Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	The Trust Board
REPORT TITLE:	Quality and Performance Report
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Nathan Wray, Senior Information Analyst
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	7 February 2023

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

Executive Summary and Reason for presentation to Committee/Board	Our Quality and Performance Report sets out performance across a range of quality and performance measures and the reasons for any significant changes or trends. Covid-19 continues to have a significant impact on a range of access standards, whilst restoration work is being undertaken to reduce the number of patients waiting and to shorten waiting times. As referrals recover to pre-Covid-19 levels this will also have an impact on services and numbers waiting. Urgent and emergency patients continue to be prioritised, to receive the treatments they need.
Recommendation	The Board is asked to discuss and note the report.

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

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

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

☐ Financial	☒ Legislation	☒ Workforce	☐ Estates	☐ ICT	☒ Patient Safety / Quality
Details:					

Equality The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics
☒ This report has not been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
☐ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planning to mitigate any identified inequalities

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
No recommendations are being made, other than to ask the Board to discuss and note the report.

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

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

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

YDH | Operating Performance Overview

December 22

CONTENTS

1) Safe
2) Effective
3) Responsive
4) Caring

Mortality Rates

Safe

December 22

Latest HSMR Oct-2021 to Sep-2022	Weekend Mortality Relative Risk	Number of Trustwide Deaths	Crude Mortality Rate (Deaths / Discharges)
0.919	**0.916**	**104**	**2.72%**

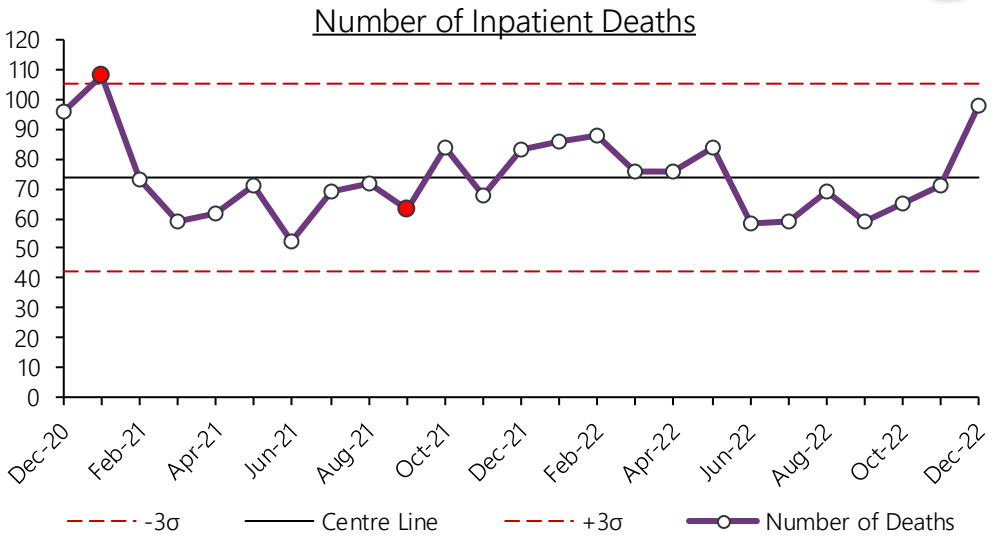
December 19

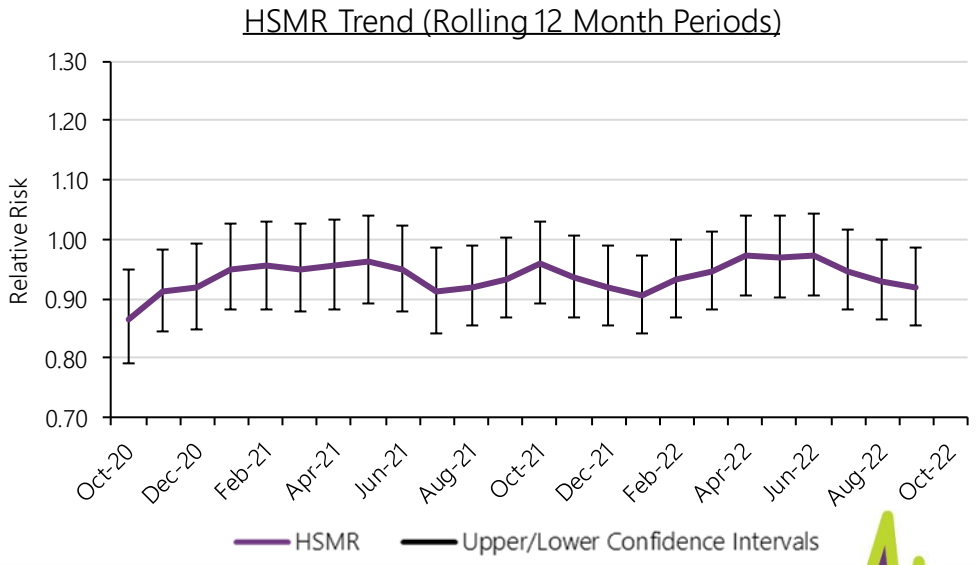
HSMR Oct-19 to Sep-20	Weekend Mortality Relative Risk	Number of Trustwide Deaths	Crude Mortality Rate (Deaths / Discharges)
0.890	**0.929**	**79**	**1.90%**

RAG status: Achieved

The trust's HSMR was 91.9 in for the 12 month period up to September 2022. The Trust continues to perform better than the National Average.

Further information is available in the quarterly mortality report.





Patient Falls and Pressure Ulcers

Safe

December 22

Patient Falls	Patient Falls Causing Harm	Patient Falls rate per 1000 bed days	Pressure Ulcers
94	**4**	**7.74**	**12**

December 19

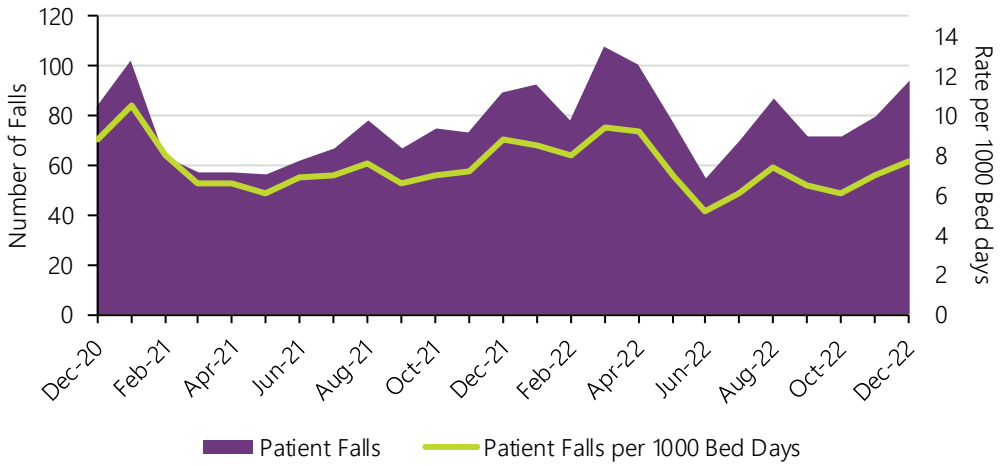
Patient Falls	Patient Falls Causing Harm	Patient Falls rate per 1000 bed days	Pressure Ulcers
60	**0**	**6.05**	**5**

Additional notes	Count	Diff	% Diff
• Patient Falls YTD:	**709**	**111**	**+18.56%**
• Patient Falls YTD 19/20:	598		
• Pressure Ulcers YTD:	**83**	**48**	**+137.14%**
• Pressure Ulcers YTD 19/20:	35		
• Pressure Ulcers 6M Avg:	**9.0**	**5.8**	**+184.21%**
• Pressure Ulcers 6M Avg	3.2		

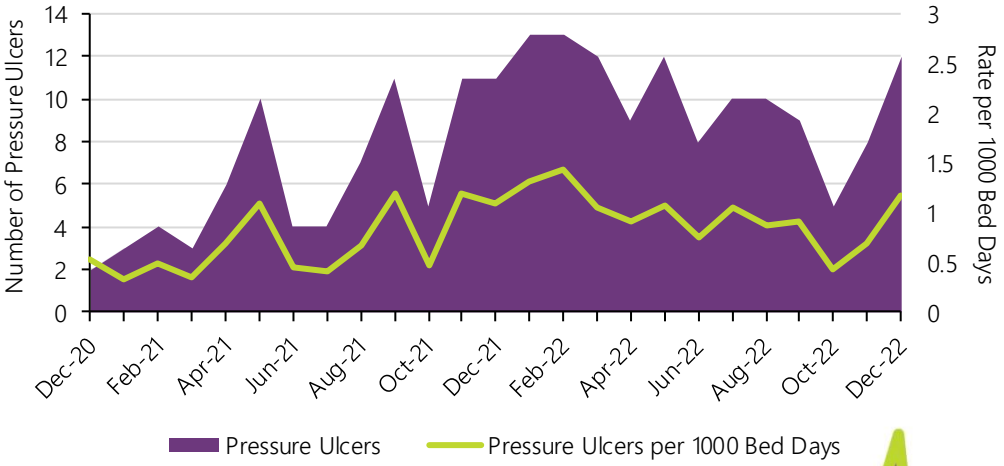
RAG status: Failed, close to achievement

Four key areas have been identified in the reviews: Documentation, Assessment, Training, Revalidation of Pressure Ulcer Category. Work is being undertaken with the Tissue Viability team and through the monthly Pressure Ulcer Steering Group.

Patient Falls



Pressure Ulcers +2



Infection Control

Safe

December 22

MRSA Bacteremia	C.Diff (Lapses in Care)	YTD C.Diff (Lapses in Care)	YTD C.Diff
0	0	0	7

E.Coli	P.Aeruginosa	Klebsiella spp.	Positive Covid-19 Cases
3	1	1	126

Additional notes

- The Trust's Threshold for C/Diff cases this year is 15

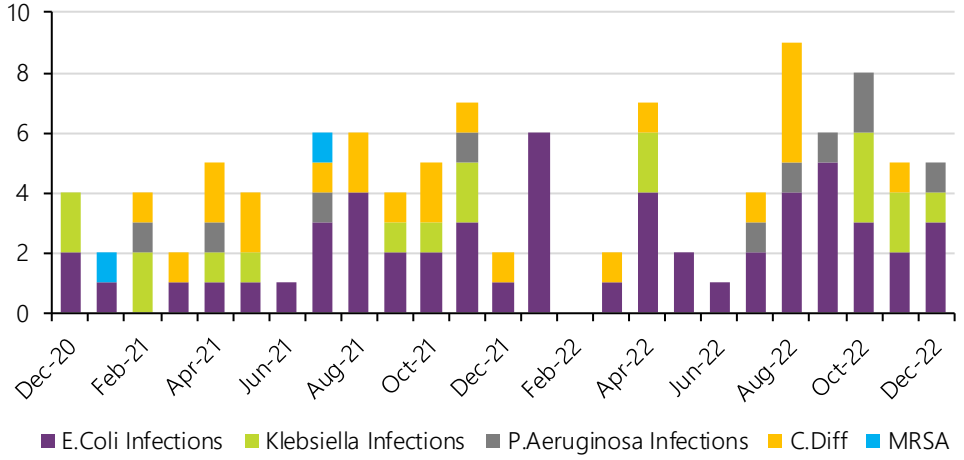
July 2022 Trust infection rate per 100,000 bed days;
E.Coli - 46.58, P.Aeruginosa - 9.32, Klebsiella - 9.32

May 2022 National infection rate per 100,000 bed days;
E.Coli - 30.59, P.Aeruginosa - 5.74, Klebsiella - 12.54
(All rates shown above are for hospital onset infections only)

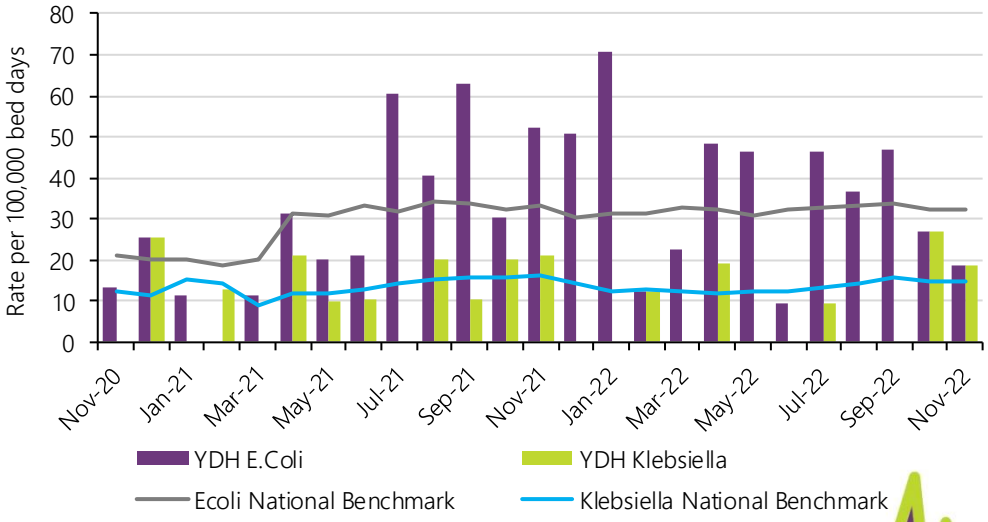
RAG status: Achieved

Targets Met.
There has been 7 reported C.Diff cases this financial year. The trust's C.Diff threshold for 22/23 is 15. Further information is available in the quarterly quality report.

Bloodstream and C.Diff Infections



YDH Hospital Onset BSI Infection rate per 100,000 bed days



Stroke Services

Effective

December 22

SSNAP Report - Jul-22 to Sep-22

YDH SSNAP Level	YDH SSNAP Score	90% Stay on Stroke Unit	12hr CT Scan
D	51.3	53.57%	97.22%
Targets			
B	**70**	**83.3%**	**83%**

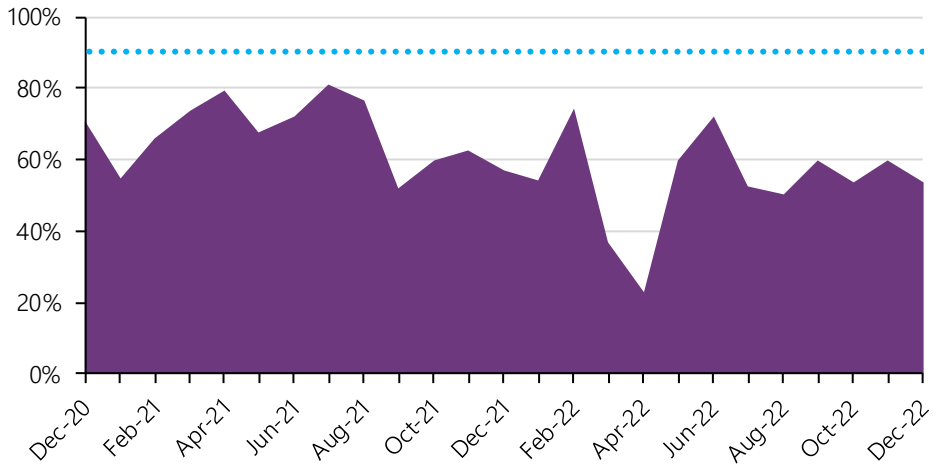
Additional notes

Stroke Performance national benchmarks from 20/21 Stroke Audit:
4hr Direct Admission = 55.10%
12hr CT Scan = 95.70%
90% Stay = 80.80%
Thombolysed = 10.70%
Consultant 24hr Review = 84.90%

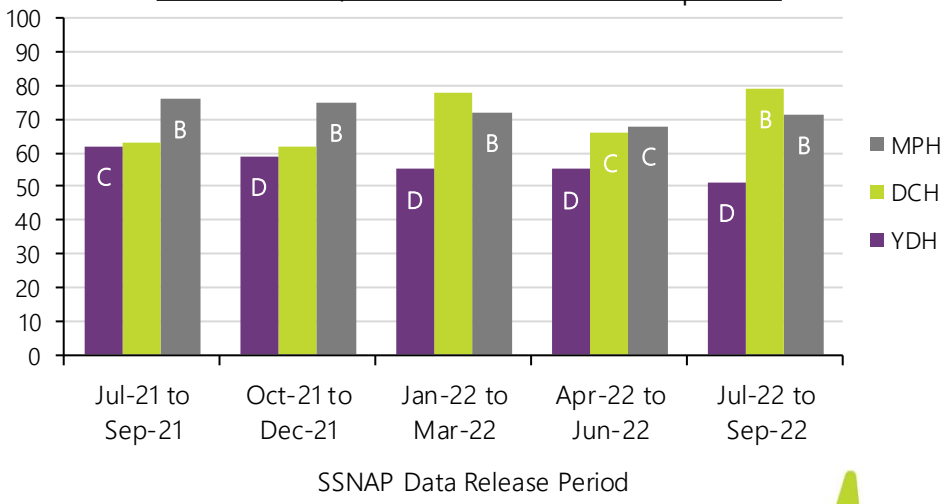
RAG status: Failed

Targets Failed. Reason:
The 90% Stay Stroke performance has been affected by a large number of patients not being directly admitted to the stroke unit, primarily due to hospital capacity pressures. High numbers of patients who have been unable to secure a discharge due to pressures of Community Services such as Stroke Rehab Units and Packages of Care in Somerset and Dorset, impacting the numbers of available beds for new admissions. There is an anticipated drop in the next SSNAP rating due to this. This is also affecting other targets.

90% Stroke Unit Stay Achievement



SSNAP Levels/Scores - Peer Trust Comparison



Admissions and LOS

Responsive

December 22

Elective Admissions	Non-Elective Admissions	Average Elective LOS	Average Non - Elective LOS
1,574	**2,252**	**2.36**	**5.29**

December 19

Elective Admissions	Non-Elective Admissions	Average Elective LOS	Average Non - Elective LOS
1,788	**2,362**	**2.14**	**4.01**

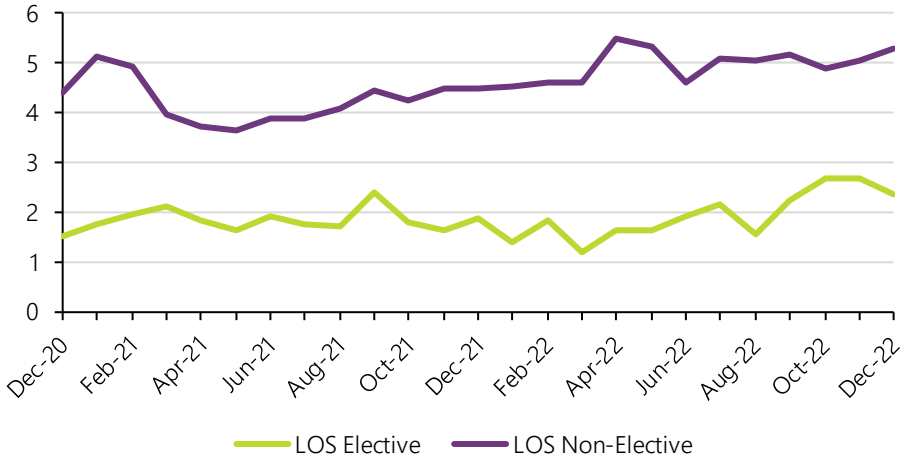
Additional notes	Count	Diff	% Diff
• Elective Admissions YTD:	**16,913**	**-1,300**	**-7.14%**
• Elective Admissions YTD 19/20:	18,213		
• Non-Elective Admissions YTD:	**19,178**	**-688**	**-3.46%**
• Non-Elective Admissions YTD 19/20:	19,866		
• Average Elective LOS vs 19/20 diff:		**+0.2**	**+10.30%**
• Average Non-Elective LOS vs 19/20		**+1.3**	**+32.09%**

RAG status: Failed, close to achievement

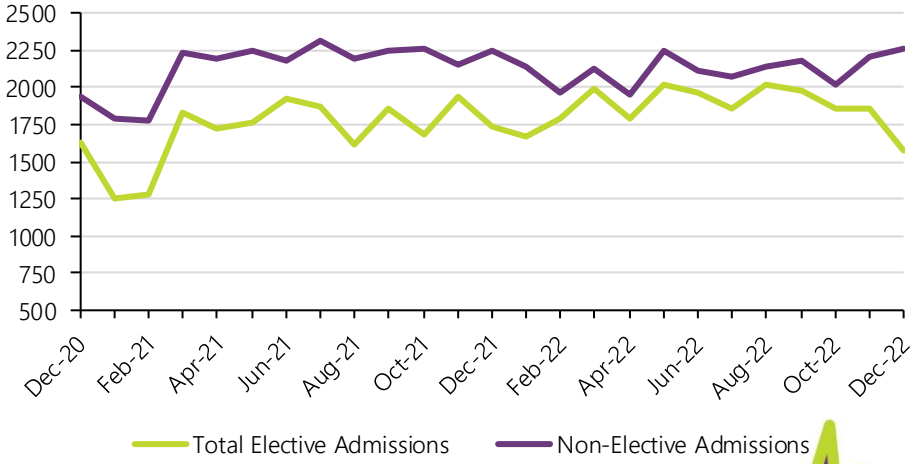
Targets Failed. Reason:

Elective and non-elective admissions are in line with pre covid levels. The increase in non-elective length of stay is reflective of an increase in patient acuity as well as an increase in patients delayed with no reason to reside.

Average Length of Stay (Days)



Admissions



Readmissions

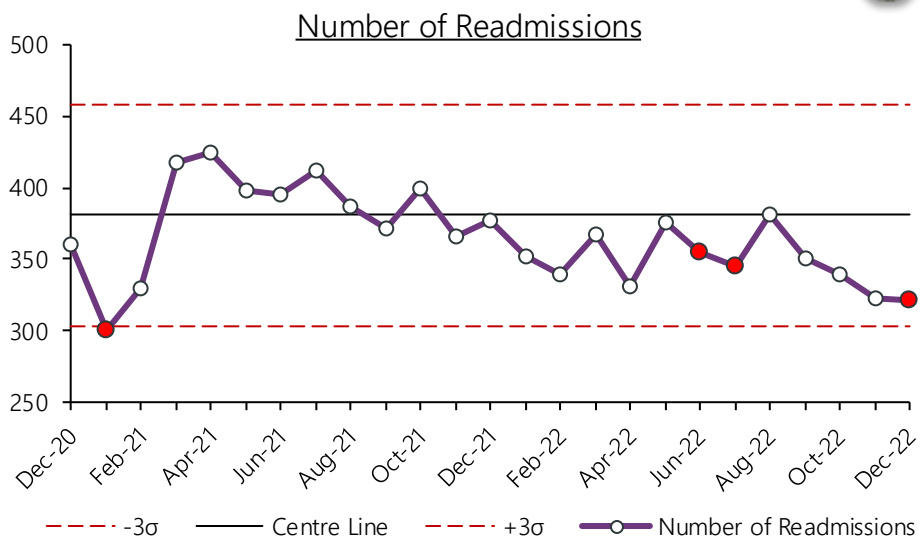
Responsive

December 22

Number of readmissions	Readmission Rate (Exc 0 day LOS)	Related Readmission Rate	Unrelated Readmission Rate
321	**7.87%**	**4.13%**	**4.26%**

December 19

Number of readmissions	Readmission Rate (Exc 0 day LOS)	Related Readmission Rate	Unrelated Readmission Rate
866	**19.66%**	**10.07%**	**10.80%**

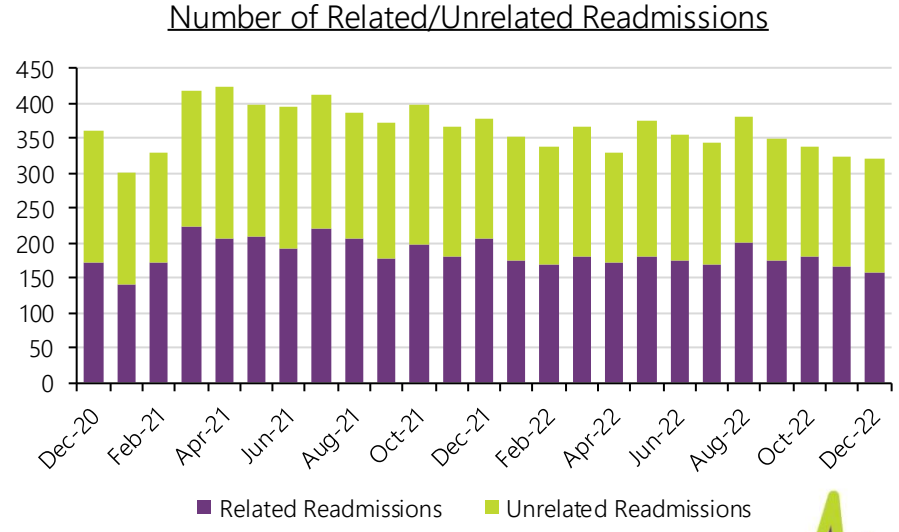


Additional notes	Count	Diff	% Diff
• Readmissions YTD: • Readmissions YTD 19/20:	**3,122** 7,396	**-4,274**	**-57.79%**
• Related Readmissions • Related Readmission 19/20:	**158** 418	**-260**	**-62.20%**
• Readmissions Rate (All) • Readmissions Rate (All) 19/20:	**8.12%** 17.78%	**-9.66%**	**--**

RAG status: Achieved

Targets Met.

Readmissions have remained within the expected range.



Criteria to Reside

Effective

December 22

Total Beddays with no criteria to reside	Beddays with no criteria to reside (Aged 65+)	Average Stranded Patients (21+ Days LOS)
2,655	**2,421**	**76.2**

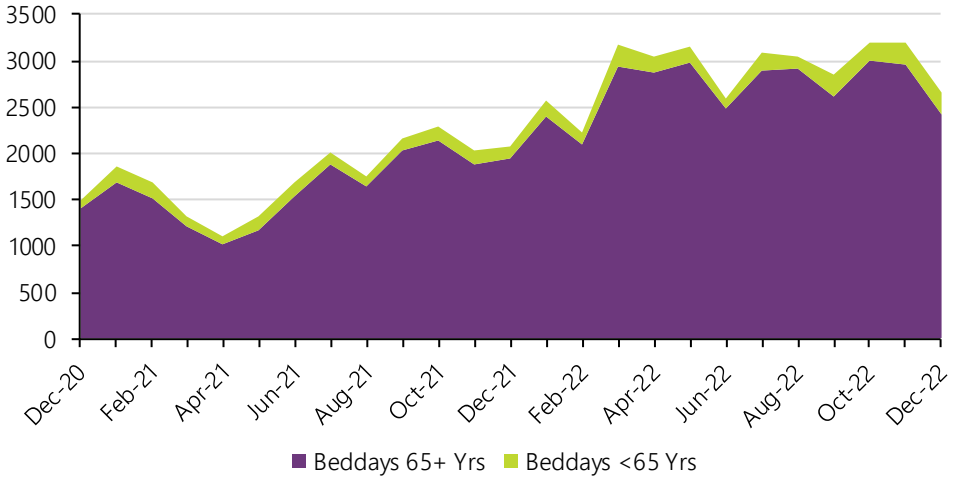
December 19

Total Beddays with no criteria to reside	Beddays with no criteria to reside (Aged 65+)	Average Stranded Patients (21+ Days LOS)
1,318	**1,241**	**38.6**

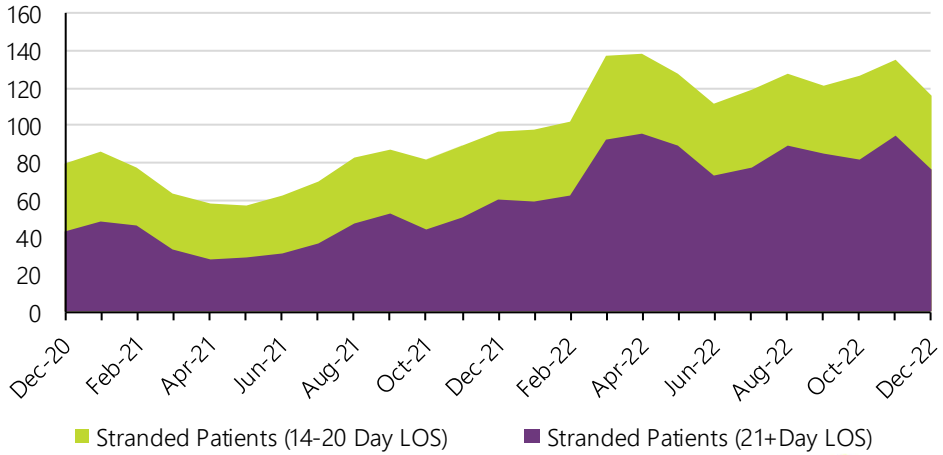
RAG status: Failed

Targets Failed. Reason:
The levels of patients with no criteria to reside is remains high although levels of patients with a length of stay of >21 days has stabilised in later months.

