NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Designated Body Annual Board Report and Statement of Compliance (Medical Appraisal and Revalidation)
SPONSORING EXEC:	Melanie Iles, Chief Medical Officer
REPORT BY:	Dr Reenee Barton, Lead Medical Appraiser
PRESENTED BY:	Melanie Iles, Chief Medical Officer
DATE:	5 November 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	Each year the trust is required to provide a detailed report to NHS England on the number of medical appraisals that have taken place and the number of connected doctors who revalidated. The report covers both the Trust and St Margaret's Hospice. The report has a new format and new requirements for data with respect to previous annual submissions.
Recommendation	The appraisal and revalidation team request that the board supports the content of the report and are assured that due diligence is being paid to the medical appraisal and revalidation processes. Due to the deadline of 31 October 2024 for sign off and submission to NHS England, electronic Board approval was sought. The Board is requested to formally ratify the electronic approval.

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: **Details**: Medical Appraisal is a mandatory annual activity required of all doctors in order to maintain their GMC registration. Appraisal is an essential part of revalidation which takes place every five years.					

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 of protected characteristics has not been considered as part of this report but are considered as part of the individual appraisals.

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. This is an annual mandated report with a standard template provided by NHS England.

Previous Consideration

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

The report is presented to the Board on an annual basis.

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

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

	HLRO Visit Action Plan						
	Responsible Officer						RAG
	Recommendation	**Priority**	**Discussion**	**Lead**	**Outcome**	**Timescale**	
1	To identify adequate resources to fund the number of appraisals required annually, the number of revalidations and to resolve the issue of having a single point of failure for the administration of supporting both systems	Must	Following the merger of the two organisations we identified that there had been a reduction of 0.9 WTE appraisal admin Band 4 and Band 5, due to other pressures and vacancies in medical workforce. Total was 1. 0 WTE	NR	Admin restructure- admin team will now undertake medical appraisal and job planning. Successful bid for 6 SPA from central monies. Expressions of interest/interviews in Q1 and Q2. Have reached sufficient expressions of interest to meet shortfall of 150 appraisal slots. Induction of new appraisers commencing Q3, ready for when new appraisal IT system goes live.	Achieved	
	Appraisal Process						
	Recommendation	**Priority**	**Discussion**	**Lead**	**Outcome**	**Timescale**	
1	To review methods to increase the uptake and engagement in appraisals completed,	Must	The appraisal processes need to be aligned across the new merged organisation. Some of the optics around engagement was due to differences in data capture between YDH and Legacy SFT, such as what consititutes a missed appraisal.	NR/RB	New-Enhanced induction for IMG and LED in MPH/YDH which includes Appraisal and Revalidation. Working group for LED with PGME has led to plan to develop an ARCP panel equivalent which will be in lieu of medical appraisal for F1/F2/ CT1-2 using their training portfolios. Increase in SPA appraiser capacity for LEDs who are at registrar level- Appointment of LED Tutor Leads who have an Appraiser role and Director of Medical Education also undertaken SPA time in appraisal. Plan to link completed annual appraisal (and job planning) to CEA award payment and pay progression (new guidance issued).	Achieved	
2	To ensure that every doctor aligned to the RO has a completed or an 'approved missed appraisal' across the whole organisation for each appraisal year,	Must		NR/RB	All doctors will have a set due month 9 months from starting in the trust and will be allocated an appraiser. Use of L2P (Go Live Nov) also makes it clear to appraisee when an appraisal is over due and sends reminder emails to appraisee. New joint medical appraisal revalidation policy has clear lines of appraisal arrangements. No doctors will be appraised by their line manager unless they are in a short term non training post (locally employed doctor). Once we have established all doctors on the new IT system, we have sufficient appraisers recruited and trained to provide enough appraisal slots, and we have allocated appraiser centrally, then we can be confident that any doctor who has not completed an appraisal has failed to do this due to their engagement. Therefore, Non engagement letters can be sent on behalf of RO for those failing to engage.	By March 31 2025	
3	To clarify the permitted requirements for 'approved missed appraisal' within the organisation	Should		NR/RB	Now defined. Maternity, Sick more than 4 weeks, sabbatical more than 3 months, shared parental leave. NB new starters need to book an appraisal within 9 months of their start date or since their last ARCP/ appraisal and will not be noted as an approved missed. They will not be "due" if joining after Q1 for that appraisal year.	Achieved	

4	To agree what the appraisal year will be, one system across the whole organisation.	Must		NR/RB	All appraisals must take place within the appraisal year which runs April 1st to March 31st the following year. Appraisals will need to take place in a due month for an individual, to prevent end of year spike. Thiswill be set as 9 months from the start date for new starters (first GMC medical appraisal), or 12 months since the last appraisal.	Achieved	
5	To allocate appraisers rather than allow appraisers to choose. Grounds to 'decline' and 'request alternative allocation' can be agreed	Should		NR/RB	Central allocation has been Agreed. However, it will take some months for system to be established- since it is contingent on L2P data migration, live system and all the new appraisers have been trained. There was a strong Legacy Taunton Somerset/ MPH hospital preference from appraisers and appraisees to choose their appraisers. Somerset Partnership adopted central allocation policy. YDH allocated appraiser centrally for first appraisal. Hybrid system of appraisees being able to choose, and then at end of Q2 if an appraisee couldnt find an appraiser, they were allocated an appraiser was trialled during the previos merger of. Hybrid system didn't work well as IT systems didnt support easily and limited admin capacity. Using the migration of all data to L2P and ensuring we have sufficient appraisers is the right time to then appropriate implement a system of central allocation. This will ensure better spread of appraisals through the year, no conflicts of interest, fewer wasted appraisal slots, fairer for overperforming appraisers, who are no longer put in position of having to accept or decline individually.	Achieved	
6	To review the arrangements to allocate appraisers for a 3 year cycle, to aid planning and spread the allocation of appraisals throughout the year	Should		Admin team		achieved	
	Appraisal - Appraisers						
	Recommendation	**Priority**	**Discussion**	**Lead**	**Outcome**	**Timescale**	
1	The team to review methods of recruitment/retention of appraisers. Consideration of a personal approach to identify and engage suitable doctors to increase numbers of appraisers to meet the needs of the organisation, ensuring the appraiser network reflects the diversity of the medical workforce.	Must	There is a lack of appraiser capacity particularly regarding the Taunton site. There is a discrepancy in appraisal allocations per appraiser in MPH/SoMPar (9 per 0.25 SPA) versus YDH (6 per 0.25 SPA). 3) Total connected doctors =831. As at 1 April 2024, we have 586 slots, and we have 751 due an appraisal. Shortfall of appraisals 165 to be conducted. This is a shortfall of 5 SPA (8 appraisals per 0.25 SPA) and 6 SPA (7 appraisals per 0.25 SPA). A bid was made due to this significant workforce capacity issue for a mandatory trust function.	RB	Bid was successful. Recruitment drive could commence 24 May 2024, once L2P had been agreed. Allocation of 8 appraisals per 0.25 SPA also agreed which includes 2 hours per year CPD and refresher every 3 years. We have been able to recruit 15 new appraisers. 3 of these doctors will join the team post retirement.	By October 2024	

2	To align ways of working, drawing on current the good practice and systematically applying across all sites, ensuring sufficient time, adequate training and updates are available, Quality Assurance and attendance recorded, to enable appraisers to carry out their roles effectively.	Should	Several examples of good practice, particularly from the SFT around quality of appraiser output forms when audited used the NHSE ASPAT audit tool- average mean score last 2020-2021, 2021-2022, 43/50 for Legacy SFT. Sample of High, adequate and below standard of practice from 2022-2023 for HLRO visit May 15th 2023	RB	Training method of sharing quality of output forms in peer groups using anonymised RAG rating of the whole audit data set, and anonymised example, adopted by SomPar and more recently by MPH TST can be used for CPD for peer group.	Achieved	
1	Ensure all Appraisers are fully trained and remain up to date with their Appraisal training.	Must	Quality Assurance (QA) of Appraisal needs to be embedded as part of the appraisal process, with sufficient time for appraisal leads/team to complete this work. There is a need to ensure adequate resources for Appraisers	RB	QA processes are already embeded and have taken place annually in legacy trusts and fedback to appraisers in different ways. There had been a gap in audit undertaken on 2022-2023 data due to capacity issues. Sample of 2023-2024 data was audited (sample of doctors who had a final appraisal about to revalidate) an included in AOA report to NHSE CPD for appraiser: LEAP platform trial- bookable training for new appraiser induction and appraiser refreshers was trialled via LEAP but did not land with appraisers. Use of some of central SPA money has been used to arrange a CPD away day (Sept 25 2024- 60 delegates attending including speakers confirmed) to launch L2P, re-engage peers and introduce merged policy . Running alongside have been monthly online drop ins for peer groups since May with L2P support have re-engaged appraisers. An additional group of new appraisers (15) have induction training lined up (Sept/Oct/Nov 2024) New guidance regarding CPD: 2 hours per annum, 1:1 email support from lead appraiser and one day refresher every 3 years delivered as live classroom.	Recruitment has been achieved. New appraisers (15) induction and training will be achieved by Jan 2025	
2	To consider face to face regular meetings and/or lunchtime sessions to update appraisers, with an agreed minimum attendance annually.	Should		RB	Established Microsoft Teams Channel for appraisers so that appraisal admin team and lead appraisers can post up to date information around allocations, training, new guidance (in addition to mass emails), monthly online peer groups with L2P / Appraisal admin presence and live large classroom training for refresher training.	May-24	
3	Feedback to be collated as part of quality assurance and passed back to Appraisers to ensure continued learning and development of Appraisers. To be included in discussions regarding toolkit contract.	Should		RB	Individual appraiser feedback from appraisees uploaded to their appraisal portfolios (Appraisal Admin Team). Redacted full report shared at MRSG. Feedback of the redacted sample of output forms using NHSE ASPAT audit tool will be shared annually to peer group. This data has been used to inform the creation of an appraisee and appraiser checklist aide memoir in L2P. After peer group training, if ongoing poor performance, RB to provided individual feedback. Consensus is to remain with ASPAT.	May-24	

4	To identify and develop experienced 'super appraisers' to support the appraisal leads in training and quality assurance of the appraisal process, and to be available to appraise leadership roles or cases where the RO feels an experience skilled appraiser is required.	Should		NR and RB	This is already done informally. A formal list will be devised and used as part of the new process to assign appraisers. This will also include as part of the offer overseas/ new to the UK appointments and LEDS who are IMGs due to issues identified further down the line. Training of appraisers will include: career conversations, how to access coaching/ mentoring. OD leadership programme offer for appraisers and appraisees, wellbeing services	May-24	
	Revalidation						
	Recommendation	**Priority**	**Discussion**	**Lead**	**Outcome**	**Timescale**	
1	The organisation currently has one person with limited support to manage the administration for Appraisal/Revalidation process, with a significant increase in the number of doctors to manage. This carries a risk of being a single point of failure.	Must	Ensure adequate resources are available to support the Revalidation Process (and Appraisal as mentioned previously)	NR	Governance has also stepped down. March 2024 a move to self declaration reduced admin burden.	Was achieved, but now has admin capacity reduced again.	
2	Review appraisal toolkit options before procurement, to consider functionality to suit needs, such as feedback from appraisers, and to improve efficiency in organising and arranging appraisals to support Revalidation of doctors.	Must		NR, RB	L2P agreed and migration Sept-Oct 2024 and Go Live Nov 2024 projected.	By the end of current contract periods (of SARD JV/360 tool and Premier IT)	
	Conflict of Interest (COI)						
	Recommendation	**Priority**	**Discussion**	**Lead**	**Outcome**	**Timescale**	
1	To review appraisal arrangements for Appraisal Leads/Leadership posts to ensure there are no perceived COI. Consider reciprocal arrangements with other organisations using 'super/senior' appraisers. Ensure that doctors are not appraised by their line manager	Should	Current appraisal arrangements for Appraisal Leads/Leadership posts to have an appraisal `in house' carries a potential risk of COI or perception of bias	RB	New joint medical appraisal revalidation policy developed has clear lines of appraisal arrangements. No doctors will be appraised by their line manager unless they are in a short term non training post (locally employed doctor). L2P and central allocation will esnure this.	By March 31st 2024	

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance *before completing.*

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of

Somerset NHS Foundation Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	Structure is Trust RO, 1x site RO for Musgrove Park Hospital (MPH /Legacy Somerset Partnership), 1x site RO for Yeovil District Hospital (YDH), 1x Deputy RO (for MPH/Legacy Somerset Partnership).
Comments:	Responsible Officer (RO): Daniel Meron MPH and Community / Mental Health, Site RO: Lucy Knight Deputy Responsible Officer (DRO) MPH and Community / Mental Health: David Beacock YDH Site RO: Meridith Kane
Action for next year:	Daniel Meron stepped down end March 2024. Replaced by Melanie Iles, Trust RO.

	Both Site ROs stepping down end October 2024 – potential plan to re- organise the structure, so Site ROS have not yet been replaced. Deputy RO for MPH is remaining in post. Deputy RO is for MPH/ Legacy Somerset Partnership

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	No the DB had not been providing this.
Action from last year:	The comparative analysis of 2022-2023, and 2023-2024 AOA figures showed that there has been: 1) reduction in appraisal compliance 2) loss of appraisers due to clinical work pressures. Analysis: 1) Appraiser SPA time is not centralised and has come out of individual job plans, this meant that there were no replacements for appraisers that had stepped down. 2) Relative reduction in WTE of appraisal admin team compared to pre covid levels and pre-merged trusts 3) A markedly changing workforce- a rapid increase in locally employed doctors in non training grade equivalent roles, many new to the UK as international medical graduates, that had reached 160 of the total workforce. Pre covid had been approximately 60 across the Trust. This group of doctors have different appraisal needs to substantive doctors and due to short contracts (6 months) that were then often extended, were then requesting appraisals too close to their due month and at this late stage would be unable to find an appraiser. 4) IT system issues. The IT appraisal systems from legacy trusts were not merged due to this requiring an additional cost which meant the appraiser pool was unable to merge. The system itself relies heavily on admin and admin require several spreadsheets to track data. A Higher Level responsible Officer Visit 15th May 2023 identified inadequate WTE revalidation admin, a bottle neck of information flows due to the small appraisal admin team, a significant short fall of

	appraisers for the slots needed and challenges with the current system of appraisees choosing their own appraisers. They recommended a move to a central allocation of appraisers to appraisees, increasing admin workforce, suggested better IT System that could remove some of the tasks currently sitting with admin, a clear agreement across sites as to what constituted an approved missed appraisal, and for the Trust to increase appraiser pool and induction/ refresher training.
Comments:	Please note that this report is submitted on behalf of the newly merged Somerset Foundation Trust. Any information that is specific to the legacy trusts will be detailed within this report. If no split in information is provided, this information is applicable to both legacy teams.
Action for next year:	A business case was developed and was successful in early 2024-2025. Lead appraiser is recruiting and inducting new appraisers 2024 Q1 and Q2. Currently projected to increase appraiser pool to fulfil the shortfall in appraisal slots. A new IT system has been contracted. It is estimated that it will take 12 months to fully establish the new IT system, migrate data, recruit and train new appraisers and provide refresher training for existing appraisers. Those who have missed 2023-2024 appraisals will be targeted. With the plan to migrate to a new e portfolio system, it will eventually reduce administrative burden and ensure better use of appraisal slots due to a central allocation process. Appraisal admin time will increase but this team will also have oversight of job planning as well as pay and contract related queries for medical staff. The CPD offer for appraisers has been increased on the back of the successful bid also. There have been changes to within Postgraduate Medical education also. The Director of Medical Education and PGME team will now be aware of all International Medical Graduates in their first UK post who will be employed locally (alongside doctors in training who are international medical graduates) who are coming into the Trust. They are receiving enhanced induction and additional support from Educational and Clinical Supervisors. The enhanced induction includes orientation to Appraisal and Revalidation from the lead appraiser. Solutions are also being developed to create a local ARCP process that will be similar to postgraduate doctors in training so that Locally Employed

	Doctors will be assessed with the same competencies as their equivalent doctors in training counterparts. Middle grade locally employed doctors will have an formal medical appraisal in parallel to their college portfolio. PGME have appointed a new Locally employed doctor tutor role which has been combined with Appraiser role to support, signpost and provide appraisal for this group of doctors.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	Yes: all records are held within the Trust's Appraisal and Revalidation systems Premier IT, which are appropriately protected and managed. Spreadsheets held on a secure Trust server are also held (a local record of all appraisees, their grade, their appraisal dates, 360 MSF dates, revalidation dates and allocated appraiser history). The revalidation administrative team check the accuracy of staff lists on these local spreadsheets against GMC connect regularly. Legacy Trusts had separate Premier IT systems and separate local Spreadsheets stored securely and separate appraisal administrators.
Comments:	Merging of systems and appraisal admin team during 2023-2024.
Action for next year:	2024-2025 Merged Appraisal Admin team will have a single system and approach to manage this, with a plan that the new appraisal provider (L2P) will connect directly to GMC connect.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Yes: all such polices exist and are reviewed through quarterly meetings of the Appraisal and Revalidation steering group:
Comments:	A number of related policies due to Trust merger are also in the process of being updated- such as Job Planning for SAS and Consultant doctors.
Action for next year:	Action for 2024-2025: A single appraisal policy can now be developed since we have had agreement of a single e -portfolio appraisal system and 360 MSF across the whole merged organisation which will allow for a merged appraiser team and admin team. We understand that the new purchased e portfolio system will eventually link directly with GMC connect (allowing ease/speed for revalidation recommendations and deferral, logging into a single system). New guidance on Pay progression guidance has been issued in April 2024. This may inform future Trust policy that successful pay progression for

	Consultants and SAS doctors will be contingent on completion of an annual appraisal (or an approved missed) and annual job planning.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	Yes: In-depth Higher Level Responsible Officer Quality Review (HLROQR) took place May 15th 2023 of processes and set of must and should recommendations shared.
Comments:	An action plan was developed from this visit, which is updated and its progress reviewed by the Medical Revalidation Steering Group and SFT Operational Leadership Team.
Action for next year:	Completion of all action plan objectives generated from HLRO QR visit recommendations.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Bank Locums who have a prescribed connection will have full access to Trust CPD and an SFT annual appraisal which will be job planned in, if logging sufficient clinical hours. Agency locums will have an independent appraisal with their agency and will access departmental CPD and governance to keep them up to date as discussed with their clinical service lead. All doctors have corporate and local induction and are signposted to mandatory training specific to their role in addition to core competency framework.
Comments:	Access to a Whole Scope of Practice Appraisal for bank locum doctors with prescribed connection who are logging sufficient hours will be incorporated into Merged Appraisal and revalidation policy. All new starters (medical recruitment) for Bank Locums will inform Medical Appraisal Admin team.
Action for next year	Whole Scope of Practice Appraisal for bank locum doctors with prescribed connection who are logging sufficient hours will be incorporated into Merged Appraisal and revalidation policy. Ensure robust information flow for new starters- from medical recruitment to Medical Appraisal Admin team.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	Agree a consistent system of how an approved missed is classified and recorded (Legacy YDH system differed from Legacy SFT. Legacy YDH did not include new starters in numbers who were due an appraisal. Legacy SFT would record any starters as an "approved missed" if they joined mid way during the appraisal year, and therefore had an appraisal due month that fell into the subsequent appraisal year, and had not yet completed an appraisal by March 31st,
Comments:	Due month is now set as 9 months after start date for first GMC appraisal or 12 months from their last appraisal or ARCP. Shortfall of 150 appraisal slots due to a number of appraisers leaving due to DCC or competing SPA pressures. Rapid increase in medical workforce of doctors new to the UK in non training posts in junior grades for 6 and 12 month contracts. Appraisal figures for merged Trust 01 April 2023 – 31 March 2024: TOTAL number of doctors with a prescribed connection to Somerset NHS FT on 31 March 2024 – **828.** Of these, the total number of doctors due an appraisal – **739** (doctors are required to have an appraisal after 9 months of starting at the Trust so we have not included figures for doctors who started in post after the end of Q1 2023-24). Breakdown of appraisal figures 2023-24: Total completed appraisals/annual reviews - **545 (73.75%).** Total incomplete appraisals – **13 (1.75%)** (2 of which are still awaiting the doctor's sign off). An incomplete appraisal is one that was held during the 2023-24 appraisal year, but not signed off until after the end of April 2024. Total missed appraisals – **181 (24.5%),** of which: approved missed – **144 (19.5% of total appraisals; 79.5% of missed appraisals);** unapproved missed – **37 (5% of total appraisals; 20.4% of missed appraisals).** Reasons for the missed appraisals are as follows: • 54 (7.2% of total Drs due an appraisal / 28.4% of the 187 Drs with missed appraisals) subsequently had a completed appraisal in the first quarter of 2024-25 (26 in April, 19 in May and 9 in June) • 20 subsequently had an appraisal within the first quarter of 2024-25 but the appraisal was signed off during the second quarter or is still awaiting sign-off • 22 have subsequently scheduled their appraisal during the second quarter of 2024-25 • 2 have subsequently scheduled their appraisal during the third quarter of 2024-25 • 5 were on sick leave (2 of the Drs on sick leave subsequently completed an appraisal in April and May 2024) • 1 was on maternity leave • 2 had left the Trust before the end of March 2024 but hadn't been removed from our GMC Connect list (1 of which had retired) • 1 had extended periods of leave overseas • 1 was retiring in Q1 of 2024-25

	• 3 reported as missed due to appraiser shortage • 1 reported as missed due to junior doctor strikes • 1 is under fitness to practice investigation • 1 had an appraisal scheduled for the first quarter but subsequently went on sick leave • 30 had joined the Trust but not yet been given an appraisal account due to staff shortages in the appraisal admin team and appraiser pool (6 of these doctors were from overseas and new to appraisals and would have needed additional help) The remaining **37** doctors with an **unapproved missed appraisal** are those who had not booked an appraisal before year end, despite being sent reminders and who did not provide a reason why this was missed (6 of these were overseas Drs new to appraisal, 2 had left the Trust before year end, but we hadn't been aware of this, a further 3 have since left the Trust, 1 subsequently relinquished their GMC registration and 1 was a GP so shouldn't have been connected to us).
Action for next year:	Increase appraiser capacity and trained appraisers Use new appraisal and 360 electronic system with central allocation ability and reminders emails for when appraisals are due (removes the responsibility of appraisee sourcing an appraiser) Improved e portfolio reduces administrator burden to chase appraisees, set appraisal dates and set the name of the appraiser.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	There is a better, but not complete full understanding of why some doctors have missed their 2023-2024 appraisal. There are 4 doctors (out of 828 doctors with a prescribed connection) who have had 2 unapproved missed annual appraisals, which we will follow up on - 4 of these were due a March 2023 appraisal and they will be allocated a senior appraiser with a deadline of when to complete these appraisals by. There are also 4 doctors who have had 3 unapproved missed appraisals showing on our appraisal system. One of these is due to retire in January 2025, the other 3 are being followed up by the senior revalidation team and as above will be given a deadline for their next appraisal.
Comments:	Reasons: • Two mergers April 2020 and April 2023. IT systems did not merge with 2nd merger, appraisers are in separate teams, using separate software accounts. • Appraisal processes – admin capacity reduced and created bottleneck with small, downsized team. Each admin team for each site had separate local/ saved securely spreadsheets and lists and systems for appraisees, previous appraisals, previous appraisers, when 360 completed and revalidation due which required merger. • Site differences for new starter processes and their information flow to Appraisal admin team leading to delays in Appraisal team being made aware of new starters; differences between two sites in the way that governance data is collated and sent to Appraisal Admin team • Significant variation across 2 sites regarding differences in SPA allocation for appraisers • No CPD budget for appraisers; differing offer / availability of CPD in legacy trusts. • Clinical / leadership demands increasing leading to appraisers leaving team. No central SPA pot for appraisers so loss of appraiser time without replacement • Transformation fatigue

Action for next year:	All doctors who had not booked an appraisal in 2023-24 were emailed at the end of the appraisal year to book in their appraisals early in 2024-25. There was a successful bid for additional SPA time for appraisers to meet shortfall; recruitment and induction of new appraisers (15) underway. Move to L2P for 2024-2025. Allocation of appraisers centrally with an appraisal due month for appraisees. Workforce strategy development regarding a meaningful appraisal (rather than a missed appraisal) for Locally Employed Doctors (LEDs) on shorter term contracts and development of a local ARCP equivalent panel.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	Yes, there are currently 2 policies in place for the legacies of SFT and YDH.
Comments:	
Action for next year:	New merged policy to be developed to reflect new changes which can be achieved with purchase of a new e portfolio, changed to allocation system, due month, central allocation method, numbers of appraisals per appraiser, site RO structures which will need sign off by MRSG, LNC and Policy Committee.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Increase appraiser capacity.
Comments:	No, the organisation does not have the necessary numbers of trained appraisals to carry out timely annual medical appraisals for all those due an appraisal. At end of 2022-2023 there were 75 appraisers (43 appraisers for 529 due an appraisal on Legacy SFT site and 32 appraisers for 192 appraisals on YDH site) . 771 doctors due an

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	appraisal in total with significant shortfall which was difficult to manage across the Trust due to separate IT systems. 2022-2023 : Based on doctors needing an appraisal- YDH 6 per appraiser, which was the agreed allocation for YDH appraisers. 2022-2023 legacy SFT (MPH/SoMPar) site- this calculates as 12 per appraiser for the same SPA time. Legacy SFT appraisers were allocated 9 per 0.25 SPA. Hence, going into 2023-2024, the shortfall in appraisal slots grew. In 2022-2023 we had 75 appraisers and 721 due an appraisal. In 2023-2024 we had 76 appraisers and 746 due an appraisal. In 2023-2024, we had 76 appraisers, of which 6 were newly inducted during 2023-2024. 8 appraisers stepped down by end of 2023-2024, which reduced the appraiser team to 68 appraisers. This further increased the projected shortfall of appraisal slots for 2024-2025 to an estimated 165 slots (if all appraisers met their allocation quota and did not under or over perform, all appraisees do not cancel their agreed slot and there were no further appraisers leaving post)
Action for next year:	Central SPA funding bid was made for 6 SPA of appraisal time managed centrally. If funding is successful, this will increase appraiser pool and meet shortfall of slots. There will be a recruitment and training induction drive, and refresher training for all appraisers to support retention of current appraisers.

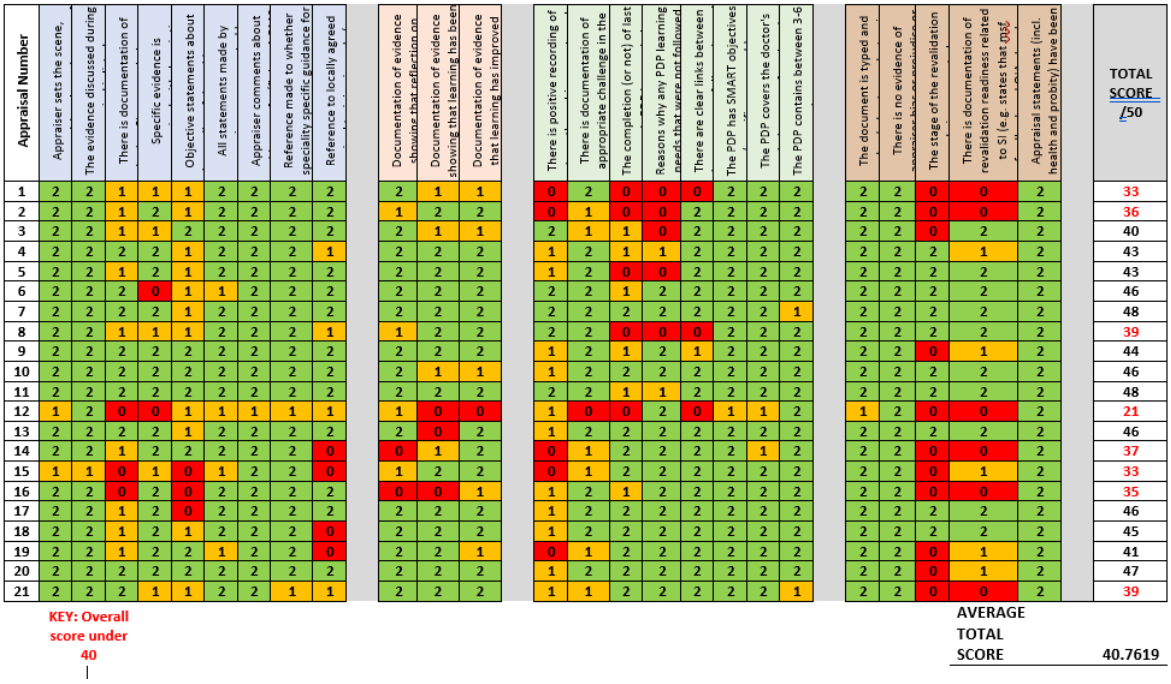
1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	No further action
Comments:	The majority of appraisers attended a half day live refresher Feb 2023 with a GMC update from our ELA office, the RO, Premier IT, Wellbeing lead and Lead Appraiser (Included ASPAT refresher). Less successful - peer groups conducted online using mandatory training platform as a vehicle. HLO RQ visit suggested increasing offer/range of CPD opportunities to re-engage appraisers.

Action for next year:	CPD programme updated to be delivered to merged team. 25 Sept 2024- Face to Face Refresher Conference Appraiser CPD event Live in house conference at Monks Yard with GMC update, MRSG presenters, Wellbeing, L2P, ASPAT, Whole Scope of Practice Appraisal, Roles and Responsibilities of an Appraiser. Monthly Peer Groups online (Combined peers from each site) with L2P joining Series of Appraiser Inductions for new appraisers who are recruited.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	No further action.
Comments:	Yes. A representative sample of appraisals are quality assured using an audit tool by the Deputy Responsible Officer and Lead Medical Appraiser (who are also both appraisers). The last two years 2020-2021 and 2021-2022 the mean average has remained constant at 43/50 for legacy SFT (YDH scores are not included in this data) The 2022-2023 appraisals were not audited due to time constraints but a sample legacy SFT and small sample of YDH cases were peer reviewed by the Higher Level Responsible Officer Quality Review team in May 2023. This small sample showed variance between the two sites in this small sample, with some YDH appraiser output forms requiring improvement and scores in the lower range.A sample of 21 appraisal outputs were audited by the Trust Lead Appraiser and the Deputy RO for the 2023-24 appraisal year. These were chosen from across both sites (approximately 50:50 split) for doctors that were approaching their revalidation submission due date. The results are pasted below and are scored out of 50 with a score of 0 – 2 being available for the evidence provided within the appraisal summary (0 = unsatisfactory; 1 = needs improvement; 2 = good) using NHSE ASPAT Audit tool. The average mean score was 40.7/50 (Range is 21- 48); this is based across both sites as a merged team. The median is 43/50. That means that the majority of scores were very positive with a few outliers. Areas for improvement are around the documentation of the doctor's revalidation readiness, as well as documenting review of their PDP, a comment on the quality of the supporting information and documenting that a whole scope of practice has taken place.

	 The Appraisers also receive aggregated anonymised feedback from their appraisees and this remains consistently positive.
Action for next year:	Lead Appraiser will continue to include learning in CPD for appraisers. New action: L2P has an appraiser checklist which will be bespoke to SFT needs- and this can focus on areas which are less well documented by appraiser in output forms based on our ASPAT audits.

Appraisal Number	Appraiser sets the scene,	The evidence discussed during	There is documentation of	Specific evidence is	Objective statements about	All statements made by	Appraiser comments about	Reference made to whether speciality specific guidance for	Reference to locally agreed	Documentation of evidence showing that reflection on	Documentation of evidence showing that learning has been	Documentation of evidence that learning has improved	There is positive recording of	There is documentation of appropriate challenge in the	The completion (or not) of last	Reasons why any PDP learning needs that were not followed	There are clear links between	The PDP has SMART objectives	The PDP covers the doctor's	The PDP contains between 3-6	The document is typed and	There is no evidence of	The stage of the revalidation	There is documentation of revalidation readiness related to SI (e.g. states that no	Appraisal statements (incl. health and probity) have been	TOTAL SCORE /50
1	2	2	1	1	1	2	2	2	2	2	1	1	0	2	0	0	0	2	2	2	2	2	0	0	2	33
2	2	2	1	2	1	2	2	2	2	1	2	2	0	1	0	0	2	2	2	2	2	2	0	0	2	36
3	2	2	1	1	2	2	2	2	2	2	1	1	2	1	1	0	2	2	2	2	2	2	0	2	2	40
4	2	2	2	2	1	2	2	2	1	2	2	2	1	2	1	1	2	2	2	2	2	2	2	1	2	43
5	2	2	1	2	1	2	2	2	2	2	2	2	1	2	0	0	2	2	2	2	2	2	2	2	2	43
6	2	2	2	0	1	1	2	2	2	2	2	2	2	2	1	2	2	2	2	2	2	2	2	2	2	46
7	2	2	2	2	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	1	2	2	2	2	2	48
8	2	2	1	1	1	2	2	2	1	1	2	2	2	2	0	0	0	2	2	2	2	2	2	2	2	39
9	2	2	2	2	2	2	2	2	2	2	2	2	1	2	1	2	1	2	2	2	2	2	0	1	2	44
10	2	2	2	2	2	2	2	2	2	2	1	1	1	2	2	2	2	2	2	2	2	2	2	2	2	46
11	2	2	2	2	2	2	2	2	2	2	2	2	2	2	1	1	2	2	2	2	2	2	2	2	2	48
12	1	2	0	0	1	1	1	1	1	1	0	0	1	0	0	2	0	1	1	2	1	2	0	0	2	21
13	2	2	2	2	1	2	2	2	2	2	0	2	1	2	2	2	2	2	2	2	2	2	2	2	2	46
14	2	2	1	2	2	2	2	2	0	0	1	2	0	1	2	2	2	2	1	2	2	2	0	0	2	37
15	1	1	0	1	0	1	2	2	0	1	2	2	0	1	2	2	2	2	2	2	2	2	0	1	2	33
16	2	2	0	2	0	2	2	2	2	0	0	1	1	2	1	2	2	2	2	2	2	2	0	0	2	35
17	2	2	1	2	0	2	2	2	2	2	2	2	1	2	2	2	2	2	2	2	2	2	2	2	2	46
18	2	2	1	2	1	2	2	2	0	2	2	2	1	2	2	2	2	2	2	2	2	2	2	2	2	45
19	2	2	1	2	2	1	2	2	0	2	2	1	0	1	2	2	2	2	2	2	2	2	0	1	2	41
20	2	2	2	2	2	2	2	2	2	2	2	2	1	2	2	2	2	2	2	2	2	2	0	1	2	47
21	2	2	2	1	1	2	2	1	1	2	2	2	1	1	2	2	2	2	2	1	2	2	0	0	2	39

KEY: Overall score under 40

AVERAGE TOTAL SCORE 40.7619

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	None
Comments:	123 recommendations were due between 01 April 2023 – 31 March 2024. Of these, 98 positive recommendations were made and 25 deferrals, most of which were due to lack of evidence (missing completed 360 MSF exercise) or a gap in the appraisal history due to periods of maternity leave or overseas work. 2 of the deferrals had a subsequent positive recommendation made within the above time period. A further 9 recommendations were made before 31 March 2024 for submission dates that were due during the 2024-25 appraisal year – of these 8 were positive recommendations and 1 was a deferral. All recommendations bar 5 were made on time – of the 5 late recommendations, this was usually due to the doctor not having a visible

	appraisal history or MSF on our systems and a delay in obtaining the necessary information. The recommendation was subsequently made within a few days of the original date. Of these, 2 doctors were revalidated and 3 were issued a deferral.
Action for next year:	New Electronic System will provide more timely information (RO dashboard on system and with a plan to link directly too GMC connect)

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	None
Comments:	The site RO or DRO routinely reviews revalidation cycle appraisal output forms and 360 MSF for those under notice. All positive recommendations, following approval are made on GMC connect; the GMC notifies the Doctor directly. Recommendations for deferral or non-engagement are discussed prior to these recommendations, through e-mail contact with the relevant doctor as necessary with recommendations for corrective action plans.
Action for next year:	To continue with process as above

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	Appointment of a Non-Executive Director
Comments:	The Responsible Officer (RO) is responsible for the delivery of the arrangements needed to support revalidation. The DRO on the MPH site supports the RO in making revalidation recommendations and following up any concerns related to Doctors. The Medical Revalidation Steering Group oversee governance and policy- Membership- Site ROS, DRO, Lead Medical Appraiser, Appraisal Admin Manager, LNC Chair (as required), Director of Medical Education (as required), Non-Executive Director, Associate Director of Medical Workforce.

	The Responsible Officer Advisory Group (ROAG) meets monthly to report problems and develop action plans as necessary. ROAG membership: RO, DRO, Director of Medical Education, Associate Director of Medical Services, Chief Medical Officer, MPH site Medical Director, Associated Director of People Services, Medical Workforce manager. A Non-Executive Director was appointed 2023-24.
Action for next year:	To continue as above

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	No further action
Comments:	Yes. The Trust Governance teams provide reports to the appraisal and revalidation team of any complaints, PALS and incidents involving doctors working at the Trust. More effective Job planning has also been introduced.
Action for next year:	Due to loss of workforce in governance team and the changes in culture to the way doctors shall be named in a serious incident due to changes in reporting style because of how trusts will report safety incidents (PSIRF), appraisees from March 22nd 2024 onwards will self declare Complaints, PALS and Patient Safety incidents. Further development of the role of job planning in ensuring timely reviews of doctors including review of their performance and their completion of mandatory and person specific patient safety training objectives with their line manager. PDP objectives generated from job plan can be brought to appraisee's appraisal by the appraisee.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	No further action
Comments:	Yes. Until March 19th 2024, an annual summary of complaints / PALS / incidents registered to the Doctor's name was uploaded to the individual appraisal portfolios collated by governance/ appraisal team, and specifically discussed at every appraisal. The appraiser assurance through the output form is also audited through the ASPAT process.

