients at the end of life and efficient coding of existing patient comorbidities.

HSMR is calculated based on the relative risk, the ratio of the observed negative outcomes to the expected number of negative outcomes, multiplied by 100. The national average, benchmark figure is always 100, hence figures below 100 represent performance better than the benchmark.

The chart below shows the HSMR trend over the last 2 years.



Diagnoses – HSMR



Inpatient deaths 2021/22

- **KEEPING CHILDREN WITH MENTAL HEALTH NEEDS SAFE ON OUR PAEDIATRIC WARDS**

A recent report from the Healthcare Safety Investigation Branch (HSIB), focussing on 18 general paediatric wards in England, found that the majority had unsafe care environments to care for young people exhibiting high risk behaviours attributed to a mental or emotional health crisis. It has called for immediate action to be taken by ICBs and NHS organisations to facilitate a system-wide response to reduce the safety and wellbeing risks associated with children and young people with high-risk behaviours on their wards.

As an integrated Trust covering acute and mental health services, Somerset FT was in a unique position to address this issue and had already implemented a number of improvements in our paediatric wards at Musgrove Park Hospital, as well as Yeovil District Hospital, and in the community, supported by our Child and Adolescent Mental Health Services (CAMHS) teams.

These include:

- Wrap around care provided by colleagues recruited, trained, and supervised by the Community Eating Disorders (CED) team, but working within the acute paediatric team to provide continuity of care, education, and care to this specific patient group. This has received positive feedback from both patients and colleagues worked well and relieved exposure to nursing staff that were feeling stressed and demoralised by the work being requested.
- Implementing bespoke “Positive Behaviour Management” educational courses, that include de-escalation and safe holding training for use with CAMHs and CED patients, for all our colleagues in acute paediatric wards at MPH and YDH.
- Prioritising supporting young people to share their views and experiences. We do this through anonymous feedback services such as 'care opinion' and weekly face to face engagement sessions led by a ward based youth worker. On admission, or ideally before, we look to create individualised and collaborative care plans with our young people and members of our integrated care team.
- CAMHS liaison practitioners operate across both paediatric sites in Somerset. We operate a fully integrated eating disorder service spanning community and acute settings. A ward based RMN guides the inpatient management for young people admitted with an eating disorder alongside the specialist consultant, a specialist paediatric nurse and trained Health Care Assistant.
- Liaison with Children’s Social Care (CSC) regarding complex and potentially violent patients, those who may have no safe place to reside, including the provision of two places of safety houses

available in Somerset offering therapeutic education avoiding prolonged stays in the hospital environment. There is planning in place for a further 6 houses.

- Where hospital admission is not deemed to be therapeutic, we aim to avoid through regular high intensity user group meetings (HIUG) between paediatrics, CAMHS liaison and the Emergency Department, where bespoke plans are designed to be implemented. Alternative provisions are actively sought when deemed more appropriate through effective joined up systems including social care, mental health and therapeutic educational settings, such as those established by the unique project 'Homes and Horizons' . This projects success rests on an innovative ten-year partnership between Somerset county council, Homes2Inspireand NHS Somerset and will provide 10 homes in Somerset offering high needs foster care for the most vulnerable.
- Where severe mental health illness prevents a safe discharge home, we are working collaboratively with the provider collaborative and our local tier 4 GAU Wessex House to ensure safe and effective shared care arrangements when needed, specifically for those under the mental health act who require physical healthcare alongside mental healthcare in our "blended care" model.
- We are in the process of creating sanctuary spaces on our wards and our Emergency Departments, away from the "hustle and bustle" and highly stimulating sensory environment, to aid with de-escalation in a crisis. We have secured all entrances and exits, and risk assess the environment on a regular basis. It does however remain a challenging environment to work with at times due to historical design and layout.
- Within the community we have refined and built on the **Children and Young People's Neurodevelopmental Partnership** (**CYPNP**), creating a single point of access, triage, and educational packages to schools.
- We have secure links with liaison psychiatry and are establishing synergistic relationships with our colleagues in Wessex House (tier 4 General Adolescent Unit) to ensure safe and effective shared care arrangements when needed, specifically for those under a mental health act. There has been opportunity for our staff nurses to shadow nurses in Wessex House and vice versa. We support regular opportunity for reflective practise for all. Training includes online "we can talk" modules , experiential learning and situational SIMs. Rolling medical teaching schedules cover aspects of mental health.

There is still further work to do to meet the needs of this specific population, including further improvements to the environment and the potential for in-reach services from the GAU. We are exploring the opportunities for service improvement, and we will be working with the provider collaborative to identify new models of care.

- **MATERNITY SERVICES**

In the year from 2022/2023, the maternity services in Somerset have continued a positive journey of integration and development across many areas, including culture, governance, workforce wellbeing, training, and clinical pathways. This has been recognised with regional achievement awards for System leadership co-production and working, women's public health improvements and implementation of National Bereavement Care Pathways. There are three specific areas of quality work which are transforming ways of working and improving safety.

Better Births in 2016, identified the need for enhanced digital maternity services to improve safety with single patient records throughout the maternity pathway and for service users to have access to their digital records through a patient portal. The challenges to achieve this level of digital availability in Somerset, where the two acute trusts use different electronic health records has been overcome, to achieve a single maternity record across somerset, accessible by service users, and staff, which went live in February 2023.

In Somerset, both Musgrove Park Hospital and Yeovil District Hospital have previously signed a commitment to the UNICEF Baby Friendly Initiative. This is a global initiative which builds upon interlinking evidence- based standards for maternity, neonatal and paediatric services, designed to provide parents with the best possible care to build a close and loving relationship with their baby and to feed their baby in

ways which will support optimum health and development. In this last year, there have been four successful assessments across the organisation, in both the neonatal and maternity services, with the maternity service at Taunton achieving reaccreditation of Gold sustainability for another three years. This is an incredible achievement and is evidence of the high level of Trust commitment towards these standards, acknowledging the positive impact on future health and wellbeing of both mothers and babies and supporting the initiative with staff, patients and visitors to our services. The success of this will underpin the next steps for the neonatal and maternity systems on both sites to continue their accreditation journey and reach the ambition of becoming a Gold Sustainable County with achievement across all domains, to include health visiting.

Nationally equity and inclusion are high on the health agenda with black mothers' disproportionality in danger during pregnancy and the first year after birth, with black mothers four times more likely to die and twice as likely to have a stillbirth. Recognising the disparity that exists in Somerset, with disadvantaged groups, vulnerabilities, and social deprivation, two midwives at Yeovil developed 'Implicit Bias' training. This training explores culture and attitude with an emphasis on the language used and social 'norms'. This training has been so successful it is being rolled out across the southwest region, with other areas expressing interest, including universities. The team has won an HSJ award for safety improvements in maternity care and were shortlisted at the RCM awards for inclusion working. As a result of this training, the Southwest Academic Health Science Network have funded black mother and baby mannequins for every maternity unit in the region. Train the trainer sessions have now taken place regionally to ensure ongoing roll out of this great work.

3.3 Patient experience

Patient engagement

- **TOM'S STORY**

Tom was due to come into hospital for a routine operation requiring general anaesthesia. Tom has learning difficulties so his mum helps him with sign language and understanding and was able to speak with the Learning Disabilities and Autism Liaison Practitioner who arranged for Tom to visit the day surgery unit before the day of the procedure. Tom would have been incredibly anxious to arrive in an unfamiliar environment, meeting people for the first time and may not have coped to have general anaesthesia in an unsettling environment. By arranging a pre-visit to the day surgery unit and the recovery room, Tom was able to visualise and ask questions about what would happen on the day. Tom's mum also took photographs to build Tom a social story that he could look over at home before the day of the procedure. When the operation day arrived, Tom was very comfortable to have the procedure as he had a full understanding of what was going to happen, that had been delivered in a way to meet his individual needs.

Tom and his mum were very keen for their experience to be shared to aid learning, so they kindly agreed to be filmed for us to use as part of the Chief Nursing Officer training box set of short videos, that the trust is producing. Tom's story will be shared to educate staff regarding communication, to demonstrate that all patients have discrete requirements that we must consider delivering the best patient experience.

In addition, we have continued to use Tom's story within the Trustwide improving accessibility working group as an example of how we can adapt a typical approach to accessing healthcare into one which is personalised and meets an individual's own needs.

- **WORKING COLLABORATIVELY AND COMPASSIONATELY WITH A PATIENT FOLLOWING A CONCERN RAISED**

The Patient Advice and Liaison Service (PALS) were contacted by a patient who was seeking help. The patient, Mrs S, described that she had recently been through a very traumatic surgical procedure at the hospital and in her correspondence with PALS, she was able to describe the very profound impact that her experience had had on her. Not only did Mrs S have several questions about her experience, but she also

needed to have further surgical intervention and she was highly anxious about this, to the point that she was unable to consent to the much-needed surgical procedure.

PALS worked swiftly and collaboratively with the clinical teams and Mrs S, gathered a response, and went above and beyond to work with the day surgery team to support Mrs S with her further surgery. Reasonable adjustments were made to enable Mrs S to wait in another area due her trauma response to her first procedure. The surgical team were made aware that Mrs S was highly anxious about coming back into hospital and they were empathetic and understanding, doing all they could to enable Mrs S to have a positive experience.

After the procedure, Mrs S came back into hospital with her husband and they both met with the PALS advisor who had worked so diligently to support them. Mrs S gave a thank you card to the PALS advisor, the surgeon and the anaesthetist for their wonderful care and empathy and said she had no worries about coming back in a years' time for her next procedure.

This case study has also been used as part of the service review of our PALS and complaints team to ensure that we continue to put our patients and their loved ones at the centre of all we do and to compassionately and collaboratively engage with those who have been affected by their experiences of our services.

Annex A: Statement from Council of Governors

Annex B: Statement from the Somerset ICB

Annex C: Statement from Dorset ICB

Annex D: Statement from Healthwatch

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	SFT Quality Account
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Steve Thomson, Director of Integrated Governance
PRESENTED BY:	Phil Brice, Director of Corporate Services
DATE:	5 September 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 SFT Quality Report – incorporating the Quality Account – is a report about the quality of services provided by Somerset NHS Foundation Trust in 2022/23. The Quality Account is a requirement as set out in the Health Act 2009 with amendments made in 2012, such as the inclusion of quality indicators. Guidance for 2022/23 once again confirmed that there was no requirement for an external audit opinion on the Quality Account. For 2022/23, the Trust focussed on six flagships - the priority programmes for delivering the five clinical care and support strategy aims: • Aim 1: Improving the health of our population • Aim 2: Best care • Aim 3: Local communities, • Aim 4: Value all people alike • Aim 5: Personalised, coordinated care The flagship projects and programmes were delivered at team and / or service group level and monitored within the Board Assurance Framework. The report has been shared with Healthwatch, the Oversight and Scrutiny Committee, Governors and the Integrated Care Board for Somerset and Dorset. Stakeholder statements are included within the report.
Recommendation	The Board is asked to discuss the Quality Reports/Quality Accounts and agree that the reports accurately reflect performance against the objectives.

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

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

Equality and Inclusion
The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
The Trust is committed to reducing inequalities across all services provided. The priorities as described and addressed in the Quality Account align to the NHS priorities set out in the NHS Long Term Plan and Operational Planning Guidance and have specific focus on reducing inequalities. The merger with Yeovil District Hospital NHS Foundation Trust was planned to provide better care for our patients and ensure that everyone in the county enjoys consistent access to high quality services. The merger eliminates organisational boundaries and puts us in a better position to support people to stay well, give equal opportunity to mental and physical health and delivery services in the most appropriate setting. As services have been and are integrated, the potential impact on individuals with protected characteristics is considered in the planning and implementation phases. This will include wider engagement with various stakeholders. A number of specific initiatives have been implemented within the year to address inequalities as detailed within the report.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History
How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
The Quality Account has been drafted within wider engagement and involvement of colleagues. In addition, the reports have been shared with external agencies as described above and their stakeholder statements are included within 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 Quality Accounts are published annually. Oversight of delivery of the objectives is delegated to the Quality and Governance Committee and within the Board Assurance Framework as reported to the Board Assurance Committees and directly to the Board.

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

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

Somerset NHS Foundation Trust

Quality Report 2022/23 – incorporating the Quality Account

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A report on the quality of the care we offer
and how we are seeking to improve
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Somerset NHS Foundation Trust

Quality Report 2022/23 – including the Quality Account

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PART ONE: STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

Welcome to the annual quality account and report for Somerset NHS Foundation Trust, for the financial year 2022/2023.

This year was an extremely important one as we prepared to merge Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust, and at the same time focussed on providing care and support for those who needed it and supporting those patients and service users whose care was delayed as a result of the COVID-19 pandemic.

We merged on 1 April 2023 because we want to provide better care for our patients and ensure that everyone in the county enjoys consistent access to high quality services irrespective of where they live. Working as one organisation, and therefore eliminating organisational boundaries, puts us in a better position to support people to stay well, give equal priority to mental and physical health, deliver services in the most appropriate setting, help us to further improve care for our patients and service users, and make better use of our resources.

As a merged trust we are a unique NHS organisation that provides acute services from Yeovil District Hospital and Musgrove Park Hospital, community-based services, and services from our 13 community hospitals in Somerset, mental health and learning disability services across the county, and we mange through our subsidiary company, Synphony Healthcare Services, a quarter of the county's GP practices.

During 2022/3, as part of our preparations to merge with Yeovil District Hospital NHS Foundation Trust, we looked afresh at our existing clinical strategy, engaging our colleagues, services and partners, to ensure it remained relevant. The aims of our refreshed clinical strategy form part of our organisational strategic objectives, are shared with our partners on the Somerset Integrated Care Board, and are to:

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

Since our current trust was formed - providing mental health, community services and services from community hospitals, and mental health and learning disability services - we have organised a number of our quality objectives into flagship programmes that go to the heart of what we aim to achieve. This quality report provides details of those programmes and our progress in 2022/23 and our priorities for those important programmes for 2023/24.

2022/23 was undoubtedly a challenging year for the NHS but one in which we made significant steps to put us on a good footing for the future. However, it is important to note that we faced operational challenges as we sought to care for those patients who

needed urgent treatment - and treat those who had waited a long time for treatment - while we faced continued difficulty to discharge patients when they were medically fit.

As we grappled with these challenges, we looked to innovative solutions and one of these were “ready to go” units at both Musgrove Park Hospital and Yeovil District Hospital (YDH). These dedicated units, focus on rehabilitation and reduce the risk of patients deconditioning while they wait to leave hospital. This new model of care was so successful that it reduced the support some patients needed after they were discharged.

Our colleagues, sites and services continued to innovate in order to provide care in a number of settings and new facilities, providing easier access and or more capacity to help us reduce waits for services. Examples of these in 2022/23 are:

- A new ophthalmology diagnostic centre, near junction 25 of the M5, is a “one stop shop” that enables patients to have a range of diagnostic tests in the same appointment. A second centre, run by Yeovil District Hospital NHS Foundation Trust, opened later in the year in Yeovil’s Quedam Shopping Centre. These centres build on the NHS’ aim to develop a series of community diagnostic centres away from acute hospital sites and will enable us to reduce the delays patients have experienced as a result of the pandemic and help us to meet the challenge of future demand for ophthalmic services.
- A new specialist community hub in the Horizon Centre in Taunton is providing children and young people with emotional and mental health support in a relaxed setting. A multi-disciplinary team of NHS professionals works alongside a range of voluntary and third sector organisations at the hub, which is run in partnership by our trust and Young Somerset.
- Two facilities in Bridgwater. The first, in partnership with Open Mental Health, provides support for people with mental health challenges. Depending on a person’s needs, support is provided by the NHS or one of a wide range of third sector partners, including, Citizen’s Advice, Age UK Somerset or Second Step, a community mental health charity. The second facility is a health and wellbeing hub located in the former Victoria Park medical centre that provides a range of services for people of all ages from pre-natal to end of life care.
- A new £11.5 million surgical decision unit at Musgrove Park Hospital means that our surgical teams can assess patients more rapidly to determine whether they need emergency surgery or can be safely discharged home. The unit, that is part of our ambitious Musgrove 2030 programme, brings surgeons, emergency doctors and other healthcare professionals closer together, with a much better environment for patients and colleagues.
- A community investigation hub at Burnham-on-Sea Community Hospital means that many patients no longer need to travel to Musgrove Park Hospital for hospital-related blood tests. It also means that they can get their tests done before they see a hospital consultant, which saves time or additional hospital appointments.
- Farmers and agricultural workers can access health and emotional wellbeing support at two new health hubs at Frome Livestock Market and Exmoor Farmers Livestock Auction. Along with general health checks, farmers can get specialist

advice from NHS professionals about lifestyle, as well as any concerns about their emotional wellbeing and mental health.

- Surgeons performed the first total hip replacement as a day case procedure. This means the patient can assessed, operated on, and be discharged from hospital on the same day, back to their home environment to continue their rehabilitation and recovery. This will significantly increase our capacity for hip and knee surgery, which will help to reduce the backlog created during the COVID-19 pandemic when most non-urgent surgery was suspended across the country.

I want to end by thanking all my colleagues within the trust, our partners, our volunteers, our charities and the families and carers who support our patients. Without their hard work, dedication and commitment, we would not have been able to make the progress we have. Thank you once again for all that you do for the people and patients of Somerset and the services that we provide.

Signed

PETER LEWIS
Chief Executive

ABOUT US

Somerset NHS Foundation Trust was formed on 1 April 2020 when Somerset Partnership NHS Foundation Trust (SPFT) and Taunton and Somerset NHS Foundation Trust (TST) merged. The transaction was ground-breaking because it created the first Trust in mainland England to provide integrated community, mental health and acute hospital services.

Somerset Partnership and Taunton and Somerset NHS Foundation Trusts established a close working relationship when we formed an alliance in May 2017. In late 2017, we established a joint executive team that oversaw all aspects of both Trusts' operations and worked to a single set of strategic objectives covering hospital, community and mental health services. With services working more closely together than ever before, we made improvements to the care and support our patients and service users receive. However, it became clear that we needed to merge in order to remove the barriers that add unnecessary delay and cost to the care we provide, and to truly integrate community, mental health and hospital services.

Map of key Somerset Healthcare Sites

The impetus for our merger came from colleagues who saw the improvements that we can make if these services work together differently. Our clinical strategy is built from the ground up, based on the experience of our colleagues and services, and our knowledge of the growing needs of our population. This impetus drove our initial merger and is core to our subsequent merger with Yeovil District Hospital NHS Foundation Trust, so that we can realise these ambitions and benefits for the whole population of Somerset.

Somerset NHS Foundation Trust provides a wide range of services for the whole of Somerset, as well as acute services for people in the north, west and centre of the county (population c.350,000) and more specialist services across the county and beyond. We work with health and social care partners in Somerset to ensure that we deliver outstanding services that meet the needs of our population.

The Trust provides acute services from Musgrove Park Hospital (MPH) in Taunton, which has around 700 inpatient beds. We also operate 13 community hospitals (with over 220 beds), providing inpatient, outpatient and diagnostic services, and seven Minor Injuries Units.

The Community Dental Service provides dental care to a caseload of over 5,700 patients across Somerset and Dorset. In addition, children with high dental needs attend the service for a single course of treatment which often includes inhalation sedation or general anaesthetic. The service has made good progress in reducing waiting times in Dorset and in both counties for adults and children needing general anaesthetic for their dental treatment.

Somerset NHS Foundation Trust's community services are wide-ranging and include district nursing, stroke services, podiatry, physiotherapy, acute home treatment for frailty and respiratory care, and diabetic eye screening. These services are provided in a range of settings including community team facilities, GP surgeries, local clinics, and patients' homes.

Somerset NHS Foundation Trust provides mental health inpatient services and specialist healthcare for adults with learning disabilities from ten mental health wards across four sites. Its community mental health services include Talking Therapies, Early Intervention in Psychosis, a community eating disorder service, and services for patients with autism and personality disorder. The Trust is also an early implementer of the new model of community mental health services called Open Mental Health. The Trust was named Mental Health Trust of the year at the 2021 Health Service Journal awards.

Somerset NHS Foundation Trust cares for some people from neighbouring counties who live close to the county border. In 2022/23, the Trust treated around 18,600 people in total from across north Somerset, Devon, Bristol and Bath & North East Somerset (BANES), Wiltshire, Swindon, and South Gloucestershire.

We are privileged to work with over 9,000 substantive and bank colleagues who deliver or support our patient services. From therapists to nurses, doctors, researchers, scientists, porters, cleaners, kitchen staff, accountants, those who teach the next generation of clinicians and the receptionists who welcome our patients, the contribution of all of our colleagues is invaluable.

The Trust's general services are commissioned by the local Integrated Care Boards while specialist services are nationally commissioned.

In addition to providing a wide range of patient services, we also contribute to training the next generation of nurses, doctors and therapists and conduct research that will help to advance clinical practice and treatments in the future.

During 2022/23 we concluded our business case and completed our merger with Yeovil District Hospital NHS Foundation Trust. We have operated with a single executive team across both organisations since January 2022 and held board meetings and sub-committees in common during the whole of 2022/23. NHS England issued an Amber rating on the proposed merger in April 2023 and the two boards and councils of governors approved the business case for merger on 17 April 2023 which was supported by the Secretary of State to create the new Somerset NHS Foundation Trust which was formally established on 1 April 2023.

A vision and mission have been developed for the merged Trust which focusses on supporting our colleagues to deliver outstanding and integrated patient care. The new mission is to improve the health and wellbeing of everyone in Somerset and to deliver outstanding integrated care by supporting our colleagues and nurturing an inclusive culture of kindness, respect and teamwork.

Some key facts about Somerset NHS Foundation Trust and our services are shown in Figure 1 below:

PART TWO - PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

UPDATE ON PRIORITIES FOR IMPROVEMENT 2021/22

In this section we review how Somerset NHS Foundation Trust (SFT) has performed against the key priorities it set itself last year.

For 2022/23, the Trust focussed on six flagships - the priority programmes for delivering the five clinical care and support strategy aims:

Aim 1: Improving the health of our population,

Aim 2: Best care,

Aim 3: Local communities,

Aim 4: Value all people alike,

Aim 5: Personalised, coordinated care.

There was one flagship for aims 1-4 with aim 5 having one flagship programme for adults and a second for children and young people. Progress of flagships over the last year has been variable. This is partly due to teams having to reset priorities across the system, establish new relationships and the impact of operational pressures and leadership changes. The intention of the flagships was to set ambitions together and develop joint working with Yeovil District Hospital NHS Foundation Trust (YDH) colleagues and teams ahead of the merger.

How they were measured, monitored and reported?

The flagship projects and programmes were delivered at team and / or service group level and monitored within the Board Assurance Framework.

Here is how the Trust performed in these areas in 2022/23:

QIP 2022/23 - PRIORITY 1 - POSITIVE STEPS: USING THE TIME WAITING FOR SURGERY TO OPTIMISE PEOPLE'S HEALTH AND WELLBEING BOTH NOW AND FOR THE FUTURE

Why was it important?

This was a new flagship programme of work in 2022, to support the Trusts' ambition to play our part in improving the health of the population. Peri-operative care is the comprehensive management of patients before, during and after surgery, from the moment surgery is contemplated right through to recovery and long-term follow-up. It is understood that the fitter a patient is, the better they can cope with surgery, enabling a quicker recovery and improved outcomes. It is also known that the earlier teams understand the health requirements of patients, the more time there is to support healthy lifestyle change, which not only supports improved outcomes from surgery but may avoid the need altogether. Peri-operative care enables better outcomes from

surgery such as reduced length of stay, speedier recovery, reduced re-admissions plus better long-term outcomes.

The aims of the peri-operative service are to:

- optimise the health of patients who need surgery.
- turn ‘Waiting time’ into ‘Preparation time’ prior to surgery.
- establish patients as partners in their own health management to positively impact their long-term health and wellbeing.

What was achieved during the year?

Prior to this work being adopted as a flagship programme, the peri-operative programme team agreed the scope of their current improvement. This was a focus on the pre-surgical period to optimise patients prior to surgery i.e., by improving mobility, cardiovascular and fitness levels, stopping or reducing smoking or helping patients to control their diabetes prior to surgery.

A core team was established, which developed 14 workstreams with leads. The programme has members from both SFT and YDH and is working to develop the Somerset Peri-operative service, building on existing services, learning from each other and taking forward the most beneficial options. Bi-weekly steering group meetings were implemented and over this time commenced c. 55+ tests of change.

Examples of workstreams developed are:

- identifying and taking action with patients as soon as the GP decides surgery may be an option i.e., diabetes pilot. This team works with GP surgeries to identify patients with diabetes, referred for elective surgery, to optimise and maintain their condition prior to their pre-operative assessment.
- targeting modifiable risk factors i.e., smoking cessation services with public health.
- working with and developing services currently available within the community to optimise health i.e., exercise pilot with Somerset Activity and Sports Partnership (SASP), the Home-based Older People's Exercise (HOPE) trial exercise programme with NHS England (NHSE) and emotional support through the talking therapies service.
- understanding how the patient can best prepare for surgery utilising services i.e., health coaches based within primary care networks.

QIP 2022/23 - PRIORITY 2 - INDEPENDENT LIVES: HELPING OLDER PEOPLE TO LIVE AS THEY WISH, GIVING THEM TIME TO DO WHAT IS IMPORTANT TO THEM

Why was it important?

Nationally an increasing number of people are at risk of developing frailty. Somerset has a higher than average elderly population with 24.8% aged 65 and over. Frailty is a clinically recognised state of increased vulnerability resulting from ageing; associated with a decline in the body's physical and psychological reserves. A person living with frailty has twice the mortality risk of a fit older person and increasing frailty is associated with substantial increases in healthcare costs. They are more likely to attend emergency departments and experience delayed transfers of care. People living with mild, moderate, or severe frailty could often have their needs best met in settings outside of acute hospital care. This flagship's ambition is to ensure quick and accurate identification of vulnerable people and to provide alternatives to hospital admission that are more responsive and better able to meet the needs of the frail person.

The frailty work is linked to Somerset system projects including the community hospital transformational work and the local delivery of the Ageing Well programme. This focuses on delivering integrated personalised care in communities and addresses the needs of older people through the inter-related service models of community multi-disciplinary teams (MDT's), urgent community response, enhanced care in care homes and anticipatory care.

What was achieved during the year?

In this last year there has been a focus on how services can more effectively manage frailer individuals at home to reduce potentially harmful lengthy hospital stays. This was achieved through early identification, provision of community alternatives and robust training and support for colleagues.

- **Identification of frailty:** Previous work demonstrated the feasibility to introduce the Rockwood Clinical Frailty Scale (CFS) into the Emergency Department (ED). The use of the CFS has been revisited as the target to screen all over 65's attending ED was not achieved due to work pressures and flow issues. Agreement has been reached by community teams to rollout the CFS for all frailty patients age 65+ who come onto the caseload.

- **Hospital at Home:** Frailty and Respiratory Hospital at Home pathways commenced late 2022. To date the service has supported 452 patients saving in excess of 3000 acute bed days. The service runs 7 days a week, 12 hours a day. The service operates with a 'team of teams' model linking closely with neighbourhood teams, primary care networks, acute hospitals and care of the elderly services. The merger has enabled Hospital at Home to introduce a geriatrician from YDH to support the service alongside the existing consultant geriatrician, to provide consistent cover across Somerset.

- **Frailty Advanced Clinical Practitioners** (ACP's) have been employed across ED and community services. These community roles sit primarily within the Hospital at Home team but are closely aligned with the neighbourhood teams. Close working between the teams has been established to support the training and supervision of the new appointments.

- **Falls clinics:** Based on the successful Frome model, a monthly community falls and frailty clinic at Shepton Hospital with an MDT approach has been

established. This clinic is attended by a consultant from the Royal United Hospital (RUH), Bath, the local community and primary care teams. Each patient is discussed, and a personalised management plan agreed. The clinics also provide an educational opportunity for staff attending.

- **Complex Care:** Clinical lead roles have been appointed in the district nursing teams, to support clinical staff with complex patients. In addition, relationships between Complex Care teams based in South Somerset and neighbourhood services are more robust. The complex care service is doctor led and supports frail patients in the community; operating an MDT approach with community teams such as district nurses (DNs), Community Rehab Service (CRS) and Older Person's Mental Health (OPMH) contributing.

- **Optimal Handed Care (OHC) practice:** South Somerset Primary Care Network (PCN) and Adult Social Care (ASC) are working together on the delivery of the Optimal Handed Care (OHC) practice. Optimal Handed Care is a person-centred, system-wide approach to providing proportionate support to enable people to stay in their own homes. The aim is to promote independence, use equipment safely and creatively, to reduce the number of care staff needed for moving and handling tasks i.e., hoisting. This has enabled people to access care and stay at home longer. A series of events run by trained OHC Ambassadors including CRS therapists and DN's, has enabled countywide implementation and a train the trainer approach. Within Wincanton community hospital the value of the OHC practice has demonstrated improved patient independence and reduced length of stay.

- **Frailty training:** Progress has been made with the roll-out of the tiered education programme to the whole Trust and wider community. It is now available to all SFT colleagues on the electronic education platform.

- **The frailty assessment unit (FAU):** continues to provide a Monday to Friday prompt and comprehensive frailty assessment for patients. This is offered by a specialist MDT, in an appropriate environment. The team have worked with patient flow teams to identify appropriate patients for the FAU to facilitate a quick transfer from ED, implement changes to the process and have developed a new operating procedure. There have been improvements in the frailty interventions in ED, resulting in more streamlined care and quicker access to a specialist frailty assessment.

- **Geriatricians working in ED**: A targeted pilot of a geriatrician working in ED for two hours in the morning resulted in 50% of patients seen, being discharged home, who were otherwise planned for admission. The plan is to look at resources to test this model further.

- **Acute Frailty Practitioners:** The existing Older Persons Assessment and Liaison (OPAL) practitioner roles have been reviewed and are now Acute Frailty Practitioners to align with the Acute Frailty Unit. They are now the named clinician for patients on arrival in ED, clinically examining, ordering diagnostics and implementing first line management. The ED team have adapted the Acute Medical Unit (AMU) proforma with a frailty focus which has been introduced across these areas as a single clerking process. This has reduced the number

of clinicians needing to see the patient and patients only have to tell their story once.

- **Rapid response:** The rapid response team has restructured to increase clinical time and colleagues have received frailty training. This has enabled them to support more people with complex needs at home, avoiding necessary hospital admissions.

- **Urgent Community Response (UCR):** In line with the national initiative, the UCR team provides a two-hour response to individuals identified as at risk of admission (or re-admission) to hospital due to a 'crisis'. They provide assessment and intervention to prevent further deterioration and to keep individuals safe at home. The teams are working with the ambulance service to divert appropriate calls. UCR support has also been given to care homes to assist with deteriorating residents; this has reduced GP and ambulance calls.

- **Work with Care Homes**: The UCR team have worked in collaboration with the care homes to help upskill staff to manage people with complex needs e.g., residents who have repeated falls. The care homes now have appropriate equipment, training and skills in place. This has resulted in a reduction in the number of ambulance call outs to care homes.

QIP 2022/23 – PRIORITY 3 – STOLEN YEARS: HELPING PEOPLE WITH MENTAL HEALTH CONDITIONS TO LIVE LONGER LIVES

Why was this important?

People with severe mental illness (SMI) struggle to live independently, are at greater risk of developing health problems and are less equipped to recognise when and how to respond to worsening health signs. People living with SMI often live with poor physical health and on average die 15 – 20 years earlier than other people. It is estimated two out of three people, with a diagnosis of SMI, die from physical illnesses that can be prevented. The main causes of death being circulatory disease, diabetes and obesity.

What was achieved during the year?

The stolen years flagship pledged to co-produce projects with 'Experts by Experience', building on work already done. There were two main areas of focus in the year. Firstly, the uptake and quality of physical health checks for patients with SMI, Secondly, growing collaborative relationships between mental health and physical health colleagues, to improve care for patients with mental ill-health when accessing physical health services.

- **Improving physical health of patients with mental ill-health project:** A workshop to improve the physical health of patients with mental ill health was held, where experts by experience shared their personal accounts of accessing and receiving physical health care. This workshop was co-produced with our experts by experience who were able to share their experiences of care received. The aim of this workshop was to listen and learn from people first-hand who have used physical health services alongside their mental ill-health, and which has been a positive step in bringing colleagues together. Colleagues

were able to ask questions, reflect on improvements and a repository of 'pledges' has started to showcase the work within physical healthcare settings. A good example was surgical booking teams did not contact patients with mental ill-health with cancellation appointments as it was felt it would be unsettling. However, experts by experience shared they would prefer a cancellation appointment as waiting triggered anxiety and stress. This has resulted in teams and experts by experience agreeing to work together on devising a letter asking patients if they would like last minute appointments and what support can be offered.

- **Expediting elective care**: Patients are waiting longer in many specialities, both to be seen and assessed and to have surgical procedures. Working with the surgical booking teams the expedition of elective treatment for vulnerable patients has been introduced. The standard approach to managing waiting lists is by clinical priority and then chronological order, but SFT is in a unique position to be able to easily identify more vulnerable patients who are more likely to deteriorate whilst waiting and expedite their care. There is good evidence that patients with these characteristics on average live shorter lives, which means they spend a disproportionately longer part of their life on a waiting list. Patients with a known learning disability, a current open mental health referral and living in one of the two most socially deprived areas are now flagged and their appointments expedited.

- **The wellbeing project**: has created a bespoke RiO report to improve the cardio-metabolic monitoring of patients using technology. The first stage of this project was to improve the timely uptake of physical health checks using RiO reports within clinic settings i.e., clozapine and depot clinics. This supports colleagues to identify and offer timely physical health checks. By using data 'in real time', colleagues can identify patients at risk of physical health complications early and ensure they seek appropriate medical /lifestyle related measures to tackle obesity, hypertension and pre-diabetes which contribute to increase mortality as well as morbidity amongst patients with severe mental illness.

- **Tobacco reduction programme**: Smoking is the largest avoidable cause of premature death, with more than 40% of adults with SMI smoking. The Trust's Tobacco Harm Reduction Service supports those with severe mental health conditions and/or learning disabilities, as well as acute hospital inpatients and maternity services and staff to stop smoking or to reduce the amount they smoke. It is also the lead on developing smoke free sites within the Trust, promoting the smoke free message across the grounds and providing training to staff on tobacco harm reduction / smoking cessation. In June 2022, SFT appointed a Tobacco Reduction Programme (TRP) manager to lead on this work which will contribute to a reduction in health inequalities. The TRP fully mobilised its' inpatient acute and mental health pathways across all sites in March 2023 and is utilising Quality Improvement (QI) methodology to inform training needs and enable wards to become smokefree by the end of 2023/24.

- **Colleagues working together**: Physical and mental health colleagues have worked together to support mental health patients when they become physically

unwell in inpatient settings. This project was started after a patient was transferred by ambulance twice from a mental health ward to an acute site for assessment of a physical issue. Recognising this was not a good experience for this patient and to further improve patient care and safety, the teams worked together to develop advice and guidance for patients who become physically unwell on mental health wards, so they can remain there wherever possible. This is planned to go live across both EDs and mental health wards from Summer 2023.

A further example of physical and mental health colleagues' collaboration was to support mental health inpatients when identified as end of life. Palliative care and bereavement colleagues provided support and training to staff so they could care for patients in familiar surroundings rather than moving to the acute trust. Simple measures such as sending beds for relatives to be able to sleep close by and providing staff with bereavement support has improved the confidence and skills of staff when caring for patients who are end of life. Staff feel energised as they can provide a holistic approach and improve patient care and experience.

- **Introduction of new roles**: Open Mental Health is an alliance of local voluntary organisations the NHS and social care, Somerset County Council (SCC) and individuals with lived experience of mental health. By working together patients get the support they need when they need it most; this includes help to attend physical health checks. The introduction of peer mentors to connect with those people who lack the confidence or motivation to attend for physical health checks or who feel isolated has been introduced. The appointment of mental health practitioners as part of the Additional Roles Reimbursement Scheme (ARRS) in primary care and the physical health assistant practitioners also support the uptake of physical health checks and signposting for further health advice and support where required.

- **'Talking Therapies'** – Improving Access to Psychological Therapies (IAPT) continues to work across boundaries by providing mental health support to patients presenting with physical health problems. Patients may be waiting for an operation longer than they were expecting, resulting in stress and frustration, alongside managing the emotional impact of lifestyle changes due to their health. Talking Therapies and the peri-operative team working together means that the patient gets joined up treatment, clinically and emotionally, by attending one appointment. Relationships between the two teams result in a better understanding of the patient as a whole and thus leads to an improved patient experience. Another example being explored is working with the neurology team on long-term neurological conditions.

- **Widening the focus:** In September 2022, Dr Katalin Fernando, Associate Medical Director for unplanned care, YDH, took on an additional portfolio role looking at the interface between acute medical and mental health services across YDH and SFT to better address the unmet physical healthcare needs of patients with mental health problems.

QIP 2022/23 – PRIORITY 4 – LAST 1,000 DAYS: VALUING PEOPLE'S PREVIOUS TIME IN THE LAST CHAPTER OF LIFE

Why was this important?

The last 1000 days flagship ambition is to identify and appropriately support patients to ensure they maximise the time they have, doing what is important to them in a place they want to be. This includes the needs of relatives and friends during life and after the death of their loved one has occurred. End of life care (EOLC) encompasses all stages of care and experience for patients and their families with a life-limiting illness. It is not confined to the last days of life and can be measured many years prior to the death of a person. This flagship supports patients, family and carers to plan their last chapter of life and enables colleagues to provide high quality, compassionate EOLC. It seeks to ensure that those patients who die in hospital have the best care possible and that those patients, who wish to die at home, or elsewhere, are enabled to do so by supportive discharge arrangements which may include partnership working with other agencies and which respects an individual's choices, values, and beliefs.

What was achieved during the year?

The Last 1000 days flagship has been pivotal in the way EOLC is viewed countywide, with multi-agency colleagues coming together to do the right thing for patients who are at the end of their life. The SFT Last 1000 days governance structure is well embedded with a steering group to which three subgroups report: operational, governance and education. Work has already begun to formally bring the two legacy EOLC teams together who have already worked on many of the projects together. The focus of many of the projects within the Last 1000 days flagship arise from colleagues themselves and/or learning from events which trigger them to work together to improve service provision.

Examples of work achieved are:

- **An EOL Homecare pilot:** commenced in November 2022 to bring about rapid discharge of EOL patients with days to short weeks to live from the acute trust. Previous data showed 29% of patients when identified as EOL die in hospital awaiting discharge and the process can take on average 6.3 days for a package of care to be set up and funding to be approved. For many patients this means they often become too unwell and one in three die in hospital and not in their place of choosing. The pilot explored the reasons why delays occurred, and teams have worked together to bridge gaps and to work differently to bring about prompt discharge. In February 2023, this moved to the project phase and to date 36 patients have been discharged home, with 68% getting home same day or next day. The teams are reviewing the data ahead of refining the pathways and considering spread to YDH and the community.

- **Packages of care audit:** Alongside the above project, colleagues were keen to understand if packages of care (POC) set up at the time of discharge met the needs of patients and families. This study reviewed POC set up in November and December 2022 and found colleagues were accurately requesting the level of care, support and equipment needed.

- **Heart failure:** An initiative to improve end of life care in heart failure is underway to introduce subcutaneous Furosemide by syringe pump as a treatment option in Somerset. This is as an alternative to hospital admission for

intravenous diuresis in patients in the end stage of their disease. Medicines management governance approval has been gained and there is a clinical protocol for using Furosemide in a syringe pump. This has been successfully used in the St Margaret's hospice inpatient unit and in peoples' own homes. Discussions are ongoing about options for delivering this as a mainstream treatment in the community, potentially via community hospitals and/or hospital at home.

- **Ascites management:** Patients receiving palliative care often need abdominal drains due to a build-up of fluid (ascites) but are too unwell to come into hospital. A pilot to reduce the need of a hospital visit by using portable ultrasound scanners was undertaken – meaning consultant sonographers can visit a patient's home to perform the drain. Around three patients a month across Somerset may require this kind of service who would otherwise struggle to get to hospital. Previously an unwell patient receiving palliative care comes into hospital for drainage; this requires ambulance transport, a porter, then after waiting in the hospital while in pain, they need an ambulance to return home. By a sonographer going to the patient's house and working with colleagues in community services, it means that they can receive care in their own home. This helps to reduce hospital admissions, supporting patients to stay at home when they near the end of their life, and improving the quality of life for patients. This service is being trialled in the east of Somerset with plans to expand it county-wide.

- **Education**: The education group has promoted the EOLC for all (e-ELCA) eLearning programme from Health Education England; with 619 Trust colleagues having completed at least one e-ELCA module in the last year. In 2022, a face-to-face syllabus was able to resume with 23 courses being held and 186 attendees. Between May 2022 and Feb 2023, a total of 300 staff across health and social care organisations have attended formal ACP (advance care planning) sessions. Jointly with either the EOLC education team or Marie Curie, public and staff engagement events have included: Care home roadshows, death cafés and Interfaith week. In November 2022 the team was approached to support with the delivery of education around the Musgrove individualised end of life care plan. This has been trialled on four wards to date with further sessions being planned.

- **Website**: The Somerset End of Life Care and Bereavement Support website was launched in March 2022. A care home roadshow was completed in year where 49 care homes were visited in person to present the website and the range of courses and services available.

- **Conference**: An inaugural EOLC conference was held in May 2022 to 200 delegates across 14 different organisations. The next conference is planned for September 2023.

- **'Patient Stories' project**: This seeks to put the patient and carer voice at the heart of the EOLC education delivered. So far two short films, one about care after death, one about Treatment Escalation Plans (TEP) have been made using families who were willing to share their experiences and from which learning opportunities exist.

- **Care of the Dying person:** a continued audit of practice in care for those in the last days of life has commenced. An action plan is being delivered by specialist palliative care teams supported by the EOLC education team.

- **The 'Talk About Project'**: advance care planning (ACP) project across Somerset used volunteers to help people personalise their care and legacy through an advance care plan. Unfortunately, the funding for this has been ceased and there is no resource in place to support advance care planning going forward.

- **A poor prognosis letter:** has been designed to help sign-post patients with a life-limiting diagnosis to resources, to help them consider things they may want to plan for, outside of their immediate medical needs. A draft letter is being adapted after feedback from a patient cohort. This will be trialled in a cancer-patient cohort with the help of the Lung cancer team.

- **Complaints**: All complaints with a focus on EOLC are reviewed by consultants to ensure oversight and effective learning from harm and improving feedback. This mechanism ensures the responses are compassionate and supports colleagues where there is learning from events.

- **Audit:** The governance group focussed on the action plan from the previous national audit of care at end of life (NACEL) audit, while the trust took a year off from participation in the national audit. Previous national reports were received just as the next data collection period started, therefore not allowing time to focus on improvements. This break in the cycle supported the completion of an action plan jointly with colleagues from YDH, and data collection is underway for this year's local version.

  The hospital and community teams participated in the Seeking Excellence in End of Life Care (SEECARE) audit. This national audit examined care of people who were in the last hours to days of life who were not known to the palliative care teams in hospital beds (acute and community). The action plan has been completed by the hospital palliative care teams. The focus of the action plan was on improving the end-of-life care plan, and delivery of direct education to teams to support people who are dying.

  A further audit reviewed patients discharged from hospital with Just in Case (JIC) medications, and their subsequent use in the community setting and to examine syringe pump use. Where data was available, the use of JIC medications and subsequent syringe pumps did not reveal any prescribing concerns.

Following CQC inspection of community end-of-life care services, it was noted '*the provider had adopted a clear quality improvement approach at service level to drive development. This included the 'Last 1000 days'; a program of projects delivered across the service to improve the overall experience of people in Somerset approaching the last 1000 days of their life'.*

QIP 2022/23 – PRIORITY 5 – CONNECTING US: USING TIME WELL BY GETTING TOGETHER TO FOCUS ON WHAT MATTERS TO PEOPLE WITH COMPLEX NEEDS

Why was this important?

A growing number of people are living with complex needs including chronic or long-term health conditions, often with physical and mental health needs as well as social deprivation challenges. Meeting the needs of this population requires anticipatory not reactive care, time to develop trusting relationships, broadening the membership of the care team and communicating across different specialties and agencies. Developing advanced and personalised models of care is essential to meet the challenge of complex care for our population.

What was achieved during the year?

- **Improvements in the support for those identified as high-intensity service users:** At the beginning of the year, colleagues worked with the Integrated Care Board (ICB) to develop a business case to establish a high-intensity service within Somerset. This was based on the national right-care model, built on the Ubuntu project (below), the developments in the ED high intensity user multi-agency group and the roles being created in the PCNs. The business case was approved; the two new posts are being hosted by SFT and are in the recruitment stage.

- **Ubuntu Project:** This partnership project between SFT and the Community Council for Somerset (CCS) supports high-intensity users referred with a focus on what is important to the individual, whilst developing self-activation and a subsequent reduction in health service use. The project team has finalised the service offer; accepting referrals from: SFT and YDH ED high-intensity user groups, primary care, South Western Ambulance Service NHS Foundation Trust (SWAST) and other partners. Sustainable funding for the Ubuntu service has been agreed as part of the development of a High-Intensity service for Somerset.

- **Multiple sclerosis (MS) care pathways:** A MS diagnosis clinic was initiated to provide a joint consultation between the patient, consultant and MS nurse. The patient feedback has been positive to date. To support care closer to home, a review clinic has been established in Bridgwater community hospital to avoid travel to Musgrove Park Hospital. The MS nurse has listened to feedback and initiated a clinic session to follow up after first treatment. Trust guidance has been developed in-line with the NHSE Treatment Algorithm for Disease-Modifying Therapies. These extra supports in the patient pathway at first diagnosis and post first treatment, support a personalised, proactive care approach, allowing patients to be more independent and live well with MS.

- **Functional Neurological Disorders (FND) improvements:** A working group was set up to discuss the existing services, and skills in teams across Somerset. The group have set a vision and drafted a future service model ready for consultation with stakeholders. Currently, the group are reviewing what improvement projects can be piloted within existing resources. Links have been made with the Regional FND network to share good practice. The FND need is being raised as part of the Neurological Rehabilitation case for change being prepared for the Integrated Care System (ICS) and there is wider colleague, patient and third sector engagement for the full case for change. The plan is to submit this at the end of June 2023.

- **Establishment of a persistent unexplained physical symptoms (PUPS) clinic (adults):** It was identified the gastroenterology and gynaecology teams received referrals for patients with unexplained physical symptoms. An improvement project was initiated to establish a clinic, led by a consultant psychiatrist. At the end of April 2023, the clinic had received ten referrals, with nine patients attending for a first appointment and seven for follow up. Overall patient experience is good. Of those who attended, 83% have agreed to mental health support and this is for a group that wasn't aware of the mind-body link prior to attending the clinic. Although small numbers, 33% of patients seen had clinically significant post-traumatic stress disorder which was diagnosed for the first time. This care is resource intensive however, demonstrates significant improvements to both physical and mental health symptoms.

- **Dementia and Delirium:** The overarching aim of the dementia services is to ensure people receive support from the point of diagnosis, throughout their experience of dementia to enable them to live an active and meaningful life.

  The Somerset Dementia Wellbeing model is currently being launched. It was jointly developed with SFT, the ICB, SCC and the Voluntary Community and Social Enterprise Sector (VCSE). The aim of the model is to connect people to services from the point of diagnosis. To enable this to happen, SFT has increased the amount of Dementia Advisors, employed by the Alzheimer's Society. The VCSE offer within the model consists of many organisations that can offer support, including activities and carers education. A website has been developed and will be launched imminently. SFT will continue to promote this model, encouraging people to come forward for assessment. The model links closely with memory assessment services. The workforce has been expanded to support the increase in referrals seen over the last year. To provide greater clinical leadership trainee advanced care practitioners (ACPs) were recruited to the Community Mental Health Teams.

  To support the diagnosis of dementia in care homes, Diadem funding was received from NHSE, enabling support plans and personalised care to be developed that better reflect individuals' needs.

  A care home liaison team, specialist care homes and SCC working together, has supported individuals in high dependency care home beds. This resulted in improved patient flow from acute and mental health inpatient beds, people receiving care in an appropriate environment, provided links to support and crisis services, and has supported care planning and management of challenging behaviour. .

  A review of the Intensive Dementia Service was completed. This crisis service focusses on admission avoidance to mental health and acute beds. The outcome of the review was improved interface with other services involved with the individuals and their families.

  The integrated dementia and delirium teams are focusing on improved personalisation, including standardisation of "what matters to me" documentation, care planning, advice and education. An education facilitator and support worker educators are being recruited to provide training to Trust

and care home colleagues, developing a consistent and person-centred approach to caring for someone with dementia and/or delirium.

The Musgrove team are piloting a seven-day service, which includes support to ED. This service will link closely with community services to ensure provision of support and implementation of the dementia model and pathway.

QIP 2022/23 – PRIORITY 5 – FUNCTION FIRST – IMPROVING LIFE CHANCES FOR CHILDREN BY INCREASING THEIR TIME IN SCHOOL

Why was this important?

Children with complex needs, including those with persistent physical symptoms where no organic cause can be found, risk over-investigation and treatment. This includes frequent medical appointments, multiple emergency department attendances and prolonged hospital stays. They are often functionally impaired, with schooling and home life negatively affected. Sadly, this frequently continues into adulthood drastically reducing life chances.

What was achieved during the year?

- **Trailblazers programme:** The mental health support teams 'Trailblazers' improve the access to emotional and mental health support for children and young people within school settings i.e., those with anxiety, phobias, behavioural issues and low mood. This programme successfully transitioned from a test of change to a permanent service. The commissioning is in place for the mental health support teams, and this is now business as usual.

- **Persistent unexplained symptoms (PUPS):** Whilst there was enthusiasm to test a multi-disciplinary clinic, the test of one patient demonstrated the resource intensity required and that there was not capacity within the team to complete a further test. If there are future opportunities, the team remain keen to address PUPs in a dedicated clinic with a holistic approach to care.

- **Out-patients service strategy:** The team have developed the strategy and have achieved the following:

  - ongoing senior doctor triage of referrals to ensure the right children are safely being seen in the right clinics.

  - prospective clinical and managerial monitoring of referrals and capacity to ensure waiting lists are well managed and capacity is maintained for urgent referrals.

  - utilising non-acute sites (community hospitals and schools) for clinics where possible to ensure there are opportunities for care closer to home.

  - commenced Darzi fellowship pilot project to provide joint primary/secondary care triage of referrals in West Somerset. This project will evaluate if Children and Young People (CYP) can be managed primarily in the community with specialist paediatric advice.

- **Allergy improvement project:** A monthly clinic to review under one-year olds has been implemented with a consultant paediatrician and a dietician. The team is now able to refer for psychological support. The aim is to see referrals within eight weeks, this enables active allergy management through early investigation of potential allergy and to support the early introduction of other allergens. Research shows that this reduces future development of allergies. This has reduced outpatient waiting times.

- **Eating Disorders:** Significant progress has been made in the offer to CYP with eating disorders, which includes the commissioning of a VCSE partner for low to moderate needs. Consequently, waiting times are significantly improved. The transition to adult services now includes regular meetings and strong links with the adult wards. The meeting includes the eating disorder lead, a gastroenterology consultant and a psychiatric liaison consultant; this enables clear decision making and care planning. All patients have a care plan within 48 hours of admission and a weekly review. Most admissions are now planned and not reactive. For those presenting to acute paediatric settings for assessment or re-feed, a senior nurse has been recruited to offer clinics to avoid admissions and ensure those admitted have a personalised care plan.

  In addition, funding has been secured for a transition lead nurse. This role will bridge Child and Adolescent Mental Health Services (CAMHS) and eating disorder services, working with young adults and their families and supporting the move into adult services. It is expected this role will prevent medical admissions. Whilst this post is in recruitment, the eating disorder team continues to build links with CAMHS to support management of patients. Funding has been agreed for two paid peer support workers, who are in full recovery. This innovative role aims to instil hope for recovery through support on the in-patient wards for example: by practicing eating with the patient away from the ward, and to build independence in eating. It is anticipated they will work with young people who are 16 – 25 years, hosting group sessions for positive peer support.

- **Paediatric Obesity Service (SPLASH):** In April 2022 it was agreed with commissioners to fund a one-year pilot to trial a weight management service for children up to the age of four. The multi-disciplinary team was set up and engaged with SASP for their input on physical activity. The team focused on the under four age group because parents are in control of their child's eating and early intervention has been shown to have better long-term health outcomes.

  38 families received an initial home visit, followed by group online sessions, or one to one dietetic and/or psychological support to help families identify goals. All receive an MDT clinic appointment with a Paediatrician.

  The team have made strong links with public health, adult weight management and specialist feeding teams. They are involved in training other professionals in having conversations about a child's weight, feeding and related behaviour.

  There are now monthly dietetic clinics held around the county. The team also have weekly meetings and offer a psychological assessment for families as

needed. The service now allows families to self-refer and has promoted the service to different areas such as childcare settings.

The outcomes from the service demonstrate children have reduced their Body Mass Index (BMI) and parents report an increase in parenting skills. This includes feeling confident in making food related decisions, cooking meals from scratch, establishing routines, reducing snacks and milk consumption. A positive impact is also noted with the rest of the family e.g., parents BMI reduced.

“The programme has influenced how we eat and move a lot as a family. We now make better choices for everyone”. Parent

QUALITY IMPROVEMENT PRIORITIES (QIP) 2023/24

In this section we set out our priorities for the merged Trust for this year. It has been agreed to continue with the current priorities giving an opportunity to reset and refresh as the new service groups, operational and clinical leads are in place. The flagships will seek out opportunities to work across the wider health and social care system in Somerset.

How they will be measured, monitored and reported.

The flagship projects and programmes will be delivered at team and/or service group level and monitored within the Board Assurance Framework. The flagships have been realigned to better fit with the clinical care and support strategy.

QIP 2023/24 - PRIORITY 1 - POSITIVE STEPS: USING THE TIME WAITING FOR SURGERY TO OPTIMISE PEOPLE'S HEALTH AND WELLBEING BOTH NOW AND FOR THE FUTURE

Why is this important?

Peri-operative care is the comprehensive management of patients before, during and after surgery, from the moment surgery is contemplated right through to recovery and long-term follow-up. It is understood that the fitter a patient is, the better they can cope with surgery enabling a quicker recovery and improved outcomes. It is also known that the earlier our teams understand the health requirements of our patients, the more time there is to support healthy lifestyle change which not only supports improved outcomes from surgery but may avoid the need altogether. Peri-operative care enables better outcomes from surgery such as reduced length of stay, speedier recovery, reduced re-admissions plus better long-term outcomes.

The aims of the peri-operative service are to:

- optimise the health of patients who need surgery.
- turn 'Waiting time' into 'Preparation time' prior to surgery.
- establish patients as partners in their own health management to positively impact their long-term health and wellbeing.

What do we want to achieve?

- To embed new services / pathways for the Peri-operative management of frailty, anaemia, exercise and smoking. To achieve this, the team will further utilise excellent pre-existing services within Public Health and our community partners (Smoke Free Somerset, Turning Point, SASP, HOPE Social Enterprise, Talking Therapies etc).

- Drawing upon the successes of the Peri-Operative Diabetes Pilot pathway, the ambition is to on-board all GP surgeries across Somerset to identify surgical elective patients with diabetes at the point of GP referral, to maximise the best outcome for diabetes optimisation prior to surgery.

- The team will work further with Primary Care network colleagues to understand the role and opportunity of the Health Coaches, to support increased mobility, exercise, emotional wellbeing and weight management for patients prior to surgery.

- Peri-operative assessment clinics will be embedded further upstream from the existing Pre-Operative Assessment Clinics, to assess and work with our patients to identify surgical optimisation goals. Patients will be regularly contacted by Care Co-ordinators to enable pre-existing conditions to be monitored and pre-surgical goals achieved.

- There will be collaborative working with our Primary and Secondary Care colleagues to understand each of these pathways to develop a service which is synonymous with the aims of the Elective Care Recovery Programme, improved surgical outcomes and patient care.

QIP 2023/24– PRIORITY 2 – LAST 1,000 DAYS: VALUING PEOPLE'S PREVIOUS TIME IN THE LAST CHAPTER OF LIFE

Why is it important?

The last 1000 days flagship ambition is to identify and appropriately support patients to ensure they maximise the time they have, doing what is important to them in a place they want to be. This includes the needs of relatives and friends during life and after the death of their loved one has occurred. End of life care (EOLC) encompasses all stages of care and experience for patients and their families with a life-limiting illness. It is not confined to the last days of life and can be measured many years prior to the death of a person. This flagship supports patients, family and carers to plan their last chapter of life and enables colleagues to provide high quality, compassionate EOLC. It seeks to ensure that those patients who die in hospital have the best care possible and that those patients, who wish to die at home, or elsewhere, are enabled to do so by supportive discharge arrangements which may include partnership working with other agencies and which respects an individual's choices, values, and beliefs.

What do we want to achieve?

In the year ahead, many of the projects will be continuing with an emphasis on ensuring patients who are identified as EOL with days or short weeks to live will be able to go home promptly which will improve hospital flow:

- The learning from the EOL homecare project which aims to take patients home from hospital within 24 hours, will inform wider rollout across the county. This will be supported by F1 quality improvement work looking at the completion of continuing healthcare fast track (CHCFT) applications to increase the approval rates of applications for funding.

- Review of current discharge pathways with consideration of EOL provision will be undertaken.

- Design of an education prospectus with the wider Somerset End of Life Care Education Network featuring all the courses and content available for all staff across Somerset working with those with life-limiting conditions.

- Following Care Quality Commission (CQC) feedback, a QI project to assess the impact of mandatory EOLC education on care outcomes will be undertaken to consider whether this has a positive impact on the experience of patients and carers.

- The appointment of a Somerset Treatment Escalation Plan (STEP) lead will enable coordinated improvement and monitoring of TEPs in the county.

- A local version of the NACEL audit, which is not running nationally this year, will be undertaken; through a case note review, staff survey and quality survey (bereavement survey).

- The merging of governance structures for the Last 1000 days flagship with one steering group to oversee the subgroups will be conducted: education, governance and operational. Many of the projects within the Last 1000 days flagship will arise from colleagues themselves and/or learning from events which trigger them to work together to improve service provision which will be captured.

QIP 2023/24 - PRIORITY 3 - INDEPENDENT LIVES: HELPING OLDER PEOPLE TO LIVE AS THEY WISH, GIVING THEM TIME TO DO WHAT IS IMPORTANT TO THEM

Why is this important?

Nationally an increasing number of people are at risk of developing frailty. Somerset has a higher than average elderly population with 24.8% aged 65 and over. Frailty is a clinically recognised state of increased vulnerability resulting from ageing; associated with a decline in the body's physical and psychological reserves. A person living with frailty has twice the mortality risk of a fit older person and increasing frailty is associated with substantial increases in healthcare costs. They are more likely to attend emergency departments and experience delayed transfers of care. People living with mild, moderate, or severe frailty could often have their needs best met in settings outside of acute hospital care. This flagship's ambition is to ensure quick and accurate identification of vulnerable people and to provide alternatives to hospital admission that are more responsive and better able to meet the needs of the frail person.

What do we want to achieve?

- The identification of frailty at the front door is now part of the Trust Commissioning for Quality and Innovation (CQUIN) for 2023-4. The Trust will be assessed on its' ability to produce a frailty assessment for over 65-year-olds presenting to ED and initiating an appropriate response for those who are frail using the CFS scale.

- Wider rollout of CFS within countywide teams e.g., hospital at home, CRS, rapid response for those aged 65+. This will ensure a common way of identifying frailty and monitoring deterioration to aid rapid intervention.

- Expansion of the hospital at home service, with the introduction of remote monitoring for frailty patients i.e., clinical observations and subjective patient

questionnaires. The results can be viewed remotely by a dedicated team of clinicians and administrators.

- A review to look at the integration of frailty services across the acute hospitals to establish current and future provision in line with national guidance and local population needs.

- Explore further opportunities to roll out community falls and frailty clinic e.g., West Mendip hospital and South Somerset areas.

- Expand links with domically care agencies to enable the agency workers to call the Urgent Community Response team initially for a review rather than the GP and Ambulance service.

- Further roll out of the tiered education programme to the whole Trust and wider community. The intention is to embed this training as a requirement for all relevant Trust colleagues.

Work in collaboration with informatics to ensure that the right data is collected to enable us to review the services.

QIP 2023/24 – PRIORITY 4 – STOLEN YEARS: HELPING PEOPLE WITH MENTAL HEALTH CONDITIONS TO LIVE LONGER LIVES

Why is it important?

People with SMI (severe mental illness) struggle to live independently, are at greater risk of developing health problems and are less equipped to recognise when and how to respond to worsening health signs. People living with severe mental illness (SMI) often live with poor physical health and on average die 15 – 20 years earlier than other people. The main causes of death being circulatory disease, diabetes and obesity. It is estimated two out of three people, with a diagnosis of SMI, die from physical illnesses that can be prevented.