Beddays that do not meet the 'criteria to reside'



Average number of daily Stranded Patients



Cancelled Operations

December 22

On the Day Non-Clinical Reasons	YTD On the Day Non-Clinical Reasons	Rebooked within 28 Day Target	Urgent Cancellations
2	**114**	**50.00%**	**1**

December 19

On the Day Non-Clinical Reasons	YTD On the Day Non-Clinical Reasons	Rebooked within 28 Day Target	Urgent Cancellations
9	**69**	**100.00%**	**2**

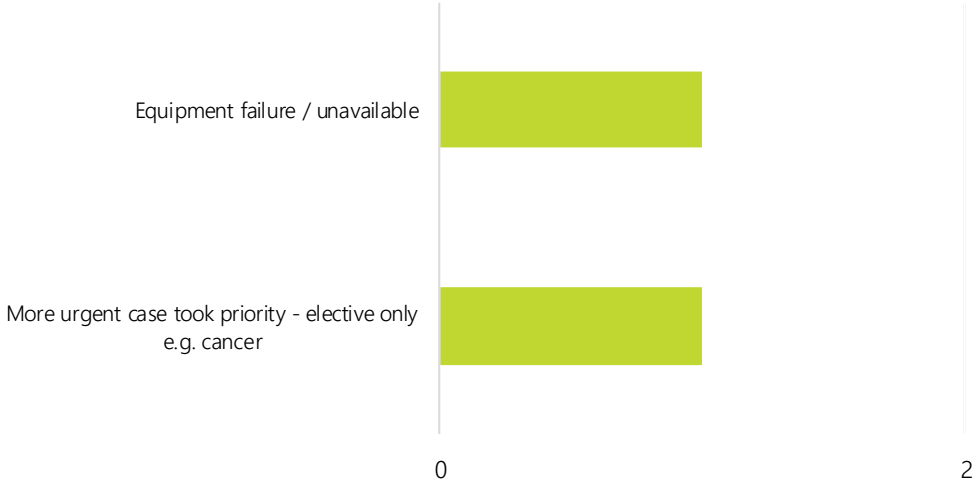
Additional notes

Note: For any elective operation cancelled by the trust on the day of the operation/admission, an offer of a new date must be within 28 days of the cancelled operation date.

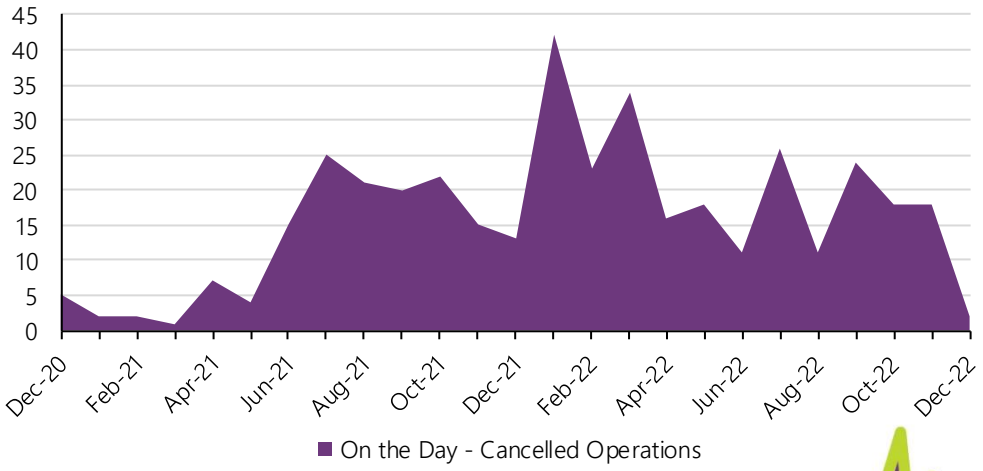
RAG Status: Failed, close to achievement

Targets Failed. Reason:
The main reason for cancellations was due to no beds available and equipment failure.

Hospital non Clinical On the Day Cancellation of Elective Operations Dec-22



Number of Cancelled Operations



Diagnostic Waits

Responsive

December 22

Overall Diagnostic 6 Week Waits

69.44%

(Target 99.0%)

Additional notes

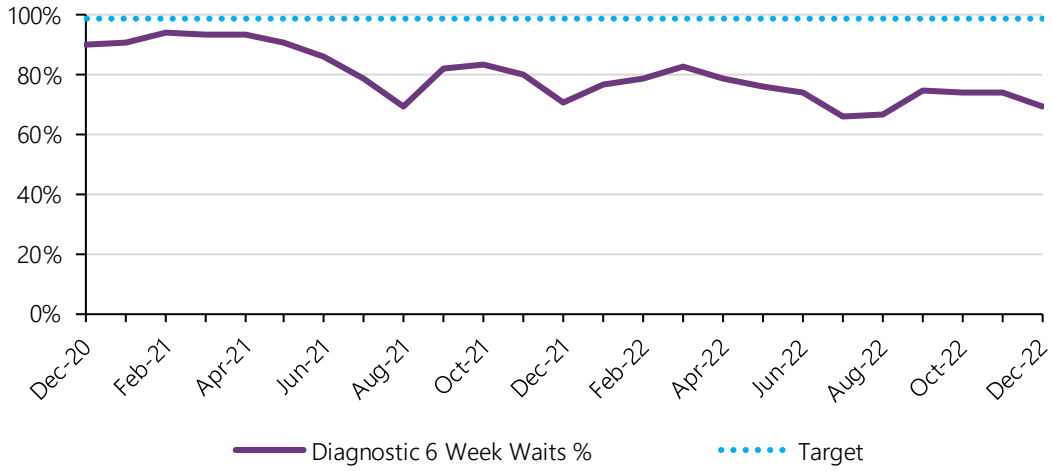
The area with the lowest diagnostics performance was:

Physiological Measurement	**32.94%**

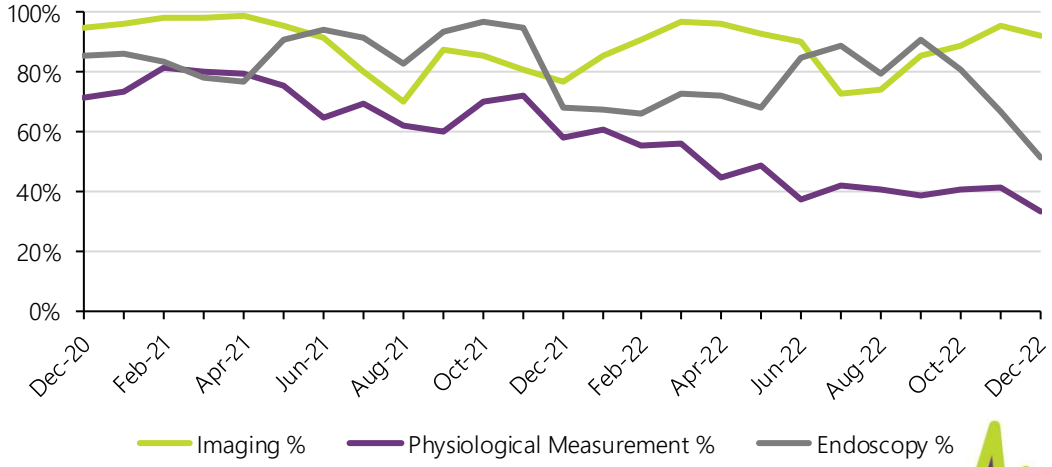
RAG status: Failed

Targets Failed. Reason:
There continues to be capacity issues with Echocardiology and Audiology Services but weekly reviews of the waiting lists continue to ensure patients are seen as soon as possible and in priority order. The Ultrasound waiting list size has increased due to an increase in bookings, extra lists have been put in place in response.

Diagnostic 6 Week Waits %



Diagnostic Waits by Type of Test



RTT Performance

Responsive

December 22

18 Week Incomplete Pathways	> 52 Week Waits	> 104 Week Waits
69.67%	**558**	**2**
Target - 92%		Dec 2022 Trajectory - 8

December 19

18 Week Incomplete Pathways	> 52 Week Waits	> 104 Week Waits
89.23%	**0**	**0**

Additional Notes:

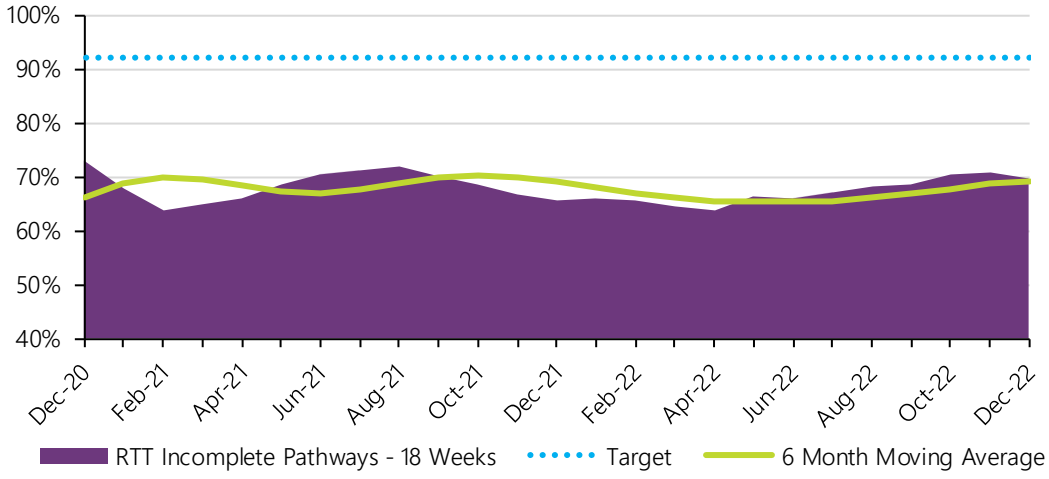
Specialties with the Lowest RTT Performance this month:

T&O - **43.20%**
ENT - **51.90%**

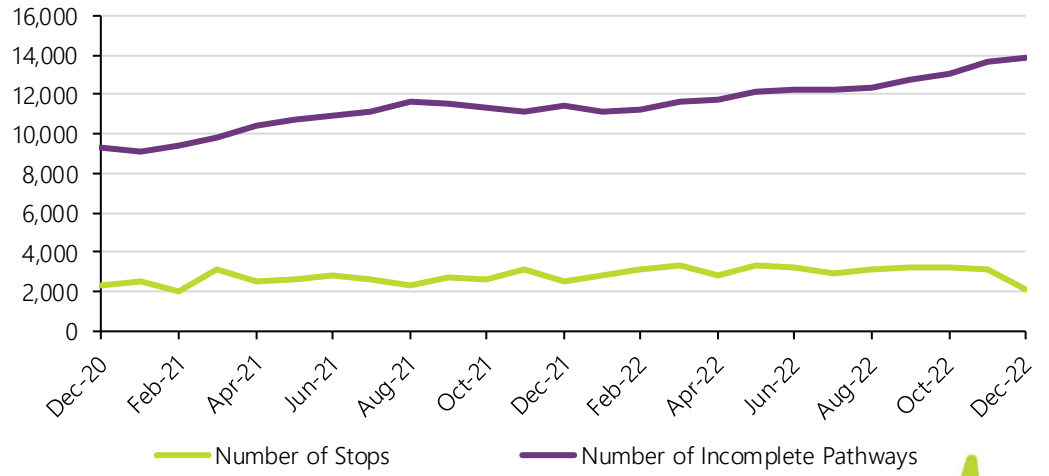
RAG status: Failed

ENT non-admitted pathways and T&O, and gynaecology admitted pathways continue to be areas of focus. RTT Performance continues to improve and the Trust is achieving target levels of 104 week waiters.

RTT Incomplete Pathways - 18 Weeks



RTT Incomplete Pathways with All Stops



RTT Pathways

Responsive

December 22

Incomplete Pathways	Pathways > 18 Weeks	Pathways > 40 Weeks	Pathways > 78 Weeks
13874	**4208**	**1162**	**58**

December 19

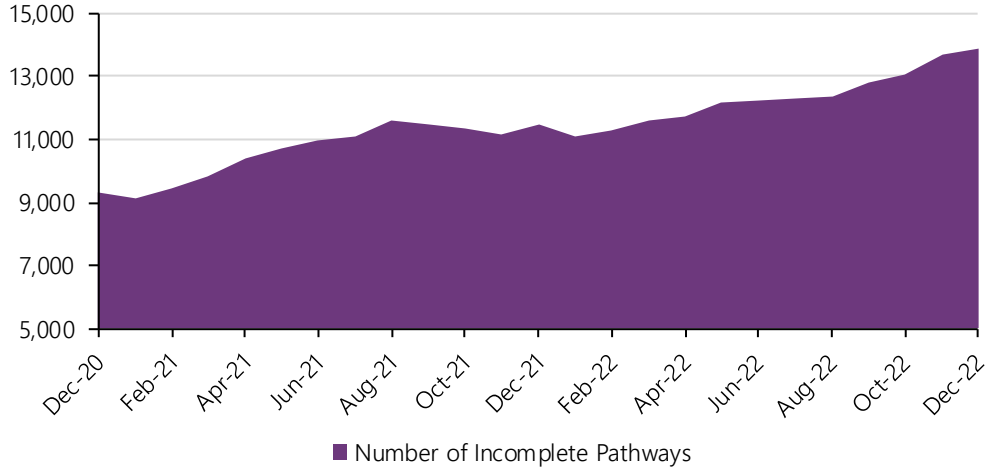
Incomplete Pathways	Pathways > 18 Weeks	Pathways > 40 Weeks	Pathways > 78 Weeks
10060	**1083**	**14**	**0**

Additional notes	Diff	% Diff
Number of Incomplete Pathways	**3814**	**37.91%**

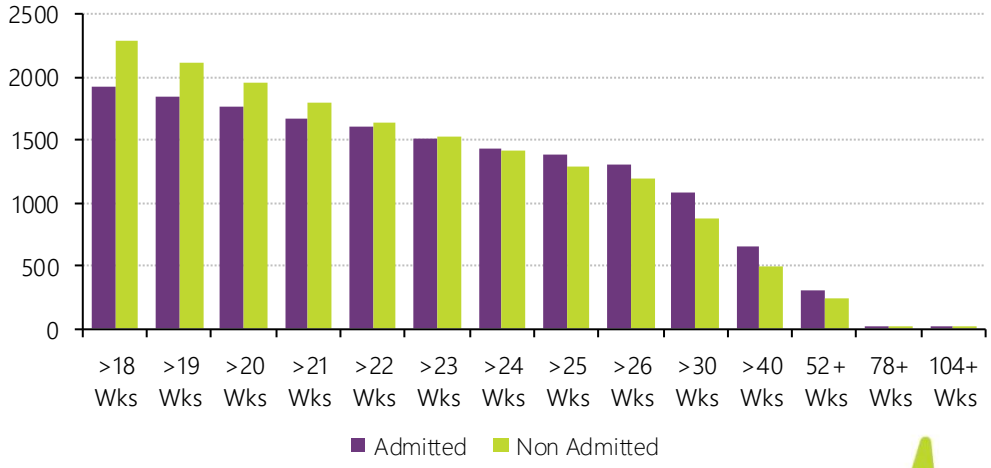
RAG status: Failed, close to achievement

Targets Failed. Reason:
Total RTT Waiting List size continues to exceed pre covid levels, with four times the number of 18 week breaches. Patients on the waiting list are reviewed and prioritised with the focus on urgent, cancer and our longest wait patients.

RTT Incomplete Pathways (total waiting list size)



RTT Incomplete Pathways - Aging



Cancer Performance

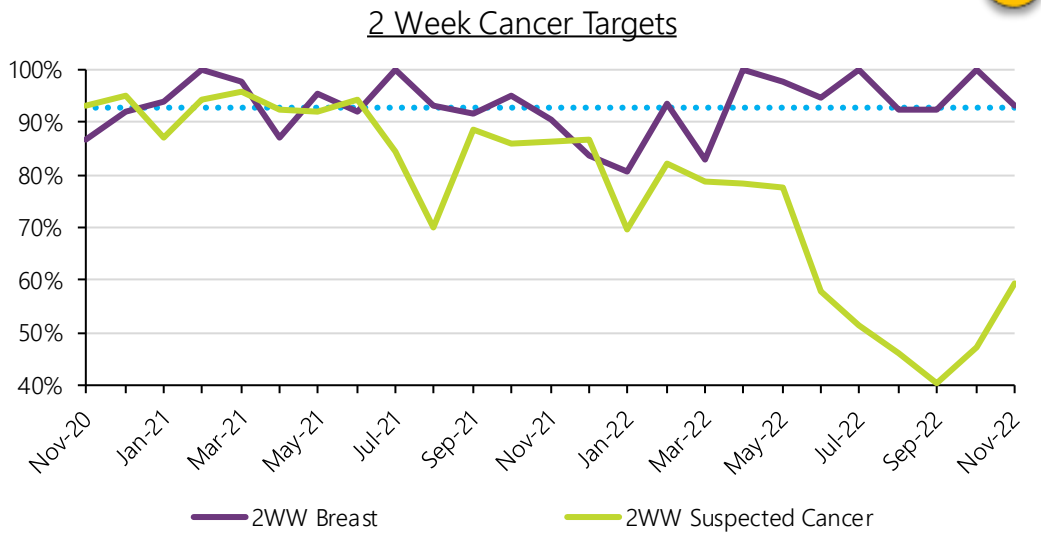
Responsive

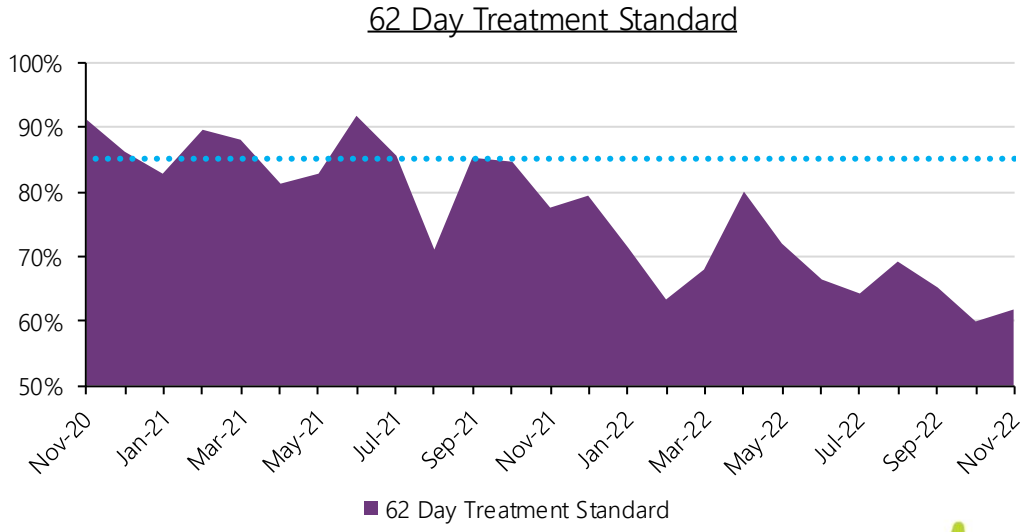
November 22

28 Day Diagnosis: 2 Week Suspected Cancer	28 Day Diagnosis: Exhibited Breast Cancer Symptoms
66.39%	**95.45%**
(National Target - 75.00%)	(National Target - 75.00%)
2 Week Suspected Cancer	2 Week Exhibited Breast Cancer Symptoms
59.35%	**93.18%**
(National Target - 93.00%)	(National Target - 93.00%)
31 Day Treatment First	62 Day Treatment Standard
91.45%	**61.88%**
(National Target - 96.00%)	(National Target - 85.00%)

RAG status: Failed, close to achievement

2ww: Breaches in Skin and Gynaecology due to reduced resource availability
31 day: Breaches in Skin due to delays in 2ww first appointments
62 day: Urology, Colorectal and Skin breaches due to diagnostic and capacity delays





Outpatients Transformation

2022/23 YTD

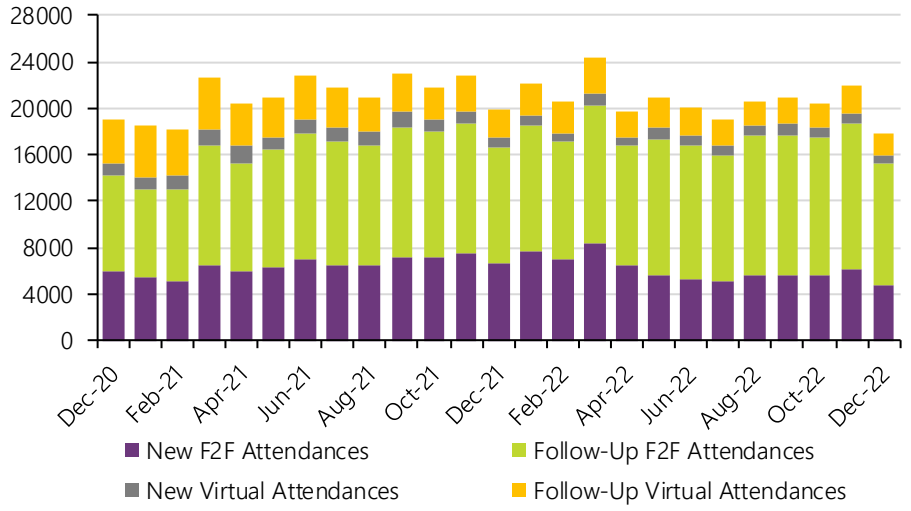
Total Outpatients Activity	Outpatient Procedures Proportion	Virtual Clinic Activity Proportion
181,067	**15.36%**	**14.3%**
ASI Rate	Average Wait to First OP (Weeks)	DNA Rate
101.48%	**10.64**	**6.34%**
All Appointment Cancellations	Patient Cancellations	Trust Cancellations
27.26%	**9.20%**	**18.07%**
Patients Offered PIFU Rate		
12.70%		

Comments

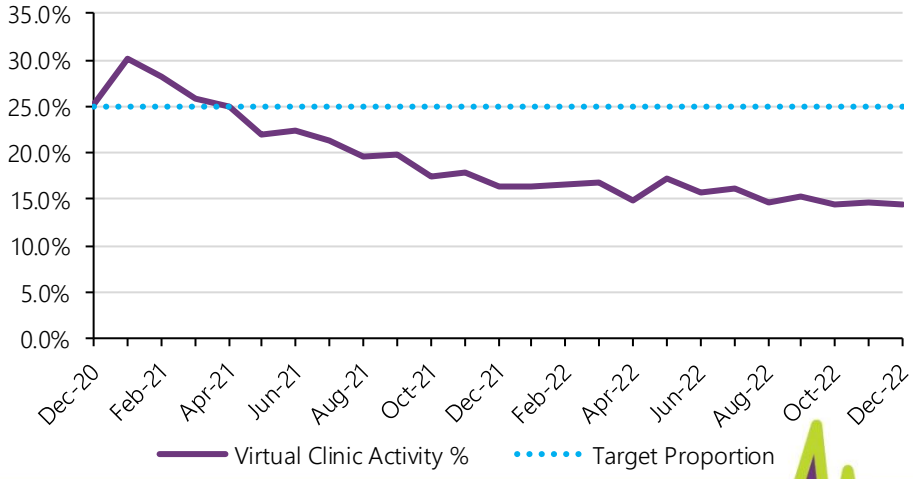
Please note that 'Virtual' Clinic activity includes Telephone follow-up clinics.

- The % Virtual activity has been in decline as the focus has shifted to restoration and recovery activity with more patients needing to be seen face to face.

Number of Outpatient Attendances



Proportion of Virtual Clinic Activity



ED Transformation

December 22

Median Time to Triage (hh:mm)	Median Time in Department (hh:mm)	
00:14	**03:33**	

A&E 4 Hour Performance	Total A&E Attendances	Year on Year A&E Growth (2019)
63.44%	**6160**	**14.81%**

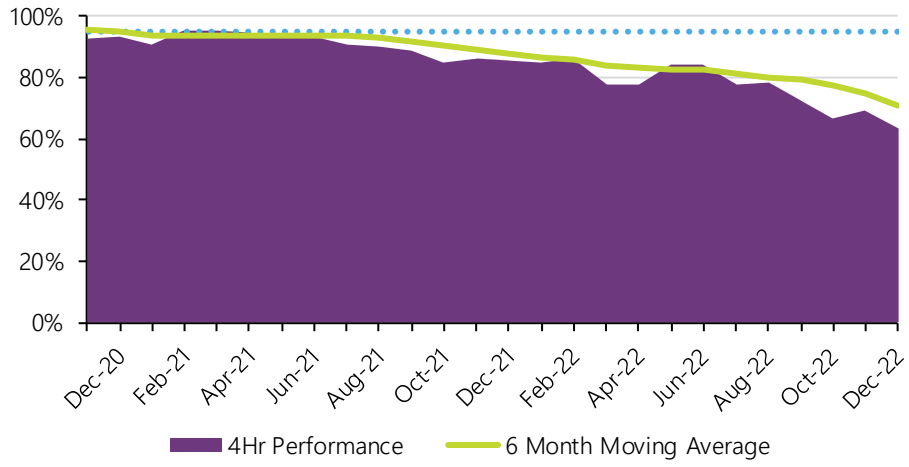
Attendances resulting in an Inpatient stay	12 Hour Trolley Waits	Handovers time lost >15 minutes
26.14%	**0**	**311:27:05**

Total Ambulance Handovers	Ambulance Handovers 30+ mins	Ambulance Handovers Performance
1213	**450**	**62.90%**

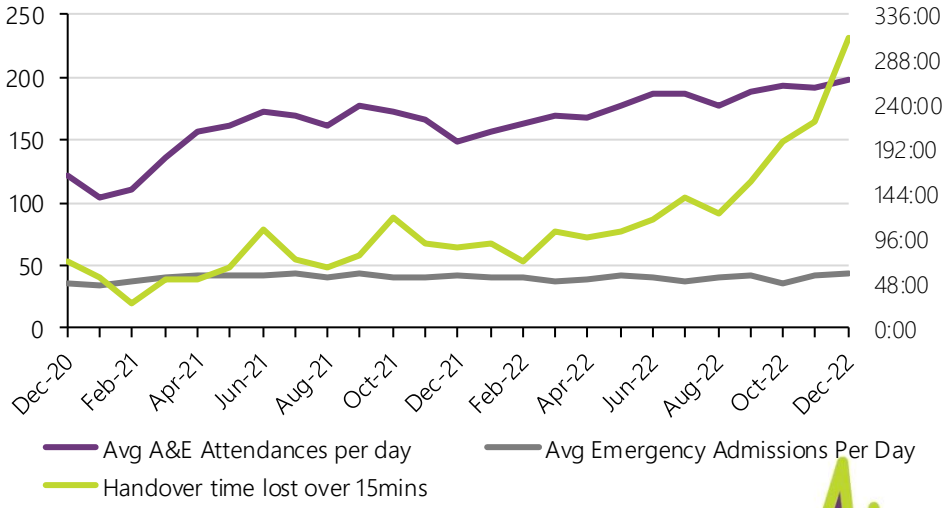
Comments

The continuing bed pressures within the Trust are impacting on the average waiting times in ED and Ambulance handover times which are at the highest level they have been in the last two years.