Action for next year:	Appraisees from March 22nd 2024 onwards will self declare Complaints, PALS and Patient Safety incidents

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	Employment of case investigators needed.
Comments:	Yes. There remain clear medical leadership structures through all clinical directorates within the Trust. Any problems can be escalated through service leads and clinical directors to the Associate Medical Directors and Medical Directors and Site ROs. Such problems can be discussed in the quarterly GMC employment liaison adviser meetings, but also at any stage should the need arise (as well as through the monthly RO advisory meetings). Should a significant, appropriately evidenced case be verified the Doctor is contacted and appropriate action taken. There has been a roll out of Case Investigator training December 2023.
Action for next year:	In liaison with HR and Clinical Leads, create systems in place to support cover arrangements to release Case Investigator time from departments.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	No further action
Comments:	Yes. The Responsible Officer Advisory Group (ROAG) meets monthly with reference to formal reporting procedures, as necessary. Concerns about medical staff are dealt with through the disciplinary policies for medical staff, as well as any remediation, re-skilling and rehabilitation through the relevant HR policies.
Action for next year:	No further action. Continue as above.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons

with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	No further action
Comments:	Yes. Information is available to relevant Responsible Officers (on an RO to RO basis), using NHSE medical practice transfer of information (MPIT) forms. There has sometimes been a delay in providing these due to the limited administrative capacity mentioned above.
Action for next year:	No further action, Continue

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	No further action
Comments:	Yes. All such actions are compliant with principle 3 of the GMC clinical governance recommendations. The RO and other appointed officers have received appropriate training and attend regional peer group meetings to help benchmark and seek advice.
Action for next year:	No further action. Continue as above.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	New item on AOA.
Comments:	Trust has Governance team who have a Cross Trust role in sharing learning. Trust is adopting PSIRF Patient Safety Incident Response Framework.
Action for next year:	A working group that includes- Governance CD, Lead Appraiser, A Site RO/ Medical Director, Job Planning lead, Medical Workforce, Learning and Development lead are developing how patient safety learning

	objectives can also be incorporated into individual job plans which will inform annual appraisal objectives also.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	New item on AOA
Comments:	Legacy Trusts have separate policies- Maintaining High Professional Standards at YDH and Performance Concerns of Senior Medical Colleagues and Doctors in Training for SFT.
Action for next year:	Policy merger

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	No further action
Comments:	Yes. These are undertaken by medical recruitment and temporary staffing and must be completed before a doctor can commence employment. All doctors newly recruited to the Trust are subject to all pre-employment checks in line with NHS Employment Standards. As a minimum this would be: • Right to work • ID verification • Enhanced DBS • Occupational Health • Professional Registration verification • References covering a minimum of 3 years employment history Doctors that have left the Trust and returned to either bank or substantive posts have their employee records checked to ensure all information held is up to date, and if required are subjected to new checks as above.

Action for next year:	No further action. Continue as above

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	New item on AOA
Comments:	- We have an Inclusion Team that supports SFT– the team supports our colleague networks, drives inclusion strategy and action plans, embeds inclusion within colleague training, and oversees annual reporting including the Workplace Race Equality Standard (WRES), Workplace Disability Equality Standard (WDES), the Gender Pay Gap reporting, and the Equality Delivery System (EDS). - There are six active colleague networks that welcome members from across SFT. These networks provide a safe space for colleagues to share their experiences and to provide peer support. The networks also host events and raise awareness of inclusion cross both organisations. Our networks include: o Armed Forces and Veterans Network o LGBTQ+ Network o Lived Experience Network (for colleagues with a disability) o Multicultural Network o Neurodiversity Network o Women's Network. - SFT hold inclusion accreditations and awards including: a Disability Confident accreditation, we are committed to the Armed Forces Covenant, 2022 received a Gold award under the Defence Employer Recognition Scheme. We are in the early stages of the Rainbow Badge accreditation scheme that focuses on improving the experience of LGBTQ+ colleagues and patients. - The Inclusion Steering Group has membership from across senior leadership roles and our network leads. The Steering Group oversees inclusion actions, listens to the voices of our networks, and identifies ways to make structural and systemic improvements across our organisation to improve equality outcomes. The merger has provided an opportunity to review progress to date, and to adopt a new, innovative, approach to inclusion. We have set out our ambitious in our 'Inclusion Roadmap'. Our roadmap outlines our short-term plan for creating the framework, governance structures and ways of working that we will put in place that will enable us to define and measure impact and create sustainable and systemic change.

	Our vision is to be a Trust where everyone knows that their unique skills and abilities are valued, and where each member of our community feels they belong. We want to be a Trust with a truly inclusive culture, and with policies and ways of working that are equitable. Our approach is how we create change. Our actions address the cultures, behaviours, policies, and processes that create or maintain inequality. Our approach is to 'fix the system'. This is fundamentally different from traditional approaches to inclusion that 'fix people' to fit into an existing system. We are moving away from one-off events or interventions that focus on the assumed deficits of underrepresented groups, towards actions that make our processes such as recruitment, development, retention, and progression inclusive and equitable. The Board and Executive Team are fully supportive of this new approach. The executive have been undertaking a range of training and development sessions to identify their own inclusion actions and priorities, and to build their skill and confidence in our 'fixing the system' approach. Two members of the Executive team co-chair the Inclusion Steering Group, and one of our Non-Executive Directors acts as an EDI representative on Board.
Action for next year:	As above

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	New item to AOA
Comments:	See 1 F i
Action for next year:	No further action.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	New item AOA
Comments:	See I F i
Action for next year:	No further action.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	New item AOA
Comments:	We use our values of kindness, teamwork and compassion, and principles of a just and learning culture to ensure application of fair decision making through our HR policies and procedures. We provide team or bespoke training and coaching to support our leaders, line managers and colleagues undertaking specific roles; e.g. ER investigations and Panels or having informal resolution conversations. Within our HR policies we use informal/formal mediation to support individual and teams in recognizing behaviours that may amount to subconscious bias or discrimination. We provide regular training for our HR colleagues to keep up with the latest employment/case law and hold learning events as required. HR work closely with other teams such as Equality, Diversity and Inclusion and Freedom to Speak up and in communications ensure staff are aware of routes available to speak up and have ongoing plans to raise awareness. Reviewing decisions made and ensuring we are free from bias and discrimination will be ongoing.
Action for next year:	No further action.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	New agenda item
Comments:	Differential Attainment Leads appointed on each hospital site and a Locally Employed Tutor lead. Enhanced Induction programme delivered through the PGME Academy for all doctors newly appointed to the UK. Induction includes introduction to Appraisal and revalidation requirements and experienced appraisers are allocated to this group of doctors. Considered as a potential contributing factor when referrals to ROAG are analysed and to the Director of Medical Education/ Dean
Action for next year:	Working group established to support the specific learning and pastoral needs for this group of doctors with leads for Foundation Years, Director of Medical Education, LED Tutor, College Tutors, Lead Medical Appraiser, PGME administrators. Separately, support for senior doctors recruited via the GMC Sponsorship scheme- a working group established in 2023-2024 and its work continues- several key individuals from recruitment, human resources and workforce development, nursing, appraisal and revalidation and differential attainment leads to ensure wrap around support including the visa/ accommodation/ cultural/ educational and appraisal support needs for this group of doctors. Training to Educational and Clinical supervisors on Differential Attainment (September 20th 2024 CPD event)

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	New agenda item
Comments:	The RO, Site RO, DRO, Lead Appraiser and Appraisal Revalidation Administrator attend Regional Quarterly HL RO meetings held in South West. We benchmark and share our learning with other Trusts. We prepared for and participated in a HLRO QR visit May 15 2023.

	We generated an Action Plan from their recommendations- progress against this plan are discussed in our Quarterly Medical Revalidation Steering Group and SFT Operational Leadership Team Meeting
Action for next year:	To achieve Green on Action Plan for HLRO QR action plan by end of 2024-2025 Appraisal year.

Section 2 – metrics

Year covered by this report and statement: 1April 2023 - 31March 2024 .

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	**828**

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	**545 (+ 13 incomplete)**
Total number of appraisals approved missed	**144**
Total number of unapproved missed	**37**

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	**123**
Total number of late recommendations	**5**
Total number of positive recommendations	**98**
Total number of deferrals made	**25**
Total number of non-engagement referrals	**0**
Total number of doctors who did not revalidate	**23**

2D – Governance

Total number of trained case investigators	**27**
Total number of trained case managers	**5**
Total number of new concerns registered	**6**
Total number of concerns processes completed	**1**
Longest duration of concerns process of those open on 31 March	**2 years, 5 months**
Median duration of concerns processes closed	**7 months**
Total number of doctors excluded/suspended	**3**
Total number of doctors referred to GMC	**1**

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	**388** (of whom 80 were doctors that left the Trust and returned to either bank or substantive posts).
Number of new employment checks completed before commencement of employment	**308** newly recruited Drs were subject to all pre-employment checks in line with NHS Employment Standards The **80** Doctors rejoining the Trust had their employee records checked to ensure all information held is up to date, and if required were subjected to new checks as above.

2F Organisational culture

Total number claims made to employment tribunals by doctors	**1**
Number of these claims upheld	**In progress**
Total number of appeals against the designated body's professional standards processes made by doctors	**0**
Number of these appeals upheld	**N/A**

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
SFT has a well-established appraisal and revalidation process. There is a dedicated team to manage the appraisal process and provide support where necessary. The increasing numbers of doctors being prescribed in the context of an increase in acuity and clinical demand, of which 1/5 are locally employed doctors, require recruitment of new appraisers, increased SPA allocation, a new appraisal allocation system, and investment into additional appraisal administrative time. This bid money has been successful and recruitment and new software migration is in implementation for 2024-2025.
Actions still outstanding
Recruitment and induction of new appraisers. Data migration and implementation of new software CPD events for merged team and introduction of new systems throughout 2024-2025
Current issues
Merging teams and cultures
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Identify adequate resources for additional recruitment of appraisers, appraiser retention, CPD of appraisers Identify adequate resources for better appraisal and 360 system Change method of allocation- to central allocation system using a new electronic system that reduces bottleneck with appraisal admin Invest in a system with a single log in for appraisal and job planning and 360 MSF with robust and timely live support Move to self declaration for governance data

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Achievements- Appraisee feedback reports high calibre of appraisal conversations; ASPAT Audit shows overall good performance with some areas that require improvement Challenges- Significant shortfall of appraisal slots, loss of governance team, small appraisal admin team led to bottleneck of being able to book appraisals, delays in getting governance data and then uploaded data to appraisal reports, loss of appraiser due to lack of centralised SPA time, changing workforce with 1/5 appraisees being new to the UK and on short term contracts Aspirations- Enhanced Induction for doctors new to UK, Recruitment and induction of appraisers, Single system for job planning and appraisal which is easy to use for appraisees, appraisers, appraisal admin and RO.

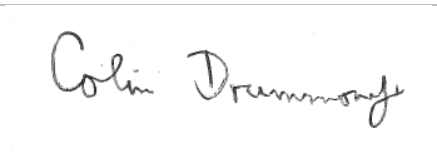
Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Somerset Foundation Trust

Name:	Colin Drummond
Role:	Chairman
Signed:	
Date:	23 October 2024

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance *before completing.*

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of

St. Margaret's Hospice

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	Structure is Trust RO, 1x site RO for Musgrove Park Hospital (MPH /Legacy Somerset Partnership), 1x site RO for Yeovil District Hospital (YDH), 1x Deputy RO (for MPH/Legacy Somerset Partnership). Historically, MPH has managed the revalidation for the St Margaret's Hospice doctors.
Comments:	Responsible Officer (RO): Daniel Meron MPH and Community / Mental Health, Site RO: Lucy Knight Deputy Responsible Officer (DRO) MPH and Community / Mental Health: David Beacock YDH Site RO: Meridith Kane

Action for next year:	Daniel Meron stepped down end March 2024. Replaced by Melanie Iles, Trust RO. Both Site ROs stepping down end October 2024 – potential plan to re- organise the structure, so Site ROS have not yet been replaced. Deputy RO for MPH is remaining in post. Deputy RO is for MPH/ Legacy Somerset Partnership

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	No the DB had not been providing this. However, this has not directly affected the appraisal and revalidation of St Marget's hospice doctors
Action from last year:	The comparative analysis of 2022-2023, and 2023-2024 AOA figures showed that there has been: 1) reduction in appraisal compliance 2) loss of appraisers due to clinical work pressures. Analysis: 1) Appraiser SPA time is not centralised and has come out of individual job plans, this meant that there were no replacements for appraisers that had stepped down. 2) Relative reduction in WTE of appraisal admin team compared to pre covid levels and pre-merged trusts 3) A markedly changing workforce- a rapid increase in locally employed doctors in non training grade equivalent roles, many new to the UK as international medical graduates, that had reached 160 of the total workforce. Pre covid had been approximately 60 across the Trust. This group of doctors have different appraisal needs to substantive doctors and due to short contracts (6 months) that were then often extended, were then requesting appraisals too close to their due month and at this late stage would be unable to find an appraiser. 4) IT system issues. The IT appraisal systems from legacy trusts were not merged due to this requiring an additional cost which meant the appraiser pool was unable to merge. The system itself relies heavily on admin and admin require several spreadsheets to track data.

	A Higher Level responsible Officer Visit 15th May 2023 identified inadequate WTE revalidation admin, a bottle neck of information flows due to the small appraisal admin team, a significant short fall of appraisers for the slots needed and challenges with the current system of appraisees choosing their own appraisers. They recommended a move to a central allocation of appraisers to appraisees, increasing admin workforce, suggested better IT System that could remove some of the tasks currently sitting with admin, a clear agreement across sites as to what constituted an approved missed appraisal, and for the Trust to increase appraiser pool and induction/ refresher training.
Comments:	Please note that this report is submitted on behalf of the newly merged Somerset Foundation Trust. Any information that is specific to the legacy trusts will be detailed within this report. If no split in information is provided, this information is applicable to both legacy teams.
Action for next year:	A business case was developed and was successful in early 2024-2025. Lead appraiser is recruiting and inducting new appraisers 2024 Q1 and Q2. Currently projected to increase appraiser pool to fulfil the shortfall in appraisal slots. A new IT system has been contracted. It is estimated that it will take 12 months to fully establish the new IT system, migrate data, recruit and train new appraisers and provide refresher training for existing appraisers. Those who have missed 2023-2024 appraisals will be targeted. With the plan to migrate to a new e portfolio system, it will eventually reduce administrative burden and ensure better use of appraisal slots due to a central allocation process. Appraisal admin time will increase but this team will also have oversight of job planning as well as pay and contract related queries for medical staff. The CPD offer for appraisers has been increased on the back of the successful bid also. There have been changes to within Postgraduate Medical education also. The Director of Medical Education and PGME team will now be aware of all International Medical Graduates in their first UK post who will be employed locally (alongside doctors in training who are international medical graduates) who are coming into the Trust.

	They are receiving enhanced induction and additional support from Educational and Clinical Supervisors. The enhanced induction includes orientation to Appraisal and Revalidation from the lead appraiser. Solutions are also being developed to create a local ARCP process that will be similar to postgraduate doctors in training so that Locally Employed Doctors will be assessed with the same competencies as their equivalent doctors in training counterparts. Middle grade locally employed doctors will have an formal medical appraisal in parallel to their college portfolio. PGME have appointed a new Locally employed doctor tutor role which has been combined with Appraiser role to support, signpost and provide appraisal for this group of doctors.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	Yes: all records are held within the Trust's Appraisal and Revalidation systems Premier IT, which are appropriately protected and managed. Spreadsheets held on a secure Trust server are also held (a local record of all appraisees, their grade, their appraisal dates, 360 MSF dates, revalidation dates and allocated appraiser history). The revalidation administrative team check the accuracy of staff lists on these local spreadsheets against GMC connect regularly. Legacy Trusts had separate Premier IT systems and separate local Spreadsheets stored securely and separate appraisal administrators.
Comments:	Merging of systems and appraisal admin team during 2023-2024.
Action for next year:	2024-2025 Merged Appraisal Admin team will have a single system and approach to manage this, with a plan that the new appraisal provider (L2P) will connect directly to GMC connect.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Yes: all such polices exist and are reviewed through quarterly meetings of the Appraisal and Revalidation steering group:
Comments:	A number of related policies due to Trust merger are also in the process of being updated- such as Job Planning for SAS and Consultant doctors.
Action for next year:	Action for 2024-2025: A single appraisal policy can now be developed since we have had agreement of a single e -portfolio appraisal system and 360 MSF across the whole merged organisation which will allow for a

	merged appraiser team and admin team. We understand that the new purchased e portfolio system will eventually link directly with GMC connect (allowing ease/speed for revalidation recommendations and deferral, logging into a single system). New guidance on Pay progression guidance has been issued in April 2024. This may inform future Trust policy that successful pay progression for Consultants and SAS doctors will be contingent on completion of an annual appraisal (or an approved missed) and annual job planning.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	Yes: In-depth Higher Level Responsible Officer Quality Review (HLROQR) took place May 15th 2023 of processes and set of must and should recommendations shared.
Comments:	An action plan was developed from this visit, which is updated and its progress reviewed by the Medical Revalidation Steering Group and SFT Operational Leadership Team.
Action for next year:	Completion of all action plan objectives generated from HLRO QR visit recommendations.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Bank Locums who have a prescribed connection will have full access to Trust CPD and an SFT annual appraisal which will be job planned in, if logging sufficient clinical hours. Agency locums will have an independent appraisal with their agency and will access departmental CPD and governance to keep them up to date as discussed with their clinical service lead. All doctors have corporate and local induction and are signposted to mandatory training specific to their role in addition to core competency framework.
Comments:	Access to a Whole Scope of Practice Appraisal for bank locum doctors with prescribed connection who are logging sufficient hours will be incorporated into Merged Appraisal and revalidation policy. All new starters (medical recruitment) for Bank Locums will inform Medical Appraisal Admin team.
Action for next year	Whole Scope of Practice Appraisal for bank locum doctors with prescribed connection who are logging sufficient hours will be incorporated into Merged Appraisal and revalidation policy. Ensure robust information flow for new starters- from medical recruitment to Medical Appraisal Admin team.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	Agree a consistent system of how an approved missed is classified and recorded (Legacy YDH system differed from Legacy SFT. Legacy YDH did not include new starters in numbers who were due an appraisal. Legacy SFT would record any starters as an "approved missed" if they joined mid way during the appraisal year, and therefore had an appraisal due month that fell into the subsequent appraisal year, and had not yet completed an appraisal by March 31st,
Comments:	Appraisal figures for 01 April 2023 – 31 March 2024: TOTAL number of doctors with a prescribed connection to St Margaret's Hospice on 31 March 2024 – **3.** Of these, the total number of doctors due an appraisal – **3** Total completed appraisals in 2023-24 – **3 (100%).**
Action for next year:	Increase appraiser capacity and trained appraisers Use new appraisal and 360 electronic system with central allocation ability and reminders emails for when appraisals are due (removes the responsibility of appraisee sourcing an appraiser) Improved e portfolio reduces administrator burden to chase appraisees, set appraisal dates and set the name of the appraiser.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	No action.
Comments:	N/A
Action for next year:	Move to L2P for 2024-2025. Allocation of appraisers centrally with an appraisal due month for appraisees.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	No action.
Comments:	Yes, there are currently 2 policies in place for the legacies of SFT and YDH.
Action for next year:	New merged policy to be developed to reflect new changes which can be achieved with purchase of a new e portfolio, changed to allocation system, due month, central allocation method, numbers of appraisals per appraiser, site RO structures which will need sign off by MRSG, LNC and Policy Committee.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Increase appraiser capacity.
Comments:	No, the organisation does not have the necessary numbers of trained appraisals to carry out timely annual medical appraisals for all those due an appraisal. At end of 2022-2023 there were 75 appraisers (43 appraisers for 529 due an appraisal on Legacy SFT site and 32 appraisers for 192 appraisals on YDH site) . 771 doctors due an appraisal in total with significant shortfall which was difficult to manage across the Trust due to separate IT systems. 2022-2023 : Based on doctors needing an appraisal- YDH 6 per appraiser, which was the agreed allocation for YDH appraisers. 2022-2023 legacy SFT (MPH/SoMPar) site- this calculates as 12 per appraiser for the same SPA time. Legacy SFT appraisers were allocated 9 per 0.25 SPA. Hence, going into 2023-2024, the shortfall in appraisal slots grew. In 2022-2023 we had 75 appraisers and 721 due an appraisal. In 2023-2024 we had 76 appraisers and 746 due an appraisal. In 2023-2024, we had 76 appraisers, of which 6 were newly inducted during 2023-2024. 8 appraisers stepped down by end of 2023-2024, which reduced the appraiser team to 68 appraisers. This further increased the projected shortfall of appraisal slots for 2024-2025 to an estimated 165 slots (if all appraisers met their allocation

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

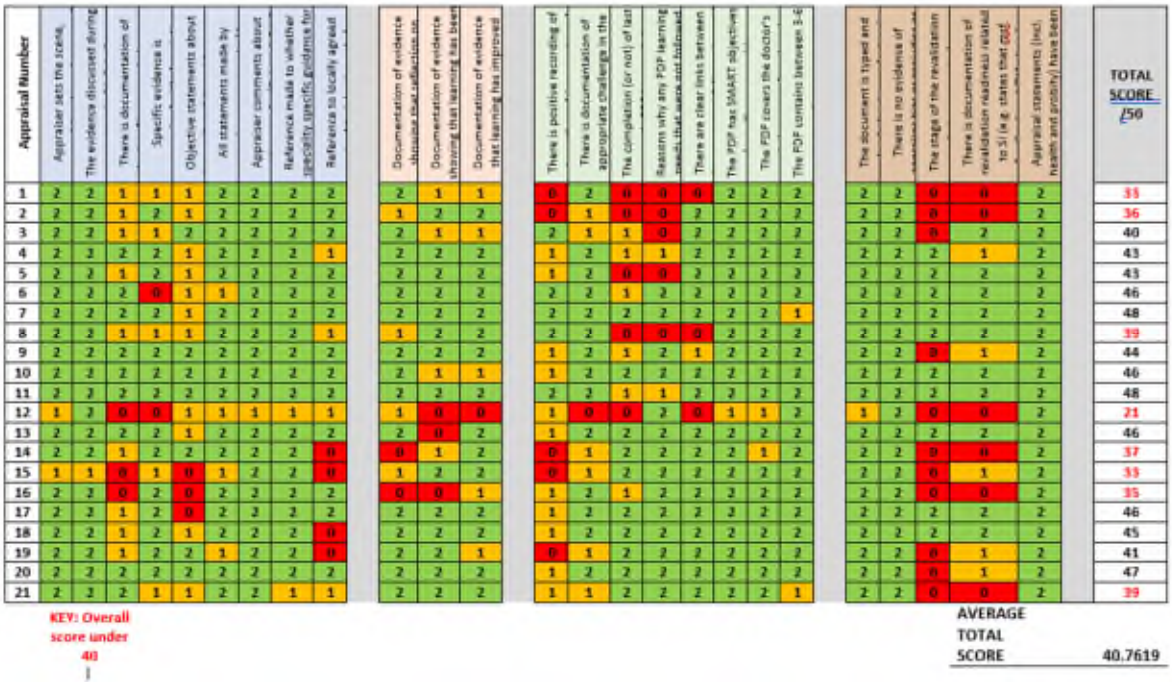
	quota and did not under or over perform, all appraisees do not cancel their agreed slot and there were no further appraisers leaving post)
Action for next year:	Central SPA funding bid was made for 6 SPA of appraisal time managed centrally. If funding is successful, this will increase appraiser pool and meet shortfall of slots. There will be a recruitment and training induction drive, and refresher training for all appraisers to support retention of current appraisers.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	No further action
Comments:	The majority of appraisers attended a half day live refresher Feb 2022 with a GMC update from our ELA office, the RO, Premier IT, Wellbeing lead and Lead Appraiser (Included ASPAT refresher). Less successful - peer groups conducted online using mandatory training platform as a vehicle. HLO RQ visit suggested increasing offer/range of CPD opportunities to re-engage appraisers.
Action for next year:	CPD programme updated to be delivered to merged team. 25 Sept 2024- Face to Face Refresher Conference Appraiser CPD event Live in house conference at Monks Yard with GMC update, MRSG presenters, Wellbeing, L2P, ASPAT, Whole Scope of Practice Appraisal, Roles and Responsibilities of an Appraiser. Monthly Peer Groups online (Combined peers from each site) with L2P joining Series of Appraiser Inductions for new appraisers who are recruited.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	No further action.
Comments:	Yes. A representative sample of appraisals are quality assured using an audit tool by the Deputy Responsible Officer and Lead Medical Appraiser (who are also both appraisers). The last two years 2020-2021 and 2021-2022 the mean average has remained constant at 43/50 for legacy SFT (YDH scores are not included in this data). The appraisers for St Margaret's are from the same pool of appraisers that had a sample of their output forms audited at random. The 2022-2023 appraisals were not audited due to time constraints but a sample legacy SFT and small sample of YDH cases were peer reviewed by the Higher Level Responsible Officer Quality Review team in May 2023. This small sample showed variance between the two sites in this small sample, with some YDH appraiser output forms requiring improvement and scores in the lower range.A sample of 21 appraisal outputs were audited by the Trust Lead Appraiser and the Deputy RO for the 2023-24 appraisal year. These were chosen from across both sites (approximately 50:50 split) for doctors that were approaching their revalidation submission due date. The results are pasted below and are scored out of 50 with a score of 0 – 2 being available for the evidence provided within the appraisal summary (0 = unsatisfactory; 1 = needs improvement; 2 = good) using NHSE ASPAT Audit tool. The average mean score was 40.7/50 (Range is 21- 48); this is based across both sites as a merged team. The median is 43/50. That means that the majority of scores were very positive with a few outliers. Areas for improvement are around the documentation of the doctor's revalidation readiness, as well as documenting review of their PDP, a comment on the quality of the supporting information and documenting that a whole scope of practice has taken place.

	 The Appraisers also receive aggregated anonymised feedback from their appraisees and this remains consistently positive.
Action for next year:	Lead Appraiser will continue to include learning in CPD for appraisers. New action: L2P has an appraiser checklist which will be bespoke to SFT needs- and this can focus on areas which are less well documented by appraiser in output forms based on our ASPAT audits.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	None
Comments:	No recommendations were due between 01 April 2023 – 31 March 2024.
Action for next year:	New Electronic System will provide more timely information (RO dashboard on system and with a plan to link directly too GMC connect)

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of

deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	None
Comments:	The site RO or DRO routinely reviews revalidation cycle appraisal output forms and 360 MSF for those under notice. All positive recommendations, following approval are made on GMC connect; the GMC notifies the Doctor directly. Recommendations for deferral or non-engagement are discussed prior to these recommendations, through e-mail contact with the relevant doctor as necessary with recommendations for corrective action plans.
Action for next year:	To continue with process as above

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	Appointment of a Non-Executive Director
Comments:	The Responsible Officer (RO) is responsible for the delivery of the arrangements needed to support revalidation. The DRO on the MPH site supports the RO in making revalidation recommendations and following up any concerns related to Doctors. The Medical Revalidation Steering Group oversee governance and policy- Membership- Site ROS, DRO, Lead Medical Appraiser, Appraisal Admin Manager, LNC Chair (as required), Director of Medical Education (as required), Non-Executive Director, Associate Director of Medical Workforce. The Responsible Officer Advisory Group (ROAG) meets monthly to report problems and develop action plans as necessary. ROAG membership: RO, DRO, Director of Medical Education, Associate Director of Medical Services, Chief Medical Officer, MPH site Medical Director, Associated Director of People Services, Medical Workforce manager. A Non-Executive Director was appointed 2023-24.
Action for next year:	To continue as above

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	No further action
Comments:	Yes. The Trust Governance teams provide reports to the appraisal and revalidation team of any complaints, PALS and incidents involving doctors working at the Trust. More effective Job planning has also been introduced.
Action for next year:	Due to loss of workforce in governance team and the changes in culture to the way doctors shall be named in a serious incident due to changes in reporting style because of how trusts will report safety incidents (PSIRF), appraisees from March 22nd 2024 onwards will self declare Complaints, PALS and Patient Safety incidents. Further development of the role of job planning in ensuring timely reviews of doctors including review of their performance and their completion of mandatory and person specific patient safety training objectives with their line manager. PDP objectives generated from job plan can be brought to appraisee's appraisal by the appraisee.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	No further action
Comments:	Yes. Until March 19th 2024, an annual summary of complaints / PALS / incidents registered to the Doctor's name was uploaded to the individual appraisal portfolios collated by governance/ appraisal team, and specifically discussed at every appraisal. The appraiser assurance through the output form is also audited through the ASPAT process.
Action for next year:	Appraisees from March 22nd 2024 onwards will self declare Complaints, PALS and Patient Safety incidents

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	Employment of case investigators needed.

Comments:	Yes. There remain clear medical leadership structures through all clinical directorates within the Trust. Any problems can be escalated through service leads and clinical directors to the Associate Medical Directors and Medical Directors and Site ROs. Such problems can be discussed in the quarterly GMC employment liaison adviser meetings, but also at any stage should the need arise (as well as through the monthly RO advisory meetings). Should a significant, appropriately evidenced case be verified the Doctor is contacted and appropriate action taken. There has been a roll out of Case Investigator training December 2023.
Action for next year:	In liaison with HR and Clinical Leads, create systems in place to support cover arrangements to release Case Investigator time from departments.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	No further action
Comments:	Yes. The Responsible Officer Advisory Group (ROAG) meets monthly with reference to formal reporting procedures, as necessary. Concerns about medical staff are dealt with through the disciplinary policies for medical staff, as well as any remediation, re-skilling and rehabilitation through the relevant HR policies.
Action for next year:	No further action. Continue as above.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	No further action
Comments:	Yes. Information is available to relevant Responsible Officers (on an RO to RO basis), using NHSE medical practice transfer of information (MPIT) forms. There has sometimes been a delay in providing these due to the limited administrative capacity mentioned above.
Action for next year:	No further action, Continue

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	No further action
Comments:	Yes. All such actions are compliant with principle 3 of the GMC clinical governance recommendations. The RO and other appointed officers have received appropriate training and attend regional peer group meetings to help benchmark and seek advice.
Action for next year:	No further action. Continue as above.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	New item on AOA.
Comments:	Trust has Governance team who have a Cross Trust role in sharing learning. Trust is adopting PSIRF Patient Safety Incident Response Framework.
Action for next year:	A working group that includes- Governance CD, Lead Appraiser, A Site RO/ Medical Director, Job Planning lead, Medical Workforce, Learning and Development lead are developing how patient safety learning objectives can also be incorporated into individual job plans which will inform annual appraisal objectives also.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	New item on AOA
Comments:	Legacy Trusts have separate policies- Maintaining High Professional Standards at YDH and Performance Concerns of Senior Medical Colleagues and Doctors in Training for SFT.

Action for next year:	Policy merger

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	No further action
Comments:	Yes. These are undertaken by medical recruitment and temporary staffing and must be completed before a doctor can commence employment.
Action for next year:	No further action. Continue as above

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	New item on AOA
Comments:	- We have an Inclusion Team that supports SFT– the team supports our colleague networks, drives inclusion strategy and action plans, embeds inclusion within colleague training, and oversees annual reporting including the Workplace Race Equality Standard (WRES), Workplace Disability Equality Standard (WDES), the Gender Pay Gap reporting, and the Equality Delivery System (EDS). - There are six active colleague networks that welcome members from across SFT. These networks provide a safe space for colleagues to share their experiences and to provide peer support. The networks also host events and raise awareness of inclusion cross both organisations. Our networks include: o Armed Forces and Veterans Network o LGBTQ+ Network o Lived Experience Network (for colleagues with a disability) o Multicultural Network o Neurodiversity Network o Women's Network. - SFT hold inclusion accreditations and awards including: a Disability Confident accreditation, we are committed to the Armed Forces Covenant, 2022 received a Gold award under the Defence Employer Recognition Scheme. We are in the early stages of the

	Rainbow Badge accreditation scheme that focuses on improving the experience of LGBTQ+ colleagues and patients. - The Inclusion Steering Group has membership from across senior leadership roles and our network leads. The Steering Group oversees inclusion actions, listens to the voices of our networks, and identifies ways to make structural and systemic improvements across our organisation to improve equality outcomes. The merger has provided an opportunity to review progress to date, and to adopt a new, innovative, approach to inclusion. We have set out our ambitious in our 'Inclusion Roadmap'. Our roadmap outlines our short-term plan for creating the framework, governance structures and ways of working that we will put in place that will enable us to define and measure impact and create sustainable and systemic change. Our vision is to be a Trust where everyone knows that their unique skills and abilities are valued, and where each member of our community feels they belong. We want to be a Trust with a truly inclusive culture, and with policies and ways of working that are equitable. Our approach is how we create change. Our actions address the cultures, behaviours, policies, and processes that create or maintain inequality. Our approach is to 'fix the system'. This is fundamentally different from traditional approaches to inclusion that 'fix people' to fit into an existing system. We are moving away from one-off events or interventions that focus on the assumed deficits of underrepresented groups, towards actions that make our processes such as recruitment, development, retention, and progression inclusive and equitable. The Board and Executive Team are fully supportive of this new approach. The executive have been undertaking a range of training and development sessions to identify their own inclusion actions and priorities, and to build their skill and confidence in our 'fixing the system' approach. Two members of the Executive team co-chair the Inclusion Steering Group, and one of our Non-Executive Directors acts as an EDI representative on Board.
Action for next year:	As above

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	New item to AOA
Comments:	See 1 F i
Action for next year:	No further action.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	New item AOA
Comments:	See I F i
Action for next year:	No further action.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	New item AOA
Comments:	We use our values of kindness, teamwork and compassion, and principles of a just and learning culture to ensure application of fair decision making through our HR policies and procedures. We provide team or bespoke training and coaching to support our leaders, line managers and colleagues undertaking specific roles; e.g. ER investigations and Panels or having informal resolution conversations. Within our HR policies we use informal/formal mediation to support individual and teams in recognizing behaviours that may amount to subconscious bias or discrimination. We provide regular training for our HR colleagues to keep up with the

	latest employment/case law and hold learning events as required. HR work closely with other teams such as Equality, Diversity and Inclusion and Freedom to Speak up and in communications ensure staff are aware of routes available to speak up and have ongoing plans to raise awareness. Reviewing decisions made and ensuring we are free from bias and discrimination will be ongoing.
Action for next year:	No further action.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	New agenda item
Comments:	Differential Attainment Leads appointed on each hospital site and a Locally Employed Tutor lead. Enhanced Induction programme delivered through the PGME Academy for all doctors newly appointed to the UK. Induction includes introduction to Appraisal and revalidation requirements and experienced appraisers are allocated to this group of doctors. Considered as a potential contributing factor when referrals to ROAG are analysed and to the Director of Medical Education/ Dean
Action for next year:	Working group established to support the specific learning and pastoral needs for this group of doctors with leads for Foundation Years, Director of Medical Education, LED Tutor, College Tutors, Lead Medical Appraiser, PGME administrators. Separately, support for senior doctors recruited via the GMC Sponsorship scheme- a working group established in 2023-2024 and its work continues- several key individuals from recruitment, human resources and workforce development, nursing, appraisal and revalidation and differential attainment leads to ensure wrap around support including the visa/ accommodation/ cultural/ educational and appraisal support needs for this group of doctors. Training to Educational and Clinical supervisors on Differential Attainment (September 20th 2024 CPD event)

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	New agenda item
Comments:	The RO, Site RO, DRO, Lead Appraiser and Appraisal Revalidation Administrator attend Regional Quarterly HL RO meetings held in South West. We benchmark and share our learning with other Trusts. We prepared for and participated in a HLRO QR visit May 15 2023. We generated an Action Plan from their recommendations- progress against this plan are discussed in our Quarterly Medical Revalidation Steering Group and SFT Operational Leadership Team Meeting
Action for next year:	To achieve Green on Action Plan for HLRO QR action plan by end of 2024-2025 Appraisal year.

Section 2 – metrics

Year covered by this report and statement: 1 April 2023 – 31 March 2024 .

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	**3**

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	**3**
Total number of appraisals approved missed	**0**
Total number of unapproved missed	**0**

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	**0**
Total number of late recommendations	**0**
Total number of positive recommendations	**0**
Total number of deferrals made	**0**
Total number of non-engagement referrals	**0**
Total number of doctors who did not revalidate	**0**

2D – Governance

Total number of trained case investigators	**27**
Total number of trained case managers	**5**
Total number of new concerns registered	**0**
Total number of concerns processes completed	**0**
Longest duration of concerns process of those open on 31 March	**N/A**
Median duration of concerns processes closed	**N/A**
Total number of doctors excluded/suspended	**0**
Total number of doctors referred to GMC	**0**

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	**N/A**
Number of new employment checks completed before commencement of employment	**N/A**

2F Organisational culture

Total number claims made to employment tribunals by doctors	**0**
Number of these claims upheld	**N/A**
Total number of appeals against the designated body's professional standards processes made by doctors	**N/A**

Number of these appeals upheld	**N/A**

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
SFT has a well-established appraisal and revalidation process for St Margaret's Doctors. There is a dedicated team to manage the appraisal process and provide support where necessary. New software migration is in implementation for 2024-2025 and the appraiser pool is being recruited to.
Actions still outstanding
Recruitment and induction of new appraisers. Data migration and implementation of new software CPD events for merged team and introduction of new systems throughout 2024-2025
Current issues
Merging teams and cultures
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Identify adequate resources for additional recruitment of appraisers, appraiser retention, CPD of appraisers Identify adequate resources for better appraisal and 360 system Change method of allocation- to central allocation system using a new electronic system that reduces bottleneck with appraisal admin Invest in a system with a single log in for appraisal and job planning and 360 MSF with robust and timely live support

Move to self declaration for governance data
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Achievements- Appraisee feedback reports high calibre of appraisal conversations; ASPAT Audit shows overall good performance with some areas that require improvement Challenges- Significant shortfall of appraisal slots, loss of governance team, small appraisal admin team led to bottleneck of being able to book appraisals, delays in getting governance data and then uploaded data to appraisal reports, loss of appraiser due to lack of centralised SPA time. Aspirations- Recruitment and induction of appraisers, Single system for appraisal and MSF which is easy to use for appraisees, appraisers, appraisal admin and RO.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	St Margaret's Hospice

Name:	
Role:	
Signed:	
Date:	

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Six monthly safe staffing establishment report
SPONSORING EXEC:	Hayley Peters, Chief Nurse
REPORT BY:	Alison Wootton, Deputy Chief Nurse, SFT (Implementation and preparation of the Safer Nursing Care Tool, delivered by Mark Robinson. Development of report informed by Associate Directors of Patient Care in Service Groups).
PRESENTED BY:	Hayley Peters, Chief Nurse
DATE:	5 November 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 provides a six-monthly update, January 2024 – June 2024, of safer staffing assurance for all Somerset NHS Foundation Trust (SFT) inpatient wards, critical care, and emergency departments. Maternity safe staffing is not reported in this paper as we are awaiting the Birth Rate Plus and external assessment. This will be presented separately to the Quality and Governance Assurance Committee. The paper provides information on associated safer staffing risks and the controls and mitigations in place for these risks. This report offers high level assurance that safe staffing is reviewed formally every six months and that it is reviewed on a dynamic basis so that appropriate action is in place to support safest and best possible quality of care. The paper provide assurance that safe staffing is reviewed holistically considering a variety of metrics, data, and professional opinion to ensure that we are anticipating seasonal flux or changes in case mix that may require alterations in staffing ratios or professions. Over the last six months we have experienced continued pressures from: • Delays to discharge with high numbers of people who are medically fit for discharge, many who still have complex nursing needs.

	• High pressures on emergency care. • On going use of escalation beds including the use of the community escalation beds for a period of this reporting time. The Board are asked to note the following: • Safe staffing levels have been reviewed as detailed in this report and have broadly been found to meet the standards and guidance. • There remains disruption and challenges to service delivery requiring a focus on a dynamic approach to monitor and oversee safe staffing. • Some services have vulnerabilities that require on going and close monitoring as well as action to mitigate and deliver safe care. • There is service level ownership and oversight of these risks and issues and there is a clear and accessible escalation process to raise concern if the risk is considered inadequately managed or mitigated.
Recommendation	The Board is offered assurance that the Trust is taking all reasonable and available measures to ensure safe staffing levels in ward areas and where this is not possible, escalation and actions are followed to try and mitigate the risks of working with a compromised level of staffing. The Board is asked to approve this report for publication on the public website as per requirements.