What do we want to achieve?

The stolen years programme remains committed to improving the physical health of patients with SMI. Areas of work planned for the year ahead are:

- Further workshops looking at improving the physical health of patients with mental ill-health across a number of physical health settings, targeting key areas such as diabetes, dietetics and surgery. A repository of ‘pledges’ will be collated to show where colleagues in physical health settings will have made changes to systems to improve access and care.

- The ‘Healthy Living on Clozapine’ project which was halted previously due to the pandemic and operational pressures will be restarted. The aim of the project is to support patients to lose weight and increase activity to achieve personalised activity goals.

- Embedding the wellbeing project RiO report within specialist outpatient clinics to increase the timeliness of physical health checks to improve identification of

risk factors and offer interventions. The next stages of the project will also look at opportunities for spread where antipsychotic medication is prescribed.

- Adopting a county wide approach to ECG interpretation. Current provision of ECG interpretation does not allow for prompt, safe management of medical interpretation. After considering options, it has been agreed ECGs will be sent externally for interpreting and flagging which will ensure patients are followed up quickly and timely management plans are put in place where appropriate.

- SFT is participating in a randomised controlled trial to investigate the clinical and cost-effectiveness of the DIAMONDS diabetes self-management intervention for people with a severe mental illness. The DIAMONDS intervention involves one-to-one sessions with a trained coach over a six-month period. The coach will provide information and help support healthy lifestyle choices.

- In 2023/24 the Trust's Tobacco Harm Reduction Service will mobilise its High Dependency Service, specifically aimed at supporting mental health discharged patients, and outpatients, with an enhanced harm reduction and smoking cessation offer. In addition to offering Nicotine Replacement Therapy (NRT), patients on the outpatient pilot pathway will be able to access e-cigarettes and up to 16-weeks Specialist Practitioner support.

QIP 2023/24 – PRIORITY 5 – CONNECTING US: USING TIME WELL BY GETTING TOGETHER TO FOCUS ON WHAT MATTERS TO PEOPLE WITH COMPLEX NEEDS

Why is this important?

A growing number of people are living with complex needs including chronic or long-term health conditions, often with physical and mental health needs as well as social deprivation challenges. It's important that we understand the health of our population and how we can meet their needs through: anticipatory, proactive not reactive care; developing trusted relationships; broadening the membership of the care team and communicating across different specialties and agencies. Developing advanced and personalised models of care is essential to meet the challenge of complex care for our population.

What do we want to achieve?

- **High intensity user service for Somerset:** With the funding in place, the Somerset high-intensity user service will be established. The new post-holders will be tasked with understanding the current service offer in Somerset and what's required for the future, before implementing the right-care model. They will work with the established HIUGs in EDs, the PCN services and the Ubuntu coaches to ensure joined up working for the individuals identified and monitor the impact of the changes made.

- **Establishment of a persistent unexplained physical symptoms (PUPS) clinic (adults):** By the end of June, a full review of the clinic will be completed including cost of the service and benefits analysis. The evaluation will be made available to allow a decision about continuation of the clinic.

- **Personalised care approach:** To play our part in supporting the work of the Somerset ICB personalised care steering group, to develop the actions to embed the personalised care model across the ICS. To support the roll-out of personalised care training and education programme to colleagues. Help our PCNs and teams to embed proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions, as per the Fuller report recommendations.

- **Proactive care**: the national framework for proactive care is due to be published this year. Once available, leads will review the recommendations and influence as a joint community, mental health and acute Trust to develop proactive care along our pathways. It is anticipated this will build on the one team approach developed in Burnham and the complex care team approach in South Somerset.

- **Dementia and Delirium care:** Somerset currently has a low diagnosis rate (53.8% compared to a national target of 66.7%); the aim going forward will be to improve diagnosis rates and associated care. Building on the work started, it is planned to further recruit to the care home liaison team and expand the benefits already seen.

  To ensure good care and prevent deterioration in older patients admitted for an emergency, the plan is to assess for the presence of delirium and if present to follow the Trust delirium guidelines. Results will be evaluated to measure the success with achieving this. Further, it is intended to develop a follow-up specialist clinic for those that have been admitted to our acute settings. All in-patient discharge summaries will clearly document the patients plan and this will be agreed with their carers.

QIP 2023/24 – PRIORITY 5 – FUNCTION FIRST – IMPROVING LIFE CHANCES FOR CHILDREN BY INCREASING THEIR TIME IN SCHOOL

Why is this important?

With the merger of SFT and YDH there has been change within the service group structures. With a new leadership team (service group director, associate medical director, and joint roles from CAMHS across paediatrics) there is a fantastic opportunity to review and reset the flagship, bringing in colleagues with their ideas, creativity and best practice from across the new SFT.

What do we want to achieve during the year?

Our priority is to address the key issues facing young people across Somerset. As such the focus will be to improve the clarity and responsiveness along our pathways caring for adolescents. There is potential to build on developments such as care closer to home through acute home treatment services. This reduces the requirement for hospital admission and improves transitions across different care environments and as young people move into adult services. The plan is to support initiatives in the care of those with learning disabilities, recognising individualised care for this specific group will establish a model to spread personalised care to CYP and their families. First

steps will be to relaunch the flagship to encompass the ambitions agreed and to garner support across the service group and beyond.

STATEMENTS OF ASSURANCE FROM THE BOARD

In the following section the Trust reports on statements relating to the quality of NHS services provided as stipulated in the regulations.

The content is common to all providers so that the accounts can be compared between organisations. This provides assurance that Somerset FT Board has reviewed and engaged in national initiatives which link strongly to quality improvement.

The board has received monthly information on quality indicators as part of the Quality Report, the Finance Report and the Performance Report. In addition, the Board has received reports on patient experience and workforce issues. The Board is satisfied with the assurances it has received.

The Board has discussed the priorities for 2022/23 and has agreed those described above.

Services provided by the Trust

During 2022/23 Somerset FT provided and/or sub-contracted 120 relevant services, including the following:

- Acute services (including emergency services; adult and paediatric care; community hospitals; minor injury units; elective surgical operations; psychiatric liaison).
- Long-term conditions services.
- Hospital services for people with mental health needs, and/or learning disabilities, and/or problems with substance misuse.
- Rehabilitation services.
- Cancer care and radiotherapy.
- Maternity services.
- Community healthcare services (including district nursing; integrated therapy services; health visiting; school health nurses; family planning and sexual health services).
- Accident and emergency treatment.
- Dental services.
- Diagnostic services.
- Community based services for people with a learning disability.
- Community based services for people with mental health needs (including community mental health teams; assertive outreach; early intervention teams; court assessment services; crisis resolution home treatment teams).
- Primary Care Services.

The Somerset FT Board has reviewed all the data available on the quality of care in all 120 of these relevant health services.

The income generated by the NHS services reviewed in 2021/22 represents 100% of the total income generated from the provision of relevant health services by Somerset FT for 2022/23.

Progress in implementing the priority clinical standards for 7-day hospital services

There are 10 national clinical standards for 7-day hospital services. Four of these (Standards 2, 5, 6 and 8) are “priority” standards. At the time of the last audit for national reporting purposes in Spring 2019, the Trust was compliant with Standard 5 (access to diagnostics), Standard 6 (access to interventions) and Standard 8 (frequency of Ongoing Consultant Review).

However, it was not compliant with Standard 2, which records how quickly patients are seen by a consultant after admission, and mandates that 90% of patients have to be seen by a consultant within 14 hours. The Trust scored 80% on this measure, which was an improvement on previous scores.

During the COVID-19 pandemic, NHS Improvement/NHS England advised trusts to de-prioritise 7-day service audits, so there have been none since 2019. However, the Trust has continued to work to improve its 7-day service offer and continues to track progress on 7-day service delivery internally. We have continued to invest in more sustainable consultant rotas overnight, to make it more likely that a consultant will be able to see a patient quickly when admitted in the evening. We have also continued to invest in digital patient tracking systems which enable us to take pro-active steps where patients are at risk of waiting too long for a consultant review.

We have a 7 Day services working group, led by the trust’s Medical Director, which has developed some internal standards which better reflect the specific needs of our trust and its patient group. This means, for example, that we have expanded our monitoring of 7-day service provision beyond the acute hospital.

There have been some minor changes to the clinical standards in recent months, including an increase in the types of doctors who can see patients for Standard 2, an increase in the numbers of relevant procedures for Standard 6, and the option to derogate from Standard 8 in some circumstances. These changes have the potential to increase our compliance rates.

The Trust will provide its next update to the Board in early 2023/24, when we will also include information on compliance from Yeovil District Hospital as part of the newly enlarged Somerset FT. this update will comply with the new guidance from NHS England on Board reporting for Seven Day Service compliance

NATIONAL QUALITY INDICATORS

Due to the COVID-19 pandemic, many of the national indicators have not been updated for 2022/23. In addition, where data for indicators are available, they are not appropriately benchmarked for an integrated Trust delivering the range of services provided by Somerset FT. Therefore, this section covers only the relevant national indicators where appropriate data is available and is only benchmarked where appropriate.

Summary Hospital-Level Mortality Indicator (SHMI)

Related domain: (1) Preventing people from dying prematurely

The Summary Hospital-Level Mortality Indicator (SHMI) is a standardised mortality indicator. It expresses actual deaths compared to an expected value. In this case, 'average' is represented by a value of 1.0.

The Trust's overall SHMI over the past years is represented in the table below:

Reporting Period	Ratio (Banding)	England	Lowest Trust	Highest Trust
April 2022 to March 2023	Data due to be published August 2023 and will be reflect the current Trust structure			
April 2021 to March 2022	1.0329 (as expected)	1.0000	0.6964	1.1942
April 2020 to March 2021	0.9983 (as expected)	1.0000	0.6908	1.2010
April 2019 to March 2020*	0.9331 (as expected)	1.0000	0.6851	1.1997

*Data prior to April 2020 is for Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust which has been combined by NHS digital and published in 2020/21.

NB: 1.00 is the SHMI average, values lower than 1.00 indicated better than average.

The Somerset FT considers that this data is as described for the following reasons:

- There has been continued focus on initiatives related to safety that have reduced the number of avoidable deaths in a range of specialties.
- Routine review of Healthcare Evaluation Data (HED) by speciality, procedure and diagnosis groups has provided early warning of problems in patient care.
- The model used to predict mortality rates will not fully reflect the changes in services and case mix resulting from the coronavirus pandemic.

The Somerset FT intends to take the following actions to improve on this rate, and so the quality of its services:

- by regularly monitoring outcomes through tools such as Healthcare Evaluation Data and the NHS digital SHMI dashboard.

- by identifying where outcomes appear to be deviating. This allows the Trust to investigate and verify the result and provides an early opportunity to make improvements to patient treatment pathways.

Percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust

Reporting Period	Somerset FT*	England	Lowest Trust	Highest Trust
April 2022 to March 2023	Data due to be published August 2023 and will be reflect the current Trust structure			
April 2021 to March 2022	20%	40%	11%	66%
April 2020 to March 2021	19%	38%	9%	63%
April 2019 to March 2021	22%	37%	9%	58%

*Data prior to April 2020 is for Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust which has been combined by NHS digital and published in 2020/21.

The Somerset FT considers that this data is as described for the following reason:

- The national standard for coding requires the addition of the palliative care code only when a specialist palliative care team have been involved in the patient's episode of care. The Somerset FT palliative care team empowers clinicians of all specialties to deliver high quality end of life care. This generalist activity is not reflected in this data. Many people will receive high quality 'palliative care' by generalist teams which will not be coded under the current rules.

The Somerset FT intends to take the following actions to improve on this rate, and the quality of its services by:

- monitoring palliative care rates (those seen by the specialist team) at the mortality surveillance group meeting. Those seen should have specialist needs which the ward teams cannot meet.
- Using palliative care activity data to support the validation of palliative care cases for clinical coding.
- continuously auditing the use of the end-of-life care pathway, a generalist tool to improve individualised care in the last days of life for use and quality of use. This is not reflected in the current coding activity.

Patient Reported Outcome Measures (PROMS)

Related domain: Domain 3 - Helping people to recover from episodes of ill health or following injury

PROMs measure a patient's health status or health-related quality of life from their perspective. Typically, this is based on information gathered from a questionnaire that

patients complete before and after surgery. The figures in the following tables show the percentages of patients reporting an improvement in their health-related quality of life following four standard surgical procedures, as compared to the national average.

The Trust's overall adjusted average health gain for each procedure group is represented in the table below:

Primary hip replacement surgery (EQ-5D Index)

(2019/20 finalised data due August 2020)

Reporting Period	Adjusted average health gain	England	Lowest Trust	Highest Trust
April 2022 to March 2023	Provisional data due to be published by NHS England in August 2023			
April 2021 to March 2022	Finalised data was due February 2023 but has not been published by NHS England			
April 2020 to March 2021	*	0.47	0.39	0.57

*Data suppressed (not enough responses)

Primary knee replacement surgery (EQ-5D Index)

(2019/20 finalised data due August 2020)

Reporting Period	Adjusted average health gain	England	Lowest Trust	Highest Trust
April 2022 to March 2023	Provisional data due to be published by NHS England in August 2023			
April 2021 to March 2022	Finalised data was due February 2023 but has not been published by NHS England			
April 2020 to March 2021	*	0.32	0.18	0.40

*Data suppressed (not enough responses)

Somerset FT considers that this data is as described for the following reasons:

- Elective surgery was disrupted in period due to COVID-19 pandemic.

Somerset FT intends to take the following actions to improve on this rate, and so the quality of its services:

- Improving our participation rate by working with the approved contractor to improving the process of having forms available to issue to patients so that more patients have the opportunity to take part in PROMS.
- Monitoring the adjusted average health gain through the Trust Data Outlier Review Meeting and sharing with the clinical and management teams.

Patients readmitted to a hospital within 30 days of being discharged

Related domain: Domain 3 - Helping people to recover from episodes of ill health or following injury

Whilst some emergency readmissions following discharge from hospital are an unavoidable consequence of the original treatment, others could potentially be avoided through ensuring the delivery of optimal treatment according to each patient's needs, careful planning, and support for self-care. Because of the complexities in collating data, national and local rates are significantly in arrears. It should also be noted that a readmission is counted for a patient within the 30-day period, even if it is for an entirely different problem, e.g., a discharge following a hip replacement and readmission due to a stroke.

The Trust's readmission rate split by ages group is represented in the tables below:

The percentage of patients readmitted to any hospital in England within 30 days of being discharged from hospital after an emergency admission during the reporting period, aged 0 to 15

Reporting Period	Percentage	England	Lowest Trust	Highest Trust
April 2022 to March 2023	Data due October 2023			
April 2021 to March 2022	14.6	12.5	3.3	46.9
April 2020 to March 2021	12.8	11.9	2.8	64.4

The percentage of patients readmitted to any hospital in England within 30 days of being discharged from hospital after an emergency admission during the reporting period, aged 16 or over

Reporting Period	Percentage	England	Lowest Trust	Highest Trust
April 2022 to March 2023	Data due October 2023			
April 2021 to March 2022	12.3	14.7	2.1	142.0
April 2020 to March 2021	13.2	15.9	1.1	112.9

Somerset FT considers that this data is as described for the following reasons:

- The percentage for patients aged 16 or over is significantly lower than the national average at the 99.8% level, and the percentage of patients aged 0 – 15 is significantly higher than the national average at the 99.8% level. This is thought to be due to the combination of services and settings offered by the Trust which is different to most Trusts being compared against.

- The Trust has introduced enhanced recovery programmes in various specialties, which would indicate that appropriate discharge criteria are being maintained.
- The Trust has a strategy to manage as many cases as possible as 'ambulatory' to minimise overall admission and length of stay.
- The Trust operates an open admission list system for children who have a chronic condition.
- Children with life limiting conditions, such as oncology related disorders and immune compromising disorders, have repeated admissions due to medical management of their condition.

Somerset FT intends to take the following actions to improve on this rate, and so the quality of its services:

- Continuing to monitor readmission rates for various procedures and conditions, as this can provide information about clinical teams in greater detail. This would allow improvements to be directed at the areas that most require them.
- Increased use of ambulatory care and urgent clinics to manage emergency care pathways.
- Working with other health and care providers in Somerset to ensure alternatives to admission are accessed where appropriate.
- Regular assessment of the reasons for admission to ensure that, within specialities and conditions, there are no trends apparent or evidence of readmissions indicating a problem in clinical treatment or processes.

Rate of Clostridium difficile infection

Related domains (5) Treating and caring for people in a safe environment and protecting them from avoidable harm.

Clostridium difficile infection (CDI) can cause diarrhoea and sometimes severe inflammation of the bowel. It can occur when the normal bacteria in the gut are disturbed, usually by taking antibiotics. Although not all cases are preventable, the rate of CDI hospital onset cases (those detected three or more days after admission) are an important indicator of improvement in protecting patients from avoidable harm and provide a useful tool for making comparisons between organisations and tracking improvements over time.

Reporting Period	Somerset Foundation NHS FT Trust-apportioned CDI rate per 100,000 bed days*	National Average (England)	Lowest Trust (Southwest)	Highest Trust (Southwest)
April 2022 – March 2023	14.57	23.47	9.91	49.81
April 2021 – March 2022	15.7	22.78	9.32	57.45

Reporting Period	Somerset Foundation NHS FT Trust-apportioned CDI rate per 100,000 bed days*	National Average (England)	Lowest Trust (Southwest)	Highest Trust (Southwest)
April 2020 – March 2021	10.94	14.72	8.29	35.15
April 2019 – March 2020	6.89	15.5	0.0	64.6
April 2018 – March 2019	9.0	13.6	0.9	90

**The data in this table are relevant to acute trusts only. As information is only available from before April 2020, the data presented is from Taunton and Somerset Foundation Trust (which merged with Somerset Partnership NHS Foundation Trust in April 2020 to form Somerset NHS Foundation Trust).*

Somerset FT considers that this data is as described for the following reasons:

- The case numbers and rates of CDI have increased in the last year which is in line with a regional and national increase.
- When compared to a regional rate, we compare well and are ranked the second lowest trust for the last year.
- When compared to the national rate we have a lower rate than the national average.
- Despite this we are experiencing higher case numbers and rates than the previous four years

Somerset FT intends to take the following actions to improve this rate, and so the quality of its services, by:

- Review the risk factors for trust apportioned cases to identify themes and new learning, sharing this learning in the organisation and driving further improvements.
- Continuing to work with the Regional Infection Control and Management Team on CDI reduction strategies.
- Continuing to reduce the CDI risk associated with antibiotic treatment through robust antibiotic stewardships and further review of antimicrobial guidance, where appropriate.
- Prompt isolation of all symptomatic patients as well as previous CDI cases, where there is an increased risk of recurrence.
- Continuing to give scrupulous attention to hand hygiene, decontamination, and cleaning practices.

Patient safety incidents reported to the national reporting and learning system

The National Reporting and Learning System (NRLS) collects and collates information from the incident databases of health service providers to provide thematic reviews and share wider learning about patient safety through a system of safety alerts sent to every organisation.

The Trust's incident software has an automatic process for uploading its incidents to the National Learning and Reporting System (NRLS). Since the merger of Somerset Partnership and Taunton and Somerset NHS Foundation Trusts, incidents reported to the NRLS are:

Reporting Period	Number of Incidents Reported	Rate per 1,000 Bed Days			
		Somerset FT	Median for Similar Trusts	Lowest Trust	Highest Trust
Apr 2021 – Mar 2022	14,707	47.0	53.5	23.7	205.5
Apr 2020 – Mar 2021	14,843	58.0	54.4	27.2	118.7

Somerset FT considers that this data is as described for the following reasons:

- The Trust actively encourages reporting of incidents to enable learning to be obtained.
- The Trust has been involved in a range of work-streams led by its in-house improvement network to improve specific aspects of patient safety and to reduce incidents.
- The Trust has introduced a new incident reporting system across the merged organisation to simplify the process and provide access to a wider range of useful data for learning at all levels across the organisation.

Somerset FT intends to take the following actions to continue to improve this rate, and so the quality of its services, by:

- Further extending the use of "Excellence reporting" to enable the Trust to learn from when things go really well in addition to learning from when things do not go so well.
- Implementing the new Learning from Patient Safety Event national reporting system.

Number of Patient Safety Incidents that Resulted in Severe Harm or Death

The NHS National Patient Safety Agency (NPSA) provided the following definitions for severe harm or death:

- Severe – Any unexpected or unintended incident which caused permanent or long-term harm to one or more persons.

- Death – Any unexpected or unintended incident which caused the death of one or more persons.

Since the merger of Somerset Partnership and Taunton and Somerset NHS Foundation Trusts, severe harm and death incidents reported to the NRLS are:

Reporting Period	Number of Severe Harm / Death Incidents Reported	% of Total Incidents			
		Somerset FT	Average for Similar Trusts	Lowest Trust	Highest Trust
Apr 2021 – Mar 2022	198	1.3%	0.4%	0.1%	1.7%
Apr 2020 – Mar 2021	208	1.4%	0.4%	0%	2.8%

Somerset FT considers that this data is as described for the following reason:

- Some data for the period was provided via legacy systems from the predecessor trusts. The Trust has introduced a new incident system from July 2020.
- Although Somerset FT is benchmarked against acute (non-specialist) organisations, its services include mental health provision, which always has a much higher percentage of severe harm and death incidents reported.

Somerset FT has taken the following actions to improve this rate, and so the quality of its services, by:

- Introducing a range of work-streams to improve specific aspects of patient safety and to reduce incidents.
- Improvements made in the quality and general approach to action planning to learn from incidents; including processes for measurement and audit to ensure learning is embedded.
- Encouraging reporting of incidents and near misses and greater consistency in the rating of incidents.

Patients admitted to hospital who were risk assessed for venous thromboembolism

Related domain: Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm

The Trust's overall percentage over the past years is represented in the table below:

Reporting Period	Percentage	England	Lowest Trust	Highest Trust
April 2021 to March 2022	90.3%	Data submission suspended		

April 2020 to March 2021*	91.7%	Data submission suspended

*Does not include Acute data for April to June 2020

Somerset FT considers that this data is as described for the following reasons:

- National data submission were suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic. Local data collection was maintained in community and mental health settings, and from July 2020 for Acute settings.
- Medical staff receive training as part of the induction programme in the protocol for risk assessment. This applies when patients are admitted as emergencies as well as for planned procedures.
- These data represent those patients with a risk assessment in place on admission. It does not account for cases where the risk assessment form is not fully completed or inaccurate.

Somerset FT intends to take the following actions to improve on this rate, and so the quality of its services:

- Implement a digital solution in the acute setting so that an electronic version of the VTE risk assessment form is completed in full on admission and that patients are reassessed at 24 hours post admission.
- Using the data from electronic risk assessment forms across all settings to continue to monitor compliance with this requirement and to provide support to teams to deliver this where required.

INFORMATION ON PARTICIPATION IN CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

National Clinical Audit Participation

During 2022/23, there were 58 national clinical audits and eight national confidential enquiries detailed within the NHSE Quality Accounts list which covered relevant health services that Somerset FT provides. Two national audits were put on hold by the providers, leaving a total of 56.

During that period Somerset FT participated in 55/56 (98%) national clinical audits and 8/8 (100%) national confidential enquiries which it was eligible to participate in.
The national clinical audits and national confidential enquires that Somerset FT were eligible to participate in during 2022/23 are as follows:

National Audit Title	Partici-pated	Status
Adult Respiratory Support Audit	Yes	Data collecting
BAUS Urology: Muscle Invasive Bladder Cancer at Transurethral Resection of Bladder (MITRE)	Yes	National report awaited
Breast and Cosmetic Implant Registry	Yes	National report awaited
Case mix programme - ICNARC	Yes	National report awaited
Elective surgery - PROMS	Yes	Low participation rates
Emergency Medicine: Care of Older People	Yes	Deferred 2023-24
Emergency Medicine: Pain in Children	Yes	Deferred 2023-24
Emergency Medicine: Mental Health (self-harm)	Yes	Data collecting
Epilepsy12 audit	Yes	National audit awaited
Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls	Yes	Continual data collection
Falls and Fragility Fracture Audit Programme: National Hip Fracture Database (NHFD)	Yes	Continual data collection
Falls and Fragility Fracture Audit Programme: Fracture Liaison Service Database	Yes	National report awaited
Inflammatory Bowel Disease (IBD) registry	Yes	National report awaited
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	Yes	Ongoing submission
MBRRACE-UK	Yes	Continual data collection
National Adult Diabetes Audit: Core diabetes audit	Yes	National report awaited
National Adult Diabetes Inpatient Safety Audit	Yes	Data collecting
National Diabetes Audit: Diabetes Foot Care audit	Yes	Continual data collection
National Diabetes Audit: National Pregnancy in diabetes audit (NPID)	Yes	National report awaited
National Asthma and COPD Audit Programme (NACAP): Adult Asthma	Yes	Continual data collection
NACAP: Children and young people	Yes	Continual data collection
NACAP: COPD	Yes	Continual data collection
National Audit of cardiac rehabilitation (NACR)	Yes	Data collecting

National Audit Title	Partici-pated	Status
National Audit of Dementia	Yes	National report awaited
National Bariatric Surgery Registry (NBSR)	Yes	Continual data collection
National Audit of Metastatic Breast Cancer	Yes	Planning
National Audit of Primary Breast Cancer	Yes	Planning
National Cardiac Arrest Audit (NCAA)	Yes	Continual data collection
National Cardiac Audit Programme: Myocardial Ischaemia (MINAP)	Yes	Continual data collection
National Cardiac Audit Programme: National Audit of Cardiac Rhythm Management (CRM)	Yes	Continual data collection
National Cardiac Audit Programme: Adult Percutaneous Coronary Interventions	Yes	Continual data collection
National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Data collecting
National Cardiac Audit Programme: National Heart Failure Audit	Yes	Data collecting
National Clinical Audit of Psychosis (EIP)	Yes	Local report pending
National early inflammatory arthritis audit (NEIAA)	Yes	Data collecting
National emergency laparotomy audit (NELA)	Yes	Continual data collection
National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit (NBOCA)	Yes	Data collecting
National Gastro-intestinal Cancer Programme: National Oesophageal-gastric cancer audit (NOGCA)	Yes	National report awaited
National joint registry	Yes	Data collecting
National lung cancer audit (NLCA)	Yes	Local briefing pending
National audit of breast cancer in older people (NABCOP)	Yes	Data collecting
National maternity and perinatal audit (NMPA)	Yes	Data collecting
National neonatal audit programme (NNAP)	Yes	National report awaited
National Ophthalmology Database	Yes	Continual data collection
National Paediatric diabetes audit (NPDA)	Yes	Continual data collection
National Prostate cancer audit	Yes	Data collecting
National Vascular registry	Yes	Data collecting
Prescribing Observatory for Mental Health: Prescribing Valproate	Yes	National report awaited
Prescribing Observatory for Mental Health: Use of Melatonin	Yes	Local briefing pending
Sentinel stroke national audit programme (SSNAP)	Yes	Data collecting
Serious Hazards of Transfusions: UK national haemovigilence scheme (SHOT)	Yes	Continual data collection
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Completed
Major Trauma audit - TARN	Yes	Continual data collection
UK Cystic fibrosis registry	Yes	Data collecting
UK Parkinson’s Audit	Yes	Local briefing pending

National Audit Title	Partici-pated	Status
BTS – Tobacco dependency – maternity services	N/A	Nationally on hold
BTS – Tobacco dependency – mental health	N/A	Nationally on hold
National audit of Care at the End of Life (NACEL)	No	Service requested to not participate this year, to give time to focus on existing action plan. Agreed by Directorate governance and Data Outlier Review Meeting.

National audits falling outside the scope of the Trust's services

These projects were included within the NHSE Quality Accounts list but relate to service types other than those the Trust provides, included for completeness:

National Audit Title	Notes
National Audit of Cardiovascular Disease Prevention	Not relevant to this Trust (primary care)
National Cardiac Audit Programme: Adult Cardiac Surgery	Not relevant to this Trust
National Cardiac Audit Programme: National Congenital Heart Disease (NCHDA)	Not relevant to this Trust
Cleft Registry and Audit Network (CRANE)	Not relevant to this Trust
National Child Mortality Database (NCMD)	Not relevant to this Trust – data comes from Child Death Overview Panels
National Asthma and COPD Audit Programme (NACAP): Pulmonary Rehabilitation	Not relevant to this Trust
National audit of pulmonary hypertension (NAPH)	Musgrove cases are reviewed by one of the 8 participating centres
Neurosurgical national audit programme	Not a neurosurgical centre
Out-of-hospital Cardiac Arrest Outcomes (OHCAO) Registry	Not relevant to this Trust
Paediatric intensive care audit network (PICAnet)	Do not have a standalone paediatric intensive care unit
UK Renal Registry National Acute Kidney Injury Programme	Not relevant to this Trust

National Confidential Enquiries with active participation during 2022/23:

Name of Confidential Enquiry	Status
NCEPOD: End of Life Care	Planning (2023-24)
NCEPOD: Rehabilitation following critical illness	Planning (2023-24)
NCEPOD: Testicular Torsion	Data collecting
NCEPOD: Community Acquired Pneumonia	Data collecting
NCEPOD: Endometriosis	Data collecting
NCEPOD: Transition for child to adult health services	National report awaited

NCEPOD: Crohn's Disease	National report awaited
NCEPOD: Epilepsy	Local action plan awaited

THE TRUST'S RESPONSE TO NATIONAL AND LOCAL AUDIT FINDINGS

Action plans are developed for all audits where significant issues are identified, and where the Trust intends to take actions to improve the quality of the healthcare provided.

NATIONAL CLINICAL AUDIT

The reports of 57 national clinical audits were reviewed by the provider in 2022/23:

- 3 from 2018/2019
- 11 from 2019/2020
- 24 from 2020/2021
- 17 from 2021/2022
- 2 from 2022/2023

Thirty-one of these completed audits identified actions to improve the quality of healthcare provided:

Bladder Outflow Obstruction (BOO) Snapshot

BOO measured compliance with NICE and European Association of Urology (EAU) guidelines and variation in assessment and treatment, including waiting times and indications for surgery across the UK

Actions include:

- Day case steam therapy (Rezume) being implemented.
- Day case transurethral resection of the prostate being assessed with procurement
- Day case prostate artery embolization service being implemented

Fracture Liaison Service Database (NFLS)

The purpose of a fracture liaison service is to reduce recurrent hip and other fractures by ensuring delivery of effective secondary prevention. This annual report describes the secondary fracture prevention received by patients 50 years and older in England and Wales

Actions include:

- Review data capture for inaccuracies to improve quality of data submitted
- Local audit of telephone clinic for 12-16 week follow up
- Improve strength and balance services by linking with AGE UK to review referral pathway due to limited falls clinic in Somerset

Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme (CMP)

CMP is an audit of patient outcomes from adult, general critical care units (intensive care and combined intensive care/high dependency units) covering England, Wales and Northern Ireland.

Actions include:

- Local audit to review delays to admission
- Review upward curve in hospital mortality (which remains within national averages) to ascertain if this is a continuing trend
- Link with Yeovil District Hospital to share results and further ways to improve the service across both sites

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)

The scope of MBRRACE:

- Surveillance and confidential enquiries of all maternal deaths
- Confidential enquiries of an annual rolling programme of topic specific serious maternal morbidity
- Surveillance of all late foetal losses, stillbirths and neonatal deaths
- A biennial programme of topic specific confidential enquiries into aspects of stillbirth and infant death or serious infant morbidity

Actions include:

- Local mortality report for perinatal deaths in 2022
- Review of post-mortem training
- Create new reporting code within the incident reporting platform (RADAR) for ‘late miscarriages’ to ensure all reportable deaths are captured

National Audit of Care at the End of Life (NCAEL) Round 3

NACEL reviews deaths in an inpatient setting taking into account the experiences of the dying person, those close to them, and for the first time in 2021, a baseline survey on staff experience of delivering end of life care

Actions include:

- Inclusion of 7 day working in merger work force planning
- Review the rapid discharge process for patients from acute and community hospitals
- Review Assessment, Management, Best Practice, Engagement and Recovery Uncertain care bundle
- Promote End of Life training, including Just in Case medications
- Include nutrition and hydration, and potential for sedation within the Syringe Pump training

National Audit of Dementia – Memory Services Spotlight Audit

This spotlight audit examined waiting times, access to assessments, treatment and post-diagnostic support for people with dementia in memory assessment services, in the context of the COVID-19 pandemic.

Actions include:

- Review of triage prompt sheet to ensure key questions are screened
- Ad hoc audits of Memory Assessment Services documentation within local teams

National Audit of Inpatient Falls (NAIF) – includes 2020 and 2021 rounds

NAIF examines delivery and quality of care for patients over 60 who fall and sustain a fracture of the hip or thigh bone in acute, mental health, community and specialist NHS trusts/health boards in England and Wales. NAIF reviews the care the patient has received before their fall as well as the post fall care.

Actions include:

- Implementation of a system to assess the gap between actual and reported falls
- Local audit of appropriateness of bed rail use within the Trust
- Appropriate flat lifting equipment to be provided (along with training)
- Develop falls training package
- Carry out a Quality Improvement (QI) project to redesign the falls proforma

National Bowel Cancer Audit (NBOCA) 2021/22 and 2020/21 rounds

NBOCA aims to describe and compare the quality of care and outcomes of patients diagnosed with bowel cancer in England and Wales.

Actions include:

- Reducing length of stay with access to pre-habilitation programmes, investment in minimally invasive surgical techniques, regular review of data
- Support day surgery/hospital at home expansion programme
- Appointed specialty doctor to lead on outcome data assessment 3 monthly

National Cardiac Arrest Audit (NCAA)

The NCAA is the clinical comparative audit for in-hospital cardiac arrest. The purpose is to promote local performance management through the provision of timely, validated comparative data.

Actions include:

- Upgrade existing report form to a better format that is easier and quicker to use

National Clinical Audit of Psychosis (NCAP) – Early Intervention for Psychosis

This audit provides national benchmarking across all Early Intervention in Psychosis (EIP) teams in England and Wales and forms the fourth round of this audit.

Actions include improving current provision for children and young people by:

- Ongoing quarterly monitoring of all domains
- Development of county-wide At-Risk Mental State (ARMS) provision
- Child and Adolescent Mental Health Services (CAMHS) link workers identified to liaise with CAMHS, improve identification of First Episode Psychosis (FEP) and prompt referral, bolster Somerset Team for Early Psychosis (STEP) and CAMHS value added care protocol and develop reciprocal training events

National Clinical Audit of Psychosis (Employment and Physical Health)

NCAP aims to improve the quality of care that NHS mental health trusts in England and Health Boards in Wales provide to people with psychosis.

Employment: measures access to employment support, which will help people with severe mental illness to find and retain employment

Actions include:

- Use of Dialog+ (user focused collaborative care planning process) to develop employment, educational and vocational issues and goals, and facilitate accurate recording

Physical Health: measures physical health monitoring and interventions offered to people with psychosis seen by adult community mental health services across England and Wales.

National Comparative Audit of NICE Quality Standards QS138

Patient Blood Management (PBM) is a multidisciplinary, evidence-based approach to optimising care of patients who might need a blood transfusion. The deployment of PBM initiatives reduces inappropriate transfusion, which improves patient safety, reduces hospital costs and helps to ensure the availability of blood components.

Actions include:

- Undertake local audit to provide assurance where data was not available for national audit
- Updated Tranexamic acid (TXA) guidance to be shared with all anaesthetists

National Diabetes Footcare Audit (NDFA) multiple rounds covering the periods 2018-2021

The aim of the NDFA is to measure factors associated with increased risk of ulcer onset and adverse ulcer outcomes. It aims to share information relating to best clinical practice, and to enable the highest quality of care of diabetic foot ulcers in England and Wales

Actions include:

- Development of virtual weekly red flag clinics
- Restarting acute rotations to upskill podiatrists and improve care planning
- New equipment to aid vascular assessment and timely referral
- Development of new coding system

National Early Inflammatory Arthritis (NEIAA) Year 4

NEIAA is a programme of work that aims to improve the quality of care for people living with inflammatory arthritis, collecting information on all newly diagnosed patients over the age of 16 referred into specialist rheumatology departments in England and Wales.

Actions include:

- Increasing data submission to NEIAA to reflect accurate practice
- Raise concerns with Service Governance Group with regards to reviewing patients at the three-month stage

National Heart Failure Audit (NHFA)

NHFA deals with a specific and crucial phase in the trajectory of patients with heart failure. It reports on the characteristics of patients requiring admission to hospital with heart failure (HF) and describes their in-hospital investigation, treatment, access to specialist care.

Actions include:

- Recruitment of additional sonographers
- Use of community diagnostic centre
- Promotion of heart failure nurse service within the Musgrove Park Hospital
- Quality improvement programme to develop heart failure checklist for AMU, and inpatient acute pathway/protocol

National Maternity and Perinatal Audit (NMPA)

The NMPA is a large-scale audit of the NHS maternity services across England, Scotland and Wales. The audit aims to evaluate a range of care processes and outcomes to identify good practice and areas for improvement in the care of women and babies.

Actions include:

- Local rolling audit to monitor low APGAR (Appearance, Pulse, Grimace, Activity, Respiration) scores
- Review each case of a low APGAR score and report to maternity and neonatal governance meetings
- Local rolling audits for more serious perineal tears, and induction of labour, reporting to maternity and neonatal governance meetings

National Neonatal Audit Programme (NNAP)

NNAP is a national clinical audit of care for babies admitted to neonatal services. The audit reports on key measures of the processes and outcomes of neonatal care.

Actions include:

- Local review to be carried out for those babies outside the normal temperature range identified in the ongoing rapid monitoring for all admitted infants

- Babies with central line associated bloodstream infections:
    - Care bundle to be updated
    - Consultants to agree on techniques that are best practice
    - Ultrasound education pack to be shared

Prescribing Observatory for Mental Health: The use of Melatonin

Current guidance on management of insomnia in children proposes that once physiological reasons for sleep disturbance are excluded, interventions that aim to change parents' management of their child's sleep should be the next step. Pharmacological interventions (such as melatonin) are recommended where such interventions prove ineffective or alongside parent-directed approaches.

Actions include:

- Development of a comprehensive sleep clinical stepped care pathway
- Joint shared care policy and clear clinical pathway for melatonin prescribing
- All versions of melatonin leaflets to be available in Medicines section of intranet

Prescribing Observatory for Mental Health: Prescribing for Depression

NICE guidelines propose a 'stepped care' approach to the treatment of depression. Most depressed patients seen in secondary care mental health services meet Step 3 criteria (depression with inadequate response to initial interventions) and Step 4 (severe and complex depression including risk to life) and require more intensive treatment. This audit looks at effective gatekeeping, prescribing and review.

Actions include:

- Facilitated discussions around gatekeeping
- Develop a template to facilitate accurate and comprehensive recording

Prescribing Observatory for Mental Health: Valproate prescribing

Valproate is an effective and evidence-based treatment for a range of indications; however the risks associated with treatment need to be carefully managed to prevent patient harm and major congenital abnormalities for children born to women taking valproate during pregnancy.

Actions include:

- Explore feasibility of developing a register of all patients prescribed valproate
- Review electronic patient record training for prescribers, to highlight where to find the Pregnancy Prevention Programme (PPP) assessment
- Pharmacy team to screen all prescriptions within 72 hours of admission, to identify patients prescribed valproate and ensure standards are followed
- Pharmacy teams to obtain quarterly reports from electronic patient record for any community patient prescribed valproate, to allow monitoring of completion of PPP

Royal College of Emergency Medicine: Assessing for Cognitive Impairment in Older People

This Quality Improvement Project (QIP) tracked the performance in emergency departments (ED) against clinical standards in individual departments and nationally, focusing on:

- Assessment for cognitive impairment during a visit to the ED
- Documentation of identified cognitive impairment in the ED
- Assessment using an established pathway when cognitive impairment is identified

Actions include:

- Appointment of Older Persons/Frailty Link Nurse
- Inclusion of Older Adults ED assessment topics in twice weekly safety huddle
- Update trauma screening tool to explicitly trigger senior review where required
- Addition of clinical frailty score to safety checklist for majors and resus patients

Sentinel Stroke National Audit Programme (SSNAP)

SSNAP is a major national quality improvement programme, measuring how well stroke care is being delivered in inpatient and community settings in England, Wales and Northern Ireland.

Actions include:

Community:

- Improve multi-disciplinary working by effective use of board rounds and patient discussion forums
- Link closely with adult social care to improve patient flow
- Local audit to identify the reason why compliance for applicable patients receiving a mood and cognition screening by discharge has fallen during the period covered

Acute:

- Local quarterly audit for thrombolysis to identify trends/areas for improvement
- Awareness sessions to improve needle to door time
- Review and improve the SSNAP data collection process

Society for Acute Medicine's Benchmarking Audit (SAMBA)

SAMBA provides a snapshot of the care provided for acutely unwell medical patients in the UK over a 24-hour period on Thursday 23rd June 2022.

Actions include:

- Recruiting for additional resource to manage medical patients for admission with prolonged stays in ED

Trauma Audit & Research Network (TARN) 2019/20, 2019/20 and 2020/21

TARN measures and monitors process of care and outcomes to provide local, regional & national information on trauma performance and patient outcomes.

Actions include:

- In-house training programme for nursing trauma competencies
- Trauma booklet designed and implemented in ED
- New trauma triage tool for adult and paediatric patients
- Improving access for urgent trauma CT scans

LOCAL CLINICAL AUDIT

The reports of 136 local clinical audits were reviewed by the provider in 2022/23. Action plans are developed for all audits where significant issues are identified, and where the Trust intends to take actions to improve the quality of the healthcare provided.

Of the 136 local clinical audits reviewed, 132 required action plans, and the following 20 are examples of projects conducted by clinical teams across the Trust and the changes proposed as a result of them:

Audiology: Cochlear Implant (CI) Criteria and Referral Audit

The aim of this audit was to identify whether all patients who meet CI criteria are given the opportunity to discuss cochlear implants and the referral rate.

Actions include:

- CI questions added to more hot keys in audit
- Two CI assessment referral templates created in EPRO
- Reminders to the department regarding CI referral criteria and where to find resources on the intranet
- Patients where no discussions were recorded will be sent letters offering the opportunity to have a discussion with an audiologist regarding CI implants

Acute Medical Unit (AMU): Treatment Escalation Plans (TEP)

The aim of this audit was to determine and improve TEP completion rates on patients moving from AMU to Barrington Ward.

Actions include:

- Improve weekend completion of TEP forms by raising awareness of this in monthly acute physician meetings
- Scheduled re-audit

Perinatal Mental Health (PMHT): Management and outcomes of borderline personality disorder (PD) patients

The aim of this audit was to determine the extent to which the guidelines in the RCPsych Report on Perinatal Mental Health Services CR232 and the NICE guidelines on Borderline PD are being followed and fulfilled within the Somerset Perinatal MH Service and put in place actions to address any improvements identified

Actions include:

- Multidisciplinary team (MDT) will be involved/informed of any decision regarding medic involvement only, via MDT meeting with clear rationale evidenced
- MDT will be involved/informed of any discharge of patients without assessment via MDT meeting
- PMHT medics to ensure diagnosis is recorded following assessment and discussion with client. Medical Secretary to flag any confirmed diagnosis in GP letter if not completed.
- PMHT assessment to be updated to give clear prompts regarding family/carer involvement
- 'Triangle of Care' heading to be used in all progress notes evidencing family/carer involvement

Cardiology: Re-audit of Discharge Summaries for patients who have had Myocardial Infarction (MI) Treatment

The aim of the audit was to improve the quality of discharge summaries of patients admitted with ST segment elevation myocardial infarction (STEMI)/Non-ST elevation myocardial infarction (NSTEMI), increasing the inclusion of relevant information on diagnosis, investigations, and management upon discharge as according to NICE guidelines NG185. This audit has been repeated annually, with an improvement for each standard demonstrated each year.

Actions include:

- Revisions to record keeping and promotional posters
- Ongoing education

Maternity: World Health Organisation (WHO) Safety Checklist

This audit reports and monitors performance of the maternity compliance with the maternity theatre WHO safety checklist. The checklist is designed tool to act as a safety net and promote safe practice.

Actions include:

- Reminders on governance weekly newsletter regarding full completion of the WHO checklist
- Ensure the correct procedure/category of lower (uterine) segment Caesarean section (LSCS) is updated if it changes
- Share audit at presentation meeting
- Re-audit ongoing with aim of achieving ≥97% compliance ('green' status)

Mental Health: Electro-convulsive Therapy (ECT)

ECT is a treatment that involves sending electric current through the brain, to relieve the symptoms of some severe mental health problems. The purpose of this audit was to check that each patient receiving ECT is receiving the correct treatment, as outlined in the ECT Policy and identify any discrepancies or gaps in implementation or provision and address this.

Actions include:

- ECT staff to raise awareness with referring team of the following, and will discuss both elements in briefings prior to treatment, raising with referring teams if not done:
    - It is their responsibility to ensure medical reviews are completed after every two treatments.
    - To complete appropriate rating scales prior to treatment commencing.
- Annual reaudit scheduled.

Musculoskeletal Physiotherapy: Weight Management with Osteoarthritis (OA) Knee patients

The aim of this audit is to ensure weight management advice is given to overweight/obese patients, to maximise efficacy of OA Knee treatment.

Actions include:

- Training for managing weight loss conversations booked with dietetics team
- Provide visual prompt with BMI calculator on RiO
- Throughout hub and band 5 training in 2023 stress importance of good documentation

Mental Health Inpatients at Wellsprings Site: Smoking Cessation and Nicotine Replacement Therapy

The aim of this audit was to review if patients are offered smoking cessation advice / nicotine replacement therapy by the medical team. This was a project undertaken with 4 rounds over the 12 month period, with interventions added at each stage.

Actions include:

- Updating the multidisciplinary team proforma to include specific smoking cessation questions
- Patient leaflets to be made available on the ward
- Signposting patients to ‘Smoke Free Life Somerset’
- Implementation of nicotine replacement therapy during induction for new doctors

Children and Young People: Speech and Language Therapy (SLT): Cleft Lip and Palate Royal College SLT Guidelines

The aim of this audit is to ensure we are meeting the national guidelines of seeing children with cleft palate for their 2-year speech assessment by 27 months of age.

Actions include:

- Improve caseload tracking processes to enable easier identification of children who are due their 2-year speech assessment, and those who may be about to breach.
- Leadership team to ensure there is adequate cover for the Link SLT should there be a prolonged period of absence from service. This will be met through a traded service with the Southwest Cleft Team

Somerset-Wide Integrated Sexual Health Service (SWISH): Contraception for women over 40

The aim of this audit was to ensure that the service is providing recommended advice for women over 40 years of age regarding STI screening prior to Intrauterine device insertion, safe use of hormonal contraception as age associated risks increase, and when to cease using contraception.

Actions include:

- Revise the process for recording that patients have been counselled about when to stop using contraception, and add to counselling template

Maternity: Waterbirth re-audit

The aim of this re-audit was to compare compliance against previous rounds of this audit, and the Immersion in water for Labour Trust guideline.

Although compliance is demonstrated at 93% or higher for the three standards, the following actions have been taken:

- Continue update on mandatory training week, in the manual handling pool evacuation session, reminding midwives of the key points of the Immersion in Water Guideline
- Share Water Birth audit results in the Governance weekly newsletter
- Purchase digital temperature probes to provide continuous read out of pool temperature

Older Persons Mental Health (Taunton and West Somerset): Post Diagnostic Support in Memory Assessment Services

The aim of the audit was to assess the current provision of post-diagnostic support against NICE and other national guidance

Actions include:

- Develop standardised documentation guidance/template
- Develop practitioner guidance for post-diagnostic support, with regular peer supervision
- Develop a standardised referral process for post-diagnostic support
- Form a steering group for post-diagnostic support interventions
- Provide training to practitioners regarding the rationale for post-diagnostic interventions and recommendations

Paediatrics: Paediatric Cardiology Transition and Transfer process

The aim of this audit was to review the current transition and transfer process and to aid successful transition/Transfer from paediatric to adult cardiology services.

Actions include:

- To outcome all complex congenital heart disease (CHD) patients into Transition clinic on Maxims system as part of the process to request booking into next transition clinic
- Young Person Clinic – Nurse specialist to start seeing the young person who has been transferred but are not yet due a review to provide reassurance whilst waiting for their first review
- CHD Network in the southwest is starting a pilot of a transition clinic model, and this service has been accepted to take part, which will enable us to assess how much benefit this could have for our future patients

Ophthalmology: Wet Age-Related Macular Degeneration (ARMD): referral to treatment

The aim of this re-audit was to review referral to treatment times for patients with wet ARMD, compare against published NICE guidelines (NG82) and previous audit results

Actions include:

- Increase use of optical coherence tomography (OCT) angiography instead of Fundus fluorescein angiogram (FFA)
- Increase Consultant/Senior clinician imaging review capacity by appointment of consultant/specialty doctor, and increasing virtual review clinics in job plan
- Consultant review of the OCTA/FFA same day, by having a rota for Retinal Consultant available for opinion and advice
- Moving Macular Service from the hospital to the Ophthalmic diagnostic centre

Haematology: End of treatment summaries for patients completing chemotherapy for high grade non-Hodgkin's Lymphoma and Hodgkin's Lymphoma

The aim of this audit was to ensure that all patients who complete chemotherapy treatment for Lymphoma in Musgrove Park Hospital receive an end of treatment summary letter in line with current recommendations by the independent cancer taskforce report.

Actions include:

- Devise and add an End of Treatment letter template onto EPRO
- Circulate to all consultants with explanation and findings of audit
- Schedule re-audit to gauge levels of improvement

Primary Care Dental Service: Use of Flumazenil

When flumazenil is used, it should be justified within the patient's clinical record. The aim of this audit is to ensure this process is being followed.

Actions include:

- Devise and implement new sedation template (after consultation) to incorporate the dose and how it is given

- Agree a list of standard reasons for use of flumazenil for non-adverse events to add to template
- Clarify the definition of an adverse event relating to midazolam use, so that the sedation team know when an incident form should be completed, and add this to the Standard Operating Procedure

Mental Health Community Services: Care Planning and Risk

The aim of this re-audit was to ensure that record keeping / case notes meet the standards stated within the Care Planning policy and aligned clinical policies, and to ensure that risk information is up to date.

Actions include:

- The Case Note management tool to be used at every other line management supervision session by Team Managers for the following areas where improvements were highlighted as being required:
    - Somerset Team for Early Psychosis (STEP) and South Somerset Community Mental Health Service (CMHS): assessing for capacity
    - Bridgwater and South Somerset CMHS: recording next of kin
- Reaudit to be scheduled to demonstrate maintained high levels of compliance and where further improvements were identified

Musculoskeletal (Msk) Physiotherapy: Upper Limb – Subacromial Shoulder Pain Physiotherapy Pathway

The Somerset CCG criteria for subacromial shoulder pain requires that patients should have undertaken conservative management (for a minimum of 6 weeks) in Primary care. The audit aims to establish if patients are being managed within this pathway.

Actions include:

- Develop Msk Physiotherapy Hub training for subacromial pain, rehabilitation and engaging patients with their exercise programme
- All new Band 5 staff to attend shoulder training and to pass the competency assessment
- Include a case review in staff supervision sessions
- Clinical supervision of follow up appointments
- Schedule reaudit to ascertain levels of improvements, and extend this to include patient outcomes

Oral and Maxillofacial: Emergency Theatre list – time to theatre

The aim of this audit was to investigate the time that emergency maxillofacial patients take to get treated in theatre from the initial injury. Standards based on published papers and International Association for Dental Traumatology (IADT) guidelines

Actions include:

- More trauma clinics to be added per week to enable review and treatment of patients within the appropriate time period.

- Emergency trauma list to be devised so patients can be automatically added to that, rather than being added to an elective list and possibly missing the recommended time periods.
- Schedule reaudit to ascertain levels of improvements as a result of these interventions

Older Persons mental health community teams (OPMHT) and Intensive Dementia Service (IDS): Discharge process and communication with GPs

This audit was carried out as a result of a serious incident investigation, and mapped practice against the Community Mental Health Framework for adults/older adults, and Trust policies of Care Planning and Clinical Assessment and management of risk. It involved all OPMHT and IDS for the whole county.

Actions include:

- Develop a single method (and content) for discharge communications with GPs
- Team Managers to carry out ad hoc reviews of completed discharge summaries and feed back during supervision
- All team members to be up to date with Clinical Risk assessment and management mandatory training
- Ensure all staff are aware of changes to the care planning policy, including the need for all patients to have an escalation plan in place
- Ensure all staff are aware of changes being made to electronic records
- Schedule reaudit to ascertain improved levels of compliance

CLINICAL RESEARCH

The conduct of clinical research has never been more important to the UK Government, NHS and the Life Sciences industry. The UK is a Global leader in delivering innovative research with medicinal and pharmaceutical products in the top 3 goods exported from the UK. The government is keen to maintain the UK's global ranking and reputation for high quality research. The life science industry in the UK turns over £89 billion annually. Much of this work is conducted in partnership or close collaboration with universities and the NHS.

Research is core business of the NHS, and this is demonstrated by the recent publishing of a series of key strategies. The Health and Care Act (2022) placed new legal duties on Integrated Care Boards around the facilitation and promotion of health research and the use of evidence obtained from research in the delivery and development of health services. Integrated Care Systems have been encouraged to develop a research strategy and strategic development work has commenced in the South West with collaboration across Somerset, Devon and Cornwall along with the Academic Health Science Network. Additionally, implementation of the Chief Nursing Officer for England's strategic plan for research has commenced and Health Education England has published its' research and innovation strategy for Allied Health Professionals. All of this makes a rich background and culture for research and development to thrive.

Commercial collaborations

Dr Tim Jobson, consultant gastroenterologist, has continued to develop his project to improve early identification of patients with declining liver health. The Trust was awarded an NIHR invention for innovation (i4i) grant of circa £1.5m in 2019/20 to undertake the project, which is a collaboration between the Trust and commercial partners. The project has developed clinician guided case finding software that has been successful in identifying patients who have developed undiagnosed liver disease allowing them to be offered the chance to commence treatment at an earlier stage than before, prior to symptoms becoming evident. Dr Jobson is now planning to collaborate further to take forward research in wider populations and is also exploring whether the same technology can be used in other diseases to bring earlier diagnosis for patients at risk of developing potentially serious illness.

The Trust works with TrinetX, a commercial data warehouse that makes anonymised data available to approved research partners. Use of the platform continues, and in 2022/23 the Trust received 21 trial connect requests via the platform, 12 were declined, three accepted and six pending further review or information.

The Trust continues to be a prime site collaborative partner with IQVIA and is now also a partner in the Investigator Networks, Site Partnerships and Infrastructure for Research Excellence (INSPIRE) program alongside Pfizer. To qualify to be part of the programme the Trust is required:

- To run trial programmes to the highest standards and to timeline.
- To ensure dedicated, high quality staff and resources for conducting clinical trials.
- To ensure a positive experience for those patients participating in trials.

- To have expertise in the key disease areas that Pfizer is researching in its medicines pipeline.

Academic grants

The Trust has several academic, grant supported, studies in various stages of progression.

Miss Jo Morrison submitted a grant application in relation to post-natal cervical screening. The outcome is awaited.

The Trust has acted as sponsor for a study for which Dr Isy Douek, Consultant Endocrinologist, is Chief Investigator. This collaborative project with University of Plymouth aims to investigate nutritional and fertility outcomes in women of reproductive age before and after metabolic (weight loss) surgery. The £15,985 grant was awarded to University of Plymouth by the British Dietetic Society. The project has now closed and the data are being analysed.

The Love Musgrove Charity is supporting development of a local project led by Ana-Maria Toth, a Clinical Nurse Researcher based at Musgrove Park Hospital. The project involves investigating the use of hypnotherapy in relation to post-operative pain relief.

The Trust continues to collaborate with its local health community partners and work in support of the merger with Yeovil District Hospital NHS Foundation Trust is well underway.

The Trust is a partner organisation of the Biomedical Research Centre led by the University of Exeter and Royal Devon University Hospital to improve diagnosis, treatment and care, in the South West and across the world. It's five core themes for development include:

- **Neurodegeneration:** finding and testing new, better drugs that prevent and treat major brain conditions in older adults such as dementia and Parkinson's disease.
- **Rehabilitation:** Using exciting new approaches to help older people to recover from illness or manage their long-term conditions like dementia and arthritis.
- **Diabetes:** Improving diagnosis and treatment, and exploring how to help those most at risk
- **Genetics:** Unlocking the power of genetics, to improve diagnosis of rare illnesses in children and rare cancers, and to create tailored treatments for common diseases.
- **Clinical Mycology:** Seeking better treatments to prevent and manage potentially deadly fungal infections.

The Trust continues to support and promote non-medical research careers and clinical academic roles. These aim to support nurses and allied healthcare professionals as Principal Investigators (PIs), Associate PIs and will develop Chief Investigators of the future.

In November the Chief Nurse Research Fellowship scheme was launched and 15 fellowships have since been awarded. The annual scheme offers successful

applicants the opportunity of having one day paid per fortnight to undertake clinical academic career development, obtain clinical research delivery experience and the development of a work-based project.

Quality improvement

The research department is required to conduct an annual Patient Research Experience Survey the results of which for 2022/23 were positive with no action plans required.

During the year staff attended Bronze Quality Improvement training and have contributed to numerous quality improvement projects and initiatives across all research sectors.

Research Patient, Public Involvement and Engagement (PPIE)

The research department was successful in its bid for NIHR Research and Innovation Funding. The aim, to increase involvement and engagement activities in the research pathway, from ideas generation, study design and delivery, through to results dissemination. The key focus is on underserved communities. This funding has enabled the appointment of a PPIE Facilitator to provide support for the lay Somerset wide PPIE research steering group. To date, work has taken place to engage with the local council's diversity group, and mental health partners group, to identify any barriers to research, to seek solutions, and in doing so increase research accessibility and awareness, to enable equity in research opportunity.

Funding and activity

In 2022/23, the Trust was allocated £1,475,932 to support research staffing and infrastructure via the NIHR Clinical Research Network: South West Peninsula, with a further £74,756 directly from the Department of Health. Revenue from the conduct of research of £783,750 has been invoiced for, as at 17/05/2023. This revenue represents a significant increase on previous years and reflects the successful delivery of a growing proportion of commercial portfolio research.

The number of staff, carers and patients receiving relevant health services, provided or sub-contracted by Somerset FT, who were recruited in 2022/23 to participate in research approved by a research ethics committee was 1,936 (in 131 studies).

CARE QUALITY COMMISSION (CQC)

Somerset NHS Foundation Trust was inspected by the CQC in September 2022 and the report published on 23 January 2023.

The CQC team carried out a short notice announced inspection of the trust's acute wards for adults of working age and psychiatric intensive care unit, specialist community mental health services for children and young people and community end of life care services of the trust as part of their continual checks on the safety and quality of healthcare services. The CQC further inspected the well-led key question for the trust overall.

The CQC rated the trust's community mental health services for children and young people (CAMHS) as outstanding and our community end of life services and our acute wards for adults of working age and psychiatric intensive care unit as good overall.

The CQC praised the trust's work and said:

"it is a remarkable achievement to merge trusts at the beginning of a national pandemic and yet Somerset NHS Foundation Trust has continued to maintain the good quality of service that we had come to expect from both Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust".

The CQC inspection team found outstanding practice which it highlights in the report and includes the CAMHS team's work and approach to eliminating waiting times for the service and the work of community end of life team to consider the specific needs of patient groups and better meet their needs.

As part of its consideration of how "well-led" the trust is, the CQC observed a number of meetings and met leaders across the trust. The CQC also spoke to a range of patients, carers and colleagues about our services during their inspection, as detailed in their report. The CQC's inspection team noted that:

- The trust has a clear vision and set of values that colleagues understand.
- The trust has well-embedded clinical leadership.
- The senior leadership team demonstrated a high level of awareness of the priorities and challenges facing the trust and how these were being addressed.
- Overall leaders had the skills and abilities to run the service, were visible and approachable for patients and colleagues and supported colleagues to develop their skills and take on more senior roles.
- Leaders operated effective governance processes and colleagues at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn.
- Leaders and colleagues actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services and collaborate with partner organisations to help improve services for patients.
- Colleagues feel respected, supported and valued.

- We promote equality and diversity in our daily work.
- Colleagues are focussed on the needs of our patients.

The CQC inspection report also provided some valuable insights about where we can improve, most notably at a trust-wide level by reviewing how we increase representation of black and minority ethnic colleagues in some areas and address the issues that black and minority ethnic colleagues report about bullying and harassment.