A&E 4 Hour Performance - All Attendances



Avg A&E Attendances per day



Patient Complaints and PALS

Caring

December 22

Complaints	PALs	PALS Concerns	PALS Enquiries
4	**118**	**34**	**84**

December 19

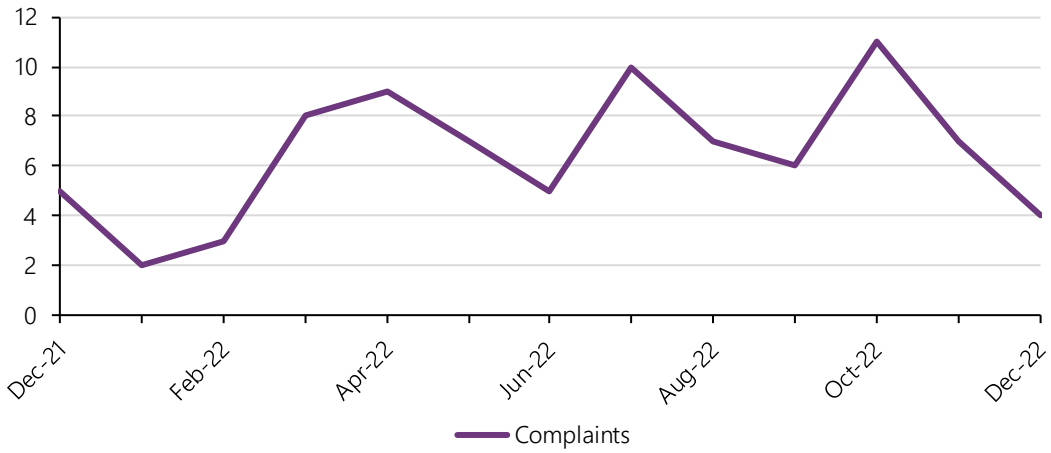
Complaints	PALs	PALS Concerns	PALS Enquiries
2	**99**	**63**	**36**

Additional notes			
• Complaints YTD:	**66**	**+27**	**+69.23%**
• Complaints YTD 19/20:	39		
• PALs YTD:	**1395**	**+461**	**+49.36%**
• PALs YTD 19/20:	934		

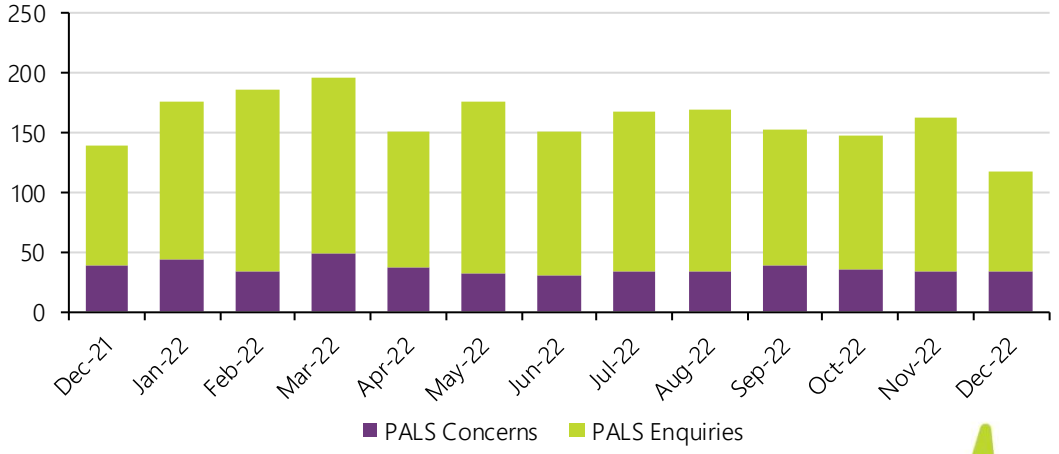
RAG status: Achieved

Themes and trends are discussed at the Patient Experience and Engagement Committee. Communication with relatives and information given to patients and relatives continues to be an issue due to restrictions on visiting. There were also high levels of PALs enquiries around cancelled operations and appointments.

Number of Complaints



PALS Breakdown



YDH Group | Workforce Report Well Led - Staffing

December 22

Workforce Assurance

December 22

Workforce Assurance - **YDH Only**

Workforce	Monthly Position	Contracted FTE						
	Dec-19 Dec-22	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
	1782.0 2211.4	54.1	407.7	461.0	151.1	10.7	300.3	802.6

Workforce	Monthly Position	Labour Turnover							Rolling 12 Month Trend
Target	Dec-19 Dec-22	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	
12% - 17%	16.78% 17.42%	23.31%	22.03%	23.06%	14.59%	16.67%	21.21%	10.45%	

Workforce	Monthly Position	Sickness Absence - In Month							Rolling 12 Month Trend
Target	Nov-19 Nov-22	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	
3%	2.81% 4.03%	0.93%	5.81%	4.36%	4.27%	0.00%	1.47%	4.21%	

Workforce	Monthly Position	Mandatory Training							Rolling 12 Month Trend
Target	Dec-19 Dec-22	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	
85%	90.23% 85.63%	87.57%	86.69%	87.73%	86.17%	88.98%	77.15%	87.23%	

Workforce	Monthly Position	Appraisals							Rolling 12 Month Trend
Target	Dec-19 Dec-22	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	
90%	88.80% 81.73%	92.75%	82.49%	77.54%	90.74%	50.00%	86.62%	79.49%	

In agreement with the People Committee in November 2022 the targets will be reviewed in line with our people strategy focus on creating an environment where colleagues can thrive. This will see a shift away from the traditional measures to a focus on understand the experience of colleagues moving forward.

Contracted FTE

December 22

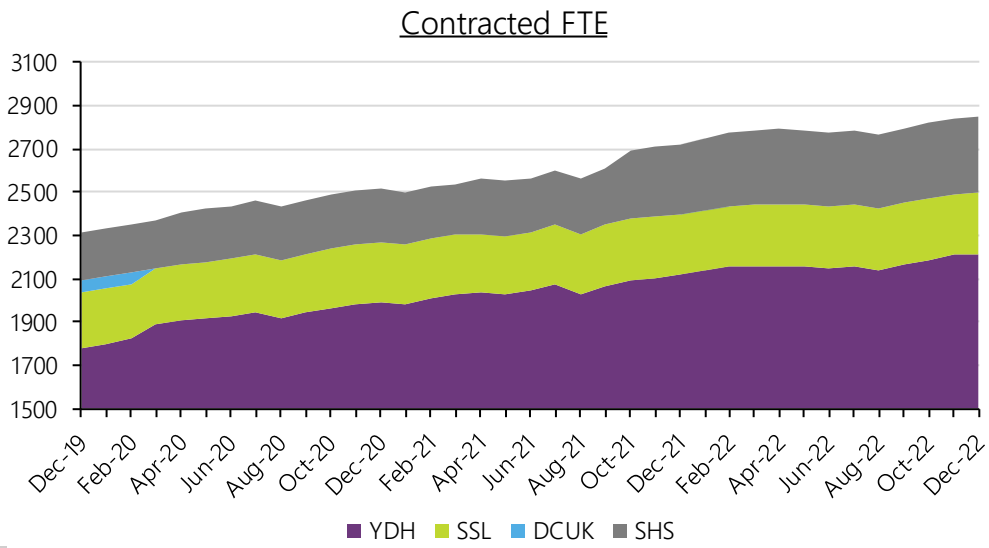
YDH Group	YDH	SHS	SSL
2852.6	**2211.4**	**357.9**	**283.2**

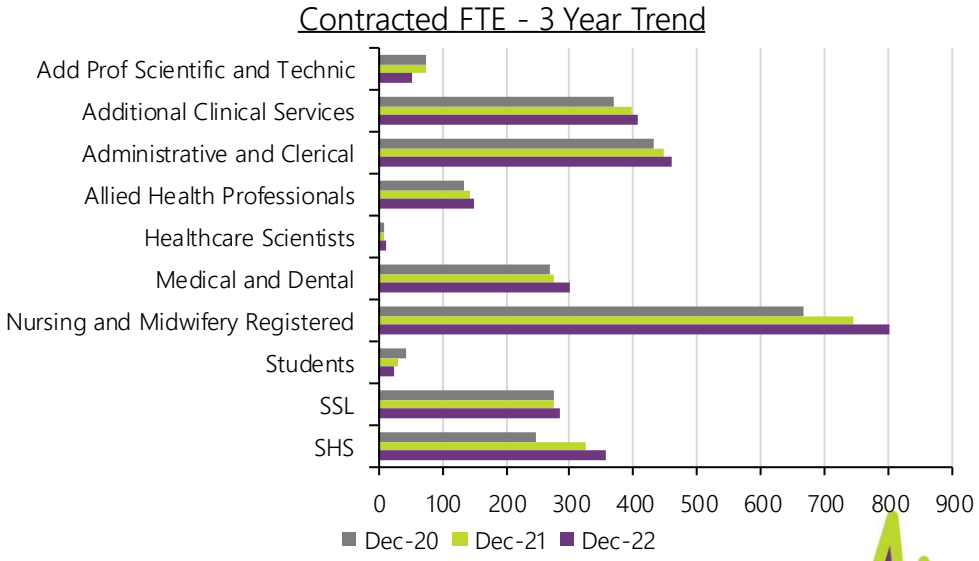
December 19

YDH Group	YDH	SHS	SSL
2314.7	**1782.0**	**220.2**	**255.9**

Additional notes	Count	Diff	% Diff
• Group FTE:	**2852.6**	**+538**	**+23.24%**
• Group FTE 19/20:	2314.7		
• Group FTE (Excl SHS):	**2494.7**	**+400**	**+19.10%**
• Group FTE (Excl SHS) 19/20:	2094.5		

Comments





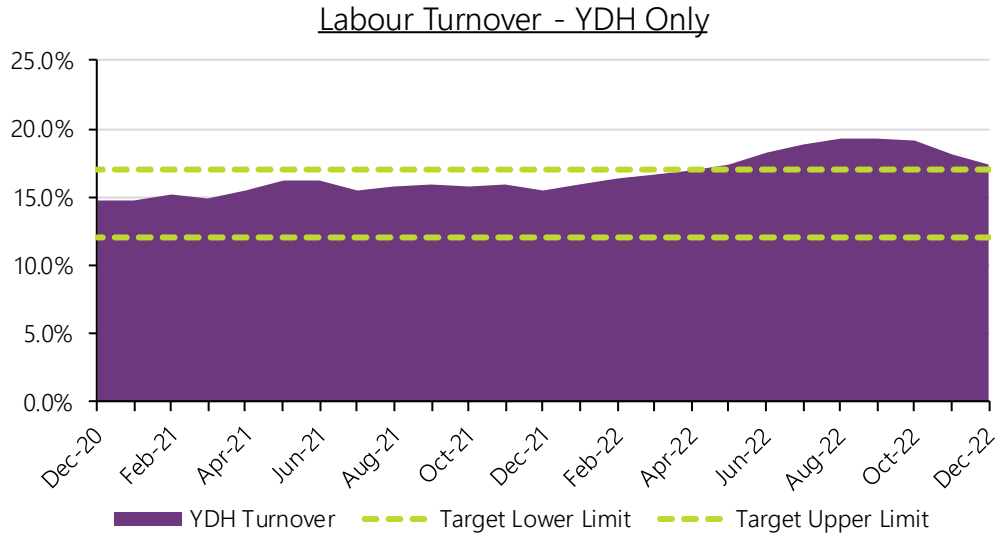
Turnover

December 22

YDH Group	YDH	SHS	SSL
17.51%	**17.42%**	**17.69%**	**17.90%**

December 19

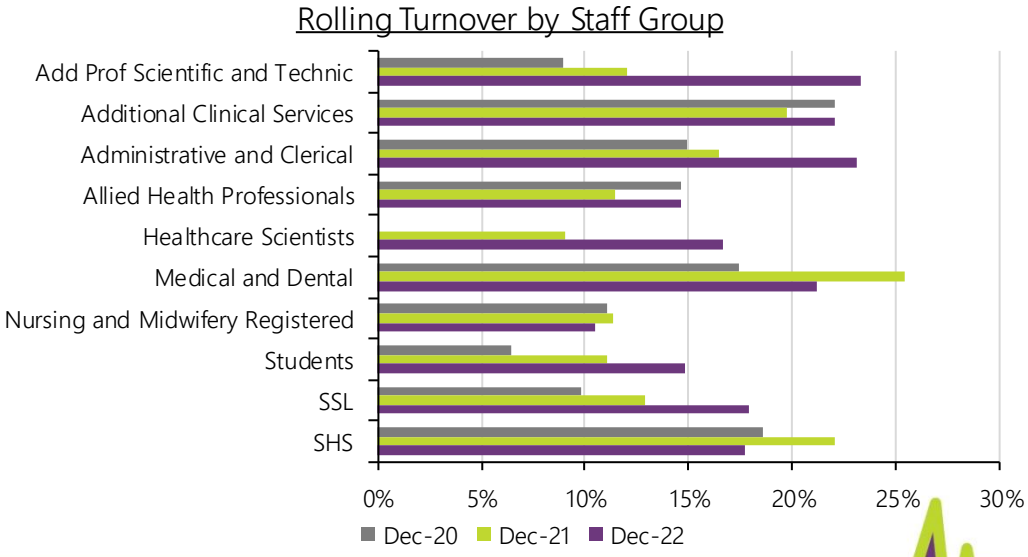
YDH Group	YDH	SHS	SSL
18.12%	**16.78%**	**27.90%**	**13.97%**



Additional notes	Achievement	Diff
• Group Turnover:	**17.51%**	**-0.61%**
• Group Turnover 19/20:	18.12%	
• YDH Turnover:	**17.42%**	**0.64%**
• YDH Turnover 19/20:	16.78%	

Comments

Focus remains on reviewing and understanding turnover, ensuing interventions are in place to reduce the level of turnover by responding to the causes of colleagues leaving. A number of interventions are being developed as part of the focus on the BHS People Promise and retention programme.



Leaving Reasons - YDH

December 22

Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
397	**323**

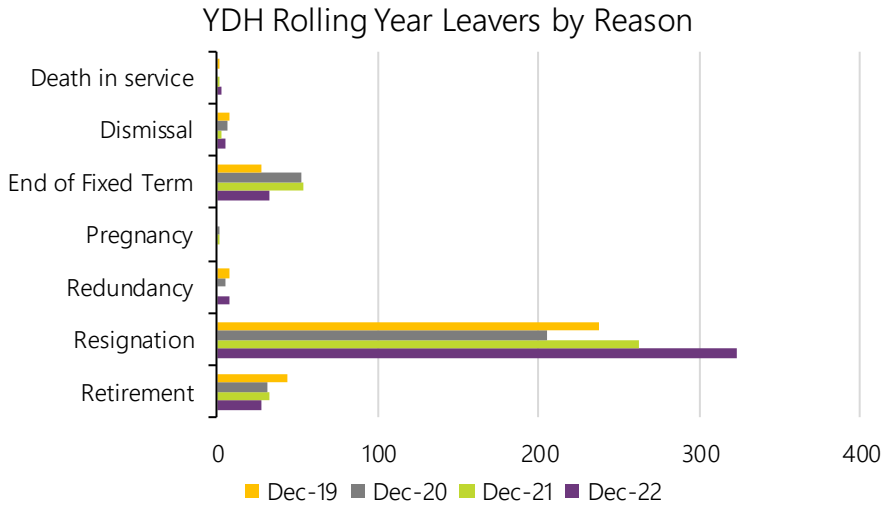
December 19

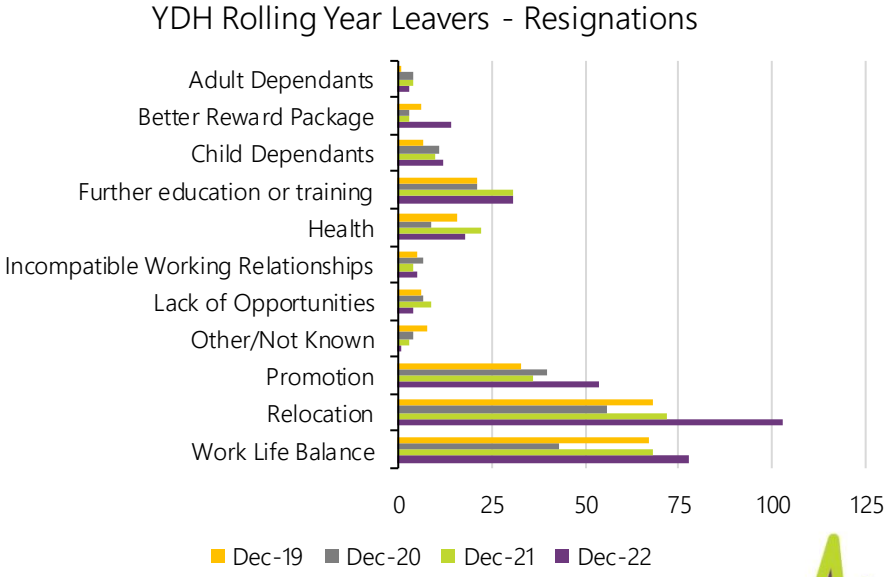
Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
300	**205**

Additional notes	Count	Diff	% Diff
• Rolling Year Leavers:	**397**	**+97**	**+32.33%**
• Rolling Year Leavers 19/20:	300		

Comments

The focus on better understanding the turnover within the admin and clerical and additional clinical services colleague groups continues. A recent review of exit interviews from YDH has reinforced the reasons for leaving as shown in this slide, the majority of leavers are leaving for career progression, relocation and retirement. The plans developed as apart of the People Promise focus will all support improvements in these areas.





Leaving Reasons - SSL

December 22

Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
53	**46**

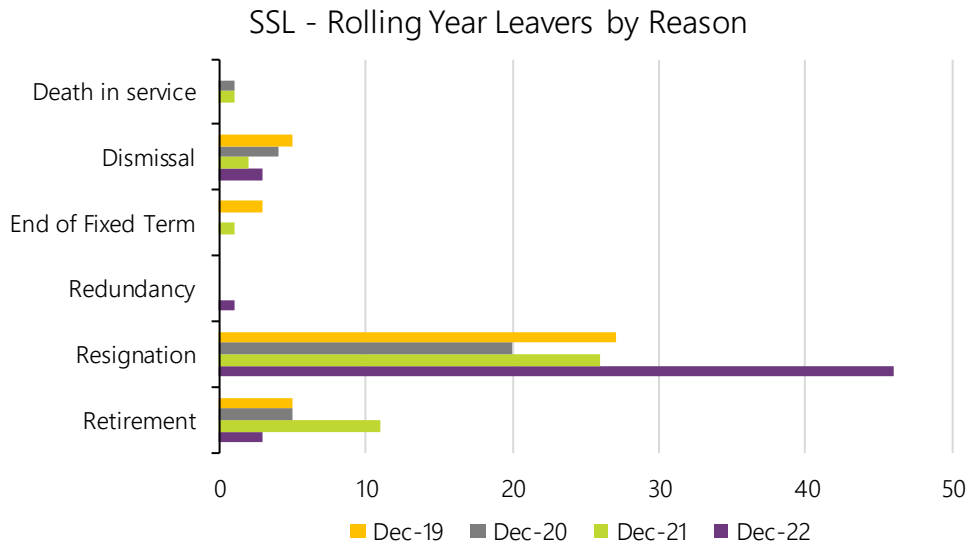
December 19

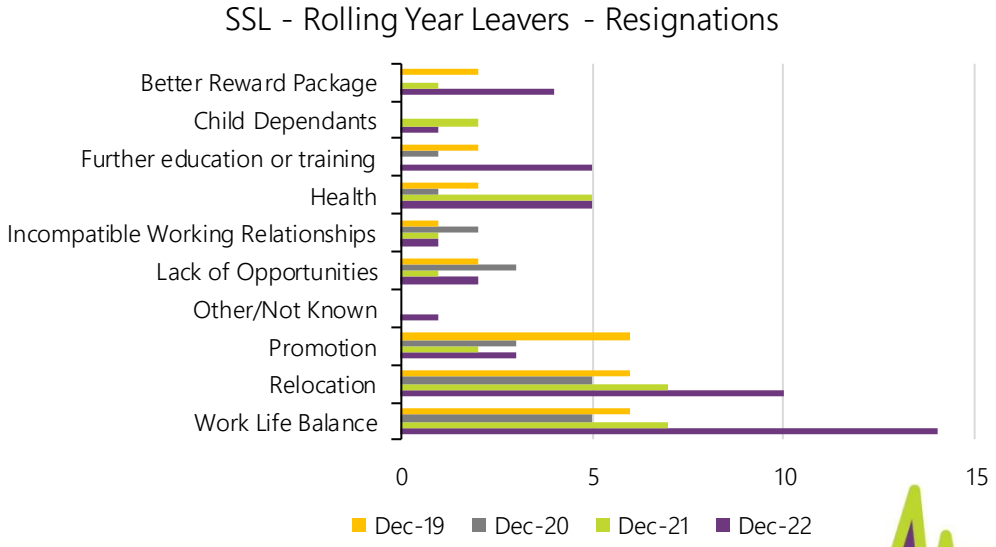
Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
40	**20**

Additional notes	Count	Diff	% Diff
• Rolling Year Leavers:	**53**	**+13**	**+32.5%**
• Rolling Year Leavers 19/20:	40		

Comments

Terms and Conditions – SSL's Terms and Conditions are seen as the major contributor towards the increased turnover rates being experienced, where employees can earn more and have better terms and conditions elsewhere within the local economy.





Leaving Reasons - SHS

December 22

Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
108	**91**

December 19

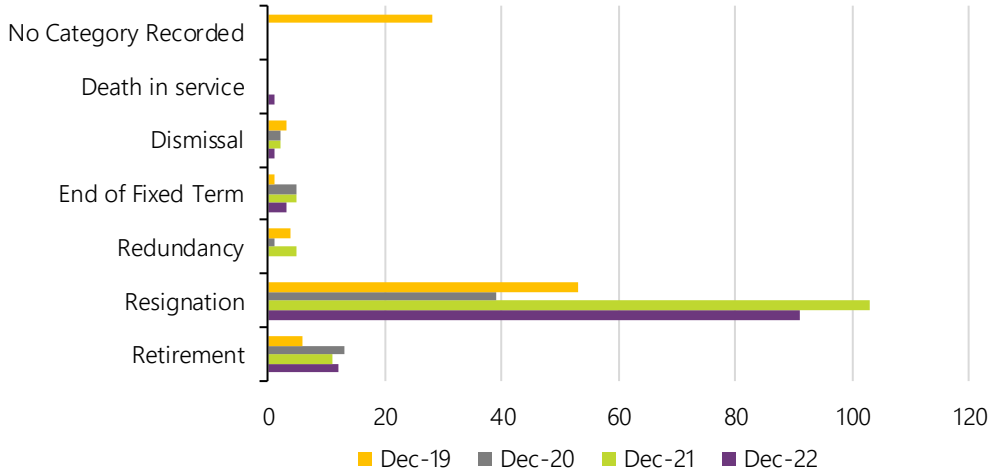
Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
95	**53**

Additional notes	Count	Diff	% Diff
• Rolling Year Leavers:	**108**	**+13**	**+13.7%**
• Rolling Year Leavers 19/20:	95		

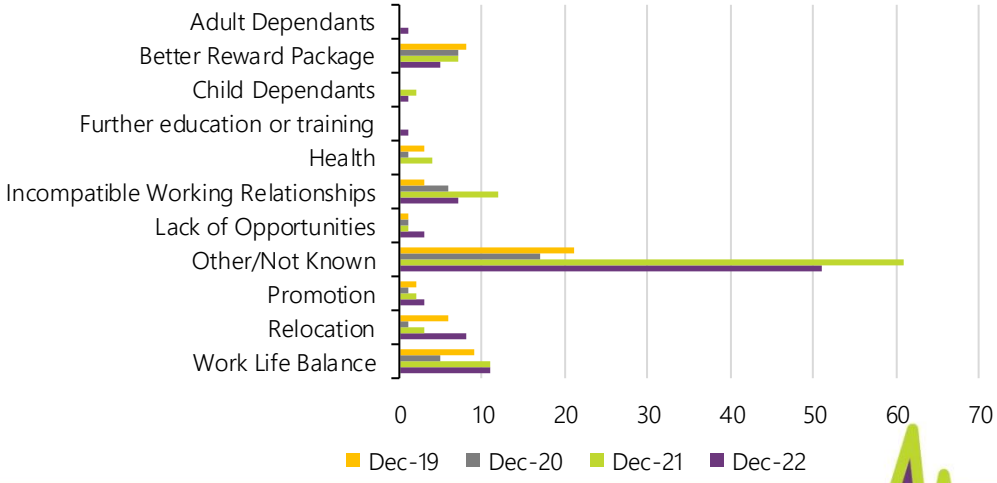
Comments

Reasons for resignations continue to be monitored by SHS.

SHS - Rolling Year Leavers by Reason



SHS - Rolling Year Leavers - Resignations



Leavers in Month

December 22

YDH Group	YDH	SSL	SHS
27	**21**	**2**	**4**

December 19

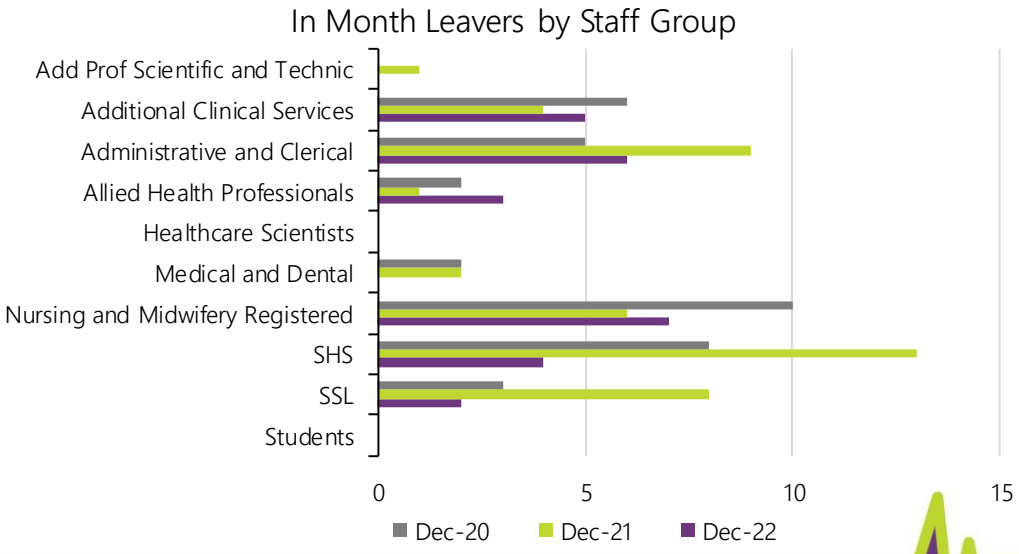
YDH Group	YDH	SSL	SHS
52	**37**	**4**	**10**

Additional notes	Count	Diff	% Diff
• In Month Leavers:	**27**	**-25**	**-48.08%**
• In Month Leavers 19/20:	52		

Comments

Analysis shows that individuals are leaving within the first 3 years and in some instances within the first 12 months. The reasons for this are currently being explored and actions to address will be reported and monitored through the Trust People Committee.

	Length of Service			
Staff Group	Less than 1 Yr	1 to 3 Yrs	Over 3 Yrs	**Total**
Add Prof Scientific and Technic	0	0	0	**0**
Additional Clinical Services	1	1	3	**5**
Administrative and Clerical	2	3	1	**6**
Allied Health Professionals	0	2	1	**3**
Healthcare Scientists	0	0	0	**0**
Medical and Dental	0	0	0	**0**
Nursing and Midwifery Registered	0	1	6	**7**
SSL	0	0	0	**0**
SHS	--	--	--	**6**
Total	**3**	**7**	**11**	**27**



Vacancies Being Recruited to - YDH Group

Vacancies being recruited to (FTE)	Oct-22	Nov-22	Dec-22
Additional Clinical Services	5.0	9.4	1.0
Additional Prof Scientific & Technical	10.2	7.3	17.0
Admin & Clerical	25.4	14.1	10.2
Allied Health Professionals	4.0	20.7	10.0
Ancillary	0.0	0.0	0.0
Estates	0.0	0.0	0.0
HCA's	4.0	20.0	27.0
Medical	20.0	17.0	17.0
Medical Training	7.0	6.0	6.0
Senior Managers	0.0	0.0	0.0
SSL	14.2	12.6	5.8
Specialist Nursing / Band 6	7.0	3.4	10.4
Nursing and Midwifery Qualified - Childrens	0.0	0.0	0.0
Nursing and Midwifery Qualified - Ward Areas	0.0	15.0	10.0
Nursing and Midwifery Qualified - EAU / ED	6.0	0.0	0.0
Nursing and Midwifery Qualified - ICU	0.0	0.0	0.0
Nursing and Midwifery Qualified - Outpatients	1.8	1.0	1.0
Nursing and Midwifery Qualified - Midwifery	0.0	0.0	0.0
Nursing and Midwifery Qualified - Theatres	5.0	6.0	0.0
Nursing and Midwifery Qualified - Total	**12.8**	**22.0**	**11.0**
Total	**109.6**	**132.5**	**115.4**

Additional notes

Sickness Absence

November 22

YDH Group	YDH	SHS	SSL
4.16%	**4.03%**	**3.91%**	**5.49%**

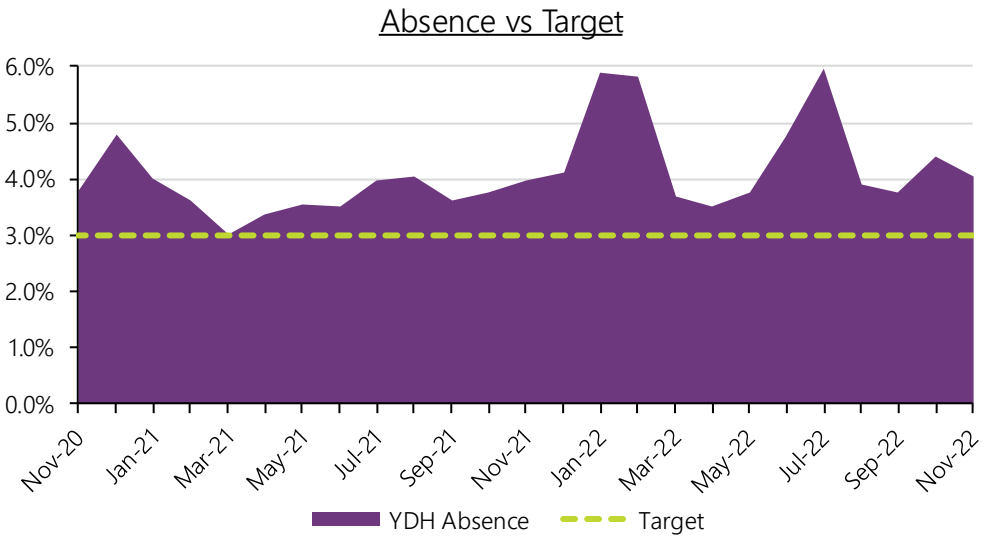
November 19

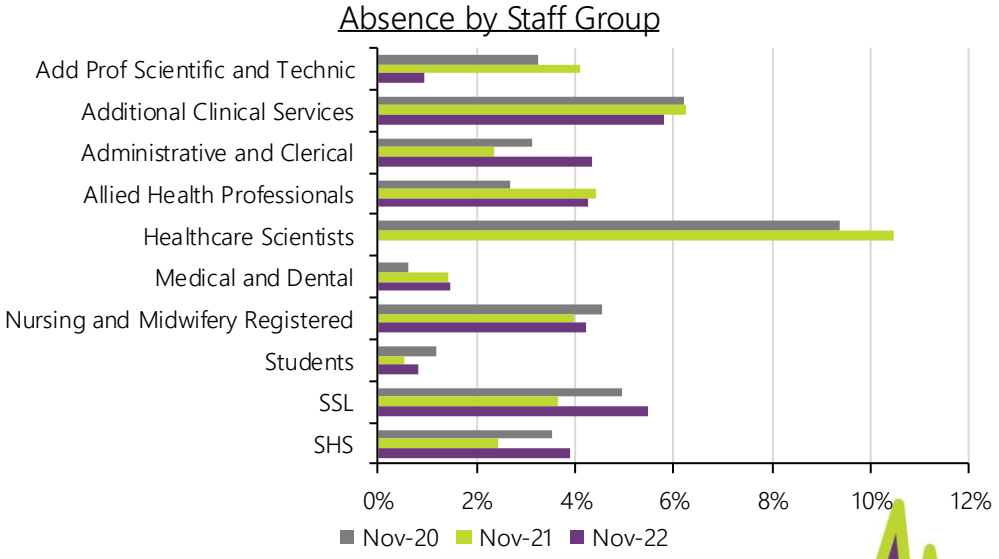
YDH Group	YDH	SHS	SSL
3.22%	**2.81%**	**3.48%**	**4.47%**

Additional notes	Count	Diff
• YDH Covid Absence (All absence):	**0.57%**	
• SSL Covid Absence (All absence):	0.84%	
• Group 12 month sickness absence:	**4.75%**	**1.94%**
• Group 12 month sickness absence 19/20:	2.81%	

Comments

Sickness Absence has increased - driven mainly by seasonal infections over the last 12 months. This is primarily affecting SSL services but also across all staff groups.
Please note that the Absence figures only relate to sickness absence, and is reported one month in arrears.