Links to Joint Strategic Objectives (Please select any which are impacted on / relevant to this paper)	
☐ Obj 1	Improve health and wellbeing of population.
☒ Obj 2	Provide the best care and support to 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?
By reviewing safer staffing levels, we will consider the individual needs of colleagues and patients on a daily basis and actions will be taken to meet individual needs where they can be, or other mitigation will be considered. The narrative in this report does not negatively impact on equality or inclusion.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

SIX MONTHLY STAFFING ESTABLISHMENT REPORT

1. BACKGROUND AND PURPOSE

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

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

2. BUSINESS CASES

2.1 There are no business cases proposed as part of this report.

2.2 There are a few areas that concern is being raised that need to be more closely reviewed and that may need adjustments in staffing levels proposed, it is likely that business cases to reduce the risk will be put forward as part of the 25/26 planning cycle.

7a YDH (surgical ward)

2.3 This is currently a 30 bedded surgical ward, and the night shift is currently 3 registered and 3 unregistered colleagues. A ratio of 1-10 for this mix of patients is lower than other areas and is considered less than is required for safe quality care. This ward team and speciality are moving from this area to ward 4a as part of the YDH configuration and will reduce by one bed. It is possible that this area will need to increase the number of colleagues working at night to achieve a better patient ratio.

7b YDH (surgical ward)

2.4 This ward is a mixed surgical ward that cares for 6 different specialities of patients including ortho-geriatrics and care of patients who have had fractured neck of femur. We have received a alert from the National Hip Fracture Database, around the 30-day mortality rates for patients having surgery

following a fractured hip in YDH saying we are an outlier for at least two quarters but from the data there is an increasing trend line against a national trend that is showing an improvement. Most patients following this type of surgery are cared for on this ward. There is an action plan in response to this alert and this has included an enhanced level of nursing monitoring and interaction.

2.5 Overall this ward has a nursing ration of ratio of 1-10, for this mix of patients is lower than other areas and is considered less than is required for safe, quality care. Currently ad hoc increased staffing levels are being put in to mitigate risk, but it is felt that an overall increase in staffing level will be required to try and mitigate the highlighted concern. This increase is likely to be required 24/7.

Ward 10 YDH

2.6 Investment into an increased staffing level went into Ward 10 from April 2024, the SNCT data from the first audit still demonstrates a large gap between staffing level recommended and the planned level. This needs to be reviewed to understand this further.

Portman Ward MPH

2.7 In the reconfiguration of beds on the MPH site a greater number of wards were dedicated to care of the elderly patients to match the greater number of inpatients requiring this care. Portman Ward changed to a care of the elderly ward last September, the establishment was not changed at that time. The ratio of unregistered colleagues is lower at night in this area that the other care of the elderly wards and we are seeing increased incidents at night and safety incidents that could be linked to staffing levels. It is felt an extra unregistered nurse is required at night. The service group have reviewed other areas and there is likely to be an opportunity to reduce the night staffing on Sheppard Ward and re-allocate to Portman Ward as Sheppard Ward will reduce the number of beds after ward improvement works are completed at the end of 2024.

3. RISKS

Corporate Risks 15+

R1815	16	Vacancies and absence rates within nursing and AHP teams
SO6	⇔	

Service Group / Corporate Function Risks 15+
Not Mapped to a Risk on the Corporate Risk Register

R0440	20	⇔	Inability to provide a robust, continuous streamlined service for direct current cardioversion patients
R2342	20	⇔	Insufficient staffing resource within speech and language therapy service on Acute Stroke unit (YDH)
R2378	20	⇔	Insufficient staffing establishment within the community urgent care service
R2724	20	NEW	Insufficient radiology staffing due to increased absence rates
R0513	16	⇔	Limited provision of specialist neurological rehabilitation and neuropsychiatry service
R0564	16	⇔	Inequitable service provision due to inability to recruit and retain (Psychology)
R0916	16	⇔	Insufficient critical care rehabilitation establishment
R2064	16	⇔	Inability to staff theatre services on the YDH site due to registered and non-registered staffing vacancies

R2227	16	⇔	Insufficient staffing resource within the Adult Speech and Language service to meet demand on the general medical wards in both acute hospitals
R2255	16	⇔	Insufficient staffing levels across the Stroke Rehabilitation units at Williton and South Petherton
R2550	16	⇔	Staffing models (in and out of hours) do not reflect safer staffing recommendations (YDH Theatres)
R2759	16	NEW	Inability to deliver 7 day pharmacy provision (MPH)
R2766	16	NEW	Lack of specialist critical care pharmacists to provide a clinical pharmacy service to ICU (YDH)
R2006	15	⇔	Inability to fill required number of Dental Core Trainee posts within the Maxillo-Facial department
R2299	15	⇔	Significant staffing vacancies in the Emergency Department - nursing and ENPs
R2742	15	NEW	Lack of resources to fund 24/7 HCAs to support RNs in delivering critical care within ICU (YDH)

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

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

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

Extract from risk register 27 September 2024

4. SIX MONTHLY REVIEW OF SAFE STAFFING
Narrative for acute, community and mental health inpatient areas.

High level combined data

4.1. (Service group and inpatient level data is presented in Appendix 1 with narrative from the Associate Directors of Patient Care (ADPC)).

Overall	SFT						
Measure	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Trend
Registered Nursing Fill Rate	93%	93%	93%	94%	95%	95%	
Unregistered Nursing Fill Rate	101%	100%	97%	100%	101%	99%	
All Staff Fill Rate - Day	95%	94%	94%	95%	96%	94%	
All Staff Fill Rate - Night	101%	100%	99%	100%	101%	101%	
All Staff Fill Rate - Overall	98%	97%	96%	97%	98%	97%	
Care Hours per Patient Day	8.4	8.3	8.5	9.0	8.6	8.8	
Registered Hours per Patient Day	4.4	4.4	4.7	5.0	4.6	4.7	
Completing Safer Staffing Measures	88%	85%	89%	90%	89%	89%	
Sickness	6.0%	5.3%	5.9%	5.6%	5.4%	5.7%	
Labour Turnover Rate	9.2%	9.3%	9.6%	10.1%	10.2%	10.4%	
Registered Nurse Vacancy Rate	4.6%	5.1%	5.5%	7.7%	6.8%	7.7%	
Unregistered Nurse Vacancy Rate	3.0%	1.4%	0.3%	-1.3%	-1.2%	-0.9%	
All Clinical Staff Vacancy Rate	4.9%	5.4%	5.8%	8.0%	7.2%	7.8%	

Model Hospital comparison

4.2. Data of care hours per patient day are submitted nationally and uploaded for comparison via the model hospital system. This can never be used as a direct comparison due to organisational differences. The high-level data also combines nursing and midwifery which is not the same as our local data, but the charts below are provided as a benchmark.

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

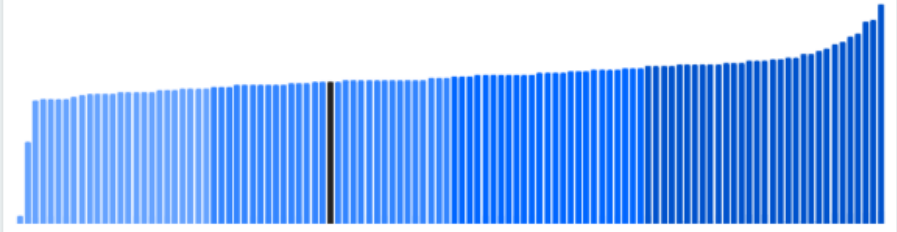
Average number of actual nursing care hours spent with each patient per day (all nursing and midwifery staff, including support staff).

Bookmark this page

May 2024

Provider value	Peer median	Provider median
Quartile 2	Quartile 2	
8.3	8.5	8.6

8.3 is in quartile 2 - Mid-Low 25% [blue]



View interactive chart

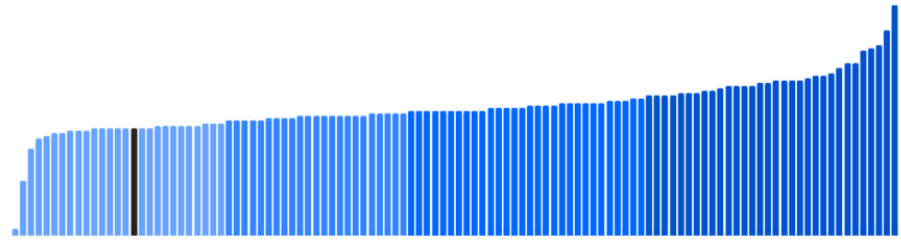
Average number of actual registered nursing care hours spent with each patient per day.

Bookmark this page

May 2024

Provider value	Peer median	Provider median
Quartile 1	Quartile 2	
4.3	4.9	5.0

4.3 is in quartile 1 - Lowest 25% [blue]



View interactive chart

5. AREAS TO NOTE

5.1. For the six months of this report, which covered the later end of the winter period, fill rates at a combined, high level have been good.

5.2. MPH has used less escalation capacity since the reconfiguration of beds in August 2023. This improvement has led to less medical outliers, and reduced lengths of stay, this has also had a significant positive impact on the number of reported incidents linked to issues such as falls and pressure areas in both the medical and surgical service groups, we are also hearing of better colleague experience and enjoyment of role.

5.3. In April 2024, Tor Ward, which was being utilised as a ready to go ward, to support escalation beds, has been closed. Following this, in May on the YDH site, Jasmine Ward, also a ready to go area, used to support extra escalation beds has also been closed, due to ongoing poor flow in YDH this area was partially re-opened in August and an agreement is in place to keep this area open with 16 beds over the winter period.

5.4. The nursing teams from these areas had been integrated into other teams and this has helped to improve the fill rate in the acute parts of the Trust. A team to work on Jasmine over the winter period has been reinstated. The closures / reduction in bed numbers have left the medical service group with an over recruited position, but these colleagues are being prioritised to move into vacant positions and fill roster gaps across the two acute sites.

6. BED AND STAFFING RECONFIGURATION

6.1. In the previous report we briefed on the changes that had happened to reorganise the bed allocation within MPH and YDH. In August 2023 these changes were mainly on the MPH site and involved some significant changes in ward teams and specialities. The ward establishments were reset at this time as reported in the previous paper.

6.2. Since this time in depth reviews of the MPH areas affected by these changes has been undertaken to ensure that teams are settled, supported and that the planned establishments are meeting the needs of the patient groups. An overview of this work was reported to the Quality and Governance Assurance Group in July 2024 and the outcome of those reviews was very positive.

6.3. Further ward moves on the YDH are due soon, this will complete the proposed moves on both sites.

7. SAFER NURSING CARE TOOL (SNCT):

A review of the accumulative data from the first nursing establishment audit using the Safer Nursing Staffing Tool (Version-2023).

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

8. RECOMMENDATION

8.1. The Board is asked to discuss and approve the report. There is a requirement for this report to be published on our public website once it is approved.

8.2. The Board is asked to note the areas for concern raised.

8.3. The Board is further asked to consider if this provides the required assurance on actions being taken to maintain and monitor safe staffing levels across Somerset Foundation Trust inpatient areas.

Appendix 1

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

1.1. The Safer Nursing Care Tool (SNCT) is the output of work undertaken by the Shelford Group (collaboration of 10 of the largest NHS Trusts in England) and over the last 20 years has undergone extensive academic and statistical analysis, to validate the algorithms that support the calculation of accurate nursing numbers to patient acuity and dependency. Links between patient acuity and dependency, workload, staffing and quality are well established and conclude that low staffing numbers contribute to poorer outcomes for patients. The national tool has been through several revision and refreshes and has been modified to recognise the changing demographic and needs of patients who are accessing healthcare. (Levels of care descriptors SNCT Adults 2023 & Paediatrics 2022, Appendix A).

1.2. Quality Improvement methodologies were used to start to understand how the SNCT could be implemented to achieve a biannual programme to review nurse establishment of our inpatient wards. Primarily using PDSA cycles were able to fully understand the impact on teams when collecting data, how to analyse and interpret the data, develop and build an appropriate IT solution to reduce the collection burden on teams and would support benchmarking across the organisation.

1.3. The first full SNCT audit was undertaken in March 2024 and included all acute wards on the MPH and YDH site including paediatric wards and EDs, as well as wards located in Community hospitals. Data was collected on acuity and dependency for a period of four weeks excluding weekends (20 data sets per area).

1.4. The ambition is to run a minimum of two SNCT audits each year during the summer and winter periods currently it has been agreed that this will happen during July and January. The July census is completed and data analysis currently underway. It should be noted that further runs of this process are likely to become more reliable as we ensure robust, standardised application of the tool and that using data over time will be more reliable than referring to a single data run alone. Data from this tool needs to be reviewed and to consider professional judgment and review of other quality and outcome metrics.

1.5. This report provides some high-level analysis of combined results for MPH, YDH, Paediatrics and Community Hospitals. Whilst both EDs undertook the SNCT audit there is still some data cleansing required before the data is ready for a fuller review.

1.6. The areas that were not covered during the March review were maternity, community nursing teams and mental health inpatient wards. That said mental health inpatient areas already use the Mental Health Optimal Staffing

Tool (MHOST), maternity are now using BadgerNet which does collect data on activity and workload. Our community nursing teams have been beta testing, as a pilot site, the Community Nursing Safer Staffing Tool (CNSST), this pilot has paused whilst NHSE review outputs and consider future recommendations. Future reports will include analysis of these areas where they are ready for utilisation.

1.7. The latest versions of the adult inpatient ward areas SNCT (2023), now includes provision for providing additional supervision needs for patients who need closer observation because of cognitive concerns e.g. dementia/delirium. The new version of the tool also reviews the appropriate establishments for inpatient areas with predominately side rooms.

2. Findings

2.1. This report seeks to share some early indicators of current acuity and dependency vs staffing levels, one of the fundamental tenets when using this tool is that any decision to change nurse establishments must only be considered when a minimum of two data-sets have been collected and this is combined with outcome measures and professional opinion.

the SHELFORD GROUP

Safer Nursing Care Tool (SNCT)

Safer Nursing Care Tool

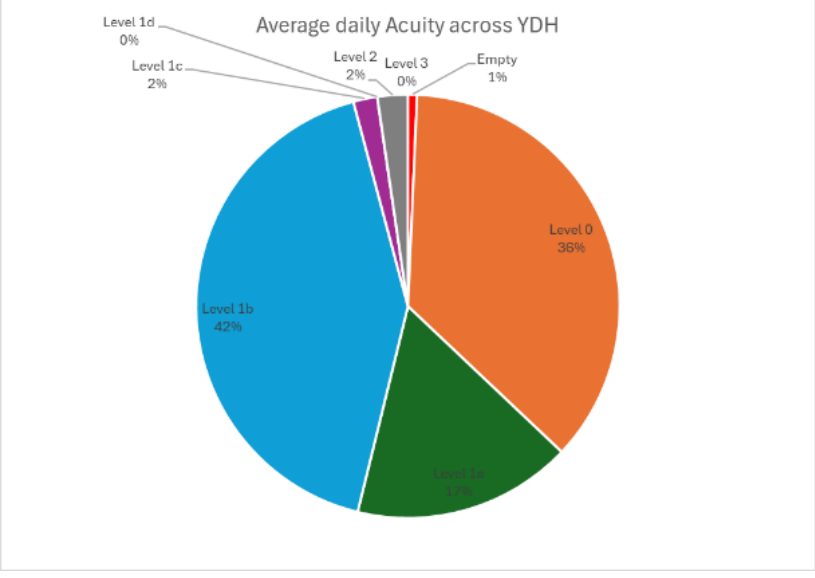
Care level	Descriptor *Care requirements may include the following:*
Level 0 Hospital Inpatient Needs met by provision of normal ward cares.	• Underlying medical condition requiring on-going treatment. • Post-operative / post-procedure care – observations recorded as per local policy. • National Early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

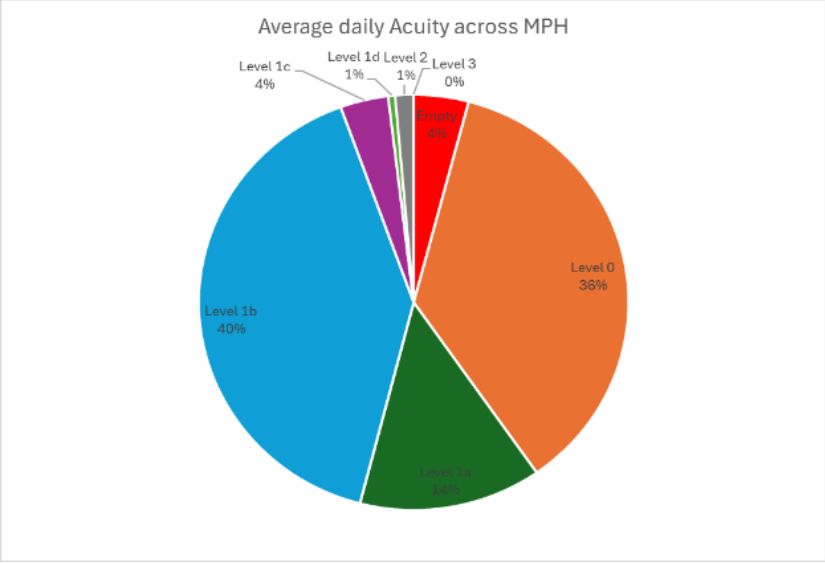
Care level	Descriptor *Care requirements may include the following:*
Level 1d Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	- Patients requiring arm's length or continuous observation by 2 or more members of staff (provided from within ward budget) as per local policy.
Level 2 Patients who may be managed within clearly identified, designated beds with the resources, expertise and staffing levels required OR may require transfer to or be cared for in a dedicated Level 2 facility/unit.	- Deteriorating / compromised single organ system. - Step down from Level 3 care or step up from Level 1a. - Post-operative optimisation/ extended post-op care. - Cardiovascular, renal or respiratory optimization requiring invasive monitoring. - Patients requiring non-invasive ventilation/respiratory support: CPAP/BiPAP in acute respiratory failure. - First 24-hours following tracheostomy insertion or patients post 24-hours requiring 2-hourly suction. - CNS depression of airway and protective reflexes. - Patients with burns where more than 30% body surface area is affected or requiring conscious sedation for dressing changes. - Requires a range of therapeutic interventions which may include: – Greater than 50% oxygen continuously – Requiring close observation due to acute deterioration and needing advanced organ support – Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium – CNS depression of airway and protective reflexes – Invasive neurological monitoring including ICP, external ventricular drains and lumbar drains
Level 3 Patients needing advanced respiratory support and/ or therapeutic support of multiple organs.	- Monitoring and supportive therapy for compromised/collapse of two or more organ/ systems. - Respiratory or CNS depression/compromise requires mechanical/invasive ventilation. - Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/ sepsis or neuro protection.

Published October 2023

2.2. SNCT describes different levels of care. Level 0 – 1d are all descriptors of levels of care that would be required on our general wards. Level 0 does not indicate a patient with no needs as all patients will require a level of care and supervision. Level 2 is a descriptor for a patient who requires a higher level of care usually delivered by registrants, these would cover patients requiring technical monitoring or technical infusions or support. This level of patients would be found in our coronary care units, hyper acute stroke areas, respiratory support unit or within our intensive care unit, these are often described as high dependency units or HDU areas. Level 3 describes a level of care where patients are usually ventilated or other major organ support. We should only have level 3 patients within our intensive care units.

3. Acuity Inpatient Adult Wards – MPH and YDH





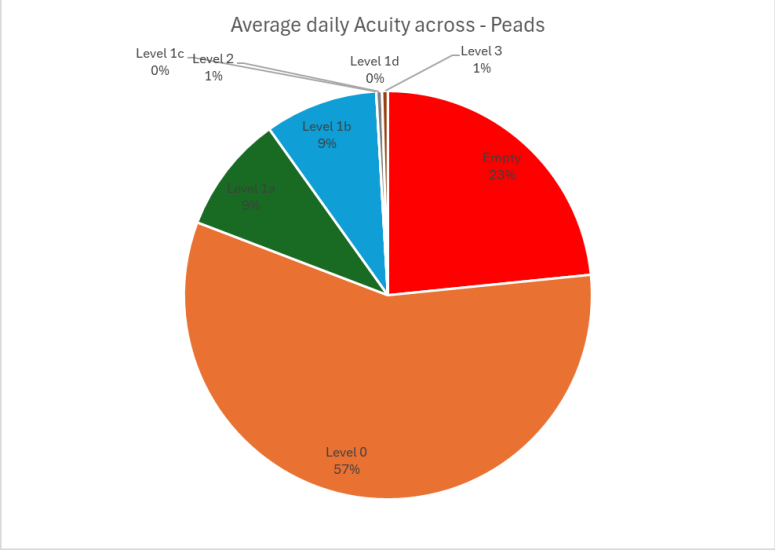
3.1. As can be seen the above profile for each of the acute sites is consistent with what would be expected with a high proportion of patients being scored as level 1b.

3.2. The patients scoring level 2 are over four areas only ACCU, CCU, respiratory support unit on Coleridge Ward and Hyper Acute Stroke on Dunkery, this was lower than would be expected, although will need some further analysis by the respective teams but it is possible there was an underscoring of these patients in these areas during the first data run.

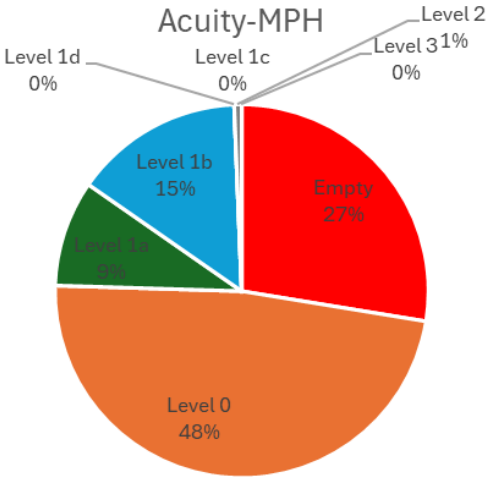
3.3. A patient assessed as 1c is someone who has extra care requirements for intensive observation and support. The patients scoring level 1c is probably proportionate for each site and in many cases is being managed without additional resources as teams are using Bay/Tag nursing approaches to continuously observe patients. The difference in % on each acute site (2% YDH and 4% MPH) can not be considered significant to review on one data-set as it is only a moment in time but as we can compare over time it may reflect a profile of care needs that is different by site.

3.4. The number of empty beds would be as expected and with continuing work on ward reconfiguration at YDH, improving patient flow pathways across the organisation and the ongoing work with social care and other partners we would expect to see this changing. National flow data recommends an occupancy of 85% to support best flow. The beds empty on this audit were a snapshot at a moment in a day rather than a demonstration of occupancy level.

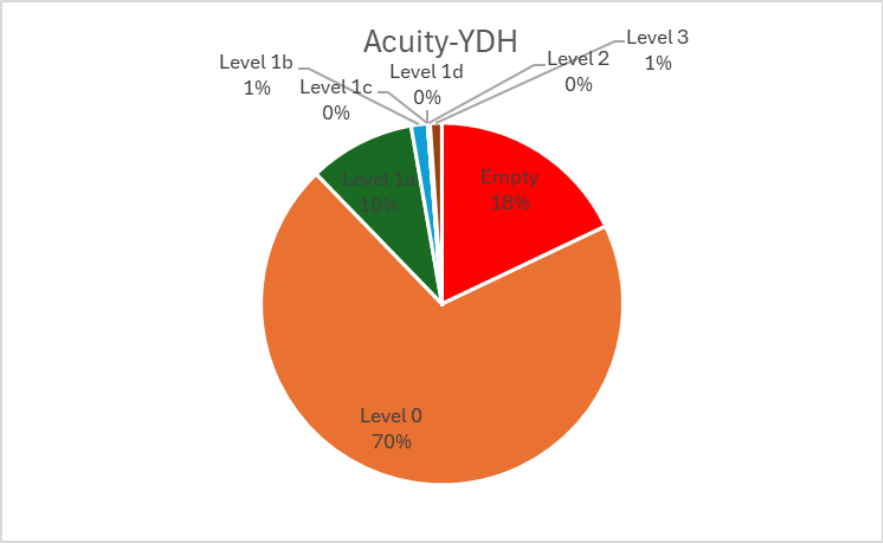
4. Acuity Inpatient Paediatric Wards – MPH and YDH



Average across paediatrics as a joined data set.



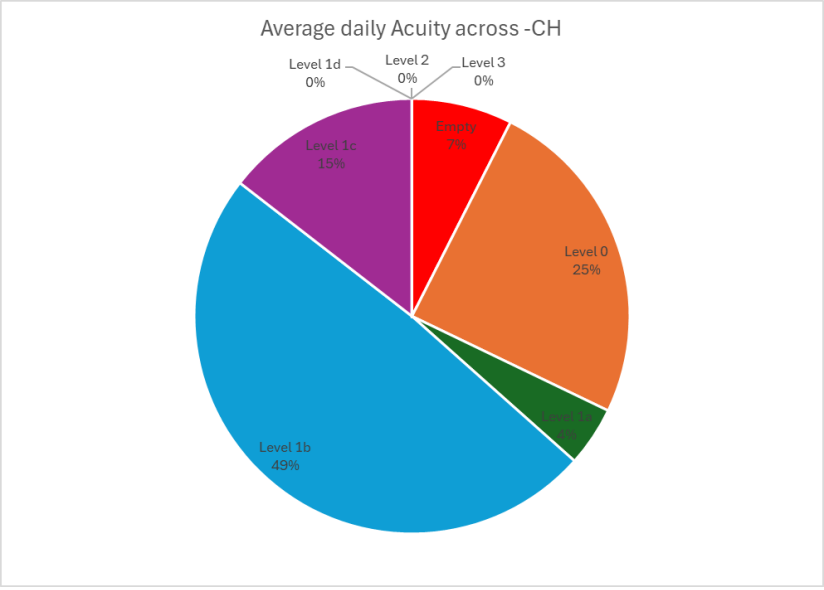
Paediatrics MPH



Paediatrics YDH

4.1. Comparing the 2 units there are some differences but again the profile is probably as expected. The children's wards appear to have a higher level of empty beds, but these beds may have had more than one patient through the area in each 24 hours as children may be admitted for shorter periods for observation. An understanding of acuity and dependency in the children's ward is a picture that will build over time as more audits are conducted.

5. Acuity Inpatient Adult Wards – Community Hospitals



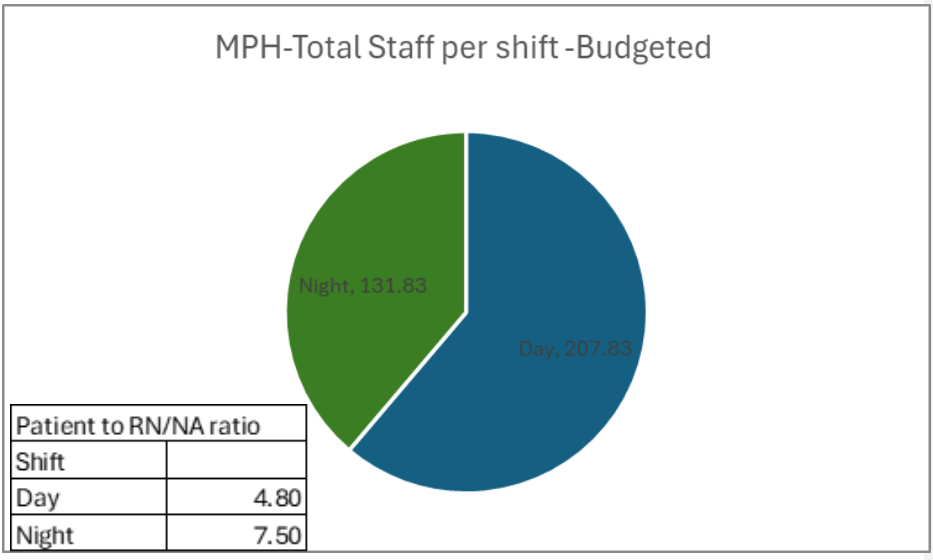
5.1. In the community hospital wards, the acuity profile is probably as expected with many of the patients being scored as level 1b. At this time, both the acute and community hospitals have larger numbers of no criteria to reside patients. As mentioned earlier in the report, these patients still often have a significant care requirement. Over time the community have expressed that care needs have risen. Ongoing use of this tool will help us monitor for changes in acuity and dependency.

5.2. The number of patients scoring 1a although low, would not necessarily have been expected as this is often a descriptor for technical care required due to acutely unwell patients. 3 out the 8 CH reporting this level of acuity and needs a further review to establish if the scoring is reflecting acuity appropriately or if the teams are not yet used to the scoring and assessment of the tool.

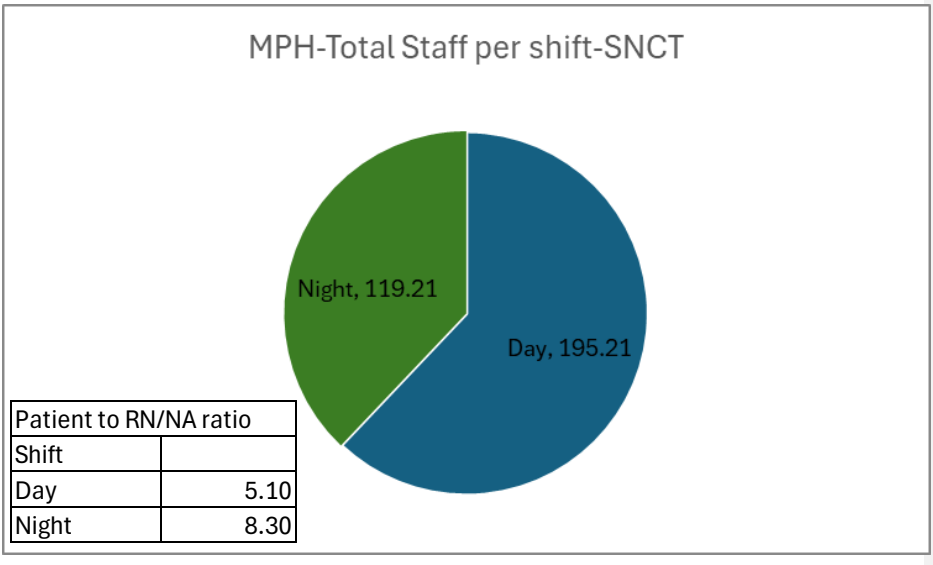
6. Staffing – Inpatient Wards – MPH

6.1. The charts below demonstrate four areas:

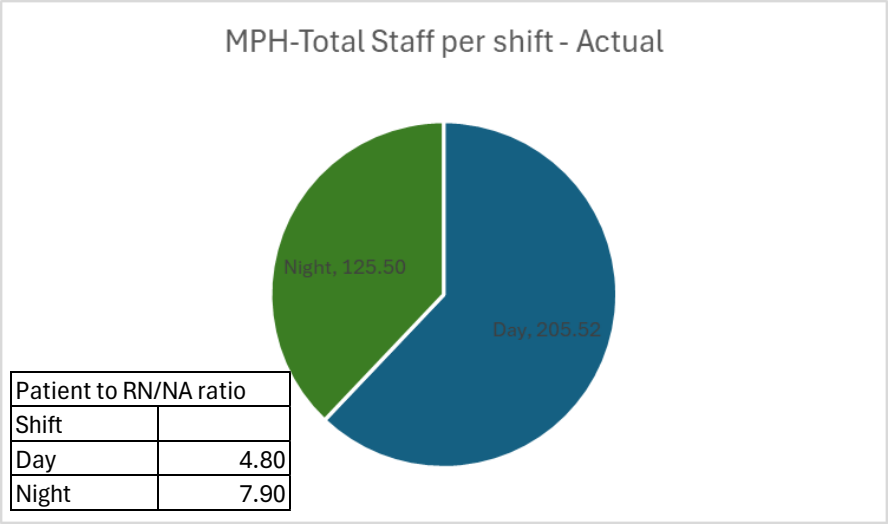
- The budgeted establishment for the hospitals as a whole.
- The establishment that the SNCT tool calculates is required to deliver the care needs.
- The establishment that was used to deliver care.
- The average number of patients per-registered nurse (registered general and registered nursing associates)



Patient to RN/NA ratio	
Shift	
Day	4.80
Night	7.50



Patient to RN/NA ratio	
Shift	
Day	5.10
Night	8.30



Patient to RN/NA ratio	
Shift	
Day	4.80
Night	7.90

Budget Day	SNCT Day	Actual Day
207.83	195.21	205.52
Budget Night	SNCT Night	Actual Night
131.83	119.21	125.5
Total budget	Total SNCT	Total 24 hrs
339.66	314.42	331.02

6.2. When reviewing the above data there a are several caveats:

a. Tor and Parkside wards have been excluded from this analysis because, Tor is now closed, and Parkside data was missing.

b. The SNCT does not include the supervisory/clinical role of the ward manager. The SNCT only includes a 20% average for management, with all other time allocated for direct patient care and activities associated with the delivery of care. Therefore 0.8wte per ward is not included for MPH wards, if this was included this would equal an additional 22.4wte. This additional establishment needs to be added to the SNCT total requirement, indicating that our budgeted requirement would be 336.82 WTE which is very close to the current funded establishments.

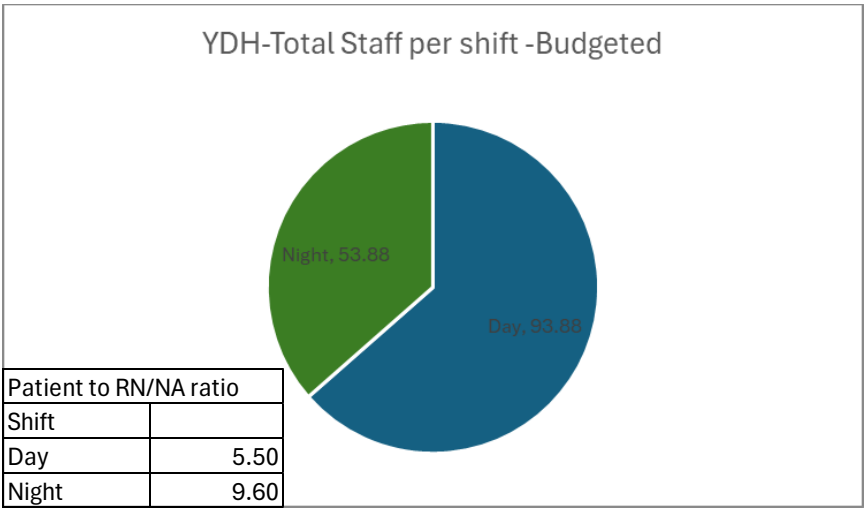
c. There are several areas across MPH (CCU, Dunkery and Coleridge) where there is provision for level 2 care which requires a higher number of registered nurses. During this audit the acuity scoring for level 2 was relatively low and consequently that has lowered the SNCT score but staffing levels would have been for level 2 patients, this may explain why use was higher than apparent need and in future audits is likely to affect the SNCT WTE number required.

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

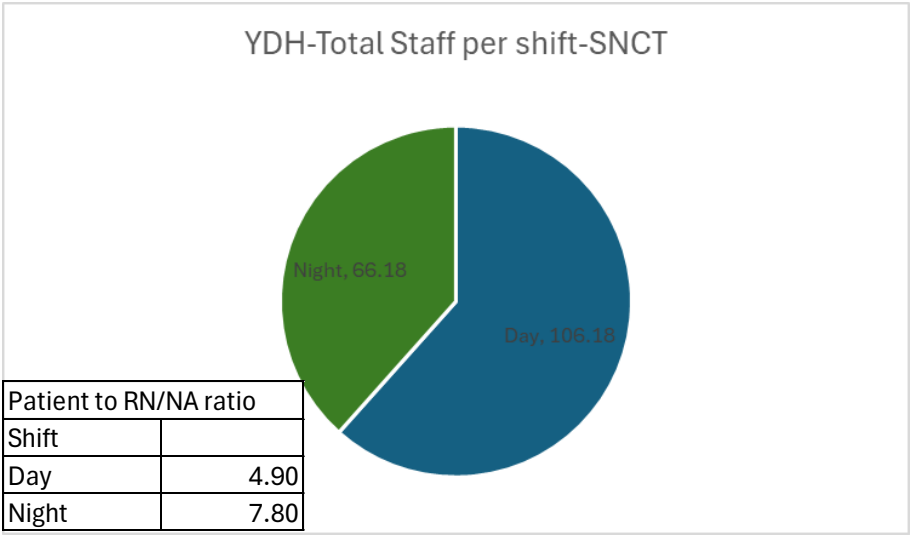
e. The SNCT does not differentiate between registered or non-registered it will simply produce a number, which can then be split once the preferred registered to non-registered ratio is confirmed. Across all of the included wards at MPH these average at 55/45 registrant to non-registrant ratio.

f. Ward budgets were not all realigned after reconfiguration until the start of this financial year, a piece of work is being undertaken to review that each area has the required budgeted establishment to cover the currently agreed level of staffing. This piece of work is not about a budget requirement but checking that the WTE are not placed in the right areas.

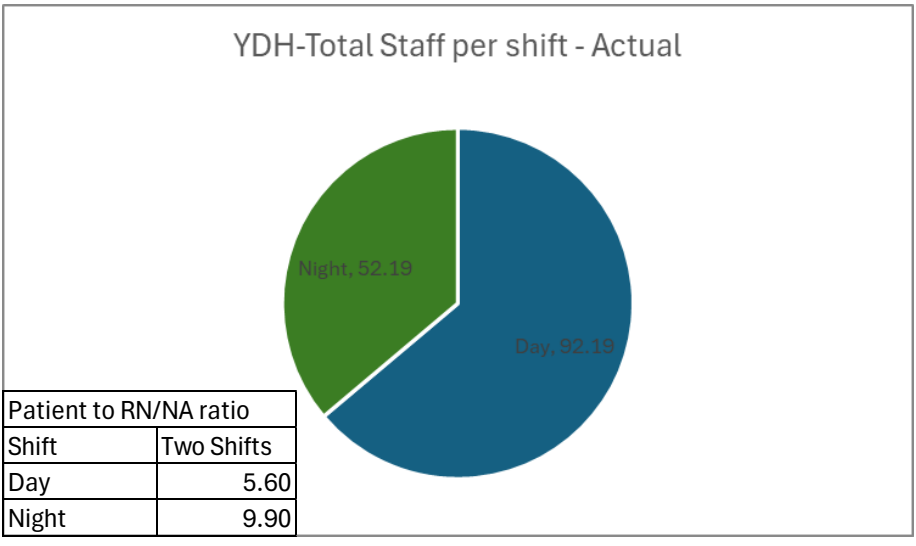
7. Staffing – Inpatient Wards – YDH



Patient to RN/NA ratio	
Shift	
Day	5.50
Night	9.60



Patient to RN/NA ratio	
Shift	
Day	4.90
Night	7.80



Patient to RN/NA ratio	
Shift	Two Shifts
Day	5.60
Night	9.90

Budget Day	SNCT Day	Actual Day
93.88	106.18	92.19
Budget Night	SNCT Night	Actual Night

53.88	66.18	52.19
Total budget	Total SNCT	Actual total
147.76	172.36	143.38

7.1. When reviewing the above data there are several caveats:

a. Jasmine and Kingston Wing wards have been excluded from this analysis because, Jasmine is now closed, and Kingston's data was incomplete.

b. The SNCT does not include the supervisory/clinical role of the ward manager. The SNCT only includes a 20% average for management, with all other time be allocated for direct patient care and activities associated with the delivery of care. Therefore 0.8wte per ward is not included for YDH wards, if this was included this would equal an additional 7.2 wte. This number needs to be added to the SNCT total requirement, indicating that our budgeted requirement would be 179.56 WTE, this is 31.8 WTE more nurses than current funded establishments.