Within the services that it inspected, the CQC also highlighted issues for us to address which we are following up. We have taken immediate action to rectify the specific environmental issues within our mental health wards. We are also making wider improvements with the development of a new ward in Yeovil and the refurbishment of Rowan ward which cares for adults of working age who are experiencing an acute mental health problem.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement → ← Jan 2023	Good → ← Jan 2023	Outstanding ↑ Jan 2023	Good → ← Jan 2023	Good → ← Jan 2023	Good → ← Jan 2023

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Good	Outstanding	Good	Good	Good
Mental health	Good	Good	Good	Good	Good	Good
Community	Requires Improvement	Good	Outstanding	Good	Good	Good
Overall trust	Requires Improvement → ← Jan 2023	Good → ← Jan 2023	Outstanding ↑ Jan 2023	Good → ← Jan 2023	Good → ← Jan 2023	Good → ← Jan 2023

A full copy of the current reports and ratings from CQC can be found on the Trust's website at www.somersetft.nhs.uk and on the CQC website at www.cqc.org.uk.

Care Quality Commission Mental Health Act Assessment

During 2022/23, the CQC continued their regular Mental Health Act Assessment visits. The reports from these visits are presented and considered by the Trust's Mental Health Act Committee. No significant concerns were identified during these visits, but the Trust initiated audits and actions in relation to the recording of sharing patient rights under section 132 of the Act; availability and recording of patient leave under section 17 of the Act; and assessment and recording of capacity and consent.

INFORMATION ON QUALITY OF DATA

Somerset FT recognises the important role of data quality in providing confidence in the accuracy of information used to inform decisions relating to service improvement. Data quality indicators relating to the timeliness and accuracy of coding are routinely reported to the Trust's Finance and Audit Committees. Additional measures which permit the regular monitoring of data quality include:

- the use of the NHS number
- the clinical coding completion rate
- the use of GP medical practice
- the Information Quality and Records Management score.

Somerset FT submitted records during 2022/23 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage of records in published data with valid NHS numbers and GP practitioner code were as follows:

Indicator	Accident & Emergency care	Admitted Patient Care	Outpatient Care
Number of records which included the patient's valid NHS Number			
% of valid NHS Numbers sent to SUS	99.5	99.9	100.0
Number of records which included the patient's valid General Medical Practice Code			
% of valid GP Practice Codes sent to SUS	99.9	100.0	100.0

There are high levels of data completeness in key monitored metrics that are submitted to SUS.

The Somerset FT data quality maturity index (DQMI) score for the submitted data in 2022/23 was 94.5% compared to a national average of 87.4%.

Somerset NHS Trust will be taking the following actions to improve data quality:

- Extending current data quality dashboard reporting on data quality issues.
- Monitor compliance with data quality policy.
- Extend the use of spine mini services through the Trust's integration engine to improve completeness of data.
- Continue to develop the patient master index work within the warehouse to help identify duplicate records within the systems.

Somerset FT was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

INFORMATION GOVERNANCE

The Trust recognises data security and information governance as a high priority and continues to ensure that high standards are met throughout the organisation. The NHS Digital Data Security & Protection Toolkit (DSPT) is an annual self-assessment tool that requires the Trust to provide evidence of compliance with the standards laid down by the National Data Guardian's (NDG) review published in 2016.

Somerset FT Data Security and Protection Toolkit submission for 2022/23 will be completed in June 2023. It is expected that all mandatory evidence items will be reached, with an assessment status of 'standards exceeded'.

In line with the DSPT reporting tool, six incidents were reported to the ICO in 2022/23. Five incidents related to information being shared in error; one incident related to members of staff accessing records inappropriately.

All incidents were fully investigated; action plans created where appropriate and additional targeted IG training sessions made available. The ICO was notified, and no further action was required. Data security and information governance breaches were reported and monitored through the Data Security and Protection Group, which, in turn, reports to the Quality and Governance Assurance Committee.

CLINICAL CODING ERROR RATE

Clinical coding is the process whereby the medical terminology in a patient's medical record is translated into standardised classification codes. These codes are used to provide the data for various local and national indicators, and therefore the accuracy of the clinical coding is paramount in ensuring the integrity of this information.

The clinical coding audit for Data Security Standard 1 Data Quality purposes was performed internally on a sample of records across a wide range of specialties within the acute and community services. The results for this again showed good overall figures, meeting the mandatory target set by the Data Security Standard 1 Data Quality in all areas.

	Percentage achieved 2022/23	DSPT Standard 1 Mandatory Target
Primary Diagnosis	90%	90%
Secondary Diagnosis	87%	80%
Primary Procedure	90%	90%
Secondary Procedure	85%	80%

The figures demonstrated above are a reflection of the current mix of experience within the Clinical Coding Team and of the Clinical Coders' understanding of the importance of coding all conditions which affect the care of the patient and all procedures performed. The better these figures are the more accurately the data reflects the complexity of the care delivered by the Trust.

In addition to this formal audit, the NHS England accredited Clinical Coding Auditors have carried out several smaller audits based on the same methodology and

percentage targets throughout the year. They also perform validation on the quality of the coded data on an adhoc basis, thereby ensuring further assurance of the quality of the data.

The Trust's NHS England accredited Clinical Coding Trainer continues to provide mandatory and supplementary training within the Clinical Coding team to develop the coders' skills and knowledge with a view to maintaining and improving the quality of the coding.

The recommendations from the 2020/21 Data Security Standard 1 Data Quality audits for Taunton and Somerset and Somerset Partnership NHS Foundation Trusts have been reviewed and have been actioned.

PART THREE - OTHER INFORMATION

Part three of the Quality Account provides an overview of the Trust's achievements and progress within quality indicators that have been selected by the board in consultation with stakeholders, including CQUINs. The data reviewed covers the three dimensions of quality – patient safety, clinical effectiveness and patient experience. This demonstrates that the Trust has provided high quality of care, but with room for further improvement as highlighted below.

In addition, part three also includes further information on a number of key work-streams that the Trust is currently focussing on to improve quality and a review of performance against national targets and regulatory requirements.

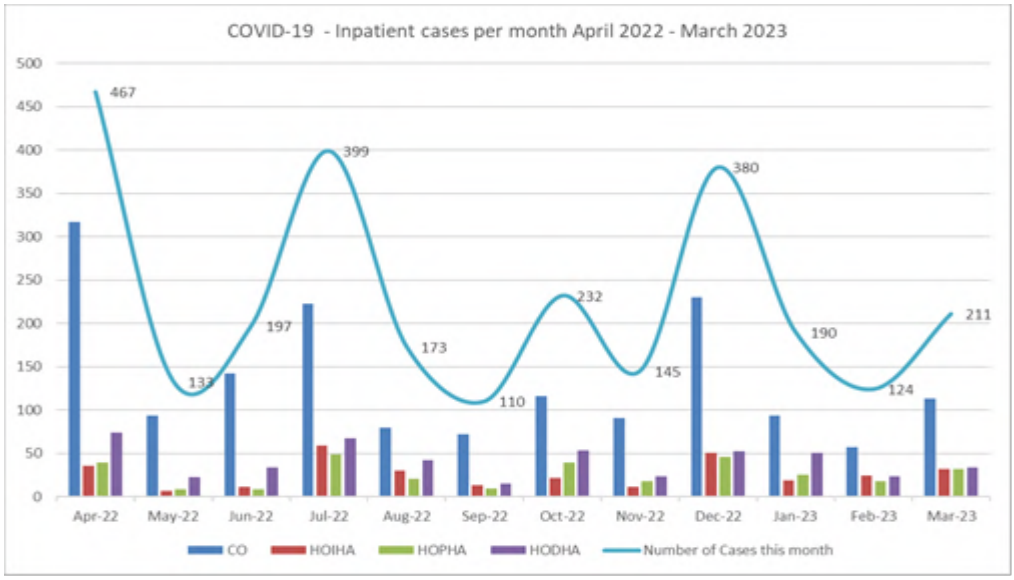
PATIENT SAFETY

• INFECTION PREVENTION AND CONTROL DURING COVID-19

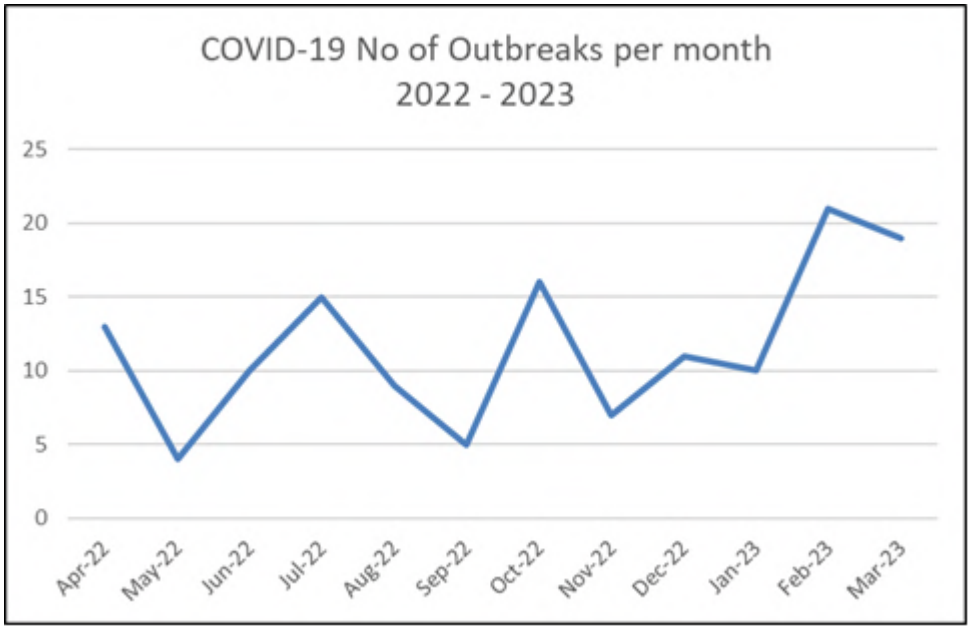
Coronavirus disease (COVID-19) is caused by SARS-CoV-2, a newly emergent coronavirus first identified in December 2019. Cases are apportioned to trusts depending on the timeframe between first positive specimen and admission date:

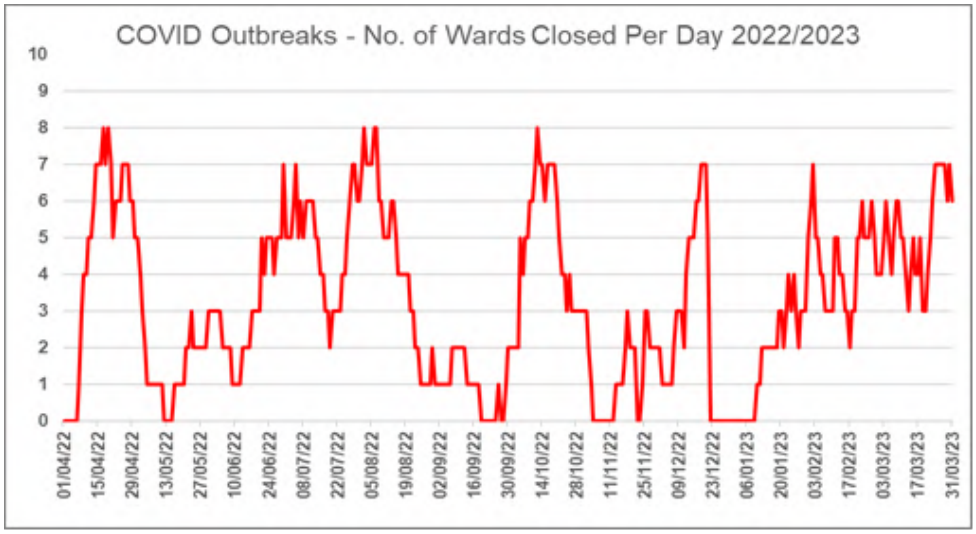
- **Community** onset, positive specimen date ≥ 2 days after admission or hospital attendance (CO)
- Hospital-onset **Indeterminate** healthcare-associated, positive specimen date 3-7 days after admission (HO**I**HA)
- Hospital-onset **Probable** healthcare- associated, positive specimen date 8-14 days after admission (HO**P**HA)
- Hospital-onset **Definite** healthcare-associated, positive specimen date 15 days or more after hospital admission (HO**D**HA)

Between April 2022 and March 2023 there were 2,386 inpatients with confirmed COVID-19, an increase on the previous year where there were 1,489. The majority were community or indeterminate cases (64%) however, the portion of Trust attributable (probable and definite) increased this year to 35% compared the 23% last financial year.



During 2022-23 the COVID-19 virus continued to evolve but it was dominated by variants from the Omicron family. In general while there was an increase in identified cases of COVID-19 less patients developed severe disease than earlier in the pandemic.
Between April 2022 and March 2023 there were 128 inpatient ward closures due to COVID-19 outbreaks. Most of the outbreak occurred between October and March when there were 77 over that period.





Outbreaks were managed in line with the Trust Management of COVID-19, Standard Operating Procedure. Key controls included isolation of all confirmed cases either in side-rooms or cohorted in bays and closing affected areas to new admissions. A total of 990 patients were affected, restrictions were in place for a total of 1,315 days with 1,253 bed days lost. By 21 December an unprecedented decision was taken to stop closing inpatient wards due to COVID-19 outbreaks. At this point, every effort was made to isolate confirmed COVID cases, but it became impossible to achieve due to the extreme pressure the Trust and the NHS was under at this period of the winter. As pressures eased by the end of January the usual management of outbreaks was reinstated.

Whilst the Trust was responding to the COVID-19 pandemic, it was still concentrating on other infection control priorities. It is a mandatory requirement for English NHS Acute Trusts to report Methicillin Resistant *Staphylococcus aureus* (MRSA), Methicillin Sensitive *Staphylococcus aureus* (MSSA), *Escherichia coli* (E.coli), *Klebsiella, Pseudomonas aeruginosa* bloodstream infections and *Clostridioides difficile* Infections (CDI) to the Department of Health via the HCAI Data Capture System, hosted by UK Health Security Agency. Case numbers of these infections are increasing nationally, and the reasons are not currently clear.

Traditionally, those infections that are Trust apportioned have been investigated using a recognised national process known as post infection review. This process was introduced during the mid-2000s in response to high levels of MRSA bloodstream infections in the UK. In partnership with other strategies this was successful in driving down case numbers of this infection. As a result, this method has gradually spread to include other infections. However, over the last few years, this process has become more time consuming and is no longer proving effective in terms of infection reduction. Similar themes are identified and despite actions, overall case numbers are not reducing.

In August 2022, it was agreed to stop post infection reviews as there was no longer a national mandate to undertake them. The process was replaced locally with a shortened, targeted review. This aims to identify the source (where possible) and collect wider information that led to the infection. Rather than focusing on every

infection, this information is thematically analysed to inform improvements. Although this process is still new several key themes have been identified:

- Previous colonisation with MSSA and presence of a peripheral vascular cannula (PVC) are strongly linked to the development of a *Staphylococcus aureus (*MRSA or MSSA) bloodstream infection.
- The presence of a urinary catheter is strongly associated with gram-negative bloodstream infections, in particular E. coli.

Relevant improvements have been commenced during the period of this report which include:

- MSSA screening, decolonisation and MSSA suppression in critical care which has significantly reduced their MSSA bloodstream infections
- A change to the skin cleansing product used prior to the insertion of a PVC has been implemented in all inpatient areas. Whilst it is early days since the change, signs of improvement are being seen.
- Trustwide improvement project on urinary catheter has commenced. This project is focussing on insertion, ongoing care and timely removal when no longer required. It is too early in the project to attribute success.

There is still significant progress to be made but the new process has allowed a change in focus away from the investigation to improvement.
Details of our response to Clostridioides difficile infection are included within the national indicator section.

- **KEEPING CHILDREN WITH MENTAL HEALTH NEEDS SAFE ON OUR PAEDIATRIC WARDS**

A recent report from the Healthcare Safety Investigation Branch (HSIB), focussing on 18 general paediatric wards in England, found that the majority had unsafe care environments to care for young people exhibiting high risk behaviours attributed to a mental or emotional health crisis. It has called for immediate action to be taken by ICBs and NHS organisations to facilitate a system-wide response to reduce the safety and wellbeing risks associated with children and young people with high-risk behaviours on their wards.

As an integrated Trust covering acute and mental health services, Somerset FT was in a unique position to address this issue and had already implemented a number of improvements in our paediatric wards at Musgrove Park Hospital, as well as Yeovil District Hospital, and in the community, supported by our Child and Adolescent Mental Health Services (CAMHS) teams.

These include:

- Wrap around care provided by colleagues recruited, trained, and supervised by the Community Eating Disorders (CED) team, but working within the acute paediatric team to provide continuity of care, education, and care to this specific patient group. This has received positive feedback from both patients and colleagues worked well and relieved exposure to nursing staff that were feeling stressed and demoralised by the work being requested.
- Implementing bespoke “Positive Behaviour Management” educational courses, that include de-escalation and safe holding training for use with CAMHs and CED patients, for all our colleagues in acute paediatric wards at MPH and YDH.
- Prioritising supporting young people to share their views and experiences. We do this through anonymous feedback services such as 'care opinion' and weekly face to face engagement sessions led by a ward based youth worker. On admission, or ideally before, we look to create individualised and collaborative care plans with our young people and members of our integrated care team.
- CAMHS liaison practitioners operate across both paediatric sites in Somerset. We operate a fully integrated eating disorder service spanning community and acute settings. A ward based RMN guides the inpatient management for young people admitted with an eating disorder alongside the specialist consultant, a specialist paediatric nurse and trained Health Care Assistant.
- Liaison with Children’s Social Care (CSC) regarding complex and potentially violent patients, those who may have no safe place to reside, including the provision of two places of safety houses available in Somerset offering therapeutic education avoiding prolonged stays in the hospital environment. There is planning in place for a further 6 houses.
- Where hospital admission is not deemed to be therapeutic, we aim to avoid through regular high intensity user group meetings (HIUG) between paediatrics, CAMHS liaison and the Emergency Department, where bespoke plans are designed to be implemented. Alternative provisions are actively sought when

deemed more appropriate through effective joined up systems including social care, mental health and therapeutic educational settings, such as those established by the unique project 'Homes and Horizons' . This projects success rests on an innovative ten-year partnership between Somerset county council, Homes2Inspireand NHS Somerset and will provide 10 homes in Somerset offering high needs foster care for the most vulnerable.

- Where severe mental health illness prevents a safe discharge home, we are working collaboratively with the provider collaborative and our local tier 4 GAU Wessex House to ensure safe and effective shared care arrangements when needed, specifically for those under the mental health act who require physical healthcare alongside mental healthcare in our "blended care" model.
- We are in the process of creating sanctuary spaces on our wards and our Emergency Departments, away from the "hustle and bustle" and highly stimulating sensory environment, to aid with de-escalation in a crisis. We have secured all entrances and exits, and risk assess the environment on a regular basis. It does however remain a challenging environment to work with at times due to historical design and layout.
- Within the community we have refined and built on the *Children and Young People's Neurodevelopmental Partnership* (*CYPNP*), creating a single point of access, triage, and educational packages to schools.
- We have secure links with liaison psychiatry and are establishing synergistic relationships with our colleagues in Wessex House (tier 4 General Adolescent Unit) to ensure safe and effective shared care arrangements when needed, specifically for those under a mental health act. There has been opportunity for our staff nurses to shadow nurses in Wessex House and vice versa. We support regular opportunity for reflective practise for all. Training includes online "we can talk" modules , experiential learning and situational SIMs. Rolling medical teaching schedules cover aspects of mental health.

There is still further work to do to meet the needs of this specific population, including further improvements to the environment and the potential for in-reach services from the GAU. We are exploring the opportunities for service improvement, and we will be working with the provider collaborative to identify new models of care.

- **FIRST RESPONSE SERVICE**

The First Response Service (FRS) has been developed over 2022/23 and has already been well utilised since it's official launch in 2023, taking over 1000 calls a week from the two hubs in the East and West of the County.

The purpose of the FRS is to improve access to mental health services for service users and their families requiring urgent mental health support and reduce the number of people attending Emergency Departments in a mental health crisis, by increasing the support available in the community. This is underpinned by the 'No wrong door' ethos in Somerset. The service works closely with the Home Treatment Service, signposting appropriate referrals to them for urgent face to face assessment.

The service is still developing and the data we are capturing will allow us to monitor the impact the service has had across the urgent care pathway, but initial feedback has been positive. Service users have told us they have had better response times to their calls and professionals have commented that it is generally quicker and easier to make referrals in a timely manner. One worker from a GP surgery praised the service for its "responsiveness, compassion and follow-up".

The FRS is available 24 hours a day on 0300 1245016 and we welcome calls from family/ carers/ concerned others as well as calls from individuals themselves. Professionals can make telephone referrals for any patient in urgent mental health need.

• MATERNITY SERVICES

In the year from 2022/2023, the maternity services at Somerset NHS Foundation Trust (SFT) have continued a positive journey of integration and development across many areas, including culture, governance, workforce wellbeing, training, and clinical pathways. This has been recognised with regional achievement awards for System leadership co-production and working, women's public health improvements and implementation of National Bereavement Care Pathways. There are three specific areas of quality work which are transforming ways of working and improving safety.

Better Births in 2016, identified the need for enhanced digital maternity services to improve safety with single patient records throughout the maternity pathway and for service users to have access to their digital records through a patient portal. The challenges to achieve this level of digital availability in Somerset, where the two acute trusts use different electronic health records has been overcome, to achieve a single maternity record across somerset, accessible by service users, and staff, which went live in February 2023.

In Somerset, both Musgrove Park Hospital and Yeovil District Hospital have previously signed a commitment to the UNICEF Baby Friendly Initiative. This is a global initiative which builds upon interlinking evidence- based standards for maternity, neonatal and paediatric services, designed to provide parents with the best possible care to build a close and loving relationship with their baby and to feed their baby in ways which will support optimum health and development. In this last year, there have been four successful assessments across the organisation, in both the neonatal and maternity services, with the maternity service at Taunton achieving reaccreditation of Gold sustainability for another three years. This is an incredible achievement and is evidence of the high level of Trust commitment towards these standards, acknowledging the positive impact on future health and wellbeing of both mothers and babies and supporting the initiative with staff, patients and visitors to our services. The success of this will underpin the next steps for the neonatal and maternity systems on both sites to continue their accreditation journey and reach the ambition of becoming a Gold Sustainable County with achievement across all domains, to include health visiting.

Nationally equity and inclusion are high on the health agenda with black mothers' disproportionality in danger during pregnancy and the first year after birth, with black mothers four times more likely to die and twice as likely to have a stillbirth. Recognising the disparity that exists in Somerset, with disadvantaged groups, vulnerabilities, and social deprivation, two midwives at Yeovil developed 'Implicit Bias' training. This training explores culture and attitude with an emphasis on the language used and social 'norms'. This training has been so successful it is being rolled out across the southwest region, with other areas expressing interest, including universities. The team has won an HSJ award for safety improvements in maternity care and were shortlisted at the RCM awards for inclusion working. As a result of this training, the Southwest Academic Health Science Network have funded black mother and baby mannequins for every maternity unit in the region. Train the trainer sessions have now taken place regionally to ensure ongoing roll out of this great work.

PATIENT EXPERIENCE

• TOM'S STORY

Tom was due to come into hospital for a routine operation requiring general anaesthesia. Tom has learning difficulties so his mum helps him with sign language and understanding and was able to speak with the Learning Disabilities and Autism Liaison Practitioner who arranged for Tom to visit the day surgery unit before the day of the procedure. Tom would have been incredibly anxious to arrive in an unfamiliar environment, meeting people for the first time and may not have coped to have general anaesthesia in an unsettling environment. By arranging a pre-visit to the day surgery unit and the recovery room, Tom was able to visualise and ask questions about what would happen on the day. Tom's mum also took photographs to build Tom a social story that he could look over at home before the day of the procedure. When the operation day arrived, Tom was very comfortable to have the procedure as he had a full understanding of what was going to happen, that had been delivered in a way to meet his individual needs.

Tom and his mum were very keen for their experience to be shared to aid learning, so they kindly agreed to be filmed for us to use as part of the Chief Nursing Officer training box set of short videos, that the trust is producing. Tom's story will be shared to educate staff regarding communication, to demonstrate that all patients have discrete requirements that we must consider delivering the best patient experience.

In addition, we have continued to use Tom's story within the Trustwide improving accessibility working group as an example of how we can adapt a typical approach to accessing healthcare into one which is personalised and meets an individual's own needs.

- **GROWING THE USE ON ONLINE PATIENT FEEDBACK – THE STORY OF OUR ACUTE CHILDREN'S UNIT**

Over the last year, our Families Service Group Associate Medical Director together with a very dedicated and passionate trainee Paediatric Doctor embarked on a journey of improvement with patient and family feedback. A project was established to relaunch the use of care opinion into the children's unit at Musgrove Park Hospital and as described by the project team 'Care Opinion became more than just a means to collect patient feedback: it created all kinds of impacts far beyond what the team expected at the start.'
Care Opinion is an independent feedback website, enabling anyone to share their experiences of healthcare services through storytelling with the fundamental belief that by sharing honest experiences of care, we learn to see the world differently and to see how the telling of stories, both good and not so good, are leading to change.

"Hear the patient voice at every level – even when that voice is a whisper" Berwick Report, August 2013

The team started small by introducing care opinion into the Paediatric Admissions Unit (PAU). Here, Care Opinion captures the feedback from patients and families at the point of care delivery from the community and the Emergency department. Building on this, the team have now established Care Opinion within the High dependency unit (HDU) and the acute Paediatric wards, Acorn, and Oak and are now looking to expand across other services within the service group.

The team focused on increasing the accessibility of care opinion by spending time explaining how we use patient and family feedback and sort to make this discussion part of everyday conversations across all specialities and colleagues in the paediatric unit. An IPad was mounted on the wall at the entrance to the unit which linked directly to the care opinion site to make it as easy as possible for anyone to leave feedback. There was a real focus on the use of QR codes and the care opinion helped the team create unique QR codes for each ward and department so that the feedback was going to the correct team.

Most of the Care Opinion posts have been very positive about paediatric unit, and can be very specific, naming individual staff members. Feedback is very much valued in the department, and everyone is very appreciative of the feedback, a really lovely way to boost staff morale. Feedback is shared in a timely way with all team members, usually within 24 hours and is also shared in the paediatric improvement group and service group governance meeting to highlight achievements and where we can improve our care. The team are very open and transparent to all the comments made, helping to improve patient care as a team.

A more recent development is the use of colleague certificates when they are individually named in posts, including the specific feedback about them. This has been really values by the whole multidisciplinary team and it has begun to be included in individual appraisals.

Initially, it was expected that the Care Opinion stories would only focus upon the paediatric department. When parents post feedback they include their child's whole

journey, mentioning other specialities and departments who looked after their child. They may talk about their A&E experience, because very often a child will be assessed first in the emergency department and then referred to paediatrics. The paediatric team may also need to refer other specialties, including ENT or surgery, and parents will include these teams within their story. Stories are now being shared beyond the walls of the paediatric unit and has helped to foster better working relationships with other specialities as cross-specialty feedback highlights how we all work as one big team when caring for patients and their families.

Sometimes the feedback received highlight a need to improve areas of our care. Care Opinion has allowed us to provide real-time and meaningful responses to be given directly to parents which has helped to rebuild and restore trust which may have been lost during the difficult time a patient and their family may have experienced during their stay with us. Care Opinion has been a hugely useful platform in giving the team the opportunity to able to response again to the family, updating them about any changes we have made later. People can see we are listening, and we want to do something about the issue, and make things better for other families. We have had a parent respond back and say: “well it wasn’t a good experience, but I can see you are listening, and that means something”.

What started as a creative mission to improve feedback opportunities for patients and families has become far more than just that. One patient story, be it sharing a kind word or encouraging a change for better care, creates a wonderful ripple effect. The positivity it creates grows and expands, touching an individual member of staff, the paediatric department, cross-speciality departments, and colleagues and most importantly the patients and families we care for. The team have seen their feedback grow from 1 story every 3 months to 3 to 4 stories per week.

- **DISCHARGE TO ASSESS (D2A)**

We know that staying in hospital too long can result in poorer health and longer recovery times and so as soon as a person is well enough, the multi-disciplinary team within the hospital work together to facilitate a discharge to the best possible place to support a person's recovery; in most cases, this will be a person's home.

Discharge to Assess, also known as D2A has been created to help people get home more quickly, offering a range of services including assessment which focus on measuring a person's health and ability to perform everyday tasks, and rehabilitation to enable people to get back to normal life.

Discharge to Assess supports more than 150 people to leave hospital every month and obtaining feedback from service users is a high priority and helps to shape the ever-evolving service. People using the service are therefore offered a telephone call review after the service has ended to provide verbal feedback on their experiences. The telephone call feedback process enables the service to 'do more' of what works well, as well as learn from experiences which may not have gone as well as they could have. Between August 2021- March 2023, 253 feedback calls have taken place.

The initiatives below describe some of the ways in which acute and community services are striving to improve discharge planning experiences for the people of Somerset based on the service feedback:

1. **Discharge Facilitator role** – there has very recently been an increase in the workforce by 25% at Musgrove Park Hospital and have introduced this role to selected pathway 2 units. The capacity of the weekend discharge facilitator role at Musgrove Park Hospital has been doubled. These roles act as the communication link between families/care givers and the hospital ward teams. Their role aims to improve communication and improve the effectiveness of transfers of care (discharge).
2. **Transport** – it is recognised that transport home from hospital can be a challenge. To improve this part of discharge planning, access to a late transport crew is available for times of increased demand. Both Yeovil District Hospital and Musgrove Park Hospital were successful in obtaining extra funding for Red Cross transport-home services during autumn / winter 2022/23 which helped an additional 22 people per month to return home with transport support, and after hospital care if required. The new discharge lounge at MPH has dedicated parking bays outside the lounge to make the collection of patients easier for families / care givers. People are now requesting for their relative to be sent to the discharge lounge because of the ease of collection!
3. **Discharge Lounge** – in addition to the transport / collection benefits, the discharge lounge provides an opportunity for patients to leave the ward earlier on the day of discharge. The discharge lounge has a dedicated team of staff and volunteers who are there to double check actions for discharge have been completed, additional explanation around changes to medication and after hospital care instructions. The infrastructure within the discharge lounge provides a peaceful environment and the flexibility for people to either sit out in a chair or rest in bed ahead of the journey home.

4. **Ready to Go Units** – Strategic plans are underway in Somerset to reduce the delays in transfers of care, particularly for those needing Pathway 1 & 2 services. Whilst those plans are underway, delays are unwanted, but inevitable. To mitigate the risks associated with staying hospital longer than needed, Ready to Go units have been created. With the support of reablement-trained staff and volunteers such as Age UK, patients are being kept active whilst remaining in hospital. In many examples, care needs have been reduced following a stay on the Ready to Go units.

CLINICAL EFFECTIVENESS

• TREATING TOBACCO DEPENDENCY

Within the NHS Long-Term Plan, smoking is seen as a chronic, relapsing medical condition, not a lifestyle choice, requiring treatment just like any other disease or illness. In fact, more than 700 Somerset residents die every year as a direct consequence of smoking (Public Health Somerset) with more than 5,700 hospital admissions in Somerset attributable to smoking in 2021/22.

We know that stopping smoking is one of the best things people can do to improve their physical and mental health and wellbeing, and it also helps to reduce health inequalities, and increase life expectancy by reducing the burden of tobacco-related disease.
Research shows that most people who come into hospital who smoke, want to stop – and that's where our tobacco reduction team come in.

We are required by NHS England to identify all smokers who come into our services and deliver our tobacco reduction interventions. However, at the heart of what we do, is supporting patients as best we can during a difficult time – and using the opportunity to help them to stop smoking or reduce the harm from tobacco and improve their health outcomes in the future.

In July 2022, Somerset FT and Yeovil Hospital launched a new tobacco reduction programme, aiming to tackle the significant health inequalities associated with smoking, and offer support to both colleagues and our patients across Somerset to quit smoking.
As part of the programme, we have introduced new tobacco reduction practitioners, who will support any patients who are admitted to our wards who smoke, and would like to quit, with additional support for any patients who are pregnant and smoke. The service covers all wards at Yeovil District Hospital and Musgrove Park Hospital, along with some of our mental health inpatient wards.

The extensive programme of work around treating tobacco dependency includes the following:

- Training packages and guidance available for all colleagues.
- The Trust is participating in Wave 1 of the Royal College of Psychiatrists national *Quality Improvement in Tobacco Treatment (QuITT)* programme which aims to reduce health inequalities experienced by people with severe mental illness, involving staff and patients.
- A quality improvement project ongoing at St Andrews ward in Wells as part of the overall Trust Quality Improvement programme.
- Tobacco treatment pathways developed for acute, mental health and maternity, with stop smoking medication protocols developed for nicotine replacement therapy and vapes.
- Full vape offer now available for patients to help reduce smoking-related incidences of violence and aggression.

- Fire Home Safety Checks offered to patients, supported by Devon and Somerset Fire service.
- New, clearer smokefree signage being rolled out across all of our sites, with vaping allowed areas planned to reduce smoking on sites.

- **SUPPORTING ROUGH SLEEPERS**

In Somerset, there are hundreds of people affected by homelessness or rough sleeping. While this number is relatively small in comparison to other groups of patients, they are some of our most vulnerable in our county, with complex and vast health needs.
People who are homeless or sleeping rough face huge barriers to accessing healthcare, and as such, can potentially only live until their mid-40s – around 30 years younger than the general population. Drug and alcohol disorders are common amongst the homeless population, and they are also more likely to struggle with their mental health. In fact, homeless people are more than nine times more likely to complete suicide.

Supporting homeless people to access healthcare when they need it can make all the difference to their lives – so it's important that we get it right, to give them the care that they so desperately need yet struggle to access.

Our homeless and rough sleepers service is a community-based, intensive outreach service, which has been supporting people across Somerset who are homeless or sleeping rough for the past two years. It provides a range of healthcare services, from general health assessments, wound care and dressings, to help with medical appointments, sexual health testing, mental health first aid, and much, much more.

Like many of our services, the team works closely with several partners across the Somerset health and care system, the police service, as well as charities – and now that our merger has created one, large NHS trust for Somerset, the hope is that there will be no wrong door when it comes to accessing services for this group of people.

Clinical lead for the homeless and rough sleepers service, Karen George, has grown the team to 14-strong since she started her role at the beginning of 2022. She shares how, together, Somerset is finding the forgotten.

"Whether it's a park bench in Taunton, a field in Wincanton, or one of the hostels in Yeovil, we will deliver care to those who need it, wherever we can," explains Karen. "There are hundreds of people in Somerset who are in difficult situations, and it's important to remember that it's not just people living on the streets that struggle. There are people living in hostels or sofa surfing, gypsies, travellers, and those who have just been released from prison – these people usually don't have a permanent home.

"When someone doesn't have a fixed address, the barriers they face to accessing healthcare can be impossible to navigate. This often means they end up coming through 'the front door' at an emergency department (ED), when they don't need to be there, or sadly, simply not accessing healthcare at all.

"Our goal as a team is to join up the gaps, by working closely together with our partners across Somerset. We link in with our colleagues at Avon and Somerset Police, with charities such as the Somerset Drug and Alcohol Service (SDAS), and with other healthcare services such as the South Western Ambulance Service

(SWAST). Now that we are one, merged trust, we also want to create a ‘no wrong door’ approach within our own organisation.”

The homeless and rough sleepers service link closely with both EDs at Musgrove Park and Yeovil Hospital, and discharge teams from across the trust – supporting any patients who don’t have a fixed address, once they leave hospital, to continue getting the care they need out in the community.

Due to the nature of their situation, people who are homeless or sleeping rough are also likely to struggle with alcohol and drug addictions, as a way of coping. This is where teams such as the substance misuse team at Yeovil Hospital, and the alcohol practitioners at Musgrove Park, play a huge part in offering this joined-up care.

“Being able to share patient information, and work together with teams from across the trust, will be a huge step forward in ensuring we can deliver care to all our patients – breaking down the barriers of inequality that we unfortunately still see,” Karen continues. “My own personal background working in ED, for the police, and in the substance misuse team at YDH, before becoming clinical lead for the homeless and rough sleepers service, means that I understand how we can all help and support each other to benefit the people we care for.”

The safeguarding service and mental health services in Somerset are also key partners helping to care for people who are homeless or sleeping rough. Karen has introduced new mental health practitioners and peer support workers to the team, providing a bridge to these services and making it easier for patients to access support.

“We are essentially creating a one-stop-shop for people with no fixed abode, enabling them to access various mental and physical health care, without the need to attend a hospital or GP. Little things can make a huge difference to the lives of these people – and that’s why we do what we do.

“The perception of people who are homeless is often fairly negative. Many assume that these people got themselves into this situation, and aren’t helping themselves to get out of it. It’s simply not the case. Some of the stories we hear are truly heartbreaking, and you can fully understand why they are living as they are. But at the end of the day, they are people, and people have healthcare needs. We are building a joined-up service in Somerset that is showing them that they haven’t been forgotten, and that they can get the care and support they need, just like anyone else.”

• ACUTE FRAILTY SERVICES

Older people living with frailty are getting extra support if they need care at Musgrove Park Hospital's emergency department (A&E) as an existing service at the hospital has been repurposed to focus on patients with frailty instead of those who are elderly. The term frailty or 'being frail' is often used to describe the health of older people, but this isn't quite right as frailty is about a person's overall resilience and how quickly they can recover following a minor health problem – in fact, some frail patients could be younger, but frailty is more likely to occur in the very old.

For many years, an older person's assessment and liaison (OPAL) team has been helping older people who present to Musgrove Park Hospital's emergency department to get the right care and treatment.

But with the introduction of a new Acute Frailty Unit at the hospital in early 2022, the four-strong team of acute frailty practitioners have refocused their efforts on identifying those older patients presenting to hospital with frailty.
It's just one of a series of intensive support services that we are putting in place, alongside our partners across the wider healthcare system in Somerset, to help keep people in their own home setting or avoid a long stay in hospital.

The service has adapted to support frail patients to target support to those who need it most, enabling us to make more of an impact by directly seeing older patients living with frailty as they arrive in our emergency department. With the specialist expertise, they offer a comprehensive geriatric assessment within the emergency department, alongside our joint emergency therapy team (JETT).

As part of the re-launch of the service, the acute frailty practitioners are assigned as named clinicians for patients at the hospital's emergency department for the first time ever.

This is a new part of the role where the acute frailty practitioners hold responsibility for the patient's care and assessment, which could involve a transfer to the hospital's acute frailty unit or discharging them home or to an alternative care setting if safe and appropriate to do so.

The service is also being extended back to seven days a week, 8am to 6pm, so patients can be assessed by our frailty team if they arrive at the emergency department over the weekend.

The assessments are holistic in nature as they look at every aspect of a patient's care, including their physical health, functional, social and environmental history, psychological components and a medication review. This includes working together with our JETT colleagues who assess the patient's therapy needs.

The frailty team work closely with the patient flow team so when a bed becomes available on the acute frailty unit, the patient's transfer can be sped up to avoid them needing to move across different areas of the hospital. The aim is for the patient to be discharged home, or to an alternative care setting, within 72 hours.

Following the assessment of a patient in our emergency department, any specific frailty issues are identified early, which leads to a reduction in their length of stay in hospital if an admission is needed or can avoid an admission altogether if care could be managed in the community.

Colleagues in the new team have a wealth of knowledge between them as they've all worked in many different areas and specialities, including acute medicine, care of the older person, same day emergency care, community services. They are advanced clinical practitioners, with strong autonomous clinical decision-making skills who holistically assess patients, request diagnostics and prescribe medication, or more importantly for our patients, look to reduce the amount of medication they might need where appropriate, all with a patient centred frailty focus.

In addition, they work closely with the dementia and delirium team, which supports our patients in the emergency department.

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) TARGETS

Somerset Integrated Care Board, our principal commissioner of services, sets annual targets under the framework for Commissioning for Quality and Innovation (CQUIN), the aim of which is to improve the quality of services delivered to patients. The achievement of the CQUIN standards generates additional income for the Trust, of up to 1.25%.

In 2022/23 the five CQUIN indicators selected for the contract were across Acute, Community and Mental Health Services and included the following programmes:

- Staff flu vaccinations
- Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service
- Use of anxiety disorder specific measures in IAPT
- Biopsychosocial assessments by Mental Health liaison services
- Assessment, diagnosis and treatment of lower leg wounds

The financial risk associated with performance of the CQUIN indicators was removed during 2022/23 due the CQUIN income being included in the block contract value.

ORGAN DONATION

The Trust continues to implement national and regional best practice and remains compliant with NICE guidance (CG 135).

The Trust has continued to support organ donation during 2022/23, with activity surpassing pre-COVID19 levels. An outstanding 96% of patients meeting the referral criteria had discussions with the organ donation service. Fifteen families have been approached to explore organ donation with 100% of these approaches being collaborative with the Specialist Nurse for Organ Donation.

The consent rate for organ donation within the Trust is above the national average. As a result, the Trust continues to perform well in terms of organ donation with a total of 25 transplants enabled over the year.

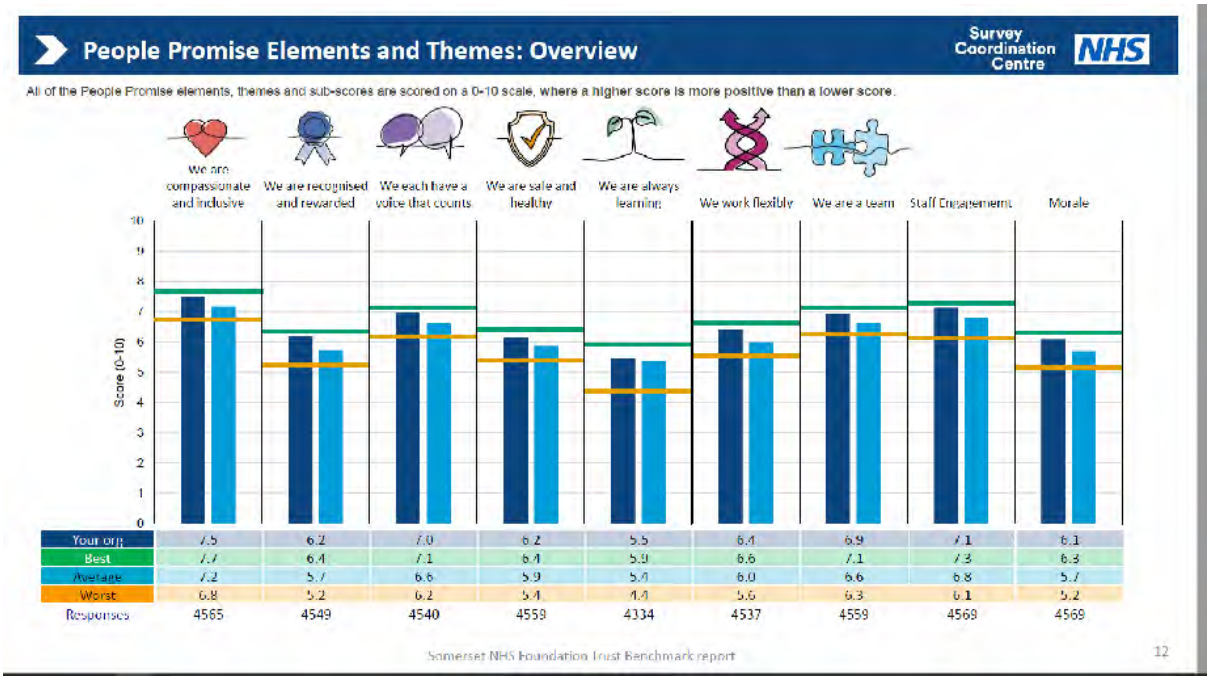
Key work for 2023/24 will be to continue to ensure all suitable patients are offered the option of organ donation at the end of their life, ensuring maximal adherence to national guidance on donor identification and referral as well as continuing to focus on minimising the time taken for the donation process. Tissue donation is another focus for the organ donation committee, and we will work toward all suitable patients having this offered as an option at the end of life. The last year has seen the formation of a single trust-wide organ donation committee. Work continues commissioning a donor memorial for Musgrove Park, and on promoting organ donation around the hospital.

STAFF ENGAGEMENT

• NHS STAFF SURVEY

The 2022 NHS Staff Survey was completed between September and December 2022 with a 45% response rate which is in line with the 2021 response rate and 1% higher than the average for the comparator group nationally. The response rate for the comparator group nationally has declined by 2%.

The NHS Staff Survey has 9 themes in total, 7 are the People promise themes with Staff Engagement and Morale as the additional themes. The 2022 survey results were positive with all 9 themes scoring better than the national average. This can be seen in the table below.



The strongest themes for the Trust in 2022 remain the People Promise of, we are compassionate and Inclusive, with the Trust scoring better than the comparator group in all 17 questions that contribute to this theme. The second strongest theme is Staff Engagement again with the Trust scoring better in all 9 questions that contribute to this theme than the comparator group.

The area of focus following the 2022 Staff Survey results is in the theme of We are always learning, this covers two sections, development, and appraisals. The Trust has made a slight improvement in both areas however continued focus is required as the theme score remains the lowest of all nine.

Appraisals – This remains an area of focus into 2023 and work continues ensuring that the quality of the conversation as well as numbers completed are a priority. The working group looking at aligning both Somerset Foundation Trust and Yeovil have come together and along with the Staff Survey results, and the recommendations from the Internal Audit carried out in 2022 in Somerset Foundation Trust a work plan had

been developed. This sits alongside the work already underway as part of the People Promise exemplar site in terms of ways of retaining colleagues.

The work around the development of the People Strategy is due to be completed by May 2023 alongside the metrics to track progress.

The work of the engagement champions will continue after the merger date and conversations have taken place with this group to ensure agreement. This group will continue to provide rich feedback monthly around colleague engagement and wellbeing and will be used to drive colleague engagement such as People Pulse and NHS Staff Survey as well as other initiatives.

Table below indicates the score for the benchmarking group for each of the nine indicators in the staff survey report for the current and the prior year and the 10 indicators for the year before.

People Promise Theme	SFT 2022	Benchmark 2022	+/- Difference
We are compassionate and inclusive	7.5	7.2	+0.3
We are recognised and rewarded	6.2	5.7	+0.5
We each have a voice that counts	7.0	6.6	+0.4
We are safe and healthy	6.2	5.9	+0.3
We are always learning	5.5	5.4	+0.1
We work flexibly	6.4	6.0	+0.4
We are a team	6.9	6.6	+0.3
Staff Engagement	7.1	6.8	+0.3
Morale	6.1	5.7	+0.4

- **OVERALL STAFF ENGAGEMENT**

Colleague Wellbeing remains a high focus and the colleague support line is in place in the current format until March 2024. The Service continues to provide the phone line service to all Health and Social Colleagues within the Somerset System and plans are now in place to expand interventions such as Compassion Circles and Staff Support post incident into the system from April 2023.

In addition to the focus on colleague wellbeing other work has taken place including:

Resolution Services – the resolution service uses the skills of trained internal coaches and accredited internal mediators to offer a several interventions to support colleagues who may be experiencing some difficulties within their teams and supports the avoidance of taking colleagues through formal processes. Interventions include:

- **Resolution Coaching** – supporting colleagues through a coaching approach to resolve conflicts by providing them with the tools to have the right conversations.
- **Facilitated Conversation** – Supporting two or more colleagues through a conflict by facilitating a conversation where they can hear the needs of the others and try to reach an agreeable solution.

- **Mediation** – Supporting 2 or more colleagues through an informal resolution process. Mediation would also include colleagues having resolution coaching as part of this pathway.

The Leadership and Organisational Development team have also focussed on the development of the Rising Star Programme. A programme that takes colleagues through a period of development in a cohort to prepare them for the next step in their career. This was a piloted with nurses at Band 5 level and in 2022 has been expanded to include colleagues who are looking to step into their first management role.

In 2023 there is a plan to further develop the internal leadership offering with the introduction of a programme that will aim to develop leaders across the new merged Trust in how to continue to have a positive leadership impact for all colleagues in a large, geographically dispersed Trust.

Facilitated Conversations

Bite-size coaching - Quick sessions made available for colleagues to receive some quick coaching to help them with specific issues they may have.

Peer to peer facilitated sessions – An opportunity for colleagues to book a session with a facilitator and share with peers some concerns they may have and seek other perspectives to help.

Difficult Conversations sessions – A forum where managers can bring a challenging conversation they have had or may need to have and seek support from others about how they may go about this.

Resolution workshops – support for teams if they have found some challenges within the team and need some help in dealing with these before they get out of hand.

Communication remains key in 2022 and the Trust continue to use various channels to ensure colleagues are kept informed. Main channels used remain Staff News which from April 2023 will be available for all colleagues across the new Trust and Live Team Brief, this has been available for all colleagues to engage with since 2022.

Senior leaders across Somerset NHS Foundation Trust and Yeovil District Hospital come together regularly to meet with Executive Team members to discuss financial, performance, operational and other issues of importance at Senior Management Operational Team Meeting. Development of this group takes place on a quarterly basis and a programme of development is planned to start from May 2023.

The Somerset Operational Partnership meeting takes place monthly which is a forum where Trade Union colleagues and Senior Managers from Somerset NHS Foundation Trust and Yeovil District Hospital meet.

APPENDICES

APPENDIX 1: STATEMENT FROM STAKEHOLDERS – SOMERSET INTEGRATED CARE BOARD (ICB)

Proud to be part of Somerset Integrated Care System

NHS Somerset

Our Ref: SM/sp

08 August 2022

Wynford House
Lufton Way
Lufton
Yeovil
Somerset
BA22 8HR
Tel: 01935 384000
somicb.enquiries@nhs.net

Phil Brice
Director of Corporate Services
Somerset NHS Foundation Trust

Dear Phil

Somerset NHS Foundation Trust (SFT) Quality Account for 2022-23

NHS Somerset (ICB) welcome the opportunity to review and comment on the Somerset NHS Foundation Trust (SFT) Quality Account for 2022/ 2023. In so far as the ICB has been able to check the factual details, the view is that the Quality Account is materially accurate in line with information presented to the ICB via contractual monitoring, quality monitoring and involved assurance, and is presented in the format required by NHSE/I presentation guidance.

The ICB recognises that 2022/2023 has continued to be a difficult year due to the workforce pressures, operational pressures and the continued recovery of services following the COVID-19 Pandemic. The ICB would like to thank colleagues at SFT for their continued contribution to supporting the wider health and social care system during this last year.

It is the view of the ICB that the Quality Account reflects SFT'S on-going commitment to quality improvement and addressing key improvement objectives in a focused and innovative way, utilising Quality Improvement methodology, and clearly aligning to the Trusts Vision and Strategy.

Achievement of some priorities during 2022/23 have continued to be affected by operational, workforce and COVID-19 recovery pressures. SFT has however, been able to make achievements against all of their identified priorities for 2022/23 including:

Priority 1: Using the time waiting for surgery to optimise people's health and wellbeing both now and for the future. It is great to see that this programme which recognises the importance of peri-operative care, the comprehensive management of patients before, during and after surgery is aiming to enable better outcomes from surgery including a reduction of length of stay, speedier recovery, reduced re-admissions plus better long-term outcomes. While this priority is in its early stages with work to be done it is encouraging to see that a core team has been established working on 14 workstreams with leads identified for each. It is also encouraging to see that c. 55+ tests of change have been undertaken to date.

Priority 2: Helping older people to live as they wish, giving them time to do what is important to them. This programme of work recognises that Somerset has a higher-than-average elderly population with 24.8% aged 65 and over. The ambition of this work is commendable in aiming to ensure quick and accurate identification of vulnerable people and to provide alternatives to hospital admission that are more responsive and better able to meet the needs of the frail person. It is great to see that in the last year there has been a determined focus on how services can more effectively manage frailer individuals at home to reduce potentially harmful lengthy hospital stays.

The achievements to be noted are those that have enabled early identification, provision of community alternatives and robust training and support for colleagues. It is noted that the aim for early identification in the Emergency Department using the Rockwood Clinical Frailty Scale (CFS) unfortunately did not achieve it's target to screen all over 65's attending ED due to work pressures and flow issues. A review of this target however led to an agreement that community teams would rollout the CFS for all frailty patients age 65+ who come onto the caseload.

It is commendable that Frailty and Respiratory Hospital at Home pathways commenced in late 2022 supported 452 patients saving in excess of 3000 acute bed days. It is also great to hear that the preparation for the merger between YDH and SFT enabled Hospital at Home to introduce a Geriatrician from YDH to support the service alongside the existing Consultant Geriatrician, to provide consistent cover across Somerset.

It is great to hear that Frailty Advanced Clinical Practitioners (ACP's) have been employed across ED and community services and that a monthly community falls and frailty clinic at Shepton Hospital with an MDT approach has been established.

It is commendable that there have been improvements in the frailty interventions in ED, resulting in more streamlined care and quicker access to a specialist frailty assessment. This has included Geriatricians working in ED two hours in the morning resulted in 50% of patients seen, being discharged home, who were otherwise planned for admission. It is important that there is a plan in place to look at resources to test this model further.

Priority 3: Helping people with mental health conditions to live longer lives. It was great to see the progress made in this stolen year's flagship programme which pledged to co-produce projects with 'Experts by Experience'. The two main areas of focus identified were the uptake and quality of physical health checks for patients with serious mental illness and growing collaborative relationships between mental health and physical health colleagues, to improve care for patients with mental ill-health when accessing physical health services. Some excellent progress has been made working with the surgical booking teams on the expedition of elective treatment for vulnerable patients. This is drawing regional and national attention and the Trust should be commended on this important piece of work.
It is noted that In June 2022, SFT appointed a Tobacco Reduction Programme (TRP) manager to lead on work contributing to a reduction in health inequalities. It is commendable that the TRP fully mobilised its' inpatient acute and mental health pathways across all sites in 2022/23.

It is also great to see the improvement in teams working together to develop advice and guidance for patients who become physically unwell on mental health wards, so they can remain there wherever possible. The outcome of this work is planned to go live across both EDs and mental health wards from Summer 2023, I look forward to following through the impact.

Priority 4: Valuing people's precious time in the last chapter of life. These last 1000 days flagship is ambitious in its aim to identify and appropriately support patients to ensure they maximise the time they have, doing what is important to them in a place they want to be. It is very encouraging that this also included the needs of relatives and friends during life and after the death of their loved one has occurred.

It is very commendable to see the improvements through the EOL Homecare pilot which commenced in November 2022 to bring about rapid discharge of EOL patients. The improvement noted from February 2023 with 68% of people getting home same day or next demonstrates the progress that has been made. It is also great to see the initiative to improve end of life care in heart failure which is underway and the launch of the Somerset End of Life Care and Bereavement Support website in March 2022.

The 'Talk About Project' looking at an advanced care planning (ACP) across Somerset using volunteers to help people personalise their care and legacy through an advanced care plan showed real collaborative working. It is sad to see that unfortunately, the funding for this work has been ceased and there is no resource in place to support advance care planning going forward. The ICB are committed to exploring further the evaluation of this work and exploring resource and funding.

It is commendable to understand that following the CQC inspection of community end-of-life care services, it was noted '*the provider had adopted a clear quality improvement approach at service level to drive development. This included the 'Last 1000 days'; a program of projects delivered across the service to improve the overall experience of people in Somerset approaching the last 1000 days of their life.*

Priority 5: Using time well by getting together to focus on what matters to people with complex needs. The focus of this priority on meeting the needs of this population required a switch to anticipatory not reactive care, time to develop trusting relationships, broadening the membership of the care team and communicating across different specialties and agencies. There have been recognisable improvements in the support for those identified as high-intensity service users through the Ubuntu Project**.** This innovative partnership project between SFT and the Community Council for Somerset (CCS) supporting high-intensity users referred with a focus on what is important to the individual, whilst developing self-activation and a subsequent reduction in health service use should be commended.

Whilst it is recognised there is still a lot of work to do in Somerset to improve the diagnosis and care of those with dementia it is great to see that the Somerset Dementia Wellbeing model is currently being launched and that a website has been developed and will be launched imminently. It is also encouraging to see the workforce has been expanded to support the increase in referrals seen over the last year.

Priority 6: Improving life chances for children by increasing their time in school. It is really encouraging to see that the Trailblazers programme improving the access to emotional and mental health support for children and young people within school settings has successfully transitioned from a test of change to a permanent service. It is also commendable to see that significant progress has been made in the offer to children and young people with eating disorders, which includes the commissioning of a VCSE partner for low to moderate needs. Consequently, waiting times are significantly improving for this group.

It is also commendable to see the trusts 'good' CQC rating overall and the positive comments following their CQC inspection in September 2022, including the trusts preparedness for merger with Yeovil District Hospital.

The ICB supports SFT's identified continued Quality Priorities for 2023/2024. It is recognised that several of the priorities described in this Quality Account align to the NHS priorities set out in the NHS Long Term Plan and Operational Planning Guidance with a crucial focus on reducing inequalities.

The ICB also welcomes continued engagement and focus on improvements in but not restricted to:

1. Progress in implementing the priority clinical standards for 7-day hospital services.
2. Improving Summary Hospital-Level Mortality Indicator (SHMI) rates.
3. Understanding and improving the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust.
4. Improving the collection of Patient Reported Outcome Measures (PROMS).
5. Reducing the number of patients readmitted to a hospital within 30 days of being discharged.
6. Reducing the rate of Clostridium difficile infection.
7. Increasing patient safety incidents reporting to the national reporting and learning system (in 2023 the Learning from Patient Safety Event national reporting system).
8. Reducing the number of Patient Safety Incidents that Resulted in Severe Harm or Death
9. Increasing the number of patients admitted to hospital who were risk assessed for venous thromboembolism.

We look forward to seeing progress with quality priorities identified in this Quality Account in conjunction with the continued transition to PSIRF and the formulation of the organisations Patient Safety Incident Response Plans (PSIRPs). We would encourage alignment to focus improvement in key areas.

NHS Somerset ICB are committed to sustaining strong working relationships with the SFT, and together with wider stakeholders, will continue to work collaboratively to achieve our shared priorities as the Integrated Care System further develops in 2023/24.

With kindest regards,

Shelagh Meldrum
Chief Nursing Officer
NHS Somerset ICB

Copy to:

Peter Lewis, CEO, Somerset NHS Foundation Trust
Hayley Peters, Chief Nurse, Somerset NHS Foundation Trust
Dan Meron, Chief Medical Officer, Somerset NHS Foundation Trust

APPENDIX 2: STATEMENT FROM STAKEHOLDERS – SOMERSET COUNTY COUNCIL – OVERSIGHT AND SCRUTINY COMMITTEE

Somerset Council
County Hall, Taunton
Somerset, TA1 4DY

Somerset Council

Phil Brice
Director of Corporate Services
Somerset NHS Foundations Trust

Please ask for: Jamie Jackson

Email:Jamie.Jackson@Somerset.gov.uk

Direct Dial: 01823 359040

Date: 24 August 2023

Dear Phil,

SFT Quality Account 2023/24

Thank you for sharing with the Scrutiny Policies for Adults and Health Committee your draft report on Quality Accounts 2022/23 for comment.

The report has been shared with the 13 members of the Committee and they have all had the opportunity to consider and review the report and have noted that this is the first report of the merged Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust. It is clear that the year has been a challenging one for the NHS but significant steps have been made to provide innovative solutions to those challenges.

The Committee has no specific comments to make on the draft report.

The Committee would like to add its thanks to the staff and volunteers of Somerset NHS Foundation Trust and for the open and frank way the Trust have worked with the Committee over the last year. The Committee look forward to continuing this constructive dialogue in the forthcoming year.

Yours sincerely,

Jamie Jackson
Scrutiny Manager

www.somerset.gov.uk

APPENDIX 3: STATEMENT FROM STAKEHOLDERS – HEALTHWATCH

25/08/2023

Healthwatch Somerset's Response to Somerset NHS Foundation Trust's Quality Account Statement 2022-2023

Healthwatch Somerset exists to promote the voice of patients and the wider public with respect to health and social care services. We work with the health and care system to ensure that patients and the wider community are appropriately involved in providing feedback.

We welcome the opportunity to comment on the Somerset NHS Foundation Trust's (SFT) quality account for 2022/23. The work being done to merger SfT and Yeovil District Hospital Foundation Trust seems to be working well with the different teams continuing to come together under the joint management arrangements put in place in 2021.

We were interested to read about the perioperative services and pathways particularly in the light of the recommendations that we made in our report on waiting lists back in November 2021 and we look forward to hearing how well this works.

We note the aspiration to improve the discharge process but we have some concerns around its integration with GP practices not quite being what it should be. However, the introduction of the discharge facilitator role is welcomed in Musgrove as communication is one of the areas that we receive significant feedback about.

The End of Life Care last 1000 days flagship ambition is to be applauded. May we also commend the work of the new Acute Frailty Unit enabling older people living with frailty to get extra support if they need care at Musgrove Park Hospital's emergency department (A&E).

May we also commend the development of the new surgical decision unit at Musgrove Park Hospital which enables surgical teams to assess patients more rapidly in order to determine whether they need emergency surgery or can be safely discharged home.

We look forward to maintaining the good working relationship that we have with SFT while working as a stakeholder on the ICB to ensure the experiences of patients, their families and unpaid carers are heard and taken seriously.

