NHS
Somerset
NHS Foundation Trust

SOMERSET NHS FOUNDATION TRUST
PUBLIC BOARD MEETING

A Public meeting of the Somerset NHS Foundation Trust Board will be held on **Tuesday 3 September 2024** at **9.00am** at South Petherton Community Hospital, Bernard Way, South Petherton TA13 5EF

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

Yours sincerely

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 2 July 2024**	Approve	Chairman		Enclosure A
4.	**Action Logs and Matters Arising**	Review	Chairman		Enclosure B
5.	**Registers of Directors' Interests and Receive any Declarations of Interests relating to items on the Agenda**	Note and Receive	Chairman		Enclosure C
6.	**Chairman's Remarks**	Note	Chairman	09.10	Verbal
7.	**Chief Executive and Executive Directors' Report**	Receive	Andy Heron	09:20	Enclosure D
ALL OBJECTIVES					
8.	**2024/25 Q2 Board Assurance Framework and Corporate Risk Register Report**	Receive	Jade Renville	9.30	Enclosure E Enclosure F

OBJECTIVE 2 – Provide the best care and support to people					
9.	**Assurance Report of the Quality and Governance Assurance Committee meeting held on 24 July 2024**	Receive	Jan Hull	9.50	Enclosure G
10.	**Learning from Deaths Framework: Mortality Review Progress Report**	Receive	Melanie Iles	9.55	Enclosure H
11.	**2023/24 Quality Accounts**	Approve	Jade Renville	10.05	Enclosure I
OBJECTIVE 6 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture					
12.	**Assurance Report of the People Committee meeting held on 9 July 2024**	Receive	Kate Fallon	10.15	Enclosure J
13.	**Guardian of Safe Working for Postgraduate Doctors Reports**	Receive	Tom Rees	10.20	Enclosure K
Coffee Break - 10.30 – 10.45					
OBJECTIVE 4 – Reducing Inequalities					
14.	**Patient Story – 'The good, the bad and the ugly'**	Receive	Candida Carter	10.45	Verbal
15.	**Assurance Report from the Mental Health Act Committee meeting held on 11 June 2024**	Receive	Alexander Priest	11.15	Enclosure L
OBJECTIVE 8 - Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies					
16.	**Quality and Performance Exception Report**	Receive	Pippa Moger	11.20	Enclosure M
17.	**One Year Review of the Merger**	Receive	David Shannon	11.40	Enclosure N
OBJECTIVE 7: To live within our means and use our resources wisely					
18.	**Finance Report**	Receive	Pippa Moger	12.00	Enclosure O
19.	**Verbal report from the Finance Committee meeting held on 30 August 2024**	Receive	Martyn Scrivens	12.20	Verbal

20.	**Assurance Report from the Audit Committee meeting held on 10 July 2024**	Receive	Paul Mapson	12.25	Enclosure P
FOR INFORMATION					
21.	**Follow up questions from the Public and Governors**		Chairman	12.30	Verbal
22.	**Any other Business**		All		Verbal
23.	**Risks Identified**		All		Verbal
24.	**Evaluation of the Effectiveness of the Meeting**		Chairman		Verbal
25.	**Items to be discussed at the Confidential Board Meetings** The items presented to the Confidential Board include:				
26.	**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.				
27.	**Date of Next Meeting** Tuesday 5 November 2024			12.45	

NHS Somerset NHS Foundation Trust

PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 2 JULY 2024 IN THE WHEELDON ROOM AT WESTLANDS ENTERTAINMENT CENTRE, YEOVIL

PRESENT

Colin Drummond	Chairman
Alexander Priest	Non-Executive Director
Martyn Scrivens	Non-Executive Director
Jan Hull	Non-Executive Director
Paul Mapson	Non-Executive Director
Kate Fallon	Non-Executive Director
Graham Hughes	Non-Executive Director
Inga Kennedy	Non-Executive Director
Tina Oakley	Non-Executive Director
Peter Lewis	Chief Executive
Phil Brice	Director of Corporate Services (non-voting)
Andy Heron	Chief Operating Officer
Pippa Moger	Chief Finance Officer
Hayley Peters	Chief Nurse
Melanie Iles	Chief Medical Officer
Isobel Clements	Chief of People and Organisational Development

IN ATTENDANCE

Jade Renville	Director of Corporate Affairs, NHS Somerset
Ben Edgar-Attwell	Deputy Director of Corporate Services
Tina Hickinbottom-Tacey	Corporate Services Officer
Emily Mock	Corporate Administration Assistant
Ben Bright	IT Nurse (shadowing Hayley Peters)
Paul Foster	Consultant Urologist/Clinical Director (for item 14 only)
Gail Rawbone	Ward 9 Manager (for item 16 only)
Toni Hall	Associate Director of Patient Care (for item 16 only)
Ria Zandvliet	Secretary to the Trust

1. WELCOME AND APOLOGIES FOR ABSENCE

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

1.2. It was noted that apologies had been received from Barbara Gregory (Non-Executive Director) and David Shannon (Director of Strategy and Digital Development).

2. QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS

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

3. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 7 MAY 2024

3.1. Jan Hull proposed, Kate Fallon Hull seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 7 May 2024 as a correct record with the following change:

- Page six – to replace "The Chief Medical Officer advised that the number of medical students coming through the medical schools was increasing but there was pressure on students to go to the Exeter medical school and this could impact on the trust." with "The Chief Medical Officer advised that the number of medical students is increasing year on year and that Exeter university are keen for the Trust to take students from them in addition."

4. MINUTES OF THE EXTRA-ORDINARY SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 4 JUNE 2024

4.1. Kate Fallon proposed, Alexander Priest seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Extra-Ordinary Public Board meeting held on 4 June 2024 as a correct record.

5. MINUTES OF THE EXTRA-ORDINARY SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 25 JUNE 2024

5.1. Graham Hughes proposed, Martyn Scrivens seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Extra-Ordinary Public Board meeting held on 25 June 2024 as a correct record.

6. ACTION LOGS AND MATTERS ARISING

6.1. The Board received the action log and noted that no actions had been identified at the May 2024 public Board meeting.

6.2. There were no matters arising from the minutes.

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

7.1. The Board received the Register of Directors' interests and the following change was received:

- Colin Drummond – to add “Trustee of the Harkness Fellows Association and Transatlantic Trust. Registered charity 1088426”

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

8. CHAIRMAN REMARKS

8.1. The Chairman advised that an invitation to visit the Trust had been extended to Ruth May, Chief Nurse NHS England, to enable her to see the environmental conditions in which the maternity teams at Musgrove Park Hospital had to work as a result of a lack of historic national capital investment. Ruth May had accepted the invite and will be visiting the Trust on 4 July 2024.

8.2. The Chairman further advised that with the national elections being held on 4 July 2024, Peter Lewis will be writing to the elected MPs to welcome them to their new, or continuing, role and to invite them to visit the Trust.

9. FIT AND PROPER PERSON TEST REPORT

9.1. Ria Zandvliet presented the report which was received by the Board. Ria Zandvliet highlighted the process followed to determine whether Board members met the fit and proper person requirements.

9.2. The Board noted that Barbara Gregory has not fully met the requirements due to the non submission of a signed self declaration and the circumstances behind this were noted; Barbara’s term of office will end on 31 July 2024.

9.3. The Board accepted the assurance that all Board members and deputy directors, with exception of Barbara Gregory, meet the Fit and Proper Persons requirements. The Board approved the signing and submission of the Fit and Proper Person Annual Submission to NHS England.

10. CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS REPORT

10.1. The Chief Executive presented the report which set out a number of significant developments. The report was received by the Board.

10.2. The Chief Executive particularly highlighted*:* the publication of the Care Quality Commission reports into maternity services; the Synnovis cyber attack; the industrial actions; the personalised cancer vaccine trial; and the letter from NHS England setting out the findings of the merger review.

10.3. The Chief Executive further highlighted the letter from NHS England dated 26 June 2024 about the actions required to maintain focus and oversight on quality of care and experience in pressured services. This letter was in response to the Channel 4 Dispatches documentary filmed in the emergency department at Royal Shrewsbury Hospital about the impact of these pressures on patients. All trusts have been asked

to assure themselves that they are working with system partners to do all they can to reduce pressures, particularly on emergency departments.

10.4. The Chief Nurse advised that the Trust, pre and post merger, had always had a clear view about the use of escalation taking account of risks across the whole system, including the need to release ambulance teams as quickly as possible back into the community. The Trust has held its red lines and previous proposals by other trusts, which included offloading patients into corridors, were not acceptable to the Trust. Any pressures in emergency departments will need to be managed through clear and robust plans, both within emergency departments and at ward level.

10.5. The Chief Nurse advised that the letter provided a good opportunity to review these plans and a whole site walkthrough had been scheduled for August 2024. A bed reconfiguration had been carried out on the Musgrove Park Hospital (MPH) site in 2023 and this had positively impacted on emergency departments and had resulted in a reduction in length of stays. The first phase of a bed reconfiguration had now also been carried out at Yeovil District Hospital and the second phase will be carried out within the next week.

10.6. The Chief Operating Officer stressed the need to always uphold standards of dignity, respect and care in spite of pressures. He assured the Board that every effort was being made to manage and reduce pressures in emergency departments. The Chief Operating Officer highlighted his system role, Co-Chair of the A&E Delivery Board, and the workstream in relation to the development of two urgent treatment centres (UTC), co-located with emergency departments. He advised that this was a common model and, in view of the increasing number of patients walking into emergency departments, UTCs were becoming necessary. The aim was to open UTCs prior to the winter but, due to space constraints on both acute site, some issues still had to be resolved. As well as a focus on UTCs, work was also taking place to expand the Hospital@Home model and review weekend discharge and seven day flow.

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

- Space and staffing was required for UTCs and it was noted that a staffing model was being developed. The aim of the UTCs was to work differently to manage emergency pressures and not to bring more patients to acute sites. Space was the largest constraint and the establishment of the community diagnostic hub in Yeovil will create space at YDH. However, further discussions will be required in terms of space at MPH.

- Over 100 patients were managed through the Hospital@Home scheme in 2023/24 and, in view of the focus on facilitating discharge and looking after patients at home, it was felt that this number would have been higher. The Chief Operating Officer advised that the Hospital@Home capacity will need to be increased. Prior to the 2023/24 winter, only consultants had been part of the Hospital@Home scheme and the full benefits of the scheme had not been realised. A number of national schemes had to be implemented and these were now all brought together into a single leadership team to ensure that all schemes were joined up.

- It was queried whether there was a workstream on enhancing primary care services, including making UTCs more primary care focussed. The Chief Operating Officer confirmed that enhancing primary care services was one of the objectives of the work taking place, working with Symphony Healthcare Services. The Chief Executive advised that work was also taking place looking at the integration between primary care and neighbourhoods, including the integration of demand not related to continuity of care. Neighbourhood working was one of the five system priorities.

- The UTC and emergency department will be managed by the same team and a decision as to which pathway is most appropriate for a patient will be taken by a senior clinician. It was expected that the UTC pathway will apply to the majority of patients.

- Concerns were expressed about the availability of space on the YDH site and it was queried whether some services could be provided off site. It was further queried what the outcome of the ward bed reconfiguration was. The Chief Executive advised that only phase 1 of the bed reconfiguration project at YDH had been completed but the aim will be to enable the acute medical unit to function as a medical unit. The community diagnostic centre will act as an enabler by freeing up space on the YDH site. The Chief Nurse agreed to provide an overview of the bed changes. **Action: Chief Nurse**.

- The Glastonbury festival had resulted in 50 ambulance transfers to YDH, and an overall 70 transfers from Glastonbury to YDH. The Chief Executive highlighted how well these additional pressures had been managed at YDH. It was noted that MPH colleagues had supported YDH colleagues on the YDH site and this had worked well.

- Clear criteria for the personalised cancer vaccine had been developed and it was the intention to introduce the vaccine in a phased way. Clinicians were part of the national study and were aware of the eligibility criteria.

- In terms of cyber security risks, it was noted that the Trust was Cyber Centre Plus accredited and the Data Security and Protection Toolkit assessment had been submitted in June 2024. The Trust had robust arrangements in place, but there was always a risk of a colleague clicking on an email link. A programme of testing cyber security fraud awareness will continue to be rolled out.

  It was recognised that vulnerability was with third party system suppliers and it was suggested that assurance should be sought from third party suppliers about the robustness of their cyber security arrangements. The Director of Corporate Services advised that seeking third party supplier assurance was part of the cyber security process, the Data Security and Protection Toolkit, and was built into the procurement process. The Director of Corporate Services advised that further assurance could be sought from the Director of Strategy and Digital Development. He agreed to ask the Director of Strategy and Digital Development to provide a report to the October 2024 Audit Committee meeting. **Action: Director of Corporate Services**.

10.8. Alexander Priest proposed, Inga Kennedy seconded and the Board approved the Continuity of Services Condition 7 – availability of resources – statement.

11. 2024/25 Q1 BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER REPORT

Board Assurance Framework (BAF)

11.1. The Director of Corporate Services presented the report which was received by the Board. It was noted that this version of the BAF had not yet been presented to the Audit Committee. The BAF had been amended to take account of the discussion at the June 2024 Board Development day.

11.2. The Director of Corporate Services highlighted the key risks on the BAF which continued to relate to: workforce shortages; access to primary care/increased ED demand; lack of pace of system-wide changes to address deficit; failure to identify and deliver sufficient recurrent cost improvements; and the risk of EHR business case not being approved or delayed.

11.3. The Director of Corporate Services highlighted objective 1 – improve health and wellbeing of the population – and it was noted that population health had been discussed at the ICB Board meeting held at the end of June 2024. Although responsibility for health and wellbeing of the population rested with the ICB, it was also important for the Trust to look at its role in terms of improving population health and identify areas where it could make direct contributions.

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

- Objective 8 – the Board had received updates on digital and capital developments, but it was important to retain a focus on progress in relation to the estate strategy and research.

- Objective 1 – the Board had received an update on population health at its May 2024 strategic session. The detailed work was encouraging and it will be helpful to see outcomes rather than more analysis.

  It was highlighted that there will need to be a focus on primary care as well as secondary care and community services and coordination and engagement with neighbourhoods and PCNs will be essential to ensure that everyone is working to the same agenda. The Chief Executive commented that the level of work on population health locally was variable. Discussions were taking place with a primary care practice in West Somerset about focussing on population health and inequalities. There were specific issues about young children and young people and their attendance and educational attainment and consideration should be given as to whether the Trust has a role in this area. West Somerset was an outlier compared to other areas in Somerset and the reasons were being explored.

- The development of the BAF was very encouraging and the BAF provided valuable information. In relation to objective 1 – the current risk had been

assessed as 12 and assurance was shown as “green”, controls were in place and actions to improve controls and assurances had been identified. The general feeling was that this risk was “green” and below its risk appetite level. However, objective 2 – provide the best care and support to people – was rated “red” – above risk appetite level, the residual risk and controls were “amber”, and actions were shown as “green”. These ratings indicated that the risk was above its risk appetite level and that this risk can only be managed to an “amber” level. It was felt that these ratings did not seem to be in line with the ratings for objective 1.

The Director of Corporate Services advised that the ratings reflected the impact on the Trust. The immediate level of risk in relation to the delivery of safe and quality of care was a bigger risk than the population health risk. On a system basis the population health risk was higher but the risk for objective 2 reflected the impact on the Trust. As a result, the Board’s attention should be on safe and high quality care and providing the right care.

- The plans were based on the financial year as it would not be prudent to make assumptions beyond the annual budget. However, the scoring against the strategies was based on the lifetime of the strategy.

- The number of KPIs had been extended and progress will be monitored as part of the quality and performance exception report.

- It was important to be realistic in terms of KPIs and recognise the potential for national policy changes, e.g. as a result of the general elections. There was a real drive and commitment to improve quality and safety of care and an improvement programme was in place. It was expected that performance in three years’ time will show significant improvements. KPIs were constantly reviewed and progress monitored.

- It was queried whether the residual workforce risks were assessed effectively and whether, in view of the actions taken, the consequence in terms of impact on safety of care was over estimated. The Chief Medical Officer advised that the use of agency colleagues was part of mitigation but as, generally, the quality of care provided by temporary colleagues could be variable the risk and consequence remained. The Chief Operating Officer agreed that the risks could not be just addressed with agency or locums and that transformational redesigns may be required for some services which will take time. The use of agency and locums was short term mitigation.

Corporate Risk Register

11.5. The Director of Corporate Services presented the report which was received by the Board. The risks had already been considered as part of the BAF discussion.

12. CARE QUALITY COMMISSION (CQC) MATERNITY SERVICES INSPECTION REPORT AND ACTION PLAN

12.1. The Director of Corporate Services presented the report which was received by the Board. The Director of Corporate Services advised that the inspection of the Trust's maternity services at Musgrove Park Hospital (MPH), Yeovil District Hospital (YDH) and at Bridgwater Community Hospital had been undertaken on 20 and 21 November 2023 with the inspection reports published on 10 May 2024.

12.2. He advised that the services were assessed against the CQC's "safe" and "well led" standards and that the CQC had rated the Trust's maternity services at MPH and YDH as "inadequate". The maternity services at Bridgwater Community Hospital had been rated as "requires improvement". As a result of these ratings, the overall location ratings for MPH and YDH had changed from "good" to "requires improvement ". The Trust was required to provide an action plan to address the concerns raised in the inspection reports and a comprehensive action plan was submitted to the CQC on 7 June 2024. The rating for the trust overall remained "good".

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

- The findings were very disappointing.
- A Section 29A Notice had been received in January 2024 with a requirement to address the issues by 1 May 2024. Confirmation had been received that the CQC was satisfied with the actions taken and that no further action in respect of the issues raised in the Section 29A Notice will be taken.
- Considerable work had been carried out since the inspection in November 2023 and the Maternity and Neonatal Acton Group had been set up to oversee the work taking place. In addition, a new maternity services leadership team was in place.

  The Chief Nurse advised that there has been significant reflection and learning since the inspection across all services. Engagement events have taken place with obstetric colleagues and the maternity leadership team wanted to express their thanks to the Maternity Neonatal Voice Partnership (MNVP) for their support in taking the engagement work forward.
- The inspection findings have an impact on the local rating for both YDH and MPH but the Trust's overall rating had remained "Good".
- The Trust's Unicef Baby Gold Standard accreditation had been suspended pending the outcome of a re-inspection.
- The Chief Nurse highlighted the progress against the action plan and it was noted that progress will be monitored through the Quality and Governance Assurance Committee. In addition, external validation of the improvement work will be sought and the Trust will be liaising with Royal United Hospital in Bath as their maternity services had been rated as outstanding.

- It was queried whether the issues identified were as a result of staff retention or recruitment issues. The Chief Nurse advised that she did not feel that this was related to retention and recruitment as the Trust was recruiting midwives and obstetricians.

- The issues raised had come as a surprise and it was queried whether learning about the governance arrangements relating to the quality of services had been identified. The Director of Corporate Services advised that Steve Thomson had been working within maternity and neonatal services for the last six months and a new framework for devolved governance had been developed and implemented. He advised that there were specific issues relating to maternity services but there was an issue about the rigour at service group level in terms of oversight and looking at assurance versus reassurance. There was also a need to close the loop – a significant number of audits were carried out but consideration will need to be given as to how to follow those through and embed learning. It was important not to lose sight of core governance arrangements and the lessons learned will also need to be considered as part of the productive care programme.

- The Quality and Governance Assurance Committee had received progress reports on compliance with the maternity incentive scheme (MIS) over the last year and the findings had come as a surprise. If the inspection had been prompted by a number of maternity or neonatal deaths or a serious incident, the issues would have been identified as part of the data submitted to the Committee. In general, estate, policies and procedures risks had been identified through the pre merger due diligence process. If overlaying all the known issues against the MIS, it provided a complex picture. At Committee level, it was acknowledged that too much time was spent on MIS and not sufficient time on the overall levels of risks across maternity services which were higher than recognised.

- The recognition that something had gone wrong and the amount of work carried out at all levels over a short period of time had been impressive. This work demonstrated that the Trust had the ability to deep dive and grip a problem and work out ways to move forward. There will always be problems and consideration should be given as to how to use learning from the inspection to manage problems as and when they arise, ensuring that they are identified as early as possible.

- A significant amount of data was presented to the Quality and Governance Assurance Committee by the service groups but, going forward, it will be essential to look at what the data is showing and the actions being taken and move away from a reassurance to an assurance approach.

- Maternity services had been treated in a different way to other operational services where a triumvirate approach was the standard approach. However, due to a more national approach to maternity services, the service had been treated in isolation of other services. This has meant that the service has not been stress tested in relation to winter and other pressures.

Although the service was stress tested on a daily basis, this was not in the same way that emergency, community and mental health services were stress tested. The service had been seen as the Chief Nurse's responsibility but this was not just a nursing or midwifery issue. The Chief Operating Officer, alongside the Chief Medical Officer, was now fully engaged with the work taking place.

The Chief Medical Officer reiterated the need for a triumvirate approach and advised that the monthly triumvirate meetings with all service groups provided a good forum to hear about the challenges and upcoming issues within the service groups.

- Going forward, it will be important to ensure that front line colleagues are fully understanding of the significance of corporate governance and the need to document good governance. Many colleagues see this as an additional burden and processes will need to be made as easy as possible. It will be helpful for the People Committee to consider this.

12.4. The Chairman thanked the Chief Nurse and Director of Corporate Services as well as the other Executive Directors for their focus on maternity services.

13. ASSURANCE REPORT OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING HELD ON 29 MAY 2024

13.1. Jan Hull presented the report which was received by the Board. She highlighted the areas of assurance received and the areas of concern/follow up, particularly the Regulation 28 Preventing Future Deaths Notice, the impact of the industrial actions; and the findings of the Joint Targeted Areas inspection.

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

- The positive assurance from the neighbourhood and community service group progress report.

- The assurance in relation to the Trust's response to the Care Quality Commission's maternity service inspection.

- The work in relation to Maternity and Perinatal Incentive Scheme (MPIS) Year 6.

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

- There were huge challenges for the maternity team and the team should be supported at every level and progress implementing the actions will need to be kept under close review.

13.4. The Chairman advised that Inga Kennedy will take over as chair of the Committee and, on behalf of the Board, he thanked Jan Hull for her excellent chairing of the Committee and the considerable progress made by the Committee.

14. LEARNING FROM DEATHS FRAMEWORK: MORTALITY REVIEW PROGRESS REPORT

14.1. Paul Foster joined the meeting for this agenda item. Paul Foster presented the report which was received by the Board. Paul Foster advised that the report demonstrated the processes for learning from deaths and how this learning was shared and improvements made within the trust. He highlighted the key findings of the reviews and examples of learning.

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

14.3. The Board discussed the reports and commented/noted that:

- The common themes from PALs and complaints related to communication, inadequate discharge planning, delays to treatment and concerns about care and treatment at end of life.

- The coding for septicaemia had been reviewed and this was reflected in the low septicaemia death rates at YDH.

- The Sentinel Stroke National Audit Programme stroke mortality report for Musgrove Park Hospital indicated that the Trust was not an outlier for mortality. The report will be further reviewed at the Mortality Surveillance Group (MSG).

- The content of the report had improved significantly and provided helpful information.

- It was queried whether the MSG received sufficient information to be able to identify the real issues. Paul Foster advised that the data and level of data presented to the Group was reviewed on an ongoing basis. The Group also took account of triangulation by reviewing national, local and “soft” data to avoid the reliance on a single source of data.

- Medical Examiners were independent in terms of their role but were employed by the Trust. The Chief Medical Officer commented that the reference to independence related to Medical Examiners reviewing cases in which they had not personally been involved.

- A request was made to include an executive summary in the report so that it will be easier to identify the key headlines. The Chief Medical Officer advised that it will be straight forward to highlight key headlines and agreed to further discuss this with the team. **Action: Chief Medical Officer**

- It was queried whether the raw data could be transferred into graphs to enable trends to be identified more easily. It was further queried what the key message from the standardised mortality ratio graph on page 12

was. Paul Foster advised that the graph reflected the Trust's position compared to peers and the graph showed that standard deviations were within expected levels.

14.4. The Board thanked Paul Foster and the team for their excellent work.

15. ASSURANCE REPORT OF THE PEOPLE COMMITTEE MEETING HELD ON 14 MAY 2024

15.1. Kate Fallon, Chairman of the People Committee meeting held on 14 May 2024, presented the report which was received by the Board. She highlighted the areas of assurance received and the areas of concern/follow up.

15.2. Kate Fallon advised that the Committee did not identify any specific risks which will need to be presented to the Board but the Committee agreed that the workforce risks remained areas for ongoing focus.

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

- The significant focus on inclusion.
- The need to focus in more detail on the onboarding and retention of international colleagues.

15.4. The Chairman advised that Tina Oakley has taken over as chair of the Committee and, on behalf of the Board, thanked Kate Fallon for her excellent chairing of the Committee and for the progress made by the Committee.

16. PATIENT STORY – "GAINING CONTROL – DELIVERING A PATIENT AND FAMILY CENTRED APPROACH TO HAEMATOLOGY CARE"

16.1. Gail Rawbone and Toni Hall joined the meeting for this agenda item.

16.2. Gail Rawbone and Toni Hall highlighted the story of two patients and their experience of a traditional model of inpatient haematology care and how, through service innovation, their care has been delivered through an ambulatory care approach. They highlighted the background to the ambulatory care approach and advised that the ambulatory care pilot, consisting of one chair in an ambulatory setting within existing resources, was set up in July 2023. The haematology service was the first service in the South West to use an ambulatory care approach for haematology patients and the delivery of ambulatory care was based on geographical needs. The pilot will be absorbed as part of the productive care work and measurable outcomes, e.g. the number of bed days saved, had been developed. Feedback from patients and carers/families was being collected and reviewed.

16.3. The story of patient one, Judith, highlighted the significant challenges faced by her and the impact long and multiple inpatient stays had on her mental health, family and

finances. She responded well to the ambulatory care approach which resulted in significant improvements in her mental health and her family life.

16.4. The story of patient two, Sue, highlighted her anxiety about a long inpatient stay and her decision to try the ambulatory care approach from the start of her treatment. Unfortunately Sue had to be admitted as an inpatient for 12 days due to poor health but the ambulatory care approach had enabled her inpatient stay to be reduced by 50%.

16.5. The Board discussed the presentation and commented/noted that:

- One ambulatory care chair was now available for ambulatory treatment and the service covered a large geographical area. Patients treated at home who experienced problems could be advised to attend ambulatory care for review. The number of ambulatory care chairs can be extended to three chairs.

- The story provided an excellent overview of the transformational work taking place and the focus on patient centred care.

- The service covered the Sherborne area and patients eligible and willing to use ambulatory care will need to be able to travel to Musgrove Park Hospital for this care.

- Chemotherapy services had been expanded to community hospitals and care was also provided in a patient's home. However the criteria for ambulatory care were more restrictive and patients will need to be within one hour of medical support; need to have a mobile phone; need to have someone at home; and need to be able to travel to hospital if feeling unwell.

- It was queried whether there was evidence that patients' blood counts recovered more quickly when treated in a home or ambulatory care environment. Gail Rawbone advised that data in relation to blood counts was not being collected but from general data it was evident that patients who slept and ate better, and who had family support, recovered quicker. It was not felt that there will be a huge difference in terms of blood count recovery.

- Data collected and monitored included the number and type of infections, e.g. fungal, as this was a key area of concern for patients staying at home.

- Chemotherapy ambulatory care was being provided in the Beacon Centre at MPH and there was overlap between haematology, oncology, cancer and rheumatology services. It was suggested that ambulatory care should be considered for as many services as possible. The Chief Executive advised that there was already a high focus on home treatments, e.g. Hospital@Home and earlier discharges, and if further extending ambulatory care, capability will need to be build up to be able to manage specific conditions. The Chief Nurse advised that transformation and looking at different ways of working had become business as usual but, in view of environmental factors and space limitations, it will not be possible to extend ambulatory care without looking at how other services are provided, e.g. what services

provided in the medical day unit can be provided elsewhere; and what surgical procedures can be provided as day surgery.

- It was queried whether feedback about the ambulatory care service had been received from colleagues. Gail Rawbone advised that significant time had been spent with consultants on the benefits of ambulatory care and the haematology team had worked hard to communicate the benefits of the service. The service had been set up with the support of consultants. The nursing team was also supportive of the service as they see the benefits for patients on a day to day basis.

16.6. The Board thanked Gail Rawbone and Toni Hall for their excellent work and focus on patient centred care.

17. INCLUSION PROGRESS REPORT

17.1. The Chief of People and Organisational Development presented the report which was received by the Board. The Chief of People and Organisational Development advised that the report outlined proposals for the next stage of inclusion across the trust with a broader focus on evidence-based and systemic approach to inclusion. The report further described the role of the Board in enabling inclusion to be fully embedded and set out proposals for development and training to support the Board in prioritising and embedding inclusion in its remit.

17.2. The Director of Corporate Services advised that inclusion also applied to patients and wider communities but not much engagement with patients and communities had taken place. A Patient and Carer Race Equality Framework (PCREF) had now been published and this provided a framework for taking inclusion work forward.

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

- The action plan had been reviewed by the People Committee.

- A draft inclusion strategy had been developed.

- The Board will need to consider the inclusion process and ensure that it was as inclusive and representative as possible. Consideration will also need to be given in terms of Board development and the systemic steps the Board can take to address inclusion.

- Inclusion covered a wide range of different dimensions with different sectors focussing on different elements. In view of the different dimensions, it was queried whether the focus on the broad inclusion definition was right. The Chief of People and Organisational Development advised that there was a large amount of data and soft intelligence and there was a clear difference in the experience of young colleagues. Colleagues covered four generations and the wants and needs of each of the generations will be different. In addition, the Trust covered a large demographic area and consideration should be given as to whether or not the Trust was representative

of this demographic area. The Trust was further learning more about neurodivergent colleagues and their needs, as well as the needs of international colleagues, will be different. It was therefore essential to look at all protected characteristics and the needs of each of these groups.

- Although protected characteristic information was collected this was not held in a central place and, going forward, progress will be reported to the Quality and Governance Assurance Committee.

- The Chief of People and Organisational Development was applauded on her energy and passion for inclusion.

- Leadership will be key in unlocking barriers to inclusion and managers will need to be supported by the Board.

- It was queried whether colleagues should be reflective of the communities the Trust served. The Chief of People and Organisational Development advised that if colleagues were not representative of local communities, it will be essential to ensure that feedback from non-represented communities was received in a different way. Managers may have become used to working in a specific way but managing a different workforce required different skills and, where needed, managers will need to be supported.

- Managers may be concerned making mistakes and more conversations with colleagues will be needed to ensure that they feel confident to act in the right way at the right time.

- Mental health leaders were felt to be less fearful of having difficult conversations and lessons could be learnt from these leaders.

- At a recent walkround, it was apparent that colleagues in the three home treatment teams visited were articulate in relation to the population in their areas. Although the population was very diverse, the teams were respectful and inclusive of the issues they were dealing with and their actions were geared towards understanding their populations.

17.4. The Board approved the appointment of the Chief Executive as the executive Inclusion Lead. The Board noted that inclusion was not restricted to the People Committee and that further discussions about Board development will be held after Phil Brice's return in October 2024.

18. QUALITY AND PERFORMANCE EXCEPTION REPORT

18.1. The Chief Finance Officer presented the report which was received by the Board. She highlighted the areas of good performance and provided an overview of the key performance challenges across the trust. The key areas of under-performance against targets and areas of concern related to: no criteria to reside within acute beds which continued to impact on patient flow; the percentage of people waiting under six weeks for a diagnostic test; the percentage of ambulance

handovers completed within 30 minutes of arrival at the Emergency Departments; the number of patients waiting 18 weeks or more for a community service; and the number of patients waiting 18 weeks or more to be seen by the community dental service.

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

- Due to the move to the new national Learn from Patient Safety Events (LFPSE) framework which requires changes to definitions and categorisations of incident data, data relating to a range of measures was unavailable whilst updates to the datasets were implemented.

- Mental health services were performing particularly well in relation to all performance metrics and were complimented on their performance.

- The precise data was not currently known but it was estimated that at least ten elective surgery lists were cancelled at MPH due to the industrial actions and it was expected that this will be the same at YDH.

- No update was available in terms of the future provision of stroke services and feedback from the Secretary of State for Health and Social Care review had not as yet been received. In the meantime, preparations for the implementation of the approved proposals will continue as planned.

- Overall stroke service performance was not good and it was queried whether any further actions could be taken. The Chief Executive advised that the original timeframe for the implementation of the stroke service proposals was May 2025 and this date took account of the lead-in time. Discussions with service groups were taken place to identify actions which could be taken to improve performance in the meantime.

- Stroke service performance was a key area to be reviewed by the Quality and Governance Assurance Committee and this will continue to be reviewed on an ongoing basis.

19. FINANCE REPORT

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

- The in-month deficit of £2.655 million which was £0.716 million favourable position compared with the plan for the month.

- The in-month agency expenditure of £2.799 million which was £0.340 million over the plan for the plan and £0.118 million above the cap.

- The in-month delivery of the cost improvement programme of £2.492 million compared with the plan of £2.573 million, an under-delivery of £0.081 million.

- The delivery of £2.5 million capital expenditure against a plan of £2.8 million.

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

- There remained a risk of further industrial actions and it was currently unclear how the financial impact and loss in activity will be managed.

- The ability to recover the slippage in the delivery of the cost improvement programme was a risk and additional cost improvements will be considered as part of the productive care programme. In addition, other opportunities for cost efficiencies were being considered. As for all cost improvement programmes, quality impact assessments will be carried out to ensure that the cost efficiencies do not impact on the quality of services.

- In view of the 10% consultant vacancy rate and the resulting financial impact, a deep dive had been carried out. It was recognised that there had been a high level of focus on nursing vacancies and this focus will also need to be extended to consultant vacancies.

20. STANDING FINANCIAL INSTRUCTIONS (SFIs) AND STANDING ORDERS (SOs) – PROCUREMENT CHANGES

20.1. The Chief Finance Officer presented the report which was received by the Board. She advised that the changes only related to the procurement elements of the SFIs and SOs and were in response to internal audit recommendations. The Chief Finance Officer highlighted the changes and advised that the changes had been discussed at the June 2024 Finance Committee meeting.

20.2. Martyn Scrivens proposed, Kate Fallon seconded and the Board approved the changes as set out in the report.

21. VERBAL REPORT FROM THE FINANCE COMMITTEE MEETING HELD ON 24 JUNE 2024

21.1. Martyn Scrivens, Chairman of the Committee, advised that the main items discussed at the meeting had already been discussed as part of previous agenda items.

21.2. Martyn Scrivens advised that the introduction of new building regulations was a concern in view of the potential delays in obtaining planning permission and the resulting delays in the completion of new builds. The Committee noted the delay in the opening of the additional ward at YDH from December 2024 to April 2025. The Committee noted that the impact of the new building regulations was being followed up with the NHS Health and Safety Executive by NHS England.

22. FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS

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

23. ANY OTHER BUSINESS

23.1. The Board noted that Wells Cathedral was holding a celebratory event for YDH colleagues on 2 July 2024 and the Board thanked the Cathedral and the Friends of Wells Cathedral for honouring colleagues.

23.2. The Chairman advised that this was the last public Board meeting for Barbara Gregory whose term of office will come to an end on 31 July 2024. On behalf of the Board, he thanked Barbara for her contributions over the last seven years.

23.3. The Chairman further advised that this was Phil Brice's last public Board meeting as Director of Corporate Services. On behalf of the Board, he thanked Phil Brice for his excellent and substantive contributions to the work of the Trust. The Board owed him its gratitude for particularly driving forward the Board Assurance Framework and for his professionalism. The Board agreed that Phil will be missed and wished him well in his retirement and new role.

23.4. Phil Brice advised that he had been in an executive director role in Somerset for 21 years and significant progress had been made over these years. The Trust was now in a good position to integrate services and break down barriers although he recognised the challenges delivering this.

24. RISKS IDENTIFIED

24.1. The Director of Corporate Services advised that no new risks which had not already been included on the Corporate Risk Register had been identified.

25. EVALUATION OF THE EFFECTIVENESS OF THE MEETING

25.1. The Board agreed that the meeting had been productive with a large number of items covered effectively, including the Care Quality Commission's report into maternity services. The patient story had been very good with lengthy discussions.

26. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

26.1. 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.

27. WITHDRAWAL OF PRESS AND PUBLIC

27.1. 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.

28. DATE FOR NEXT MEETING

28.1. 3 September 2024

SOMERSET NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETINGS

HELD ON 2 JULY 2024

	AGENDA ITEM	ACTION	BY WHOM	DUE DATE	PROGRESS
10.	Chief Executive and Executive Directors Report	To provide an overview of the bed reconfiguration on the YDH site.	Hayley Peters	September 2024	• EAU that was previously on Level 4 (previously 24 beds) with an additional 1 bed in each bay taking them up to 29 beds. These 5 additional beds added to the bays, are now included in the permanent bed base. On top of these 29 beds there were the 2 additional escalation beds, totalling (31). EAU now relocated to 6B and renamed AMU. This increases their bed to 36 Beds. Of these 36 beds 5 of these beds are in Bay 5 known as the Frailty Assessment Unit, (FAU), but not currently working as an FAU.

					• 9B Gastroenterology/ Oncology/ General medical ward previously - 37 Beds have now moved down to the old EAU footprint, 29 beds in total. • 6B Endocrine/ Gen Med/ Elderly Care ward. Moved to 9B. The bed base remained unchanged this was just a flip of wards, 37 core beds in total.
10.	Chief Executive and Executive Directors Report	To ask the Director of Strategy and Digital Development to provide a report on the process to seek assurance from third party suppliers about their cyber security process to the October 2024 Audit Committee meeting.	Phil Brice	October 2024	The Director of Strategy and Digital Development has confirmed that a report will be presented to the October 2024 Audit Committee meeting.
14.	Learning from Deaths Report	To consider the inclusion of an executive summary to the report.	Melanie Iles	November 2024	This request has been raised with the team and an executive summary will be included in future reports.

Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Registers of Directors' Interests
SPONSORING EXEC:	Jade Renville, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Colin Drummond, Chairman
DATE:	3 September 2024

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 26 August 2024.
Recommendation	The Board is asked to: • note the Register of Interests; • declare any changes to the Register of Interests; • declare any conflict of interests in relation to the agenda items.

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

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

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

Details: N/A

Equality and Inclusion

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

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

No impact on people with protected characteristics has been identified as part of the attached report.

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

Public/Staff Involvement History

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

Public or staff involvement or engagement has not been required for the attached report.

Previous Consideration

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

The report is presented to every Board meeting.

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

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

REGISTERS OF DIRECTORS' INTERESTS

NON EXECUTIVE DIRECTORS	
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 – Deputy Master • Trustee of the Harkness Fellows Association and Transatlantic Trust. Registered charity 1088426
Jan Hull Non-Executive Director	• 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 • Chairman Symphony Health Services
Alexander Priest Non-Executive Director	• Chief Executive Mind in Somerset
Martyn Scrivens Non-Executive Director (Deputy Chairman)	• Non Executive Director and Chair of Audit Committee of Hampshire Trust Bank Limited • Wife works as a Bank Vaccinator for the Trust • Non-Executive Director and Chairman of Wesleyan Bank Limited, a 100% subsidiary of Hampshire Trust Bank Limited" (with effect from 28 February 2022) ▪ Member of the Boards of Directors of the Ardonagh Group – consisting of the following companies: - Ardonagh Holdco Limited (Jersey) - Ardonagh New Midco 1 Limited (Jersey) - Ardonagh Group Holdings Limited (UK) - Ardonagh New Midco 3 Limited (Jersey) - Ardonagh Midco 1 Limited (Jersey) - Ardonagh Midco 2 plc (UK) - Ardonagh Midco 3 plc (UK) - Ardonagh Finco plc (UK) • Director of Ardonagh International Limited

Graham Hughes Non-Executive Director	• Chairman of Simply Serve Limited • Parish Councillor of Babcary Parish Council
Paul Mapson Non-Executive Director	Nothing to declare.
Inga Kennedy Non-Executive Director	• IJKennedy Healthcare Consultancy - Position - Director (however this Ltd Company is registered as not trading at this time. • Portsmouth Hospitals University Trust - Position - Non-Executive Director (end of term is Mar 24) • Isle of Wight NHS Trust - Position - Non-Executive Director (end of term is Mar 24)
Tina Oakley Non-Executive Director	• Son, Dr Tom Oakley, is Chief Executive Officer of a digital medical imaging company, Feedback plc.
EXECUTIVE DIRECTORS	
Peter Lewis Chief Executive (CEO)	• Member of the NHS Confederation Community Network Board • Management Board Member, Somerset Estates Partnership (SEP) Board • Director, Somerset Estates Partnership Project Co Limited
Jade Renville	• Executive Director of Corporate Services, Somerset ICB Board • Chair, Richard Huish Multi-Academy Trust (voluntary capacity) • Father is Director and owner of Renvilles Costs Lawyers
Isobel Clements Chief of People and Organisational Development	• Sister in law works in the pharmacy department at MPH • Nephew works as a physio assistant within MPH.
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	• Stepdaughter works at Yeovil District Hospital • Son works for the Trust

Chief Finance Officer	• Director of the Shepton Mallet Health Partnership • Director of Somerset Estates Partnership Project Co Limited • Member of the Southwest Pathology Services (SPS) Board • Shareholder Director for SSL
Hayley Peters Chief Nurse	None to declare
David Shannon Director of Strategy and Digital Development	• Member of the Southwest Pathology Services (SPS) Board • Daughter is employed as a healthcare assistant at Musgrove Park Hospital • Member of the Symphony Health Care Services (SHS) Board • Director of Symphony Health Services (SHS) • Wife works within the Neighbourhood's Directorate. • Management Board Member, Somerset Estates Partnership (SEP) Board • Director Predictive Health Intelligence Ltd
Melanie Iles Chief Medical Officer	None to declare

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Chief Executive/Executive Director Report
SPONSORING EXEC:	Peter Lewis, Chief Executive
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Peter Lewis, Chief Executive
DATE:	3 September 2024

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

Executive Summary and Reason for presentation to Committee/Board	The purpose of the report is to update the Board on the activities of the executive and senior leadership team and/or points of note which are not covered in the standing business and performance reports, including media coverage and any key legal or statutory changes affecting the work of the Trust. The report covers the period 27 June 2024 to 20 August 2024.
Recommendation	The Board is asked to note the report.

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

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

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

Equality and Inclusion The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
There are a range of issues covered in the report that highlight work we are doing and/or national initiatives in relation to equality, diversity and inclusion.

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

Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
The report includes a number of references to work involving colleagues, patients and system partners.

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

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

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

SOMERSET NHS FOUNDATION TRUST

CHIEF EXECUTIVE / EXECUTIVE DIRECTOR REPORT

1. RECRUITMENT FOR A NEW CHAIR

1.1. We have begun the process to recruit a new chair following Colin Drummond's announcement in April 2024 that he intends to retire after being the chair of Somerset FT and its predecessors since 2014. During that time, Colin has overseen the mergers of the three separate NHS foundation trusts which previously existed in Somerset, to create our single unique organisation.

1.2. We are working with GatenbySanderson to recruit a new chair. They have created a microsite and will be advertising the role in a number of online and media outlets.

2. GP COLLECTIVE ACTION IN SOMERSET

2.1. The British Medical Association (BMA) and GPs have voted to take national collective action starting from Thursday 1 August 2024. Action is not being taken by Symphony practices and therefore the impact on our services is likely to be seen through our Emergency Departments, Urgent Treatment Centres and Minor Injury Unit and referrals for elective care.

2.2. NHS Somerset is leading the communications and is advising that:

- GP services in Somerset will remain open
- Patients can still book appointments and attend any planned appointments unless their GP tells them otherwise
- Patients should continue to contact their practice as usual for their healthcare needs. However, some GPs may direct patients to other local services.
- Patients and the public are directed to a website with the information they need to access health and care services during the GP collective action in Somerset.

3. PATIENTS MOVE FROM ST ANDREWS TO NEW WARD IN SUMMERLANDS, YEOVIL

3.1. 23 July 204 marked an important milestone in the delivery of mental health services across the county, with the relocation of St Andrews ward in Wells, to the new mental health inpatient ward in Yeovil. The new ward in Yeovil

continues to provide 15 inpatient beds, supported by an experienced mental health team that will provide care for people with acute mental health needs. It is located next to the existing Rowan ward 1, that has also been extensively refurbished.

3.2. The ward cares for people with acute mental health needs and will enable us to provide safer care for those who need this level of mental health support. In addition to the four adult acute inpatient wards across the county, there are a broad range of other community based mental health services available. Over a number of years, the Open Mental Health alliance in Somerset, of which we are part, has expanded the range of mental health support that is available in communities in Somerset.

3.3. Patients on both Rowan wards are now able to access a range of facilities including their own en-suite bedroom, an activity room, a communal lounge, a separate female lounge, dining room, outdoor space, private quiet spaces, a family room, a gym, and a kitchen.

3.4. Multi-disciplinary teams are located on-site to cover both wards and provide 24 hour, safe and compassionate care, seven days a week. The team includes specialist mental health doctors, nurses, psychologists, occupational therapists, health care assistants, service assistants, ward clerks, and activity organisers.

3.5. You can find out more information about both Rowan wards and the range of mental health services provided in Somerset later on our website. We have also created a short video to show you round the new Rowan ward.

4. IMPROVEMENTS TO OUR MATERNITY SERVICES

4.1. We are making temporary changes that will affect women and pregnant people having a planned caesarean for approximately six weeks. Our service group and maternity colleagues have planned extensively for these changes with the support of Somerset Maternity and Neonatal Partnership to ensure that we support families and colleagues appropriately during this time.

4.2. Since 15 July 2024 we have been carrying out some essential work to upgrade and improve our current procedure room on labour ward at Musgrove Park Hospital. Once complete, this will allow us to provide a better experience for pregnant women and people having a planned caesarean, while continuing to provide emergency obstetric care.

4.3. The building works are part of our ongoing plans to make improvements to our maternity buildings and overall service. The need for this was set out in our recent Care Quality Commission report from November last year.

5. PUBLICATION OF CARE QUALITY COMMISSION'S (CQC) REVIEW OF MENTAL HEALTH SERVICES AT NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST

5.1. The CQC published the final part of its special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust (NHFT) in August 2024.

5.2. The review was commissioned, under Section 48 of the Health and Social Care Act 2008, following the conviction of Valdo Calocane in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber. The CQC was asked to look at three specific areas:

- a rapid review of the available evidence related to Valdo Calocane.
- an assessment of patient safety and quality provided by NHFT; and
- an assessment of progress made at Rampton Hospital since the most recent CQC inspection activity.

5.3. The publication makes recommendations for NHFT that relate to the care of Valdo Calocane. It also makes recommendations for NHS England (NHSE), including:

- Ensuring that providers' boards fully understand their role in the oversight of the needs of patients who have serious mental illness and who find it difficult to engage with services. This includes developing local services in partnership with others to provide intensive support to prevent this cohort of patients from falling through the gaps.
- Ensuring every provider and commissioner in England undertakes a review of the model of care in place for patients with complex psychosis who typically services struggle to engage and who present with high risk.
- Within the next 12 months, providing evidence-based guidance setting out the national standards for high-quality, safe care for people with complex psychosis and paranoid schizophrenia. Within 3 months of its publication, ensuring every provider and commissioner develops and delivers an action plan to achieve these.

5.4. The Health and Social Care Secretary Wes Streeting has called for the review's recommendations to be implemented across the country. The first report of the review, published in March 2024, included findings of CQC's assessment of patient safety and quality of care provided by NHFT at Rampton Hospital since CQC's last inspection in July 2023. The CQC has said the gaps and challenges identified at NHFT – demand for services and access to care, staffing, and leadership – are longstanding issues at the trust which need to be addressed. The report also noted that other community

mental health services are facing many of the same challenges as NHFT. Key recommendations for NHSE included to:

- Work with DHSC to define and agree clear standards in waiting times for community mental health services alongside those already established for Early Intervention in Psychosis (EIP) services and crisis services.

- Together with the CQC, work to establish what datasets are needed for monitoring the quality and safety of community mental health services, particularly around waiting times, unexpected deaths and suicide, crisis response times, incidents of serious harm to the public involving people using mental health services and treatment outcomes.

- Define clear standards for answering calls to mental health crisis lines so that improvements can be made to the number of calls that are abandoned each year by patients using those services.

- Work with the Royal College of Psychiatrists and the DHSC to review the community mental health framework for adults to standardise pathways of care and ensure there is a specific pathway for individuals who require assertive support and may be hard to engage.

5.5. As well as implementation of these recommendations, next steps include:

- NHSE will be conducting a more detailed scrutiny of Valdo Calocane's wider interaction with mental health services in its Independent Homicide Review. This has a broader scope than this and will be published by the end of 2024.

- CQC has begun work to look in detail at the standard of care in community mental health across the country to fully understand the gaps in the quality of care, patient safety, public safety, and staff experience in community mental health services. They are also working with NHSE to improve data on the quality and safety of community mental health services.

- The recommendations are being reviewed to identify any actions to be taken by the trust.

5.6. In addition, on 26 July, NHSE wrote to NHS mental health trusts and foundation trusts to highlight new guidance on intensive and assertive community mental health treatment which is designed to support ICBs to review their provision in this area. We also expect new waiting times data to be released in the autumn and national focus on reducing long waits.

6. SUPPORT AND REASSURANCE FOR COLLEAGUES FOLLOWING CIVIL UNREST

6.1. We have provided support for our colleagues following the civil unrest that has taken place in England and Northern Ireland during august 2024.

6.2. We sent a message from the Chief Executive and the Multicultural Network to all colleagues expressing our support, providing information about the practical steps that colleagues can take both to seek support if they need it and the actions they can take if they experience unacceptable behaviour from a patient or visitor.

6.3. In addition, we have written to all colleagues to ask them to please discuss any concerns they have about their welfare with their line manager to agree any actions that we can take to support them, to let them know that operational colleagues from across the trust have been meeting to ensure that we are prepared if there is any impact from further civil unrest on our services, and to respond to queries from colleagues.

7. PUBLICATION OF JOINT TARGETED AREA INSPECTION OF THE MULTI-AGENCY RESPONSE TO SERIOUS YOUTH VIOLENCE IN SOMERSET

7.1. A joint targeted area inspection (JTAI) of the multi-agency response to serious youth violence in Somerset was published on Thursday 18 July 2024. The report evaluates the effectiveness of the multi-agency response to children aged 10 and over who are at risk of or affected by serious youth violence and/or criminal exploitation. It recognises the complexities for agencies in intervening to address serious youth violence when risk and harm occur outside of the family home, and that a multi-agency inspection is likely to highlight some of the challenges to partnerships in improving practice. However, one of its headline findings is that ineffective partnership working between agencies has led to a failure to identify, understand and respond to the extent of serious youth violence and the criminal exploitation of children in Somerset, and, as a result, children are being left at risk of significant harm.

7.2. The report also finds that serious weaknesses in multi-agency safeguarding practice, professional curiosity and information-sharing mean that for many children with increased vulnerability to serious youth violence, the risks are not identified at the earliest opportunity. Examples of this include colleagues in our Emergency Departments not always recognising the need for a safeguarding referral and these sometimes being delayed, and Avon and Somerset Constabulary routinely capturing information and intelligence relating to serious youth violence and the criminal exploitation of children, but not sharing it with the local authority or other relevant partners.

7.3. Clearly, there is a lot of learning for us in Somerset. The Safer Somerset Partnership and the Safeguarding Children's Partnership are collating action

plans from all relevant organisations and strategically on behalf of each partnership to improve partnership working in reducing serious youth violence and criminal exploitation in Somerset. Progress on these plans will be overseen by both partnerships and the Integrated Care System Children and Families' Board.

8. VISIT BY DAME RUTH MAY, CHIEF NURSE FOR NHS ENGLAND

8.1. We were delighted to welcome NHSE chief nursing officer (CNO), Dame Ruth May, to Musgrove Park Hospital on 4 July 2024 in response to Colin Drummond's invitation earlier this year. She was able to learn more about our Somerset maternity and neonatal services; to hear about some of the key improvements that have been made since the CQC inspection in November 2023; and to be briefed about our plans to build a vitally needed new maternity and paediatric centre to replace our current estate which dates back to the second world war.

8.2. In her last clinical visit as chief nursing officer for NHS England before her retirement, Ruth met our own chief nurse Hayley Peters, director of redevelopment and new hospitals programme lead (NHP) Ian Boswall, director of midwifery Sally Bryant, associate medical director for obstetrics James Coulston, Maternity and Neonatal Voices Partnership (MNVP) chair Donna Butland and Colin Drummond as chair of the trust.

8.3. As part of the visit, Ruth heard positive feedback from service users about their experiences of our maternity services through our MNVP, and the clinical team described some of the improvements that we have made to care pathways, including the maternity triage service and elective surgery. The team also shared the proposed estates improvement plan for our current maternity and neonatal buildings as part of the national New Hospitals Programme.

8.4. During a tour of the facilities, Ruth also spoke to a number of colleagues from our maternity and neonatal services to hear about the challenges presented by the current condition of the maternity buildings and the interim improvements that have taken place to ensure that women and birthing people can continue to receive high quality care and have a positive birthing experience.

8.5. It was a pleasure to welcome Ruth to Musgrove Park Hospital and to have the opportunity to describe the development plans for our maternity and neonatal services, and to demonstrate some of the challenges that we are facing with our estates. It is vitally important that we are able to move our plans forward and we are very grateful to Ruth for taking the time to visit Somerset and to meet the teams who are working so incredibly hard to care for our service users.

9. HPMA EXCELLENCE IN PEOPLE AWARDS 2024

9.1. The Healthcare People Management Association has shortlisted our trust for the Social Partnership Forum Award for Partnership Working between Employers and Trade Unions in the national HPMA Excellence in People Awards 2024.The nomination is specifically for our work with trade unions in successfully resolving the healthcare support worker collective claim over rates of pay.

9.2. Following a national campaign by Unison to ensure healthcare assistants are rewarded, respected, and recognised, we received a ‘collective claim’ submitted by Unison members in February 2022 regarding the potential inconsistency of pay bandings for HCSWs.

9.3. The traditional response from all parties involved may have historically been to 'defend' each other’s position, providing mitigation and justification as to why each party holds the views/opinions/stance that they do. This approach is highly likely to escalate the issue, intrench positions and quickly lead to a policy-led or legalistic solution that only addresses the specific issue raised. This approach would focus on and address the symptom (pay) rather than the underlying cause of the issue, which is likely to be more complex and multifaceted.

9.4. Our trust and Unison engaged with each other early in open and honest conversation. We decided the best path forwards would be to work in genuine partnership, to fully understand the issue and why this issue had come about. Once we fully understood the current landscape, we could then work together to ensure our solutions and future ways of working were appropriate and addressed the underlying issues, not simply the issue of pay. This process could not have been successful without a level of trust and understanding from both parties, which is synonymous with effective partnership working.

9.5. By engaging at the earliest opportunity and mutually agreeing how best to approach this issue in the interests of colleagues, patients, and the trust, we were able to design a process that objectively established the root cause of the issue and how best to resolve this moving forwards. The focus was always on the process, not driven by a predetermined outcome. Early engagement from key stakeholders was fundamental to ensure wider ‘buy-in’ and commitment was in place to support the findings of the working group. Identifying those stakeholders at all levels of the organisation and maintaining regular/appropriate communications with these stakeholders allowed us to maintain momentum and focus as we developed our recommendations. By doing this in partnership, it also resulted in some innovative recommendations being created and colleagues feeling heard by the Trust in a way they hadn’t experienced previously.

9.6. The aim of this project was to resolve the Unison collective claim. However, the benefits delivered have been wider reaching than the initial objective of the project due to the approach taken:

- Visibility of HCA workforce and their trust in the organisation – the project has empowered junior colleagues to work closely with senior leads on a clear collective goal. HCA feedback has been that they have felt heard and valued as a key part IN finding a collective solution. New communication channels have been made and colleagues' confidence in the trust as an authentic and caring organisation in which to work has been reaffirmed.

- Workforce planning – supported by the research undertake as part of this project, we now have a clearly defined development pathway for all HCAs, directly linked to meeting patient need. This has had wider benefits in terms of how we recruit, and we hope will positively impact retention rates. It will also have a wider impact on patient care, as we are appropriately resourced to deliver the activities our wards/patients need.

9.7. The awards ceremony will take place in Belfast on Thursday 3 October, during the annual HPMA Conference.

10. VIOLENCE, PREVENTION AND REDUCTION SUPPORT FOR COLLEAGUES

10.1. At a trust-wide level, the results of our 2023 NHS Staff Survey showed that colleagues very sadly experienced violence, bullying, harassment and abuse from patients, service users and members of the public. This is a huge concern, and last year colleagues from across the trust came together to form a new Violence Prevention and Reduction steering group to review, develop and implement improved processes and information to support colleagues to deal with difficult situations.

10.2. One of the key developments has been the creation of an overarching draft strategy to address the significant and ever-increasing risk to colleagues from violence and aggression by members of the public. This will support colleagues to work in a safer and more secure environment, which safeguards against abuse, aggression, and violence.

10.3. The core principles and aims of the strategy are based on the belief that every individual within the NHS system deserves to feel secure and protected from all forms of violence and abuse, whether physical or verbal.

10.4. An additional development from the steering group, has been the introduction of the new 'Violence and Aggression (Concerning Behaviours') policy that has now been added to Radar and can be found on the intranet. The policy outlines our duty and commitment to provide a safe and secure environment and sets out the steps to support colleagues experiencing violence and aggression to support the health, work and well-being of colleagues and contractors, patients and visitors.

10.5. In addition to the policy, there are a variety of new tools that have been introduced to support colleagues. These include risk assessment tools, incident support advice, support for colleagues and managers through the colleague support service and new training resources that can be found on the electronic training system “LEAP”.

11. INTRODUCING OUR IV ANTIBIOTIC AT HOME SERVICE

11.1. A new care pathway has been introduced within our Hospital@Home service that has made it possible for patients to safely receive intravenous (IV) antibiotic treatment in the comfort of their own home.

11.2. As part of IV at Home, patients who are well enough to return home but require ongoing IV antibiotics, will receive them outside of the hospital setting.

11.3. The pathway has been developed by our pharmacy team, alongside both our frailty and respiratory Hospital@Home teams, complementing the services Hospital@Home already provides to patients that can be treated in the community.

12. REACHING OUT TO LESSER-HEARD VOICES IN SOMERSET

12.1. Gypsy and traveller communities are just one of a group of communities that struggle to access healthcare, with many barriers such as no fixed abode, accessibility, and discrimination and prejudice making it difficult for them to get the care they need. Teams across our integrated care system are working on addressing these health inequalities and colleagues from our patient experience and engagement service went to visit one of the three permanent, settled sites in Somerset, to find out more about their experiences.

12.2. Patient engagement and involvement manager, Lauren Hunter, and patient engagement and involvement assistant, Clare Charles, were supported by Edwina Heard, gypsy liaison officer at Somerset Council, with a visit to the gypsy and traveller site in Tintinhull on Wednesday 7 August.

12.3. While there, Lauren and Clare were able to meet with several residents, to understand their experiences of accessing healthcare, and to offer support, information and guidance.

12.4. Engaging with local communities is really important to help break down the barriers faced by some groups of people, and the patient experience and engagement service is looking to do more outreach work over the coming months.

13. ZAHARI BRIMACOMBE NAMED PURPLE PIONEER BY LEADING DISABILITY CHARITY

13.1. Zahari Brimacombe received a Purple Pioneer award for the work they have done, inside and outside of work, to champion the cause of disabled people in Somerset.

13.2. The Scope Disability Equality Awards shine a spotlight on equality champions, recognising and celebrating the achievements of people who campaign for disability equality, a change in attitudes, and bring about social change.

13.3. Zahari began their career at the trust in 2017 as a medical secretary in our mental health services, as well as a role in our temporary staffing team, while they have recently started as a trainee clinical coder, based at Musgrove Park Hospital.

13.4. The awards nomination says that Zahari "champions the cause of disabled people in Somerset" and that their achievements include "helping to establish a reasonable adjustments fund for disabled colleagues at Somerset FT, and contributing to the co-production of Somerset's autism services." It also says that "as inclusion adviser to Girlguiding Somerset, Zahari enables autistic and neurodivergent girls and disabled adult volunteers to attend camps and weekly meetings." Zahari also plays and promotes wheelchair tennis, and is a key member of Open Table Taunton, an LGBTQ+ inclusive church meeting accessible to disabled people.

14. CHANCELLOR'S STATEMENT ON PUBLIC SPENDING INHERITANCE

14.1. On 29 July 2024 the Chancellor Rachel Reeves gave a statement in Parliament on public spending.

14.2. In Fixing the Foundations, a public spending audit for 2024/25, civil servants found that there was a projected overspend of £21.9bn against departmental budgets presented at the Spring Budget, stemming from a range of unfunded spending commitments. In her statement, the chancellor set out work to reduce this pressure urgently, cutting spending by £5.5bn this year and £8.1bn next year. The chancellor's speech can be found here.

14.3. Of note for the NHS, the chancellor announced:

- Departments have been asked to find £3.2bn of savings from departmental budgets, including the end of all non-essential consulting.
- Public sector pay plans, as recommended by the independent pay review bodies, will be accepted in full. The 22% pay deal with junior doctors was also confirmed.
- The New Hospital Programme pledge to build 40 new hospitals will be

reviewed, and a new "thorough, realistic and costed timetable for delivery" will be published.

14.4. We had expected a review to take place after the change of Government and we are continuing to work on our programme as before, which will put us in good stead for the next steps.

15. HEALTHWATCH SOMERSET'S ANNUAL REPORT FOR 2023/24 AND ANNUAL REPORT EVENTS

15.1. Healthwatch Somerset has published its annual report for 23/34 detailing its work over the past year and its impact. The report demonstrates the depth and breadth of its work, how it has heard voices from across our county and how feedback is influencing decision making.

16. USE OF THE CORPORATE SEAL

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

16.2. The seal register entries over the period 1 April 2024 to 31 July 2024 are set out in the attached appendix.

17. MEDIA COVERAGE

17.1. Over the period 27 June 2024 to 20 August 2024, there has been the following media coverage:

- **GP from Symphony's Exmoor Medical Practice talks to Radio 4's Farming Today**
  Dr Jenny Capps from Symphony's Exmoor Medical Practice has been interviewed by Radio 4's Farming Today programme about how the practice is supporting farmers and rural workers. They set up an online booking service so that patients can tell the practice about their health concerns and receive a call back the next working day at a time convenient to them, or on the same day if their concern is urgent. The link to Jenny's interview on the programme is on BBC iPlayer.

- **Self-test cervical screening**
  Interview with Jo Morrison, consultant gynaecologist, on BBC Radio Somerset about the benefits of self-test cervical screening.
  Simon Parkin - 22/07/2024 - BBC Sounds (16:25 into programme).

- **ADHD diagnosis waiting times**
  There was widespread coverage on national, regional and local BBC outlets about waits for adult ADHD tests.

NHS England's national response is:
"Patients are waiting too long for an ADHD diagnosis which is why the NHS has launched an independent expert taskforce which will investigate the challenges facing ADHD services, so we help them manage the rising numbers of referrals."

Background
NHS England » NHS to launch cross-sector ADHD taskforce to boost care for patients in England
Rosie Grenter, clinical lead for our adult ADHD service was interviewed by BBC Radio Somerset. Her interview is 2.38.55 into the programme followed by an interview with a person who set up a support group in Somerset.

The following messages underpinned our interview:

- We want to apologise to anyone who has experienced a long wait for an ADHD assessment. Our waiting times are longer than people should expect, and this is something that's also reflected in many areas across the country.

- We are working hard to make improvements to our waiting times, and in 2021 we introduced a specialist adult ADHD service in Somerset, as a direct response to the increasing demand of people requesting an ADHD assessment.

- We are also working closely with our colleagues at the NHS Somerset Integrated Care Board to address how we can continue to meet this demand in a timely way, this involves us taking positive and innovative steps to become a more efficient service, such as exploring digital solutions, and how we can work better with our health and social care partners to help improve people's experience of our service.

- This includes carrying out a waiting list audit to clarify our current position and to provide a service update on patients who are waiting for assessment, refining and defining our referral pathway and assessment process.

- Soon, we will be implementing e-prescribing and are purchasing a digital platform which electronically collates pre-assessment information. These efficiencies will improve access to the service and swifter access to ongoing treatment.

- This increase in demand is also being discussed as part of a national NHS task force. The aims are: (Source NHS England » Attention Deficit Hyperactivity Disorder Taskforce chairs announced)

- To develop a national ADHD data improvement plan
- To carry out more detailed work to understand the provider and commissioning landscape
- To capture examples from local health systems which are trialling innovative ways of delivering ADHD services and to ensure best practice is captured and shared across the system.

- We anticipate the outcome will strategically shape the future on ADHD service provision across the UK.

- The steps we have already taken to improve our service are in alignment with this proactive and collaborative approach. We also anticipate the conclusion will inform our thinking on implementing further service developments.

- **Laser ablation for bladder tumours**
  Coverage appeared this week on BBC channels about our trust's use of a transurethral laser ablation (TULA) tool to destroy small bladder tumours. It is hoped that the tool will allow us to treat the majority of bladder tumours without needing more invasive surgery and enable us to treat patients more quickly.

- **Interview with Hannah Litchfield who swam the English Channel for Somerset NHS Charity**
  On Wednesday 17 July, our energy manager, Hannah Litchfield, took on an almighty challenge and swam the English Channel – a distance of around 21 miles. She took on the challenge to raise money for our Somerset NHS Charity and has so far had a huge amount of support, equating to £1,500. Her interview on BBC Somerset is available here, 2.54:30 into programme.

- **Introduction of surface guided radiotherapy treatment at MPH**
  Media coverage this week included interviews on BBC Somerset with specialist therapeutic radiographer Megan Le Riche and Paul Alway, chair of the SURE charity about the introduction of surface guided radiotherapy treatment at Musgrove Park Hospital. This has been made possible thanks to a donation of over £800,000 from the Somerset Unit for Radiotherapy Equipment (SURE) charity and means that our teams no longer need to tattoo reference points onto a patient's body, and they are not left with a permanent reminder of their cancer.
  The interview begins at 1.34:15 into programme.

- **Interview with Mr Sanjit Das about the TULA (trans urethral laser ablation) treatment for bladder cancer**
  Please see below coverage on yesterday's BBC Asian Show (south west) that includes an interview with Mr Sanjit Das about the TULA laser procedure – well worth a listen!
  https://www.bbc.co.uk/sounds/play/p0jbrkf5 (1:20.30 into programme)

18. NATIONAL DEVELOPMENTS

Interim Report into the Care Quality Commission (CQC)

18.1. The interim report into the Care Quality Commission (CQC) was published on 26 July 2024 and is available on the following link CQC Interim Report. The Government's response to the report is in this press release from the Department of Health and Social Care. The CQC's response is published on its website.

Impact of industrial action

18.2. NHS England has published the impact of the industrial action by junior doctors that took place from 27 June – 1 July. The data includes information on the number of colleagues absent from work as a result of industrial action, and the rescheduled acute inpatient and outpatient, community and mental health activity that will need to be rescheduled. The cumulative total of acute inpatient and outpatient appointments rescheduled since strikes began is now nearly 1.5 million according to NHS England in its press release.

Ipsos poll shows public satisfaction with the NHS has fallen to a record low

18.3. New polling published by the Health Foundation and undertaken by Ipsos shows that only 28% of the public think the NHS is providing a good service nationally, 6% less than in 2023, and the lowest since the Health Foundation started asking this question in 2021. This compares with 46% who disagree that the NHS is providing a good service nationally and 23% who neither agree nor disagree.

18.4. The polling, which was undertaken in May 2024, shortly before the General Election was called, also highlights the strength of concern about pressures on general practice, with more than three-quarters (78%) of the public now concerned about the level of pressure that GP practices are facing, up from 73% in May 2022.

18.5. When asked about different priority areas for the NHS, the public's top priority is reducing the number of staff leaving the NHS by improving working conditions (39%). This is closely followed by making it easier to get appointments at GP practices (34%) and increasing the number of staff in the NHS by increasing recruitment (32%).

18.6. The polling shows that more than half of people (52%) think the NHS will get worse over the next year. In particular, they think that pressure or workload on NHS staff (65%) and waiting times for routine services (62%) will get worse.

SOMERSET NHS FOUNDATION TRUST

SEAL REGISTER

1 APRIL 2024 – 31 JULY 2024

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

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	2024/25 Q2 Board Assurance Framework
SPONSORING EXEC:	Jade Renville, Director of Corporate Services
REPORT BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
PRESENTED BY:	Jade Renville, Director of Corporate Services
DATE:	3 September 2024

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

Executive Summary and Reason for presentation to Committee/Board	Somerset NHS Foundation Trust (SFT) has identified eight strategic objectives, which remain the long term aims for the newly merged organisation. The five clinical objectives are aligned with the system clinical aims which also form the basis for the clinical model. These sit alongside our financial, people and organisational objectives. **The Board Assurance Framework (BAF)** An Assurance Framework has been developed to clearly outline the highest risks to the Trust in achieving these objectives; the plans in place to manage and mitigate these and to provide the Committees and Board with a summary of key plans and strategies supporting their delivery. The highest risks to the strategic objectives are currently: • Access to primary care / increasing ED demand (objective 2) – 20 • Workforce shortages (objectives 2) – 20 • Vacancies within doctor workforce (objective 6) – 20 • Failure to identify and deliver sufficient recurrent CIP (objective 7) – 20 • Lack of pace of system-wide changes to address deficit (objective 7) – 20 • Risk of EHR business case is not approved or delays to process (objective 8) - 20

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

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

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

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

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

Details: N/A

Equality and Inclusion

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

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

The needs and impacts on people with protected characteristics have not been considered as part of this report but are considered as part of the mitigating actions taken at service group level.

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

2024/25 Q2 BOARD ASSURANCE FRAMEWORK

1. PURPOSE OF THE REPORT

1.1 To present the 2024/25 Q2 SFT Board Assurance Framework to the Board of Directors in line with the governance and monitoring arrangements outlined within Appendix 1 of this report.

2. CURRENT POSITION

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

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

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

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

- Vacancies within doctor workforce (objective 6) – 20
- Failure to identify and deliver sufficient recurrent CIP (objective 7) – 20
- Lack of pace of system-wide changes to address deficit (objective 7) – 20
- Risk of EHR business case is not approved or delays to process (objective 8) – 20
- Shortfalls in Social Care capacity (objectives 2 and 3) – 16
- Fragility of Primary Care (objective 3) – 16
- LOS > 21 days due to insufficient intermediate care capacity (objective 5) – 16
- Retention rate for some colleague groups (objective 6) – 16
- Burnout and exhaustion resulting in increased sickness absence (objective 6) – 16
- Unsafe premises and environment/fire compartmentalisation (objective 8) - 16

3. HERO/ASPIRATIONAL MEASURES

3.1 There has been further development of the hero/aspirational measures for each objective as included within the summary page of the BAF. A number of these are still in development to ensure their suitability and measurability.

5. CONCLUSION

5.1 The Trust continues to carry a significant number of high strategic risks that are over and above the level of risk it is willing accept within its Risk Appetite Statement.

5.2 There has been a reduction in the highest level of risks relating to Objective 3 (Strengthen care and support in local communities) bringing this within the agreed Risk Appetite level.

5.3 The level of risk associated with Objective 5 (Respond well to complex needs) has increased since Quarter 1 although this is still operating within the agreed Risk Appetite level.

5.4 Due to the nature of the wider NHS, a number of the highest rated risks are residual strategic or operational risks that the Trust may not be able to directly

influence. Consideration should be made as to whether or not further mitigations can be identified.