Statutory Training

December 22

YDH Group	YDH	SHS	SSL
85.85%	**85.63%**	**81.36%**	**95.40%**

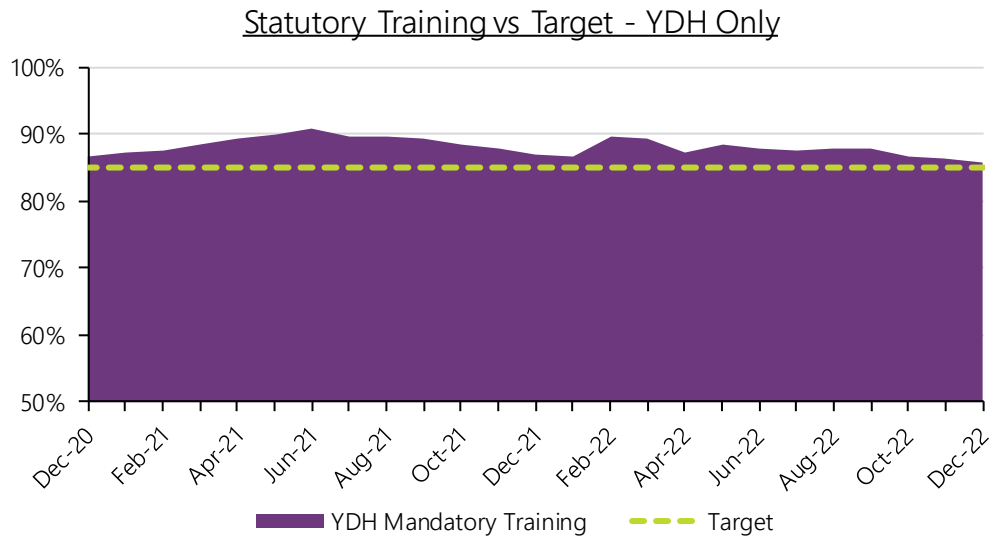
December 19

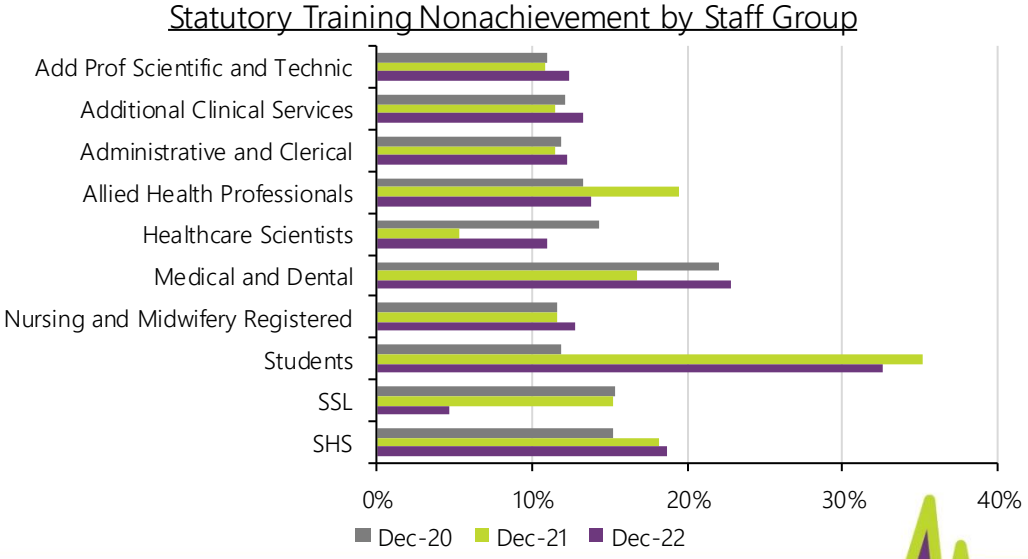
YDH Group	YDH	SHS	SSL
88.36%	**90.23%**	**75.32%**	**89.16%**

Additional notes	Count	Diff
• Group Statutory Training:	**85.85%**	**-2.51%**
• Group Statutory Training 19/20:	88.36%	
• YDH Statutory Training:	**85.63%**	**-4.60%**
• YDH Statutory Training 19/20:	90.23%	

Comments

Remains over target, however Infection Control, Information Governance, and Resus remain a focus. Additional training sessions are being provided on the Wards to support staff who are unable to be released. The Statutory training calculations include the Health, Safety and Welfare element from Aug '21 onwards.





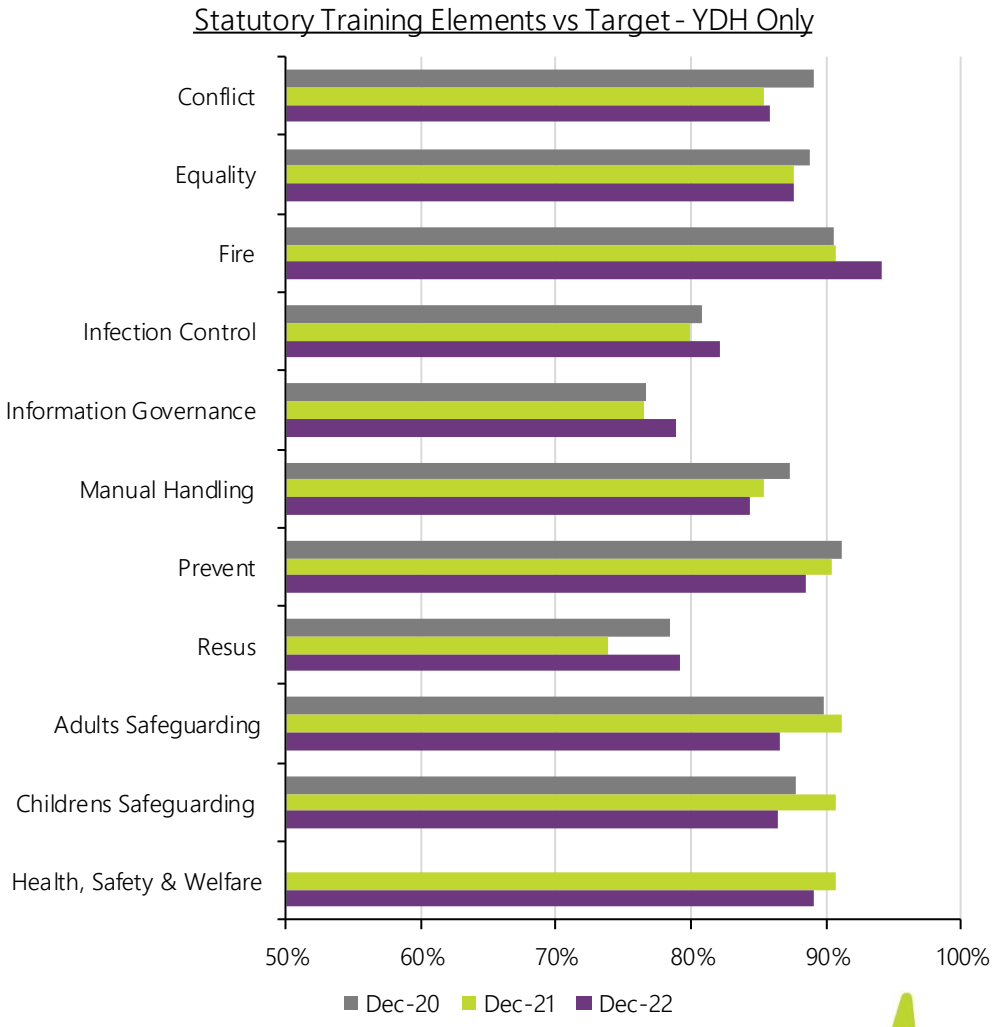
Statutory Training Elements

December 22

Overall Achievement	Conflict	Equality
85.85%	85.78%	87.57%
Fire	**Infection Control**	**Information Governance**
94.13%	82.08%	78.88%
Manual Handling	**Prevent**	**Resus**
84.34%	88.45%	79.14%
Childrens Safeguarding	**Adults Safeguarding**	**Health, Safety & Welfare**
86.60%	86.60%	89.05%

Comments

Please note that the trust's target for statutory training is 85%, with the safeguarding elements benchmarked against a 90% target. Both YDH and SFT Trusts have started to work together to align Mandatory Training programmes and agree targets and reporting approaches in preparation for the upcoming Merger.



Safeguarding Training

December 22

Childrens Safeguarding	Adults Safeguarding
86.41%	86.60%

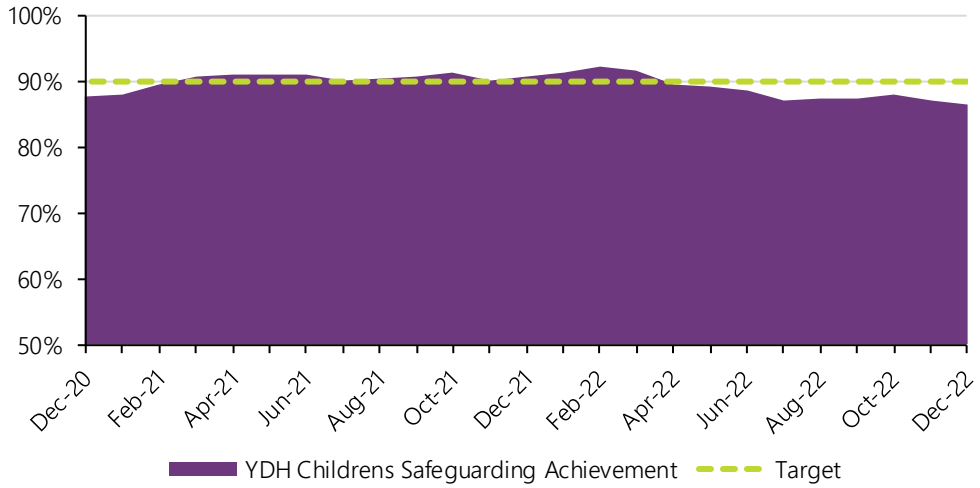
Childrens Safeguarding - Level 1	Childrens Safeguarding - Level 2	Childrens Safeguarding - Level 3
89.46%	86.16%	87.65%

Additional notes	Achievement
• Childrens Safeguarding Level 1 - YDH	86.18%
• Childrens Safeguarding Level 2 - YDH	86.37%
• Childrens Safeguarding Level 3 - YDH	87.65%
• Adults Safeguarding - YDH	86.75%

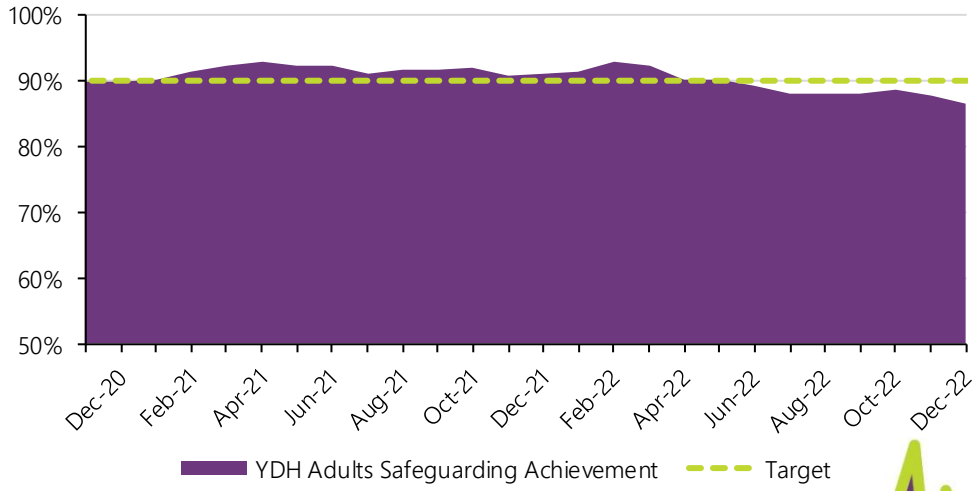
Comments

Please note that the trusts contractual target for safeguarding training compliance is 90%.

Childrens Safeguarding Achievement vs Target - YDH Only



Adults Safeguarding Achievement vs Target - YDH Only



Appraisals

December 22

YDH Group	YDH	SHS	SSL
83.98%	**81.73%**	**89.96%**	**91.80%**

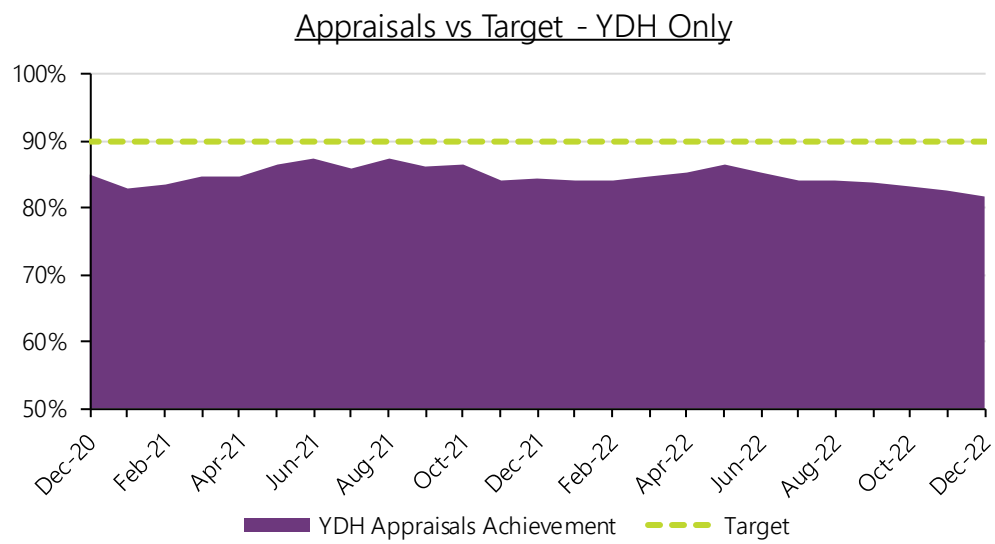
December 19

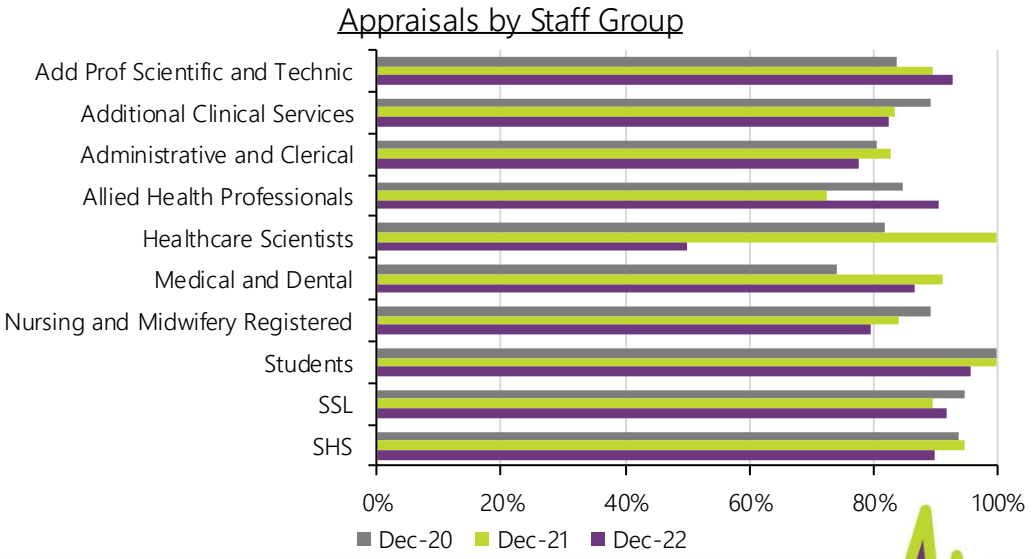
YDH Group	YDH	SHS	SSL
87.92%	**88.80%**	**86.23%**	**83.51%**

Additional notes	Count	Diff
• Group Appraisals:	**83.98%**	**-3.94%**
• Group Appraisals 19/20:	87.92%	
• YDH Appraisals:	**81.73%**	**-7.07%**
• YDH Appraisals 19/20:	88.80%	

Comments

The YDH Group 12 month appraisals achievement in December was 77.1%. Appraisal performance is below target as expected because of Covid, however there is now a real focus on improving this over the following few months.





Appendix A - Slide Index

Slide Index - Performance

1) Performance Section Title Slide
2) Contents
3) Mortality Rates
4) Patient Falls and Pressure Ulcers
5) Infection Control
6) Stroke Services
7) Admissions and Length of Stay
8) Readmissions
9) Criteria to Reside
10) Cancelled Operations
11) Diagnostic Waits
12) RTT Performance
13) RTT Pathways
14) Cancer Performance
15) Outpatients Transformation
16) ED Transformation
17) Patient Complaints and PALS

Appendix A - Slide Index

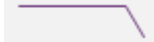
Slide Index - Workforce

18) Workforce Section Title Slide
19) Workforce Assurance
20) Contracted FTE
21) Staff Turnover
22) Leaving Reasons - YDH
23) Leaving Reasons - SSL
24) Leaving Reasons - SHS
25) Leavers in Month
26) Vacancies Being Recruited to - YDH Group
27) Sickness Absence
28) Mandatory Training
29) Mandatory Training Elements
30) Safeguarding Training
31) Appraisals

Appendix B - YDH Quality Measures

December 22

Admissions	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
Number of medical outliers in acute wards (beddays)	1299	1063	1252	1333	1152	971	1033	1134	978	1183	1126	1358	
MSA breaches: Acute wards	0	0	5	0	0	0	0	0	0	0	0	0	
Number of patients transferred between acute wards after 10pm	97	84	143	102	81	61	51	53	70	66	73	95	

Mortality (acute services)	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
Hospital Standardised Mortality Ratio (HSMR)	0.91	0.93	0.95	0.97	0.97	0.97	0.95	0.93	0.92	--	--	--	
Summary Hospital-level Mortality Indicator (SHMI)	95.30	95.90	97.60	95.80	96.27	95.00	94.29	--	--	--	--	--	

Incident reporting	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
No of Serious Incidents Requiring Investigation (SIRIs)/Never Events - acute services	0	0	1	0	0	2	1	0	2	0	1	1	

Infection Control	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
Clostridium Difficile cases	0	0	1	1	0	0	1	4	0	0	1	0	
MRSA bacteraemias (post)	0	0	0	0	0	0	0	0	0	0	0	0	
E. coli bacteraemia	6	0	1	4	2	1	2	4	5	3	2	3	
Methicillin-sensitive staphylococcus aureus	2	1	0	0	0	1	1	3	2	4	3	3	

Appendix B - YDH Quality Measures (2)

December 22

Maternity	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
No. of still births	0	0	0	0	0	0	1	0	0	0	0	1	
No. of babies born in unexpectedly poor condition	0	0	2	0	2	1	0	1	4	0	2	0	

Falls	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
Number of patient falls - all services	93	78	108	101	78	55	70	87	72	72	80	94	
Rate of falls per 1,000 occupied bed days - all services	8.48	7.96	9.42	9.20	6.95	5.17	6.10	7.42	6.54	6.09	6.96	7.74	
Number of falls resulting in harm - all services	5	3	4	3	2	1	6	7	6	3	0	4	
Rate of falls resulting in harm per 1,000 occupied bed days - all services	0.46	0.31	0.35	0.27	0.18	0.09	0.52	0.60	0.55	0.25	0.00	0.33	

Pressure ulcer damage	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
Acute wards - number of incidents	1032	885	1118	987	999	1144	1113	982	907	1020	912	903	
Rate of pressure ulcer damage per 1,000 acute ward occupied bed days	1.31	1.43	1.05	0.91	1.07	0.75	1.05	0.87	0.92	0.42	0.70	1.18	

Cardiac Arrests	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
No. ward-based cardiac arrests - acute wards	11.00	12.00	3.00	11.00	9.00	3.00	4.00	14.00	4.00	5.00	6.00	5.00	

Appendix C - YDH Corporate Scorecard

December 22

Accident & Emergency	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend	Threshold
4-hour performance: Accident and Emergency department (ED)	85.1%	86.3%	77.7%	78.0%	84.5%	84.4%	78.0%	78.2%	72.2%	66.4%	69.1%	63.4%		>=95% = Green >=85% - <95% = Amber <85% = Red
4-hour performance: Trust-wide	85.1%	86.3%	77.7%	78.0%	84.5%	84.4%	78.0%	78.2%	72.2%	66.4%	69.1%	63.4%		

Cancer	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend	Threshold
Maximum 2-week wait from GP referral (suspected cancer)	69.6%	82.3%	78.6%	78.3%	77.7%	57.8%	51.5%	46.2%	40.3%	47.2%	59.4%	--		>=93% = Green <93% = Red
Cancer - 28 days Faster Diagnosis All Cancers	71.8%	76.5%	73.4%	74.3%	69.7%	74.4%	72.3%	75.9%	67.4%	75.0%	66.4%	--		>=75% = Green <75% = Red
Cancer - maximum 31 day wait from diagnosis to first treatment	86.8%	99.0%	90.4%	91.6%	93.4%	91.6%	92.2%	96.8%	87.9%	90.8%	91.5%	--		>=96% = Green <96% = Red
Cancer - maximum 62 day wait from urgent GP referral	71.3%	63.4%	67.8%	80.0%	71.9%	66.4%	64.2%	69.2%	65.2%	59.9%	61.9%	--		>=85% = Green <85% = Red
Cancer: 62-day wait from referral to treatment for urgent GP referrals – number of patients treated on or after day 104	4	4	6	5	1	6	6	7	6	5	11	--		0 = Green >0 = Red

Appendix C - YDH Corporate Scorecard (2)

December 22

Referral to treatment (RTT)	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend	Threshold
Diagnostic 6-week wait - acute services	77.0%	78.5%	82.8%	78.8%	76.3%	74.4%	66.1%	66.5%	74.6%	74.0%	73.8%	69.4%		>=99% = Green >=98% - <99% = Amber <98% = Red
Incomplete pathway: percentage of people waiting under 18 weeks	65.9%	65.6%	64.5%	63.9%	66.2%	65.9%	67.1%	68.4%	68.6%	70.5%	70.8%	69.7%		>=92% = Green <92% = Red
52 week RTT breaches	702	692	756	837	811	805	827	799	743	646	564	558		0 = Green <= Plan = Amber > Plan = Red
78 week RTT breaches	201	179	183	219	174	103	90	92	96	72	62	58		N/A
104 week RTT breaches	22	24	37	30	12	2	0	0	0	4	1	2		0 = Green <= Plan = Amber > Plan = Red
Referral to Treatment (RTT) incomplete pathway waiting list size	11117	11273	11623	11722	12157	12230	12285	12388	12781	13062	13705	13874		<= Plan = Green > Plan = Red

Intermediate Care	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend	Threshold
Intermediate Care - Patients aged 65+ discharged home from acute hospital beds on pathway 0 or 1	83.2%	84.6%	85.0%	83.5%	83.5%	86.2%	82.6%	83.0%	84.0%	84.1%	79.9%	80.7%		>=95% = Green >=85% - <95% = Amber >85% = Red

Appendix C - YDH Corporate Scorecard (3)

December 22

Workforce	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend	Threshold
Mandatory training: percentage completed	86.6%	89.5%	88.7%	87.3%	88.0%	87.2%	86.3%	87.0%	86.8%	87.0%	86.8%	85.9%		All courses >=90% = Green Overall rate <80% = Red Any other position = Amber
Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)	2.9%	3.3%	2.7%	3.0%	4.1%	5.2%	4.3%	4.8%	4.1%	4.4%	5.3%	4.6%		<=5% = Green >5% to <=7.5% = Amber >7.5% = Red
Sickness absence levels - rolling 12 month average (Trust-wide)	3.9%	4.1%	4.2%	4.2%	4.5%	4.6%	4.8%	4.7%	4.7%	4.7%	4.8%	4.8%		<=4.6% = Green >4.6% to <=5.1% = Amber >5.1% = Red
Sickness absence levels - monthly average (Trust-wide)	5.6%	5.7%	4.1%	3.7%	4.0%	4.7%	5.8%	4.2%	3.8%	4.6%	4.2%	5.0%		<=4.6% = Green >4.6% to <=5.1% = Amber >5.1% = Red
Reduce the number of working days lost due to stress and anxiety (Trust-wide)	468.7	427.8	511.5	458.6	497.5	512.2	524.4	552.4	483.4	550.9	619.9	607.9		Monitored using Special Cause Variation Rules. Report by exception.
Retention / turnover rates (Trust-wide)	16.3%	16.5%	17.0%	17.5%	17.8%	18.7%	19.3%	19.6%	19.6%	19.3%	18.6%	17.5%		=<12% = Green 12% to <15% = Amber >15% = Red
Career conversations (12 months) - formerly 'Performance review (12-month)'	79.5%	80.4%	80.5%	78.6%	79.1%	77.9%	77.7%	79.0%	79.2%	79.0%	77.0%	77.1%		Trajectory to be agreed

Somerset NHS Foundation Trust	
REPORT TO:	The Trust Board
REPORT TITLE:	Quality and Performance Exception Report
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Associate Director – Planning and Performance Senior Performance Manager Chief of People and Organisational Development Deputy Chief Nurse Director of Elective Care
PRESENTED BY:	Chief Finance Officer
DATE:	7 February 2023

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

Executive Summary and Reason for presentation to Committee/Board	Our Quality and Performance Exception Report sets out the key exceptions across a range of quality and performance measures, and the reasons for any significant changes or trends. Covid-19 continues to have a significant impact on a range of access standards, whilst restoration work is being undertaken to reduce the number of patients waiting and to shorten waiting times. As referrals recover to pre-Covid-19 levels this will also have an impact on services and numbers waiting. Urgent and emergency patients continue to be prioritised, to receive the treatments they need. Areas in which performance has been sustained or has notably improved include: • Compliance in Early Intervention of Psychosis. • The percentage of IAPT (Talking Therapies) patients moving to Recovery.