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

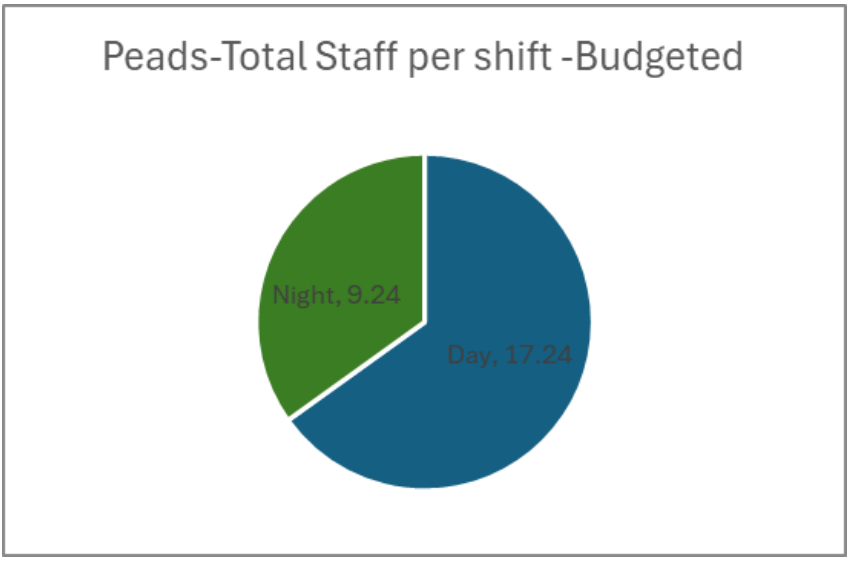
d. Some of the ward areas included have a smaller number of beds. The total number of beds per ward is used in the SNCT algorithm, along with the acuity score to calculate the number of staff required. In some instances, this would take the number of staff down per shift to an unsafe level. Consequently,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

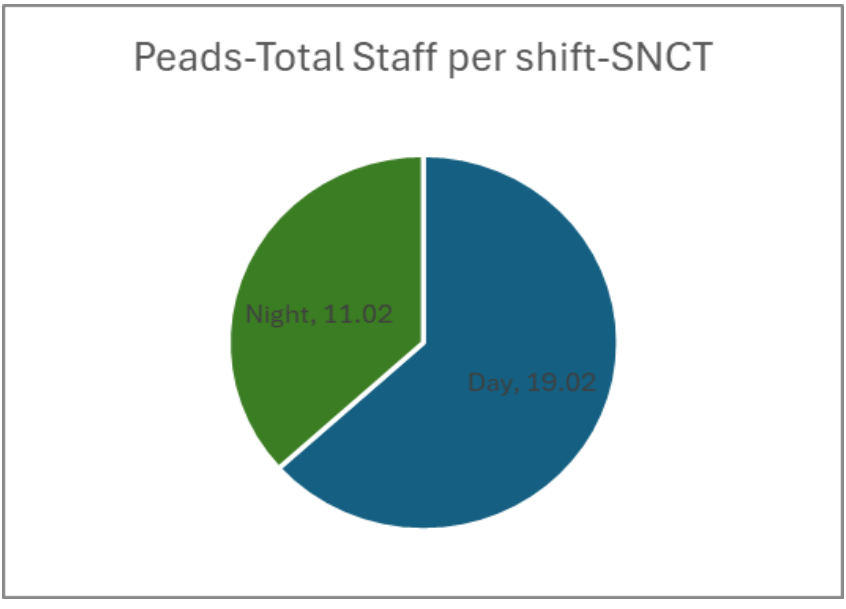
e. The SNCT does not differentiate between registered or non-registered it will simply produce a number, which can then be split once the preferred registered to non-registered ratio is confirmed. Across all of the included wards at YDH this averages at 55/45 registrant to non-registrant ratio.

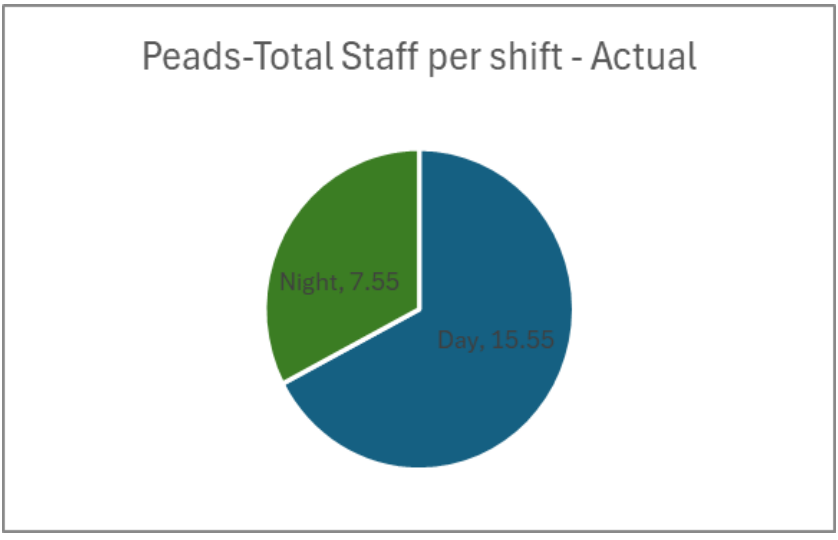
f. Ward budgets were not all realigned after reconfiguration until the start of this financial year, and further movement has happened on the YDH site, a piece of work is being undertaken to review that each area has the required budgeted establishment to cover the currently agreed level of staffing. The new budget for the planned level of staffing on Ward 10 did not go into effect until the new financial year.

8. Staffing - Inpatient Wards – Paediatrics

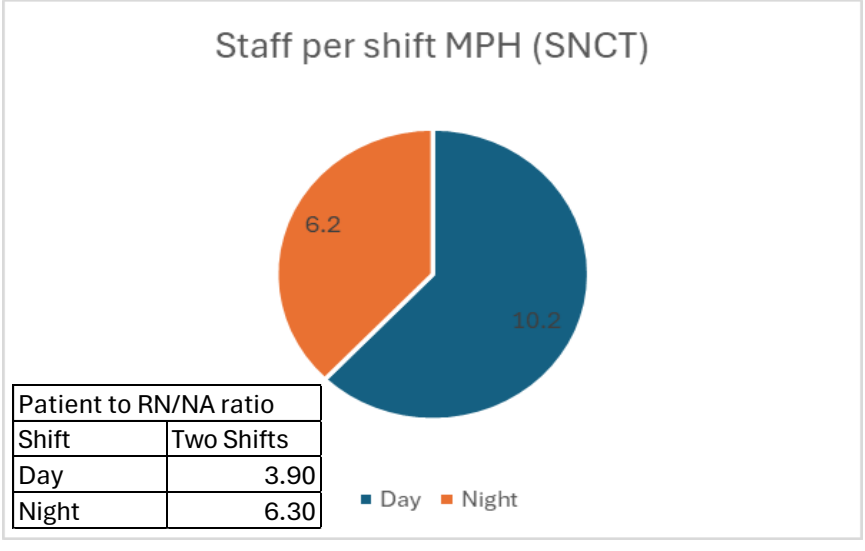
Total:


Peads-Total Staff per shift -Budgeted
Night, 9.24
Day, 17.24

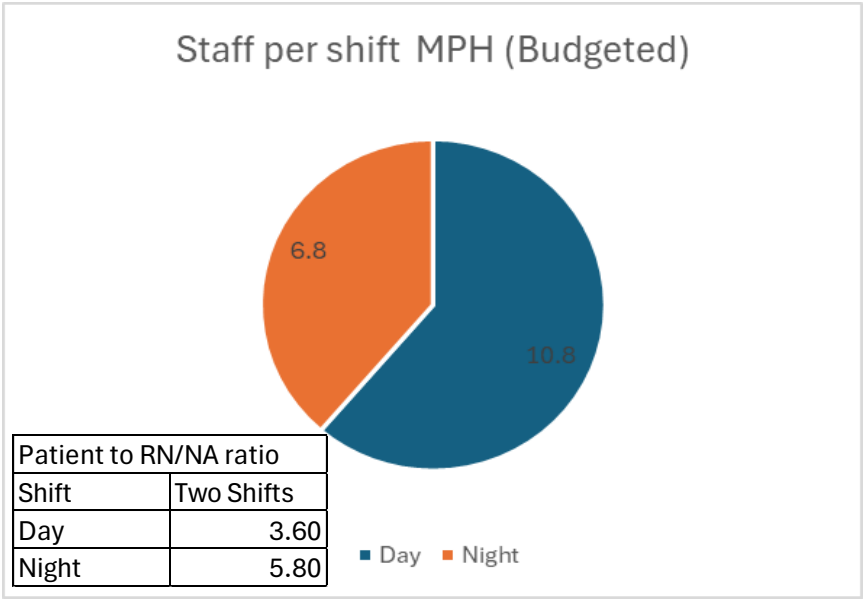

Peads-Total Staff per shift-SNCT
Night, 11.02
Day, 19.02



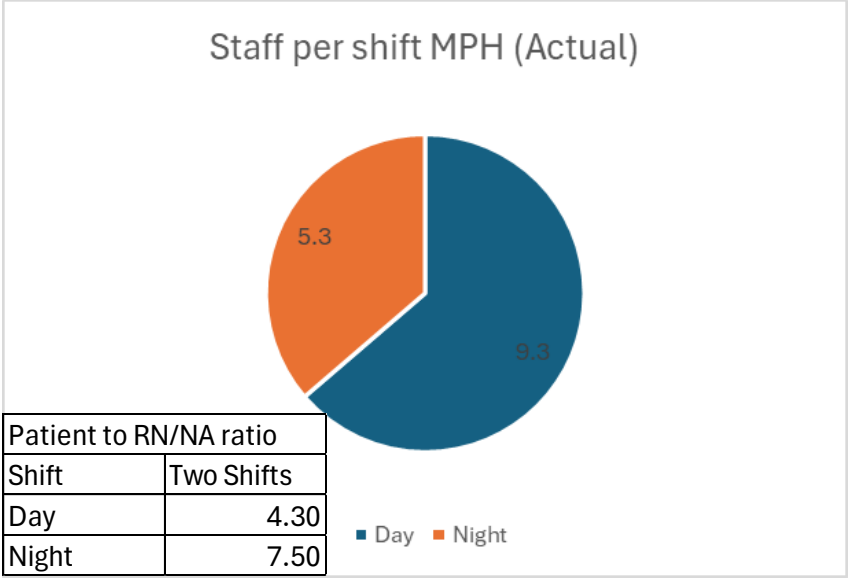
MPH:



Patient to RN/NA ratio	
Shift	Two Shifts
Day	3.90
Night	6.30

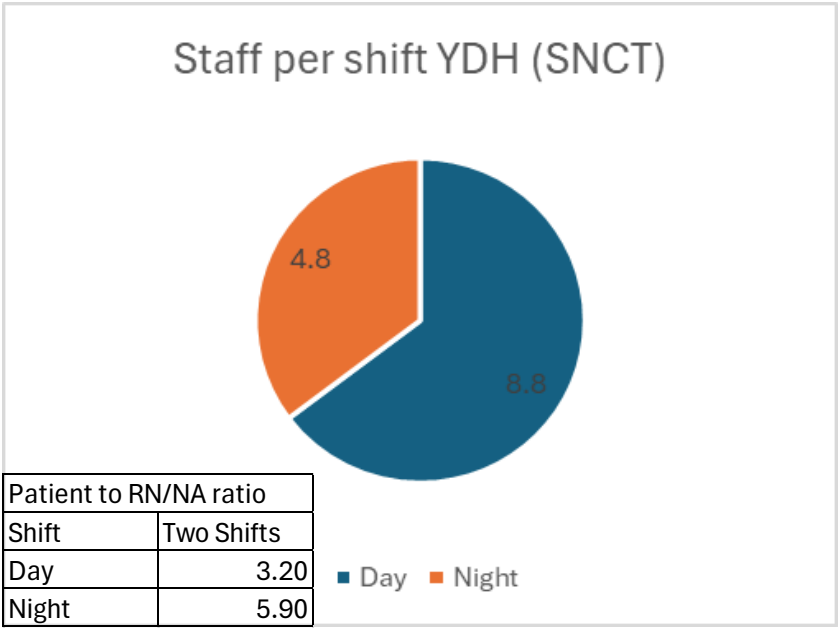


Patient to RN/NA ratio	
Shift	Two Shifts
Day	3.60
Night	5.80

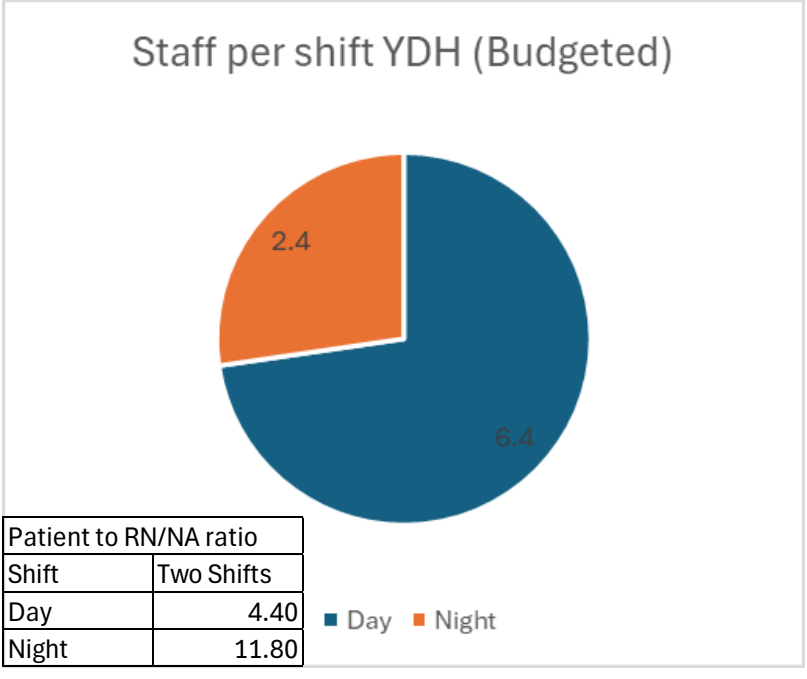


Patient to RN/NA ratio	
Shift	Two Shifts
Day	4.30
Night	7.50

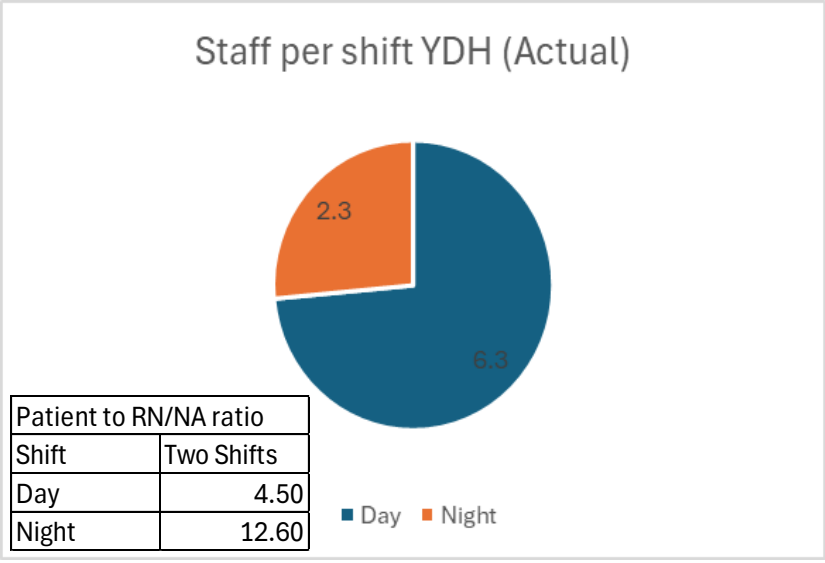
YDH:



Patient to RN/NA ratio	
Shift	Two Shifts
Day	3.20
Night	5.90



Patient to RN/NA ratio	
Shift	Two Shifts
Day	4.40
Night	11.80



Patient to RN/NA ratio	
Shift	Two Shifts
Day	4.50
Night	12.60

	Budget Day	SNCT Day	Planned	Actual Day
MPH	10.8	10.2	8	8.3
YDH	6.4	8.8	5	5.35
	Budget Night	SNCT Night		Actual Night
MPH	6.8	6.2	7	7.7
YDH	2.4	4.8	4	4
	Budget total	SNCT total	Planned total	Actual total
MPH	17.6	16.4	15	16
YDH	8.8	13.6	9	9.35

8.1. When reviewing the above data there are several caveats:

a. Unlike the adult version of the SNCT (2023) the Paediatric SNCT (2022) does not include empty beds and consequently these are not factored into the algorithm.

b. The SNCT does not include the supervisory/clinical role of the ward manager. The SNCT only includes a 20% average for management, with all other time be allocated for direct patient care and activities associated with the delivery of care. Therefore 0.8wte per ward is not included for the 2 paediatric areas across the acute sites, if this was included this would equal an additional 0.8WTE to each site, meaning MPH would have a need for 17.2 WTE against the budget of 17.6 WTE, YDH would require 14.4 WTE against a budget of 8.8 WTE

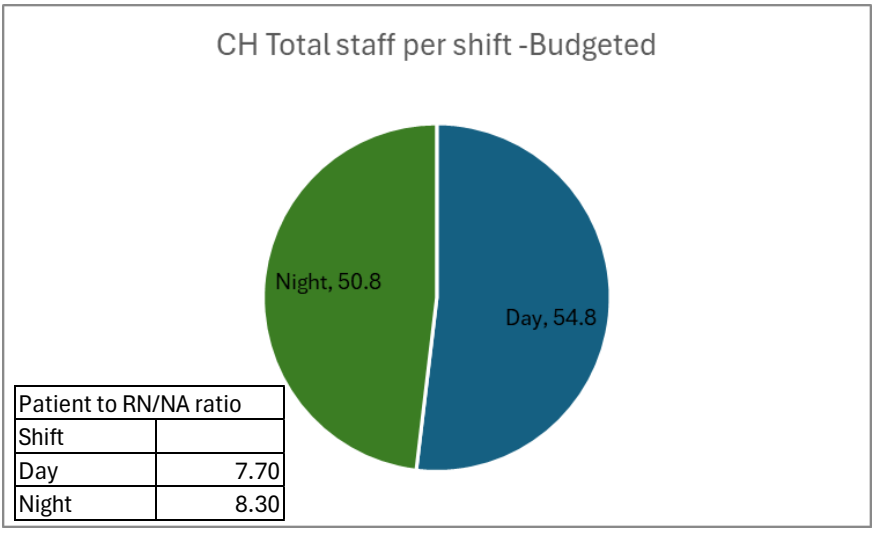
c. There is an expectation that both paediatric units on each of our acute sites to manage the care of the child requiring level 2 care, during this audit there was very little level 2 care scored and this has lowered the SNCT score.

d. The SNCT does not differentiate between registered or non-registered it will simply produce a number, which can then be split once the preferred registered to non-registered ratio is confirmed. Across both acute sites this averages at 76/24.

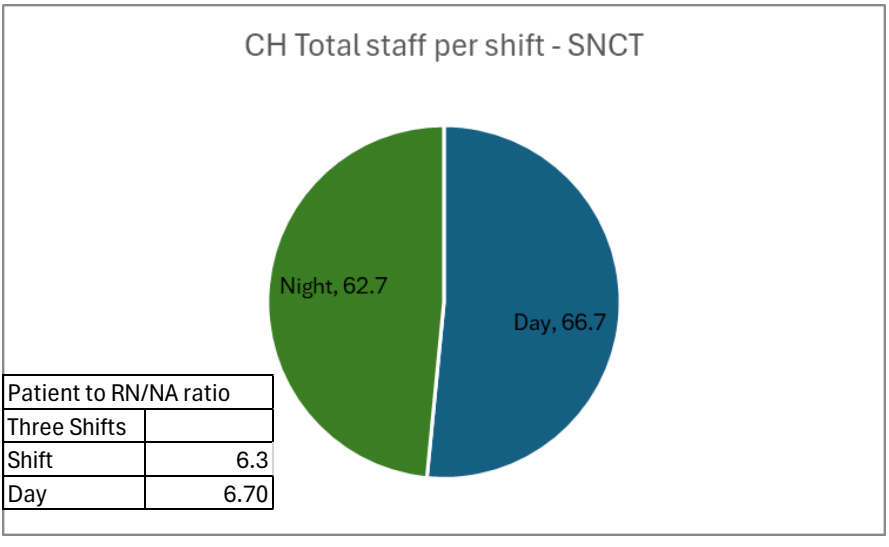
e. The individual result for both paediatric units are also shown above. When comparing the 2 units there is a discrepancy in the number of staff available to care for children with the YDH unit falling short by 4.6 staff members on day and night shifts. There has been some investment already agreed for the YDH unit but the uplift would not achieve the numbers recommended by the SNCT tool.

f. The calculation used to determine the split between day and night shifts and generate the pie charts is not exact and only provides an indicative number. It can be seen by the table of the actual numbers rostered per shift that is more equally divided across the 24-hour period.

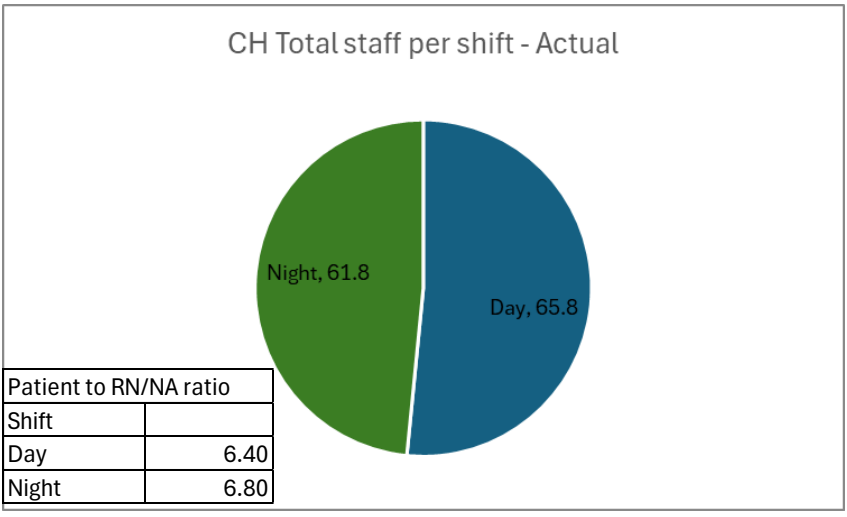
9. Staffing – Inpatient Wards – Community Hospitals



Patient to RN/NA ratio	
Shift	
Day	7.70
Night	8.30



Patient to RN/NA ratio	
Three Shifts	
Shift	6.3
Day	6.70



Patient to RN/NA ratio	
Shift	
Day	6.40
Night	6.80

Budget Day	SNCT Day	Actual Day
54.8	66.7	65.8
Budget Night	SNCT Night	Actual Night
50.8	62.7	61.8
Budget total	SNCT total	Actual total
105.6	129.4	127.6

Some of the ward a

9.1. When reviewing the above data there are several caveats:

a. The SNCT does not include the supervisory/clinical role of the ward manager. The SNCT only includes a 20% average for management, with all other time be allocated for direct patient care and activities associated with the delivery of care. Therefore 0.6wte (allocation of supervisory time in CH is not 100% for band 7) per ward is not included for Community Hospital wards, if this this was included this would equal an additional 5.4wte.

b. reas included have a smaller number of beds. The total number of beds per ward is used in the SNCT algorithm, along with the acuity score to calculate the number of staff required. In some instances, this would take

the number of staff down per shift to an unsafe level (e.g each ward must have a minimum of two registrants per shift).

c. The SNCT does not differentiate between registered or non-registered it will simply produce a number, which can then be split once the preferred registered to non-registered ratio is confirmed. Across all of the community hospital wards the average is at 43/57 registered to non-registered ratio.

10. ANALYSIS

10.1. Data for individual areas is included in chart at the end of the appendix, when looking at this it is recommended to look at 24 hour totals rather then directly the split by day or night.

10.2. Undertaking any analysis of individual wards or service groups after just one audit is difficult although there is a significant difference between what is budgeted vs the number of staff rostered. There are a variety of reasons that could explain this and some of these have been identified above as:

- The supervisory/clinical role of the ward manager
- The low number of level 2 acuity during the audit
- The lower number of beds in some wards
- The budgets were not yet realigned post ward reconfiguration.
- A piece of work is being undertaken to check that the budgets match the current establishment and rostering plan for each area. This check will only be able to ensure the agreed funding that is in place is in the right budget, if there is a surplus at the end of this task this may support correction of areas where increase may be needed, if there is a deficit then required actions will need to be considered.

10.3. Other factors which would need to be consider are:

- The number of staff calculated for the AMU at MPH is lower than would be expected for an acute assessment unit that is a single side room ward. Having spoken to the national team we have been advised that the Acute Assessment Unit algorithm has been adjusted to reflect the higher acuity of this patient group and there will not be an additional SNCT calculator for side rooms and therefore any recommendations to be made should be through a review of outcomes, nurse indicators and professional judgment.
- The service groups have not yet undertaken any review of their data applying professional judgement or outcome data. This will be undertaken when the data from the 2nd round has been compiled and is planned for October.

11. NEXT STEPS

11.1. The July audit data is being compiled and then the nursing leadership teams will review this with ward leadership, matrons and ADPCs, applying the principles of professional judgement, nurse sensitive indicators and outcomes.

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

11.3. Review the data for areas that manage the provision of level 2 care to ensure data is being correctly captured.

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

11.5. Continue to work on a PowerBI application so that data can be reviewed overtime.

11.6. A review of budgets against planned staffing is being undertaken by the finance team to ensure all budgets are correctly allocated post ward moves and to highlight any surplus or deficits. The output of this will need to be reviewed.

Data by individual ward area

	Budget		SNCT		Planned		Actual	
	day	night	day	night	day	night	day	night
MPH (Acc)	207.9	130.7	195.2	119.2	179	152	169.06	156.9
Beacon	5.8	1.8	5.6	1.6	6	3	5	3.05
Triscombe	17.6	13.6	17	13	17	14	16.20	14.20
SDU	12.2	8.2	8	4	10	9	10.05	11.15
Shepperd	9.7	5.7	9.4	5.4	8	7	7.25	6.65
Mont South	10.9	6.9	11.7	7.7	9	9	9.05	8.25
Mont North	8.4	4.4	10.2	6.2	6	6	6.08	6.15
Hest South	11.3	7.3	14	10	9	8	10.3	10.15
Hest North	8.8	4.8	9.6	5.6	6	6	6.25	6.25
Gould	9.9	5.9	10.2	6.2	8	7	6.55	6.40
Fielding	9	5	7.3	3.3	8	5	6.10	3.75
Exmoor	9.6	5.6	8.8	4.8	8	7	9.28	8.8
Dunkery	20.1	16.1	15.6	11.6	20	16	18.6	18.60

Comment
on Nights
patient.

	Budget		SNCT		Planned		Actual	
	day	night	day	night	day	night	day	night
AMU	19.7	15.7	14	10	17	17	13.50	14.10
AFU	7.6	3.6	10.5	6.5	6	5	6.3	5.75
Coleridge	17.8	13.8	15.3	11.3	17	16	16.05	16.30
CCU	5.6	1.6	4.3	0.3	3	3	3.45	3.05
Blake	7.9	2.7	6.7	2.7	7	4	6.2	4.15
Conservators	10	6	11.5	7.5	8	7	8.15	7.15
Ward 9	6	2	5.5	1.5	6	3	4.7	3
Elliot	No data	Incomplete data						
ParkSide	No data							
Portman	No data							
YDH (Acc)	100.6	56.9	114.4	70.4	89.5	68	89.43	68.78
ACCU	5.1	1.1	4.4	0.4	3.0	3.0	3.0	3.0
EAU (pre ward reconf now 6B))	9.3	5.3	12	8	12	10	10.40	8.55
9B (pre ward reconf now 4A)	10.1	6.1	14	10	9	6	10	7.0
9A	9.6	5.6	12.4	8.4	9	6	8.95	6.35
8B	9.1	5.1	9.5	5.5	8	6	7.95	6.45
8A	8.8	4.8	10.7	6.7	8.5	6	8.5	6.0
7B	11.4	7.4	12.4	8.4	10	8	9.9	7.6
7A	10.7	6.7	10.4	6.4	9	6	8.85	6.05
6B pre ward reconf now 9B)	11.3	7.3	9.6	5.6	9	7	9.33	7.8
6A	8.6	4.9	10.8	6.8	8	6	8.05	6.05
KW	6.6	2.6	8.2	4.2	4	4	4.5	3.93
Peads MPH	10.8	6.8	10.2	6.2	8	7	8.3	7.7

	Budget		SNCT		Planned		Actual	
	day	night	day	night	day	night	day	night
Peads YDH (Wd10)	6.4	2.4	8.8	4.8	5	4	5.35	4.0

	Budget		SNCT		Planned		Actual	
	day	night	day	night	day	night	day	night
Community (Acc)	67.7	35.7	80.7	48.7	57.5	39	60.07	43.95
West Mendip	11.5	7.5	15.3	11.3	10	7	12.8	8.8
Frome	8.5	4.5	11.1	7.1	8	5	7.0	5.55
Crewkerne	7.1	3.1	8.3	4.3	5	4	6.7	5.4
Wincanton	7.4	3.4	6	2	6	4	5.0	4.15
Burnham	6.9	2.9	10	6	5	4	5.0	4.2
Williton	9	5	7.7	3.7	9	5	7.8	5.0
Bridgewater	10.1	6.1	13.6	9.6	9.5	6	9.85	6.8
Minehead	7.2	3.2	8.7	4.7	5	4	5.92	4.05
South Petherton	No data							

Appendix 2.

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

1. Clinical Support & Cancer Services, narrative from the Associate Director of Patient Care:

CSCS	MPH

Measure	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Trend
Registered Nursing Fill Rate	95%	99%	98%	98%	97%	100%	
Unregistered Nursing Fill Rate	98%	87%	93%	90%	97%	93%	
All Staff Fill Rate - Day	97%	96%	94%	93%	93%	96%	
All Staff Fill Rate - Night	99%	99%	100%	99%	104%	101%	
All Staff Fill Rate - Overall	98%	97%	96%	95%	97%	98%	
Care Hours per Patient Day	7.6	7.2	7.4	7.0	7.4	7.5	
Registered Hours per Patient Day	4.8	4.8	4.8	4.6	4.7	4.9	
Completing Safer Staffing Measures	76%	78%	75%	86%	85%	82%	
Sickness	3.5%	4.4%	2.7%	1.8%	2.7%	5.1%	
Labour Turnover Rate	2.3%	2.3%	4.3%	2.9%	2.9%	2.9%	
Registered Nurse Vacancy Rate	-6.7%	-3.9%	-7.0%	-1.5%	-4.5%	-4.2%	
Unregistered Nurse Vacancy Rate	1.2%	1.2%	4.9%	5.4%	5.4%	5.4%	
All Clinical Staff Vacancy Rate	-6.7%	-3.9%	-7.0%	-1.5%	-4.5%	-4.2%	

1.1. We have seen turnover and workforce challenges in the out-patient chemo unit at Yeovil, these should settle in the coming months following successful recruitment and training (supported by agency use for skill mix need), and new leadership.

1.2. We are currently trialling ambulatory care on Ward 9 (haematology). This requires increase in nursing establishment (1.49 Band 6, 0.62 Band 5) to deliver safely, however, it will realise greater benefits in saved bed days and improved patient experience. This is being progressed through our Productive Care programme.

1.3. We currently hold no Service Group risks associated with ward nursing staff levels and have none emerging.

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

Toni Hall, Associate Director of Patient Care

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

CYP & Families Services	MPH						
Measure	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Trend
Registered Nursing Fill Rate	92%	90%	90%	93%	94%	93%	
Unregistered Nursing Fill Rate	83%	82%	91%	77%	99%	68%	
All Staff Fill Rate - Day	95%	92%	92%	92%	96%	92%	
All Staff Fill Rate - Night	90%	91%	94%	91%	103%	88%	
All Staff Fill Rate - Overall	93%	92%	93%	92%	99%	90%	
Care Hours per Patient Day	9.7	10.0	9.4	12.9	5.5	9.9	
Registered Hours per Patient Day	8.3	8.4	7.8	11.1	3.5	8.7	
Completing Safer Staffing Measures	84%	88%	82%	83%	89%	83%	
Sickness	6.7%	7.0%	5.2%	5.0%	4.2%	4.4%	
Labour Turnover Rate	8.2%	8.2%	10.1%	10.2%	10.4%	11.0%	
Registered Nurse Vacancy Rate	4.4%	4.1%	5.1%	5.2%	4.5%	6.0%	
Unregistered Nurse Vacancy Rate	2.0%	3.4%	11.0%	3.0%	0.7%	1.1%	
All Clinical Staff Vacancy Rate	3.9%	3.6%	4.6%	4.2%	3.5%	5.5%	

CYP & Families Services	YDH						
Measure	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Trend
Registered Nursing Fill Rate	94%	88%	90%	90%	90%	83%	
Unregistered Nursing Fill Rate	72%	71%	64%	64%	75%	74%	
All Staff Fill Rate - Day	86%	80%	78%	78%	82%	77%	
All Staff Fill Rate - Night	92%	91%	94%	94%	94%	90%	
All Staff Fill Rate - Overall	88%	84%	83%	83%	86%	81%	
Care Hours per Patient Day	10.6	18.2	19.1	19.1	25.4	33.4	
Registered Hours per Patient Day	8.4	14.1	15.3	15.3	19.8	25.6	
Completing Safer Staffing Measures							
Sickness	6.0%	1.9%	8.2%	8.6%	7.8%	8.6%	
Labour Turnover Rate	17.7%	17.7%	21.8%	19.6%	17.5%	17.3%	
Registered Nurse Vacancy Rate	-3.1%	-3.5%	-0.2%	5.2%	4.0%	4.3%	
Unregistered Nurse Vacancy Rate	-4.2%	-23.7%	-9.9%	-10.4%	-16.1%	-18.4%	
All Clinical Staff Vacancy Rate	-3.1%	-3.5%	-0.2%	5.2%	4.0%	4.3%	

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

2.2. Over the past two years, to ensure safe staffing on Ward 10, it has been necessary to use agency staff at short notice to supplement the core team. This approach is costly and disrupts continuity of care for patients and the nursing team. We are now avoiding the use of agency staff unless patient safety is a concern- we then use lower tier agencies if at all possible. This has been supported by the business case agreed last year and recruitment against this.

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

2.4. Currently, safe staffing levels are maintained through the use of agency staff. However, recruitment efforts are underway, a group of international nurses joined in April on both sites and have adapted well to their new environment. Preceptee nurses are joining the teams at both sites following the completion of their training. This is a testament to both teams' support throughout their colleagues' training, leading these nurses to choose to join the teams permanently. We anticipate that the two paediatric teams will achieve a fully established staffing team by October 2024.

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

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

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

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

2.9. The high level of over recruitment (figures in red on vacancy line) for unregistered colleagues was caused by recruiting ahead of the agreed funding being allocated to budgets to avoid temporary staffing costs or rota gaps.

Suki Norris, Associate Director of Patient Care

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

Medical Services	MPH					

Measure	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Trend
Registered Nursing Fill Rate	92%	93%	94%	96%	97%	97%	
Unregistered Nursing Fill Rate	97%	97%	95%	102%	102%	97%	
All Staff Fill Rate - Day	93%	94%	94%	97%	99%	96%	
All Staff Fill Rate - Night	102%	102%	100%	106%	103%	102%	
All Staff Fill Rate - Overall	97%	97%	97%	101%	101%	99%	
Care Hours per Patient Day	7.4	7.6	7.8	8.0	8.2	8.0	
Registered Hours per Patient Day	3.6	3.8	3.9	4.0	4.5	4.1	
Completing Safer Staffing Measures	84%	85%	89%	89%	87%	90%	
Sickness	5.7%	5.3%	5.6%	5.3%	4.8%	6.0%	
Labour Turnover Rate	8.5%	8.5%	9.0%	9.8%	9.0%	9.9%	
Registered Nurse Vacancy Rate	7.7%	9.2%	7.4%	7.7%	3.8%	0.6%	
Unregistered Nurse Vacancy Rate	-0.6%	2.7%	-6.1%	-7.2%	-5.3%	-5.9%	
All Clinical Staff Vacancy Rate	7.7%	9.2%	7.4%	7.7%	3.8%	0.6%	

Medical Services	YDH					

Measure	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Trend
Registered Nursing Fill Rate	96%	95%	99%	99%	102%	97%	
Unregistered Nursing Fill Rate	99%	97%	93%	93%	99%	95%	
All Staff Fill Rate - Day	98%	98%	97%	97%	101%	97%	
All Staff Fill Rate - Night	101%	99%	100%	100%	104%	100%	
All Staff Fill Rate - Overall	99%	98%	98%	98%	103%	99%	
Care Hours per Patient Day	7.0	5.9	5.8	5.8	6.4	6.3	
Registered Hours per Patient Day	3.6	3.1	3.1	3.1	3.5	3.4	
Completing Safer Staffing Measures	100%	83%	99%	99%	98%	96%	
Sickness	5.0%	3.6%	4.1%	4.8%	3.6%	4.8%	
Labour Turnover Rate	10.3%	10.3%	9.7%	9.2%	9.8%	9.1%	
Registered Nurse Vacancy Rate	-4.2%	-2.2%	-2.5%	-1.5%	-2.3%	-9.7%	
Unregistered Nurse Vacancy Rate	3.5%	5.9%	0.5%	-5.6%	-3.9%	-13.6%	
All Clinical Staff Vacancy Rate	-2.4%	-0.4%	-0.7%	0.2%	-0.6%	-9.7%	

3.1. In summary, the last 6 months we have seen ongoing continued improvement within the nurse staffing in the Medical Service Group, we continue to see a large reduction in nurse agency and bank spend across both sites. We still have some work to do with the bank spend, but the data sent through from the bank lead team suggests we do have a good bank fill rate for any shifts sent to bank at 98%, and the reason mainly for these requests are late sickness. Our observation and support requests are decreasing within the service group, due to O/S training ongoing with our HCA workforce.

3.2. Our RN vacancy position remains positive, due to the closure of a ward on each site and our retention level improving we do have some over establishment of registered nurses. These nurses are allocated to teams and any gaps caused by vacancy, sickness or other needs are covered with this resource. We are working with all other service groups to move this over establishment into funded roles rather than advertise vacancy. David Thomas,

Director for nursing strategy and transformation, is working with the recruitment team to review the pipeline of international nurses and our requirement over the next 2-3 years. The overseas pipeline is currently switched off on both sites, and all newly qualified and overseas nurses are now mapped in to all our trackers, with the last cohort of overseas nurses arriving at the end of July 2024. We have seen a much-improved picture from our large deficit of HCA`s this time last year. July figures ae showing a vacancy of 30.45 for the service group, yet to be validated with our recruitment team. Ongoing recruitment will be managed at individual ward/ department areas and all vacancies will be approved through our vacancy recruitment panel. With a more settled workforce, skill mix on our wards has improved over the last 6 months, but this remains a focused piece of work and we will continue, with our ongoing projects in place and with the support of our clinical skill facilitators to ensure all teams have the skills and competence required.