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

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

6. RECOMMENDATION

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

DEPUTY DIRECTOR OF CORPORATE SERVICES

BOARD ASSURANCE FRAMEWORK SUMMARY

Quarter 2 2024/25

Ref	Executive Owner	Corporate Objective		Hero/Aspirational Measure	Overseeing Committee	Risk Appetite		Highest Risk		Priority Programmes & Strategies		Risk Controls		Oversight Arrangements - Governance & Engagement	
1	MI	**Improve the health and wellbeing of the population**		**Healthy life expectancy**	Board	G	Seek 15-16	12	⇔	G	⇔	G	⇧	A	⇔
2	HP	**Provide the best care and support to people**		**TBC**	Quality & Governance Assurance Committee	R	Open 12	20	⇔	A	⇔	A	⇔	G	⇔
3	AH	**Strengthen care and support in local communities**		**TBC**	Quality & Governance Assurance Committee	A	Seek 15-16	16	⇩	G	⇔	G	⇔	A	⇔
4	HP	**Reduce inequalities**		**TBC**	Quality & Governance Assurance Committee	G	Seek 15-16	12	⇔	A	⇔	A	⇔	R	⇔
5	MI	**Respond well to complex needs**		**Criteria to Reside in acute beds**	Quality & Governance Assurance Committee	A	Seek 15-16	16	⇧	A	⇔	G	⇔	G	⇔
6	IC	**Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture**		**Retention rate: rolling 12-months**	People Committee	R	Seek 15-16	20	⇔	A	⇔	A	⇔	A	⇔
7	PM	**Live within our means and use our resources wisely**		**Underlying deficit - year on year reduction**	Finance Committee	R R	Financial Management Open 12 Commercial Seek 15-16	20	⇔	A	⇔	A	⇔	A	⇔
8	DS	**Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies**		**TBC**	Board	R	Seek 15-16	20	⇔	G	⇔	A	⇔	A	⇔

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

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

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

Diabetes: HbA1C checks	95% ⇩	Diabetes: pats on hybrid closed loops	65 ⇔	Smoking status: acute IP	32.3% ⇧
Smoking quit rates: Mental health IP	50% ⇔	28 day cancer faster diagnostic	75% ⇩	Suicide/Self harm prev: MH Staff	378 ⇧⇩
Suicide/Self harm prev: non-MH	233 ⇔				

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

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

Controls (*What we have in place to support delivery of the objective*)	Assurance (*Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*)	Outcome of assurance	Assessment (*See assessment guidance*)
Priority Programmes and Strategies			
ICS Population Health Strategy	ICS System Assurance Forum	Positive	
Smoking Cessation and Perioperative care programme	Priorities developed for ICS aligned with core20 plus 5	Positive	Green
Suicide prevention programme		Neutral	
Healthy Livers Project		Neutral	
Risk Controls			
Digital Strategy Board	Reports to the Board	Positive	
Weekly / fortnightly reviews of Patient Tracking Lists for tumour sites	Cancer gov invol System Performance Group, Cancer Performance S	Positive	Green
Oversight Arrangements for Governance & Engagement			
ICS Population Health Transformation Board	Progress on KPIs presented to Board on regular basis	Positive	
ICS Data Development Group	Overview of Programme to Board Development Session	Neutral	Amber
Trust Information and Data Group	Oversight of flagship priorities & clinical strategy - QGAC	Positive	
Quality Assurance Group	Oversight of topic assurance	Neutral	

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

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

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

Incidents involving ligatures	Apr	49 ⇩	Patient Initiated follow up (PIFU)	9.0% ⇧	Ambulance handover hrs lost >15m	12221 ⇩
CDiff cases in inpatient settings: YTD		38 ⇩	Falls per 1000 days	5.88 ⇧	Pressure ulcers per 1000 bed days	1.43 ⇧
End of Life pat discharges <24hrs		75.0% ⇔	Acute Home Treatment caseload	56 ⇧	No criteria to reside: % of acute beds	23.8% ⇩

	Key Risks (*High Consequence risks that may stop us achieving the objective*)	Risk Reference (*From corporate risk register*)	Current Risk Con	Lik	RS	Target Risk Con	Lik	RS
1	Access to primary care / increasing ED demand	1811, 372, 551, 673, 1709	4	5	20	3	3	9
2	Shortfalls in Social Care capacity	2273 & 1513	4	4	16	4	3	12
3	Age of acute and community estates	1789	5	3	15	4	2	8
4	Workforce shortages	2044, 1815, 1880, 1944, 2306, 2307, 2	5	4	20	4	3	12

Risk Appetite	
Open 12	Red - above risk appetite level

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

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

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

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

Adm. Prevented by Rapid Resp/AHT	440 ⇧	Pats admitted to Acute Home Treatmt	162 ⇩	Increase Open MH attendances	21729 ⇧
Increase numbers of self-referrals	##### ⇧	Urgent Community response <2hrs	87.5% ⇩	Treatmt Escalatn Plans -pat/fam involv	

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

Risk Appetite

Seek 15-16	Amber - within risk appetite level

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

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

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

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

Prot characteristics data completeness	⇔	Maternity: continuity of care hi risk tbc	⇔	Ethnicity equity of access:acute RTT	Equit ⇔
Ethnicity equity of access: cancer	Equit ⇔	Ethnicity equity of access: MH	Equit ⇔	Screening for people with LD - tbc	⇔
Safeguarding children Level 3 training	84.8% ⇩				

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

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

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

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

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

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

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

CYP Eating Disorders - Routine	96.6% ⇩	Reduce time in ED: intensity users	71897 ⇩	Time to assessment in CYPNP	90 wks ⇩
Av wait for assessment: adults w/ASD	59 wks ⇔	MH bed days: Cmplex emotionl needs	163 ⇧	Personalised care planning tbc	⇔
Dementia diagnosis rate-Symphony	55.3% ⇧	Homeless service: annual referrals	773 ⇧		

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

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

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

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

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

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

Retention: rolling 12 months	89.0% ⇩	Pulse Engagement	7.1 ⇧	Pulse Advocacy	7.1 ⇧
Learning measure tbc	⇔	Inclusion: % Band 8a+ who are female	58.3% ⇧	Retention: leavers <5yrs service tbc	⇔

	Key Risks (*High Consequence risks that may stop us achieving the objective*)	Risk Reference (*From corporate risk register*)	Current Risk Con	Lik	RS	Target Risk Con	Lik	RS
1	Vacancies within consultant workforce	2044	5	4	20	4	3	12
2	Retention rate for some colleague groups	1880	4	4	16	3	3	9
3	Burnout and exhaustion resulting in increased sickness absence	1944	4	4	16	3	3	9

Risk Appetite

Seek 15-16 — Red - above risk appetite level

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

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

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

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

Financial position v plan (YTD)	£1184k adv ⇩	% of CIP identified as recurrent	32% ⇧	Agency v plan (YTD)	2141k fa ⇧
No criteria to reside: % of acute beds	23.8% ⇩	Performance v workplan trajectory	##### ⇩		

	Key Risks (*High Consequence risks that may stop us achieving the objective*)	Risk Reference (*From corporate risk register*)	Current Risk Con	Lik	RS	Target Risk Con	Lik	RS
1	Failure to identify & deliver sufficient recurrent CIP	6	5	4	20	5	3	15
2	Lack of pace of system-wide changes to address deficit	960	5	4	20	4	3	12
3	The Trust fails to deliver the elective activity trajectory	1859	5	3	15	3	3	9

Risk Appetite

Financial Management Open 12	Red - above risk appetite level
Commercial Seek 15-16	Red - above risk appetite level

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

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

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

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

Research: active trials / studies open	243 ⇔	Quality Improvmt: training packages	301 ⇔	Data Delivery Strategy on track	⇔
Patient interactions via Patient Hub	4861 ⇔	Electronic Health Record on track	⇩	WTEs freed up: Robotic Process Auto	52.8 ⇧
New Hospital Programme on Track	⇩				

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

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

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

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

Appendix 1

1. BOARD ASSURANCE FRAMEWORK

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

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

2. ASSURANCE FRAMEWORK GOVERNANCE ARRANGEMENTS

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

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

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

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Corporate Risk Register Report
SPONSORING EXEC:	Peter Lewis, Chief Executive
REPORT BY:	Samantha Hann, Deputy Director of Integrated Governance
PRESENTED BY:	Peter Lewis, Chief Executive
DATE:	3 September 2024

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

Executive Summary and Reason for presentation to Committee/Board	The Board of Directors are ultimately responsible and accountable for the comprehensive management of risks faced by the Trust. They will: … ***receive and review the Corporate Risk Register via the Board Assurance Committees*** *and the Assurance Framework quarterly, which identify the principal risks and any gaps in assurance regarding those risks* Each Board Assurance Committee will receive the Corporate Risk Register report with the specific risks assigned to them. The Committees will formally review and scrutinise the risks within their remit. These reports will be received at least once a quarter together with the Board Assurance Framework. The highest areas of risk for the organisation are: • Pressures in social care; intermediate care; and primary care • Insufficient capacity to meet demand • Workforce recruitment and retention • Aging estates - acute and community • Financial position.
Recommendation	The report covers those risks detailed on the Somerset Foundation Trust Corporate Risk Register on 5 August 2024. The report focusses 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 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

Equality
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 (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
Not applicable

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

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

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

SOMERSET NHS FOUNDATION TRUST

CORPORATE RISK REGISTER REPORT

1. INTRODUCTION

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

2. PURPOSE OF THE REPORT

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

2.2 This risk report aims to provide details of the key risks detailed on the Trust's Corporate Risk Register on 5 August 2024 as shown within Appendix 1.

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

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

2.5 The report also includes the corporate risks identified by Simply Serve Limited (SSL) which is a wholly owned subsidiary of SFT. These risks will either be shown as additional corporate risks for SFT (currently no risks scoring 15 or above) or mapped into existing SFT corporate risks (Risk R2409).

3. CORPORATE RISK REGISTER

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

- Risk 0004 Demand (20)
- Risk 0006 Delivery of CIP 2024/25 (20)
- Risk 0012 Waiting Times (20)
- Risk 0862 Use of escalation beds across SFT (20)
- Risk 0960 Failure to deliver financial plan (20)
- Risk 2044 Vacancies within senior doctor workforce (20)

New Risks

3.2 There have been two new risks added to the Corporate Risk Register since the last report on 3 June 2024:

- Risk 1878 – Inefficient use of Safeguarding resource due to the current need to develop workarounds for using the multiple systems to ensure delivery of a safe Safeguarding Service

- Risk 2556 – Failure to secure necessary digital, data and technology infrastructure due to inadequate investment in people, their digital skills and literacy impacting recruitment and retention

Increased Risks

3.3 There have been no risks which have increased since the last report on 3 June 2024.

Risks which have Reduced

3.4 There has been one risk which has reduced since the last report on 3 June 2024:

- Risk 2192 – SHS not becoming financially self-sustaining

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 June 2024.

Risk Appetite and Risk Tolerance

3.6 Each of the risks on the Corporate Risk Register have been assigned to the most relevant strategic objective for the organisation, including for SSL where relevant. The risk has then been RAG rated to demonstrate whether the risk is within or outside of the agreed risk appetite level for the strategic objective the risk has been assigned to. This is shown within Appendix 1.

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

Emerging Risks

3.7 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.

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

4. RISK MANAGEMENT ARRANGEMENTS UPDATE

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

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

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

4.4 A progress report against the Year 1 Risk Management Strategy performance indicators was presented to the Audit Committee in July 2024 as part of the monitoring of the implementation of the Strategy. In addition, the draft 2024/25 Risk Appetite and Risk Tolerance Statement was also presented to the Audit Committee following the discussion at the Board of Directors on 7 May 2024 and approved.

4.5 The risk management training packages (Level 1 & Level 2 training as defined by the Risk Management Strategy) are in the final stages of development. The Risk Team presented to the Learning Committee in July 2024 for the Level 1 training to be mandated and uploaded to LEAP for use within the organisation. The outcome of the meeting is awaited. The Board of Directors received their annual Level 3 risk training on 7 May 2024.

4.6 On 5 August 2024, the SSL Board undertook its annual development session on risk management which included the Level 3 risk training for the Board. The SSL Board were presented with the following risk updates/document and made the following decisions:

Risk Update / Risk Document	Session Outcome
Changeover to risk register on Radar within the previous quarter	Noted
SSL Quarter 1 202425 Corporate Risk Register	Noted and approval to continue with the revised format of the report
SFT Risk Management Maturity Internal Audit Report	Noted the progress with the two recommendations within the audit that related specifically to SSL
SSL Strategic Objective Review	Discussed and agreed to remain with the existing 2023/24 strategic objectives for SSL
2024/25 Draft SSL Risk Appetite and Risk Tolerance Statement	Approved statement following agreement to remain with the existing SSL strategic objectives and the risk appetite levels

SFT Risk Management Policy & SSL Governance Structure Annex	SSL formally adopted SFT's policy for use within SSL with the addition of the approved SSL governance structure annex
Risk Management Framework Performance Indicator Report	Noted

5 CONCLUSION

5.1 The Trust continues to respond and manage to an exceptionally high level of risk. There has been progress in mitigating a number of risks but the position remains challenging due to workforce challenges 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 5 August 2024

NHS Somerset NHS Foundation Trust

People Committee

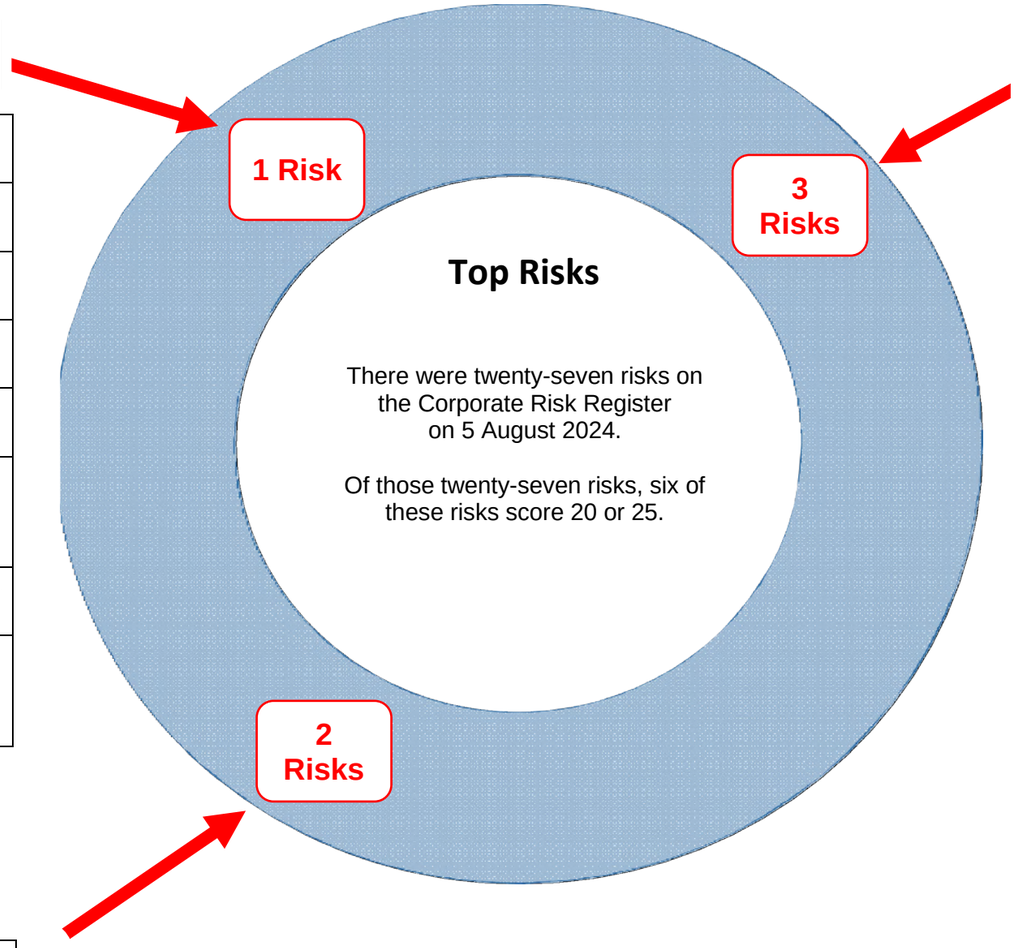
20	R2044	Vacancies rates within senior doctor workforce
⇔	SO6	

16	R1815	Vacancies and absence rates within nursing and AHP teams
⇔	SO6	
16	R1827	Lack of unified policy and approach for the management of colleague personal files
⇔	SO6	
16	R1880	Retention and turnover of staff
⇔	SO6	
16	R1944	Reduced colleague resilience due to prolonged impact of integration
⇔	SO6	
16	R2307	Current medical workforce establishment not mapped to year on year increasing demand
⇔	SO6	
15	R2306	Vacancies rates within trainee doctor workforce as a result of national shortage of trainees; Deanery allocations; and the structure of run throughs
⇔	SO6	
15	R2320	Decontamination techniques and processes not being followed due to lack of training
⇔	SO6	
15	R2556	Failure to secure necessary digital, data and technology infrastructure due to inadequate investment in people, their digital skills and literacy impacting recruitment and retention
NEW	SO6	

Financial Committee

20	R0006	Delivery of CIP 2024/25
⇔	SO7	
20	R0960	Failure to deliver financial plan
⇔	SO7	

16	R1611	Failure to secure necessary infrastructure due to the assurance of availability of capital funding either locally or through national programmes
⇔	SO7	
15	R1624	Failure to secure necessary digital, data and technology infrastructure due to inadequate investment and portfolio delivery
⇔	SO7	



Quality & Governance Committee

20	R0004	Demand
⇔	SO2	
20	R0012	Waiting Times
⇔	SO2	
20	R0862	Use of escalation beds across SFT
⇔	SO2	

16	R0007	Referral to Treatment Times
⇔	SO2	
16	R0673	Current capacity and future resilience of primary care in Somerset
⇔	SO3	
16	R1238	Fire Compartmentation
⇔	SO8	
16	R1852	Unsupported infection control electronic case management system
⇔	SO2	
16	R1878	Inefficient use of Safeguarding resource due to the current need to develop workarounds for using the multiple systems to ensure delivery of a safe Safeguarding Service
↑	SO8	
16	R2273	Insufficient intermediate care capacity
⇔	SO3	
16	R2413	Inability to proceed with planned go live of new ordercomms system
⇔	SO8	
15	R1789	Unsafe premises and environment
⇔	SO2	
15	R2053	Increased risk of harm due to development of episode of care pressure ulcers
⇔	SO2	
15	R2257	Non-compliance with National Bed Rails Patient Safety Alert
⇔	SO2	
15	R2462	Lack of knowledge, skill and resource to demonstrate compliance with national guidance and legislation for decontamination due to not having a dedicated decontamination lead in place
⇔	SO2	

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

Risk Appetite: Within Risk Appetite for the Strategic Objective (SO) risk is assigned to | Outside of Risk Appetite for the Strategic Objective (SO) risk is assigned to

7. BOARD ASSURANCE FRAMEWORK & CORPORATE RISK REGISTER

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

Board Assurance Framework

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

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

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

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

Corporate Risk Register

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

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

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

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

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

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

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

8. VALIDATION OF RISKS

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

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

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

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

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

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

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

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

9. RISK APPETITE AND RISK TOLERANCE

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

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

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

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

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

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

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

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

Figure 1

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

Figure 2

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

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 24 July 2024
SPONSORING EXEC:	Jade Renville, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Jan Hull, Chairman of the Quality and Governance Assurance Committee
DATE:	3 September 2024

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the Quality and Governance Assurance Committee meeting held on 24 July 2024. The Committee received assurance in relation to: • The management of the Corporate Risk Register. • The review of the quality of general ward care at the acute and community hospitals. • The Family Care service group assurance report. • The overview of emergency department performance across the acute hospital sites. • The quarterly maternity and neonatal safety and quality report. The Committee identified the following areas of concern or for follow up: • The further report on progress in relation to the MHRA bed rails alert to be presented to the September 2024 Committee meeting. • The emerging risk in relation to ICE/OrRderComms. • The update in relation to Wessex House and the closure of the ward to new patients.

	• The maternity services update and in particular the risk in relation to multi-disciplinary working on the YDH site. • The deep dive into maternity staffing with the findings of the review to be presented to the September 2024 Committee meeting. The Committee identified the following areas to be reported to the Board: • Maternity services – the increased risk in relation to multi-disciplinary working at YDH. • MIS Year 6 – clear indication of areas of compliance and areas where further evidence will be required. The Committee was also provided with a quarterly quality and safety report which provided an overview of the perinatal surveillance dashboards and perinatal safety. • The concerns in relation to paediatric services at YDH. • The Wessex House "reset" programme – risk of requirement for out of areas placement for Somerset CAMHS patients needing acute admission. • The GP industrial action ballot. • The OrderComms risk.
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Quality and Governance Assurance Committee. The Board is further asked to note the areas to be reported to the Board.

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

☒ Obj 8 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING HELD ON 24 JULY 2024

1. PURPOSE

1.1. The report sets out the items discussed at the formal meeting held on 24 July 2024, along with the assurance received by the Committee and any areas of concern identified. The meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

Corporate Risk Register

2.1. The Committee received the up-to-date combined Corporate Risk Register report and noted that there were currently 28 corporate risks on the risk registers of which seven scored 20 or above. The Committee noted the details of these risks, including the two new risks relating to: inefficient use of safeguarding resource; and failure to secure digital, data and technology infrastructure.

2.2. The Committee was advised of a further emerging risk in relation to discrimination and noted that the risk assessments will be discussed at the next People Committee meeting prior to the risk being added onto the risk register.

2.3. The Committee further received an update on the progress made in relation to risk management processes and noted: the proposal to make level 1 risk training mandatory for all colleagues; and the ongoing discussions in relation to system risk management and a system Board Assurance Framework.

Quality of Ward Care

2.4. The Committee received a presentation on the review of the quality of general ward care at the acute and community hospitals.

2.5. The Committee noted: the challenges obtaining ward level data and metrics due to the lack of a single source of ward to board information; the need to ensure the triangulation of information from wide ranging sources; the different type of care provided during the Covid pandemic and the impact on the quality of care; the speed of post-Covid change; the increase in care needs in terms of complexity, acuity and dependency; the cultural compatibility of ward teams; the ward reconfiguration; and the need to improve and standardise ward level data.

2.6. The Committee noted the staffing and leadership challenges observed following the reconfiguration of four acute units on the Musgrove Park Hospital (MPH) site and further noted that a review of the four wards had been commissioned to explore the challenges in more detail. The Committee received feedback from the detailed review and noted that, after initially struggling with the changes, wards were now settling down with stable metrics and with robust improvement plans. Further discussions with ward sisters and matrons will take place to ensure that they have the right resources.

2.7. The Committee received an update on ward leadership and noted that the review had highlighted that over 50% of ward leaders had been in post for less than three years with a number of ward and departmental leaders having retired or moved to less stressful roles. The Committee noted: the impact on the availability of mentors on adjacent wards or departments; the actions taken to enable ward leaders to focus on their development; and the development of a programme of ward accreditation with all wards expected to have undertaken this programme in the next 12 months.

2.8. The Committee acknowledged the challenges and issues raised and agreed that the detailed overview provided good assurance in terms of oversight and actions being taken.

Service Group Assurance Report – Family Care

2.9. The Committee acknowledged the challenges faced by the service group particularly in relation to maternity services.

2.10. The Committee received the assurance report from the family care service group and noted the key highlights from the report, including: the appointment of a new leadership team for maternity services and the changes in leadership structure and governance assurance; leadership changes in other teams; the strong engagement from all clinicians and managers; and the progress in relation to the productive care programme.

2.11. The Committee was informed of the concerns in relation to multi-disciplinary working on the YDH site and the services to which these concerns related were noted. The Committee further noted: that risk assessments of safety and quality risks were being undertaken with risks expected to score 16; and the mitigation actions being put in place to manage these risks.

2.12. The Committee received an update on the actions taken to address the quality and safety concerns of the paediatric services at Yeovil District Hospital (YDH) and noted: the establishment and work of the Paediatric Action Group; the integration of service level governance processes; and the work in relation to the development of the paediatric and CAMHS leadership structure.

2.13. The Committee received an update on the actions taken following the Care Quality Commission's maternity services inspection and noted: the implementation of the maternity improvement programme; oversight of the programme by the Maternity and Neonatal Action Group; that significant

improvements had been made since the inspection but that further work was still required; the recognition by the CQC of the significant improvements made; the decision to seek the support from the Maternity Safety Support Programme (MSSP) and enable their diagnostic team to undertake a deep dive of services.

2.14. The Committee received an overview of the service group's achievements which included: an exceptionally strong service user voice within maternity care and dental services leading to co-production and significant changes in dental services; the involvement of the CAMHS participation workers on the paediatric acute wards and the impact of their feedback on the delivery of care across CAMHS and paediatric services; the findings of the staff survey which were particularly positive in view of the many challenges faced by the service group; the introduction of a new leadership model and the resulting transformational thinking; the reduction in the number of children eating disorder patients requiring inpatient care as a result of the training and education of colleagues within the paediatric ward; and the successful tender bids by SWISH and SAINT services.

2.15. The Committee noted that the next steps for the leadership team will be to strengthen relationships across the integrated service group.

2.16. The Committee acknowledged the significant challenges and achievements and agreed that the report provided assurance about the progress made and oversight arrangements.

Emergency Department/A&E Waiting Times

2.17. The Committee received an overview of emergency department performance across the acute hospital sites. The Committee noted that the performance information reported nationally included performance data from the two emergency department, urgent treatment centres and minor injury units.

2.18. The Committee noted: the key challenges in relation to flow into the ED, processing within the ED, and flow out of the ED; the increase in demand both nationally and locally; the actions being taken to manage demand, e.g. projects such as "Call before you convey", care coordination hubs and Hospital@Home; the reasons for patients presenting at ED and not requiring to be admitted – core ED business or overspill from primary care where capacity to manage urgent care needs is stretched.

2.19. The Committee noted that a large amount of urgent care activities took place in minor injury units and noted the development of co-located urgent care centres on the acute sites; the environmental and workforce challenges; and the work taking place to address these challenge.

2.20. The Committee received an overview of the process for admitting patients presenting to the emergency department and noted: the pressure on the Acute Medical Unit – the admitting unit – due to the demand on the unit; the impact of long admission waits on the older population; the work taking place

to develop an acute frailty pathway alongside the acute medical pathway to address the inequality of care experienced by older patients; the implementation of the acute frailty pathway on the Musgrove Park Hospital site and the future implementation of the pathway on the Yeovil District Hospital site; and the focus on the recruitment of Care of the Older People consultants.

2.21. The Committee further noted the ongoing work to increase weekend discharges and the continued pressures as a result of the volume of patients with no criteria to reside remaining in inpatient beds.

Maternity and Perinatal Incentive Scheme (MPIS) Year 6

2.22. The Committee received the quarterly maternity and neonatal safety and quality report and welcomed the new format and the combination of a number of reports into a single report.

2.23. The Committee noted: that the number of maternity and neonatal safety referrals and outcomes were in line with the regional and national position; the details of the new referrals; evidence of the improved governance arrangements and the triangulation of information; the review of the maternity guidance and the prioritisation of updating site specific guidance; the reduction in compliance for the overall Savings Babies Lives standards as a result of the merger of site specific compliance data; the work taking place to improve anaesthetic colleague's compliance with PROMPT; the recent recruitment of neonatal colleagues and the recruitment campaign for 2 wte band 5 colleagues; and the position in terms of safeguarding children and adult training.

3. AREAS OF CONCERN OR FOLLOW UP

MHRA Bed Rails Alert

3.1. The Committee received an update on the progress made actioning the alert and noted that progress was ongoing. The Committee was informed of an incident involving a patient's arm getting trapped in the bed rail causing them harm and noted that this incident had been reported in line with reporting processes. The Committee noted that a further progress report will be presented to the September 2024 meeting.

Corporate Risk Register

3.2. The Committee received an update on an emerging risk relating to ICE/ Ordercomms and noted that discussions with the digital team were taking place to ensure that the three individual elements of the risk – cyber security, unsupported lab centre and resilience of the system, and the impact on EMIS - were captured on the corporate risk register. The Committee further noted the overarching risk relating to the implementation of ICE and the impact on Ordercomms; and the concern about the primary care element of the implementation of ICE.

Wessex House SBAR

3.3. The Committee received an update on the Wessex House tier 4 CAMHS inpatient ward and noted the concerns raised by a number of different sources in relation to treatment, colleague attitude and practice; the escalation of these concerns to the South West Provider Collaborative; the establishment and membership of the Wessex House Improvement Group; and the findings from a recent Leadership Quality Walkround.

3.4. The Committee noted the decision by the Improvement Group to close the ward to new patients for a period of time; the criteria which will need to be met to enable the re-opening of the ward; the clinical review and the safe discharge of the two remaining patients; the strengthening of the senior leadership arrangements; and the development of a "reset" programme.

3.5. The Committee noted that the opportunity will be taken to carry out a strategic review of the Tier 4 admission needs for young people in Somerset as well as a review of PICU, low secure and specialist eating disorder services. This review will be in addition to the "reset" programme.

3.6. The Committee noted the concerns that young people needing an acute admission will need to be send out of area during the closure of the ward to new patients and noted that, due to the focus on outreach and community services, the admission rate was very low but, if needed, placements will be available in Devon or Dorset.

3.7. The Committee acknowledged that the actions being taken were justified and appropriate. The Committee will monitor progress made through regular progress reports.

Maternity Services Update

3.8. The Committee received a detailed update on the risk in relation to multi-disciplinary working on the Yeovil site and the actions taken to mitigate this risk. The Committee noted: the externally facilitated consultation looking at multi-disciplinary cultures in the professions within maternity and obstetrics which was part of a national programme of work commissioned by NHS England; the remit of the programme – to look at leadership and culture within services and to undertake listening exercises and focus groups; and the leadership and cultural issues identified as part of this programme and as part of other processes.

3.9. The Committee noted that the consultation report had now been received and that the findings of the consultation and the next steps to be taken had been discussed with the relevant team. The Committee noted the immediate actions taken, the programme of work to be implemented over the next 18 months, and the work with Royal United Hospital in Bath and other trusts which had been assessed as having a strong maternity and obstetric service leadership.

3.10. The Committee noted that the consultation report in relation to Musgrove Park Hospital had also been received but that the report did not include the same level of challenges in terms of multi-disciplinary working.

Maternity and Perinatal Incentive Scheme (MPIS) Year 6

3.11. The Committee noted the deep dive to be undertaken into staffing in preparation for the BirthRate+ report and the presentation of the findings to the September 2024 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:

- Maternity services – the increased risk in relation to multi-disciplinary working at YDH.
- MIS Year 6 – clear indication of areas of compliance and areas where further evidence will be required. The Committee was also provided with a quarterly quality and safety report which provided an overview of the perinatal surveillance dashboards and perinatal safety.
- The concerns in relation to paediatric services at YDH.
- The Wessex House “reset” programme – risk of requirement for out of areas placement for Somerset CAMHS patients needing an acute admission.
- The GP industrial action ballot.
- The OrderComms risk.

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 – the Committee received some assurance, both positive and negative, from the presentation around Quality of Ward Care.
- Objective 2 – the Committee received positive and negative assurance from the Family Care Service Group assurance report.
- Objective 4 – The Committee received negative assurance regarding Wessex house but also positive assurance about the low admission rate for Somerset CAHMS patients which highlights the strength of the community CAMHS services.

5.2 The Board is asked to direct the Committee as to any future areas of deep dives relating to the above objectives and the others within its delegated remit.

Jan Hull
CHAIRMAN OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Learning from Deaths Report – Quarter 1
SPONSORING EXEC:	Melanie Iles, Chief Medical Officer
REPORT BY:	Claire Bailey, Learning from Deaths Lead Laura Walker, Head of Patient Safety and Learning Gary Filer, Quality and Safety Analyst
PRESENTED BY:	Dr Paul Foster, Clinical Director
DATE:	3 September 2024

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

Executive Summary and Reason for presentation to Committee/Board	This report is a requirement of the *National Guidance on Learning from Deaths* (National Quality Board, March 2017) and the *Implementing Learning from Deaths framework, key requirements for Trust Boards* (NHS Improvement, July 2017). Executive Summary and highlights from this report: Learning from the deaths • Our learning appears to be aligned with our PSIRF priorities, themes of TEP and communication continue. Good care seen in patient with Learning disability. • Joint cross-service level governance meetings is a good forum to embed learning. • A reminder that care to the patient and family continues after death especially around communication. Learning from the data • Our overall Trust Mortality Rate is as expected – SHMI 1.02. Learning from the detail • Medical examiners are reviewing 98% of SFT deaths, concerns are cascaded appropriately to SJR/PSI.
Recommendation	The Board of Directors are asked to discuss this report.

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

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

Details:

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

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

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

Equality and Inclusion **The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.** **How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?**
This report has been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics.

All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.
Not applicable.

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

LEARNING FROM DEATHS REPORT – QUARTER 1 2024-2025

1. BACKGROUND AND PURPOSE

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

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

2. UPDATE ON THE MORTALITY REVIEW PROCESS

2.1. The next phase of the national roll out of the Medical Examiner Service, in which they will provide independent scrutiny to all non-coronial deaths without exception, is expected to come into force on 9th September 2024. Helen Waldon, the Lead Bereavement and Medical Examiner Officer and Implementation Lead for the Somerset Medical Examiner Service, has been developing the local arrangements to meet the requirements set out for the statutory service. To date, 49 out of 64 GP practices in the catchment area are referring deaths to the Medical Examiner service. There has been a significant increase in activity for the service, who have completed scrutiny on 373 community deaths during the reporting period, compared to 215 in Quarter 4, 149 in Quarter 3 and 99 in Quarter 2. We continue to see an impact of this roll-out with the Medical Examiner team sharing an increasing amount of feedback about SFT care for patients who have died in the community. We are working closely with colleagues in the Patient Experience team to ensure that we can maximise on the opportunity to learn and improve our services from the feedback that we receive.

2.2. The core function of the Mortality Surveillance Group (MSG) is to ensure that we have strategic level oversight of the Trust's position regarding mortality and can provide assurances that our processes maximise learning from the deaths of people in our care. The Terms of Reference for this meeting have been reviewed in line with the organisation's devolved governance structure.

The first meeting using this new format was held on 17/06/2024. Service group representation is an essential component of this meeting, and those colleagues in attendance will play a vital role in escalating concerns, disseminating learning, and reviewing our data.

2.3. Learning from Patient Safety Events (LfPSE) was implemented as planned on 01/05/24 and marks a change to how patient safety events will be reported. Early analysis of the data suggests that whilst there hasn't been a significant change in incidents reported with a fatal outcome, there has been a drop in overall reporting during this quarter, including during April ahead of the switch to LfPSE. It isn't currently clear whether this is due to the transition to the new system, or if this is being driven by other factors. This will continue to be monitored closely as more data becomes available and we will be able to explore this further.

2.4. On 24/05/24, Laura Walker and Paul Foster attended a system wide mortality meeting chaired by the ICB. In this meeting, Laura presented to the group an overview of the Trusts approach to Learning from Deaths, outlining the successes and challenges that we have seen to date with this as well as sharing examples of learning that has led to service improvements. The feedback from this was positive, with system partners reflecting that they could extract learning for their own processes from this.

2.5. At the beginning of May, the Trust received confirmation that both of our acute hospital sites were accepted to be in the first phase of a regional pilot programme to support the national development and implementation of Martha's rule. Once fully implemented, patients, families, carers, and staff will have round the clock access to a rapid review from a team skilled in managing deterioration if they are worried about a person's condition as well as being asked on a routine basis about how they are feeling. An overall steering group has been established to ensure that there is a consistent approach across both sites and small working groups are being set up to explore next steps.

2.6. On 12/06/24, a joint specialty Mortality and Morbidity meeting took place involve colleagues from our Cardiology, Vascular and Critical Care teams at our MPH site. The aim of this meeting was to establish better cross specialty working when complex cases arise and share learning and insights. In this meeting, 4 such deaths were discussed. A theme was identified around communication. It was felt that there was a reluctance of junior nursing and medical staff to approach consultants that needed to be addressed as well as the ability of other specialties to contact the on-call cardiologist. All in attendance agreed that this was a useful meeting, and it was decided that these would be held regularly on a six-monthly basis.

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

3.1. Examples of learning:

- A Patient Safety Incident Investigation (PSII) was conducted following the unexpected death of an inpatient, in line with the trust PSIRF priority of *recognition, escalation and management of deteriorating patients*. The PSII identified several key areas for improvement and made several safety recommendations. These recommendations will feed into an existing safety improvement plan that was developed as an initial response to the incident. For instance, the PSII found that there were occasions when physical observations were incomplete and/or incorrectly calculated, which may have delayed recognition that the patient was deteriorating. Whilst a programme of training for all clinical staff on monitoring physical observations is in place, the PSII highlighted concerns around the potential for ongoing risk of human error/omission by relying primarily on a paper-based observation recording system. It has been recommended that the trust implement a digital clinical monitoring system.

- Following the death of a patient with Learning Disability on one of our medical wards, an SJR was completed. This found that the care given to the patient during this admission was good. The SJR was provided to LeDeR for inclusion in their Focussed Review, and feedback from this review was shared with the Trust. Concerns were raised about the care provided by another trust in the months prior to this admission. The LeDeR review described an episode of care in which a urethral catheter was inserted. It was thought that this episode of care fell short of best practice. The placement of a urethral catheter had not been discussed with the patient's carers or family, resulting in a missed opportunity to make a Best Interest decision as well as put in place specialist support to prepare the patient for the procedure. Sadly, the patient was extremely distressed by the device and frequently pulled it out, causing further trauma and catheter associated Urinary Tract Infections. These issues continued for the rest of the patient's life. This patient's story has been shared with our specialist Learning Disability teams so that the learning points can be disseminated widely.

- The bereavement team shared feedback with the Patient Experience team and Learning from Deaths Lead from the family of a patient who died on one of our medical wards. Despite treatment for cardiovascular issues, the patient continued to deteriorate and became increasingly frail. It was recognised that the patient was approaching the end of their life. The family described that they had asked for a nominated member of the family to be contacted at any time with updates to the patient's condition to ensure that they were able to support the patient's spouse. Sadly, when the patient died during the night the family were not contacted, and they found out after the patient's spouse visited the ward. This was incredibly distressing for the family. It was agreed that PALS would follow up with this concern. The ward team contacted the

family and apologised for the poor communication. The family were happy for their experiences to be shared with staff to emphasise the importance of delivering high quality care after death to both our deceased patients and their families. Furthermore, extra checks around documentation have been put into place.

- The Medical Examiner highlighted the death of an inpatient who was under the care of our vascular team. The patient had been admitted electively for a metatarsal amputation and was initially clinically stable post-operatively, but sadly deteriorated acutely a couple of days later and died unexpectedly. The team completed an SJR. It was acknowledged that this was not an avoidable death as the patient's prognosis was poor with or without surgery. Whilst it would not have changed the outcome in this case, it was discussed that there was no pre-operative assessment completed or clerking relating to the admission. To increase clarity of when a clerking entry is needed, this can now be prompted through the electronic patient record.

- Following the death by suicide of a patient known to our community mental health services, an investigation was completed. The patient had been making frequent contact with multiple services and was reporting suicidal ideation. A Dialog+ started, following which there was a marked reduction in contact from the patient. It was found that during this time, it was not recognised that the patient was presenting with an increased risk of completing suicide. One of the learning points identified by the investigation concerned an expectation for patients to initiate contact with services. This has led to the introduction of the First Response Service, which operates like a hub by triaging all urgent contacts made by patients and providing brief intervention. This has enabled the Home Treatment Teams and Duty Workers to reconfigure their workloads with an emphasis on "proactive" rather than "reactive" contact and support for patients.

- The Medical Examiner shared feedback about End-of-Life Care following their scrutiny of a death of a patient who had been admitted to one of our medical wards after having a stroke. The team completed an SJR and found that it was quickly identified that the patient's prognosis was poor. This was discussed with the patient's family, who agreed with a plan for ward-based care only. The patient's Treatment Escalation Plan was updated accordingly, and they were switched to a palliative pathway. Without further discussion with the family, this decision was reversed, and elements of active treatment were restarted. Learning was identified around recognition of the dying patient and the importance of involving families in these decisions. This patient story will be included as a scenario for Simulation training in End-of-Life Care education.

3.2. The following section of the report describes the differing processes used to identify learning such as that noted above. Where there has been activity

within the reporting period this is included along with details of any more general themes identified.

- **Scrutiny through the Medical Examiner service**
  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. Whilst the Medical Examiner service is independent of SFT, 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.

  The Medical Examiner's office had 555 deaths of patients under the care of SFT reported to them between January and March 2024. Of these, 495 were within our acute hospitals and 59 were within our community hospitals. 98% of the 555 deaths were scrutinized by the Medical Examiner team. In total, 65 deaths were highlighted to Learning from Deaths.

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

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

During this reporting period there was 1 inpatient death of a person with Learning Disability. Concerns were raised by the Medical Examiner and the family of the deceased about their inpatient care, as well as by colleagues in the LD liaison team via the incident reporting system. These concerns were discussed via the rapid review process, where it was agreed that they met two of the Trust's PSIRF priorities around Treatment Escalation Plans (TEP's) and people who matter.

- **Incident process**

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

  Within this reporting period, eight deaths have been discussed at rapid review meetings. Three of these deaths met the criteria for a Patient Safety Incident Investigation, three deaths met the criteria for an internal review using an alternative PSIRF tool, one case will be looked at internally using the Perinatal Mortality Review Tool (PMRT). For the remaining one death, no further internal review was required, and all learning had been identified and was being actioned by the clinical team.

- **PALS and complaints**

  During this quarter, 19 PALS queries and 6 formal complaints have been raised concerning the deaths of patients in our care. Common themes are around poor communication (including communication that lacked compassion and kindness), not feeling listened to, inadequate discharge planning, and concerns about care and treatment at the end of life.

- **Maternal and Perinatal Deaths**

  There have been no maternal deaths during this reporting period.

  Eligible perinatal deaths are reviewed using the Perinatal Mortality Review Tool (PMRT). In this reporting period, there were 6 perinatal deaths that were eligible for PMRT. All are on track for completion within expected timescales. We have been made aware of 1 further death that triggered PMRT processes, which will be led by another NHS Trust. As antenatal and/or postnatal care was provided by SFT services, we will be involved in this review as there may be learning opportunities for our services.

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**
  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.

  During this reporting period, there was 1 expected inpatient death of a child who was on a palliative care pathway. No additional internal review. We have been made aware of a paediatric death of a child who died whilst under the care of another trust but had been under the care of SFT prior to this. This care was thought to be relevant to the outcome and was discussed at a rapid review meeting. In addition to participating in the CDOP process, the paediatric team will complete an MDT review.

- **Coronial activity**
  During this reporting period, there were 47 new enquiries from the coroner concerning the deaths of patients known to SFT. Formal statements have been requested for all cases.

  Several inquests pending from previous reporting periods have been concluded during this quarter. This includes 28 read-only inquests and 4 inquests heard with witnesses called, 1 of which was a jury inquest. There have been 3 pre inquest review hearings heard for inquests that are due to be heard at a later date. During this quarter, the Trust has been issued with 2 regulation 28 prevention of future deaths reports, both of which related to patients who were under the care of our Mental Health services at the time of their deaths. To date, we have submitted a response to 1 of these reports, which was issued due to concerns about observation practices in Mental Health inpatient areas. This has led to a full review of the Trust policy on *Observations while maintaining Safety and Engagement* to provide greater clarity about the 4 different prescribed levels of observation, as well as the training requirements for colleagues who carry out observations, including practices for the safe removal of ligatures. A response to the second report, which raised concerns about mental health deterioration and menopause, is due in Quarter 2 and this is being prepared by colleagues.

3.3. Standardised mortality

Summary Hospital-level Mortality Indicator (SHMI), February 2023 – January 2024

Source: NHS England (June 2024)

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

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

Trust level

Trust	Provider spells	Observed deaths	Expected deaths	SHMI value
Somerset NHS FT	80,950	3,285	3,220	1.02 As expected

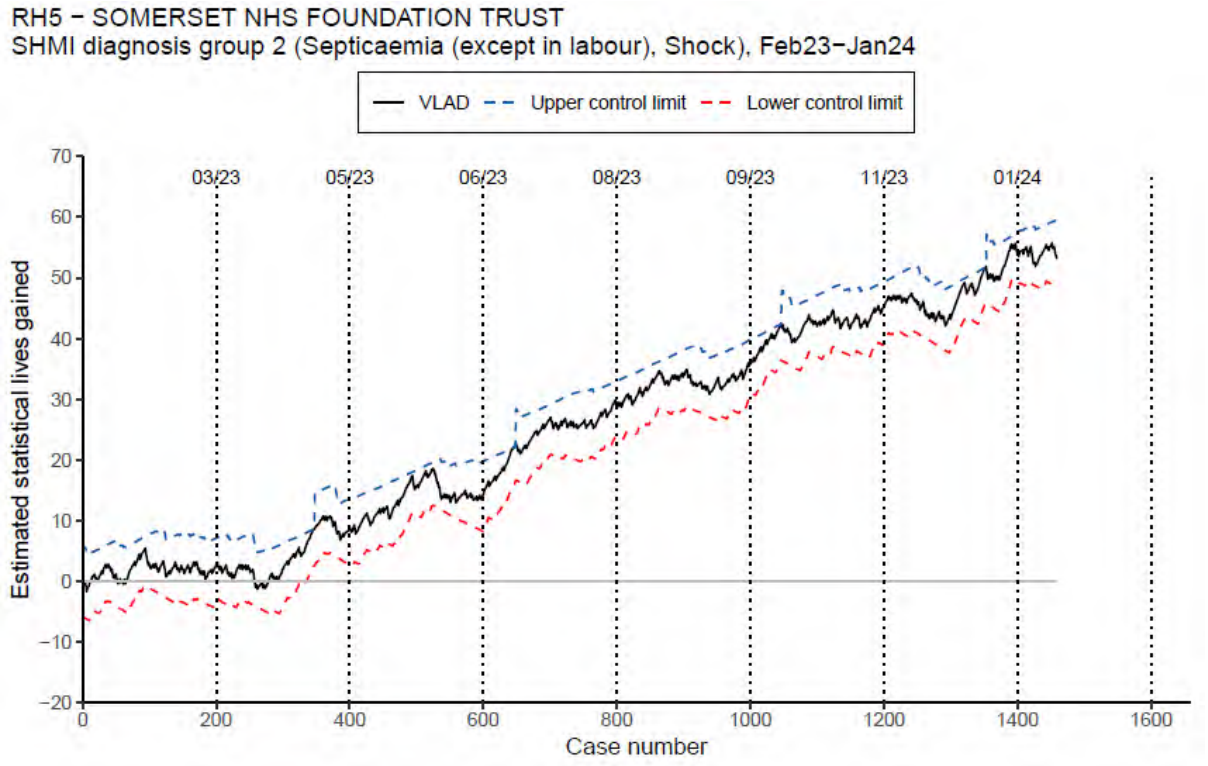
Site level *Acute hospitals and exceptions*

Site	Provider spells	Observed deaths	Expected deaths	SHMI value
Musgrove Park Hospital	56,435	1,950	1,980	0.98 As expected
Yeovil District Hospital	22,585	1,180	1,115	1.06 As expected

Diagnosis group *Reported groups by exception*

Diagnosis group	Provider spells	Observed deaths	Expected deaths	SHMI value
Septicaemia (except in labour), Shock	1,460	295	350	0.85 **Lower than expected**

Visual life adjusted display (VLAD) – recent alerts



3.4. **Standard mortality ratios from HED**

Source: HED.nhs.uk - SHMI HES and HSMR HES modules (24 June 2024)

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

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

Trust level

Trust	SHMI (Mar 23 – Feb 24)	HSMR (Apr 23 – Mar 24)
Somerset NHS FT	101.4 (As expected) 95% CI: 97.8 - 105.0 Observed: 3,115 Expected: 3,073 Spells: 77,281	105.9 **(Above expected)** 95% CI: 101.0 - 111.1 Observed: 1,728 Expected: 1,631 Spells: 50,484

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

Site	SHMI (Mar 23 – Feb 24)	HSMR (Apr 23 – Mar 24)
Musgrove Park Hospital	97.1 (As expected) 95% CI: 92.7 - 101.6 Observed: 1,841 Expected: 1,897 Spells: 54,200	113.3 **(Above expected)** 95% CI: 106.1 - 120.9 Observed: 913 Expected: 806 Spells: 31,241
Yeovil District Hospital	106.0 (As expected) 95% CI: 99.9 - 112.4 Observed: 1,122 Expected: 1,059 Spells: 21,312	93.8 (As expected) 95% CI: 87.1 - 100.8 Observed: 735 Expected: 784 Spells: 17,448

Plans for reviews in response to Standardised Mortality Data

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

3.6. We have been alerted by the National Hip Fracture Database that one of our acute sites is an outlier for mortality. The team have an action plan in place to address this and an internal review of cases is ongoing.

Appendix 1

Somerset NHS Foundation Trust

		2023/2024												2024/2025							
		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)	182	203	202	587	157	183	156	502	187	171	233	591	236	195	201	632	163	179	153	495
	Total Scrutinised by ME	182	199	190	571	157	183	156	502	175	168	207	550	231	193	195	619	156	179	153	488
	SJR's requested by LfD	12	9	8	29	14	10	12	36	10	9	10	29	10	9	8	27	10	3	9	22
	SJR's completed	24	18	25	67	24	27	23	74	19	18	22	59	21	15	9	45	6	1	0	7
	Problems in care**	5	3	1	9	0	2	2	4	1	0	0	1	0	0	1	10	0	0	0	0
	Serious Incident/PSIRF***	0	0	0	0	0	0	0	0	1	0	0	1	1	1	1	3	2	3	3	8
	Learning Disabilities: internally all deaths in acute inpatient settings are subject to review or investigation																				
	Total deaths	3	0	2	5	4	0	3	7	1	1	2	4	3	2	5	10	0	0	1	1
	Review/investigation completed	2	0	2	4	4	0	3	7	0	1	1	2	2	1	3	6	0	0	0	0
COMMUNITY HOSPITAL	Total deaths	22	22	16	60	19	18	29	66	24	22	17	63	19	15	20	54	19	18	22	59
	Total scrutinised by ME	22	19	15	56	19	18	29	66	24	22	17	63	19	15	20	54	19	18	22	59
	SJR's requested by LfD	0	1	1	2	1	0	2	3	0	1	0	1	0	0	0	0	0	0	0	0
	SJR's completed	0	1	1	2	1	0	2	3	0	1	0	1	0	0	0	0	0	0	0	0
	Problems in care**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incident/PSIRF***	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MENTAL HEALTH	Total deaths (reported as incident)	5	10	6	21	8	10	3	21	4	9	6	19	10	4	9	23	3	4	5	12
	Total scrutinised by ME	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0
	SJR's requested by LfD	1	5	3	9	1	0	2	3	2	2	1	5	3	0	2	5	1	2	3	6
	SJR's completed	1	5	3	9	1	0	2	3	0	2	1	3	2	0	1	3	0	2	0	2
	Problems in care**	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
	Serious Incident/PSIRF***	0	1	0	1	1	0	0	1	0	0	1	1	2	0	1	3	1	1	2	4
COMMUNITY SERVICES	SJR's requested by LfD	0	0	1	1	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0
	SJR's completed	0	0	1	1	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0
	Problems in care**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incident/PSIRF process initiated	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total deaths subject to Coroner's Inquests		18	31	16	65	12	12	10	34	14	19	18	51	24	18	20	62	12	20	15	47

* Note – figures for legacy SFT and YDH Trusts have been combined for this report
**Where SJR has identified that a death was thought more likely than not to be related to problems with care
***All PSIRF learning responses included from January 2024

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	2023/24 Quality Account
SPONSORING EXEC:	Jade Renville, Director of Corporate Services
REPORT BY:	Steve Thomson, Director of Integrated Governance
PRESENTED BY:	Jade Renville, Director of Corporate Services
DATE:	3 September 2024

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 2023/24. 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 2023/24 once again confirmed that there was no requirement for an external audit opinion on the Quality Account. For 2023/24, the Trust continued to focus 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. Stakeholder comments are awaited and will be included in the final version to be presented to the September 2024 Council of Governors meeting.
Recommendation	The Board is asked to discuss the Quality Report/Quality Account 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 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

Equality and Inclusion

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

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

The 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 provided an opportunity to ensure that everyone in the county enjoys consistent access to high quality services. The merger eliminated organisational boundaries and puts the Trust 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.

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 report has 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 Account is published annually. Oversight of delivery of the objectives is delegated to the Quality and Governance Assurance 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

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust

Quality Report 2023/24

- 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 2023/24 – 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 (SFT), for the financial year 2023/24.

This was a particularly important year for us, as it was the first following our merger of legacy Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust. Together, we provide a broad range of services. These are services from the two acute hospitals in Somerset (Yeovil District Hospital (YDH) and Musgrove Park Hospital (MPH) in Taunton), community-based services across the county, services from our 13 community hospitals across Somerset, mental health and learning disability services across the county, and we manage a quarter of the county's GP practices through our subsidiary company, Symphony Healthcare Services.

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

Our NHS Trust is created on the foundation of our clinical strategy. The five aims of this strategy form are also our Trust's strategic objectives and are shared by NHS Somerset. They have the prevention of ill health, care and support in local communities, and reducing inequalities, at their core because it is essential that we focus work in communities to support people to remain in good physical and mental health for as long as possible.

These aims are to:

- **Improve the health and wellbeing of our population**. Enable people to live socially connected healthy, independent lives, promote early intervention and prevent avoidable illness.
- **Provide the best care and support to children and adults**. Ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting.
- **Strengthen care and support in local communities**. Develop and enhance support in local neighbourhood areas and bring care closer to home.
- **Reduce inequalities**. Value all people alike, target our resources and attention where it is most needed, giving equal priority to physical and mental health.
- **Respond well to complex needs**. Improve outcomes for children and adults with complex needs through personalised, co-ordinated support.

There is very good evidence to show that colleagues who are supported in their roles, supported to develop, engaged in the work of their team and services, and supported to maintain their health and wellbeing, provide better care and services to patients. It is

therefore very important that another one of our Trust's strategic objectives is to support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture.

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

During 2023/24, colleagues in different services in different parts of Somerset, have taken strides to implement our clinical strategy. Examples of this include:

- The development of new techniques and ways of working within our acute hospitals to provide more procedures as day cases, which support patients' recovery and free up acute hospital beds, enabling us to reduce waiting lists. Examples of developments this year include colleagues in our gynaecology team performing a laparoscopic and a vaginal hysterectomy as day case procedures for the first time; the introduction of an endoscopic spinal surgical system which means that more patients can leave hospital on the day of their surgery with very little physiotherapy or follow up care required; and becoming the first Trust in England to perform a "closure of ileostomy" as a day case. This development has enabled patients to return home under the care of our Hospital@Home service which monitors our patients closely in the same way they would be observed while in hospital.
- The expansion of community diagnostic centres in Somerset, which will give patients quicker access to the diagnostic tests that inform their treatment. During the year we expanded the Taunton Diagnostic Centre and the Yeovil Diagnostic Centre, adjacent to the hospital, is due to open this winter. This centre will provide outpatient appointments and over 70,000 diagnostic tests including radiology, endoscopy, cardiology and audiology diagnostic tests.
- The launch of a new service that has completely transformed care for those suffering post-menopausal bleeding, which can be a sign of womb cancer. The number of patients being referred to the Trust with these symptoms had increased very significantly, which resulted in long waits for patients to be seen and have the diagnostic tests they need to rule out cancer. In response, we developed the new service enabling people with symptoms to make a self-referral into the service, bypassing their GP. If they meet the criteria, they are booked into a one-stop appointment. Historically patients on a suspected womb cancer pathway would attend 3 appointments taking 63 days on average. With the new service, the patient attends only 1 appointment, on average taking 4 days from self-referral.
- The work of our community rehabilitation service, which gives people the confidence to remain at home without needing a stay in hospital. The multi-disciplinary team looks after patients with long-term conditions, helping people to remain as independent as possible either in their own home, or in a nursing or care home. The team works closely with colleagues at MPH, YDH, our

community hospitals, and adult social care, and focus on what's important to the people they support, with everything they do tailored to each individual patient.

- The work of our homeless and rough sleepers nursing service that also supports people in communities, while also addressing health inequalities and responding well to complex needs, by helping people who live on the streets, in hostels, in tents and in vans access support with their physical and mental health.
- Our new children's and young people's access team that supports families to access mental health support and our new maternal mental health service that supports families following the loss of a baby, or a traumatic experience related to pregnancy, birth, or a post-natal experience.

We implemented many developments during 2023/24, but it was once again a challenging year for the NHS with many people needing urgent care. It is vitally important that we address the underlying causes of inequalities and poor mental and physical health in our communities and focus our services and work with health and social care in Somerset to support this.

We work very hard to do our best for patients and this means also acknowledging, reflecting, and taking action when we do not get things right. The Care Quality Commission inspected our maternity services at Musgrove Park Hospital, Yeovil District Hospital and Bridgwater Community Hospital in November 2023 and those reports were published in May 2024. The services at the two acute hospitals were rated as Inadequate overall and the service at Bridgwater Community Hospital was rated as Requires Improvement overall. Following the maternity services inspection, the overall rating for both our acute hospital sites decreased to Requires Improvement.

Those reports illustrate that we have fallen short of the standards we expected to be delivering, and we said sorry to our families that use these services and to our hard-working colleagues. We are committed to improve, so that we provide an excellent service that supports women, birthing people, and families in Somerset and have made significant changes since the inspection in November 2023. I am very grateful for our colleagues who are working very hard to improve our service, to the Somerset Maternity and Neonatal Voices Partnership who are working with us to ensure that the voices of those who use our services are at the heart of our improvements.

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

In April 2020, Somerset Partnership NHS Foundation Trust (SPFT) and Taunton and Somerset NHS Foundation Trust (TST) merged to create the legacy Somerset NHS Foundation Trust, which was the first Trust in mainland England to provide integrated community, mental health, and acute hospital services. Subsequently, on 1 April 2023, the current Somerset NHS Foundation Trust was formed when legacy Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust (YDHFT) merged.

The merger between the legacy Somerset NHS Foundation Trust and YDHFT was in response to the recognition that no individual organisation in Somerset had what it would take to respond to the challenges alone. The merger bought together our skills, knowledge and resources in health together with those of our colleagues in social care, education, housing and the voluntary sector to tackle health inequalities and to enable our communities to thrive.

The journey towards merging both YDHFT and the legacy Somerset NHS Foundation Trust started in May 2020, where both Trusts signed a Memorandum of Understanding (MoU) in which the Trusts committed to work together for the benefit of the Somerset population by aligning the Trusts' strategic goals and operational activities. The Trusts signed the MoU to improve services for patients, but it was not intended to be a permanent position. Moving towards acting as one Trust, but legally being two separate organisations, carries cost and time inefficiencies which were hard to justify in the long-term. There was also a risk of lack of clarity around accountabilities as we continued to integrate and blur some organisational boundaries.

Following directly from this greater collaborative working, the Trust Boards explored options for the future. This included using an agreed selection criteria leading to three shortlisted options. Independent support was sought from Deloitte LLP, resulting in the conclusion that neither a Partnership Board nor a Strategic Group Board model would deliver the sustainable system change that Somerset needs; and that a single leadership team and Board would be the most effective mechanism for realising the significant benefits to be had from closer collaboration. The Trust Boards therefore concluded that formally bringing the two organisations together was the preferred model.

The merger brings together all of Somerset's NHS acute, community, mental health and learning disability services, and around a fifth of primary care into a single NHS Foundation Trust. Our plans were developed closely with our Somerset system partners. The merged Trust is now in a unique position to provide genuinely integrated mental and physical health care, spanning whole patient pathways.

Purpose and Activities of the Trust

Somerset NHS Foundation Trust provides a wide range of services for the whole of Somerset, as well as parts of North and West Dorset. 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's general services are commissioned by the local Integrated Care Boards while specialist services are nationally commissioned.

The Trust provides acute services from Musgrove Park Hospital (MPH) in Taunton, which has around 700 inpatient beds, and Yeovil District Hospital (YDH) in Yeovil, which has around 330 beds. We also operate 13 community hospitals (with over 220 beds), providing inpatient, outpatient and diagnostic services, six Urgent Treatment Centres and one Minor Injuries Unit.

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.

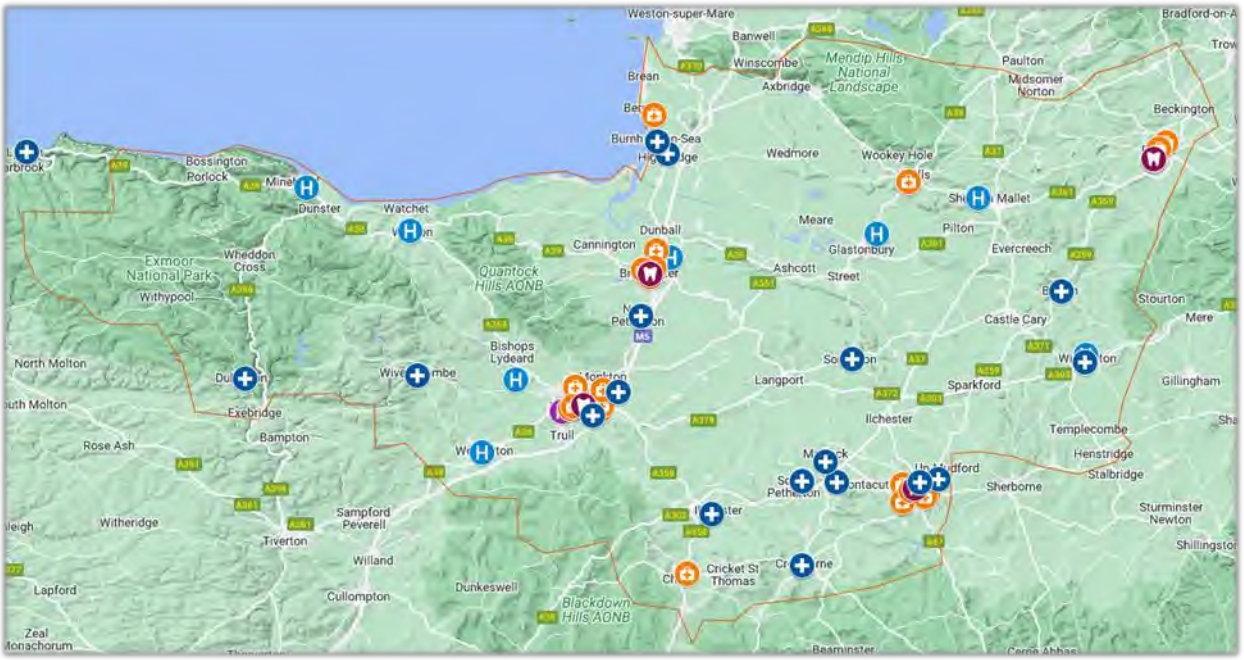
Somerset NHS Foundation Trust provides mental health inpatient services and specialist healthcare for adults with learning disabilities from ten mental health wards across four sites. Its community mental health services include Talking Therapies, Early Intervention in Psychosis, a community eating disorder 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, including people from across north Somerset, north and west Dorset, Devon, Bristol, Bath & North East Somerset (BANES), Wiltshire, Swindon, and South Gloucestershire.

We are privileged to work with over 15,000 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.

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.

Map of key Somerset Healthcare Sites



Some key facts about the Trust and our services

Urgent, Emergency and Elective care

Emergency Attendances	155,080
Non elective and emergency care spells	72,323
Outpatient attendances (inc via telehealth)	707,686
Elective spells, inc day surgery	74,883
Minor Injury Unit attendances	114,574
Inpatient beds	1,081
Theatres	27

Dental

Number of Locations	Somerset	4
	Dorset	3
Number of appointments	Somerset	10,352
	Dorset	12,195

Somerset NHS Foundation Trust

CQC Rated as Good

Contracted employees 14,715

Bank employees 2,752

Total 17,467

Community services

Open Community Hospitals (ALL the community hospitals are open. Three have no inpatient services currently.)	10
Total Beds (at 31 March 2024)	204
Community Health Admissions	1,720
Clinic Attendances at Community Hospitals	173,892
Clinic Attendances in non-Hospital settings	569,662
Virtual Attendances	65,230

Mental health and learning disability services

Mental Health Wards	10
Mental Health Admissions	505
Outpatient Appointments	
Somerset Patients	338,241
Non-Somerset Patients	8,534
Total	346,775

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

UPDATE ON PRIORITIES FOR IMPROVEMENT 2023/24

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

For 2023/24, the Trust continued to focus 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. With the advent of merger, the teams from the two legacy organisations have worked together to develop joint working and establish new relationships. The flagship teams have reset priorities for the new Somerset Foundation Trust and wider across the system. Progress over the last year has been variable as teams have worked on competing priorities including integration, ongoing operational pressures, and leadership changes.

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.

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 was it important?

Peri-Operative Services at SFT aim to optimise the health of patients requiring surgery, empowering them as active participants in their health management for positive long-term outcomes. We understand that a patient's fitness directly impacts their recovery post-surgery and recognise the importance of early health assessment to provide timely support.

Whilst Peri-Operative care includes support before, during, and after surgery, this project started with pre-surgical care. The aim is to optimise patients' health and wellbeing at the earliest point in their surgical journey. To achieve this aim, we established 14 workstreams, including diabetes, anaemia, frailty, nutrition, exercise,

smoking, and weight management. Initially, these workstreams were in a test and learn phase. This initiative enabled us to conduct over 60 PDSA (Plan, Do, Study, Act) cycles and monitor approximately 600 patient referrals across the 14 workstreams to decide on the model for implementation.

What was achieved during the year?

In June 2023, with an investment of £320k the team sought to scale up the early pilots and tests of change. The team was expanded to include clinical and non-clinical roles such as specialist nurses and care coordinators (CC), to facilitate patient-centred care throughout the Peri-Operative journey.

Our Clinical Service Lead successfully applied for the Somerset system peri-operative medicine lead role and was awarded funding to provide consultant leadership to facilitate improvements across the South West.

We partnered with Somerset Public Health Specialists to be selected site for a one-year pilot of the Digital Weight Management Programme. Additionally, we showcased our Diabetes pathway and Care Coordinator pathway to the national network of Getting It Right First Time (GIRFT) Pre-operative assessment (POA) leads.

Our steering group provides strategic direction, ensures alignment with organisational goals and is a safe, communicative forum where workstream leads update their progress and reach out to our stakeholders for advice & guidance. Our stakeholders include colleagues from the acute hospitals, primary care, the Integrated Care Board (ICB), tertiary centres and community representation. Partnerships with our Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations broaden our reach and enhance community engagement, fundamentally allowing a more holistic approach to patient care.

The steering group agreed a primary focus on anaemia, diabetes, and smoking recognising the greatest benefit from optimisation in these areas, however all workstreams remain in train.

Anaemia: Our goal was to create a comprehensive service focused on proactive identification and management of anaemia. The introduction of single-dose iron infusions in the community significantly improves patient accessibility to treatment closer to home and efficiency in anaemia treatment. We have developed patient information materials and educational resources for healthcare professionals. The team now collect baseline data and develop treatment plans for surgical patients with anaemia. This data will inform our ongoing efforts to optimise the pathway and improve patient outcomes.

Diabetes: The Diabetes Peri-Operative team has worked collaboratively with colleagues in primary care to develop and roll out a pathway which identifies patients requiring diabetes optimisation at the point of referral to secondary care. To date, the pathway has been implemented in 40% of GP practices.

The introduction of Pathpoint at the Musgrove Park Hospital (MPH) site also enables a second point to identify patients with diabetes requiring optimisation prior to surgery. All patients identified via this route are provided with self-management education and either supported by a member of the Peri-Operative team or referred to other diabetes

optimisation services. It is our intention to implement Pathpoint at the Yeovil District Hospital (YDH) site in due course to replicate this picture across the county.

Smoking cessation: The aim of this workstream has been to identify patients across all surgical services irrelevant of surgical pathway type (minor, major, day case or in-patient surgery) to support in reducing or quitting smoking prior to surgery and to continue to refrain from using tobacco post-surgery. Surgical advantages are realised within just 8 hours of a patient quitting smoking. Thus, we can enable tangible benefits for patients regardless of the immediacy of their surgery. The Peri-Operative service works in collaboration with the Somerset Stop Smoking service (SmokeFreeLife Somerset) and SFT's Tobacco Reduction Team have agreed an approach to take in conversations around smoking reduction, quitting and referrals onto the service. SmokeFreeLife Somerset report data analytics of patient numbers achieving (or not) milestone quit dates.

Frailty: To manage this population effectively and prepare older adults for surgery, a prehabilitation pathway was designed, integrating various therapy programs, dietary adjustments, and medical reviews tailored to individual needs. Identifying frail patients early was a priority, due to the risk of adverse outcomes post-surgery. With the implementation of PathPoint, a digital Pre-Operative Assessment tool in the pre-assessment process, the identification of frail patients significantly improved.

Across two pilot cohorts, following shared decision-making approaches within multi-disciplinary teams (MDT) clinics, 55% of patients chose to come off the elective surgical waiting list, instead opting for alternative support options offered within the community including community rehabilitation team, Age UK, exercise programmes, home aids and social prescribing support.

Cancer pathways: SFT Cancer PreHab hub services have been in pilot phases across both acute hospitals since March 2023. They offer prehabilitation services to patients with colorectal, prostate and lung cancer regardless of whether the patient is awaiting surgery or chemotherapy / radiotherapy treatment or systemic anti-cancer treatment. Patients are offered support in optimising three key areas: Exercise, Nutrition, Wellbeing.

Exercise: In partnership Somerset Activity and Sports Partnership (SASP) we have established a dedicated webpage on their site titled 'Fit for Surgery and Beyond,' tailored to support patients awaiting lower limb orthopaedic surgery by providing guidance on enhancing fitness and strength during the waiting period. Patients are referred following consultations with physiotherapists at the Orthopaedic Assessment Service in Somerset (OASIS), where they gain access to exercise tuition and guidance, as well as referrals to exercise programs developed by Age UK and Arthritis UK.

Nutrition: The dietetics teams have helped to develop a peri-operative nutrition webinar and have tests of change underway within the frailty pathway.

Other optimisation workstreams: Depending on the conversation we can refer patients onto a community health coach, a village agent, a digital or face to face weight management programme, inhouse alcohol reduction service or public health alcohol reduction service, Talking Therapies for support around anxieties, and improving wellbeing service. We also have access to a wide range of Apps within the

NHSE approved ORCHA site.

In October 2023, Simon Bishop, Associate Professor in Organisation Behaviour at Nottingham Business School, reviewed the SFT Peri-Op programme to understand the approach taken and lessons learnt. The final report concluded that SFT Peri-Operative Service coordinated a 'system improvement' approach, with work taking place across a number of workstreams, coordinated through a central perioperative care management team and actively supported by a steering group of senior clinical and administrative staff. The report concluded a collective approach, strong coordination, organisational support, and commitment to improvement methodology, as well as its focus on building relationships across the healthcare system, all contribute to its effectiveness in improving perioperative care. The program addresses complex challenges in healthcare and seeks to provide better care for patients undergoing surgery.

QIP 2023/24 – Priority 2 – 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. Its' focus includes the needs of relatives and friends during life and after the death of their loved one has occurred. End-of-life care 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, families, and carers, to plan their last chapter of life, and enables colleagues to provide high-quality, compassionate end-of-life care. 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 remains pivotal in the way end-of-life care is viewed countywide, with multi-agency colleagues coming together to do the right thing for patients who are at the end of their life. Whilst this was to a degree in place pre-merger, the official transaction has strengthened this, formalised closer working, and has brought the governance into a single leadership structure. The SFT Last 1000 days governance structure is well embedded with a single merged steering group, to which three subgroups report: operational; governance; and education. Colleagues across both legacy organisations attend these meetings and the focus and learning from projects is shared across both acute sites and the community. Progress of focused projects has been co-ordinated and monitored via the operational group with several projects/workstreams now fully embedded and converted to business as usual. Examples of work achieved are:

End-of-Life Homecare: This project commenced in November 2022 to bring about rapid discharge of end-of-life patients with days to short weeks to live. Previous data showed 29% of patients when identified as end-of-life 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. Between February and December 2023, the project aimed to get patients home within 24 hours when identified as having days or short weeks to live. For those who did achieve their wish to go home, the median time to discharge was one day. Median overall survival for these 94 people from discharge was nine days; only 26 people (29%) survived more than 30 days. Ten people (9.6%) either died on the ward or were not stable enough to discharge. This work has been shortlisted for an HSJ award and publication as an example of stream-lining delivery of end-of-life care countywide. Unfortunately, the project has been scaled back due to a lack of funding of care pathways for patients who are near end-of-life but do not have a primary health related care need. Ongoing conversations with ICB colleagues and the continuing healthcare (CHC) team have led to a recognition in improvements at the Musgrove site need to be made. We are reassured the quality of information at referral is an issue and expect that with specialist involvement the acceptance of CHC fast track funding requests will rise to match that of YDH. This is a key change for the integrated palliative medicine teams and has required a productivity review and 7 day working change which is ongoing.

End-of-life care education syllabus: This has been developed across SFT post-merger. This ensures colleagues have parity in access to training and development opportunities in end-of-life care. By streamlining the process, the education team hope to attract greater numbers of staff to end-of-life care education and therefore improve understanding of the Five Priorities for Care for the Dying Person as recommended by Health Education England (HEE). HEE also recommends that staff are supported to not only improve their skills and knowledge in caring for those at the end-of-life, but also their confidence, therefore cross site collaborative simulation opportunities have been key to staff having the opportunity to experience the delivery of such care.

Universal care plan for last days of life care: This has been developed for use across both acute sites, which builds upon the importance of communicating the Five Priorities of Care. It will have a complimentary education programme for staff when it is launched. When staff understand how and when to initiate and deliver the care plan, they, their patients and patients' families will benefit from a holistic framework that is underpinned by NICE Quality Standards. The care plan will be trialled on site this summer with the view to a full Trust wide rollout at the end of 2024.

Somerset Treatment Escalation Plan (STEP): Since merger and the appointment of a Treatment Escalation Plan Lead, partnerships have been brokered system wide to develop an updated form which will be released in early Summer 2024. This will aim to improve conversations between clinicians and patients and their families and completion of the form. The STEP policy will be updated in a similar timeframe and give updates on who can complete a STEP form, alongside updated mental capacity act information.

There has also been ongoing work around digital access. A pilot of a digital STEP on Somerset Integrated Digital e-Record (SIDeR) is planned for Summer 2024, with a

view to future roll out into 2025. This will be supported through the ICB digital group. SIDeR will be the platform where all STEPs will be held and amended, so all clinicians across the county, including South Western Ambulance Service NHS Foundation Trust (SWASFT), can access these forms. SWASFT will be able to use the national records locator service from the SIDER form to get up to date and trusted resuscitation and escalation data.

We are working together with system partners to update our education to reflect the latest changes in policy and the form. The end-of-life care education team are providing conversation skills workshops available to all staff and working to make the e-learning mandatory for certain staff members.

All the workstreams above are working alongside YDH, MPH, the wider SFT footprint, the ICB, and with other system partners along the way to ensure merged working across the whole county.

'Have you thought about' letter: This was 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. This was previously trialled within the lung cancer teams at MPH but is now being rolled out wider across both acute sites for further patient and colleague feedback.

The National Audit of Care at the End-of-Life (NACEL): This has been conducted across the county since pre-merger. There is now equity in administrative support for this audit between acute sites because of the merger. Data is now viewed for community hospitals, YDH and MPH to allow deeper dives into variation and is reported at the merged steering group which enables better oversight than pre-merger.

Learning disability (LD) and transition care: a pilot of consultant time, for care of people admitted in crisis who have a neurocognitive and physical disability, was supported by the ICB learning disability team. This began with a regional audit of resus decision-making and advance care planning. The audit showed areas for improvement in decision-making, communication and using individualised care approaches. This pilot of consultant time has showed a need for an increased LD team within the hospital, in addition to a coordinated, holistic approach to transitional care across Somerset. This case is being made to the ICB in the summer of 2024 prior to transitional care becoming a CQC area of inspection in 2025.

Verification of expected death policy: this policy has been updated with the new medical examiners' role and changes to coroner's requirements in mind. Through learning from deaths, and complaints/incident forms, we have changed the policy to better reflect the 'sooner but still expected' deaths, to reduce distress for families and system workload. Previously, the coroner, or, out of hours, the police, would need to be coordinating care, but with the new policy we hope to reduce this considerably. It will also help the staff we ask to verify to gain improved fulfilment by taking appropriate steps to verify, rather than feel uncomfortable or distressed by referral to the coroner, just because the old policy did not consider a wide enough, but still safe, scope.

Joint Motor Neurone Disease (MND) clinic: the neurology, hospice, palliative care, and allied health teams of the Motor Neurone MDT have collaborated and started a clinic at South Petherton. This has a growing list of attendees that include neurology specialist practitioners and consultants from neurology and palliative care, alongside speech and language, occupational therapy, and hospice community teams. The aim is a personalised 'one stop shop' guided by a person's goals and needs with the professionals fitting the clinic to them. This should improve NICE guidelines compliance, efficiency of patient review and staff morale, as the teams work together and support each other's skillsets. At present, the time spent in clinic is unfunded and for some members it represents additional clinical time. Depending on the success of the clinic, a business case will need to be brought forward to sustain the clinic.

End-of-life complaints peer review: the palliative care consultants receive each complaint that meets the national definition of an end-of-life complaint. They review each complaint, offer constructive support to the investigating teams, and offer a review of the response where helpful. This continues to drive the involvement of the palliative care team in supporting those affected by care that could have been improved and supports trust learning by feeding back into the end-of-life curriculum.

Musgrove Park site increased specialist contacts: following integration, a palliative care nurse consultant is now working across the county. This is having a positive effect on cross-site working and integration with an increased number of patients being seen. This improved productivity has really helped those in the last days of life gain additional support and symptom control on busy wards.

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 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 and with nearly 90% of the population growth in this age group. 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. These individuals 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. The 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.

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 (MDT's), urgent community response, enhanced care in care homes and anticipatory care.

What was achieved during the year?

In this last year the focus has continued to be how services can more effectively manage frailer individuals at home to reduce potentially harmful lengthy hospital stay and to provide services more locally to meet the needs for this vulnerable population.

Progress has been made in the following areas:

Identification of frailty: The identification of frailty at the front door is part of the Trust Commissioning for Quality and Innovation (CQUIN) for 2023-4. The year one target for the Trust is to ensure a minimum of 30% of patients aged 65 and over attending the emergency department (ED) or same-day emergency care, receive a clinical frailty score (CFS) assessment and appropriate follow up. This audit looked at the front door services across both acute sites and exceeded the target and achieved 33%. However, the team's ambition is to identify all people and, if needed to implement a comprehensive geriatric assessment which involves a whole team approach. Work is continuing on training and process e.g. the CFS screening to be a compulsory question on the computer system across the front door. Compliance has improved, not only for front door services, but also for advice and guidance requests and inward referrals, as part of 'Advice First' in which the CFS for over 65's is a compulsory question.

The use of the clinical frailty score for those over 65 has also been rolled out to most of the community teams to ensure a common way of identifying frailty and monitoring deterioration to aid rapid intervention. This will be further embedded to ensure consistency and work is underway to build and support teams in multiple settings to implement the comprehensive geriatric assessment. This work is being supported by an e-learning training programme which has been made mandatory for some teams e.g. discharge to assess team.