	• Patients followed up within 72 hours of discharge from an adult mental ward. Areas in respect of which the contributory causes of, and actions to address, underperformance are set out in greater detail in this report include: • the percentage of patients seen within four hours and spending longer than 12 hours, in our accident and emergency department and minor injury units. • CAMHS Eating Disorders - Urgent referrals to be seen within one week and Routine referrals to be seen within four weeks. • Compliance in respect of waiting times inside of six weeks for Adult, Older Persons and Children and Young People's mental health services, and services for people with Learning Disabilities. • The percentage of people waiting under 18 weeks from referral to treatment with our acute services. • The percentage of people waiting under six weeks for a diagnostic test. • The numbers of people waiting 18 weeks or more to be seen by our community physical health services, including our community dental service.
Recommendation	The Board is asked to discuss and note the report.

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

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

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

Details:

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

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

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

Equality

The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics

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

☐ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planning to mitigate any identified inequalities

Public/Staff Involvement History

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

No recommendations are being made, other than to ask the Board to discuss and note the report.

Previous Consideration

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

A report is presented to every meeting

Reference to CQC domains (Please select any which are relevant to this paper)

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

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

DSOMERSET NHS FOUNDATION TRUST

QUALITY AND PERFORMANCE EXCEPTION REPORT: DECEMBER 2022

1. PURPOSE

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

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

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

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

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

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

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

1.7 Supporting information relating to referral levels, activity levels, lengths of stay, tumour-site-specific activity and performance, and other key measures for our services is included in Appendix 5. The activity information in Appendix 5 shows the levels and trends for the current year and last year, and also for 2019/20, the most recent year unaffected by the impact of the pandemic.

1.8 Details of our work on elective recovery and theatre productivity are included in Appendix 6.

Overview

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

Successes	**Priorities**
• we remain ahead of planned levels for making reductions in the numbers of patients waiting over 104 weeks and over 78 weeks from referral to treatment. • the six-week diagnostic wait 75% regional ambition for March 2023 was met in the month. • urgent and emergency patients continue to receive the treatments they need. • compliance remains high in respect of mental health inpatients receiving a follow-up within 72 hours of discharge. • our Talking Therapies (IAPT) service continues to maintain recovery rates which are above the national standard. • the compliance level in respect of mandatory training has been maintained despite the operational challenges faced by services.	• continue to maintain a safe service and making sure urgent patients are treated as quickly as possible within the context of the challenges the current coronavirus outbreak brings. • continue to support the health and wellbeing, both physically and psychologically, of colleagues across the Trust, as they continue to deliver high quality care to patients whilst managing significant and ongoing pressures associated with COVID-19 and rising levels of demand. • continue to restore and expand capacity above pre-COVID-19 levels, to address backlogs in routine elective work which has built up. • work with the Somerset system to encourage continued referrals and presentations at hospital where needed and appropriate, especially in respect of urgent or emergency care.
Opportunities	**Risks and Threats**
• continue to progress the health and wellbeing plans for our colleagues at pace; this includes the psychological support offered alongside practical aspects of support such as accommodation provision and nutrition. • continue with new ways of working, particularly through the use of technology. • continue to adapt our recruitment practice, developing more innovative arrangements and reducing time to hire significantly. • develop reporting solutions to improve robustness of recording and reporting.	• COVID-19 will continue to have a significant impact on clinical capacity and the Trust's ability to recover elective activity, which will continue to have a negative impact on waiting times for some time to come. • delays in discharging medically fit patients needing domiciliary care will result in further cancellations of surgery which will reduce our capacity to treat long waiting patients. • significantly increasing levels of demand, particularly for urgent care and mental health services, leading potentially to increased pressures on teams and longer waiting times. • nursing vacancy levels remain challenging. Sickness / absence also presents a challenge for colleagues within some critical areas, and we need to ensure that we continue to support colleagues accordingly.

Safe

Infection Prevention and Control (IPC) performance is assessed by means of the numbers of key healthcare associated infections (HCAI) (Trust apportioned) against agreed thresholds. These are: MRSA bloodstream infections (BSI): zero tolerance, Clostridioides difficile (C. diff) infection (CDI): 41 cases, MSSA BSIs: 30 cases E. coli BSIs: 73 cases, Klebsiella BSIs: 23 Pseudomonas aeruginosa BSIs: 12.

Current performance (including factors affecting this)

- **MRSA –** There were no Trust-attributed MRSA bloodstream infections (BSIs) reported during December 2022. The total for the year to date is one case.
- **C. diff** - There were two Trust-attributed cases in December 2022, bringing the total to 37 against a threshold for the year of 41.
- **MSSA –** Three Trust-attributed MSSA BSIs were reported during December 2022, bringing the total for the year to 35, against an internal threshold of 30.
- **E. coli** - Nine Trust-attributed E. coli BSIs were reported in December 2022, bringing the total to 63 against a threshold of 73.
- **Klebsiella –** Four Trust-attributed Klebsiella BSIs were reported in December 2022. The total to date is 30 against a threshold of 23.
- **Pseudomonas –** One Trust-attributed Pseudomonas aeruginosa BSI was reported in December 2022 bringing the total to six against a threshold of 12.

Respiratory Viral Infections

- **COVID-19** – There were 317 inpatient cases of COVID-19 identified during December 2022. A total of 100 were healthcare attributed. Overall, the numbers increased during December 2022.
- **Influenza** – Case numbers increased significantly in December 2022. A total of 302 inpatient cases were identified, almost all of which were Influenza A (300). Over half of the cases were in patient over 65 years old, most of whom were admitted with influenza.
- **Respiratory Syncytial Virus (RSV)** - There were a 124 inpatient cases of RSV identified during December 2022. This was a slight increase on November 2022. Children remain the affected majority; most of them are under five years old.

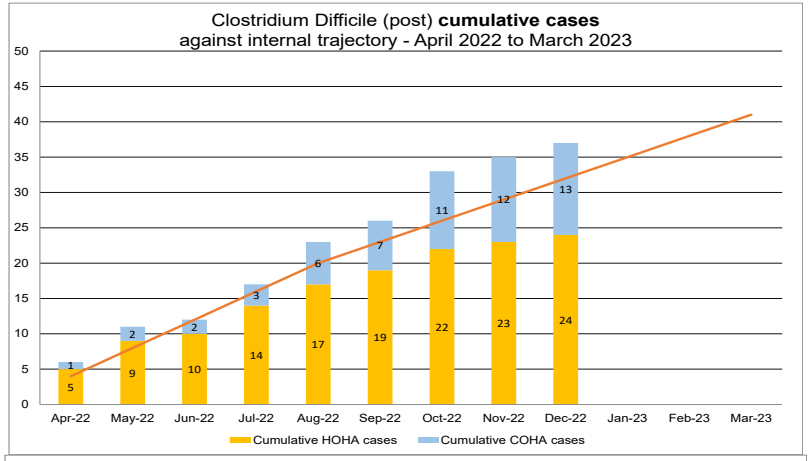
Outbreaks

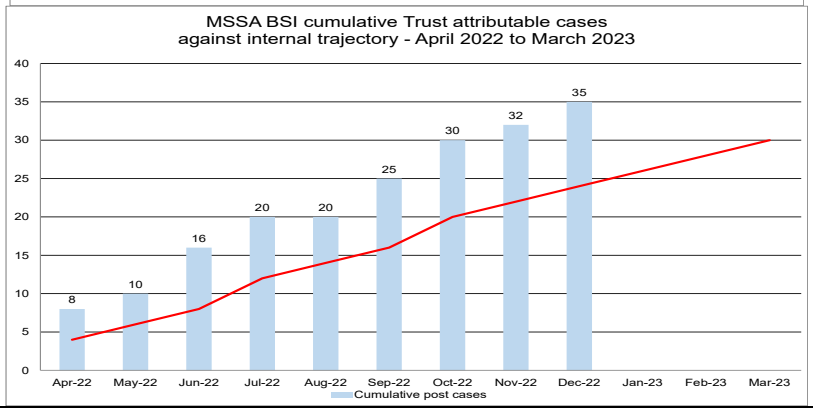
- There were 19 respiratory virus outbreaks affecting inpatient wards during December 2022. These were a mixture of COVID and influenza.

Focus of improvement

- As predicted, managing all three respiratory viruses simultaneously this winter has been a challenge. In line with predictions from the Southern Hemisphere, the 'flu season began earlier and has resulted in significantly more inpatient admissions than has been seen since the 2017/18 season. Therefore, infection control has focused on the management of respiratory viruses through December 2022.

Line/Bar Charts





Recent performance

Area	Jul	Aug	Sep	Oct	Nov	Dec
MRSA	0	0	1	0	0	O
C.Diff	5	6	3	7	2	2
MSSA	4	0	5	5	2	3
E.coli	9	7	5	8	3	9

Safe

Fall incidents: monthly rates of falls incidents across all of our inpatient wards, reported via our RADAR reporting system, per 1000 occupied bed days. Our aims are to maintain high rates of reporting, and have a low proportion of incidents which result in harm.

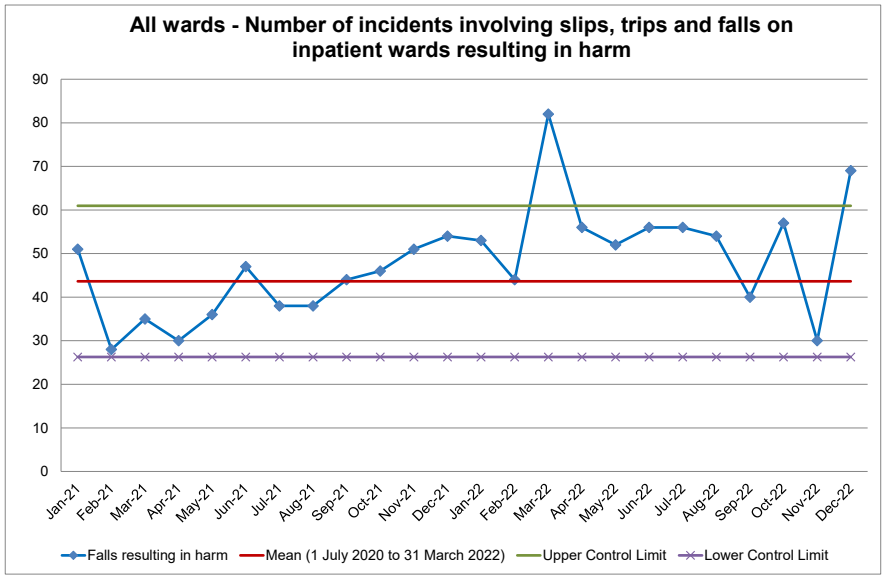
Current performance (including factors affecting this)

- During December 2022, 270 inpatient falls were recorded across all of our inpatient wards, of which a total of 69 resulted in harm, a rate of 2.32 per 1,000 occupied bed days.
- Operational pressures have increased the number of medical patients with complex physical and or mental health needs who have been placed on surgical or other medical wards, which do not always have the appropriate skill mix or experience of such patients. Patients in community hospitals also have higher levels of acuity and dependency on admission.
- Within this increased number of reported falls are falls where the patient has been assisted to the ground and no injury has occurred. These often occur during rehab sessions and are not unexpected as people recover from significant periods of deconditioning.

Focus of improvement work

- The Trust Falls group meets quarterly. An overarching action plan is reviewed and updated at each meeting, with actions are identified for implementation.
- The Trust's Falls lead has commenced various audits in accordance with local and national requirements (including bedrails, lying and standing blood pressures). The results from each audit will be fed back to the wards and the identified actions will be monitored.
- The Falls lead is working with colleagues from Yeovil District Hospital to review the online education for all clinical colleagues, and to make the training mandatory. They also continue to work with the Quality and Improvement team on a ward-based pilot for bay nursing which will also help to identify themes and inform necessary actions.
- Members of the Falls Group are working to address areas where practice requires support and guidance including the introduction of new equipment, and focused teaching on neuro observations. The aim is to reduce the number of falls in the first instance and to reduce the impact of a fall if it does occur.

SPC Chart



How do we compare

The overall number of falls and the numbers resulting in harm during December 2022 significantly increased compared to November 2022.

Recent Performance

The monthly numbers of incidents since July 2022 were as follows:

Area	Jul	Aug	Sep	Oct	Nov	Dec
Number of falls	217	232	210	228	160	270
Falls rate per 1,000 occupied bed days	7.54	7.96	7.32	7.58	5.57	9.09
Falls resulting in harm	56	54	40	57	30	69
Harm rate per 1,000 occupied bed days	1.95	1.85	1.39	1.89	1.04	2.32

Safe

Medication Incidents: Total number of incidents reported via RADAR. Our aims are to maintain high rates of reporting, and have a low proportion of incidents resulting in harm.

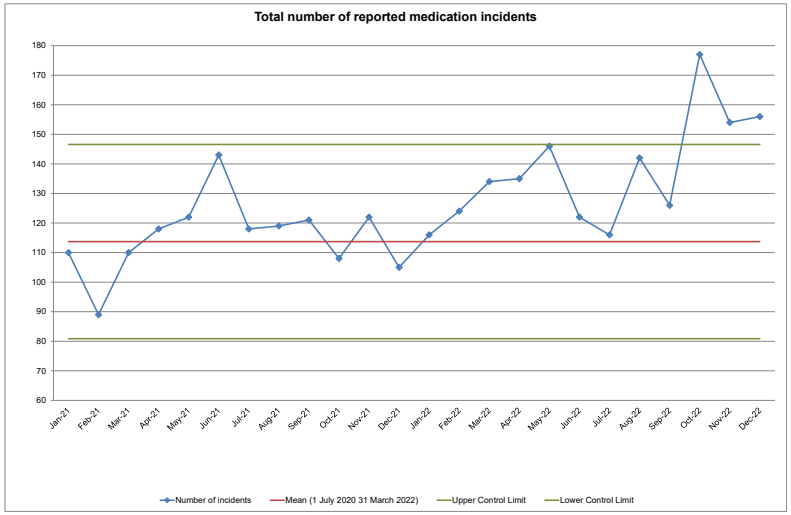
Current performance (including factors affecting this)

- There were 156 medication incidents reported during December 2022, an increase from 154 recorded during November 2022. Of the numbers reported, 112 related to drug errors, equating to 71.8% of all incidents reported.
- Of the 154 incidents recorded, 21 (20 relating to drug errors and one incorrect storage) resulted in harm. One drug error incident resulted in moderate harm to the patient and 20 resulted in minor harm.

Focus of improvement work

- Reported incidents are managed at department level with local investigations and actions put in place. Significant events are subject to a 72-hour report and where appropriate further investigation.
- Medication incidents are reviewed quarterly by topic leads to identify common themes and system-wide learning. The Medicines Incidents Review Group provides overarching scrutiny of reported incidents and arrangements are proceeding to provide this scrutiny across reported incidents throughout the entire Trust.
- The Governance Support Team will be developing a specific medication analytics dashboard within our incident reporting system, RADAR, to aid the review of common themes and trends.
- Indicators relating to numbers of reported incidents are more of a measure of a safety culture (recognition of safety-related incidents and openness) rather than patient harm. Work to encourage reporting of medication incidents is ongoing and has recently been a focus of our Integrated and Urgent Care matrons and as a result of the implementation of the electronic prescribing and medicines administration (ePMA) solution in the acute setting.

SPC Chart



How do we compare

The number of reported incidents during December 2022 increased compared to November 2022.

Recent performance

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

Area	Jul	Aug	Sep	Oct	Nov	Dec
Total reported	116	142	126	177	154	156

Safe

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

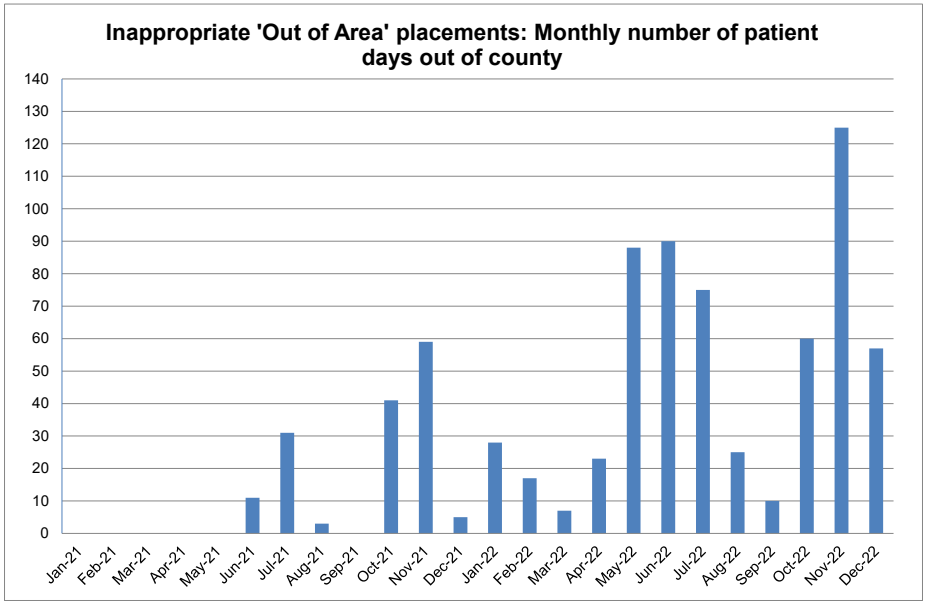
Current performance (including factors affecting this)

- During December 2022, four patients were placed out of area, for a total of 57 days.
- Three patients were repatriated to Somerset during December 2022. One was a transfer to Holford ward, our Psychiatric Intensive Care Unit (PICU). The other two patients are being supported by community mental health teams.
- One patient, placed on 30 December 2022, remains out of county. This was due to being unable to admit to a female acute bed (not PICU). This patient is due to be repatriated to a Somerset bed by then end of January 2023.

Focus of improvement work

- We continue have amongst the lowest levels of inappropriate out of area placements of all providers of mental health services nationally.
- The majority of out of area placements are due to patients requiring admission into our Psychiatric Intensive Care Unit (PICU). With only 10 beds available there are occasions when, due to clinical acuity or gender, it would be unsafe to admit a patient.
- When a patient is so placed, a key worker is immediately assigned to maintain regular contact with the patient until the patient is either transferred back to our wards, discharged, or moved to secure services. The placements sought are always as close to Somerset as possible.
- At times, espisodes relate to patients awaiting transfer to secure services. We work closely with other NHS providers, to facilitate such transfers and closely montitor processes to minimise risk.
- The service is reviewing processes to ensure barriers to repatriation and/or discharge of patients are minimised and escalated with system partners where appropriate.

Bar Chart



How do we compare

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

Recent Performance

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

Area	Jul	Aug	Sep	Oct	Nov	Dec
Number of Days	75	25	10	60	125	57
Number of patients	3	2	2	5	6	4

Responsive

The Accident & Emergency (A&E) 4-hour standard is a measure of the length of wait from arrival in an Emergency Department (ED) to the time the patient is discharged, admitted or transferred to another provider. The target is that at least 95% of patients will wait less than four hours in the Emergency Department.

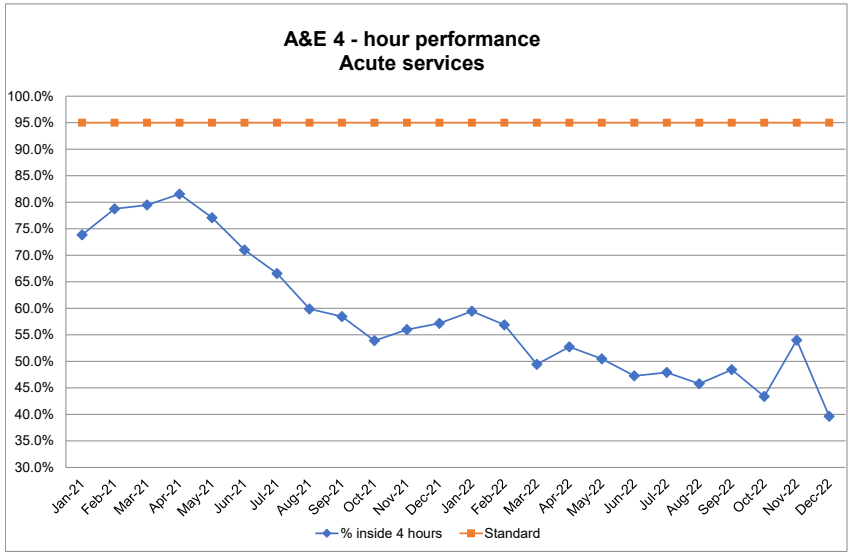
Current performance (including factors affecting this)

- A&E 4-hour performance was 39.6% for the Musgrove site in December 2022. Compliance within Minor Injury Units (MIUs) was 93.9%, the first time it has ever fallen below 95%. Overall compliance was 70.5%, hence still below the 95% national standard.
- COVID-19 admissions have fallen in recent weeks and have remained lower than the peaks seen in previous waves of the pandemic. Most patients being admitted with COVID-19 are admitted because of other conditions they have.
- A&E attendances in December 2022 were 3.0% above December 2019 levels and 9.6% up on December 2021 levels. Overall, emergency admissions in December 2022 were 0.6% down on pre-COVID levels, but with a significant reduction for zero length of stay admissions. Hospital stays of one or more days were up by 2%. Those patients being admitted to an inpatient bed continue to have longer stays. This is consistent with a slowing of the rate of discharge for medically fit patients due to domiciliary capacity challenges and a shortfall in bedded care packages. A reduction in the shorter stays may reflect a higher acuity of admitted patients

Focus of improvement work

- The recovery plan developed for the ED focuses on:
  1. Internal ED systems and processes, including triage and department flow.
  2. Workforce, including roles and responsibilities, allocation, and internal professional standards.
  3. The wider hospital system, including clinical pathways, new Surgical Decision Unit (SDU) and paediatrics, and hospital patient flow linked to ED escalation pressures.
  4. The wider system, including the implementation of the new SWAST Hospital Ambulance Liaison Officer (HALO) role, and a focus on ambulance handover.
  5. Onboarding of medical patients from the Acute Medical Unit to wards, where patients have been identified for planned discharge on the same day, has now been embedded on several wards.

Line Chart



How do we compare

National average performance for Trusts with a major Emergency Department was 49.6% in December 2022. Our performance was 39.6%. We were ranked 97 out of 110 trusts. With Minor Injury Unit attendances included, we were ranked 28, with performance of 70.5%.

Recent performance

Area	Jul	Aug	Sep	Oct	Nov	Dec
Actual	47.9%	45.8%	48.4%	43.4%	54.0%	39.6%

Responsive

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

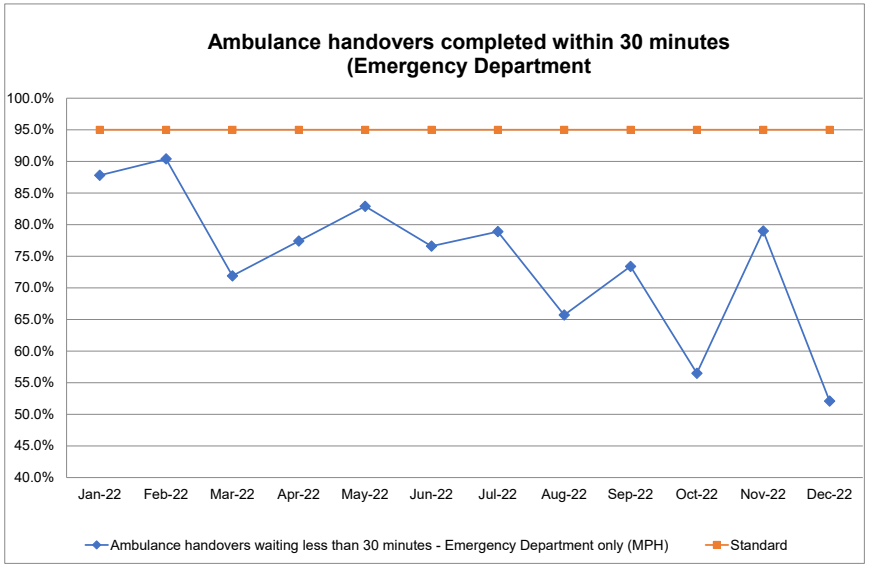
Current performance (including factors affecting this)

- During December 2022, of 2,003 patient arrivals by ambulance received into our Emergency Department (ED), a total of 1,044 (52.1%) were completed within 30 minutes, down from 79.0% in November 2022.
- In December 2022, 28.6% of all ambulance handovers were completed within 15 minutes, compared to 48.3% during November 2022. The average performance across all hospitals served by SWAST in December 2022 was 18.7%.
- Arrivals by ambulance accounted for 29.3% of all patients attending ED during December 2022, down from 32.5% of arrivals during November 2022.

Focus of improvement work

- The new South Western Ambulance Service NHS Foundation Trust (SWAST), Hospital Ambulance Liaison Officer (HALO) role has been implemented across both Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust, to support ambulance flow and handovers.
- HALO liaises with ED team leads and Patient Flow teams, flagging current and pending activity and flow options.
- The new role, along with other planned reviews of current available information, will enable further work to be undertaken to develop improvement plans.
- The ED improvement plan continues to test new ways of working to maximise flow within ED, supporting ambulance handovers.
- Onboarding of medical patients from the Acute Medical Unit to wards, where patients have been identified for planned discharge on the same day, has now been embedded on several wards.
- Bi-monthly meetings are held with the Integrated Care Board (ICB), and system providers, supporting improvement work.

Line Chart



How do we compare

In December 2022, 52.1% of all ambulance handovers at Musgrove Park Hospital were completed within 30 minutes. The average performance across all hospitals served by SWAST was 36.9%.

Recent performance

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

Area	Jul	Aug	Sept	Oct	Nov	Dec
Actual	78.9%	65.7%	73.4%	56.5%	79.0%	52.1%

Responsive

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

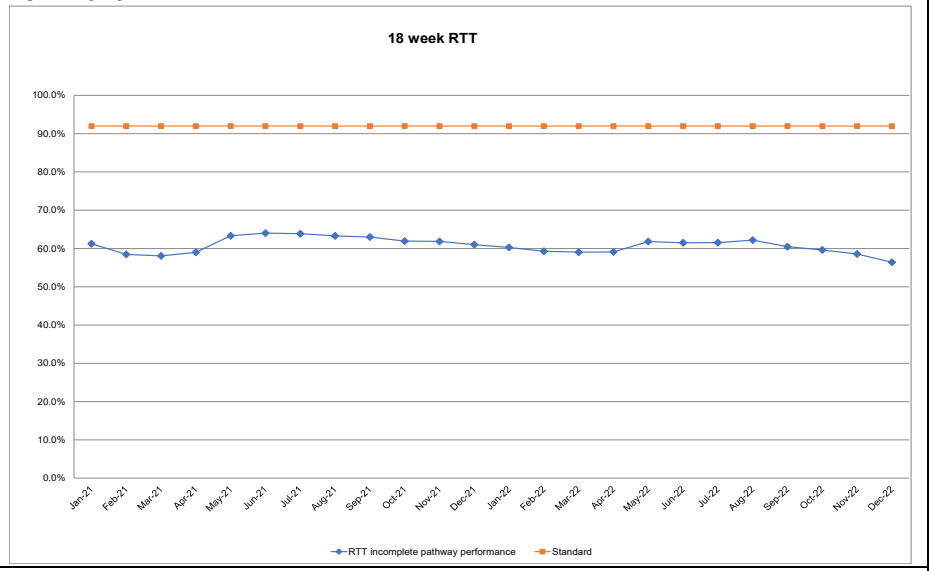
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT was 56.4% (acute + community) in December 2022.
- The over 18-week backlog increased by 840 pathways. The total waiting list size also increased, by 124 pathways, and was 3,643 above (i.e. worse than) trajectory (36,831 actual vs. 33,188). There was an increase in both acute and community pathways.
- RTT clock starts (i.e. referrals) in December 2022 were 3.9% below average pre-COVID levels (working days adjusted).
- 52-week waiters increased slightly in December 2022, to 1,860 pathways, against a trajectory of 2,461 or fewer. The number of patients waiting 78 weeks or more increased by 38 pathways to 257. We reported three patients waiting over 104 weeks (due to clinical complexity).
- Until November 2021 the Trust remained one inpatient theatre's worth of capacity down due to the conversion of a theatre into critical care capacity. This along with other factors has resulted in a backlog of more complex, longer routine cases on the waiting list.
- Significant bed pressures and theatre staff sickness/shortages continue to limit full restoration of inpatient activity, along with other factors such as increasing patient complexity.

Focus of improvement work

- The number of patients needing surgery this year to avoid becoming a 78-week RTT waiter has been quantified for each specialty, and detailed plans continue to be progressed to manage these volumes through improved productivity, increased capacity (including use of the Independent Sector) and reprioritisation of theatre capacity across the system.
- A significant programme of work to support elective care recovery in the medium and long-term is in place.
- A programme of waiting list validation includes contacting patients to check whether they still need to be seen. Details of work undertaken on elective recovery and theatre productivity are included in Appendix 6.