Gillian Keniston-Goble
Manager
Healthwatch

APPENDIX 4: STATEMENT FROM STAKEHOLDERS – SFT GOVERNORS

Having reviewed the whole Quality Account for 2022/23 it is clear to me that the massive commitment to our integrated trust is an opportunity to improve performance across the many and varied indicators and comparisons

The Trust performs well in all aspects compared with national averages but in every case there are better performances that we can strive to emulate.

Every interaction I have had with Trust activities this year has demonstrated the effects of outstanding leadership and unswerving commitment to make best possible provision for our Somerset population. In partnership with the Public Health and Social Services we can deliver a unique comprehensive service to our ageing demographic.

Dr Paull Robathan
Lead Governor

24/08/2023

APPENDIX 5: STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements), and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2022/23 and supporting guidance.

- The content of the Quality Report is not inconsistent with internal and external sources of information including:

    - Board minutes and papers for the period April 2022 to March 2023
    - Papers relating to quality reported to the Board April 2022 to March 2023
    - Feedback from the commissioners dated 09/08/2023
    - Feedback from Local Authority Overview and Scrutiny Committee dated 24/08/2023
    - Feedback from local Healthwatch organisations dated 25/08/2023
    - Feedback from governors dated 24/08/2023

- The Quality Report presents a balanced picture of Somerset NHS Foundation Trust's performance over the period covered.

- The performance information reported in the Quality Report is reliable and accurate.

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm they are working effectively in practice.

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and

- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations), as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Report.

By order of the Board.

05/09/2023 Date…… Chairman

COLIN DRUMMOND

05/09/2023 Date……Chief Executive

PETER LEWIS

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the People Committee meeting held on 25 July 2023
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Jan Hull, Non-Executive Director Member of the People Committee
DATE:	5 September 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 25 July 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 colleague story in relation to the "attract and retain" deep dive • The work in relation to "retain and attract talent" • The international recruitment position • The guardian of safe working report • The preceptorship programme • The review of objective six of the Board Assurance Framework and review of the workforce corporate risks • The director report relating to attract and retain talent; flexible working; and the work on allyship training The Committee identified the following aeras for follow up: • A deep dive into medical workforce and medical

	locums spend • The inclusion of more qualitative data in the guardian of safe working report • The impact of integration of the workforce. The Committee identified the following area to be reported to the Board: • The impact of integration of the workforce. 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:					

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

The colleague story is one way of identifying potential impacts on colleagues with protected characteristics and any lessons learned will be followed up. There is a high focus within the Committee on culture and a culture and strategy group has been set up. This group will strengthen oversight of culture across the organisation. The deep dives into the attract and retain people promise enables performance data to be robustly reviewed and any areas for follow to be identified, e.g. reasons for leaving and high vacancy rates.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
The views from colleagues has been considered through the colleague story.

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 25 July 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 – Attract and Retain Deep Dive

2.1. The Committee received an overview from a colleague about her journey from an apprentice HCA to a nursing associate and her subsequent work experience. The Committee noted the difficulties experienced during Covid-19 in view of the closure of the ward where the colleague worked, the need to work in other areas, the impact on the colleague; and the colleague's move to a teaching position at Yeovil whilst still providing clinical support.

2.2. The Committee was advised that the first pilot of the nursing associate training had been challenging in view of the lack of clarity about the direction of the programme and that consideration will be given as to how best to support colleagues undertaking the nursing associate training.

2.3. The Committee noted that the Yeovil support team had an open door policy and that the colleague would be happy to speak to managers or departments to put actions plans in place.

2.4. The Committee further noted the work with schools to raise awareness of a career in the health services, including in digital and IT services; and the need to continue to engage with colleagues, especially colleagues who have become slightly disengaged.

Deep Dive – Retain and Attract Talent Overview

2.5. The Committee received an update on the work to retain and attract talent and noted: the risks associated with high vacancy rates; that the highest number of leavers were younger, white females, bands two to six, working in administrative or clerical services; the retention of the Covid-19 workforce; the success of the SWAP training and support programme; the number of young people leaving school without destination into work; and the focus on collaborative information sharing and providing support.

2.6. The Committee received an overview of non-medical staffing and agency data and noted the reduction in the number of bank and agency shift requests; the

increase in the percentage of shift fulfilments; and the reduction in the use of agency staff.

2.7. The Committee further received an overview of the non-medical staffing and agency data specific for Musgrove Park Hospital, Yeovil District Hospital, community hospitals and MIUs; and mental health wards and noted that the removal of the bank and hot shift incentives had not negatively affected fill rates.

2.8. The Committee noted: the successful implementation of the Wagestream system which bank colleagues can use to draw up to 50% of their worked shift pay; the shortages of colleagues in some specialist areas (including theatres, and children, adolescent mental health services); the need to further reduce agency spend to achieve the annual agency cap; the need to discuss strategic leadership of education with the ICS; the need to accommodate candidates with specific needs by offering alternative options to complete an application form; and the availability of work experience opportunities.

International Recruitment Position

2.9. The Committee received an update on overseas recruitment and the key achievements were noted.

2.10. The Committee further noted that the Devon Hub used the same recruitment model as the trust but this was not considered a high risk as the Devon model only covered specific services.

2.11. The Committee discussed the opportunity for the trust to recruit social care colleagues but noted the challenges translating qualifications and the view of the ICB not to disrupt the current supply chain.

Guardian of Safe Working

2.12. The Committee received the quarterly progress report and noted the key highlights.

2.13. The Committee discussed the number of exception reports in both medicine and surgical services and noted that junior doctors were actively encouraged to report exceptions which had contributed to the increase.

2.14. The Committee further discussed the increase in the number of medical colleagues moving from full time to 80% contracts and noted that this was a personal choice and enabled colleagues to have an interest outside of medicine. This was in line with Health Education England guidance but had a cost implication due to the requirement for medical locum cover. The Committee agreed that the work life balance for colleagues working full time should also be considered.

Learning Item

2.15. The Committee received an update on the preceptorship programme and noted the key achievements, including being awarded the Gold Award for the programme.

2.16. The Committee noted that the preceptorship programme was well received and feedback indicated that the programme was one of the reasons why colleagues choose the trust for their employment.

Review of the Board Assurance Framework

2.17. The Committee reviewed strategic objective six of the Board Assurance Framework (BAF).

2.18. The committee discussed the new corporate risk relating the inability to fill vacancies across the trust and noted that this risk consisted of multiple vacancy related risks across different services and service groups.

Workforce (Corporate Risk Register)

2.19. The Committee discussed the workforce risks and noted that there were currently 23 risks on the Corporate Risk Register. The Committee noted the details of the risks and noted that the risk systems will be merged into a single system by April 2024.

Director Report

2.20. The Committee received the report and noted the update regarding attract and retain talent; flexible working; and the work on allyship training.

2.21. The Committee further received an update on the work of the Culture and Strategy Group and noted the work with internal auditors to provide assurances about the role of the Group. The Committee noted that the first meeting of the Group will be held in September 2023.

Review of Terms of Reference and Planning Proforma

2.22. The Committee discussed the Terms of Reference and planning proforma. The Committee approved the addition of the Deputy Director of Resourcing and Supply to the membership of the Committee and further approved the planning proforma.

Review of Effectiveness

2.23. The Committee agreed that the focus on People Strategy Commitment 4 – recruitment and retention - had enabled productive discussions.

3. AREAS OF CONCERNS/FOLLOW UP

Deep Dive – Retain and Attract Talent Overview

3.1. The Committee asked for a deep dive into medical workforce and medical locums spend to be scheduled for a future meeting as these remained high risk areas.

Guardian of Safe Working

3.2. The Committee asked for future reports to include more qualitative data to enable the Committee to review the quality impact of exception reports.

Workforce (Corporate Risk Register)

3.3. The Committee discussed the integration risk and noted that although integration had not been included as a high level risk on the Corporate Risk Register, it was referred to in the Directorate/service group level risk registers. The Committee noted that some colleagues had felt unsettled due to the uncertainty caused by integration and that this uncertainty had caused colleagues to leave. The Committee agreed that this was a concern and, on behalf of service group directors, the Committee agreed to raise this concern with 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:

- The impact of integration of the workforce.

5. ASSURANCE FRAMEWORK

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

- The focus of the meeting on the People Strategy Commitment 4 – recruitment and retention, including the colleague story; the deep dive into retain and attract talent; and international recruitment.
- The positive assurances in relation to agency and bank shifts and medical staffing.
- The Gold Award for the preceptorship programme.
- The guardian of safe working report.
- The preceptorship programme.
- The high level workforce risks provided negative assurance.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Guardian of Safe Working for Postgraduate Doctors
SPONSORING EXEC:	Daniel Meron, Chief Medical Officer
REPORT BY:	Tom Rees (SFT) and John McFarlane (YDH), Guardian of Safe Working Lee-Ann Toogood, Medical Workforce Manager
PRESENTED BY:	Daniel Meron, Chief Medical Officer
DATE:	5 September 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	This report covers quantitative and qualitative summary of exception report data generated between 1 April 2023 and 30 June 2023 across the Trust. The medical Service Group consistently creates the majority of (Exception Reports) ERs each quarter. With an expanding bed base, this will need to be acknowledged going forward with a clear workforce plan to avoid further detriment – particularly given the worrying trend of increasing educational opportunities being missed. The weekend coordinator for medicine at MPH has appeared to have a positive impact on ERs submitted. Consideration should be made to expand this to re-cover T&O and Surgery – we understand this has been discussed at the Hospital Out Of Hours (HOOH) working group.
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: N/A					

Equality and Inclusion

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

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

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

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

Public/Staff Involvement History

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

Not applicable for this report.

Previous Consideration

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

The report is presented to the Board on a quarterly basis. The report has been reviewed by the People Committee.

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

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

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SOMERSET NHS FOUNDATION TRUST

QUARTERLY REPORT ON SAFE WORKING HOURS:

DOCTORS AND DENTISTS IN TRAINING

1. EXECUTIVE SUMMARY

1.1. Consistent with the previous quarter report, there have been no Immediate Safety Concerns (ISCs) regarding weekend working at MPH this quarter, suggesting the re-allocation of the weekend HOOH coordinator has provided an immediate and sustained impact.

1.2. Total number of Exception Reports (ERs) this quarter are comparable with the previous quarter and the large majority relate to deviated working hours within the medical directorate.

1.3. We have not seen an increase in ERs submitted immediately after the industrial action.

1.4. The report has been reviewed by the People Committee.

2. INTRODUCTION

This report covers and comprises quantitative and qualitative data on working patterns for postgraduate doctors in training across the Trust.

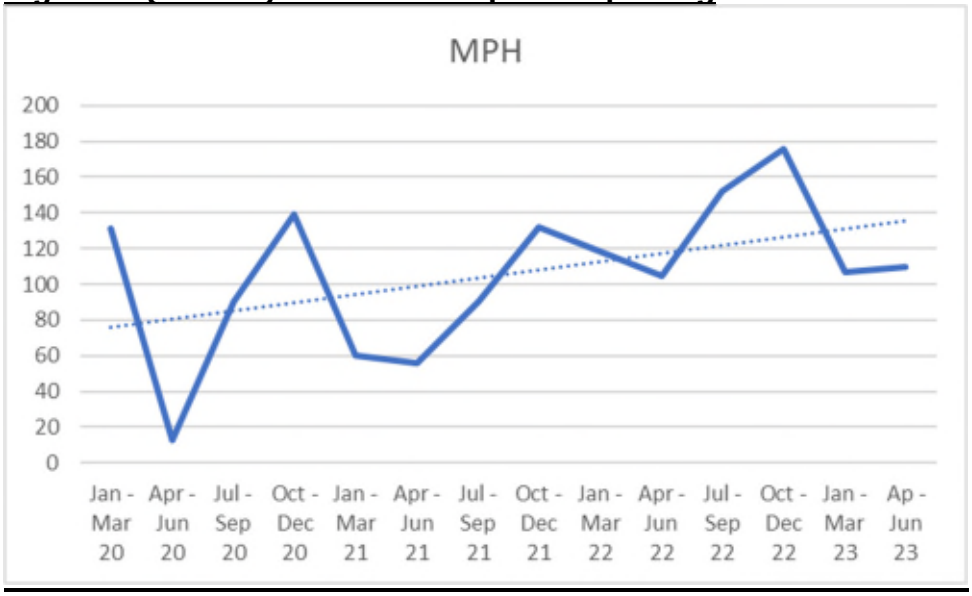
3. EXCEPTION REPORT DATA:

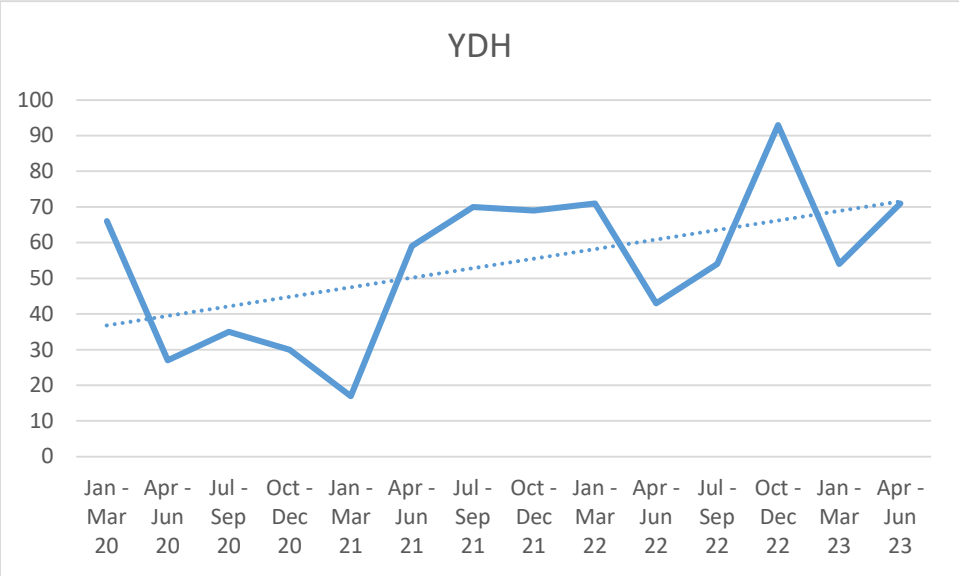
Number of doctors/dentists in training on 2016 TCS (total):	348
Job plan allocation for Guardian of Safe Working:	2.5 PAs
Job plan allocation for Educational Supervisors per trainee:	0.125 PAs

Exception reporting since the introduction of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016

3.1. As of 14/07/2023 - Total of exception reports since implementation of 2016 TCS (December 2016). 3037 for Taunton and for Yeovil 1424. The overall cost of exception report overtime is £81,044.01

Figure 1 Quarterly total for exception reporting





Exception reports this quarter - please find the information in brackets from the previous quarterly report for comparison:

Table 1: Exception reports per specialty

Specialty	No. exceptions raised	No. exceptions closed	No. exceptions outstanding	Type
Acute & General Medicine	TSTMPH 71 (52) YDH 45 (26)	52 43	19 2	Hours MPH 61 YDH 39 Educational MPH 7 YDH 2 Service Support MPH 3 Pattern MPH 4
Anaesthetics	0 *(0)*	0	0	
DCT Trainees	0 *(0)*	0	0	
Emergency Medicine	YDH 2 (0)	2	0	Hours 1 Service Support 1
ENT	0 *(0)*	0	0	
General Surgery	MPH16 *(26)* YDH 29 (3)	5 27	11 2	Hours MPH 20 YDH 2 Pattern YDH 1
O&G	0 *(0)*	0	0	
Oncology/ Haematology	MPH 5 *(0)*	0	5	Hours MPH 5
Paediatrics	MPH 3 *(6)*	3	0	Hours MPH 2 Pattern MPH 1
Psychiatry	MPH 9 *(10)*		9	Hours MPH 5 Service Support MPH 4
Trauma & Ortho	MPH10 *(16)* YDH 5 (22)	4 5	6 0	Hours MPH 12YDH 1 Educational MPH 1YDH 1 Service Support MPH1YDH 1
Urology	MPH 1 *(6)*	0	1	Hours MPH 1
Vascular	0 *(2)*	0	0	
Total	**192**	**64**	**51**	

Table 2: Exception reports per trainee grade

Grade of trainee	No. exceptions raised Taunton	No. exceptions raised Yeovil
F1	71	53
F2	31	13
CT1-2 / ST1-2	5	6
ST3+	8	1
Total	**115**	**73**

Locum Agency Spend

Division	Pay Gross (No VAT)	Booking Gross (No VAT)
CYP & Families Services	£141,911.54	£173,819.13
Medical Services	£827,472.30	£970,683.06
Medicine	£4,224.00	£5,280.33
Mental Health and LD	£114,293.76	£138,794.95
Primary Care & Neighbourhoods	£144,578.84	£162,591.31
Surgical Services	£98,033.73	£118,265.59
Grand Total	£1,330,514.17	£1,569,434.37

Qualitative summary of exception reports

3.2. Consistent with previous quarters, the majority of ERs relate to the medical directorate and deviated hours, highlighting continued pressure on inpatient medical wards and workload.

3.3. There is a trend towards increasing ERs relating to missed Educational opportunities at F1 level in the medical directorate further highlighting ward pressures. This will continue to be monitored and discussed with medical staffing/DME if current trend continues.

Immediate safety concerns (ISCs)

3.4. There have been 5 ISCs raised this quarter across the trust:

- 3 ISCs were raised at MPH this last quarter (5 separate ERs were recorded however, 2 were duplicate entries). 1 was misclassified, and has been downgraded to hours deviation and payment issued. 1 related to staffing on AMU overnight below minimum which was escalated to the AMD and rota coordinator and no further ISCs were raised on subsequent nights. 1 related to staffing on Conservators ward during a period of high acuity and complexity patients, although staffing was at minimum required. This has been raised with the rota coordinator for medicine with a view to potentially arranging additional support in the form of a PA.

- 2 ISCs were raised at YDH this quarter. 1 was raised on Orthopaedics nights which has been addressed by doubling the SHO night cover in surgery from August 2023 (i.e. 1 SHO for Ortho and 1 SHO for Surgery). 1 was raised on ED nights which was escalated to the ED rota co-ordinator and subsequently addressed.

Fines

3.5. No fines were issued during this quarter.

Work schedule reviews

3.6. There were no work schedule reviews this quarter.

4. ISSUES ARISING

Workforce development

4.1. Workforce remains challenging as per previous quarter reports, particularly within the medical and emergency department directorates. The increasing uptake of category 3 less-than-full-time working (0.8 full time equivalent) will continue to put pressure on the workforce, with the 20% gap needing to be backfilled by locums and/or an expansion in the clinical fellow program.

Postgraduate Doctor Forum (PDF)

4.2. The last PDF at MPH was conducted in May 2023 and was chaired by the previous GoSW at MPH - Janet Fallon. Issues raised were similar to previous meetings; industrial action and rota gaps. A particular topic of conversation was the provision of hot food for doctors during OOH working, particularly overnight, with limited options available in the trust. The mess president for MPH will see whether the provision of hot food can be paid out of the existing mess budget.

4.3. At YDH, 2 JDFs were held this quarter. These were conducted prior to each of the first two periods of industrial action. Topics discussed were mainly related to conduct (i.e. notification and pickets) and junior support and reassurance during the strike periods.

Rota management

4.4. There has been recruitment of an assistant for Wendy Burman in managing the medical rota at TST which has helped with regards to filling rota gaps with internal and external locum.

4.5. There remains the issue of disjointed rotas between specialities, meaning that junior doctors on call commitments can ‘clash’ when moving between specialities at changeover. A centralised rota team and/or consistent electronic program pan-trust would help mitigate this. An electronic rota is frequently brought up by post graduate doctors.

5 SUMMARY

- Overall numbers of ERs are consistent with previous quarters, although a total of 7 working days were lost due to industrial action at Postgraduate Doctor level.

- There did not appear to be an uptick in ERs raised post industrial action suggesting that workloads after strike dates were not above average.

- Consistent with previous quarters there remains a higher number of ERs submitted by Foundation grade postgraduate doctors suggesting greater engagement at these levels. It remains a challenge to engage more senior postgraduate doctors, particularly within the surgical specialities. It is therefore anticipated that overall ER numbers may

increase over the coming years as the Foundation Year doctors become more senior.

- ISCs raised this quarter were acknowledged and acted upon in a timely manner with resolution.

6 RECOMMENDATIONS

- The medical directorate consistently creates the majority of ERs each quarter. With an expanding bed base, this will need to be acknowledged going forward with a clear workforce plan to avoid further detriment – particularly given the worrying trend of increasing educational opportunities being missed.

- The weekend coordinator for medicine at TST has appeared to have an impact on ERs submitted. Consideration should be made to expand this to re-cover T&O and Surgery – we understand this has been discussed at the HOOH working group.

Tom Rees and John McFarlane Guardian of Safe Working

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Freedom to Speak Up Guardian (FTSU) Report
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Caroline Sealey, Lead Freedom to Speak Up Guardian
PRESENTED BY:	Caroline Sealey, Lead Freedom to Speak Up Guardian
DATE:	5 September 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	All organisations which regulate or provide NHS healthcare should implement the principles and actions set out in the report Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. This paper provides an update regarding FTSU activity in Somerset Foundation Trust (SFT) and Yeovil District Hospital (YDH) covering the period October 2022 – March 2023 (pre-merger). It informs the Trust Board about the number of concerns received and the professional background of the colleagues contacting the service. It also outlines the themes of the concerns, the service progress and planned actions. A total of 85 cases were raised in this period by SFT colleagues and 22 by YDH colleagues. This is an increase of 19.7% for SFT and an increase of 15.8% for YDH compared to the previous two quarters. Data collected demonstrates that most concerns in this period were raised by Nursing and Midwifery colleagues and Admin / Clerical colleagues in SFT and by Nursing and midwifery colleagues and medical / dental colleagues in YDH. A significant number of concerns (SFT = 50.6%, YDH = 54.5%) contained an element of bullying / harassment or inappropriate attitudes / behaviours.
Recommendation	The Board is asked to note and discuss the report.

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

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

Equality and Inclusion
The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
Colleagues are asked to provide demographic information so data trends can be reviewed. FTSU guardians link with the colleague networks and inclusion team. The diversity of the FTSU team is extended via the Wellbeing champions.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History
How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Colleagues who have used the FTSU service are asked to provide feedback via an MS Forms survey.

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The SFT and YDH Freedom to Speak Up six monthly progress report was presented to the March 2023 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

FREEDOM TO SPEAK UP GUARDIAN REPORT

1. INTRODUCTION

1.1 The Freedom to Speak Up (FTSU) service is now fully established across the newly formed Somerset Foundation Trust (SFT). This is the first paper post-merger that has been presented to Board but, as the data relates to pre-merger, it will be presented as the former SFT and Yeovil District Hospital (YDH).

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

1.3 The FTSU model consists of a full-time lead guardian, Caroline Sealey, and a full time guardian, Stephanie Hayward.

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

2. ASSESSMENT OF FTSU CASES

2.1. On 6 July 2023, the National Guardian's Office (NGO) published "A Summary of Speaking Up to Freedom to Speak Up Guardians – 1st April 2022- 31st March 2023" (202223-Annual-Data-Report.pdf (nationalguardian.org.uk). Cases of speaking up have risen to 25,382 which is a 25% increase compared to 2021-22.

2.2. The national data highlights are:

TOTAL CASES

25,382 cases
were raised with
Freedom to Speak Up Guardians
in 2022/23

The highest number of cases recorded - 25% increase from 2021/22.

QUARTER 3 HAD THE LARGEST AMOUNT OF CASES

Quarter 3 (Oct-Dec 2022) had the highest number of cases raised with Freedom to Speak Up Guardians in a single quarter (6,947), a record number of cases.

This may be as a result of the awareness raising which takes place during Speak Up Month every October.

SOURCES OF CASES

Cases raised with Freedom to Speak Up Guardians in NHS Trusts (23,392) accounted for 92.2% of cases in 2022/23.

A further 1,990 cases (7.8%) were raised in other organisation types.

PROFESSIONAL GROUPS

Workers from a range of professional groups spoke up to Freedom to Speak Up Guardians.

Nurses and midwives accounted for the biggest portion (29%) of cases raised.

ANONYMOUS CASES

The percentage of cases which were raised anonymously has fallen to ten percent (9.3%).

This continues the downward trajectory from 2017, when 17.7% of cases were raised anonymously.

BULLYING AND HARRASSMENT

22 % of cases reported included an element of bullying or harassment.

A 10-percentage point fall compared to 2021/22 - this is at least in part due to cases being reported against the new category of 'inappropriate attitudes and behaviours'

WORKER SAFETY AND WELLBEING

One in every four cases raised (27.4%) involved an element of worker safety or wellbeing.

PATIENT SAFETY AND QUALITY

19.3% of cases raised included an element of patient safety/quality, up from 18.8% in 2021/22.

INAPPROPRIATE BEHAVIOURS

30% of cases involved an element of inappropriate behaviours and attitudes.

The most reported theme in 2022/23.

DETRIMENT

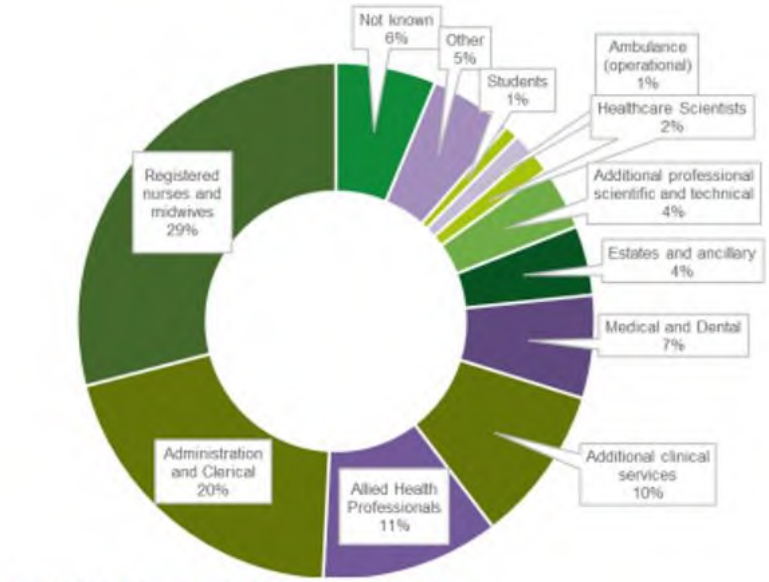
Detriment for speaking up was indicated in 3.9% of cases.

This is down from 4.3% in 2021/22 but higher than 2019/20 and 2020/21 levels.

FEEDBACK

Over four-fifths (82.8%) of those who gave feedback said they would speak up again.

2.3. In total, FTSU Guardians have handled over 100,000 cases since their establishment in 2016:



Proportion of cases raised by professional group[1]

2.4. Cases raised nationally by professional group are as follows:

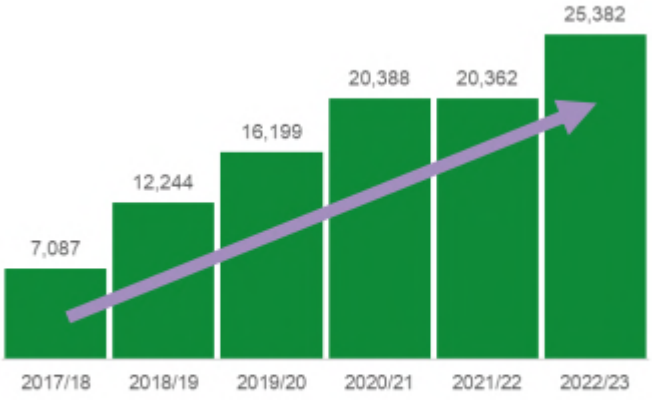


Figure 1. Total cases raised with FTSU Guardians

2.5. The NGO also recently published [Fear and Futility: what does the staff survey tell us about speaking up in the NHS? - National Guardian's Office] (June 23). Within this report the FTSU sub-score has been calculated and used as a comparator for organisations. The 4 questions included within the sub-score are:

- Q19a - I would feel secure raising concerns about unsafe clinical practice
- Q19b - I am confident that my organisation would address my (clinical practice) concern
- Q23e - I feel safe to speak up about anything that concerns me in this organisation
- Q23f - If I spoke up about something that concerned me I am confident my organisation would address my concern

2.6. Nationally the sub-score declined from 6.5 in 2021 to 6.4 in this year's NHS Staff Survey and this decline has also been reflected in all NHS regions:

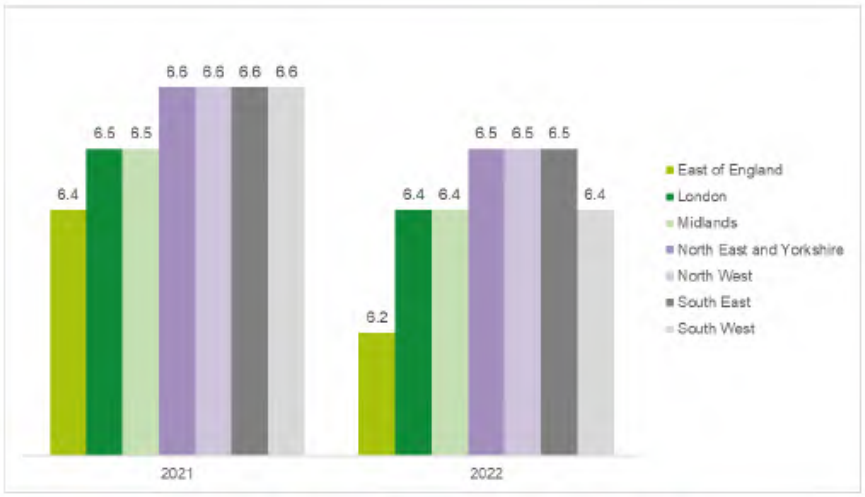


Figure 5. Freedom to Speak Up sub-score by region

2.7. Further analysis by sector shows that ambulance services have the lowest sub-score (5.9) and Mental Health & Learning Disabilities and Mental Health, Learning Disabilities & Community have the largest disparity (1.7) indicating the widest range in sub-score for this organisation type. Acute and Acute Community Trusts (the comparator for SFT and YDH) have a subscore of 6.4:

Sector	Lowest sub-score	Highest sub-score	Mean sub-score
All Trusts	5.3	7.6	6.5
Acute specialist	6.4	7.3	6.8
Acute and Acute Community	5.7	7.1	6.4
Ambulance	5.3	6.9	5.9
Community	6.5	7.6	7.0
Mental Health & Learning Disabilities and Mental Health, Learning Disabilities & Community	5.7	7.4	6.7

3. LOCAL DATA FOR SFT AND YDH

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

Table 1

Quarter	Number of concerns raised		Number of cases raised anonymously		Disadvantageous and / or demeaning treatment	
	SFT	YDH	SFT	YDH	SFT	YDH
Q3: 2022-23	49	10	5	2	1*	0
Q4: 2022-23	36	12	8	6	0	0

* This is not related to speaking up to FTSU Guardian. The colleague's comment is "I spoke to matrons regarding my concerns of feeling intimidated and unsupported by my line manager. I was told to think why the line manager felt insecure? There was no pro active support regarding the situation I was in". This case went into a formal process following the colleague's actions.

3.2. As of 1 August 2023 the FTSU Guardians are supporting 31 cases of speaking up.

Themes (for period 1 October 2022 – 31 March 2023)

SFT	YDH
• Poor leadership with lack of visibility and support • Bullying / harassment • Incivility / microaggressions • Discrimination • Poor culture with colleagues demonstrating unprofessional behaviours • Increased work demands impacting on patient safety and colleague wellbeing • Lack of staffing / poor skill mix • Lack of adherence to policy / procedure and a delay in implementation • Poor communication especially regarding consultations and organisational change	• Bullying and Harassment • Poor behaviours and attitude • Lack of fair processes • Concerns regarding patient safety related to poor practices

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

Table 2

	Number with an element of patient safety/ Quality*		Number of concerns with an element of worker safety or wellbeing*		Number with an element of bullying or Harassment*		Number with an element of inappropriate attitudes / behaviours*		Number of other concerns*	
Quarter	**SFT**	**YDH**	**SFT**	**YDH**	**SFT**	**YDH**	**SFT**	**YDH**	**SFT**	**YDH**
Q3 2022-23	**3**	**6**	**10**	**1**	**15**	**2**	**7**	**2**	**20**	**1**
Q4 2022-23	**5**	**2**	**4**	**0**	**13**	**3**	**8**	**5**	**7**	**2**

* Some concerns have elements that span multiple categories

Table 3 Professional / Worker Group of colleagues speaking up:

Professional / Worker Group	Q3: 2022-23		Q4: 2022-23		Totals	
	SFT	YDH	SFT	YDH	SFT	YDH
Additional clinical services	6	0	5	1	11	1
Additional professional scientific & technical	1	0	1	1	2	1
Admin and clerical	10	0	5	2	15	2
AHP's	2	2	1	1	3	3
Estates and ancillary	3	0	0	0	3	0
Healthcare scientists	0	0	0	0	0	0
Medical and dental	0	2	2	2	2	4
Nursing and midwifery - registered	20	4	13	4	33	8
Students	2	0	2	0	4	0
Other	2	0	0	1	2	1
Not Known	3	2	7	0	10	2
Totals	49	10	36	12	85	22

3.4. Some examples of speaking up in this period include:

- A medical consultant felt bullied due to several protected characteristics, resulting in fear of their position and livelihood. Introduced to Medical Director to support resolution. Fearful that their line managers favoured reputation within the trust would negate their concerns.

- Concerns about organisational change including how this had been communicated, the impact on colleagues, behaviours within the team and what the future looked like. Colleagues within this team were direct to individual support through the Colleague Support Service, a team away day was held, a team charter developed and the service manager worked with the HR business partner and organisational development team to ensure communication was timely and robust and that processes were followed.

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

Quarter	Working Days taken to respond				
	0	1	2	3	3+
3 (49 concerns)	48 (98%)	1 (%)	0	0	0
4 (36 concerns)	31 (86%)	5 (14%)	0	0	0

3.6. YDH data collection has started but, due to changes in the database and change of guardians in the service, the data is not complete. From April 23 however the reporting is accurate and will be presented in the next report.

3.7. Local data for Q3-Q4 2022/23 has shown:

- 19.7% increase in reported cases from Q1– Q2 for SFT and 15.8% increase for YDH.

- 9.4% of the cases raised in this period for SFT and 36.4% for YDH contained an element of patient safety/quality compared to 15.5% for SFT and 21.1% for YDH in Q1 – Q2.

- 32.9% of the cases raised in this period for SFT and 22.7% for YDH contained and element of bullying and harassment compared to 22.5% for SFT and 21.1% for YDH in Q1 – Q2.

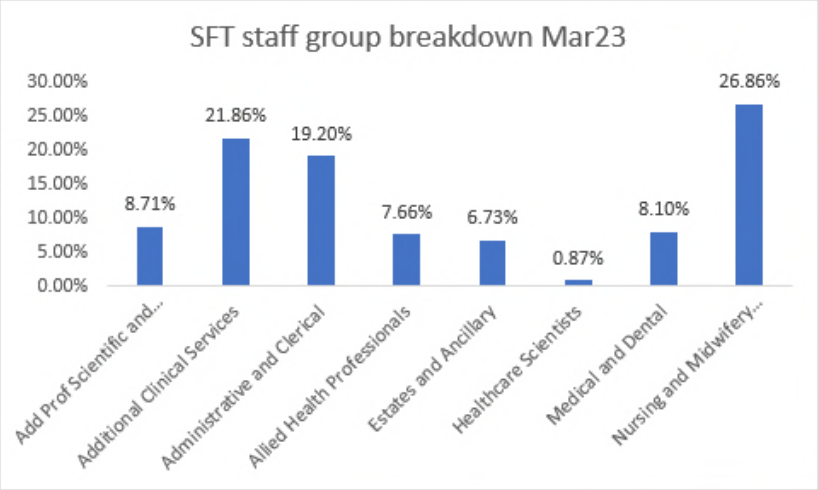
- 17.6% of cases raised in this period for SFT and 31.8% of cases for YDH contained an element of inappropriate attitudes and behaviours compared to 36.6% for SFT and 50% for YDH in Q1 – Q2.

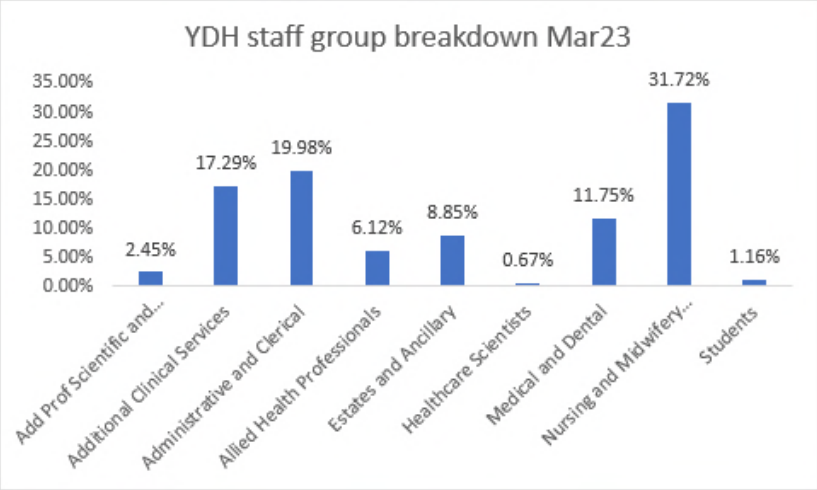
- Combining concerns with an element of bullying and harassment with those containing an element of inappropriate attitudes and behaviours give a total of 50.6% for SFT and 54.5% for YDH in this reporting period

- 15.3% of cases were raised anonymously for SFT and 36.3% for YDH compared to 14.1% for SFT and 47.4% for YDH in Q1 – Q2. Although this is higher than the national average, very few organisations have invested in an anonymous reporting system.

- Disadvantageous and / or demeaning treatment as a result of speaking up is 1.2% of cases, a decrease from 2.8% in Q1 – Q2 for SFT. YDH is 0% for both periods.

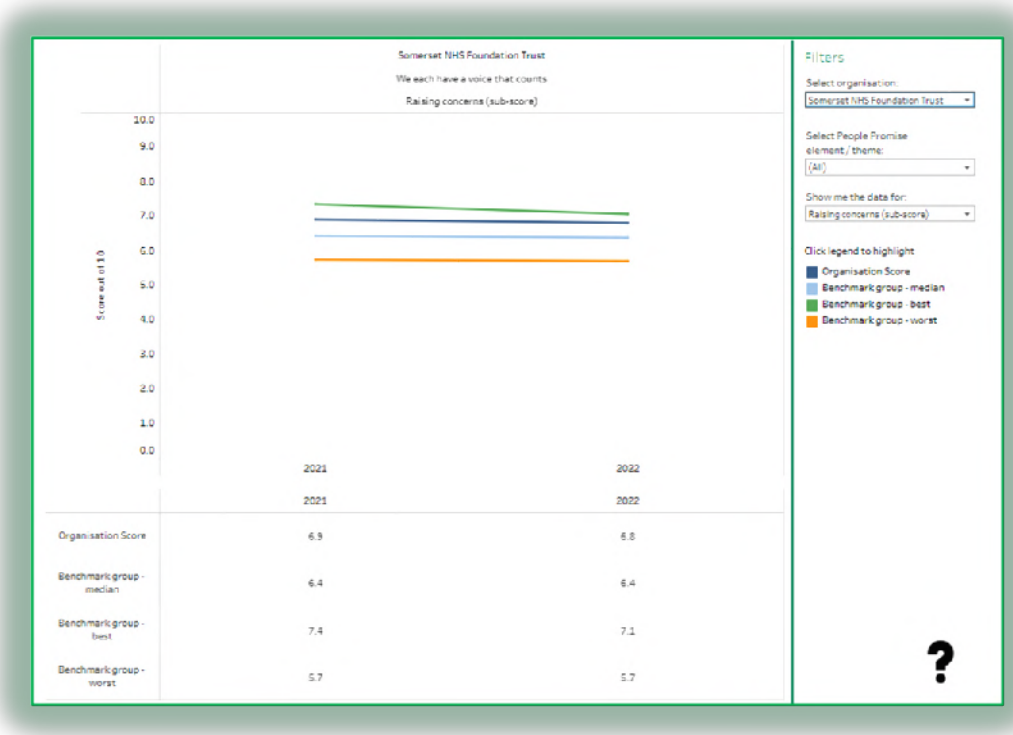
- In SFT, 38.8% of concerns raised came from Nursing and Midwifery colleagues, 17.6% from Admin and Clerical colleagues, 12.9% from colleagues in additional clinical services roles and 4.7% from students. In YDH, 33.6% of concerns raised came from Nursing and midwifery colleagues, 18.2% from medical and dental colleagues, 13.6% from allied health professionals and 9.1% from Admin and Clerical colleagues. The staff group breakdown as of March 2023 for comparison was:

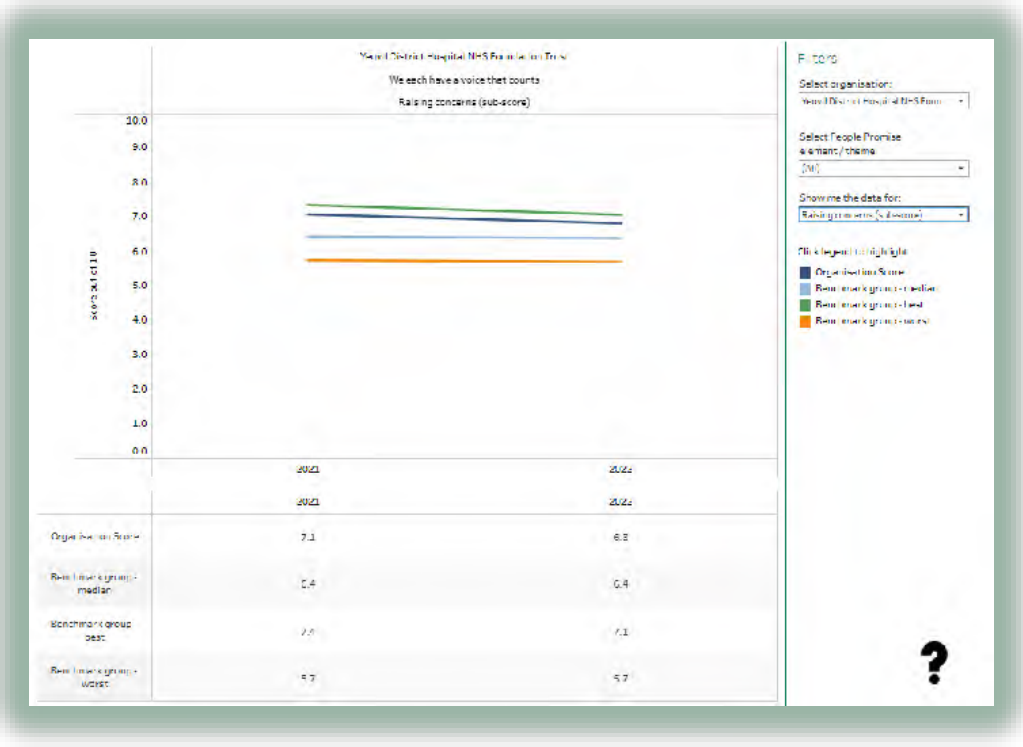




- Over 95% of those who gave feedback across both organisations said they would speak up again. This is a very slight reduction from Q1- Q2 which was over 97%.

3.8. FTSU sub-score for SFT and YDH are as follows:





3.9. Scores for both organisations have seen a slight reduction in the 2022 score compared to the 2021 score. It is pleasing that the scores sit above the mean for the sector but, this should not result in complacency.

4. ACTIONS AND RECOMMENDATIONS

4.1. Our progress continues to raise awareness of FTSU and create a positive speaking up culture. As of 3 July 2023, we have over 90% compliance with the 'Speaking Up' module of mandatory training for substantive colleagues following the launch in August 2021. Bank colleagues is significantly lower at 46.1% but this is mainly due to the mapping being inaccurate. Work is being done with payroll to resolve this and it is hoped this will be complete by the end of the year. In addition, monthly walkarounds with the Bank Lead Nurse team are being completed to engage with this workforce and ensure compliance with training.

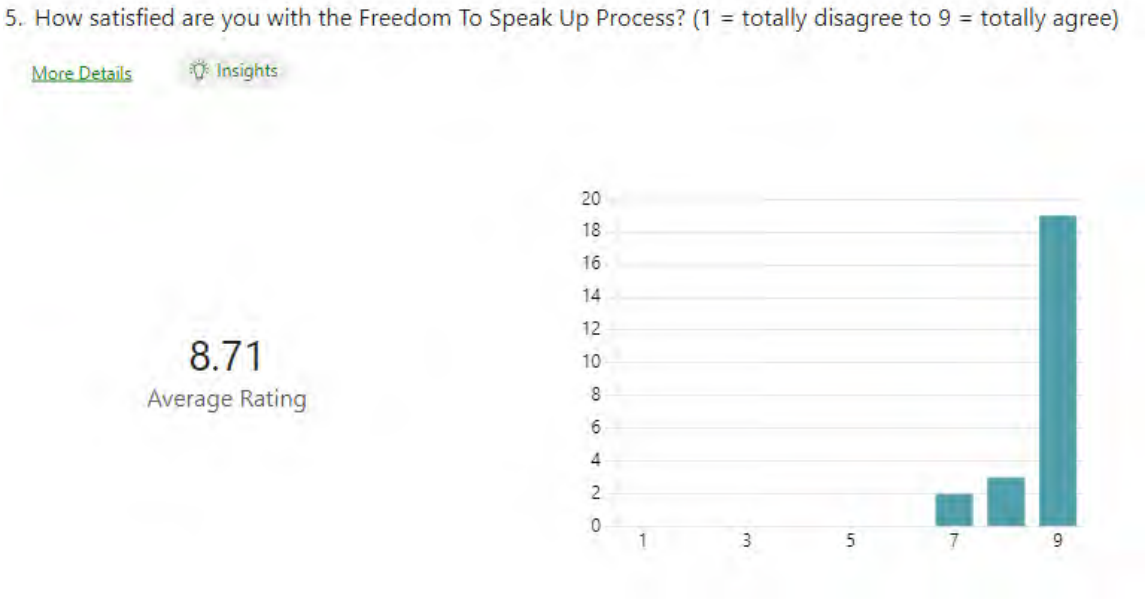
Directorate	Number to be Trained	Certified	Percentage Trained Q1 Apr-Jun-23	Expired/ Training Required
Simply Serve	317	304	95.9%	13
Mental Health and LD	1168	1115	95.5%	53
Primary Care & Neighbourhoods	1926	1831	95.1%	95
Corporate Support Services	1544	1440	93.3%	104
Clinical Support & Specialist	1391	1283	92.2%	108
Families Care Directorate	1244	1139	91.6%	105
Surgical Care	2573	2310	89.8%	263
Integrated and Urgent Care	1968	1750	88.9%	218
Operational Management	132	117	88.6%	15
Freedom to Speak Up for for Q1 April - June 2023 by Directorate (Excludes Bank and New Starters)	**12263**	**11289**	**92.1%**	**974**
Freedom to Speak Up for Q1 April - June 2023 by Directorate BANK STAFF ONLY	**2512**	**1157**	**46.1%**	**1355**
Freedom to Speak Up for Q1 April - June 2023 by Directorate ALL STAFF (Substantive, Bank and New Starters)	**15324**	**12813**	**83.6%**	**2511**

4.2. The ‘Follow Up’ module for colleagues at band 8a and above was launched in May 2023 and compliance for SFT colleagues as of 3 July is as follows:

Directorate	Number to be Trained	Certified	Percentage Trained Q1 Apr-Jun-23	Expired/ Training Required
Clinical Support & Specialist	152	36	23.7%	116
Corporate Support Services	145	52	35.9%	93
Families Care Directorate	107	31	29.0%	76
Integrated and Urgent Care	92	20	21.7%	72
Mental Health and LD	101	20	19.8%	81
Operational Management	13	4	30.8%	9
Primary Care & Neighbourhoods	80	18	22.5%	62
Surgical Care	189	26	13.8%	163
Freedom to Speak Up Follow Up Module for for Q1 April - June 2023 by Directorate (Excludes Bank and New Starters)	**879**	**207**	**23.5%**	**672**
Freedom to Speak Up for Follow Up Module for Q1 April - June 2023 by Directorate BANK STAFF ONLY	**53**		**0.0%**	**53**
Freedom to Speak Up Follow Up Module for Q1 April June 2023 by Directorate ALL STAFF (Substantive, Bank and New Starters)	**952**	**213**	**22.4%**	**739**

4.3. Mapping for YDH colleagues is currently being undertaken and compliance will be detailed within the next reporting period.

4.4. Colleagues from the former SFT who used the FTSU service since start of Q3 2021-22* to end Q4 2022-23 have given an average rating of 8.71 out of 9 with how satisfied they are with the service. This is a slight increase from 8.67 reported previously:



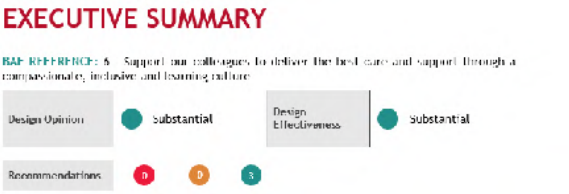
*the rating is only available from Q3 2021-22 due to a change in feedback provider

4.5. Data collection for YDH colleagues has commenced. The first full quarter of data will be available in Q1 2023/24.

4.6. The service also collates feedback from service users and some of the feedback received is detailed below:

- I felt listened to and unrushed
- I found it a very simple process, quick responses and most importantly felt heard.
- It is always good to speak to an experienced member of the team in the organisation to open up and have better understanding of the situation.
- I feel comfortable speaking through this platform and Caroline has always been very understanding and helpful
- Caroline has been extremely approachable and supportive. I would definitely speak up again.
- Support and advice has been outstanding in getting me through a very difficult time where it was not clear where I could turn for help.
- Always reply promptly, always very calm and helpful.
- The concern I had was dealt with efficiently and I was kept informed at all times.
- Felt listened too without judgement

4.7. An internal audit was conducted by BDO in May 2023 and the draft report released in July 2023. Substantial assurance was achieved for 'Design Opinion' and 'Design Effectiveness' with only 3 low level recommendations being made.



4.8. The team are continuing to build on the progress achieved to date and have from April 2023 aligned the services in SFT and YDH, to support the creation of a culture where every colleague, irrespective of role, feels safe to speak up. Some of the work includes:

- Increasing visibility in both acute hospitals and throughout the community sites through day to day working, planned 'drop-in' sessions and walkarounds with a focus on bank colleagues.

- Creating a single point of access for all colleagues. This work is being considered alongside the procurement of the incident reporting system for the merged organisation and will be in place by mid 2024.

- Update of the promotional posters and development of a service leaflet.

- Launching of the new Freedom to Speak Up policy in June 2023 in line with the National policy.

  NHS-Freedom-to-speak-up-national-policy-eBook.pdf (england.nhs.uk)

- Continuing to work collaboratively across the organisation and in particularly within the newly formed Experience and Learning portfolio to:

  ✓ offer timely, bespoke, integrated support for individuals, teams and the organisation that can be tailored according to need and intensity.

  ✓ Triangulate and review data / intelligence with actions planned, instigated, and evaluated. This coordinated approach reduces duplication and improves communication.

  ✓ This results in improved colleague experience and satisfaction, reduced sickness absence and a reduced complexity of cases.

  ✓ Identify areas of good practice that can be shared, extended and replicated across the organisation.

- Alongside the wellbeing lead, supporting the wellbeing champion model across the merged organisation by provide training and support sessions to extend the reach and diversity of the FTSU service.

- Extending our training to colleagues completing the ‘Prepare to Care’ programme – this reaches approximately 50 colleagues per month.

- Supporting teams with departmental / ward training either post incident or proactively.

- Completing ‘walkarounds’ with the temporary staffing team to address the barriers bank / agency colleagues have to speaking up. Lessons learnt have been shared across the organisation.

- Continuation of monthly meetings with the CEO and Executive lead for FTSU to discuss themes, areas of concern and develop a plan for support and assurance.

- Working in union with Network chairs and Inclusion team to raise the profile of FTSU, address barriers to speaking up and also ensure effective resolution to concerns raised through the networks.

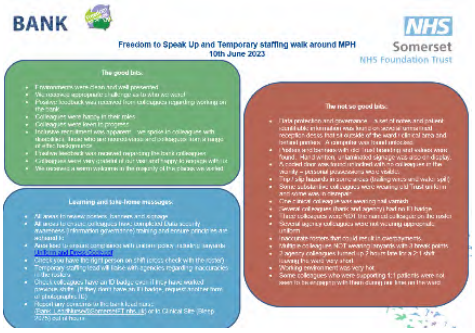
- Attending the Safety Action Group to allow triangulation of safety specific data and themes.

- Supporting the delivery of the respectful resolution work.

- Working more closely with bank colleagues, volunteers and estates / ancillary colleagues as these are areas that demonstrate more barriers to speaking up.

- Focusing on 2 key barriers to speaking up: fear and futility. This will be the topic for Speak Up month in October 2023.

- Listening to the silence; It is essential that these missing voices are identified and sought out, as they too can contribute to learning and improvement for the benefit of patients and colleagues.



- Further work with the Trust Board and Exec lead to ensure the FTSU arrangements comply with the latest guidance and provide assurance that we are on track to implement an improvement plan.

B1245_iii_Freedom-To-Speak-Up-A-reflection-and-planning-tool_060422.docx-RC_RW_Final_Arial12.docx (live.com)
B1245_ii_NHS-FTSU-Guide-eBook.pdf (nationalguardian.org.uk)

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Six Monthly Staffing Establishment Report
SPONSORING EXEC:	Hayley Peters, Chief Nurse
REPORT BY:	Alison Wootton, Deputy Chief Nurse, SFT (Development of report supported by Associate Directors of Patient Care in service groups)
PRESENTED BY:	Hayley Peters, Chief Nurse and Alison Wootton, Deputy Chief Nurse
DATE:	5 September 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	This report provides a six monthly update, January 2023 – June 2023, of safer staffing assurance for all Somerset NHS Foundation Trust (SFT) inpatient wards, critical care, and emergency departments. SFT is comprised of the legacy YDH and SFT, this report covers data inclusive of these areas. The paper provides information on associated safer staffing risks and the controls and mitigations in place for these risks. This report offers high level assurance that safe staffing is regularly reviewed on a dynamic day-to-day and shift-by-shift basis and that appropriate action is in place to support safest and best possible quality of care. We also provide reassurance that safe staffing is reviewed holistically taking into account a variety of metrics, data and professional opinion to ensure that we are anticipating seasonal flux or changes in case mix that may require alternation in staffing ratios. Over the last six months we have experienced continued pressures from: • Delays to discharge with high numbers of people who are medically fit for discharge, many who still have complex nursing needs. • High pressures on emergency care.

	• Industrial action. Over the last few months we have experienced: • A reduction in colleague sickness levels • A reduction in the numbers of escalation beds opened, this includes closing all 30 escalation beds in the community hospitals. The Board are asked to note the following: • Safe staffing levels have been reviewed as detailed in this report and have broadly been found to meet the standards and guidance. • There remains disruption and challenges to service delivery requiring a focus on a dynamic approach to monitor and oversee staffing. Some services have vulnerabilities that require on going and close monitoring as well as action to mitigate and deliver safe care. There is service level ownership and oversight of these risks and issues and there is a clear and accessible escalation process to raise concern if the risk is considered inadequately managed or mitigated.
Recommendation	The Board is asked to accept reassurance that the trust is taking all actions to try and ensure safe staffing levels in all ward areas and where this is not possible, escalation and actions are followed to try and mitigate the risks of working with a compromised level of staffing. The Board is asked to approve this report for publication on the public website as per requirements.

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

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

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

Public/Staff Involvement History
How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Senior nursing and service group level leadership teams have been involved in the preparation of this report.

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The six-monthly review was last presented to board in March 2023 covering the period of July – December 2022.

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

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

SOMERSET NHS FOUNDATION TRUST

SIX MONTHLY STAFFING ESTABLISHMENT REPORT

1. BACKGROUND AND PURPOSE

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

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

2. BUSINESS CASES

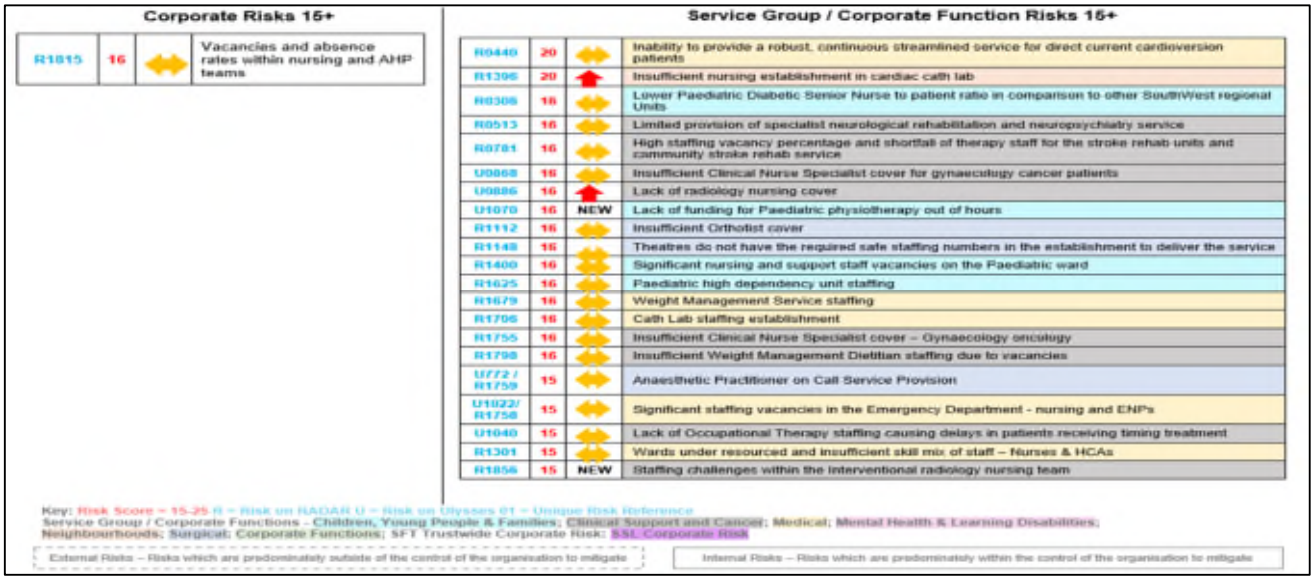
2.1. It is not intended to present any business cases in this report, but as part of this report the amendments to staffing levels that have been agreed as part of a planned bed reconfiguration process will be described, these have all be agreed but should be noted by the Board. Service groups may seek local resource investment through standard Trust processes but at this point there are no cases linked with general inpatient care.

3. DATA METRICS

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

4. RISKS

4.1. Summary of risks above 15 that relate to all nursing and AHP staffing within service groups are now all overseen at a corporate level under risk R1815 and this is summarised in the chart below.



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

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

5. SIX MONTHLY REVIEW OF SAFE STAFFING

Overview (*service group and inpatient level data is presented in Appendix 1*.)
Narrative for acute, community and mental health inpatient areas.

5.1. Over the last 6 months we have experienced continued pressures from:

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

5.2. Over the last few months, we have experienced some improvements:

- A reduction in colleague sickness levels.

- A reduction in the numbers of escalation beds opened, this includes closing all 30 escalation beds in the community hospitals.

- A reduction in the numbers of patients requiring care for infectious conditions (covid, flu and norovirus).

- Ward sisters are more consistently getting their supernumerary time to support and develop their teams.

- We have inducted less new nurses as our vacancy level has improved and the training and development of teams is leading to more confident and skilled teams, but this development is ongoing.

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

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

5.5. The improvement in vacancy level for unregistered colleagues in the two acute sites has continued and this has supported to mostly stop the use of any agency for unregistered staff but still maintain good fill rates in the wards. Some specialist unregistered nurses are booked to support patients with specific enhanced care needs. We have also seen a good reduction in the use of agency nurses in most ward areas apart from the specialist areas described in 5.2.