Front door and acute services: A review is underway to look at the integration of frailty services across both acute hospitals to establish current and future provision in line with national guidance and local population needs. There has been an increased use of nominated consulting rooms at YDH for rapid access appointments to avoid admission. Both acute sites have frailty practitioners / nurses who provide seven days a week, operating within ED and other acute areas. Work is still ongoing to try and identify space for an acute frailty unit at YDH in line with the provision at MPH.

Operational structure: Since the merger in April 2023 there has been a change in the operational structure with one service manager for all our elderly care services across acute and community services. This is enabling a full review of all pathways and a commitment to looking at how we ensure we have an equitable county offer. This work is still in its infancy and senior clinicians are coming together to work on the key priority pathways. Pathways identified are Parkinson's, orthogeriatrics, management of osteoporosis and front door services. Although data is being inputted into the two different legacy electronic systems the merger has enabled work on building a single data dashboard for our elderly care services across both acute settings. This will make it easier to make comparisons, understand where the gaps are, focus of improvement work and to understand the impact of any changes implemented.

Hospital at Home: Frailty Hospital at Home pathways has continued to grow in workforce and capacity. To date the whole Hospital at Home service has had 2034 admissions. The service runs 7 days a week, 12 hours a day. A second community geriatrician has been recruited alongside several associate specialists to enhance the support for patients with frailty across the county. The service is supporting individuals with complex co-morbidities with personalised care at home, that may have previously been in hospital. The next 12 months will see a continued growth in the caseload and an extension of senior clinical support at the weekends to help maximise safety and availability of the service. 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. Work is ongoing aligning the urgent care response (UCR) services.

Neighbourhood and community services: Below are a few examples of the many projects that are underway in the community:

- There has been an increase in Discharge to assess (D2A) capacity to support a higher number of patients home sooner ensuring people spend less time within the hospital environment, despite an increase in the complexity and dependency of individuals.
- Development of therapeutic groups in Older Persons Mental Health (OPMH) in the community using a flexible workforce across the neighbourhoods and utilising SFT estate more fully.
- There has been a full review of our community rehabilitation services (CRS) and a series of improvement projects are underway to support people to be more independent in their own homes.
- Mental Health investment monies has expanded the workforce for older people with an increase in clinical psychologists, development of dual diagnosis roles, and peer engagement workers to work with carers. This supports the physical health check clinics for those patients requiring cardiometabolic monitoring due to their prescribed medications.
- The Mendip falls clinics continue to provide a person-centred multidisciplinary approach to falls management and are based in Shepton and Frome. The clinic at West Mendip is still in its' exploratory phase.
- Rural Health Hubs have continued to grow and have secured permanent funding. They are well established at J24 Auction Mart, Exmoor Market at Wheddon Cross and Standerwick Market, Frome. There is also a well-established monthly HGV clinic based at J24 working collaboratively with Wincanton Logistics, which has built on the success of the health hub model. Currently, Wheddon Cross are also a pilot site for Somerset's Dermatology pathway. Other services have approached the hubs such as Sexual Health and Pre-hab.
- South Somerset West project – This innovative programme of work is an opportunity to complete end to end pathway reviews to design and transform services across four GP practices, acute and mental health services and two community hospitals for a population of 37,000.

QIP 2023/24 – Priority 4 – Stolen years: helping people with mental health conditions to live longer lives.

Why was it important?

The SFT stolen years programme continues to support people with severe mental illness (SMI) who 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. It is well documented that people living with SMI often have 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?

In the last year, the merger between SFT and YDH has strengthened the need to bridge the physical health and mental health divide by bringing together both acute Trusts, community, primary care, and mental health colleagues to treat people holistically.

Historically cultural divides between our physical health and mental health colleagues, teams and services resulted in a mismatch of terminology, expectations and silo working. People with SMI are at high risk of experiencing chronic physical conditions whilst similarly people who live with chronic physical conditions are at risk of developing poor mental health. Therefore, putting the patient at the centre of their care and looking at the whole person will result in better health outcomes, enhance patient and carer satisfaction, and bring about system efficiencies. A new culture is now felt across our merged organisation; within care discussions the language has changed from ‘your’ patient to ‘our’ patient.

The shift away from compartmentalising physical and mental ill health will take time, but since merger, several initiatives have been implemented in Year one to drive this agenda. Examples to date are:

Workshops co-produced with ‘Experts by Experience’: Further workshops have been held across Somerset, where Experts by experience shared personal accounts of accessing and receiving physical health care in Somerset. Colleagues were able to ask questions, reflect on improvements and a repository of ‘pledges’ is underway to showcase the work within physical healthcare settings. These workshops have strengthened emerging collaborative relationships between mental health and physical health colleagues working in both acute hospitals and community teams.

Expediting elective care: Patients still wait a long time in many specialities, both to be seen and assessed and to have surgical procedures. SFT is in a unique position to be able to easily identify vulnerable patients who are more likely to deteriorate whilst waiting and to 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. A project started at MPH in

January 2023 to flag and expedite patients with a known learning disability, and/or both a current open mental health referral and living in one of the two most socially deprived areas. It was expanded to include Children Looked After (CLAs) in February 2024. To date 510 patients waiting for their first routine outpatient appointments have been upgraded so that they are managed as if urgent. Of these: 475 routine patients received 'urgent' appointments on average 7.3 weeks after being flagged, and 147 were seen within a month (versus typically 6 months without intervention). 85 of the patients had learning disabilities and 13 were supported by the LD Liaison team to ensure the best possible outcome at the appointment. This project is still only available to MPH patients as there has been a technical delay in merging the two elective waiting lists so that YDH patients can also be included. It was hoped that his would be in place in Quarter 1 of 2024/2025 but is now set to be expanded by the end of Quarter 2.

The PLT (Psychiatric Liaison Team): over the last year, merger has embedded a collaborative approach to achieving outcomes together with a 'no barriers' approach. There is a shared focus on learning from incidents and complaints and teams are committed to working together to form joint action plans. Recent reviews by the Royal College of Psychiatrists at both acute sites have commented on the relationships and collaboration between the acute colleagues and PLT staff as being 'exceptional'.

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.

The Tobacco Reduction Programme has been rolled out across the whole of Somerset Foundation Trust since April 2023. The team provides specialist advice and guidance and facilitates nicotine replacement therapy (prescribed by authorised staff) to all inpatients within Musgrove Park, Yeovil Hospital, and our Mental Health units. There is also an in-house referral system to our community partners for Maternity. In this time, staff have seen and supported more than 2,200 patients who smoke in the acute hospitals, with 546 being referred to quit programmes in the community. Of those, over 100 former Somerset in-patients have gone on to quit smoking. In addition, almost 200 Mental Health patients have engaged with the team, with 14 going on to quit smoking.

In the last year, since merger, the programme has become established and local data requirements have evolved. Working across one organisation has been positive in terms of being able to deliver the tobacco reduction programme countywide. As the programme continues to become embedded, a key project going forward is to implement the Trust smoke free policy in our Mental Health units, making the whole site at each unit smoke free. Historically this has been difficult to achieve, especially during Covid. It is acknowledged mental health inpatients are often experiencing a crisis and therefore it has been questioned as to whether this is the right time to implement going smoke free. However, with the support of our experienced team we

are now able to take this forward ensuring our patients and colleagues are fully supported.

Advice and guidance pathway: During the Covid pandemic our physical and mental health colleagues set up an advice line. It was run by the AMU (Acute Medical Unit) team at MPH to support the mental health inpatient units with managing their patients with physical health presentations. This avoided these patients being transferred to the acute site unnecessarily. Following merger, SFT has built upon this and developed an advice and guidance pathway to support patients when they become physically unwell in mental health 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 developed an advice and guidance pathway for patients who become physically unwell on mental health wards, so they can remain there wherever possible. This pathway went live in June 2023 and brings together colleagues across both acute sites and mental health inpatient wards.

NHS Somerset Talking Therapies Service (formally Improving Access to Psychological Therapies): This team continues to work across boundaries by providing mental health support to patients presenting with physical health problems. Patients waiting for an operation or on receipt of a physical health diagnosis may experience anxiety and stress, alongside managing the emotional impact of lifestyle changes due to their health. Building on our first merger, where Talking Therapies colleagues co-located with MPH cardiology clinics to run joint clinics to support this patient group; this has been expanded to YDH. However, due to a lack of clinic space, they have not been able to co-locate to date but receive referrals from the cardiology team. Since April 2024, diabetes clinics have been introduced at the Queensway unit at YDH and the service is supporting patients discharged from the Intensive Care Units in both Yeovil and Musgrove. Conditions such as depression, anxiety, post-traumatic stress disorder (PTSD) and cognitive dysfunction are increasingly recognised among patients who survive an intensive care admission and are described collectively as the 'post-intensive care syndrome'. SFT are running clinics at South Petherton Hospital at 3 months post discharge to support these patients and improve their quality of life.

Psychological wellbeing practitioners (PWPs) are trained to assess and support people with common mental health problems – mainly anxiety disorders and depression. At MPH, there is a PWP who offers support within the NICU (neonatal intensive care unit) at Musgrove and so to mirror this in the East side of the county, YDH has now got a PWP in the low dependency unit. The merger has enabled us to see the importance of bringing acute and mental health teams together to best support this patient group.

Adopting a county wide approach to ECG (electrocardiogram) interpretation: Previously, ECG interpretation in our mental health clinics did not allow for prompt, safe management of medical interpretation. After considering options, it was agreed ECGs would 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. This has now been fully embedded within clinical practices.

Codesigned and co-delivered training: This has become embedded at both acute sites to support physical health colleagues in managing patients with mental ill health presentations. Our recovery partners have helped support the upskilling of nurses, doctors, and specialists with a range of topics such as self-harm and managing challenging behaviour which has been well received across both sites.

Recruitment opportunities: These are planned through the creation of rotational nurse posts. Mental health and acute colleagues are working together to offer something different. We are hoping to be able to offer four posts, that will attract the new cohort of dual trained nurses, offering the opportunity to work across AMU, A&E, inpatient mental health wards and PLT.

Whilst we have made progress, there is still more to be done. By raising the awareness of mental ill health across our Trust, it has encouraged colleagues to have a more open dialogue to get involved, and to work together to get it right.

QIP 2023/24 – 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?

High intensity user (HIU) service for Somerset: With the funding in place, the Somerset high-intensity user service was established in August 2023 with the HIU Lead and HIU Support Manager coming into post. The team monitors people who have attended either of our A&Es in Musgrove Park Hospital (MPH) or Yeovil District Hospital (YDH) more than 10 times in 3 months or complex non-elective admissions (NELs) to help reduce admissions for those medically fit. People are identified through data capture or by services contacting the team directly (A&Es, Psychiatric Liaison Teams, Wards). The team aims to identify and focus on the unmet need for the person thereby reducing the need for A&E attendances and highlighting any health inequalities.

In their first six months, they have created a data analysis tool with support from our information team, that is a live dashboard showing the attendance data across both hospitals.

The HIU team are currently actively working with 48 people, 44 people are on their watching tracker and 7 post service (no longer monitored but can be reactivated if required). They have chaired and co-ordinated 29 HIU MDTs. A total of 65% of the

HIU Caseload have had a Personalised Care Support plan (PCSP). PCSPs are an essential tool to integrate the persons experience of the services they access so they have one joined up plan covering their health and wellbeing needs. They are critical in improving outcomes and ensuring people have more choice and control. 66% caseload clients are active with the UBUNTU coaches, offering personalised support to identify and address the client's goals.

Of the clients worked with, the HIU service has measured a 55% reduction of attendances. The National target is 20-40% reduction, so the team are demonstrating fantastic outcomes to date.

The HIU Somerset Steering Group has been reestablished, which is jointly chaired by SFT/ICB. Attendees include A&S Police, SWAST, PCNs, ICB, Lloyds Pharmacy, VCSFE representation including UBUNTU and Young Somerset, Open Mental Health, and NHSE. To date the Steering group has reviewed the Multi agency Information Sharing agreement and signed off the terms of reference. The Data Impact Assessment tools are currently being agreed.

Establishment of a persistent unexplained physical symptoms (PUPS) clinic (adults): The test clinic evaluation was completed and the model for the service was set out. Unfortunately, due to a key post becoming vacant the work has not progressed. With a new post holder coming into role this year, it is scheduled for action.

Personalised care approach: Throughout the year we have actively contributed to the work led by the Somerset ICB personalised care steering group, to develop the actions to embed the personalised care model across the ICS. Following the completion of a personalised care audit which showed we have more progress to make across SFT, we have now established a personalised care improvement group. The primary aim of the group is to enable Personalised Care to become 'everyone's business'. We have already introduced personalised care training onto our learning platform and over the coming months will collaborate with our public voice partners to finalise our improvement plan.

Proactive care: All four PCN footprints in South Somerset have a GP led complex care team model. There is also an in-patient team which is currently being reviewed to ensure the model is effective in delivering the best outcomes for patients. Improvements include:

- Working with PCN's (currently South Somerset West (SSW), Yeovil and South Somerset East (SSE)) to utilise Brave AI to identify patients e.g. severely/moderately frail who are likely to experience an acute hospital admission within the next 12 months.

- The teams are linking with Adult Social Care using their waiting list to respond to need in a timelier way. The benefits of integrated working and a co-located workforce have been realised in a highly successful pilot in SSE. Active discussions with Adult Social Care to role this model out to Yeovil and SSW teams (April 2024).

- Consistency of care for patients, on the basis that people living with complex needs are best supported by those that already know them.

- Personalised care conversation approach to become embedded in all areas of practice which support the proactive care requirements.

- MDTs completed by complex care teams at both GP surgery huddles (GP practice level) and neighbourhood weekly/biweekly MDTs where multi-disciplines including VCFSE come together to talk through complex cases and agree a shared plan.

- All patients referred to complex care have a comprehensive assessment performed as per proactive care guidelines.

- The Complex Care team are using Foundry data for unplanned care intelligence. There is also an opportunity to improve links with the unplanned neighbourhood services including Urgent Community Response (UCR), Rapid Response and Hospital at Home.

- The in-patient complex care team at YDH link with HIU teams to review multiple admissions and reduce length of stay.

- The teams follow up of all Complex Care patients in the community after acute and community hospital admission.

Dementia and Delirium care: Dementia and Delirium care: Dementia Diagnosis rates (DDRs) remain low for Somerset; this is being addressed through our ICB steering group and we are working closely with their digital team as it remains a system issue. We know through regular audits that 25-30% of people diagnosed by SFT services are not coded to GP registers. The DDR for April is 55% against a 66.7% target.

Delirium screening: The recent National audit of dementia has identified that MPH is currently an outlier for delirium screening and an action plan is in the process of completion to address this. YDH remains compliant. Improvement on delirium screening will be impacted by service provision within MPH.

The MPH dementia team is currently piloting a 7-day service (since May 2023), this is currently funded until November 2024. There is a business case to make this permanent. Improvement on delirium screening is dependent on its approval and the ability to sustain the current service.

We have developed the system wide Somerset Dementia Wellbeing model, which aims to provide post diagnostic support to everyone. The model includes a collective of 60 VCFSE agencies who work closely with all our services to ensure support is provided for everyone diagnosed with dementia.

We have developed a Countywide single point of access for Dementia Assessment services, to ensure consistency of pathways and greater efficiency of triage. This service commenced June 2024.

We have established high intensity OPMH care home beds, funded by the Local Authority but heavily supported by our services – Intensive Dementia Support and care home liaison.

We have implemented a Training team – providing training across the organisation and pathway bed providers. 3 WTE band 4s currently are delivering this on 12-month contract, which will end in September 2024.

Connecting the Dots: This was established to improve the working relationships between SFT and primary care by building communication. There are three arms to it, the first a regular monthly meeting where everyone is welcome to come, share ideas and projects, or raise issues that affect primary care and SFT working well together. The second is the introduction of a podcast and the third is a newsletter to share information from SFT with primary care and highlight discussions held at the meeting.

In addition, regular quarterly Teams meeting between PCNs, and Peter Lewis (CEO) and Andrea Trill (Medical Director for Integrated and Primary care) have been held over the last year. These were set up as 'temperature check' meetings to share issues that were concerning organisations and were followed up by face-to-face visits with 9 of the 13 PCNs.

More recently an Interface Working Group has been established, with cross organisational representation to address issues arising at the interface between primary care and SFT. This programme is developing high level principles for working together which will then inform improvement workstreams e.g. onward referrals, following up test results and the quality of referrals coming in from primary care. The programme of work will be grouped into three themes: Understanding how each other works, working more efficiently and developing the processes for working together e.g. in co-designing pathways.

QIP 2023/24 – Priority 5 – CREATE – improving life chances for children.

Why was this important?

Our priority is to highlight and address the key issues facing young people in Somerset impacting on their opportunities for healthy lifestyle, good school attendance and positive social development. Specifically, we aimed to add clarity, accessibility, and responsiveness in our pathways for adolescent care, advice and guidance and weight management support. Through ongoing partnership working across community and acute care there is potential to build on these developments to optimise care in a young person's own community.

What was achieved during the year?

We have supported initiatives in the care of those with learning disabilities, obesity, common childhood medical complaints, and eating disorders. Each project recognising the importance individualised care for children, young people, and their families.

We are proud of the work that we have undertaken that has resulted in no admissions of young people due to care breakdown since Nov 2022.

In response to unnecessary admissions and highly expensive unregulated care placements, we have developed a new partnership with the Local Authority and the Shaw Trust known as Homes2Inspire. This partnership brings together health, social care, and education. A series of local residential care homes are now operational and high needs foster placements are coming online. A new Alternative Education Provision which will be co-delivered by the partnership will be opening in September with a second school opening the following year. Many of the young people who would have previously been admitted had nowhere to go; with this innovative new offer, they have somewhere safe to live where their needs are fully met.

Continued development of eating disorder holistic care: Nationally, there has been a sustained increase in eating disorder presentations. Following the COVID pandemic, there was a significant spike in young people presenting in highly compromised physical states. Additionally, we do not have a local Tier 4 Specialist Eating Disorder offer. In response, we have developed new ward roles whose focus is the provision of a personalised approach to care. This now includes CAMHS funded band 3 HCA's and Band 7 Nurses. In addition, the Band 6 mental health link roles employed by the wards have become eating disorder nurse specialists. This has led to greater consistency with care planning. We are now in discussions to develop these roles further, to support admission avoidance or shorter stays where discharge is in the best interest of the young person.

Personalised Care: innovating use of the Paediatric Admission Unit (PAU) and Wessex House day offer to contribute to bespoke care plans. A number of young people have benefited from a bespoke day offer from Wessex House. Importantly, this has included an offer of psychological support and education from the ward. There has been good success at effecting discharge home with this support. There remains scope for developing this further.

Investment in Effective Early Intervention – 'why won't they eat training', SPLASH project: Staff across the system were telling us that they did not feel skilled enough to work with eating disorders or disordered eating. In response, we have delivered a new training known as "Why Won't They Eat?" This has been offered to all statutory agencies and Homes2Inspire staff. The feedback has been very positive and there is evidence of care staff feeling increasingly confident in supporting young people with eating needs. Additionally, CAMHS and Local Authority staff are better able to identify eating needs earlier, preventing deteriorations. Paediatric nurses who have attended the course have reported feeling much more empathetic to young people with eating needs, including having a greater understanding of the reasons eating disorders can develop and how to adopt a trauma-informed approach.

Development of LINK LDA (learning disabilities and / or autism team): A new service – LINK LDA, is delivered by CAMHS in partnership with paediatrics and the voluntary sector. The team was developed to support children and young people with autism and / or learning disabilities. They specifically support those at risk of admission to hospital or a 52-week residential school. An independent evaluation has

identified significant strengths in the offer which includes robust consultation, direct clinical activity, and prevention of admission. For example, we provided direct intervention for a young person with LD admitted to Wessex Ward (from Bristol) who was in distress because he was physically unwell. To prevent an admission to paediatrics, which would have caused further distress, a Link LDA attended the ward and supported the team to complete the necessary investigations on Wessex Ward. This supported an upskilling of the team, whilst also preventing avoidable harm to the young man.

Child health team joint triage: partnership working between paediatric secondary care and primary care. Working together we are providing health care plans for children and young people (CYP) at the point of referral. This supports families to feel heard, implement appropriate management arrange investigations, access local third sector support and reduce reattendance for same concerns with primary & acute care providers. The triage team can direct CYP to the right care pathway from referral reducing CYP waits for secondary care outpatient paediatric services. In developing a professional network, we are upskilling patch-based professionals in paediatric care and developing intelligence around local care and support services for CYP. The ICB are supporting gradual role out of Child Health Team Joint Triage service with support of local primary care services and SFT paediatric service.

CREATE – improving the inpatient environment for CYP (Musgrove site): One third of admissions to paediatric wards are CYP with co-existing medical, emotional, and mental health needs. Our environment and workforce have reflected historical needs around younger children with medical issues. Our CREATE team at the children's unit at Musgrove Park Hospital have been making incremental improvements in our ward offer to support adolescents. We recognise that an improved environment is key. This vision is central to our new build project plans (2030) and reflects the recommendations made by Health Services Safety Investigation Body (HSSIB) report in May 2024 calling for improvement and changes in the design of paediatric wards to provide a safe and therapeutic environment for CYP with mental health needs. Recent quality improvements over the last year have included introduction of emotional observation monitoring from presentation and through admission with associated support offer, welcome leaflet for young people and their families, coproduction of videos by young people explaining our ward offer are in progress, collaboration with clinical psychology to work with CYP to support them in understanding choices around their care to help them feel in control and central to decisions, minor updates to ward environment (treatment rooms and relaxed consultation space), pronoun videos to support staff to feel comfortable about talking about preferences with young people, and involvement in the trauma informed care multiagency forum.

Darzi 2024 project – multiprofessional collaboration to explore school absenteeism in Somerset: Somerset has one of the highest rates of CYP being absent from primary and secondary school in the UK. Absence is commonly associated with medical, emotional, and mental health needs. It impacts on long term health, well-being, participation, attainment, and employment potential are well known. Historically health and education have worked in silos leaving CYP and their families and children feeling unseen and frustrated and care and support poorly co-ordinated. Our 2024 Darzi clinical fellow has explored this ‘wicked’ problem through widespread

stakeholder engagement and has brought together a motivated, invested, and energised group of professionals from commissioners, public health, education, paediatric medical care, primary care, child and adult mental health team, Connect Somerset and voluntary sector in a working group to explore early intervention pathways for children and young people struggling with school attendance. Our vision is to be able to help young people access the right support at the right time in their communities to maximise their health and school attendance.

QUALITY IMPROVEMENT PRIORITIES (QIP) 2024/25

In this section we set out our priorities for the Trust for this year. Our priorities take into account the work currently underway to develop the Quality Strategy since merger, along with the review and analysis work carried out as part of the implementation of the Patient Safety Incident Response Framework.

As we developed our Quality Strategy, we wanted to engage directly with our Service Groups to establish Quality Priorities, and make sure that not only would the Quality Strategy deliver on the Trust's Corporate Objectives, but also help to deliver the specific priorities of the Service Groups directly caring for patients every day.

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

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

How they will be measured, monitored and reported.

The quality projects and initiatives are a combination of corporate-led Trust-wide programmes and team / service group level, with central support and co-ordination where required. As part of the ongoing work on development of the Quality Strategy, key performance indicators will be developed and, with the quality priorities having been aligned to fit with the overall Trust objectives, overall progress will be monitored within the Board Assurance Framework.

QIP 2024/25 - Priority 1 – Personalised Care

Why is this important?

Personalised Care according to the NHS England long term plan will benefit people by giving them the same choice and control over their mental and physical health that they have come to expect in every other aspect of their life.

A one-size-fits-all health and care system simply cannot meet the increasing complexity of people's needs and expectations.

Personalised care and support planning is a series of facilitated conversations in which the person, or those who know them well, actively participates to explore the management of their health and wellbeing within the context of their whole life and family situation.

Personalised care and support planning is key for people receiving health and social care services. It is an essential tool to integrate the person's experience of all the

services they access so they have one joined-up plan that covers their health and wellbeing needs.

The process recognises the person's skills and strengths, as well as their experiences and the things that matter the most to them. It addresses the things that are not working in the person's life and identifies outcomes or goals and actions to resolve these.

Through ensuring people are active participants and experts in the planning and management of their own health and wellbeing, ensures that the outcomes and solutions have meaning to that person in the context of their whole life and therefore leading to improved changes of successfully supporting them.

The personalised care and support plan is developed following an initial holistic assessment about the person's health and wellbeing needs. There is no set template for what a personalised care and support plan should look like, but it should reflect the following:

- A way of capturing and recording conversations, decisions and agreed outcomes or goals in a way that makes sense to the person
- Should be proportionate, flexible and coordinated and adaptable to a person's health condition, situation and care and support needs
- Should include a description of the person, what matters to them and all the necessary elements that would make the plan achievable and effective.

An internal audit was completed in 2023, the purpose of the audit was to provide assurance on whether the Trust completes personalised care plans within existing patient documentation. The audit showed areas of good practice but in most areas it was difficult to demonstrate that people had been give choice and control and actively participated in their treatment plans.

Following the audit, the Trust has established a co-produced personalised care improvement group. This is co-chaired by Healthwatch and has three public/patient partners to ensure we are involving the voice of our population.

What do we want to achieve?

An action plan was developed following the audit report and recommendations which will:

- Collate the results of the survey that was developed to gain awareness of our colleagues understanding of what personalised care is, whether we deliver personalised care, what stops us and what would help us to deliver care in a personalised way.
- Produce a personalised care policy.
- Develop a multi-faceted audit programme that will enable the organisation to gain assurance that personalised care is being delivered.

- Launch a training programme for colleagues

In addition to the corporate actions informed by the internal audit, Service Groups have identified a number of specific actions related to personalised care. These include, but are not limited to:

- Implement GP & nurse led clinics, supported by tele-derm solutions, to provide a more personalised and responsive dermatology service.
- Pilot a frailty nurse for SDEC at YDH
- Develop pre-surgery optimisation across 14 identified workstreams (anaemia, smoking, diabetes, frailty, nutrition/dietetics, alcohol, weight management, advance care planning, exercise, emotional support, pain management, cancer, health coaches, departmental process) to prevent deconditioning in surgical patients.
- Empower people living with cancer in care planning & delivery
- Help our PCNs and teams to embed proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions, as per the Fuller report recommendations.
- Prioritise End-of-Life Care planning for last few days of life.
- Support initiatives in the care of those with learning disabilities, recognising individualised care for this specific group will establish a model to spread personalised care to children and young people and their families.

QIP 2024/25 - Priority 2 – Patient Involvement & Co-Production

Why is this important?

In 2022, the health and care act introduced significant reforms to the organisation and delivery of health and care services in England. At the heart of the changes was the need to establish a framework that supports collaboration and partnership working across a system to make it easier to deliver joined up care for our patients which is grounded in listening to what really matters to our patients and the public we serve.

As an NHS Foundation Trust we are subject to the triple aim duty which requires us to have regard to all likely effects of our decisions in relation to 3 areas:

- Health and wellbeing for people including its effects in relation to inequalities.
- Quality of health services for all individuals including the effects of inequalities in relation to the benefits people get from these services.
- The sustainable use of NHS resources.

In addition, Section 242 (Duty to Involve) of the NHS Act defines how, by law, NHS Trusts must ensure that patients and / or the public are in involved in certain decisions that affect the planning and delivery of NHS services.

Central to our responsibility to deliver against the triple aim duty, is how we work in partnership with people and communities to truly design and deliver a healthcare service which is meaningful and prioritises and delivers against what matters most to our local community. Working in partnership is delivered through a variety of approaches such as engagement, participation, involvement, consultation and co-production and has a golden thread of listening to, and responding to, feedback. These terms often overlap but also mean different things to different people and occasionally, they have a legal or technical definition.

Our organisational approach to engagement and involvement approach needs to help all colleagues understand that engaging with our communities is not seen as an obstacle to overcome on the way to achieving a pre-determined outcome.

What do we want to achieve?

By working in collaboration with people across our local communities we have an opportunity to better tailor services to meet needs and preferences unique to that community. Working in partnership enables us to design and deliver care more effectively and will help us to prioritise our resources to have the greatest impact and to support senior managers with making informed decisions about any potential service changes. Working in partnership will help us to address health inequalities by understanding local communities needs and to develop solutions **with** them.

Each service group will be working on delivering their own engagement and involvement plan utilising the NHS England resource 'Planning Engagement – a step-by-step guide'. This will enable each service group to shape a plan which is meaningful to the needs of the population they serve, to recognise that each service group is at different stages of their engagement and involvement journey and to enable all colleagues to build confidence with understanding why this is important.

We aspire to embed engagement and involvement and responding to feedback so that it is at the heart of all we do; to hardwire this across the organisation.

This work will underpin the Trust Patient Engagement and Involvement Strategy 2024 – 2027.

QIP 2024/25 - Priority 3 – Right Care, Right Bed

Why is this important?

It is crucial to ensure that patients are cared for in the most appropriate care setting, by staff with the skills to provide this care.

When healthcare services are under pressure due to excessive demand and system issues, including delayed transfers of care, patients can come to harm and in addition this creates massive increased and avoidable costs for both the NHS and social services, as well as the wider public sector. Much serious avoidable harm to patients,

such as hospital acquired infection and injurious falls, occurs when patients are cared for in the wrong setting.

What do we want to achieve?

Along with embedding the recent acute ward reconfiguration at MPH and YDH and building on the early successes of Hospital at Home, the Trust is focussing on a wide range of initiatives to support care in the right place. This includes system-wide work to address delayed transfers of care along with projects aimed at improving specific patient pathways within specialties.

Service Groups have identified a number of specific actions related to right care, right bed. These include, but are not limited to:

- Embedding the 20 min transfer policy across the sites to further improve the flow out of ED.
- Reducing length of stay by improving pathways, focussing on eight identified strategies.
- Using digital technology to improve dermatology pathways.
- Optimising pre-surgery to prevent deconditioning in surgical patients, with fourteen identified workstreams: Anaemia, Smoking, Diabetes, Frailty, Nutrition/dietetics, Alcohol, Weight management, Advance Care Planning, Exercise, Emotional Support, Pain Management, Cancer, Health Coaches, Departmental Process.
- Further development of Hospital at Home to understand the demand and capacity of for the service, including paediatric pilot.
- Further development of criteria led discharge
- Review of physiotherapy demand and capacity work to minimise inequity in waiting times.
- Reviewing reporting turnaround times for Radiology.
- Development of a 7-day paediatric assessment service

QIP 2024/25 - Priority 4 – Colleague Health and Wellbeing

Why is this important?

Colleague health and wellbeing is central in supporting our colleagues to deliver the best care and support through a compassionate, inclusive, and learning culture. Wellbeing demands a holistic approach, applied in different ways at multiple levels (individual, managerial, team, strategic and organisational). Wellbeing is sometimes positioned as an afterthought when something difficult happens rather than underpinning and contributing to high quality ‘business as usual’ which everyone must take ownership of.

Basic physical wellbeing needs are not always met successfully across the whole of the organisation (e.g. hydration, toilet breaks, rest breaks etc). Research evidence identifies this leads to reduced cognitive capacity, impacting on decision making, patient care/outcomes and potentially short term and long-term health outcomes for staff. The culture and structure of the team plays a significant role in enabling these behaviours. The tone for the organisation can be set by responsive and attuned support from senior leaders and managers across the organisation, as well as in the way colleagues work together. Ongoing Service Pressures can make releasing colleagues to attend formal wellbeing interventions challenging. There is a risk that interventions may be perceived as not an effective use of resources if colleagues are not enabled to make use of them – there is a difficult balance to strike.

Educating senior managers with regards to best practice, available support and existing protocols may help managers feel more informed and supported thereby enabling them to support teams more effectively.

What do we want to achieve?

A range of preventative strategies and responsive interventions are required at each level of ownership (individual, managerial, team, strategic and organisational) to ensure the organisation nurtures a commonplace culture of wellbeing, and to reduce the frequency and impact of events which significantly challenge the wellbeing of colleagues.

The strategic and organisational focus for 2024/25 is on consolidating the “Care for Our People” Year 1 deliverables of the People Strategy (focussed on violence and aggression, and a just and restorative culture) and moving on to Year 2 deliverables (focussing on stress and burn out). These include:

- Supporting delivery of the Trust’s violence reduction and prevention action plan
- Rolling out training for staff support post incident, linked to ongoing PSIRF implementation work
- Launching the Team Immediate Meet (TIM) tool, a communication tool designed to facilitate a hot debrief following events which cause distress, across inpatient environments
- Implementing a new Occupational Health contract with clearer guidance on heath and wellbeing support
- Gathering and reviewing information and key data to identify key priorities for reducing stress and burnout

Service Groups have identified a number of specific actions related to supporting colleagues. These include, but are not limited to:

- Improved facilities for colleague wellbeing
- Protected time for wellbeing interventions
- Focus on flexible working
- Senior leadership drop-ins

- Culture and emotional support

QIP 2024/25 - Priority 5 – Patient Safety Incident Response Framework Themes

Why is this important?

The Patient Safety Incident Response Framework (PSIRF) advocates a coordinated and data-driven response to patient safety incidents. It embeds a response into a broader system of improvement and promotes a significant cultural shift towards systematic patient safety management.

PSIRF supports the creation of much stronger links between incidents and learning and improvement. We aim to work in collaboration with those affected by incidents – colleagues, patients, families, and carers – to improve learning opportunities and subsequent quality improvement work, leading to effective change. This approach will continue to increase transparency and openness amongst our colleagues in reporting incidents and engagement in establishing learning and improvements that follow.

We are committed to learning from incidents and continuously improving the care and services we provide. We recognise and acknowledge the significant impact incidents can have on colleagues, patients, their families, and carers. Patient, family, and colleague engagement and involvement in responding to incidents is crucial to safe delivery of care and service improvement.

PSIRF allows organisations to explore patient safety incidents that are relevant to the organisational context and the populations served. It also supports a proportionate response, enabling a focus on incidents where there are real opportunities for learning and improvement.

Following detailed analysis and stakeholder engagement, the Trust identified a number of safety concerns contributing to incidents across the Trust. Further exploration of these concerns identified some areas where, although there were ongoing safety issues, these were well understood, and work was already underway to address them. However, there were some key themes where further exploration was required and could help identify significant safety improvements.

The three key themes selected by the Trust for further exploration are:

- Recognition, escalation and response to deterioration of patients within maternity, neonates, paediatrics, acute medical admissions, surgical decisions unit and emergency admissions unit.
- Involving people who matter (families, friends, carers and loved ones) in patient care.
- TEP decision making, documentation and communication issues with patients and families that impact on discharge and transfers across SFT locations.

Details of the work that carried out to identify and agree these priorities in included in Section 3 of this document.

What do we want to achieve?

The key aim of reviewing the identified themes is to support the creation local organisational recommendations and actions to feed into new or existing patient safety priorities and improvement programmes. Due to the nature of these themes and the fact that they were chosen because they are not fully understood, although there is a clear plan for review, it is not possible to set out clear improvement goals that will come out of the review.

In line with national guidance, the Trust will conduct out 3-6 learning responses per priority per year. Attempting to do more than this will impede our ability to adopt a systems-based learning approach from thematic analysis and learning from excellence. The outcomes of these learning responses will be thematically analysed and will inform our patient safety improvement planning and work.

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 the SFT 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.

Services provided by the Trust

During 2023/24, SFT 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 SFT 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 2022/23 represents 100% of the total income generated from the provision of relevant health services by SFT for 2023/25.

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. In the coming year we will continue to invest in improvements, including a focus on weekend discharges and renewed efforts to define suitable local targets which reflect the needs of our patient cohort.

Improvements to 7-day working are led by the Trust’s Medical and Nursing Directors, who ensure that 7-day working is considered at Board level. As a Trust delivering acute, community and mental health services, we have developed targets which ensure the monitoring of 7-day service provision beyond the acute hospital.

We continue to deliver our clinical strategy and the supporting strategies underpinning it. These include our workforce strategy, which we hope will deliver a more stable clinical workforce including more doctors who will enable us to better deliver the 7-day working standards into the future.

NATIONAL QUALITY INDICATORS

Many of the national indicators, where data for indicators is available, are not appropriately benchmarked for an integrated Trust delivering the range of services provided by SFT. 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 2023 to March 2024	Data due to be published August 2024			
April 2022 to March 2023	0.988 (as expected)	1.0000	0.7191	1.2074
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 2022 is for Somerset NHS Foundation Trust. 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.

SFT 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.

SFT 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 2023 to March 2024	Data due to be published August 2024			
April 2022 to March 2023	36%	40%	14%	66%
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 2022 is for Somerset NHS Foundation Trust. 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.

SFT 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 SFT 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.

SFT 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)

Reporting Period	Adjusted average health gain	England	Lowest Trust	Highest Trust
April 2023 to March 2024	Data has not been published by NHS England			
April 2022 to March 2023 (Provisional)	*	0.47	0.38	0.53
April 2021 to March 2022	*	0.46	0.37	0.53
April 2020 to March 2021	*	0.47	0.39	0.57

*Data suppressed (not enough responses)

Primary knee replacement surgery (EQ-5D Index)

Reporting Period	Adjusted average health gain	England	Lowest Trust	Highest Trust
April 2023 to March 2024	Data has not been published by NHS England			
April 2022 to March 2023 (Provisional)	*	0.35	0.23	0.42
April 2021 to March 2022	*	0.32	0.25	0.42
April 2020 to March 2021	*	0.32	0.18	0.40

*Data suppressed (not enough responses)

SFT considers that this data is as described for the following reasons:

- Elective surgery was disrupted in period due to covid pandemic

SFT 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.

- Monitor the adjusted average health gain through the Trust's Data Review Meeting and share findings 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 2023 to March 2024	Data has not been published by NHS England			
April 2022 to March 2023	SFT: 14.0 YDH: 9.6	12.8	3.7	302.9
April 2021 to March 2022	SFT: 11.8 YDH: 14.7	12.5	3.4	49.1
April 2020 to March 2021	SFT: 12.9 YDH: 13.6	11.9	5.6	34.0

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 2023 to March 2024	Data has not been published by NHS England			
April 2022 to March 2023	SFT: 12.9 YDH: 11.5	14.4	2.5	46.8
April 2021 to March 2022	SFT: 12.3 YDH: 12.8	14.6	2.1	110.2
April 2020 to March 2021	SFT: 13.2 YDH: 13.9	15.9	1.0	111.2

SFT considers that this data is as described for the following reasons:

- 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.

SFT 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 Clostridioides difficile infection

Related domains (5) Treating and caring for people in a safe environment and protecting them from avoidable harm.

Clostridioides 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 2023 – March 2024	20.48	24.5	14.47	60.87

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 (legacy SFT) 9.91 (legacy YDH)	23.47	9.91	49.81
April 2021 – March 2022	15.7 (legacy SFT) 18.07 (legacy YDH)	22.78	9.32	57.45

SFT merged with Yeovil District Hospital in April 2023, therefore data prior to that is presented as the two legacy Trusts.

SFT 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. The reasons for the national increase remain unclear.
- When compared to a regional rate, we compare well and are ranked the third lowest Trust for the last year.
- When compared to the national rate we have a slightly lower rate than the national average.
- Despite this we are experiencing year on year increase in case numbers

SFT intends to take the following actions to improve this rate, and so the quality of its services, by:

- Reviewing 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 send all specimens from Trust apportioned cases for ribotyping to identify links or transmission.
- Continuing to reduce the CDI risk associated with antibiotic treatment through robust antibiotic stewardships and further review of antimicrobial guidance, where appropriate
- Undertaking analysis of the antibiotics used in Trust apportioned cases and match these with ribotyping to identify and trends.
- Continuing to work with the Regional Infection Prevention and Control Team on CDI reduction strategies.

- 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 (NRLS)

Most Trusts are now reporting incidents to the new Learn from Patient Safety Events (LfPSE) service and are no longer reporting to the NRLS. As a result, they are showing as reporting no reports in the NRLS monthly data report. Therefore, NHS England has currently paused the publishing of this data while considering future publications in line with the introduction of LfPSE. NHS England plans to start publishing data on patient safety events recorded on LfPSE soon, when all organisations have made the transition from reporting to the NRLS.

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 2023 to March 2024	Data submission suspended			
April 2022 to March 2023	Data submission suspended			
April 2021 to March 2022	Data submission suspended			
April 2020 to March 2021*	Data submission suspended			

*Does not include Acute data for April to June 2020

SFT considers that this data is as described for the following reasons:

- National data submission was 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. Although national data submission has been suspended, the Trust has continued to collect the data and act on findings to improve compliance.
- 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.

- Different parts of the organisation currently measure compliance with VTE risk assessment on admission in slightly different ways, making an overall Trustwide figure unreliable.

SFT 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.
- Align measurement of VTE risk assessment compliance across the organisation.

INFORMATION ON PARTICIPATION IN CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

National Clinical Audit Participation

During 2023/24, there were 56 national clinical audits and eight national confidential enquiries detailed within the NHSE Quality Accounts list which covered relevant health services that SFT provides. Three national audits were withdrawn by the providers, and one did not commence until June 2024, leaving a total of 52.
During that period SFT participated in 51/52 (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 enquiries that SFT were eligible to participate in during 2023/24 are as follows:

National Audit Title	Partici-pated	Status
Adult Respiratory Support Audit	Yes	Completed
BAUS Urology: Nephrostomy Audit	Yes	National report awaited
Breast and Cosmetic Implant Registry	Yes	Data collecting
Case mix programme - ICNARC	Yes	Data collecting
Elective surgery - PROMS	No	No submissions 23/24
Emergency Medicine: Care of Older People	Yes	Data collecting
Emergency Medicine: Mental Health (self-harm)	Yes	Data collecting
Epilepsy12 audit	Yes	Data collecting
Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls	Yes	National report awaited
Falls and Fragility Fracture Audit Programme: National Hip Fracture Database (NHFD)	Yes	National report awaited
Falls and Fragility Fracture Audit Programme: Fracture Liaison Service Database	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	National report awaited
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	Data collecting
National Diabetes Audit: National Pregnancy in diabetes audit (NPID)	Yes	Data collecting
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Asthma	Yes	Data collecting
NACAP: Children and young people	Yes	Data collecting
NACAP: COPD	Yes	National report awaited
National Audit of cardiac rehabilitation (NACR)	Yes	Data collecting
National Audit of Dementia	Yes	Data collecting
National Bariatric Surgery Registry (NBSR)	Yes	Data collecting
National Audit of Metastatic Breast Cancer	Yes	National report awaited

National Audit Title	Partici-pated	Status
National Audit of Primary Breast Cancer	Yes	National report awaited
National Cardiac Arrest Audit (NCAA)	Yes	National report awaited
National Cardiac Audit Programme: Myocardial Ischaemia (MINAP)	Yes	Data collecting
National Cardiac Audit Programme: National Audit of Cardiac Rhythm Management (CRM)	Yes	Data collecting
National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Data collecting
National Cardiac Audit Programme: National Heart Failure Audit (NHFA)	Yes	Data collecting
National Comparative Audit of blood transfusion: Bedside Transfusion audit	Yes	Data collecting
National Comparative Audit of blood transfusion: NICE Quality Standard 138	Yes	National report published, local report pending
National Clinical Audit of Psychosis (EIP)	Yes	Data collecting
National early inflammatory arthritis audit (NEIAA)	Yes	National report awaited
National emergency laparotomy audit (NELA)	Yes	Data collecting
National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit (NBOCA)	Yes	National report awaited
National Gastro-intestinal Cancer Programme: National Oesophageal-gastric cancer audit (NOGCA)	Yes	National report awaited
National joint registry (NJR)	Yes	Data collecting
National lung cancer audit (NLCA)	Yes	Data collecting
National maternity and perinatal audit (NMPA)	Yes	Data collecting
National neonatal audit programme (NNAP)	Yes	Data collecting
National Ophthalmology Database - cataract	Yes	Data collecting
National Paediatric diabetes audit (NPDA)	Yes	Data collecting
National Prostate cancer audit	Yes	Data collecting
National Vascular registry (NVR)	Yes	National report awaited
Prescribing Observatory for Mental Health (POMH-UK): Use of medicines with anticholinergic properties in older people's mental health services	Yes	National report published, local report pending
POMH-UK: Monitoring of patients prescribed lithium	Yes	Completed
Sentinel stroke national audit programme (SSNAP)	Yes	Data collecting
Serious Hazards of Transfusions: UK national haemovigilence scheme (SHOT)	Yes	Data collecting
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Data collecting
Major Trauma audit - TARN	Yes	National database unavailable, no submissions possible. Data collection locally occurring.
UK Cystic fibrosis registry	Yes	Local report pending
National Obesity Audit	N/A	Withdrawn by provider
Improving Quality in Crohn's and Colitis (IQICC)	N/A	Withdrawn by provider

National Audit Title	Partici-pated	Status
National audit of Care at the End-of-Life (NACEL)	N/A	Withdrawn by provider
British Hernia Society Registry	N/A	Not relevant to this period, new 2024

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	Data extracted direct from all GP records and reported on ICB basis.
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
National Cardiac Audit Programme: National audit of Mitral Valve Leaflet Repairs (MVLR)	Not relevant to this Trust
National Cardiac Audit Programme: The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	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
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 2023/24:

Name of Confidential Enquiry	Status
NCEPOD: Emergency Paediatric Surgery	Planning
NCEPOD: Blood Sodium study	Planning
NCEPOD: End-of-Life Care	Data collecting
NCEPOD: Rehabilitation following critical illness	Data collecting
NCEPOD: Juvenile Idiopathic Arthritis	Data submitted, closed
NCEPOD: Testicular Torsion	Data submitted, closed
NCEPOD: Community Acquired Pneumonia	Data submitted, closed
NCEPOD: Crohn's Disease	Data submitted, closed

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 43 national clinical audits were reviewed by the provider in 2023/24:

- 1 from 2019/2020
- 7 from 2020/2021
- 16 from 2021/2022
- 18 from 2022/2023
- 1 from 2023/24

Twenty-five of these completed audits identified actions to improve the quality of healthcare provided and the following 20 are examples of the changes planned (some of these 20 are multiple rounds of the same project):

British Thoracic Society (BTS) - Adult Respiratory Support Audit

The aim of the BTS audit programme is to drive improvements in the quality of care and services provided for patients with respiratory conditions across the UK.

Actions include:

- Explore with the Emergency Department (ED) team reasons as to why there is a delay to non-invasive ventilation (NIV) initiation
- Medical Specialty Registrars (SpRs) and Critical Care Outreach Team to be made aware of need for NIV within 1 hour by teaching sessions and reminders
- Departmental move of Respiratory Support Unit (RSU) to sit within respiratory footprint reducing time taken for NIV

Dementia Audit (NAD) Round 5

NAD is a clinical audit programme commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England and the Welsh Government looking at the quality of care received by people with dementia in general hospitals.

Actions include:

- Add delirium screening tool to admission area clerking paperwork, monthly audit
- Teaching session to medics and nursing staff of screening and how to manage positive scores
- Specialist team to contact relative on initial assessment, ensuring team contact details are provided
- Carer questionnaire to be included in weekly key performance indicators (KPI) data collection across both YDH and MPH

- Consult Patient Experience Team on how to improve communication
- Teaching on use of the Abbey Pain Scale
- Tier 1 dementia training to be made mandatory at YDH (as per ex-SFT staff)
- Increase provision of Tier 2 dementia training

Epilepsy12 audit round 3 and 4 2020/21 – 2021/22

Epilepsy12 is a national audit with the aim of helping epilepsy services, and those who commission health services, to measure and improve the quality of care for children and young people (CYP) with seizures and epilepsies.

Actions include:

- Ongoing monitoring for children meeting the Children's Epilepsy Surgery Service (CESS) or tertiary care referral criteria by peer review of complex cases
- Contact Adult Neurology Service to explore support for complex epilepsy transition to adult care
- Broader departmental service development work for CYP with medically unexplained symptoms, to provide early assessment and psychological support

MITRE: Muscle Invasive Bladder Cancer Snapshot Audit – British Association of Urological Surgeons (BAUS):

The aim of MITRE is to collect data on the management and outcomes of patients with muscle invasive bladder cancer at transurethral resection of bladder and to determine variations in pathways and treatments received in the UK, including receipt of neo adjuvant chemotherapy and timings to treatment.

Actions include:

- Review of patients who experienced a delay to surgery
- Carry out reaudit of the Muscle Invasive Bladder Cancer (MIBC) pathway after 12 months

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK): 2021 births

The scope of MBRRACE:

- Surveillance and confidential enquiries of all maternal deaths
- Topic specific serious maternal morbidity
- Surveillance of all late fetal losses, stillbirths and neonatal deaths
- Aspects of stillbirth and infant death or serious infant morbidity

Actions include:

- Reduce number of still birth cause of death recorded as 'unknown' or 'missing' by focussing on the quality of coding

- Cross check electronic record system (BadgerNet) to ensure all deaths continue to be reported including late fetal loss
- Carry out an SFT local mortality review for 2022 deaths

National Clinical Audit of Psychosis – EIP

This audit provides national benchmarking across all Early Intervention in Psychosis (EIP) teams in England and Wales and forms the fifth 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
- Identification of Physical Health (PH) Leads, with PH as regular agenda item on spoke meetings, and bi-monthly meetings on review and monitor progress

National Early Inflammatory Arthritis Audit (NEIAA) Yr5

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:

- Review recruitment issues, explore possibility of dedicated audit staff to support submission
- Implement a single point of triage across Somerset
- Set up an appropriate early inflammatory arthritis care pathway

National 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:

- Return to face-to-face appointments, but retain telephone appointments during this period
- Review the pathway into falls prevention services – strength and balance within 16 weeks of the fracture occurring

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:

- Reduce number of patients referred to Consultant follow up by increasing Consultant Nurse Specialist follow up where appropriate
- Define specific exclusions for patients that are not suitable for cardiac rehabilitation

National Maternity and Perinatal Audit (NMPA) 2020/21 and 2021/22 rounds

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 audit of Induction of Labour (IOL) at both acute sites to understand rationale for IOL as this is higher than the national average

National Vascular Registry (NVR) 2020/21, 2021/22, and 2022/23

The NVR Annual Report provides information on activity and outcomes from interventions in patients with vascular disease. It allows us to compare our local unit-level data with national data.

Actions include:

- Abdominal Aortic Aneurysm (AAA) patient pathways to be tracked in fortnightly meetings, and further investigation around ways to reduce delay in elective AAA pathway
- Angioplasty: reminder to staff of importance of inputting data into NVR in a timely fashion
- Review of Carotid pathway
- Vascular Department to review case selection when considering surgery for high-risk carotid patients, including not to perform carotid endarterectomies in asymptomatic patients until their stroke risk is <3%
- Chronic limb threatening ischaemia (CLTI): ensure completeness of data entry – consideration for provision of admins support for this task

POMH-UK Monitoring of patients on Lithium

Lithium is used for the prophylaxis and treatment of mania, hypomania and depression in bipolar disorder, and in the prophylaxis and treatment of recurrent unipolar depression. It is also used as concomitant therapy with antidepressant medication in patients who have had an incomplete response to treatment for acute bipolar depression and to augment other antidepressants in patients with treatment-resistant depression

Actions include:

- Inclusion of Lithium monitoring in Mental Health Wellbeing Clinic Standard Operating Procedure, and lithium statement on Dialog+
- Offer Lithium App to patients at initiation, Wellbeing Clinics and annual reviews
- Include Lithium monitoring on Post Graduate Medical Education (PGME) and Non-medical Practitioners (NMP) teaching sessions

POMH - Prescribing Valproate

Valproate is an effective and evidence-based treatment for a range of indications; 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:

- Pregnancy Prevention Programme (PPP) assessments to be reviewed by the pharmacist for completeness
- Annual risk acknowledgment form completion to be included alongside existing valproate PGME and NMP training sessions
- Prescribing guidance, off label considerations and need for pre-initiation checks to be included in induction booklet for junior doctors
- Somerset wide review of valproate patients as per Medicines and Healthcare products Regulatory Agency (MHRA), including all off label prescribing

Seeking Excellence in End-of-life care (SEECare) (Acute and Community Hospital Inpatients)

The aim of SEECare is to understand areas of particular excellence or need while also demonstrating which structures of support hospital palliative care teams offer correlate with differing levels of unmet needs.

Actions include:

- Provision of ward-based End-of-Life care training using simulation training (SIM)
- Development of educational resources
- Countywide review of care plans

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 Stroke Rehab Units (SRU):

- Review provision of speech and language provision in SRU
- Review of longer stay patients to identify contributing factors

MPH:

- Review dashboard to ensure real time data is available
- Review patients who received thrombolysis out of hours
- Review data being captured for swallow screening to determine reasons for current scores

YDH:

- Medically fit for discharge patients to be discharged more swiftly
- Training for local and rotational staff for thrombolysis
- Encourage attendance to the Stroke multi-disciplinary team (MDT) meetings by appropriate staff
- Investigate key indicator result for Malnutrition Universal Screening Tool (MUST) score to dietitian

UK Parkinson's audit

The overall aim of the UK Parkinson's Audit is to provide timely information to clinicians, commissioners, funders, members of the Parkinson's community, and the public on how well Parkinson's care is being delivered so it can be used as a tool to improve the quality of care.

Actions include:

Speech and Language:

- Referrer to be copied into patient care plans
- Patients on/off phases to be documented in patient record
- 'Communication assessment' and 'interventions' templates to be devised

Occupational Therapists (OT's):

- To receive training in techniques that maintain and initiate movement
- To address cognitive, mental wellbeing and carer strain where appropriate
- Training to highlight importance of advice and information to carers

Physiotherapists:

- Use of outcome measures and goal setting to be covered in clinical supervision
- Develop a set of outcome measures
- Promote use of discharge reports

Care of the Elderly and Neurology:

- QI project to improve consideration of bone health
- Patient pathway data to be reviewed and managed at MDT
- Enrol in Quality Improvement (QI) training with PD UK around therapy induction

LOCAL CLINICAL AUDIT

The reports of 129 local clinical audits were reviewed by the provider in 2023/24. 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 the129 local clinical audits reviewed, 118 required action plans, and the following 20 are examples of projects conducted by clinical teams across the Trust and the changes proposed because of them:

Care Homes: Listening and Responding to Care Homes (LARCH) - Discharges to Pathway beds in care homes

The audit was carried out following a critical incident discussed at a Discharge Improvement Group (DIG) meeting which involved an inappropriate Somerset Treatment Escalation Plan (STEP) form being sent on discharge with a resident to a care home.

Actions included:

- Monthly discharge training to specifically include discharges to care homes
- Flow Manager to report every ‘poor discharge incident’, and present at DIG
- Improve communication between care home and SFT staff to provide collaborative approach.
- Review policy to establish if terminology could be clarified
- Share audit results amongst all stakeholder groups and leaders

Community Urgent Care/Minor Injury Unit (MIU): Wound Assessment and Documentation

The aim of this re-audit was to ensure and improve correct assessment of wounds, for patients to receive appropriate treatment and choice of dressing. Also, recognition of early intervention if required. Compare against previous year results.

Actions included:

- Devise Standing Operating Procedure (SOP) for MIU, taking advice from Tissue Viability Team and Emergency Department (ED)
- Add to team folder, on notice board and twice weekly huddle
- Include in clinical supervision
- Move pain score documentation to the front of MIU notes to prompt consideration and completion

Learning Disabilities (LD): Advance Care Planning (ACP) for people with LD

The aim of this audit was to understand and improve advance care planning, development of Treatment Escalation Plans (TEP) and Cardiopulmonary resuscitation

(CPR) decision making for people with LD. Also to contribute to the overall regional position.

Actions included:

- Piloting advance care planning clinic, and make case for funding for an additional post in the End-of-Life care education team to provide ongoing support to staff
- Develop criteria for when the LD Liaison team would be involved in review of TEP/ACP
- Engage with digitalisation of TEP/ACP

Mental Health: Capacity Assessment for proposing informal admission to mental health ward

The aim of this audit was to review practice against issues identified in the NHSE independent investigation following an incident in 2020.

Actions included:

- Development of an 'Informal Admission' SOP
- Ward managers to review a sample of records for 6 months
- Development of a patient leaflet to be made available at the point of admission
- Add provision of information leaflet and assessment of capacity to admission checklist
- Capacity assessment to be updated and aligned with the new Trust Mental Capacity Assessment (MCA) form
- Good practice example to be prepared and circulated

Mental Health: Mental Health Act (MHA) Assessment Outcome Recording

This audit arose from the death of a patient following a Mental Health Act assessment where it was agreed not to detain.

Actions included:

- Convene working group to investigate process and procedures and develop a MHA Assessment SOP
- Develop templates to record information provided on referral, outcomes of MHA assessments, onward referrals, and proposed treatment plans.

Mental Health: Prescribing and Monitoring of antipsychotic medication in an older adult inpatient psychiatric ward

The audit was designed to compare the current practice in the Older People's Mental Health ward with NICE guidelines for the prescription and monitoring of antipsychotic medications.

Actions included:

- Improve involvement of patient in choice of medication, by ensuring thorough discussions at ward rounds
- Commence routine morning Capillary Bood Glucose (CBG) monitoring to effectively manage metabolic risks
- Procurement of waist circumference measurement tapes
- Utilise Glasgow Antipsychotic Side-effect Scale (GASS)
- Provide readily accessible generic information about diet to patients
- Integrate eating and exercise components into patient care plans

Mental Health: Physical Health Checks in older people (Mendip)

The aim of this audit was to ensure that all patients who are prescribed antipsychotic medication in the community receive physical health checks in line with local Shared Care Guidelines (informed by NICE).

Actions included:

- Implement a physical health monitoring focus group
- Make case for funding for additional equipment to be based in all localities, and for additional Assistant Practitioner for physical health checks
- Quarterly spot checks to monitor provision of information to patients, electrocardiogram (ECG) carried out at required points, use of standardised side effect monitoring tool, and questions about lifestyle, drug and alcohol use are being asked.

Occupational Therapy (OT): Early Intervention

The aim of this audit was to establish and improve meeting delivery timescales, to enable patients to receive appropriate therapy in preparation for leaving hospital.

Actions included:

- Create written specification for service delivery and provide education on timescales for interventions via discussion in 1:1 supervision, new nurse induction and local ward training
- Provide guidance on how to deliver OT process in acute setting with regards to caseload management
- Review of supervision process to incorporate regular case review

Ophthalmology: Wet age-related macular degeneration (AMD) referrals

The aim of this audit was to assess the average and range of waiting times of wet AMD Referral to Treatment pathway.

Actions included:

- Registrars to redirect all neovascular AMD (nAMD) on Maxims to one of the Retinal Consultants

- Increase access to Rapid Access Macular (RAM) clinic slots by: increasing number of slots, increase staffing cover, providing alternative if clinic day cancelled, booking directly to Macular Treatment Clinic (MTC) if RAM full
- All Fast Track Virtual Macular Clinic reviews to be requested within 1 week
- Requests for new nAMD cases to be seen in MTC must happen within 1 week

Oral and Maxillofacial Dept: Trigeminal Nerve Injury

Trigeminal nerve injury is a potential complication of lower wisdom teeth extractions. The aim of this audit was to assess compliance with protocol and its effectiveness.

Actions included:

- Investigate potential for having separate codes for lower and upper wisdom teeth
- Increase availability of the assessment proforma
- Standardisation of consent forms, including all risks and benefits of oral surgery procedures
- Update protocol

Parkinson's (acute Inpatient): Missed/delayed administration of Parkinson's medication

The aim of this audit was to establish whether patients with Parkson's receive their medication on time; delays can lead to serious health implications.

Actions include:

- Implement 'Get it on time' resources from Parkinson's UK
- Design and deliver bi-monthly snack box training
- Poster campaign

Pharmacy: Antimicrobial Prescribing at MPH and YDH

The aim of this audit was to establish the quantity and quality of prescribing antimicrobials, which are a life-saving intervention used in every speciality. They are not however, without significant issues for the patient and the population.

Actions included:

- Design and implement a continuous audit tool to enable focused intervention for improvement
- Audit Sepsis of Unknown Origin (SUO) prescriptions to ascertain if this indication is an area where practice could be improved

Podiatry: Records re-audit

The aim of this audit was to ascertain whether the Podiatry Service is meeting the Trust's and the Royal College of Podiatry's record keeping standards.

Actions included:

- Share approved abbreviations with team members, work with IT to add this to the electronic patient record
- Place into care processes the need to reassess within 12 months, investigate possibility of automated flag within electronic system.
- Provide further support (clinical supervision and CPD sessions) to embed need for detailed and clear treatment plans
- Alert team members of need to complete ulcer template, and record ulcer sizes at all times.

Radiotherapy: Use of the Assessment of Late Effects of Radio Therapy – Bowel (ALERT-B) tool for patients with late effects of pelvic radiotherapy

The ALERT-B tool is a validated tool for patients with consequences of cancer treatment. The aim of this audit was to ensure the team are using the tool consistently (including across the region) and to evaluate its effectiveness.

Actions include:

- Evaluate pathway to identify if tool can be completed at a more effective point
- Analyse wider referral data to investigate onward referrals being made in response to ALERT-B answers

Safeguarding adults: Process and Quality of Referrals

The aim of this audit was to ensure the referral forms were fully completed and provide sufficient information relating to the concern raised. This will reduce delays in the referral triage process and improve efficiency.

Actions included:

- Develop referral checklist and add to Safeguarding Adult policy
- Safeguarding Advisory Service (SAS) to work with staff to better utilise the Multi-Agency Risk Management (MARM) process, to enable a more proactive and protective approach to safeguard the adult

Safeguarding children: Parenting Observation Forms

The aim of this audit was to determine and improve the completion rates of the parenting observation forms, introduced because of a Child Safeguarding Practice Review in 2021.

Actions included:

- Escalation of concerns to midwife to be included in clinical supervision
- Accurate completion of forms to be discussed in hospital midwife supervision sessions
- Scanning of forms to BadgerNet (patient record) to be added to Maternity Safeguarding Standard Operating Procedure (SOP)

Tissue Viability: Negative Pressure Wound Therapy (NPWT)

The aim of this audit was to ensure that NPWT is being delivered in an effective and safe manner across the whole Trust, and to improve adherence where required.

Actions included:

- All areas to review tools/care plan templates to ensure documentation of verbal consent and treatment aims
- Complete weekly evaluations, either by the Tissue Viability Nurse or via District Nurses
- Develop/review existing dressing change forms to ensure avoidance of retained product

Trustwide: Clinical Supervision

The aim of this audit was to establish provision of good quality clinical supervision for all registered and non-registered staff

Actions included:

- Update Introduction to Clinical Supervision workshops to reflect issues raised in this audit (e.g. frequency, need for a contract, improve provision)
- Add definitions and options on the clinical supervision tab on LEAP (Trust electronic system for learning and development)
- Distribute copies of contract to all Clinical Supervisors
- Quarterly Service Group feedback on colleagues who have completed Trust Clinical Supervision training

Trustwide: Record Keeping Quality

Following merger, and acknowledgement of many different recording systems, this audit was designed to focus on the extent to which the whole patient record provides a basis for safe and effective multidisciplinary care for the patient, across the Trust.

Actions included:

- Review of data entry points within clinical systems to ensure they are adequate to evidence all patient care given
- Develop an overarching Record Keeping Guideline/top tips document, including reference to acronyms and abbreviations
- Develop a SOP relating to the uploading and checking of patient information

Vascular Department: Peripheral Arterial Disease (PAD) Quality Improvement Framework (QIF) time to treatment pathway

PADQIF provides guidelines for the management of patients with Chronic Limb Threatening Ischaemia (CLTI). The aim of this audit is to establish time from referral to treatment and to put in place actions to expedite this pathway.

Actions include:

- Creation of hot slots in clinics to expedite initial duplex imaging in new patients with CLTI
- Education amongst managerial and clerical staff to enhance awareness of urgent clinic slots for patients referred with CLTI

CLINICAL RESEARCH

Introduction

The UK has a vibrant and growing life science industry which turns over £94.2 billion annually. Clinical research is a high national priority and is a hugely important part of the life sciences industry and the UK economy. Levels of commercial research have declined since Covid and in response the UK government commissioned a review, led by Lord O' Shaughnessy to investigate the challenges that face commercial clinical trials within the UK. Following the review all recommendations on how to improve the environment for running clinical trials in the UK are being taken forward. All NHS research sites are requested to do what they can to deliver commercial research to support improvements in health and wealth of the nation, to double commercial research activity in the next two years, and double again by 2027.

There is a focus on ensuring processes are efficient and safe, legislation governs many of these processes. In early 2023 the Medicines and Healthcare products Regulatory Agency (MHRA) announced results of a public consultation on proposals to amend the clinical trials of human medicines legislation. The MHRA aim to enable a thriving clinical research environment in the UK and support the UK vision for the future of clinical research delivery in Saving and Improving Lives: The Future of UK Clinical Research Delivery (2021).

These proposals lay out recommendations to improve the life sciences and research ecosystem, removing bureaucracy to support efficient and effective clinical trials delivery, fostering growth and wider access to research for the population of the UK.

As a site we must also look to our processes, ensuring that we have efficient and streamlined approach to study setup and delivery, utilising quality improvement and grasping opportunities to develop and broaden the work. Merger has been a focus over the past 12 months, we continue to work on harmonising processes and ensuring equal access to all research opportunities in services for Somerset, whilst expanding our commercial portfolio and further developing our strategic partnerships.

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 has now collaborated 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. A Innovate UK grant of £1m has been awarded, the grant is held, and the project is sponsored by Sano Genetics, and work will be in collaboration with the Trust to deliver the project.

A number of Trust clinicians have been approached to become UK wide chief investigator for new commercially sponsored projects, Dr Oliver Miles for Haematology projects and Dr Saiqa Spensley for a commercially sponsored drug trial in Oncology. The Trust will act as Lead R&D Department for the projects.

The Trust continues to work with TrinetX, a commercial data warehouse that provides anonymised data to approved research partners across a global network of healthcare organizations and life sciences companies driving real-world research to accelerate the development of new therapies.

The Trust continues to be a prime site collaborative partner with IQVIA and a partner in the **I**nvestigator **N**etworks, **S**ite **P**artnerships and **I**nfrastructure for **R**esearch **E**xcellence (INSPIRE) program alongside Pfizer.

Academic grants

The Trust has several academic, grant supported, studies in various stages of progression.

Miss Jo Morrison, Consultant Gynaecological Oncologist, submitted a successful grant application in relation to post-natal cervical screening. The first stage of this project explored acceptability of cervical screening and self-sampling in postnatal women at 6-week postnatal check, this project has now closed, and results are awaited. Second stage is investigating the acceptability and accuracy of cervical screening and self-sampling in women at 6-weeks postnatal, this project has received ethical approval and will open in SFT, and multiple other centres across England in the next few months.

The Love Musgrove Charity supported 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 project has now closed, and the data is being analysed.

The Trust merger has expanded opportunities to work across county and collaborate with its local health community partners. Work on merging the YH and pre-merger SFT research teams continues. The Trust and Symphony Healthcare Services have worked collaboratively on several projects and will continue to identify projects where we can work collaboratively.

The Trust continues to work as a partner organisation of the Biomedical Research Centre (BRC) 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. Dr Marianne Hollyman, Upper GI Consultant Surgeon, is a BRC Senior Fellow, this provides funded time and resources through the BRC to develop academic research projects.

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 2022 the first Chief Nurse Research Fellowship (CNRF) scheme was launched. The annual scheme, funded by the NIHR, offers successful applicants the

opportunity of having one day paid per fortnight to undertake clinical academic career development, to gain an understanding and experience of clinical research delivery and the opportunity to develop a service-based quality improvement or audit project as a basis for future research.

Year one 15 fellowships were awarded, 12 successfully completed. Since then, many continue to be research interested or research active, some have been successful in having posters accepted at conferences, both in the UK and Internationally. The second CNRF cohort 2023 is currently underway with 4 fellowships awarded.

Quality improvement

The research department is required to conduct an annual Patient Research Experience Survey the results of which for 2023/24 were positive with no action plans required.

During the year staff have utilised Bronze Quality Improvement training and have contributed to numerous quality improvement projects with particular focus on merger and initiatives across all research sectors.

Research Patient, Public Involvement and Engagement (PPIE)

Last year our PPIE facilitator aimed to tackle research equity through engaging with the local council's diversity group, and mental health partners group, to help identify research barriers, seek solutions, and increase research accessibility and awareness.

This year our research team have been an active and collaborative partner in the Somerset Research Engagement Network (REN) project, funded by the NIHR, hosted by the ICB with all ICS partners. The project aimed to work in partnership with the voluntary, community, faith and social enterprise (VCFSE) organisations, to engage under-represented groups and communities, such as under-served groups with protected characteristic as well as inclusion health groups, to improve participation in NHS research. Spark Somerset was funded to undertake the community facing activities and utilised their research connectors to do the outreach work with their communities. The Trust along with collaborators contributed to the development of the questions and were active in providing the baseline data about current research recruitment for Somerset. The project is now complete, and the outcome report is pending. The networking opportunities and relationships established during the REN project will now enable the PPIE agenda to progress more effectively and sustainably. SFT research team also shared their research exhibition and presented at a recent Spark Somerset '**Research in Somerset: learning and networking event'** for people to 'Learn the importance of research within the VCFSE sector and how we can increase involvement within our communities.' A number of the research connectors in attendance plan to join our Somerset wide PPIE group which will enhance the coverage and increase involvement and engagement activities in the research pathway, from ideas generation, study design and delivery, through to results dissemination. To maintain this momentum, provide support for the lay Somerset wide PPIE research steering group, it will be necessary to recruit into the current vacant PPIE facilitator role. To date we have internal staff engaged and interested and the NIHR have funded a place on the PPIE summer school at Exeter University.

Funding and activity

In 2023/24, the Trust was allocated £2,297,010 to support research staffing and infrastructure via the NIHR Clinical Research Network: South West Peninsula, with a further £111,188 directly from the Department of Health & Social Care. Revenue from the conduct of research of £854,404 has been invoiced for, as at 31/03/2024. 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 SFT, who were recruited in 2023/24 to participate in research approved by a research ethics committee was 3,579 (in 241 studies).

CARE QUALITY COMMISSION (CQC)

Somerset NHS Foundation Trust's maternity services were inspected by the CQC between 20 and 21 November 2023 and the report published on 10 May 2024.

This was a short notice announced inspection as part of the CQC's national maternity inspection programme, which aimed to give an up-to-date view of hospital maternity care across the country. The maternity services at Yeovil District Hospital, Musgrove Park Hospital and the Mary Stanley midwife-led unit at Bridgwater Community Hospital were inspected as part of this visit.

The reports indicated that we have fallen short of the standards we expected to be delivering and we apologise to our families who use these services and to our hard-working colleagues.

Whilst there was evidence of good and outstanding practice within the three units, there were a number of areas of significant improvement identified. In January 2024, following the inspection, the CQC issued the Trust with a Section 29a Warning Notice in January 2024. This outlined a conclusion that the quality of health care provided by the Trust for maternity services requires significant improvement due to the following:

- The service at Musgrove Park Hospital does not operate clear triage processes to ensure the safety of women, birthing people, and babies.
- Somerset NHS Foundation Trust does not have an effective program of regular audits to ensure the safety and quality of maternity services are monitored, and processes to learning from incidents are not effective.
- Leaders at Somerset NHS Foundation Trust do not operate effective systems and processes to improve the quality of the maternity service, nor do they maintain clear oversight of maternity services to keep women, birthing people, and babies safe.
- Improvement to systems is needed to ensure that policies and procedures are in place to provide staff with relevant guidance.

CQC Ratings

As a consequence of these inspections, the overall rating for Musgrove Park Hospital maternity services has decreased from Good to Inadequate. The rating for how well-led it is has decreased from Good to Inadequate. How safe it is has decreased from Requires Improvement to Inadequate. This was a focused inspection, and the areas of effective, caring and responsive retain their previous ratings of Good. Following the maternity services inspection, the overall rating for the Musgrove Park Hospital as a service location has also decreased from Good to Requires Improvement.

Yeovil District Hospital maternity services have been rated as Inadequate overall, as well as for being safe and well-led and the overall rating as a service location has also decreased from Good to Requires Improvement.

It was the first time Bridgwater Community Hospital's Mary Stanley Birth Centre, a midwife-led unit, has been rated. The maternity service has been rated as Requires Improvement overall, and for being safe and well-led.

Response to Inspections

The Trust has taken immediate action following the inspections and an action plan outlining the relevant steps and actions to be completed to address the findings is monitored through a newly formed Maternity and Neonatal Action Group. This group is jointly chaired by the Chief Nurse and Chief Operating Officer. It supports and monitors progress against the high-level action plan that includes the following areas:

- Governance oversight
- Clinical pathways and processes
- People issues relating to CQC
- Estates issues
- Equipment issues
- Governance process review and development

We have strengthened our processes to provide ongoing review of quality, performance and governance including developed a strong audit and policy programme to drive continual improvements in our services. All guidance and policies that were highlighted have been reviewed and updated and we have increased scrutiny and governance around our policy processes ensuring these are available to all colleagues. We have also reviewed and mapped all mandatory training, strengthened our oversight, and significantly improved our compliance.

At Musgrove Park Hospital's maternity unit, we have put in place a new evidence-based, standardised triage process to risk assess and prioritise care based on clinical need and reconfigured the ward to facilitate safe and effective clinical oversight of our service users. In addition, we immediately sourced additional emergency equipment at Musgrove Park and Yeovil District Hospital.

The CQC report for Musgrove Park's maternity service particularly highlights issues that are as a result of the poor condition of the building. There are plans to replace this as part of the national New Hospitals Programme, but we have already made improvements specifically around safety and security.

The inspectors noted an open culture, good engagement with local communities to make improvements and plan services, good team working, and that colleagues felt valued and supported.

The Trust met with the CQC in May 2024 where the Trust provided detailed summaries of the improvements made in response to the Section 29a Warning Notice and the ongoing plans to continue to develop, embed and sustain those improvements. At this meeting it was recognised that the Trust had made significant changes since the inspection and would continue to do so and were confident that

these gave a good foundation on which to build and to move forward. Following assessment, the CQC confirmed it was satisfied that the actions described manage the risks identified within maternity services.

We anticipate that follow up inspections will take place within maternity services at Musgrove Park Hospital, Yeovil District Hospital and the Mary Stanley midwife-led unit during 2024/25. We will continue to work with the CQC to address all of the points identified in the full inspection reports.

INFORMATION ON QUALITY OF DATA

SFT 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.

SFT submitted records during 2023/24 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	99.6	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	100.0	100.0	100.0

There are high levels of data completeness in key monitored metrics that are submitted to SUS.

The SFT data quality maturity index (DQMI) score for the submitted data in 2023/24 was 94.6% compared to a national average of 90.4%.

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.
- Progression through an extensive data cleansing and migration programme to prepare for the procurement of the Trust's replacement EHR system.
- Continue to develop the patient master index work within the warehouse to help identify duplicate records within the systems.

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.

SFT's Data Security and Protection Toolkit submission for 2023/24 was completed in June 2024 where all mandatory evidence items were reached, with an assessment status of 'standards exceeded'.

In line with the DSPT reporting tool, 7 incidents were reported to the ICO in 2023/24. Three incidents related to information being shared in error; three incidents related to members of staff accessing records inappropriately; one related to information not being held securely.

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. One incident has been reported to the Police, their investigation is still in progress. 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 both the acute sites (MPH & YDH). Whilst the Trust met the DSPT Standards Met attainment level for 3 of 4 coding fields it did not reach this level for primary diagnosis accuracy which as a whole means the Trust did not achieve the DSPT Standards Met attainment level.

Percentage achieved 2023/24		**DSPT Standard 1 Mandatory Target**
Primary Diagnosis	87%	90%
Secondary Diagnosis	91%	80%
Primary Procedure	92%	90%
Secondary Procedure	91%	80%

These figures are representative of challenging circumstances within the department, with significant staff turnover resulting in a trainee heavy department in addition to absorbing ~10,000 additional admissions across 2023/24.

Reassuringly the department did evidence a higher attainment level in all other coding fields compared to the previous 2022/23 audit, bringing the accuracy level above 90% in each of these areas.