Line Chart



How do we compare

The national average performance was 60.1% in November 2022, the latest data available. Our performance was 58.6%. National performance was unchanged between October and November 2022, and the number of 52-week waiters across the country decreased by 4,408 to 406,575 (representing 5.5% of the national waiting list compared with 5.1% for the Trust).

Performance trajectory: 104+ and 78 week wait performance

Area	Jul	Aug	Sep	Oct	Nov	Dec
104 week trajectory	8	12	10	16	16	16
104 week actual	17	16	13	7	1	3
78 week trajectory	447	417	401	333	432	660
78 week actual	373	330	297	262	219	257

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

Responsive

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

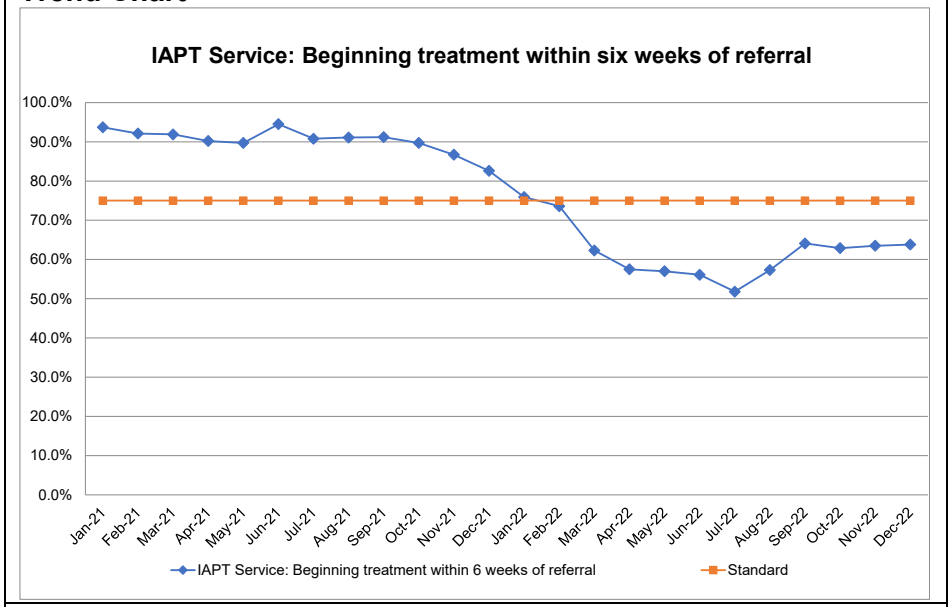
Current performance (including factors affecting this)

- During December 2022, compliance increased slightly for the second consecutive month, to 63.8%.
- The fall in compliance since February 2022 has been primarily due to rising levels of demand and a shortfall in capacity within the service. Between 1 April 2021 and 31 March 2022 referrals into the service increased by 26.7% compared to the same months of 2020/21 and by 17.1% compared to same months of 2019/20.
- Referrals between 1 April and 31 December 2022 were 6.8% lower than the same months of 2021/22, but 11.8% higher than the same months of 2019/20.
- The position continues to be exacerbated by vacancy levels, long term sickness and maternity leave.

Focus of improvement work

- Recruitment continues to be challenging, although several recent appointments have been made with varying commencement dates. Once new colleagues commence in post, their contribution will be gradual until they are fully up to speed. Further advertisements are currently out and results are awaited as to how many appropriately qualified persons apply.
- A Quality Improvement project with the Improvement Team continues, considering system improvements.
- The service is re-asserting the commissioned eight-session treatment model, to offset against too many extensions to treatment.
- The service is also employing locums and is continuing to use external online providers creatively.
- A deep dive of the performance data is being planned to ascertain the impact of vacancy levels and recruitment.

Trend Chart



How do we compare

National average performance against the six-week standard in September 2022 (the latest published data) was 89.3%; our performance was 64.1%.

Recent Performance

Area	Jul	Aug	Sep	Oct	Nov	Dec
Total Discharges	484	492	398	401	420	373
First treatment inside of six weeks	251	282	255	253	267	238
Compliance %	51.9%	57.3%	64.1%	63.1%	63.6%	63.8%

Responsive

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

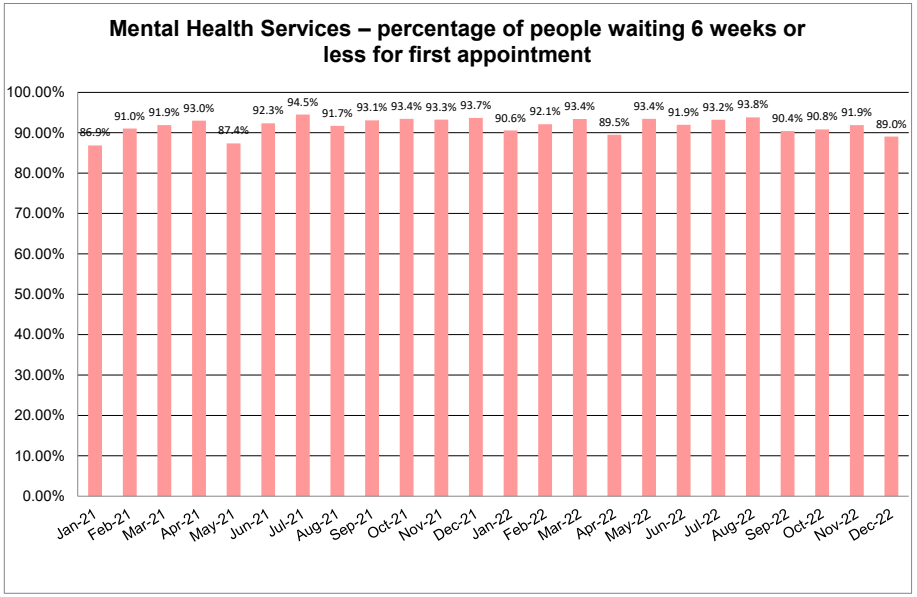
Current performance (including factors affecting this)

- As at 31 December 2022, 406 out of 456 people (89.0%) waiting to be seen by our mental health services were reported as waiting under six weeks, against a required standard of 90%.
- Compliance in respect of the six-week standard by service area was as follows:
  - CAMHS: 95.9%
  - Learning Disabilities: 88.9%
  - Adults: 86.3%
  - Older adults: 89.8%
- Performance for our adult mental health services has been particularly affected by the continued level of vacancies across both our community mental health and open mental health services, which significantly affects the capacity of the services to meet levels of presenting demand.

Focus of improvement work

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

Run Chart



How do we compare

The latest NHS Benchmarking Network data shows our CAMH service to be amongst the best performing nationally, in terms of waiting times. Our adult community mental health service median waiting time is in the best quartile nationally, and our older people's median waiting time is near the best quartile.

Recent performance

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

Area	Jul	Aug	Sep	Oct	Nov	Dec
Vacancy rate	93.2%	93.8%	90.4%	90.8%	91.9%	89.0%

Responsive

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

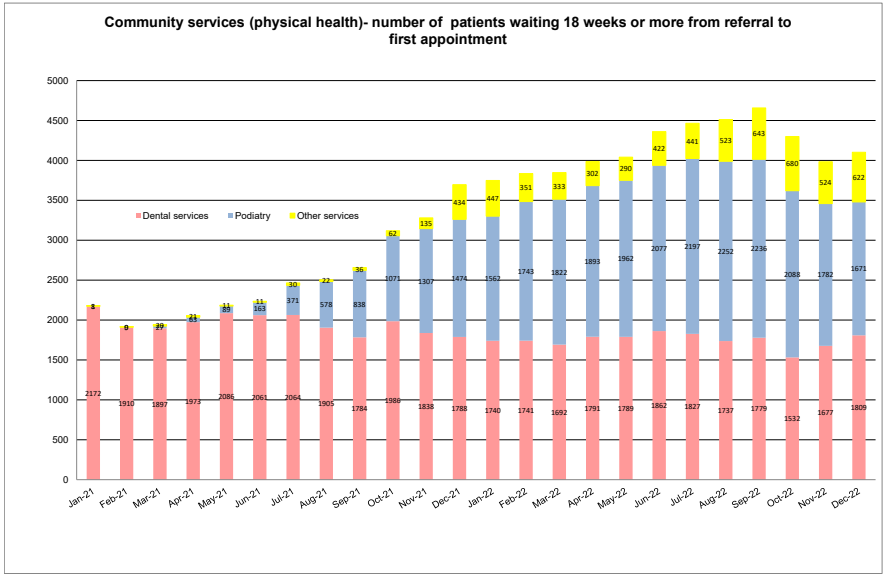
Current performance (including factors affecting this)

- As at 31 December 2022, the number of patients waiting 18 weeks or more totalled 4,102, an increase of 119 patients compared to the position as at 30 November 2022.
- The number of people waiting 18 weeks or more to be seen by our Podiatry service reduced to 1,671 patients, from 1,782 as at 30 November 2022. The Podiatry service continues to have significant levels of vacancies, which is a national issue.
- Our Somerset and Dorset dental service had 1,809 patients waiting 18 weeks or more to be seen, up from 1,677 as at 30 November 2022 (Somerset: 1,620 patients, up from 1,502 and Dorset: 189 patients, up from 175).
- Of the numbers within 'Others', 46% related to our Musculoskeletal Physiotherapy (MSK) service, which increased from 239 as at 30 November to 284 as at 31 December 2022.

Focus of improvement work

- In Podiatry, priority has been given to high risk vascular / diabetic foot care and acute nail surgery cases. All routine patients are contacted by letter and telephone to provide advice and guidance. A waiting list initiative began in September 2022 and remains ongoing, with the aim of reducing the number of patients waiting and the length of wait.
- The Dental service faces challenges due to vacancies, sickness absence and maternity leave, and continues with various recruitment initiatives. The installation of air exchange units has reduced the fallow time between appointments.
- The MSK service has undertaken a review of patients listed as having waited 18 weeks or more. Staffing has improved compared to earlier months, both in respect of vacancies and sickness/absence. The review will enable actions to be implemented to improve waiting times.

Bar Chart



How do we compare

The number of patients waiting 18 weeks or more as at 31 December 2022 increased by 119 when compared to 30 November 2022.

Recent performance

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

Area	Jul	Aug	Sep	Oct	Nov	Dec
Number waiting	4,465	4,512	4,658	4,300	3,983	4,102

Responsive

Waiting Times – One of our key priorities is to ensure that patients are able to access our services in as timely a manner as possible, and without unnecessary delays. Our aim is to reduce the number of people waiting over 18 weeks from being referred to having treatment. The data shown relates to our Somerset and Dorset Dental services, specifically children and young people waiting 18 weeks or more for an appointment to have a procedure requiring a general anaesthetic (GA).

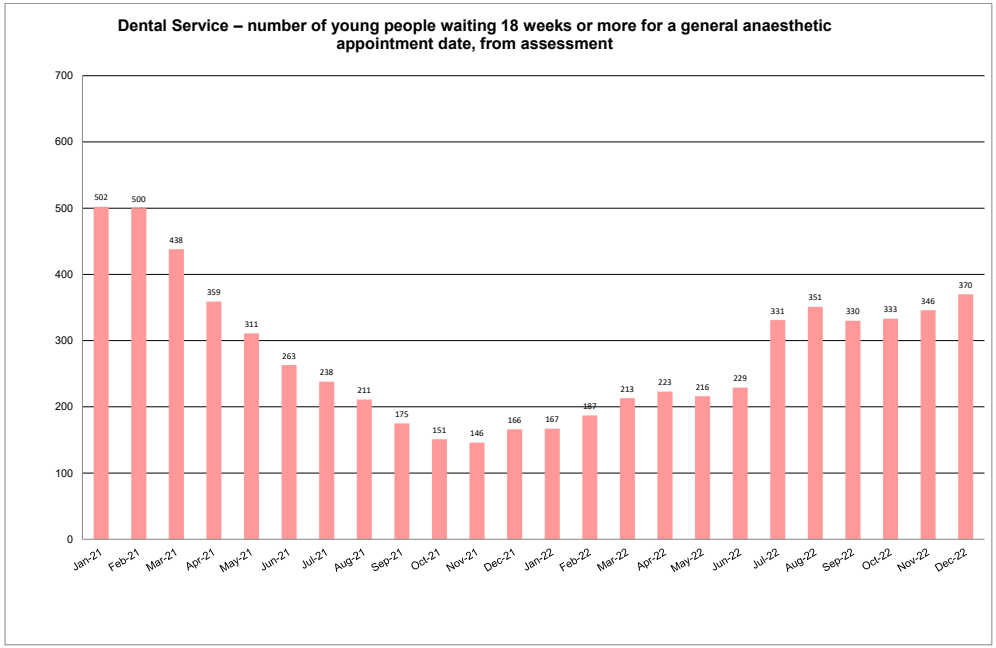
Current performance (including factors affecting this)

- As at 31 December 2022, 370 young people had waited 18 weeks, an increase of 24 compared to 30 November 2022.
- Of the 370 patients waiting, 322 related to our Dorset service (up from 310 as at 30 November 2022), and 48 related to our Somerset service (up from 36 as at 30 November 2022).
- The service continues to have significant levels of vacancies, which is a national issue, and which is exacerbated by sickness/absence that affects capacity within the service, as well as the loss of some theatre slots.

Focus of improvement work

- The service continues with various initiatives to recruit and has interviews planned in the forthcoming weeks.
- The number of children per list has been increased to five where possible but many of the children with additional needs require more than one slot due to complexities, reducing the number of children who can be seen on a list.
- Work continues to validate the paediatric GA list. A 'welfare check', and using a surgical coding system, will 'RAG' rate children based on clinical need and prioritise accordingly.
- There remain challenges with theatre availability due to current demand pressures of other specialities. The service is working with the theatre management team to establish solutions and resource more theatre time.

Bar Chart



How do we compare

The number of young people waiting 18 weeks or more as at 31 December 2022 increased by 24 compared to 30 November 2022.

Recent Performance

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

Area	Jul	Aug	Sep	Oct	Nov	Dec
Number waiting	331	351	330	333	346	370
% > 18 weeks	60.3%	61.1%	56.0%	55.0%	51.3%	51.7%

Responsive

Child and Adolescent Mental Health Service Eating Disorders (CEDS) – At least 95% of urgent referrals to be seen within one week and at least 95% of routine referrals to be seen within four weeks, based on performance across a rolling 12 months.

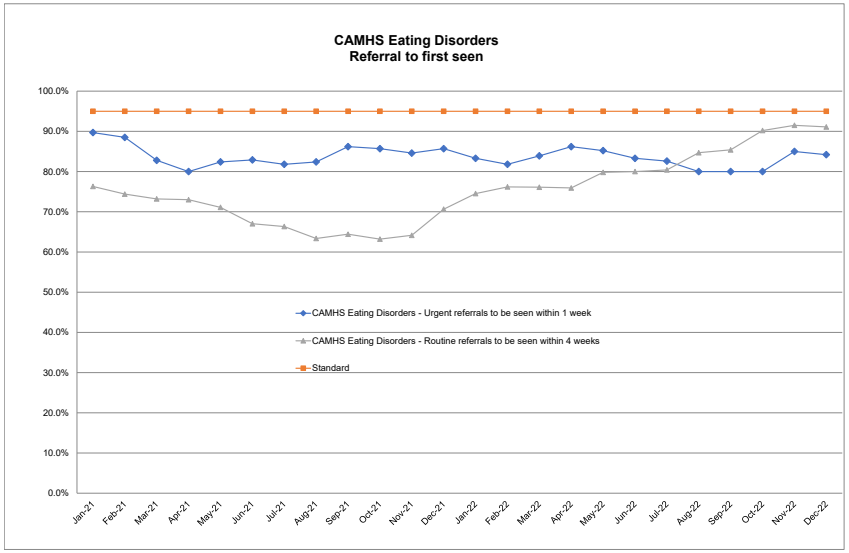
Current performance (including factors affecting this)

- Between 1 January 2022 and 31 December 2022 of 19 urgent referrals, three patients were seen outside of the seven-day reporting standard.
- Two urgent referrals were seen during in December 2022, both inside of the seven-day standard. With no further breaches, compliance with the 95% 12-month standard is predicted not to be achieved until at least March 2023.
- During the period 1 January 2022 and 31 December 2022 of 101 routine referrals, a total of nine patients were seen outside of the four-week reporting standard.
- During December 2022, of five routine referrals, all patients were seen within the four-week standard. As the monthly numbers referred are low, with no further breaches, compliance of the 95% standard is predicted not be achieved until at least March 2023.
- Over the 12-month reporting period the main reasons for breaches were a shortfall of capacity in the team, and patient / family delays.
- Between 1 April and 31 December 2022, 100% of appointments offered were within the required timeframes.

Focus of improvement work

- An Assistant Psychologist triages referrals offering early advice, to help to reduce waiting times.
- The service, alongside Somerset and Wessex Eating Disorder Association (SWEDA), has extended a pilot as part of the pathway to take on early intervention and low-to-moderate presentations, and to reduce referral numbers.
- The service is recruiting into a Band 4 role to support the Musgrove Park Hospital paediatric ward with meal support. This will be a 12-month, fixed-term role to gauge effectiveness. The team has recruited a Cognitive Behavioural Therapist Trainee to support with work relating to low mood / anxiety / trauma.
- A new Band 7 role within CEDS will be positioned within the acute hospital to develop nurse-led clinics. This will free up capacity within the team to increase assessment clinics

Line Chart



How do we compare

The latest national performance, reported as at 30 September 2022, was 63.6% for urgent referrals and 68.6% for routine referrals. Our performance was 80.0% and 85.4% respectively.

Performance over the last six months

Performance is based on a rolling 12 months.

Area	Jul	Aug	Sep	Oct	Nov	Dec
Urgent – patients seen within one week	82.6%	80.0%	80.0%	80.0%	85.0%	84.2%
Routine – patients seen within four weeks	80.4%	84.7%	85.4%	90.2%	91.5%	91.1%

Responsive

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

Current performance (including factors affecting this)

- During December 2022, 93.2% of patients aged 65 or over who were discharged from acute hospital beds within Somerset were transferred onto Pathway 0 or Pathway 1.

Pathway 0

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

Pathway 1

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

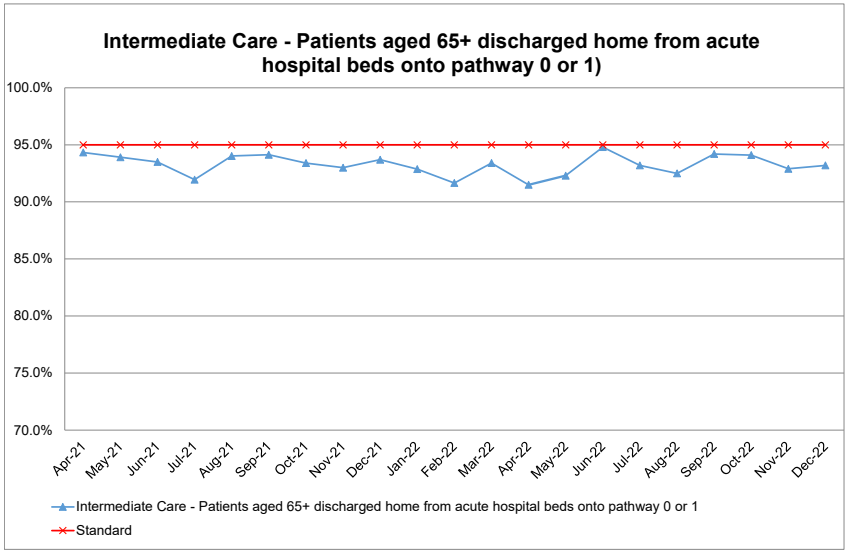
Focus of improvement work

- Strategic action, as part of Somerset's 'Winter Schemes', is being taken to address the numbers delayed leaving intermediate care pathways.
- Care pods: 50 hours to start in South Somerset to reduce delays.
- 45 extra Pathway 2 beds.
- 25 Older People's Mental Health (OPMH) Plus beds (currently eight open, awaiting confirmation of more opening dates).
- 4.0 whole time equivalent (WTE) Band 3 Discharge Facilitators for a selection of bedded units.
- 1.0 WTE Social Worker in Primary Link to support early social care conversation to prevent admissions to hospital.

Other workstreams underway to support more people to return home and improve hospital flow include:

1. Removal of triage from the Musgrove Park Hospital site, following a five-week onsite intervention period.
2. Streamlining of intermediate care hub processes through process mapping and digitalisation – community navigator scheme.
3. Community Pull Events commencing during January 2023, to facilitate the appropriate and timely discharge of inpatients.

Line Chart



How do we compare

The percentage of patients aged 65 or more transferred onto pathway 0 or 1 during December 2022 increased slightly compared to November 2022.

Performance over the last six months

Area	Jul	Aug	Sep	Oct	Nov	Dec
Total Discharges	2,657	2,869	2,916	2,665	2,804	2,799
Pathway 0	2,268	2,450	2,529	2,324	2,398	2,443
Pathway 1	208	201	217	183	207	166
% onto P0 or P1	93.2%	92.4%	94.2%	94.1%	92.9%	93.2%

Responsive

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

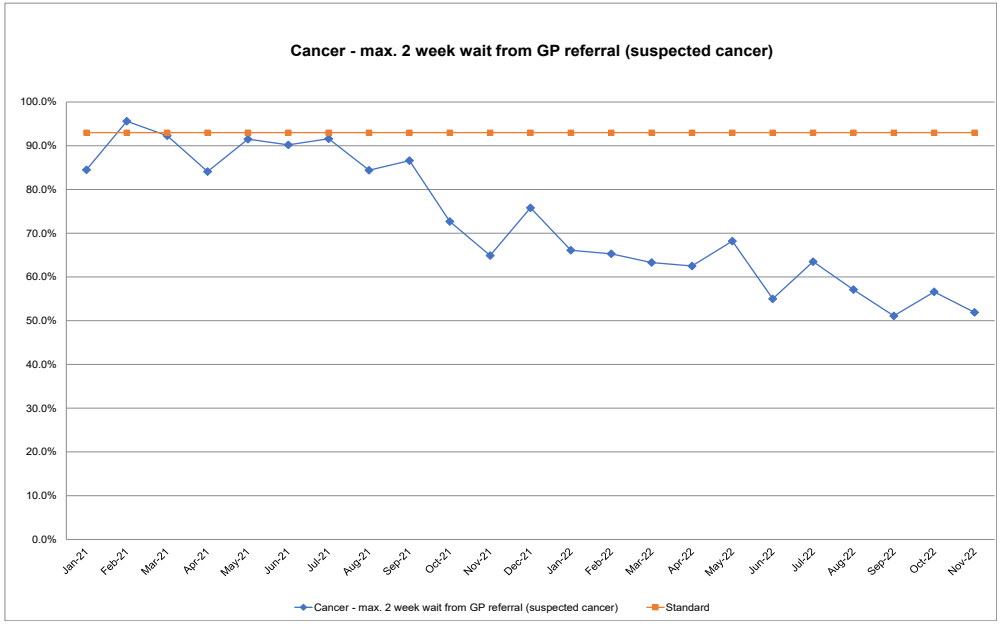
Current performance (including factors affecting this)

- The percentage of patients seen within 14 days of referral by their GP for a suspected cancer was 51.9% in November 2022, below both the 93% national standard and the national average.
- Colorectal made up 42% of two-week wait breaches in November 2022. The Faster Diagnosis team has struggled to meet demand, with a 52% growth in referrals compared with the pre-COVID period, although the triage time has now reduced significantly. The primary care-based referral hub, funded by Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Alliance, is helping to reduce pathway delays as far as possible. However, waiting times for colonoscopies, which are the two-week wait step for many lower GI referrals, have lengthened due to the high demand and staff shortages.
- Breast made up a further 40% of the breaches. Changes to service capacity due to a departure from the team has limited the ability of the service to meet demand and keep waits within two weeks.
- The breast symptomatic (cancer not suspected) 93% two week wait standard was not achieved in November 2022, with performance of 12.9% and 88 breaches, 86 of which were due to capacity problems described above.

Focus of improvement work

- A review has been undertaken of the breast service capacity and demand. Evening clinics have been run, to provide additional capacity. Yeovil District Hospital has also again been supporting with capacity. With the recruited GPs now trained to run clinics independently, there has been a significant improvement in the 28-day Faster Diagnostic Standard performance (see exception report). However, consistently meeting the two-week wait standard will remain a challenge.
- Please see also the Diagnostics exception report for actions to address the increase in colonoscopy waiting times.

Line Chart



How do we compare

National average performance in November 2022, the latest data available, was 78.8%. Our performance was 51.9%. We were ranked 134 out of 141 providers.

Recent Performance

Area	Jun	Jul	Aug	Sep	Oct	Nov
% seen in two weeks	55.0%	63.5%	57.1%	51.1%	56.6%	51.9%
Patient choice breaches	73	60	56	50	54	63
Other breaches (including capacity, delayed blood tests)	342	290	356	510	393	498

Responsive

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

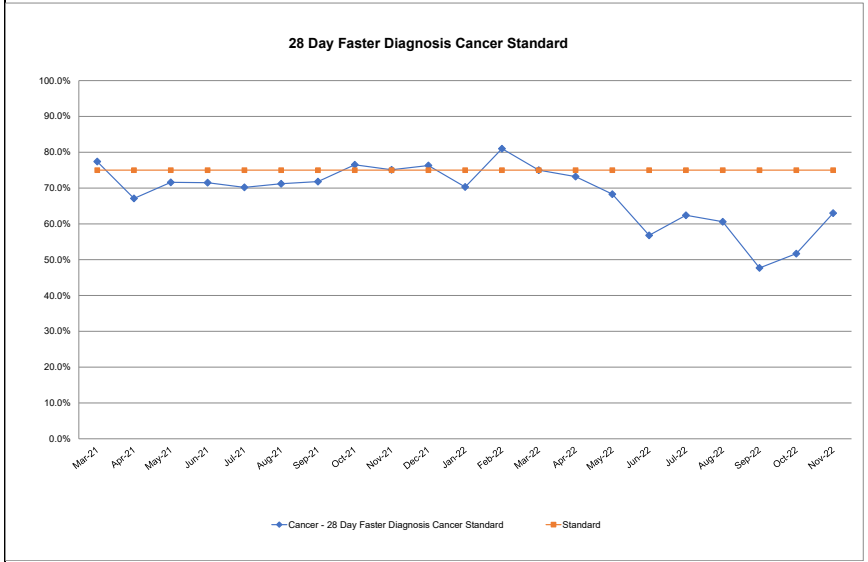
Current performance (including factors affecting this)

- The percentage of patients diagnosed with cancer or given a benign diagnosis within 28 days of referral improved to 63.0% in November 2022, but remained below the national standard and the national average.
- The higher-volume tumour sites not meeting the 75% national standard in November 2022 were: colorectal (38% against the 75% standard), and gynaecology (44%). Overall colorectal made-up 48% of all the breaches of the 28-day standard and gynaecology 18%. Colorectal and gynaecology have seen a 52% and 25% growth in referrals over the past three months, respectively, compared to pre-COVID levels.
- The improvement in performance was largely due to breast achieving the standard again in the month. Breast achieved the 28-day standard for the first time since April 2022, following the additional capacity put in place with GPs recruited and trained to run two-week wait clinics, support provided by Yeovil District Hospital, and evening clinics established by the team.

Focus of improvement work

- A significant programme of work continues to try to reduce delays in the diagnostic part of the colorectal pathway (please see the two-week wait exception report); improvements have already been made but work is focusing on how to sustain these in the face of exceptional growth in demand.
- For details of the actions taken to address the breast issues please also see the two-week wait exception report.
- A new community-based/self-referral gynaecology pathway is being developed for post-menopausal bleed patients and patients who have a finding on imaging that would ordinarily require them to be referred back to their GP to initiate a two-week wait referral.

Line Chart



How do we compare

National average performance for providers was 69.7% in November 2022, the latest data available. Our performance was 63.0%. We ranked 113 out of 142 providers.