3.3. Our band 7 ward leaders are not being pulled into the numbers as frequently as they were 12 months ago and now able to spend time clinically teaching and mentoring the new members of the team. The quality indicators and metrics for all ward areas continue to be a key area of focus.

3.4. The bed and ward re configuration work has now been completed on the MPH site and phase 1 of the bed re configuration on the YDH was completed on the 28th of June 2024. The moves on the YDH site, has de stabilised some of our nursing teams, as new teams have formed, but we are confident that over the coming months with the continued support of the senior leadership teams and our OD support are teams we will stabilise and are teams will thrive in their new work environments. Our escalation beds on the MPH site are not used as often as they were 6 months ago, but we are still consistently in the escalation beds on the YDH site. This has resulted in an increase in the use of bank staff to mitigate patient safety and staff wellbeing concerns particularly in our EDs and our EAU on YDH, where we have been corridor nursing. There is currently a full review of both Emergency departments safer staffing in readiness for the opening of our UTCs.

3.5. The matrons/ ADPCs have good oversight and good grip and control over our over established areas, drilling down rosters day by day and plans are made to cover the gaps and move staff should this be required. They also review each request that comes in for enhanced care or observation/ support to ensure that those patients that require a higher level of support are prioritised, however although there has been a reduction in the request for enhanced care and observation and support, we had seen an increase in our requests for RMNs, through June and July on the YDH site for our complex young adults with eating disorders resulting in high costs to the service group with the delays in Mental Health Beds. These requests for RMN and specialist HCAs are reviewed by the psychiatric liaison team (PLT), and they support the teams to produce a plan of care for our patients presenting with mental health concerns. We have now stood down the use of Bed watch on the YDH site but have not seen an increase in requests for additional 1:1 support.

3.6. We are currently running at a risk of a nursing overspend on 6A a 31 bedded ward, due to the change from a medically fit for a discharge ward to an acute

general medical ward, as previously running on 3:4 ratio during the day and an uplift to 4:4 over the seven days and working with our finance manager to see how this could be funded.

3.7. During the last 6 months sickness levels have fluctuated from 5.2% in December 23 to 3.6% in May 24, with a slight increase in June to 4.6%, and this could be due to a measles outbreak on two wards. The highest cause remains musculoskeletal pain., and we ae currently in the process of reviewing wards teams around manual handling training, to ensure we have not training gaps.

3.8. The data shows an improvement from the previous 6 months which is indicative of the all the hard work and effort the teams are contributing. It feels like we are moving in the right direction, but with the recognition that we still have some way to go but feel confident we are heading in the right way.

Jacqueline Phillips, Associate Director of Patient Care

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

Mental Health and Learning Disabilities MH wards

Measure	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Trend
Registered Nursing Fill Rate	98%	101%	98%	100%	100%	104%	
Unregistered Nursing Fill Rate	107%	111%	112%	114%	114%	119%	
All Staff Fill Rate - Day	92%	93%	96%	99%	99%	96%	
All Staff Fill Rate - Night	105%	108%	111%	110%	110%	115%	
All Staff Fill Rate - Overall	96%	98%	102%	103%	103%	103%	
Care Hours per Patient Day	13.5	13.2	14.1	14.5	14.3	13.9	
Registered Hours per Patient Day	5.3	5.0	5.4	5.6	5.5	5.2	
Completing Safer Staffing Measures	90%	91%	89%	92%	92%	90%	
Sickness	6.3%	5.3%	6.2%	5.0%	6.3%	5.3%	
Labour Turnover Rate	7.1%	7.7%	6.4%	8.2%	8.7%	8.4%	
Registered Nurse Vacancy Rate	15.5%	14.8%	15.7%	15.4%	16.2%	18.0%	
Unregistered Nurse Vacancy Rate	8.7%	7.5%	4.0%	4.7%	4.9%	5.1%	
All Clinical Staff Vacancy Rate	16.7%	16.1%	17.1%	16.9%	17.8%	19.0%	

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

4.2. Wards, including Holford, Rydon and Rowan are areas where we frequently need to have additional staffing to support the acuity of their patient groups, including when they need to be seen in the Acute Hospitals.

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

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

a) The ward nursing fill rate levels fluctuate when managing complex and vulnerable patients requiring additional 1:1, 2:1 or **3:1** staffing, sometimes for lengthy periods. Especially on the Psychiatric Intensive Care Unit (PICU) when vulnerable females need to be supported on a mainly male ward or where is a significant risk to others identified.

b) In the absence of RNs to cover shifts, and to ensure the wards remain safe, the wards will undertake a risk assessment at the time and sometimes prefer and agree a nursing associate or an experienced HCA

who is familiar with the ward to work alongside the registered nurse and other team members to ensure safety and stability of the ward, as an alternative to employing an unknown RN agency worker, who may not know the ward or patients.

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

d) Following the successful RN and HCA recruitment to Rydon, Pyrland, we have a number of vacancies across Wessex and Rowan 2 (relocated St Andrews Ward).

e) The ward teams aim to complete twice daily patient acuity and dependency scoring.

f) The wards continue to manage daily challenges through their capacity meetings and continue to strive to reduce reliance on temporary and agency staffing.

g) We have three trainee Advanced Nurse Practitioners who are working well across Rydon Wards, Rowan and Pyrland Wards, which enhances the clinical support available to the wards.

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

Holford

4.5. Due to the acuity over the past few months, and management of a number of high-risk patients on a mixed sex PICU with only one extra care area, this has required additional staffing to support patients on 1:1, 2:1 and 3:1. This has been managed primarily using bank staff and using agency HCA staff where bank staff have not been available to maintain safety and due to the high level of observations.

Rowan 1 & 2

4.6. St Andrews relocated to Rowan 2 on 23 July 2024, which has given us the opportunity to review the safer staffing over both wards as they are co-located. The wards also need to have staff available to cover the 2 health-based places of safety on site 24/7.

4.7. Currently Rowan 1 & 2 are working to their usual safer staffing numbers with a view by the end of November, when the ward has become established, to

review this to agree the full establishment to manage the wards, health-based places of safety and extra care area.

Staffing at Wessex House - briefing

Situation

4.8. In the first part of 2024 a number of concerns were escalated to the Trust from previous patients, current patients and carers, Wessex House staff, and case managers. These concerns relate to treatment and staff attitude and practice at Wessex House. Initially these concerns were managed on a "case by case" basis.

4.9. The Southwest Provider Collaborative have placed Wessex House on "enhanced surveillance" and set up fortnightly meetings with Somerset Foundation Trust MH and LD senior team.

4.10. A Leadership Quality Walkaround (LQW) validated these concerns and in addition identified further significant concerns regarding ward culture.

Background/Assessment

4.11. Wessex House has been without a clinical service manager for 6 months and recruitment to this post is yet to be successful.

4.12. The MH and LD senior leadership team has been closely involved with the ward and have now transferred an interim manager from PLT.

4.13. The MH and LD senior leadership team have been working closely with the provider collaborative to ensure robust governance and improvement plans.

4.14. A review of the risk register in relation to Wessex House by the MH and LD senior team led to recommendation that a Wessex House Improvement Group was set up; this will provide senior leadership support for changes.

4.15. The development of this group has been welcomed by the SWPC who will have a representative on the group.

4.16. Staffing levels and vacancies on Wessex House have deteriorated further and the ward are not able to populate rotas with staff with appropriate competencies.

4.17. The recent LQW indicated further staffing and cultural issues within the ward and the need for urgent action.

Recommendation

4.18. Given the above risk assessment and the ongoing significant cultural and staffing issues at Wessex House – a "reset programme" to be launched for the ward.

4.19. This “reset programme” would necessitate a temporary closure of the ward.

4.20. For this reset programme to be developed across service groups (MH and LD and CYP) to address clinical and operational knowledge, skills and experience, values and attitudes and for the programme to include interface opportunities with appropriate clinical areas (including paediatrics, CAMHS and Adult Mental Health).

4.21. For there to be a criteria-based approach to ending the “reset position” – completion of the predetermined reset programme, and development of rota in line with agreed safer staffing position for at least 3 months.

4.22. Safer staffing criteria to include at least one registrant at any time with 12 – 18 months of CAMHS experience and / or inpatient experience and appropriate attitudes and values.

4.23. For service groups to commence the above work with (pending meeting criteria) a target date of releasing the reset position by the end of September.

4.24. Ongoing review of this position across service groups.

Ali van Laar, ADPC

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

Neighbourhood Services	Community

Measure	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Trend
Registered Nursing Fill Rate	102%	101%	104%	103%	103%	99%	
Unregistered Nursing Fill Rate	116%	112%	110%	110%	110%	101%	
All Staff Fill Rate - Day	114%	108%	103%	102%	102%	98%	
All Staff Fill Rate - Night	111%	110%	107%	106%	106%	107%	
All Staff Fill Rate - Overall	113%	109%	105%	104%	104%	101%	
Care Hours per Patient Day	7.0	7.2	6.9	7.0	7.2	7.5	
Registered Hours per Patient Day	2.7	2.9	2.7	2.8	2.9	3.1	
Completing Safer Staffing Measures	88%	89%	90%	89%	88%	90%	
Sickness	7.1%	6.7%	6.0%	7.1%	5.7%	5.5%	
Labour Turnover Rate	9.3%	9.3%	11.8%	12.0%	14.0%	13.7%	
Registered Nurse Vacancy Rate	10.8%	11.4%	8.3%	10.2%	9.9%	9.6%	
Unregistered Nurse Vacancy Rate	5.3%	5.1%	3.6%	4.0%	4.6%	7.0%	
All Clinical Staff Vacancy Rate	10.8%	10.6%	8.3%	10.2%	9.9%	9.6%	

5.1. The overall picture for community hospitals is an improving one but significant challenges remain as below:

a. Recruitment to the more geographically isolated hospitals remains a challenge, resulting in long term vacancy which then impacts on agency usage.
b. High age profile across service group, with significant potential for retirement to impact
c. Sickness rates higher than Trust average (potentially related to age profile)
d. Increased cognitive dependency as well as patient acuity across community hospitals, which is driving agency spend for 1:1 support and observation requirement.

5.2. Succession planning and investment in leadership capacity is one of the service group's people priorities which will help ensure optimum succession planning in view of age profile as well as optimum use of flexible working and retire and return options.

5.3. In addition, a full roster review is underway as part of productive care work which will optimise staffing resource. This will also be supported by the safe staffing audit work which is currently underway which will capture the increased acuity and dependency all the Community Hospitals are dealing with.

5.4. There is on-going work with HR colleagues re innovative ways to attract colleagues to community hospitals, including transfer windows, offering rotations, transferring any overrecruited colleagues from the acute sites.

Debra Nash, Associate Director of Patient Care

6. Surgical Care narrative, from the Associate Director of Patient Care.

Surgical	MPH						
Measure	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Trend
Registered Nursing Fill Rate	87%	87%	87%	86%	85%	90%	
Unregistered Nursing Fill Rate	96%	93%	89%	94%	92%	98%	
All Staff Fill Rate - Day	90%	89%	89%	89%	89%	93%	
All Staff Fill Rate - Night	97%	96%	91%	93%	92%	98%	
All Staff Fill Rate - Overall	93%	92%	90%	91%	90%	95%	
Care Hours per Patient Day	10.7	9.2	10.0	12.3	10.1	9.8	
Registered Hours per Patient Day	5.8	5.0	6.3	7.7	5.5	5.4	
Completing Safer Staffing Measures	79%	75%	79%	81%	81%	79%	
Sickness	6.5%	6.3%	7.2%	6.6%	7.4%	6.6%	
Labour Turnover Rate	8.8%	8.8%	8.8%	10.0%	10.2%	10.7%	
Registered Nurse Vacancy Rate	2.2%	2.2%	5.2%	10.4%	11.5%	21.4%	
Unregistered Nurse Vacancy Rate	-0.3%	-9.4%	-1.9%	-4.1%	-5.0%	2.0%	
All Clinical Staff Vacancy Rate	1.9%	1.9%	4.9%	10.1%	11.3%	21.2%	

Surgical	YDH						
Measure	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Trend
Registered Nursing Fill Rate	97%	94%	96%	96%	89%	91%	
Unregistered Nursing Fill Rate	102%	102%	96%	96%	89%	89%	
All Staff Fill Rate - Day	99%	97%	98%	98%	91%	92%	
All Staff Fill Rate - Night	102%	98%	97%	97%	91%	92%	
All Staff Fill Rate - Overall	100%	97%	97%	97%	91%	92%	
Care Hours per Patient Day	6.5	8.2	8.1	8.1	8.3	8.2	
Registered Hours per Patient Day	4.2	5.4	5.4	5.4	5.4	5.4	
Completing Safer Staffing Measures	100%	83%	99%	99%	99%	100%	
Sickness	6.0%	3.9%	6.5%	4.6%	4.7%	4.8%	
Labour Turnover Rate	11.7%	11.7%	9.9%	10.4%	10.1%	9.5%	
Registered Nurse Vacancy Rate	0.6%	1.2%	2.9%	9.4%	9.8%	7.1%	
Unregistered Nurse Vacancy Rate	4.8%	-16.8%	5.0%	7.0%	-0.7%	2.4%	
All Clinical Staff Vacancy Rate	0.6%	1.2%	2.9%	9.4%	9.8%	7.1%	

6.1. The turnover rate for unregistered healthcare assistants has been relatively unstable over the past six months, presenting an ongoing challenge for skill-building within most of the surgical wards. Although the overall establishment numbers remain relatively steady, high turnover persists. There is a mixture as to the reasons for this so it cannot be pointed to one cause. Ward Managers are seeking to understand when colleagues are leaving and having stay conversations where appropriate. The ward team leads are actively working on retention improvement initiatives and have seen an increase in bank nurses seeking substantive hours of late which should support a reduction in turnover and an increase of skill.

6.2. Theatres and Critical Care departments have continued to face some challenges with agency spending across both sites, this is however a reducing position. Targeted efforts are being made to enhance retention, upskill the

workforce, and establish comprehensive career pathways. There is a strategic plan in place to significantly reduce the number of agency shifts over the upcoming months across both sites. Although not represented in this data yet, early indications demonstrate measures are working.

6.3. Following the bed reconfiguration last year, nursing teams have been reorganised to occupy existing vacancies. As a result, the fill rate is expected to return to full capacity for the surgical group. There are still some colleagues moving from other service groups to fill vacancies where they have been over established. Ongoing efforts continue to be made to streamline rosters ensuring stronger data accuracy.

6.4. Throughout all departments, ward managers have been able to dedicate more of their time to supernumerary duties, particularly during the summer months. This focus has enabled them to provide enhanced leadership, supervision, and overall team management. Many of them are also delivering patient experience QI projects sourced from complaints from their wards and environments.

6.5. Sickness rates continue to be higher than the service group would hope for them to be, although it is lower than the previous report. The Matron team are doing some work in addressing this with more robust support offered to colleagues to support their attendance.

6.6. Due to the combination of fewer registered nurse vacancies and higher turnover rates among both registered and unregistered nurses, there remains significant proportions of more junior-skilled colleagues within the nursing workforce. Multiple teams are assisting colleagues with less experience, supported by our ongoing training and development initiatives. The re-specialisation of the Surgical wards following the reconfiguration is helpful as colleagues have developed their identities and are working within tighter competencies to achieve.

Melody Schultz, Associate Director of Patient Care

Appendix 3.

7. Maternity SFT

7.1. There are two consultant-led units at Somerset Foundation Trust, on the acute sites at Yeovil and Taunton hospitals. Since January 2024, 2 new Heads of Midwifery have been in post and a new Director of Midwifery has been appointed into post since the end of March. A new Matron has also been appointed on the YDH site as a fixed term post covering for the substantive matron who is seconded to a Clinical Lead role in the Local Maternity & Neonatal System (LMNS). The senior midwifery leadership teams are coming together regularly to continue work on integration and aligning our service provision across the county.

7.2. The Clinical Negligence Scheme for Trusts (CNST) Maternity (and perinatal) Incentive Scheme (MIS) supports the delivery of safer maternity and neonatal care by evidencing compliance with 10 safety standards. Safety Action 5 relates specifically to the midwifery workforce and details 5 elements to the required standard:

Safety action 5: *Can you demonstrate an effective system of midwifery workforce planning to the required standard?*

a) A systematic evidence-based process to calculated midwifery staffing establishment has been completed within the last three years.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.

d) All women in active labour receive one-to-one midwifery care.

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.

7.3. Safety Action 5 a): Birthrate Plus® is the only nationally validated workforce evaluation tool to calculate required midwifery and maternity support worker workforce requirements. Following the Ockenden report (2020) Birthrate Plus® have revised the tool to take into account the additional staffing needs identified by the Ockenden review plus an increase in headroom and percentage of

specialist midwives required to deliver safe and effective modern maternity services.

7.4. SFT last undertook a Birthrate Plus® review in 2020/ 21. The last review acknowledged an increase in complexity of women both socially and medically. A Birthrate Plus® review is underway in both acute sites and across all community maternity services with the draft report expected at the beginning of August. As mentioned above, Birthrate Plus® has amended allowance in calculations for headroom and specialist midwifery requirements in the modelling tool and as such a recommended uplift to the funded establishment is anticipated.

7.5. Safety Action 5 b): The tables below represent the 20/21 Birthrate Plus® recommendations for each site. (NB the calculations used by Birthrate Plus® in 20/21 did not include the more recent staffing recommendations in National Reports (Ockenden 2020).

7.6. The data demonstrates that both funded and actual staffing establishments are in excess of the Birthrate Plus® recommendations. The tool accepts nuances of staffing models to meet local service needs and calculates establishment as an overall whole time equivalent. It does not look at individual staff group variation. (As highlighted in blue).

Table 1 Staffing Establishment YDH

	Band 5-7 wte	Band 3-4 providing PN care	Contribution from specialist roles wte	Total clinical wte
Birthrate Plus recommendation wte	56.87	2.99	7.18	67.04
Funded Establishment	55.12	5.34	7.44	67.90
Actual Establishment	60.26	5.34	9.69	75.29
Variance from budget	+ 5.14	0	+ 2.25	+ 7.39
Variance (funded vs BR+ recommendation)	-1.75	+ 2.35	+ 0.26	+ 0.86

Table 2 Staffing Establishment MPH

	Band 5-7 wte	Band 3-4 providing PN care	Contribution from specialist roles wte	Total clinical wte
Birthrate Plus recommendation wte	127.52	14.17	(included in band 5-7)	141.69
Funded Establishment	120.86	31.98	10.72	163.56
Actual Establishment	123.59	23.92	16.53	164.04
Variance from budget	+ 2.73	-8.06	+5.81	+0.48
Variance (funded vs BR+ recommendation)	-3.93	+9.75	(included in band 5-7)	+22.35

7.7. Ockenden (2020) made recommendations for an increase in specialist midwives to address key areas of concern highlighted by national maternity service reviews for midwifery leadership roles in specialist areas such as: Bereavement, Retention and Foetal monitoring. Additional funding was then secured by NHSE and distributed to trusts via the LMNS. SFT successfully recruited into all of these additional posts internally as fixed term secondments. Many of the successful candidates' clinical posts were not backfilled and therefore an impact is felt in shop floor staffing for rota cover.

7.8. SFT midwifery establishment remains over funded establishment as of end June:

Table 3 Funding Establishment - MPH and YDH

Site	Funded Establishment (includes some	In Post	Variance	BR+ 20/21 recommendations

	Ockenden related uplift)			
MPH	173.36	179.38	+6.02	141.69
YDH	83.41	79.68	-3.73	67.04

7.9. The midwifery leadership team are working with Birthrate Plus® to ensure that calculations reflect all areas of service delivery and provide robust and sustainable staffing recommendations for all specialities within midwifery care. Once the Birthrate Plus® report and recommendations are available, the team will begin a full workforce development plan.

7.10. Safety action 5 c & d): Midwifery services in each acute site capture maternity Red Flag data via the Birthrate Plus® acuity app. Midwifery coordinator in charge and 1:1 care in labour is routinely collected via the app along with other (non- staffing related) red flag data.

7.11. In the YDH maternity unit, midwifery red flag events have been recorded via the birthrate plus acuity tool app which had been in place for some time on the labour ward but had not been in use on the ward. In May 2024, the tool was implemented for use in all inpatient areas at YDH. At MPH the tool has only been in use since May 2024, replacing a legacy paper-based recording system. As such compliance with recording via the app has taken some time to reach the suggested level for reliable data of 85%. In May compliance was 74% and in June 86%, work to maintain this level is now underway.

7.12. Analysis of the data available from both the paper-based data capture and that available in the Birthrate Plus® acuity app confirms that SFT is 100% complaint with both the labour ward coordinator being supernumerary at the start of each shift and with 1:1 care being provided to all women in active labour.

Table 4 Ward Coordinator Supernumerary and Active Labour Data

	Site	Jan	Feb	March	April	May	June
Midwifery coordinator supernumerary at start of shift	MPH	100%	100%	100%	100%	100%	100%
	YDH	100%	100%	100%	100%	100%	100%
Women in active labour	MPH	100%	100%	100%	100%	100%	100%

receiving 1:1 care	YDH	100%	100%	100%	100%	100%	100%

7.13. SFT maternity services have in place an escalation policy which provides clear instruction to mitigate risk and actions to take in the event that a substitute co-ordinator is required where there is no co-ordinator available at the start of a shift.

7.14. Safety action 5 e) A detailed staffing report is submitted to the Quality and Governance Assurance Committee twice a year. For September a deep dive into maternity staffing is planned to include data received from the Birthrate Plus® workforce evaluation recommendations.

7.15. Safe staffing over the last six months has been affected by an average maternity leave rate of 2.4wte and sickness and turnover rates.

Table 5 Sickness - Combined Sites %

	Jan 24	**Feb 24**	**Mar 24**	**Apr 24**	**May 24**	**Jun 24**
In Month sickness rate	6.5	7.1	5.9	5.5	4.9	5.3
Rolling sickness rate%	7.6	7.5	7.1	6.7	6.3	6.0

Table 6 Turnover - Combined Sites %

Midwifery	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
	11.6	11.1	12.1	11.6	11.1	11.2

7.16. SFT midwifery sickness is slightly higher that the trust average (5.2%) with S10 (stress/anxiety/depression) being the highest reported reason for sickness. This is also slightly higher than the regional and national peer median of 5.5%. A targeted action plan has been developed by the Midwifery retention lead to address.

7.17. Available turnover data for midwives in SFT requires further cleansing in order to provide a clear picture as the data includes staff who have chosen to retire & return and do not actually leave employment at SFT. The ability to retire & return helps keep skilled and experienced staff in the service and supporting more junior colleagues. When disaggregated, the actual turnover for SFT midwives is a 12-month rolling average of 3.2%. This is lower than the regional peer median of 5.2% and the national average of 4.8% and considerably lower than the trust average of 10.8%.

7.18. In line with the escalation guideline, the maternity service regularly reviews staffing levels and skill mix to ensure adequate and safe cover at all times. In times of high acuity and activity, there is a requirement to fill shifts by mobilising non-clinical staff such as specialist midwives to work clinically or to use bank or agency staff to ensure safe care delivery. SFT bank staff are almost exclusively substantive contract holders and as such any additional shifts worked must be considered to ensure support for effective work life balance to maintain resilience within the team. Where this is not possible, the service will move to fill shifts using agency. This predominantly occurs on the YDH acute site where the pool of available staff is much smaller which impacts on the ability to flex staff across the service.

7.19. In 20/21 and line with a national recruitment drive, SFT recruited a number of international midwives. The first 2 recruits were welcomed in our YDH site in July 22, both of whom have since successfully completed their preceptorship year and are now working as Band 6 midwives in the YDH team. To date YDH have successfully recruited 8 international midwives, 6 of whom have successfully gained their NMC Pin and 1 who is due to take her OSCE's in preparation to join the preceptorship programme. 1 candidate chose to return to home.

7.20. The MPH site have successfully recruited 9 international midwives all of whom have successfully gained their NMC Pin and are working as Band 5 preceptor midwives working towards gaining their Band 6 at the end of their preceptorship period in the service.

7.21. The IR recruitment campaign has given the service many challenges and many lessons have been learned not least the need for individual adjustments to training needs for internationally educated colleagues. The service has responded in innovative ways to address challenges and support the teams to wrap around the international midwives including tailored training and support programmes for each individual colleague and an enhanced practice development programme.

Sally Bryant, Director of Midwifery

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 25 September 2024
SPONSORING EXEC:	Peter Lewis, Chief Executive
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Jan Hull, Chairman of the Quality and Governance Assurance Committee meeting held on 25 September 2024
DATE:	5 November 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 25 September 2024. The Committee received assurance in relation to: • The progress relating to the MHRA bed rails alert action plan. • The review of the Board Assurance Framework. • The management of the Corporate Risk Register. • The Governance Support summary – feedback from the Quality Assurance Group and Data Review Group. • The work of the Patient Safety Board. • The learning from Deaths report. • The Medical Care Services service group assurance report. • The Simply Serve Limited Assurance Report. • The Maternity and Perinatal Incentive Scheme Year 6 compliance position. • The work by the Maternity and Neonatal Action Group.

	• The progress in relation to the implementation of the Care Quality Commission Action Plan. The Committee identified the following areas of concern or for follow up: • The launch of the Ward Accreditation Programme and the further progress report to the presented to a future meeting. • The Quality and Performance Exception Report – deep dive to be scheduled for a future meeting. • The Maternity and Perinatal Incentive Scheme – the challenge achieving compliance with safety action 8. The Committee identified the following areas to be reported to the Board: • Maternity and Perinatal Incentive Scheme (MPIS) – risks of non-compliance. • The Fractured Neck of Femur concerns. • The findings from the GMC survey. • Progress in relation to the Hospital@Home programme. • The impact from the Building Safety Regulations. • The positive assurance provided by the Service Group Assurance report. • The positive assurance in relation to the Patient Safety Board report.
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 25 SEPTEMBER 2024

1. PURPOSE

1.1. The report sets out the items discussed at the formal meeting held on 25 September 2024, along with the assurance received by the Committee and any areas of concern identified. The meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

MHRA Bed Rails Alert

2.1. The Committee received an update on the progress made actioning the alert and noted that all but one of the actions had been completed. The outstanding action related to a risk assessment, particularly linked to adult social care, and the Committee noted that progress will be followed up with the ICB.

Board Assurance Framework

2.2. The Committee received the Board Assurance Framework and noted that, due to timing issues, a detailed discussion had taken place at the September 2024 Board meeting.

2.3. The Committee noted the following high level risks: ongoing pressures within primary care; increasing ED demand; workforce shortages within primary care; and the number of patients with a length of stay greater than 21 days due to insufficient intermediate care capacity.

2.4. The Committee received an update on the Hospital@Home programme and noted that good progress was being made but that only approximately 50% of capacity was being used. The number of referrals into the programme will need to be increased and this will be a key area of focus in discussions with service groups. It was further noted that a new Care Co-ordination Hub will come on stream in pilot form in the next few weeks and it was expected that the hub will result in a reduction in the number of ambulances conveyances to hospital.

Corporate Risk Register

2.5. The Committee received the up-to-date combined Corporate Risk Register report and noted that there were currently 27 corporate risks on the risk registers of which six scored 20 or above. The Committee noted the details of these risks and noted that no new risks had been added to the register and that there had not been an increase in risk ratings.

2.6. The Committee noted that nine out of the 14 risks allocated to the Committee were outside of their risk appetite levels.

2.7. The Committee discussed the emerging risks: the impact of the new Buildings Safety Act; the transfer of Ordercomms to the ICE digital solution and the implementation of the ICE digital solution.

2.8. The Committee further received an update on the progress made in relation to the risk management training proposals and noted that a survey of those staff who have already completed the level 1 training will be undertaken to check whether this training meets the deliverables of mandatory training. The Committee further noted that the level 2 training was being finalised for uploading onto the training platform LEAP.

Quality and Performance Exception Report

2.9. The Committee received the report and discussed the following areas: Fractured Neck of Femur Mortality Rate in YDH; GMC trainee survey; Hospital@Home; Paediatrics at YDH; multi-disciplinary team working; critical care cover; and the Patient Safety Board.

2.10. The Committee noted: the details of the concerns; the positive progress made in relation to MDT working, critical care cover, and the Patient Safety Board; and the progress made in relation to the GMC trainee survey actions. The Committee noted that progress in relation to Hospital@Home and Paediatrics at YDH was slower than expected and noted the reasons and actions being taken.

2.11. The Committee particularly discussed the Fractured Neck of Femur Mortality Rate in YDH concerns and noted the improvements required as requested by the Royal College. The Committee noted that the trust was achieving or over-achieving on eight quality indicators but that the accrued mortality rate had increased resulting in the trust being a data outlier compared to other organisations. The Committee noted the areas of improvement, the actions already taken and further noted that a robust action plan had been developed. The Committee however recognised the need to balance the actions with the reality of what can be done with immediate effect within current resources.

Governance Support Summary

2.12. The Committee received feedback from the Quality Assurance Group and Data Review Group meetings. In relation to the Quality Assurance Group, the Committee noted the discussion in relation to: the control of contractors; the topic role support; and the policy and procedural document management. In relation to the Data Review Group, the Committee noted the discussion in relation to the hip fracture database; the findings from the national dementia audit; and the findings from the national paediatric diabetes audit.

2.13. The Committee further noted: the additional pressures on workloads due to the volume of national audits and the need to build this into service group governance processes; and the development of guidance for governance at

service level. The Committee agreed that the guidance for service group governance was a helpful and important document for the Committee as it provided a framework to challenge service group assurance reports in a robust way.

Patient Safety Board Report (PSB)

2.14. The Committee received a report on the work of the Patient Safety Board and noted the refresh of the PSB and the focus of its Terms of Reference on understanding the patient safety challenges.

2.15. The Committee noted that the PSB recommends that updates on the following topics are presented to the Board: progress on the National Safety Strategy and Patient Safety Incident Response Framework (PSIRF) learning responses and themes.

2.16. The Committee discussed the report and noted: that the Committee will look at safety as a specific topic alongside regular PSB progress reports; that the report highlighted the whole patient safety agenda and that the PSB was bringing all the different safety aspects under one umbrella; the request for a patient experience representative to be included on the membership of the PSB.

2.17. The Committee highlighted the need to ensure that safety related issues, which were already overseen by the Committee, were raised at the PSB to improve visibility of the issues and more oversight of actions required across the organisation. The Committee identified a role for the Committee in terms of monitoring the implementation and embedding of PSIRF and noted that the PSIRF structures had been put in place with devolved responsibility to be passed to the service groups to allow them to embed the practice in business as usual.

Learning from Deaths Report – Q1 2024/25

2.18. The Committee received the report and noted that the report had already been discussed at the recent Board meeting. The Committee noted the lessons learned from deaths, data, and from details. The Committee noted that 98% of all deaths were now reviewed by the Medical Examiner and that a review of all deaths following a fractured neck of femur had taken place by the Medical Examiner and that no common themes had been identified.

2.19. The Committee noted that a response to the Regulation 28 Preventing Future Deaths had been submitted.

Service Group Assurance Report – Medical Care Services

2.20. The Committee received the assurance report from the medical care service group and noted the key highlights from the report, including: the significant improvements in the service group's governance arrangements; the robust plans across the specialty triumvirates to raise the profile and expectations of governance; the focus and improvement in mandatory training compliance; the significant improvements to the Acute Medical Unit as evidenced by the

findings of the GMC trainee survey; the positive impact of the focus on “right patient, in the right bed under the care of the right specialty” on length of stay; the decrease in incidents and complaints following the implementation of phase 1 of the bed remodelling at YDH.

2.21. The Committee received an update on the position in relation to policies and noted: that some of the policies had been transitioned onto Radar; the process for reviewing the overall policy position; the improvement in the review of policies and the ongoing focus on prioritising out of date policies; the learning from the Musgrove Park Hospital Emergency Department’s (ED) policy transfer to try to align the YDH and ED policy systems.

2.22. The Committee received an update on bank and agency spend and noted the improvements made; the improved position in relation to medical staffing; the progress made in the review of the nursing roster to support wellbeing and achieve sound financial grip and control.

2.23. The Committee received an update in relation to the progress made in responding to complaints and training and noted: the number of members of the senior leadership having attended the complaints resolution and meditation sessions; the increased confidence of the team responding to formal complaints; the work with the patient experience team to improve responsiveness and the learning identified.

2.24. The Committee queried the group’s experience in terms of engagement of the teams and the impact of the implementation of PSIRF. The Committee noted: the significant work required to implement the PSIRF; the completion of the PSIRF training by some matrons, ward leaders and service managers; the challenges implementing PSIRF; the challenges implementing the devolved governance processes and the support provided by the governance support team.

2.25. The Committee acknowledged the significant improvements relating to the GMC trainee survey and complimented the team on this achievement.

Simply Serve Limited (SSL) – Assurance Report

2.26. The Committee received the assurance report and noted the key highlights from the report and in particular: the appointment of Dave Shire as joint Director of Estates and Facilities across SSL and the trust to ensure strategic oversight of estates and facilities; the British Assessment Bureau surveillance audit scheduled for November 2024; the audit programme put in place to monitor the variety of aspects relating to the quality management and environmental standards; the progress made in relation to the implementation of the SSL governance arrangements and the subsidiary governance audit to be carried out in 2025/26.

2.27. The Committee noted the challenges, including: the introduction of the Building Safety Regulations (BSR) and its significant impact on the delivery of capital projects and/or works at Yeovil Hospital due to its classification as a High Risk

Building; the impact on the backlog maintenance programme and the delivery of major capital developments; the impact of the significant amount of capital works on SSL colleagues due to the ability to support the projects as well as maintain business as usual; and recruitment and retention – retention rates had improved possibly as a result of the pay harmonisation.

2.28. The Committee further noted the findings from the audit carried out by the Devon and Somerset, Fire and Rescue Services on the Women' Hospital and Maternity Unit (WH&MU) at Yeovil Hospital. The Committee particularly noted: the risk areas on the building fire compartmentation layout and material structure; and the focus on Level 3 Labour Ward Theatre in view of the increased ignition source risk identified. The Committee noted that an action plan to address the risks identified was being developed alongside the investment requirements.

Maternity and Perinatal Incentive Scheme (MPIS) Year 6

2.29. The Committee received the quarterly maternity and neonatal safety and quality report and noted: the position in relation to the ability to declare compliance with:

- Safety action 4 (effective clinical workforce planning) - the neonatal service not meeting all British Association of Perinatal Medicine (BAPM) standards for junior medical staffing. The Committee noted the progress made in terms of the 2023 action plan and the approval of the updated action plan for 2024/25.

- Safety action 6 (Saving Babies Lives Care Bundle) – progress was on track to achieve compliance of 73% by October 2024.

- Safety action 9. The Committee noted that a newly established "triangulation" meeting where all data and intelligence relating to experience and outcomes is reviewed by the multi disciplinary team and other key stakeholders has begun to identify trends and themes on which the service can develop action plans or quality improvement projects.

Maternity and Neonatal Action Group (MNAG)

2.30. The Committee received an update on the work of the MNAG and noted the significant change to the frequency of meetings and focus as the service and Service Group governance structures have become clearer. The Committee noted that the service group has taken ownership of the agenda and that the key focus will remain on the Care Quality Commission (CQC) action plan.

2.31. The Committee noted the focus of the recent meeting on Day Surgery and Room 9 procedure at MPH and noted that the new procedure room had been completed and that the standard operating procedure was being updated to reflect the new arrangements. The Committee further noted the discussion in

relation to MDT working at YDH and the development of a detailed risk assessment.

Care Quality Commission Action Plan

2.32. The Committee received the updated action plan and agreed that the action plan provided assurance that the review process was underway and that appropriate support was in place to consider the evidence required to demonstrate delivery of the improvements made.

2.33. The Committee noted that further discussions will focus on the “should do” actions, several of which are already being implemented, and on the review of the available evidence.

3. AREAS OF CONCERN OR FOLLOW UP

Quality of Ware Care

3.1. The Committee noted that the Ward Accreditation Programme will be launched in the Autumn and that a progress report will be presented to the Committee in Spring 2025.

Quality and Performance Exception Report

3.2. The Committee agreed to schedule a deep dive session at a future meeting.

Maternity and Perinatal Incentive Scheme (MPIS) Year 6

3.3. The Committee discussed progress in relation to Safety Action 8 (training plans for maternity specific multi professional training) and noted: the challenge to achieve compliance with Newborn Basic Life Support training, predominantly across neonatal, medical and nursing staff. The Committee noted that a detailed action plan to address compliance in each staff group and to mitigate slippage will be developed and will be provided to the next 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 and Perinatal Incentive Scheme (MPIS) – risks of non-compliance.
- The Fractured Neck of Femur concerns.
- The findings from the GMC survey.
- Progress in relation to the Hospital@Home programme.

- The impact from the Building Safety Regulations.
- The positive assurance provided by the Service Group Assurance report.
- The positive assurance in relation to the Patient Safety Board report.

5. BOARD ASSURANCE FRAMEWORK (BAF)

5.1 The Committee agreed that it had received both positive and negative assurance for the various objectives that this Committee is responsible for, including the GMC survey; the Royal College Fractured Neck of Femur letter and the action plan that has been drafted to address this; and the Maternity and Perinatal Incentive Scheme (MPIS).

5.2 The Committee agreed that it had received positive assurance in terms of the development of the Patient Safety Board.

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

Jan Hull
CHAIRMAN OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 4 October 2024
SPONSORING EXEC:	Peter Lewis, Chief Executive
REPORT BY:	Phil Brice, Director of Quality Assurance and Involvement
PRESENTED BY:	Inga Kennedy, Chairman of the Quality and Governance Assurance Committee
DATE:	5 November 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 details of the annual reports discussed at the Quality and Governance Assurance Committee meeting held on 4 October 2024. The Committee received assurance in relation to: • Safeguarding Adults • Safeguarding Unborn Babies and Children • Emergency Planning, Response and Resilience (EPRR) • Patient Experience (including Complaints and PALS) • Infection Prevention and Control • Information Governance • Health and Safety The Committee acknowledged the excellent work over the last 12 months highlighted in all of the reports. The reports reflect a year of strong consolidation post-merger, with all the central teams fully integrated. However, not all of the systems, policies and processes are yet at that point. The demands on the relatively small central teams were significant but the devolved model of governance also had significant impacts for operational services and Service Groups, which were new to many and still in development.

	These aspects need further review in the coming year to ensure we have the right model and balance. Other clear themes emerging from the reports were the need for further improvements to the consistency of approach across the different parts of the organisation; the continued impact and risk of multiple digital systems; and the need to improve patient and carer engagement in our governance processes. Overall, the annual reports demonstrated high levels of assurance for the Trust across these key statutory and regulatory areas which we can provide to the Trust Board in the form of this summary report. The annual reports will be published on the Trust's public website for people to access.
Recommendation	The Board is asked to note the assurances received, the issues discussed and recognise the positive achievements reflected in these reports.