Considering the challenges facing the coding team the Trust authorised additional recruitment into the team, with 3 WTE coding positions being appointed into. However, without a full EHR it wasn't possible to offer fully remote working to entice qualified coders into the department and as such the team elected to train and develop our own junior coders. The Trust has also created a development role for a Senior Coder to provide additional support to the training requirements of the department by means of supporting this coder to become an NHSE accredited Clinical Coding Trainer.

The Trust's existing NHSE accredited Clinical Coding Trainer provides both the 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 coded data produced by the team.

To this end the Trust has supported 3 candidates to sit and pass the National Clinical Coding qualification (the gold standard of Clinical Coding) in March 2024.

In addition to 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 regular validation on the quality of the coded data to ensure further assurance of the quality of the data.

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

PATIENT SAFETY AND QUALITY IMPROVEMENT ROADSHOW

Teams across the Trust are working on quality improvement projects that aim to improve patient safety across our sites – and they gave everyone the opportunity to see what they've been up in a roadshow that tied in with World Patient Safety Day, sharing some of the latest patient safety and improvement work from across our acute, community, and mental health services.

Linking in with World Patient Safety Day, colleagues from the Governance Support, Quality Improvement and Patient Safety Teams, supported by our Patient Safety Partners, developed and delivered a roadshow to showcase some of the latest patient safety and improvement work from across our acute, community, and mental health services.

Teams and services taking part included:

- Clinical skills
- Dementia and delirium
- Deteriorating patients
- Digital
- Discharge
- End of life
- Falls and deconditioning
- Freedom to Speak Up and how to raise concerns
- Governance
- Hospital at Home
- Infection control
- Learning disabilities
- Library
- *Little Hospital of Horrors* – interactive learning
- Maternity
- Medical devices

- Mental Health
- Never Events
- National Safety Standards for Invasive Procedures
- NG Tubes
- Patient experience and Patient Advice and Liaison Service
- Paediatrics
- Pharmacy
- Point of Care Testing
- Pressure ulcers
- Quality improvement
- Resus
- Speech and Language Therapy.

Along with a variety of stands and other information, there was simulation (a simulated patient bedside scenario with a catalogue of errors) and interactive learning.

Hundreds of colleagues attended the roadshow at Yeovil District Hospital and Musgrove Park hospital. There was a real buzz in the room, lots of interaction and useful conversations with clinical, patient safety, governance, and quality improvement colleagues, supported by patient safety partner volunteers.

Feedback from colleagues was sought, with 96% saying they felt it was a good use of time, 92% saying that it was good for networking and 96% saying they would recommend it to a colleague.

Work is already underway to deliver another roadshow in 2024/25, with an aim to build on the success of the event but improve access for colleagues based on our other sites and in the community.

PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK – IDENTIFICATION OF LOCAL PRIORITIES

As part of the implementation of the new patient safety incident response framework (PSIRF), organisations were required to identify local priorities based on an understanding of their incident profile. As locally defined priorities, PSIRF enables organisations to focus on those areas for improvement by undertaking several patient safety incident investigations (PSIIs) for each priority. This allows application of a systems-based approach to learning from these incidents exploring multiple interacting contributory factors. The outcomes of the PSIIs can then be thematically analysed to inform our patient safety improvement planning and work. Within SFT, the safety improvement plans and workstreams will be overseen by Patient Safety Board.

The work to describe the patient safety incident profile at SFT was undertaken between June and November 2023 and was conducted by the Quality & Safety Analysts and PSIRF implementation teams within the Governance Support Team, in conjunction with a wide range of stakeholders including medical directors, safety teams and topic specialists.

Over a three-year period almost 100,000 incidents were reported by colleagues at SFT and its legacy organisations. During this time, incidents were reported using two separate incident management systems, Radar and Ulysses, which collected data in different ways.

An extract of the details from each incident across both systems were taken and combined into a minimum incident dataset that included where and when the incident happened, what the impact of the incident was and how the reporter categorised the incident. The categories from each system were mapped to standardised groups aligning to the existing governance framework topics or other specialist subjects. The standardised groups and topics were considered, and a number of areas were selected for review. This was based on the triangulation of the volume of incidents occurring across the Trust and their relevance, for example those groups that include patient safety incidents, but also alongside the views of senior leaders and other stakeholders across the organisation. The selected groups accounted for approximately 75% of incidents reported within SFT.

Information has been collected and synthesised from a wide variety of sources, including wide stakeholder engagement with key people across the organisation. This information gathering and data analysis exercise enabled the Trust to identify a list of eleven broad patient safety themes across the organisation:

- Deteriorating patient (including sepsis)
- End-of-life and treatment escalation planning
- Medical devices (including extravasation)
- Medication management
- Pressure ulcers & tissue viability
- Slips, trips & falls
- Suicide, self-harm and ligatures
- Transfer of care (including discharge)
- Violence and aggression
- Communication (including with people who matter) and documentation
- Treatment and care

For each priority area, an initial analysis of incident data was undertaken to describe the number of incidents reported, how this changed over time, where in the organisation they occurred and what level of harm resulted. It also included topic specific data that was captured on both incident systems. This initial analysis was shared with subject matter experts knowledgeable about each priority area, followed up with a conversation to gain insight into the common types of incidents, current areas of concern, the level of understanding of system factors in relation to these areas, and any existing quality improvement work being undertaken.

Following each conversation, additional analytical work was undertaken to further describe the specific areas that are potentially for patient safety incident investigation.

These are subsets of the wider topic that would benefit from a thorough understanding of the system factors that results in these incidents and could benefit from targeted improvement work.

A detailed summary of this work was shared with key stakeholders, both internal and external, in advance of a planning session to choose the Trust's priorities. Following detailed discussions at this session, the final three priorities were chosen by consensus as:

- Deteriorating patient (including sepsis)
- Treatment escalation planning
- People who matter

These priorities will form the focus of patient safety incident investigations at SFT for the next 12-18 months, after which the exercise will be repeated to identify new priorities.

FALLS REDUCTION ON ELIOT WARD

When an elderly or frail patient experiences a fall, it can have devastating consequences that they may never fully recover from.

It is not possible to prevent every fall, but there are measures that can be put in place to reduce the chances of it happening. Significant improvement work is happening across the Trust, supported by a Falls Lead within the Patient Safety Team and a co-ordinating Falls Group, alongside numerous local initiatives.

One such local initiative has seen Eliot Ward celebrate having zero falls that caused an injury over a whole 12-month period thanks to a falls improvement project that began in 2022 after a number of elderly patients experienced a fall with injury on the ward during the year before.

There are different levels of falls on hospital wards, from those resulting in no injury whatsoever, to a potentially debilitating fracture or head injury that may mean the patient needs emergency surgery.

In addition to having zero falls with injury over 12 months, the Eliot ward team has also reduced the number of falls without injury from around 15-20 to fewer than five.

Vicki Burgess, Eliot's ward sister highlighted that one of the ways that they achieved this was by extending so-called 'bay nursing', where there is always have at least one healthcare assistant or nurse with a bay of patients at one time – day or night. It is a "tag team" approach and means colleagues are able to spot a patient who looks unsteady on their feet, so they can give them the support they need to get about on the ward, such as if they need the toilet. Bay nursing is now very much business as usual on the ward, and the benefit has been a huge reduction in patient falls.

Quite a lot of falls tend to happen at night, so another action was to change the structure of colleagues' break times and undertake a programme of colleague education to reinforce the importance of someone being in the bay at all times.

In addition, patients at high risk of falling are always highlighted during the safety briefing in the morning, and the catch up between each shift, to reinforce our knowledge of our patients so we can be more alert. If a particular bay is identified as a potential hotspot on the day, additional colleagues can be deployed there.

Other colleagues were involved group training days, where consultants talked about the certain medications, or changes in blood pressure to look out for, that could mean a patient is more likely to fall.

Mel Smith, a staff nurse on Eliot ward, also played a lead role in the falls improvement project.

“The work we’ve done to reduce falls has been reassuring for relatives, as although it’s not possible for one-to-one nursing, they’re happier in the knowledge that we’ll always have a colleague based within their loved one’s bay,” she says.

“We know it’s impossible to prevent all falls as we do want our patients to be up, dressed and mobilised when in hospital to give them a better chance of recovering. As a nurse it’s natural to feel guilty if a patient under our care has fallen, but if we can do everything we can to prevent this from happening then we are doing our best for patients. For example, even if we’re behind a curtain attending to another patient, it’s still possible to sense if another patient is trying to get up and about but is likely to struggle with their mobility.”

“On Eliot ward we predominantly care for elderly patients, many of who are likely to have dementia or other cognitive issues, so they’re at a much greater risk of falling. Therefore, even if we witness a fall that can be a good thing, as we’re more likely to know the severity and can deal with it appropriately. So now, even if both nurses in the bay need to go somewhere, they’ll tell the doctor, physiotherapist, or other colleague, so they can provide cover for a short time – we’re all part of the team.”

PATIENT EXPERIENCE

ESTHER CAFES

Our patient engagement team recently relaunched its Esther cafes. These are one-hour sessions in which patients, their carers, and clinical colleagues meet to discuss how we can all improve patient care.

What’s an Esther cafe?

Originating from Sweden, Esther cafes were created following the case study of a real patient – Esther – who experienced delays in diagnosis and treatment. The Swedish health system used Esther’s patient journey as a way of identifying how they could make outcomes better for the ‘Esthers’ in the health system.

Each one-hour café session features a story or case study told by an ‘Esther’, and patients, carers, relatives, and healthcare professionals work together to answer one question: "What’s best for Esther?”

Before the pandemic, our patient engagement team organised Esther cafes quarterly, and have recently relaunched them, with the first session recently taking place at Yeovil Hospital.

“At the start of each session, the patient and/or their carer will share their experience, identifying what could have been done better and to share best practices,” explains Krystle Pardon, our head of patient engagement and involvement.

“After that, colleagues are encouraged to ask questions to understand what could have contributed to a better patient and carer experience. The sessions are open to anyone involved in patient care, apart from those directly involved in the care of the person sharing their experience.”

What are the benefits?

The sessions are a unique opportunity to hear feedback from a patients' personal experience, enabling colleagues to reflect and learn from those experiences, and put improvements in place for the future ‘Esthers’ coming into our care.

“Feedback is largely positive, from both the patients and carers who join us as our ‘Esther’, as well as the colleagues that attend,” Krystle continues. “One particular session resulted in a group of colleagues identifying that they could change how they interact with families and carers when a loved one is nearing the end of their life, ensuring the conversation is personal and respectful of their individual wishes.”

For patients and carers, the Esther cafes provide a chance to engage and respond with how they have experienced care being given – and they are often pleased to be able to contribute to future improvements.

The patient engagement team are developing a rolling programme across the whole organisation and are working in collaboration with the service groups to ensure we hear a breadth of stories.

ENGAGING WITH OUR LOCAL COMMUNITIES

The Patient Engagement and Involvement Team have been liaising with local businesses including Leonardos and Screwfix, to attend their places of work with the pop-up health and wellbeing hub. We share information about long term conditions, offer advice and signposting, and gather demographic information about our local population to help us develop processes, systems and services that best meet the needs of the public we serve.

The businesses are displaying our health and wellbeing leaflets in their occupational health waiting rooms, which gives people the opportunity to reach out for assistance which may help prevent a GP appointment and see that they receive the help and support they need in a timelier way. As this is a new initiative, it is important that we review this intervention and seek feedback from the people who are being offered this service, to help us develop and deliver to the required needs of our business community.

MELANOMA SUPPORT GROUP

Being told the news that you have cancer can be scary, unfamiliar and create feelings on anxiety and stress. It can be a lonely place if you don't have a direct network of support or access to the advice you're looking for, especially from those who've been through a similar experience.

Unique to our trust in Somerset, our dedicated team of cancer support workers have created a support lifeline for patients who've been diagnosed with melanoma - a type of skin cancer that is usually caused by overexposure to UV light, from the sun or in sunbeds.

Set up in March 2023, the melanoma support group provides patients with a place to meet to share openly, receive advice and get help in understanding how to manage their diagnosis.

The group was formed when a patient, who had skin cancer at the time, decided she wanted to help create a support network for patients just like them after she had moved down to Somerset and had their first appointment at Musgrove. She found out a group didn't currently exist and decided she wanted to help set one up, having previously helped organise one in her hometown of Milton Keynes.

The skin cancer team had always had it on their agenda to create such a group, however time and resources had always been a barrier. With the help of a few more patients who were keen to get involved, the skin cancer team created a series of questionnaires and feedback forms to see what patients might want to see from a support group, and it evolved from there.

Macmillan Cancer Support offered funding to the team to invest in venue hire, refreshments, and advertising of the group to local communities and patients.

Although the group remains relatively small, the team are aiming to continue promoting it, with the help of patients, with the eventual goal being to create a patient-led initiative, with the support workers providing aid when booking guest speakers or assisting with venue changes.

Claire Lloyd and Zoe Evans, cancer support workers within our skin cancer team, lead the melanoma support group and aim to provide a holistic approach to patient guidance and care.

"I've been part of the skin cancer team for five years and it wasn't something I'd done before joining the trust, although I'd been in supportive roles in the past," says Claire. "The role is amazing and it's so nice to join such a support-driven team who really want to help provide aid to patients at such a difficult time in their lives."

The melanoma support group creates a safe space where patients can share their experiences and listen to guests who can help aid in the patients' mental and physical wellbeing. The group has welcomed representatives from craft therapy groups, as well as SASP (Somerset Activity & Sports Partnership) and the HOPE counselling service.

“Patients tell us the value of the group is getting to talk to people who are going through the same thing as them,” continues Claire.

Zoe adds: “It’s a safe place to share, with no expectation to talk about their diagnosis. “As much as family and friends can empathise with patients, they haven’t themselves been through the same experiences as the people in the room when they’re at the group.”

Our cancer support team are vital in providing advice to patients that have any worries or concerns about anything that’s going on in their life. Often the diagnosis of cancer sends patients into a state of emotional overwhelm and patients will begin to worry about the impact on their personal lives too.

The cancer support workers use what’s called a holistic needs assessment to determine what practical things may become a problem for patients and how the team can look to provide a support network for the individual.

“It feels like a privilege to be involved in supporting patients in this way,” adds Claire. “It’s nice to join a patient at this stage in their life and be able to have an impact on their wellbeing. We often get told by the patients, or other members of the team, that just having a conversation with us makes the world of difference.

“And the melanoma support group helps extend this wider too, by providing specialist support to patients as opposed to them seeking help from a generalised group. Skin cancer has such a misconception as being a non-serious cancer. Most people think you just cut it out and carry on with your life, but it can be very serious, and patients deserve to be looked after throughout that experience.”

Not only do the cancer support team focus on advice, guidance, and practical help, they also provide tools and support for patients’ mental health and wellbeing. “The impact a diagnosis has on our skin cancer patients emotionally is huge,” says Zoe. “If they’re struggling with their mental health, it can have an impact on their treatment.

“Having our support and the backing of their peers within the group means they’re heard, and their feelings are valued. Sometimes all that someone needs is to be listened to."

CLINICAL EFFECTIVENESS

DEVELOPING A CLINICAL PATHWAY FOR MANAGING SLEEP DISORDERS

Since 2005, the Prescribing Observatory for Mental Health (POMH-UK) has been conducting audit-based quality improvement programmes (QIPS) addressing various aspects of prescribing practice in mental health services. As a Trust (initially Somerset Partnership and latterly Somerset NHS Foundation Trust) we have been actively involved in all their projects from the beginning and together have built an excellent working relationship.

The local findings from the POMH audit into the use of melatonin for sleep disorders raised three issues:

- There was no agreed Trust-wide formulary for melatonin products leading to several products being used and varying costs
- There are several entry points to secondary care where sleep issues are part of the referral, and a variable offer of sleep advice. A need to develop a clear 'stepped care sleep pathway' for secondary care or Tier 3 CAMHS was identified
- Melatonin is available for secondary care prescribing only in the local health economy. Consideration needed to be given to moving to a Shared Care model across the system.

A local melatonin formulary has been agreed. Clinicians from community paediatrics and CAMHS, pharmacists and service managers have worked constructively together to agree a formulary and develop a stepped-care clinical pathway. A co-design approach has been taken that included parents/carers. Although considerable progress has been made, this has been a complex piece of work and there are details that still need to be agreed/finalised. Major enabling factors were a team of champions (psychiatry, paediatrics, governance, pharmacy) who used their network of connections to generate a supportive infrastructure to deliver the plan.

Once formulary choice has been embedded and the stepped care sleep pathway implemented, the plan is to work with the ICB on a shared-care agreement for continuing prescription for melatonin.

The Trust was approached by POMH-UK to share their experiences and learning from a selection of QIPS. After workshops, discussions and piloting, the final questionnaires were distributed to all mental health organisations for completion during October 2023.

Where notable examples were given, Trusts were invited to provide a more in-depth case study to be included in the final report. SFT were invited to provide a case study into the work undertaken and learning as a result from the Use of Melatonin QIP, with the final report which was published in April 2024.

FIRST RESPONSE SERVICE

The Somerset First Response Service was launched in March 2023 following an increase in the number of people needing support from our adult mental health services.

First Response Service is a 24-hour telephone service, available 365 days a year to patients, carers, professionals and anyone else concerned that a person maybe in a mental health crisis.

Laura Hopkins, operational service manager for our countywide home treatment service, First Response Service, and urgent care hub, explains: "The vision and values of our First Response Service were co-produced with our experts by experience, ensuring that patients get a personalised, non-judgemental, and compassionate response. We know how difficult it is for people to reach out in their

darkest moments, and we want individuals to feel safe to talk to us and know that their voice will be heard.

“Most people who sadly take their own life tend not to have reached out to mental health services, and we want to encourage people to call, knowing that we are available and accessible for all. We will listen, and together we’ll find a way forward.”

The First Response Service works closely with Somerset’s Mindline 24/7, which provides a 24-hour mental health telephone support line for people of all ages in emotional and mental distress.

It takes over 1,000 calls a week, supporting individuals with a wide range of difficulties. This could be those who may be distressed, depressed or anxious, are contemplating harming themselves, or those who may need support with managing distressing hallucinations and delusions.

Caroline Cordy manages the team in the eastern part of Somerset, with Carolyn Broom heading up the western part of Somerset team.

“Our new first response team was set up following a 30% increase in the number of calls from people needing help with their mental health over the last few years,” says Caroline. This led to our home treatment team colleagues spending more time answering calls than going out to support patients – which in turn meant patients weren’t getting help in a timely enough manner. By taking this call handling role off our home treatment team colleagues, it means they can spend more quality time with patients when they experience a mental health crisis, without the worry of needing to get back to the office to cover the phone lines. Colleagues tend to rotate between the first response and home treatment services too.”

Our home treatment team tends to take calls from people are feeling distressed and upset, often needing support as they feel in a situation where they have nowhere to turn.

Caroline continues: “We also accept calls from our GP and ambulance service colleagues, as well as the police and other professionals, if they feel the person needs a follow-up with our team.

“It’s really important that we get to know patients’ families and carers too, so they are able to access us for advice and support too – this could include a carers’ assessment.

The First Response Service provides support 24-hours a day and are happy to talk to people or signpost them to a service that will meet their needs. It is an important part of our home treatment team and is very much designed to improve access to urgent mental health services and reduce the number of people needing to attend our emergency departments, which aren’t best placed to provide mental health support.

PROSTATE CANCER DIAGNOSIS

A groundbreaking way of supporting doctors to diagnose prostate cancer using the latest artificial intelligence (AI) technology has launched in Somerset.

The Trust has joined forces with Cambridge-based technology company, Lucida Medical, as the first NHS trust in the UK to introduce its AI tool, called Pi, to work alongside teams of radiologists.

With support from charities Macmillan Cancer Support and Prostate Cancer Research, the Pi tool is being introduced at both Yeovil District and Musgrove Park hospitals to assist radiologists in detecting clinically significant prostate cancer, using an AI technique that looks at a prostate MRI scan.

Macmillan estimates that there are more than 500,000 men living with prostate cancer in the UK. It's the most common cancer in men, and 1 in 8 men will be diagnosed in their lifetime. Prostate cancer is particularly dangerous when found at stages 3 or 4, and more than 12,000 deaths occur in the UK each year.

Dr Paul Burn, one of the Trust's consultant radiologists, explains how the trust came to be involved in this innovative project.

"This all started when we participated in a multi-centre national trial, called 'PAIR-1', that assessed the effectiveness of Pi," he says.

"We then trialled a version of Pi at our trust, and we compared its results to radiologists' reports in over 700 patients, to check that it would work for our purpose. The way it works is really simple – within a few minutes of the patient having their MRI scan, the Pi tool displays a number that gives a probability of cancer on the scan. It also shows the exact location of any tumours in the prostate by adding a colour overlay to the scan images. The software is located securely on a server within the hospital, so no patient data leaves the trust.

"Using it, we expect to help relieve pressure within our hospital, by enabling patients to go through the diagnostic pathway more rapidly and reducing diagnostic waiting times. It will also support our clinical departments that have smaller numbers of MRI reporters to manage their workload. We know that we have to be very careful with the way we use AI, and it's absolutely not intended to replace a human being in any way – instead it's simply helping to speed up the workflow and potentially aiding our radiologists in providing a more accurate diagnosis."

"In many ways we're using it as a 'reporting buddy', so it'll help with prioritising patients based on clinical need and telling us which patients we should report on first because they have a higher probability of cancer. Pi also measures the volume of the prostate gland for us, a repetitive job that is time-consuming for radiologists to do manually. Patients with prostate cancer have a complicated diagnostic pathway, needing an MRI and a biopsy and it is often challenging to complete all the steps within the national 28-day Faster Diagnosis Standard."

"Our aim is that by using this AI software, we will be able to speed up the process and enable us to prioritise those with cancer. It'll also free up our radiologists to report on additional patients every day and may in future allow us to book the patient in for a biopsy more quickly."

Dr Anthony Cunliffe, National Lead Medical Adviser at Macmillan Cancer Support, said: "Our investment in Lucida Medical and its pioneering AI platform, Pi, is the latest

venture as part of our Innovation Impact Investment Portfolio. Pi has the potential to transform how we diagnose and monitor patients with prostate cancer, so we're thrilled to see this software being put to use in Musgrove Park and Yeovil District."

Oliver Kemp, CEO at Prostate Cancer Research (PCR), said: "We're passionate about bringing the best diagnostics and treatments into clinical use to benefit prostate cancer patients. We are delighted that Lucida Medical has reached this tremendous milestone following PCR's investment in the company and its revolutionary Pi technology."

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 2023/24 the five CQUIN indicators selected for the contract were across Acute, Community and Mental Health Services and included the following programmes:

- Supporting patients to drink, eat and mobilise after surgery
- Identification and response to frailty in emergency departments
- Routine outcome monitoring in community mental health services
- Reducing the need for the use of restrictive practices in adult and older adult inpatient settings
- Assessment, diagnosis and treatment of lower leg wounds

The financial risk associated with performance of the CQUIN indicators was removed during 2023/24 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).

An outstanding 100% of patients meeting the referral criteria were referred to the organ donation service. Twenty-four 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 15 transplants enabled over the year.

Key work for 2024/25 will be to continue to ensure all suitable patients are offered the option of organ donation at the end of their life and ensuring maximal adherence to national guidance on donor identification and referral. Tissue donation is another focus for the organ and tissue donation committee, and we will work toward all suitable patients having this offered as an option at the end-of-life. The organ donation committee hopes to see a clinical lead for organ donation appointed to the YDH site and working to ensure best practice continues to be followed across the trust.

STAFF ENGAGEMENT

Our aim is to ensure our colleagues are informed, engaged, that they feel connected to their team, their service, site, and the trust, and that their hard work is recognised.

Our shared values of Kindness, Respect and Teamwork govern how we behave and interact with colleagues, patients, their families and carers. These values were developed from extensive engagement with colleagues from both our legacy trusts before we merged, and they were launched on 1 April 2024. They are front and centre in our communications with our colleagues and in the visual elements of our communications.

At the start of April 2023, as part of the merger of our legacy trusts, we launched trust-wide internal communications channels aimed at all colleagues right across our new organisation, providing a regular drumbeat that keeps colleagues up to date about the trust's work. These include a weekly online newsletter, new intranet cover page, three-weekly online briefings with the chief executive and colleague emails or announcements to support large trust-wide announcements.

The Senior Leadership Forum is held once a quarter and brings together senior leaders and the executive team on a regular basis throughout the year to discuss, debate and agree an approach to quality, performance, operational, financial, and other issues. The Operational Leadership Team meets once a month and brings our senior leaders together.

Each service group, and professional networks such as our senior nurse and medical leadership, hold regular meetings at all levels across our service groups and services. Our aim is to ensure that teams are connected, work well together, understand how they contribute to the trust's work, and that team members are well supported.

This financial year we also launched our recognition framework across our new merged trust, taking the best elements from both our legacy trust's frameworks. This framework provides opportunities for thanks and recognition of excellent work with thank you cards for teams to use; "everyday champions" which say well done when a colleague or team has done something above and beyond; our "star of the month" which enables teams to submit a nomination to be judged against others; and our annual awards process - the OSCAs (Our Somerset Colleague Awards). We also recognise long service and retirement.

Our colleagues have been through an enormous amount of organisational change – the majority of our workforce has worked through two organisational mergers in three years – and we have worked through a pandemic. Many of our clinical teams are still going through change processes.

We were therefore particularly interested in our NHS Staff Survey 2023 results to see overall how supported our colleagues feel, the teams that need more support, and the areas where we do not score as well as we would like. Just over 53% of colleagues completed the survey, providing us invaluable insight into our colleagues' experiences

of working at our newly formed organisation. Both our legacy trusts started from good bases with high results, but this year's results have surpassed even the combined results of from 2022. When compared against our comparative trusts, we were amongst the highest scoring trusts for morale and colleague engagement.

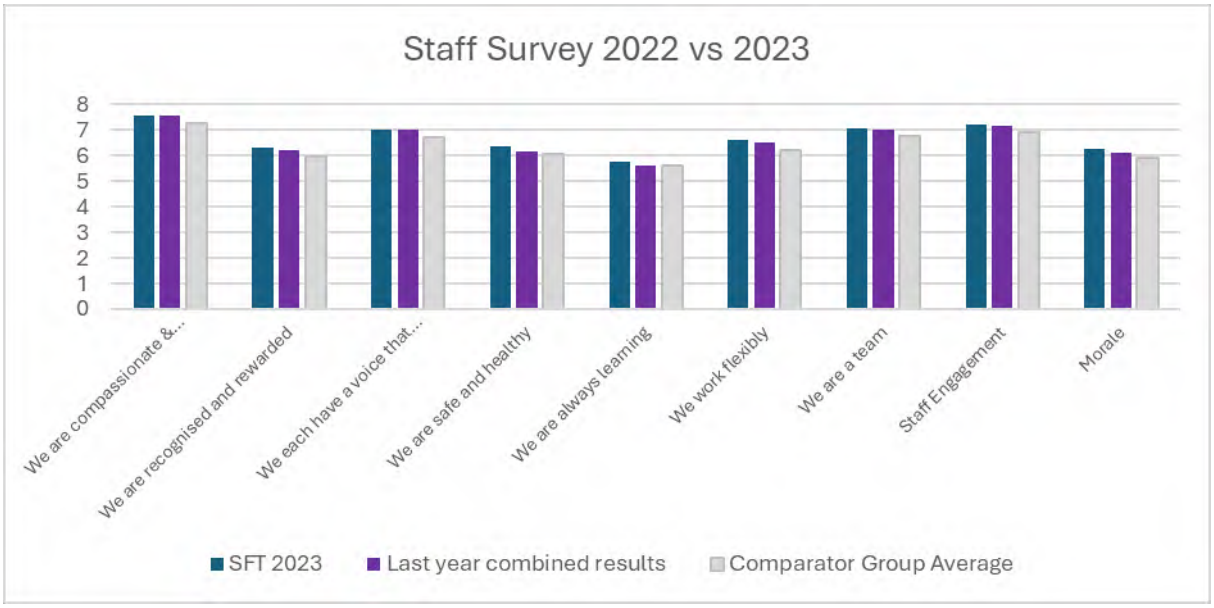
Despite these good overall scores, we know that we are not getting it right for every colleague and our plans for 2024/5 include:

- Building and embedding a 'just and restorative culture' with focus groups for colleagues taking place in April
- Focusing on violence and aggression prevention through training and communications campaigns
- Providing heatmaps with demographic data for service groups.
- Continuing the work in engaging and collaborating with our Colleague networks.

Staff Survey

The 2023 NHS Staff Survey was completed during October and November 2023 with a 53% response rate. This year was the third year that the staff survey was aligned to the themes of the NHS people promise and our first year as a newly merged Trust. Our results can be seen in the table below and include responses from Simply Serve Limited.

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



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

- We are compassionate and inclusive
- Staff engagement

The element of “we are always learning”, which is made up of the element of appraisals and development, is our lowest ranked and has made a slight improvement on last year's results (5.60 to 5.75). This was on the back of a significant improvement from the 2021 result in 2022.

In last year’s report, the people promises of ‘we are safe and healthy’ and ‘morale’ were noted to have significantly lower scores than the 2021 survey. These promises have both increased in score in the 2023 survey.

The staff survey for 2023 was the third to be aligned to the national themes of the people promise, retaining staff engagement and morale themes from staff surveys before 2021. The comparator data against the previous years are shown in the following table:

People Promise Theme	2023		2022		2021		
	SFT Score	Benchmarking Group Score	SFT & YDH Score	Benchmarking Group Score	SFT Score	YDH Score	Benchmarking Group Score
We are compassionate and inclusive	7.54	7.24	7.54	7.2	7.5	7.7	7.1
We are recognised and rewarded	6.32	5.94	6.22	5.7	6.2	6.5	5.8
We each have a voice that counts	7.00	6.70	7.03	6.6	7.0	7.2	6.6
We are safe and healthy	6.34	6.06	6.17	5.9	6.1	6.4	5.9
We are always learning	5.75	5.61	5.60	5.3	5.2	5.6	5.2
We work flexibly	6.59	6.20	6.51	6.0	6.4	6.7	5.9
We are a team	7.04	6.75	7.00	6.6	6.9	7.1	6.5
Staff engagement	7.49	6.91	7.15	6.8	7.2	7.3	6.8
Morale	6.25	5.91	6.10	5.7	6.1	6.4	5.7

Score: 0 = low 10 = high

Benchmarking data for previous years is shown below.

Staff Survey Theme	2020			2019			
	SFT Score	YDH Score	Benchmark Group	TST Score	SomPar Score	YDH Score	Benchmark Group
Equality, diversity and inclusion	9.3	9.2	9.1	9.3	9.4	9.3	9.0
Health and wellbeing	6.5	6.9	6.1	6.3	6.3	6.7	5.9
Immediate managers	7.2	7.2	6.8	7.1	7.2	7.4	6.8

Staff Survey Theme	2020			2019			
	SFT Score	YDH Score	Benchmark Group	TST Score	SomPar Score	YDH Score	Benchmark Group
Morale	6.6	6.6	6.2	6.6	6.4	6.6	6.1
Quality of appraisals	n/a	n/a	n/a	5.7	5.0	5.9	5.6
Quality of care	7.5	7.7	7.5	7.6	7.3	7.7	7.5
Safe environment – B&H	8.2	8.4	8.1	8.3	8.1	8.3	7.9
Safe environment – violence	9.5	9.3	9.5	9.4	9.5	9.4	9.4
Safety culture	7.0	7.0	6.8	7.0	6.8	7.0	6.7
Staff engagement	7.3	7.4	7.0	7.4	7.2	7.4	7.0
Team working	6.8	6.7	6.5	n/a	6.9	7.0	n/a

Score: 0 = low 10 = high

Future

The People Strategy, released in 2023, provides a clear direction for the people priorities within the Trust and as part of the first year, nine workstream groups were created to drive the initial work forward. The groups are:

1. Violence and aggression
2. Just and restorative culture
3. Digital
4. Leadership capability
5. Engagement
6. Retention
7. Recruitment
8. Future workforce models
9. Strategic workforce planning

The result of the 2023 Staff Survey will support the measures of work within the people strategy as well as providing an opportunity to reflect if any plans need to be recalibrated. Reassuringly, the areas being highlighted are already under focus.

Appraisals remain an area of focus into 2024 and work continues to ensure that the quality of the conversation as well as numbers completed are a priority.

We note that whilst our staff survey scores are encouraging there are still colleagues within our organisation that do not have as positive an experience as others do. Work that has already been started but will continue to develop include:

- aligning the work of people services and network leads, with monthly meetings that are joining up crucial relationships between networks leads and Heads of Service within People Services.

- arrangements for co-design and co-delivery of training between the organisational development team and network members.
- Inclusion colleagues embedding themselves within the HR Advisory and organisational development teams to help create a thread of inclusion throughout the support that is provided to leaders, managers and colleagues.

Freedom to Speak up remains strong as a Trust score however, we recognise improvements can be made and survey data informs us that some colleagues feel less able to speak up than others more notably colleagues aged 51 and over, and colleagues reporting a disability or long-term condition. Further work to understand the barriers to enable improvements in the service are underway and one of the key actions taken is for the Freedom to Speak Up Guardians working alongside the networks and being a member of the group and regular meetings that take place. This work will be incorporated into the engagement workstream that is part of further work emanating from the people strategy. This is looking to provide a listening roadmap to ensure that feedback loops are completed, and the second year of this deliverable will look to operationalise this.

Future Priorities and Targets

The People Strategy 2023 – 2028 is designed around 5 commitments; care for our people, develop our people, compassionate and inclusive leadership, retain and attract talent and learning and transforming. Each commitment has several high-level ambitions which describe the commitment in more detail and is aligned to one or more elements of the NHS People Promise. The purpose of the strategy is to set out the framework for achieving corporate objective 6, Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture. The ambitions within the People Strategy support the core focus of improving retention and is supported by the Trust values, Respect, Kindness and Teamwork.

In the first year of the strategy the focus was on nine key deliverables, spanning reducing violence and aggression towards our colleagues, implementing a just and restorative culture for our people polices, creating a People Digital strategy, understand leadership capability and developing plans to support leaders to create an environment where colleagues thrive, development of a listening roadmap, improving talent management, moving to skills based inclusive recruitment practices, developing a resource strategy and improving approaches to workforce planning. It was an ambitious year one, with many of the workstreams continuing into year two of the strategy. In addition to embedding the year one focus, the second year of the strategy will focus on:

- How we ensure healthy working lives for our colleagues where we prioritise their physical and mental health equally, where we create roles where are colleagues thrive and through this support the population of Somerset to life healthy lives.
- Developing packages of support for leaders to ensure they are compassionate, overtly respect and value equity, quality, diversity and inclusion through engaging and empowering their teams.

- How we drive improvement through ensuring decision making is underpinned by evidence and where the research strategy is central to all we do, attracting and retaining colleagues.

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

Wynford House
Lufton Way
Lufton
Yeovil
Somerset
BA22 8HR
Tel: 01935 384000
somicb.enquiries@nhs.net

APPENDIX 2: STATEMENT FROM STAKEHOLDERS – SOMERSET COUNTY COUNCIL – OVERSIGHT AND SCRUTINY COMMITTEE

Somerset Council
County Hall, Taunton
Somerset, TA1 4DY

APPENDIX 3: STATEMENT FROM STAKEHOLDERS – HEALTHWATCH

APPENDIX 4: STATEMENT FROM STAKEHOLDERS – SFT GOVERNORS

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 2023/24 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 2023 to March 2024
    - Papers relating to quality reported to the Board April 2023 to March 2024
    - Feedback from the commissioners dated XX
    - Feedback from Local Authority Overview and Scrutiny Committee dated XX
    - Feedback from local Healthwatch organisations dated XX
- Feedback from governors dated XX

- 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.

03/09/2024 Date…… Chairman

COLIN DRUMMOND

03/09/2024 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 9 July 2024
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Martyn Scrivens, Chairman of the People Committee meeting held on 9 July 2024
DATE:	3 September 2024

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 7 July 2024 and the assurance received. The meeting was conducted as a video call. The Committee received assurance in relation to: • The colleague story and the assurance in relation to the inclusion agenda, development, leadership and the Trust values. • The review of the Board Assurance Framework and Corporate Risk Register. • Strategic workforce planning. • the learning item – workforce planning within theatres. • The Simply Serve Limited update in relation to the work on the cultural agenda. • The Chief of People and Organisational Development report, particularly in relation to the productive people services work and the relationship with trade unions. The Committee identified the following areas for follow up: • The medical workforce residual risk level.

	• A Board level discussion on digital prioritisation. The Committee identified the following issue to be reported to the Board: • A discussion on digital prioritisation at a future Board Development Day. 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 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

Equality and Inclusion The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
The colleague story and learning item are ways of identifying potential impacts on colleagues with protected characteristics and any lessons learned will be followed up.

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

Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
The views from colleagues have been considered through the colleague story.

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 9 July 2024, 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 – Development Journey

2.1. The Committee received a story from a colleague about his progression over the last three years from a maintenance carpenter role within Simply Serve Limited to a more senior role involving minor works, ventilation lead and leading a team.

2.2. The journey showed his ability to take on more responsibility at a more senior level but also highlighted the challenges he faced - demonstrating his abilities to other colleagues, the use of abbreviations, and his commitment to work at a more senior level and ongoing development. The Committee noted the colleague's learning in terms of decision making, communicating effectively with team members, how to deal with conflict, and ensuring that team members were listened to.

2.3. The Committee further noted the lack of development opportunities for a maintenance worker to progress to a managerial role and the support the colleague had received from his managers to progress.

2.4. The Committee discussed the journey and noted: the lack of understanding of some colleagues about his new responsibilities; the excellent support he received from his direct manager; the need for clear communications and his commitment to support his team members reaching their potential.

2.5. The Committee agreed to share the colleague story more widely across the organisation.

Review of Board Assurance Framework (BAF)

2.6. The Committee received the updated Board Assurance Framework in relation to strategic objective six.

2.7. The Committee noted the changes to the controls and assurance sections; the additional action in relation to a regular people plan update to be presented to the Quality, Operational, Finance and Performance Group meetings; the need to develop a measure to assess and monitor a compassionate, inclusive and

learning culture; the need to triangulate information around retention and turnover relating to leadership; the challenges measuring how leaders cope with difficult situations; and the impact a lack of leadership can have on the health and safety of colleagues.

Corporate Risk Register

2.8. The Committee received the updated corporate risk register and noted: the new risk in relation to the resources required for the digital data and technology infrastructure; the senior doctor workforce risk which had been rated outside of its risk appetite; the emerging risk in relation to inclusive care for non-binary patients; the approval of the risk management policy; the availability of level 1 risk management training on the electronic training system and the consideration to make this training mandatory for all colleagues.

2.9. The Committee further noted: the development in terms of system wide risks; the review of the risk relating to the large annual intake of new doctors; and the review of the digital data and technology infrastructure risk by the digital team.

Strategic Workforce Planning

2.10. The Committee received an update on strategic workforce planning and noted: the background to workforce planning and the understanding of the challenges and opportunities for workforce planning; the need to accelerate workforce planning in view of the productive care programme; and the use of the internal audit recommendations and findings to support the next phase of the planning process.

2.11. The Committee noted the workforce challenges and the need to embed workforce planning across the Trust so that it becomes part of business as usual.

Learning Item

2.12. The Committee received an update on workforce planning within theatres and noted that there was a requirement to develop a new workforce model in view of the new surgical centre at Musgrove Park Hospital and the additional theatre at Yeovil District Hospital, the financial position and the productive care programme.

2.13. The Committee noted: the process to develop the workforce model; the involvement of a wide range of colleagues; the focus on the retention of colleagues; the focus on productive care and the need to review data with the use of model health and workforce information; and the need to challenge the culture.

2.14. The Committee discussed the need for a focus on career structures; hard to fill medical vacancies and skill mix arrangements and noted that this work will continue as part of the people strategy. The Committee agreed that, although

this work was led by people services, service groups will need to own their workforce plans with support from people services where needed.

2.15. The Committee agreed that good progress had been made moving away from the traditional workforce plans with People Business Partners now also attending Finance Committee meetings to ensure a link between workforce and finance.

Simply Serve Limited Update

2.16. The Committee received an update on Simply Serve Limited and noted: the services covered; the background; the different terms and conditions; the transfer of colleagues band 4 or under to Agenda for Change terms and conditions; the age profile and the risk relating to the percentage of colleagues aged 55 and over.

2.17. The Committee further noted: the reduction in the turnover rate over the last 12 months; the absence of women in trade roles and the need to recruit more women into engineering roles; mandatory training compliance of 94%; the further work required in terms of career conversations; the excellent staff survey response rate; the development work in one service due to cultural issues and the progress made; the creation of a Joint Director of Estates role; the development of a the people services plan, taking account of the staff survey findings; and the four Freedom to Speak Up concerns.

2.18. The Committee discussed the staff survey findings in relation to culture and noted that cultural issues had existed for many years and that an action plan had been developed to address these issues with support from people services. The merger and the post merger leadership arrangements had enabled cultures to be more aligned but it was recognised that full alignment will take some time.

Director Report

2.19. The Committee received the report and noted: the productive people services project; the areas which could more easily be measured and areas which were more difficult to measure in terms of medium to long term impact, e.g. wellbeing and culture; the shortlisting for a Healthcare People Management Association Award relating to partnership work with trade unions in successfully resolving the Healthcare Support Worker (HCW) collective claim over rates of pay; the downgrading of the consultant vacancy risk from 25 to 20; the significant work in relation to agency staffing; and the future review of the consultant and junior workforce risk.

2.20. The Committee discussed the financial impact in relation to the Band 2 HCW pay dispute and noted the £2.7 million back pay and the £1.6 million recurrent cost commitment which had been included in the baseline position. The Committee further discussed the concerns in relation to the lack of affordable accommodation for band 5 nurses and noted that this was discussed on a regular basis at the Estates Group.

Assurances Received

2.21. The Committee agreed that assurances had been provided in following areas:

- Colleague story and the assurance in relation to the inclusion agenda, development, leadership and the Trust values.
- Workforce planning but there was a need to consider the next steps and ambitions.
- The Simply Serve Limited update in relation to the work on the cultural agenda.
- The Chief of People and Organisational Development report, particularly in relation to the productive people services work and the relationship with trade unions.

3. AREAS OF CONCERNS/FOLLOW UP

Review of Board Assurance Framework (BAF)

3.1. The Committee discussed the medical workforce residual risk level in view of the mitigating actions taken and noted that the risk level remained rated as "red" in view of the financial impact. The Committee agreed to seek the Audit Committee's view in respect of this risk level.

Director Report

3.2. The Committee further discussed the prioritisation of the digital agenda and the need to prioritise people service systems. The Committee noted: that a People Services Digital Board had been convened as part of the wider Digital Board to develop a local strategy; and that clinical requests were prioritised over corporate requests as it was easier for clinical requests to quantify quality and safety needs and impacts. The Committee agreed that it will be helpful to discuss digital prioritisation at a future Board Development Day.

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

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

- A discussion on digital prioritisation at a future Board Development Day.

4.2 The Committee identified the following issue to be reported to the Audit Committee:

- The medical workforce residual risk level.

5. ASSURANCE FRAMEWORK

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

- The inclusion agenda.
- Workforce planning.
- The cultural agenda.
- The productive people services project.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Guardian of Safe Working for Postgraduate Doctors Quarterly Report – Q1 2024/25
SPONSORING EXEC:	Melanie Iles, Chief Medical Officer
REPORT BY:	Tom Rees (TST) and John McFarlane (YDH), Guardian of Safe Working; Lee-Ann Toogood, Medical Workforce Manager
PRESENTED BY:	Tom Rees, Guardian of Safe Working
DATE:	3 September 2024

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

Executive Summary and Reason for presentation to Committee/Board	This report covers quantitative and qualitative summary of exception report data generated between 11 April 2024 and 12 July 2024 across Somerset NHS Foundation Trust. The recommendations from the report are: • To recommend a robust SOP for managing short term rota gaps, including how to agree hourly rate escalation if required. • To continue to encourage Postgraduate doctors (GoSW / Induction / Supervisors) to agree/disagree with the ER outcome to avoid high numbers of outstanding ERs. • The missed educational opportunity ERs will be monitored into the next quarter and brought up at next PDF as to whether there is common theme.
Recommendations	The Board is asked to discuss and note the report.

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

Improve health and wellbeing of population

☐ Obj 2 Provide the best care and support to children and adults

☐ Obj 3 Strengthen care and support in local communities

☐ Obj 4 Reduce inequalities

☐ Obj 5 Respond well to complex needs

☒ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture

☐ Obj 7 Live within our means and use our resources wisely

☒ Obj 8 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

Details:

Equality and Inclusion

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

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

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

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

Public/Staff Involvement History

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

Not applicable for this report.

Previous Consideration

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

The report is presented to the Board on a quarterly basis. 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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1. EXECUTIVE SUMMARY	*4*
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5. SUMMARY	*9*
6. RECOMMENDATIONS	*10*

QUARTERLY REPORT ON SAFE WORKING HOURS:

DOCTORS AND DENTISTS IN TRAINING

1. EXECUTIVE SUMMARY

a) ER numbers are down overall, particularly within General Surgery and Medicine and in line with numbers seen in Q1 in previous years.

b) Numbers of outstanding ERs is significantly down from previous quarters.

c) We continue to see low numbers of ERs generated from OOH work.

2. INTRODUCTION

2.1. This report covers and comprises quantitative and qualitative data on working patterns and associated exception reports for postgraduate doctors in training across the Trust.

2.2. Exception reports are a mandatory requirement of the 2016 Junior Doctor Contract. All doctors on this contract should report any hours worked above their standard contract via the software provided by the hospital in order to be awarded time off in lieu (TOIL) or additional payment where TOIL cannot be accommodated.

3. EXCEPTION REPORT DATA

Number of doctors/dentists in training on 2016 TCS (total):	424
Job plan allocation for Guardian of Safe Working: (1.5 legacy SFT, 1 YDH)	2.5 PAs
Job plan allocation for Educational Supervisors per trainee:	0.125 PAs

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 12/01/2024 - Total of exception reports since implementation of 2016 TCS (December 2016). 3307 for Taunton and for Yeovil 1489. The overall cost of exception report overtime is £93,426.17

Figure 1 Quarterly total for exception reporting

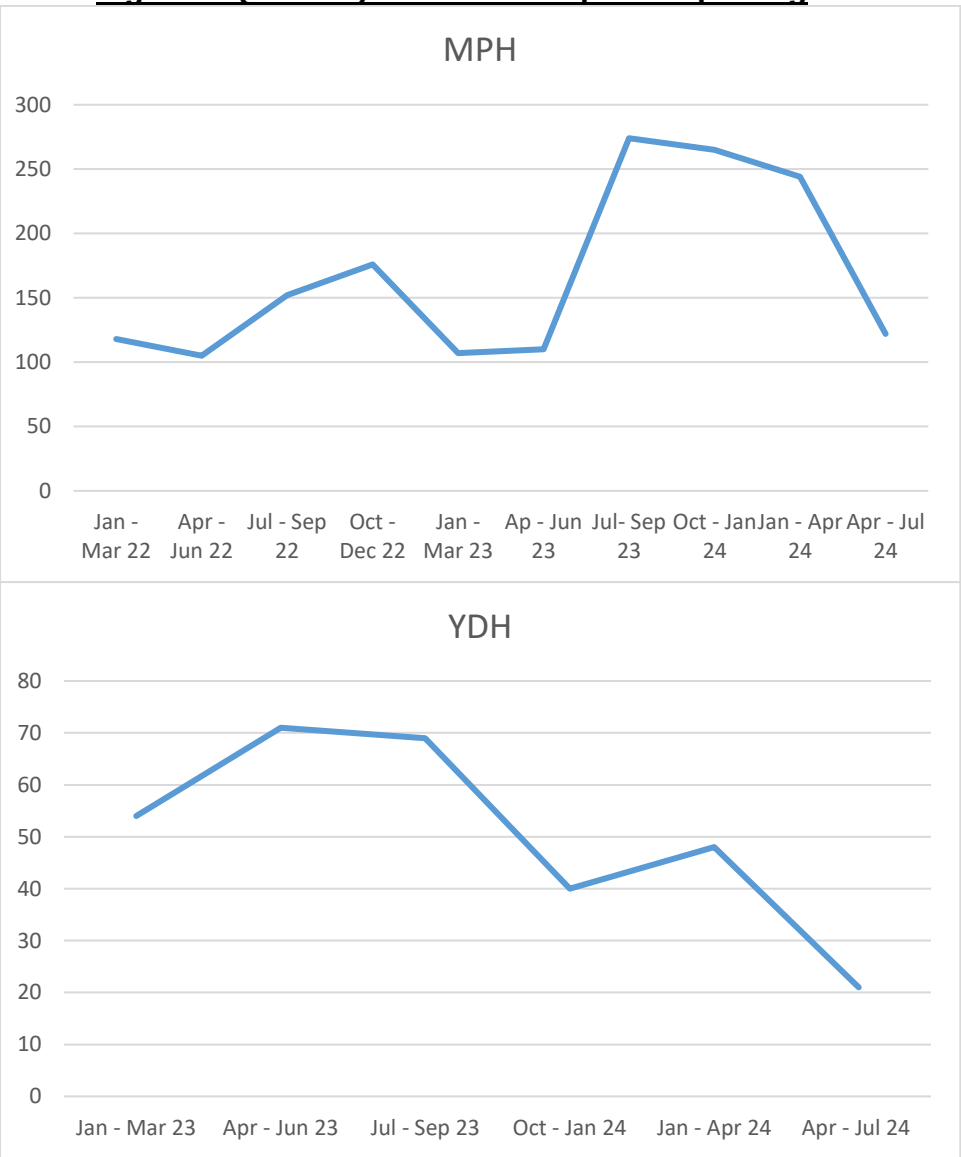
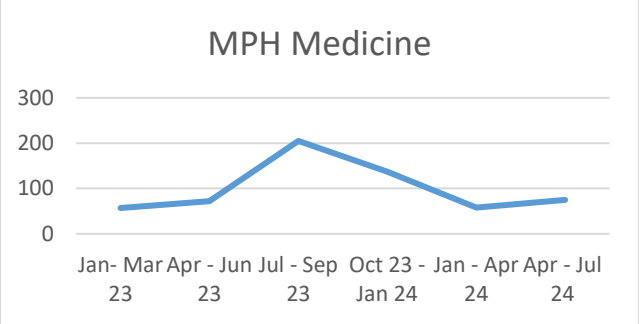
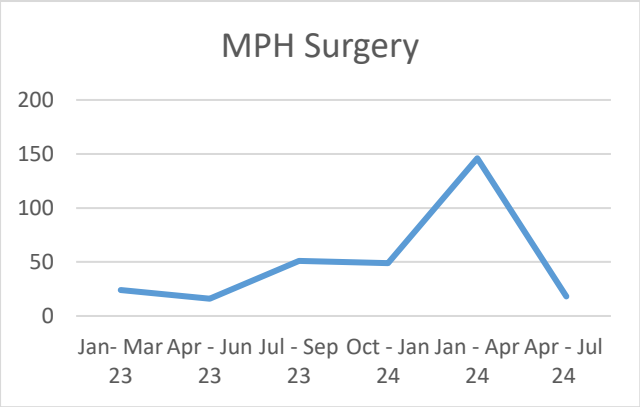
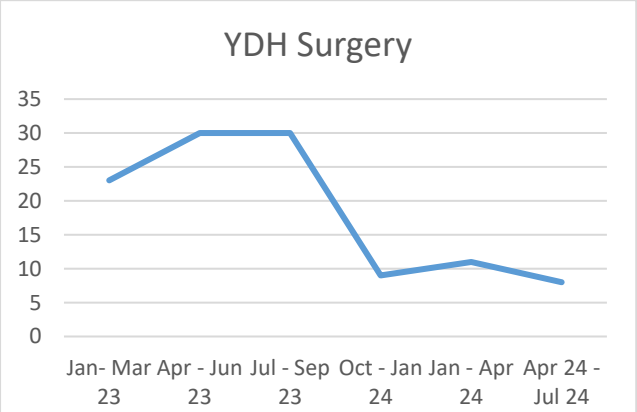
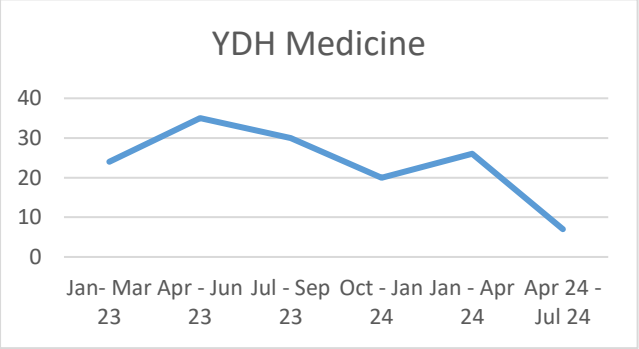


Figure 2 Exception Report Trends by Specialty









3.2. **Exception reports this quarter** - please find the information in brackets from the previous quarterly report for comparison:

Table 1: Exception reports per specialty

Specialty	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**	**Type**
Acute & General Medicine	MPH 75 (65) YDH 7 (25)	58 6	17 1	Hours MPH 62 YDH 7 Educational MPH 13
Anaesthetics	0 *(1)*	0	0	
DCT Trainees	0 *(0)*	0	0	
Emergency Medicine	MPH 2 (2) YDH 0 (1)	2	0	Hours MPH 2
ENT	0 *(0)*	0	0	
General Surgery	MPH 15 *(146)*	14	1	Hours MPH 15 YDH 6

Specialty	No. exceptions raised	No. exceptions closed	No. exceptions outstanding	Type
	YDH 6 (9)	5	1	
O&G	MPH 0 (9) YDH 0 *(0)*	0 0	0 0	
Oncology/ Haematology	MPH 1 *(3)*	0	0	
Paediatrics	MPH 0 *(13)*	0	0	
Psychiatry	MPH 0 *(5)*	0	0	
Trauma & Ortho	MPH 0 *(0)* YDH 29 (11)	0 29	0 0	Hours 29 YDH
Urology	MPH 2 *(0)* *YDH 2 (0)*	2 2	0 2	Hours 2 MPH 2 YDH
Vascular	4 *(0)*	4	0	Hours 4 MPH
Total	**143**	**122**	**21**	

Table 2: Exception reports per trainee grade

Grade of trainee	No. exceptions raised Taunton	No. exceptions raised Yeovil
F1	82	18
F2	22	26
CT1-2 / ST1-2	18	0
ST3+	0	0
Total	**122**	**44**

Locum Agency and Bank Spend to cover Post Graduate Doctors in Training

Division	Pay Gross (No VAT)	Commission Gross (No VAT)	VAT	Booking Gross (No VAT)
Clinical Support & Cancer Services	£312,986.50	£26,402.00	£7,744.00	£377,623.42
CYP & Families Services	£675,764.66	£43,518.14	£57,284.07	£791,226.74
Medical Services	£2,354,397.14	£124,573.80	£125,201.30	£2,740,938.16
Mental Health and LD	£1,071,709.96	£74,269.15	£93,036.40	£1,243,272.94
Neighbourhood Services	£126,054.88	£12,402.40	£7,080.48	£155,852.50
OPMH Sedgemoor	£9,600.00	£1,200.00	£0.00	£12,124.80
OPMH Taunton	£52,000.00	£0.00	£0.00	£59,176.00
Surgical Services	£283,753.76	£9,439.58	£0.00	£332,351.00
Grand Total	£4,886,266.89	£291,805.07	£290,346.25	£5,712,565.56

Qualitative summary of exception reports

3.3. We have seen an overall downtrend in ER this quarter with absolute numbers comparable to Q1 in prior years. As mentioned in previous reports, ER numbers are typically less during the summer months as winter pressures are relieved, particularly from medical specialities.

3.4. We have seen a decrease in the numbers of ERs generated from General Surgery this quarter, following a spike in numbers in Q4 which was due to staffing issues. Numbers of ERs will continue to be monitored in General Surgery going forward.

3.5. Numbers of outstanding ERs has decreased this quarter following a drive to remind the postgraduate Doctors in Training to agree/disagree with the outcome following the supervisor review.

3.6. Educational opportunities have been affected at MPH this Q (total 13 ERs) due to multiple factors.

3.7. We have noticed an increase in ERs generated from T&O at YDH which will need to be monitored (JM to update further at a later date).

Immediate safety concerns (ISCs)

3.8. No immediate safety concerns were raised this quarter.

Fines

3.9. No fines were issued during this quarter.

Work schedule reviews

3.10. There were no work schedule reviews this quarter.

4. ISSUES ARISING

Postgraduate Doctor Forum (PDF)

4.1. The latest PDF was conducted on 20 June at MPH. We discussed:

- The impact that short term rota gaps had on the medical on call team, an issue which was also raised at the HOOH board meeting. A review of the SOP for short term rota gaps is being conducted.

- Postgraduate doctors were reminded to agree/disagree with the outcome of the ER following their supervisor meeting so the report can be closed.

- The interim method of submitting ER was explained to the postgraduate doctors (as Allocate is no longer in use), until new software is implemented.

Rota management

4.2. Short term rota gaps (short term sickness etc) for OOH working, particularly in medicine, continue to affect safe working and place additional burden onto the on call team – although this is not always reflected in ER data.

Weekend working

4.3. We continue to see low numbers of ERs submitted for weekend work, despite anecdotal evidence that work intensity is high. We may see an increase in engagement once e-rostering software is implemented which may help in understanding specific issues.

5. RECOMMENDATIONS

5.1. Recommend a robust SOP for managing short term rota gaps, including how to agree hourly rate escalation if required.

5.2. Continue to encourage Postgraduate doctors (GoSW / Induction / Supervisors) to agree/disagree with the ER outcome to avoid high numbers of outstanding ERs.

5.3. Missed educational opportunity ERs will be monitored into the next quarter and brought up at next PDF as to whether there is common theme.

Tom Rees and John McFarlane Guardian of Safe Working

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Mental Health Act Committee meeting held on 11 June 2024
SPONSORING EXEC:	Jade Renville, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Jan Hull, Chairman of the June 2024 Mental Health Act Committee meeting
DATE:	3 September 2024

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 11 June 2024 and the assurance received by the Committee. The meeting was conducted as a video conference call. The Committees received assurance in relation to: • The Mental Health Act Lead report. • The MCA, DoLs and LPS updates. • The update from the Approved Mental Health Professional Service. • The ICB commissioning update. • The update from the children and adolescent mental health services (CAMHS). • The forensic progress report. • The out of Area Treatment Somerset (OATS) progress report. • The progress in relation to the Care Quality Commission reports. • The position in relation to complaints and other issues.

	The following areas of concern or for follow up were identified: • The Mental Health Lead report in relation to the review of the Community Treatment Order policy, further to the recent audit. • The forensic report in relation to the reporting lines and increasing visibility of the provider collaborative. • The inpatient deaths and homicides progress report and the presentation of the quality assurance review report to the September 2024 Committee meeting. • The risk register and the request for an update on the learning disability liaison service risk to be presented to the September 2024 Committee meeting. No new risks or items to be reported to the Board were identified.
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Mental Health Act Committee. The Board is further asked to note the areas to be reported to the Board.

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

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

Equality and Inclusion
The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
The needs and potential impacts on people with protected characteristics are considered with the mental health teams. The Committee reviews data presented to the Committee and will raise any queries if required.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.
Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
N/A

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON 11 JUNE 2024

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 11 June 2024, the assurance received by the Committee and any areas of concern identified.

2. ASSURANCE AND UPDATES RECEIVED

Mental Health Act Co-Ordination Report

2.1. The Committee received the Mental Health Act Lead report and noted that it had been a busy period in terms of increasing scrutiny of legal processes and recording.

2.2. The Committee discussed the workload and noted the significant increase in workload over the last few years for a team which had not changed in size since 2012. Although the team was currently able to cope with this workload, there was no scope for further flexibility. The Committee noted that support was being provided to the team and further noted the positive comments about the team as part of Care Quality Commission inspections.

2.3. The Committee further noted: the progress made in relation to setting up additional training sessions; the ongoing work with Swan Advocacy about detentions in acute services and raising awareness of advocacy services; the reduction in the number of patients who have not had their Section132 rights read to them and been made aware of their right to an advocate; the large number of compliments received; and the absence of complaints regarding the team.

2.4. The Committee received an update on the work in relation to lapsed detentions and timely second opinion appointed doctor (SOAD) requests and noted that the work looking into lapsed detentions recording will be extended to recording in other areas, e.g. discharge from a ward without a CTO being made. The Trust was in a better position regarding SOAD referrals and having an electronic portal for these referrals will enable a clearer overview of the referrals and progress made. The Committee noted that the information collected through the electronic portal will be reviewed against the Care Quality Commission requirements.

2.5. The Committee noted that a Mental Health Act recording training session for clinicians had been set up. The Committee further noted that a Standard Operating procedure (SOP) regarding the recording of mental health

assessments will be finalised in September 2024 and that two new RiO templates had been circulated for implementation from July 2024.

2.6. The Committee further noted: the work with the Police in relation to the Section 136 pathways; the progress in relation to the work with the RiO team on producing statistical information; the reduction in the number of Section 2 and 3 detentions; and the increased availability of beds as a result of focussed discharge planning.

MCA, DoLs and LPS updates

2.7. The Committee received an update in relation to the MCA, DoLs and LPS work and noted the report. The Committee particularly noted the need to further improve communications between the Psychiatric Laision Team and acute services; and the establishment of regular liaison meetings to discuss complex patients.

2.8. The Committee further noted the discussions in relation to the detention framework for patients on Section 17 leave whilst admitted to acute services. There was a lack of clear national and legal guidance and, once available, training on the legal framework will be arranged. Work on the Section 17 and Deprivation of Liberty (DoLs) interface will be ongoing.

2.9. The Committee noted that the review date of the Mental Capacity Act policy had been extended to enable a full review of the policy to make the policy more visual and user friendly. The Committee noted that the policy will be finalised by early Autumn.

2.10. The Committee agreed that the report provided a good level of assurance.

AMHP (Approved Mental Health Professional) Services

2.11. The Committee received an update and noted: the changes in the team; that three colleagues will be joining the AMHP rota following the completion of their training after the summer; the lack of a consistent pattern to the number of assessments being received; and the impact of organisational changes within Somerset Council on the team.

ICB Commissioning

2.12. The Committee received an update and noted that the commissioning team was being restructured which will impact on the mental health, autism and learning disability teams.

2.13. The Committee noted that progress continued to be made in relation to the usage of the Section 17 app. Although the pool of doctors on the Section 17 app was still low, numbers continued to increase.

CAMHS

2.14. The Committee received an update on child and adolescent mental health services (CAMHS) out of area placements and noted that there were currently no out of area patients. There was one Somerset patient in Wessex House

and this was in line with the provider collaborative arrangements.

2.15. The Committee noted that the overall position was positive which demonstrated the good care and support available for Somerset's children and young people within the community.

Forensic Report

2.16. The Committee received a progress report covering the last 12 months and noted the restructuring within the team to bring together all the services which work with patients who present a high risk to others and who are working with the criminal justice system. Bringing these services together had created clear management structures and has improved governance processes.

2.17. The Committee noted that all secure beds were now placed within the South West Provider Collaborative footprint and that, with the exception of patients requiring an older person's secure bed, all patients admitted to an inpatient unit outside of the provider collaborative footprint had been repatriated.

2.18. The Committee further noted: that each ward/hospital had a dedicated provider collaborative case officer who visits monthly for quality assurance checks; that feedback from these visits is fed back into the quarterly commissioning meetings; the team's focus on admission avoidance; and the work with community mental health services and inpatient wards to support the services and wards in relation to forensic patients.

2.19. The Committee further noted: that the provider collaborative model included patient and family participation workers to ensure that, where appropriate and possible, families were kept informed; and the recruitment for a post within the forensic service to embed families and patients engagement and involvement.

2.20. The Committee agreed that the report provided the assurance requested by the Committee.

Out of Area Treatment Somerset (OATS) patients

2.21. The Committee noted that there had been one inappropriate out of area placement due to the inappropriateness of placing the patient in a mixed PICU. Ten patients were placed out of county and their progress will be closely monitored by the complex case team.

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

Care Quality Commission Reports

2.23. The Committee received an update on the provider action statement relating to St Andrews and the Committee noted that no issues were raised by the Care Quality Commission in relation to the trust's response. The Committee noted that the transfer of the ward to Rowan was expected to take place by July 2024.

2.24. The Committee received the CQC MHA compliance report regarding the visit to Rowan Ward and noted: the positive feedback from patients, carers and the CQC inspection team; and the four concerns raised which related to: sharing findings of the visit with patients; ensuring that Independent Mental Health Advocate (IMHA) referrals are made for qualifying patients; informing patients of their legal rights; and ensuring that timely requests for SOADs are made.

Complaints and Issues

2.25. The Committee received the report and noted that eight new complaints had been received via the Care Quality Commission or through the Trust's complaints process. The Committee noted the details of the complaints and agreed that it was assuring that no common themes or areas of concern had been identified, although the number of complaints is higher than usual.

2.26. The Committee further noted that the Somerset ICB had received fewer complaints and that complainants were redirected to the trust/tribunal as appropriate.

3. AREAS OF CONCERN OR FOR FOLOW UP

Mental Health Act Co-Ordination Report

3.1. The Committee noted that an internal audit on face to face contacts with patients on Community Treatment Orders (CTOs) had been carried out. The findings indicated that no more than two face to face contacts with the 31 patients on CTOs had been carried out over a six month period but that there was good evidence of oversight of patient care. The Committee agreed to review the policy in relation to the number of face to face contacts, further to the recent audit.

Forensic Report

3.2. The Committee discussed the relationship between the trust and the provider collaborative and the importance of this relationship. The Committee discussed how to increase visibility of the work of the provider collaborative and agreed to consider reporting to the Committee and other reporting lines and how to increase visibility at Board level outside of the meeting.

Inpatient Deaths and Homicides

3.3. The Committee noted that the most recent homicide report was being finalised before publication and presentation to the Southwest Independent Review Group in July 2024. The Committee further noted: the progress in relation to an external investigation about the death of a mental health and learning disability patient; details of a quality assurance review of a homicide which took place in Mendip and the presentation of the report to the September 2024 Committee meeting; the death of a detained patient on an end of life pathway on Willow Ward.

Risk Register

3.4. The Committee received the Mental Health and Learning Disability service

group risk register and noted the high rated risks and actions taken to mitigate risks. The Committee particularly noted the progress made in relation to the following risks: recruiting to medical vacancies – appointment of seven international doctors; and learning disability liaison service staffing – a business case for additional part time staff was being prepared.

3.5. The Committee asked for an update on the learning disability liaison service risk to be presented to the September 2024 Quality and Governance Assurance Committee meeting.

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

4.1. The Committee did not identify any new risks or areas to be reported to the Board.

Jan Hull
CHAIRMAN OF THE JUNE 2024 MENTAL HEALTH ACT COMMITTEE MEETING

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Quality and Performance Exception Report
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Associate Director – Planning and Performance Senior Performance Manager Chief of People and Organisational Development Deputy Chief Nurse Director of Elective Care
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	3 September 2024

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

Executive Summary and Reason for presentation to Committee/Board	Our Quality and Performance Exception Report sets out the key exceptions across a range of quality and performance measures, and the reasons for any significant changes or trends. Areas in which performance has been sustained or has notably improved include: • 28 Day Faster Diagnosis: all Cancers – performance has been maintained at a level higher than the national reporting standard. • CAMHS Eating Disorders – Urgent and routine referrals seen within the required time periods remain above the national standards and the national averages. • Access to our perinatal service was significantly above the 10% mandated standard. • the number of patients waiting 52 weeks or more from referral to acute treatment reduced. • patients followed up within 72 hours of discharge from an adult mental ward remained above 90%. Areas in respect of which the contributory causes of, and actions to address, underperformance are set out in greater detail in this report include:

	• the numbers of patients in our acute beds not meeting the criteria to reside continues to impact on patient flow. • the percentage of people waiting under six weeks for a diagnostic test. • the percentage of ambulance handovers completed within 30 minutes of arrival at our Emergency Departments. • the number of patients waiting 18 weeks or more for a community service. • the number of patients waiting 18 weeks or more to be seen by our community dental service In Appendix 3, data relating to a range of patient safety / incident measures, including pressure ulcer damage and ligatures is currently unavailable whilst we implement updates to the datasets, due to the move to the new national Learn From Patient Safety Events (LFPSE), which requires changes to definitions and categorisations of incident data.
Recommendation	The Board is asked to discuss and note the report.

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

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

Equality The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

QUALITY AND PERFORMANCE EXCEPTION REPORT: JULY 2024

1. BACKGROUND AND PURPOSE

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

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

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

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

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

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

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

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

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

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

CHIEF FINANCE OFFICER

Overview

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

Successes	**Priorities**
• our eating disorders service for children and young people continued to exceed the national waiting times standard for routine appointments. • Talking Therapies achieved all nationally mandated standards. • compliance remains high in respect of mental health inpatients receiving a follow-up within 72 hours of discharge. • there was a reduction in the number of patients waiting over 52 weeks from referral to treatment. • the national 75% 28-day Faster Diagnosis standard was achieved again. • the compliance level in respect of mandatory training remains high despite the operational challenges faced by services. • our mental health perinatal service continues to exceed the 10% national reporting standard.	• 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 backlogs arising from the time of the COVID-19 pandemic, and rising levels of demand. • continuing to restore and expand capacity above pre-COVID-19 levels, to address backlogs in routine elective work which has built-up. • work with the Somerset system to encourage continued referrals and presentations at hospital where needed and appropriate, especially in respect of urgent or emergency care.
Opportunities	**Risks and Threats**
• continue to progress the health and wellbeing plans for our colleagues at pace; this includes the psychological support offered alongside practical aspects of support such as accommodation provision and nutrition. • continue with new ways of working, particularly through the use of technology. • continue to adapt our recruitment practice, developing more innovative arrangements and reducing time to hire significantly. • develop reporting solutions to improve robustness of recording and reporting.	• the growth in the size of waiting lists caused by the reduction in capacity during the COVID-19 pandemic continues to present a significant challenge to the restoration of waiting times. • delays in discharge of inpatients not meeting the criteria to reside and needing domiciliary care will result in further cancellations of surgery which will reduce our capacity to treat long waiting patients. • significantly increasing levels of demand, particularly for urgent care and mental health services, leading potentially to increased pressures on teams and longer waiting times. • sickness / absence presents a challenge for colleagues within some critical areas, and we need to ensure that we continue to support colleagues accordingly.

Safe

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

Current performance (including factors affecting this)

- **MRSA:** No Trust-attributed MRSA bloodstream infections (BSIs) were reported in July 2024. The total for the year remains at one.
- **MSSA:** There were four Trust-attributed MSSA BSIs reported in July 2024, bringing the total to 20.
- **E. coli**: There were nine Trust-attributed E. coli BSIs reported in July 2024, bringing the total to 39.
- **Klebsiella:** There were four Trust-attributed Klebsiella BSI reported in July 2024, bringing the total to 10.
- **Pseudomonas:** There were no Trust-attributed Pseudomonas aeruginosa BSI reported in July 2024, the total remains at 3.
- **C. diff**: There were 14 Trust-attributed cases reported in July 2024, bringing the total to 38.

Respiratory Viral Infections

- **COVID-19:** 239 inpatient cases of COVID-19 were identified during July 2024, of which 68 were healthcare-attributed.
- **Influenza:** 9 inpatient cases were identified during July 2024, all of which were 'Flu A.

Outbreaks

- During July 2024 a total of 20 outbreaks affected inpatient wards, 15 due to COVID-19, and 5 due to norovirus.
- Carbapenemase Producing Organism, the outbreak on the YDH site, remains ongoing with a total of 48 cases between January and July 2024.

Surgical Site Infections – Data as of June 2024

Total Hip Replacement

- MPH rate of infection = 0%
- YDH rate of infection = 1.76%

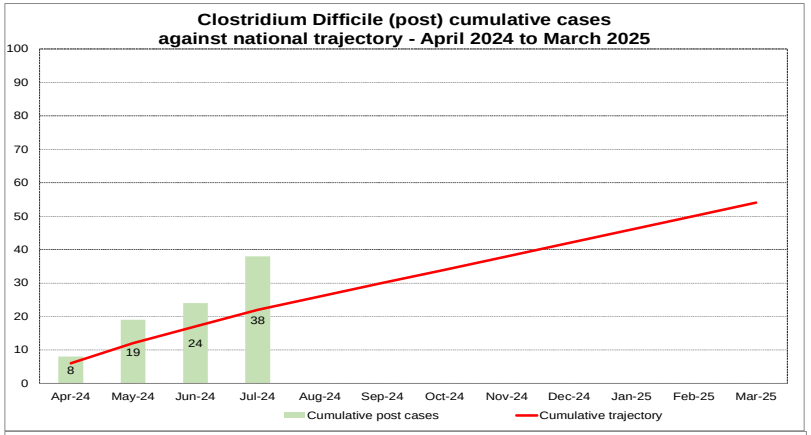
Total Knee Replacement

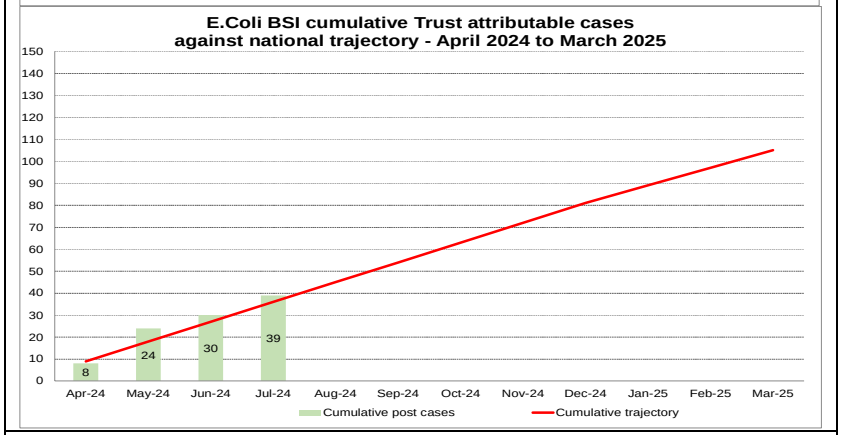
- MPH rate of infection = 0.53%
- YDH rate of infection = 0%

Spinal Surgery

- MPH rate of infection = 0.89%

Line/Bar Charts





Recent performance

Area	Feb	Mar	Apr	May	Jun	Jul
MRSA	0	0	0	1	0	0
C.Diff	9	11	8	11	5	14
MSSA	6	2	5	8	3	4
E.coli	7	8	8	16	6	9

Safe

Emergency Department patients screened for sepsis - the registered nurse should immediately inform the medical team caring for the patient.