Recent performance

Performance in recent months was as follows:

28-day Faster Diagnosis performance

Area	Jun	Jul	Aug	Sep	Oct	Nov
Compliance	56.8%	62.4%	60.6%	47.7%	51.7%	63.0%

Responsive

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

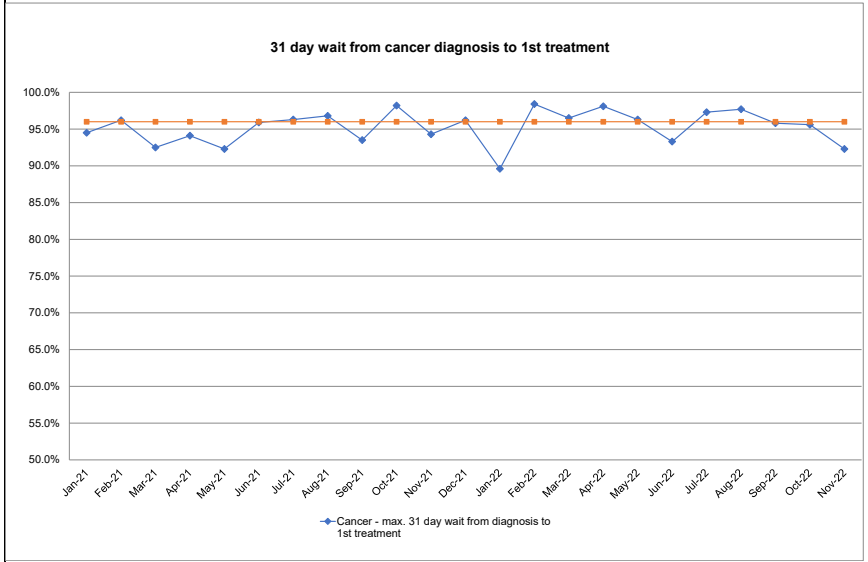
Current performance (including factors affecting this)

- Performance against the 31-day first definitive treatment standard was 92.3% in November 2022, below the 96% national standard but above national average performance.
- There were 16 breaches of the first definitive treatment standard, seven of which were for breast and five of which were for colorectal pathways.
- The higher level of breaches in November 2022 was largely related to surgical capacity, with the recent bed pressures, but also to bulges in demand for these tumour sites affecting the ability to operate on patients within the target time. All delays or cancellations of surgery are clinically risk-assessed on a case-by-case basis by the operating surgeon.

Focus of improvement work

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

Line Chart



How do we compare

National average performance for providers was 91.6% in November 2022, the latest data available. Our performance was 92.3%. We ranked 94 out of 143 providers.

Recent performance

28-day Faster Diagnosis performance

Area	Jun	Jul	Aug	Sept	Oct	Nov
Compliance	93.3%	97.3%	96.7%	95.8%	95.6%	92.3%

Responsive

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

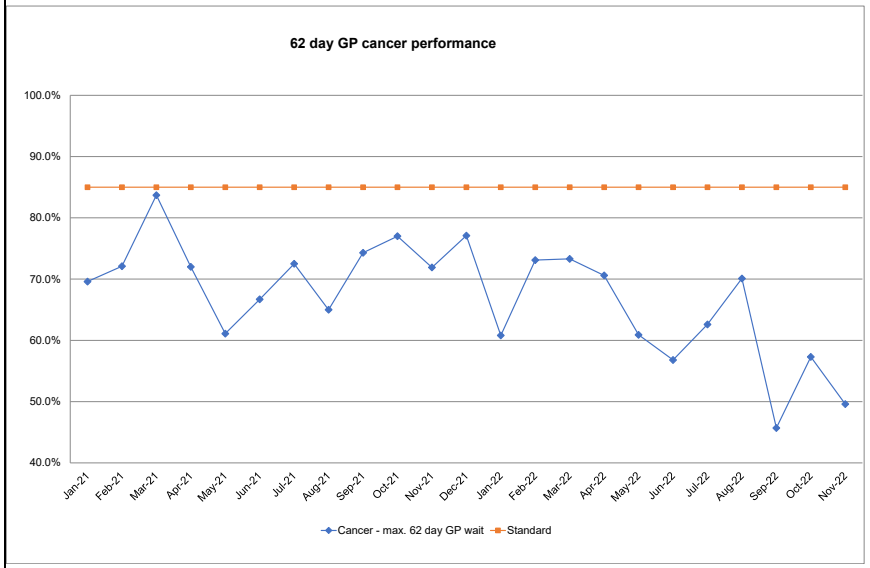
Current performance (including factors affecting this)

- The percentage of cancer patients treated within 62 days of referral by their GP was 49.6% in November 2022.
- The main breaches of the 62-day GP standards were in urology (27% of breaches), breast (27%) and colorectal (14%). The main causes of the breaches for colorectal and urology were very high levels of demand (44% growth for urology in two-week wait referrals and 52% growth in colorectal, compared to pre-COVID), and an associated increase in diagnostic waits. There are also delays in patients undergoing prostate surgery at another provider due to high levels of demand. The breaches of the standards for breast were due to the issues set out in the two-week wait exception report.
- Ten patients were treated in November 2022 on or after day 104 (the national 'backstop'). For further details see please Appendix 5a.
- The number of patients waiting over 62 days at the end of December 2022 was higher than the recovery trajectory (141 against a plan of 120). The high level of the backlog relative to pre-COVID levels mainly reflects the growth in colorectal referrals received in recent months (52% above 2019/20 levels), the breast staffing challenges and the recent shortfall in multi-disciplinary team co-ordinators due to vacancies and sickness.

Focus of improvement work

- The colorectal improvement group continues to meet weekly to redesign the diagnostic part of the colorectal cancer pathway. Work also continues in piloting changes to the prostate pathway.
- Three new multi-disciplinary team co-coordinators are now in post, filling the vacancies. A 'Super Tracker' post has also been developed and appointed to, to enable dedicated time to be given to patient tracking.
- Please also see the two-week wait exception report for the breast-related actions.

Line Chart



How do we compare

National average performance for providers was 61.0% in November 2022, the latest data available. Our performance was 49.6%. We were ranked 115 out of 138 trusts.

Recent performance

62-day GP cancer performance

Area	Jun	Jul	Aug	Sep	Oct	Nov
Compliance	56.8%	62.6%	70.1%	45.7%	57.3%	49.6%

Appendix 5a provides a detailed breakdown of tumour-site level performance.

Responsive

The Diagnostic six-week wait is a measure of the length of wait from referral through to diagnostic testing being carried out. This standard is applied to the top 15 national high-volume tests. The target is for at least 99% of patients to have been waiting less than six weeks for a test at month-end.

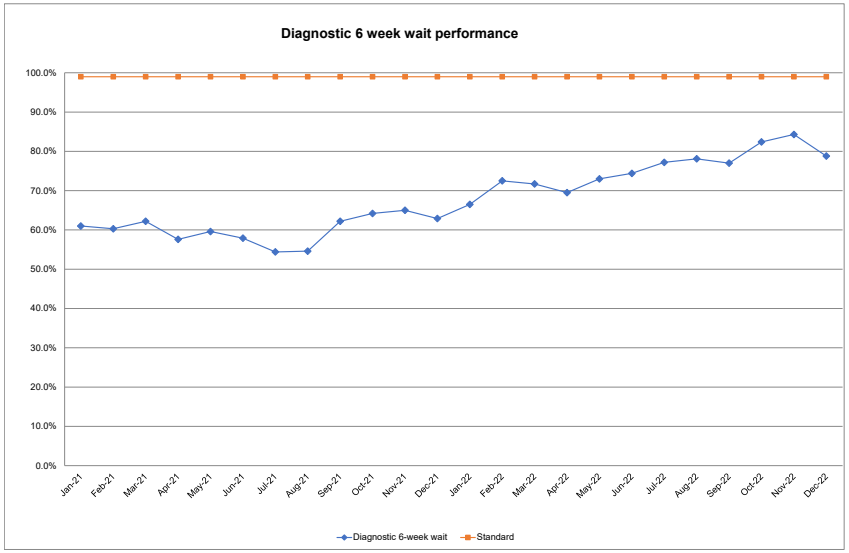
Current performance (including factors affecting this)

- The percentage of patients waiting under six weeks for their diagnostic test decreased to 78.8% in December 2022, but continued to meet the regional March 2023 ambition of greater than 75%.
- The number of patients waiting over six weeks increased from 1,144 in November 2022 to 1,340 in December 2022; the highest numbers of patients were waiting for a Colonoscopy (increased from 274 to 325), CT (235 to 274), and Audiology (288 to 254), which together made up 64% of the long waiters.
- The increase in the patients waiting over six weeks or more reflects capacity lost due to the bank holidays, and patient choice.
- The total waiting list size decreased by 13% due to a reduction in referrals in the period, which has also impacted on the percentage performance.
- The high level of over six-week waiters for colonoscopy is due both to high demand (a 52% increase in lower GI cancer referrals compared to pre-COVID) and staffing shortfalls earlier in the year.
- Audiology demand remains high, set against a backdrop of reduced capacity in other providers we have been using.

Focus of improvement work

- The third endoscopy room at Bridgwater Community Hospital is open, allowing additional colonoscopy sessions to be run.
- Additional insourcing endoscopy sessions are being run during the week, as well as at the weekend.
- A member of the endoscopy team returned in September 2022 following extended leave, which has increased colonoscopy capacity again.
- Additional audiology capacity is being sought on top of the existing outsourcing contract. Additional lists are being undertaken in-house.
- The current backlog of CT over six-week waiters is now largely specialist scans needed for cardiac patients. Additional sessions are planned in January and February 2023.

Line Chart



How do we compare

National average performance for NHS providers (i.e. excluding Independent Sector providers) was 72.5% in November 2022. Our performance was 84.3%. We were ranked 63 out of 157 trusts for the 15 high volume diagnostic tests.

Recent performance

Area	Jul	Aug	Sep	Oct	Nov	Dec
Actual	77.2%	78.1%	77.0%	82.4%	84.3%	78.8%

Responsive

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

Current performance (including factors affecting this)

- During December 2022, 30 responses were sent out, a decrease on the 60 responses sent out in November 2022.
- Of the 30 complaints responded to during December 2022, a total of 14 (46.7%) were responded to within the 40 working day standard, down from 55.0% in November 2022.

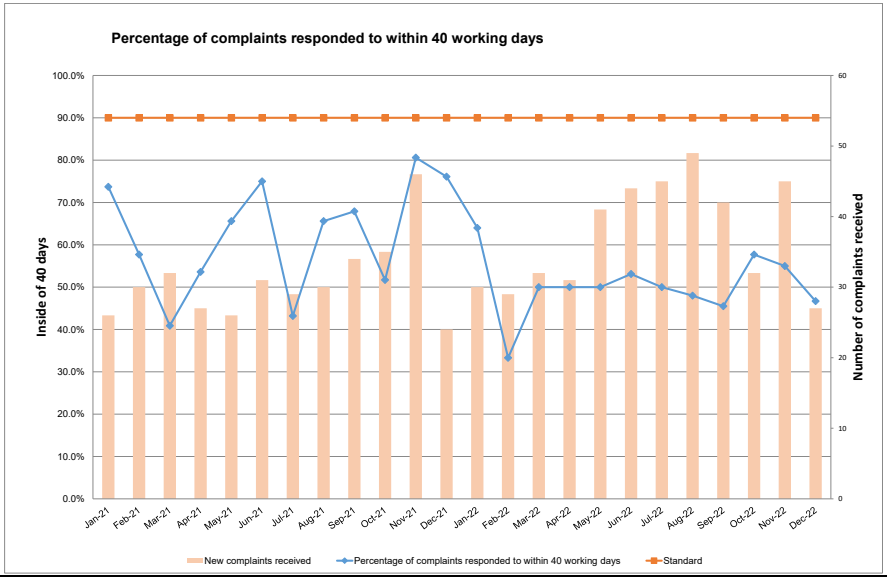
Delays occurred due to a combination of reasons including:

- The highest number of complaints remains in the Surgical directorate. At the start of December 2022, the Complaints & Governance Co-ordinator left the directorate and a new Co-ordinator joined. This transitional period would have led to some delays in complaint responses being processed.
- During December 2022 there was an increased level of sickness absence, including long term staff sickness, as well as further operational escalation across the Trust which contributed to delays in investigations and late responses.
- Some draft responses require further work; for example: in some cases, not all of the concerns have been addressed; such cases create additional work for directorate staff and the complaints team.
- Some delays relate to the difficulties in finding mutually acceptable dates for resolution meetings, particularly when they involve a number of staff from multiple teams and/or directorates.
- Delays often occur when the directorate leading an investigation requires a statement from another directorate or directorates.

Focus of improvement work.

- The new Complaints & Governance Co-ordinator in the Surgical team is meeting with managers regarding the backlog of late complaint responses; additionally, she is working with matrons and managers to consider improved ways of managing complaint investigations.
- One member of our Patient Experience Complaints team continues to assist the Surgical team specifically with co-ordinating their complaints and responses.
- The complaints team continues to meet bi-weekly with Directorate Co-ordinators/Associate Directors of Patient Care (ADPCs) to review the progress and co-ordination of every open complaint investigation.

Line Chart



How do we compare

During December 2022 the percentage of complaints responded to within 40 working days decreased compared to November 2022.

Recent Performance

Our performance in recent months is as follows:

Area	Jul	Aug	Sep	Oct	Nov	Dec
% within 40 working days	50.0%	48.0%	45.5%	57.7%	55.0%	46.7%

Current open complaints:

Directorate	Within date	Late	Total
Surgery	22	22	44
Integrated	17	1	18
Families	6	2	8
Mental Health	14	0	14
Primary Care	0	1	1
Clinical Support	6	3	9
Centrally Coordinated	1	2	3
Totals:	**66**	**31**	**97**

Well Led

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

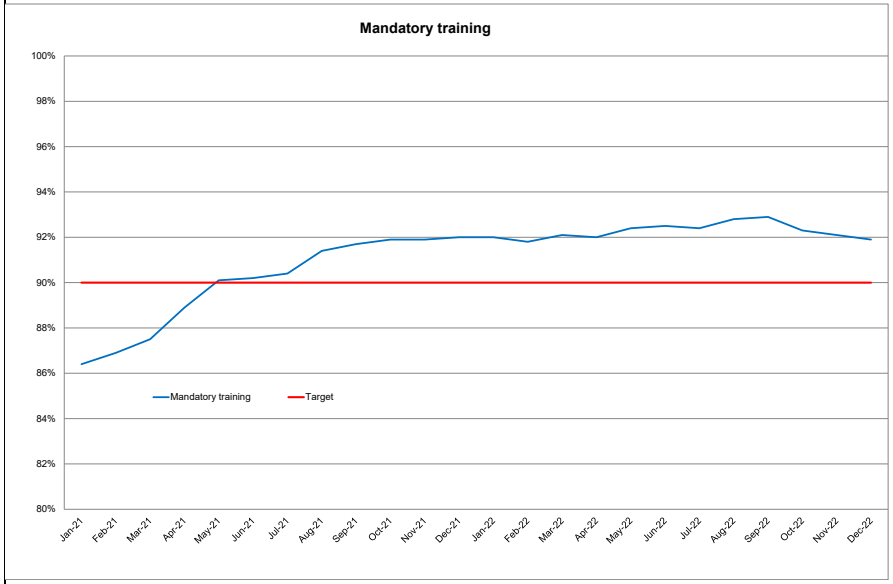
Current performance (including factors affecting this)

- As at 31 December 2022, our overall mandatory training rate was 91.9%, a slight decrease when compared to 30 November 2022.
- To be compliant, all eleven core training subjects must have compliance rates above 90%. Of the 31 courses within these eleven core subjects, the 90% target has been met for 17.
- Eleven of the 14 courses below 90% compliance relate to resuscitation.
- Operational pressures, and limited resource capacity for areas with large backlogs such as life support and safeguarding continue to remain a challenge to full recovery.
- 'Failure to attend' rates also remain high, reflecting the operational pressures, for face-to-face and increasingly virtual courses.

Focus of improvement work

- The Resuscitation team continues to create additional curriculum and training opportunities to target those who will become out of date now that the reversion to a 12-month training cycle has been applied.
- Merger charter project work continues to address compliance rates for the merged organisation and the preparation of a single learning management system for the merged Trust from day one.
- Directorates continue to receive tailored reports via their People Business Partners, and have real-time access via the learning management system to data on their teams, to help identify areas which need action.
- Action to support re-mapping in directorates for Level 3 safeguarding is underway, where teams flag that they may be incorrectly mapped.
- Work will be undertaken with the Safeguarding Team to consider a risk-based solution to cover periods when operational pressures occur.

Run Chart



How do we compare

The compliance rate as at 31 December 2022 was 0.2% lower than the rate as at 30 November 2022.

Recent Performance

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

Area	Jul	Aug	Sep	Oct	Nov	Dec
Compliance %	92.4%	92.8%	92.9%	92.3%	92.1%	91.9%

Well Led

Career Conversations: We are committed ensuring that colleagues have timely and appropriate career reviews, at least annually, to outline all aspects of their role, to highlight and promote excellence and identify core or developmental training needs to enable colleagues to progress in their chosen careers. A trajectory has been set to attain 92% compliance by 30 April 2023.

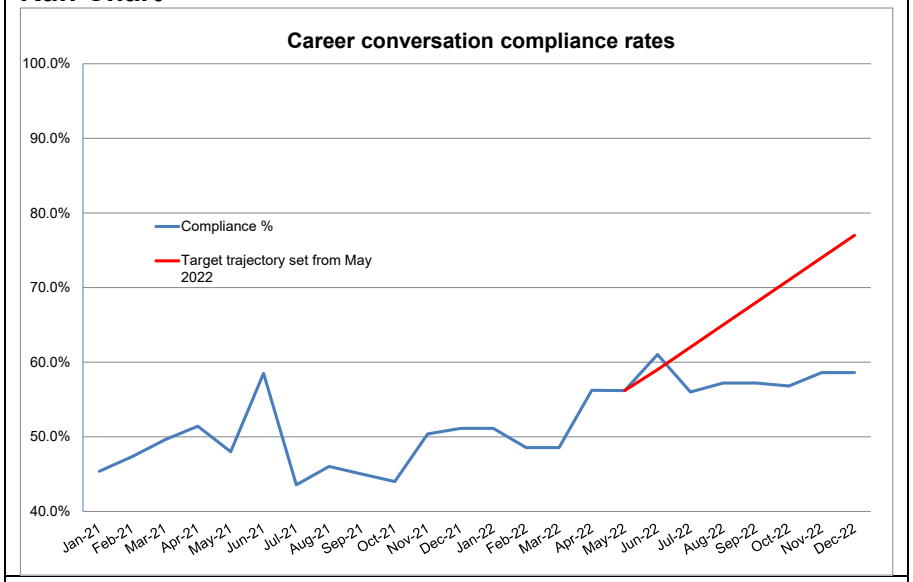
Current performance (including factors affecting this)

- Compliance as 31 December 2022, in respect of career conversation reviews being undertaken at least annually, decreased by 0.6% from the rate as at 30 November 2022.
- The rate recorded as at 31 December 2022 was 58.0%, which was 19.0% below the target trajectory set to restore compliance to 92% by 30 April 2023.
- A combination of operational pressures and high levels of sickness absence continue to impact on compliance.

Focus of improvement work

- Continued conversations with People Business Partners and Leadership and directorate leads with a more focused approach with directorates to support teams in understanding and removing barriers to achieving the trajectory.
- Continued focus on career conversations in directorate meetings to ensure this is reviewed at every opportunity and the right level of focus is given.
- People Business Partners now have access to information relating to colleagues who are due an increment award this year and whose review is currently out of date. This informs the monthly conversations held with service managers and assists with highlighting the importance of ensuring that career conversations for all colleagues are in date.
- The accessibility and functionality of the recording system is being reviewed, with feedback from focus groups being collated with a view to possible adjustments of the system and support within the leadership development programme. The review also forms part of a comprehensive review of career conversations and the alignment of the SFT and Yeovil District Hospital processes.

Run Chart



How do we compare

Compliance as at 31 December 2022 decreased compared to rate as at 30 November 2022.

Recent performance

The compliance rates in recent months were as follows:

Area	Jul	Aug	Sep	Oct	Nov	Dec
Trajectory	62.0%	65.0%	68.0%	71.0%	74.0%	77.0%
Monthly rate	56.0%	57.2%	57.2%	56.8%	58.6%	58.0%

Well Led

Sickness/Absence: We are committed to improving the health and wellbeing of our workforce in a supportive work environment, in order to reduce sickness absence and thereby ensure continuity of care and quality service provision. Our aim is to reduce staff sickness absence levels to 4.6% or less. The data outlined shows our monthly sickness absence percentage rate.

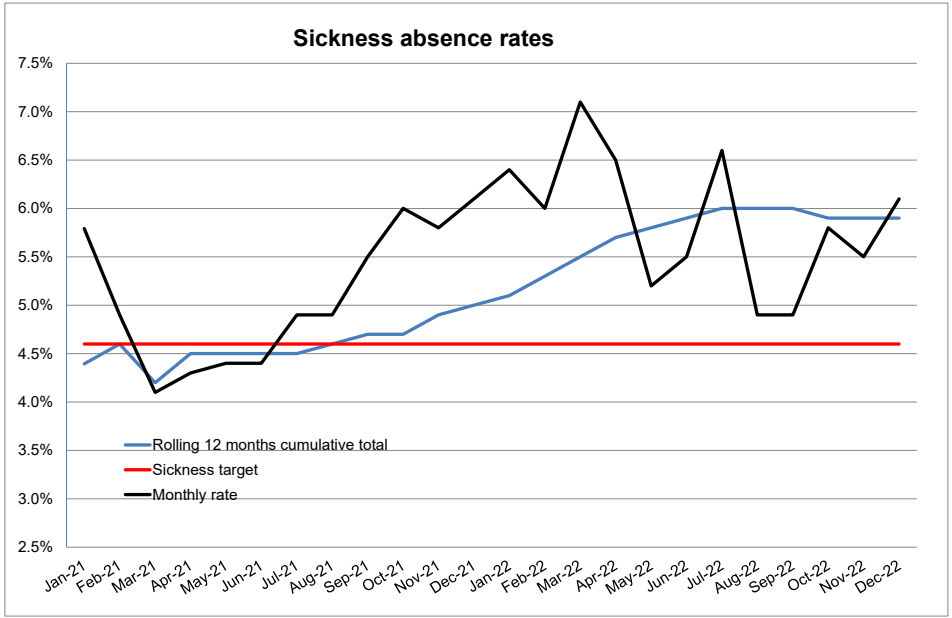
Current performance (including factors affecting this)

- The 12-month rolling sickness absence rate for the period ending 31 December 2022 remained at 5.9%. The monthly rate of sickness absence increased to 6.1% in December 2022, from 5.5% in November 2022.
- The number of working days lost due to stress and anxiety in December 2022 totalled 306, down from 326 reported during November 2022.
- COVID-19 accounted for 21.5% of all sickness absence in the 12 months to 31 December 2022. The monthly percentage of all absence that was due to COVID-19 in December 2022 was 9.8%, up from 8.0% recorded during November 2022.

Focus of improvement work

- Recommendations from the internal audit into sickness management undertaken during 2022 have been implemented and are currently being evaluated to assess the impact on absence levels.
- Regular focus on increasing 'flu and COVID-19 vaccinations for colleagues.
- Continued focus on long term absence and opportunities to support colleagues back to work.

Run Chart



How do we compare

As the only acute, community and mental health Trust we are currently unable to benchmark our position directly against similar providers. We have used national data published by NHS Digital to review our target level, and to develop a realistic target.

Recent performance

The sickness absence rates in recent months were as follows:

Area	Jul	Aug	Sep	Oct	Nov	Dec
12 monthly rate	6.0%	6.0%	6.0%	5.9%	5.9%	5.9%
Monthly rate	6.6%	4.9%	4.9%	5.8%	5.5%	6.1%

Well Led

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

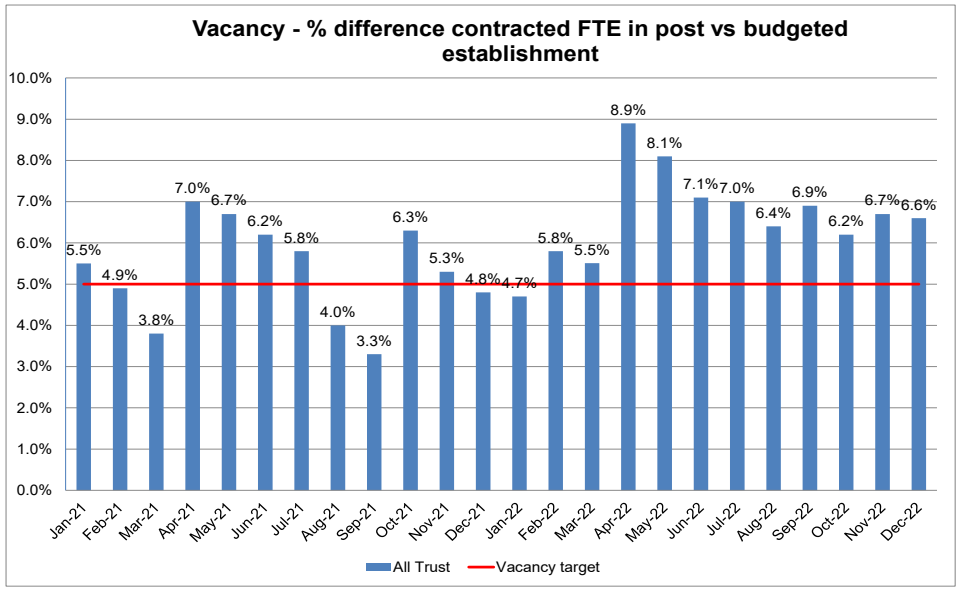
Current performance (including factors affecting this)

- The vacancy rate as at 31 December 2022 was 6.6%, down from 6.7% as at 30 November 2022.
- In the year between December 2021 and November 2022 there were 1,697.74 whole time equivalent (WTE) new starters and 1,166.48 WTE leavers. This means that 69% of recruitment relates to our leavers and therefore does not reduce our vacancy position.

Focus of improvement work

- Improving retention remains the focus to improve the vacancy position.
- The national People Promise Exemplar programme, in which our Trusts are involved, is starting to see marginal gains in the leaver position for all colleague groups and especially within the nursing workforce.
- The People Promise Exemplar work is focused on those areas where we know we can make the biggest difference on retention:
  - Providing access to life and career stage wellbeing and career advice and support.
  - The introduction of stay interviews.
  - Onboarding and induction redevelopment.
  - Career coaching / pathways and connectivity.
  - Retirement support.
  - Introduction of a legacy mentor role.
  - Exit interviews.
  - The introduction of an inclusive talent management framework.
  - The development of systems to identify rising talent.
  - A drive to revamp our approach to flexible working.

Run Chart



How do we compare

A recent benchmarking exercise relating to employment checks showed the best performance was approximately 18 days, for Trusts with similar activity to us, and the worst was 68 days. Our Trust performance was 27 days.