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

5.7. **High level combined data**
(Service group and inpatient level data is presented in Appendix 1)

Overall	SFT + YDH

Measure	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend
Registered Nursing Fill Rate	99%	99%	96%	96%	96%	95%	
Unregistered Nursing Fill Rate	103%	104%	99%	99%	100%	102%	
All Staff Fill Rate - Day	99%	99%	96%	96%	98%	98%	
All Staff Fill Rate - Night	106%	106%	102%	102%	101%	101%	
All Staff Fill Rate - Overall	102%	102%	99%	99%	99%	100%	
Care Hours per Patient Day	8.3	8.8	8.4	8.6	8.3	8.3	
Registered Hours per Patient Day	4.3	4.6	4.4	4.6	4.4	4.4	
Completing Safer Staffing Measures	82%	81%	65%	81%	84%	85%	
Sickness	6.3%	5.8%	5.4%	5.1%	5.4%	5.2%	
Labour Turnover Rate	10.4%	13.0%	10.2%	10.4%	9.8%	9.6%	
Registered Nurse Vacancy Rate	4.5%	3.5%	3.0%	4.6%	5.0%	7.1%	
Unregistered Nurse Vacancy Rate	4.9%	4.4%	1.4%	4.7%	0.8%	0.7%	

Fill Rates: Actual Hours/Planned Hours	Formatting Key>	95 – 105%	90 – 94% and 106 – 110%	<89% and >111%

5.8. The high-level data represents an encouraging picture with colleague fill rates in the 95-99% for registered nurses and 99-104% for unregistered nurses. The higher fill rate for unregistered nurses is due to a higher number being used if the registered nurse gap could not be filled, but also an extra unregistered nurse may be used if individual patients require higher levels of observation and support. It should be noted that as this is high level data, we should not assume that all areas have a consistently good fill rate against shift requests but there is a robust escalation process in place for any area who have a staffing shortfall so that this can be balanced across the wards and units.

5.9. Sickness levels are reducing and have shown a significant improvement on the previous safer staffing report and turnover overall is also showing an improving picture towards the later end of this period.

5.10. Our vacancy rates remain lower in most inpatient areas with focus to fill all gaps and we can see significant improvement in the unregistered nurse lines. We continue to actively recruit registered nurses both internally and externally to the UK. We are working both on our people plan to retain the colleagues already in post but to also have a pipeline of recruits to try and minimise the negative impact of having vacancy.

6. AREAS OF NOTE

Paediatric Ward at YDH

6.1. The funded establishment on children's ward at YDH does not currently meet the outline guidance for the numbers of staff per bed and when the ward is full. If the ward is full and acuity is higher, then agency staff are often required to supplement the core number of staff. This has been a long-standing issue and is being reviewed by the leadership team in the new Families service group. At this time, it is felt that safe staffing numbers are achieved and a review of data for acuity and bed fill rate is ongoing to consider if any longer-term options need to be considered.

Stroke Ward at YDH

6.2. The stroke ward at YDH had 25 core beds and two escalation beds – 27 total. Staffing levels were good during the day, however, they dropped to only two registered nurses at night which was a ratio of 1:13.5 patients. Given the acuity and dependency in this area, it was considered that this was not sustainable to meet the care needs of the patient group. During the reconfiguration of beds at YDH, (described below), the ready to go unit has moved and the staffing establishment altered to reflect this new patient group. This has released some funding and an extra registered nurse at night on the stroke unit has been funded, this now gives a ratio of 1:9 patients.

Emergency Admission Unit (EAU) at YDH

6.3. This area was funded and established for 24 beds; 5 escalation beds have been added to the ward and remain in constant use. The staffing ratio for this is felt to be adequate in general but there are times when acuity and dependency can be raised, and this is then made more challenging by the addition of a further two extra escalation beds. The Matron and ADPC review this staffing daily with the ward sister and if the extra escalation beds are open, or acuity is particularly high, extra staffing support is arranged. This need for extra staff will be reviewed to consider if other action is required to make this more sustainable.

Hyperacute stroke beds at MPH

6.4. Since the last report a system business case has been agreed to increase the number of hyperacute stroke beds at MPH on Dunkery ward from 4 beds to 8 beds. The staffing for these beds has all been funded and will be in line with the national stroke requirements.

7. MATERNITY

7.1. Maternity services have not been formally reviewed as part of this report as they report regularly through Quality and Governance Assurance (Q&GA) sub–Board Committee, but data can be viewed in Appendix 2.

7.2. Maternity services continue to experience high levels of sickness and staff vacancies which did impact the community services for MPH with the suspension of homebirths and births at the Mary Stanley Birth Centre. It was suspended for a period of three months and was reinstated at the end of July. We have successfully recruited 21 of our student midwives which will cover our vacancies at both MPH & YDH; these midwives are due to start around October.

8. PLANNING AHEAD – BED AND STAFFING RECONFIGURATION

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

8.2. As part of this modelling, Medical and Surgical service groups, in the acute part of the Trust, have agreed to re-allocate some of the previous bed allocation to try and better match the required demand and capacity model. This new model will require movement of ward specialities and bases.

8.3. The model indicates that the acute part of the Trust will require a higher number of beds overall than we have, and over previous years, we have achieved this with temporary escalation beds and the use of temporary staffing. In the reconfiguration plan, some of the escalation beds will become part of the core number, and the establishments and ratios of staffing have all been reviewed with a staffing plan agreed and signed off by the Chief Nurse. This change in establishments is primarily driven by the need for the continued use of escalation beds. The ICB have noted this and have awarded some recurrent funding which will be used to support this new model, but we also require work across the system to provide further mitigation to avoid the use of these beds or to reduce length of stay.

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

8.5. The embedded document has the detail of staffing and speciality pre-configuration and post-configuration for both the YDH and MPH sites (medical and surgical split). Wards are only listed where these changes have affected them, and other wards remain unchanged.

bed reconfiguration safe

(Double click to open on electronic version)

8.6. These documents are a working plan, and we are progressing to deliver this bed reconfiguration and start the new staffing models ahead of the winter escalation period. All the moves were achieved in YDH in June and July.

8.7. Engagement with the medical and nursing teams to plan all these changes is on-going and is a significant piece of work but the anticipated benefits for right patient, right bed, right clinician are positive. There is a risk during the transition period to safe staffing, but as we are aware of this, the matrons and sisters will closely monitor to try and mitigate any issues that arise.

9. SAFER NURSING CARE TOOL (SNCT)

9.1. National Quality Board (2016) and Developing Workforce Standards (2018) provide a framework that underpins the principles of safer staffing combining evidence-based tools, professional judgement, and outcomes to ensure the right staff with the right skills are in the right place at the right time. This

tool is known as the Safer Nurse Staffing Tool (SNCT). The adoption of this tool across the NHS is highly recommended and is endorsed by the Chief Nurse for England. The Trust is now in position to start using this tool to inform decisions around nursing workforce and match this to patient acuity and activity across our acute inpatient areas and will be able to provide additional assurance to the Board on the quality of patient care and associated outcomes.

9.2. Training of some senior staff has already been undertaken and two wards at MPH have been identified to start using the tool from August. Using QI methodologies, we hope to be able to develop a sustained programme of biannual audit of all inpatient areas across the organisation; these audits will start with the acute parts of the Trust but will then roll out to community, and there is also a version of the tool for mental health wards which will also be utilised. The usefulness of this data builds overtime and we will look to start incorporating this in our review once we have completed two full sets of audits.

10. RECOMMENDATION

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

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

Appendix 1 – Service group and inpatient level data

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

1. Clinical Support & Cancer Services, narrative from the Associate Director of Patient Care:

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

CSSS MPH

Measure	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend
Registered Nursing Fill Rate	97%	97%	96%	96%	96%	94%	
Unregistered Nursing Fill Rate	96%	96%	92%	92%	96%	96%	
All Staff Fill Rate - Day	95%	95%	93%	93%	96%	94%	
All Staff Fill Rate - Night	102%	102%	100%	100%	99%	100%	
All Staff Fill Rate - Overall	97%	97%	96%	96%	97%	96%	
Care Hours per Patient Day	7.6	8.3	7.4	3.5	7.3	7.4	
Registered Hours per Patient Day	4.9	5.3	4.8	2.2	4.7	4.7	
Completing Safer Staffing Measures	81%	82%	80%	84%	72%	79%	
Sickness	7.2%	6.2%	5.8%	6.0%	7.1%	2.4%	
Labour Turnover Rate	1.0%	0.0%	0.9%	2.6%	2.6%	2.6%	
Registered Nurse Vacancy Rate	-6.0%	-5.5%	-5.5%	-5.0%	4.9%	6.8%	
Unregistered Nurse Vacancy Rate	3.2%	3.2%	3.2%	6.5%	6.5%	9.2%	

1.1. We have recently had positive movements in recruiting and training in both ward areas and chemotherapy out-patient services to the point that we were looking to remove agency support (from Beacon Day unit and chemo out-patients at YDH). This has been delayed due to unplanned absence but is still the focus objective.

1.2. We are currently trialling ambulatory care on Ward 9 (haematology), though require additional nursing staff to realise maximal impact from this initiative. This will be discussed through Service Group planning and QAFP.

1.3. We currently hold no risks associated with nursing staff levels and have none emerging.

1.4. We hold numerous risks and vulnerabilities relating to non-medical and non-nursing staffing levels across multiple professions and services. Many of these will be impacting on patient care (inpatient and outpatient) and resulting in pathway delays and suboptimal care.

(Toni Hall, ADPC)

2. Family Services narrative from the Associate Director of Patient Care:

(This area is only one paediatric ward, one neonate ward and maternity services linked to each site so the over recruitment represents about 7 nurses,

data for Jan – Mar was pulled from the YDH system and different coding may have been in place.)

Families	MPH

Measure	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend
Registered Nursing Fill Rate	92%	92%	94%	94%	94%	91%	
Unregistered Nursing Fill Rate	89%	89%	82%	82%	77%	85%	
All Staff Fill Rate - Day	94%	94%	92%	92%	92%	93%	
All Staff Fill Rate - Night	94%	94%	95%	95%	92%	90%	
All Staff Fill Rate - Overall	94%	94%	93%	93%	92%	92%	
Care Hours per Patient Day	13.6	13.5	12.7	14.8	13.0	13.3	
Registered Hours per Patient Day	10.0	10.0	9.5	11.0	9.9	9.8	
Completing Safer Staffing Measures	66%	70%	74%	77%	85%	78%	
Sickness	8.0%	6.4%	6.1%	6.3%	6.5%	5.9%	
Labour Turnover Rate	8.4%	6.2%	8.0%	7.9%	7.6%	6.3%	
Registered Nurse Vacancy Rate	8.7%	6.4%	8.2%	9.8%	10.0%	10.1%	
Unregistered Nurse Vacancy Rate	1.5%	8.3%	5.1%	9.3%	11.8%	8.9%	

Families	YDH

Measure	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend
Registered Nursing Fill Rate	88%	90%	91%	95%	95%	94%	
Unregistered Nursing Fill Rate	98%	89%	84%	94%	88%	83%	
All Staff Fill Rate - Day	86%	85%	83%	91%	90%	86%	
All Staff Fill Rate - Night	97%	98%	100%	101%	98%	100%	
All Staff Fill Rate - Overall	90%	90%	89%	95%	93%	91%	
Care Hours per Patient Day	14.1	13.1	16.3	15.3	14.6	16.6	
Registered Hours per Patient Day	10.5	9.9	12.5	11.4	11.0	12.7	
Completing Safer Staffing Measures							
Sickness	5.3%	6.1%	6.0%	4.1%	5.2%	7.0%	
Labour Turnover Rate	11.8%	12.3%	10.7%	13.7%	13.8%	14.0%	
Registered Nurse Vacancy Rate	-1.1%	-4.6%	-5.9%	0.5%	0.5%	-0.2%	
Unregistered Nurse Vacancy Rate	-14.8%	-28.5%	-24.6%	-9.3%	-5.1%	-31.1%	

2.1. Issues for Ward 10 and maternity services noted in main body of report.

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

2.3. Recruitment of paediatric nurses at MPH has been challenging for several years, at this point in September we are hoping to be fully recruited.

(Suki Norris, ADPC)

3. Medical Services narrative from the Associate Director of Patient Care.

(Data for Jan – Mar was pulled from the YDH system and different coding may have been in place.)

Integrated and Urgent Care	MPH						

Measure	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend
Registered Nursing Fill Rate	101%	101%	95%	95%	99%	96%	
Unregistered Nursing Fill Rate	99%	99%	93%	93%	94%	102%	
All Staff Fill Rate - Day	99%	99%	93%	93%	96%	100%	
All Staff Fill Rate - Night	108%	108%	101%	101%	102%	102%	
All Staff Fill Rate - Overall	103%	103%	97%	97%	99%	101%	
Care Hours per Patient Day	7.5	8.4	7.4	8.0	7.4	7.7	
Registered Hours per Patient Day	3.9	4.3	3.8	4.2	3.8	3.9	
Completing Safer Staffing Measures	70%	72%	71%	74%	79%	80%	
Sickness	6.2%	5.9%	5.1%	4.3%	5.0%	4.8%	
Labour Turnover Rate	10.8%	15.6%	9.6%	8.7%	8.7%	8.9%	
Registered Nurse Vacancy Rate	7.6%	7.5%	5.7%	5.8%	4.6%	8.1%	
Unregistered Nurse Vacancy Rate	12.1%	8.8%	2.4%	-0.2%	-6.6%	-9.9%	

Medical Services	YDH						

Measure	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend
Registered Nursing Fill Rate	101%	100%	100%	100%	99%	97%	
Unregistered Nursing Fill Rate	90%	92%	96%	95%	95%	95%	
All Staff Fill Rate - Day	98%	99%	102%	101%	100%	99%	
All Staff Fill Rate - Night	99%	98%	99%	100%	100%	99%	
All Staff Fill Rate - Overall	98%	98%	101%	101%	100%	99%	
Care Hours per Patient Day	6.0	6.0	6.3	6.2	6.3	5.8	
Registered Hours per Patient Day	3.0	3.0	3.1	3.1	3.1	3.0	
Completing Safer Staffing Measures	97%		6%	98%	100%	99%	
Sickness	4.2%	4.3%	3.8%	3.7%	3.1%	3.1%	
Labour Turnover Rate	11.2%	11.4%	11.9%	12.9%	12.9%	11.3%	
Registered Nurse Vacancy Rate	-6.5%	-8.5%	-11.1%	-10.4%	-5.2%	-1.7%	
Unregistered Nurse Vacancy Rate	-2.1%	-2.6%	-11.6%	-2.5%	-4.9%	-1.4%	

3.1. In summary, the last 6 months have seen an improvement within the nurse staffing in the Medical Service Group, we have seen a large reduction in nurse agency spend but recognise that we still have a lot of work to do with the bank spend, but the data sent through from the bank lead team suggests we do have a good bank fill rate for any shifts sent to bank.

3.2. Our registered nurse vacancy position is positive, and we are seeing smaller numbers of nurses coming through our overseas pipeline. We have seen a much-improved picture from our large deficit of health care assistants this time last year. Ongoing recruitment events are scheduled in the coming months, we are also supporting growing our own and have had several ward assistants move into the health care assistant's role. The OD team and our HR support has been invaluable to offer advice and to help us understand how we can improve retention, and this is something that aligns with our medical service group quality strategy.

3.3. Skill mix was highlighted in the last staffing paper as a concern and although this has improved, this remains a work in progress and will continue over the coming months, with our ongoing projects in place and with the support of our clinical skill facilitators. We do have several senior nurses new into post that are

requiring a high level of support from the matrons but are doing well and we do not foresee this as an issue in the coming months ahead.

3.4. The ward sisters are not being pulled into the numbers as frequently as they were over the last year and are now able to spend time clinically teaching and mentoring the new members of the team. The key performance indicators are now showing an improved picture such as appraisals and monthly 1:1 meeting with their teams.

3.5. We do recognise that we currently need to factor in the bed and ward reconfiguration work that is ongoing. Alongside the stroke pathway consultation and the increase of our hyper acute stroke beds, this will potentially destabilise some of our nursing teams, as staff will need to move wards, or request to move because of the bed and ward configuration work.

3.6. At time of extreme pressure, we have enacted pre-emptive boarding (extra escalation of beds into an area of ward with no bed space facilities) which has resulted in some areas having 5 extra beds within their wards. This has resulted in a marked increase in the use of bank staff to mitigate patient safety and staff wellbeing concerns, but these escalations have been less frequent on the MPH site but remain frequent at YDH.

3.7. The matrons and ADPC's have good oversight and good grip and control over our over established areas, drilling down rosters day by day and plans are made to cover the gaps and move staff should this be required. They also review each request that comes in for enhanced care or observation/support to ensure that those patients that require a higher level of support are prioritised, however there has been a reduction in the request for enhanced care, we have seen an increase in our requests for RMN or observation and support. These requests for RMN and specialist health care assistants, are reviewed by the psychiatric liaison team (PLT) and they support the teams to produce a plan of care for our patients presenting with mental health concerns.

3.8. During the last 6 months, sickness levels have come down month on month, May being the lowest at 3.1% in YDH and April at 4.3% at MPH, the highest cause remains musculoskeletal pain.

3.9. The data shows an improvement from the previous 6 months which is indicative of the all the hard work and effort the teams are contributing. It feels like we are moving in the right direction, but with the recognition that we still have some way to go and winter season is approaching.

(Jacqueline Phillips, ADPC)

4. Mental Health and Learning Disabilities narrative from the Associate Director of Patient Care.

Mental Health and Learning Disabilities	MH wards

Measure	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend
Registered Nursing Fill Rate	107%	107%	97%	97%	101%	98%	
Unregistered Nursing Fill Rate	113%	113%	108%	108%	114%	117%	
All Staff Fill Rate - Day	102%	102%	96%	96%	102%	102%	
All Staff Fill Rate - Night	109%	109%	105%	105%	107%	108%	
All Staff Fill Rate - Overall	105%	105%	99%	99%	104%	104%	
Care Hours per Patient Day	12.4	13.4	12.6	12.5	11.9	11.9	
Registered Hours per Patient Day	5.0	5.4	5.0	4.9	4.7	4.5	
Completing Safer Staffing Measures	88%	89%	85%	64%	76%	81%	
Sickness	7.9%	7.3%	7.0%	6.0%	6.4%	6.1%	
Labour Turnover Rate	8.6%	4.8%	8.9%	9.0%	9.1%	9.6%	
Registered Nurse Vacancy Rate	18.8%	18.8%	12.8%	16.6%	17.5%	18.7%	
Unregistered Nurse Vacancy Rate	4.6%	5.0%	6.0%	7.5%	3.2%	4.6%	

4.1. Like the last report, staffing remains challenging on the mental health inpatient wards, with additional colleagues being required for managing vacancies, sickness, and complex high-risk individuals. Where additional observation and supervision is required for this complex patient group, this will sometimes artificially inflate the average fill rates for health care assistants.

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

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

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

- Newly recruited internationally educated nurses will be recorded as supernumerary on Band 4 until they have completed their OSCE training and received their PIN numbers, at this point they will be recorded as registered nurses. For this group of nurses, additional supervision, and support from the registered nurses is required until they have completed their OSCE and are competent and confident.

- In the absence of registered nurses to cover shifts, and to ensure the wards remain safe, the wards will undertake a risk assessment at the time and sometimes prefer and agree a nursing associate or an experienced

health care assistant who is familiar with the ward to work alongside the registered nurse and other team members to ensure safety and stability of the ward, as an alternative to employing an unknown registered nurse agency worker, who may not know the ward or patients.

- On Rydon ward, whilst vacancies have been filled, this is by several newly qualified staff who have been appointed and who will be commencing employment between September 2023 and January 2024, so additional staffing will be required to cover these posts.

- On St Andrews ward, most staff on the ward will be relocating to Rowan ward 2. Rowan ward is continuing to over recruit in preparation for the move of St Andrews ward to the Summerland's site. This will include the recruitment of 2 international nurses who will be starting in November 2023 at Rowan but have been appointed for Rowan ward 2.

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

- The service group have been successful in recruiting 50 international educated nurses over the last 2.5 years, which has supported the nursing vacancies across all wards.

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

- Over the last year the service group have continued to develop the skills mix on the inpatient wards to ensure additional senior clinical leadership is available on each site 7 days a week. All 3 trainee advanced nurse practitioners have now started on Rydon wards, Rowan & St Andrews and Pyrland wards, which enhances the clinical support available to the wards.

- The service group is currently undertaking workforce deep dives, involving the ADPC, People Business Partner, Recruitment and Ward Leads. The aim is to complete these by December 2023, reviewing all areas of workforce.

- All ward managers use the risk registers to escalate concerns around staffing and recruitment to the service group, which are reviewed within the regular governance meeting and operational management meetings.

- To reduce agency costs, reviews have identified areas of improvement with assurance processes and improved communication with the temporary staffing team. This continues to be a priority for the service group.

(Alison van Laar, ADPC)

5. Neighbourhoods and Community Services narrative from the Associate Director of Patient Care.

Community hospitals were consistently above planned fill rates over this time due to escalation bed staffing. By June most of these extra beds were closed and staffing numbers are returning to normal.

Primary Care and Neighbourhoods	Community

Measure	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend
Registered Nursing Fill Rate	104%	104%	102%	102%	103%	96%	
Unregistered Nursing Fill Rate	118%	118%	112%	112%	114%	106%	
All Staff Fill Rate - Day	109%	109%	107%	107%	108%	102%	
All Staff Fill Rate - Night	121%	121%	113%	113%	113%	105%	
All Staff Fill Rate - Overall	114%	114%	109%	109%	110%	103%	
Care Hours per Patient Day	6.8	7.7	7.3	7.1	6.8	7.4	
Registered Hours per Patient Day	2.8	3.1	3.0	3.0	2.8	3.1	
Completing Safer Staffing Measures	84%	94%	94%	89%	84%	88%	
Sickness	6.0%	6.2%	4.6%	5.0%	5.3%	4.3%	
Labour Turnover Rate	12.1%	14.6%	10.8%	10.4%	7.9%	7.2%	
Registered Nurse Vacancy Rate	17.1%	15.1%	15.1%	13.6%	12.8%	13.5%	
Unregistered Nurse Vacancy Rate	6.9%	5.2%	2.9%	6.2%	5.0%	3.7%	

5.1. Although the recruitment picture overall is improved for community hospitals it remains challenging to keep pace with turnover. Sickness is also higher than Trust average and this combined with vacancy this is leaving some areas pressured. Some of this pressure has been reduced by the closure of escalation beds and this has significantly reduced agency spend but some agency is still required to fill staffing gaps at short notice when other mitigation is not possible.
(Debra Nash, ADPC)

6. Surgical Care narrative from the Associate Director of Patient Care.

Surgical	MPH

Measure	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend
Registered Nursing Fill Rate	96%	96%	92%	92%	89%	94%	
Unregistered Nursing Fill Rate	110%	110%	100%	101%	100%	102%	
All Staff Fill Rate - Day	99%	99%	93%	93%	91%	96%	
All Staff Fill Rate - Night	108%	108%	103%	103%	99%	103%	
All Staff Fill Rate - Overall	103%	103%	97%	98%	95%	99%	
Care Hours per Patient Day	9.6	9.5	9.8	10.7	9.6	9.5	
Registered Hours per Patient Day	5.3	5.2	5.5	6.0	5.4	5.4	
Completing Safer Staffing Measures	76%	76%	80%	80%	80%	78%	
Sickness	6.4%	5.4%	6.2%	6.5%	6.7%	6.2%	
Labour Turnover Rate	8.7%	10.0%	9.2%	11.8%	9.0%	9.0%	
Registered Nurse Vacancy Rate	-1.2%	-0.6%	1.1%	4.3%	3.6%	5.1%	
Unregistered Nurse Vacancy Rate	2.1%	3.4%	5.7%	10.4%	5.2%	4.4%	

Surgical	YDH						
Measure	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Trend**
Registered Nursing Fill Rate	101%	98%	99%	97%	94%	97%	
Unregistered Nursing Fill Rate	87%	92%	95%	94%	97%	96%	
All Staff Fill Rate - Day	97%	96%	98%	97%	96%	97%	
All Staff Fill Rate - Night	97%	99%	101%	99%	96%	97%	
All Staff Fill Rate - Overall	97%	97%	100%	98%	96%	97%	
Care Hours per Patient Day	7.9	7.7	8.0	8.0	8.2	7.4	
Registered Hours per Patient Day	4.9	4.6	4.8	4.7	4.8	4.6	
Completing Safer Staffing Measures	97%		6%	98%	100%	99%	
Sickness	6.1%	5.1%	3.9%	4.3%	4.0%	4.8%	
Labour Turnover Rate	16.0%	17.6%	17.5%	16.6%	16.5%	16.1%	
Registered Nurse Vacancy Rate	-6.2%	-8.1%	-6.2%	-3.6%	-2.5%	2.2%	
Unregistered Nurse Vacancy Rate	-0.8%	5.2%	-0.3%	8.8%	-1.0%	6.8%	

6.1. As a result of a combination of reduced registered nurse vacancies and increased turnover among both registered and unregistered nurses, there remains a high proportion of junior skilled workforce within nursing, with many teams supporting colleagues with less experience. We have ongoing training and development plans in place.

6.2. As the bed reconfiguration (described above) takes effect, nursing teams are being relocated and absorbed where the vacancies lie, and thus the fill rate should level back towards full establishment for the surgical group. Within the new bed reconfiguration exercises across both sites, the nursing teams will need to realign themselves to new/different specialities and therefore will require additional support and training.

6.3. In all areas the ward sisters are achieving more of their supernumerary time, this allows them to focus on providing leadership, supervision, and overall management of the teams.

6.4. The status of our unregistered healthcare assistants has fluctuated over the past six months, with a turbulent turnover vacancy position. Although the numbers suggest a relatively steady state in terms of establishment, turnover has remained high, and thus traction in team skill building remains a challenge for most surgical wards. Efforts are underway to address implementing retention improvement initiatives.

6.5. Agency spends at MPH for surgical wards have reflected a position around some of the highest bed occupancy of ‘medical’ patients requiring observation and support for their needs. Agency spends for theatres, and critical care remain challenged across both sites due to a more challenging picture around staffing retention that reflects a national trend and position. Bespoke work is being undertaken to improve retention in these areas, as well as how to upskill the workforce and create full career pathway opportunities.

6.6. The reconfiguration of the bed base in the hospital, specifically aimed at limiting the occurrence of medical outliers, holds great promise in terms of ensuring that surgical nurses can focus on caring for surgical patients. This strategic

adjustment will have a substantial positive impact on staffing levels and morale. By reducing the presence of medical patients within surgical wards, nurses will be able to allocate their time and expertise more efficiently, delivering specialised care tailored to the unique needs of surgical patients. With a streamlined and more focused workload, nurses can devote their attention to surgical cases, leading to increased efficiency, reduced burnout, and higher retention rates within the surgical service group.

(Mel Schultz, ADPC)

Appendix 2 Maternity SFT and YDH
(Both report to quality and governance, for information only)

1. Maternity MPH

1.1. The integration of the maternity services in Somerset is now actively being developed as part of the SFT and YDH merger. There are three LMNS funded project roles at this time working across the system to drive implementation of the National Maternity Service Review deliverables (Better Births 2015). This includes the maternity specific public health agenda and development of bereavement services aligned to the National Bereavement Care Pathway (NCBP).

1.2. SFT has undertaken the staffing assessment Birthrate Plus using retrospective data from August to October 2020. The final report was sent in November 2021. The methodology used in this review draws upon a set of national assumptions and benchmarked data from other recent reviews. The data assessed that establishment met the requirement at the time of the data capture. Additional assessments were undertaken to calculate the number of midwives required to deliver continuity of care. Although a reduction in birth rate, the report acknowledged a 23% rise in complexity of women accessing maternity care, both socially and medically. Maternal mental health and safeguarding concerns and referrals have seen a significant rise during the pandemic.

1.3. In the last six months midwifery numbers have fluctuated but overall, the establishment has remained within national recommendations for a 1:28 midwife to birth ratio.

Midwife to Birth ratio Nov 2022 to April 2023

	Green	Amber	Red	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr
Midwife / birth ratio (establishment)	≤29	29-31	>31	20	23	25	22	26	22

1.4. The care acuity levels have remained low between 52 – 77%. Midwifery Red Flag events (NICE – safe staffing in Midwifery Settings 2015), have been impacted with a frequent delay in treatment and staffing shortages. There have been no reported safety incidents because of delays, although user feedback has reflected dissatisfaction with some induction of labour delays. Supernumerary labour ward co-ordinator and 1:1 care in labour ward remains 100%. The acuity assessment does not reflect workforce requirements outside of the obstetric led labour ward.

Acuity Data Jan – June 2023

	Acuity	Supernumerary labour ward coordinator	1:1 care in labour (core delivery suite only)
Jan	70%	100%	100%
Feb	55%	100%	100%
March	61%	100%	100%
Apr	80%	100%	100%
May	65%	100%	100%
June	80%	100%	100%

1.5. Workforce review is ongoing to ensure each area has staffing and appropriate skill mix to support the changing national drivers.

1.6. Successful recruitment of our student midwives has been undertaken with 21 accepting posts across both YDH & MPH. Once commenced in post this will fill our current vacancies of 9wte midwives at MPH. We currently have 5 international midwives with another 2 that will start next month.

1.7. SFT maternity has a small separate pool of bank staff and vacant shifts are covered by substantive staff working additional hours.

1.8. The number of specialist maternity midwives is 15.46wte which includes digital, screening, infant feeding, safeguarding, governance, practice development, bereavement, retention/recruitment lead and PMA lead. This equates to 10.9% of the funded establishment. Birthrate Plus accounts for 8 – 10% of the establishment in these roles, we therefore meet this requirement.

1.9. The newborn hearing screening service is system wide. Despite the current issues with retention of staff, the service continues to provide an exceptional service meeting KPIs and the top performing in the Southwest Region.

2. Maternity YDH

2.1. The integration of the maternity services in Somerset is now actively being embedded as part of the SFT and YDH merger. There are 3 LMNS funded project roles at this time working across the system to drive implementation of the National Maternity Service Review deliverables (Better Births 2015). This includes the maternity specific public health agenda and development of bereavement services aligned to the National Bereavement Care Pathway (NCBP).

2.2. YDH has undertaken the staffing assessment Birthrate Plus using retrospective data in 2021. The final report was sent in December 2021 and has been reviewed by the Trust's executive team.

2.3. The 2021 Birthrate Plus report shows a current deficit in midwifery staffing of 1wte at Yeovil District Hospital. This is a reduction from the last staffing report in June which showed a 1.59wte deficit. Active local and international recruitment for midwives is ongoing. `The first 2 internationally recruited midwives who joined us July 2022, have now passed their OSCE exams and move into band 5 preceptorship roles from January 2023. This brings us in line to show current midwifery staffing is equal to the funded establishment.

2.4. In April 2023, Yeovil Maternity Unit implemented a new triage service. This was introduced to improve the workflow within the unit, enabling safer patient care whilst supporting the role of the labour ward coordinator to remain supernumery. Additional staffing requirements to facilitate this service will not be accounted for in the last Birthrate Plus report.

2.5. In the 22/23 Financial Year, midwives at YDH facilitated or were present at 1259 births of all gestations. An agreed "safe" ratio for midwife to birth ratio is <29, YDH overall ratio is 21 births to 1wte for this financial year.

Midwife to Birth ratio Nov 2022 to March 2023

	Green	Amber	Red	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Midwife / birth ratio (establishment)	≤29	29-31	>31	20.55	19.59	19.31	17.92	19.47

2.6. As of July 2023, YDH employ 8.1wte midwives in specialist roles to include digital, screening, bereavement, infant feeding, safeguarding, governance, practice development and PMA, this equates to 12.2% of the funded establishment. There are also 4wte specialist midwives working across SFT in specialist roles, these include Safety and Quality, Public health, Guideline Lead and Wellbeing and retention lead. There are 4wte band 7 midwives in management positions. These midwives can be used in periods of escalation due to increased activity and shortages of planned staffing as per the escalation guideline.

Acuity Data Jan – June 2023

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
One to One care in labour NOT achieved	1	0	0	0	0	1
Deep dive review	0	0	0	0	0	0
LW Coordinator NOT supernumerary	3	0	4	3	3	7
Deep dive review	0	0	0	0	1	0
Acuity met	91%	88%	96%	93%	91%	86%

2.7. The above chart shows the initial findings of the birthrate review as well as the findings following a deep dive. There is one episode on 1 May where the LW coordinator was not supernumery due to the quick admission of antenatal women on the sepsis pathway. The senior oncall midwife was not contacted and the escalation process would have allowed for the homebirth midwife to be called in and this was not requested. The continuity of care midwife was called in and the situation was resolved. Out of 174 entries on birthrate for May this 1 episode = 0.5%.

2.8. It is recognised that there is a need to update the coordinators on the correct completion of birthrate. With the addition of junior staff joining the coordinator group in June, there has a seen a rise in red flags for this status. One to one care in labour has been achieved and the coordinators are not providing this care. The escalation pathway is being updated to ask coordinators to contact the senior midwife on call if they have marked birthrate as supernumery status of LW coordinator not achieved. This way we can ensure the escalation pathway is followed and the team supported to maintain safe care.

Somerset NHS Foundation Trust	
REPORT TO:	The Trust Board
REPORT TITLE:	Quality and Performance Exception Report
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Lee Cornell, Associate Director – Planning and Performance Ian Clift, Senior Performance Manager Isobel Clements, Chief of People and Organisational Development Alison Wootton, Deputy Chief Nurse Xanthe Whitaker, Director of Elective Care
PRESENTED BY:	Chief Finance Officer
DATE:	5 September 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 above the national standard and the national average. • The percentage of Talking Therapies patients moving to recovery, which is also above the national standard and the national average. • 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, 5, and 6. (patient safety and quality)

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

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

Equality and Inclusion

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

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

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

QUALITY AND PERFORMANCE EXCEPTION REPORT: JULY 2023

1. BACKGROUND AND PURPOSE

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

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

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

1.3 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

Overview

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

Successes	Priorities
• our eating disorders service for children and young people continued to exceed the national waiting times standards for both urgent and routine appointments. • the six-week diagnostic wait 75% regional ambition for March 2023 was met again in the month. • there was a reduction in the number of 52-week, 65-week, 78-week and 104-week acute RTT waiters in the month. • 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 and national average. • 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. • delays in discharge of medically fit patients needing domiciliary care will result in further cancellations of surgery which will reduce our capacity to treat long waiting patients. • significantly increasing levels of demand, particularly for urgent care and mental health services, leading potentially to increased pressures on teams and longer waiting times. • 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)

- **MRSA:** There were no Trust-attributed MRSA bloodstream infection (BSI) reported in July 2023. The total since 1 April 2023 remains at one.
- **C. diff**: There were three Trust-attributed cases reported in July 2023, bringing the total to 29 against a threshold for the year of 54.
- **MSSA:** There were six Trust-attributed MSSA BSIs reported in July 2023, bringing the total to 22 against an internal threshold for the year of 64.
- **E. coli**: There were eight Trust-attributed E. coli BSIs reported in July 2023, bringing the total to 53 against a threshold for the year of 105.
- **Klebsiella:** There were seven Trust-attributed Klebsiella BSIs reported in July 2023, bringing the total to 14 against a threshold for the year of 31
- **Pseudomonas:** There were two Trust-attributed Pseudomonas aeruginosa BSIs reported in July 2023, bringing the total to six against a threshold for the year of 15.

Appendix 6 provides further details.

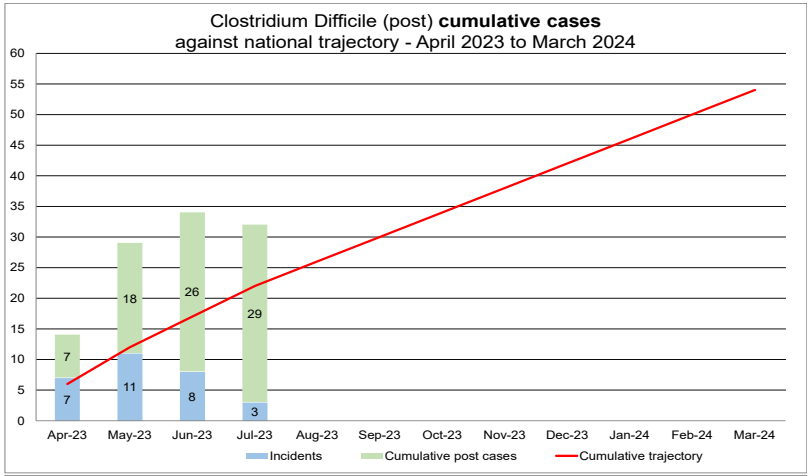
Respiratory Viral Infections

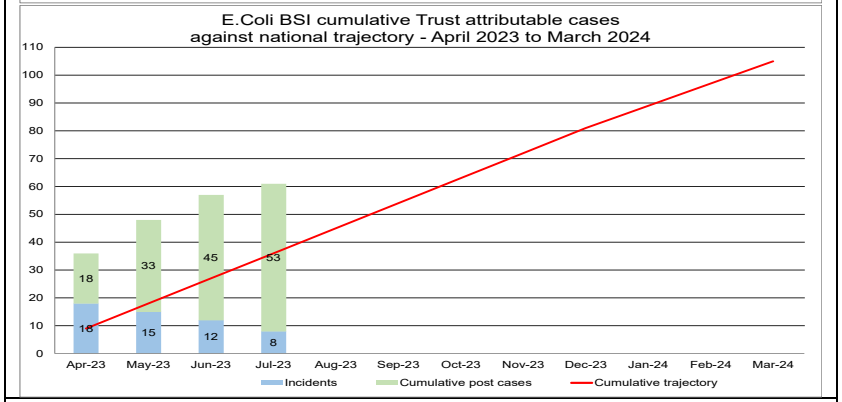
- **COVID-19:** 129 inpatient cases of COVID-19 were identified during July 2023, of which 56 were healthcare-attributed.
- **Influenza:** three inpatient cases were identified during July 2023.
- **Respiratory Syncytial Virus (RSV):** No cases of RSV were identified during July 2023.

Outbreaks

- During July 2023 a total of 12 outbreaks affected inpatient wards, ten of which were due to COVID-19 and two of which were due to Norovirus.

Line/Bar Charts





Recent performance

Area	Feb	Mar	Apr	May	Jun	Jul
MRSA	0	1	0	1	0	0
C.Diff	4	3	7	11	8	3
MSSA	5	6	6	6	4	6
E.coli	10	12	18	15	12	8

Safe

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

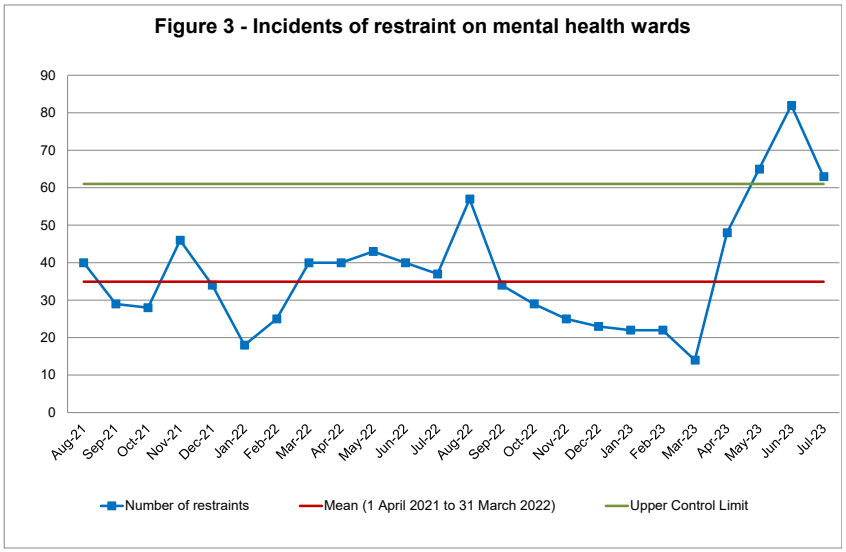
Current performance (including factors affecting this)

- During July 2023 a total of 63 restraint incidents were reported, of which two were prone restraints.
- The 63 incidents related to 21 patients, with 24 of the incidents relating to two patients.
- The two patients, one on Wessex House and the other on Rowan ward were each restrained on 12 separate occasions. These interventions were required in order to administer medication as part of their treatment plans.
- Of the two prone restraints, one occurred on Wessex House, and the other occurred on Rydon ward 2.

Focus of improvement work

- All incidents involving restraint are reviewed to ensure that assessments and care plans accurately reflect observation levels and the management of identified risk.
- Reducing Restrictive Interventions link workers continue to support teams in reviewing incidents of restraint and feeding into the wider Reducing Restrictive Interventions Strategy across the Mental Health and Learning Disabilities service group.

SPC Chart



How do we compare

The latest NHS Benchmarking Network report, covering the year 2022/23, showed that Somerset NHS Foundation Trust had comparatively lower levels of restraint incidents per 1,000 bed days, and fewer patients restrained per 1,000 patients admitted, than peer providers nationally.

Recent Performance

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

Area	Feb	Mar	Apr	May	Jun	Jul
Number of Restraint incidents	22	14	48	65	82	63
Number resulting in prone restraints	1	4	4	4	8	2

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.

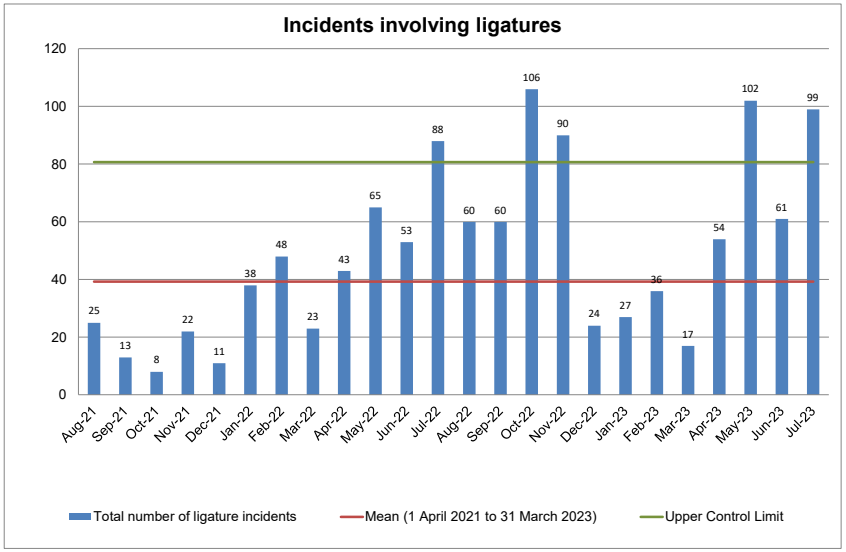
Current performance (including factors affecting this)

- During July 2023 a total of 99 ligature incidents were reported. No ligature point incidents were reported.
- Of the 99 ligature incidents, 43 occurred at Rowan Ward, with 30 relating to one patient. Rydon Ward 1 reported 33 incidents, with 27 relating to one patient.
- Of the 99 ligature incidents, 12 resulted in minor harm. No harm above minor was recorded.

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 Rowan Ward relates primarily to one patient diagnosed with an Emotionally Unstable Personality Disorder. Similarly, the one patient diagnosed with a Recurrent Depressive Disorder on Rydon Ward 1 accounted for 27 out of 33 incidents that occurred on that ward during the month. Both patients were using clothing or bed linen to tie non-fixed ligatures, where either no actual harm or minor harm occurred to the patients.
- Risk management plans are in place, and are being carefully managed in order not to adopt an overly restrictive approaches, which would severely impact on either patient's privacy and dignity.
- Potential technological solutions are currently available including door-top alarms, and room monitors which will continue to be evaluated, to be used as an addition to evidenced-based risk assessment and appropriate observation and engagement.

SPC Chart



How do we compare

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

Recent Performance

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

Area	Feb	Mar	Apr	May	Jun	Jul
Number of Ligature incidents	36	17	54	102	61	99
Number resulting in harm	5	1	8	9	12	12

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.

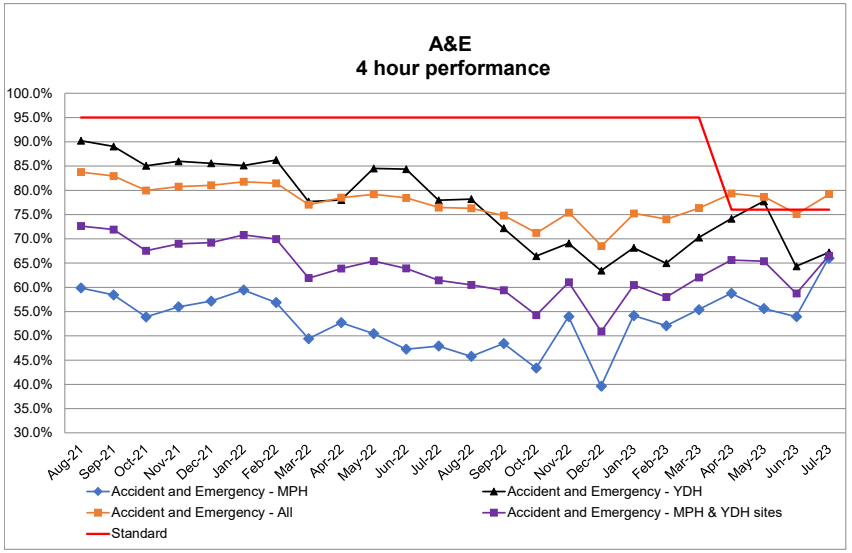
Current performance (including factors affecting this)

- Trust-wide A&E 4-hour performance for July 2023 significantly improved to 66.5% compared to June 2023. Compliance within our Minor Injury Units (MIUs) was 96.9%. Overall compliance across all attendance types was 79.2%, above the revised national standard of 76%.
- Compliance in respect of our two A&E departments was:
  - Musgrove Park Hospital (MPH): 66.0%.
  - Yeovil District Hospital (YDH): 67.2%.
- Although the combined year-to-date A&E attendances at MPH and YDH to 31 July 2023 were only 1.3% higher than those for the same period in 2022, both sites have experienced a number of pronounced daily 'spikes' in activity levels, which have affected performance against the four-hour standard. The cause of these spikes is being investigated by the countywide A&E Delivery Board.
- The number of patients spending more than 12 hours in the departments was 0.7% at MPH but 3.6% at YDH.

Focus of improvement work

- An ED performance trajectory continues to be developed. A joint site meeting is planned for 31 August 2023 to share learning and agree actions.
- Work is under way to review the numbers of diagnostic requests in ED, and to work with Radiology to streamline pathways.
- On the MPH site, plans are being taken forward for the new CT scanner in the ED/ Same Day Emergency Care (SDEC) footprint. This will support the improvement of patient flow.
- A rota review is being undertaken, to ensure rotas are efficient and mapped against demand, with an aim to complete the review by October 2023.
- SDEC at MPH will undertake a 'Yes' week, during the week commencing 4 September 2023 to increase referrals to SDEC rather than the Acute Medical Unit (AMU).
- A joint-site SDEC task and finish is planned, to aim towards a seven-day service, 12 hours per day.

Line Chart



How do we compare

In July 2023, the national average performance for Trusts with a major Emergency Department was 60.9%. Our performance was 66.5%. We were ranked 33 out of 122 trusts. With Minor Injury Unit attendances included, we were ranked 12, with performance of 79.2%.

Recent performance

Area	Feb	Mar	Apr	May	Jun	Jul
A&E only	58.0%	62.0%	65.6%	65.4%	58.7%	66.5%
Including MIU	74.0%	76.3%	79.3%	78.7%	75.1%	79.2%

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.

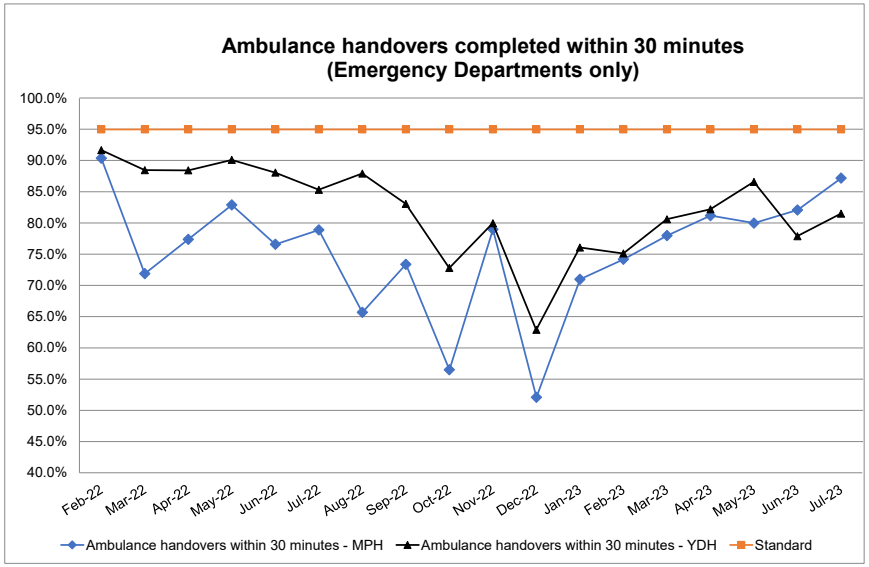
Current performance (including factors affecting this)

- During July 2023, the handover of patient arrivals by ambulance received into our Emergency Departments (EDs) at Musgrove Park Hospital (MPH) and at Yeovil District Hospital (YDH) improved compared to June 2023:
  - MPH: 87.2% (1,8963 out of 2,251 handovers were within 30 minutes).
  - YDH: 81.5% (1,120 out of 1,375 handovers were within 30 minutes).
- The average performance across all hospitals served by SWAST in July 2023 was 66.2%.
- During July 2023, arrivals by ambulance accounted for 31.4% of all patients attending the MPH ED, down from 33.8% in June 2023. The percentage of arrivals by ambulance at our YDH ED was 24.9%, up from 23.2% in June 2023.

Focus of improvement work

- The South Western Ambulance Service NHS Foundation Trust (SWAST) and both acute sites will review the Hospital Ambulance Liaison Officer (HALO) role and refine processes. This is planned for September 2023.
- Acute sites are working with SWAST and community partners to look at alternative pathways for patients to follow. The audits have been completed and a review of results is planned for 13 September 2023 to inform actions.
- Both sites are working with SWAST to streamline and improve direct access pathways to Same Day Emergency Care (SDEC).
- The ED improvement plan continues to test new ways of working to maximise flow within ED, supporting ambulance handovers.
- Work has commenced to review ED and Trustwide escalation, which should improve ambulance handover times.

Line Chart



How do we compare

In July 2023, 87.2% of all ambulance handovers at Musgrove Park Hospital and 81.5% of all ambulance handovers at Yeovil District Hospital were completed within 30 minutes. The average performance across all hospitals served by SWAST was 66.2%.

Recent performance

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

Area	Feb	Mar	Apr	May	Jun	Jul
MPH	74.2%	78.0%	81.2%	80.0%	82.1%	87.2%
YDH	75.1%	80.6%	82.2%	86.6%	77.9%	81.5%

Responsive

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

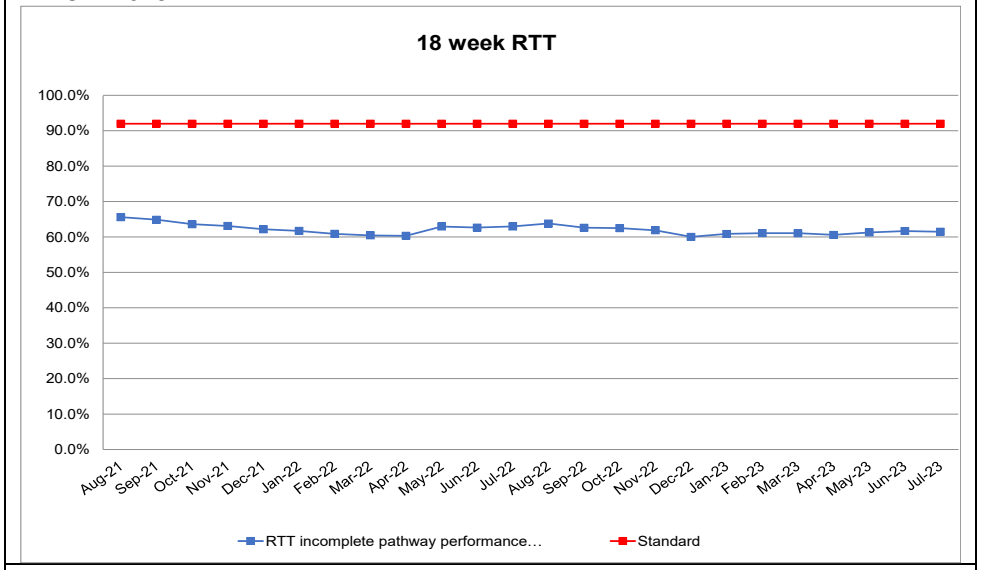
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT was 61.5% (combined acutes + community) in July 2023.
- The total waiting list size increased by 718 pathways, but was 828 lower (i.e. better) than the planning trajectory (55,037 actual vs. 55,865).
- The number of patients waiting over 52 weeks decreased by 22 pathways in July 2023 to 2,375 pathways, against a trajectory of 2,813 or fewer. The number of patients waiting over 65 weeks was 659 at the month end, down from 712 in June and 177 better than the trajectory of 836. The number of patients waiting 78+ weeks decreased by 12 to 49 and was again better than the trajectory for July 2023 of 55 or fewer. We reported no patients waiting over 104 weeks.
- Until November 2021 Musgrove remained one inpatient theatre's worth of capacity down due to the conversion of a theatre into critical care capacity. This, along with other factors, has resulted in a backlog of more complex, longer routine cases on the waiting list.

Focus of improvement work

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

Line Chart



How do we compare

The national average performance against the 18-week RTT standard was 59.2% in June 2023, the latest data available; our performance was 61.7%. National performance deteriorated by 0.3% between May and June 2023; our performance improved by 0.4%. The number of 52-week waiters nationally decreased by 1,939 to 383,083 (representing 5.1% of the national waiting list compared with 4.3% for the Trust).

Performance trajectory: 78week and 65 week wait performance

Area	Feb	Mar	Apr	May	Jun	Jul
78-week trajectory	440	300	0	0	65	55
78-week actual	179	68	84	87	61	49
65-week trajectory	N/A	N/A	1,105	1,352	749	836
65-week actual			714	710	712	659

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

Responsive

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

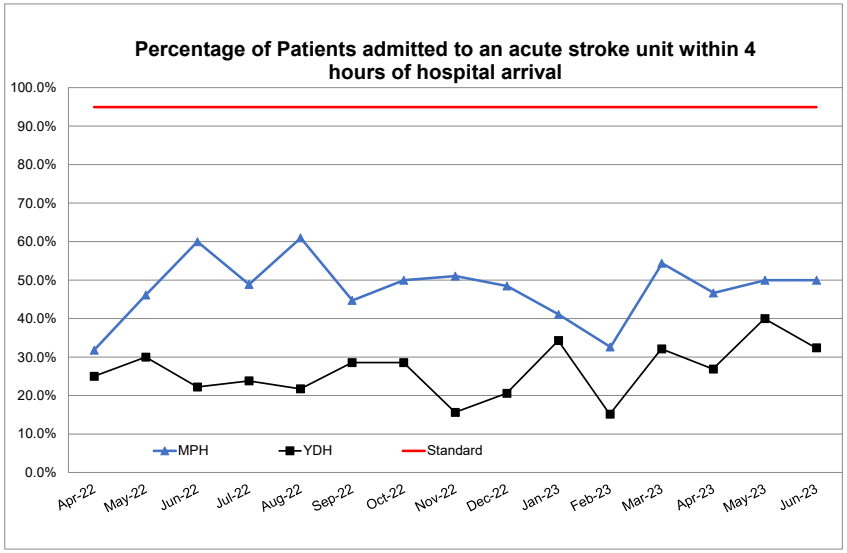
Current performance (including factors affecting this)

- During June 2023, the latest validated information available, compliance remained unchanged at Musgrove Park Hospital but decreased at Yeovil District Hospital when compared to May 2023. Both sites remained below the four-hour direct admission standard of 95%. Performance at the two sites was as follows:
  - Musgrove Park Hospital (MPH): 50.0%
  - Yeovil District Hospital (YDH): 32.4%
- Performance is heavily influenced by bed availability (i.e. no stroke beds being available at the time), clinical presentation that may not immediately suggest stroke on admission, and medical decisions as when appropriate to move/transfer patients from the emergency departments (EDs) to the wards.

Focus of improvement work

- The Stroke team are proactive in aiming to identify promptly patients who present to ED with stroke symptoms, to ensure that any delays to transferring to a stroke unit are minimised.
- Current performance levels are reflective of wider pressures on the hospital rather than a disjointed pathway of treatment for patients, and when bed availability and flow are favourable, the four-hour target is achieved in the majority of cases. On review, the majority of those who are not admitted to a stroke bed within the four-hour standard transpire to be patients with stroke-like symptoms who have not actually had a stroke.
- 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 business case is being prepared to recruit a full-time administrator to help improve the timeliness and robustness of information.
- The reasons attributable to delays are now being recorded and will enable themes to be identified and actions to be implemented.

Line Chart



How do we compare

During June 2023 compliance remained unchanged at Musgrove Park Hospital but decreased at Yeovil District Hospital when compared to May 2023.

Performance over the last six months

Area	Jan	Feb	Mar	Apr	May	Jun
% compliance MPH	41.1%	32.6%	54.4%	46.7%	50.0%	50.0%
% compliance YDH	34.3%	15.2%	32.1%	26.9%	40.0%	32.4%

Responsive

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

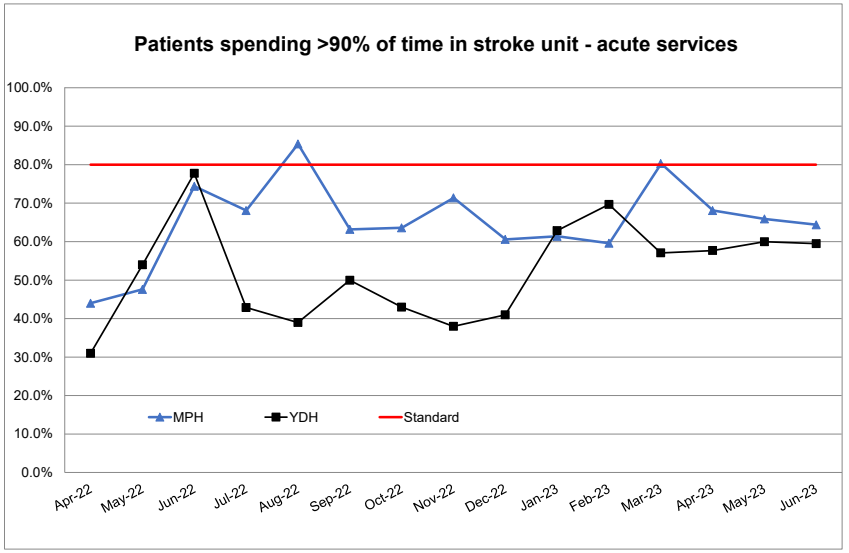
Current performance (including factors affecting this)

- During June 2023, the latest validated information, compliance at both Musgrove Park Hospital and Yeovil District Hospital decreased slightly from the previous month and remained below the 80% standard. Performance at the two sites was as follows:
  - Musgrove Park Hospital (MPH): 64.4%
  - Yeovil District Hospital (YDH): 59.5%
- 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 undertaken, please refer to the report on the four-hour direct admission standard.
- It should be noted that, regardless of whether or not they are on a Stroke ward, all patients remain on a stroke pathway throughout the whole time of their care, and are seen by specialist stroke practitioners on non-Stroke wards and also throughout their time with our community Stroke rehabilitation services.

Line Chart



How do we compare

During June 2023, compliance for both Musgrove Park Hospital and Yeovil District Hospital decreased slightly compared to May 2023.

Performance over the last six months

Area	Jan	Feb	Mar	Apr	May	Jun
% compliance MPH	61.4%	59.6%	80.3%	68.1%	65.9%	64.4%
% compliance YDH	62.9%	69.7%	57.1%	57.7%	60.0%	59.5%

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.

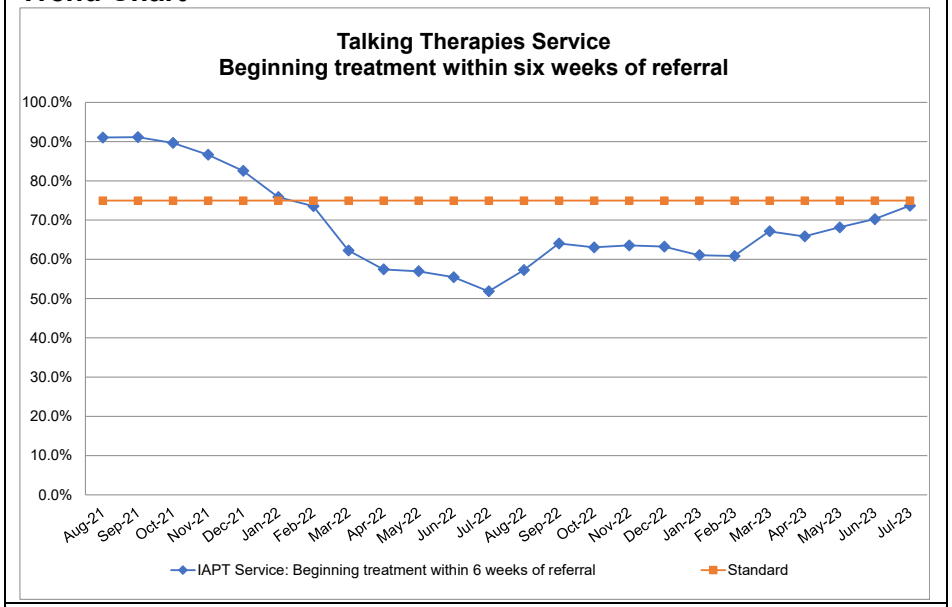
Current performance (including factors affecting this)

- During July 2023, compliance was 73.7%, the highest rate recorded since January 2022 when 75.9% was reported.
- The fall in compliance that occurred from February 2022 has been due primarily 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 had been exacerbated by vacancy levels, long term sickness and insufficient cover for colleagues on maternity leave. However, successes in appointing new staff, plus other accompanying actions, waiting times have started to improve.