Current performance (including factors affecting this)

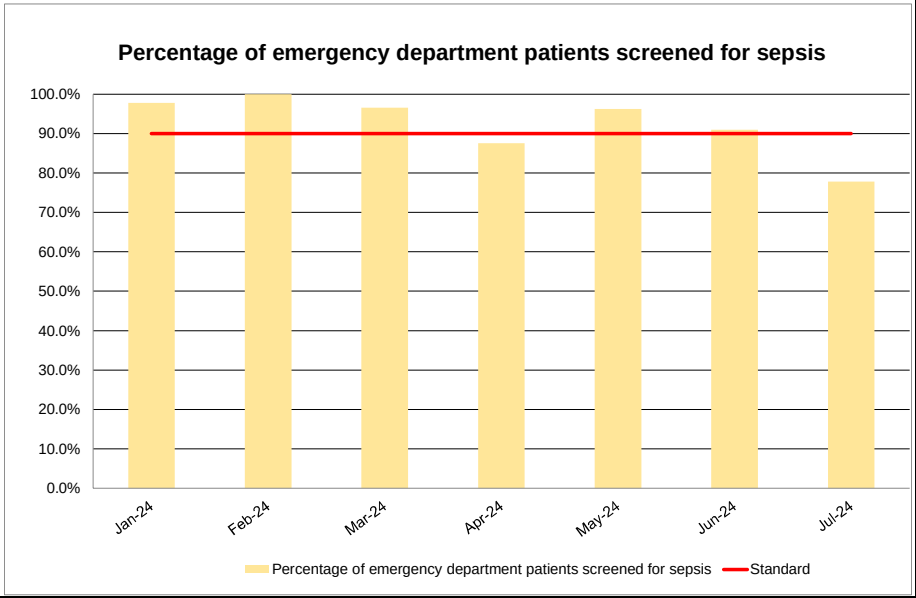
- During July 2024, compliance decreased when compared to June 2024.
- Of 72 patients screened for Sepsis and identified with a National Early Warning Score (NEWS2) of five or above during the reporting period, a total of 56 (77.8%) were appropriately acted upon by the registered nurses informing the medical team, against a compliance standard of 90% or more.

Focus of improvement work

Actions include:

- When conducting the NEWS2 audit, ensuring there is documented evidence in the patients' notes that the nurses have escalated to the medical team who in turn have reviewed the patient.
- Ensuring that documented timings used to determine whether escalation was immediate are recorded accurately.
- To have the NEWS2 audit results available for each ward and Service group, every other month.
- For the results to be available for discussion at the service groups' monthly meetings. These reports provide details of compliance by ward and ownership

Bar Chart



How do we compare

Compliance during July 2024 decreased when compared to the period June 2024.

Performance over the last six months

Area	Feb	Mar	Apr	May	Jun	Jul
ED – MPH	100%	100%	82.6%	100%	100%	88.5%
ED – YDH	100%	95.2%	92.0%	92.9%	88.9%	71.7%
Overall compliance	100%	96.6%	87.5%	96.2%	90.9%	77.8%

Safe

Patients in an inpatient setting 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.

Current performance (including factors affecting this)

- During the reporting period 1 June to 31 July 2024, compliance increased when compared to the period 1 April to 31 May 2024.
- Of 78 patients identified with a National Early Warning Score (NEWS2) of five or above during the reporting period, a total of 59 (75.6%) were appropriately acted upon by the registered nurses informing the medical team, against a compliance standard of 90% or more.

Focus of improvement work

Actions include:

- When conducting the NEWS2 audit, ensuring there is documented evidence in the patients' notes that the nurses have escalated to the medical team who in turn have reviewed the patient.
- Ensuring that documented timings used to determine whether escalation was immediate are recorded accurately.
- To have the NEWS2 audit results available for each ward and Service group, every other month.
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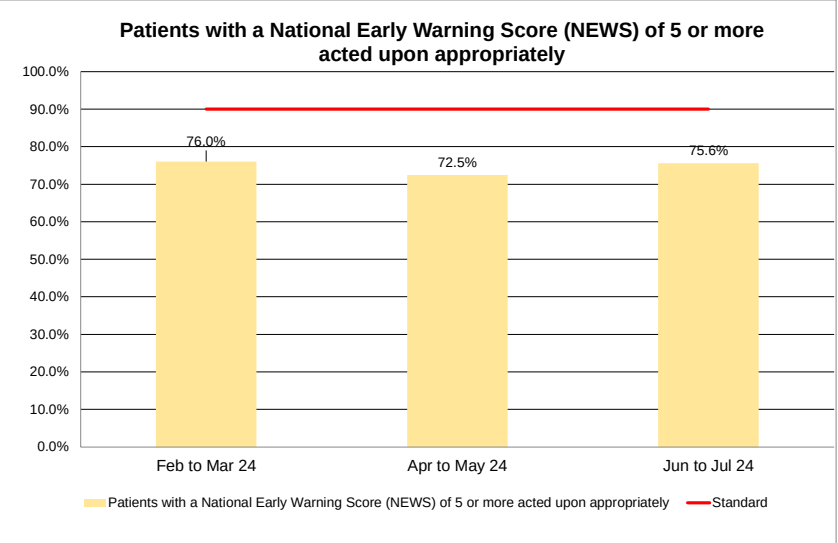


How do we compare

Compliance for the period 1 June to 31 July 2024 increased when compared to the period 1 April to 31 May 2024.

Performance over the last six months

Area	Feb to Mar	Apr to May	Jun to Jul
% compliance	76.0%	72.5%	75.6%

Safe

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

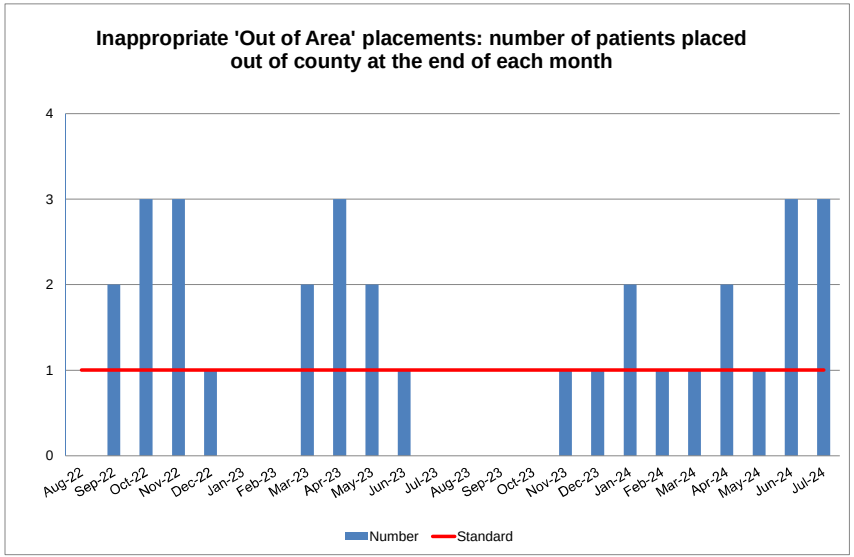
Current performance (including factors affecting this)

- As at 31 July 2024 three patients remained placed out of area.
- One patient was placed out of county on 28 June 2024, and this was clinically indicated due to their requiring a gender-specific ward.
- The other two patients were placed out of county during July 2024 due to the need to access seclusion, which was already occupied at Holford ward, our Psychiatric Intensive Care Unit (PICU).

Focus of improvement work

- The majority of out of area placements are due to patients requiring admission into our PICU. With only ten beds available there are occasions when, due to clinical acuity or gender, it would be unsafe to admit a patient. In the last 12 months (1 August 2023 to 31 July 2024) all out of area innappropriate admissions were due to the need for PICU, of which 63% were due to the need for a gender-specific ward.
- When a patient is placed out of area, the Urgent Care Hub and/or Holford ward maintains regular contact with the patient until the patient is either transferred back to our wards, discharged, or moved to secure services. Every effort is made to place people as close to Somerset as possible.
- At times, episodes relate to patients awaiting transfer to secure services. We work closely with other NHS providers, to facilitate such transfers and closely monitor processes to minimise risk.
- An out of area esclation proccess is in place to ensure that barriers to repatriation and/or discharge of patients are minimised and escalated with system partners where appropriate.
- Our Inpatient Quality Transformation Programme, a two-to-three-year programme, is reviewing processes and procedures in relation to patients who do not meet the Criteria to Reside, with the aim of improving patient flow and reducing the need for Out of Area placements.

Bar Chart



How do we compare

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

Recent Performance

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

Area	Feb	Mar	Apr	May	Jun	Jul
Number of patients out of area on last day of month	1	1	2	1	3	3

Responsive

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

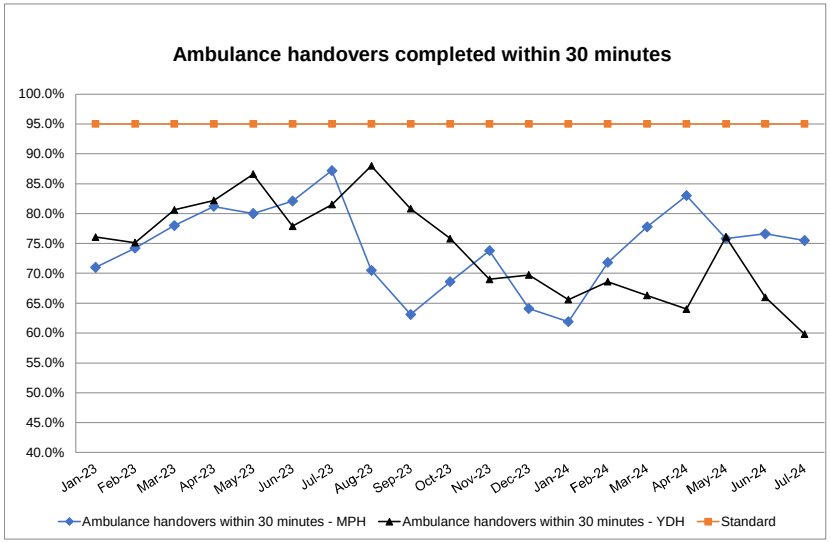
Current performance (including factors affecting this)

- During July 2024, performance for the handover within 30 minutes of patient arrivals by ambulance decreased at Musgrove Park Hospital (MPH) and at Yeovil District Hospital (YDH) when compared to June 2024. Compliance in July 2024 was as follows:
  - MPH: 75.5% (1,921 out of 2,543 handovers were within 30 minutes).
  - YDH: 59.8% (813 out of 1,360 handovers were within 30 minutes).
- The average performance across all hospitals served by South Western Ambulance Service NHS Foundation Trust (SWAST) in July 2024 was 60.4%. MPH was ranked fifth out of 19 sites served by across the Region and YDH was ranked thirteenth.

Focus of improvement work

- The main issue that has affected our handover times at YDH is the number patients awaiting admission to specialty, coupled with an increase in bed occupancy levels from May 2024 onwards. Outward flow from the department has been a challenge. Recently the decision was made to re-open Jasmin ward as escalation space to support this.
- Both departments are undertaking an in-depth front door audit over a seven-day period, to review appropriate conveyance and reasons for delays in handover. Dates and times have now been agreed as from 8am to 8pm during the week commencing 9 September 2024 at YDH, and from 8am to 8pm during the week commencing Monday 16 September 2024 at MPH.
- An internal divert process is being drafted to support early communication around divert decisions, which is important to support departments in preparation for increasing ambulance handover arrivals.
- A staff suggestion questionnaire is being drafted for circulation. Suggestions will be reviewed by the ambulance handovers working group. National improvement resources are also being reviewed to gather examples of initiatives from alternative Trusts.

Line Chart



How do we compare

In July 2024, 75.5% of all ambulance handovers at Musgrove Park Hospital and 59.8% of all ambulance handovers at Yeovil District Hospital were completed within 30 minutes. The average performance across all hospitals served by SWAST was 60.4%.

Recent performance

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

Area	Feb	Mar	Apr	May	Jun	Jul
MPH	71.8%	77.8%	83.0%	75.8%	76.6%	75.5%
YDH	68.6%	66.3%	64.0%	76.1%	66.0%	59.8%

Responsive

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

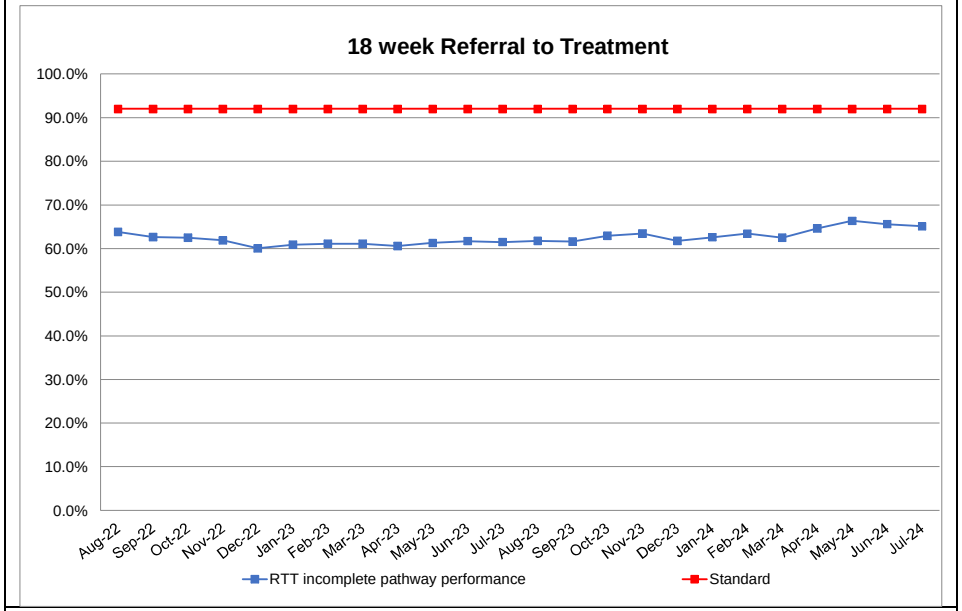
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT was 65.1% (combined acutes + community) in July 2024, 0.5% lower than the position for June 2024.
- The total waiting list size increased by 843 pathways, and was 3,757 higher (i.e. worse) than the planning trajectory (57,442 actual vs. 53,685). Performance against the 18-week standard would have been lower, had there not be an increase in total waiting list size.
- The number of patients waiting over 52 weeks reduced slightly, decreasing by 31 pathways in July to 1,842 pathways, 421 lower (i.e. better) than the planning trajectory of 2,263.
- The number of patients waiting over 65 weeks was 426 at month-end, 248 higher (i.e. worse) than the planning trajectory of 178.
- The number of patients waiting 78+ weeks remained at 15, against a trajectory of zero.

Focus of improvement work

- The number of patients needing a first outpatient appointment or surgery, to avoid becoming a 65-week RTT waiter by the end of September 2024, has been quantified for each specialty to support the development of capacity plans. These plans have undergone a significant refresh in the last month and continue to emphasise productivity and ways of increasing capacity internally, along with insourcing and outsourcing solutions.
- Cohort clearance monitoring reports have been established for all high-volume specialties, split by hospital site and pathway type.
- A significant programme of improvement work to support elective care recovery in the medium and long-term remains in place.
- A programme of waiting list validation continues, which includes contacting patients to check they still need to be seen; additional validation is taking place for patients in the September 2024 65-week cohort, to check the waiting times are being correctly reported.

Line Chart



How do we compare

The national average performance against the 18-week RTT standard was 58.9% in June 2024, the latest data available; our performance was 65.6%. National performance deteriorated by 0.2% between May and June 2024; our performance reduced by 0.7%. The number of patients waiting over 52 weeks across the country decreased by 4,807 to 302,693 (4.0% of the national waiting list compared with 3.2% for the Trust). The number of patients waiting over 78 weeks nationally decreased by 1,976 to 2,621.

Performance trajectory: 78 week and 65 week wait performance

Area	Feb	Mar	Apr	May	Jun	Jul
78-week trajectory	40	35	34	22	0	0
78-week actual	48	40	37	35	15	15
65-week trajectory	698	673	483	373	289	178
65-week actual	538	434	463	484	493	426

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

Responsive

Acute bed days lost due to patients not meeting the criteria to reside: Working with strategic partners to facilitate the timely and appropriate discharge of patients from our hospitals, and reduce the number of patients occupying a bed who no longer require treatment or therapy.

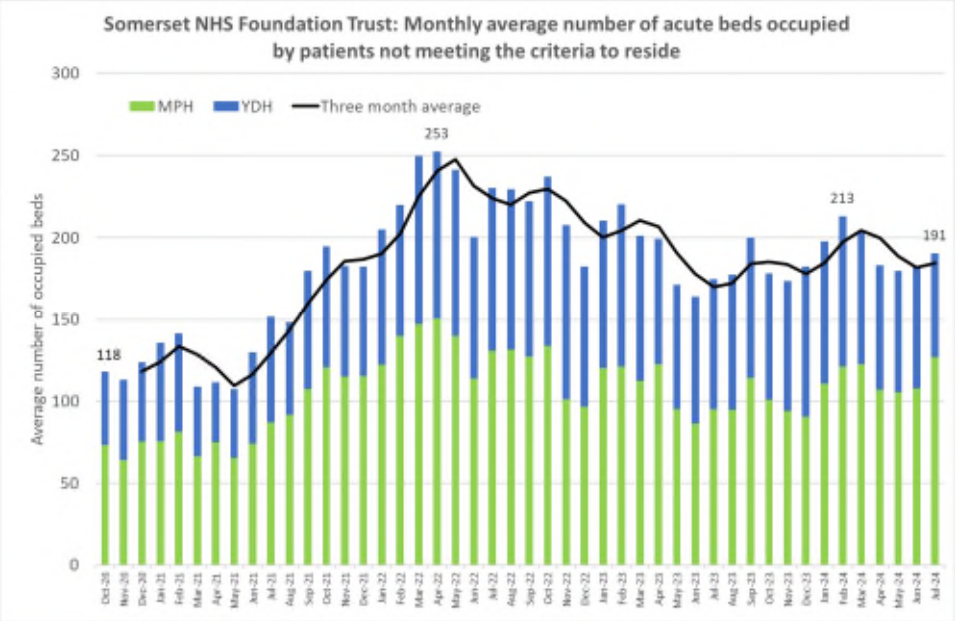
Current performance (including factors affecting this)

- During July 2024, the Trust-wide number of acute bed days occupied by patients not meeting the criteria to reside was 5,908 (3,939 at MPH and 1,969 at YDH), up from 5,490 in June 2024. This equates to 191 fully occupied beds for the month of July 2024, up from 183 in June 2024.
- In our community hospitals, the number of patients not meeting the criteria to reside increased, from 42 as at 30 June 2024 to 54 as at 31 July 2024.
- Of the 1,702 acute inpatients discharged during July 2024 who had a Discharge Ready Date recorded, the average duration between the Discharge Ready Date and the actual date of discharge was 2.6 days, up from 2.5 days during June 2024. This is currently artificially low as presently it is not possible for YDH wards to input Discharge Ready Dates in respect of Pathway 0 patients.
- Recording of Ready to Discharge Dates in respect of all discharges was 51.5%, an increase from 51.1% achieved during June 2024. A performance improvement trajectory has been set to increase recording compliance.

Focus of improvement work

- A range of actions are being taken to improve patient flow, care for people at home where appropriate, facilitate timely and appropriate discharge and address the difficulties in the domiciliary care market.
- These actions include the expansion of Criteria-Led Discharge, to discharge a patient when they meet pre-agreed clinical criteria for discharge, as identified by the lead clinician. This reduces delays in the discharge process and ensures discharges are in an appropriate and timely way.

Trend Chart



How do we compare

As at 31 July 2024, national best-quartile performance was that 7.4% of Adult General & Acute and critical care beds were occupied by patients who did not meet the criteria to reside. Our performance as at that date was 23.8% of beds. We were ranked 110 of 119 Trusts nationally.

Recent performance

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

Area	Feb	Mar	Apr	May	Jun	Jul
MPH	3,516	3,805	3,215	3,267	3,230	3,939
YDH	2,660	2,487	2,283	2,307	2,260	1,969
Total	6,176	6,292	5,498	5,574	5,490	5,908

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.

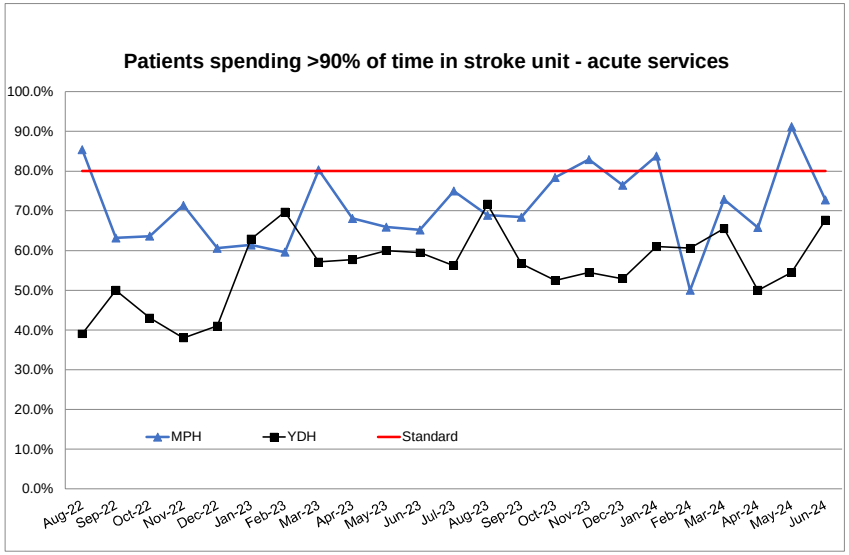
Current performance (including factors affecting this)

- During June 2024, compliance decreased at Musgrove Park Hospital but increased at Yeovil District Hospital. Performance at the two sites was as follows:
  - Musgrove Park Hospital (MPH): 72.7%
  - Yeovil District Hospital (YDH): 67.7%
- As is the case with the four-hour standard, performance in respect of this reporting standard is heavily influenced by patient flow and the availability of stroke beds.

Focus of improvement work

- 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.
- The number of hyper acute stroke beds available at MPH increased from four to eight in January 2024, which has helped improve patient flow, although the position remains challenging.
- A review of the reporting indicators is currently being undertaken improve availability of appropriate management information.

Line Chart



How do we compare

During June 2024, compliance decreased at Musgrove Park Hospital but increased at Yeovil District Hospital when compared to June 2024.

Performance over the last six months

Area	Jan	Feb	Mar	Apr	May	Jul
% compliance MPH	83.8%	50.0%	72.9%	65.8%	91.2%	72.7%
% compliance YDH	61.0%	60.6%	65.5%	50.0%	54.5%	67.7%

Responsive

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

Current performance (including factors affecting this)

During July 2024, 94.7% of patients aged 65 or over who were discharged from acute hospital beds within Somerset were transferred onto Pathway 0 or Pathway 1.

Pathway 0

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

Pathway 1

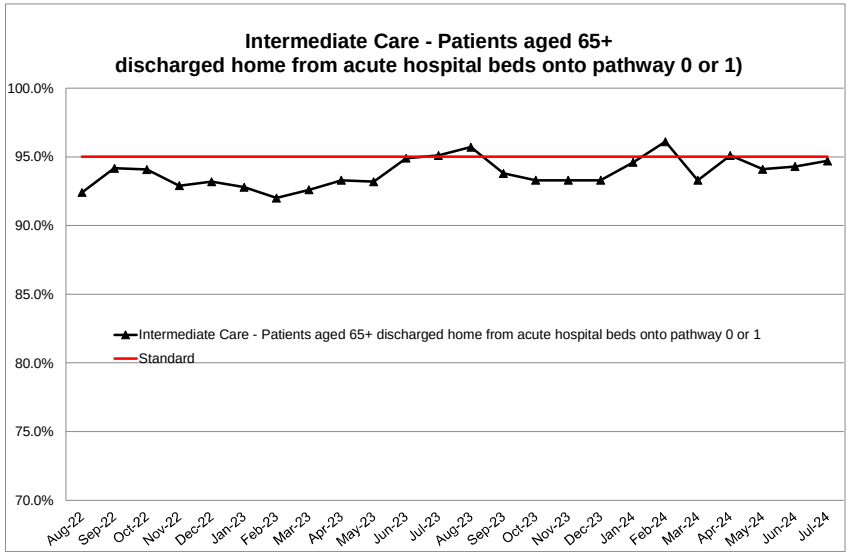
These discharges are supported by the Intermediate Care Discharge to Assess Service (D2A). These people require reablement and ongoing assessment within their own home.

Focus of improvement work

Actions being taken include:

1. **Continuing to strengthen the decision-making within the Transfer of Care (TOC) Hubs** – positive risk taking, personalised care approach to increase P0.
2. **Out of Hospital Care models –** strengthening Urgent Community Response at the front door for those patients not requiring an acute bed.
3. **Increase Pathway 1 capacity –** completed in South Somerset with good effect.
4. **Increase Pathway 1 discharges in Taunton and West Somerset –** supporting Pathway 1 providers to deliver against commissioned targets.

Trend Chart



How do we compare

The percentage of patients aged 65 or more transferred onto pathway 0 or 1 during July 2024 increased compared to June 2024.

Performance over the last six months

Area	Feb	Mar	Apr	May	Jun	Jul
Total Discharges	2,148	2,126	2,230	2,233	2,150	2,113
Pathway 0	1,794	1,743	1,876	1,892	1,790	1,793
Pathway 1	271	240	244	210	237	207
% onto P0 or P1	96.1%	93.3%	95.1%	94.1%	94.3%	94.7%

Responsive

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

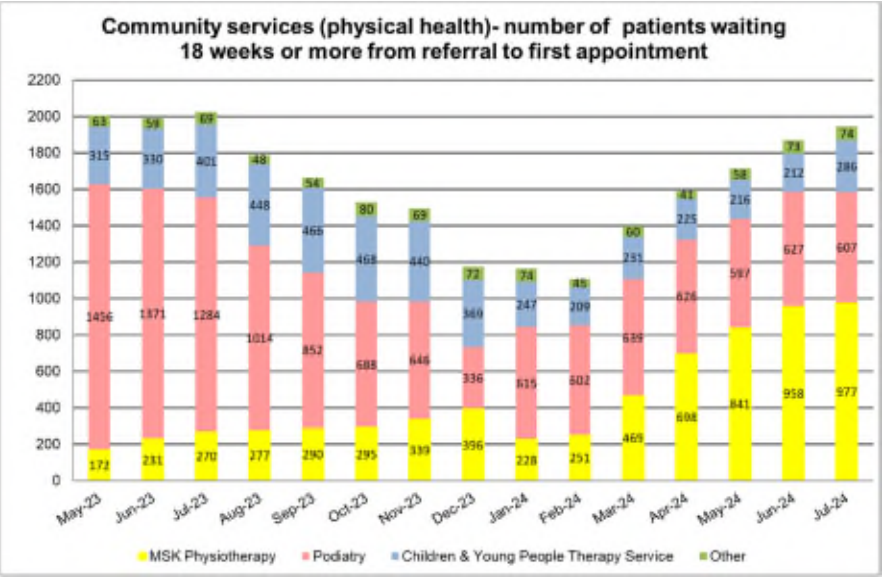
Current performance (including factors affecting this)

- As at 31 July 2024, the number of patients waiting 18 weeks or more totalled 1,944 an increase of 74 compared to 30 June 2024.
- Our Musculoskeletal Physiotherapy Service had the highest number of patients waiting 18 weeks or more with 977, up from 958 as at 30 June 2024. The recent increase in the numbers waiting has primarily been due to vacancies within the service.
- The number of people waiting 18 weeks or more to be seen by our Podiatry service reduced to 607 patients, from 627 as at 30 June 2024. The service continues to have significant levels of vacancies, which is a national issue.
- Numbers with our Children and Young People Therapy Service totalled 286, an increase from 212 as at 30 June 2024.
- Of 277 patients waiting 52 weeks or more as at 31 July 2024, a total of 276 related to Podiatry, with the other patient waiting for the Children and Young People's Therapy Service.

Focus of improvement work

- The Musculoskeletal Physiotherapy Service is planning to hold an Appointment Day in September 2024, with an aim to see 150 patients who had waited 18 weeks or more. The service has also had recent success in recruiting a therapist, which will aid plans to increase capacity and throughput.
- For 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. Plans have been developed to introduce additional capacity, commencing in early October 2024.
- The Children and Young People's Therapy Service has had success in recruiting to occupational therapy, the area with the highest numbers waiting. Plans have been developed that should reduce the number of patients waiting 18 weeks or more to zero by April 2025.

Bar Chart



How do we compare

The number of patients waiting 18 weeks or more as at 31 July 2024 increased by 74 when compared to 30 June 2024.

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	1,107	1,399	1,590	1,712	1,870	1,944

Responsive

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

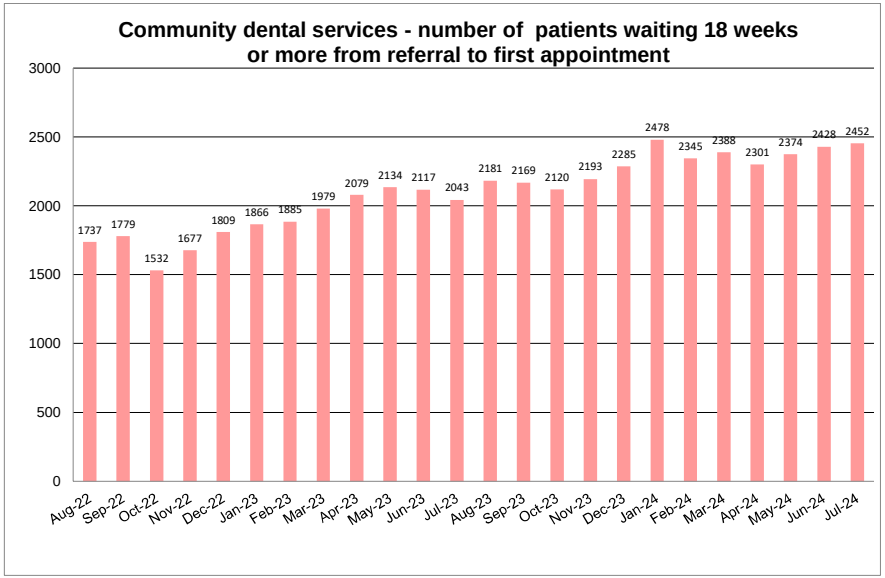
Current performance (including factors affecting this)

- As at 31 July 2024, the number of patients waiting 18 weeks or more totalled 2,452, an increase of 24 compared to 30 June 2024.
- Of the patients waiting 18 weeks or more to be seen, there were 1,832 waiting within Somerset (up from 1,766 as at 30 June 2024), and 620 within Dorset (down from 662 as at 30 June 2024).
- The number of people waiting 52 weeks or more decreased from 620 as at 30 June 2024 to 600 as at 31 July 2024.

Focus of improvement work

- The Dental service continues to face considerable challenges due to vacancies, sickness absence and insufficient cover for colleagues on maternity leave. Recruitment campaigns now include a testimonial service video, glossy brochures, social media material and open drop in events for all posts including senior specialists.
- With demand currently exceeding capacity, the service has been reviewing pathways and is also reviewing trajectories and actions to reduce numbers waiting.
- The service is balancing seeing core primary care patients and completing their courses of treatment, with those who have been referred into the service. Unfortunately, the with the volume of referrals it is proving very challenging, and the service has been asking for a catch-up meeting with the Integrated Care Board, to try to work with them to review how this can be approached.
- The service works regionally, through the Managed Clinical Network structure, the Local Dental Committee, and work with NHS England network managers, to ensure we are able to align with the latest thinking, and to share challenges and initiatives with all other similar services in the South West. The service continues to seek engagement from the Integrated Care Boards of Dorset and Somerset to assist in finding resolutions to the challenges faced.

Bar Chart



How do we compare

The number of patients waiting 18 weeks or more as at 31 July 2024 increased by 24 when compared to 30 June 2024.

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	2,345	2,388	2,301	2,374	2,428	2,452

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).

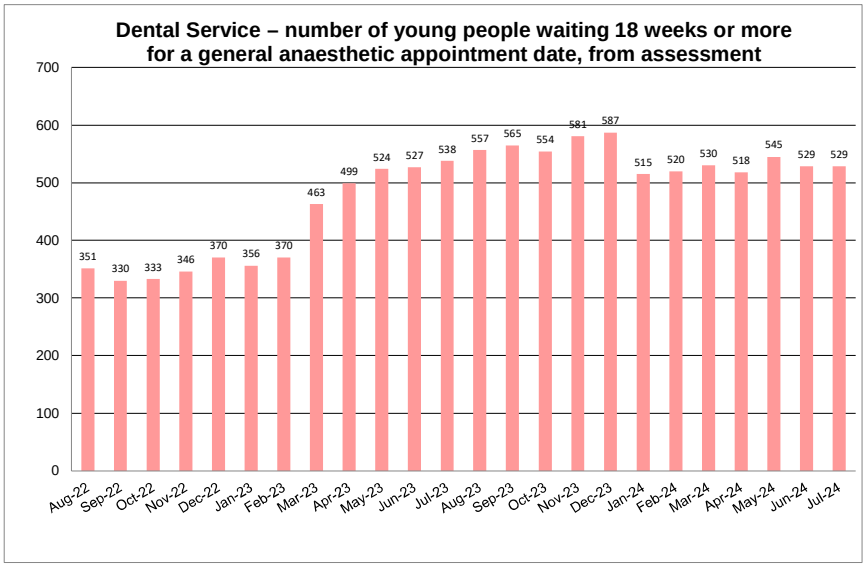
Current performance (including factors affecting this)

- As at 31 July 2024 a total of 529 young people had waited 18 weeks or more, unchanged from 30 June 2024.
- Of the 529 patients waiting, 446 related to our Dorset service (down from 452 as at 30 June 2024), and 83 related to our Somerset service (up from 77 as at 30 June 2024).
- The service continues to have significant levels of vacancies, which is a national issue, exacerbated by four GA dentists now on maternity leave, for whom there is insufficient cover.
- Demand for these services across the counties remains high.

Focus of improvement work

- The Get It Right First Time (GIRFT) report into Community and Paediatric Dental GA still awaited.
- Recruitment challenges in Somerset persist, although some interviews are scheduled for more junior dentist posts. Plans are in place to progress a Clinical Director post for Somerset to try to attract as wide a pool of dentists as possible to lead services within Somerset.
- There is limited capacity in respect of GA dental clinicians, although maternity returners will help with this by mid-2025.
- There has been a positive impact from the number of patients on the morning lists at YDH increasing to six patients on the majority of occasions. Ward capacity and Pre-Operative Assessment Clinic (POAC) limitations remain a work in progress.
- The pool of GA dentists in Dorset is adequate to meet current levels of demand. A business case to Dorset Integrated Care Board has had limited acceptance, making proposals less viable. A meeting / discussion with the commissioners has been requested.

Bar Chart



How do we compare

The number of young people waiting 18 weeks or more as at 31 July 2024 remained unchanged from numbers as at 30 June 2024.

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	520	530	518	545	529	529
% > 18 weeks	70.2%	67.7%	66.4%	66.1%	64.1%	60.9%

Responsive

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

Current performance (including factors affecting this)

- Performance against the 31-day first combined treatment standard was 91.2% in June 2024, below the 96% national standard but above the national average performance.
- There were 52 breaches of the standard, 19 for skin (37% of breaches), nine for urology (17%) and eight for breast (15%). There were smaller volumes of breaches across a range of tumour sites.
- There has been an increase in breaches of the 31-day standard for skin patients which has followed the full repatriation of the skin cancer service for the west of the county from University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) from the start of November 2023.
- 63% of the breaches were for surgical treatments and 31% were for radiotherapy. The ability to start treatment within 31 days of the decision to treat is affected by bulges in demand. Urology and has seen significant growth in referrals over the past three months, at 15% above last-year's levels.

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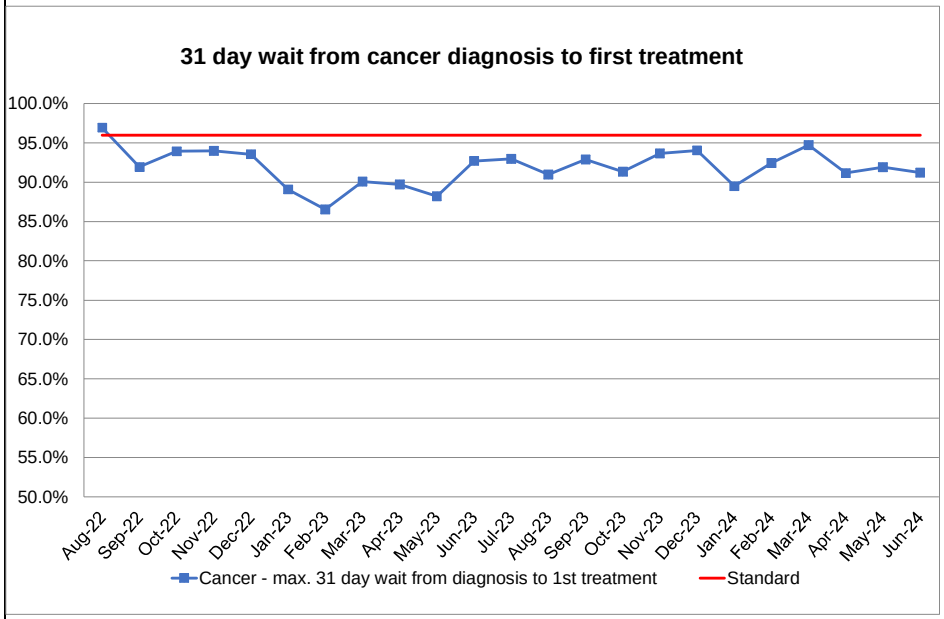
Focus of improvement work

- The work outlined in the combined 62-day cancer standard will help to reduce delays in cancer pathways which will also help to smooth bulges in demand for cancer treatments.
- Capacity and demand modelling has been undertaken for the repatriated dermatology two-week wait service. Additional capacity continues to be established, including further consultant appointments, GPs with Extended Roles being trained and insourcing. Allied service capacity continues to be planned for, including pathology, plastics, and melanoma oncology. A new Artificial Intelligence (AI) system is now being piloted which will help with the triage and management of suspected cancer referrals. The new teledermatology system (Cinapsis) is live across both sides of the county, helping to manage routine demand and free-up capacity for suspect cancer and other specialist referrals.

Line Chart



How do we compare

National average performance for providers was 90.9% in June 2024, the latest data available. Our performance was 91.2%. We ranked 93 out of 138 providers.

Recent performance

31-day diagnosis to first treatment performance

Area	Jan	Feb	Mar	Apr	May	Jun
% Compliance	89.5%	92.4%	94.7%	91.2%	91.9%	91.2%

Responsive

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

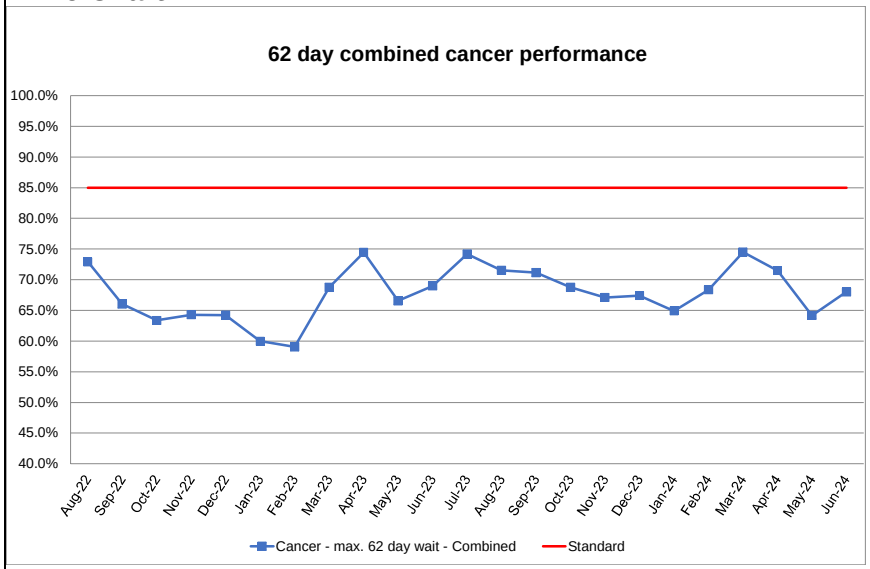
Current performance (including factors affecting this)

- The percentage of patients treated for a cancer within 62 days of referral was 68.0% in June 2024, which was below the national standard but above the national average.
- The main breaches of the 62-day GP cancer standard were in urology (36% of breaches), skin (23%) and colorectal (15%).
- The main cause of the breaches continues to be high demand (urology 15% growth, colorectal 17% growth, relative to the same three-month period last year). This has resulted in an increase in diagnostic and treatment waiting times, both at the Trust and other treating providers. The increase in skin breaches relates to the sooner than planned repatriation of the service from University Hospitals Bristol and Weston NHS Foundation Trust (UHBW).
- Twenty-three GP-referred patients were treated in June 2024 on or after day 104 (the national 'backstop'); please see Appendix 5a.
- 28-day Faster Diagnosis Standard performance was 75.0% in June 2024, against the current national target of 75%; the target will rise to 77% in March 2025.

Focus of improvement work

- A new cancer 'front door' is under development, for implementation in the summer; this will create a single-entry point for cancer referrals across Somerset, helping to smooth demand across the two hospital sites; it will include nurse-led triage and management of the initial diagnostic phase of cancer pathways.
- Prostate pathway redesign work continues on the diagnostic phase, focusing on nurse-led management and steps being condensed or removed to achieve a diagnosis sooner.
- Additional colorectal diagnostic capacity continues to be established, to try to meet increasing demand. This includes additional CT colon scans being undertaken at Musgrove for Yeovil patients, as well as additional CT colon lists at Yeovil.
- Please also see the 31-day exception report for actions relating to skin.

Line Chart



How do we compare

National average performance for providers was 67.4% in June 2024, the latest data available. Our performance was 68.0%. We were ranked 90 out of 146 trusts.

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

Recent performance

62-day GP cancer performance

Area	Jan	Feb	Mar	Apr	May	Jun
% Compliance	64.9%	68.3%	74.5%	71.5%	64.2%	68.0%
Trajectory				71.4%	64.6%	65.9%

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.

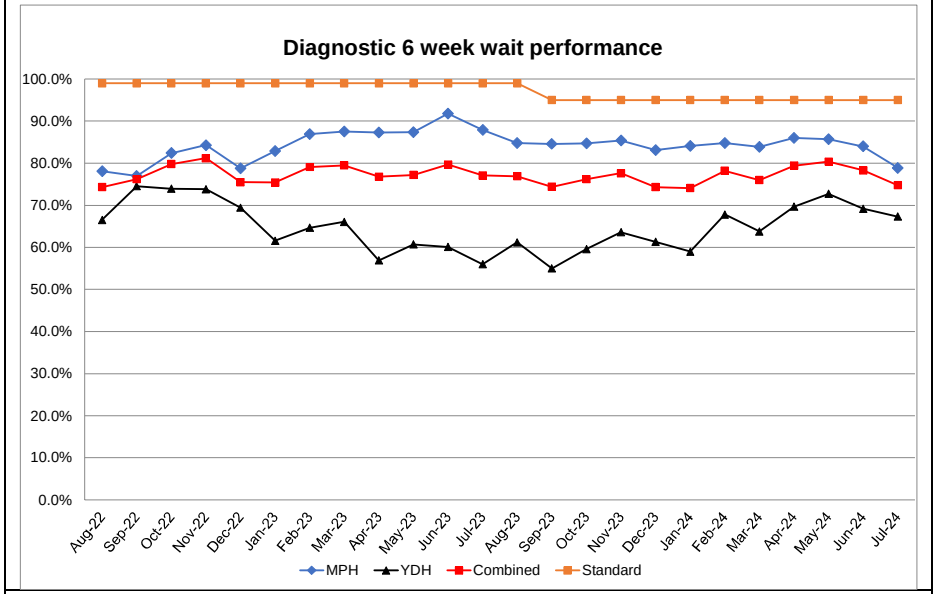
Current performance (including factors affecting this)

- The combined percentage of patients waiting under six weeks for their diagnostic test decreased to 74.8% in July 2024, which is below the regional March 2024 ambition of greater than 85%, and below the planning trajectory.
- The number of patients waiting over six weeks as at 31 July 2024 increased by 198 patients compared to the previous month; the highest numbers of patients waiting over six weeks were waiting for the following diagnostic tests:
  - echo (up from 671 to 1,009: 36% of over six-week waiters).
  - MRI (up from 530 to 569: 21%).
  - Audiology (down from 199 to 198: 7%).
- Together these three diagnostic modalities made up 64% of the over six-week diagnostic waiters.
- The total waiting list size decreased by just over 7% (839 patients), which has contributed to the deterioration in performance but does also mean that less demand will need to be met in future months.
- The deterioration in the echo backlog position reflects staff departures on both hospital sites over the last three months.

Focus of improvement work

- Additional echo capacity has been established through the extension of the insourcing contract which is currently in place, and weekend waiting list initiatives have been established. Additionally, a member of the team will return from maternity leave in September 2024.
- Echo capacity and demand modelling has been undertaken, which has confirmed the scale of additional capacity required to meet recurrent demand and eliminate the backlog by the end of March 2025, but ideally sooner.
- Additional MRI capacity has been established, through the rental of a modular scanning unit, which is now being rented until March 2025 using Community Diagnostic Centre (CDC) funds. Additional MRI waiting list initiatives are also being run.

Line Chart



How do we compare

National average performance for NHS providers (i.e. excluding Independent Sector providers) was 77.1% in June 2024, the latest data available. Our performance was 78.3%. We were ranked 84 out of 157 trusts for the 15 high-volume diagnostic tests.

Recent performance

Area	Feb	Mar	Apr	May	Jun	Jul
Musgrove Park Hospital (MPH)	84.8%	83.9%	86.0%	85.7%	84.0%	78.9%
Yeovil District Hospital (YDH)	67.8%	63.8%	59.4%	72.7%	69.2%	67.3%
Combined	78.2%	76.0%	79.4%	80.4%	78.3%	74.8%
Trajectory			75.2%	77.2%	80.3%	83.3%

Well Led

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

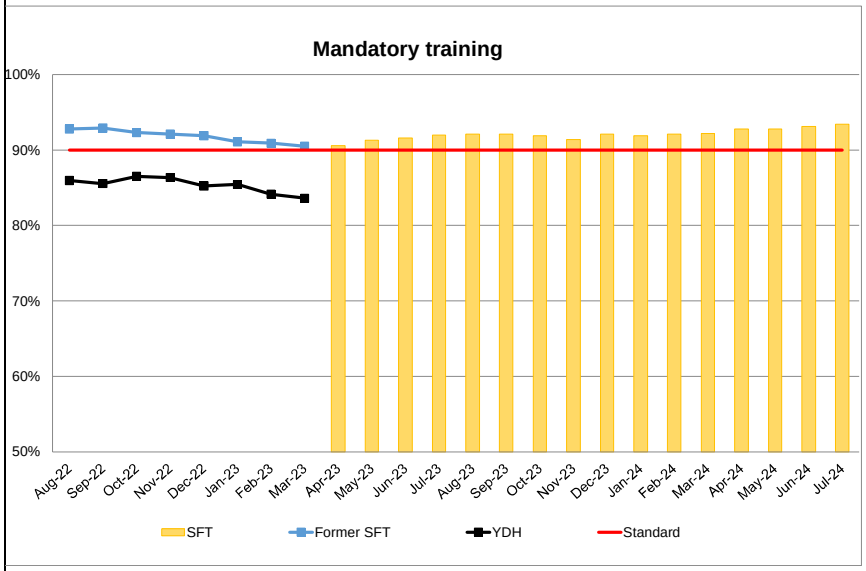
Current performance (including factors affecting this)

- As at 31 July 2024, our overall mandatory training rate was 93.3%, a slight increase from 30 June 2024.
- Apart from Symphony Health Service (SHS), all colleagues moved to the new Trust training system, LEAP, on 1 April 2023. As at 30 June 2024, compliance reported from the two separate systems was as follows:
  - LEAP: 93.3% (93.1% as at 30 June 2024)
  - SHS: 76.5% (76.5% as at 30 June 2024)
- Operational pressures, and limited capacity in areas with large backlogs, such as life support and safeguarding, continue to remain a challenge to full recovery.

Focus of improvement work

- Work to align and re-map colleagues in respect of resuscitation training is nearing completion and reporting will become more stable as a result. The Resuscitation Services development programme (of trainers) has improved the resilience of the team, and the current focus is now shifting to increasing the size of the team to match the needs of the organisation.
- Tailored reports continue to be distributed to the Service Groups and Corporate Directorates and our People Business Partners liaise with managers to assist in addressing any issues. Managers also have access to real-time reporting and data on their services/teams via the learning management system.
- The Safeguarding Team undertakes regular reviews to ensure all colleagues have the appropriate level of training. These reviews result in more colleagues being required to undertake higher levels of training, which impacts on compliance.
- Action is being undertaken to follow up colleagues with three or more courses outstanding.

Run Chart



How do we compare

Compliance as at 31 July 2024 increased slightly when compared to 30 June 2024.

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
% Compliance	92.1%	92.2%	92.8%	92.8%	93.1%	93.3%

Well Led

Career Conversations: We are committed ensuring that colleagues have timely and appropriate career reviews, at least annually, to outline all aspects of their role, to highlight and promote excellence and identify core or developmental training needs to enable colleagues to progress in their chosen careers.

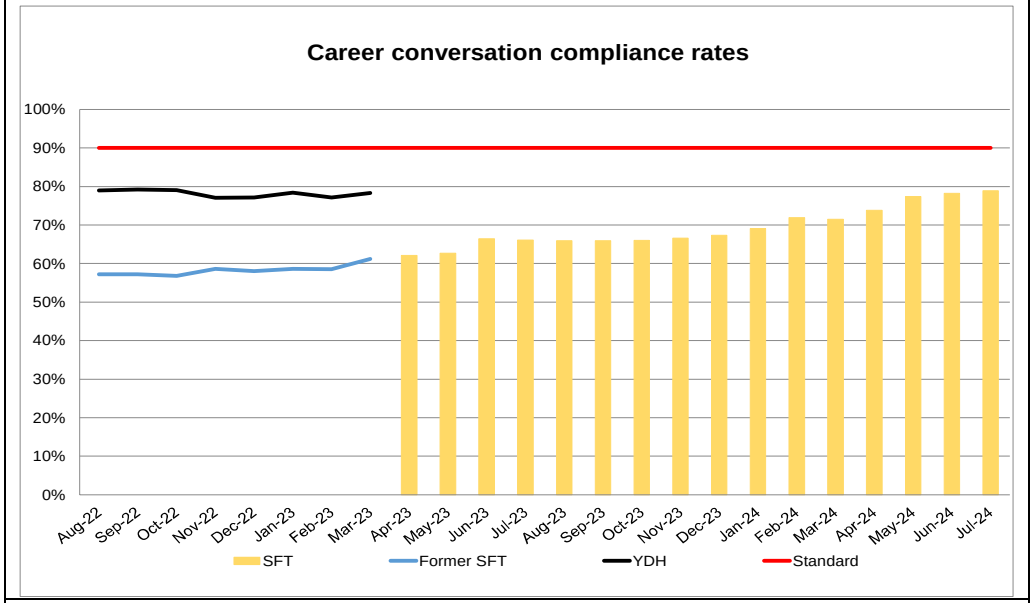
Current performance (including factors affecting this)

- Compliance as at 31 July 2024, in respect of career conversation reviews being undertaken at least annually was 78.9%, up by 0.7% from the previous month, and the highest rate reported since the new Trust was established in April 2023, but still significantly below the standard of 90%.
- Neighbourhoods continues to be the best performing service group, with compliance of 83.7%.
- The Mental Health & Learning Disabilities service group has seen the greatest improvement over the 12-month period, increasing from 48.2% in August 2023 to 74.1% in July 2024.

Focus of improvement work

- A Year-2 People Strategy deliverable has been developed, to focus on improving compliance with appraisal rates and modernising the approach to appraisals.
- Service groups continue to provide assurance of their focus through the Quality, Outcomes, Finance and Performance meetings.

Run Chart



How do we compare

Compliance as at 31 July 2024 increased by 0.7% compared to the position as at 30 June 2024.

Recent performance

The compliance rates in recent months were as follows:

Area	Feb	Mar	Apr	May	Jun	Jul
% compliance	71.9%	71.5%	73.8%	77.4%	78.2%	78.9%

Well Led

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

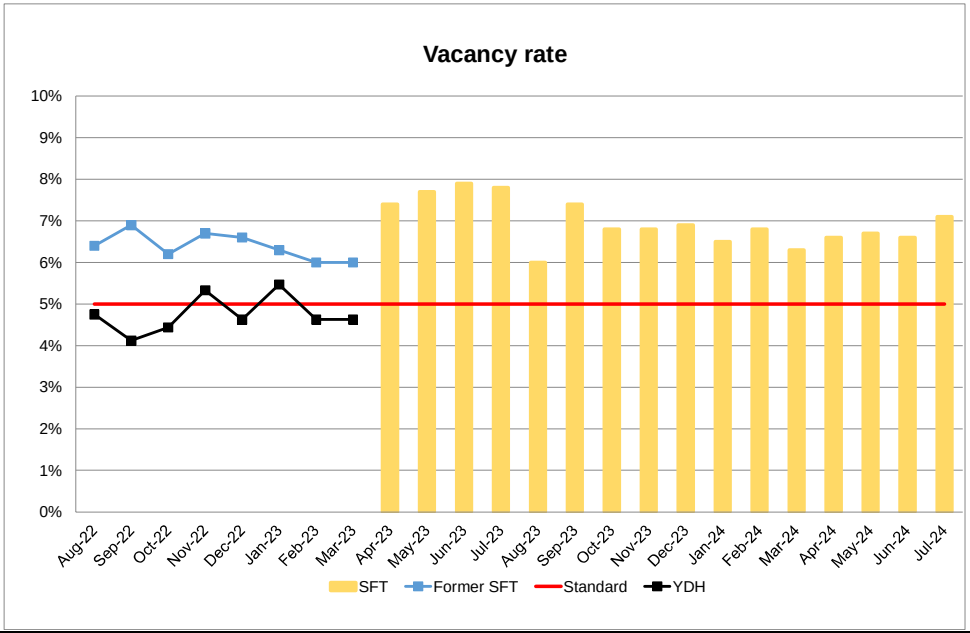
Current performance (including factors affecting this)

- Our vacancy rate as at 31 July 2024 was 7.1%, up from 6.6% reported as at 30 June 2024.
- The areas with the highest vacancy rates are:
  - Estates and Facilities: 13.8%
  - Neighbourhood Services: 10.0%
  - Mental Health and Learning Disabilities: 8.1%
- As part of the NHSE workforce whole time equivalent cap there will be some roles which are deliberately not being filled, as service groups progress their productive care plans.
- Twenty-three risks on the risk register relate to recruitment challenges, spanning many services and roles. The highest-scoring risks are with senior medical and nursing and allied health professional roles with community hospitals, pharmacy, theatres, bowel cancer screening and digital recruitment challenges scoring 15 and above.
- For many hard-to-recruit roles, there are national and local shortages, making it a very competitive environment in which to recruit.

Focus of improvement work

- We are currently exploring an approach to join up recruitment with research to attract more candidates into roles, particularly for medial and dental and senior clinical roles.
- Workforce plans are being developed at service level to provide greater clarity of future workforce requirements.
- We are utilising the international recruitment team to support medical recruitment.

Run Chart



How do we compare

The vacancy rate within the Trust in July 2024 increased slightly when compared to June 2024.

Recent performance

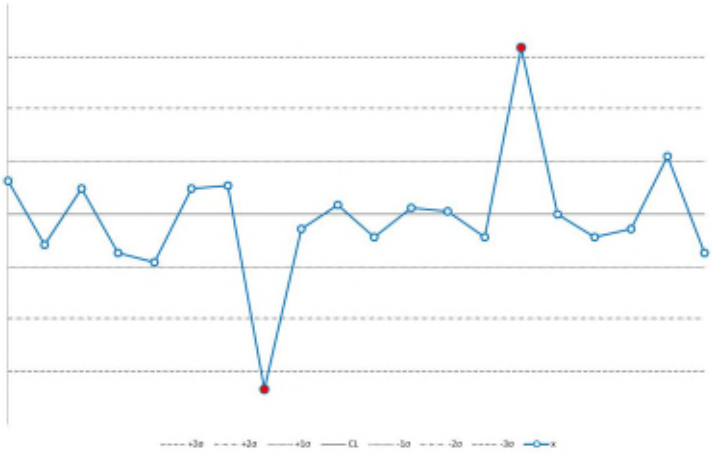
The performance against the vacancy rate standard in recent months was as follows:

Dec	Feb	Mar	Apr	May	Jun	Jul
Vacancy rate	6.8%	6.3%	6.6%	6.7%	6.6%	7.1%

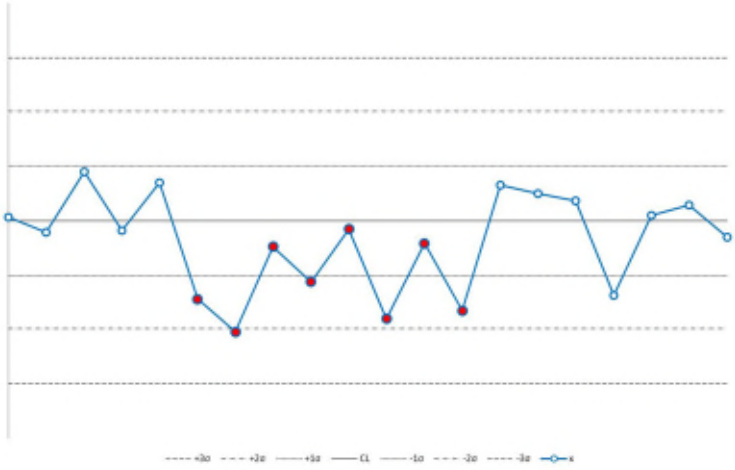
Appendix 1 - Procedure for Interpreting Run Charts

Special Cause Variation Rules

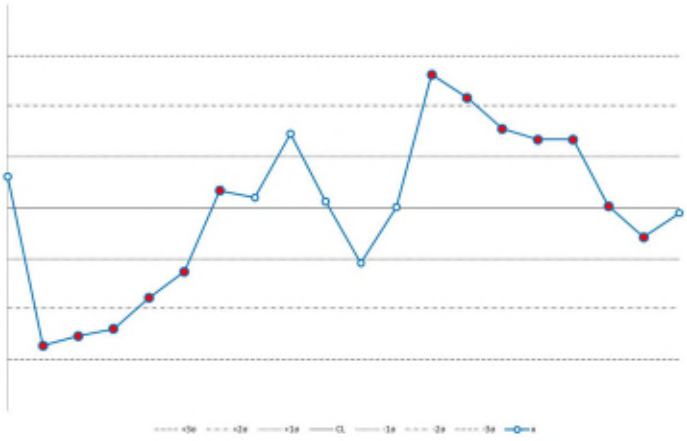
1. A single point outside the control limits



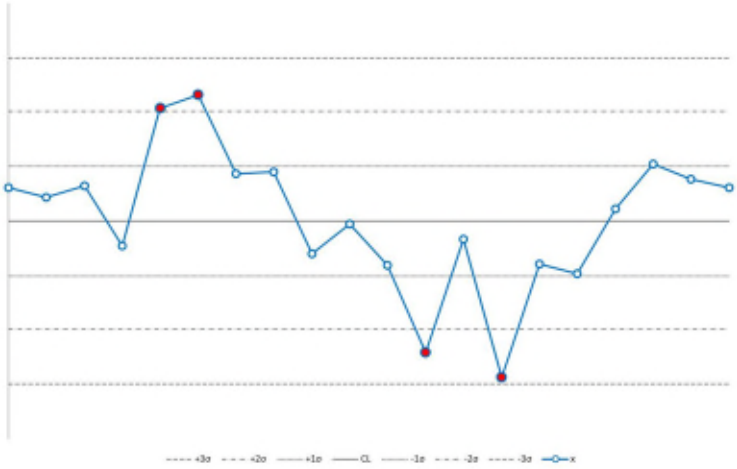
2. A run of eight or more points in a row above (or below) the centreline



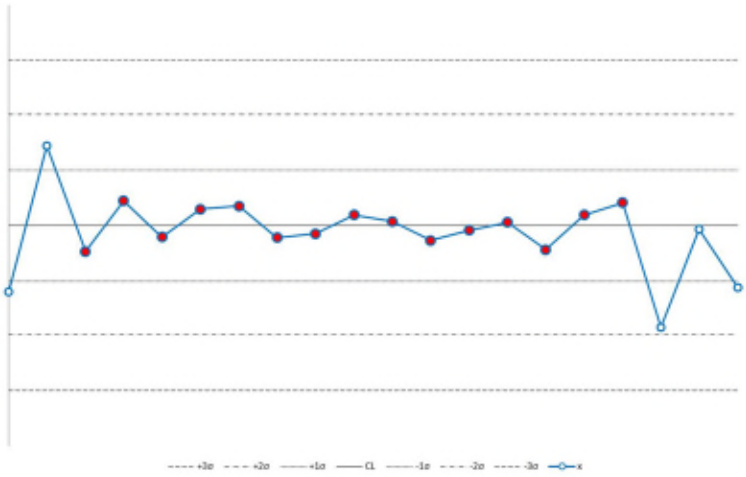
3. Six consecutive points increasing (trend up) or decreasing (trend down)



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



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



APPENDIX 2

OUR CARE QUALITY COMMISSION RATINGS

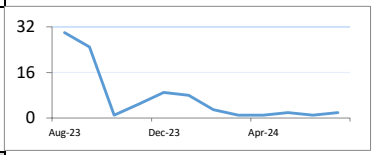
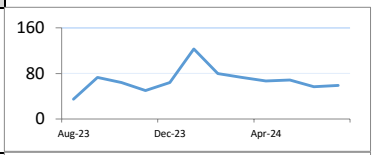
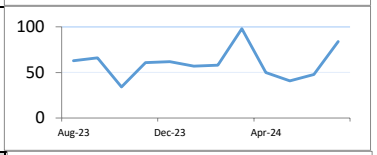
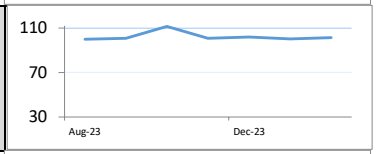
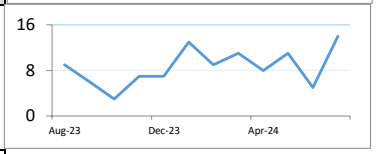
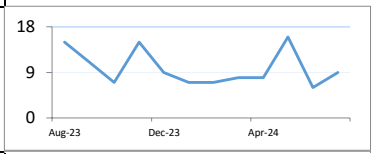
Our current Care Quality Commission ratings are as follows:

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

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

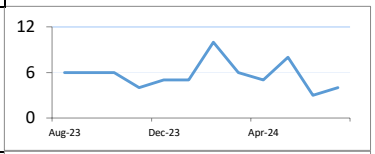
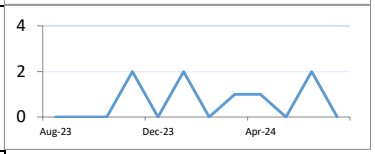
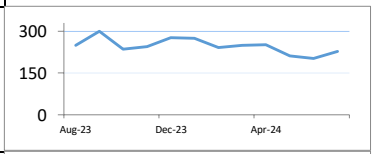
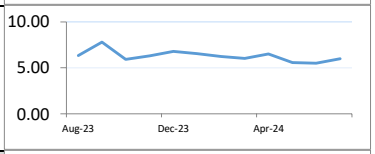
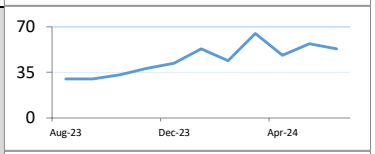
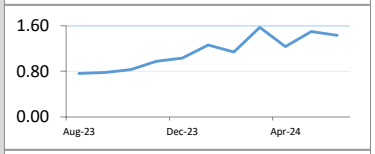
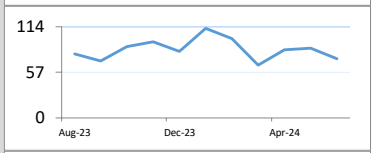
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2024/25

Area	Ref	Measure		Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	
Admissions	1	Average daily number of medical and surgical outliers in acute wards during the month	MPH	30	25	1	5	9	8	3	1	1	2	1	2	
	2		YDH	Reporting criteria to be changed to be same as MPH reported numbers												
	3	Number of patients transferred between acute wards after 10pm	MPH	35	73	64	50	64	123	80	73	67	69	57	59	
	4		YDH	63	66	34	61	62	57	58	98	50	41	48	84	
Mortality (acute services)	5	Summary Hospital-level Mortality Indicator (SHMI)		100.07	100.92	111.63	100.86	101.93	100.31	101.42	Data not yet due - March 2024 to be reported after July 2024					
Infection Control	6	Clostridium Difficile cases HOHA cases (Hospital Onset Hospital Acquired) and COHA cases (Community Onset Hospital Acquired)		9	6	3	7	7	13	9	11	8	11	5	14	
	7	MRSA bacteraemias (post)		1	0	0	0	0	1	0	0	0	1	0	0	
	8	E. coli bacteraemia		15	11	7	15	9	7	7	8	8	16	6	9	

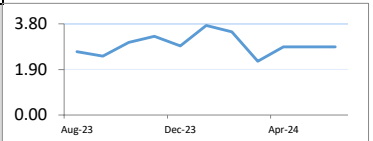
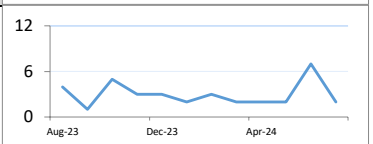
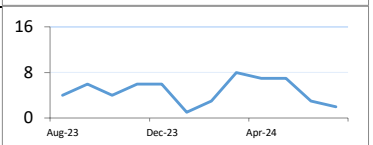
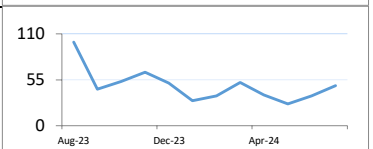
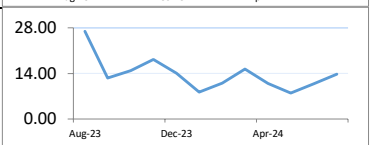
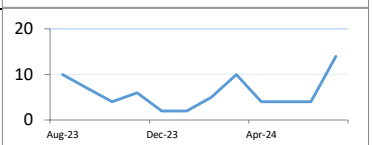
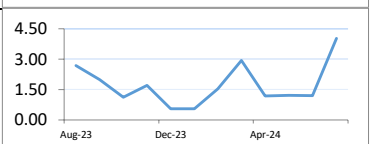
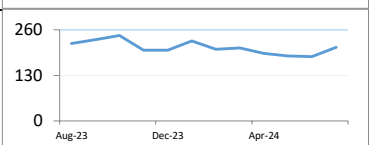
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2024/25

Area	Ref	Measure	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	
	9	Methicillin-sensitive staphylococcus aureus	6	6	6	4	5	5	10	6	5	8	3	4	
Maternity	10	No. of still births	0	0	0	2	0	2	0	1	1	0	2	0	
	11	No. of babies born in unexpectedly poor condition	0	0	0	0	0	0	0	0	0	0	0	0	
Falls	12	Total number of patient falls	249	300	236	245	277	275	241	249	252	211	203	227	
	13	Rate of falls per 1,000 occupied bed days - all services	6.35	7.79	5.93	6.31	6.80	6.56	6.25	6.04	6.49	5.56	5.51	5.97	
Pressure ulcer damage	14	Inpatient wards - number of incidents	30	30	33	38	42	53	44	65	48	57	53	Data not yet due	
	15	Rate of pressure ulcer damage per 1,000 inpatient ward occupied bed days	0.76	0.78	0.83	0.98	1.03	1.26	1.14	1.58	1.24	1.50	1.43		
	16	District nursing - number of incidents	80	71	89	95	83	112	99	66	85	87	74		

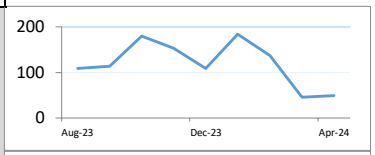
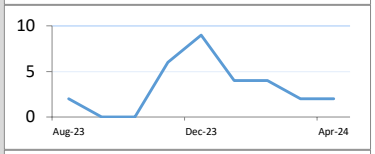
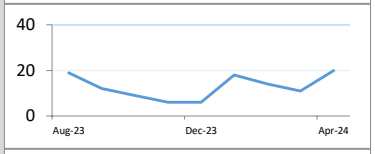
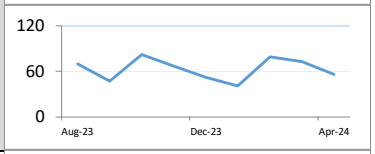
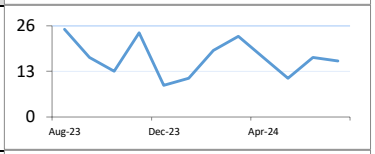
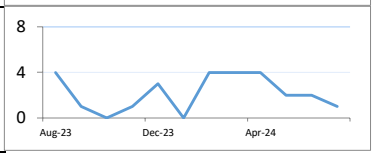
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2024/25

Area	Ref	Measure		Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	
Pressure ulcer damage	17	Rate of pressure ulcer damage per 1,000 district nursing contacts		2.65	2.46	3.03	3.29	2.89	3.73	3.48	2.24	2.85	2.85	2.85		
Cardiac Arrests	18	No. ward-based cardiac arrests - acute wards	MPH	4	1	5	3	3	2	3	2	2	2	7	2	
Cardiac Arrests	19	No. ward-based cardiac arrests - acute wards	YDH	4	6	4	6	6	1	3	8	7	7	3	2	
Restraints (mental health wards)	20	Total number of incidents	Mental Health Wards	100	44	53	64	51	30	36	52	37	26	36	48	
	21	Restraints per 1,000 occupied bed days	Mental Health Wards	26.94	12.57	14.84	18.31	14.11	8.32	11.08	15.32	10.97	7.94	10.85	13.81	
	22	Number of prone restraints	Mental Health Wards	10	7	4	6	2	2	5	10	4	4	4	14	
	23	Prone restraints per 1,000 occupied bed days	Mental Health Wards	2.69	2.00	1.12	1.72	0.55	0.55	1.54	2.95	1.19	1.22	1.21	4.03	
Medication incidents	24	Total number of medication incidents		221	232	244	202	202	228	205	208	193	185	184	210	

SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2024/25

Area	Ref	Measure		Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	
Ligatures and ligature points	25	Ligatures: Total number of incidents	Mental Health Wards	109	114	180	153	109	184	137	46	49	Changes being implemented due to the introduction of Learning From Patient Safety Events (LFPSE)			
Ligatures and ligature points	26	Number of ligature point incidents	Mental Health Wards	2	0	0	6	9	4	4	2	2				
Violence and Aggression	27	Violence and Aggression: Number of incidents patient on patient (inpatients only)	MPH, Community Hospitals and Mental Health wards	19	12	9	6	6	18	14	11	20				
Violence and Aggression	28	Violence and Aggression: Number of incidents patient on staff	MPH, Community Hospitals and Mental Health wards	70	47	82	67	52	41	79	73	56	Changes being implemented due to the introduction of Learning From Patient Safety Events (LFPSE)			
Seclusion	29	Number of Type 1 -Traditional Seclusion	Mental Health Wards	25	17	13	24	9	11	19	23	17	11	17	16	
Seclusion	30	Number of Type 2 -Short term Segregation	Mental Health Wards	4	1	0	1	3	0	4	4	4	2	2	1	

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Thresholds
1	Accident and Emergency / Urgent Treatment Centre 4-hour performance	Accident & Emergency department (ED) - MPH	2	51.0%	48.0%	51.4%	55.5%	54.0%	52.0%	53.1%	61.9%	59.2%	58.4%	55.2%	56.0%	From April 2024 >=76%= Green >=66% - <76% =Amber <66% =Red (the standard will rise to 78% in March 2025)
2		Accident & Emergency department (ED) - YDH		73.3%	67.3%	66.6%	62.8%	62.6%	61.4%	67.3%	69.5%	67.5%	68.0%	62.1%	64.1%	
3		Accident & Emergency department (ED) - Combined		60.6%	56.4%	58.1%	58.7%	57.8%	56.1%	59.2%	65.2%	62.7%	62.5%	58.2%	59.4%	
4		Urgent Treatment Centres (formerly Minor Injury Units)		97.5%	95.1%	96.9%	97.4%	96.3%	96.0%	95.1%	97.9%	98.9%	97.3%	98.1%	98.3%	
5		Trust-wide		76.0%	72.5%	74.1%	74.3%	73.3%	72.5%	74.2%	79.6%	78.3%	77.7%	75.7%	76.2%	
6	Accident and Emergency / Urgent Treatment Centres: percentage of patients spending more than 12-hours in the department	Accident and Emergency department (ED) - MPH	2	2.9%	4.7%	2.4%	1.7%	4.8%	6.2%	3.3%	2.4%	1.1%	1.4%	1.3%	2.1%	<=2%= Green >2% - <=5% =Amber >5% =Red
7		Accident and Emergency department (ED) - YDH		1.6%	3.2%	3.3%	4.1%	5.9%	7.6%	3.6%	5.1%	4.7%	2.3%	3.3%	5.9%	
8		Urgent Treatment Centres (formerly Minor Injury Units)		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
9	Ambulance handovers waiting less than 30 minutes: MPH		2	70.5%	63.1%	68.6%	73.8%	64.1%	61.9%	71.8%	77.8%	83.0%	75.8%	76.6%	75.5%	>=95%= Green >=85% - <95% =Amber <85% =Red
10	Ambulance handovers waiting less than 30 minutes: YDH			88.0%	80.8%	75.8%	69.0%	69.7%	65.6%	68.6%	66.3%	64.0%	76.1%	66.0%	59.8%	
11	Cancer - 28 days Faster Diagnosis All Cancers		1,2	78.8%	76.0%	77.0%	76.9%	76.6%	70.8%	84.7%	84.1%	78.6%	80.6%	75.0%	Data not yet due	>=75%= Green <75% =Red (the standard will rise to 77% in March 2025)
12	31 day wait - from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment			90.9%	92.9%	91.3%	93.7%	94.0%	89.5%	92.4%	94.7%	91.2%	91.9%	91.2%	Data not yet due	>=96%= Green <96% =Red
13	Cancer - 62 day wait - from an Urgent Suspected Cancer or Breast Symptomatic Referral, or Urgent Screening Referral, or Consultant Upgrade to a First Definitive Treatment			71.7%	71.3%	68.8%	67.1%	67.4%	64.9%	68.3%	74.5%	71.5%	64.2%	68.0%	Data not yet due	>=85%= Green From April 2024 at or above trajectory =Amber and below trajectory =Red
14	Cancer: 62-day wait from referral to treatment for urgent referrals – number of patients treated on or after day 104			22	28	22.5	23	23	19	22	29	21	20	23	Data not yet due	0= Green >0 = Red
15	CAMHS Eating Disorders - Urgent referrals to be seen within 1 week - (rolling 3 months)		1,2,5	100.0%	-	-	-	-	-	-	-	100.0%	100.0%	100.0%	100.0%	>=95%= Green >=85% - <95% =Amber <85% =Red
16	CAMHS Eating Disorders - Routine referrals to be seen within 4 weeks - (rolling 3 months)		1,2,5	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.9%	96.9%	97.1%	97.3%	97.1%	96.6%	>=95%= Green >=85% - <95% =Amber <85% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Thresholds
17	Mental health referrals offered first appointments within 6 weeks	All mental health services	1,2,3	92.8%	92.5%	90.0%	93.9%	93.6%	94.2%	96.8%	92.8%	93.0%	95.7%	95.7%	96.2%	>=90%= Green >=80% - <90% =Amber <80% =Red
18	Mental health referrals offered first appointments within 6 weeks	Adult mental health services		90.4%	93.7%	91.6%	92.2%	93.9%	93.5%	96.1%	92.2%	92.1%	94.7%	92.5%	94.9%	>=90%= Green >=80% - <90% =Amber <80% =Red
19		Older Persons mental health services		94.0%	89.0%	87.5%	95.3%	93.0%	93.7%	96.0%	90.3%	93.8%	97.0%	100.0%	100.0%	
20		Learning disabilities service		100.0%	100.0%	100.0%	80.0%	87.5%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	100.0%	
21		Children and young people's mental health services		96.9%	100.0%	92.0%	96.6%	94.7%	96.1%	100.0%	100.0%	95.0%	95.4%	95.3%	98.5%	
22	Percentage of women accessing specialist community Perinatal MH service - 12 month rolling reporting		1,2	10.5%	11.0%	11.1%	11.7%	11.6%	12.2%	12.4%	12.6%	12.9%	13.0%	13.1%	13.3%	>=10%= Green >=7.5% - <10% =Amber <7.5% =Red
23	Diagnostic 6-week wait - acute services	MPH	1,2	84.8%	84.6%	84.7%	85.4%	83.1%	84.1%	84.8%	83.9%	86.0%	85.7%	84.0%	78.9%	From March 2024 At or above trajectory = Green Below trajectory = Red
24		YDH		61.2%	55.0%	59.6%	63.6%	61.3%	59.0%	67.8%	63.8%	59.4%	72.7%	69.2%	67.3%	
25		Combined		76.9%	74.4%	76.2%	77.6%	74.3%	74.1%	78.2%	76.0%	79.4%	80.4%	78.3%	74.8%	
26	RTT incomplete pathway performance: percentage of people waiting under 18 weeks		1,2,4	61.8%	61.6%	62.9%	63.4%	61.7%	62.6%	63.4%	62.5%	64.6%	66.3%	65.6%	65.1%	>=92%= Green <92% =Red
27	52 week RTT breaches - Patients of all ages			2,419	2,504	2,547	2,577	2,519	2,252	2,158	2,270	1,969	1,871	1,873	1,842	From April 2023 At or below trajectory = Green Above trajectory = Red
28	52 week RTT breaches - Patients aged 18 or under			New reporting - to commence from May 2024									185	168	165	
29	65 week RTT breaches - Patients of all ages			724	741	687	661	725	605	538	434	463	484	493	426	
30	Referral to Treatment (RTT) incomplete pathway waiting list size			54,986	55,532	54,777	53,406	53,667	53,787	53,800	53,524	54,625	55,014	56,599	57,442	