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

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

Equality and Inclusion

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING

ANNUAL REPORTS – 2023/24

1. EXECUTIVE SUMMARY

1.1 The report sets out a summary of discussions relating to the following annual reports which were considered by the Quality and Governance Assurance Committee at a meeting held on 4 October 2024, in line with the delegated authority from the Trust Board:

- Safeguarding Adults
- Safeguarding Children
- Emergency Planning, Response and Resilience (EPRR)
- Patient Experience (including Complaints and PALS
- Infection Prevention and Control
- Information Governance
- Health and Safety

1.2 In its review, the Committee acknowledged the excellent work over the last 12 months highlighted in all of the reports. The reports reflect a year of strong consolidation post-merger, with all the central teams fully integrated – but not all of the systems, policies and processes are yet at that point. The demands on the relatively small central teams were significant but the devolved model of governance also had significant impacts for operational services and Service Groups, which were new to many and still in development. These aspects need further review in the coming year to ensure we have the right model and balance.

1.3 However, the ability to drive quality improvement despite this capacity issue is evident in all the reports and to be commended.

1.4 Other clear themes emerging from the reports were the need for further improvements to the consistency of approach across the different parts of the organization; the continued impact and risk of multiple digital systems; and the need to improve patient and carer engagement in our governance processes.

1.5 Overall, the annual reports demonstrated high levels of assurance for the Trust across these key statutory and regulatory areas which we can provide to the Trust Board in the form of this summary report. The annual reports will be published on the Trust's public website for people to access.

1.6 The Board is asked to note the Committee's report and receive assurance of the levels of compliance and delivery demonstrated by the annual reports.

2. SAFEGUARDING ADULTS 2023/24 PRESENTED BY HEATHER SPARKS, NAMED PROFESSIONAL SAFEGUARDING ADULTS

2.1 The report provided the Committee with both assurance and evidence that Somerset NHS Foundation Trust fulfilled its statutory responsibilities to adults at risk of abuse, set against the guidance within the Care and Support Statutory Guidance 2020.

2.2 The areas of compliance covered in the report on which assurance was given included:

- Safeguarding Adults – the Care Act 2014
- Mental Capacity Act (MCA) 2005 and Codes of Practice
- Deprivation of Liberty Safeguards (DoLS) and Code of Practice and preparation for the Liberty Protection Safeguards
- PREVENT – section 26 of the Counter Terrorism and Security Act 2015
- Domestic Abuse Act 2021
- Domestic Violence Crime and Victims Act (2004(- Part 1(9)
- Equality Act (2010)
- Human Rights Act 1998
- Modern Slavery Act 2015

2.3 The Committee particularly noted:

- Due to the increasing numbers of contacts received into the Single Point of Contact (SPOC) year on year (up by 45%), the Safeguarding Advisory Service (SAS) had introduced changes to their processes and on 23 August 2023 the new SAS Clinic went live. The service is available Monday / Wednesday / Thursday and but still operates a telephone and email single point of contact. This is allowing the service to provide a timely, responsive service.
- The Safeguarding Adults audit undertaken in March 2024 focused on the following areas:

- Safeguarding referral process
- Raising concerns and referrals
- Making safeguarding personal.

All clinical objectives were met to an acceptable standard and an action plan implemented to improve practice in areas where the adult experience of the safeguarding referral process could be enhanced.

- That safeguarding adults level 3 training compliance remained challenging. Compliance for Level 3 training was at 77% at year end, which is an increase on the previous financial year which stood at 74.8%. The Committee noted that compliance rates were impacted by the merger and a consequent remapping exercise but, as at August 2025, compliance for Level 3 stood at 85.3%. Level 3 training will be extended to all Band 6 nurses and allied health professionals in 2025. This will impact the compliance rates again for a period of time (up to 12 months) but will significantly improve the safeguarding awareness and support to our population.

- Whilst not yet mandatory, from April 2023 Domestic Abuse basic awareness training has been woven into Safeguarding Adults mandatory training via the local-processes e-learning and also within Safeguarding Adults and Safeguarding Children level 3 training. This ensures all staff will receive some level of Domestic Abuse awareness training. The Committee discussed the benefits of making this mandatory which will be considered further by the Chief Nurse.

- The number of Domestic Homicide Reviews (DHRs) and Safeguarding Adult Reviews (SARs) have increased in number over the last year. A thematic review regarding self-neglect was completed and six cases were identified as having been known to SFT. From this review, targeted work was undertaken, and a self-neglect workshop was developed for staff to attend. Self-neglect is also included as part of the level 3 training.

- During the last financial year, SFT received a total of 16 Section 42 enquiries. Emerging themes included increasing concerns about the neglect of patients under our care, including poor discharge e.g., where patients were discharged to unsafe environments; and a lack of legal literacy regarding use of mental capacity assessment (Mental Capacity Act). To address these concerns, all section 42 outcome reports are now being shared with the relevant Associate Director of Patient Care (ADPCs) for them to take ownership with targeted work and actions to address risks and concerns. Section 42 workshops will also be offered to all wards and teams.

- Targeted work has been planned with mental health services to explore undertaking a review regarding domestic abuse related

suicides and risk assessment. This will be a stepped approach including audit of patient suicides, whether DA was indicated, plus co-existing factors of substance/alcohol misuse and child safeguarding concerns.

- A training needs analysis has been undertaken regarding transitional safeguarding requirements and this will be developed in 2025.

- The capacity within the central safeguarding service was limited which puts pressure on operational services to develop their skills and practice to support the requirements of the safeguarding agenda. A restructure of the service has been undertaken to provide additional support but there remains a risk, particularly as activity increases across a complex organisation. The Chief Nurse confirmed that work was underway to consider and address this risk.

- Responsibilities for multi-agency public protection arrangements (MAPPA) had been temporarily moved into corporate services, while the safeguarding restructure was undertaken. It was not therefore covered in this report but was overseen by the Safeguarding Committee. It was agreed that separate assurance on these arrangements would be provided.

2.4 The Committee agreed that the report provided significant assurance and approved the report.

3. SAFEGUARDING UNBORN BABIES AND CHILDREN - PRESENTED BY NICOLE MITCHELL, NAMED NURSE FOR SAFEGUARDING CHILDREN

3.1 The report provided the Committee with both assurance and evidence that Somerset NHS Foundation Trust fulfilled its statutory responsibilities to protect children's rights to live in safety, free from abuse and neglect; to protect children from maltreatment in order to prevent the impairment of children's health and development; to work with other organisations to prevent and stop the risks and experience of abuse or neglect. This included working with Somerset Safeguarding Children Partnership.

3.2 The areas of compliance covered in the report on which assurance was given, included:

- The Children Acts 1989 and 2004

- United Nations Convention on the Rights of the Child (UNCRC)

- Every Child Matters (2004 and 2015)

- National Service Framework for Children (2004)

- Working Together to Safeguard Children (2018)
- Intercollegiate Document (2019) Safeguarding Children and Young People: Roles and Competencies for Health Care Staff
- Children and Social Work Act (2017)
- CONTEST – Counter Terrorism Strategy (2018)
- Modern Slavery Act (2015)
- Domestic Abuse Act (2021)
- Domestic abuse Statutory Guidance (July 2022)

3.3 This included compliance with the Safeguarding and Protection of unborn Babies and Children Policy; the Safeguarding Clinical Supervision Policy; the Court Procedures for Safeguarding Unborn Babies and Children Policy; Safeguarding Children and Young People from Child Exploitation Policy.

3.4 The Committee particularly noted:

- The increase in referrals to just under 700 contacts and the challenges faced by the team managing this increase.
- All Safeguarding Policies have now been integrated and reviewed and are in line with national and local guidance including Working Together. The new intercollegiate document for Safeguarding Children will be amalgamated with Children Looked After and is due to be published at the end of 2024. This will support improvements in training, supervision, and roles and responsibilities.
- During the last reporting period seven audits had been completed providing assurance that safeguarding themes raised through serious or unexplained incidents are acted upon.
- One of the policies audited was the Safeguarding Protection of Children policy and it was audited in terms of the Child Not Brought (CNB) criteria. This was the first cross-Trust audit following the merger between SFT and YDH. The audit was undertaken over a three-month period (January – March 2023) in response to development of the Trust-wide Non-Attendance (Child not Brought) No Response SOP, learning from significant events when children were not brought to appointments. In addition, the audit contributed to an understanding of our current practice as a merged trust and the lived experience of children with health needs who are not brought to appointments. The findings identified that there

appeared to be limited understanding currently of CNB and actions required by Trust staff. The main area for improvement when a Child is not brought is the need for accurate, robust and contemporaneous documentation. The study sample was chosen randomly, however, Children Looked After (CLA) were over 13 times more likely not to be brought to appointments. The Committee queried if there had been a deep dive to see why this happens and if there was anything we could do about it as this is a health inequality and whether postcodes had been reviewed for other children from deprived families. NM responded that this level of detail had not been reviewed in the demographics but discussions had taken place across partnerships to encourage attendance and support the corporate parent to bring the child to appointments. There is further work to do on this. The CNB position has been shared with the Health and Wellbeing Board and with the Designated Nurse for CLA. The Committee agreed it was important to question ourselves as to whether we are addressing the health inequalities in a thorough enough way particularly in an area where we do feel there is risk in children slipping through the net.

- The Safeguarding Advisory Service, highlighted in the Safeguarding Adults report, was also providing a robust and sustainable offer from early help to child protection including when legal processes are enacted.

- One of the biggest challenges and concerns for the service is the multiple recording systems and lack of interoperability between them. This means that, unless the child is already known to Safeguarding Services and has a protection plan in place, there is additional work required to make sure that children are not missed. This will be addressed once a new Electronic Health Record (EHR) is in place but in the interim teams are working to find a way to use all of the multiple systems safely. Work is taking place at present to ensure colleagues use SIDeR+ transform family view and it is hoped that this can be embedded in RiO, which is the main system used by safeguarding to record contacts. The issue of multiple recording systems is not a new risk and has been with us for 10 - 20 years but we are now seeing our digital technology falling behind the benefits of integration. It is likely to be 2028 when the new EHR will be effectively operational but we need to find a solution in the interim to ensure alerts are seen and with some targeted effort we can do this.

- NM has been working with the Improvement Team regarding compliance with Safeguarding Supervision to develop a measure for improvement and reducing health inequalities. A Silver Quality Improvement Programme and a BDO safeguarding supervision audit is being considered to help areas for improvement.

- Women Requiring Extra Nurturing (WREN) plans are not always being followed and there is a lack of pre-birth communication

across the wider health system. SFT's Named Midwife is working closely with the community midwives on this as they need to share their concerns across teams in a better way. IK indicated that she would like to see this added to the Maternity Committee agenda so it can be monitored. It should also be raised at the LMNS Board as there needs to be system approach to this.

- Over the coming year, the service will continue to raise the profile of the Safeguarding Advisory Service, including Safeguarding Supervision. This is important following the findings of the JTAI inspection around serious youth violence in May 2024 to ensure colleagues know how to access the safeguarding service and respond to and escalate safeguarding concerns.

- In terms of triangulating information around safeguarding and risks to children, all concerns are escalated to the Operational and Service Managers in the first instance as they need to take ownership of any issues. All concerns are also raised with the Safeguarding Committee on a quarterly basis and the Director of Safeguarding will escalate any concerns to the Chief Nurse and wider Exec Team.

3.5 The Committee noted that an annual report in respect of Children Looked After (CLA) would be presented to the Safeguarding Committee later in October. Although there is not a statutory requirement to report this to the Board, the Committee will review the content on behalf of the Board and present assurance in a similar way to these reports.

3.6 The Committee agreed that the report provided significant assurance and approved the report.

4. EMERGENCY PLANNING RESILIENCE AND RESPONSE (EPRR) – PRESENTED BY ANGELA TURNER, HEAD OF RESILIENCE

4.1 The report provided the Committee with assurance that the trust was fulfilling its statutory responsibilities with regard to emergency planning and civil contingencies, and that the trust is fully compliant with the NHSE core standards for EPRR.

4.2 The Committee noted in particular:

- The completion of the annual NHSE EPRR Annual Assurance Self-Assessment against the national EPRR core standards and the submission of the self-assessment to the Somerset Integrated Care Board (ICB). The self-assessment had been agreed by the ICB and showed full compliance against all core standards. The Committee agreed that this was an excellent achievement.

- This year's deep dive assessment was focused on cyber security and IT incident related responses. The Trust's self-assessment for the deep dive also achieved full compliance. Both of these assessments were subject to moderation by the ICB and NHS England which confirmed full compliance.

- There has been a change in approach of auditing Chemical, Biological, Radiological and Nuclear (CBRN) planning and contingency arrangements. A 'capability assessment' was conducted at our two acute hospital sites, carried out by South Western Ambulance Service NHS Foundation Trust (SWAST), with representation from NHS England (NHSE) attending the YDH visit in late July 2024. This assessment is made against the national CBRN response standards which remain unchanged from previous years. The Trust has received its reports from these visits and has been confirmed as fully compliant across both sites.

- There had been an extensive programme of live and tabletop exercises of plans across the organisation, all of which have identified learning which has been shared across the Trust.

- An internal audit relating to EPRR system working in Somerset was also carried out in the year and this is the first to be completed collaboratively with Somerset ICB which provided good assurance of the system level responses.

- The Committee discussed the challenges of operational engagement with due to high operational pressures. The Committee agreed that this was an area to consider further, particularly across an organisation such as ours that has changed enormously and is still changing and how assured we are that core business continuity is in place and how we measure it.

- The number of participants engaging in exercises has been significant with colleagues attending from senior clinical levels and operational as well. One area to consider further is the general business continuity and what this looks like

- Other challenges include the ongoing risk relating to another emerging pandemic, cyber and digital resilience, the UK economic situation and global political unrest.

- There is a particular challenge to communicate learning from incidents across a large organisation with a disparate geographical spread such as SFT.

4.3 The Committee agreed that the report provided significant assurance and approved the report.

5. PATIENT EXPERIENCE AND ENGAGEMENT - PRESENTED BY EMMA DAVEY, DIRECTOR OF PATIENT EXPERIENCE AND ENGAGEMENT, CAROLINE WALKER, HEAD OF PATIENT EXPERIENCE AND KRYSTLE PARDON, HEAD OF PATIENT ENGAGEMENT

5.1 The report set out an overview of the area of work for 2023/24 and Trust's activity in relation to patient experience, PALS and complaints and the opportunities for learning and service improvement.

5.2 The Committee noted that 2023/24 had been another busy year for the patient experience, engagement, and involvement team with significant changes within the service which has gone through a full consultation and restructure programme.

5.3 The Committee noted in particular:

- The number of formal complaints received was 314. This represented a has decreased by of 33% from last year and the team are looking at whether this is due to the change in population demographic, and again, whether the service is sufficiently accessible to the public. Going forward the team will collect the demographics of the complainants so the service can be improved accordingly.

- As a Trust we have a 90% target for all formal complaints to be responded to within an agreed timeframe of 40 – 60 days. In 2023/24 only 53% of formal complaints were responded to within this timeframe across the whole Trust. This does vary across Service Groups but there is no individual service that is meeting the 90% target. The Committee agreed that when Service Groups present their assurance reports to the Committee, this would be an area of focus over the next year.

- The total number of PALS enquiries for the year was 4317. This had reduced over the last 12 months by 4% (and 19% since 2021). The raw data has been reviewed to try to understand the reasons for this and consider any actions required to address this during 2024/25. The timeframe for responses to PALS enquires is 90% of concerns to be responded to within 10 working days. In 2023/24, 73% were responded to within this timeframe, and the team are working to improve this.

- Care Opinion has been reintroduced. This platform enables a conversation and engagement with the person sharing their story and allows individuals teams to provide a response and an update when a change has happened as a result of the feedback received. The report included examples of this feedback and responses.

- Future aims and next steps for the team include the completion of an organisational diagnostic regarding the team using NHSI NHSE Patient Framework alongside the NHS complaints standards. The framework allows the team to assess itself against other organisations which will provide a baseline for developing an improvement strategy.

- The central team works collaboratively with the Governance Co-ordinators in each of the individual Service Groups to develop a culture that use concerns positively and does not see the receipt and response to complaints as a wholly negative process.

- There was positive assurance to be gained particularly in the reduction in the requirement for second letters in terms of the quality of responses. When reviewing the cases going to the Ombudsman, of the 25 referred only 2 cases were upheld which also recognises the quality of the responses being sent.

5.4 The Committee agreed that the report provided good assurance and approved the report.

6. INFECTION PREVENTION AND CONTROL –PRESENTED BY VAL YICK, LEAD NURSE FOR INFECTION PREVENTION AND CONTROL, AND ALISON WOOTTON, DEPUTY CHIEF NURSE

8.1 The Committee received the report for Somerset NHS Foundation Trust which provided an overview of the infection prevention and control activity during the year and assurance on investigation and learning from outbreaks.

8.2 The Committee noted in particular:

- Completion of integration of the teams under one single annual programme of work. There have been some significant challenges managing a joint team across the two acute sites due to their difference in size and workload.

- The alignment of the Surgical Site Surveillance across both acute sites. This is the surveillance of all elective surgical site procedures with orthopaedics as a focus. This provides us with a good understanding of the position we are in, in terms of post-operative infections in our elective orthopaedic cases.

- There are two quite higher risks in IPC related to blood stream infections, firstly Staph Aureus MSSA links linked to peripheral cannulas, and secondly, gram-negative blood stream infections linked to urinary catheters. Following a number of improvement programmes, MSSA blood stream infections have seen a reduction from 29% to 23% linked to these devices and the

changes in place have helped identify where we need to focus on improvements. There has been a dramatic reduction in the number of gram-negative blood stream infections linked to urinary catheters which has reduced from 32% to 14.5%.

- There has been a high level of sickness within the IPC team and this resulted in a period of where up to 50% of the team being were absent at a single time on the MPH site. This was also in the middle of a challenging winter period which meant that priorities had to change to focus on the clinical management of infection control and specifically the outbreaks. This meant that the work to align all policies and guidelines had to take a back seat during this period and the team are still playing catch up from this period, but although plans are in place to achieve this.

- There has been a significant outbreak of carbapenemase-producing organisms (CPO) affecting the YDH site. This outbreak began in January 2022 and up to the end of March 2024 has affected a total 37 patients. The source of the outbreak was identified as environmental with a reservoir of bacteria in the drains. The Trust has received support from UKHSA in managing the outbreak. Initial work was successful and the outbreak was closed in November 2023 as no new cases had occurred since August. However, the outbreak was subsequently opened again in January 2024 when new cases were identified. The conclusion was that bacteria had repopulated the drainage system and contamination of the environment was occurring. Chemical disinfection has been restarted alongside deep cleaning. UKHSA have continued to support the Trust including reviewing strategies employed by other organisations nationwide during similar outbreaks. It is important to note that this is a national issue and not unique to the YDH site.

- Respiratory viruses have remained a challenge and during the period of the report the Trust was in a better position than the previous winter. However, on reviewing the data the Trust dealt with over 400 cases of influenza, over 400 cases of RSV and over 2000 cases of Covid-19, w. With significant peaks in September 2023 which has not been replicated in 2024. There were more than 156 outbreaks of Covid-19 alone which was a significant amount to be managing.

- At present the role of Decontamination Lead is held by VY in addition to being the IPC Lead. This is not ideal and is a challenge in itself. The Trust is widespread with areas of local and centralised decontamination. An external assurance report from the Authorising Engineer for Decontamination (AED) has provided more positive assurance as to the better position we are in, but the role of the Decontamination lead needs to be addressed urgently.

- Future aims will include a focus on sustainability and reduction of waste and IPC is represented on the Green Care Action Group and are supporting theatres to introduce a move away from disposable equipment, (such as the introduction of theatre caps that are washable and can be reused).

- We have had a number of different issues related to this and with current site development and the issues with signing off some of the work. The Committee sought assurance around learning from past incidents and noted that the Sterile Services Department (SSD) at MPH was opened 18 months ago and we have had to learn significant lessons of from how that water system was brought into operation. There is a document for sign off of new builds in terms of design and commissioning of services related to ventilation and water which has been built into practice.

8.3 The Committee recognised the continued pressure on the team; the excellent levels of assurance received by the reports; and the ongoing need to adapt to changes in guidance and working closely with clinical and operational colleagues to explain the changes and provide a level of assurance.

8.4 The Committee agreed that the report provided significant assurance and approved the report.

7. INFORMATION GOVERNANCE – PRESENTED BY LOUISE COPPIN, HEAD OF INFORMATION GOVERNANCE AND DATA PROTECTION OFFICER

7.1 The report provided the Committee with assurance that Somerset NHS Foundation Trust is fulfilling its statutory responsibilities with regard to the Data Protection Act 2018 and the Freedom of Information Act 2000.

7.2 The Committee noted in particular:

- That the final assessment of the Data Security and Protection toolkit for the trust was submitted in June 2024 with a level of Standards Exceeded, the highest level of attainment.

- The internal audit on the Toolkit was undertaken in February 2024 and that the two recommendations relating to available evidence were corrected prior to the Toolkit submission. The internal audit had rated the quality of the Trust's Toolkit return as high and in line with the requirements of the independent assessment framework.

- One of the areas of concern for last the previous year was had been not having an up to date and accurate information asset register. A working group was put together and working with the projects team and the application development team to build a new electronic

system which was successfully implemented in March 2024. The Trust now has an accurate picture of its almost 500 assets, all with information asset owners, contract and procurement information, and online training has been implemented for the information asset owners so they can be sure of their responsibilities.

- The main area of concern is compliance with data subject access requests as this year the Trust is likely to receive over 4,000 data requests which is a 46% increase on the number of requests received since 2020. Due to a significant increase in the number of requests and ongoing staffing issues, there is a backlog of data access requests causing problems with compliance requirement of one calendar month. The Information Commissioner's Office (ICO) is aware of our backlog and our continued efforts to rectify this issue and are happy with the actions we have taken to date.

- For the coming year, the Data Security Protection Toolkit is due to change for the next submission in June 2025 and will be more focused on the Cyber Assessment Framework. This is based on 5 objectives of managing risk, protection against cyber attacks and data breaches, detecting cyber events, minimising the impact of incidents and using and sharing information appropriately. There will only be two levels of compliance, and we are currently working towards 'Standards Met' which is the highest level of achievement. We are currently assessing ourselves as achieving 'Standards Met'.

7.3 The Committee agreed that the report provided significant assurance and approved the report.

8. HEALTH AND SAFETY – PRESENTED BY SAMANTHA HANN, HEAD OF HEALTH, SAFETY AND RISK

8.1 The report provided the Committee with continued assurance that the processes and systems that are in place for managing health and safety within Somerset NHS Foundation Trust remain effective and are compliant with the Health and Safety at Work etc. Act 1974 and other legislation protecting colleagues, patients and visitors at our sites.

8.2 Due to timings, this report was being presented to the Committee in advance of it being considered by the Health and Safety Committee. Any changes, following discussion at the Health and Safety Committee in October would be shared with the Committee and included in the final published version.

8.3 The Committee noted in particular:

- The continued work to integrate teams and systems to support health and safety, including an active Health and Safety Committee, the Safety Environmental Advisors Group (SEAG) and almost all

processes for health and safety areas are aligned now including RIDDOR and DSE and most recently COSHH. Support to Service Groups and subsidiaries has developed and reporting to the Health and Safety Committee is now much more comprehensive in terms of coverage and data across the Trust.

- Training compliance remains over 95% for health and safety training which is excellent. Compliance at the end of 2023/24 was 95.6%. The latest compliance data for 2024/25 has continued to improve and currently sits at 96.9%.

- Work is currently underway to align the processes for COSHH from the legacy organisations, develop and finalise the integrated COSHH policy and integrate the training programme.

- There are a number of H&S policies that have not yet been integrated following merger, particularly across estates and facilities. There will be a focus in 2024/25 on reviewing the health and safety processes within the organisation across the breadth of Health and Safety topics and to ensure there are effective policy monitoring arrangements in place. This includes a review of the health and safety topic leads and the reporting of the topics to the Quality Assurance Group.

- Local health and safety and building manager guidance has been reviewed and developed and further support is being put in place to help nominated individuals in those roles.

- The appointment of a new occupational health provider presents an opportunity to improve triangulation of data for health surveillance and support for colleagues to make their working environments and conditions safer.

- There is a challenge regarding resource and capacity within the central team, aligned with the different structures and expectations of the legacy organisations.

- Availability of trade union health and safety representatives has been a challenge but the existing reps are committed and there are some new reps coming on board.

- It is planned to develop a five-year strategy which will set out the vision for health and safety in the trust, defining the process and provision. The team will continue to develop the arrangements within Service Groups, corporate teams and on all our sites to ensure compliance and improve the safety arrangements for our colleagues, visitors and patients.

- Our devolved governance relies on the topic links and reports to support the process. There are gaps in the topic lead structure, as a result of integration, but also leads do not always have a perspective

across the whole organisation. Due to the complexity of the topic lead roles for each subject area, we have multiple or partial topic leads in a number of these. Discussions have been had at QAG as to whether capacity has been taken into account due the complexity of the roles now and the Chief Executive and Exec Team are considering this.

8.4 The Committee agreed that the report provided significant assurance and approved the report.

CHAIR OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Report from the Organ and Tissue Donation Committee
SPONSORING EXEC:	N/A
REPORT BY:	Jan Hull, Non-Executive Director Dr James Sidney, Clinical Lead for Organ Donation
PRESENTED BY:	Jan Hull, Non-Executive Director Dr James Sidney, Clinical Lead for Organ Donation
DATE:	5 November 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 this report is to provide assurance to the Board regarding organ donation performance within the Trust, to confirm the reporting arrangements for the Trust's Organ and Tissue Committee, and more generally to raise awareness and visibility of organ donation activity within the Trust.
Recommendation	The Board is asked to receive the Annual Report for 2023/24 from NHS Blood and Transplant, recognising the Trust's success in facilitating donation and transplantation. The Board is asked to note the future reporting arrangements for the Organ and Tissue Donation Committee. The Board is asked to continue to support the Clinical Leads and the work of the Committee, including efforts to promote the NHSBT Organ Donor Register.

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?
Not considered as part of 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 contents of this report were discussed at the Organ Donation Committee in October 2024.

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

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

SOMERSET NHS FOUNDATION TRUST

REPORT FROM THE ORGAN AND TISSUE DONATION COMMITTEE

1. BACKGROUND AND PURPOSE

1.1 The purpose of this report is to provide assurance to the Board regarding organ donation performance within the Trust, to confirm the reporting arrangements for the Trust's Organ and Tissue Donation Committee, and more generally to raise awareness and visibility of organ donation activity within the Trust.

2. PURPOSE OF THE ORGAN AND TISSUE DONATION COMMITTEE

2.1 All acute trusts are required to establish an Organ and Tissue Donation Committee. The purpose of the Committee is as follows:

- Maximise the overall number of organs donated, through raising awareness amongst staff and providing better support to potential donors and their families
- Influence policy and practice to ensure that organ donation is considered in all appropriate situations, and to identify and resolve any obstacles to this.
- Ensure that a discussion about donation features in all relevant and appropriate end of life care across the Trust, recognising and respecting the wishes of individuals.
- Ensure processes are in place to optimise the condition of donated organs.

3. TERMS OF REFERENCE

3.1 The terms of reference for the SFT Organ and Tissue Donation Committee are in the process of being updated. A key change that has been agreed in principle is that the Committee will in future report to the Quality and Governance Assurance Committee. This will secure closer links to the overarching governance processes across the Trust, and also increase visibility of the Organ Donation Service.

4. CLINICAL LEADERSHIP

4.1 All acute hospitals have a designated Clinical Lead for Organ Donation (CLOD). The CLOD for Musgrove Park is Dr James Sidney, Consultant Anaesthetist, and for Yeovil, Dr Rupak Kundu, Consultant Intensivist, who has recently been appointed to the role.

4.2. The Trust also has a Specialist Nurse for Organ Donation (SNOD), who is employed by NHS Blood and Transplant but embedded in the Trust. The SNODs operate regionally and generally cover a number of hospitals.

5. PERFORMANCE

5.1 Performance reports for organ and tissue donation are produced by NHS Blood and Transplant, on the basis of data collected and reported by the SNOD. The annual letter from the National Director of Organ and Tissue Donation and Transplantation regarding Somerset NHS Foundation Trust's performance for 2023/24 is attached as Appendix 1, and the Trust's Summary Annual Report as Appendix 2.

5.2 Overall the Trust is categorised as an 'Exceptional' performer. The two key criteria are the percentage of potential organ donors referred, and specialist nurse presence in discussions with families of potential donors. During the year 2023/24 no referrals were missed, and the specialist nurse was present in 100% of discussions with families.

6. RECOMMENDATIONS

6.1 The Board is asked to receive the Annual Report for 2023/24 from NHS Blood and Transplant, recognising the Trust's success in facilitating donation and transplantation.

6.2 The Board is asked to note the future reporting arrangements for the Organ and Tissue Donation Committee.

6.3 The Board is asked to continue to support the Clinical Leads and the work of the Committee, including efforts to promote the NHSBT Organ Donor Register.

JAN HULL
NON-EXECUTIVE DIRECTOR

DR JAMES SIDNEY
CLINICAL LEAD FOR ORGAN DONATION

NHS
Blood and Transplant
www.nhsbt.nhs.uk

May 2024

Dear Mr Lewis and Dr Iles,

The number of donors and transplants in the UK have continued to improve and we are returning to pre-pandemic levels. Please accept our recognition and thanks for the effort of your staff.

This letter explains how your Trust contributed to the UKs deceased donation programme.

Organ and tissue donation and transplantation activity - 2023/24

From 14 consented donors, Somerset NHS Foundation Trust facilitated 8 actual solid organ donors resulting in 15 patients receiving a transplant during the time period. Additionally, 16 corneas were received by NHSBT Eye Banks from your Trust.

Quality of care in organ donation - 2023/24

When compared with national data, during the time period your Trust was:

- Exceptional for the referral of potential organ donors
- Exceptional for Specialist Nurse presence when approaching families to discuss organ donation

- Your Trust referred 48 patients to NHSBT's Organ Donation Services Team; no referrals were missed (100% referral rate) and 23 met the referral criteria for inclusion in the UK Potential Donor Audit.
- A Specialist Nurse participated in 16 organ donation discussions with families of eligible donors. There were no occasions when a Specialist Nurse was absent for the donation discussion.
- In South West, 50% of the population have registered an NHSBT Organ Donor Register (ODR) opt in decision. This compares to 42% of the population nationally.

Up to date Trust metrics are always available via our Power BI reports found here:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

What we would like you to do

- Ensure your Trust supports your Organ Donation Committee and Clinical Lead for Organ Donation in promoting best practice as they seek to minimise missed donation opportunities.
- Discuss activity and quality data at the Board with support from your Organ Donation Committee Chair.
- Recognise any successes your Trust has had in facilitating donation or transplantation, especially during the ongoing NHS pressures.
- An opt-in registration on the NHSBT Organ Donor Register results in the highest rates of consent, please support your Organ Donation Committee in their efforts to promote the NHSBT Organ Donor Register where possible.

Deemed Consent Legislation - England

England introduced deemed consent (Max and Keira's Law) in May 2020. In England between 20 May 2020 – 31 March 2024 there were 1812 occasions when consent was deemed from 3215 occasions where deemed consent applied.

Why it matters

In 2023/24, 261 people benefited from a solid organ transplant in the South West. However sadly, 28 people died on the transplant waiting list during this time.

Thank you once again for your vital ongoing support for donation and transplantation.

Yours sincerely,

Anthony Clarkson
Director of Organ and Tissue Donation and Transplantation
NHS Blood and Transplant

Business Disability Forum
Building disability-smart organisations

Positive About Disabled People

Actual and Potential Deceased Organ Donation 1 April 2023 - 31 March 2024

NHS Blood and Transplant

Somerset NHS Foundation Trust

Organ Donation and Transplantation 2030: Meeting the Need

In 2023/24, from 14 consented donors the Trust facilitated 8 actual solid organ donors resulting in 15 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

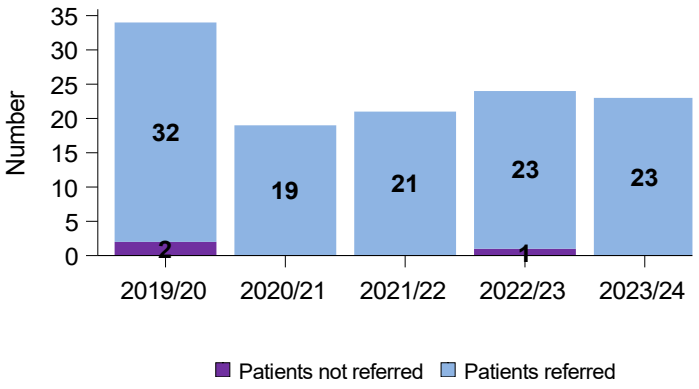
In addition to the 8 proceeding donors there were 6 consented donors that did not proceed.

Best quality of care in organ donation

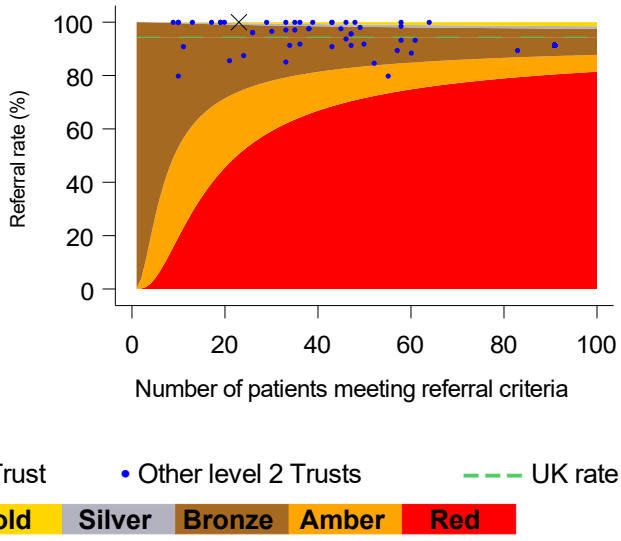
Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart



Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold



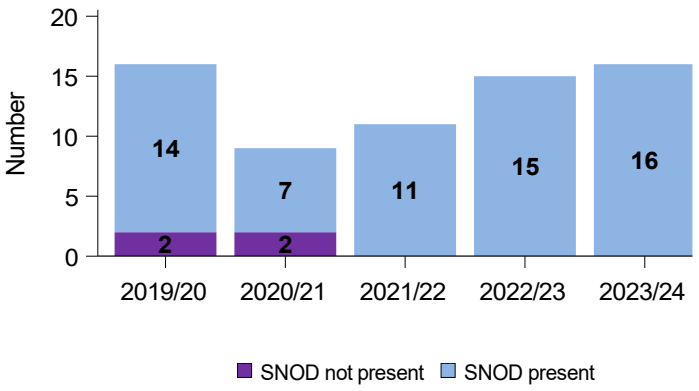
The Trust referred 23 potential organ donors during 2023/24. There were no occasions where potential organ donors were not referred.

When compared with UK performance, the Trust was exceptional (gold) for referral of potential organ donors to NHS Blood and Transplant.

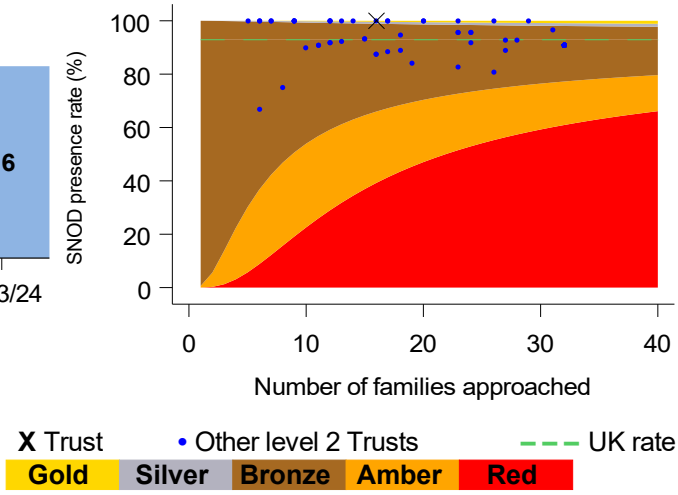
Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart



Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold



A SNOD was present for 16 organ donation discussions with families during 2023/24. There were no occasions where a SNOD was not present.

When compared with UK performance, the Trust was exceptional (gold) for SNOD presence when approaching families to discuss organ donation.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South West*	UK
1 April 2023 - 31 March 2024		
Deceased donors	157	1,510
Transplants from deceased donors	261	3,723
Deaths on the transplant list	28	418
As at 31 March 2024		
Active transplant list	551	7,484
Number of NHS ODR opt-in registrations (% registered)**	2,872,363 (50%)	28,161,705 (42%)
Number of NHS ODR opt-out registrations (% registered)**	118,055 (2%)	2,577,667 (4%)

*Regions are defined using the NHS region definitions
* % registered based on population of 5.71 million, based on ONS 2021 census data

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Trust are shown below, including a UK comparison. Data obtained from the Potential Donor Audit (PDA).

Key numbers, rates and comparison with UK data, 1 April 2023 - 31 March 2024

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	5	2029	19	5331	23	6911
Referred to Organ Donation Service	5	2017	19	4949	23	6522
Referral rate %	G *100%*	*99%*	G *100%*	*93%*	G *100%*	*94%*
Neurological death tested	4	1534				
Testing rate %	B *80%*	*76%*				
Eligible donors[2]	4	1426	14	3635	18	5061
Family approached	4	1259	12	1849	16	3108
Family approached and SNOD present	4	1215	12	1672	16	2887
% of approaches where SNOD present	G *100%*	*97%*	G *100%*	*90%*	G *100%*	*93%*
Consent ascertained	3	858	10	1023	13	1881
Consent rate %	B *75%*	*68%*	S *83%*	*55%*	S *81%*	*61%*
- Expressed opt in	2	533	6	637	8	1170
- Expressed opt in %	*100%*	*95%*	*100%*	*85%*	*100%*	*89%*
- Deemed Consent	0	246	3	323	3	569
- Deemed Consent %	*N/A*	*58%*	*60%*	*47%*	*60%*	*51%*
- Other*	1	78	1	63	2	141
- Other %*	*50%*	*52%*	*100%*	*34%*	*67%*	*42%*
Actual donors (PDA data)	2	788	6	710	8	1499
% of consented donors that became actual donors	*67%*	*92%*	*60%*	*69%*	*62%*	*80%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

For further information, including definitions, see the latest Potential Donor Audit report and up to date metrics via our Power BI reports at:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Learning from Deaths Progress Report
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:	Melanie Iles, Chief Medical Officer
DATE:	5 November 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, managing the deteriorating patient and communication with people who matter continue to be seen. There are several areas where palliation could be improved across the community, mental health and acute settings. • Learning from the ***Detail*** Medical examiners are reviewing 100% of SFT deaths, totalling 552 in Quarter 2, with concerns being cascaded appropriately. The Learning from Deaths team co-ordinate the triage of these so an agreement can be reached on a proportionate response. Responses and action plans are in place to address the fractured neck of femur mortality alert. • Learning from the ***Data*** Our overall Trust Mortality Rate continues to be as expected – SHMI **1.02.**

Recommendation	The Board is asked to discuss this report.