Focus of improvement work

- Successes in recruitment with varying commencement dates, although several posts remain 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.
- Several months ago, all four team bases commenced a countywide waiting list protocol whereby referrals are solely dealt with by length of wait rather by than team base and then length of wait. This change has had a significant impact on the management of the waiting lists.

Trend Chart



How do we compare

National average performance against the six-week standard in May 2023 (the latest published data) was 90%; our performance was 68.2%.

Recent Performance

Area	Feb	Mar	Apr	May	Jun	Jul
Total Discharges	468	528	487	585	657	628
First treatment inside of six weeks	285	355	321	399	462	463
Compliance %	60.9%	67.2%	65.9%	68.2%	70.3%	73.7%

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.

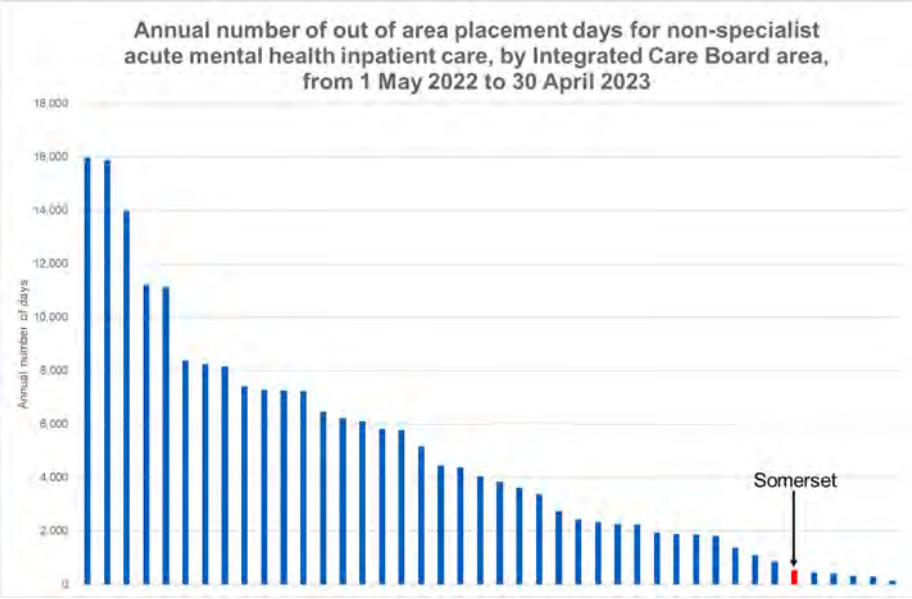
Current performance (including factors affecting this)

- During July 2023, two patients were placed out of area, for a total of 14 days.
- One patient placed out of area during March 2023 was repatriated to Somerset on 11 July 2023. The other patient, who was placed out of county on 1 July 2023, was repatriated to Somerset on 5 July 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	Feb	Mar	Apr	May	Jun	Jul
Number of Days	0	34	78	67	57	14
Number of patients	0	2	3	3	2	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.

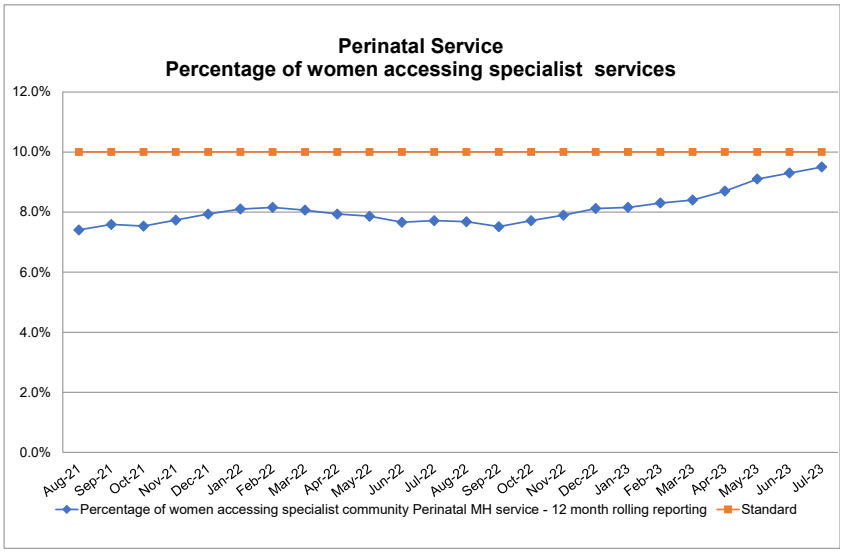
Current performance (including factors affecting this)

- Between 1 August 2022 and 31 July 2023, a total of 517 women accessed the service, which equates to 9.5% of the Somerset 2016 birth rate.
- The reported rate has increased for the last ten 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 10.2%, thus above the mandated standard.

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.

Trend Chart



How do we compare

As at 31 May 2023 – the latest national data available - the 12-month rolling access rate nationally was 7.6%, and for the South West region it was 8.6%. Our rate was 9.1%.

Recent Performance

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

Area	Feb	Mar	Apr	May	Jun	Jul
% compliance	8.3%	8.4%	8.7%	9.1%	9.3%	9.5%

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.

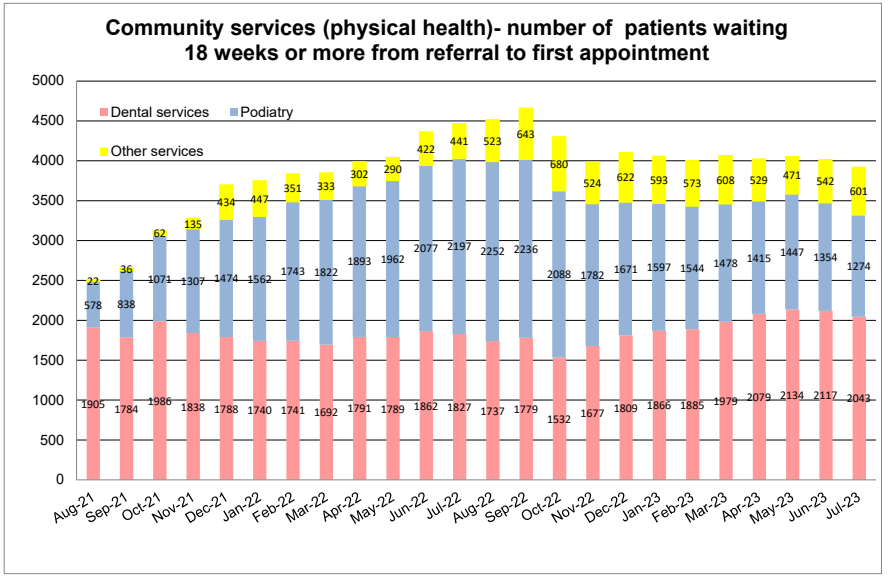
Current performance (including factors affecting this)

- As at 31 July 2023, the number of patients waiting 18 weeks or more totalled 3,918, the lowest number recorded since 31 March 2022 when 3,847 patients were reported as waiting 18 weeks or more.
- Our Somerset and Dorset dental service had 2,043 patients waiting 18 weeks or more to be seen, down from 2,117 as at 30 June 2023 (Somerset: 1,619 patients, down from 1,741 and Dorset: 424 patients, up from 376).
- The number of people waiting 18 weeks or more to be seen by our Podiatry service decreased to 1,274 patients, from 1,354 as at 30 June 2023. The Podiatry service continues to have significant levels of vacancies, which is a national issue.
- As at 31 July 2023, a total of 1,309 patients had waited 52 weeks or more to be seen (down from 1,319 in June 2023), 722 had waited 65 weeks or more (down from 840 in June 2023), and 336 had waited 78 weeks or more (down from 466 in June 2023). All but two patients were waiting for either the Podiatry service or the Dental service. The Podiatry service made reductions to the numbers waiting in all three time bands for the second consecutive month. Of the numbers within 'Others', 58.7% related to our Children and Young People Therapy Service, which increased from 321 as at 30 June 2023 to 353 as at 31 July 2023.

Focus of improvement work

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

Bar Chart



How do we compare

The number of patients waiting 18 weeks or more as at 31 July 2023 decreased by 95 when compared to 30 June 2023.

Recent performance

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

Area	Feb	Mar	Apr	May	Jun	Jul
Number waiting	4,002	4,065	4,023	4,052	4,013	3,918

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).

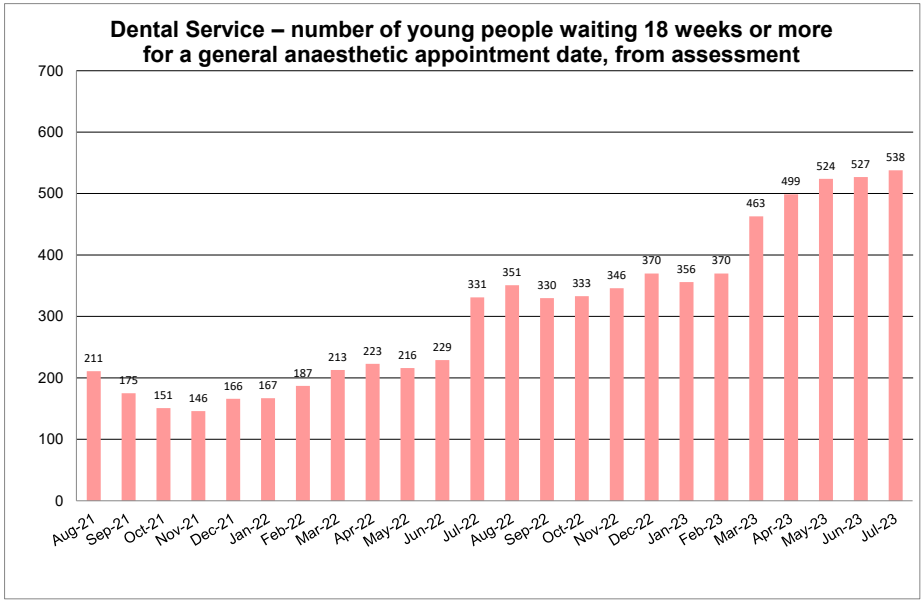
Current performance (including factors affecting this)

- As at 31 July 2023, 538 young people had waited 18 weeks or more, up slightly from 30 June 2023.
- Of the 538 patients waiting, 468 related to our Dorset service (up from 464 as at 30 June 2023), and 70 related to our Somerset service (up from 63 as at 30 June 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, 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 July 2023 increased by 11 compared to 30 June 2023.

Recent Performance

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

Area	Feb	Mar	Apr	May	Jun	Jul
Number waiting	370	463	499	524	527	538
% > 18 weeks	51.4%	59.7%	63.4%	66.4%	66.0%	67.4%

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.

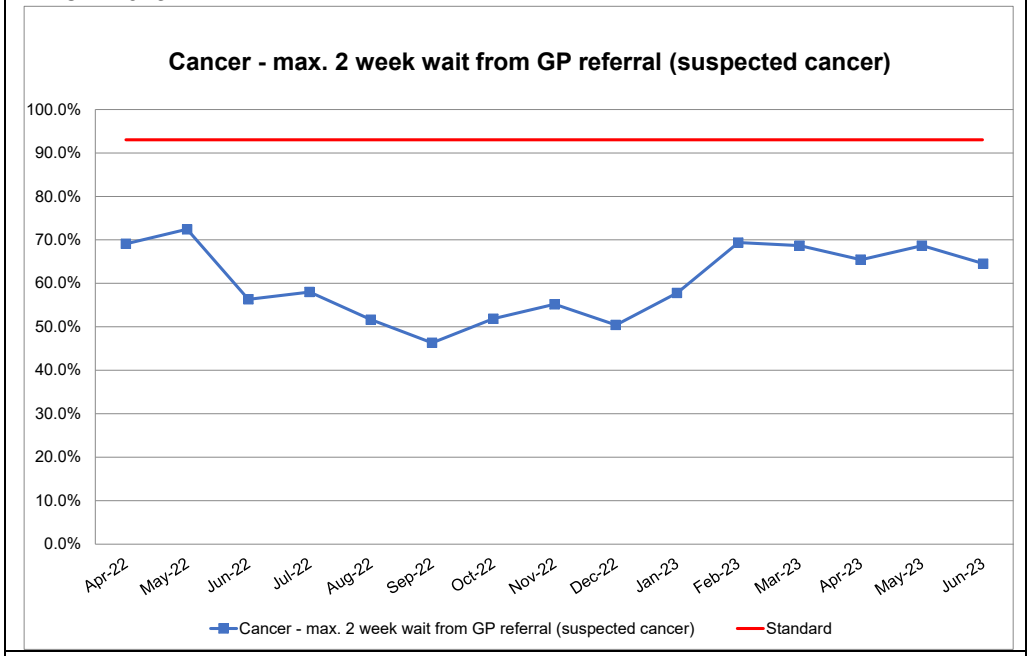
Current performance (including factors affecting this)

- The percentage of patients seen within 14 days of referral by their GP for a suspected cancer was 64.5% in June 2023, below both the 93% national standard and the national average.
- Lower GI (Gastrointestinal) pathways made up 32% of breaches of the two-week wait standard, gynaecology made up 21% and skin 17%.
- Triage times are improving for the lower GI pathway, which is helping to improve the 28-day Faster Diagnosis Standard performance, but 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.
- Gynaecology referrals are currently 47% 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.
- Skin performance reflects seasonal increases in referrals.
- The breast symptomatic (cancer not suspected) 93% two-week wait standard was not achieved in June 2023, with performance of 86.2% and 17 breaches, the majority related to the Musgrove capacity problems described above.

Focus of improvement work

- Please refer also 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.
- Additional dermatology capacity has been established, through a combination of additional appointments being made within the team and insourcing.

Line Chart



How do we compare

National average performance in June 2023, the latest data available, was 80.5%. Our combined performance was 64.5%. We were ranked 126 out of 141 providers.

Recent Performance

Area	Jan	Feb	Mar	Apr	May	Jun
% Compliance	57.8%	69.4%	68.6%	65.4%	68.6%	64.5%

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.

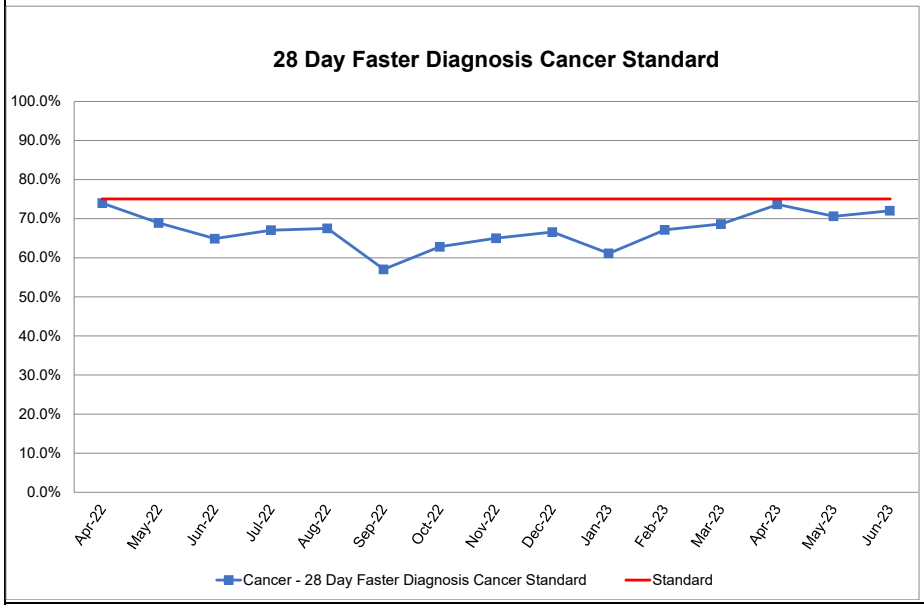
Current performance (including factors affecting this)

- The percentage of patients diagnosed with a cancer or given a benign diagnosis within 28 days of referral improved slightly to 72.0% in June 2023, but hence remained below the national 75% standard and slightly below the national average. This is the third consecutive month in which performance has exceeded 70%. Draft performance for July 2023 is expected to be confirmed as above the 75% national standard.
- The higher-volume tumour sites not meeting the 75% national standard in June 2023 were: colorectal (50.9%), urology (54.8%) and gynaecology (37.2%). Colorectal made up 39% of all the breaches of the 28-day standard and gynaecology made up 34%. Colorectal and gynaecology have both shown growth in referrals in recent months, relative to pre-COVID levels.

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 has led to a reduction in triage times, which will start to be more evident in the July 2023 figures.
- A new community-based/self-referral gynaecology pathway for post-menopausal bleed patients will commence in September. 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 as cancer two-week wait patients. People will be able to self-refer to the clinic.

Line Chart



How do we compare

National average performance for providers was 73.5% in June 2023, the latest data available. Our Trust-wide performance was 72.0%. We ranked 90 out of 141 providers.

Recent performance

Performance in recent months was as follows:

28-day Faster Diagnosis performance

Area	Jan	Feb	Mar	Apr	May	Jun
% Compliance	61.1%	67.1%	68.6%	73.6%	70.6%	72.0%

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 of diagnosis, the second step in a 62-day cancer pathway.

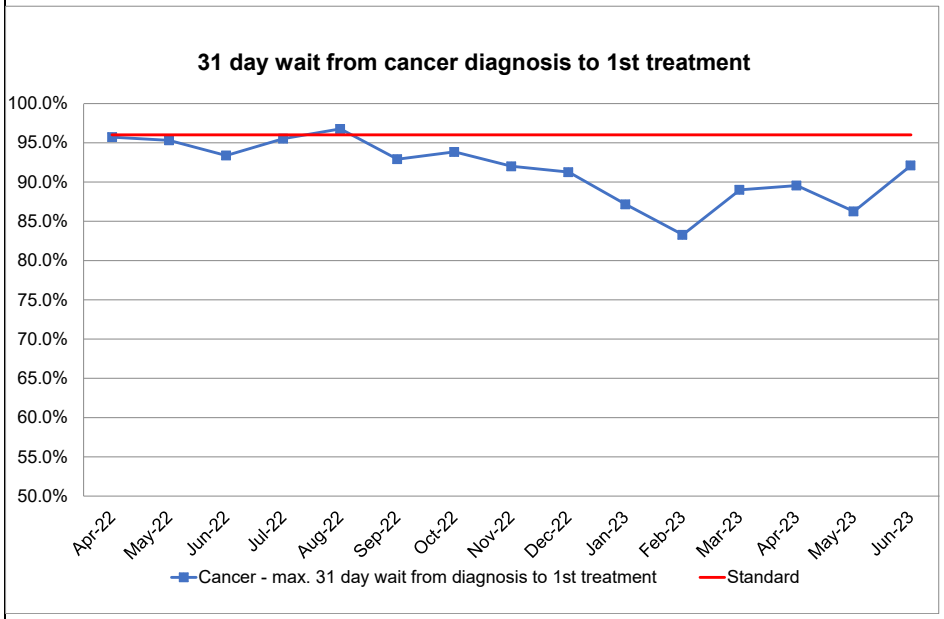
Current performance (including factors affecting this)

- Performance against the 31-day first definitive treatment standard increased from 86.3% in May 2023 to 92.1% in June 2023, below the 96% national standard but above the national average performance.
- There were 24 breaches of the first definitive treatment standard, of which 12 were for breast pathways and six were for colorectal. This again represents an unusually high number of breaches of the 31-day standard for breast patients. The breaches mainly relate to bulges in referral demand a few months ago, which translates into more patients needing treatment at the same time. Although this standard only related to first treatment, the bulges in demand include patients needing follow-up treatment within a clinically defined timescale, following an initial course of treatment earlier in the year.
- 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 try 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 91.3% in June 2023, the latest data available. Our Trust-wide performance was 92.1%. We ranked 98 out of 142 providers.

Recent performance

31-day diagnosis to first treatment performance

Area	Jan	Feb	Mar	Apr	May	Jun
% Compliance	87.1%	83.3%	89.0%	89.5%	86.3%	92.1%

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.

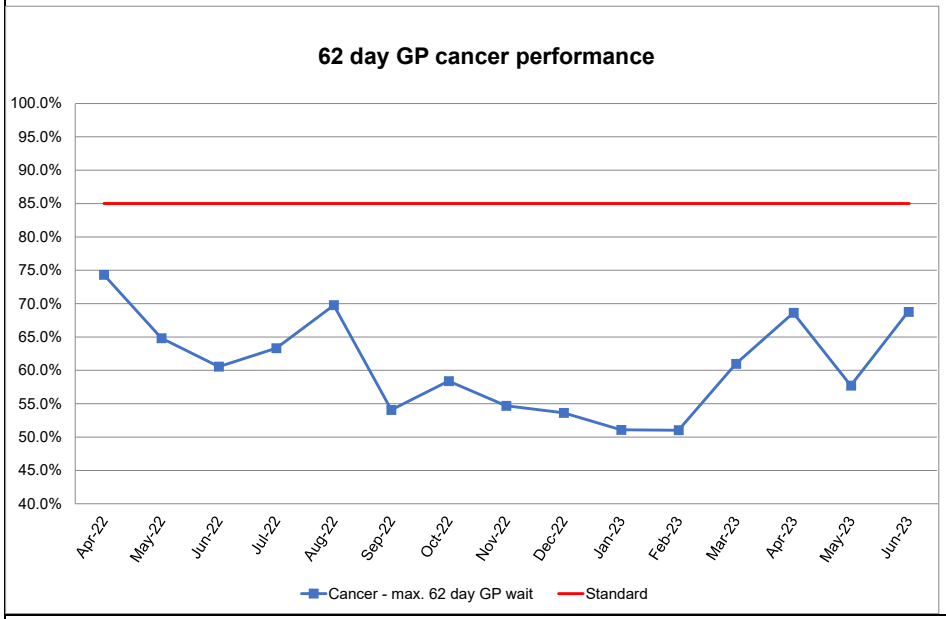
Current performance (including factors affecting this)

- The percentage of cancer patients treated within 62 days of referral by their GP was 68.8% in June 2023, up from 57.7% in May 2023 and above the national average.
- The main breaches of the 62-day GP standard were in urology (30% of breaches) and gynaecology (14%). 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 high levels of demand.
- Twenty-two patients were treated in June 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 July 2023 was 21 patients above (i.e. worse than) the recovery trajectory (201 against a plan of 180).

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. This will enable job plans to be re-set.
- Pathways redesign work is continuing for prostate, across both SFT and YDH, to align both sites and reduce any delays.
- 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 59.2% in June 2023, the latest data available. Our Trust-wide performance was 68.8%. We were ranked 43 out of 142 trusts.

Recent performance

62-day GP cancer performance

Area	Jan	Feb	Mar	Apr	May	Jun
% Compliance	51.1%	51.0%	61.0%	68.6%	57.7%	68.8%

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

Responsive

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

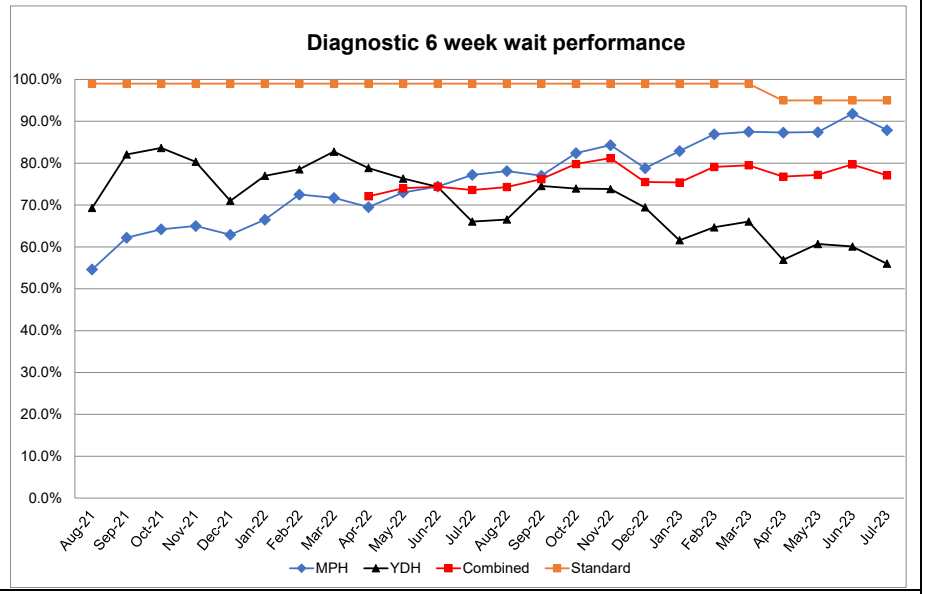
Current performance (including factors affecting this)

- The combined percentage of patients waiting under six weeks for their diagnostic test decreased from 79.7% in June 2023 to 77.1% in July 2023 but continued to meet the regional March 2023 ambition of greater than 75%.
- The number of patients waiting over six weeks increased by 372. The highest numbers of patients were waiting for an echo (down from 747 to 734, 26% of over six-week waiters), non-obstetric Ultrasound (up from 306 to 588, 21%) and Audiology (down from 323 to 314, 11%), together making up 58% of the long waiters.
- The total waiting list size increased by 2%, largely due to an increase in the ultrasound waiting list because of staff shortages, which has also led to a significant increase in six-week wait breaches. Demand for audiology appointments remains high but the additional capacity which has been established has reduced the number of long waiters.

Focus of improvement work

- An additional echo room has been established on the Yeovil site. The upgrade of the clinical reporting system has also now been completed, which brings the two sites on to the same system. This will allow image sharing across sites and more flexible use of capacity. An insourcing contract has been agreed, to provide additional capacity, which has now commenced at Yeovil.
- Additional ultrasound capacity is being sought, in addition to sharing-out the demand as far as possible, across the Musgrove and Yeovil sites.
- Additional in-house clinics are being run in audiology, to support backlog clearance, on top of the existing outsourcing contract. The Musgrove site has now recruited to posts agreed in this year's business cases, which will 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 74.0% in June 2023, the latest data available. Our performance was 79.7%. We were ranked 79 out of 159 trusts for the 15 high-volume diagnostic tests.

Recent performance

Area	Feb	Mar	Apr	May	Jun	Jul
Musgrove Park Hospital (MPH)	86.9%	87.5%	87.3%	87.4%	91.8%	87.9%
Yeovil District Hospital (YDH)	64.7%	66.1%	56.9%	60.7%	60.1%	56.0%
Combined	79.1%	79.5%	76.8%	77.2%	79.7%	77.1%

Well Led

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

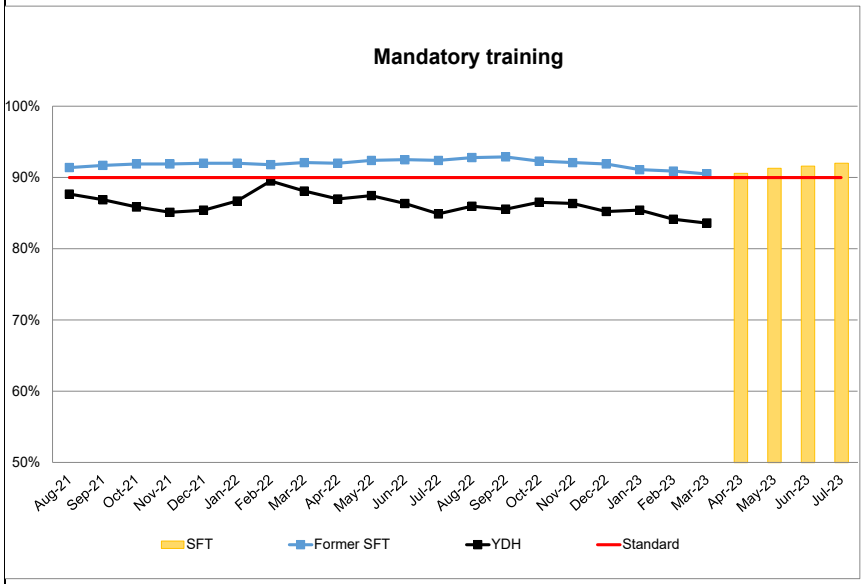
Current performance (including factors affecting this)

- As at 31 July 2023, our overall mandatory training rate as a merged Trust was 92.0%.
- Apart from Symphony Health Service (SHS), all colleagues moved to the newly commissioned Trust training system, LEAP, on 1 April 2023. As at 31 July 2023, compliance reported from the two separate systems was as follows:
  - LEAP: 91.6% (91.6% as at 30 June 2023)
  - SHS: 81.4% (78.8% as at 30 June 2023)
- Operational pressures, and limited capacity in areas with large backlogs such as life support and safeguarding continue to remain a challenge to full recovery.

Focus of improvement work

- Work is in progress to review the impact of colleagues failing to attend courses, and to formulate mitigating actions.
- 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 require 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 is 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 performance.

Run Chart



How do we compare

Compliance as at 31 July 2023 increased by 0.4% compared to 30 June 2023.

Recent Performance

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

Area	Feb	Mar	Apr	May	Jun	Jul
Former SFT	90.9%	90.5%				
YDH	84.1%	83.6%				
Merged Trust			90.6%	91.3%	91.6%	92.0%

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.

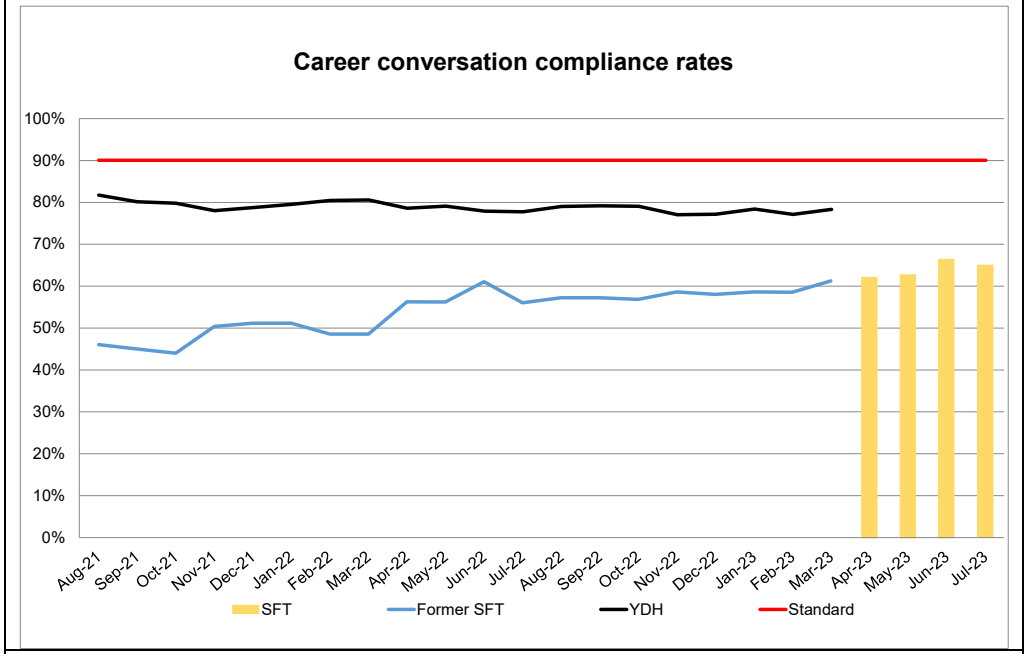
Current performance (including factors affecting this)

- Compliance as at 31 July 2023, in respect of career conversation reviews being undertaken at least annually, was 65.0%, down from 66.4% as at 30 June 2023, and still below the standard of 90%.
- Operational pressures continue to affect compliance.

Focus of improvement work

- People Business Partners and Leadership and service group leads are continuing to support teams and assist with actions where barriers are identified, in order to help improve 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.
- Work continues to merge the workforce information of both predecessor Trusts, to enable retrospective analysis to be undertaken and presented.
- 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 July 2023 decreased by 1.4% compared to position as at 30 June 2023.

Recent performance

The compliance rates in recent months were as follows:

Area	Feb	Mar	Apr	May	Jun	Jul
Former SFT	58.5%	61.2%				
YDH	77.1%	78.3%				
Merged Trust			62.1%	62.7%	66.4%	65.0%

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.

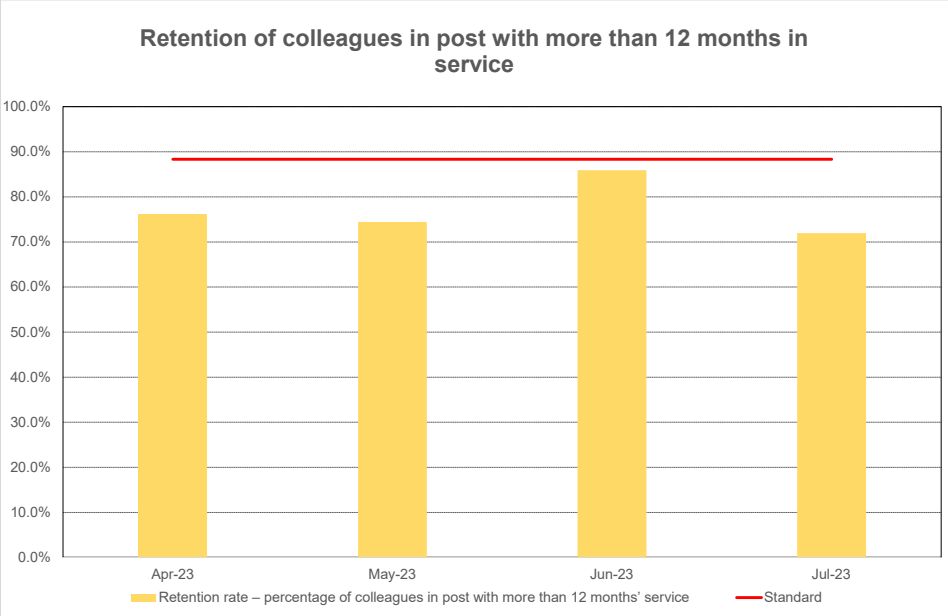
Current performance (including factors affecting this)

- Of 153 colleagues who had commenced employment on or after 1 August 2022, a total of 110 (71.9%) were still with the Trust as at 31 July 2023.

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 during July 2023 compared to June 2023.

Recent performance

The retention rates in recent months were as follows:

Area	Feb	Mar	Apr	May	Jun	Jul
Monthly rate			76.0%	74.4%	85.9%	71.9%

Well Led

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

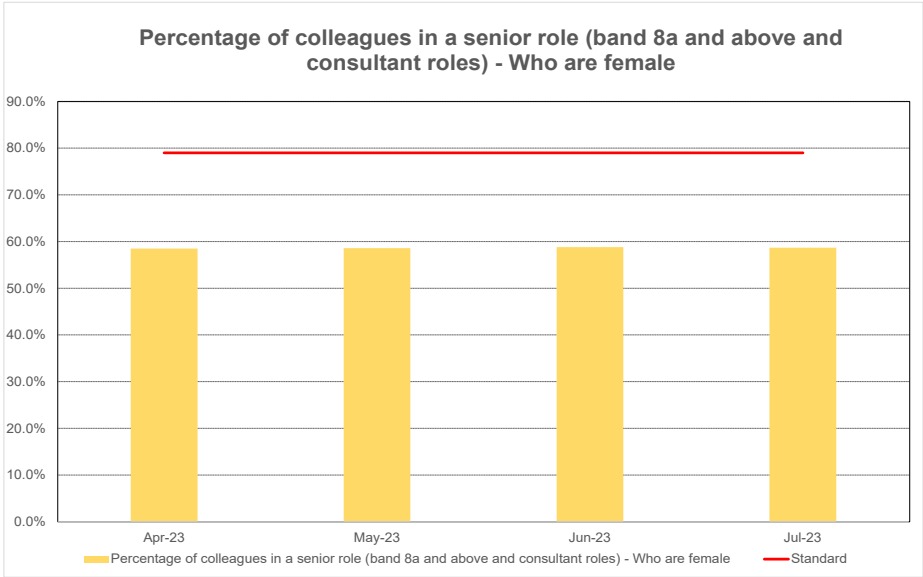
Current performance (including factors affecting this)

- Across Somerset NHS Foundation Trust as a whole, 79% of colleagues (excluding bank, locums and those on secondment) 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 July 2023, of 1,814 colleagues employed at Band 8a or above, a total of 1,065 identified as female, a rate of 58.7%. This is a slight decrease from the rate reported as at 30 June 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	Feb	Mar	Apr	May	Jun	Jul
Monthly rate			58.5%	58.6%	58.8%	58.7%

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.

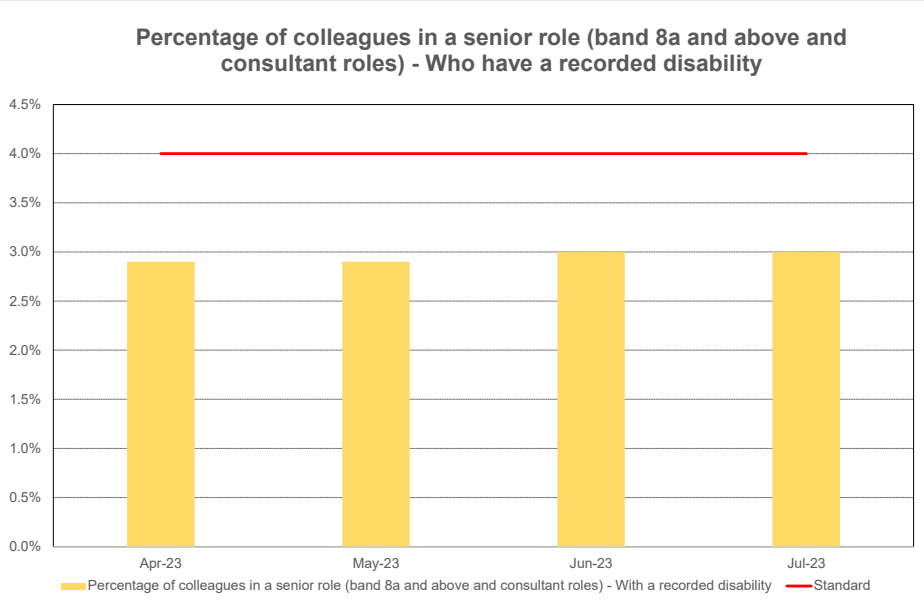
Current performance (including factors affecting this)

- Within Somerset NHS Foundation Trust, 4% of colleagues are recorded as having a disability.
- As at 31 July 2023, of 1,814 colleagues employed at Band 8a or above, a total of 54 (3.0%) were recorded as having a disability, unchanged from 30 June 2023.
- Colleagues with a disability are under-represented when compared to the general population and under-represented at senior levels.
- Our data indicates that the proportion of colleagues who have not completed their data in ESR increases with seniority.

Focus of improvement work

- 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	Feb	Mar	Apr	May	Jun	Jul
Monthly rate			2.9%	2.9%	3.0%	3.0%

Well Led

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

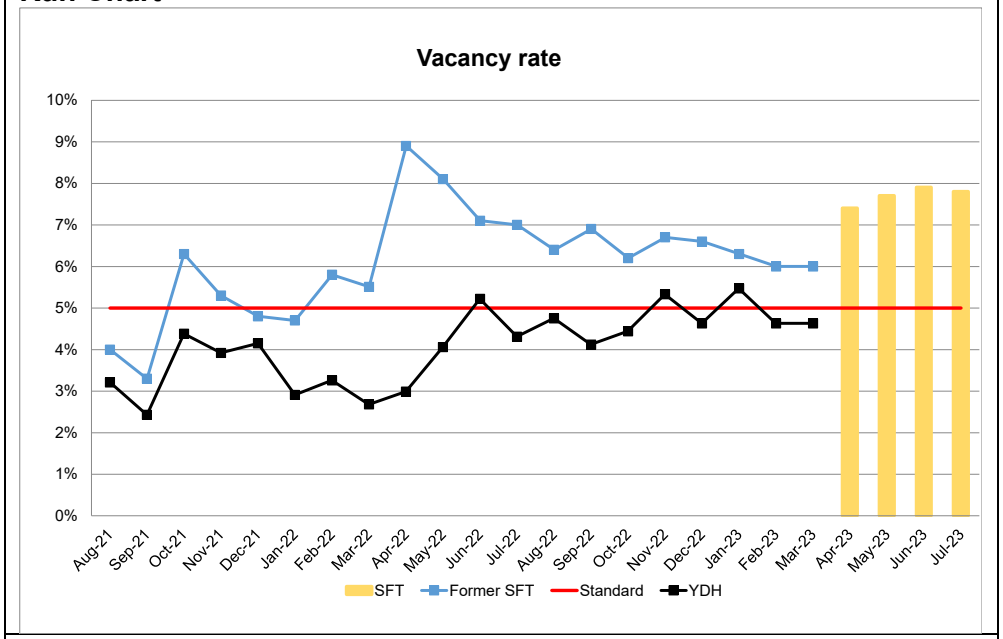
Current performance (including factors affecting this)

- The vacancy rate as at 31 July 2023 was 7.8%, which is 2.8% above the 5% compliance standard.
- The reported vacancy rate recently 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 our risk registers, both corporately and at service level.
- Retaining healthcare support workers also remains 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 reduced slightly in July 2023 compared to June 2023.

Recent performance

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

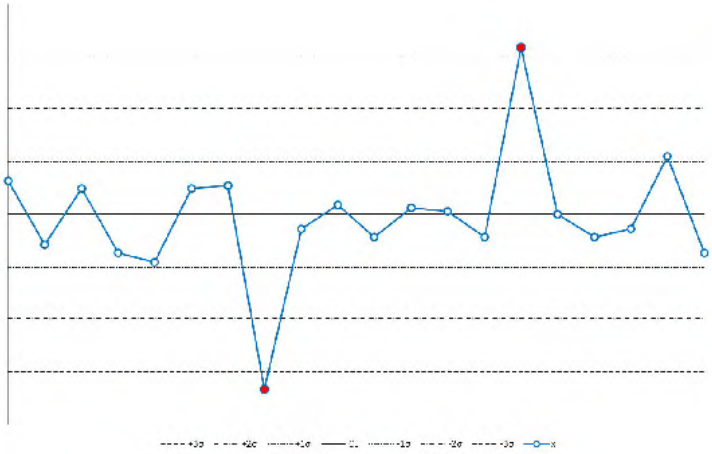
Dec	Feb	Mar	Apr	May	Jun	Jul
Vacancy rate			7.4%	7.7%	7.9%	7.8%

7.9%

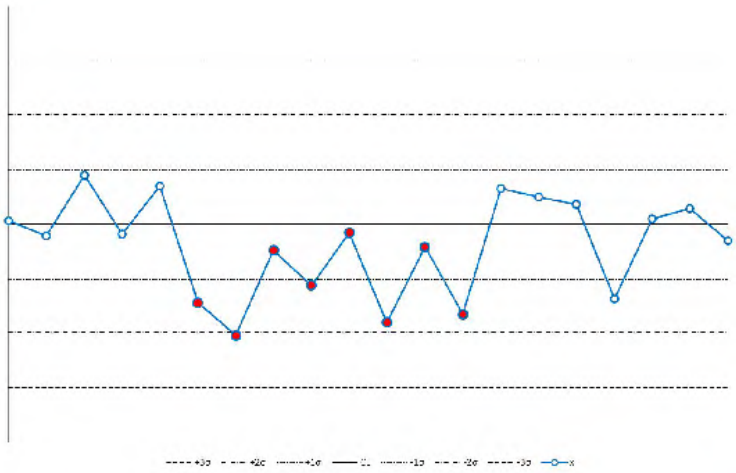
Appendix 1 - Procedure for Interpreting Run Charts

Special Cause Variation Rules

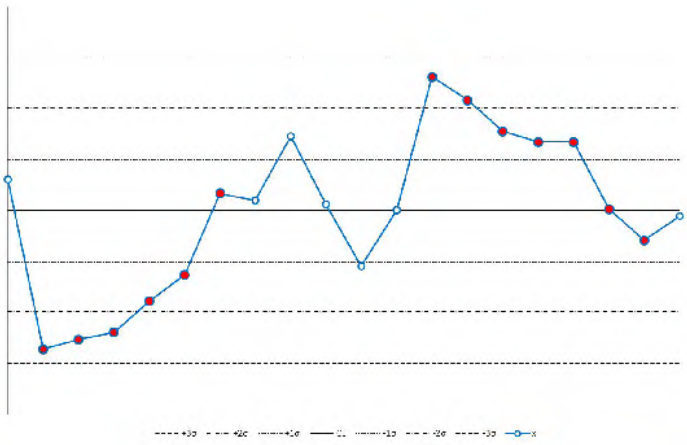
1. A single point outside the control limits



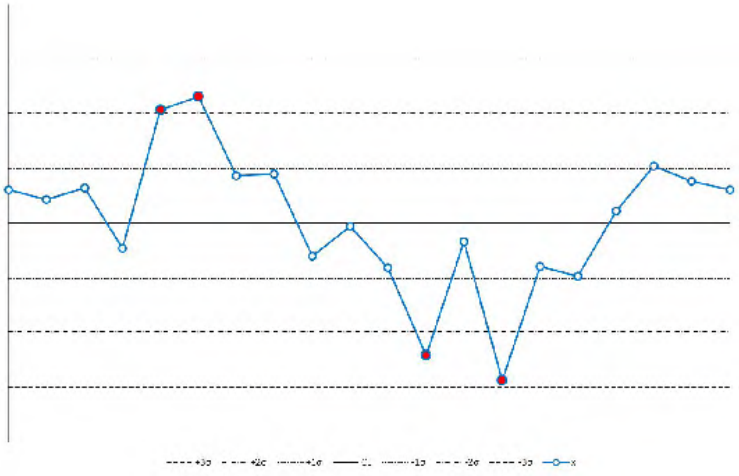
2. A run of eight or more points in a row above (or below) the centreline



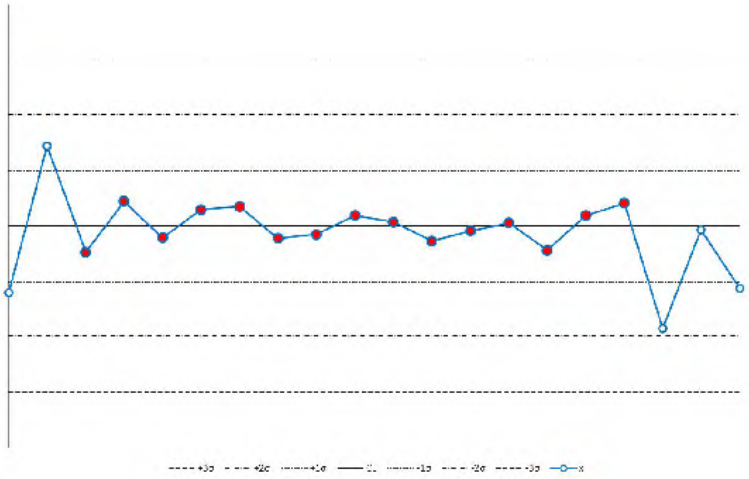
3. Six consecutive points increasing (trend up) or decreasing (trend down)



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



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



APPENDIX 2

OUR CARE QUALITY COMMISSION RATINGS

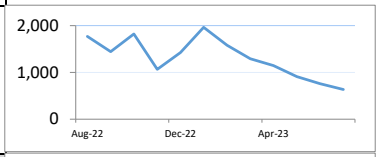
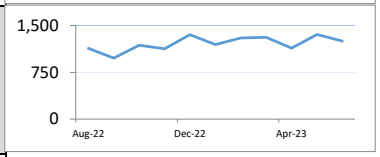
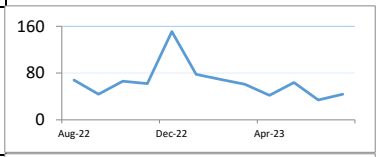
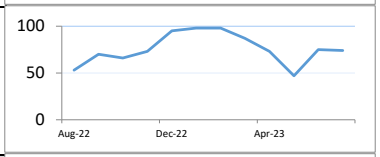
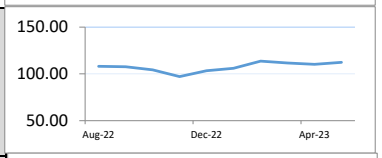
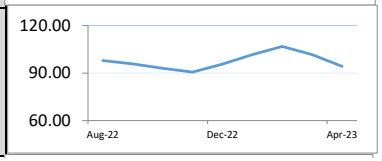
Our current Care Quality Commission ratings are as follows:

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

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

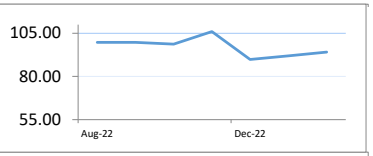
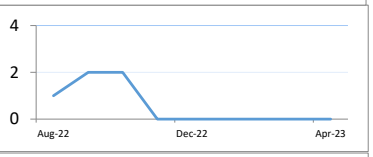
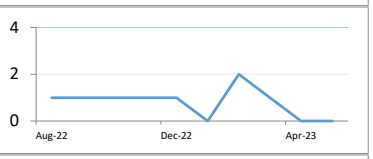
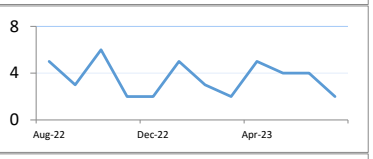
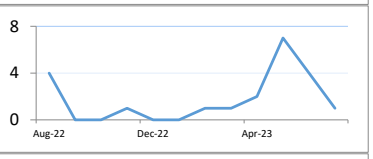
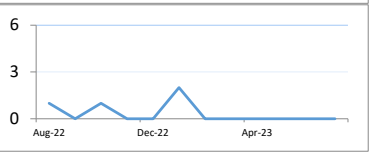
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	
Admissions	1	Number of medical and surgical outliers in acute wards	MPH	1,770	1,442	1,824	1,067	1,424	1,964	1,579	1,293	1,145	911	757	635	
	2		YDH	1,134	978	1,183	1,126	1,354	1,196	1,302	1,313	1,138	1,356	1,253	Data awaited	
	3	Admissions of under 16 year olds to adult mental health wards		0	0	0	0	0	0	0	0	0	0	0	0	
	4	Mixed sex accommodation breaches	Acute wards	0	0	0	0	0	0	0	0	0	0	0	0	
	5	Number of patients transferred between acute wards after 10pm	MPH	68	44	66	62	151	78	69	61	42	64	34	44	
	6		YDH	53	70	66	73	95	98	98	87	73	47	75	74	
Mortality (acute services)	7	Hospital Standardised Mortality Ratio (HSMR)	MPH and Community Hospitals	108.17	107.58	104.45	97.13	103.41	106.04	113.66	111.69	110.28	112.27	June 2023 to be reported after July 2023		
	8	Summary Hospital-level Mortality Indicator (SHMI)	MPH and Community Hospitals	97.97	95.78	92.98	90.63	95.65	101.72	106.84	101.74	94.26	May 2023 to be reported after July 2023			

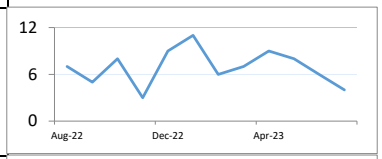
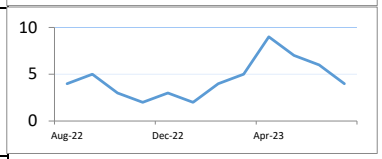
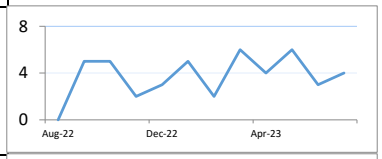
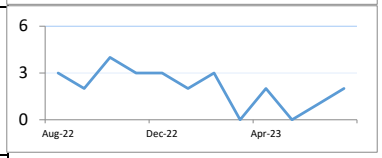
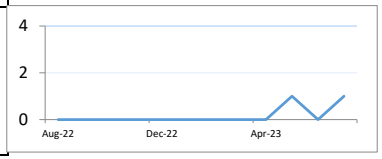
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	
Mortality (acute services)	9	Summary Hospital-level Mortality Indicator (SHMI)	YDH	99.76	99.72	98.70	105.98	89.84	91.92	94.11	March 2023 to be reported after July 2023					
Incident reporting	10	No of Serious Incidents Requiring Investigation (SIRIs)/Never Events - acute services		1	2	2	0	0	0	0	Data awaited	Data awaited	Data awaited	Data awaited	Data awaited	
	11	Number of recorded Serious Incidents Requiring Investigation - community and mental health services		1	1	1	1	1	0	2	1	Data awaited	Data awaited	Data awaited	Data awaited	
Infection Control	12	Clostridium Difficile cases HOHA cases (Hospital Onset Hospital Acquired) and COHA cases (Community Onset Hospital Acquired)	MPH,	5	3	6	2	2	5	3	2	5	4	4	2	
	13		YDH	4	0	0	1	0	0	1	1	2	7	4	1	
	14		Community Hospitals and Mental Health wards	1	0	1	0	0	2	0	0	0	0	0	0	
	15	MRSA bacteraemias (post)	MPH,	0	0	0	0	0	0	0	0	0	1	0	0	
	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		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	
	17	MRSA bacteraemias (post)	Community Hospitals and Mental Health wards	0	1	0	0	0	0	0	1	0	0	0	0	
	18	E. coli bacteraemia	MPH,	7	5	8	3	9	11	6	7	9	8	6	4	
Infection Control	19	E. coli bacteraemia	YDH	4	5	3	2	3	2	4	5	9	7	6	4	
	20		Community Hospitals and Mental Health wards	0	0	0	0	0	0	0	0	0	0	0	0	
	21	Methicillin-sensitive staphylococcus aureus	MPH,	0	5	5	2	3	5	2	6	4	6	3	4	
	22		YDH	3	2	4	3	3	2	3	0	2	0	1	2	
	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		0	0	0	0	0	0	0	0	0	1	0	1	

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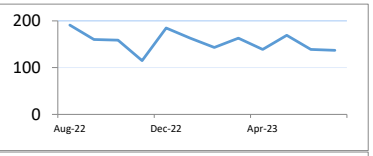
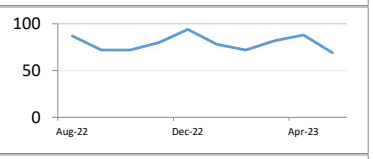
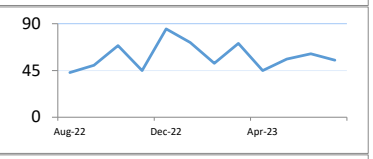
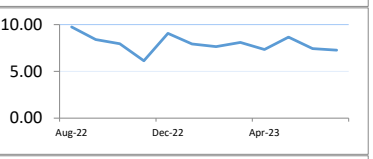
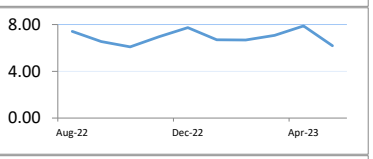
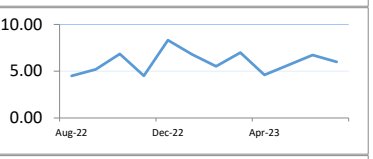
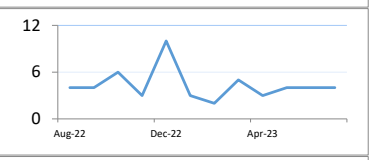
QUALITY MEASURES - 2023/24

Area	Ref	Measure		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-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	191	160	159	115	185	163	143	163	139	169	139	137	
	27		YDH	87	72	72	80	94	78	72	82	88	69	Data awaited	Data awaited	
Falls	28	Total number of patient falls	Community Hospitals and Mental Health wards	43	50	69	45	85	72	52	71	45	56	61	55	
	29	Rate of falls per 1,000 occupied bed days - all services	MPH	9.75	8.40	7.95	6.13	9.06	7.94	7.65	8.09	7.35	8.67	7.43	7.26	
	30		YDH	7.42	6.54	6.09	6.96	7.74	6.69	6.67	7.08	7.88	6.19	Data awaited	Data awaited	
	31		Community Hospitals and Mental Health wards	4.50	5.19	6.84	4.51	8.32	6.80	5.53	7.00	4.60	5.68	6.72	5.99	
Falls	32	Moderate Harm - Number of falls resulting in moderate harm - all services	MPH	4	4	6	3	10	3	2	5	3	4	4	4	

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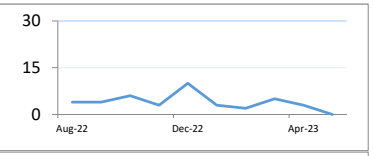
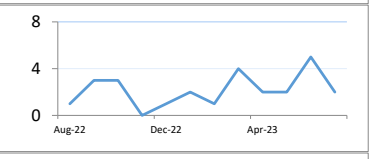
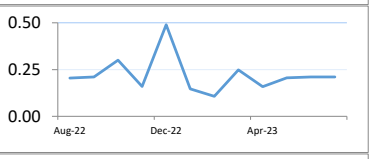
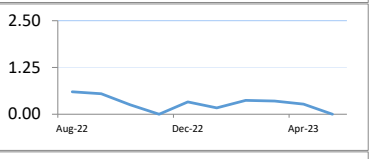
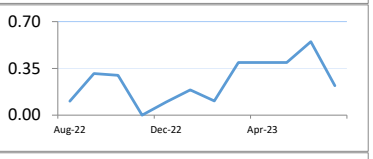
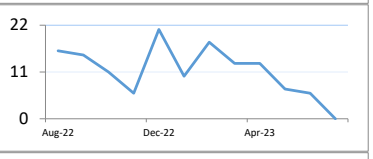
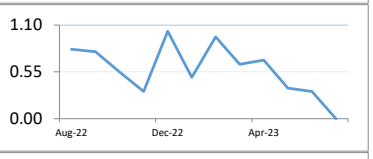
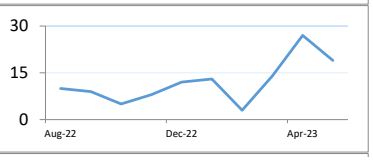
QUALITY MEASURES - 2023/24

Area	Ref	Measure		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	
	33	Moderate Harm - Number of falls resulting in moderate harm - all services	YDH	4	4	6	3	10	3	2	5	3	0	Data awaited	Data awaited	
	34		Community Hospitals and Mental Health wards	1	3	3	0	1	2	1	4	2	2	5	2	
	35	Moderate Harm - Rate of falls resulting in moderate harm per 1,000 occupied bed days - all services	MPH	0.20	0.21	0.30	0.16	0.49	0.15	0.11	0.25	0.16	0.21	0.21	0.21	
	36		YDH	0.60	0.55	0.25	0.00	0.33	0.17	0.37	0.35	0.27	0.00	Data awaited	Data awaited	
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	0.10	0.31	0.30	0.00	0.10	0.19	0.11	0.39	0.39	0.39	0.55	0.22	
	38	Acute wards - number of incidents	MPH	16	15	11	6	21	10	18	13	13	7	6	Data awaited	
	39	Rate of pressure ulcer damage per 1,000 acute ward occupied bed days	MPH	0.82	0.79	0.55	0.32	1.03	0.49	0.96	0.64	0.69	0.36	0.32	Data awaited	
	40	Acute wards - number of incidents	YDH	10	9	5	8	12	13	3	14	27	19	Data awaited	Data awaited	

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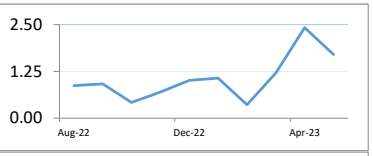
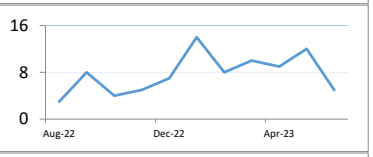
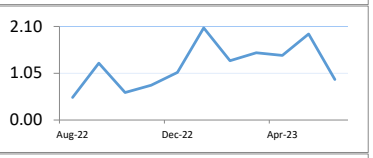
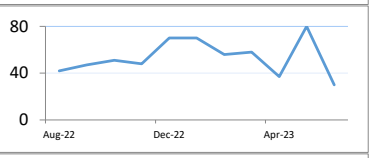
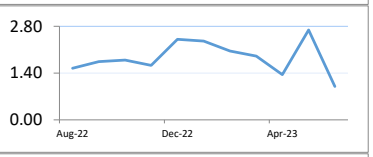
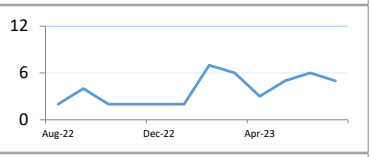
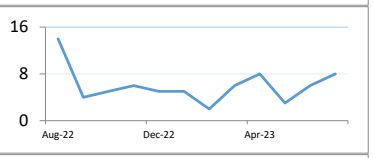
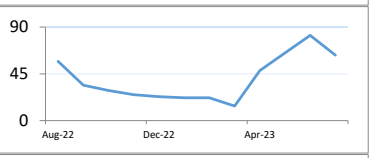
QUALITY MEASURES - 2023/24