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Thresholds
31	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	2,7	6.0	6.4	6.5	6.1	6.1	6.4	6.4	6.0	5.9	6.0	5.9	5.9	Monitored using Special Cause Variation Rules. Report by exception.
32		YDH		6.8	7.0	6.8	6.9	7.5	7.7	6.9	7.1	7.0	6.7	6.3	5.5	
33	Patients not meeting the criteria to reside: % of occupied bed days lost	MPH	2,7	16.5%	20.3%	18.1%	17.1%	15.9%	18.4%	20.5%	21.0%	18.9%	19.2%	19.4%	23.2%	<=9.8%= Green >15% =Red
34		YDH		23.7%	23.4%	22.1%	21.0%	24.6%	22.8%	24.7%	21.4%	20.8%	21.4%	22.2%	18.3%	
35	Acute bed days lost due to patients not meeting the criteria to reside	MPH	2,7	2,942	3,432	3,134	2,819	2,807	3,435	3,516	3,805	3,215	3,267	3,230	3,939	TBC
36		YDH		2,565	2,569	2,519	2,394	2,844	2,691	2,660	2,487	2,283	2,307	2,260	1,969	
37	Community service waiting times: number of people waiting over 18 weeks from referral to first appointment (excluding dental)		1,2,3	1,787	1,662	1,531	1,494	1,173	1,164	1,107	1,399	1,590	1,712	1,870	1,944	From April 2024 <1,399 = Green >=1,399 = Red
38	Community service waiting times: number of people waiting over 52 weeks from referral to first appointment (excluding dental)			311	249	237	245	223	232	229	264	257	259	280	277	From April 2024 <264 = Green >=264 = Red
39	Community dental services - General, Dominciliary or Minor Oral surgery waiting 18 weeks or more		1,2,3	2,181	2,169	2,120	2,193	2,285	2,478	2,345	2,388	2,301	2,374	2,428	2,452	From April 2024 <1,979 = Green >=1,979 = Red
40	Community dental services - General, Dominciliary or Minor Oral surgery waiting 52 weeks or more			551	539	476	491	541	584	575	574	531	584	620	600	From April 2024 <574 = Green >=574 = Red
41	Community dental services - Child GA waiters waiting 18 weeks or more		1,2,3	557	565	554	581	587	515	520	530	518	545	529	529	From April 2023 <463 = Green >=463 = Red
42	Early Intervention In Psychosis: people to begin treatment with a NICE-recommended care package within 2 weeks of referral (rolling three month rate)		1,2,3	83.3%	82.4%	84.6%	85.7%	82.4%	89.5%	93.3%	87.5%	86.7%	73.7%	77.8%	70.6%	>=60%= Green <60% =Red
43	Talking Therapies RTT : percentage of people waiting under 6 weeks		1,2,3	74.6%	72.5%	77.7%	77.8%	82.9%	81.1%	78.4%	83.0%	84.3%	84.0%	85.4%	82.5%	>=75%= Green <75% =Red
44	Talking Therapies RTT: percentage of people waiting under 18 weeks		1,2,3	99.0%	99.5%	98.9%	99.6%	98.5%	99.4%	99.2%	98.9%	99.0%	98.9%	98.7%	98.4%	>=95%= Green <95% =Red
45	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) Recovery Rates		1,2,3	60.3%	55.6%	58.1%	59.2%	59.8%	57.5%	60.7%	56.6%	58.3%	60.2%	59.4%	59.0%	>=50%= Green <50% =Red
46	Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Improvement		1,2,3	79.6%	76.2%	76.7%	80.6%	74.0%	74.7%	74.1%	75.9%	69.2%	78.9%	72.0%	74.5%	>=67%= Green <67% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Thresholds
47	Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Recovery		1,2,3	57.0%	53.6%	55.8%	57.2%	54.7%	55.5%	57.0%	54.8%	54.5%	58.0%	55.8%	55.5%	>=48%= Green <48% =Red
48	Adult mental health inpatients receiving a follow up within 72 hrs of discharge		1,2	96.2%	96.9%	100.0%	97.0%	100.0%	100.0%	100.0%	92.9%	97.6%	90.9%	90.5%	100.0%	>=80%= Green <80% =Red
49	Inappropriate Out of Area Placements for non-specialist mental health inpatient care. Number of 'active' out of area placements at the month-end		1,2	0	0	0	1	1	2	1	1	2	1	3	3	1= Green >1 = Red
50	Intermediate Care - Patients aged 65+ discharged home from acute hospital beds on pathway 0 or 1		1,2,3	95.7%	93.8%	93.3%	93.3%	93.3%	94.6%	96.1%	93.3%	95.1%	94.1%	94.3%	94.7%	>=95%= Green >=85% - <95% =Amber <85% =Red
51	Urgent Community Response: percentage of patients seen within two hours		1,2,3	92.3%	94.4%	93.8%	95.9%	90.9%	91.1%	91.6%	95.9%	90.5%	87.8%	87.5%	Data not yet due	>=70%= Green >=60% - <70% =Amber <60% =Red
52	% Stroke Patients direct admission to stroke ward in 4 hours	MPH	1,2,5	54.6%	55.9%	51.4%	64.7%	58.1%	52.8%	47.5%	56.4%	Reporting being reviewed - meeting to be held on 6 Setpember 2024 to review and agree timescale to implement changes required.				>=90%= Green >=75% - <90% =Amber <75% =Red
53		YDH		33.3%	23.3%	42.5%	24.2%	29.4%	35.9%	48.5%	37.9%					
54	Patients spending >90% of time in stroke unit - acute services	MPH	1,2,5	68.9%	68.4%	78.4%	82.9%	76.5%	83.8%	50.0%	72.9%	65.8%	91.2%	72.7%	Data not yet due	>=80%= Green >=70% - <80% =Amber <70% =Red
55		YDH		71.7%	56.7%	52.5%	54.5%	52.9%	61.0%	60.6%	65.5%	50.0%	54.5%	67.7%	Data not yet due	
56	Percentage of patients with a National Early Warning Score (NEWS) of 5 or more acted upon appropriately - The registered nurse should immediately inform the medical team caring for the patient	MPH, YDH, Community Hospitals and Mental Health wards	1,2,5	Reporting change from 1 January 2024 to include both acute sites and community and mental health wards						76.0%		72.5%		75.6%		>=90%= Green >=80% - <90% =Amber <80% =Red
57	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services	MPH	1,2,5	Testing of a reporting solution using electronic forms has been completed by the Trust's Digital Team. Reporting via this system is to commence by June 2024.					78.8%	77.8%	95.3%	94.4%	91.9%	83.3%	Data being validated	
58	Percentage of emergency patients screened for sepsis - Emergency Departments			Reporting solution developed and after training rolled out with reporting commencing from January 2024.					97.8%	100.0%	96.6%	85.7%	96.2%	90.9%	77.8%	
59	National paediatric early warning system (PEWS)	MPH	1,2,5	Reporting to commence from January 2024					66.7%	80.0%	100.0%	64.3%	87.5%	Data being validated	Data not yet due	
60	Mandatory training: percentage completed	Combined	6	92.1%	92.1%	91.9%	91.4%	92.1%	91.9%	92.1%	92.2%	92.8%	92.8%	93.1%	93.3%	All courses >=90%= Green Overall rate <80% =Red Any other position = Amber
61	Proportion of days lost due to sickness		6	4.8%	5.0%	5.3%	5.1%	5.2%	5.5%	5.5%	5.1%	5.0%	4.8%	4.8%	5.2%	SPC (Upper Control Limit 5.6%)

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Thresholds
62	Sickness absence levels - rolling 12 month average (Trust-wide)		6	4.9%	5.0%	5.0%	5.0%	4.9%	4.9%	5.3%	5.3%	5.2%	5.2%	5.2%	5.2%	SPC (Upper Control Limit 6.3%)
63	Career conversations (12 months) - formerly 'Performance review (12-month)'		6	65.9%	65.9%	66.0%	66.6%	67.3%	69.1%	71.9%	71.5%	73.8%	77.4%	78.2%	78.9%	>=90%= Green >=80% - <90% =Amber <80% =Red
64	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)		6	6.0%	7.4%	6.8%	6.8%	6.9%	6.5%	6.8%	6.3%	6.6%	6.7%	6.6%	7.1%	<=5%= Green >5% to <=7.5% =Amber >7.5% =Red
65	Retention rate – rolling 12 months percentage of colleagues in post		6	88.5%	88.7%	89.0%	89.0%	89.2%	88.9%	89.0%	89.2%	89.1%	89.0%	89.2%	89.0%	>=88.3%= Green >=80% to <88.3% =Amber <80% =Red
66	Percentage of colleagues in a senior role (band 8a and above and consultant roles):	Who are of an ethnic minority	4,6	20.3%		20.9%			21.6%			21.8%			Quarterly reporting	>=Trajectory = Green <=10% below trajectory = Amber >10% below trajectory = Red
67		Who are female	4,6	58.4%		58.7%			58.1%			58.3%			Quarterly reporting	
68		With a recorded disability	4,6	2.8%		3.1%			3.0%			3.0%			Quarterly reporting	
68	Number of formal HR case works (disciplinary, grievance and capability).		6	Reporting in respect of this new		31	23	23	38	38	38	33	38	62	62	TBC

Appendix 5a – Specialty and tumour-site level performance

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

RTT specialty	Over 18-week waiters	Over 52-week waiters	Incomplete pathways	Incomplete pathways performance
General Medicine	1		18	94.44%
Dermatology	503	10	3235	84.45%
Cardiology	687	6	3,765	81.75%
Geriatric Medicine	161	3	642	74.92%
Other - Paediatric Services	411	7	1,554	73.55%
General Surgery	642	52	2321	72.34%
Other – Medical Services	768	25	2,745	72.02%
Other – Other Services	305	14	1058	71.17%
Plastic Surgery	60	2	201	70.15%
Cardiothoracic Surgery	11		34	67.65%
Gynaecology	1,343	84	3,947	65.97%
Thoracic Medicine	811	8	2,297	64.69%
Rheumatology	329	8	931	64.66%
Oral Surgery	852	50	2,371	64.07%
Ophthalmology	1948	63	5,149	62.17%
Other - Surgical Services	2,254	343	5,905	61.83%
Gastroenterology	1021	72	2630	61.18%
Trauma & Orthopaedics	3246	567	7972	59.28%
Neurology	878	38	2,106	58.31%
Urology	1,406	216	3,204	56.12%
Ear, Nose & Throat (ENT)	2,386	274	5,357	55.46%
Total	**20,023**	**1,842**	**57,442**	**65.14%**

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

Tumour site	No of breaches	Trust performance
Breast	7.0	75.0%
Colorectal	10.0	44.4%
Gynaecology	4.5	71.0%
Haematology	4.0	63.6%
Head & Neck	2.0	63.6%
Lung	8.0	50.0%
Other	1.0	50.0%
Skin	10.0	77.8%
Upper GI	8.0	65.2%
Urology	12.0	72.7%
Total	**66.5**	**68.0%**

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

- Fourteen patient pathways had internal delays, which in some cases resulted in a late transfer to the treating provider. But these pathways also had unavoidable delays, due to additional investigations, medical complexity, waiting times at other organisations and periods of patient choice.
- Three patients chose to delay their investigations for a significant period of time.
- Three pathways were impacted by outpatient capacity issues.
- Three patients had a complex pathway, including patients requiring additional or repeat diagnostics, transferring from a different cancer pathway and being treated at the same time for another cancer.

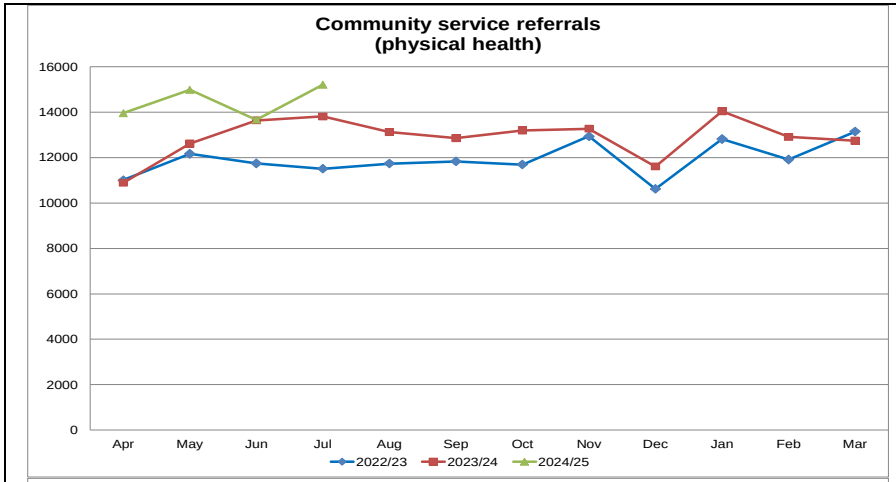
Appendix 2 – RTT validation progress

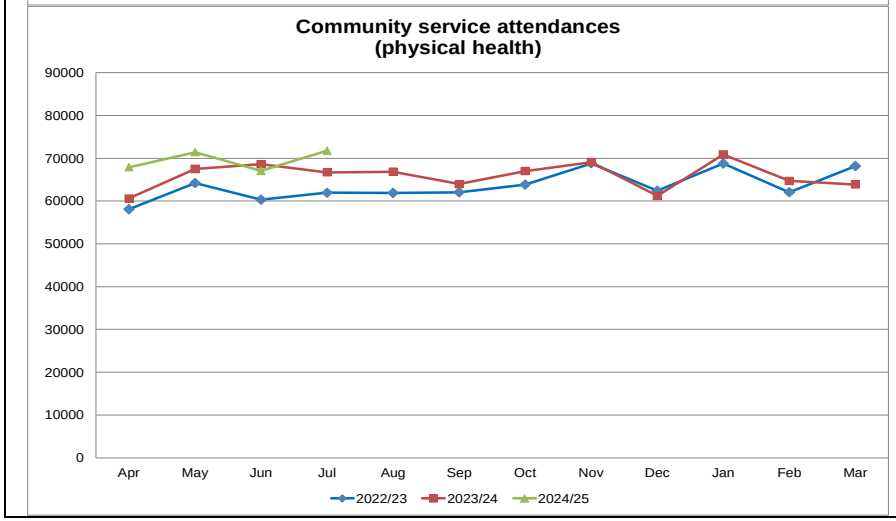
The national target is to reach a level of 90% validation of patients waiting 12 weeks and over from Referral to Treatment (RTT) by the 31 of October 2023. Validation includes both the administrative/technical validation and also contacting the patient to confirm they still wish to be seen.

RTT waiting times bands	Week ending 17th Dec	Week ending 14th Jan	Week ending 4th Feb	Week ending 10th Mar	Week ending 14th Apr	Week ending 12th May	Week ending 9th Jun	Week ending 14th Jul	Week ending 11th Aug
12 weeks and over	69%	70%	69%	74%	77%	75%	76%	69%	67%
26 weeks and over	76%	73%	72%	77%	77%	77%	76%	77%	76%
52 weeks and over	89%	89%	87%	93%	93%	97%	99%	99%	95%

Operational context

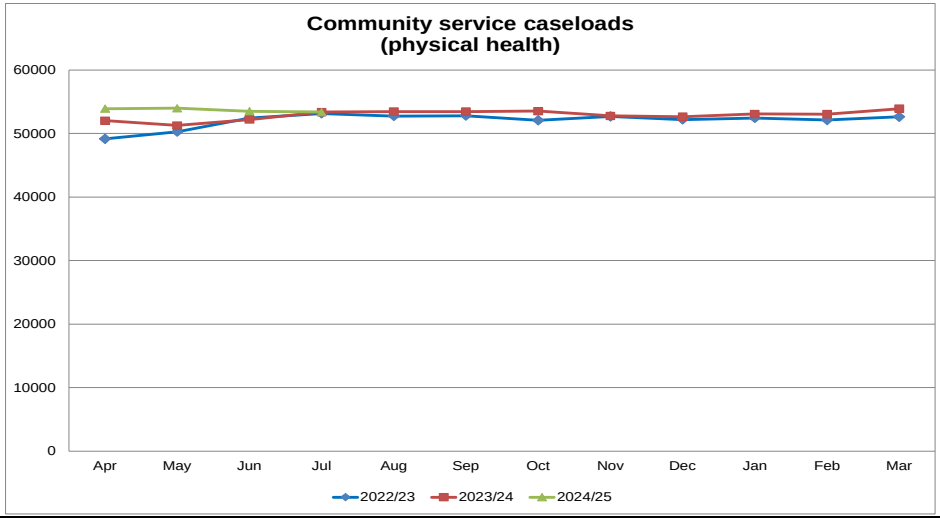
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





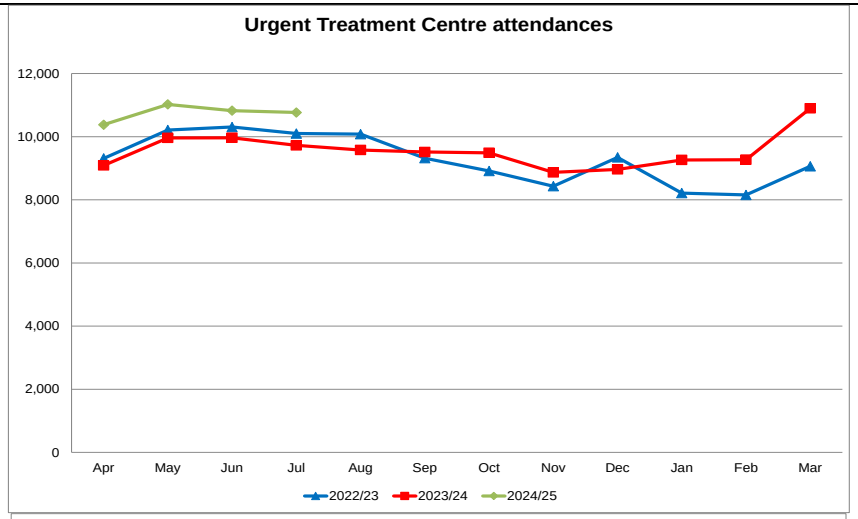
Summary:

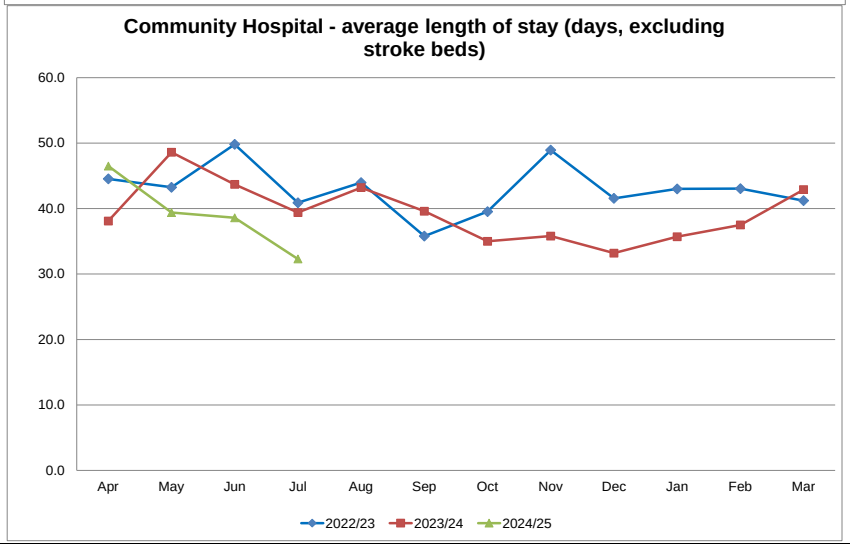
- Direct referrals to our community physical health services between 1 April and 31 July 2024 were 13.5% higher than the same months of 2023 and 24.6% higher than the same months of 2022. Services with the highest increases include Rapid Response, Musculoskeletal Interface and District Nursing.
- Attendances for the same reporting period were 5.6% higher than the same months of 2023 and 13.7% higher than the months of 2022.
- Community service caseload levels as at 31 July 2024 were the same level as at 31 July 2023, and 0.4% above 31 July 2022 levels.



Operational context

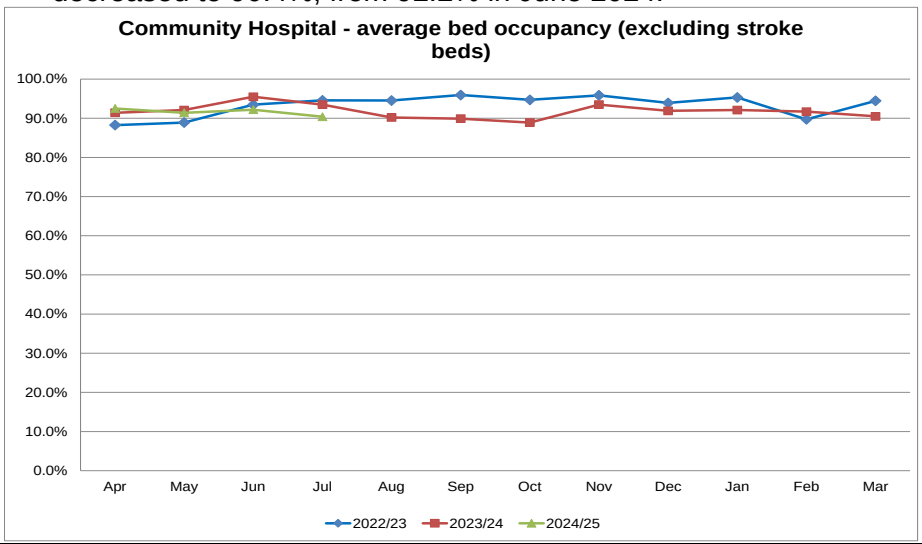
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





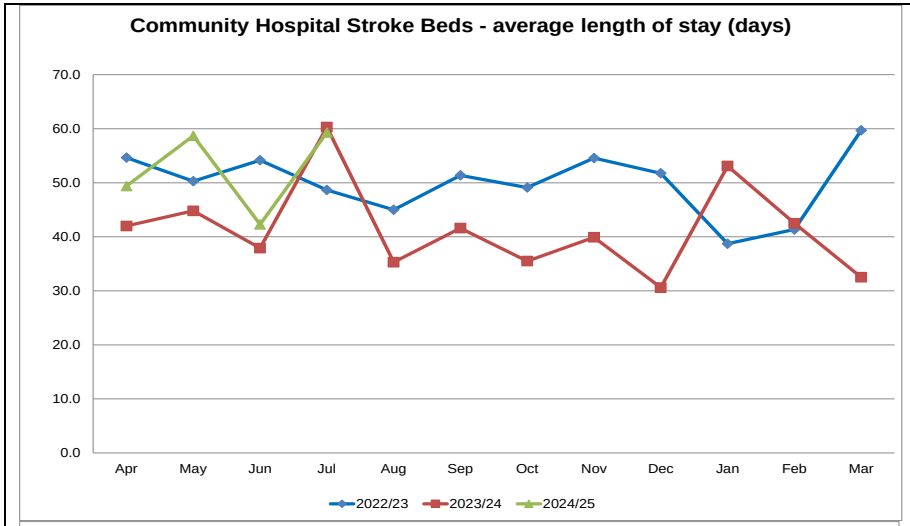
Summary:

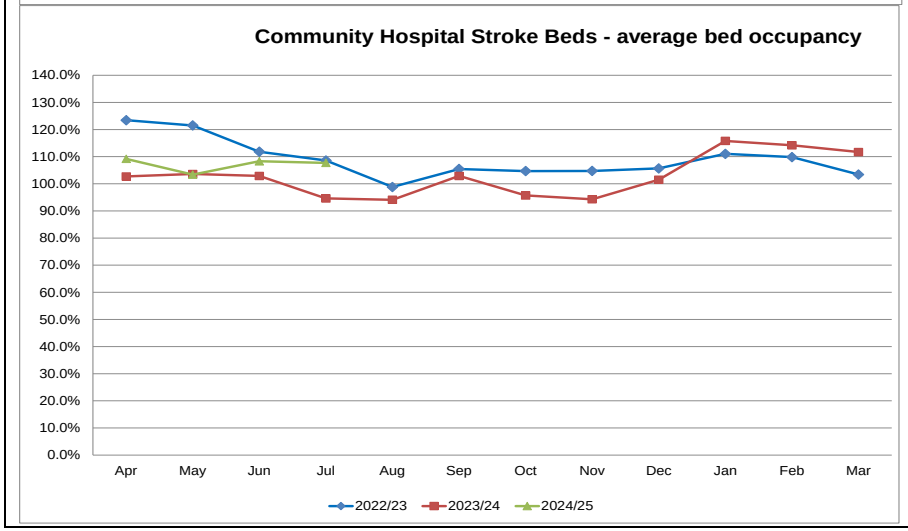
- Between 1 April and 31 July 2024, the number of Urgent Treatment Centre (formerly Minor Injury Unit) attendances was 11.0% higher than the same months of 2023, and 7.7% higher than the same months of 2022. During July 2024, 98.3% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 78%, to be achieved by March 2025.
- The average length of stay for non-stroke patients in our community hospitals in July 2024 was 32.3 days, a decrease compared to June 2024. Two patients were discharged with lengths of stay longer than 100 days; the longest was 217 days for a patient at West Mendip community hospital. The community hospital bed occupancy rate for non-stroke patients in July 2024 decreased to 90.4%, from 92.2% in June 2024.



Operational context

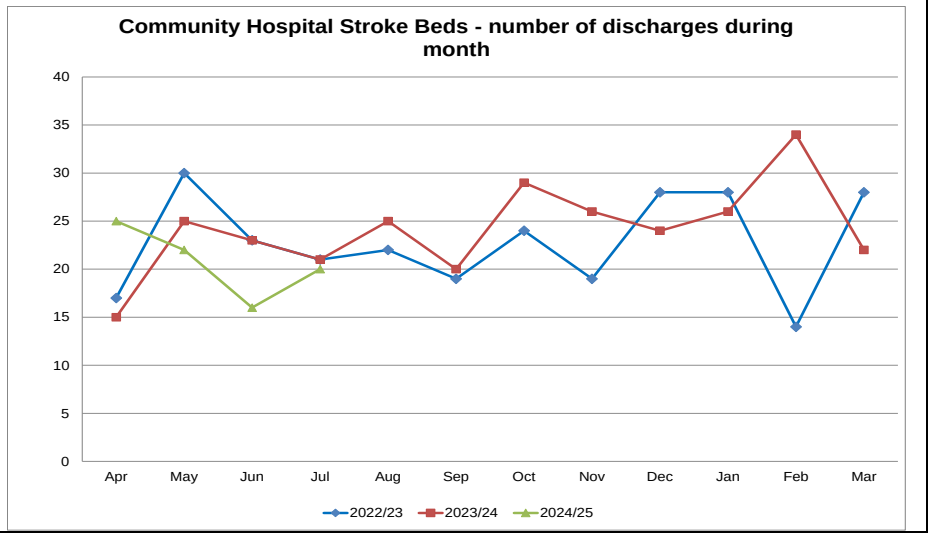
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





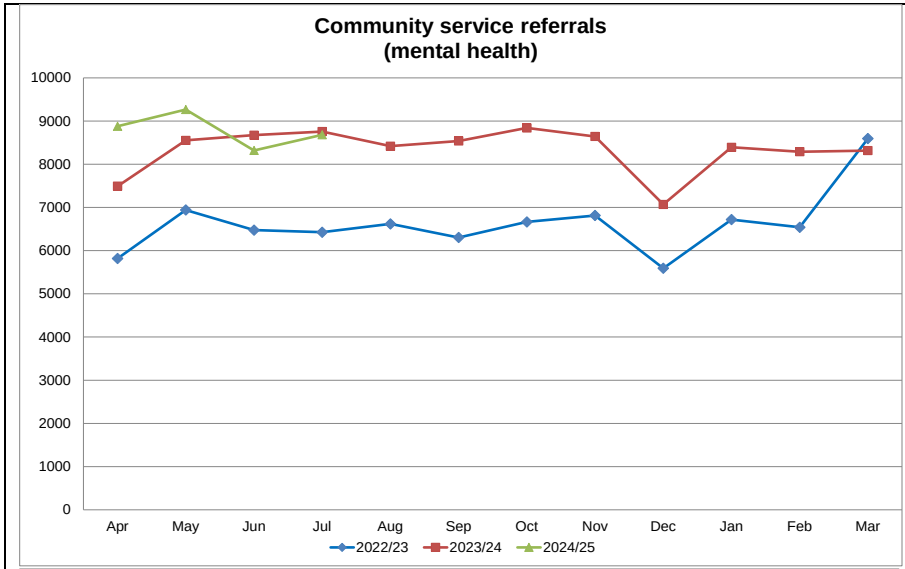
Summary:

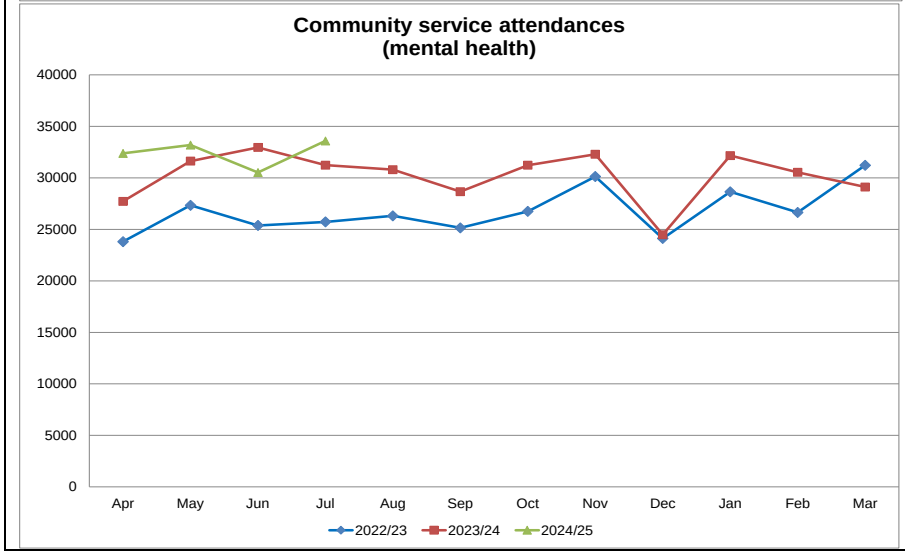
- The average length of stay for stroke patients in our community hospitals in July 2024 increased to 59.3 days, from 42.3 days in July 2024. Three patients discharged during July 2024 had a length of stay exceeding 100 days; the longest was 130 days for a patient at South Petherton community hospital
- Stroke bed occupancy in July 2024 decreased compared to June 2024.
- During July 2024 there were 20 discharges of stroke patients, up from 16 discharged during June 2024.



Operational context

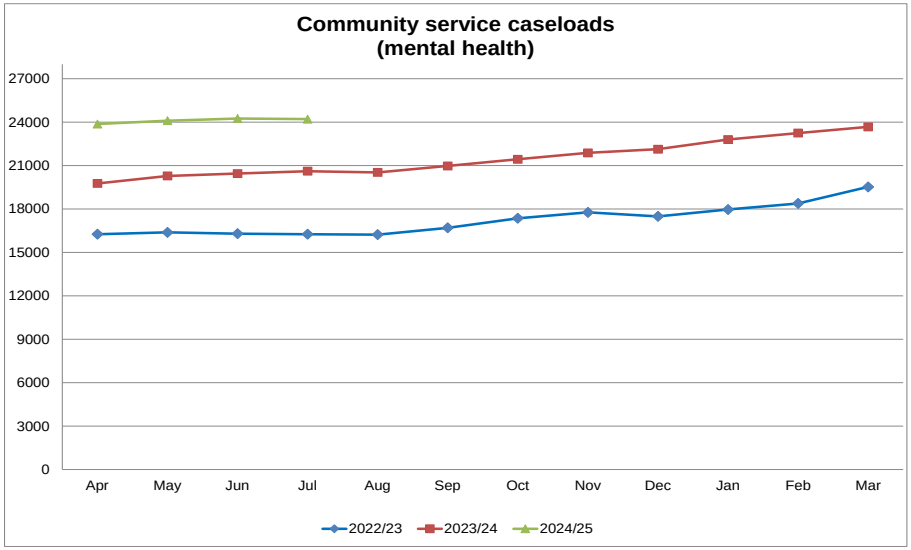
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





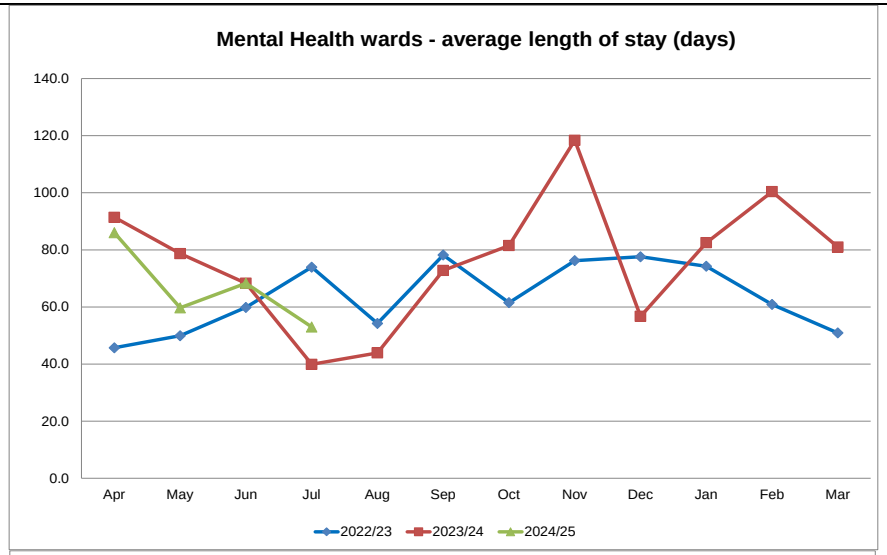
Summary:

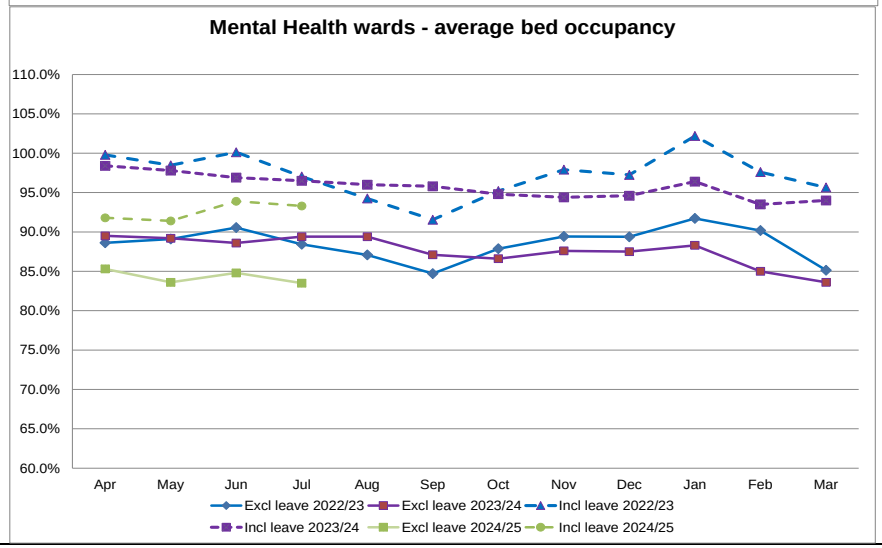
- Direct referrals to our community mental health services between 1 April and 31 July 2024 were 5.0% higher than the same months of 2023 and 37.0% higher than the same months of 2022.
- Attendances for the reporting period were 5.0% higher than the same months of 2023 and 26.8% higher than the months of 2022. 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 2024 increased by 17.5% when compared to 31 July 2023 and were 48.9% higher than as at 31 July 2022. It should be noted that investment has facilitated the expansion of some community mental health services.



Assurance and Leading Indicators

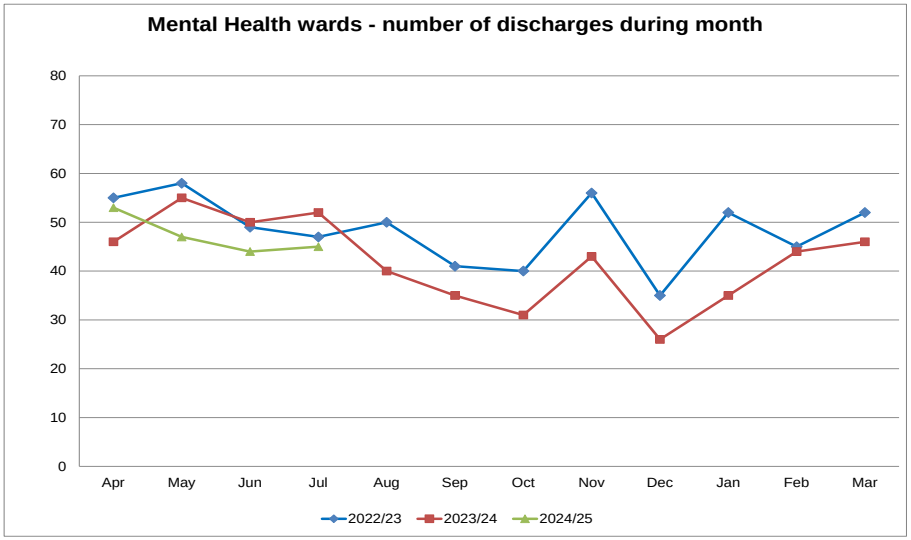
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





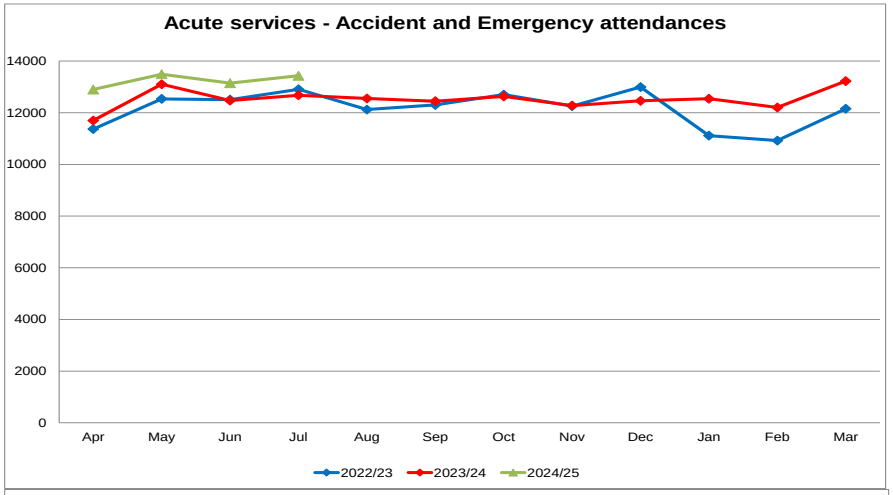
Summary:

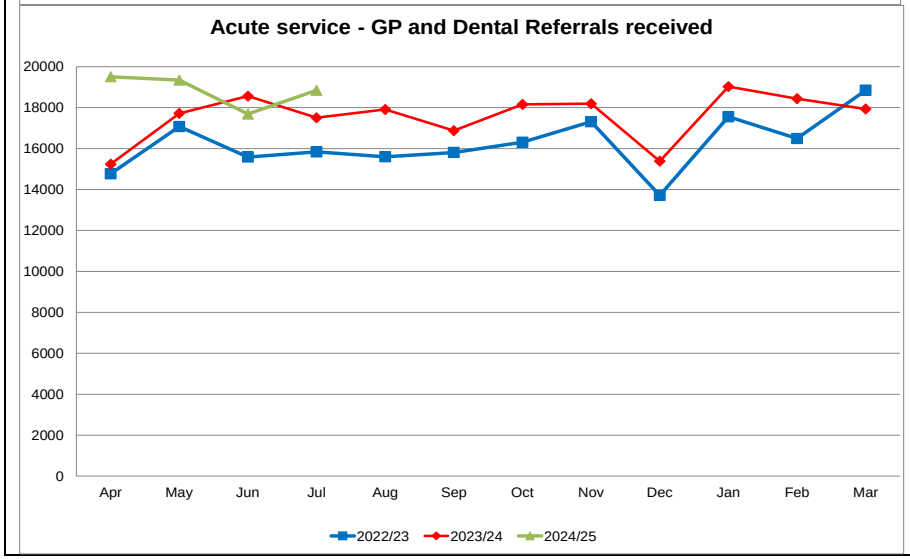
- The average length of stay in our mental health wards in July 2024 decreased compared to June 2024. During July 2024, eight patients were discharged with lengths of stay of 100 days or more, including one patient discharged from Rydon Ward One, one of our adult wards, who had a length of stay of 217 days.
- The mental health bed occupancy rates, on the basis of including and excluding leave, decreased in July 2024 compared to June 2024.
- A total of 45 patients were discharged in July 2024, up from 44 in June 2024.



Operational context

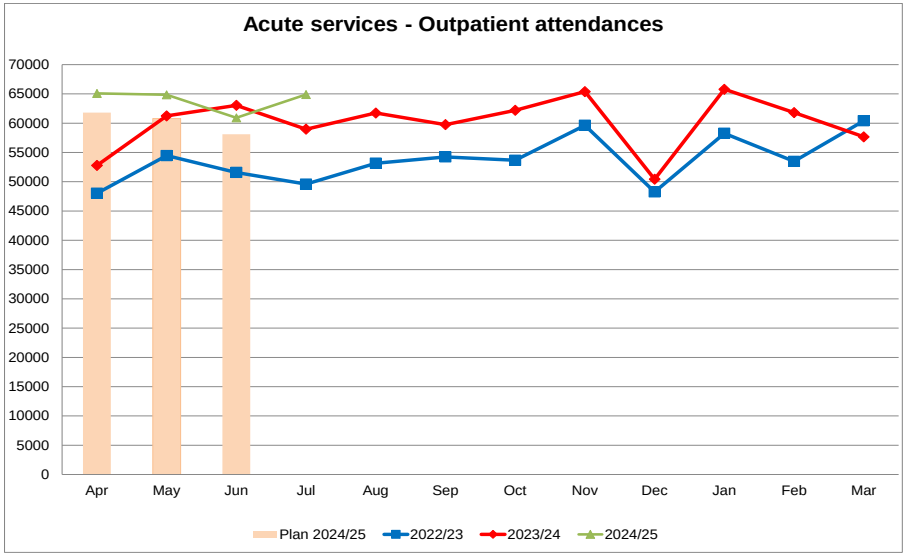
Acute services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior years.





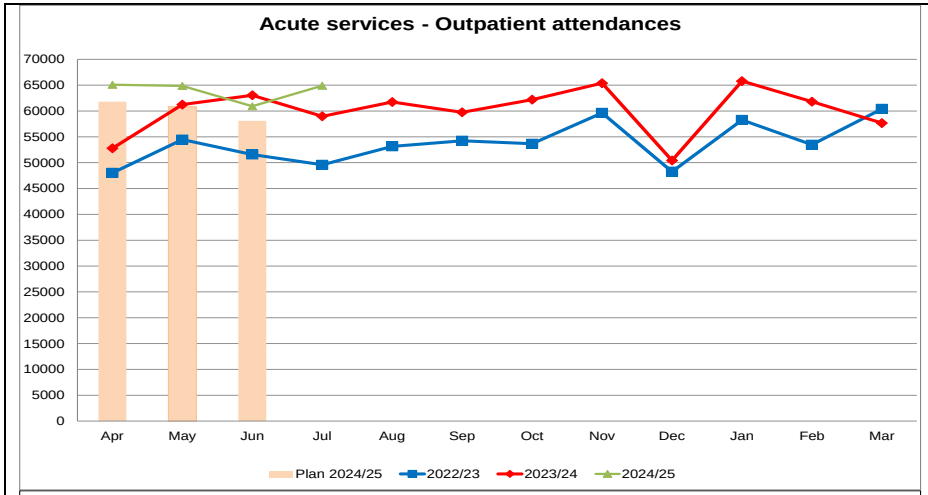
Summary:

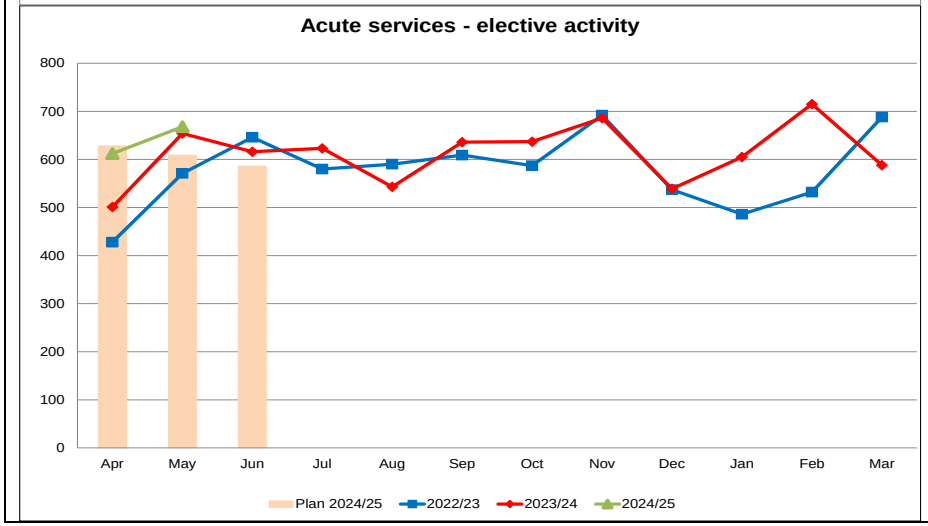
- Between 1 April and 31 July 2024 attendances to Accident and Emergency were 6.0% higher than the same months of 2023 and 7.4% higher than the same months of 2022. In July 2024, 59.4% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 78%.
- GP and Dental referrals between 1 April and 31 July 2024 were 9.2% higher than the same months of 2023 and 19.2% higher than the same months of 2022.
- Outpatient attendances for the same period were 8.3% higher than the corresponding months of 2023 and 25.6% higher than the same months of 2022. Attendances are currently 4.2% above the interim plan for 2024/25.



Operational context

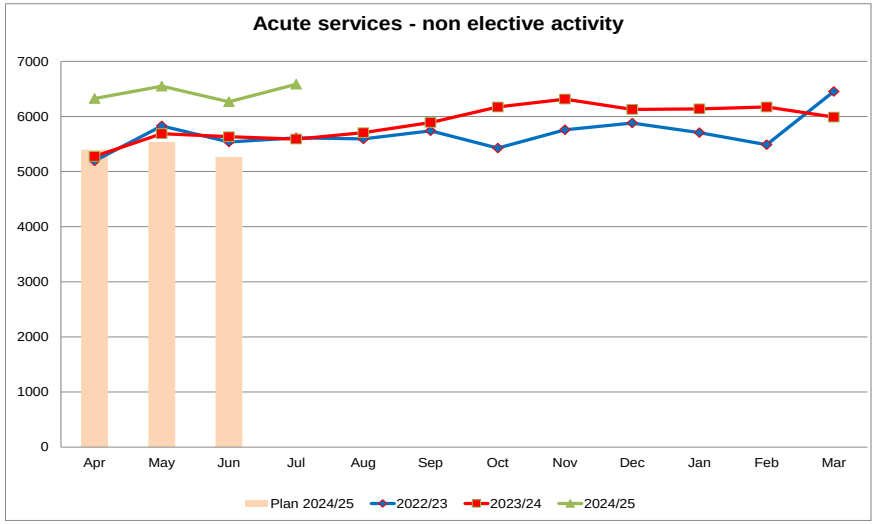
Acute services: This section of the report provides a summary of the levels of day case, elective, and non elective activity during the reporting period, compared to the previous months and prior years.





Summary:

- The number of day cases undertaken by our acute services between 1 April and 31 July 2024 increased by 38.3% compared to the same months of 2023 and by 44.8% compared to the same months of 2022. Activity was 0.5% below the current year plan.
- Over the same period, elective admissions were 6.1% higher than the corresponding months of 2023 and 14.1% higher compared to the same months of 2022. Activity was 4.1% above the current year plan.
- Non elective admissions also saw increases, of 16.0% compared to 2023 and 16.0% compared to 2022. Activity was 21.2% above the current year plan.



Appendix 6 – Infection Control and Prevention – July 2024

MRSA bloodstream infections	**Commentary on MRSA / MSSA BSIs**
Musgrove Park Hospital = 0 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0	Case numbers of MSSA bloodstream infection remain stable and we are on trajectory. However, we are in the upper third regionally. Improvement work continues focusing on peripheral vascular cannulae care. This year national definitions are being applied to the case reviews to determine if the cannula is the source of the infection. Two definitions are used: • **PVC Related BSI –** the PVC is definitely the source of the infection • **PVC Associated BSI** – the PVC is probably the source of the infection To date, three of the MSSA bloodstream infection were probably due to a cannula.
MSSA Bloodstream Infections	
Musgrove Park Hospital = 3 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0	
E. coli bloodstream infections	**Commentary on Gram-negative bloodstream infections**
Musgrove Park Hospital = 5 Yeovil District Hospital = 4 Community Hospitals / Mental Health = 0	**E. coli** - Case numbers slightly increased this month, and we remain slightly above trajectory. Despite this we have the second lowest rates in the region as per data for end of June. **Klebsiella** – Case numbers increased this month. We remain on trajectory and have the lowest rates in the region and our rate per 100,000 occupied bed days (5.1) is significantly lower than the national rate (13.58) as per data for the end of June. Sources remain varied with no clear trends. **Pseudomonas** – We remain under trajectory and have the second lowest rates in the region as per data for end of June. Sources due to indwelling urinary catheters have increased. Some learning has already been identified and actioned. However, several patients had a long-term catheter which is essentially required. Further work is needed to identify how their risk of a bloodstream infection can be reduced.
Klebsiella bloodstream infections	
Musgrove Park Hospital = 2 Yeovil District Hospital = 2 Community Hospitals / Mental Health = 0	
Pseudomonas bloodstream infections	
Musgrove Park Hospital = 0 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0	
C. difficile	**Commentary on C. difficile**
Musgrove Park Hospital = 11 Yeovil District Hospital = 3 Community Hospitals / Mental Health = 0	Case numbers of C. difficile have increased again this month and we remain significantly over trajectory. However, our rates remain the second lowest in the region as per data for the end of June.

Respiratory Viral Infections - inpatients	Commentary on Respiratory Viral Infections
COVID (Trust Cases) = 68 Musgrove Park Hospital = 30 Yeovil District Hospital = 24 Community Hospitals / Mental Health = 14 **Influenza = 9 (Inpatients)** Musgrove Park Hospital = 6 Yeovil District Hospital = 3 Community Hospitals = 0	**COVID** COVID cases increased during July, driven by outbreaks however overall levels remain relatively low. **Influenza** Levels of influenza slightly increased during July. These were incidentally identified as we now test all year. The season is technically over but it is normal to see some cases over the summer months and there are no concerns.
Outbreaks	**Commentary on outbreaks**
COVID = 15 Musgrove Park Hospital = 7 Yeovil District Hospital = 5 Community / Mental Health = 3 **Carbapenemase Producing Organism (CPO)** **YDH -** Since January 2022 there have been 48 cases of CPO identified on the YDH site. Typing is still awaited to confirm if they are part of the original outbreak or a separate cluster.	**Respiratory Outbreaks** Outbreaks due to COVID-19 continue to occur. **Carbapenemase Producing Organism (CPO)** Detailed information about the outbreak has been sent to UKHSA who are reviewing the data to see if any additional actions are indicated. This will take time and the predicted completion of this work is October. The immediate review by the health protection / public health specialists have not identified any interventions that we have not already implemented.
Surgical Site Infections	**Commentary on Surgical Site Infections**
Surgical Site Infection Surveillance enables early recognition of infections to inform remedial and improvement actions. **Musgrove Park Hospital Site** Continuous surveillance for Total Hip Replacement (THR), Total Knee Replacement (TKR) and Spinal Surgery has been in place on the MPH site since 2009.	**<u>Musgrove Park Hospital Site</u>** • **Total Hip Replacement** Within the last year (July 2023 to June 2024) a total of 321 operations have been undertaken with no infections identified. • **Total Knee Replacement** Within the last year (July 2023 to June 2024) a total of 189 operations have been undertaken and 1 infection identified giving an infection rate of 0.53%. This is in line with the national benchmark of 0.52%.

Yeovil District Hospital Site Continuous surveillance on total hip replacement surgery has been in place on the YDH site since April 2022 and continuous surveillance was commenced on total knee replacement surgery from January 2024.	• **Spinal Surgery** Within the last year (July 2023 to June 2024) a total of 338 operations have been undertaken and 3 infections identified giving an infection rate of 0.89%. One new infection was identified increasing the Trust rate slightly although this remains below the national benchmark of 1.2%. **<u>Yeovil District Hospital Site</u>** • **Total Hip Replacement** Within the last year (July 2023 to July 2024) a total of 341 operations have been undertaken and 6 infections identified giving an infection rate of 1.76%. This is higher than the national benchmark of 0.5%. • **Total Knee Replacement** Surveillance began in January 2024 therefore since then a total of 205 operations have been undertaken with no infections identified. The national rate is calculated over the period April 2018 to March 2023 and therefore not directly comparable to trust infection rates. However, as a trust the national benchmark is always used as a guide and has triggered some internal actions. The One Together framework is being used to assess, investigate, and manage increased incidence of surgical site infections, particularly on the YDH site.

NHS Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	One year evaluation of the merger between Somerset FT and Yeovil District Hospital FT that created the new Somerset FT
SPONSORING EXEC:	David Shannon, Director of Strategy and Digital Development
REPORT BY:	Richard Baum, Head of Strategic Planning
PRESENTED BY:	Richard Baum, Head of Strategic Planning
DATE:	3 September 2024

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 new Somerset FT came into existence in April 2023, following the merger of the old Somerset FT with Yeovil District Hospital FT. This paper is an evaluation of the first year since the merger, which was presented for discussion at the Board Development day in June and which has since been shared with NHS England as part of their ongoing work with us. We planned to undertake this evaluation as a way of reflecting on the merger, and learning for the future so that we can continue to make the most of the opportunities afforded to us by coming together. The evaluation reflects on the governance arrangements that we put in place to ensure that the merger process itself went well. It then considers the progress that has been made against our clinical integration priorities, corporate integration including financial savings, and how the merger affected our colleagues and organisational culture. It considers the trust's performance against national standards and how this has changed over time and concludes with a series of "lessons learned" from the process.
Recommendation	Board members are asked to note the final version of this document, which has taken into account feedback received at the Board Development day in June.

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

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

Implications/Requirements (Please select any which are relevant to this paper)					
☒ Financial	☒ Legislation	☒ Workforce	☒ Estates	☒ ICT	☒ Patient Safety/ Quality
Details: The evaluation of the merger relates to all aspects of the work of the trust.					

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 but impact assessments had been carried out as part of the merger business case.

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 from a range of corporate functions, and the Clinical Integration Team, were involved in the provision of information which informed the evaluation. Interviews took place with several Executive Director Board members as part of the preparation of this document, which has also been discussed at the SFT/YDH Merger Programme Board.

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 Board received regular updates on the progress against merger objectives in the months immediately following merger and has received reports on various aspects of progress against objectives in the last year. A draft version of this report was presented to the Board in June 2024, and following feedback there and from other contributors, this is the final version.

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

One Year Review of the merger of

Somerset NHS Foundation Trust

and Yeovil District Hospital NHS Foundation Trust

Introduction

1. Somerset NHS Foundation Trust (SFT) and Yeovil District Hospital NHS Foundation Trust (YDHFT) came together to form a new and enlarged Somerset NHS Foundation Trust (SFT) on 1st April 2023. The completion of the merger was the final stage of several years of collaboration between the two legacy organisations, in which services across the two trusts worked together to improve outcomes for the people of Somerset.

2. The new SFT serves approximately 600,000 people across all of Somerset, and is the only NHS provider of acute hospitals, and of secondary care community, learning disability and mental health services in the county. We also provide some services to parts of mid- and north Devon, community dental services in Dorset, and are a regional centre for services such as bariatric surgery. We have over 1,000 acute hospital beds at Musgrove Park Hospital in Taunton and at Yeovil District Hospital, as well as inpatient mental health wards. We deliver services from a dozen community hospitals and many more sites across the county, and our wholly owned subsidiary company Symphony Healthcare Services operates 16 GP practices.

3. This review of the merger looks back over our first year, and considers how we have achieved our integration plans to deliver benefits for patients, colleagues and the Somerset health economy. It considers areas where we have done well, and areas where we have encountered challenges. It describes the lessons learned and focus for the second-year post-merger to build on where we are now.

4. The focus of this review document will be on how we have sought to deliver our clinical strategy, and the integration of clinical services and support functions to achieve our merger aims. This report focuses on the initial twelve-month period following the merger and specifically on the delivery of integration tasks. It was recognised in the business case for the creation of Somerset Foundation Trust that the process of integration and merger will take a number of years. The first-year focused on ensuring a safe transition to the new service model. Further review of progress following the merger will be undertaken at two- and five-year intervals.

Why we merged

5. The two legacy trusts worked closely for many years prior to merger as partners in the Somerset health economy. In May 2020, the two trusts signed a Memorandum of Understanding (MOU) in which they committed to work together for the benefit of the Somerset population by aligning their strategic goals and operational activities. The Trusts signed the MOU to improve services for patients, and we continued to develop services in a more joined up way throughout 2020-23 in the run-up to merger.

6. The decision to work more collaboratively, and ultimately to merge, was taken in response to increasing challenges faced by the local health economy, particularly in how we met changing patient need. Health and care services in Somerset were struggling to meet the increasing demands of an ageing population and a rising number of people with complex or long-term health conditions. We also faced considerable financial challenges. These issues continue, but we are much better placed to respond to them now that we are merged.

7. The newly formed Trust is a key organisation in the Somerset Integrated Care System (ICS), and our objectives are aligned with those of the ICS. Our merger has taken place in the context of other structural changes within the ICS. For example, the predecessor

Somerset Foundation Trust itself came into existence following a merger in 2020, which brought together acute services in the west of Somerset with cross-county community and mental health services. In 2022, the county's structure of local government changed from a two-tier County/Districts model to a unitary model, and there is now a single Somerset Council. The removal of the district now means that the single Council and the single Foundation Trust serve the same population within the ICS, and as a result we are in a much better position to implement a population health approach because geographies and populations are aligned. The town and parish councils that continue to exist are more aligned with Primary Care Networks (PCNs), and although they do not cover exactly the same areas, they still allow for an ICS-wide approach to neighbourhood-based decision making and improvement, which is a key part of how we want to improve services.

8. As a trust, we are building on the strong existing relationships with the council, the local voluntary sector, and those parts of the primary care sector that are not within our trust. The simplified local system architecture facilitates the implementation of new models of care which support better health and wellbeing for the people of Somerset.

9. Bringing together our acute services into a single provider has enabled us to maximise the use of our elective capacity, and to streamline pathways to improve equity of access and performance. It has also facilitated our work to modernise care in Somerset and rebalance our resources away from bed-based care and into community-based services that support early intervention. This paper provides the detail of the progress in the first year since merger as well as the challenges faced.

Summary of the key benefits of merger

Key benefits of merger

10. Our merger has delivered significant benefits to the local population and the Somerset system. We faced many challenges in bringing two very different trusts together, to create a single trust for the whole county. We knew that the cultural and operational differences between a large trust that combined Acute, Community and Mental Health provision, and a smaller acute-only trust operating predominantly from a single site, would be significant. Despite these challenges, our years of close working, and the experience that we gained from the merger that created the old SFT in 2020, helped us in both preparation and delivery.

11. During the planning for merger, we identified the benefits that we expected to be able to deliver as a single trust for patients, colleagues and for the Somerset NHS system. These can be summarised as follows:

Benefits	
PATIENTS	
More time in good health (from better health outcomes) • Earlier intervention meaning illness is less likely to escalate to crisis or emergency	**Making every minute count (by eliminating wasted time in healthcare)** • Effective use of spare diagnostic and treatment capacity wherever it exists in the county

Benefits	
• Quicker access to diagnosis and treatment, including specialist care • Improved access to holistic care which meets both physical and mental health needs • Improved patient safety from simpler, quicker pathways and shared patient record systems • Better health outcomes as colleagues see wider range of clinical cases, share knowledge & best practice • Unwarranted variation reduced through consistent county-wide pathways • Ready access to patients' full clinical history via shared IT systems which increases patient safety and good clinical outcomes • Equity of care across the county from consistent approach • Improved patient experience from streamlined pathways, and in some cases less travel for care.	• Eliminating wasteful steps in pathways, including duplicate investigations or steps without clinical value • Smoother transfer between acute, community and mental health settings when all are run by the same Trust • More care closer to home (in community settings) which increases patient choice and reduces patient travel time & inconvenience
COLLEAGUES	
• Improved wellbeing and motivation from more resilient services • Increased job satisfaction from broader career opportunities • Colleagues freed up for front line care by efficiencies deriving from streamlined pathways, shared IT systems, and removal of duplicate tasks • Greater colleague capacity to implement transformational changes which benefit patients	
TRUST & SYSTEM	
• Improved recruitment & retention from improved staff offer • Fragile services placed on a more sustainable footing • Better able to respond to rising demand • Easier to redirect resources to services or parts of a pathway where most needed • Better placed to work with partners to implement new care models which are more responsive, and less bureaucratic & costly • Easier to integrate with the work of partners when we are one organisation • Better able to implement population health management and tackle health inequalities • Creates further opportunities to align functions and services in Somerset	

12. Subsequent sections of this document outline the clinical, financial and cultural benefits that we have achieved, and the challenges that we have faced.

13. It was clear that the integration process would be more challenging than the merger between Somerset Partnership and Taunton and Somerset FT. That first merger was focused more on equity between physical and mental healthcare, and on the creation of vertical pathways between community and acute care. This time, merging two acute trusts meant significant overlap between services albeit in different geographies and the need to align pathways and clinical processes across different locations.

14. Strategically, we are now in a better place to make improvements. Our enhanced flexibility means that we can work as one body across the county to meet need. For example, we have a merged bed base and can flex it as required. At a daily operational level, site management is now county-wide , helping with escalation planning and discharges.

15. We have launched county-wide improvement programmes like our Productive Care Programme and can bring clinical specialties together as one team rather than split between geographies. All of these promote consistency, resource-flexibility and will deliver common outcomes for local people rather than them being dependent on geography. For YDH patients in particular, the local hospital is now part of a much larger organisation that is more resilient and has access to broader expertise. This has been particularly noticeable in the integration of mental health services, and the support from Community services. The resilience and support from services across the wider organisation for example in critical care has enabled the maintenance and development of those services.

16. We are taking advantage of these opportunities even more by using enhanced digital technology, which allows us to physically be at one site and review patients at another. This has been made much simpler and robust within a single organisation. Over the year, our data collection and reporting processes have become more aligned, improving our understanding of services, and enabling better decision making.

17. We have learned from the experiences of other local and national mergers. For example, our Medical Education service learned from the experience of the University Hospitals Bristol / Weston General Hospital merger in the delivery of medical training post integration of hospital sites. As a result of the learning, we put in place a single management structure which ensured equity and continuity of staffing which has been positively received by the Deanery.

18. Throughout the merger process we took some of the learning taken from the previous integration between Somerset Partnership FT and Taunton and Somerset FT, in particular the approach to merger planning and the relationship with the regional and National Team. One particular learning from the previous merger related to the timing of the development and implementation of the operating model and service group structure. Thiswas undertaken much earlier and which allowed for service integration and the operational and clinical leadership to be implemented at an earlier stage.

Integration Overview

19. The merger transaction date was 1st April 2023. In the run up to that date, our merger planning involved a considerable amount of work to bring teams together, develop a shared vision and values to enable cultural alignment and bring together the best of both previous trusts. Many colleagues from the old SFT had experience of the merger which formed that organisation three years previously, and this was also true of the Project Management Office (PMO) managing the merger process itself. This allowed us to use the lessons we had learned from that previous merger and help prepare better for the merger between old SFT and YDH.

20. We worked across clinical and corporate services to develop new structures and ways of working which maximised the opportunities of merger, whilst reducing disruption and allowing clinicians and managers to be creative in developing new pathways for patients.

21. The new trust governance framework was embedded to ensure assurance and controls were in place to manage risks, and we implemented a new Service Group structure that reflected the new challenges of running two acute general hospitals as well as services for community and mental health patients.

22. The NHS has continued to face significant pressures throughout the pre- and post-merger periods, as we recover from the Covid-19 pandemic and manage ongoing industrial action, waiting list recovery and staffing challenges. These pressures have been felt across the country, but our response to them has been made easier because of the merger, which has created a more flexible and resilient organisation without many of the boundaries which existed before. Aligning services across the whole county, and bringing together hospital-based teams across two hospitals, has meant that the Somerset system is more aligned, more flexible and more responsive. We have more resources at our disposal to tackle the challenges we face, and less competition between providers which has sometimes made services less sustainable in the past.

23. Our responses to ongoing pressures have been enhanced in several ways specifically because we are now a county-wide merged trust. We have been able to more effectively marshal our acute hospital services to plan for Covid and waiting list recovery better, and to work in a more joined up way as part of a single organisational plan. We have taken advantage of a combined Information Team to better plan for service developments and identify county-wide trends, and we have been able to make the financial efficiencies necessary to re-direct funds to the front line.

24. Our teams have come together to deliver better services for local people. The trust Board, Governors and critical Day 1 posts were in place as expected at the time of merger, as was a new Service Group structure and operating model, which is delivering improvements.

25. We have focused on delivering operational changes since merger, but also continue to develop more strategic developments which will lead to benefits for patients and the wider community. One such example has been the development of our Peri-Operative care service (for further details, see below). The increased size, flexibility and experience of our surgical team across the enlarged trust has allowed us to focus more on the conditions which lead patients to need surgery. It targets resources at the preventative stage to give patients more choice and to reduce the numbers of patients requiring surgery in the first place. Those who do undergo surgery are better prepared, lead healthier lifestyles and recover quicker as a result, which is better for them and for the trust. The development of this service would not have been possible without the scale now achievable as a county-wide single organisation.

26. At the same time as working on new and better clinical services internally, the new trust is one of the key partners in continuing to develop the Somerset Integrated Care System (ICS). We believe that partnership working across the county is the best way to deliver improved care, and this was one of the key drivers of our merger business case. Now we continue to develop links with the Integrated Care Board, Somerset

Council and other partners to take maximum advantage of our merger to more quickly and easily develop services for local people, without the hindrance or organisational barriers.

27. A key piece of work in ensuring the success of our merger has been the alignment of organisational cultures, to create the type of culture in the new organisation that promotes innovation and quality for patients, supports existing colleagues and attracts new ones. We wanted to take the strengths of both predecessor trusts and create a compassionate, inclusive and learning culture. Our organisational development team continues to work with thousands of colleagues to help embed our values, support colleagues managing pressures in their services, and give everyone a say in how to make services better for local people. We were pleased to see the results of the first NHS Staff Survey since merger, which were very positive and showed improvements across almost all areas since the two legacy trusts came together (see below for further details).

28. We have also strived to deliver efficiencies and savings as part of the NHS' national effort to manage costs and deliver better value. Uncertainties and additional costs caused by pandemic and waiting list recovery have meant that there has been limited ability to focus on cost improvement. However, longer term merger savings plans remain in place and savings are being made as a result of the single trust board, within corporate services, and as a result of synergies between the two legacy trusts. We have made £3.2m of recurrent savings across corporate services since merger.

Integration Governance

29. The governance arrangements for Somerset FT are as described in the Post Transaction Implementation Plan (PTIP). The new corporate governance structure has been embedded with trust Board committees and sub-structures in place, Terms of Reference and reporting structures agreed and groups and committees continuing to develop their role. The overarching governance structure is attached at Appendix 1 of this report.

30. The new trust also has a new Service Group structure, reflecting the fact that the trust operates two acute hospitals, community and mental health services across the age range and across all the neighbourhoods in Somerset. The structure of our operational services is attached at Appendix 2 of this report.

31. Our clinical and operational services are supported by integrated corporate functions that have been operational since day 1.

Clinical Integration – benefits and challenges

32. Our primary driver for merger was to improve the health of our population by improving the care we provide inside and outside of hospital. This merger was both a vertical and a horizontal integration. The vertical integration involved the hospital services at YDH becoming fully integrated into an organisation that provided mental health and community services. This allowed for many of the benefits of enhanced pathways

across acute/community care and involving mental health care which old-SFT delivered when it was merged. For some services, such as Stroke, there were already strong links between YDHFT's acute services and SFT's community services. For many other services though, there has been a significant amount of work to do to make the most of the opportunities of merger.

33. The horizontal integration brought together YDHFT and SFT's hospital-based care into single county-wide services, building on the best from both trusts. Merger has helped us create more resilient clinical teams, with improved clinical decision-making derived from larger Multi-Disciplinary Teams (MDTs) and integrated digital systems.

34. We set out the desired benefits for our patients in the merger business case. These were:
    - earlier intervention meaning illness is less likely to escalate to crisis or emergency.
    - quicker access to diagnosis and treatment, including specialist care.

    improved access to holistic care which meets both physical and mental health needs.
    - improved patient safety from simpler, quicker pathways and shared patient record systems.
    - better health outcomes as colleagues see a wider range of clinical cases, share knowledge and best practice.
    - unwarranted variation reduced through consistent county-wide pathways.
    - ready access to patients' full clinical history via shared IT systems which increases patient safety and good clinical outcomes.
    - equity of care across the county from consistent approach.
    - improved patient experience from streamlined pathways, and in some cases less travel for care.

35. We developed our thinking behind these desired benefits more fully in the Patient Benefits Case which accompanied the merger business case. The Patient Benefits Case set out six case studies explaining how these benefits would develop and be delivered at a service level. The six case studies were selected to cover the breadth of services that the new trust offers, across the range of ICS-level strategic objectives:
    - Maternity
    - Oncology
    - Cardiology
    - Stroke
    - Peri-Operative Care
    - Homelessness

36. Our progress against each of these areas is as follows:

Maternity:

37. Ensuring high-quality services for women, birthing people, babies and their families, is a national and local priority. The sustainability of Somerset's maternity services has been subject to scrutiny in recent years. We anticipated that integration would speed up our ability to transform maternity services in acute and community settings, as well as perinatal mental healthcare.

38. When we began our work to merge Maternity services, we anticipated the following benefits and number of affected patients:

Change	Benefit to patients	No. of patients benefitting a year
Combining our maternity teams, including WREN (Women Requiring Extra Nurturing) team	• Increased scale and ability to implement national requirements (including personalised care)	c. 4,300
	• Improved maternity care and experience for women living in the 'corridor' in the middle of the county, especially those with complex pregnancies or with additional needs	c. 600

39. We have embedded a single midwifery and service group leadership team however, this focus on integration resulted in diversion from conflicting priorities resulting in several issues (see point 42 below). The integration of the team came at the conclusion of a gradual journey towards full integration. We realised that a successful bringing together of two teams would need time, good communications and appropriate resourcing. To that end we instigated site walk-arounds for colleagues from different sites, Integration Champion roles, shadowing opportunities and a new newsletter prior to integration. We also took local satisfaction surveys to try and ensure that colleagues were happy and to identify areas of concern.

40. Specific improvements since the merger include:

- **Delivery of a new structure** including the creation of a Director of Midwifery role, supported by Heads of Midwifery for acute and community care. Our integrated team also includes Professional Midwifery Advocates (PMAs) and legacy midwives. Joint recruitment exercises have been a significant help in terms of inter-team bonding.

- Creation of a **5-year strategy** for the combined service, including plans for improved governance, and the integration of supporting services e.g. bereavement. We have produced a bereavement care plan that has been developed in collaboration with users and is now standardised across all sites.

- **Integration of Neonatal services** within Maternity services, and the development of more service-user involvement through via the Maternity and Neonatal Voices Partnership.

- **Harmonising of clinical guidelines**. This has proven to be a complex and highly challenging task where despite the creation of additional midwifery roles to support the exercise, the lack of adequate medical capacity for coproduction and oversight has resulted in further challenge. We have recruited a consultant with dedicated capacity to address these challenges going forward.

- An **integrated digital maternity care record** was achieved with the introduction of Badgernet in early 2023. We are now a paper-light service across our acute and community services utilising an electronic patient record (EPR) for all clinical documentation. Feedback from women and birthing people who can now see their own records via an app on their phone has been extremely positive. The

development means that when women transfer between sites, colleagues can see their notes and ensure care is continued seamlessly.

- Successful **alignment of our midwife education and training**. We have brought together the practice development teams, and now offer the same training on both sites. Colleagues can attend whichever training suits their timetable, not limited to one site. The training itself has taken the best from both legacy organisations, for example the original YDH equalities training is now part of our mandatory training annual updates.

41. As we have integrated, we have sought to ensure changes benefit our women, birthing people, babies and families across our county. For example, our WREN team flexes across the service providing enhanced continuity for our most vulnerable service users and those who may be more likely to experience poor outcomes, this has embedded since integration. The Rainbow clinic (providing enhanced care and support for those who have previously experienced late pregnancy or neonatal loss) at YDH is now being replicated on the MPH site so all service users receive equity in high-quality choice and service offer.

42. Despite progress, our December 2023 Care Quality Commission (CQC) inspection has highlighted a significant number of issues and ongoing challenges. Working to respond to identified issues has required a redirection of focus resulting in a delay in progress on some of the identified areas of focus for integration. Our senior integrated team have worked hard to respond and deliver changes required at pace to ensure safety and quality of care in both MPH and YDH sites. A robust action plan supported by executive oversight has underpinned delivery of complex projects including implementation of a new triage system at MPH. Based on the BSOTS (Birmingham Symptom Specific Obstetric Triage System) our triage service provision is now running in both YDH and MPH providing equity of care across the county.