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

☒ Obj 1 Improve health and wellbeing of population
☒ Obj 2 Provide the best care and support to children and adults
☐ Obj 3 Strengthen care and support in local communities
☒ Obj 4 Reduce inequalities
☒ Obj 5 Respond well to complex needs
☒ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☐ Obj 7 Live within our means and use our resources wisely
☒ Obj 8 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 not been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics.

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. Staff are involved in the Learning from Deaths process.

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

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

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

SOMERSET NHS FOUNDATION TRUST

LEARNING FROM DEATHS REPORT – QUARTER 2 2024-2025

1. BACKGROUND AND PURPOSE

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

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

2. UPDATE ON THE MORTALITY REVIEW PROCESS

2.1. The 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, came into force on 9th September 2024. Whilst still in the early stages, the initial feedback is that the new process is working well and appears to be reducing the time taken for our medical staff to complete the death certification process. In anticipation of these changes, there has been a steady rise in referrals from GP's concerning community deaths over the last year. We have likewise seen a corresponding increase in the 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 Mortality Surveillance Group (MSG) met on 11th September 2024. A colleague from Clinical Support and Cancer Services shared a theme that has emerged from recent oncology Mortality and Morbidity meetings around patients who were transferred from one ward to another when known to be extremely unwell or death is imminently expected. There was a helpful discussion around whether this could be considered an unnecessary intervention in line with Treatment Escalation Plans. A colleague from our Neighbourhoods service group shared an update on the review process for deaths at our Community Hospitals. In line with the target set, they are now

managing to review 10-20% of their deaths and are managing to complete these reviews within a month of allocation. Whilst there is still some work to be done around agreeing any specific triggers for review, they have already identified learning from those undertaken and have found the involvement of their Advanced Clinical Practitioners to be the key to this success. Colleagues from the End of Life Service shared an update on long-standing concerns about fast-track funding being declined. A pilot project called CareFFul (Care First Fund Later) has been agreed, which will change the fast-track referral process to facilitate earlier transfer from an acute hospital setting. There will no longer be a wait for a funding decision to be made, under the new process this will be reviewed 6 weeks after discharge if required.

2.3. Learning from Patient Safety Events (LfPSE) was implemented as planned on 1 May 2024 and marks a change to how patient safety events are reported. Analysis of the data suggests that there hasn't been a significant change in the number of incidents reported with a fatal outcome, however, since April 2024, there continues to be a drop in overall reporting. A scoping exercise is underway to try to understand the factors that may be contributing to this issue. Until this is resolved, we are working closely with our Incident and Learning Lead colleagues to ensure that any deaths that relate to a patient safety issue are appropriately responded to. We have some assurance that the Medical Examiner service, with their high standard of scrutiny and robust processes for raising concerns, provides another avenue for such deaths to be flagged.

2.4. On 29 July 2024, Claire Bailey attended a system wide mortality meeting chaired by the ICB. One of the aspirations of the group was to share outcomes from all Regulation 28 Prevention of Future Deaths reports within Somerset. In line with this, we have begun to share the learning from Regulation 28 Reports that have been sent to the trust. A colleague from our Maternity services shared the outcome from the 2020/2021 MBRRACE briefing report. There was an action for the ICB to set up a sub-group tasked with developing a process for capturing information and learning from across the perinatal system. A presentation was delivered by a colleague from the Local Authority about the pan Dorset and Somerset Child Death Overview Panel (CDOP) outlining the process as well as the learning from the 2022/2023 and 2023/2024 reports. It was agreed that there needs to be triangulation of data and information through the system to enable exploration of areas where age relate outliers were noted. In future meetings, we have also been asked to present our Learning from Deaths reports. Following changes to the personnel who support workstreams related to mortality in the ICB, we have offered to share our knowledge around mortality metrics. A session has been arranged with Gary Filer, Quality and Safety Lead Analyst.

2.5. On 26 September 2024, Laura Walker attended the Paediatric Quality Improvement Group where a consistent process for reviewing paediatric deaths across the trust was agreed. All expected and unexpected paediatric deaths will be subject to the Medical Examiner process. In addition to our trust bereavement services, specialist support from a bereavement charity, 2wish, will also be offered. The Medical Examiner and Bereavement team have been

asked to automatically refer any paediatric deaths to Learning from Deaths. If there are any concerns that may relate to a patient safety incident, then the rapid review process will be triggered, otherwise a mortality review will be requested. Our internal mortality review processes do not negate our requirement to contribute fully to the CDOP process but are intended to enable us to understand any areas of learning or improvement in a timely manner.

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

3.1. Examples of learning:

- The Medical Examiner Service has shared feedback from the family of a patient who died whilst in our bedded care. The family described being aware that the patient had a life-limiting illness but were concerned that whilst at one of our community hospitals, there were delays with escalating the patient back to an acute setting which may have hastened their death. The SJR found that the overall care of this patient was good, and their death was viewed as being unavoidable due to evidence of disease progression. Whilst there were some instances of the NEWS policy not being followed correctly, this was not thought to have impacted on the outcome. This has however prompted learning for the clinical team who have revisited available training on physiological observations.

- The family of a patient who sadly died of metastatic bladder cancer raised a complaint about the patient's care in the months leading up to their death. They described an episode where a urethral catheter was incorrectly inserted, resulting in damage to the patient's urethra. Whilst it is known that these kinds of difficulties with catheterisation are not uncommon and often do not mean that an "error" has occurred, it was acknowledged that this event caused significant distress to the patient and their family and impacted on their ongoing care. This experience has been shared as part of a trust wide catheter project, which has led to improvements to training provided to staff as well as work to standardise the catheter products that are in use across the trust.

- Feedback was shared by the Medical Examiner following their scrutiny of the notes of a patient who died in one of our Critical Care Units. The patient had initially been admitted electively for a stoma reversal, and whilst the initial surgery was uneventful, they sadly developed post-operative complications. An SJR was completed by the Critical Care team. Whilst this was thought to be an unavoidable death, it was highlighted that there were some care issues that related to a lack of continuity of consultant cover. For instance, there were changes made to the patient's Treatment Escalation Plan without any clear documentation of the rationale for these changes. To ensure there is more consistency for patients, there been changes to ensure the

staffing is more structured. For the specific example of changes to Treatment Escalation Plans, this will enable a multidisciplinary team discussion, with at least two consultants, to take place.

- Colleagues in our Mental Health and Learning Disability service group undertook an After Action Review following the death of a patient who had been referred to services with symptoms of anxiety, depression and paranoia. Following a period of support from the Home Treatment Team, it was agreed that an intervention from Open Mental Health (a service which offers brief interventions) would be offered. Learning was identified in the After Action Review. It was agreed that this patient would have likely required longer term support via Specialist Psychological Interventions. It was thought that there was a need for a clearer understanding of the different parts of the Community Mental Health Service and the interventions that these offer, as well as consistent documentation of the interface meetings that demonstrates the clinical reasoning behind plans for care.

- The family of a patient who died on one of our medical wards contacted PALS to share concerns about their experience of finding their loved one had died. They described being called to come to the ward as their relative had become more unwell. Their relative had sadly died before they arrived at the ward but were not told this before they entered the room. When they spoke to a member of the nursing team, they felt that the staff member confirmed that their relative had died in a way that lacked compassion. This experience caused significant distress to the family. Following sharing their concerns with PALS, learning was identified for the ward team including training on “care after death” for both the deceased patient and the bereaved.

- Several learning points were identified from the Perinatal Mortality Review Tool (PMRT) and an independent Maternity and Newborn Safety Investigation (MNSI) following a stillbirth:

    - The expectant mother had contacted the triage service, but there were delays with inviting her in to be seen in person. The Birmingham Symptom Specific Obstetric Triage System (BSOTS) has since been implemented. This is a tool to improve the safety of mothers, babies and the management of the department, and standardises the response to mothers when the present with unexpected problems or concerns.

    - Aspirin was indicated but had not been prescribed. This has been added to the medicine exemption list for midwives

    - Patient information leaflets are only available on the Badgernet app when push notifications have been enabled on the device. Work has been done to raise the profile of this to staff and families to make sure families have access to support and information

- Improvements have been made to the bereavement suite as part of renovation works. When this facility is not available, signage showing the national bereaved parents symbol will be displayed on doors to inform staff that the family using the room have experienced a loss.

- An SJR was completed following the expected death of a patient on one of our Mental Health inpatient wards. The SJR identified may areas of excellence with the care the patient received at the end of their life. There was early recognition that the clinical team were not experienced in delivering palliative care. To overcome this, specialist training was delivered, and the support of our community palliative care services was sought. The patient and their family were kept involved in all decisions about their care and their wishes were adhered to as far as possible. The patient expressed a wish to die in their own home. Sadly, this was not possible, yet there was evidence that the care team put considerable effort into working towards this goal. The patient received person-centred care until their death. For example, their spiritual needs were recognised and staff supported them to attend church services in the community or engage with chaplaincy services on the ward. This excellence has been shared as a patient story to highlight the importance of good care at the end of life.

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

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

  The Medical Examiner's office had 552 deaths of patients under the care of SFT reported to them between July and September 2024. Of these, 479 were within our acute hospitals, 70 were within our community hospitals and 3 patients were under the care of Hospital @ Home. The Medical Examiner team looked at 100%of these deaths and highlighted 80 deaths 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. During this reporting period, 42 SJR's were requested through this pathway. In addition to these reviews, specialities should also routinely undertake SJR's on a sample of cases in the absence of any particular concern about care. The output from all completed reviews is collated so that common themes and trends can be seen from looking at good practice as well as problems with quality of care. This can then inform the Trust's quality improvement work.

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

  During this reporting period there were 2 inpatient death of a person with Learning Disability. No concerns were raised regarding the care of either of these patients.

- **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, 2 deaths have been discussed at rapid review meetings. As a result, 1 of these deaths met the criteria for a Patient Safety Incident Investigation, and the other death will be subject to an SJR.

- **PALS and complaints**
  During this quarter, 25 PALS queries and 3 formal complaints have been raised concerning the deaths of patients in our care. Common themes are around:

  - Poor communication. An example being of a family who reported that they struggled to get meaningful updates and were repeatedly informed that their relative was “fine” when they were approaching the end of their life.

  - Inadequate and unsafe discharge planning. An example being of families who described failed discharges necessitating readmission.

  - Concerns about care and treatment at the end of life. An example being of families who reported delays to managing pain at the end of life.

- **Maternity Deaths**
  The Perinatal Mortality Review Tool (PMRT) is completed locally for all notifiable fetal and neonatal deaths. In this reporting period, there have been 6 eligible perinatal deaths:

  - 1 late fetal loss
  - 4 stillbirths
  - 1 early neonatal death

  There has been 1 additional neonatal death at another trust where we will contribute to the PMRT process as we provided antenatal care.

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

  There have been no maternal deaths during this reporting period.

- **Paediatric Deaths**
  Reviews of these deaths are mandatory and undertaken by the Child Death Overview Panel (CDOP). Notification of a child death to the local Safeguarding Children Board is made at the time of any agency becoming aware of the death of a child. Where the death occurs within the hospital, responsibility for completing this notification is usually undertaken by the paediatrician managing the case. During this reporting period, there has been 1 infant (up to 1 year of age) death. This will be reviewed internally using the PMRT as described above in addition to the CDOP review.

- **Coronial activity**
  During this reporting period, there were 51 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 50 read-only inquests and 6 inquests heard with witnesses called. A further 7 pre inquest review hearings have been heard.

  During this quarter, the Trust has responded to a regulation 28 prevention of future deaths report that was issued following an inquest that took place in Quarter 1. This related to a patient who was known to our Mental Health services and raised concerns about a lack of understanding and appreciation of the menopause and the potential effect this hormonal change and/or imbalance may have on women, and the potential link between menopause and a woman experiencing mental health decline. Whilst it was acknowledged that there is no national guidance on the potential link between menopause and mental health decline, there have been steps taken within the Trust to address the concerns raised. The Royal College of Psychiatrists offer online training, which is available to all mental health colleagues. The Director for Primary Care, who is a GP and menopause specialist, has been leading on bespoke menopause training for colleagues. Guidance for considering menopause/perimenopause as part of an assessment, and how to signpost to other services (such as the patient's GP), will be shared with Mental Health colleagues.

3.3. Standardised mortality

3.3.1 Summary Hospital-level Mortality Indicator (SHMI), June 2023 – May 2024

Source: NHS England (October 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	84,110	3,250	3,175	1.02 As expected

Site level *Acute hospitals and exceptions*

Site	Provider spells	Observed deaths	Expected deaths	SHMI value
Musgrove Park Hospital	59,645	1,920	1,960	0.98 As expected
Yeovil District Hospital	22,715	1,180	1,105	1.07 As expected

Diagnosis group *Reported groups by exception*
All 10 reported diagnosis groups are 'As expected'

Visual life adjusted display (VLAD) – recent alerts
No new alerts in October 2024

3.3.2 **Standard mortality ratios from HED**

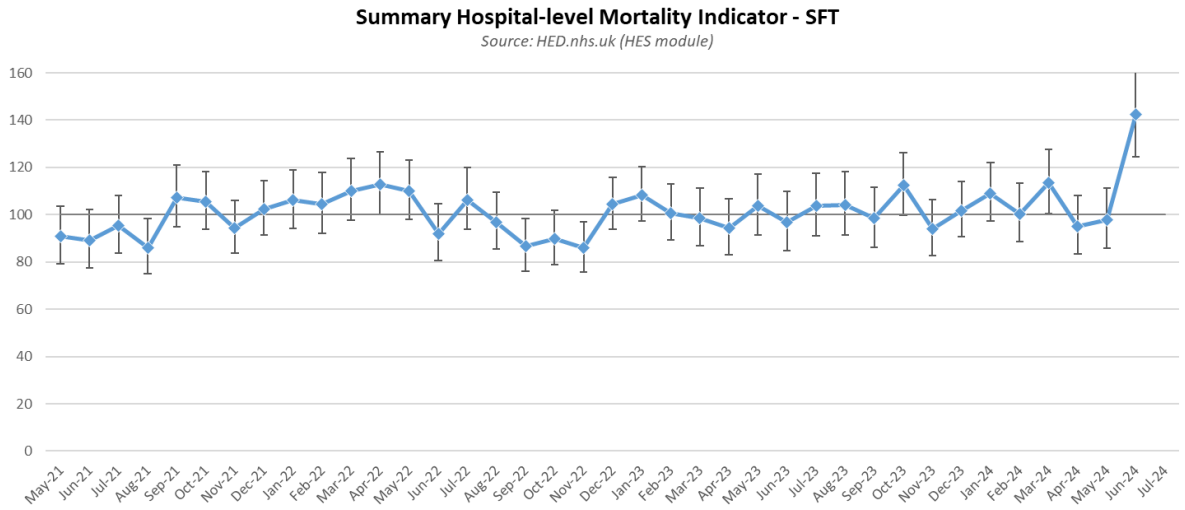
Source: HED.nhs.uk - SHMI HES and HSMR HES modules (17th October 2024)

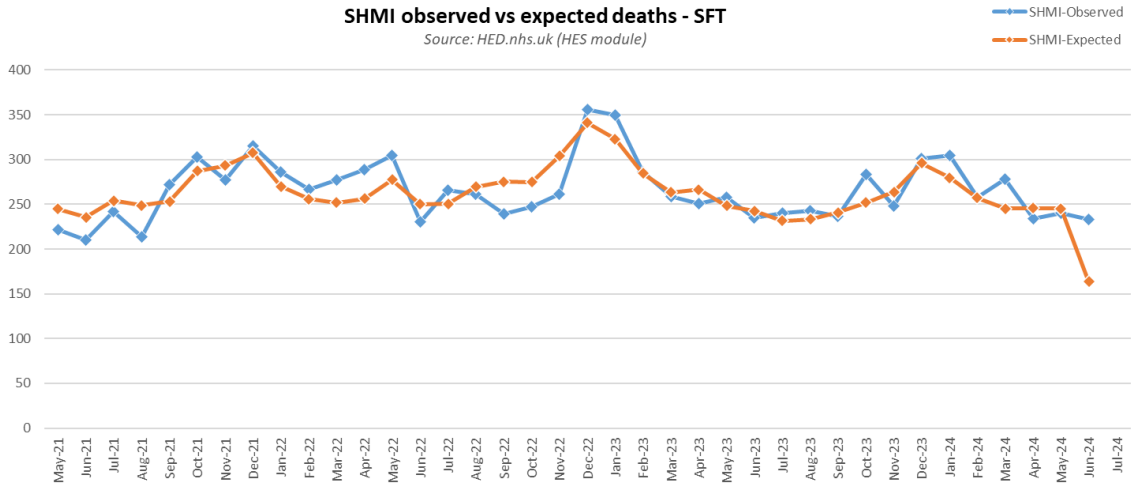
This report refers to two measures of standardised mortality: summary hospital-level mortality index (SHMI) and hospital standardised mortality ratio (HSMR).

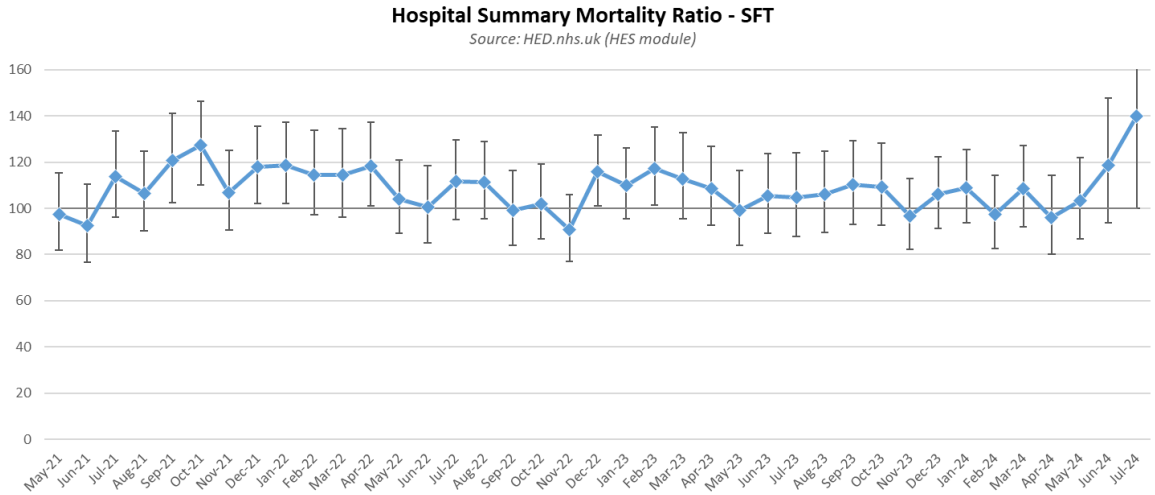
The following alerts are based on confidence intervals to allow for earlier identification of possible differences.

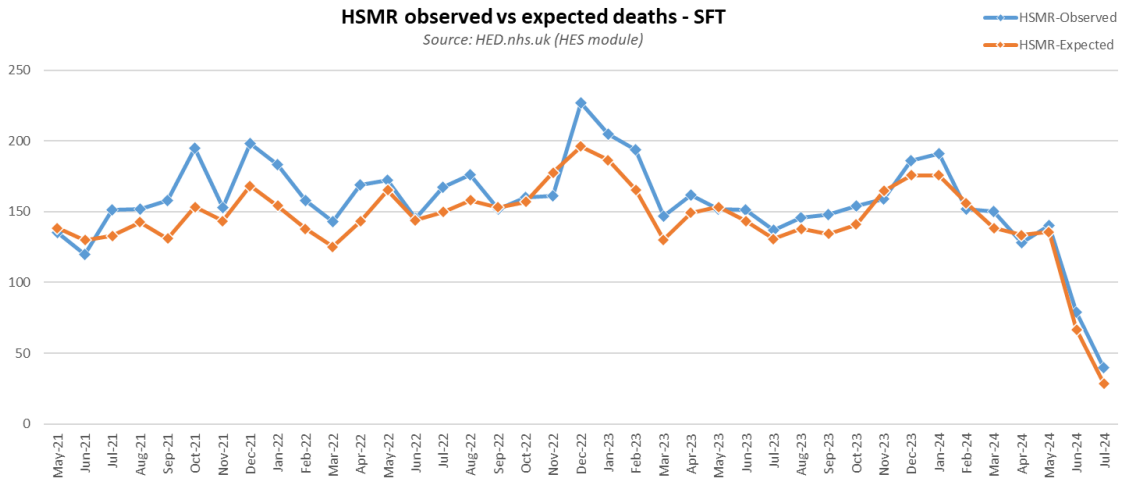
Trust level

Trust	SHMI (Jul 23 to Jun 24)	HSMR (Aug 23 to Jul 24)
Somerset NHS FT	103.6 (As expected) 95% CI: 99.9 - 107.4 Observed: 2,956 Expected: 2,854 Spells: 78,415	105.4 **(Above Expected)** 95% CI: 100.4 - 110.6 Observed: 1,673 Expected: 1,587 Spells: 52,684


Summary Hospital-level Mortality Indicator - SFT
Source: HED.nhs.uk (HES module)
160
140
120
100
80
60
40
20
0
May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24


SHMI observed vs expected deaths - SFT
Source: HED.nhs.uk (HES module)
SHMI-Observed
SHMI-Expected
400
350
300
250
200
150
100
50
0
May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24


Hospital Summary Mortality Ratio - SFT
Source: HED.nhs.uk (HES module)
160
140
120
100
80
60
40
20
0
May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24



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

Site	SHMI (Jul 23 to Jun 24)	HSMR (Aug 23 to Jul 24)
Musgrove Park Hospital	102.2 (As expected) 95% CI: 97.6 - 107.0 Observed: 1,865 Expected: 1,824 Spells: 56,846	111.8 **(Above expected)** 95% CI: 104.7 - 119.2 Observed: 933 Expected: 835 Spells: 32,643
Yeovil District Hospital	106.0 (As expected) 95% CI: 99.8 - 112.5 Observed: 1,091 Expected: 1,029 Spells: 21,569	93.1 (As expected) 95% CI: 86.2 - 100.5 Observed: 663 Expected: 712 Spells: 18,149

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

Diagnosis group (CCS)	SHMI (Jul 23 to Jun 24)	HSMR (Aug 23 to Jul 24)
109 - Acute cerebrovascular disease	106.85 (As expected) 95% CI: 93.1 - 122.1 O: 216 E: 202 S: 1,249	117.82 **(Above expected)** 95% CI: 102.0 - 135.4 O: 198 E: 168 S: 1,049
125 - Acute bronchitis	140.67 **(Above expected)** 95% CI: 107.6 - 180.7 O: 61 E: 43 S: 1,614	144.64 **(Above expected)** 95% CI: 101.3 - 200.3 O: 36 E: 25 S: 1,530

Diagnosis group (CCS)	SHMI (Jul 23 to Jun 24)	HSMR (Aug 23 to Jul 24)
127 - Chronic obstructive pulmonary disease and bronchiectasis	130.02 **(Above expected)** 95% CI: 105.4 - 158.6 O: 97 E: 75 S: 1,188 VLAD alerts in last 3 months: 1	135.03 **(Above expected)** 95% CI: 105.7 - 170.1 O: 72 E: 53 S: 1,095
245 - Syncope	306.38 **(Above expected)** 95% CI: 146.7 - 563.5 O: 10 E: 3 S: 512	223.69 (As expected) 95% CI: 96.3 - 440.8 O: 8 E: 4 S: 589
250 - Nausea and vomiting	280.63 **(Above expected)** 95% CI: 112.4 - 578.2 O: 7 E: 2 S: 248	

3.3.1 **Plans for reviews in response to Standardised Mortality Data:**

- 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.

- We have been alerted to a spike in the SHMI value report by HED for June 2024. This appears to be an outlier when compared with the previous 11 months. When examined further, our MPH site appears to have a high number of excess deaths with 161 observed versus 99 expected (RR 163). Diving deeper into this to look at the SHMI diagnostic groups, *144 – invalid primary diagnosis* has excess deaths with 105 observed versus 45 expected (RR 231). This has been discussed with Head of Clinical Coding who believes this spike to correspond with a backlog of uncoded records due to capacity challenges within the department. There is plan in place to address this, but this will take time to resolve, and we may see further spikes in the coming months. We will continue to monitor this situation.

- Having been made aware of alerts for mortality in hip fracture patients at our YDH site by the National Hip Fracture Database (NHFD) and across SFT site by a SMHI Variable Life Adjusted Display (VLAD) chart, a proportionate response was agreed with colleagues in our orthopaedic team. This included reviewing if any deaths in the dataset had been flagged by the ME service, undertaking SJR's for all deaths during October-December 2023 (which corresponded with a period of higher mortality), and SJR's for all hip fracture deaths going forward. Whilst this plan was in progress, we received further alerts from the NHFD that our YDH site was an outlier for case-mix adjusted 30-day mortality for two consecutive reporting periods (January-December 2023 and April 2023 – March 2024). This has activated the NHFD outlier policy. The orthopaedic team are leading on the response to this

with support from the Trust Mortality Lead, Katy Darvall. The reviews undertaken so far have not revealed any obvious theme or concerns around poor care and avoidability. Katy Darvall has completed a deep dive exercise into the available reviews, which has highlighted areas of good and excellent practices, for example:

- Prompt recognition of post-operative issues, including when palliative management would be appropriate
- Family involvement in care discussions
- Early consultant review

Some areas for improvement were also drawn out, for example:

- Observations continuing for a patient on a palliative pathway
- Documentation
- Delay to a patient being seen by an orthogeriatrician and/or the senior medical team (this delayed end of life care decisions rather than impacted on the outcome)

These learning points have been collated and shared with the orthopaedic team. In our formal response to the NHFD alert, further actions have been described. The deaths in the October-December 2023 period will be subject to further multidisciplinary review to ensure that any concerns around perioperative care are fully explored. It was noted that a similar issue was flagged by the MHFD in 2018 at our MPH site, and a discussion has taken place between the two orthopaedic teams to share any relevant learning from this earlier review. All of the hip fracture cases from 2023 will be reviewed to check if there are any errors in the data submitted. This had been identified as an issue from the MPH review, particularly around the ASA score. Whilst these reviews are ongoing, the orthopaedic team have instigated several immediate changes, including:

- Specific bays for hip fracture patients, and development of a Standard Operative Procedure to manage any excess in volume and/or acuity
- Review of the nursing establishment to increase the ratio of nurses in these bays to provide enhanced post-operative monitoring
- Patients with the SORT score more than 5% to be admitted to HDU, depending on bed availability
- Anaesthetic team to provide cover for most of the trauma lists
- Orthopaedic consultant team to ensure consultant supervision for all operations
- Establishment of a twice weekly orthogeriatric ward round.

We have had further contact from the NHFD clinical lead for orthopaedic surgery, sharing additional recommendations for ongoing improvements, which the orthopaedic team are considering as a priority.

Appendix 1

Somerset NHS Foundation Trust

		2023/2024												2024/2025							
		July	Aug	Sept	Q2 total	Oct	Nov	Dec	Q3 total	Jan	Feb	Mar	Q4 total	April	May	June	Q1 total	July	Aug	Sept	Q2 total
ACUTE INPATIENTS*	Total deaths (including ED)	157	183	156	502	187	171	233	591	236	195	201	632	163	179	153	495	150	147	182	479
	Total Scrutinised by ME	157	183	156	502	175	168	207	550	231	193	195	619	156	179	153	488	150	147	182	479
	SJR's requested by LfD	14	10	12	36	10	9	10	29	10	9	8	27	10	8	13	31	9	12	11	32
	SJR's completed	24	28	23	75	19	18	22	59	25	17	19	61	15	13	7	35	7	7	0	14
	Problems in care**	0	2	2	4	2	0	0	2	2	0	1	3	0	1	0	1	0	0	0	0
	Serious Incident/PSIRF***	0	0	0	0	1	0	0	1	1	1	1	3	2	4	3	9	1	0	1	2
	Learning Disabilities: internally all deaths in acute inpatient settings are subject to review or investigation																				
	Total deaths	4	0	3	7	1	1	2	4	3	2	5	10	0	0	2	2	1	0	1	2
	Review/investigation completed	4	0	3	7	0	1	1	2	2	1	4	7	0	0	0	0	0	0	0	0
COMMUNITY HOSPITAL	Total deaths	19	18	29	66	24	22	17	63	19	15	20	54	19	18	22	59	25	23	22	70
	Total scrutinised by ME	19	18	29	66	24	22	17	63	19	15	20	54	19	18	22	59	25	23	22	70
	SJR's requested by LfD	1	0	2	3	0	1	0	1	0	0	0	0	0	0	1	1	0	1	0	1
	SJR's completed	1	0	2	3	0	1	0	1	0	0	0	0	0	0	3	3	2	2	0	4
	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)	8	10	3	21	4	9	6	19	10	4	9	23	3	5	5	13	10	8	4	22
	Total scrutinised by ME	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	1	1
	SJR's requested by LfD	1	0	2	3	2	2	1	5	3	0	2	5	1	2	3	6	5	2	2	9
	SJR's completed	1	0	2	3	2	2	1	5	2	0	2	4	0	2	1	3	0	0	0	0
	Problems in care**	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incident/PSIRF***	1	0	0	1	0	0	1	1	2	0	1	3	1	1	2	4	2	1	0	3
COMMUNITY SERVICES	SJR's requested by LfD	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
	SJR's completed	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
	Problems in care**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incident/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		13	13	10	36	14	20	18	52	24	19	22	65	13	20	21	54	20	16	15	51

* 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:	Assurance Report from the Mental Health Act Committee meeting held on 17 September 2024
SPONSORING EXEC:	Jade Renville, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Alexander Priest, Chairman of the Mental Health Act Committee
DATE:	5 November 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 17 September 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 Section 117 Proposal. • The Swan Advocacy progress report. • 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 progress made in relation to the management of risks. The following areas of concern or for follow up were identified: • Training compliance for medical and dental colleagues • The review of the Committee's Terms of Reference and the presentation of the Terms of Reference to a future Board meeting. • The Mental Health Lead report in relation to the Second Opinion Appointed Doctors (SOADs), lapsed detentions, and the Section 136 assessment times and outcomes. • The increase in the number of complaints. The Committee identified the following areas to be reported to the Board: • Ensuring the right people are informed when patients are in seclusion. • The number of CAMHS out of area patients is higher than usual. • The CQC action report. • The updated and agreed Terms of Reference. • Complaints slightly higher than usual.
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)

R

☐ 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 17 SEPTEMBER 2024

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 17 September 2024, the assurance received by the Committee and any areas of concern identified.

2. ASSURANCE AND UPDATES RECEIVED

Section 117 Proposal

2.1. The Committee received an update on the Section 117 proposal and noted that the Integrated Care Board's (ICB) finance team was working with the local authority in relation to funding streams and duties. The Standard Operating Procedure (SOP) was being reviewed and it was expected that a revised SOP will be in place by the end of October 2024.

Swan Advocacy

2.2. The Committee received a progress report and noted the findings from the visits to inpatient units. Positive comments included: friendly, approachable and responsive staff; good engagement; good communication; weekly visits working well; good working relationships; good advocacy awareness at YDH. Issues identified included: de-escalation room being inappropriately used for seclusion; showers not draining properly; Have Your Say meetings clashing with ward round or being cancelled; issues with grouping patients who want to see an advocate together; and scope to improve advocacy awareness at MPH.

2.3. The Committee noted: the production of a leaflet on S117 rights and the support available for individuals under a Community Treatment Order; and the importance of activities and the extension of activities to weekends as well as week days.

2.4. The Committee further discussed the issues raised as part of the visits and noted the actions taken to address these issues. The Committee highlighted the inconsistency of outdoor spaces between wards and the Committee noted that discussions to make environments as good as possible were taking place.

2.5. The Committee agreed to raise the outdoor issues with the Environmental Risk Group. The Committee further agreed to: raise the need for ongoing maintenance of outdoor spaces with the appropriate forum; timetable Non-Executive Director ward visits to coincide with Have Your Say meetings

or activities; and invite Swan Advocacy to present a further progress report in six months' time.

Mental Health Act Co-Ordination Report

2.6. The Committee received the Mental Health Act Lead report and noted that the team's workload appeared steady but that colleagues were working to full capacity.

2.7. The Committee noted the following highlights from the report: the publication of the Care Quality Commission's report into Nottingham Healthcare NHS Foundation Trust and the need to consider the trust's processes and areas of work to focus on in the near future; the need to review the Police Right Care, Right Person (RCRP) policy; the need for an audit on the use of the Absence Without Leave (AWOL) template; the opportunity to consider forward planning and support clinicians to develop a deeper knowledge and understanding of the Act; the development of training modules; the findings from the CTO audit and the discussions about whether to increase the number of face to face reviews by the Responsible Clinician; the review of Section 117 training; and the issues with Section 132 reporting following a RiO update and the need for a resolution.

MCA, DoLs and LPS updates

2.8. The Committee received an update in relation to the MCA, DoLs and LPS work and noted the report.

2.9. The Committee received the draft Mental Capacity Act Policy and noted the involvement of the patient engagement team in the review of the Policy and the request for feedback on the draft version. The Committee noted that the policy had been significantly amended to ensure that the content was as user friendly as possible.

2.10. The Committee received an update on training and noted that a significant amount of training had been delivered, including training on decision making for 16/17 year olds to improve the knowledge of colleagues working with that age group. Deprivation of Liberty and assessing capacity training will also be delivered in acute/community settings as this was an area where colleagues may not feel as confident.

2.11. The Committee noted the Mental Capacity Act training pilot and the emerging evidence that training outcomes were worse for mandated training. Consideration was being not to mandate this training for medical colleagues and the findings from the pilot will be reviewed to decide whether to roll the pilot out more widely. The Committee noted that the pilot will commence from January 2025.

AMHP (Approved Mental Health Professional) Services

2.12. The Committee received an update and noted*:* the completion of training by the three trainee AMHPs and the resulting reduction in vacancies; the changes in the management team; the difficulties finding responsible

clinicians for individuals on a CTO extension or put on a new CTO; the lack of contact with Police colleagues over the last six months; and the discussions with the transport company in relation to the difficulties sourcing transport.

ICB Commissioning

2.13. The Committee received an update and noted that: the S12 app contract will be renewed for a further year and that the app will have improved functionalities; and the ongoing restructuring of the ICB and the significant changes to the commissioning team and size of the team.

2.14. The Committee noted that Andrew Keefe will be leaving the ICB and the Committee thanked him for his work and acknowledged the loss of his expertise in commissioning mental health.

CAMHS

2.15. The Committee received an update on child and adolescent mental health services (CAMHS) out of area placements and noted that Wessex House had been temporarily closed but that, subject to the successful recruitment to the team, it was due to reopen in January 2025. The Committee noted the number of posts to be recruited to and the progress made to date.

2.16. The Committee observed that the temporarily closure of Wessex House had not appear to have impacted on out of area placements.

Forensic Report

2.17. The Committee received a progress report and noted that 46 patients were currently in secure services across the Southwest Provider Collaborative and that a small number of patients fell outside of the remit of the collaborative due to their specific needs.

Out of Area Treatment Somerset (OATS) patients

2.18. The Committee received and noted the report.

Care Quality Commission (CQC) Reports

2.19. The Committee received feedback from the recent CQC visit to Holford Ward and noted the generally positive feedback with minor issues raised in relation to consent to treatment. The Committee noted that a provider action statement will be produced following the receipt of the final report.

Complaints and Issues

2.20. The Committee received the report and noted that nine 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.

Risk Register

2.21. 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 noted the following risks: the three risks related to ADHD; the increase in the medical vacancy risk; and the increase in the risk relating to GPs confirming to share care plans with patients with eating disorders. The ADHD related risks were due to the demand on services and the limited availability of ADHD medication resulting in patients starting on this medication having to be put on a waiting list. The Committee noted that a working group was being set up to look into the ADHD issues in more detail.

2.22. The Committee noted the progress made in relation to the medical staffing and psychology vacancies and noted that, although good progress was being made, some vacancies will remain outstanding. The Committee noted that there were no concerns in relation to nursing staffing levels.

3. AREAS OF CONCERN OR FOR FOLOW UP

Training compliance for medical and dental colleagues

3.1. The Committee noted that a review of training was being undertaken and that a pilot will be run until December 2024. A progress report will be presented to the December 2024 Committee meeting.

Terms of Reference

3.2. The Committee reviewed its Terms of Reference and agreed to add wording in relation to continuous improvement. The revised Terms of Reference will be presented to a future Board meeting for approval.

Mental Health Act Co-Ordination Report

3.3. The Committee noted the risks in non compliance relating to Second Opinion Appointed Doctors (SOADS) due to SOADs not being allocated in a timely manner and lapsed detentions. A review of lapsed detentions had been carried out and all detentions had been updated. The Committee noted the small increase in the number of detentions.

3.4. The Committee received an update on the progress in relation to Section 136 assessment times and outcomes and noted: the instances of inaccurate recording of waiting times and outcomes: the number of outstanding follow ups; the focus on data to ensure that data was captured correctly; the possible higher threshold for the Police responding to call outs for intervention in cases of suspected mental health issues; and the complexity of Section 136 interventions due to the large number of contributory factors.

Complaints and Issues

3.5. The Committee discussed the number of complaints and noted the increase in the number of complaints over the last month with some of the complaints being very complex or historic.

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

4.1. The Committee identified the following areas to be reported to the Board:

- Ensuring the right people are informed when patients are in seclusion.
- The number of CAMHS out of area patients is higher than usual.
- The CQC action report.
- The updated and agreed Terms of Reference.
- Complaints slightly higher than usual.

Alexander Priest
CHAIRMAN OF THE MENTAL HEALTH ACT COMMITTEE

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Somerset Foundation Trust (SFT) Board
REPORT TITLE:	Review of Mental Health (MH) Services in Somerset FT against CQC findings relating to Nottinghamshire HealthCare Trust
SPONSORING EXEC:	Peter Lewis, Chief Executive
REPORT BY:	Jane Yeandle (Service Group Director, Mental Health and Learning Disabilities)
PRESENTED BY:	Jane Yeandle (Service Group Director, Mental Health and Learning Disabilities) Dr Andreas Papadopoulos (Associate Medical Director, Mental Health and Learning Disabilities)
DATE:	5 November 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	In 2023 three members of the public (Ian Coates, Grace O'Malley-Kumar and Barnaby Webber) were killed in Nottingham by Valdo Calocane. Valdo Calocane had been a patient of Nottinghamshire HealthCare Foundation Trust (NHFT). The Care Quality Commission (CQC) has recently completed a final review of NHFT mental health services. NHS England have required all mental health providers to report against the final review findings at respective public Trust Boards. The Trust has undertaken an assurance review exercise against the findings and recommendations set out in the CQC report. The results of that review have been discussed at the Quality and Governance Committee and are shared here with the Board.
Recommendation	The Board is asked to review this paper and support the actions outlined.

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 impact will be considered as part of the development of an action plan and the implementation of the action plan.

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

Public/Staff Involvement History

(Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)

Experts by Experience will be members of the Severe Mental Illness Steering Group that will monitor and contribute to the report's findings and actions.

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]

This paper has been tabled at the Quality and Governance Committee. It has been nationally mandated that this paper is presented to the Board.