Area	Ref	Measure		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	
Pressure ulcer damage	41	Rate of pressure ulcer damage per 1,000 acute ward occupied bed days	YDH	0.87	0.92	0.42	0.70	1.01	1.07	0.36	1.21	2.42	1.70	Data awaited	Data awaited	
	42	Community hospitals - number of incidents		3	8	4	5	7	14	8	10	9	12	5	Data awaited	
	43	Rate of pressure ulcer damage per 1,000 community hospital occupied bed days		0.51	1.28	0.62	0.78	1.07	2.07	1.33	1.51	1.45	1.93	0.91	Data awaited	
	44	District nursing - number of incidents		42	47	51	48	70	70	56	58	37	80	30	Data awaited	
	45	Rate of pressure ulcer damage per 1,000 district nursing contacts		1.54	1.74	1.79	1.63	2.41	2.36	2.06	1.91	1.35	2.69	1.00	Data awaited	
Cardiac Arrests	46	No. ward-based cardiac arrests - acute wards	MPH	2	4	2	2	2	2	7	6	3	5	6	5	
	47		YDH	14	4	5	6	5	5	2	6	8	3	6	8	
	48	Total number of incidents	Mental Health Wards	57	34	29	25	23	22	22	14	48	65	82	63	

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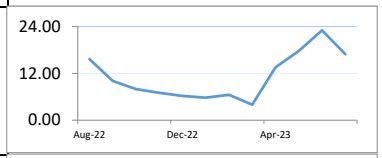
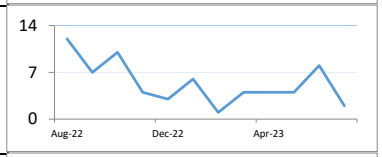
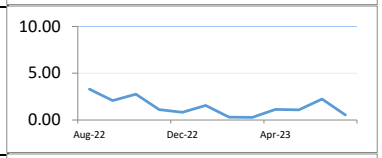
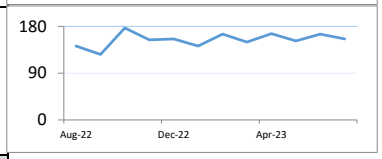
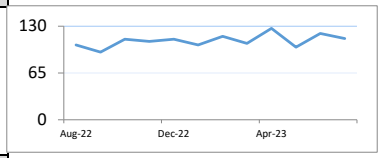
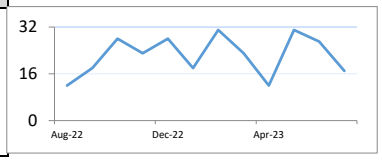
QUALITY MEASURES - 2023/24

Area	Ref	Measure		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	
Restraints (mental health wards)	49	Restraints per 1,000 occupied bed days	Mental Health Wards	15.69	10.06	8.00	7.02	6.25	5.77	6.49	3.97	13.51	17.77	23.05	16.94	
	50	Number of prone restraints	Mental Health Wards	12	7	10	4	3	6	1	4	4	4	8	2	
	51	Prone restraints per 1,000 occupied bed days	Mental Health Wards	3.30	2.07	2.76	1.12	0.82	1.57	0.30	0.28	1.13	1.09	2.25	0.54	
Medication incidents	52	Total number of medication incidents	MPH, Community Hospitals and Mental Health wards	142	126	177	154	156	142	165	150	166	152	165	156	
	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	104	94	112	109	112	104	116	106	127	101	120	113	
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 - incorrect storage	MPH, Community Hospitals and Mental Health wards	12	18	28	23	28	18	31	23	12	31	27	17	

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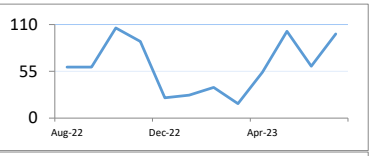
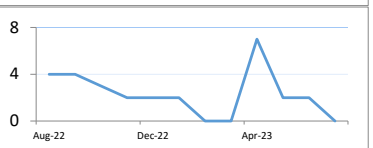
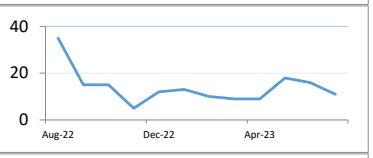
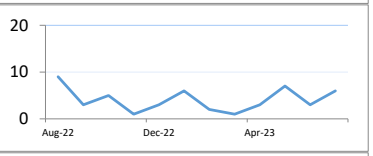
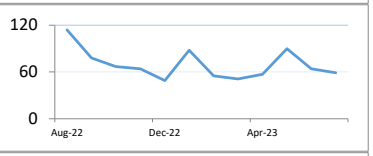
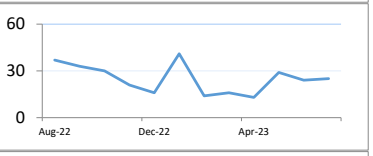
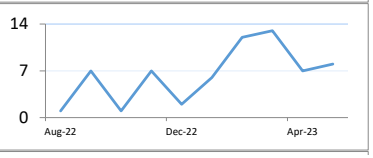
QUALITY MEASURES - 2023/24

Area	Ref	Measure		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	
M	57	Medication incidents - 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	60	60	106	90	24	27	36	17	54	102	61	99	
	59	Number of ligature point incidents	Mental Health Wards	4	4	3	2	2	2	0	0	7	2	2	0	
Violence and Aggression	60	Violence and Aggression: Number of incidents patient on patient (inpatients only)	MPH, Community Hospitals and Mental Health wards	35	15	15	5	12	13	10	9	9	18	16	11	
	61	Violence and Aggression: Incidents resulting in harm - patient on patient (inpatient only)	MPH, Community Hospitals and Mental Health wards	9	3	5	1	3	6	2	1	3	7	3	6	
	62	Violence and Aggression: Number of incidents patient on staff	MPH, Community Hospitals and Mental Health wards	114	78	67	64	49	88	55	51	57	90	64	59	
	63	Violence and Aggression: Incidents resulting in harm - patient on staff	MPH, Community Hospitals and Mental Health wards	37	33	30	21	16	41	14	16	13	29	24	25	
Unexpected deaths	64	Unexpected Deaths: Total number of incidents to be investigated	Community and mental health services	1	7	1	7	2	6	12	13	7	8	Data awaited	Data awaited	

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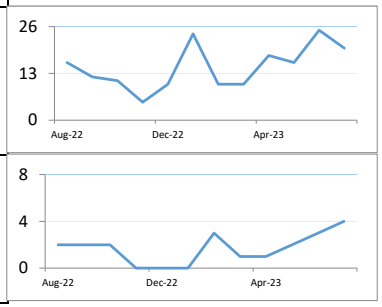
QUALITY MEASURES - 2023/24

Area	Ref	Measure		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Seclusion	65	Number of Type 1 -Traditional Seclusion	Mental Health Wards	16	12	11	5	10	24	10	10	18	16	25	20
	66	Number of Type 2 -Short term Segregation	Mental Health Wards	2	2	2	0	0	0	3	1	1	2	3	4



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CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Thresholds
1	Accident and Emergency / Minor Injury Unit 4-hour performance	Accident & Emergency department (ED) - MPH	4, 6, 9	45.8%	48.4%	43.4%	54.0%	39.6%	54.2%	52.1%	55.4%	58.8%	55.6%	54.0%	66.0%	From April 2023 >=76%= Green >=66% - <76% =Amber <66% =Red
2		Accident & Emergency department (ED) - YDH		78.2%	72.2%	66.4%	69.1%	63.4%	68.2%	65.0%	70.3%	74.1%	77.7%	64.3%	67.2%	
3		Accident & Emergency department (ED) - Combined		60.5%	59.4%	54.3%	61.0%	50.9%	60.5%	58.0%	62.0%	65.6%	65.4%	58.7%	66.5%	
4		Minor Injury Units		96.9%	96.8%	97.0%	97.6%	93.9%	96.3%	96.8%	96.7%	98.1%	97.1%	96.9%	96.9%	
5		Trust-wide		76.3%	74.8%	71.2%	75.4%	68.5%	75.2%	74.0%	76.3%	79.3%	78.7%	75.1%	79.2%	
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	8.8%	4.2%	8.4%	2.9%	10.2%	7.1%	5.3%	2.6%	2.3%	2.1%	1.8%	0.7%	<=2%= Green >2% - <=5% =Amber >5% =Red
7		Accident and Emergency department (ED) - YDH		2.2%	3.3%	5.8%	3.8%	7.4%	7.5%	6.2%	4.4%	3.3%	1.1%	3.4%	3.6%	
8		Minor Injury Units		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
9	Ambulance handovers waiting less than 30 minutes - Emergency Department only (MPH)		4, 6, 9	65.7%	73.4%	56.5%	79.0%	52.1%	71.0%	74.2%	78.0%	81.2%	80.0%	82.1%	87.2%	>=95%= Green >=85% - <95% =Amber <85% =Red
	Ambulance handovers waiting less than 30 minutes - Emergency Department only (YDH)			87.9%	83.1%	72.8%	80.0%	62.9%	76.1%	75.1%	80.6%	82.2%	86.6%	77.9%	81.5%	
10	Cancer - maximum 2-week wait from GP referral (suspected cancer)		3, 4, 9	51.6%	46.3%	51.9%	55.2%	50.4%	57.8%	69.4%	68.6%	65.4%	68.6%	64.5%	Data awaited	>=93%= Green <93% =Red
11	Cancer - 28 days Faster Diagnosis All Cancers			67.5%	57.0%	62.8%	65.0%	66.5%	61.1%	67.1%	68.6%	73.6%	70.6%	72.0%	Data awaited	>=75%= Green <75% =Red
12	Cancer - maximum 31 day wait from diagnosis to first treatment			96.8%	92.9%	93.8%	92.0%	91.3%	87.1%	83.3%	89.0%	89.5%	86.3%	92.1%	Data awaited	>=96%= Green <96% =Red
13	Cancer - maximum 62 day wait from urgent GP referral			69.8%	54.1%	58.4%	54.7%	53.6%	51.1%	51.0%	61.0%	68.6%	57.7%	68.8%	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			17	19	16	21	22	20	29	20	14	23	22	Data awaited	0= Green >0 = Red
15	CAMHS Eating Disorders - Urgent referrals to be seen within 1 week - (rolling 12 months)		3, 4, 9	80.0%	80.0%	80.0%	85.0%	84.2%	88.9%	93.5%	100.0%	100.0%	100.0%	100.0%	100.0%	>=95%= Green >=85% - <95% =Amber <85% =Red
16	CAMHS Eating Disorders - Routine referrals to be seen within 4 weeks - (rolling 12 months)			84.7%	85.4%	90.2%	91.5%	91.1%	91.4%	92.5%	95.4%	96.2%	97.1%	97.1%	97.1%	>=95%= Green >=85% - <95% =Amber <85% =Red

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CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Thresholds
17	Mental health referrals offered first appointments within 6 weeks	All mental health services	4, 6, 9	93.8%	90.4%	90.8%	91.9%	89.0%	91.3%	94.6%	94.4%	88.2%	90.0%	93.6%	93.0%	>=90%= Green >=80% - <90% =Amber <80% =Red
18	Mental health referrals offered first appointments within 6 weeks	Adult mental health services		93.6%	87.4%	89.2%	90.0%	86.3%	90.2%	92.7%	94.0%	89.6%	92.4%	94.5%	95.2%	>=90%= Green >=80% - <90% =Amber <80% =Red
19		Older Persons mental health services		93.0%	90.2%	90.0%	90.8%	89.8%	91.1%	95.2%	94.4%	86.5%	87.2%	92.0%	91.2%	
20		Learning disabilities service		80.0%	100.0%	100.0%	100.0%	88.9%	92.3%	100.0%	92.9%	88.9%	100.0%	100.0%	100.0%	
21		Children and young people's mental health services		100.0%	100.0%	97.3%	100.0%	95.9%	95.1%	96.5%	95.4%	93.6%	95.1%	95.4%	93.2%	
22	Percentage of women accessing specialist community Perinatal MH service - 12 month rolling reporting		4, 6, 9	7.7%	7.5%	7.7%	7.9%	8.1%	8.2%	8.3%	8.4%	8.7%	9.1%	9.3%	9.5%	>=10%= Green >=7.5% - <10% =Amber <7.5% =Red
23	Diagnostic 6-week wait - acute services	MPH	4, 9	78.1%	77.0%	82.4%	84.3%	78.8%	82.9%	86.9%	87.5%	87.3%	87.4%	91.8%	87.9%	From April 2023 >=95%= Green >=90% - <95% =Amber <90% =Red
		YDH		66.5%	74.5%	74.1%	73.8%	69.4%	61.6%	64.7%	66.1%	56.9%	60.7%	60.1%	56.0%	
		Combined		74.3%	76.2%	79.8%	81.2%	75.5%	75.4%	79.1%	79.5%	76.8%	77.2%	79.7%	77.1%	
24	RTT incomplete pathway performance: percentage of people waiting under 18 weeks		4, 6, 9	63.8%	62.6%	62.5%	61.9%	60.0%	60.9%	61.1%	61.1%	60.6%	61.3%	61.7%	61.5%	>=92%= Green <92% =Red
25	40 week RTT breaches			New reporting			5,128	5,495	5,036	5,015	4,975	5,359	5,524	5,409	5,430	TBC
26	52 week RTT breaches			2,714	2,695	2,601	2,405	2,418	2,298	2,216	2,187	2,247	2,340	2,396	2,375	From April 2023 At or below trajectory = Green Above trajectory = Red
27	65 week RTT breaches			New reporting								714	710	712	659	
28	78 week RTT breaches		4, 6, 9	422	393	334	281	315	252	179	68	84	87	61	49	From April 2023 At or below trajectory = Green Above trajectory = Red
29	Referral to Treatment (RTT) incomplete pathway waiting list size			47,214	48,294	49,404	50,412	50,705	51,244	51,542	52,869	53,351	53,856	54,319	55,037	
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	7.0	6.6	6.6	6.9	6.6	7.2	6.8	6.2	6.5	6.2	6.1	5.9	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	

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CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Thresholds
32	Patients not meeting the criteria to reside: % of occupied bed days lost	MPH	4, 9	22.6%	21.7%	22.5%	17.6%	16.0%	19.6%	19.8%	19.1%	21.9%	16.7%	15.1%	17.2%	SPC (Upper Control Limit 25.1%)
33		YDH		26.2%	25.5%	26.7%	27.5%	22.3%	23.0%	25.0%	23.1%	20.4%	21.1%	21.0%	22.0%	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	4,512	4,658	4,881	3,983	4,102	4,056	4,002	4,065	4,023	4,052	4,013	3,918	< 82 patients = Green >=82 - <86 = Amber >86 = Red
35	Community dental services - Child GA waiters waiting 18 weeks or more		4, 6, 9	351	330	333	346	370	356	370	463	499	524	527	538	0 = Green >=0 - =<50 =Amber >50 =Red
36	52 week RTT breaches			New reporting								1,530	1,544	1,319	1,309	TBC
37	65 week RTT breaches											891	919	840	722	
38	78 week RTT breaches											515	566	446	336	
39	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	69.2%	66.7%	75.0%	58.8%	61.9%	60.9%	68.8%	83.3%	88.2%	82.4%	83.3%	Data awaited	>=60%= Green <60% =Red
40	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) RTT : percentage of people waiting under 6 weeks		4, 6, 9	57.3%	64.1%	63.1%	63.6%	63.3%	61.1%	60.9%	67.2%	65.9%	68.2%	70.3%	73.7%	>=75%= Green <75% =Red
41	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) RTT: percentage of people waiting under 18 weeks		4, 6, 9	98.6%	98.0%	97.5%	98.1%	98.7%	98.5%	97.6%	98.9%	98.0%	98.5%	99.1%	99.0%	>=95%= Green <95% =Red
42	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) Recovery Rates		4, 7, 9	59.9%	64.5%	56.5%	61.0%	58.4%	62.1%	59.2%	64.3%	60.6%	60.0%	57.8%	59.7%	>=50%= Green <50% =Red
43	Adult mental health inpatients receiving a follow up within 72 hrs of discharge		4, 9	100.0%	96.6%	100.0%	97.4%	100.0%	93.9%	90.3%	100.0%	97.8%	100.0%	97.3%	100.0%	>=80%= Green <80% =Red
44	Inappropriate Out of Area Placements for non-specialist mental health inpatient care (monthly number of patient days)		4, 5, 9	25	10	60	125	57	27	0	34	78	67	57	14	0= Green >0 = Red
45	Intermediate Care - Patients aged 65+ discharged home from acute hospital beds on pathway 0 or 1		4, 5, 9	92.4%	94.2%	94.1%	92.9%	93.2%	92.8%	92.0%	92.6%	93.3%	93.2%	94.9%	Data awaited	>=95%= Green >=85% - <95% =Amber <85% =Red
46	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%	94.0%	Data awaited	Data awaited	>=70%= Green >=60% - <70% =Amber <60% =Red
47	% Stroke Patients direct admission to stroke ward in 4 hours	MPH	4, 6, 9	61.0%	44.7%	50.0%	51.1%	48.5%	41.1%	32.6%	54.4%	46.7%	50.0%	50.0%	Data awaited	>=90%= Green >=75% - <90% =Amber <75% =Red
48		YDH		21.7%	28.6%	28.6%	15.6%	20.6%	34.3%	15.2%	32.1%	26.9%	40.0%	32.4%	Data awaited	

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CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Thresholds
49	Patients spending >90% of time in stroke unit - acute services	MPH	4, 6, 9	85.4%	63.2%	63.6%	71.4%	60.6%	61.4%	59.6%	80.3%	68.1%	65.9%	64.4%	Data awaited	>=80%= Green >=70% - <80% =Amber <70% =Red
50		YDH		41.0%	57.0%	53.0%	46.0%	53.0%	62.9%	69.7%	57.1%	57.7%	60.0%	59.5%	Data awaited	
53	Percentage of patients with a National Early Warning Score (NEWS) of 5 or more acted upon appropriately - The registered nurse should immediately inform the medical team caring for the patient	MPH, community hospitals and mental health wards	4, 9	Reporting criteria reviewed and updated. Bi-monthly reporting will recommence from April 2023 and will cover February/March 2024						67.2%		66.7%		Bi-monthly reporting Information being validated		>=90%= Green >=80% - <90% =Amber <80% =Red
51	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. Testing is being undertaken of a reporting solution using electronic forms, completed by the Trust's Digital Team. Users of systems have been identified and training is to commence during the second week of September 2023. Training is estimated to last four to six weeks.											>=90%= Green >=49% - <90% =Amber <49% =Red
52	Percentage of emergency patients screened for sepsis - acute services	MPH		75.0%												
54	Percentage of complaints responded to within 40 working days - Trust-wide	Former SFT	9	48.0%	45.5%	57.7%	55.0%	46.7%	39.4%	37.5%	56.7%	51.5%	48.4%	51.5%	Review of reporting indicator being undertaken	>=90%= Green >=75% - <90% =Amber >75% =Red
55		YDH		100.0%	100.0%	100.0%	100.0%	80.0%	67.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
56		Combined		New reporting								56.8%	52.9%	56.0%		
57	Mandatory training: percentage completed	Former SFT	1, 8, 9	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
58		YDH		87.0%	86.8%	87.7%	86.8%	85.9%	85.6%	84.6%	84.5%					
59		Combined		New reporting								90.6%	91.3%	91.6%	92.0%	
60	Proportion of days lost due to sickness		1,8,9	5.0%	4.9%	5.8%	5.5%	6.3%	5.4%	5.0%	4.8%	4.2%	4.2%	4.2%	4.7%	SPC
61	Sickness absence levels - rolling 12 month average (Trust-wide)		8, 9	6.0%	6.0%	5.9%	5.9%	5.9%	5.8%	5.8%	5.6%	5.2%	5.1%	5.1%	4.9%	SPC
62	Career conversations (12 months) - formerly 'Performance review (12-month)'		1,8,9	New reporting								62.1%	62.7%	66.4%	65.0%	>=90%= Green >=80% - <90% =Amber <80% =Red
63	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)		8, 9									7.4%	7.7%	7.9%	7.8%	<=5%= Green >5% to <=7.5% =Amber >7.5% =Red
64	Retention rate – percentage of colleagues in post with more than 12 months' service		8, 9									76.0%	74.4%	85.9%	71.9%	>=88.3%= Green >=80% to <88.3% =Amber <80% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Thresholds
65	Percentage of colleagues in a senior role (band 8a and above and consultant roles):	Who are of an ethnic minority	1,8,9	New reporting								19.8%	19.8%	19.8%	19.5%	>=17%= Green >=14% to <17% =Amber <14% =Red
66		Who are female	1,8,9									58.5%	58.6%	58.8%	58.7%	>=79%= Green >=70% to <79% =Amber <70% =Red
67		With a recorded disability	1,8,9									2.9%	2.9%	3.0%	3.0%	>=4%= Green >=2% to <4% =Amber <2% =Red
68	Number of formal HR case works (disciplinary, grievance and capability).		1,8,9	New reporting								166	Data awaited	Data awaited	Data awaited	TBC

Appendix 5a – Specialty and tumour-site level performance

Table 1 – Performance against the RTT performance standard in July 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	898	56	2446	63.3%
Urology	1270	154	2849	55.4%
Trauma & Orthopaedics	2887	533	7545	61.7%
Ear, Nose & Throat (ENT)	2358	151	4984	52.7%
Ophthalmology	2468	328	5602	55.9%
Oral Surgery	1064	125	2494	57.3%
Plastic Surgery	107	23	242	55.8%
Cardiothoracic Surgery	12		14	14.3%
General Medicine	8	1	27	70.4%
Gastroenterology	1138	41	2545	55.3%
Cardiology	811	5	3792	78.6%
Dermatology	217	4	1624	86.6%
Thoracic Medicine	514	3	1761	70.8%
Neurology	472	7	1449	67.4%
Rheumatology	395	12	1173	66.3%
Care of the Elderly	133	1	602	77.9%
Gynaecology	1468	130	4132	64.5%
Other – Medical Services	1372	276	2714	49.4%
Other - Paediatric Services	586	20	1779	67.1%
Other - Surgical Services	2757	499	6378	56.8%
Other – Other Services	258	6	885	70.8%
Total	**21193**	**2375**	**55037**	**61.5%**

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

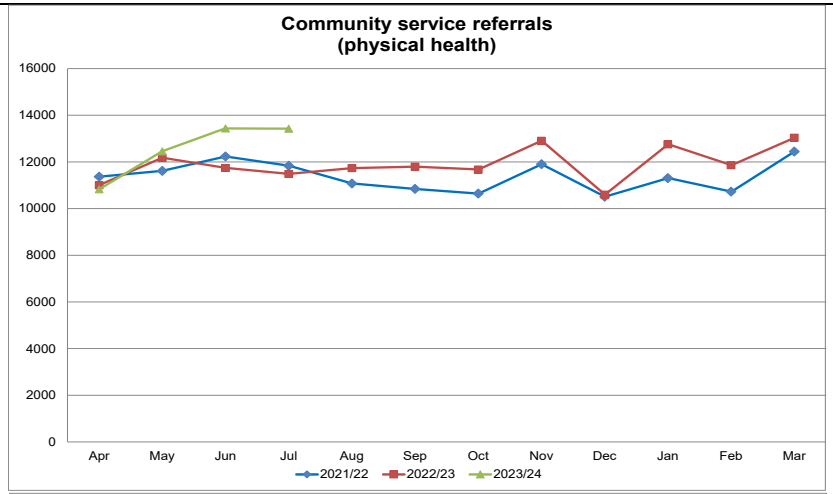
Tumour site	No of breaches	Trust performance
Breast	6.0	80.0%
Colorectal	5.5	64.5%
Gynaecology	8.0	46.7%
Haematology	2.0	71.4%
Head & Neck	5.0	58.3%
Lung	6.5	43.5%
Other	1.0	66.7%
Sarcoma	1.0	0.0%
Skin	4.0	89.5%
Upper GI	1.0	88.9%
Urology	17.0	58.0%
Total	**57.0**	**68.8%**

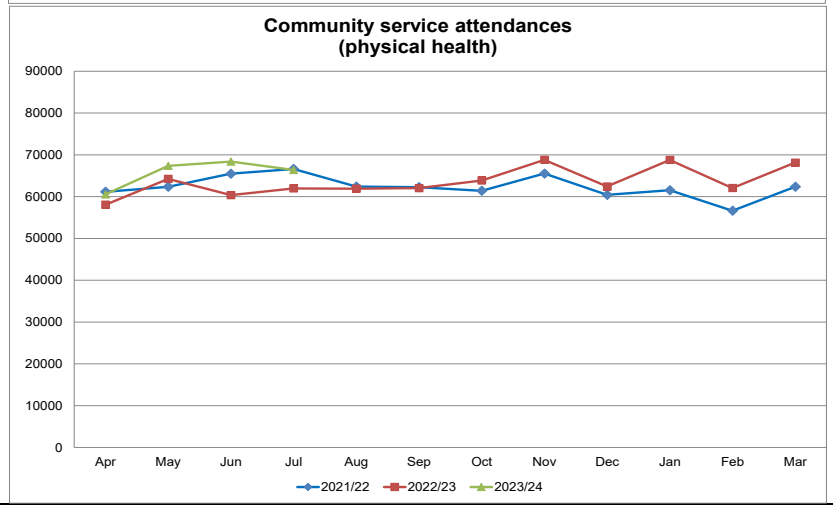
Twenty-two patients were treated in June 2023 on or after day 104 (the national 'backstop'). One patient pathway was incorrectly reported by another provider and should not have been reported. Of the remaining twenty-one, 16 were assessed as having unavoidable delays, with five pathways having been impacted largely by internal capacity problems. A breakdown of the unavoidable breaches is as follows:

- Seven patients had a complex pathway, including patients requiring additional diagnostics, requesting second opinion, transferring from a different cancer pathway and the treatment plan changing.
- Four patients chose to delay their diagnostic tests or treatment for a significant period of time.
- Four patient pathways had some internal delays, which in some cases resulted in a late transfer to the treating provider. But the pathways were unavoidably delayed thereafter, as a result of wait times being longer than ideal for investigations and appointments at other providers.
- One patient transferred to the Trust late for diagnostics and treatment, due to medical complexity (i.e., the patient had a stroke, delaying their first appointment).

Operational context

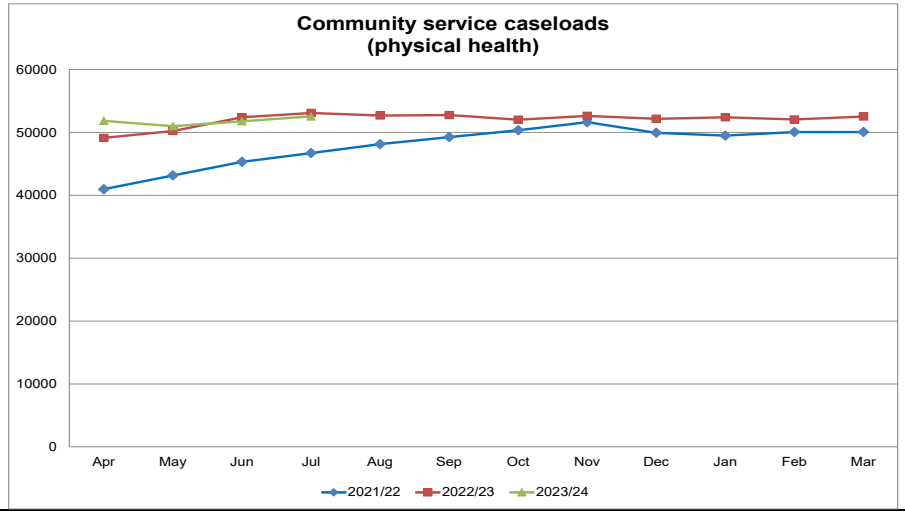
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





Summary:

- Direct referrals to our community physical health services between 1 April and 31 July 2023 were 8.1% higher than the same months of 2022 and 6.6% higher than in the same months of 2021.
- Attendances for the same period were 7.4% higher than the same months of 2022 and 2.8% higher than the same months of 2021.
- Community service caseload levels as at 31 July 2023 were 1.1% lower than as at 31 July 2022, but 12.5% above 31 July 2021 levels.



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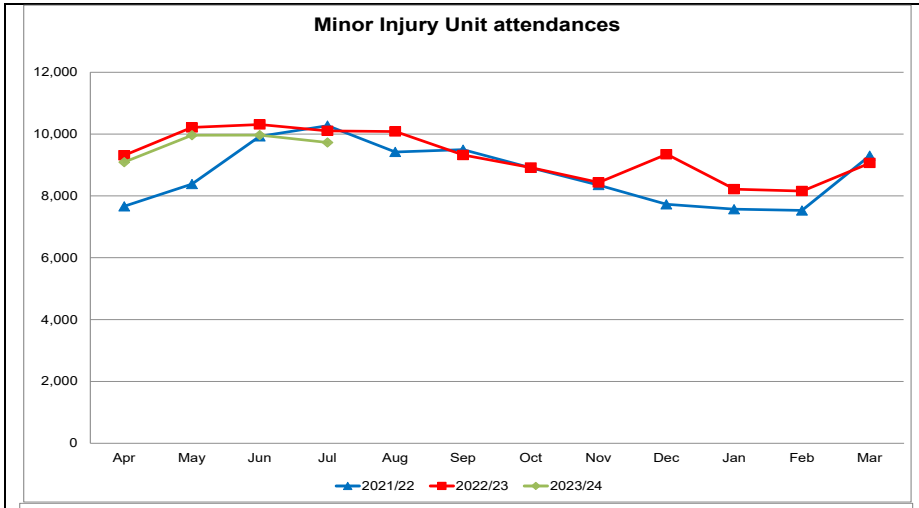
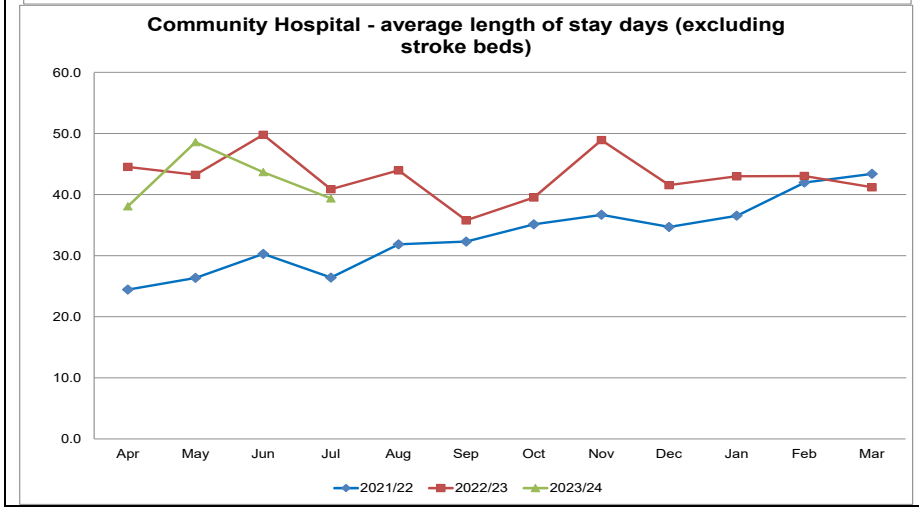
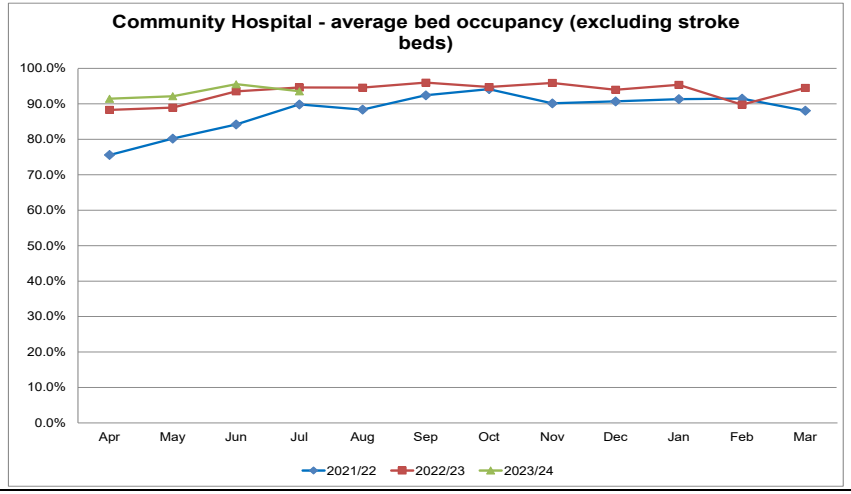




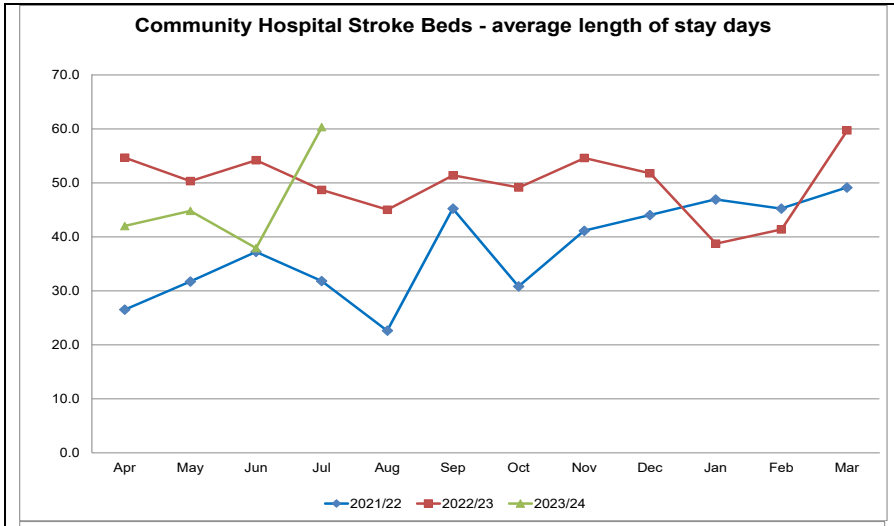
Summary:

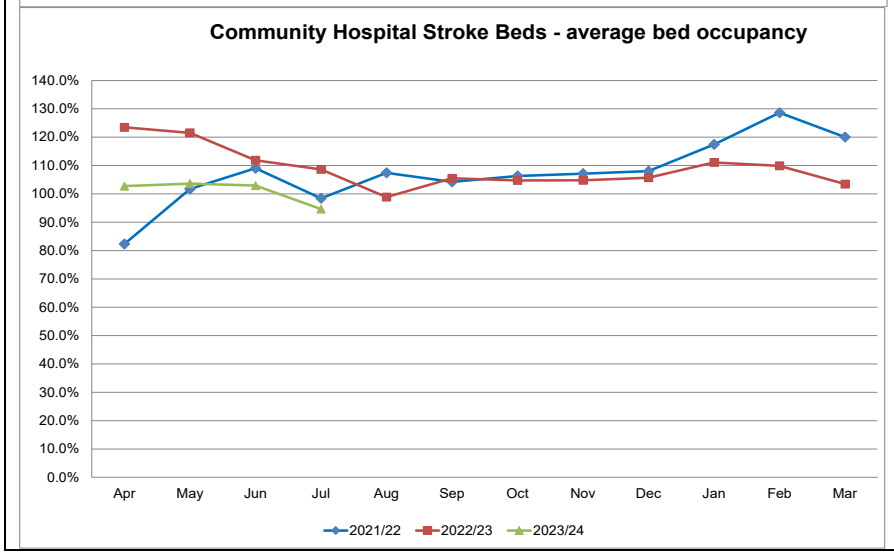
- Between 1 April and 31 July 2023, the number of Minor Injury Unit attendances was 3.0% lower than the same months of 2022/23, but 6.9% higher than same months of 2021/22. During July 2023, 96.9% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 76%, to be achieved by March 2024.
- The average length of stay for non-stroke patients in our community hospitals in July 2023 was 39.4 days, a decrease compared to June 2023. Six patients were discharged with lengths of stay longer than 100 days; the longest was 200 days for a patient at West Mendip community hospital.
- The community hospital bed occupancy rate for non-stroke patients in July 2023 slightly decreased to 96.5%, from 96.9% in June 2023.



Operational context

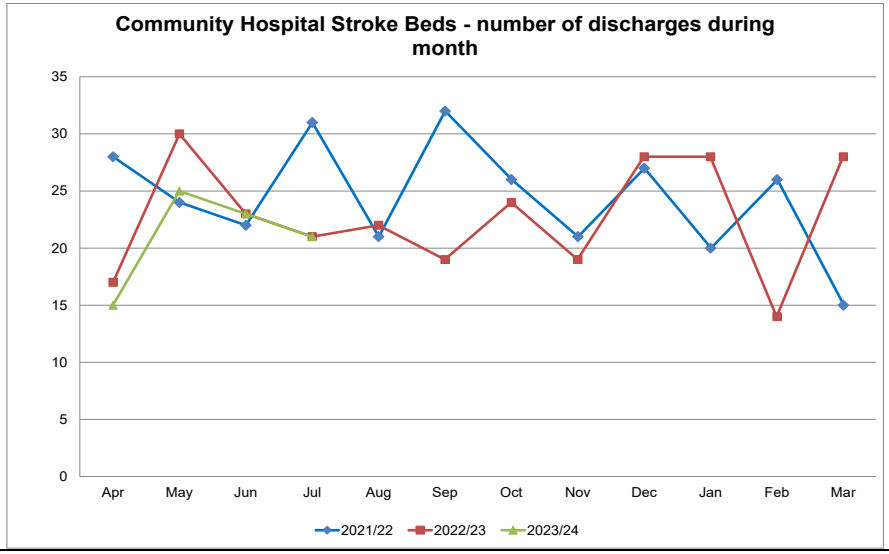
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





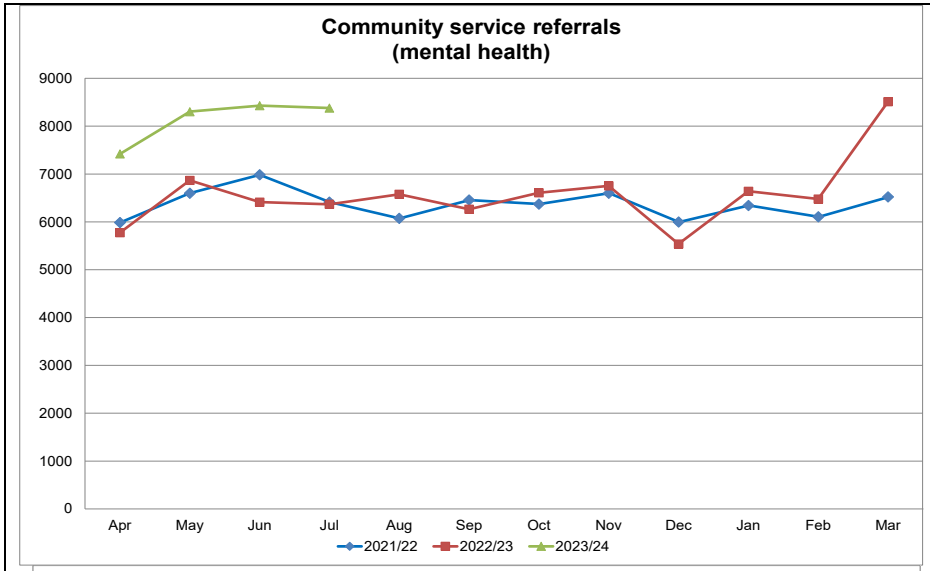
Summary:

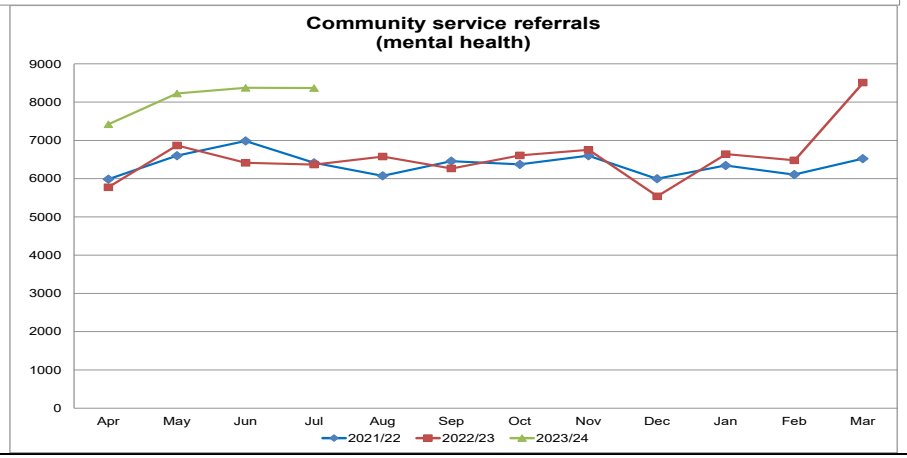
- The average length of stay for stroke patients in our community hospitals in July 2023 significantly increased to 60.3 days, from 37.9 days in June 2023, affected by three patients discharged in July 2023 with lengths of stay of longer than 100 days. One patient discharged from South Petherton community hospital had a length of stay of 158 days.
- Stroke bed occupancy in July 2023 decreased compared to June 2023.
- During July 2023 there were 21 discharges of stroke patients, down from 23 discharged during June 2023. The monthly average number of stroke patients discharged from our community hospitals in 2022/23 was 23.



Operational context

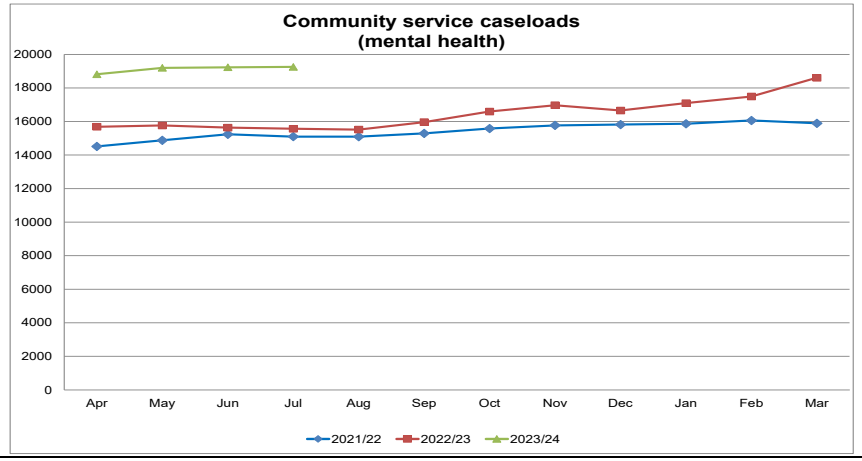
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





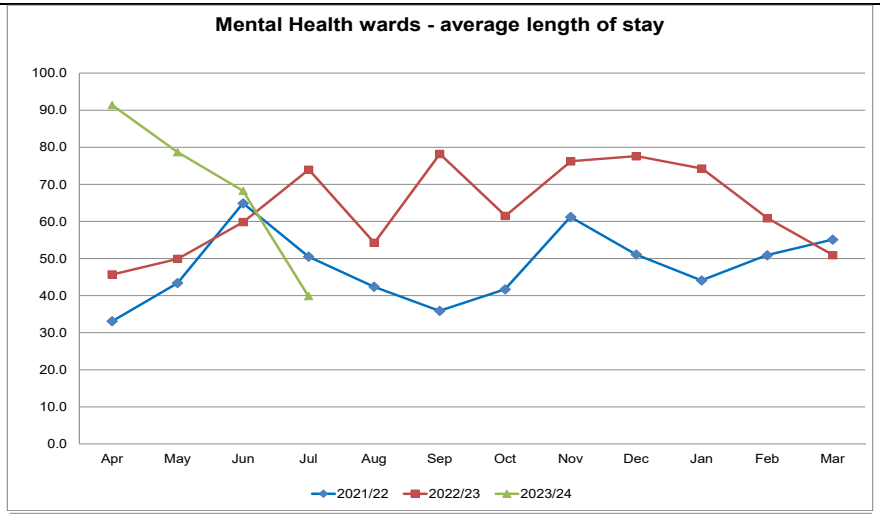
Summary:

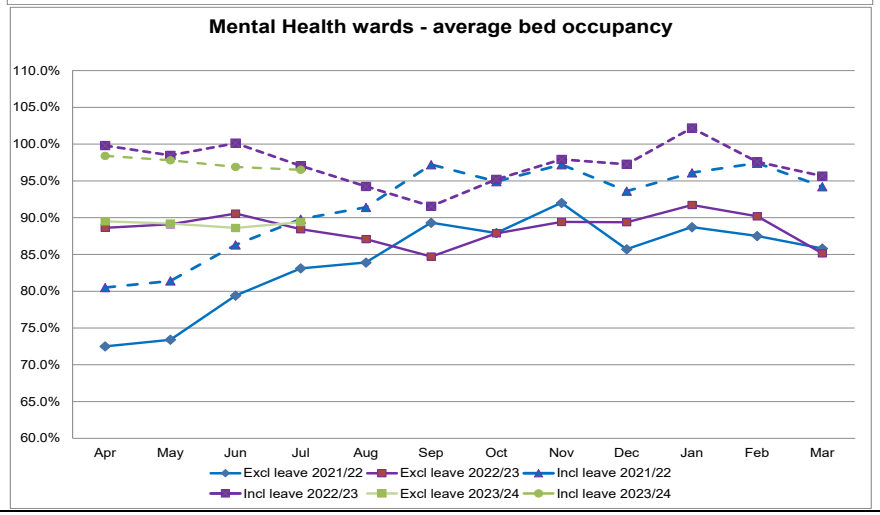
- Referrals to our community mental health services between 1 April and 31 July 2023 were 27.4% higher than the same months of 2022/23 and 24.6% higher than the same months of 2021/22.
- Attendances for the same reporting period were 19.7% higher than the same months of 2022/23 and 14.0% higher than the months of 2021/22. Services which have seen significant increases in recorded activity include Primary Care Mental Health Services (Open Mental Health), Home Treatment, and Older People's Community Mental Health services.
- Community mental health service caseloads as at 31 July 2023 increased by 23.7% when compared to 31 July 2022 and were 27.5% higher than as at 31 July 2021. It should be noted that investment facilitated the expansion of some community mental health services.



Assurance and Leading Indicators

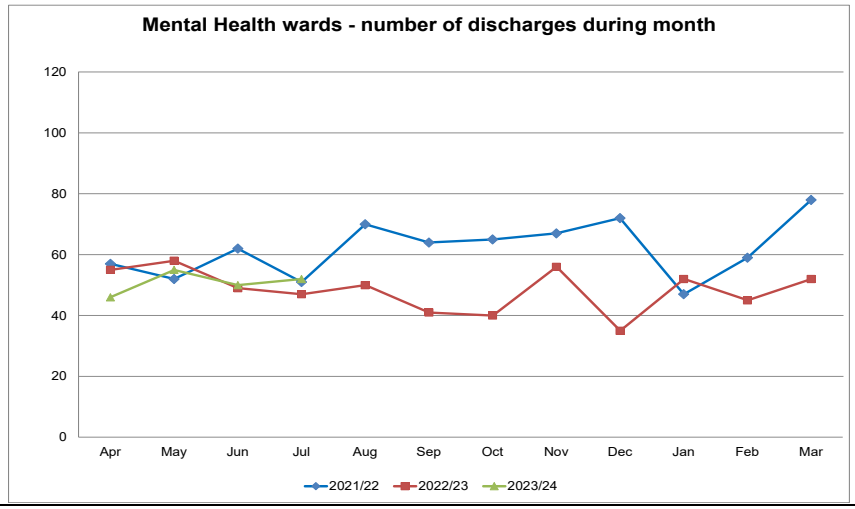
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





Summary:

- The average length of stay in our mental health wards in July 2023 significantly decreased for the third consecutive month. The monthly average lengths of stay have been significantly affected by the discharge of individual patients with very long lengths of stay. Four patients discharged in July 2023 had lengths of stay of 100 days or more, including one patient with a length of stay of 146 days.
- The mental health bed occupancy rate in July 2023, based on excluding leave increased but decreased in respect of including leave when compared to June 2023.
- A total of 52 patients were discharged in July 2023, up from 50 in June 2023.



Appendix 6 – Infection Control and Prevention – July 2023

MRSA bloodstream infections	Commentary on MRSA / MSSA BSIs
Musgrove Park Hospital = 0 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0	The Infection Control team continue to be a part of the Southwest Infection Control Network's regional MSSA bloodstream infection improvement group. There are a wide variety of factors influencing these infections, initially the group will concentrate on vascular devices and soft tissue infections. As a trust our focus for improvement is to reduce the number of MRSA / MSSA bloodstream infections linked to peripheral vascular cannulae. These devices are frequently used and essential to patient care however, they can result in infections. When they are sited in the ante-cubital fossa (elbow) it increases the risk of infection. There are clinical occasions when use of this site is essential, but for most patients it is more appropriate to site them on the hand or forearm where there is a lower risk of infection. Targeted work is in progress to minimise the use of the ante-cubital fossa when not essential.
MSSA Bloodstream Infections	
Musgrove Park Hospital = 4 Yeovil District Hospital = 2 Community Hospitals / Mental Health = 0	
E. coli bloodstream infections	**Commentary on Gram-negative bloodstream infections**
Musgrove Park Hospital = 4 Yeovil District Hospital = 4 Community Hospitals / Mental Health = 0	Whilst the main burden of disease from gram-negative BSIs remains in primary care, trust apportioned case numbers of E. coli are significantly over trajectory for the year to date. Equal numbers of E. coli BSIs have been identified on both acute sites. Closer review of cases shows that men are more affected than women with the most common source being urine. Of these, they have either had recent or recurrent urinary tract infections or have an obstruction in the urinary tract such as renal stones or enlarged prostates. Further work is required on these two groups to see if any preventative measures could be implemented to reduce the risk of these factors leading to a BSI. The Trustwide (all sites) catheter care improvement group continues.
Klebsiella bloodstream infections	
Musgrove Park Hospital = 4 Yeovil District Hospital = 3 Community Hospitals / Mental Health = 0	
Pseudomonas bloodstream infections	
Musgrove Park Hospital = 1 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0	

C. difficile	Commentary on C. difficile
Musgrove Park Hospital = 2 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0	Whilst case numbers have reduced during July, the trust remains significantly over trajectory. Equal numbers of C diff have been identified on both acute sites. The case rate for the Yeovil site has significantly increased this year whereas the Musgrove site remains stable. The majority are antibiotic driven however the number of relapses (further C diff infection in the same patient) has increased across both sites. These are being further investigated to understand why each relapse has occurred.
Respiratory Viral Infections - inpatients	**Commentary on Respiratory Viral Infections**
COVID Musgrove Park Hospital = 49 Yeovil District Hospital = 59 Community Hospitals / Mental Health = 21 **Influenza** Yeovil District Hospital = 2 Community Hospitals = 1 **Respiratory syncytial virus (RSV)** Nil	**COVID** COVID cases slightly increased during July. The Emergency department on the MPH site has noted an increase in attendances with COVID infection. This is a likely indicator that there is an increase across our local population and explains our recent rise in inpatient cases. A new variant is being monitored - EG.5.1, a descendent of Omicron which was classified as a new variant in the UK on 31st July. This could account for our rise in cases during July. Despite this, the severity of the disease remains low. **Influenza & RSV** Levels of influenza and RSV remain low, as a nation the season is over for these viral infections.
Outbreaks	**Commentary on outbreaks**
COVID = 10 Musgrove Park Hospital = 1 Yeovil District Hospital = 6 Community Hospitals = 3 **Norovirus = 2** All Musgrove Park Hospital Site	**COVID** Outbreaks due to COVID remain stable but constant. **Norovirus** Whilst norovirus outbreaks continue to occur, the number has decreased in July. It is expected that outbreaks will occur throughout the summer months this year as the normal season pattern of this virus has changed following the COVID pandemic.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Elective Recovery Outpatient Checklist
SPONSORING EXEC:	Andy Heron, Chief Operating Officer
REPORT BY:	Xanthe Whittaker, Director of Elective Care
PRESENTED BY:	Xanthe Whittaker, Director of Elective Care
DATE:	5 September 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	In the context of furthering elective recovery, trusts are required to sign-off a checklist of outpatient transformation. This briefing sets-out the Trust's position against the assurance statements in the checklist and the next steps where the requirement is not currently being met.
Recommendation	It is recommended that the Board approves this declaration of assurance.

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

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

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

Equality and Inclusion

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

How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
There are no planned changes to services, or service delivery, that are expected to impact on people with protected characteristics, which have not already been previously assessed.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

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

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

ELECTIVE RECOVERY OUTPATIENT CHECKLIST

1. BACKGROUND AND PURPOSE

1.1. On 7 of August 2023, NHS trusts received a letter (PRN00673; attached Appendix 1) from the NHS England team, setting-out the required next steps for the transformation of outpatient services, needed to support elective recovery. This letter, whilst acknowledging the progress made over the last year, set-out a checklist of expectations as to what trusts should be doing to transform how outpatient care is delivered. A checklist for trust boards, in the form of four key areas of focus, was included in Annex A of the letter.

1.2. The table shown in Appendix 2 of this briefing, provides 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.

2. RECOMMENDATION

2.1. The Board is asked to approve the Trust's submission to NHS England against the items in the checklist and to note the actions being taken to improve compliance where appropriate.

Appendix 1: Protecting elective capacity letter.

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

cc.
- NHS England regional directors

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

4 August 2023

Dear Colleagues,

Protecting and expanding elective capacity

In May, we wrote to you outlining the priorities for elective and cancer recovery for the year ahead. Last week, as part of the winter letter, we also asked you to maintain as far as possible ring-fenced elective and cancer capacity through winter.

We would like to thank you for your continued hard work in these areas, in the face of significant wider operational challenges, including ongoing industrial action. Thanks to the efforts put in by staff across the NHS, we have now virtually eliminated pathways waiting over 78 weeks, down by 94% since the peak of 124,000 in September 2021 (and now representing c0.1% of the total list), and significantly decreased the number of patients with urgent suspected cancer waiting longer than 62 days from a high of 34,000 to around 21,000 today.

However, one area where we know there remains more to do is outpatients. We have listened to your feedback on the support you need for this transformation and have set out the next steps below.

National support for outpatient transformation

To support outpatient transformation, we have met with royal colleges, specialist societies and patient representatives to agree a way forward, working in partnership, to champion and enable outpatient recovery and transformation. At the 'call to arms', colleges agreed to:

- review their guidance on outpatient follow-ups
- support new approaches to increasing wider outpatient productivity, including reducing variation in clinical templates, patient discharge, and following clinically-informed access policies.

Together with this clinical leadership, we need to build on the expectation of freeing up capacity and increasing productivity. This can be achieved through reducing follow up appointments with no procedure, fully validating RTT waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups, reviewing clinical pathways and workforce models.

We are continuing to provide support to trusts in this area, through the following:

- Regional support
- NHS England's GIRFT outpatient guidance
- Action on Outpatients series
- The Model Health System
- Support to specific trusts via NHS England's GIRFT Further Faster programme, NHSE Tiering programme and Elective Care Improvement Support Team (IST) – learning from the Further Faster programme will be shared in the Autumn
- Access to additional capacity through the NHS Emeritus Consultant programme
- Luna weekly data quality report, which can be accessed by contacting lunadq@mbihealthcaretechnologies.com and Foundry data dashboards
- RTT rules suite
- Elective Care IST Recovery Hub - FutureNHS Collaboration Platform
- Guidance on shared decision making.

Next steps on outpatient transformation

With the majority (c80%) of patient waits ending with an outpatient appointments, we need to increase the pace in transforming outpatient services to release capacity for patients awaiting their first contact and diagnosis. This will be particularly important ahead of and during winter, when pressure on inpatient beds can be at its highest. Nationally, achieving a 25% reduction in follow up attendances without procedures would provide the equivalent to approximately 1m outpatient appointments per month.

This letter therefore sets out further detail on three key actions that we are asking you to take:

- Revisit your plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.

- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

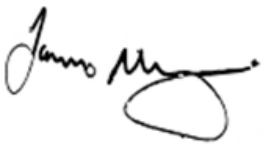
We are now asking trusts to provide assurance against a set of activities that will drive outpatient recovery at pace. This process will require a review of current annual plans, detailing the progress that can be made on outpatients transformation. As part of the above priorities, we are asking each provider to ensure that this work is discussed and challenged appropriately at board, undertake a board self-certification process and have it signed off by trust chairs and chief executives by **30 September 2023**.

The details of this self-certification can be found at Appendix A. Please share this letter with your board, key clinical and operational teams, and relevant committees.

If you are unable to complete the self-certification process then please discuss next steps with your regional team.

Thank you again for colleagues' efforts in this area, which are making a real difference to the timeliness of care we deliver to patients. We look forward to receiving your returns and, as always, if you need to discuss this in more detail, or support in conducting this exercise, please contact england.electiverecoverypmo@nhs.net.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
Chair, Getting It Right First Time (GIRFT) Programme
NHS England

Appendix A: self-certification

About this self-certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by **30 September 2023**, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

Trust return: [insert trust name here]

The chair and CEO are asked to confirm that the board:

Assurance area	Assured?
1. Validation The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation. b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation. c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	

d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	
2. First appointments The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023. b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	
3. Outpatient follow-ups The board: a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan. b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty. c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments. d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking	

data (via the Model Health System and data packs) to identify further areas for opportunity. e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	

Sign off

Trust lead (name, job title and email address):	
Signed off by chair and chief executive (names, job titles and date signed off):	

Appendix 2 Assurance Checklist

Assurance statement	Current position	Additional information, including next steps
1. Validation		
The Trust Board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.	Please see Appendix 3 Table 1, which shows the progress with validating cohorts of patients on the RTT waiting list. The type of validation now undertaken requires three elements: technical validation, administrative validation, and clinical reviews. All three types of validation were not formally in place and measured pre-COVID, and for this reason a comparison of 19/20 validation levels has not been provided. The size of the combined Musgrove and Yeovil RTT validation teams, who carry-out administrative validation, have increased relative to pre-COVID. So, it is reasonable to assume we are carrying out more technical and administrative validation than previously. Nationally and locally available data quality information continues to be used to inform where validation efforts are targeted, including duplicate pathways and missing data fields. Validation priorities have recently been reviewed and updated, to ensure we are maximising opportunities for improving data quality.	From October an updated table showing validation rates and associated relevant data quality measures, will be included with the RTT reports the Board receives on a monthly basis.

b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation.	The Trust has developed a plan for achieving the requirement that at least 90% of patients waiting over 12 weeks are contacted and validated. Please see Appendix 3 Table 2, for an over-view of the plan. It should be noted that the Trust previously took a decision to not contact patients in the 12 to 26 weeks wait category, because it was relatively soon after referral to contact patients to check they still wished to be seen, given current waits are circa 78 weeks from referral to treatment in some specialties. It is felt that how quickly and how often we ask patients whether they still wish to be seen, is a difficult balance to strike. However, the Trust is planning to meet the national guidance set-out in this letter.	The validation plan Is contingent upon the roll-out of the existing digital solution for contacting patients, both within the Taunton site, and to also set this up in Yeovil. Digital team support is required for this, which has been agreed.
c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the	NHSE recently published a re-statement of the RTT rules -set. We have reviewed this publication and the Trust's application of the RTT rules are consistent with what is set-out in this document. The application of RTT rules has been the subject of recent annual data quality audits. No significant issues have been identified. These audits have been reviewed by the Audit Committee. A report was recently shared with the Trust	The Musgrove access policy has been recently reviewed and is in line with the national RTT ruleset. The Yeovil access policy will also be reviewed in the next six months, with the aim of bringing the two policies together into a unified policy which has been re-confirmed as compliant with the national policy. As part of unifying the management of the RTT validation teams, the aim will be to: 1) even-out the RTT validation efforts across sites, 2) establish the same digital approach to contacting patients,

Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	relating to multiple RTT pathways for individual patients. This report has been reviewed and themes identified which include the potential for duplicate pathways due to the two former trusts having separate Patient Administration Systems (PAS) which mean some pathways shared across sites are present on each system when the care of the patient is being shared. The Trust has a dedicated team working on specific aspects of data quality that support the timely management of RTT pathways, such as missing outcomes for outpatient appointments. The Trust currently has two legacy access policies, which are under review, but are felt to be compliant with the national model access policy. The two former trust RTT validation teams have now come together under a single management structure. The two site teams sit within the Operational Management team (Director of Elective Care's team within the Chief Operating Officer's Department).	on the Yeovil site and 3) to contact, on a rolling basis, all patients exceeding a 12-week wait. A data-quality report to flag duplicate pathways has been established for each trust site. Duplicate pathways will be individually validated by the RTT validator teams. The Trust is part way through developing a single RTT Patient Tracking List (PTL), which will further help to identify duplicate pathways and other data quality issues.
d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	Non RTT cohorts include patients having post treatment follow-ups, patients on planned waiting lists (i.e., patients needing procedures/treatments at clinical specified intervals) and patients seen in community	Overdue follow-ups continue to be managed according to the scale of clinical risk. This risk is managed alongside the risk of not seeing / treating overdue patients on ongoing RTT pathways. The scale of overdue follow-ups is one reason why the

	services, not currently reported as part of the consultant-led RTT national submission. As of the end of July there were just under 18,500 patients overdue a planned follow-up appointment. This is circa three times the levels of overdue un-booked follow-ups relative to the pre-COVID period. There are also circa 700 patients overdue their planned procedure that don't have a date for surgery. Since September 2022, overdue follow-ups and overdue planned procedures numbers have been reported via the Quality & Outcomes, Finance & Performance (QOFP) Service Group monthly reviews. This provides assurance that actions are being taken and any associated clinical risk is being managed as appropriate. Where there is a potential clinical risk, Service Groups have logged overdue patient backlogs on their risk register. NHSE is in the process of reviewing differing approaches trusts across the country take to reporting patients on community pathways, with a view to agreeing a consistent approach. The Trust will ensure it is compliant with the agreed new approach to reporting, when this is published.	Trust has not reduced overall follow-up activity in line with the 25% national requirement. The national reporting requirement for overdue planned procedures has been clarified to all trusts in a recent publication. Overdue planned patients should be included in the RTT dataset. Further validation of overdue planned patients is currently being completed, following which the overdue planned patients will be included in reporting and the RTT waiting list. This will help to ensure the right balance is achieved in the relative prioritisation of overdue planned and longer waiting patients, due to come in for their treatment.