43. The table below shows how we have achieved against the indicators and targets that we set ourselves pre-merger. Performance is mixed, and whilst we have achieved a number of our goals it is clear that there have been challenges and we have not achieved all. We have reflected on the complexities involved in bringing together two complex and distinct services each facing individual challenges themselves. The urgency of some of these challenges has meant that the important parts of merging have sometimes had to be de-prioritised. After engagement with the CQC and our own internal improvement plans, we hope that we will be able to make further progress in the areas where we have struggled.

Indicator	Source	Baseline	Target	Position 04/24
CQC rating	CQC inspection	Good (both trusts)	Outstanding by next CQC assessment	Not achieved
NHS maternity patient survey	NHS maternity patient survey	Both trusts are currently at 'better than or about the same' on all indicators	To maintain all indicators at 'better than or the same', and increase the number of 'better than' indicators	Maintained
Increase % of home deliveries *(whilst maintaining safety, this is to increase*	LMNS dashboard	YTD combined	3.5% by April 2024	Not achieved

Indicator	Source	Baseline	Target	Position 04/24
choice rather than avoid hospital settings where needed)		19/20: 3.6% 20/21: 3.5% 21/22: 3.0% 22/23: 1.3% 23/24: 1.7% (at Feb Jan 24)		
Continuity of care offered in ante and post-natal pathways	LMNS dashboard	YTD combined 19/20: 33.6% 20/21: 33.1% 21/22: 44.3% 22/23: 43.5% 23/24: 43% (at Jan Feb 24)	YTD combined: ≥35% is set by LMNS; however, seek to achieve 50% by April 2024	Achieved target set by LMNS CoC* has been removed as a target nationally with trusts asked to focus on enhanced continuity for those most likely to experience poor outcomes
Workforce review	Workforce review	Underway	Complete by December 2022	Whole midwifery and support worker workforce modelling assessment has commenced to help us understand the required staffing establishment to meet the complexity and demand for maternity services care.
Colleague wellbeing Staff to report they are happy at work Reduced staff absence due to stress/anxiety	Staff survey: Q2a I look forward to going to work (often/always) Workforce reports PMA wellbeing reports Workforce	(2022) Average taken across maternity teams: SFT - 60% YDHFT - 60% (Sept 2022) 37% of total absence	Score maintained in next staff survey results. < 5% by Sept 2023	Achieved: average is 62%. 'Rolling sickness rate' for maternity services was 7.6% (trust at 5%). The highest cited reasons was: 23% - S10 Anxiety/stress/depression/other psychiatric illnesses. Figures taken in Feb 24.

Indicator	Source	Baseline	Target	Position 04/24
Recruitment and retention	reports	(October 2022) Turnover rates - 10.7%	< 7% by April 2024	11.1% (trust 11%) on Feb 24. Since Mar23 - Feb 24, there has been 74 leavers of which the highest cited reasons were 31% retirement.
Patient experience Achieving UNICEF (baby friendly initiative – BFI) gold standard across maternity and neonatal	Local UNICEF reports	SFT maternity Gold sustainable Neonatal – Level 1 YDH - Level 3 Neonatal - intention of commitment	All gold sustainable for both maternity units by 2024 and whole of maternity neonatal care by 2026	Maintained gold at MPH – rolling across the system. Recruiting a BFI matron to take forward to help sustain and develop to neo nates and paediatrics across both sites.
Patient experience Complaints	Number of formal complaints (LMNS dashboard)	YTD combined 19/20: 7 20/21: 14 21/22: 14 22/23: 20	YTD combined: 10 for 2023/24 (acknowledging the need to maintain an open culture to receiving complaints)	23/24: 12 (at Jan 24) Not achieved
Personalised care plans in place (Ockenden action)	Personalised care plans audit of use	0%	100% women offered a personalised care plan by April 2023 (evidence suggests uptake will be about 35%)	Personalised care and support plans in place across all areas of Maternity care.
Digital implementation	Progress against Digital programme plan implementation	Not integrated	Go live as per plan is 22/2/2023	Completed
Ensuring safety in change – no increase in safety incidents	MNSI/HSIB referrals	YDHFT SFT 19/20: 4 10 20/21: 1 5 21/22: 2 7	No increase in safety incidents reported	YDHFT SFT 22/23: 2 7 23/24: 1 7 Achieved
Alignment of policies and	Reports to the Maternity	156 to align. 0 complete	95% complete by June	Extended as more extensive work than

Indicator	Source	Baseline	Target	Position 04/24
guidance	Transformation Programme board		2023	anticipated. Plan to complete by end of 2024. Recruited two new consultants, one with lead for audit and policies which will support this ambition.

*The continuity of carer model (CoC)

Oncology

44. Our oncology services in Somerset had a track record of cross-county collaboration due to the commissioning of oncology services in Somerset and historic workforce challenges. A Memorandum of Understanding (MOU) signed in 2020 brought the teams together to deliver safe, effective care whilst remaining part of two separate organisations. Without merger though, the teams found it difficult to maintain workforce cover and to reduce inequalities as they focussed on their immediate local service concerns. This was particularly evident during the acute phase of the Covid pandemic. The merger process re-engaged the teams to drive forward their vision of a single integrated service with joint oversight and reporting processes.

45. As we began our merger work, we anticipated the following specific improvements, and the numbers of patients who would benefit from them.

Change	Benefit to patients	No. of patients benefitting a year
Overhaul of psychological support offer	• Better care for the psychological aspects of cancer	c. 550
Improved access to clinical trials	• Earlier access to innovative drugs, closer monitoring during treatment, and improved patient outcomes from trial participation • Enhanced colleague knowledge of leading-edge treatments	c. 100-150
Fewer inter-site transfers	• Reduced clinical risk from site transfers • Less discomfort & inconvenience from being transported between sites • Less colleague time spent administrating patient transfers which frees up time for front line care	c. 5

46. Around the time of merger, staff turnover in the teams, resulted in significant de-stabilisation of the services and concern for delivering safe and effective care. The focus was to operationally respond to this by strengthening team structures and work processes.

47. Interim county-wide leadership was put in place from July 2023, and despite the challenges of being a newly appointed leadership team, colleagues have progressed a number of key areas following merger. Specific improvements since merger include:

    - Our **staffing** situation has improved. Whilst oncologists continue to be difficult to recruit and retain; SFT is now in a more stable position. Historically, whenever there was sickness or consultant availability, we were unable to fill the gaps but now the majority of tumour sites has an oncologist in post. The oncologists are currently based at MPH, but have a presence at the St Margaret's site in Yeovil where they deliver outpatient clinics. This county-wide expansion has strengthened and formalised links between the two teams, but there remains inequities in oncology consultant provision for inpatients across the two sites.

    - Our **systemic anti-cancer therapy (SACT) nursing teams** have seen a number of changes post-merger. Our SACT services are run at St Margaret's hospice site in the east and a hub and spoke model in the west of the county. Due to high staff turnover at St Margaret's, staffing the unit has been challenging. Merger has given the opportunity of easier cross county working at times of need, including upskilling and shared learning, and has enabled a review of processes cross county to ensure equity of care for patients.

    - **Better care for the psychological aspects of cancer** Pre-merger we identified several inequities in the provision of psychological support for patients and colleagues. Hope Somerset Services is a county-wide service which we launched at the point of merger. It has resulted in an increase of 110% in referrals for cancer patients and their significant others in the last 12 months. The benefits of effective psychological support for cancer patients include reduced depression, anxiety and pain, improved self-management and coping skills; these help patients feel more in control and improves their quality of life. The service is also able to support all staff working within cancer services, including with communication skills training to staff who work with cancer patients.

    - Our **Cancer helpline staffing** has been expanded county-wide, meaning that it has a more flexible workforce and can continue even when cover is difficult due to pressures elsewhere.

    - We have introduced a **countywide neutropenic sepsis card** which has seen a dramatic improvement in door to needle time. Our approaches to antiemetic medication have also been standardised to reduce the risks associated with differing clinical practices.

48. The table below shows our performance against the measures we identified pre-merger as areas for improvement. We have seen a variety of performance improvement levels. Some targets have been achieved, whilst we continue to make progress against others. As with Maternity above, the challenges we faced in maintaining "business as usual" in challenging clinical circumstances meant that some of our desired merger improvements have not been prioritised in the way we envisaged. We will continue to work to achieve them in Year 2 post-merger.

Measure	Purpose	Baseline	Target		Performance as at March 2024
Neutropenic sepsis	To reduce inequity of access to antibiotics within 1 hour	SFT 89% YDH 47% (Jan-July 22)	100% within 1 hour of arrival to hospital by 1 April 2023	MPH YDH	93% 100%
Metastatic spinal cord compression	To reduce inequity of access to spinal MRI within 24 hours	SFT 99% YDH not collected	100% of patients with suspected MSCC having spinal MRI within 24 hours by 1 April 2023	MPH YDH	100% 50%
Metastatic spinal cord compression (MSCC)	To ensure prompt management of MSCC within national guidelines	SFT 100% YDH not collected	100% receive definitive treatment within 24 hours of receiving a confirmed diagnosis of MSCC by 1 April 2023	MPH YDH	100% 100%
Clinical research trials	To reduce inequity of cancer recruitment to trials	81 patients (21/22)	To increase cancer recruitment to trials by 25%.		128
Reduce locum / agency spend	To reduce locum usage	SFT 5% (£153,779) YDH 80% (£376,333	To reduce combined locum expenditure by 25% by Dec 2024		YDH reduction to 70% over goal not yet achieved
Reduce staff turnover	To ensure staff are retained and have job satisfaction	SFT 8.6% YDH 23.1% (July 2022)	<3% by 1 April 2024		11.90%
Access to clinical supervision within oncology	To ensure all colleagues have equitable access to clinical supervision in line with SFT's current provision	SFT 100% YDH 100%	All oncology staff (YDH and SFT) will be offered restorative clinical supervision by 1 April 2023		100% Completed

Measure	Purpose	Baseline	Target		Performance as at March 2024
Numbers of colleagues accessing restorative clinical supervision	To ensure colleagues needs are met where currently capacity is an issue.	SFT approx. 25% YDH 0%	% of oncology staff (n=754) who access RCS (recognising not all staff require this at the same time)		48%

Cardiology

49. Cardiology services across the two legacy trusts had worked closely together since the opening of the regional Cardiac Catheterisation Lab in the early 2000s. We knew though that despite the close working arrangements in place, there were further opportunities which could be realised by merger. We wanted to further the integration of the cardiology teams and change the clinical pathways to bring about equity of waiting times, access, and service provision.

50. When we started our merger work, we anticipated the following benefits and numbers of patients who would be impacted:

Change	Benefit to patients	No. of patients benefitting a year
Amended acute NSTEMI pathway	• Quicker patient access to diagnostics and specialist care leading to improved patient outcomes • Reduced clinical risk from fewer inter-site patient transfers • Less patient time waiting for specialist care and feeling anxious. • Eliminate duplicate investigations which will reduce patient waiting and free up clinical time • Improved use of combined diagnostic capacity, which reduces patient waits • Less patient time (and less discomfort) from being transported between sites • Reduced administrative work associated with inter-site transfers, which frees up colleague time to care for other patients	c. 200
Amended pacemaker pathway, and remote monitoring county-wide	• Right pacemaker first time which reduces risk of heart failure • Quicker identification of deteriorating heart function, which supports early intervention • Fewer pacemaker upgrades which frees up clinical time and catheterisation lab capacity for other patients • Greater patient convenience from not having to attend as many face to face appointments	c. 690

Change	Benefit to patients	No. of patients benefitting a year
	• Greater patient peace of mind from continuous heart monitoring	
County-wide clinics	• Improved access to care for heart failure patients for mental health aspects of their condition • Improved access to cardiac rehabilitation • Improved access to care which meets both physical and mental health needs	c. 150 for patients with heart failure and angina + c. 50 for patients benefitting from emotional health checks

51. A cardiology service manager was appointed shortly after merger, to help to deliver these aims. Progress since then has included:

- We undertook a workforce review to understand the teams and the needs of the merger service, with a particular focus on longstanding vacancies. We **have begun to address consultant vacancies**, which are key to service sustainability. As a merged trust operating county-wide, we can offer more flexible, exciting roles and more successfully recruit.

- A **review of our physiologist led echocardiogram services** at both MPH and YDH recognised these were run differently and so couldn't be directly compared and have therefore to date been treated as separate services. Currently, MPH has trialled a scientist led service, the standard operating procedure for this when finalised could be shared with YDH but there are no scientists in post at YDH at this time. This will form the basis of further work as we go forward with our integration plans.

- We have **begun to address service inequalities**, for example YDH patients' have always had access to the MPH cath-lab but the geography and being two separate organisations resulted in longer access times to treatment. The building of relationships between the two sites has started to be felt and the two sites feel they are working as one service. Whilst colleagues report feeling as if YDH is another ward, the logistics of bringing a patient from Fielding, a few yards away, compared with across county, will always exist.

- Challenges remain in ensuring **timely access to specialist care for patients in Yeovil**. These cannot be addressed simply by rearranging teams – they require significant investment in facilities. However, as part of a larger trust, this investment is easier now for Yeovil. We are building the Yeovil Diagnostic centre, which will open later in 2024, and which will support the equitable access to diagnostics such as echocardiograms countywide.

- Our **Heart Failure service** has implemented rapid access referral processes which are now the same across the county, with standardised GP referral forms in use.

- The **pacemaker care / remote monitoring** teams have come together to share Standard Operating Procedures (SOPs) and ways of working.

- Our **data and reporting** has improved. Pre-merger, the different data systems involved in the patient pathway made it difficult to gather data for purposes such as

the National Audit for Cardiac Rehabilitation (NACR) submission. Over the last year, the clinical teams have been working with digital colleagues to ensure the correct data has been submitted to the NACR database.

52. Overall, there have been some successes, but challenges remain. Whilst the cardiology transformation plans have been delayed, it is recognised the initial plan did not accurately reflect the team starting position or engagement. Forming trusted relationships and having a shared vison has taken more time and is still ongoing with the support of leadership. The teams have needed to build confidence to proceed with transformation which was felt to be present until the move from planning to implementation.

Stroke

53. Stroke care was chosen as a case study because there is a history of close collaboration in Somerset along the whole Stroke pathway (acute and community and third-party providers). The teams have worked in partnership to develop a countywide vision and deliver optimal stroke care in line with national guidance. The TSFT/SPFT merger delivered shorter lengths of stay for Stroke patients. The SFT/YDH merger had the potential to address rising demand and gaps in the specialist Stroke workforce at both acute sites.

54. When we began our merger work, we anticipated the following benefits for Stroke patients in Somerset:

Change	**Benefit to patients**	**No. of patients benefitting a year**
Combined patient and carer education and support programmes	• Equity of provision of support leading to improved health outcomes • Care better tailored to individuals' needs • Increased patient confidence to self-manage • Healthcare workers' time focused on what only they can do (rather than taking on tasks better done by others)	c. 1,100-1,400 patients + 700-800 carers
Improved use of physical capacity	• More care provided closer to home • Rehabilitation support less likely to be stood down	c. 1,100-1,400

55. Since merger, we have made progress in the following areas:

- We have a single county-wide **agreed vision and local pathways** which are in line with the national model and guidance.

- The integration work has been undertaken with the backdrop of the Integrated Care Board Led consultation on the provision of hyperacute/acute stroke services and therefore has been a period of uncertainty whilst this was undertaken.

- We have **reorganised the management of community stroke services** under the Neighbourhood Service Group alongside all other community services. The benefit of this change is that stroke patients with co-morbidities can be managed in conjunction

with other community services such as district nursing and primary care services. This has also enabled improved early discharge and transition of care through collaborative working with reablement care, adult social care and the third sector providers in the community. This has not resulted in a fragmentation of the stroke pathway as there is a clear commitment to a single clinical pathway. Joint working continues to improve the efficiency of transfers between acute and community settings to support seamless continuity of care and optimise patient outcome and experience.

- We are working towards a one service, two acute sites model, which has started to enable us to use resources flexibly. As part of the workforce review, we have now appointed advanced clinical practitioners (ACP's) to work in stroke diagnosis, thrombolysis and to be key clinical decision makers in transient ischaemic attack (TIA) and acute stroke care. This will enable a more resilient senior clinical team across the two acute sites, more responsive patient care and free up consultants for the most complex presentation. The consultant nurse is now working across both acute sites and is leading the development of the new ACP posts. This will ensure consistency in roles development, training and processes, as well establishing a peer support group for these individuals who are extending their expertise to work at the top of their licence. The ACP roles will enable increased capacity to support the 24/7 hyperacute provision as well as improving equitable access to TIA and post stroke clinics.

- We have consolidated the resources devoted to Sentinel Stroke National Audit Programme (SSNAP) data entry and the production of reports. Our newly formed, merged SSNAP team has ensured that there is a **single approach to data entry and reporting**, there is now team resilience in providing cover when needed and it has started to free up clinical time for front line care.

- The bed base at MPH has increased by four Hyper Acute Stroke Unit (HASU) beds due to closure of the beds at Weston General Hospital. We have appointed two HASU nurses and two specialist grade doctors at MPH to support this and recruited into a further two specialist grades for YDH who are about to undertake their Certificate of Completion of Training (CCT) pathway towards a consultant role. This has increased the resilience of the service, started to enable weekend cover and provide succession planning for existing medical staff.

56. Overall, progress has been made on bringing the services and the teams together. Taking the time to bring together staff across the different sites to learn about each other's services, frustrations, and aspirations at the beginning of the process laid the foundations for starting the service integration. However, the amount of time, commitment and work that was required to support the ICB review and the effect on colleagues in the teams was significantly more than anticipated This combined with the operational management review andlack of appointment of a lead consultant has meant that the team are having to review the timescales of the integration plans.

57. The table below shows the progress that we have made against the targets we set ourselves prior to merger.

Indicator	Source	Baseline	Target	Status
Therapy intensity in acute setting (minutes)	SSNAP data	June 2022 Physiotherapy (YDH: C; SFT: C) Occupational Therapy (YDH: B; SFT: B) Speech & Language Therapy (YDH: D; SFT: C)	B level SSNAP rating across all disciplines by March 2024 A level SSNAP rating across all disciplines by March 2025	December 2023 (latest available figures) **Physiotherapy** (YDH: C SFT: B) **Occupational Therapy** (YDH: D SFT: A) **Speech & Language Therapy** (YDH: C SFT: C)
Therapy intensity in community service (minutes)**	SSNAP data (mean minutes)	June 2022 Physiotherapy: 14.7 mins OT: 10.5 mins SLT: 10 mins Psychology: 4.1 mins	Physiotherapy: 17.5 minutes per day by March 2024 20 minutes per day by March 2025 OT: 13 minutes per day by March 2024 15.5 minutes per day by March 2025 SLT: 12.5 minutes per day by March 2024 15 minutes per day by March 2025 Psychology: 6.5 minutes per day by March 2024 9 minutes per day by March 2025	September 2023 All figures have decreased except SLT. Service is launching a productive care project to examine this. At present there is increased demand and, in some disciplines, reduced staffing over the report period. **Physiotherapy**: 13.8 mins **OT:** 9.8 mins **SLT:** 11.7 mins **Psychology**: 2.6 mins
Length of stay – acute**	SSNAP data (median days)	Jan-Jun 2022 YDH: 6.8 days MPH: 8.5 days	Median LOS MPH 8 days by March 2024 Median LOS MPH and YDH 6 days by March 2025	Jul-Dec 2023 Improved at MPH, slight increase at YDH. YDH: 7.1 days MPH: 6.9 days
Length of stay – Stroke rehabilitation units**	SSNAP (median days)	Jan--Jun 2022 44.5 days	Median LOS 40 days by March 2024 Median LOS 35 days by March 2025	Improved Jul-Dec 2023 31.7 days
% patients access to education programme	Local data	4%	50% by March 2024 90% by March 2025	No change
% carers access to education programme	Local data	0%	50% by March 2024 90% by March 2025	No change
Overall SSNAP rating – bed-based care	National SSNAP data set	June 2022: SFT: Acute: C SFT: SRUs: C YDH: Acute: D	B rating across bed-based locations by March 2024 A rating across bed-based locations by March 2025	December 2023 Improved across all sites. SFT: Acute: B SFT: SRUs: B YDH: Acute: C
% patients with improved mRS and EQ-5D-5L at 6 months	SSNAP data	*New data set* *Need to establish baseline*	Improvement in EQ5D-5L score by March 2025 Baseline new SSNAP dataset of	Revised SSNAP data set to be introduced in July 2024 including patient reported outcome measure (EQ5D-5L) and outcome measure (mRS) and Barthel.

Indicator	Source	Baseline	Target	Status
			patient outcome measures by December 2024 20% increase in patients showing improved mRS and EQ5D-5Lby 6 months by March 2026	Following introduction of new dataset a baseline of patient outcome measures can be determined.
% of patients initially admitted to an outlying ward not on the stroke unit.	SSNAP	Jan 2020-Dec2021 18% of SFT's stroke patients (240) 30% of YDHFT's stroke patients (239)	Jan22-Jan24 % initially admitted to Outlier ward MPH32% YDH40% Reduction of patients admitted to outlying ward	Jan22-Jan24 Increase in % of patients admitted to outlying ward rather than stroke unit % initially admitted to Outlier ward MPH32% YDH40%

Peri-operative care:

58. Peri-Operative care includes support before, during, and after surgery, focusing on optimising patient outcomes from contemplation to long-term follow-up. Peri-operative care was chosen as a case study because it was a promising programme of work that was developing in the legacy Somerset Foundation Trust with the potential to become county-wide. Recognising its' potential to improve population health, Peri-Operative care was prioritised to become a joint program pre-merger.

59. Before we merged, we anticipated the following benefits arising from the development of a Peri-Operative service:

Change	Benefit to patients	No. of patients benefitting a year
Introduction of a county-wide approach to peri-operative care	• Quicker recovery and fewer complications post-surgery • Better patient experience • Lasting lifestyle improvements which benefit long-term health	c. 24,850

60. Our Peri-Operative service development work is made up of 14 workstreams, including diabetes, anaemia, frailty, nutrition, exercise, smoking, and weight management. These were developed to optimise patient pathways, focusing on general health, medical health, exercise, and well-being to aid prehabilitation and post-surgical recovery.

61. Since merger, we have worked to develop and refine our service offer using evidence gathered during testing and monitoring of our interventions with patients. We have monitored approximately 600 patient referrals across the 14 Peri-Operative workstreams, and have observed 400 patients achieving their goals, providing invaluable insights for service development. With evidence of our findings, we successfully advocated for the establishment of a startup Peri-Operative service to address health inequalities and ensure equitable health optimisation opportunities across Somerset. The Peri-Operative team commenced their patient pathway testing in one GP practice in Yeovil, optimising patients on a surgical journey through Yeovil District Hospital and have since achieved partnership with over 15 GP practices Somerset wide. Knowledge and experience was gathered from YDH hospital teams in

respect of anaemia services and alcohol / substance abuse. Neither of these services were in place at MPH before merger.

62. We have invested £320,000 to establish the next elements of the service to scale up the early pilots and tests of change. We have worked closely with the Pre-Operative Assessment Clinic (POAC) teams at both MPH and YDH sites to assess hospital policies within each, aiming to align them with the best clinical guidelines. As the service has developed, we have made progress across all of the workstreams. Specific progress has been as follows:

63. Anaemia

- The initiative to establish a county-wide anaemia service for surgical pathways stemmed from the existing service at Yeovil District Hospital (YDH). We wanted to create a county-wide service, and since merger we now have **county-wide SOPs and policies related to anaemia management**.

- We have introduced **single-dose iron infusions in the community**, facilitated by the expertise of the YDH anaemia team. This initiative will significantly improve patient accessibility to treatment closer to home and efficiency in anaemia treatment.

- We have developed **patient information materials and educational resources for healthcare professionals**. These initiatives aim to enhance awareness and understanding of anaemia management practices.

- We have appointed a **dedicated Peri-Operative Anaemia nurse** and Peri-Operative Support. This has allowed us to collect baseline data and develop treatment plans for surgical patients with anaemia. This data will inform our ongoing efforts to optimise the pathway and improve patient outcomes.

64. Despite these achievements, challenges remain, and we recognise the need for continued collaboration with the YDH anaemia team for clinical support and knowledge sharing. Additionally, ongoing evaluation and refinement of treatment plans are essential to ensure the effectiveness and sustainability of the anaemia service.

65. Diabetes

- The Diabetes Peri-Operative pilot scheme was commenced in the run-up to merger, to develop a **pathway to support patients to optimise their diabetes prior to surgery**. The team has worked collaboratively with colleagues in primary care to develop and commence roll out of a pathway which identifies patients requiring diabetes optimisation at the point of referral to secondary care. Since merger, the pathway has been rolled out to 40% of GP practices referring into SFT across both sites.

- The introduction of Pathpoint at the MPH site is now also allowing a **second point to identify patients with diabetes requiring optimisation prior to surgery**. All patients identified via this route are provided with self-management education and either supported by a member of the Peri-Operative team or referred to other

diabetes optimisation services. We implement Pathpoint at the YDH site in due course to replicate this picture across the county.

66. Frailty

- A **dedicated Frailty nurse** was appointed with a remit to develop the peri-operative frailty programme for Somerset.

- We **designed a prehabilitation pathway**, integrating various therapy programs, dietary adjustments, and medical reviews tailored to individual needs. Identifying frail patients early on became a priority, as they are at risk of adverse outcomes post-surgery. With the implementation of PathPoint, a digital Pre-Operative Assessment tool in the pre-assessment process, the identification of frail patients significantly improved, enhancing the service's ability to prepare and manage their needs.

- We wanted to reduce length of hospital stay, and one way to do this would be to **reduce the number of people opting for surgery** as opposed to other interventions now more easily available due to the Peri-Operative service's existence. Across two pilot cohorts, 55% of patients chose to come off the elective surgical waiting list, following shared decision-making approaches within MDT clinics, preferring instead alternative support options offered within the community such as Community Rehabilitation Team, Age UK, exercise programmes, home aids and social prescribing support.

Patient story

Mrs. Smith's journey began when she was referred by OASIS (Orthopaedic Assessment Service in Somerset) to the Peri-Op Frailty team. Initially seen by a Frailty Nurse in her Nursing Home, it was evident that Mrs. Smith, faced challenges highlighted by her high score on the Clinical Frailty Scale (CFS). Recognising the need for shared decision making and optimisation prior to surgery being considered, a decision was made to refer her to the Geriatrician clinic and the Community Rehab Team.

Mrs Smith attended the MDT clinic and engaged in a thorough discussion with the team regarding her goals, notably her aspiration to regain mobility despite months of knee pain and limited participation in prehabilitation exercises. Mrs. Smith shared her objectives, including enjoying outings in the car, managing shopping trips, and walking short distances with minimal pain and these were carefully reviewed by the team. Subsequently, Mrs. Smith consented to a referral to the CRS team, to explore exercise options aimed at achieving her goal of walking short distances without the need for surgery. Initially apprehensive about surgery, Mrs. Smith's reported her concerns eased once she understood the associated risks and the potential limitations in achieving her goals. Mrs Smith was consequently willing to explore alternative solutions. Mrs. Smith valued the team's attentive approach in listening to her goals and assisting her in selecting the most suitable plan, for which she expressed gratitude.

Throughout her journey, Mrs. Smith received comprehensive care from various healthcare professionals, emphasising collaboration and patient-centered decision-making to address her complex needs.

Other pathways

67. We have begun work on a range of other Peri-Operative pathways. These include cancer, nutrition and weight management, pain management for opiate users, smoking cessation and substance management, social prescribing, and exercise. Personalised, tailored pathways can be created using the various strands of care available within these services. Below are two patient stories illustrating this:

Ryan was contacted by a Care Coordinator (CC) as it was identified he was significantly exceeding the weekly recommended alcohol limit. The CC discussed with Ryan the government guidelines and explained the risks of surgery associated with elevated alcohol levels and to ascertain if he would be agreeable to participate in an alcohol reduction programme. Ryan took time to consider the support offered but opted not to pursue a referral into an alcohol program, preferring instead to manage this himself. Unexpectedly, the conversation headed in a different direction as Ryan expressed a desire for assistance with exercise to overcome a recent respiratory infection and build his strength back up. Leveraging the Care Coordinator Reference Guide and her training, our CC switched the conversation into a discussion around exercise options available within the community and referred the patient into a health coach pathway. Ryan was pleased with this option and the chance to improve his health prior to his planned surgery.

Lucy is in her 30's and had recently been screened for surgery and identified as potentially benefiting from a little support. We contacted Lucy to open a discussion around her surgical goals and whether she had any health and wellbeing targets she would like to reach prior to her surgical date. Lucy was astounded to understand there was so much help and support available to her whilst she was waiting for her surgical procedure and gratefully accepted a full suite of multiple referrals into a tobacco reduction programme, and alcohol reduction programme and Talking Therapies for assistance with wellbeing. Lucy agreed to being contacted again by the Care Coordinator team to follow up on her progress. In the interim she will also consider a referral into the Health Coaching team dependent on the outcome of the first three referrals.

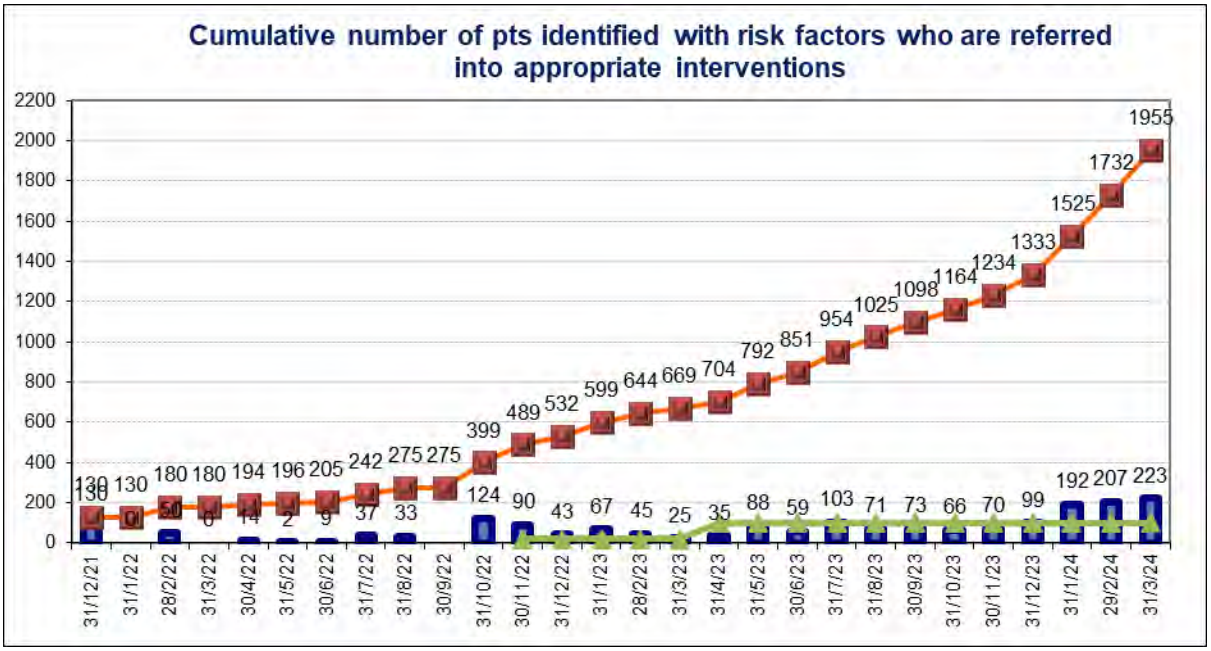
Lucy's story embodies the very essence of addressing health inequalities and shows a strong collaboration between the acute teams in the hospital, the Peri-Operative support services team, public health and local community programmes.

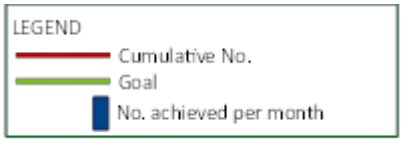
68. Both scenarios underscore the significance of perioperative care in treating patients holistically, beyond their initial surgical concerns. The service aims to empower patients as active participants in their own health management and helps to foster positive long-term health outcomes.

69. Initial indications here suggest the value in referring patients into these pathways extends well beyond their surgical journey and may well contribute to long term positive health trajectories.

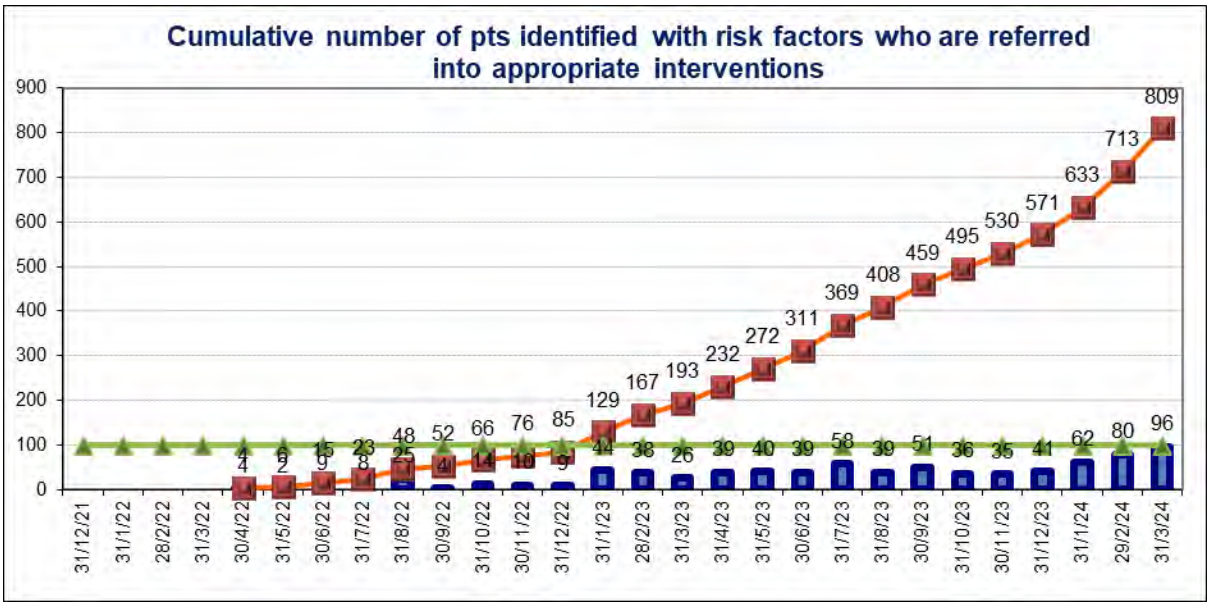
70. Our performance against the targets we set ourselves for this developing service have been met and exceeded, as shown in the charts below. We continue to develop our service, recognising that in many areas it is novel and embryonic. As a merged trust, the flexibilities and opportunities we see will help this new service help many more patients in our second year of merger.

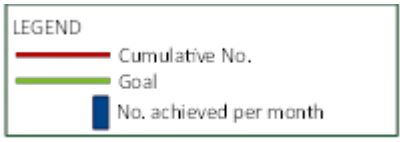
71. The first chart shows the **number of patients identified for modifiable risk factors** since December 2021. After merger, we aimed to identify 100 patients per month. While this target has been challenging, we hit this milestone in January this year. As at March 2024, the service has identified a total of 1,955 patients with modifiable risk factors (March 24).



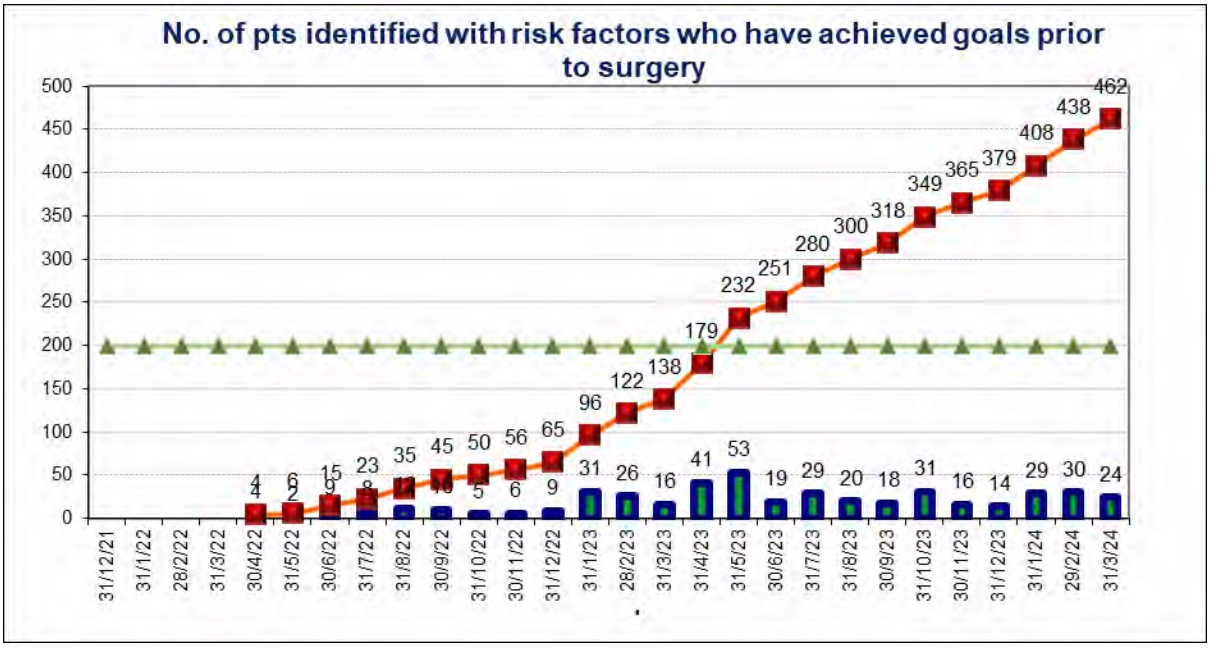


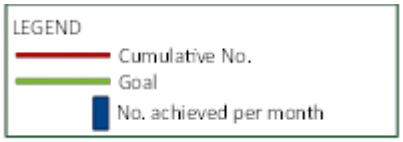
72. The chart below shows our goal of **number of patients referred into services**. This goal was also set at 100 patients by April 2023, and we have made significant progress, with a total of 809 patients referred into optimisation services. On average, we are referring around 50 patients per month.



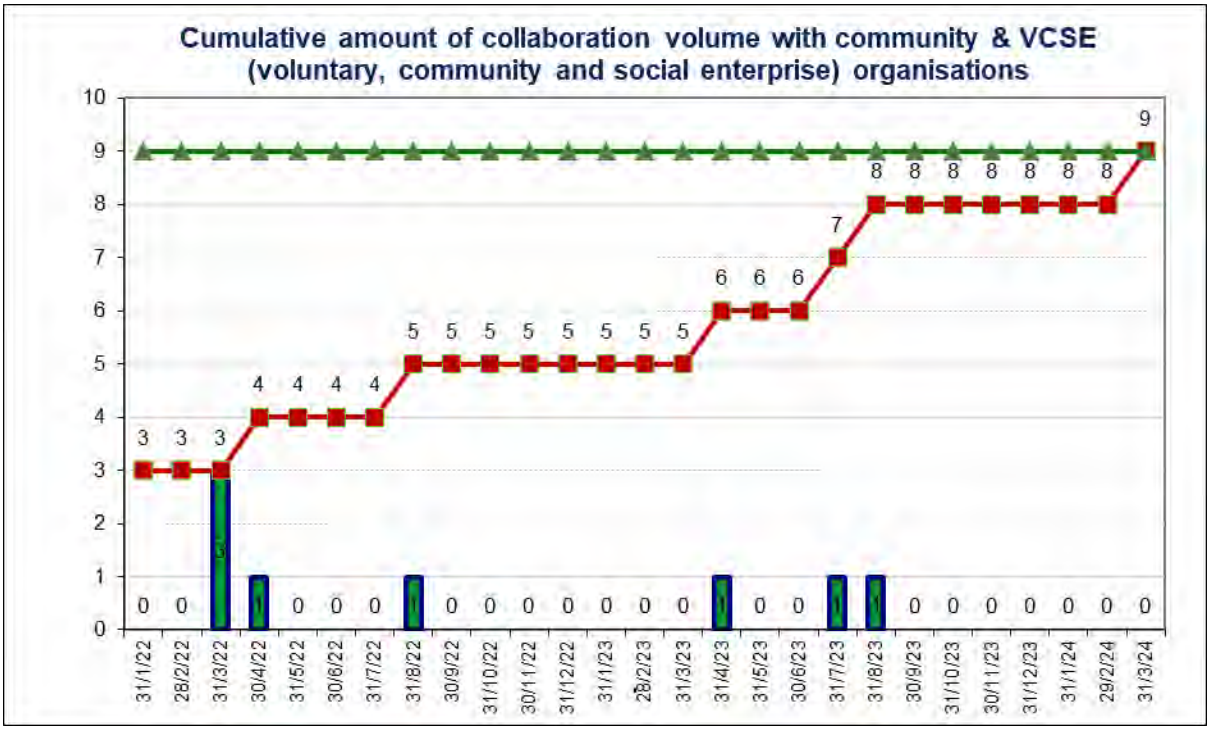


73. The chart below shows the **number of patients achieving their optimisation targets**. We have doubled our initial target of 200 patients by November 2023, with 462 patients successfully meeting their goals. This includes various interventions such as diabetes management, frailty assessments, tobacco reduction, and exercise programs.





74. The chart below shows the **collaboration with voluntary, community, and social enterprise organisations.** We aimed for nine collaborations, and have reached our target.



Homelessness

75. Homelessness was chosen as a case study because reducing health inequalities across our population is one of our system's five health and care aims, and a priority for the trust reflected its strategic objectives.

76. Prior to merger, we anticipated the following merger benefits and the number of people likely to be impacted:

Change	Benefit to patients	No. of patients benefitting a year
Introduction of a county-wide approach to care of homeless people	• Intervene early to prevent escalation of health need • Address a significant health inequality in our county • Provide coordinated care which is tailored to the complex needs of this patient cohort	up to c.300-400

77. Since merger, we have made progress in our vision of a countywide approach to the care of people experiencing homelessness which focuses on early proactive care to prevent ill health, and aims to reduces the health inequalities this patient group face.

78. Care is delivered, where possible, via outreach by the homeless rough sleepers nursing services (HRS) in partnership with other services e.g. public health and the council and well as support from condition specific health care specialists in both acute and community services. This has enabled care to be brought to the homeless wherever they are rather than expecting them to attend healthcare settings unless medically required. Settings include shelters / hostel, YMCA, prison release hostels, tents, cars, caravans, temporary accommodation e.g. hotels and sofa surfing as well as our

counties streets. As the HRS team become more established and trust is built up within the homeless community, their referrals and follow up patient numbers are increasing.

79. Since merger, we have made the following progress:

- We have designed a **more streamlined and equitable care pathway**. All parts of Somerset now have well-established nurse drop-in clinics at different venues linking up with other services e.g. dedicated GP sessions and Council homeless workers. These locations offer a safe place for individuals and the attendance at these clinics are increasing as word of mouth gets out and trust develops. However, due to staff sickness and vacancies we still have not achieved our aspiration to equitable service provision in all four neighbourhood areas.

- The merger has enabled the homeless team to have **equitable access to information and services on both acute sites** which has improved safe more timely care including direct referral into same day emergency care for a full range of clinical issues e.g. deep vein thrombosis (DVT). As the integration of condition specific clinical pathways and services progresses there will be a further benefit in the streamlining of referrals and offer to this patient group as they often have multiple conditions and need to access services across many sites. In addition, working with and developing services with agencies external to the trust e.g. Somerset Drug and Alcohol Service (SDAS) and Hep C trust has become easier now we are one trust.

- The HRS team attend **ward rounds at both MPH and YDH** when clients who are known to our service are admitted. They now document in the hospital notes and link with the ward staff to assist with onward treatment from discharge.

- A smoother, **single discharge approach** across both acute sites has been developed.

- Our **workforce has been developed to make the most of merger**. Four Mental Health posts were introduced to the HRS team to work alongside to bridge the gap and enable a more holistic approach.

- All staff now have access to all relevant clinical systems, and this has **improved access to information and care**. An alert is now attached to each of the clients known to the HRS team on all the three main legacy systems. The alert notifies the hospital / treating clinician that the client is known to the team. For YDH this produces an automatic email to the team to inform them who has attended ED or are an inpatient at the hospital. This then triggers the HRS team to support this individual and the treating colleagues. For MPH the outreach team receive a report three times a week as the system does not have the same capacity to provide real time notifications.

- An **e-learning package** has been developed to raise awareness of homelessness.

80. Overall, the merger has allowed the HRS team to match care across both acute sites, particularly with the interface of acute and community provision and helped align it to the needs of our patients. A key success has been the raising awareness of the issues and support needed for this group and advocating for changes in service provision. This

has reduced acute presentations to emergency services and admissions and helped to improve the health of some of the most vulnerable people in Somerset. The pace of the work, in some cases has been dictated by the integration journey of other clinical specialities as these individuals have complex needs that cross many clinical pathways.

81. **Integration progress across all clinical services**
The wider integration of 47 clinical teams across SFT was monitored through a monthly Merger Programme Board. Clinical service integration reports detailed progress against transformation plans, and against milestones (Appendix 6). Despite challenges, the majority of teams have started integrating. 55% of teams now have a joint vision, 35% have a transformation plan and to date, two teams have completed their integration milestones.

Corporate Integration Overview

82. We have made good progress against the corporate integration plans as outlined in the Post Transaction Implementation Plan. There have been some delays in delivery of the post-merger activities, but the critical Day 1 activities identified in the run-up to merger were all achieved on time, ensuring that the new organization was safe, legal and reputationally sound on Day 1.

83. The merger Project Management Office (PMO) coordinated corporate workstreams during our preparations for merger. The PMO reported exceptions and risks to Senior Responsible Officers (SROs) at Board level, and mitigations were put in place to ensure delivery. The workstreams continue to deliver the post transaction deliverables, which have now become part of "business as usual" service planning.

84. We split our integration planning process into two key stages:
    - activities required by Day 1 and by Day 100 to provide a 'safe landing' for the merged trust; and
    - activities which support clinical and corporate service integration and support the transformation we need to deliver.

85. An overview of the critical Day 1 actions and the post-merger integration activities is covered in the following sections. The specific highlights are summarised in the individual sections for each workstream.

Critical Day 1 Actions

86. We identified 44 Day 1 business critical tasks across our merger workstreams. All of these tasks were completed by Day 1, ensuring that the newly merged trust was safe, legally compliant and at no reputational risk on the day of the merger. The business critical Day 1 projects that we delivered are listed at **Appendix 3**

Delivering integration projects after merger

87. As part of our preparations for merger, we identified over 250 corporate merger projects which were not necessary for Day 1, but were required to deliver to maximise the benefits of merging. We delivered many of these on or before the

date of merger as our preparations developed, but 167 were outstanding after Day 1. The merger PMO monitored our progress in delivering these projects.

88. By the end of May 2023, five workstreams had completed all of their outstanding projects, and most others had completed over 90%. By August, only 40 projects remained outstanding. All of these were on-track to be delivered according to their previously assessed time frames, other than 4 which had been programmed to start at a later date. These became managed as part of our "business as usual" processes.

Corporate Function Integration

89. During the preparation for our merger, our corporate functions each developed a "merger charter" which set out their success criteria for the merger itself. In the year since merger, significant progress and achievements against these success criteria have been secured, although challenges remain.

90. In **Clinical Governance**, we have implemented a revised devolved governance framework that supports delivery and oversight of quality and safety in our services. For example, we now have an integrated quality assurance process that is well embedded and has identified areas of concern including some issues that have required immediate action. Each of the six service groups and our estates and facilities service have developed internal governance structures and report monthly across the merged trust through Quality Outcomes Finance and Performance meetings and annually to the Quality & Governance Assurance Committee. Such widespread coverage would have been impossible without merging. Overall, as a trust, we continue to be rated "Good" by the CQC, but in November 2023, our maternity services were inspected as part of the national targeted inspection programme. Whilst there was evidence of Good practice reported, there were a number of areas of significant improvement identified. The CQC issued the trust with a Section 29a Warning Notice in January 2024 and rated the maternity units at Taunton and Yeovil inadequate for the safe and well led domains. We are taking the learning from these inspections to revisit our devolved governance framework, board and sub-committee reporting and our readiness for the new CQC assessment regime.

91. We have begun to implement the new Patient Safety Incident Response Framework (PSIRF), and the launch has been successful across the merged trust, meaning that the whole county is making these improvements together. We have achieved our target of being in the lowest quartile for overall cost and below national median cost for Quality and Audit in the NHS corporate benchmarking report, which has been made possible as a result of efficiencies created by merging teams. Further efficiencies will emerge in the coming months as a result of restructures.

92. Our **Corporate Governance** team is more resilient across the trust, where previously small teams with single points of failure has become part of a larger team. We have more of an ability to deliver an enhanced service that does more than simply meet statutory requirements. For example, we have been able to engage more with FT Members and have launched a membership engagement strategy to increase the input that service users and local people can give to service developments. Without a merger, we would not have had the resources to do this across the whole of Somerset.

93. Our **Finance** team achieved its' main important goal of ensuring business continuity during the technically challenging merger period. The Finance, Procurement and Payroll functions were operational from Day 1 and have continued to operate normally throughout, ensuring the financial stability of the organisation. Legacy systems have not

presented difficulties, and every system that could have been merged to increase resilience and improve functionality has been merged e.g. a single payroll and a single ledger. These efficiencies have boosted resilience and reduced variation across the county. Complications have reduced, and services have become “business as usual” without interruption. Good grip and control has been maintained, and there were no major financial incidents despite the obvious complications in bringing together two Finance functions.

94. We now have a single Finance team, aligned to the business and operating well. Staff survey response rates for the team have been good, and there are now more opportunities for colleagues, more cover and more resilience across the enlarged trust. Appraisal rates have improved, and there has been no increase in sickness rates. Gaps in teams can be more easily plugged, and there is more scale to respond to issues, whilst delivering significant cost reductions. Sharing good practice is easier, and we have made improvements by doing so, for example to our internal reports which have taken good practice in financial information presentation from YDH and applied it to trust-wide reporting. We have continued to provide assurance to regulators, and receive positive assurance from Internal and External Audit.

95. Our trust **Charity** has seen a 5% increase in social media followers across the Board, who have been attracted as part of a communications campaign launched as the trusts merged. Such a campaign would not have been possible given the smaller budgets of two separate charities. There were concerns that donors who identified with the legacy trusts may be put off donating to the new trust, but our income levels have remained the same. The rebranded charity has been well received and there has been no reduction in the number of charity supporters, early signs are a positive response from the supporter base to the broadened scope of the charity.

96. Whilst our **Estates and Facilities** Services remain separate due to the operating Model including Simply Serve Ltd, we have improved the strategic management of our estate, using a combined Strategic Estates Group to better plan for space utilisation and the prioritisation of estates usage and maintenance. Our larger budgets mean that some projects at YDH which might have been unaffordable as a small organisation can now be more easily delivered, for example, the new operating theatre due to open in 2025. We have used best practice from legacy trusts to create joint processes which have improved fire safety and security management across the whole combined trust. We have also created efficient and unified ways of leading Estates improvements, such as through the creation of a joint Head of Sustainability post which supports the agenda across the larger organisation.

97. Our **Communications** service has been redesigned following the merger. The trust had a new visual identity from Day 1 and which allowed both colleagues and the public to identify with the organisation as a single entity. This is particularly helpful in our efforts to develop a more unified staff culture. The increased size of the single Communications team now means that we can engage in greater analysis of the effectiveness of our internal and external communications through readership and engagement levels. We have been able to expand our offer, particularly to those with less access to a computer, for example the new trust podcast and the launch of an Instagram channel in December 2023, both of which have contributed to steady engagement growth since merger. Our locally produced programme of content related to winter service pressures generated significantly more engagement than both the national NHS programme did in Somerset, and our engagement as separate trusts in previous years.

98. Our trust website now has better analytics, meaning that we can improve it as a result of the data we have. This level of information was not possible before merger, but our scale now means that it is, whilst recognising this needs to further evolve to the needs of the public and as our services change. We will also be launching a new intranet in autumn 2024.

99. The trust has better **resilience and emergency planning** capability. After merger, we achieved full compliance against national standards in this area for the first time, largely because the team itself is now more resilient due to its' size. Single points of failure in individual trusts have been replaced with a county-wide team that is more flexible and responsive. The trust has faced numerous resilience challenges in its first year e.g. ongoing industrial action, but these have been managed well using new command and control arrangements and using learning which has been developed through our enhanced training and scenario planning capabilities.

100. As a result of the team growing in size, it has been able to change the type of service it offers, becoming more strategic and able to offer a wider range of advice and support to operational services. There is more of a focus now on planning rather than response, which is better for the trust and its' services, and is much easier to deliver with a larger team. This has led to real change on the ground, for example the alteration of emergency plans to divert P3 casualties (casualties from major incidents in which 50% or more have minor injuries) away from acute hospitals and towards MIUs. This has happened in several incidents this year.

101. We have been able to deliver enhanced management of **capital projects** as a result of merger. We now hold a monthly Capital Delivery Group across the combined trust, and have rolled out better control processes to YDH that were previously only applicable to the predecessor SFT, and we have been able to share skills and knowledge across capital projects.

102. We have been able to make more of our **commercial** opportunities. A unified approach to the use of digital media (screens) and space (panels) has been adopted across all SFT sites via the contractual agreement set up with our delivery partner. The insights derived from past experiences have empowered the formulation of new contracts with third parties, fostering a more precise and coherent approach. One example has been the inclusion of staffing retention as a Key Performance Indicator (KPI) in the new Diagnostic Centre Contract set up with InHealth for Provision at our YDH site.

103. We have been able to improve our Private Patients offer, benefitting patients and also the trust's reputation and financial position. The Private Patient Units at both YDH and MPH run clinics which both units feed into and support, for example the Iron Clinic, Hormone Clinic and Well Man Clinic. We are now able to deliver these more flexibly, and with less duplication. The growth of the Private GP service on the Kingston Wing has allowed us to learn lessons for Taunton and introduce a similar service via the Parkside Unit at MPH. We have been able to better manage Private Patient referrals, because if no consultant is available in one location, the information can be shared with the other site to enable the trust to keep the referral.

104. Working as a combined trust means that we can have better tariff arrangements with health insurers. Using tariffs at one site as the baseline for future negotiations for the combined trust.

105. Our **Digital** services merged with uninterrupted business continuity. Full systems and email migration occurred with minimal disruption. Many systems migrated using temporary measures at first, but background integration work has ensured seamless transition since merger.

106. Longer-term, the combined trust's Digital Strategy for 2030 is now in place, with targets for year 2 and year 5 which have been approved by Board and towards which good progress is being made.

107. The Digital workforce endured some retention difficulties around the time of merger, and there were vacancies within the team as a result of internal promotions and moves. However, the situation has improved and the full transformation of the Digital service has resulted in significant opportunities for many colleagues to work in new functions.

108. The merged trust has allowed for more digital innovation, since the team can now work more flexibly at scale. We have continued the roll-out of Robotic Process Automation, and now have six robots undertaking tasks in services such as Outpatients. We have been able to develop more digital systems and roll them out across the county. For example, there have been expansions across both hospital sites in Maternity, ITU, e-Prescribing and Patient Hubs, as well as in supporting activities which now share Office 365, Teams, Sharepoint and other software.

109. The increased size of the combined Digital team has allowed for increased data analytic capacity, taking the good practice and skills from the YDH team and building skills and capability of the wider team. More analysed data means more actionable insights, and we have been able to recruit to a new Head of Data Insights role, leading a team specifically designed to promote this field of work. We have also received initial approval for the trust's new Data Warehouse, which will combine three existing facilities into one. There is further work to do on our analytics offer but the first year has been building the capability and capacity.

110. The digital service is well placed to support the significant benefits of an integrated Electronic Health Record system. Alignment of the organisations' aims and decision making has made the development of the case for change, organisational engagement and identification of resource easier. The delivery of an integrated health record will be vital to achieve the ambition within our clinical model.

111. Our **People** service has significantly re-shaped its' leadership team, to streamline structures and help implement a wider range of People services across the combined trust. This has included a new Productive People services approach, modelled on our Productive Care work in clinical services.

112. We ensured that the broad People offer was available at both old-SFT and YDH, including both traditional HR services and support, as well as enhanced Wellbeing, Freedom to Speak Up and other services such as Practice Facilitators.

113. We have enhanced our efforts in recruitment and retention, merging processes and functions. Around 25% of our workforce is now from overseas, and the newly merged People function has focused more on reducing temporary staffing by increasing the onboarding and inclusion support we can give to our overseas colleagues. We have increased this support especially in hard to fill medical roles, such as Psychiatry.

114. We now have an integrated Learning and Development service, with closer links to colleagues working on both colleague and patient experience. And we have continued our work to make our culture more inclusive. This has included an increase in skills-based recruitment to address disparity against colleagues from different backgrounds.

115. The merger has allowed us to focus on the future, including our new Digital People Plan. This has involved the alignment of all our People systems with the incoming Electronic Health Records (EHR) system, with the aim of helping to boost workforce digital literacy to optimise productivity.

116. In our **Procurement** service, we now have more system-wide resilience around processes. We kept two separate Procurement teams because YDH procurement is managed through our wholly-owned subsidiary Simply Serve Ltd (SSL), but we do have a single Finance and Procurement system now in place as a result of the merger. Everyone in both teams are now following the same procedures. There are fewer single points of failure across the system, and a better grip of which team does what in terms of contracting, which reduces duplication. Even though two teams remain, combined policies for many aspects of Procurement are now in place.

117. A single Procure to Pay (P2P) system has been introduced across SFT and SSL as planned, allowing swifter and easier ordering and supply.

118. Patient safety is paramount to the success of our services, and we have been able to improve our **Infection Prevention and Control** services as a result of the merger. Colleagues from across the combined trust have harmonised policies, and can share knowledge and skills. This is particularly beneficial within YDH where a 24/7 advice service via the single trust-wide IP&C team is in place which was not available previously. A specific example of improved practice has come from the harmonisation of outbreak control procedures, which saw significant improvements in practice at YDH. We have also been able to use our combined team to save money on the procurement of cleaning products by standardising suppliers. We have also broadened IP&C knowledge to all staff by implementing a standardised annual e-learning package across the whole trust.

119. We want our patients and their loved ones to experience the best care when they use our services. Where this doesn't happen, we have **Complaints, PALS and Patient Experience** colleagues to help. This team has also been able to offer improved services as a result of the merger. We have undertaken a full review of the service, changing its' focus and making it more responsive and collaborative. Whereas in the past we analysed service performance based solely on speed of response, now we consider the quality of the response and numbers of complaints that are resolved without subsequently being reopened.

120. We have still maintained or improved performance against time limits for acknowledging issues and complaints, but now work closer with complainants, often face to face or over the phone, rather than in writing (unless the complainant prefers). This has resulted in significant improvements to satisfaction – In 2022/3, before the merger, 15% of PALS concerns or formal complaints were re-opened after an initial resolution. After the post-merger service review this has fallen to 0%.

121. Our complaints and PALS processes have been mapped and streamlined to enable us to be quicker and more effective. We have new posts in place which allow us to be more responsive to the needs of the organisation, working in collaboration with our

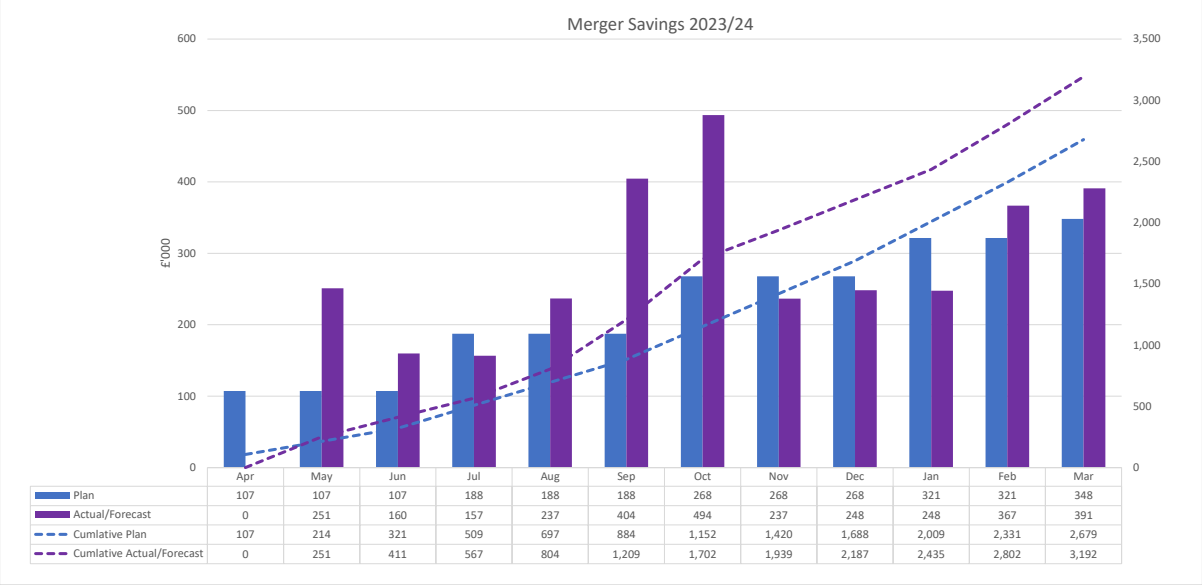
service groups to look at data and to highlight clusters of incidents. The team has become more able to offer support, allowing for better connections between services and service users. We have achieved these improvements whilst simultaneously reducing staff costs as a result of the restructure. We are now also using more Patient Reported Experience (PREM) measures such as Care Opinion to give us a better understanding of our patients' views and needs, and to guide future work. This fits into the culture of openness and transparency that we want to work within, and which has guided the restructure and re-focus of the team.

Financial Benefits

122. Despite the challenges facing the NHS in terms of Covid recovery and recovering our waiting list position, we have been able to achieve our initially planned financial benefits and remain on course to deliver the savings set out in the business case.

123. Significant work has been undertaken to restructure corporate functions enabling us to make savings in the year since merger, with future savings also expected as the planning and implementation of the organisational change processes to realise savings continues

124. The summary table below shows the savings achieved in 2023/24:



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	107	107	107	188	188	188	268	268	268	321	321	348
Actual/Forecast	0	251	160	157	237	404	494	237	248	248	367	391
Cumlative Plan	107	214	321	509	697	884	1,152	1,420	1,688	2,009	2,331	2,679
Cumlative Actual/Forecast	0	251	411	567	804	1,209	1,702	1,939	2,187	2,435	2,802	3,192

125. Total merger savings of £3.2m have been delivered compared with the original planned savings of £2.7m, an overachievement of £0.5m. The savings have been achieved in the following areas:-

Area	Saving £m
Chief Nurse	0.3
Chief Finance Officer	0.7
Chief of People and OD	0.6
Director of Strategy & Digital	0.3

Director of Corporate Services	1.3
Total	3.2

126. Further savings of £1m are planned in corporate functions in 2024/25 with a further £1.3m expected in 2025/26. In addition, through the Productive Care Programme our Clinical Service Groups are focussed on driving clinical transformation to deliver productivity improvements and financial efficiencies through the opportunities afforded by the integration and consolidation of services.

Cultural benefits (including results from the NHS Staff Survey)

127. We knew the two merging organisations had different cultures, borne to a large extent from the significant differences in size and scope of services as well as different experiences of integration. YDH was a single-site acute-only trust, whereas the previously merged SFT had three times as many employees, worked across multiple sites in acute, community and mental health and the degree of change was greater for YDH colleagues.

128. We have delivered a significant body of work to try to take the best of the cultures of the old organisations and create a new and unified culture. We knew YDH had a culture of open access to senior leadership, and innovative ideas such as the “internal transfer window” to address recruitment and retention issues internally. We have looked to mirror this in the new organisation, as well as to foster in YDH colleagues the greater autonomy that is vital to delivery of the strategy and work within a large organisation. We have done this with the formal introduction of new trust values and new leadership expectations for the organisation. As time goes on, we will launch specific programmes to address identified skills gaps. We want to celebrate success and are doing so with our monthly Somerset Stars awards, and the annual OSCAs (Our Somerset Care Awards) which will take place for the first time in June 2024. On a day-to-day basis, we have introduced the trust-wide Operational Leadership Team, and trust-wide Senior Leadership Forum meeting every two months to create and sustain a county-wide identity and to foster a unified culture.

129. We have levelled-up the provision of roles which contribute more significantly to the culture of the organisation, for example those directly concerned with patient experience and patient safety. As a smaller organisation, YDH often didn’t have specific roles for these areas, but in the larger trust these roles do now exist.

130. Our efforts in creating a good culture have also included relationships with our Trades Union colleagues and with the subsidiary companies owned by YDH. In a challenging year for both industrial action and internal restructures we have maintained and developed relationships with Staff Side colleagues, and undertaken positive work on aligning terms and conditions and on bringing formerly outsourced colleagues back into the NHS.

131. One area in which we were conscious that improvements needed to be made was in temporary staffing. We know that pressured working conditions have a big impact on how colleagues perceive the organisation. We also know that well-staffed services are safer and better. As a result, we have made significant efforts to improve our approach to temporary staffing safety, with new systems and the removal of poor incentives. The Temporary Staffing team itself is more available, making clinical environments safer and more appealing places to work. This has led to significant improvements.

    a. Overall Agency staffing is down **by 34%** against last year. At points during the year agency shifts have been at record low levels in both hospitals. At YDH in week 27 of the year, only 9 agency shifts were booked.
    b. We have completely removed off-framework Agency booking from YDH and mental health wards.
    c. Overall shift fulfilment is at **81%**, an improvement of 11 percentage points in a year. YDH performance is 85%, which is higher than ever before.
    d. Shift requests are **down by 24%** against last year.
    e. Bank fulfilment has remained stable despite the removal of premium payments which has led to a £2m saving.
    f. Invoicing improvements in temporary staffing will enable clawback of up to £50,000 in erroneous bills.

<u>NHS Staff Survey results</u>

132. We have recently seen the results of the first NHS Staff Survey undertaken since we merged. The survey ran between September and November 2023, meaning responses were taken between 6-8 months post-merger. We knew the survey would be a good barometer of our success in creating a positive culture for colleagues. Our response rate was 53%, which was five percentage points above the average comparator trust response rate.

133. The overall results were positive but recognise that there are areas of continued focus and improvement. In total, 92% of questions scored significantly better than comparator trusts, with only two questions scoring significantly worse. The People Strategy which we developed for the post-merger trust identified 8 “People Promises”, with themes such as “We are compassionate and Inclusive”, and “We each have a voice that counts”. Our results were significantly better than comparator trusts in all 8 areas.

134. Some of the areas in which we scored particularly well included:

    a. Over 80% of respondents said that care of patients was the trust’s number one priority, which was significantly better than comparator trust.
    b. Nearly 90% of colleagues reported that their job made a difference to patients.
    c. 7.5% of colleagues reported facing discrimination in the past year, which is around 25% fewer than reported in comparator trusts.
    d. 92% of colleagues reported feeling trusted to do their job.

135. The areas in which we scored less well than comparator groups were appraisal rates (78% reported an appraisal in the last 12 months against a sector average of 83%) and staff reporting unwanted behaviour of a sexual nature from patients/colleagues (9.2%

against an average of 8%). We take these issues seriously and welcome these results as a way for us to target our improvement efforts.

136. Overall, a year into the merged trust, there is a mixed picture about how the culture has developed. This is not surprising given the significant differences between the organisations, and the more challenging nature of the relationships involved in this merger. Whilst our overall NHS Staff Survey scores are good, they do mask some inconsistencies which are part of the people strategy to work through. We also know that there will always be challenges in the development of an organisational culture which will take time to embed and develop.

Organisational performance against key national targets

137. Both the old SFT and YDH faced performance challenges before the merger, as the legacy trusts sought to recover from the Covid pandemic. Challenges have continued in the first year of the combined trust, as demand for both emergency and elective capacity have remained very high.

138. The focus of this section is on Acute based metrics recognising the nature of the integration. The full merger evaluation will include the changes to all performance metrics.

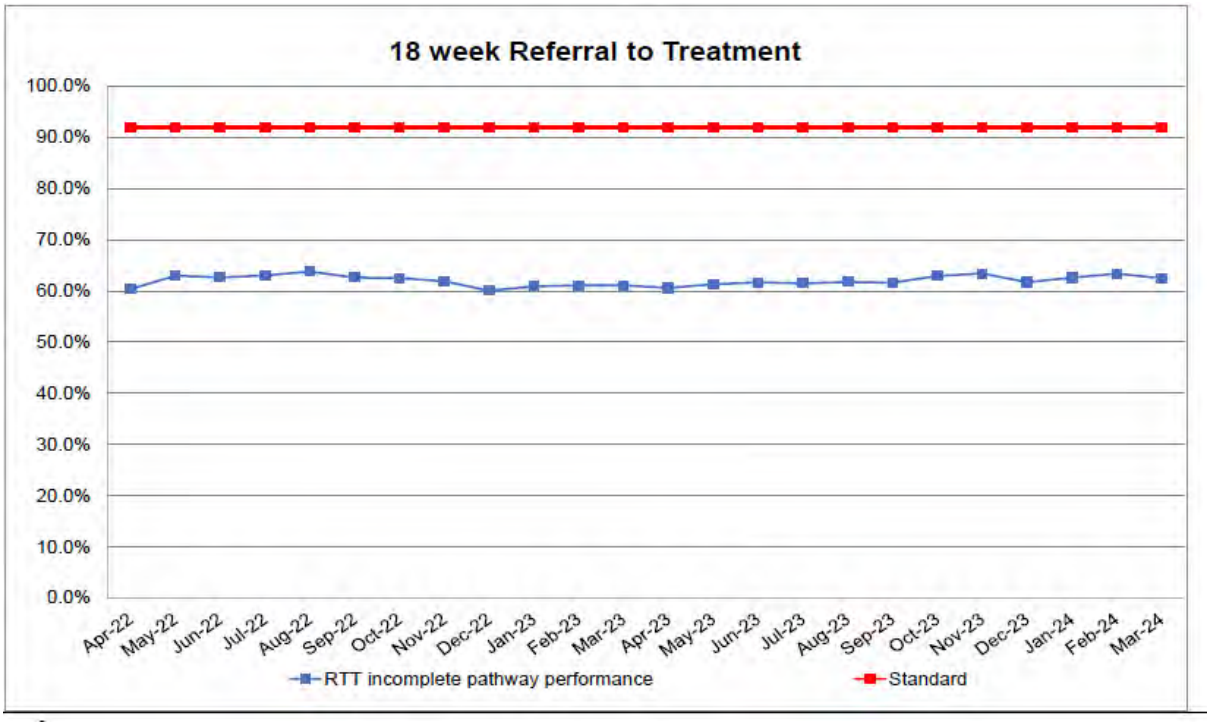
139. We have improvement plans in place to recover our position against the key targets, and are working across the system to ensure improvements. Performance against all of the key performance targets is considered below:

a) Referral to Treatment (RTT)

140. 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.

141. The trust was not meeting these targets at the end of March. The percentage of patients waiting under 18 weeks RTT was 62.5% (combined acutes + community) in March, down from 63.4% in February. This is better than the national average (57.6%) but still does not meet the national target. The number of patients waiting over 65 weeks had reduced by 104, but still stood at 434.

142. Performance has been steady at or around this level for the last two years, both pre- and post-merger, as shown in the graph below:



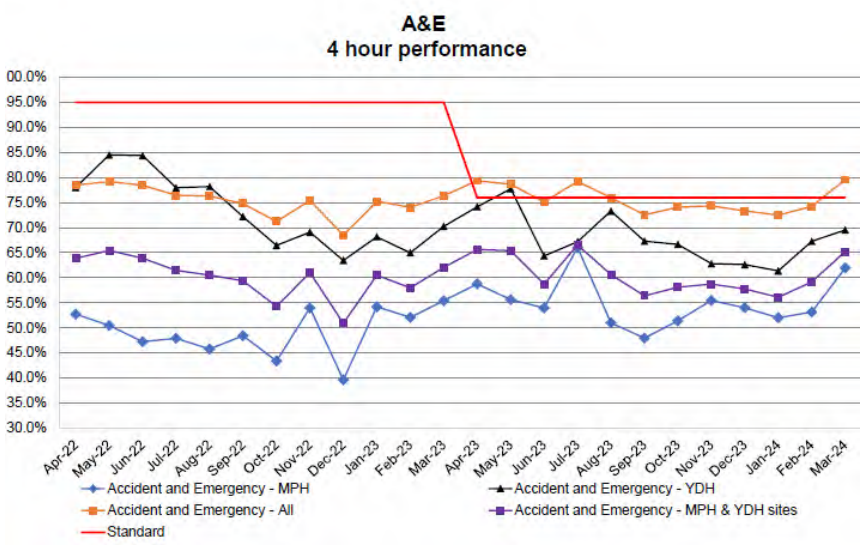
143. The focus of our improvement work will be on reducing the 65-week waiters further. We have quantified all such patients by specialty, and detailed plans continue to be progressed to manage these volumes through improved productivity, increased capacity (including use of the Independent Sector) and reprioritisation of available theatre capacity across the System.

b) Accident and Emergency 4 hour waits

144. 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.

145. Trust-wide A&E 4-hour performance for our EDs was 65.2% during March 2024, up from 59.2% in February 2024. With Minor Injury Units (MIUs) compliance included at 97.9%, our overall compliance was 79.6%, up from 74.2% in February 2024, above the revised 76% national standard, and the highest level of compliance since the establishment of the merged trust.

146. Our performance trend can be seen in the graph below:



147. We perform relatively well compared to other trusts in England. In March 2024, the national average performance for trusts with a major Emergency Department was 60.9%. Our performance was 65.2%. We were ranked 40 out of 122 trusts. With Minor Injury Unit attendances included, we were ranked 14, with performance of 79.6%. National average performance was 71.9%.

148. Combined A&E attendances at MPH and YDH from 1 April 2023 to 31 March 2024 were 3.3% higher than the same months of 2022/23. Since 1 January 2024, the numbers of attendances have significantly increased, which has affected performance against the four-hour standard.

149. We continue to work to improve our performance. Initiatives include the following:

- Senior Operational Managers are now in post and are working to share ways of working, for example sharing the progress chasers/trackers roles.
- A review of the four-hour performance data highlighted an error in the validation reports at YDH which has now been corrected, and which will result in improved performance.
- Focused work on Criteria-Led Discharge and reducing the number of patients not meeting the Criteria to Reside is underway, with the aim of facilitating earlier discharge and improving ED flow.
- A gap analysis of ED overcrowding recommendations from the Royal College of Emergency Medicine is being initiated in April 2024 to support the development of prioritised action planning.
- A joint departmental push on the Productive Care Programme has highlighted multiple projects which will affect our four-hour performance positively.
- Scoping work has been initiated on projects relating to time to be seen, time to diagnostics and timely transfers from ED.

150. There are two cancer service targets:

- At least 96% of patients to be treated within 31 days of a decision to treat. This target includes first and subsequent treatments for cancer.
- At least 85% of patients to be treated within 62 days of referral.