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

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

SOMERSET NHS FOUNDATION TRUST

REVIEW OF MENTAL HEALTH (MH)SERVICES IN SOMERSET FT AGAINST CQC FINDINGS INTO NOTTINGHAMSHIRE HEALTHCARE TRUST

1. BACKGROUND AND PURPOSE

1.1 In 2023 three members of the public (Ian Coates, Grace O'Malley-Kumar and Barnaby Webber) were tragically killed by Valdo Calocane. Valdo Calocane had been a patient of Nottinghamshire HealthCare Foundation Trust (NHFT).

1.2 The Care Quality Commission (CQC) has recently completed a final review of NHFT mental health services, and this paper outlines a desktop review against the CQC findings.

1.3 The principal CQC findings were:

People struggled to access the care they needed when they needed it, putting them, and members of the public, at risk of harm. Like many other mental health services across the country, mental health services at NHFT were in high demand, with long waiting lists for community mental health teams, difficulties in accessing crisis care and lack of access inpatient beds. A lack of oversight for people on waiting lists and too many patients without a care coordinator was putting them, and the public, at risk of harm.

The quality of care and treatment across the trust varied and care provided did not always meet the needs of individuals. While most patients were treated with kindness, compassion and dignity, the quality of care planning was inconsistent and patients, their families and carers were not always involved. The make-up and size of teams did not meet the needs of the local populations, and care and treatment were not always in line with the Mental Health Act 1983 and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as well as current evidence-based good practice and standards.

High demand for services and issues with staffing levels meant that patients were not always being kept safe. Complex staffing arrangements in community mental health services meant that staffing levels did not always match caseload sizes and the number of referrals received. Staff approach to risk assessment and risk management was inconsistent, which increased the risk of people coming to harm.

Leaders were aware of risks and issues faced by NHFT, but action to address safety concerns was often reactive. There have been a number of changes in leadership in recent years. While leaders were aware of some of the current risks in safety and quality of services, they did not appear to have clear oversight of these. NHFT was taking action to address safety concerns, but these activities were predominantly reactive.

At a system level, we found issues with communication between services, which affected continuity of care for people. While the integrated care board was taking steps to improve quality, changes weren't happening quickly enough. Patients told us that transferring between inpatient care and crisis care into community care was difficult, and that services did not always ensure continuity of care. This was made worse by poor communication between services. While the integrated care board and NHS England were taking steps to oversee and improve care, we were concerned that change was not happening quickly enough.

2. SOMERSET NHS FOUNDATION TRUST (SFT) REVIEW

2.1 Following receipt of the CQC report and recommendations, the Trust has undertaken a review of its performance and outcomes, set against the findings of the report. This covered:

- A review of access, demand and capacity, including waiting times, to all SFT adult community and inpatient mental health services

- Quality of Care, including an evidence review and quality assurance visits to forensic and home treatment team services, focused on:

    - Quality of care planning
    - Involvement of patient in care planning
    - Involvement of families and carers

- Staffing levels, team configuration and service demands

- Leadership, risk management and patient safety

- System Working, including:

    - Transfer between services and agencies.
    - Continuity of Care
    - Interface and escalation processes

2.2 The results of this review were shared with the Quality and Governance Committee for discussion at its meeting on 30 October 2024.

3. NOTABLE PRACTICE FINDINGS IN SOMERSET

3.1 The review highlighted a number of positive findings in respect of the service provided in Somerset. These included:

- Demand and access is well managed, with robust systems in place to both manage risk when people do have to wait, and manage and support effective responses to non-attendance.

- Bed occupancy is broadly comparable with other MH providers. Use of Out of Area placements is low; indicating that when an admission is required, patients can be admitted to a Somerset bed.

- There is evidence of good quality of care and positive therapeutic relationships.

- There is evidence of robust approaches to caseload management and support; alongside a consistent approach to risk assessment and risk management.

- Appropriate governance and escalation processes are in place.

4. AREAS FOR IMPROVEMENT

4.1 Areas for improvement identified in the review, included:

- Waiting times between initial appointment and the start of an intervention is higher than we would wish.

- Not all colleagues are aligned to the same approaches to caseload management and recording.

- Having access to reliable data relating to “internal waits” and care and safety plans is challenging, impacting on robust oversight of performance.

- A review of staffing against population size and deprivation has not been undertaken for some time.

- There has not been an audit against practice relating to Severe Mental Illness for some time.

5. RECOMMENDATIONS

5.1 The Board is asked to discuss and approve the following recommendations. These fit into three broad areas: Governance and oversight, clinical pathways and delivery models, resources and operating structures:

Governance and oversight

i. To develop reliable means of measuring the waiting time between initial appointment/assessment, and the start of an intervention.

ii. Work with Community Mental Health Service managers to ensure that case management is delivering all available clinical slots and patient flow.

iii. We need to take immediate action to support all colleagues with caseload management and contributing to care plans as appropriate (with an agreed minimum standard of colleagues completing any management plans around safety).

iv. Ongoing work with digital team to generate reliable data to measure compliance with care planning standards.

v. Ensure senior oversight of care planning compliance via the Mental Health and Learning Disabilities performance dashboard. Ensure senior oversight of quality standards relating to care planning at the Mental Health and Learning Disabilities Governance Group.

Clinical Pathways and delivery

vi. Undertake an audit to review practice standards in relation to Paranoid Schizophrenia.

vii. Stand up a Serious Mental Illness Steering Group to monitor and develop above actions (including actions highlighted by the Assertive and Intensive Service Review).

Resources and operating structures

viii. A review of population demographics against locality resources to ensure appropriate allocation of resources.

ix. Undertake a review of all appropriate standard operating procedures.

x. Align actions with Intensive and Assertive review (including gap analysis relating to additional investment).

SERVICE GROUP DIRECTOR FOR MENTAL HEALTH & LEARNING DISABILITIES

ASSOCIATE MEDICAL DIRECTOR FOR MENTAL HEALTH AND LEARNING DISABILITIES

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Group Finance report – Month 6
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Mark Hocking, Deputy Chief Finance Officer
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	5 November 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 September, the Trust recorded a surplus of £0.739m, this was £1.184m favourable to the planned position for the month. Cumulatively, the Trust is £12.601m in deficit, which is breakeven to plan.

1.2 NHSE recently made available £90m of funding to meet the direct costs of the postgraduate doctors in training industrial action in June and July. The Somerset system allocation was £0.6m and this has been fully reflected in the month 6 position. This has off-set the majority of direct backfill costs which comprise primarily of claims from the medical workforce to cover absent doctors.

1.3 In addition, the organisation received a one off HMRC bank interest payment to compensate for an HMRC delay in repayment of recovered VAT. There are a number of operational pressures being experienced, these are currently being mitigated through the use of non-recurrent benefits and a favourable income position.

1.4 The impact of the pay awards for agenda for change and medical colleagues has now been fully assessed. The current year impact for staff in post is c£42.2m, of which c£14m was included within the agreed 2024/25 plan based on the original planning guidance. Additional funding will be provided principally through contractual uplifts to contracts with our commissioners and a smaller element will be received directly from NHSE for the retrospective element of postgraduate doctors in training. We expect funding to be sufficient to meet the costs in year.

1.5 The main headlines for September are:

- Agency expenditure was £2.110m, this was £0.888m below the plan for the month, £0.152m above the ceiling for the month and £0.485m below August expenditure. Medical agency use for vacancies continues to be the main driver.
- £4.563m of CIP was delivered in September, which is consistent with the planned level. Recurrent savings of £1.617m (35%) were delivered in month. Cumulatively, £21.996m has been delivered, again on plan.
- Whole time equivalents were 12,561 in September, 95.06 below the expected trajectory for the month. Services have put in place effective governance arrangements to consistently review and challenge vacancies. As a result, we continue to make solid progress managing our overall workforce numbers.

2. INCOME AND EXPENDITURE

2.1 Table 1 below sets out the summary income and expenditure account to 30 September 2024:

Table 1: Income and Expenditure Summary September

Statement of Comprehensive Income	Annual Plan	Current Month 6			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	80,530	84,057	3,528	485,501	490,893	5,391
Other Operating Income	72,568	6,526	7,874	1,348	31,789	36,351	4,561
Total operating income	**1,042,000**	**87,056**	**91,931**	**4,875**	**517,291**	**527,243**	**9,952**
Operating expenses							
Employee Operating Expenses	(713,634)	(60,070)	(60,293)	(224)	(360,220)	(364,009)	(3,789)
Drugs Cost: Consumed/Purchased	(90,479)	(7,292)	(9,610)	(2,318)	(46,174)	(47,328)	(1,153)
Clinical Supp & Serv Exc-Drugs	(32,992)	(3,051)	(6,488)	(3,437)	(20,970)	(32,274)	(11,304)
Supplies & Services - General	(35,549)	(2,962)	(3,137)	(175)	(17,776)	(17,368)	408
Other Operating Expenses	(158,268)	(13,201)	(11,139)	2,062	(79,210)	(75,533)	3,677
Total operating expenses	**(1,030,922)**	**(86,575)**	**(90,668)**	**(4,093)**	**(524,350)**	**(536,512)**	**(12,162)**
Operating Surplus/Deficit	11,078	480	1,263	782	(7,059)	(9,269)	(2,210)
Finance Expense	(13,070)	(1,089)	(1,351)	(262)	(6,536)	(6,333)	204
Finance Income	2,424	202	752	550	1,212	2,288	1,076
Other	0	0	0	(0)	(0)	0	0
Overall Surplus/(Deficit)	432	(408)	664	1,071	(12,385)	(13,313)	(928)
Depr On Donated Assets	1,397	116	78	(39)	698	473	(226)
Donated Assets Income	(2,591)	(216)	(73)	143	(1,295)	(1,332)	(36)
Amortisation	9	1	1	(0)	5	4	(0)
Impairments (Reversals)	0	0	0	0	0	1,039	1,039
Other	753	63	70	7	378	527	149
Adjustments to control total	(432)	(36)	75	111	(216)	712	926
Adjusted Financial Performance	0	(445)	739	1,184	(12,601)	(12,601)	0

2.2 The tables below set out pay expenditure and whole time equivalent (WTE) information by month. Actual performance is compared with plan in each table.

2.3 In September, overall staffing levels were 95.06 WTE below the workforce cap trajectory for the month:

- Substantive staffing was 5 WTE under plan
- Bank 69 WTE under plan
- Agency 31 WTE under &
- Locums 10 WTE over plan

2.4 The Trust is continuing to exercise good control over its workforce numbers. There are vacancy control panels in place in each clinical service group and for non-clinical areas, an executive director approval process is place. If we compare total WTEs at the end of September with the year-end target position (12,505) the Trust is currently only c56 away from this trajectory.

Table 2: Pay expenditure information

2024/25 Monthly Pay Expenditure analysis	Apr-24 £000	May-24 £000	Jun-24 £000	Jul-24 £000	Aug-24 £000	Sep-24 £000	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	2,090	1,927	1,894	1,882	1,975	1,826	2,111	285	11,593	12,979	1,386
Medical Agency	1,830	1,685	1,275	1,411	1,779	1,424	1,801	376	9,404	11,020	1,616
Medical Locums	1,152	1,032	938	1,159	818	1,000	502	(498)	6,099	3,012	(3,087)
Nursing Agency	771	618	547	547	486	369	921	552	3,337	6,039	2,702
Other Agency	484	497	391	405	331	317	278	(40)	2,423	1,696	(727)
Total Temporary Staff	**6,326**	**5,759**	**5,044**	**5,404**	**5,388**	**4,936**	**5,612**	**676**	**32,857**	**34,746**	**1,889**
Nursing	15,075	14,998	15,079	14,949	14,854	14,993	16,232	1,239	89,948	96,178	6,230
Support to Nursing	6,307	6,229	6,256	6,106	5,999	6,061	5,375	(686)	36,958	31,764	(5,194)
Medical	12,773	10,722	11,723	12,261	12,263	12,138	11,974	(165)	71,881	70,631	(1,250)
AHP's	8,615	8,680	8,658	8,656	8,616	8,646	9,455	809	51,871	56,592	4,721
Infrastructure Support	9,657	9,326	9,461	9,302	9,599	9,355	8,276	(1,079)	56,701	51,490	(5,211)
Other	3,191	4,956	3,611	4,026	3,845	4,164	3,146	(1,018)	23,793	18,819	(4,974)
Substantive Staff	**55,618**	**54,912**	**54,789**	**55,300**	**55,176**	**55,357**	**54,458**	**(899)**	**331,152**	**325,474**	**(5,677)**
Total All Staff	**61,943**	**60,671**	**59,833**	**60,704**	**60,565**	**60,293**	**60,070**	**(224)**	**364,009**	**360,220**	**(3,789)**
% Temporary	10.21%	9.49%	8.43%	8.90%	8.90%	8.19%	9.34%		9.03%	9.65%	

Table 3: WTE information

2024/25 Monthly Workforce analysis	Apr-24 WTE	May-24 WTE	Jun-24 WTE	Jul-24 WTE	Aug-24 WTE	Sep-24 WTE	In Month WTE	In Month Plan WTE	F/(A) Variance WTE	Year end Plan WTE	YTD Variance WTE
Temporary staff											
Bank Staff	588.90	493.89	493.02	516.60	518.54	487.53	487.53	556.32	68.79	539.24	51.71
Medical Agency	74.57	67.68	59.07	68.38	69.16	62.13	62.13	64.84	2.71	60.16	(1.97)
Medical Locums	31.19	25.72	26.61	33.27	32.54	29.98	29.98	20.38	(9.60)	19.76	(10.22)
Nursing Agency	94.58	69.57	64.96	70.88	67.02	46.30	46.30	82.77	36.47	76.79	30.49
Other Agency	67.26	77.61	59.76	58.10	58.65	55.32	55.32	47.48	(7.84)	44.05	(11.27)
Total Temporary Staff	**856.50**	**734.47**	**703.42**	**747.23**	**745.91**	**681.26**	**681.26**	**771.80**	**90.54**	**740.00**	**58.74**
Nursing	3,380.35	3,402.66	3,406.98	3,419.94	3,422.15	3,423.35	3,423.35	3,454.31	30.96	3,419.62	(3.72)
Support to Nursing	2,171.87	2,153.16	2,159.23	2,138.57	2,097.38	2,088.21	2,088.21	2,118.62	30.41	2,097.34	9.14
Medical	1,079.95	1,084.89	1,079.97	1,074.69	1,205.17	1,142.05	1,142.05	1,101.07	(40.99)	1,090.01	(52.04)
AHP's	1,590.04	1,589.92	1,586.06	1,600.67	1,607.25	1,629.72	1,629.72	1,610.23	(19.50)	1,594.06	(35.67)
Infrastructure Support	2,484.95	2,470.55	2,477.64	2,471.69	2,465.93	2,465.71	2,465.71	2,532.53	66.82	2,507.10	41.39
Other	1,136.01	1,161.37	1,145.51	1,126.36	1,127.82	1,130.79	1,130.79	1,067.59	(63.20)	1,056.87	(73.92)
Substantive Staff	**11,843.17**	**11,862.55**	**11,855.39**	**11,831.92**	**11,925.70**	**11,879.82**	**11,879.82**	**11,884.34**	**4.52**	**11,765.00**	**(114.82)**
Total All Staff	**12,699.67**	**12,597.02**	**12,558.81**	**12,579.15**	**12,671.61**	**12,561.08**	**12,561.08**	**12,656.14**	**95.06**	**12,505.00**	**(56.08)**
% Temporary	6.74%	5.83%	5.60%	5.94%	5.89%	5.42%	5.42%	6.10%		5.92%	

2.5 September agency expenditure was £2.110m, £0.485m lower than August 2024 and £0.520m lower than in the equivalent period in 2023/24. When compared to the same period last year, the Trust has spent £3.3m less on agency to date and remains on course to deliver £6.8m of recurrent cip.

2.6 Medical agency in September 2024 was £1.424m (£0.355m lower than August 2024). Vacancies continue to be the largest driver of agency usage and accounted for £0.915m (64%) of the total SFT agency spend in month. In September SHS used £0.265m to cover gaps in their workforce, this was £0.065m lower than their spend in August.

2.7 The Trust agency cap is £27.390m and is based on a 3.2% of planned pay spend. At the end of September 2024, we are £1.443m above the cap. This variance has increased by £0.152m in September 2024. The cap has been profiled pro-rata to the pattern of 2023/24 expenditure. Services continue to exercise rigorous controls on agency use and usage is reviewed regularly by senior colleagues.

2.8 In addition to the strong controls on agency usage, 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.

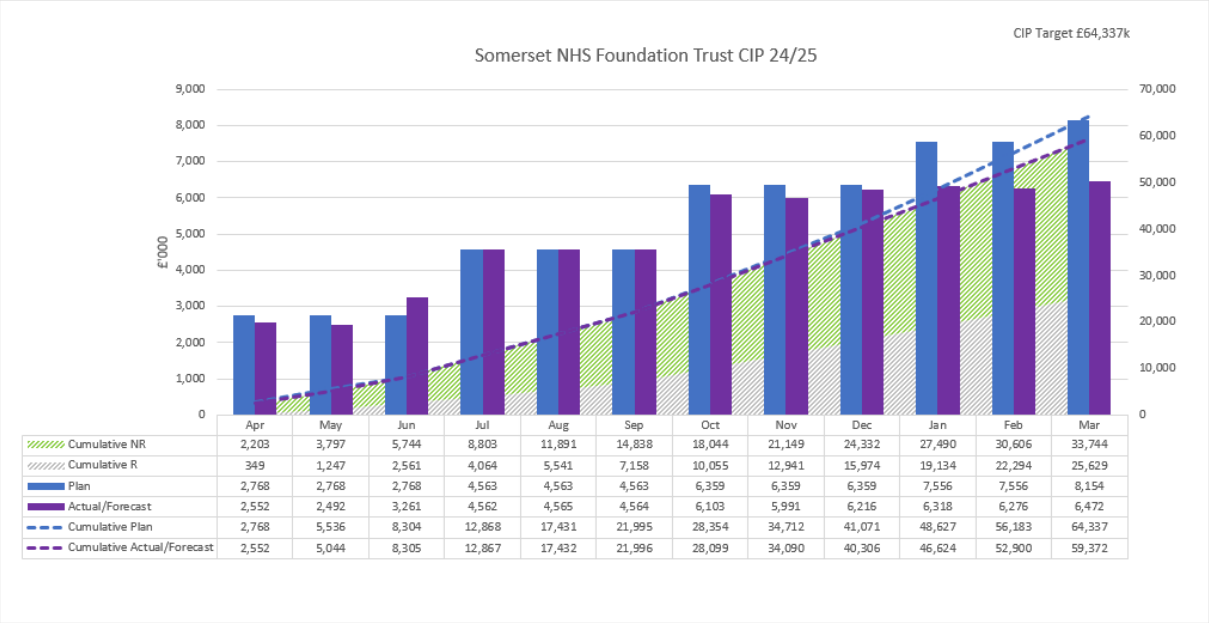
3. COST IMPROVEMENT PROGRAMME

3.1 The Trust has an annual efficiency plan of £64.337m this year, this includes £1.025m of merger savings.

3.2 In September, savings of £4.563m were delivered. This was breakeven to plan. Recurrent savings formed £1.617m of the savings achieved (35%).

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
Cumulative NR	2,203	3,797	5,744	8,803	11,891	14,838	18,044	21,149	24,332	27,490	30,606	33,744
Cumulative R	349	1,247	2,561	4,064	5,541	7,158	10,055	12,941	15,974	19,134	22,294	25,629
Plan	2,768	2,768	2,768	4,563	4,563	4,563	6,359	6,359	6,359	7,556	7,556	8,154
Actual/Forecast	2,552	2,492	3,261	4,562	4,565	4,564	6,103	5,991	6,216	6,318	6,276	6,472
Cumulative Plan	2,768	5,536	8,304	12,868	17,431	21,995	28,354	34,712	41,071	48,627	56,183	64,337
Cumulative Actual/Forecast	2,552	5,044	8,305	12,867	17,432	21,996	28,099	34,090	40,306	46,624	52,900	59,372

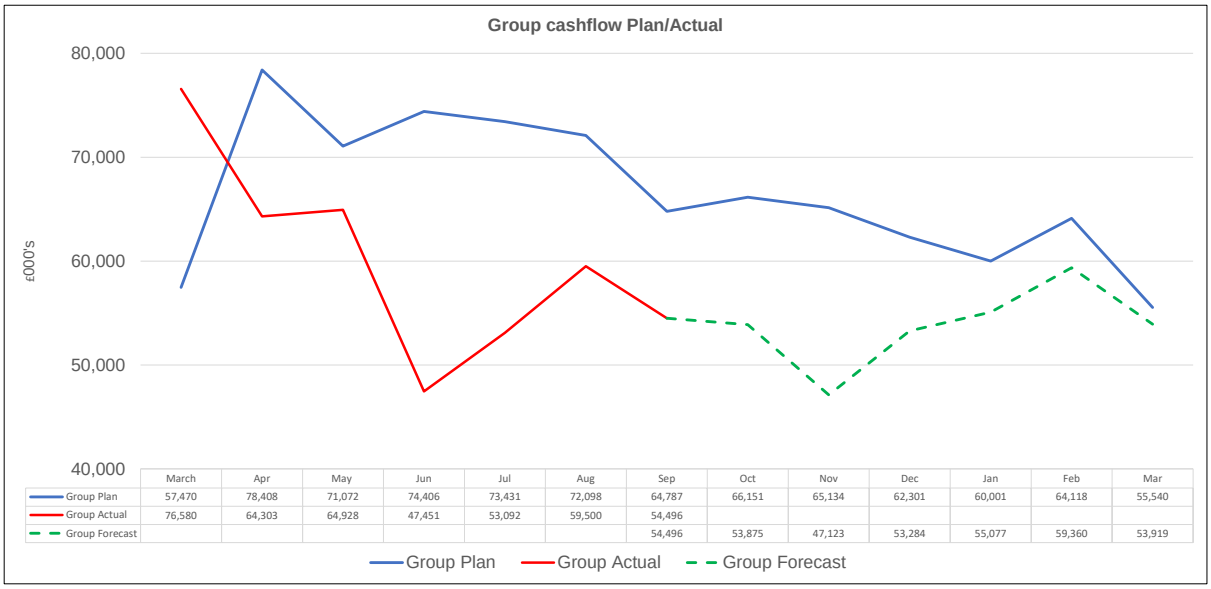
3.4 We continue to scope and identify further opportunities to close the gap in our current plans, recognising also that the schemes already identified may not deliver in full. The level of unidentified savings has reduced again in September and is now c£4.9m an improvement of £0.4m since August. The risk profile has also improved with high-risk schemes now accounting for 12% of the total forecast.

4. CASH

4.1 Cash balances at 30 September were £54.5m; £10.2m lower than plan; this is due to capital expenditure incurred in advance of PDC drawdown (£3.6m drawn down in October); and the balance due to working capital movements in trade and other receivables and payables.

4.2 The planned, actual and forecast cash balances are set out in Chart 2 below:

Chart 2: Cash flow Actual/Plan



	March	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Group Plan	57,470	78,408	71,072	74,406	73,431	72,098	64,787	66,151	65,134	62,301	60,001	64,118	55,540
Group Actual	76,580	64,303	64,928	47,451	53,092	59,500	54,496						
Group Forecast							54,496	53,875	47,123	53,284	55,077	59,360	53,919

5. STATEMENT OF FINANCIAL POSITION (BALANCE SHEET)

Aug-24	Sep-24	Movement		Mar-24	Sep-24	Movement in Year
£000	£000	£'000		£000	£000	£000
37,408	38,158	750	Intangible Assets	37,804	38,158	355
402,878	404,527	1,649	Property, plant and equipment, other	390,713	404,527	13,814
27,469	27,292	(178)	On SoFP PFI assets	28,360	27,292	(1,069)
78,319	82,805	4,486	Right of use assets	83,020	82,805	(215)
14	14	(0)	Investments	14	14	(0)
14	14	0	Other investments/financial assets	14	14	0
3,124	3,382	258	Trade & other receivables >1yr	2,957	3,382	424
549,228	**556,192**	**6,964**	**Non-current assets**	**542,883**	**556,192**	**13,309**
11,568	11,115	(452)	Inventories	11,902	11,115	(787)
19,525	10,475	(9,051)	Trade and other receivables: NHS receivables	7,105	10,475	3,369
11,994	17,838	5,844	Trade and other receivables: non-NHS receivables	24,035	17,838	(6,196)
466	466	0	Non current assets held for sale	466	466	0
59,500	54,496	(5,003)	Cash	76,580	54,496	(22,084)
103,053	**94,390**	**(8,663)**	**Total current assets**	**120,088**	**94,390**	**(25,697)**
(79,550)	(75,811)	3,739	Trade and other payables: non-capital	(112,416)	(75,811)	36,604
(9,875)	(9,279)	597	Trade and other payables: capital	(14,419)	(9,279)	5,141
(30,290)	(26,804)	3,486	Deferred income	(58)	(26,804)	(26,746)
(14,208)	(17,744)	(3,536)	Borrowings	(14,305)	(17,744)	(3,439)
(5,006)	(4,928)	78	Provisions <1yr	(7,818)	(4,928)	2,890
(138,929)	**(134,566)**	**4,363**	**Current liabilities**	**(149,017)**	**(134,566)**	**14,450**
(35,876)	**(40,176)**	**(4,300)**	**Net current assets**	**(28,929)**	**(40,176)**	**(11,247)**
(110,732)	(112,653)	(1,921)	Borrowings >1yr	(111,977)	(112,653)	(676)
(4,664)	(4,664)	0	Provisions >1yr	(3,060)	(4,664)	(1,604)
(1,574)	(1,553)	22	Deferred income >1yr	(1,682)	(1,553)	129
(116,970)	**(118,870)**	**(1,900)**	**Total long-term liabilities**	**(116,719)**	**(118,870)**	**(2,151)**
396,381	**397,146**	**765**	**Net assets employed**	**397,234**	**397,146**	**(88)**
			Financed by:			
376,359	376,367	8	Public dividend capital	363,752	376,367	12,615
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
(55,921)	(55,272)	649	I&E reserve	(38,050)	(55,272)	(17,221)
			Other's equity			
330	438	108	Non-controlling Interest	548	438	(109)
396,381	**397,146**	**765**	**Total financed**	**397,234**	**397,146**	**(88)**

6. CAPITAL

6.1 Schemes are being progressed in accordance with the agreed programme for the year. There are several timing differences within the internal programme around backlog maintenance and IT (including digital and EHR) that continue to be reviewed ensuring spend is considered later in the programme.

6.2 Year to date, capital expenditure is £30m compared with the plan of £33m, resulting in an underspend of £3m.

6.3 The continued pressure on access to clinical areas remains an ongoing risk as we move into the autumn and winter period and may hinder the progress of a number of backlog schemes. This is being actively managed between the estates and site teams on a weekly basis.

6.4 Reviews have been carried out with all capital project managers to assess the likely outturn capital expenditure for the financial year and a number of additional schemes have been identified to mitigate any potential shortfall in the originally agreed programme.

6.5 A summary at overall programme level are shown in Table 4 below:

Table 4: Capital Programme monitoring

Acute Programme	Plan £000	YTD Plan £000	YTD Actual £000	Variance Act v plan YTD £000
Total MPH Site Risks / Plant & Equipment	550	51	282	231
Total MPH Site and Service Development	4,073	1,267	558	(709)
Total YDH Main Site Budgets	2,665	1,076	950	(126)
Total - YDH Site and Service Development	5,552	300	90	(210)
Total - YDH Site Risks / Plant and equipment Replacement	430	122	89	(33)
Total Acute	**13,270**	**2,816**	**1,968**	**(848)**
Total Community / Mental Health Site and Service Development	2,450	1,461	908	(553)
Total Community / Mental Health - Site Risks / Plant & Equipment	300	120	12	(108)
Total Community/Mental Health	**2,750**	**1,581**	**920**	**(661)**
Trustwide	27,503	11,042	5,059	(5,983)
Total Internal Capital Envelope	**43,523**	**15,439**	**7,948**	**(7,491)**
Total Additional Schemes	**35,732**	**14,490**	**17,478**	**2,987**
IFRS Leases	14,523	3,119	4,584	1,465
TOTAL TRUST PROGRAMME	**93,778**	**33,048**	**30,010**	**(3,039)**

7. CONCLUSION AND RECOMMENDATION

7.1 We remain on track to deliver a balanced plan. There are a number of key actions we need to complete and to continue to make progress on. These include:-

- Finalising the pay award funding and contractual uplift.
- Continue to close the CIP gap including system stretch schemes and support delivery of service group schemes in line with their forecast, ensuring any slippage in identified schemes is mitigated.
- Review elective recovery performance once NHSE information is received to determine any financial risk.

- Manage the impact of winter pressures within the agreed funding envelope.

- Continue to focus on medical agency reduction and ensure our forecasts accurately reflect the expected run rate in the remaining months.

7.2 Provided we can progress and complete the actions outlined above, we remain on track to deliver our agreed breakeven position.

7.3 The Board are asked to note the financial performance for September.

CHIEF FINANCE OFFICER

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance report from the Audit Committee meeting held on 9 October 2024
SPONSORING EXEC:	Jade Renville, Director of Corporate Services
REPORT BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
PRESENTED BY:	Paul Mapson, Chairman of the Audit Committee
DATE:	5 November 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 meeting held on 9 October 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 six-monthly reports from the Quality and Governance Assurance Committee, People Committee and Finance Committee • The corporate risk register and the management of the operational risks • The work of the counter fraud service • The findings of the Cyber Security Audit Report • The findings of the Performance Management Audit Report • The findings of the Frailty Audit Report • The Escalation Process Progress report • Report on third party system suppliers' cyber security arrangements • 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 risk management update in relation to delayed roll out of Level 1 mandatory training • The counter fraud recommendations tracker – the request for executive support for seeking information from external parties • Report on third party system suppliers' cyber security arrangements – potential for an IA review of third-party management The Committee identified the following area to be reported to the Board or other committees: • The findings of the frailty internal audit report (Executive and Operational Leadership Team) • The work in progress with the CRR and BAF • The concern about third-party suppliers and the additional request for a review of third-party management.
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 MEETING HELD ON 9 OCTOBER 2024

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 9 October 2024.

2. ASSURANCE RECEIVED

Six Monthly Progress Report from the Quality and Governance Assurance Committee (QGAC)

2.1. The Committee received and discussed the report. The Committee noted that the QGAC was responsible for reviewing a significant number of risks and the QGAC reviewed these on a regular basis through the Corporate Risk Register and Board Assurance Framework. There was discussion about the purpose of the report, and it was noted that there was to be a session on governance at a further Board Development Session.

Six Monthly Progress Report from the People Committee

2.2. The Committee received and discussed the report. The Committee heard that work was underway to create assurance trackers to provide updates and measures on the progress of activity that was underway. A deep dive around the Strategic Objective as monitored by the People Committee was planned.

Six Monthly Progress Report from the Finance Committee

2.3. The Committee received and discussed the report. The report was reviewed, and assurance was taken that the Finance Committee monitors the risks assigned to the Committee.

Board Assurance Framework

2.4. 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 September 2024 Board meeting.

2.5. 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 risks had been assigned for oversight by Committees. The Committee noted that there was to be a planned session at a future Board development day.

Corporate Risk Register (CRR)

2.6. The Committee received and discussed the report. The Committee noted the key themes; the high scoring corporate risks and the mitigating actions taken.

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2.7. 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.

2.8. The Committee discussed in detail the risk related to the unauthorised merge of patient records completed by an external supplier and received assurance that this was being effectively managed internally with the supplier.

Risk Management Update

2.9. The Committee took assurance that Simply Serve Limited (SSL) had reviewed and adopted the updated Risk Management Policy with a separate addendum for SSL's governance arrangements. An updated Risk Appetite statement had also been developed.

2.10. The Committee received an update on the work underway across the system for the development of a system Board Assurance Framework although there had been challenges in personnel within the Somerset Council.

External Audit Progress Report and Technical Update

2.11. The Committee received the report and noted that work had been finalised on the audit of SSL and these would be submitted following signing and receipt of the Management Representation Letter. A debrief had taken place with the finance teams to talk through lessons learnt to streamline the processes in future years.

2.12. Task Force on Climate-Related Financial Disclosures (TCFD) reporting is to be expanded for 2024/25 alongside revised auditing standards which changes the documentation and assessment of individual risks in subsidiary companies and flowing into the group accounts. This will have a limited impact due to KPMG also auditing the subsidiary companies.

2.13. The Committee sought assurance about the processes and asked whether there were any areas of concern for the 2024/25 audit. No concerns were raised.

Counter Fraud Progress Report

2.14. The Committee received the counter fraud progress report and noted the proactive work, investigations and performance against the functional standards.

2.15. The Committee sought assurance on the processes around secondary employment where it was advised that there were clear processes in place at various stages although there was a need for constant messaging.

2.16. The Committee also noted: the extended deadline for the NHS Counter Fraud Authority (NHSCFA) local exercise; a stakeholder engagement request from the NHSCFA; and the new work on recruitment risk assessment and splitting risks between domestic and international recruitment.

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Counter Fraud Recommendations Tracker

2.17. The Committee received the counter fraud recommendations follow up report and the Committee agreed that the report provided significant assurance about the implementation of the recommendations. The Committee noted that three of the recommendations would be actioned following a meeting being held on 9 October 2024.

Internal Audit progress report

2.18. The Committee received the internal audit progress report and agreed that good progress was being made implementing the internal audit plan with the field work underway for a further four reports.

Cyber Security Audit Report

2.19. The Committee received the audit report and noted the substantial opinion issued for design and moderate assurance for effectiveness. The Committee agreed that the findings were positive with sound processes in place.

Performance Management Audit Report

2.20. The Committee received the audit report and noted that a moderate opinion was issued for design and substantial for effectiveness. The Committee agreed that the findings were positive, with a request that the findings were read across to the other Service Groups. It was confirmed that this had already taken place for consistency.

Frailty Audit Report

2.21. The Committee received the audit report and noted that a moderate opinion had been issued for design and a limited opinion for effectiveness, with one high and two medium priority recommendations. The recommendations related to: completion of Treatment Escalation Plan (TEP) forms and communication with family and Next of Kin, documentation of Clinical Frailty Score (CFS) on admissions and discharge, and utilisation of out of hospitals options and early discharge planning.

2.22. The Committee agreed that the report provided some assurance but recognised that further work will be required.

Escalation Process Progress Report

2.23. The Committee received the first iteration of this report which was to provide assurance of where reports had been escalated where they met the criteria. The Committee agreed that the report provided some assurance but requested further detail in the reporting of reports to other Committees.

Report on assurance about third party system suppliers' cyber security arrangements

2.24. The Committee received the report which had been requested at a previous meeting. The Committee took assurance from the arrangements in place to manage the risk of cyber-attacks through third-party suppliers. In additional, assurance was provided around the work with the procurement teams

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on the business continuity aspect of external supplier systems. The Committee agreed that the report provided assurance around this area although a couple of points were agreed for follow-up – see below.

Losses and Special Payments

2.25. 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 which dated back to before the current advance payment arrangements were in place.

2.26. The Committee agreed that the report did not highlight any areas of concern.

Single Quotation/Tender Waiver Action report

2.27. The Committee received the single quotation/tender waiver action report for the trust and for Simply Serve Limited and noted the single quotation and tender waiver actions and the reasons for these actions.

Policy Changes/Updates/Statutory requirements

2.28. The Committee noted that no policy changes or updates were to be brought to the attention of the Committee.

Terms of Reference Progress Report

2.29. The Committee received the report which monitored progress against the Committee's Terms of Reference.

2.30. The Committee agreed that the report provided significant assurance about the work of the Committee although the information provided for section 4.2 was to be reviewed and amended to reflect that executive directors whom are not members of the Committee, and had not attended meetings during the year, had the option to attend meetings.

3. AREAS FOR FOLLOW UP

Risk Management Update

3.1. The Committee noted that the roll out of the mandatory Level 1 risk management training had been delayed due to the Learning Committee requesting that a survey of all staff who had completed the training to date is completed. This would result in the delay of the roll out of this training.

Counter Fraud Recommendations Tracker

3.2. Executive support was requested to assist with getting information from external parties, i.e. Allied Healthcare Professionals Council.

Cyber Security Audit Report

3.3. The Committee requested that a review is undertaken following the recent Synnovis cyber-attack that affected other NHS organisations.

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Report on assurance about third party system suppliers' cyber security arrangements

3.4. The Committee queried whether there should be an Internal Audit review of third-party management alongside the private sector arrangements. The Director of Strategy and Digital Development agreed to look at this with the Chief Finance Officer as it was covered by digital and procurement services.

3.5. The Committee asked for the business continuity aspect to be cross referenced to the Corporate Risk Register to ensure this was adequately identified and monitored.

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 frailty internal audit report.
- The work in progress with the CRR and BAF.
- The concern about third-party suppliers and the additional request for a review of third-party management.

CHAIRMAN OF THE AUDIT COMMITTEE

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Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Charity Committee meeting held on 22 July 2024
SPONSORING EXEC:	David Shannon, Director of Strategy and Digital Development
REPORT BY:	Katie Fry, Executive PA
PRESENTED BY:	Graham Hughes, Chairman of the Charity Committee
DATE:	5 November 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 Charity Committee meeting held on 22 July 2024. The Committee received assurance in relation to: • The Open Mental Health proposed relationship • Proposed projects for major £2million donation • Future fundraising campaigns • Charity Risk Register • Business cases 161, 165, 170 and 178. The Committee did not identify any areas of follow up. The Committee did not identify any issues to be reported to the Board.
Recommendation	The Board is asked to note the assurance and areas for follow up identified by the Charity Committee.

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

☐ Obj 4	Reduce inequalities
☐Obj 5	Respond well to complex needs
☒ Obj 6	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☒ Obj 7	Live within our means and use our resources wisely
☐ Obj 8	Develop a high performing organisation delivering the vision of the Trust

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

Equality and Inclusion

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

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

This report has not been assessed against the Trust's Equality Impact Assessment Tool.

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

Public/Staff Involvement History

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

N/A

Previous Consideration

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

The assurance report is presented to the Board after each meeting.

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

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

SOMERSET NHS FOUNDATION TRUST

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

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 22 July 2024, along with the assurance received by the Committee and any areas for follow up identified. The meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

Open Mental Health

2.1. Graham Hughes has been introduced to the chair of Open Mental Health by Juliet Lyon. Open Mental Health would like to act as an intermediary to help disperse small grants of up to £10,000.

2.2. The major donation of £2million remains confidential.

Fundraising Report

2.3. There is a healthy account balance and strong income.

2.4. A donation has been received from Q-Park

2.5. A new partnership has been formed with Somerset Life Magazine

2.6. Research continues on how the cost of living crisis is affecting fundraising.

Major Donation

2.7. Potential projects to be funded by the major donation are still being proposed.

Charity Risk Register

2.8. There is an anticipated higher risk around fundraising due to the cost of living. This is being researched further.

Finance Report and Approvals

2.9. Business cases 161, 165, 170 & 178 were ratified.

2.10. Nick Boatwright will ask a representative from the CCLA to attend October's meeting to discuss underperforming against the benchmark.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. There were no areas of concern or follow up.

4. BE REPORTED TO THE BOARD OR OTHER COMMITTEES

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

Graham Hughes
CHAIRMAN OF THE CHARITY COMMITTEE