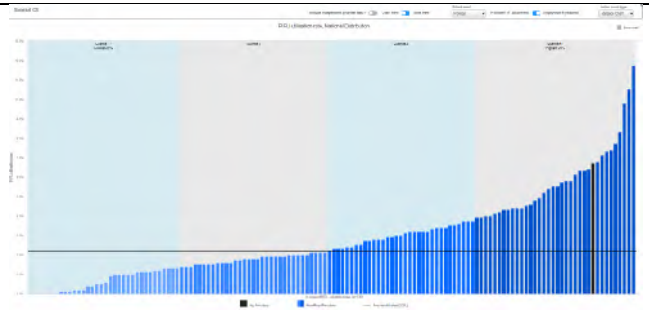
2. First appointments		
The Trust Board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.	The Quality & Governance Committee on 24th May received a briefing on the Trust's overarching 65-week wait plans and approach. We continue to closely monitor at a specialty and pathway level the aim for all patients in the March 24 cohort of future 65-week waiters to have had a first outpatient appointment by the end of October 23. At a specialty-level we are currently on track to deliver this aim (barring individual patient exceptions outside of our control, such as patient choice to wait), other than in Endocrinology, Orthodontics, Trauma & Orthopaedics and ENT.	Plans continue to be developed for the following specialties: • Endocrinology (weight management) – first outpatient appointments stop the RTT clock in the vast majority of pathways, hence to meet the March 24 maximum 65-week wait, we need to ensure patients have a first outpatient appointment by March as the latest, rather than end of October; an additional locum dietician has been found; additional tier 2 weight management capacity has been sourced from an external provider, which should be appropriate for a proportion of patients on the waiting list. In combination this additional capacity should be enough to clear the 65-week cohort. • Orthodontics – capacity continues to be sought to ensure all patients can start their treatment by the end of March 24 (rather than seeing all patients for the first time by the end of October), which will likely include outsourcing to a previously used external provider or using a locum. The scale of capacity required is significant, and this was a known high risk specialty in terms of breaches of the 65 weeks at the end of the year, as declared in our plan.

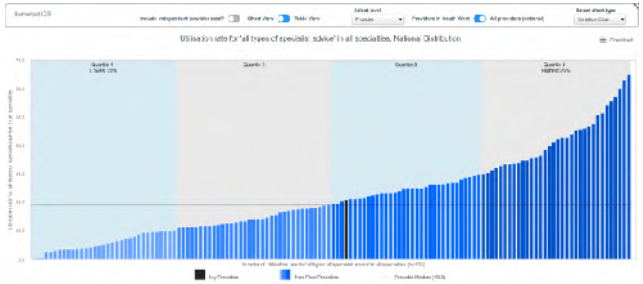
		• Trauma & Orthopaedics – there are circa 400 patients needing to be seen by the end of October who currently do not have appointments; these patients have where appropriate already been offered a referral to the Independent Sector (IS) via their pathway through OASIS (Musculo Skeletal interface service); a further review is being undertaken to identify any patients who might be suitable for the IS, and additional in-house clinics will be established as far as possible. We have already sought capacity for T&O non-admitted pathways via the national Digital Mutual Aid System (DMAS) but has so far received no viable offers. The scale of required recovery remains significant for the specialty. • ENT – insourcing clinics are being established, but the scale of the numbers of patients needing to be seen means there are risks of this amount of activity not being able to be delivered in the required timescales. We have already sought capacity for ENT non-admitted pathways via DMAS but has so far received no viable offers. The scale of required recovery remains significant for the specialty.
b. has signed off the trust's plan to ensure that Independent Sector capacity is being used	The use of the Independent Sector (IS), in the form of both insourcing and outsourcing, continues to be an important component of the	The Trust is now contacting patients using Patient Hub, to ask them, as part of a validation process, whether they still wish to be seen and also

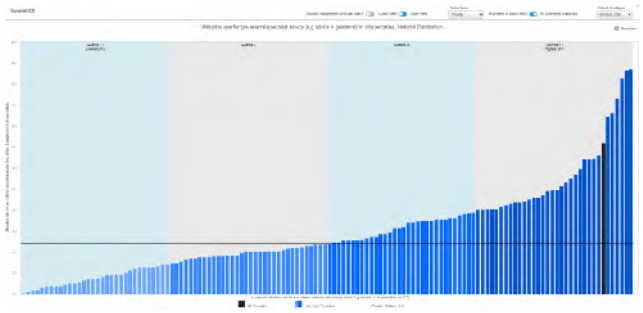
	where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	capacity being utilised to deliver care and reduce long waiters. The priority is to make use of available Independent Sector outsourcing capacity to enable long waiters to be treated as quickly as possible. Local IS treatment centres receive direct referrals from GPs. Patients currently being referred and treated in the IS are less complex and have fewer morbidities than the majority of patients on SFT's waiting list. Waiting times to treatment are in many cases under 18 weeks, which means the IS is largely now treating patients not in the March 24 65-week wait cohort. Our plan remains to try to transfer as many appropriate patients as possible, who want to transfer, across to the IS, to enable them to be treated more quickly. The Trust is making use of the DMAS mutual aid system, to identify available NHS and IS capacity outside of the local area. So far, we have requested aid for 5 specialties, including those where we have known capacity challenges for first providing first outpatient appointments. This has included a request for virtual appointment support, to maximise the transfer opportunities for providers further afield. We have also offered support to another provider, to try to treat some of their complex patients more quickly.	whether they would like to consider being referred to another provider who can potentially see them more quickly. So far 27% of patients contacted have confirmed they are willing to consider transfer. The ICB will be contacting these patients to identify possible transfer options, which may include both other trusts and the IS. We are also re-exploring options for treatment at local IS providers, where for instance the range of services/procedures they offer has now changed, or where patients are now choosing to be treated elsewhere, where they have previously chosen to only have treatment at Musgrove or Yeovil. Where options are not immediately available, we will again use the DMAS system to ask for aid.

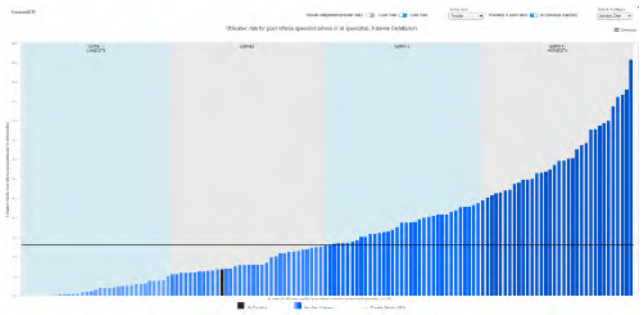
3. Outpatient follow ups		
a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan.	The required 25% reduction in follow-up activity is not currently being delivered and remains a challenge in 23/24. SFT is currently delivering circa 112% 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 RTT waiters by March 24 unless treated before, many 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 has recently received an update on, actions continue to be taken to deliver a reduction in future 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). • Clinical and/or patient validation of future follow-ups. • Interventions and check-ins with patients, 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 will be established to provide 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. The Senior Leadership Forum (SLF) in September will be discussing Outpatient Transformation, focusing in particular to generate new ideas on how to change the way we deliver the right level of follow-up care in a sustainable way, as part of business as usual processes. SLF includes all senior managers and clinical leads across the Trust. This will be present a good opportunity to revisit the Trust's approach to how it balances the need to see new patients versus providing follow-up care, from which we will re-launch our transformation of outpatient care.
b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your	The Trust and Somerset system is consistently delivering in excess of the 5% national standard in aggregate (i.e., greater than 5% of appointments are outcomed as a Patient Initiated Follow-up). The below shows performance for June, with the SFT being in the upper quartile performance.	There are a number of strands to the PIFU work-stream, which we are continuing to progress, including the work-streams set-out below. Increased PIFU utilisation will initially be focused on specialities with longest waiting times and greatest pressures. • Engaging with clinical leaders, including service leads, to understand the pathways and patients in which PIFU can be applied effectively.

local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty.	 National performance in June for individual trusts varied between 0% and 11.7%, with SFT performing at 6.7% and the 10th best performance trust in the country. However, the Trust is aware that the spread of PIFU across specialties is not as optimal as we would like, especially with reference to the PIFU rates for high volume specialties. So, this is one of the areas of focus of the STOC programme.	• Utilising resources such as GIFRT and the National Outpatient Transformation & Recovery programme to help guide the above conversations. • Promotion and Education – Working with services and the wider Trust to build awareness and confidence in PIFU as an appropriate option for patients and clinicians.
c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies	The Trust continues to have an active programme of improvement work focusing on outpatients, through the Somerset Transformation of Outpatient Care (STOC). The programme includes work on reducing DNAs. In quarter 1 23/24 the Trust was in the lower quartile (best performing) with a DNA rate of 5.2%, with performance nationally varying between 0.2% and 13.4%. This placed the Trust 19th best in the country, in terms of remaining	Areas of focus to further reduce DNAs are as follows: 1) Reminder calls (review of timing of these to minimise DNAs). 2) Digital validation and review to understand the causes of DNAs – Starting in Maxillo Facial in October; this will help us. understand what support patients need to attend, and through this also help us address health inequalities.

to clinically review patients who miss multiple consecutive appointments.	opportunities to reduce DNAs, and close to upper decile performance. 	3) Development of a new look appointment letter, focusing on the date, time, and location of appointment being clearer and more visible. 4) Systems and processes reviewed and improved to enable patients to contact us sooner, and out of hours, to request the rescheduling of an appointment. 5) Patient appointment portal implemented in Endocrinology (completed in August); roll-out across all specialities over the next 8-10 weeks. 6) Partial booking implemented for follow-ups to allow patient choice of the time/date of the outpatient appointment.
d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has	Overall performance in June 23 was 21.1 advice & guidance requests per 100 referrals, against the target of 21 and a national median of against a provider median of 19.3. 	The Somerset System has recently procured an Advice & Guidance (A&G) IT system, to improve the quality of the pre-referral A&G offer for both secondary care and primary care clinicians. This will allow better conversations to take place relating to the shared management of patient care between GP teams and secondary care clinicians. The system procured is first being used to support Teledermatology, closely followed by a number of other specialties. The plan is to roll-out to circa eight specialties by year-end, including several high-volume specialties such as dermatology, gynaecology and cardiology, as well as transferring

utilised the OPRT and GIRFT checklist, national benchmarking	However, within the overall figures there are two difference types of Advice & Guidance (A&G), which are pre-referral (i.e., advice being sought prior to a referral being made by the GP) and post-referral, which includes ad hoc advice at the point a referral is triaged. The below shows performance for June, with the Somerset system being in the upper quartile performance for pre-referral A&G:  National performance in June for individual trusts, varied between 0.1% and 21.4%, with SFT performing at 14.4% and the 7th best performing trust in the country for **pre-referral** specialist advice.	existing specialties providing A&G, such as gastroenterology and paediatrics, across to the new system. Sample audits of the time required to respond to A&G requests will be undertaken. The provision of A&G will be built-in to the job plans. The Somerset System has already commissioned modelling to understand the impact of providing A&G on waiting list size. This has allowed us to understand the key success factors, in terms of what determines whether this is going to be an effective use of clinical time. This is allowing us to target those specialties with the greatest likelihood of improving patient throughput.

	In contrast, the trust performs less well on post-referral A&G.  National performance in June varied between 0% and 60.9%, with SFT performing at 6.7% and ranked 92nd in the country for **post-referral** specialist advice. For many systems post-referral advice is being delivered through system-level Referral Management Centres (RMCs) where all GP referrals are reviewed and go through a form of clinical triage. For these systems across the country, the RMC triage is counting in the post-referral specialist advice numbers.	
e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider	The Trust already utilises a wide range of models of outpatient care including one-stop, straight to test, Advice First (Advice & Guidance), shared care, group appointments, etc. There are also good examples of flexible use of workforce in some specialties. There is an opportunity to increase the use of these models and develop different models for working with Primary Care.	The Senior Leadership Forum (SLF) in September will be focusing on Outpatients. This will be an opportunity to understand the rate limiters for wider and faster transformation, and how we more effectively propagate the spread of effective models of care. SLF includes all senior managers and clinical leads across the Trust. This will be present a good opportunity to revisit the Trust's

workforce to maximise clinical capacity.		approach our delivery of outpatient care, and share good practice.
4. Support required		
The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	No additional support is felt to be required from NHSE at this stage.	

Sign off:

Trust lead (name, job title and email address):	Xanthe Whittaker Director of Elective Care Xanthe.Whittaker@SomersetFT.nhs.uk
Signed off by chair and chief executive (names, job titles and date signed off):	

Appendix 3 Validation progress and plan

Table 1: Current validation position

Cohort of patients	Type of validation	Validated (Yes/No)	Rationale where not fully compliant
Weeks 12-25 weeks non-admitted pathways.	Technical	Yes	Community pathways are validated to 17 weeks.
	Administrative	Partly	There is limited validation resource, so the focus is currently on longer waiters for acute pathways.
	Clinical	No	Concerns regarding contacting patients so soon after referral led to a decision being previously taken to not contact this cohort of patients.
Weeks 26-51 weeks non-admitted pathways.	Technical	Yes	
	Administrative	Partly	Yeovil waiting lists are routinely validated down to 29 weeks; limited validation resource and complexity of PAS workarounds for Taunton lists means that the waiting list is validated down to only 40 weeks for routine pathways (18 weeks for some cancer pathways).
	Clinical	Partly	Taunton patients waiting for the first appointment are contacted at 26 weeks then again at 42 weeks, using Waiting List Module of Patient Hub. This is not yet available at Yeovil but will be rolled-out shortly. Patients on follow-up pathways are not currently contacted, to avoid confusion as they wait for diagnostic tests or results.
Weeks 52 and over non-admitted pathways.	Technical	Yes	
	Administrative	Yes	
	Clinical	Partly	Trust's safety netting criteria dictate which patients are contacted, with those patients having recently been seen or with an appointment in the next few weeks, not contacted.

Weeks 12 and over admitted pathways.	Technical	Yes	
	Administrative	No	When patients are on the Elective Waiting List waiting for a date, there is felt to be little gain in frequent validation.
	Clinical	Partly	Patients are contacted as part of Trust's safety-netting processes when 8 weeks past date added to the waiting list (P2s - urgents), 26 weeks past date added to EWL (P3s - soons), 52 weeks past RTT start date (P4s - routines).

N.B. The national target relates to three types of validation having taken place for each patient pathway. These are defined as follows:

- Technical = multiple pathway and duplicate pathway checks for individual patients, and resolution of any issues identified.
- Administrative = reviews of individual patient pathways to check the recorded RTT events are correct, and nothing is missing (e.g. treatment/RTT stop having taken place); this is undertaken by RTT validators and medical secretaries
- Clinical = contact with patients to ensure they wish to remain on the waiting list, followed up by clinical review and/or re-prioritisation if appropriate.

Table 2: Plan for achieving 90% validation of patients waiting over 12 weeks.

Cohort of patients	Action	Timescale
Non-admitted patients	Extend digital contact for patients waiting for the first appointment at Taunton down to 12 weeks – cohort has been identified and contacting backlog will commence in September, then will become business as usual. Implement digital contact for Yeovil site patients (from 12 weeks) – reliant on Patient Hub so contingent on digital roll-out plan.	30/9/23 To be confirmed.
	Extend **admin** validation of community pathways from 17 weeks to 12 weeks and ensure reported on WLMDS	Complete
	Identify process to capture dates that patients are contacted as part of partial booking processes (i.e., when contacted to see if they are ready to book their appointments) – these dates will be used as clinical validation dates - meeting arranged to take forward w/c 28/8/23.	To be confirmed.

Admitted patients	Introduce digital contact for patients on Taunton surgical waiting list – meeting arranged w/c 28/8/23 to discuss process and resource requirements.	15/10/23
	Introduce digital contact for patients on Yeovil waiting list – reliant on Patient Hub, so contingent on digital roll-out plan	To be confirmed.
All pathways from 12 weeks	Identify process to capture dates that patients are contacted and reviewed on Pathpoint (pre-operative assessment system) – these dates will be used as clinical validation dates because the patient is contacted and is through engagement, confirming their wish to continue with their treatment plan; Meeting arranged to take forward w/c 28/8/23.	To be confirmed.
	Increase identification of patients on multiple and duplicate pathways for technical validation and add to weekly processes for Taunton team. Add tab to RTT dashboard identifying patients on multiple pathways and include validation in the weekly process. Strengthen the internal Inter Provider Transfer processes to reduce patients reported twice.	Complete 31/8/23 Complete
	Validate cancer pathways (admin validation) down to 12 weeks (Taunton & Yeovil) – these are often pathways which have stopped from a cancer diagnosis/treatment point of view, but their RTT clock has not caught-up with this and been stopped.	30/10/23

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Finance Report
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Mark Hocking, Deputy Chief Finance Officer
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	5 September 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:					

Equality and Inclusion

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

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

This report has been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

FINANCE REPORT

1. SUMMARY

1.1 In July 2023 the Trust recorded a deficit of £0.903m, this was £0.325m adverse compared with the plan for the month. Cumulatively, the Trust is £6.218m in deficit, this is £1.159m adverse to the planned position.

1.2 The in-month and year date variances are being driven by the unfunded impact of industrial action and specifically the costs of backfilling medical staff.

1.3 We have received guidance which confirms that our elective recovery target will be reduced by 2% to 107% to mitigate the financial impact of activity lost as a result of the April industrial action. We expect to receive information on how subsequent periods of industrial action will be mitigated. We are currently assessing our elective performance in light of this new guidance to understand the financial impact.

1.4 Service pressures have continued to reduce in July meaning that escalation beds can be closed and further improvements in our agency expenditure can be seen as a result. Although agency expenditure has reduced this month, we remain above our plan and cap. We review all agency use on an ongoing basis to ensure controls are in place and working effectively.

2. INCOME AND EXPENDITURE

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

Table 1: Income and Expenditure Summary July

Statement of Comprehensive Income	Annual Plan £000	Current Month 4			Year to date		
		Plan £000	Actual £000	Fav./ (Adv.) Variance £000	Plan £000	Actual £000	Fav./ (Adv.) Variance £000
Income							
Patient Care Income	923,065	76,885	76,651	(234)	307,414	308,732	1,318
Other Operating Income	54,102	4,431	4,712	282	17,469	20,455	2,987
Total operating income	977,167	81,316	81,363	47	324,883	329,188	4,305
Operating expenses							
Employee Operating Expenses	(668,800)	(55,822)	(55,357)	465	(224,757)	(228,457)	(3,699)
Drugs Cost: Consumed/Purchased	(71,060)	(5,990)	(6,842)	(852)	(23,585)	(23,444)	141
Clinical Supp & Serv Exc-Drugs	(45,272)	(4,063)	(4,485)	(422)	(17,530)	(20,010)	(2,481)
Supplies & Services - General	(27,780)	(2,315)	(2,820)	(505)	(9,260)	(11,246)	(1,986)
Other Operating Expenses	(151,017)	(12,597)	(12,090)	508	(50,387)	(48,982)	1,405
Total operating expenses	(963,929)	(80,788)	(81,594)	(806)	(325,519)	(332,139)	(6,620)
Operating Surplus/Deficit	13,238	528	(230)	(758)	(636)	(2,951)	(2,315)
Finance Expense	(12,651)	(1,054)	(1,094)	(39)	(4,217)	(4,332)	(115)
Finance Income	613	51	324	273	204	1,038	834
Other	0	(3)	0	3	(11)	0	11
Overall Surplus/(Deficit)	1,200	(478)	(1,000)	(522)	(4,659)	(6,245)	(1,585)
Depr On Donated Assets	1,386	115	97	(19)	462	394	(68)
Donated Assets Income	(2,591)	(216)	0	216	(864)	(370)	494
Amortisation	9	1	1	(0)	3	3	(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)	98	198	(400)	27	427
Adjusted Financial Performance	(0)	(578)	(903)	(325)	(5,059)	(6,218)	(1,159)

2.2 Agency expenditure was £2.839m (June 2023 £3.185m), this was £0.107m over the plan for the month and £0.748m above the cap. The cap (c£30m for the year) is profiled pro-rata to the pattern of 2022/23 actual expenditure. At the end of July, the Trust is c£4.3m above the cap.

2.3 The impact of the post graduate doctors in training July industrial action was c£0.400m, this was the net cost of backfill. The impact of the consultant industrial action in July offset this cost by c£0.075m.

2.4 The impact of industrial action on our patient care income has not been adjusted inline with NHSE guidance. The adjustment to our elective recovery target is intended to mitigate the impact of the April industrial action. We are working through how our actual performance in the first quarter will affect our elective income position with the ICB. We are expecting to report this position from August. There is no further information on how the periods of industrial action in June, July and August 2023 (and any ongoing dates) will be managed.

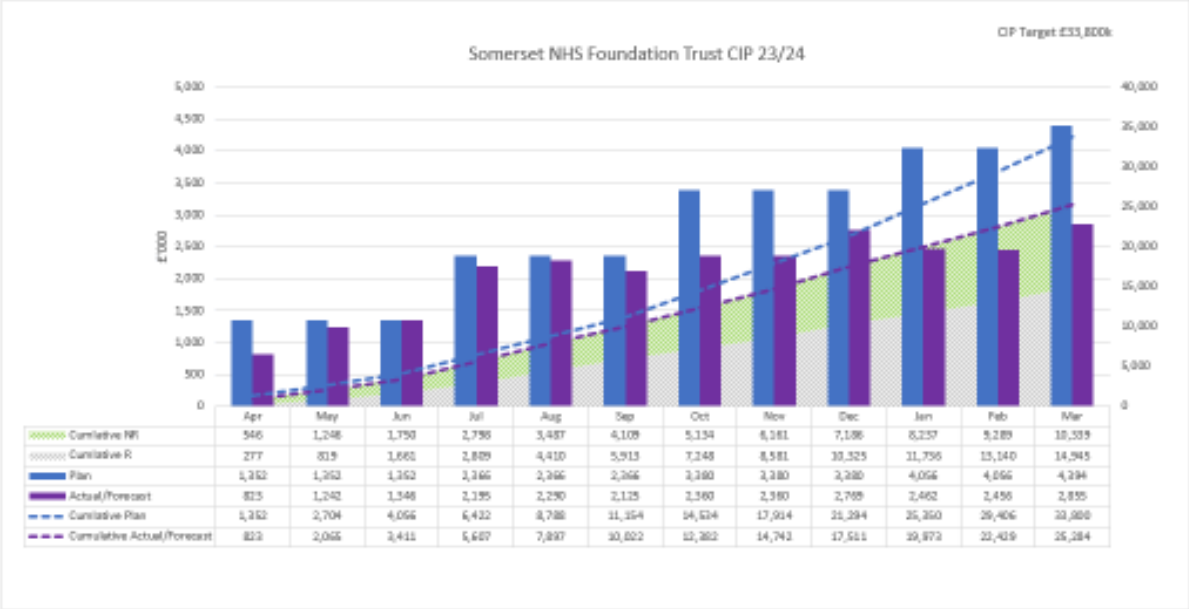
3. COST IMPROVEMENT PROGRAMME

3.1 In July 2023, savings of £2.195m were delivered which is a shortfall of £0.171m against the plan. Recurrent savings formed £1.148m of the savings achieved (52%). Both of these were lower than planned and are an indicator of the challenges services are facing. We continue to support them in their work to identify opportunities and although we are making progress, an unidentified gap currently remains.

3.2 We have recently discussed further opportunities with services, and these are currently being assessed. The delivery of the cost improvement programme is central to our financial plan so we will need to consider what further action we may need to take to ensure the full level of deficiencies are achieved.

3.3 Further analysis is shown in the chart below: -

Chart 1: CIP Plan 23/24



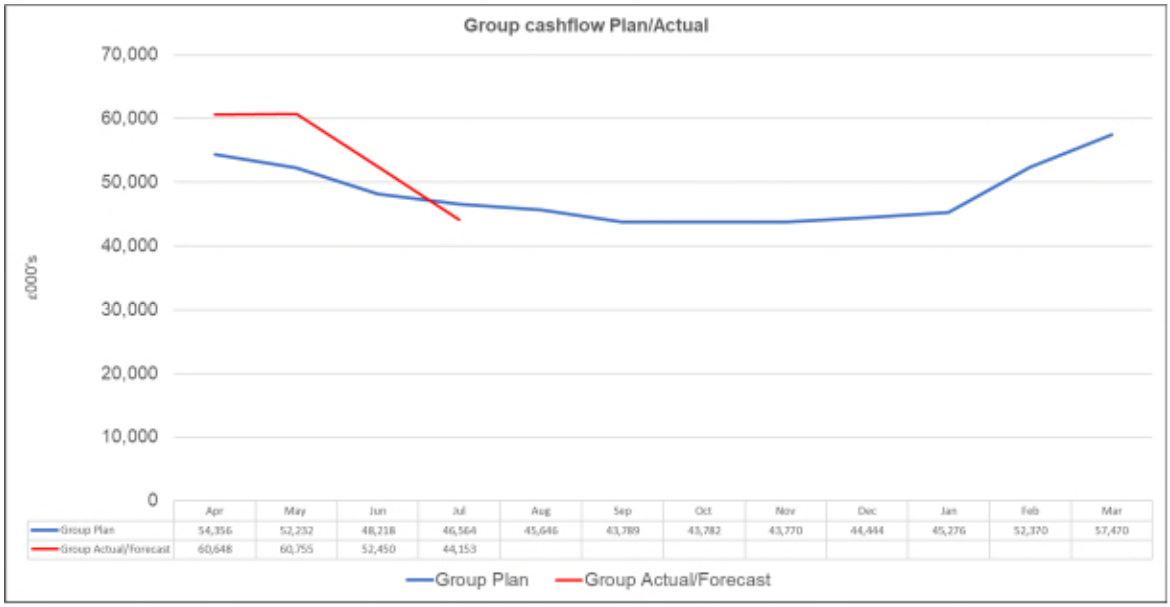
4. CASH

4.1 Cash balances as at 31 July were £44.2, £2.4m lower than plan.

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 Year to date, capital expenditure is £12.0m compared with the plan of £12.4m, resulting in a small underspend of £0.4m. Further details at programme level 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	250	0	53	53
Total MPH Site and Service Development	2,048	515	122	(393)
Acute Programme YDH	**Plan £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
Total YDH Main Site Budgets	3,800	295	1,504	1,209
Total - YDH Site and Service Development	6,091	398	118	(280)
Total - YDH Site Risks / Plant and equipment Replacement	370	0	217	217
Total Acute	12,559	1,208	2,014	806
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	999	1,445	446
Total Community / Mental Health - Site Risks / Plant & Equipment	300	0	91	91
Total Community/Mental Health	6,620	999	1,536	537
Trustwide	**Plan £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
Trustwide	13,650	1,645	2,992	1,339
Total Internal Capital Envelope	32,829	3,852	6,542	2,682
AEditional Capital Schemes	**Plan £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
Total Additional Schemes	47,195	8,232	5,422	(2,810)
IFRS Leases	3,781	331	0	(331)
TOTAL TRUST PROGRAMME	83,805	12,416	11,964	(459)

5.2 Monthly monitoring is undertaken by the Capital Delivery Group to ensure schemes remain on track and where there is slippage this is identified quickly to enable corrective action to be taken or alternative schemes accelerated.

The Finance Committee receive a regular capital monitoring update at their meetings.

5.3 Statement of Financial Position (Balance Sheet)

Jun-23	Jul-23	Movement		Mar-23	Jul-23	Movement in Year
£000	£000	£'000		£000	£000	£000
24,292	23,320	(971)	Intangible Assets	25,142	23,320	(1,822)
356,070	357,124	1,054	Property, Plant and Equipment, Other	356,521	357,124	603
28,705	28,512	(193)	On SoFP PFI Assets	24,654	28,512	3,858
80,141	84,012	3,871	Right of Use Assets	82,143	84,012	1,869
210	413	202	Investments	296	413	117
14	14	0	Other investments/financial assets	14	14	0
2,810	2,860	49	Trade & other Receivables >1Yr	3,113	2,860	(253)
492,243	**496,254**	**4,011**	**Non Current Assets**	**491,883**	**496,254**	**4,371**
11,662	10,480	(1,182)	Inventories	10,833	10,480	(353)
20,148	23,851	3,703	Trade and other receivables: NHS receivables	39,244	23,851	(15,393)
37,134	56,848	19,715	Trade and other receivables: non-NHS receivables	22,158	56,848	34,690
466	466	0	Non Current Assets Held for Sale	0	466	466
52,450	44,153	(8,298)	Cash	64,388	44,153	(20,235)
121,860	**135,797**	**13,937**	**Total Current Assets**	**136,623**	**135,797**	**(826)**
(125,277)	(112,139)	13,137	Trade and other payables: non-capital	(124,670)	(112,139)	12,531
(5,927)	(5,485)	442	Trade and other payables: capital	(10,942)	(5,485)	5,457
(10,387)	(42,426)	(32,039)	Deferred Income	(8,524)	(42,426)	(33,902)
(4,872)	(6,138)	(1,266)	Borrowings	(6,210)	(6,138)	72
(4,671)	(4,667)	4	Provisions <1yr	(4,893)	(4,667)	226
(151,135)	**(170,857)**	**(19,723)**	**Current Liabilities**	**(155,239)**	**(170,857)**	**(15,618)**
(29,275)	**(35,060)**	**(5,786)**	**Net Current Assets**	**(18,616)**	**(35,060)**	**(16,444)**
(96,647)	(95,896)	753	Borrowings >1yr	(103,041)	(95,896)	7,145
(4,015)	(4,015)	0	Provisions >1yr	(4,034)	(4,015)	19
(1,876)	(1,855)	22	Deferred Income >1yr	(1,941)	(1,855)	86
(102,538)	**(101,766)**	**774**	**Total Long Term Liabilities**	**(109,016)**	**(101,766)**	**7,250**
360,430	**359,429**	**(1,000)**	**Net Assets Employed**	**364,251**	**359,429**	**(4,822)**
			Financed by:			
322,064	322,064	0	Public Dividend Capital	322,064	322,064	(0)
70,490	70,490	(0)	Revaluation Reserve	76,094	70,490	(5,604)
(2,471)	(2,471)	0	Other Reserves	(2,472)	(2,471)	1
(29,652)	(30,653)	(1,000)	I&E Reserve	(31,435)	(30,653)	782
360,430	**359,429**	**(1,000)**	**Total Financed**	**364,251**	**359,429**	**(4,822)**

6. CONCLUSION AND RECOMMENDATION

6.1 Although operational pressures have eased, performance in month was again adverse to plan due to the unfunded impact of the industrial action. Other variances have broadly offset one another and mitigated the shortfall in CIP delivery.

6.2 The Board are asked to note the financial performance for July.

CHIEF FINANCE OFFICER

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance report from the Audit Committee meetings held on 7 June and 27 June 2023
SPONSORING EXEC:	Paul Mapson, Chairman of the Audit Committee
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Paul Mapson, Chairman of the Audit Committee
DATE:	5 September 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 Audit Committee meeting held on 7 June and 27 June 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 counter fraud 2022/23 annual report • The 2022/23 SFT and YDH Audit Committee Annual Reports • The recommendation to the Board to approve the SFT and YDH annual accounts, annual reports and letters of representation • The unqualified opinion of the SFT and YDH annual accounts The Committee identified the following areas of concern: • The challenges in relation to the MEA process The Committee identified the following area to be reported to the Board: • The challenges in relation to the MEA process and the recommendation to review MEA valuation assumptions by a committee and management group prior to year end.

Recommendation	The Board is asked to note the assurance and area of concern identified by the Audit Committee. The Board is further asked to note the areas to be reported to the Board.

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

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

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

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

Details: N/A

Equality and Inclusion

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

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

This report has not been assessed against the Trust's Equality Impact Assessment Tool.

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

Public/Staff Involvement History

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

N/A

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

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

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

SOMERSET NHS FOUNDATION TRUST

AUDIT COMMITTEE MEETING HELD ON 12 JUNE 2023 AND 27 JUNE 2023

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 12 June 2023 and 27 June 2023.

MEETING HELD ON 7 JUNE 2023

2. ASSURANCE RECEIVED

Counter Fraud 2022/23 Annual Report

2.1. The Committee received the annual report and noted that, with the exception of the counter fraud functional standards return, the report provided an overview of the items presented to the Committee during the year.

2.2. The Committee noted that the counter fraud functional standards return had been submitted following approval by the Chief Finance Officer and Barbara Gregory, Chairman of the Committee prior to 1 August 2023. The Committee noted the compliance ratings and the differences between the legacy organisations in terms of fraud awareness training.

2.3. The Committee agreed that good progress had been made during the year and that the report did not highlight any areas of concern. It was noted that some areas of work will need to be aligned to reflect best practice.

2.4. The Committee approved the annual report.

Review of the SFT and YDH 2022/23 Audit Committee Annual Report

2.5. The Committee discussed the report which set out the work undertaken during 2022/23 and agreed to recommend the approval of the report to the Board.

3. AREAS OF CONCERN/FOLLOW UP

REVIEW OF THE SOMERSET NHS FOUNDATION TRUST ACCOUNTS

3.1. ***Report on the Annual Accounts 2022/23 and Annual Accounts***
The Committee discussed the report and annual accounts and noted that the production of the accounts had been challenging in view of the double sets of accounts to be produced, but also due to the need for a full evaluation based on the Modern Equivalent Asset (MEA) model; and the implementation of IFRS16.

S

3.2. The Committee discussed the MEA Model, the impairment figures and the areas covered under IFRS 16.

Review of External Audit – Draft ISA 260 report

3.3. The Committee noted that the SFT report had been substantially completed, but further work was required in relation to the YDH report. Auditors were confident that the National Audit Office's deadline of 30 June 2023 will be achievable and it was expected that unqualified opinions will be issued.

3.4. The Committee received an overview of the work in relation to the MEA evaluation, details of the approach used and the change in valuations. The Committee noted that auditors had challenged some of the assumptions made but had concluded that the assumptions made were in line with guidance. Auditors had made two recommendations and these related to the need to present the MEA assumptions to a Committee and management group prior to the year end; and to minute the discussions with the valuers to show challenges.

3.5. In view of the further work required, a further meeting was set up for 27 June 2023.

REVIEW OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST ACCOUNTS

Report on the Annual Accounts 2022/23 and Annual Accounts

3.6. The Committee discussed the report and annual accounts and noted that the same challenging as for SFT also applied to the YDH annual accounts process.

Review of External Audit – Draft ISA 260 report

3.7. The Committee noted that the external audit had not yet been fully completed and the issues were similar to the SFT issues set out above, including in relation to the MEA valuation. The Committee noted the areas which still needed to be finalised.

3.8. The Committee discussed the MEA valuation for YDH in more detail and challenged the assumptions in relation to the size of of the MEA model. The Committee further discussed the internal control recommendation in relation to bank reconciliations and noted that this recommendation had been addressed.

3.9. In view of the further work required, a further meeting was set up for 27 June 2023.

MEETING HELD ON 27 JUNE 2023

4. ASSURANCE RECEIVED

Review of the Somerset NHS Foundation Trust Accounts and ISA 260 report

4.1. The Committee received the final version of the annual accounts for 2022/23 and noted that there were no material changes since the 7 June 2023 meeting.

4.2. The Committee received the annual report for 2022/23 and noted that the report had been audited and no material issues or non compliance with the guidelines had been identified.

4.3. The Committee received the final version of the ISA 260 report and noted that there were no material changes with no uncorrected audit statements and that an unqualified opinion had been provided.

4.4. The Committee further received the auditor's annual report which had been discussed in detail at the 7 June 2023 meeting; the Independent Auditor's report to the Council of Governors; and the Letter of Representation.

4.5. The Committee agreed that the annual accounts, annual report and letter of representation had not highlighted any concerns which affected the Committee being able to recommend its approval to the Board.

Review of the Yeovil District Hospital NHS Foundation Trust Accounts

4.6. The Committee received an updated version of the annual accounts for 2022/23 and noted the amendments made to the accounts.

4.7. The Committee received the annual report for 2022/23 and noted that the report had been audited and no material issues or non compliance with the guidelines had been identified.

4.8. The Committee received the updated version of the ISA 260 report and noted that the audit had not yet been completed but that, from the work to date, an unqualified opinion could be provided. The Committee noted that the work to be completed mainly related to internal administrative elements rather than the audit itself.

4.9. The Committee further received the auditor's annual report which had been discussed in detail at the 7 June 2023 meeting; the Independent Auditor's report to the Council of Governors; and the Letter of Representation.

4.10. The Committee agreed that the annual accounts, annual report and letter of representation had not highlighted any concerns which affected the Committee being able to recommend its approval to the Board.

5. RISKS – ISSUES TO BE REPORTED TO THE BOARD

5.1. The Committee did not identify any specific risks to be reported to the Board but asked the Board to note the challenges in relation to the MEA process and review of the assumptions by a Committee and management group prior to year end.

CHAIRMAN OF THE AUDIT COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance report from the Audit Committee meeting held on 12 July 2023
SPONSORING EXEC:	Paul Mapson, Chairman of the Audit Committee
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Paul Mapson, Chairman of the Audit Committee
DATE:	5 September 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 Audit Committee meeting held on 12 July 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 format and content of the Board Assurance Framework • The risk management processes • The work of the counter fraud service • The timely implementation of counter fraud recommendations • The progress made on the internal audit plan • The findings of the clinical validation of waiting lists audit • The findings of the cleaning standards audit • The formal sign off and submission of the SFT and YDH annual accounts and reports. • The losses and special payments report • The single quotation/tender waiver action report • The reference cost report

	The Committee identified the following areas of concern: • The counter fraud progress report – the low conflict of interest compliance rate for decision makers • The findings of the consultant job planning audit • The findings of the environmental sustainability audit • The number of workforce related overdue internal audit recommendations The Committee identified the following area to be reported to the Board: • The declarations of interests' compliance rate (Executive Team). • The limited opinion for both design and design effectiveness in relation to consultant job planning (Executive Team). • The environmental sustainability report and the need for staff and cultural engagement to be able to deliver the Green Plan. (Executive Team). • The overdue workforce related internal audit recommendations (People Committee).
Recommendation	The Board is asked to note the assurance and area of concern identified by the Audit Committee. The Board is further asked to note the areas to be reported to the Board.

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

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

☒ Financial	☒ Legislation	☐ Workforce	☐ Estates	☐ ICT	☐ Patient Safety/ Quality
Details: N/A					

Equality and Inclusion

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

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

This report has not been assessed against the Trust's Equality Impact Assessment Tool.

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

Public/Staff Involvement History

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

N/A

Previous Consideration

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

The assurance report is presented to the Board after each meeting.

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

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

SOMERSET NHS FOUNDATION TRUST

AUDIT COMMITTEE MEETING HELD ON 12 JULY 2023

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 12 July 2023.

2. ASSURANCE RECEIVED

Board Assurance Framework

2.1. The Committee discussed the Board Assurance Frameworks (BAF) and noted that the actions had been updated. The Committee agreed that the format of the BAG had matured and was more accessible.

2.2. The Committee noted that this version of the BAF had already been discussed at the July 2023 Board meeting and the Committee agreed that the Board discussion provided assurance that the BAF had been robustly scrutinised.

Corporate Risk Register (CRR)

2.3. The Committee received and discussed the report. The Committee agreed that some of the risks, especially the workforce risks were less well defined but noted that the CRR provided a high level summary of the risks and that the risks in the underlying risk registers were well defined and specific about the risk and impact.

2.4. The Committee noted that the content of the report to the Committee was different from the report to the governance assurance committees and agreed that the level of detail was appropriate in terms of the Committee's oversight of the assurance process.

2.5. The Committee agreed that the report provided significant assurance in terms of risks management processes.

Counter Fraud Progress Report

2.6. The Committee received the counter fraud progress report and noted the proactive work, investigations and performance against the functional standards.

2.7. The Committee noted that, following the findings of a previous proactive exercise, a trial was being undertaken in mental health services to centralise the approval of agency invoices and discussions were taking place to roll the trial out to all services which were currently not using a centralised process.

2.8. The Committee further discussed the increase in counter fraud referrals and noted that the increase was due to an increased focus on raising awareness of counter fraud services particularly on the YDH site.

2.9. The Committee agreed that the report provided significant assurance about the work of the counter fraud service.

Counter Fraud Recommendations Tracker

2.10. The Committee received the counter fraud recommendations follow up report and the Committee agreed that the report provided significant assurance about the implementation of the recommendations.

Internal Audit progress report

2.11. The Committee received the internal audit progress report and agreed that good progress was being made.

Clinical Validation of Waiting Lists Report

2.12. The Committee received the audit report relating to YDH and noted that a moderate opinion for both design and design effectiveness had been issued.

2.13. The Committee agreed that the findings provided the Committee with good assurance.

Cleaning Standards Report – YDH

2.14. The Committee received the audit report relating to YDH and noted that a substantial opinion for design and a moderate opinion for design effectiveness had been issued.

2.15. The Committee agreed that the findings provided the Committee with good assurance.

Annual report 2022/23

2.16. The Committee received and noted the final report for YDH.

External Audit Progress Report and Technical Update

2.17. The Committee received a verbal update and noted that both sets of accounts had been signed off and submitted and that a debrief meeting with the team had been set up.

2.18. The Committee further noted that the audit of the subsidiary accounts had not raised any areas of concern. The Committee discussed the process for approving the subsidiary accounts and agreed that it will be helpful to receive an overview of formal arrangements between the subsidiaries and the Audit Committee.

Losses and Special Payments

2.19. The Committee received the losses and special payments report and noted the reasons for the losses and special payments.

2.20. The Committee agreed that the reports did not highlight any areas of concern.

Single Quotation/Tender Waiver Action report

2.21. The Committee received the single quotation/tender waiver action report and noted the single quotation and tender waiver actions and the reasons for these actions.

Terms of Reference Progress Report

2.22. The Committee received the report which monitored progress against the Committee's Terms of Reference.

2.23. The Committee agreed that the report provided significant assurance.

Reference Cost Report

2.24. The Committee received the report and approved the costing and submission process for the 2022/23 National Cost Collection for both SFT and YDH.

3. AREAS OF CONCERN/FOLLOW UP

Counter Fraud Progress Report

3.1. The Committee discussed the declarations of interests' compliance rate and noted that the two legacy systems had now merged into a single system. The Committee expressed its concern about the 51.9% compliance rate for decision makers and recognised the work already taking place to improve the compliance rate.

3.2. The Committee agreed to escalate this to the Executive Team and to ask the Executive Team to take appropriate actions to improve compliance.

3.3. The Committee further discussed the investigations and noted that, where possible and appropriate, it was important to await the outcome of the counter fraud investigation before any HR related actions are taken.

Consultant Job Planning Report

3.4. The Committee received the audit report relating to YDH and noted that a limited opinion for both design and design effectiveness had been issued.

3.5. The Committee agreed that the findings set out in the report were a concern and agreed to escalate this to the Executive Team for urgent follow up.

Environmental Sustainability Report

3.6. The Committee received the audit report and noted the maturity levels and the conclusion that although some progress had been made, progress had been slow. The Committee noted the recommendations.

3.7. The Committee agreed that staff and cultural engagement will be essential in being able to deliver the Green Plan and agreed to refer this back to the executive team for follow up.

Internal Audit Follow Up Report

3.8. The Committee received the internal audit recommendations follow up report and noted the high number of overdue recommendations. The Committee noted the need to action particularly the high priority recommendations as soon as possible to avoid the delay impacting on the Head of Internal Audit Opinion.

3.9. The Committee expressed its concern about the overdue recommendations and some of the reasons for the delays and agreed to refer the outstanding recommendations to the People Committee for further discussion.

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

4.1. The Committee identified the following issues to be reported to the Executive Team or other committees:

- The declarations of interests' compliance rate (Executive Team).
- The limited opinion for both design and design effectiveness in relation to consultant job planning (Executive Team).
- The environmental sustainability report and the need for staff and cultural engagement to be able to deliver the Green Plan. (Executive Team).
- Overdue workforce related internal audit recommendations (People Committee).

CHAIRMAN OF THE AUDIT COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Charity Committee meeting held on 12 July 2023
SPONSORING EXEC:	Director of Strategy and Digital Development
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Barbara Gregory, Chairman of the Charity Committee
DATE:	5 September 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 Charity Committee meeting held on 12 July 2023. The Committee received assurance in relation to: • The investment update • The fundraising report • The garden funding proposal to enable volunteers to assist with gardening tasks • The approval of the research funding proposal • The financial position for the legacy charitable funds • The approval of the business case for air conditioning in the children's outpatient department The Committee identified the following areas for follow up: • The review of the ethical policy at the next Committee meeting • The review of the 25th anniversary appeal project list to ensure that all items were still required The Committee did not identify any issues to be reported to the Board.

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

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

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

Equality and Inclusion
The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
This report has not been assessed against the Trust's Equality Impact Assessment Tool.

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE CHARITY COMMITTEE MEETING HELD ON 12 JULY 2023

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 12 July 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

Investment Update

2.1. The Committee received an investment update and noted the funding available in both the investment and deposit accounts and the purpose of both accounts. The Committee noted that income had been maintained at the same level as the previous year and that the deposit fund had increased in view of the interest rate increases.

2.2. The Committee noted that inflation had impacted on the stability of financial and property markets and that for the first time in the last few years investments had been made into bonds.

2.3. The Committee received details of the investment company's (CCLA) investment strategy and quarterly performance data. In view of the inflation, CCLA's aim to deliver an "inflation plus 5%" target will be challenging to achieve in the current financial year but this will remain a longer term aim.

2.4. The Committee noted CCLA's ethical investment strategy and their engagement programmes. The Committee confirmed that the strategy met the ethical policy and investment restriction in place for the charity.

2.5. The Committee received detailed information on the management of the funds and asset allocations and noted that investments were spread with a maximum of a 2% investment in each holding.

2.6. The Committee previously queried whether cash from the deposit account should be transferred to the investment account to receive a higher interest rate but noted that, due to the change in interest rates, there was no urgency to transfer cash and, in any case, a certain level of cash should be kept to cover expenditure.

2.7. The Committee agreed to review the trust's ethical policy at the next meeting.

2.8. The Committee noted that the investment fund did not include the previous YDH charity funds due to a delay in Charity Commission approval. A significant proportion of the YDH funds were earmarked for the Breast Unit, but, when the funds have been combined, all funds will be managed in the same way.

Fundraising Report

2.9. The Committee received the fundraising report and noted that the delay linking the previous SFT and YDH funds was due to a longer Charity Commission's turnaround time and this delay was therefore not a concern. The Committee noted that the new brand had been registered as a working name.

2.10. The Committee noted the joint fundraising events held across the county, including the overseas trek and the cricket festival at Yeovil cricket club which had raised over £6,500 to be split between the charities.

2.11. The Committee further noted: the launch of the new charity brand at South Petherton community hospital; the work to create new charities; the successful Big Tea fundraising event; the promotion of the new brand; the progress in relation to the breast unit appeal; the legacies received; details of the Love Musgrove 25th anniversary fund; the donation to the children's ward; the donations pledged by a couple of families.

2.12. The Committee approved the allocation of the unrestricted £5,000 legacy for Love Musgrove to the 25th anniversary fund.

Garden Funding Proposal

2.13. The Committee noted that confirmation had been received that, with advance warning and clear assignment of tasks, volunteers will be able to assist with gardening tasks and normal health and safety governance processes will need to be followed.

Research Funding Proposal

2.14. The Committee received the research funding proposal and noted the details of the proposal to support home grown research, including the approval and monitoring processes.

2.15. The Committee approved the proposal to allocate a proportion of the general funding in addition to the £13,000 research funding already allocated to the research project. The Committee further approved the proposal to allow access to the restricted funds for research as these funds had not been accessed for some time.

Finance Reports

2.16. The Committee received an update on the financial positions for both legacy charitable funds. The Committee noted that the YDH and SFT funds had now been combined in the overall accounts and that the charities were performing well.

2.17. The Committee considered whether it will be helpful to produce separate finance information for the legacy charities to ensure that commitments were followed through and evidenced. The Committee agreed to ask for financial information about specific projects to be provided to the Committee as and when required. The Committee received assurance that all funding was recorded and monitored appropriately.

Requests for Funding

2.18. The Committee received the business case for air conditioning in the children's outpatient department in view of the uncomfortable temperatures in the department.

2.19. The Committee approved the business case subject to a limit of £28,296.80.

3. AREAS OF CONCERN OR FOLLOW UP

Investment Update

3.1. The Committee agreed to review the trust's ethical policy at the next meeting.

25th Anniversary Appeal Project List

3.2. The Committee received the project list and noted the split between "funded", "part funded" and "unable to fund" items.

3.3. The Committee asked for the project list to be reviewed to ensure that all items were still required.

4. 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 CHARITY COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Mental Health Act Committee meeting held on 13 June 2023
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Alexander Priest, Chairman of the Mental Health Act Committee
DATE:	5 September 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 Mental Health Act Committee meeting held on 12 June 2023 and the assurance received by the Committee. The meeting was conducted as a video conference call. The Committees received assurance in relation to: • The use of the Section 12 app • The development of a proposal for transitional patients in single sex wards across the trust • The Mental Health Lead report – the work taking place and compliance with the Act and Code of Practice • The update on MCA, DoLs and LPS – the continuation of Liberty Protection Safeguards training • The CAMHs out of area placements • The findings of the mental health review audit • The complaints and PALs and serous investigation processes • The homicide review – robustness of the trust's response to the review report and the invitation to present the trust's work to the South West

	Independent Review Group as an example of best practice The Committee identified the following areas of concern or for follow up: • The future ICB's contribution to the Committee • The Independent Quality Assurance Review and the meeting with the new chair of the South West Independent Review Group • The Section 117 update – progress on the Section 117 hub in Dorset and work on Section 117 registers to be presented to the next Committee meeting • The Police National Partnership – a progress report to be presented to the next Committee meeting • The forensic report - a progress report to be presented to the next Committee meeting • The staffing shortages in the AMHP service • Out of Area Treatment Somerset patients - the number of patients detained under the Mental Health Act placed out of area via a planned admission; and the impact of a lack of availability of specialist placements on patient flow from PICU beds • Complaints and issues - the delay of the thematic review; and the need for complaints sent to the ICB to be reported and included in the report • The review of the impact of the AMHP capacity on the risk for the service group • The consideration of CAMHS and older adults related risks at a future Committee meeting

	The Committee agreed to report the following issues to the Board: • AMHP capacity • Out of area placements
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Mental Health Act Committee. The Board is further asked to note the areas to be reported to the Board.

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

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

Equality and Inclusion
The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
The needs and potential impacts on people with protected characteristics are considered with the mental health teams. The Committee reviews data presented to the Committee and will raise any queries if required.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON 12 JUNE 2023

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 12 June 2023, the assurance received by the Committee and any areas of concern identified.

2. ASSURANCE AND UPDATES RECEIVED

Section 12 App

2.1. The Committee received an update and noted that the app was working well and that awareness of the use of the app will continue to be raised. The Committee noted that the app was due for re-procurement later in the year but it was suggested reviewing the use of the app to consider whether it provides value for money.

Transitional patients in single sex wards

2.2. The Committee noted that work was taking place to develop a proposal for transitional patients across the whole organisation. This work was still in its early stages and multiple workstreams may be required.

Mental Health Lead report

2.3. The Committee received the report of the Mental Health Lead and noted:

- The additional pressures created as a result of the junior doctors industrial actions.
- The ongoing challenges coordinating tribunals.
- The increase in the number of training requests from acute sites and overseas nurses.
- The increased complexity of casework.
- the sharing of information regarding detentions to Musgrove Park Hospital with the Psychiatric Liaison Team to support the provision of patient information.
- The positive findings of the NICE Guidelines for advocacy review and the actions to be taken to achieve full compliance.

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- The approval of the AWOL policy; and the final review of the Community Treatment Order and Doctors/Approval Clinicians policies.

- The overall reduction in the detention rates.

- The lack of progress in relation to the Mental Health Bill. It was noted that more information on the implementation of the Bill may be available in September 2023.

- The progress made in relation to the integration of mental health services with acute services at YDH.

- The conclusion in a case in Manchester that the Mental Capacity Act should not be relied upon when the Mental Health Act was available.

- That an additional place of safety had been created at YDH during the refurbishment of the place of safety at Rydon. It was the intention for three place of safety suites to be available following the move of St Andrews to Rowan Ward.

- The challenges relating to councils in neighbouring areas refusing to be part of discharge planning until a discharge decision has been made, therefore creating possible delays discharging a patient.

- The review of patients under S136 with no conversion, and patients who have been on a S136 more than three times in a six week period, to explore how these patients can be best supported. The Committee discussed inviting a Police representative to the Committee meeting on a regular basis but agreed that a one-off invitation to discuss particular issues will be more beneficial. The Committee further discussed whether some patients used S136 as a safety net instead of contacting mental health services or being able to access mental health services.

2.4. The Committee agreed that the report provided significant assurance about the work taking place and compliance with the Act and Code of Practice.

Update on MCA, DoLs and LPS

2.5. The Committee received the report and noted that the implementation of LPS (Liberty Protection Safeguards) had been postponed but that training to prepare colleagues for the implementation will continue.

CAMHS

2.6. The Committee received an update on child and adolescent mental health services (CAMHS) out of area placements and noted that three CAMHS patients had been placed out of area into a medium secure unit. The Committee further noted that discharge planning was already taking place.

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Mental Health Review Audit Report

2.7. The Committee noted that an audit on access to community mental health services for adults and older people had recently been carried out and the findings will be presented to the July 2023 Audit Committee meeting. Initial feedback showed good levels of assurance in relation to the overall process, including the management of waiting times and reporting and monitoring processes. A small number of recommendations had been identified but there were no recommendations to be followed up by the Committee.

Complaints and Issues

2.8. The Committee received the report setting out the complaints and issues received and resolved by the Trust in relation to patients under the MHA during the period 1 March 2023 to 31 May 2023 and noted that ten new complaints had been received during this period.

2.9. The Committee noted that Section 17 leave and follow up care had been raised in a number of complaints. Details of all complaints were noted.

2.10. The Committee agreed that the report provided significant assurance about the complaints and PALs and serious investigation processes.

Homicide Review

2.11. The Committee received the Homicide Review report and noted that the report had been presented to the Board and Quality and Governance Assurance Committee. The Committee noted the recommendations and progress made implementing the recommendations.

2.12. The Committee further noted the peer review undertaken with Devon Partnership and the work undertaken to map the trust's response to homicides and the processes through rapid review.

2.13. The Committee agreed that good progress was being made implementing the recommendations.

2.14. The Committee received assurance about the robustness of the trust's response to the review report and noted that the trust had been invited to present the work which had taken place to the South West Independent Review Group as an example of excellent work.

3. AREAS OF CONCERNS/FOLLOW UP

ICB Commissioning

3.1. The Committee noted that the ICB's contribution to the Committee may need to be reviewed to be able to achieve the ICB's running costs target.

Independent Quality Assurance Review

3.2. The Committee received the review which was linked to a homicide which

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occurred in 2017. The Committee noted the system wide recommendations and progress in relation to the implementation of the recommendations and further noted that the lessons learned in 2017 had been implemented immediately.

3.3. The Committee recognised that processes had significantly changed since 2017 and it was therefore not always easy to link recommendations to current practices. In view of the significant changes in practices and processes, the Committee agreed not to reopen discussions.

3.4. The Committee noted that a meeting with the new chair of the South West Independent Review Group had been scheduled after which the report will be published.

3.5.

S117 Update

3.6. The Committee received an update on the work in relation to S117 processes and noted: that a meeting with Dorset colleagues had taken place to share learning on registers, collating data and discharge from S117; and that Dorset colleagues will be developing Care Act compliant templates for sharing with the trust.

3.7. The Committee further noted that a S117 hub had been created in Dorset to oversee S117s and that arrangements were still being finalised. The Committee asked for a progress report to be provided to the September 2023 Committee meeting.

3.8. The Committee discussed how S117 legal and clinical processes will link into the new electronic patient record system and noted that S117 had been included in the mapping exercise for the new electronic patient record and included referrals, detention paperwork and discharge process.

3.9. The Committee welcomed the work in relation to S117 registers but noted that the process of discharging a S117 patient was complex and multi-layered; required significant resources; and “must do” actions will need to be prioritised.

3.10. Alexander Priest volunteered to take on the role of Non-Executive Director lead and will follow this up.

Police National Partnership

3.11. The Committee had received assurance from the Police that they will continue their collaborative Right Care, Right Person approach and not adopt the MET/Humberside Police approach.

3.12. The Committee asked for a progress report on the National Partnership Agreement to be presented to the next Committee meeting.

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Forensic Report

3.13. The Committee received a progress report and noted that a robust system for monitoring patients to and from secure hospitals was in place and that a review of patients under S37/41 in the community will be caried out to ensure that support by the team can be offered.

3.14. The Committee asked for a detailed update on forensic services to be presented to the next Committee meeting.

AMHP Services (Approved Mental Health Practitioner)

3.15. The Committee received an update and noted: the staffing shortages as a result of retirements and relocations; staff sickness; the recruitment of two new AMHPs; the model to work six months with an existing AMHP in the hub before undertaking the local AMHP training course.

3.16. The Committee agreed that the staff shortages were a concern.

Out of Area Treatment Somerset (OATS) patients

3.17. The Committee noted that 12 patients detained under the Mental Health Act had been placed out of area via a planned admission and that another two patients will be brought back closer to Somerset.

3.18. The Committee noted that it was anticipated that within the next few weeks the number of inappropriate out of area placements will be reduced to one. The Committee noted that the limited number of PICU beds was the main reason for inappropriate placements and that, in most cases, an inappropriate out of area placement was still preferred above admission in a general mental health inpatient ward.

3.19. The Committee further noted that the lack of availability of specialist placements impacted on patient flow from PICU beds.

Complaints and Issues

3.20. The Committee noted that complaints sent to the ICB had not been included in the report as requests for responses were sent directly by the ICB to the relevant teams. The Committee agreed that it will be helpful to include all complaints received in the report and asked for this to be followed up with the ICB.

3.21. The committee noted that the thematic review report had been delayed and will be presented to the next Committee meeting.

Risk Register

3.22. The Committee received the Mental Health and Learning Disability service group risk register and noted the high rated risks and actions taken to mitigate risks.

3.23. The Committee asked for the impact of the AMHP capacity on the risk for the service group to be considered to decide whether this will need to be included on the Corporate Risk Register.

3.24. The Committee noted that the risk register covered community services for adults but not CAMHS and older adults as these services and risks were covered under a different service group. The Committee agreed that it will be helpful to consider these risks at a future meeting.

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

4.1 The Committee agreed to report the following issues to the Board:

- AMHP capacity
- Out of area placements

Alexander Priest
CHAIRMAN OF THE MENTAL HEALTH ACT COMMITTEE