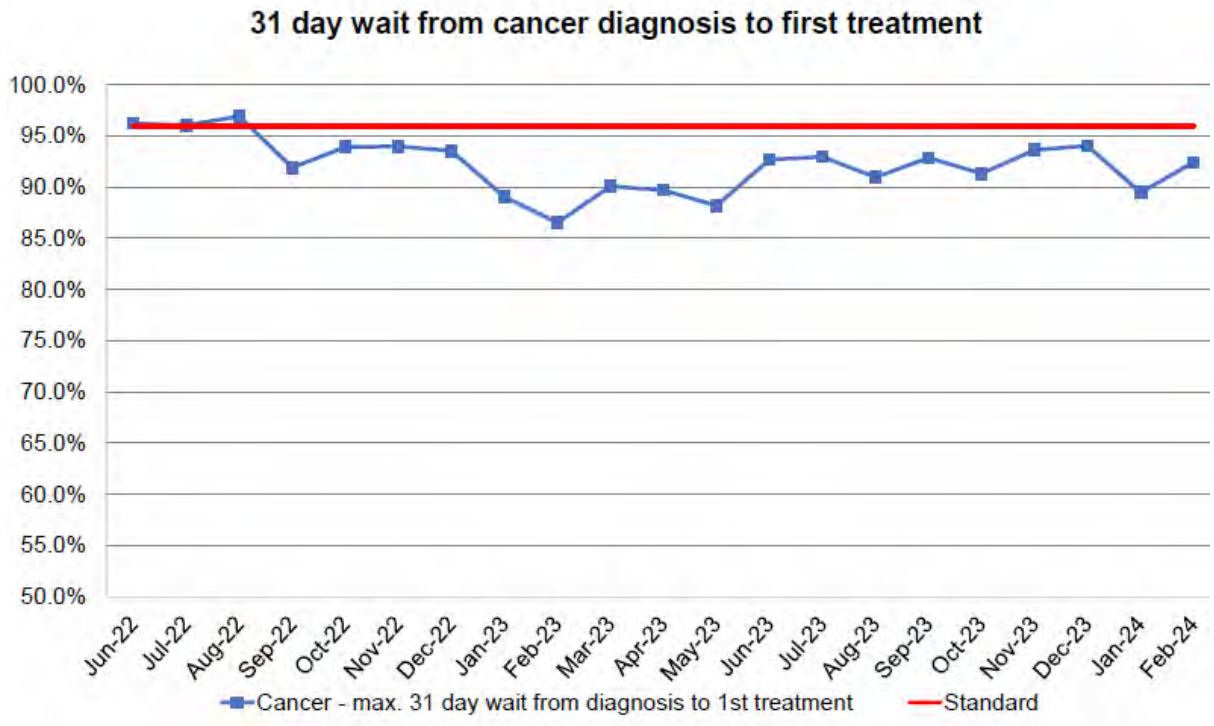
151. The most up to date performance figures are for February 2024. Performance against the 31-day first combined treatment standard was 92.4% in February 2024, below the 96% national standard but above the national average performance. 77% of

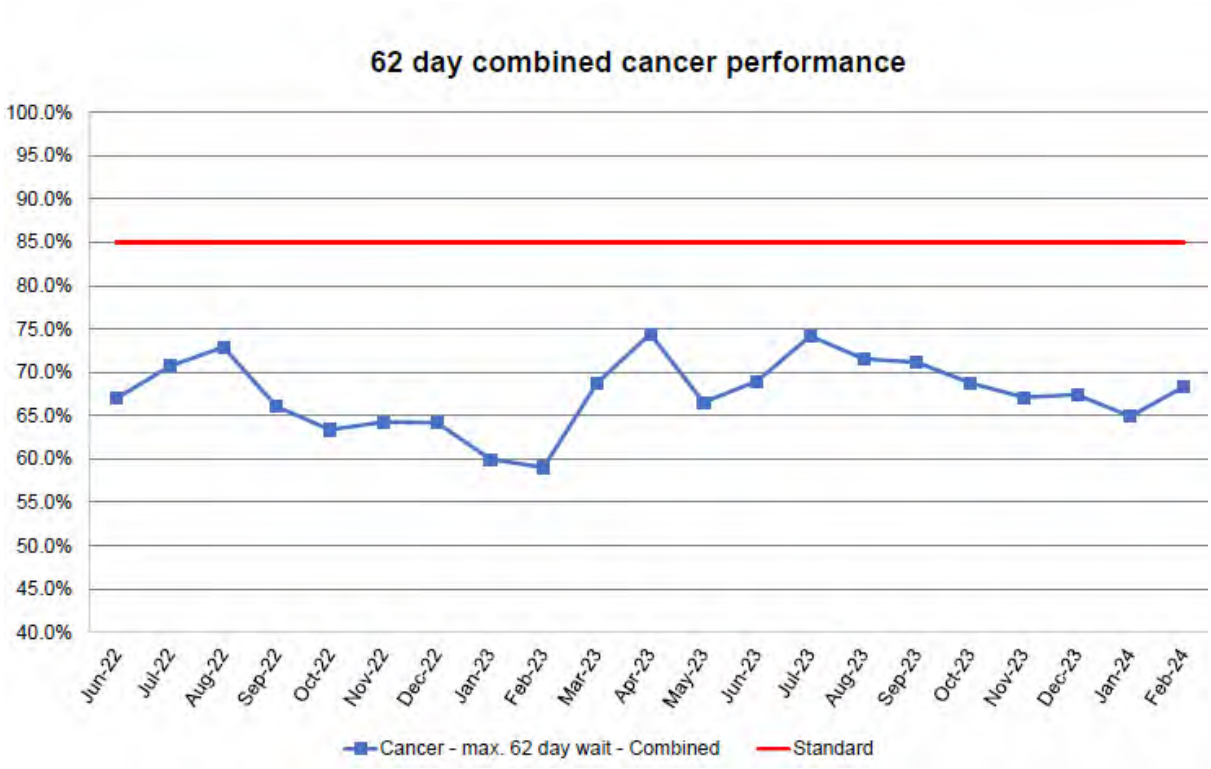
the breaches were for surgical treatments. The ability to operate within 31 days of the decision to treat is affected by bulges in demand, which we have been seen particularly in some specialties.

152. The percentage of patients treated for a cancer within 62 days of referral was 68.3% in February 2024, up from 64.9% in January and above the national average.

153. Industrial action had some impact on planned cancer treatments over the December 2023 and January 2024 action, which has had a knock-on impact to February 2024 performance. However, the delays and cancellations of surgery were clinically risk-assessed on a case-by-case basis by the operating surgeon.

154. The focus of our improvement work involves more demand and capacity modelling, particularly in challenging specialties. Performance graphs can be seen below for both targets, showing that performance has generally been at or above pre-merger levels, and is on an upward trajectory.





Lessons Learned from the Merger

155. The two legacy **trusts had worked closely together** for a number of years prior to merger. Our collaboration and cooperation significantly aided the development of the clinical strategy, and the planning for corporate service change. Our close working relationship, and the synergies and improvements already achieved, made it much easier to develop both the case for merger, and the benefits to be derived from it.

156. This merger was the second merger in Somerset in recent years. The legacy SFT had itself been formed as a result of a merger in 2020. That was a vertical integration of an acute trust with a Community and Mental Health trust. The merger between old-SFT and YDH was a horizontal integration between two acute trusts. The **horizontal integration presented different challenges** which were not present in the vertical integration, for example teams delivering the same services in different ways. We had far more clinical services to merge this time compared to the first merger, which meant resources needing to be deployed in a different way, and different expectations over timescales and outcomes It was not simply a question of repeating the same processes and getting the same outcomes.

157. One organisation going through **a second merger presented both challenges and opportunities.** Old-SFT colleagues had the chance to bring prior learning into the preparations for this merger, which was helpful. But YDH colleagues reported that they sometimes felt as if they were “playing catch-up” with colleagues, or merging in a way which had been decided upon in advance. We acknowledged the risk of a perceived takeover, and this was not helped when the Joint Executive Team was appointed and it was almost entirely made up of old-SFT colleagues. A more pro-active approach to mitigating the risk of perceived takeover may have been helpful. For old-SFT colleagues themselves, the second merger so quickly after the first meant both the risk of merger-fatigue, and a need to direct effort and resource away from realising the benefits of the first merger to plan for the second.

158. This merger saw a much larger and geographically diverse organisation merge with a small organisation on a single site. The **size and location disparity** between the two meant that colleagues coming together had differing experiences and outlooks. We found colleagues from YDH often had ready and immediate access to Executive Directors, and were sometimes frustrated that this was less possible in a larger organisation. As a very large organisation, there is now the opportunity for the Executive team to work differently, devolving more operational accountability to service groups whilst being able to focus more on strategic issues. This approach, less centralised and more facilitative, means that colleagues can develop with more autonomy. When it came to competitive appointments (from the Executive team downwards) it was often the case that the old-SFT colleague had a wider experience than the YDH equivalent, coupled with the larger organisation, gave the impression that a disproportionate number of 'old' SFT colleagues were successful in roles.

159. We ran a **merger PMO** which was key in engaging with both clinical and corporate services. The central contact point and coordinating resource led to a commonly-held view of why we were merging, and what was expected of teams during the process. The PMO also performed a vital listening function, feeding back to the Boards about concerns, and making changes to process where necessary. Both of the merging trusts were represented at senior level in the PMO, which was helpful.

160. The merger itself was **delayed twice.** The organisations were not ready to enact a merger process on the previously agreed timescales, in reality the initial date of April 2022 was never achievable and the revised date of October 2022 became untenable as the continued impact of Covid-19 and associated recovery plans inevitably took resource away from the work needed. The process of gateway reviews helped this process to give a clear decision framework.

161. We found developing **shared vision, values, and cultural** plans, and the establishment of a **Joint Executive Team** were key to driving the merger forward in each organisation. This helped to convey a clear message that merger was happening for good clinical reasons as well as for the good of colleagues and to bring financial benefits. This vision and rationale should be determined at an early stage and communicated to staff and stakeholders.

162. **Clinical engagement and leadership** were key to the success of the merger. Our **Clinical Integration Team** contained leads from both organisations and a variety of clinical services, working with other key clinicians to understand concerns, communicate the rationale for merger, and develop the new clinical model and associated strategy.

163. Taking time in advance to undertake good **cultural change work in advance** of the merger helped to minimise the "shock" of Day 1, and create a more blended merger than something that occurred as a "big bang" on a particular date. However, we acknowledge that the cultures of the two merging organisations remain very different and were more difficult to harmonise than during the merger which established the old SFT. This may have been due to the perception of takeover previously mentioned.

164. The regulatory process was complex and time consuming. The work of the PMO was vital in managing the process, and the **relationships between regulators, external consultants and the trusts**. There were also significant costs involved, for example the costs of any external support in developing the business case or in Due Diligence. The new requirement for a Patient Benefits Case meant working in a different way on this merger, and although it was an additional task, it provided a helpful framework for us to

support services. Whilst we employed external support to help develop the patient benefit case, however it became clear that we needed to resource this within the trust.

165. We found it useful to **split merger tasks** so that it was clear which ones were necessary to ensure legality, patient safety and organisational reputation on Day 1, and which ones were to be delivered to different timescales (e.g. Day 100). The sheer number of tasks necessary for Day 1 is significant, as is the number of external bodies we needed to work with or inform of the change.

166. We found that harmonising policies was particularly challenging, and on top of existing work. For some specialties this led to an almost overwhelming amount of work, and the **merger work itself must be seen as an additional task and resourced appropriately.** It may be beneficial to **give some specialties longer to deliver on merger benefits** so that existing commitments are not added to unreasonably.

167. The involvement of the local **Integrated Care System (ICS)** in the merger and the support of the ICS was very helpful in demonstrating to wider partners and regulators that the merger was an enabler to realising ICS plans and not an end in itself.

168. Following completion of the transaction, a continued **focus on realising benefits** of the merger is required, with perhaps a particular emphasis on cultural alignment in order to genuinely bring teams together. Many merger actions will become "business as usual", and the realisation of benefits will take years in some instances.

169. The **merger programme board** provided a singular focus on the process of merger as well as clinical integration. However, a year post merger it became clear that having a separate process for oversight of integration compared to our ongoing business processes was no longer effective. The clinical integration is now formally within our performance framework and as part of the productive care programme.

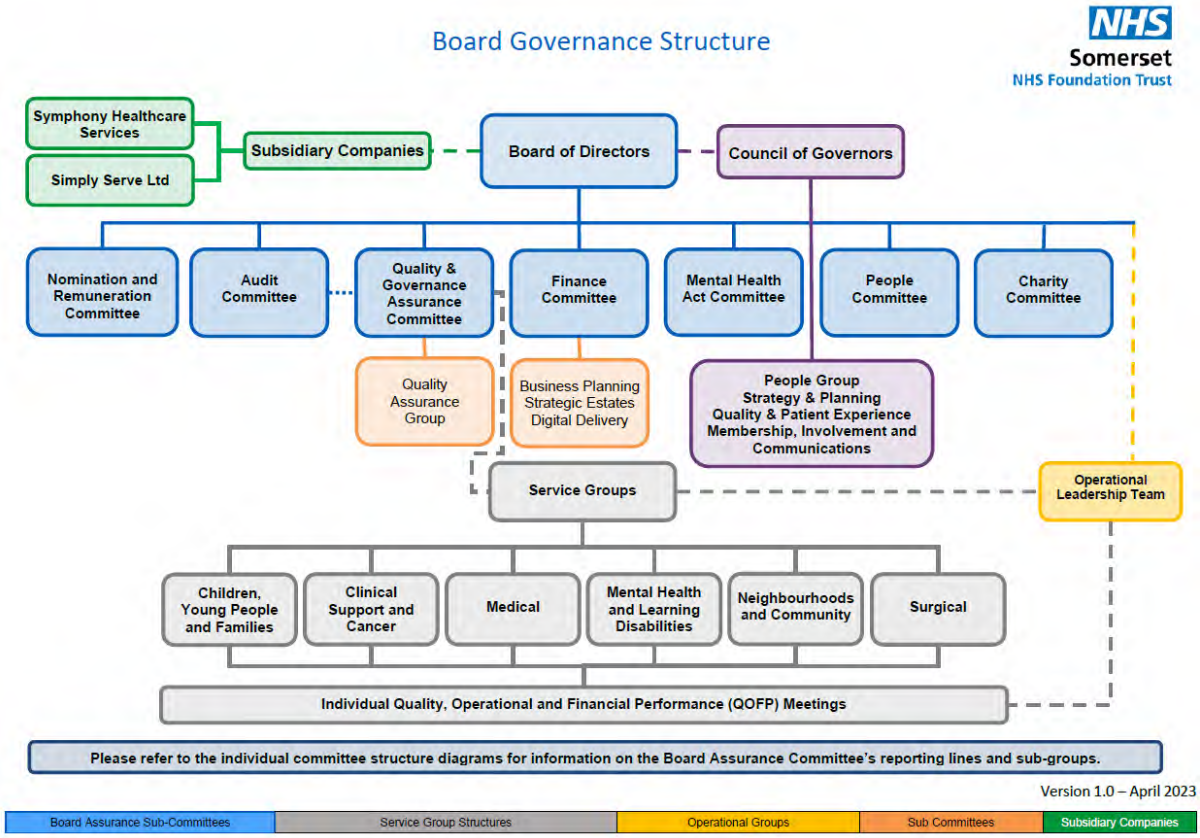
170. A sustained focus on **Quality** helps embed this key part of service improvement. In our first year we focused on putting the right foundations in place, including the development of the Board Assurance Framework, and the prioritisation of good patient experience. We viewed the first year as creating the platform for our approach to quality in the new trust. We learned from our previous merger that building an organisation with the right focus on quality is crucial to achieving our wider goals, as quality needs to be central to what we want to do. As we move forward, our focus will build on the foundations we have laid, with additional work on better review measures, and devolved governance of these to the Service Groups which will deliver higher quality services. We will continue work on our Quality Strategy, with a renewed focus on the experience of patients and the people who matter to them.

Conclusion

171. The merger of YDH and Somerset FT built on the merger of Somerset Partnership and Taunton and Somerset FT and took place in the context of Covid-19 recovery, unprecedented financial challenges and significant structural changes in our partner organisations. The formal process of merger and integration was successful whilst recognising there were challenges in the ongoing integration work.

172. The document has set out the plans for the first year, whilst recognising that the benefits outlined will take a number of years to progress. A follow up review at year 2 and year 5 will be produced to assess the ongoing progress and learning.

Appendix 1 – Somerset NHS Foundation Trust committee structure



Appendix 2 – Directorate structure

YDH Services	Old-SFT Services
Medical Services Group	
A&E	A&E
Acute Frailty	Acute Frailty (inc OPEL and SDEC) Acute Frailty Unit
Acute Medicine / EAU	COOP inpatient beds
COOP inpatient beds	Acute General Medicine
Cardiology (inc Cardiac Rehab and CCU)	Cardiology
Dermatology	COOP
FAU / FAU Escalation	Dene Barton
High Intensity Users	Dermatology
Internal Medicine	Endocrinology High Intensity Users Internal Medicine IUC
Investigations	MAU
Jasmine escalation ward	MDU / SDEC / Ambulatory Care
Long Term Conditions / LTC Specialist Nurses	Medical wards
MDU	Nephrology
Medical wards	Neuro Rehab
Neurology	Neurology
QDH Respiratory	Respiratory
Rheumatology	Rheumatology
Sleep nurses	Stroke
Stroke	
Clinical Support and Cancer Services	
Bereavement support/hospital based end of life services	Bereavement Support/End of life services
Cancer (direct service provision, i.e. oncology and haematology)	Cancer
Chaplaincy	Chaplaincy
Medical examiner officers	Dietetics
Mortuary	Haematology

YDH Services	Old-SFT Services
Pathology Pharmacy Phlebotomy	JETT
Radiology, incl Medical	Medical examiner officers
Physics and PACS Therapies	Medical Imaging – PACS, Radiology
	Medical physics (does not exist yet)
	Mortuary Oncology Orthotics OT
	Palliative Care
	Pathology (inc Phlebotomy) Pharmacy
	Physio
	Podiatry
	Podiatry
	Radiotherapy
	Radiotherapy Physics
	Speech Therapy
	Ward 9
	Spiritual Care
	Southwest Pathology Services (SPS)
	Radiotherapy Physics
	Beacon Day Unit/Beacon Ward
	Adult SLT
Children, Young People and Families	
Child Health / Paeds	AOT
Gynaecology	CAMHS inc EOT Clinical Genetics
Maternity / Midwifery	Community Paeds
Obstetrics	including Children's Community Health (CCH)
	Children's Community Psychology
	Children's Community Therapies (CYPTS)
	Children's Neurodevelopmental Team (CYPNP)
	School-age Immunisations Team (SAINT)
	Dental (community)
	ENPs

YDH Services	Old-SFT Services
	EPAC
	Grace Centre
	Gynae Oncology
	Gynaecology
	Maternity – inpatients and community
	Midwifery
	Obstetrics
	Paeds inpatients and outpatients
	SNICU Starling Clinic
	SWISH
Mental Health and Learning Disabilities	
None	ADHD
	CEN (Complex Emotional Needs) CMHTs
	Community Rehab
	Co-production Services
	Crisis Resolution
	Eating Disorders
	Employment Support Service
	Forensic Services
	Inpatient MH Wards
	LD
	Liaison Psychiatry
	Open Mental Health
	Peri-Natal services
	Placement support services
	Psychological Services
	STEP services
	Suicide Prevention
	Urgent Care Hub
	Talking Therapies

YDH Services	Old-SFT Services
	PICU
	Low Secure Rehab
	Long stay Rehab
	Advice & Support in Custody & Court (ASCC)
Surgery	
Anaesthetics	Acute Surgery
Audiology	Anaesthetics
Breast Care	Audiology
Critical Care	Bariatrics
Day Surgery	Breast Surgery
Endoscopy ENT Gastroenterology	Colorectal Continence Critical Care
General surgery	DSC
Main theatres Ophthalmology Oral Max Fax Orthopaedics	Endoscopy
Outpatients inc Contact Centre	ENT Gastro
Plastic Surgery	Head and Neck
POAC Private Patients	Max Fax
SSD (provided by SSL) Stoma Care	OASIS Ophthalmology
Urology	Orthodontics
	Outpatients
	Plaster Room
	Plastics
	POAC Podiatric Surgery
	Private patients Restorative Dentistry SSD
	Stoma
	T&O Surgery
	Upper GI Urology
	Vascular
Neighbourhoods	
Care of Older Persons	Ambulatory Care Services
Complex Care team	Care of Older Persons, inc

YDH Services	Old-SFT Services
Home First	Carers Assessment Service
Hospital at Home	Chronic Fatigue Services/ME/Long Covid
Non-acute frailty	Community Ambulatory Care
	Community EOL, including Palliative Care consultants, Education team, and EOL Care Coordination Centre
	Community Hospitals
	Community Pain Management services
	Community Rehabilitation Service (CRS)
	Complex Care
	Dementia team
	Homeless and Rough Sleeper service
	Hospital at Home incl
	Respiratory
	Integrated Neighbourhood teams, including District Nursing and Waking District Nursing Night team.
	Intermediate Care incl D2A, Home Care, Rapid Response, Somerset Hub for Coordinating Care and Pulse Oximetry.
	LARCH
	Mass Vaccination service
	Memory Assessment services
	MIUs - Minor Injury Units
	Non-acute Frailty
	OPMH including Intensive
	Dementia Support Team
	Palliative Care Rural hubs Stroke CH

Appendix 3 – Day 1 Business Critical Projects achieved by the trust

The following is a list of Day 1 business critical projects completed by the trust before / on the day of merger. The list is split by merger workstream:

Charities

- Transfer of the trust charity corporate trustee complete.

Clinical Governance

- CQC Registration in place
- Policy Approval and Management Processes agreed.
- Health and Safety Arrangements and Policy agreed.
- Strategy for Provision of Specialist Advice for Key Elements of H&S in place.

Safeguarding

- Single Process Supporting NICE and Best Practice in place.
- Safeguarding Colleague Engagement & Consultation for new Integrated Service
- Protocols to Access Patient/Colleague Databases established.
- Safeguarding Committee & Governance Structure for the new trust in place.
- Learning & Development/Competencies for Safeguarding Colleagues reviewed.
- Integrated Safeguarding Training Offer for new trust
- Countywide Safeguarding Service created.

Digital

- Hard-Coded Email addresses updated.
- National DSPG Toolkit compliance
- BI & Analytics: ODS Code for new trust in place.
- BI & Analytics: Statutory & workforce reporting processes in place for combined trust.
- BI & Analytics: National mandated returns completable for new trust.
- Informatics/Finance data transfer rules re Acute/Community Transfers complied with.

Estates & Soft FM

- Transfer of Leases complete.

Security Management

- Security Management Director (SMD) Appointment for new trust
- CCTV Policy updated.

Finance Workstream

- Payroll functioning for combined entity.

Procurement

- Contracting function in place and operational.
- Procurement systems updated to reflect new trust name.
- Communications systems in place for both P2P and contracting.

Corporate Governance

- Risk Appetite Statement completed.

- Board Assurance Framework completed.
- Single trust Board in place.
- Single Executive Team in place.
- New Constitution agreed.
- SFIs, Scheme of Reservation and Delegation, Standing Orders updated and harmonised.
- TORs for Required Committees in place.
- Registered Office identified and in place.
- CQC Registration completed.
- All policies within Governance (not covered in other charters) which require harmonisation by Day 1 harmonised.

Information Governance

- Appointment of one DPO, one SIRO, one Caldicott Guardian for the combined trust.
- Freedom of Information Publication Scheme harmonised.
- Privacy Notices updated.

EPRR Integration

- Coordinated On Call system across the new organisation
- Tactical Major Incident Plans merged.
- Hospital control room processes and procedures harmonised.

People & OD

- Certificate of Sponsorship (COS) for all affected employees complete.
- TUPE transfer of all affected employees complete.

Appendix 4 – NHS England Quality and Financial Governance review

NHS England undertook a Quality and Financial Governance review as part of the merger transaction process. 15 actions were identified following this review.

	NHSE Recommendation	Trust Response/Update	Exec Lead/ Action Holder	Due By	Status	Comment
Quality Governance Domain 1: Leadership and behaviours						
1	A number of Non-Executive Directors (NEDs) are approaching the end of their respective terms. The enlarged trust would benefit from reviewing its succession plans for its NEDs to ensure that there are no gaps in the skills and experience needed at Board level as they move forward with integration and to build on the work done to date on Board diversity. Specifically, the trust should consider how it will ensure NEDs have active clinical expertise as well as both acute and non-acute experience within their skills and experience mix.	In 2022, the Board completed a thorough skill mix review for the proposed post-merger Non-Executive Directors and this skill mix highlighted strong areas of expertise in: strategy and planning; governance; finance; and performance management. This was followed by expertise in HR; and Mental Health and Learning Disabilities. The areas of expertise for possible focus for future Non-Executive Director appointments are: primary care; voluntary sector and social care. In addition, from 2024 onwards, there will be a need to also focus on financial expertise and consider the gender balance on the Board. The skills mix will be reviewed at the time of any recruitment to take account of changing circumstances.	**Exec Lead**: Phil Brice **Action Holder**: Ben Edgar-Attwell	COMPLETE		The Trust recently commenced recruitment for Associate Non-Executive Directors as part of succession planning to ensure there are no gaps in the skills and experience needed. This process was completed in August 2023 with the Associate Non-Executive Directors started in October 2023 and made full NEDs in 2024.
2	The enlarged trust should put in place a checkpoint review towards the end of 2023 to ensure that the trust's Quality Governance Framework remains effective and fit for purpose across the 3-tier model as services integrate and the	The trust will complete a review of its Quality Governance Framework as part of its regular review of corporate governance processes to ensure that they are fit for purpose.	**Exec Lead**: Phil Brice **Action Holder**: Ben Edgar-Attwell	COMPLETE Q3 23/24		Governance Committee effectiveness reviews completed in Q3 into Q4 2023/24. Wider review completed and presented to Board in May 2024.

	new operating model embeds. We would recommend this checkpoint involves the NHS England South West regional team. Moving forward there should be an annual review in line with standard corporate governance processes.					
3	The enlarged trust should continue to plan their Board development days for 2023/24 so they can review and reflect on post transaction integration plan (PTIP) milestones and integration plans.	The trust will continue with its Board development days. Oversight of the PTIP milestones and integration plans will also form part of the post-merger governance processes. Updates will be provided to the trust Board reviewing integration and PTIP delivery.	**Exec Lead**: David Shannon **Action Holder**: Victoria Keilthy	COMPLETE		Integration continued to be reported to the Programme Board in 2023/24 and has transitioned into BAU reporting in 2024/25.
Quality Governance Domain 2: Data and reporting						
4	The trusts will benefit from integrating their performance reporting approach at Board and subcommittee level for the new enlarged organisation. This includes considering enhancing the use of SPC charts in “Making Data Count” guidance to help increase familiarity with process limits, comparison (benchmarking), seasonality and rolling averages and how to make information more digestible, for example explore the wider use of summary icons. This will support agenda planning at Board, quicker identification of special cause variation and assist in focusing time and give greater scrutiny given the breadth of the new organisation’s activities.	We will build upon the work already been taken to integrate performance reporting across the two trusts and establish a commonality of approach, including the production of a single performance presentation to the Board, spanning both trusts, and the establishment of consistent arrangements for performance review at directorate level. The SFT quality and performance report identifies exceptions using SPC, as outlined in “Making Data Count”, and includes guidance on how to interpret SPC charts. We will make this approach consistent across the breadth of performance reporting to the Board of the merged organisation, and consideration will also be given to the use of summary icons, also as outlined in “Making Data Count”,	**Exec Lead**: Pippa Moger **Action Holder**: Lee Cornell	COMPLETE		Consistent arrangements for monthly performance management review meetings with service directorates are now well-established. The SFT quality and performance report identifies exceptions using SPC, as outlined in “Making Data Count”, and includes guidance on how to interpret SPC charts. We have applied this approach, where appropriate, across the breadth of performance reporting to the Board of the merged organisation, in conjunction with monitoring performance against specified national and local performance standards. We use benchmarking information,

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		with a view to making information more digestible. We will also seek to expand the use of benchmarking information, to facilitate comparison with other organisations nationally, and we will build upon the use of trend information for key indicators to illustrate seasonal patterns of demand and performance.				sourced from the NHS Benchmarking Network and also by reference to nationally published statistics, via sources including NHS England and NHS Digital, enabling more regular, nearer real-time comparisons to be made against national performance levels, and also against peer providers, which are also used to help support the contextual narrative in reports to the trust Board. We report performance to the trust Board on an exception basis, highlighting any key issues, the contributory causes of adverse performance, and actions being taken to address or mitigate them. We also routinely use trend information for key indicators to illustrate seasonal patterns of demand and performance.
5	The trusts should continue plans to harmonise incident reporting, risk management and complaints arrangements and continue with its joint plan to prepare for the implementation of the PSIRF by August 2023. Post-implementation, the enlarged trust should ensure it has reviews in place to ensure this has embedded effectively.	Harmonisation of arrangements for incident reporting, risk management and complaints form a key part of integration plans. The details for risk management are included in point 6 below. The integration of the governance teams was completed by April 2023, with incident processes aligned as part of the "Diagnostic and discovery" phase of PSIRF implementation.	**Exec Lead**: Phil Brice **Action Holder**: Steve Thomson	COMPLETE		Integration of the Governance Support Team was completed for the start of April 2023. PSIRF went fully live across the trust at the beginning of January 2024, with some dual running until April 2024 when all Service Groups will move fully over to the new ways of working. The trust will be moving to a single software system across the whole organisation for risk

		A senior lead for implementation of PSIRF was included in the governance team structure as part of the move towards integration, with a core implementation team working in line with the national PSIRF implementation timetable to deliver the patient safety incident response policy and plan by August 2023. All our governance processes are subject to regular review as part of our monitoring and assurance processes. In addition to this, we will be including regular auditing, measurement, and review as part of the "Embedding sustainable change and improvement" phase of PSIRF implementation.				management, incident reporting and associated governance processes from April 2024.
6	The trusts should ensure that there are effective controls in place with regard to decisions to escalate to the corporate risk register. For example, if a risk score is set at 15 but is related to a wider thematic risk already on the register, such as workforce capacity, a clear rationale and explanation should be recorded as to why it has not been directly included. Internal audit plans for 2023/24 and beyond should include a review of risk register controls to ensure that they are robust.	Currently under development are the Risk Management Framework documents (Strategy & Policy). These will be shared with key shareholders as part of the consultation period during February 2023 and will be presented to the trust Board in March 2023. The Framework will include the escalation route from department/divisional/specialty levels through to the Corporate Risk Register. The Corporate Risk Register report is currently under development and will include a section within the report which outlines the risks scoring 15 or above from a service group level which feed directly into a wider thematic Corporate risk. This will be in place by April 2023.	**Exec Lead**: Phil Brice **Action Holder**: Sam Hann	COMPLETE April 2023		Risk Management Strategy (RMS) approved by trust Board on 7 March 2023 and cascaded to key stakeholders for dissemination. Training with service groups and corporate teams has commenced on the new RMS. RM Policy in final stages of development. New Corporate Risk Register report was in place on 1 April 2023 which has been reviewed by the Board of Directors and the Board Sub-Committees since April 2023. The report has been revised and shows the clear link between service group

		This will be an ongoing piece of work throughout 2023/24 to educate and train colleagues on the new Risk Management Framework which will include educating staff on the agreed process for escalating risks onto the Corporate Risk Register and the relationship between service group and corporate risks. Risk Maturity Internal Audit due to be undertaken in Q3 2023/24		2023/24 Q3 2023/24		risks and the risks on the corporate risk register. This is an ongoing piece of work throughout 2023/24 and into 2024/25 to educate and train colleagues on the new Risk Management Framework which will include educating staff on the agreed process for escalating risks onto the Corporate Risk Register and the relationship between service group and corporate risks. Risk Maturity Internal Audit completed in Q3 and is to be reported to the Audit Committee in April 2024. There were 11 recommendations; 10 of these were previously recognised and work was already underway to address.
Financial Governance **Domain 1: Leadership and behaviours**						
7	The trusts should continue with their proposal to align workforce and financial planning more closely between the People and Finance subcommittees.	We continue to work on ensuring that our finance and workforce plans and reporting triangulate to support effective oversight and scrutiny.	**Exec Lead**: Pippa Moger and Bel Clements **Action Holder**: Michael Scott	COMPLETE		Since the ESR merge in August 23, Finance and Workforce have been collaborating to meet our objective to align ESR and the Ledger. A working group with key departments, finance reviewed the PWR data vs ESR and updated the hierarchy within ESR to ensure our hierarchy structures aligned. Workforce took the role of updating the hierarchy from

						finance in September 23 as it was deemed to be best suited here, and meetings are ongoing to ensure that we have an optimised process in place. The background process of our new position request process has been implemented with both finance and workforce collaborating for oversight across both teams and this will be optimised further by an intuitive electronic form for manager completion, which is auditable across each of the department pathways and ensures that we get it right first time, improving data quality and removing duplication of effort. Electronic change forms and new starter forms have been introduced across the trust, we have already seen greater data quality due to mandatory fields and intuitive drop-down menus for managers and those completing the forms, these forms have provided a more robust process with much better oversight. A working group is set up for the termination form project which will enable us to have assurance over our home office sponsorship responsibilities, reduce overpayments and reclaim

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						monies owed from retention and relocation where appropriate. The 2024/25 Planning guidance from NHSE has emphasised the requirement to ensure that organisations have robust arrangements and triangulation between finance, workforce and activity. As part of the refresh of reporting to the Finance Committee for 2024/25 a review is being undertaken in conjunction with NED colleagues to ensure that the relevant information being provided delivers assurance to committee members on the relationship between finance, workforce and activity so that the relevant challenge can be undertaken where necessary.
8	The Board's understanding of the underlying position can be aided by analysis of 'one-off' adjustments and non-recurrent sources of funding used to meet the year-end target. The Better Payments Practice Code (BPPC) metric should be amended within monthly finance reports so the year-to-date trend is shown alongside performance in-month.	The format and content of internal financial reporting is currently being revised. This process is considering the existing reports for both trusts to ensure we continue to use the most effective elements of both. We are also reviewing how other trusts report their financial performance to ensure we incorporate other areas of best practice. A small group of Finance Committee Non-Executive Directors will review the development before Go Live.	**Exec Lead**: Pippa Moger **Action Holder**: Mark Hocking	COMPLETE		Action complete

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9	The Finance Committee should consider the level of challenge raised on the detail of finances across the organisation.	As we consider the format of reporting into the Finance Committee for the merged trust, that will reveal the level of detail that we think is necessary to enable us to challenge adequately.	**Exec Lead**: Pippa Moger **Action Holder**: Mark Hocking	COMPLETE		Action complete
10	We would encourage the Finance Committee to consider if more opportunities could be taken to translate comments raised into formal actions.	The finance committee have reviewed and noted the recommendations of this review.	**Exec Lead**: Pippa Moger **Action Holder**: Mark Hocking	COMPLETE		Action complete
Financial Governance Domain 2: Reporting						
11	The new format of reporting for the enlarged organisation should retain analysis of agency, CIP and capital spend and rolling cash flow forecasts. In addition, the following improvements are suggested for consideration: • Directorate reports should be made consistent in format and presentation and include sufficient narrative as well as summaries of key risks and mitigations • Narrative across all finance reports (directorate/committee/Board) should explain drivers of key trends. Reports should clearly set out the 'so-what', risks and mitigations • An estimate of the underlying position could be added to each finance subcommittee and Board finance report • The Finance Committee could be presented with summaries of directorate performance, alongside the corporate level summary. This	The format and content of internal financial reporting is currently being revised and will take into consideration the financial and governance review findings. The reporting review will look at the existing reports for both trusts to ensure we continue to use the most effective elements of both. We are also reviewing how other trusts report their financial performance to ensure we incorporate other areas of best practice.	**Exec Lead**: Pippa Moger **Action Holder**: Mark Hocking	COMPLETE		Revised internal service group level reports are in place for monthly reporting. The new monthly report to Finance Committee includes significant additional analysis on pay, CIP, income etc and a summary of service group performance. Forecast information including risks and mitigations has been incorporated from month 3 onwards.

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	could be accompanied by 'heat map' exception reporting highlighting areas of underperformance at the divisional, directorate or service level. This can show any significant swings within particular services • Forecast outturns should be added to Board and Finance Committee reports, alongside plan and year-to-date as at present • Include explanations for all aged debt over 90 days • Consider greater use of charts and other visualisation methods within the Board report, as well as a concise 'dashboard' summary of key risks and issues • Ensure both clinical and corporate synergies are clearly reported as separate to overall CIP achievement • Consider which operating metrics the members of the Finance Committee would find most useful for inclusion within the monthly finance report					
12	We would encourage the enlarged organisation to review internal financial reporting approximately one-year post-transaction, once the new reporting has been embedded, to monitor and ensure effectiveness of this.	We encourage Finance Committee members to provide feedback on reporting on an ongoing basis and have provided additional analysis to aid understanding during the year. We will formally review the revised reporting format one year post merger as recommended.	**Exec Lead**: Pippa Moger **Action Holder**: Mark Hocking	COMPLETE		Changes have been made to our internal reporting in-year with further changes to be implemented for April 2024 in response to Non-Executive director feedback.

13	The 23/24 business plan should be clearly linked to the transaction strategy. As clinical models are worked up in detail, we recommend the trust embed business partnering resource to ensure that the digital, estates and other enablers of these models are costed.	The trust's 2023/24 business plan will reflect the organisational strategy as set out in the merger case as far as practical and where sufficient progress has been made to allow the impact to be fully quantified and embedded within the plan for next year. Finance staff will continue to work closely with their clinical and non-clinical colleagues to refine the financial impact of the clinical model as it emerges in greater detail.	**Exec Lead**: Pippa Moger **Action Holder**: Mark Hocking	Ongoing		The Productive Care Programme will support business planning for 24/25 and link service and clinical transformation into the financial planning process.
14	The trusts should proceed with their plan to align risk scoring methodology and create an appropriate framework to escalate material issues from divisional level.	The joint trust Board agreed the risk scoring matrix to be used by the organisation in July 2022. This saw a change in the risk escalation levels at YDH which was communicated and shared with the risk owners, risk leads & risk actions in July 2022 and changes made to the YDH Risk Register module on Ulysses, the trust's Risk Management system. The risk scoring matrix will be included within the Risk Management Framework documentation (see below). Training on the risk scoring matrix is included in the risk management training provided to colleagues. Currently under development are the Risk Management Framework documents (Strategy & Policy). The strategy will be shared with key shareholders as part of the consultation period during February 2023 and will be presented to the trust Board in March 2023. The Framework will include the escalation route from	**Exec Lead**: Phil Brice **Action Holder**: Sam Hann	March 2023		Risk Management Strategy (RMS) was approved by trust Board on 7 March 2023 and cascaded to key stakeholders for dissemination. Training with service groups and corporate teams has commenced on the new RMS and is ongoing. RM Policy has been developed and

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		department/divisional/specialty levels through to the Corporate Risk Register.				following consultation with key stakeholders was approved and disseminated on 3 June 2024. The RMS shows the clear escalation route from 'ward to board' and the Corporate risk register report has been revised to show the relationship between the service group and corporate risks.
15	We understand that Internal Audit will perform a cyclical review of key financial systems and controls in early 2023. The proposed control framework for the enlarged trust and plans to transition key financial systems should also be reviewed by internal audit and signed off by the Finance Committees and Board.	The Finance Committee and Board have reviewed and approved the SFI's and Scheme of Delegation for the new organisation which is the basis of the control framework. Internal Audit completed the cyclical review of key financial systems in December 2022 before the trust received this recommendation, however the Finance Committee and Board have been kept updated on the financial ledger project as it forms part of the merger charter work programme. Any risks will be reported on an exception basis.	**Exec Lead**: Pippa Moger **Action Holder**: Mark Hocking	COMPLETE		The recent Key Financial System Audits concluded there was substantial assurance that key controls were in place and are operating effectively.

Appendix 5 Summary of Clinical Services Integration by Service Group

Report Date	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Jan 24	Feb 24	Mar 24
Children & Young People & Families Group	G	G	G	G	G	G	G	G	G	G	G
Clinical Support & Cancer Services	G	G	A	A	A	A	A	A	R	A	G
Medical Services	A	A	A	MR	A	A	A	MR	A	A	A
Neighbourhoods and Community Services	G	G	G	G	G	G	MR	G	G	G	G
Surgical Services	G	G	G	G	A	A	A	MR	A	A	A

MR – Missing report

Appendix 6 Summary of Clinical Service Integration Milestone Achievement March 2024

CSI Milestone Data	One single vision	Written comprehensive transformation plan	Unified governance structure	Unified policies	Shared Information	Reporting as one service	Single Budget	Agreed countywide pathways and processes	Single Waiting List
Total No. per type	44	42	43	44	42	43	40	43	26
No. complete Mar 24	25	14	13	6	15	15	17	5	3
% complete at Mar 24	56.8%	33.3%	30.2%	13.6%	35.7%	34.9%	42.5%	11.6%	11.5%
No. complete Jan 24	24	14	9	6	12	13	16	4	2
Trend at Mar 24	↑	→	↑	→	↑	↑	↑	↑	↑

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Group Finance report – Month 4
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Mark Hocking, Deputy Chief Finance Officer
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	3 September 2024

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

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

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

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

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

Equality and Inclusion

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

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.

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 June, the Trust recorded a deficit of £1.797m. This was £0.286m adverse compared with the plan for the month. Cumulatively, the Trust is £13.202m in deficit, which is an adverse position to plan of £1.184m.

1.2 The main headlines in July are:

- Agency expenditure was £2.363m, this was £0.878m below the plan for the month and £0.249m above the ceiling although an increase of £0.150m when compared to June expenditure.
- £4.562m of CIP was delivered in July, which is consistent with the planned level. Recurrent savings of £1.503m (33%) were delivered in month.
- The impact of the fifth day of the post graduate doctors in training industrial action was recognised in July. The total impact was c£0.237m and this was split: £0.131m for the net cost of backfill and £0.106m to recognise the loss of ERF income due to postponed elective activity. The year-to-date impact of industrial action reported in the position is £1.184m. There is currently no update on the availability of national funding for these costs.

2. INCOME AND EXPENDITURE

2.1 Table 1 below sets out the summary income and expenditure account to 31 July 2024:

Table 1: Income and Expenditure Summary July

Statement of Comprehensive Income	Annual Plan	Current Month 4			Year to date		
		Plan	Actual	Fav./ (Adv.) Variance	Plan	Actual	Fav./ (Adv.) Variance
	£000	£000	£000	£000	£000	£000	£000
Income							
Patient Care Income	969,432	83,512	81,631	(1,881)	324,442	325,223	781
Other Operating Income	66,887	4,358	5,077	719	16,829	20,404	3,575
Total operating income	1,036,319	87,870	86,707	(1,162)	341,271	345,627	4,356
Operating expenses							
Employee Operating Expenses	(707,362)	(59,463)	(60,704)	(1,241)	(238,436)	(243,151)	(4,714)
Drugs Cost: Consumed/Purchased	(90,479)	(9,623)	(8,051)	1,572	(31,545)	(31,812)	(267)
Clinical Supp & Serv Exc-Drugs	(29,724)	(2,886)	(4,771)	(1,885)	(13,670)	(20,275)	(6,605)
Supplies & Services - General	(39,409)	(3,284)	(2,921)	363	(13,138)	(11,889)	1,249
Other Operating Expenses	(158,267)	(13,202)	(11,504)	1,698	(52,807)	(49,241)	3,566
Total operating expenses	(1,025,241)	(88,458)	(87,950)	508	(349,597)	(356,368)	(6,771)
Operating Surplus/Deficit	11,078	(588)	(1,243)	(655)	(8,326)	(10,741)	(2,416)
Finance Expense	(13,070)	(1,089)	(1,003)	87	(4,358)	(3,961)	397
Finance Income	2,424	202	274	72	808	1,304	496
Other	0	0	0	(0)	1	0	(1)
Overall Surplus/(Deficit)	432	(1,475)	(1,972)	(496)	(11,875)	(13,398)	(1,523)
Depr On Donated Assets	1,397	116	78	(39)	466	317	(148)
Donated Assets Income	(2,591)	(216)	(10)	206	(864)	(508)	355
Amortisation	9	1	1	(0)	3	3	(0)
Impairments (Reversals)	0	0	0	0	0	0	0
Other	753	63	106	43	252	384	132
Adjustments to control total	(432)	(36)	175	211	(143)	196	339
Adjusted Financial Performance	0	(1,511)	(1,797)	(286)	(12,018)	(13,202)	(1,184)

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

2.3 In July, overall staffing levels were 110.30 WTE under the workforce cap trajectory for the month:

- Substantive staffing was 52 WTE under plan
- Bank 26 WTE under plan
- Agency 11 WTE under &
- Locums 12 WTE over plan

2.4 If we compare total WTEs at the end of July with the year-end target position (12,505) the Trust is c74WTE over plan. The in-month performance and comparison with the year-end target demonstrates both the progress being made in delivering productive care plans and the level of general grip and control services are exercising over their workforce levels.

Table 2: Pay expenditure information

2024/25 Monthly Pay Expenditure analysis	Mar-24 £000	Apr-24 £000	May-24 £000	Jun-24 £000	Jul-24 £000	2024/25 In Month Plan £000	F/(A) Variance £000	2024/25 Total £000	2024/25 YTD Plan £000	F/(A) Variance £000
Temporary staff										
Bank Staff	3,554	2,090	1,927	1,894	1,882	2,184	302	7,792	8,748	956
Medical Agency	1,819	1,830	1,685	1,275	1,411	2,000	589	6,201	7,265	1,064
Medical Locums	1,409	1,152	1,032	938	1,159	502	(657)	4,281	2,008	(2,273)
Nursing Agency	966	771	618	547	547	954	407	2,482	4,194	1,712
Other Agency	466	484	497	391	405	286	(118)	1,776	1,141	(635)
Total Temporary Staff	**8,214**	**6,326**	**5,759**	**5,044**	**5,404**	**5,926**	**523**	**22,533**	**23,356**	**823**
Nursing	21,933	15,075	14,998	15,079	14,949	15,871	922	60,101	63,953	3,852
Support to Nursing	8,300	6,307	6,229	6,256	6,106	5,186	(920)	24,898	21,128	(3,770)
Medical	15,301	12,773	10,722	11,723	12,261	12,227	(35)	47,480	46,881	(599)
AHP's	13,095	8,615	8,680	8,658	8,656	8,873	217	34,608	35,626	1,017
Infrastructure Support	10,612	9,657	9,326	9,461	9,302	8,263	(1,038)	37,746	34,944	(2,803)
Other	5,196	3,191	4,956	3,611	4,026	3,117	(910)	15,784	12,548	(3,236)
Substantive Staff	**74,437**	**55,618**	**54,912**	**54,789**	**55,300**	**53,536**	**(1,764)**	**220,618**	**215,080**	**(5,537)**
Total All Staff	**82,651**	**61,943**	**60,671**	**59,833**	**60,704**	**59,463**	**-1,241**	**243,151**	**238,436**	**(4,714)**
% Temporary	9.94%	10.21%	9.49%	8.43%	8.90%	9.97%		9.27%	9.80%	

Table 3: WTE information

2024/25 Monthly Workforce analysis	Planning Month WTE	Apr-24 WTE	May-24 WTE	Jun-24 WTE	Jul-24 WTE	In Month WTE	In Month Plan WTE	F/(A) Variance WTE	Full Year Plan	F/(A) Variance WTE
Temporary staff										
Bank Staff	611.40	588.90	493.89	493.02	516.60	516.60	575.51	58.91	539.24	22.64
Medical Agency	73.21	74.57	67.68	59.07	68.38	68.38	69.30	0.92	60.16	(8.22)
Medical Locums	22.40	31.19	25.72	26.61	33.27	33.27	21.09	(12.18)	19.76	(13.51)
Nursing Agency	93.45	94.58	69.57	64.96	70.88	70.88	88.46	17.58	76.79	5.91
Other Agency	53.61	67.26	77.61	59.76	58.10	58.10	50.75	(7.35)	44.05	(14.05)
Total Temporary Staff	**854.07**	**856.50**	**734.47**	**703.42**	**747.23**	**747.23**	**805.10**	**57.87**	**740.00**	**(7.23)**
Nursing	3,428.00	3,380.35	3,402.66	3,406.98	3,419.94	3,419.94	3,454.31	34.37	3,419.62	(0.32)
Support to Nursing	2,179.48	2,171.87	2,153.16	2,159.23	2,138.57	2,138.57	2,118.62	(19.95)	2,097.34	(41.23)
Medical	1,090.19	1,079.95	1,084.89	1,079.97	1,074.69	1,074.69	1,101.07	26.37	1,090.01	15.32
AHP's	1,649.76	1,590.04	1,589.92	1,586.06	1,600.67	1,600.67	1,596.74	(3.93)	1,580.71	(19.96)
Infrastructure Support	2,501.85	2,484.95	2,470.55	2,477.64	2,471.69	2,471.69	2,532.53	60.84	2,507.10	35.41
Other	1,093.86	1,136.01	1,161.37	1,145.51	1,126.36	1,126.36	1,081.08	(45.28)	1,070.22	(56.14)
Substantive Staff	**11,943.12**	**11,843.17**	**11,862.55**	**11,855.39**	**11,831.92**	**11,831.92**	**11,884.34**	**52.43**	**11,765.00**	**(66.92)**
Total All Staff	**12,797.19**	**12,699.67**	**12,597.02**	**12,558.81**	**12,579.15**	**12,579.15**	**12,689.44**	**110.30**	**12,505.00**	**(74.15)**
% Temporary	6.67%	6.74%	5.83%	5.60%	5.94%	5.94%	6.34%		5.92%	

2.5 Total agency and locum costs in month were £3.522m, an increase of £0.371m compared with June. Nursing agency expenditure was £0.547m, the same as in June and was £0.128m lower than in the equivalent month last year.

2.6 Total medical agency in July was £1.411m (£0.136m higher than June). Vacancies continue to be the largest driver of agency usage and accounted for £1.017m (72%) of the total SFT agency spend in month. In July SHS used £0.365m to cover gaps in their workforce, this was £0.111m higher than their spend in June.

2.7 The Trust continues to explore recruitment opportunities overseas and all service groups are working with their People Business Partners to explore additional supply avenues and alternative staffing models to recruit into hard to fill vacancies e.g. physician's associates, clinical fellows etc.

2.8 Further recruitment opportunities in relation to medical staffing are currently being explored in India with a particular focus on reducing the high level of vacancies within mental health.

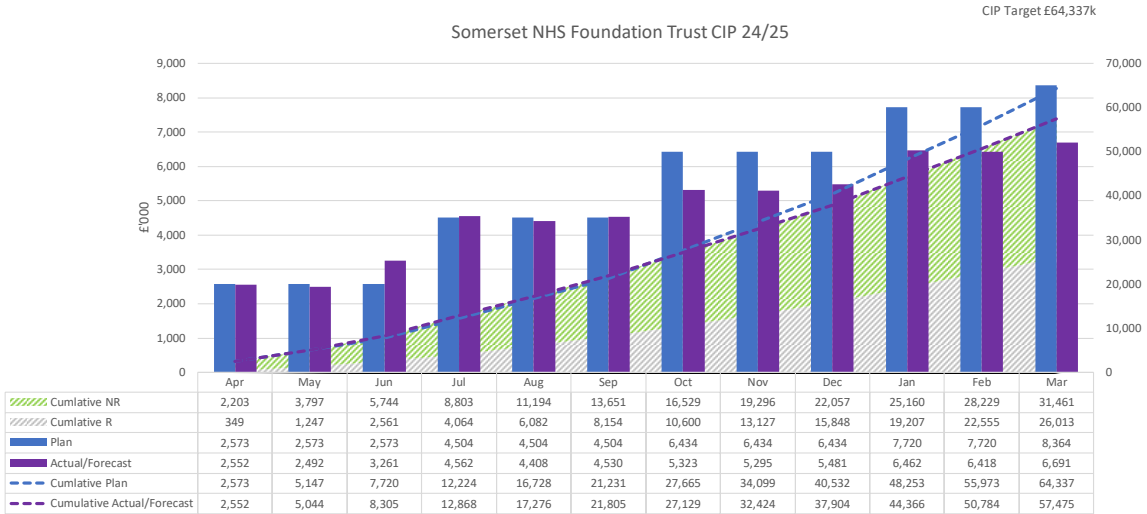
3. COST IMPROVEMENT PROGRAMME

3.1 The Trust has an annual efficiency plan of £64.337m this year, this includes £1.025m of merger savings.

3.2 In July, savings of £4.562m were delivered. This was breakeven to plan and is a notable achievement as the plan in month was c£2m higher than in previous months. Recurrent savings formed £1.503m of the savings achieved (33%).

3.3 Further analysis is shown in the chart below:

Chart 1: CIP Plan 2024/25



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumlative NR	2,203	3,797	5,744	8,803	11,194	13,651	16,529	19,296	22,057	25,160	28,229	31,461
Cumlative R	349	1,247	2,561	4,064	6,082	8,154	10,600	13,127	15,848	19,207	22,555	26,013
Plan	2,573	2,573	2,573	4,504	4,504	4,504	6,434	6,434	6,434	7,720	7,720	8,364
Actual/Forecast	2,552	2,492	3,261	4,562	4,408	4,530	5,323	5,295	5,481	6,462	6,418	6,691
Cumlative Plan	2,573	5,147	7,720	12,224	16,728	21,231	27,665	34,099	40,532	48,253	55,973	64,337
Cumulative Actual/Forecast	2,552	5,044	8,305	12,868	17,276	21,805	27,129	32,424	37,904	44,366	50,784	57,475

3.4 Services continue to develop their plans but there are gaps compared to their targets in a number of areas. Clinical areas continue to work on increasing and identifying more traditional CIP schemes to mitigate shortfalls in their productive care plans. Corporate services continue to work on the development and delivery of their CIP and Merger savings.

3.5 We continue to scope and identify further opportunities to close the gap in our current plans, recognising also that the schemes already identified may not deliver in full. The level of unidentified savings has reduced again in July and is now c£6.9m.

3.6 Through our business-as-usual governance processes we will continue to support all areas to increase their delivery and continue working with the ICB to progress system wide opportunities set out in the Joint Forward Plan.

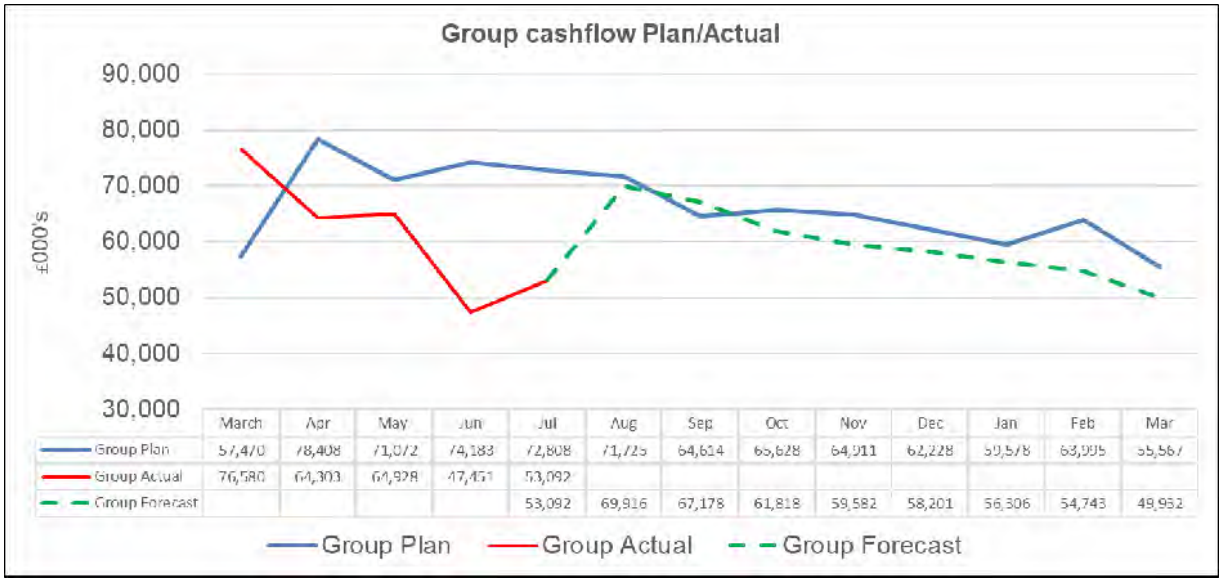
3.7 We have still not received any firm information on our elective recovery fund performance (ERF) in 2024/25. Our CIP plans assume a £14m contribution from ERF and although our internal activity and contract monitoring information is encouraging, full validation of our performance can only be confirmed by NHSE.

4. CASH

4.1 Cash balances at 31 July were £53.1m; £19.7m lower than plan; this is due to capital expenditure incurred in advance of PDC drawdown (£11.3m); cash since received in August and reduction in trade and other payables (£13m).

4.2 The planned, actual and forecast cash balances are set out in Chart 2 below:

Chart 2: Cash flow Actual/Plan



The cashflow plan is based on the final 2024/25 plan that was submitted on 12 June. The forecast 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.

5. CAPITAL

5.1 Schemes are being progressed in accordance with the agreed programme for the year. There are several timing differences within the internal programme around backlog maintenance and IT (including digital and EHR) that are being reviewed to ensure spend is considered later in the programme.

5.2 Year to date, capital expenditure is £18.2m compared with the plan of £17.7m, resulting in a small overspend of £0.5m. Further details at programme level are shown in Table 4 below:

Table 4: 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	550	51	95	44
Total MPH Site and Service Development	4,073	464	139	(325)
Acute Programme YDH	**Plan £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
Total YDH Main Site Budgets	2,665	579	450	(129)
Total - YDH Site and Service Development	5,552	96	70	(26)
Total - YDH Site Risks / Plant and equipment Replacement	430	101	66	(35)
Total Acute	**13,270**	**1,291**	**820**	**(471)**
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	2,450	936	673	(263)
Total Community / Mental Health - Site Risks / Plant & Equipment	300	60	(8)	(68)
Total Community/Mental Health	**2,750**	**996**	**664**	**(332)**
Trustwide	**Plan £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
Programme Management & Feasibility Work MPH	400	121	143	22
HEAG (PEAG/ Environment)	100	25	8	(17)
MPH Backlog Maintenance	2,682	699	185	(514)
YDH Backlog Maintenance	2,551	665	143	(522)
CMH Backlog Maintenance	1,100	222	(23)	(245)
Contingency Backlog Maintenance	2,150	75	0	(75)
Major Medical & Surgical Equipment	4,550	583	403	(180)
Departmental relocations (Includes Corporate Decant)	100	39	42	3
Information Technology	2,300	476	47	(429)
Revenue Recognition	750	188	0	(188)
Infrastructure Upgrade & Carbon Neutral	250	28	11	(17)
AI Technology	0	0	48	48
Stroke Services Reconfiguration Planning	350	0	0	0
Slippage 23/24	0	0	30	30
Internal Digital Programme - Trust Wide	4,500	1,242	775	(467)
Internal Digital 'EHR	5,000	1,171	473	(699)
IMIP phase 2 onwards	345	87	103	16
Trust wide Risk contingency	375	0	0	0
Trustwide	27,503	5,620	2,386	(3,234)
Total Internal Capital Envelope	**43,523**	**7,907**	**3,870**	**(4,037)**
Additional Capital Schemes	**Plan £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
PDC STP 3 - MPH Surgical Centre	24,631	4,977	8,681	3,704
PDC NHP - MPH	900	274	286	13
PDC NHP Enabling	1,137	591	353	(237)
PDC Pathology Network	222	82	69	(13)
PDC Diagnostic Network	733	25	0	(25)
PDC Endoscopy - MPH	549	3	7	4
PFI Funded IFRIC 12 - SFT MES	424	106	0	(106)
Donated Acute MPH	50	41	44	3
PDC Tif - Elective Recovery/Theatre expansion	4,076	355	1,483	1,128
PFI Funded IFRIC 12 - YDH MES	333	83	(1)	(84)
Donated Salix (Slippage)	0	0	36	36
Donated Acute YDH Breast Unit	1,000	642	780	138
Donated YDH	0	0	32	32
PDC Yeovil CDC	1,292	259	106	(153)
PDC Somerset CYP Safe Spaces	275	0	2	2
Donated Community	110	27	0	(27)
Total Additional Schemes	**35,732**	**7,464**	**11,878**	**4,414**
IFRS Leases	14,523	2,321	2,471	150
TOTAL TRUST PROGRAMME	**93,778**	**17,692**	**18,219**	**527**

6. STATEMENT OF FINANCIAL POSITION (BALANCE SHEET)

Jun-24	Jul-24	Movement		Mar-24	Jul-24	Movement in Year
£000	£000	£'000		£000	£000	£000
38,110	39,471	1,360	Intangible Assets	37,804	39,471	1,667
396,304	397,793	1,488	Property, plant and equipment, other	390,713	397,793	7,080
27,825	27,647	(178)	On SoFP PFI assets	28,360	27,647	(713)
82,104	82,088	(17)	Right of use assets	83,020	82,088	(932)
14	14	0	Investments	14	14	0
14	14	0	Other investments/financial assets	14	14	0
1,737	1,767	30	Trade & other receivables >1yr	2,957	1,767	(1,190)
546,110	**548,794**	**2,684**	**Non-current assets**	**542,883**	**548,794**	**5,912**
11,446	11,402	(45)	Inventories	11,902	11,402	(500)
20,488	31,273	10,785	Trade and other receivables: NHS receivables	7,105	31,273	24,168
13,690	15,114	1,424	Trade and other receivables: non-NHS receivables	24,035	15,114	(8,921)
466	466	0	Non current assets held for sale	466	466	0
47,451	53,092	5,640	Cash	76,580	53,092	(23,488)
93,541	**111,345**	**17,805**	**Total current assets**	**120,088**	**111,345**	**(8,742)**
(79,550)	(82,830)	(3,280)	Trade and other payables: non-capital	(96,111)	(82,830)	13,280
(6,134)	(6,134)	0	Trade and other payables: capital	(14,419)	(6,134)	8,286
(31,196)	(48,549)	(17,353)	Deferred income	(16,364)	(48,549)	(32,185)
(13,917)	(14,044)	(127)	Borrowings	(14,305)	(14,044)	261
(6,910)	(4,999)	1,910	Provisions <1yr	(7,818)	(4,999)	2,819
(137,705)	**(156,556)**	**(18,851)**	**Current liabilities**	**(149,017)**	**(156,556)**	**(7,539)**
(44,165)	**(45,210)**	**(1,046)**	**Net current assets**	**(28,929)**	**(45,210)**	**(16,281)**
(111,054)	(111,323)	(269)	Borrowings >1yr	(111,977)	(111,323)	655
(2,966)	(4,684)	(1,718)	Provisions >1yr	(3,060)	(4,684)	(1,624)
(1,617)	(1,596)	22	Deferred income >1yr	(1,682)	(1,596)	86
(115,637)	**(117,603)**	**(1,966)**	**Total long-term liabilities**	**(116,719)**	**(117,603)**	**(883)**
386,308	**385,981**	**(327)**	**Net assets employed**	**397,234**	**385,981**	**(11,253)**
			Financed by:			
363,752	365,052	1,300	Public dividend capital	363,752	365,052	1,300
77,897	77,897	0	Revaluation reserve	77,897	77,897	0
186	186	0	Other reserves	(4,441)	186	4,628
(2,471)	(2,471)	0	Financial assets at FV through OCI reserve	(2,471)	(2,471)	0
(53,388)	(55,278)	(1,890)	I&E reserve	(38,050)	(55,278)	(17,227)
			Other's equity			
331	594	263	Non-controlling Interest	548	594	46
386,308	**385,981**	**(327)**	**Total financed**	**397,234**	**385,981**	**(11,253)**

6.1 The in-month movement in deferred income is primarily driven by education income (£8m), high-cost drugs (£4m) and talking therapies (£5m). Some of these are offset in Trade and other receivables and will clear in month 5.

7. CONCLUSION AND RECOMMENDATION

7.1 If we exclude the unfunded and unplanned impact of industrial action in month, the Trust would be slightly ahead of plan which is encouraging. We await details on how the impact of industrial action will be treated and if there will be national funding made available to offset the financial impact.

7.2 The level of forecast efficiency savings has increased and reduced the unidentified gap again this month. The forecast does contain a level of risk e.g. ERF income as set out in the report but overall we continue to make progress. Service groups are being supported to reduce the risks in their plans and identify additional schemes to close gaps where applicable. While

there is a clear determination to make further progress it should be recognised there is also inherent risk in some of the schemes already set out. We will continue to monitor progress, risks and actions being taken in this regard through our business as usual structures.

7.3 We continue to focus on controlling costs and delivering within agreed budgets, supporting services who are facing challenges in doing so. Agency has been a key pressure for us in recent years and coupled with growth in the workforce has placed considerable pressure on the delivery of our financial plan. There are encouraging signs that both agency usage and workforce levels remain within our planning assumptions which is good news. This will require ongoing oversight and monitoring to ensure we remain on course and identify any issues quickly and that these are managed.

7.4 There has been a proposed pay offer of 5.5% for Agenda for Change staff and a proposed change to incremental progression for Band 8's. The NHS Staff Council has been recommended to approve the offer but confirmation is awaited. The funding embedded within 2024/25 plans was significantly lower than the offer made (2.1%) so we wait for further information on how this will be settled with systems.

7.5 The Board are asked to discuss and 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 25 June 2024 and 10 July 2024
SPONSORING EXEC:	Jade Renville, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Paul Mapson, Chairman of the Audit Committee
DATE:	3 September 2024

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 meetings held on 25 June and 10 July 2024 and the assurance received by the Committee. The meeting was conducted as a video conference call. The Committee received assurance in relation to: • The annual accounts and report external audit process. • The Audit Committee's annual report for 2023/24. • The corporate risk register and the management of the operational risks. • The risk management update and the approval of the risk management policy. • The work of the counter fraud service. • The reduction in the number of outstanding counter fraud recommendations. • The progress made on the internal audit plan. • The Patient Safety Incident Reporting Framework report. • The findings of the EPRR audit. • The findings of the Workforce audit.

	• The approval of the 2024/25 internal audit plan. • The six monthly reports from the Quality and Governance Assurance Committee and People Committee and the oversight of risks by the Committees. • The losses and special payments report. • The single quotation/tender waiver action report. • The Terms of Reference progress report. The Committee identified the following areas for follow up: • The Board Assurance Framework and the assurance in relation to the high rated risks and residual risks. • The counter fraud progress report – the need to clarify the oversight arrangements for security. • The findings of the Cancellations of Eelctive Operations report. • The follow up report – the number of internal audit recommendations becoming due prior to October 2024 and the presentation of a progress report to the Operational Leadership Group meeting. • The six monthly report from the Quality and Governance Assurance Committee – the discussion with Non-Executive Directors about the assurance required in relation to the management of strategic risks. The Committee identified the following area to be reported to the Board or other committees: • The findings of the cancellation of elective operations audit (Executive Team/Operational Leadership Group). • It is recommended that a whole Board discussion takes place at some stage to consider the management and reporting of red rated risks along with the way assurance is given and taken using the

	formal governance structures in the Trust i.e Exec committees, Board Assurance Committees, Audit Committee and Trust Board.
Recommendation	The Board is asked to note the assurance and areas of concern identified by the Audit Committee. The Board is further asked to note the areas to be reported to the Board or to Committees.

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

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

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

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

Details: N/A

Equality and Inclusion

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

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

This report has not been assessed against the Trust's Equality Impact Assessment Tool.

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

Public/Staff Involvement History 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 MEETINGS HELD ON 25 JUNE 2024 AND 10 JULY 2024

1. PURPOSE

1.1. The report sets out the items discussed at the meetings held on 25 June 2024 (focus on annual accounts and annual report) and 10 July 2024.

2. ASSURANCE RECEIVED

2023/24 Internal Audit Annual Report

2.1. The Committee received the report and noted that a moderate Head of Internal Audit Opinion had been issued.

2023/24 Counter Fraud Annual Report

2.2. The Committee received the report and noted that progress in relation to the Functional Standards which had been rated as amber will be followed up as part of the 2024/25 work plan.

Review of the 2023/24 Annual Accounts and Annual Report

2.3. The Committee reviewed the 2023/24 Annual Accounts and Annual Report and agreed to recommend the approval of the annual accounts and annual report to the Board meeting to be held on 25 June 2024.

Audit Committee Annual Report 2023/24

2.4. The Committee discussed its annual report which sets out the Committee's activities during the year and the Committee agreed that the report provided good assurance in support of the Annual Governance Statement.

Review of the ISA 260 Report

2.5. The Committee received the ISA 260 report and noted that an unqualified audit opinion will be issued.

2.6. The Committee agreed that this was a significant achievement in view of the technical adjustments required to combine two sets of accounts into single accounts, and the turnover of the merged organisation.

Auditors' Annual Report

2.7. The Committee received the report and noted the impact of the findings of the Care Quality Inspection of maternity services on the Value for Money assessment.

Independent Auditors Report to the Council of Governors

2.8. The Committee received the report to the Council of Governors and noted that

the report will be attached to the annual accounts and annual report and submitted to Parliament.

Letters of Representation

2.9. The Committee received the letters of representation and agreed to recommend the approval of the letters of representation to the Board meeting to be held on 25 June 2024.

Simply Serve and Symphony Health Services Annual Accounts

2.10. The Committee received the annual accounts for information.

Corporate Risk Register (CRR)

2.11. The Committee received and discussed the report. The Committee noted the key themes; the high scoring corporate risks and the mitigating actions being taken.

2.12. The Committee noted that the risks had been assessed against the risk appetite and risk tolerance statement and noted the risks which had been assessed as outside of the risk tolerance level and which should be a key area of focus.

2.13. The Committee agreed that there was more assurance about the management of the operational risks and that the Committee's main concerns related to the strategic risks.

Risk Management Update

2.14. The Committee noted that all risk management systems had now transferred to Radar and that further work will be required to ensure that the risks were consistent and to merge duplicate risks. The Committee noted that the Radar system will be reviewed to check whether it will be possible to clearly set out internal and external controls.

2.15. The Committee noted that a proposal had been submitted to add the level 1 risk management training to the mandatory training programme for all colleagues.

2.16. The Committee further: received an update on the system wide work on the development of a system Board Assurance Framework and Corporate Risk Register; noted the updated Risk Management Strategy; reviewed the progress against the Year 1 2023/24 Risk Management Strategy implementation plan; and noted the implementation plan for Year 2 of the Risk Management Strategy.

2.17. The Committee approved the Risk Management Policy and Risk Appetite and Risk Tolerance statements.

Counter Fraud Progress Report

2.18. The Committee received the counter fraud progress report and noted the

proactive work, investigations and performance against the functional standards.

2.19. The Committee noted: the declaration of interests compliance levels; the positive interaction with the human resources team; the improved training compliance figures, particularly at YDH; the procurement local proactive exercise and the focus on due diligence and contract management.

Counter Fraud Recommendations Tracker

2.20. The Committee received the counter fraud recommendations follow up report and the Committee agreed that the report provided significant assurance about the implementation of the recommendations. The Committee noted the reduction in the number of outstanding recommendations.

Internal Audit progress report

2.21. The Committee received the internal audit progress report and agreed that good progress was being made implementing the internal audit plan.

Patient Safety Incident Reporting Framework (PSIRF) Report

2.22. The Committee received the audit report and noted that the report took the form of a guidance document. The Committee noted that the framework was considerably different from the previous framework with a stronger focus on learning; and that progress against the PSIRF was monitored through the Quality and Governance Assurance Committee.

2.23. The Committee agreed to share the report with the Quality and Governance Assurance Committee.

EPRR Audit Report

2.24. The Committee received the audit report and noted that a moderate opinion had been issued for both design and design effectiveness, with four medium priority recommendations. The recommendations related to: debriefs of major incidents; the identification of lessons learnt; the completion of training; and the lack of a system call agenda for major incidents.

2.25. The Committee agreed that the findings were positive with significant areas of strength and no fundamental concerns identified.

Workforce Planning Report

2.26. The Committee received the audit report and noted that a moderate opinion had been issued for both design and design effectiveness, with three medium priority recommendations. The recommendations related to: the time required for culture change and risk log requiring review; the need to clarify the expectations for workforce plans; and the need to include equity, diversity and inclusion in the people impact analysis.

2.27. The Committee agreed that the report provided some assurance but recognised that further work will be required.

2024/25 Audit Plan

2.28. The Committee received the annual plan and noted that the plan had been amended following the comments made at the April 2024 Committee meeting.

2.29. The Committee approved the 2024/25 audit plan.

Six Monthly Progress Report from the Quality and Governance Assurance Committee

2.30. The Committee received the six monthly progress report and noted the change in the format of the report to more clearly set out the discussions about the risks assigned to the Committee.

2.31. The Committee discussed the need for a six monthly report from the Finance Committee and agreed that a report will be included on the meeting planner.

2.32. The committee agreed that the report provided good assurance in relation to the Committee's risk oversight.

Six Monthly Progress Report from the People Committee

2.33. The Committee received the six monthly progress report and agreed that the report provided good assurance about the Committee's discussions and oversight of the workforce risks.

Losses and Special Payments

2.34. The Committee received the losses and special payments report and noted the reasons for the losses and special payments. The Committee approved the write-off of a debt relating to an overseas patient.

2.35. The Committee agreed that the reports did not highlight any areas of concern.

Single Quotation/Tender Waiver Action report

2.36. The Committee received the single quotation/tender waiver action report for the trust and for Simply Serve Ltd and noted the single quotation and tender waiver actions and the reasons for these actions.

Policy Changes/Updates/Statutory requirements

2.37. The Committee noted that no policy changes or updates were to be brought to the attention of the Committee. The Committee noted that a national briefing had been set up for 15 July 2024.

Terms of Reference Progress Report

2.38. The Committee received the report which monitored progress against the Committee's Terms of Reference.

2.39. The Committee agreed that the report provided significant assurance about the work of the Committee.

3. AREAS FOR FOLLOW UP

Board Assurance Framework

3.1. The Committee discussed the Board Assurance Frameworks (BAF) and noted that the actions had been updated and that the BAF had already been presented to the July 2024 Board meeting.

3.2. The Committee discussed the large number of high rated risks, including the residual risks, and discussed the information presented to the Committee in terms of mitigating actions being taken. The Committee noted that the workforce risks had been discussed in detail at the People and Finance Committee meetings and that risks had been assigned for oversight by Committees. The Committee agreed that it was unable to determine whether there was sufficient assurance in relation to the mitigation of the high rated risks and whether sufficient controls were in place to manage the residual risks. The Committee agreed to escalate the number of high rated risks, and residual risks, and assurance about these risks, to the Board.

Counter Fraud Progress Report

3.3. The Committee discussed the oversight arrangements for security and Paul Mapson agreed to meet with the Security Manager to discuss the oversight arrangements.

Cancellations of Elective Operations Report

3.4. The Committee received the audit report and noted that a moderate opinion had been issued for both design and design effectiveness and that four medium priority recommendations had been made. The recommendations related to: avoidable non-clinical cancellations; data quality validation; the recording of cancellations and new appointments at YDH ophthalmology services; and the need to update the cancellation standing operating procedures.

3.5. Based on the findings in the report, the audit opinion and the impact on the elective waiting lists, the Committee agree to escalate the report to the Executive Team.

Follow Up Report

3.6. The Committee noted the progress made implementing the audit recommendations and noted that a large number of audit recommendations will become due at the next Committee meeting.

3.7. The Committee expressed its concern about the potential for a large number of overdue audit recommendations and noted that a progress report, setting out the recommendations in progress and overdue, will be presented to the next Operational Leadership Team meeting.

Six Monthly Progress Report from the Quality and Governance Assurance Committee

3.8. The Committee further discussed oversight of strategic risks and the additional elements of assurance to be provided. Jade Renville agreed to seek the views from Non-Executive Directors on what further assurance can be provided.

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

4.1. The Committee identified the following issue to be reported to the Executive Team or other committees:

- The findings of the cancellation of elective operations audit.

- The assurance in relation to the number of high rated strategic risks, including residual risks. It is recommended that a whole Board discussion takes place at some stage to consider the management and reporting of red rated risks along with the way assurance is given and taken using the formal governance structures in the Trust i.e Exec committees, Board Assurance Committees, Audit Committee and Trust Board.

CHAIRMAN OF THE AUDIT COMMITTEE