Recent performance

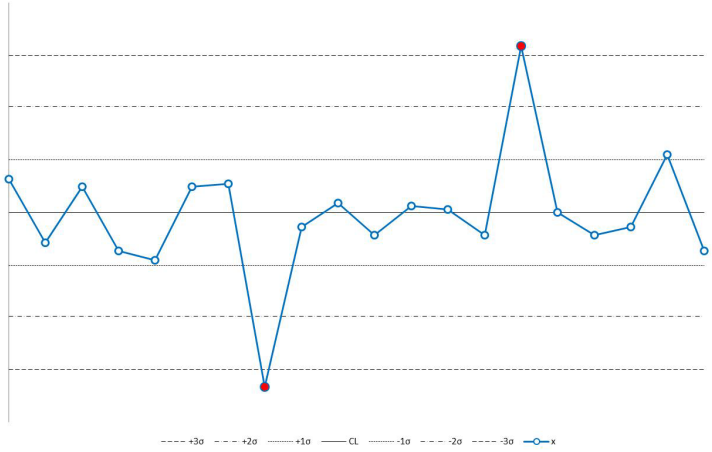
The performance against the vacancy rate standard in recent months was as follows:

Area	Jul	Aug	Sep	Oct	Nov	Dec
Vacancy rate	7.0%	6.4%	6.9%	6.2%	6.7%	6.6%

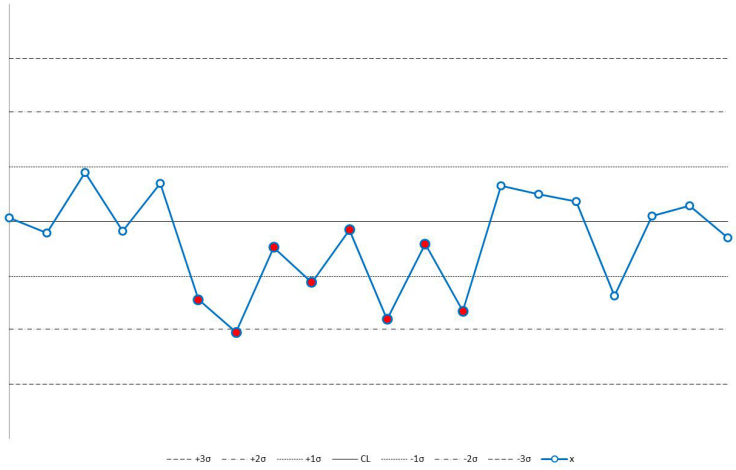
Appendix 1 - Procedure for Interpreting Run Charts

Special Cause Variation Rules

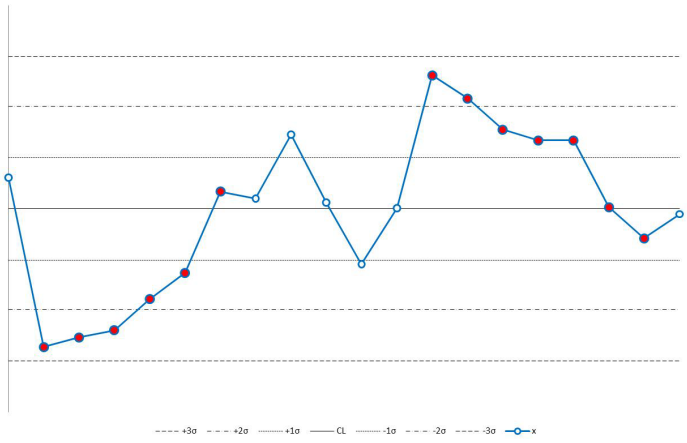
1. A single point outside the control limits



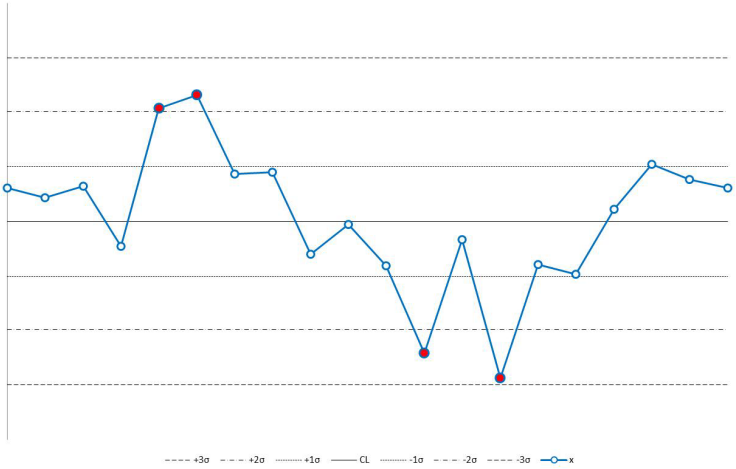
2. A run of eight or more points in a row above (or below) the centreline



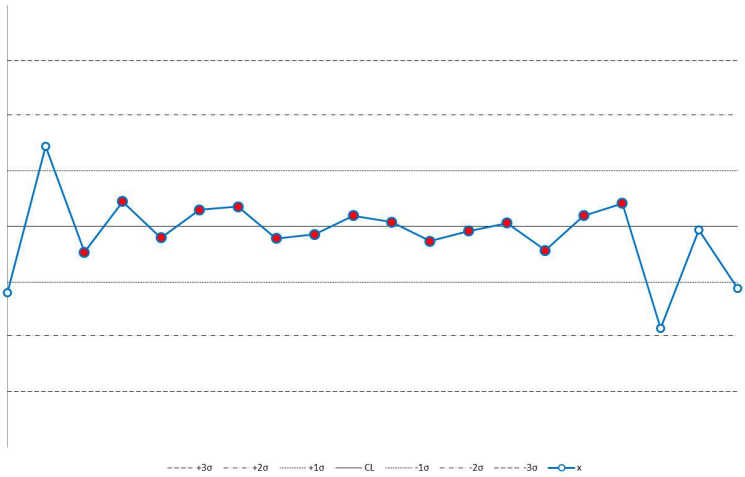
3. Six consecutive points increasing (trend up) or decreasing (trend down)



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



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



APPENDIX 2

OUR CARE QUALITY COMMISSION RATINGS

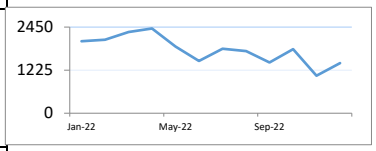
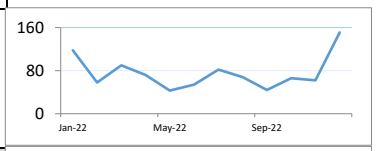
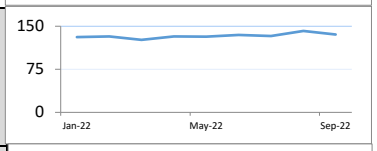
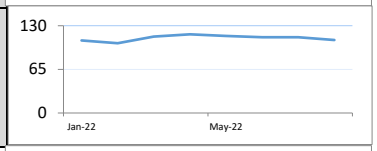
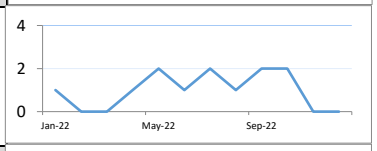
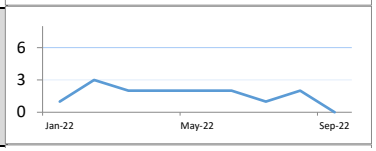
Our current Care Quality Commission ratings are as follows:

	Somerset NHS Foundation Trust
Overall rating for the Trust	Good

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

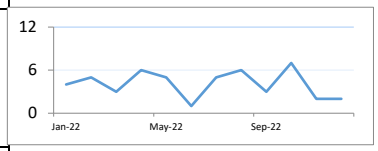
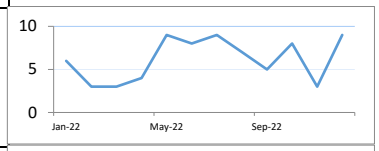
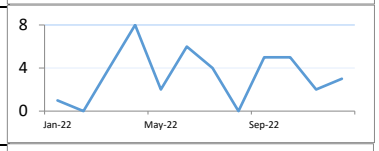
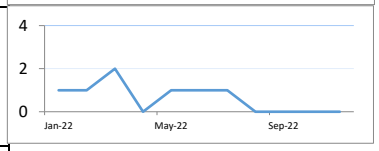
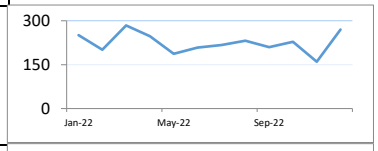
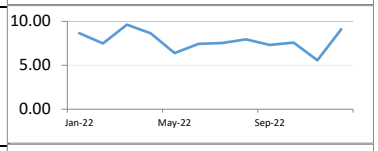
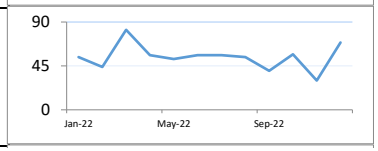
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2022/23

Area	Ref	Measure		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	
Admissions	1	Number of medical and surgical outliers in acute wards		2048	2089	2309	2410	1893	1489	1835	1770	1442	1824	1067	1424	
	2	Admissions of under 16 year olds to adult mental health wards		0	0	0	0	0	0	0	0	0	0	0	0	
	3	Mixed sex accommodation breaches	Acute wards	0	0	0	0	0	0	0	0	0	0	0	0	
	4		Community and mental health wards	0	0	0	0	0	0	0	0	0	0	0	0	
	5	Number of patients transferred between acute wards after 10pm		118	58	90	72	43	54	82	68	44	66	62	151	
Mortality (acute services)	6	Hospital Standardised Mortality Ratio (HSMR)		131.08	132.06	126.28	132.2	132	134.71	133.00	141.78	135.45	133.44	November 2022 to be reported after January 2023		
	7	Summary Hospital-level Mortality Indicator (SHMI)		108.21	103.94	113.87	117.22	114.92	112.75	112.88	108.77	106.52	October 2022 to be reported after January 2023			
Incident reporting	8	No of dia- acute services		1	0	0	1	2	1	2	1	2	2	0	0	
	9	Number of recorded Serious Incidents Requiring Investigation - community and mental health services		0	1	3	2	2	2	2	1	2	Data awaited	Data awaited	Data awaited	

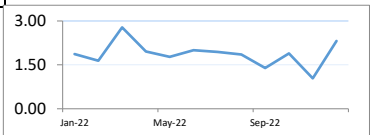
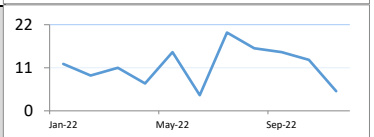
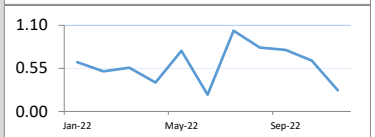
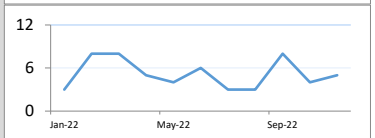
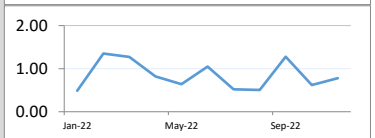
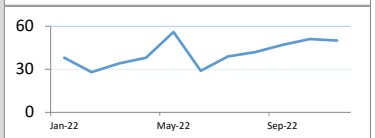
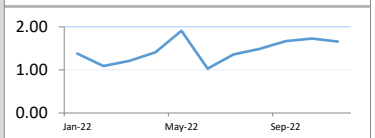
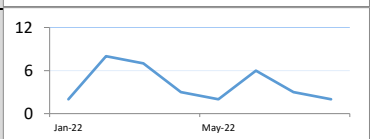
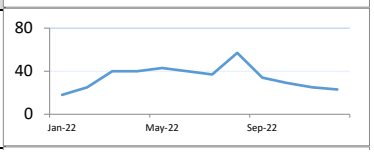
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2022/23

Area	Ref	Measure	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	
Infection Control	10	Clostridium Difficile cases HOHA cases (Hospital Onset Hospital Acquired) and COHA cases (Community Onset Hospital Acquired)	4	5	3	6	5	1	5	6	3	7	2	2	
Infection Control (acute services)	11	MRSA bacteraemias (post)	1	0	0	0	0	0	0	0	1	0	0	0	
	12	E. coli bacteraemia	6	3	3	4	9	8	9	7	5	8	3	9	
	13	Methicillin-sensitive staphylococcus aureus	1	0	4	8	2	6	4	0	5	5	2	3	
Maternity	14	No. of still births	1	1	2	0	1	1	1	0	0	0	0	0	
	15	No. of babies born in unexpectedly poor condition	0	0	0	0	0	0	0	0	0	0	0	0	
Falls	16	Number of patient falls - all services	251	201	284	247	187	208	217	232	210	228	160	270	
	17	Rate of falls per 1,000 occupied bed days - all services	8.67	7.49	9.63	8.65	6.39	7.43	7.54	7.96	7.32	7.58	5.57	9.09	
	18	Number of falls resulting in harm - all services	54	44	82	56	52	56	56	54	40	57	30	69	

SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2022/23

Area	Ref	Measure	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	
Falls	19	Rate of falls resulting in harm per 1,000 occupied bed days - all services	1.87	1.64	2.78	1.96	1.78	2.00	1.95	1.85	1.39	1.89	1.04	2.32	
Pressure ulcer damage	20	Acute wards - number of incidents	12	9	11	7	15	4	20	16	15	13	5	Being validated	
	21	Rate of pressure ulcer damage per 1,000 acute ward occupied bed days	0.63	0.51	0.56	0.37	0.78	0.21	1.03	0.82	0.79	0.65	0.27		
	22	Community hospitals - number of incidents	3	8	8	5	4	6	3	3	8	4	5		
	23	Rate of pressure ulcer damage per 1,000 community hospital occupied bed days	0.49	1.35	1.27	0.82	0.64	1.05	0.52	0.51	1.28	0.62	0.78		
	24	District nursing - number of incidents	38	28	34	38	56	29	39	42	47	51	50		
	25	Rate of pressure ulcer damage per 1,000 district nursing contacts	1.38	1.09	1.21	1.41	1.91	1.03	1.36	1.49	1.67	1.73	1.66		
Cardiac Arrests	26	No. ward-based cardiac arrests - acute wards	2	8	7	3	2	6	3	2	Data awaited	Data awaited	Data awaited	Data awaited	
Restraints (mental health wards)	27	Total number of incidents	18	25	40	40	43	40	37	57	34	29	25	23	

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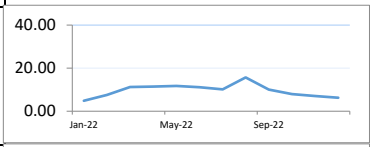
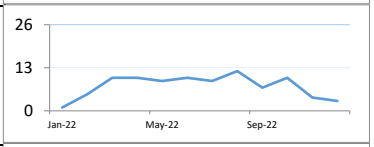
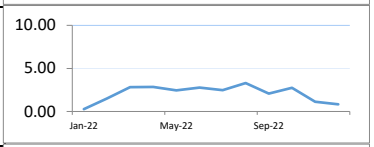
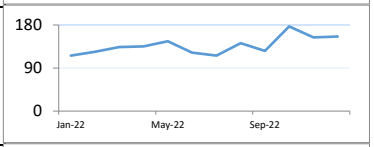
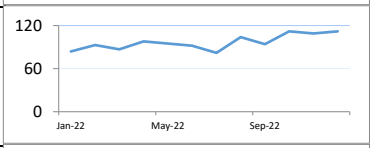
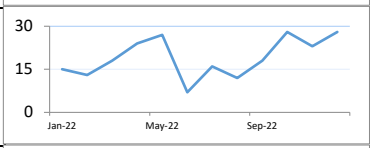
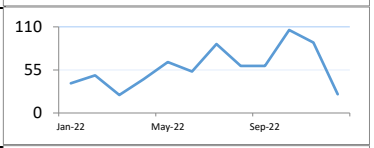
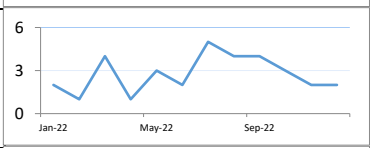
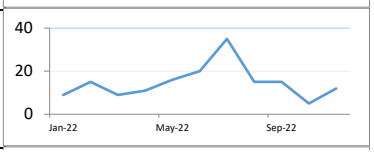
QUALITY MEASURES - 2022/23

Area	Ref	Measure	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	
Restraints (mental health wards)	28	Restraints per 1,000 occupied bed days	4.86	7.55	11.26	11.44	11.74	11.13	10.15	15.69	10.06	8.00	7.02	6.25	
	29	Number of prone restraints	1	5	10	10	9	10	9	12	7	10	4	3	
	30	Prone restraints per 1,000 occupied bed days	0.27	1.51	2.82	2.86	2.46	2.78	2.47	3.30	2.07	2.76	1.12	0.82	
Medication incidents - community and mental health wards	31	Total number of medication incidents	116	124	134	135	146	122	116	142	126	177	154	156	
	32	Medication incidents - drug errors	84	93	87	98	95	92	82	104	94	112	109	112	
	33	Medication incidents - incorrect storage	15	13	18	24	27	7	16	12	18	28	23	28	
Ligatures and ligature points - mental health wards	34	Ligatures: Total number of incidents	38	48	23	43	65	53	88	60	60	106	90	24	
	35	Number of ligature point incidents	2	1	4	1	3	2	5	4	4	3	2	2	
Aggression - d mental health rds	36	Violence and Aggression: Number of incidents patient on patient (inpatients only)	3	9	15	9	11	16	20	35	15	15	5	12	

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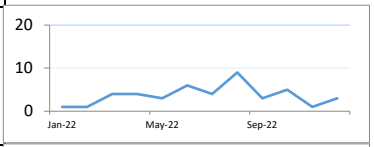
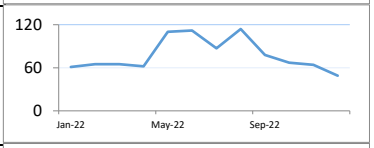
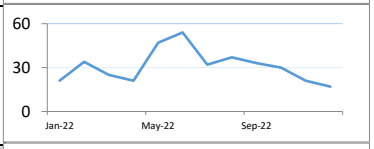
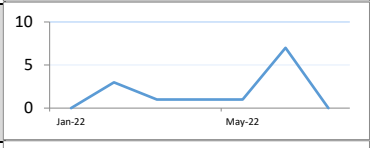
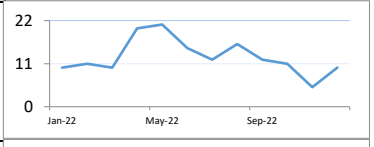
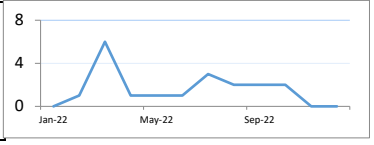
QUALITY MEASURES - 2022/23

Area	Ref	Measure	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	
Violence and community and wa	37	Violence and Aggression: Incidents resulting in harm - patient on patient (inpatient only)	1	1	4	4	3	6	4	9	3	5	1	3	
Violence and Aggression - community and mental health services	38	Violence and Aggression: Number of incidents patient on staff	61	65	65	62	110	112	87	114	78	67	64	49	
	39	Violence and Aggression: Incidents resulting in harm - patient on staff	21	34	25	21	47	54	32	37	33	30	21	17	
Unexpected deaths	40	Unexpected Deaths: Total number of incidents to be investigated - community and mental health services	0	3	1	1	1	7	A review of this area of reporting is currently being undertaken.						
Seclusion - mental health wards	41	Number of Type 1 -Traditional Seclusion	10	11	10	20	21	15	12	16	12	11	5	10	
	42	Number of Type 2 -Short term Segregation	0	1	6	1	1	1	3	2	2	2	0	0	

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2022/23

No.	Description		Links to corporate objectives	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Thresholds
1	Accident and Emergency / Minor Injury Unit 4-hour performance	Accident and Emergency department (ED)	4, 6, 9	59.4%	56.9%	49.4%	52.7%	50.5%	47.3%	47.9%	45.8%	48.4%	43.4%	54.0%	39.6%	>=95%= Green >=85% - <95% =Amber <85% =Red
2		Minor Injury Units	4, 6, 9	99.4%	98.9%	98.1%	98.0%	97.9%	97.4%	97.1%	96.9%	96.8%	97.0%	97.6%	93.9%	
3		Trust-wide	4, 6, 9	80.5%	79.7%	76.8%	78.6%	77.4%	76.4%	75.9%	75.6%	75.8%	73.1%	77.9%	70.5%	
4	Accident and Emergency / Minor Injury Units: percentage of patients spending more than 12-hours in the department	Accident and Emergency department (ED)	4, 6, 9	5.4%	4.5%	7.9%	7.0%	3.7%	4.1%	4.7%	8.8%	4.2%	8.4%	2.9%	10.2%	<=2%= Green >2% - <=5% =Amber >5% =Red
5		Minor Injury Units	4, 6, 9	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
6	Ambulance handovers waiting less than 30 minutes - Emergency Department only (MPH)		4, 6, 9	87.8%	90.4%	71.9%	77.4%	82.9%	76.6%	78.9%	65.7%	73.4%	56.5%	79.0%	52.1%	>=95%= Green >=85% - <95% =Amber <85% =Red
7	Cancer - maximum 2-week wait from GP referral (suspected cancer)		3, 4, 9	66.1%	65.3%	63.3%	62.5%	68.2%	55.0%	63.5%	57.1%	51.1%	56.6%	51.9%	Data awaited	>=93%= Green <93% =Red
8	Cancer - 28 days Faster Diagnosis All Cancers		3, 4, 9	70.3%	81.0%	75.0%	73.2%	68.3%	56.8%	62.4%	60.6%	47.7%	51.7%	63.0%	Data awaited	>=75%= Green <75% =Red
9	Cancer - maximum 31 day wait from diagnosis to first treatment		3, 4, 9	89.6%	98.4%	96.5%	98.1%	96.3%	93.3%	97.3%	96.7%	95.8%	95.6%	92.3%	Data awaited	>=96%= Green <96% =Red
10	Cancer - maximum 62 day wait from urgent GP referral		3, 4, 9	60.8%	73.1%	73.3%	70.6%	60.9%	56.8%	62.6%	70.1%	45.7%	57.3%	49.6%	Data awaited	>=85%= Green <85% =Red
11	Cancer: 62-day wait from referral to treatment for urgent GP referrals – number of patients treated on or after day 104		3, 4, 9	12	10	10	3	10	18	12	10	13	11	10	Data awaited	0= Green >0 = Red
12	CAMHS Eating Disorders - Urgent referrals to be seen within 1 week (rolling 12 months)		3, 4, 9	83.3%	81.8%	83.9%	86.2%	85.2%	83.3%	82.6%	80.0%	80.0%	80.0%	85.0%	84.2%	>=95%= Green >=85% - <95% =Amber <85% =Red
13	CAMHS Eating Disorders - Routine referrals to be seen within 4 weeks (rolling 12 months)		3, 4, 9	73.6%	75.2%	75.2%	75.0%	74.0%	79.0%	80.4%	84.7%	85.4%	90.2%	91.5%	91.1%	>=95%= Green >=85% - <95% =Amber <85% =Red
14	Mental health referrals offered first appointments within 6 weeks	All mental health services	4, 6, 9	90.6%	92.1%	93.4%	89.5%	93.4%	91.9%	93.2%	93.8%	90.4%	90.8%	91.9%	89.0%	>=90%= Green >=80% - <90% =Amber <80% =Red
15		Adult mental health services	4, 6, 9	87.4%	91.7%	90.3%	86.4%	90.2%	87.9%	94.7%	93.6%	87.4%	89.2%	90.0%	86.3%	>=90%= Green >=80% - <90% =Amber <80% =Red
16		Older Persons mental health services	4, 6, 9	90.4%	90.4%	96.0%	90.1%	95.1%	93.1%	92.0%	93.0%	90.2%	90.0%	90.8%	89.8%	>=90%= Green >=80% - <90% =Amber <80% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2022/23

No.	Description		Links to corporate objectives	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Thresholds
17	Mental health referrals offered first appointments within 6 weeks	Learning disabilities service	4, 6, 9	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	88.9%	>=90%= Green >=80% - <90% =Amber <80% =Red
18		Children and young people's mental health services	4, 6, 9	98.5%	96.9%	96.8%	98.3%	98.6%	98.9%	91.9%	100.0%	100.0%	97.3%	100.0%	95.9%	>=90%= Green >=80% - <90% =Amber <80% =Red
19	Diagnostic 6-week wait - acute services		4, 9	66.5%	72.5%	71.7%	69.5%	73.0%	74.4%	77.2%	78.1%	77.0%	82.4%	84.3%	78.8%	>=99%= Green >=98% - <99% =Amber <98% =Red
20	RTT incomplete pathway performance: percentage of people waiting under 18 weeks		4, 6, 9	60.3%	59.3%	59.0%	59.1%	61.8%	61.5%	61.5%	62.2%	60.5%	59.6%	58.6%	56.4%	>=92%= Green <92% =Red
21	52 week RTT breaches		4, 6, 9	1,693	1,736	1,741	1,923	1,934	1,984	1,952	1,915	1,952	1,955	1,841	1,860	At or below trajectory = Green Above trajectory = Red
22	78 week RTT breaches		4, 6, 9	410	418	359	427	427	400	373	330	297	262	219	257	From April 2022 At or below trajectory = Green Above trajectory = Red
23	104 week RTT breaches		4, 6, 9	131	145	86	80	61	33	17	16	13	7	1	3	From April 2022 At or below trajectory = Green Above trajectory = Red
24	Referral to Treatment (RTT) incomplete pathway waiting list size		4, 6, 9	32,013	32,729	33,196	33,822	34,349	35,000	34,392	34,826	35,513	36,342	36,707	36,831	From April 2022 At or below trajectory = Green Above trajectory = Red
25	Average length of stay of patients on Musgrove Park wards (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).		4, 9	7.1	7.1	7.0	7.8	7.2	6.5	6.5	7.0	6.6	6.6	6.9	6.6	Monitored using Special Cause Variation Rules. Report by exception.
26	Waiting times: number of people waiting over 18 weeks from referral to first appointment - community services including dental		4, 6, 9	3,745	3,835	3,847	3,986	4,041	4,361	4,465	4,512	4,658	4,881	3,983	4,102	< 82 patients (2017/18 outturn) = Green >=82 - <86 = Amber >86 = Red
27	Community dental services - Child GA waiters waiting 18 weeks or more		4, 6, 9	167	187	213	223	216	229	331	351	330	333	346	370	0 = Green >=0 - =<50 =Amber >50 =Red
28	Early Intervention In Psychosis: people to begin treatment with a NICE-recommended care package within 2 weeks of referral (rolling three month rate)		4, 6, 9	66.7%	78.6%	66.7%	63.2%	75.0%	76.9%	63.6%	69.2%	66.7%	75.0%	58.8%	61.9%	>=60%= Green <60% =Red
29	Improving Access to Psychological Therapies (IAPT) RTT : percentage of people waiting under 6 weeks		4, 6, 9	75.9%	73.6%	62.3%	57.5%	57.0%	55.5%	51.9%	57.3%	64.1%	63.1%	63.6%	63.8%	>=75%= Green <75% =Red
30	Improving Access to Psychological Therapies (IAPT) RTT: percentage of people waiting under 18 weeks		4, 6, 9	98.7%	98.9%	97.9%	97.9%	98.4%	98.3%	98.6%	98.6%	98.0%	97.5%	98.1%	98.4%	>=95%= Green <95% =Red
31	Improving Access to Psychological Therapies (IAPT) Recovery Rates		4, 7, 9	63.7%	58.4%	55.7%	66.6%	63.1%	62.1%	57.6%	60.1%	64.0%	54.4%	59.8%	56.5%	>=50%= Green <50% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2022/23

No.	Description	Links to corporate objectives	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Thresholds
32	Adult mental health inpatients receiving a follow up within 72 hrs of discharge	4, 9	90.6%	90.2%	88.9%	97.1%	90.2%	97.2%	91.4%	100.0%	96.6%	100.0%	97.4%	100.0%	>=80%= Green <80% =Red
33	Inappropriate Out of Area Placements for non-specialist mental health inpatient care (monthly number of patient days)	4, 5, 9	28	17	7	23	88	90	75	25	10	60	125	57	0= Green >0 = Red
34	Intermediate Care - Patients aged 65+ discharged home from acute hospital beds on pathway 0 or 1	4, 5, 9	92.9%	91.7%	93.4%	91.5%	92.2%	94.8%	93.2%	92.4%	94.2%	94.1%	92.9%	93.2%	>=95%= Green >=85% - <95% =Amber >85% =Red
35	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services	4, 9	90.0%	90.0%	93.0%	76.0%	96.0%	90.0%	89.0%	85.0%	82.0%	83.0%	Data awaited	Data awaited	>=90%= Green >=80% - <90% =Amber <80% =Red
36	Percentage of emergency patients screened for sepsis - acute services	4, 9	90.0%			75.0%			Reported quarterly Results of audit being validated. Operational pressures has impacted and delayed work			Reported quarterly			>=90%= Green >=49% - <90% =Amber <49% =Red
37	Percentage of patients receiving antibiotics within one hour of red flag diagnosis of sepsis - acute services	4, 9	62.5%			47.1%									>=90%= Green >=49% - <90% =Amber <49% =Red
38	Percentage of patients with a NEWS of 5 or more acted upon appropriately - acute services	4, 9	48.1%	61.1%	49.1%	57.4%	Reporitng processes being reviewed and updated								TBC
39	District nursing - cumulative increase / (reduction) in external referrals from 1 April 2021 to 31 March 2022 compared to same months of 2019/20	9	0.3%	-0.2%	0.3%	-8.5%	-9.1%	-6.4%	-6.0%	-3.4%	-1.9%	-2.3%	0.3%	1.3%	TBC
40	Percentage of complaints responded to within 40 working days - Trust-wide	9	64.0%	33.3%	50.0%	50.0%	50.0%	53.1%	50.0%	48.0%	45.5%	57.7%	55.0%	46.7%	>=90%= Green >=75% - <90% =Amber >75% =Red
41	Mandatory training: percentage completed	1, 8, 9	92.0%	91.8%	92.1%	92.0%	92.4%	92.5%	92.4%	92.8%	92.9%	92.3%	92.1%	91.9%	All courses >=90%= Green Overall rate <80% =Red Any other position = Amber
42	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)	8, 9	4.7%	5.8%	5.5%	8.9%	8.1%	7.1%	7.0%	6.4%	6.9%	6.2%	6.7%	6.6%	<=5%= Green >5% to <=7.5% =Amber >7.5% =Red
43	Sickness absence levels - rolling 12 month average (Trust-wide)	8, 9	5.1%	5.3%	5.5%	5.7%	5.8%	5.9%	6.0%	6.0%	6.0%	5.9%	5.9%	5.9%	<=4.6%= Green >4.6% to <=5.1% =Amber >5.1% =Red
44	Sickness absence levels - monthly average (Trust-wide)	8, 9	6.4%	6.0%	7.1%	6.5%	5.2%	5.5%	6.6%	4.9%	4.9%	5.8%	5.5%	6.1%	<=4.6%= Green >4.6% to <=5.1% =Amber >5.1% =Red
45	Reduce the number of working days lost due to stress and anxiety (Trust-wide)	8, 9	388	311	333	341	361	314	330	279	301	351	326	306	Monitored using Special Cause Variation Rules. Report by exception.
46	Retention / turnover rates (Trust-wide)	8, 9	11.4%	12.4%	11.9%	11.9%	11.9%	11.2%	10.9%	11.0%	10.8%	11.0%	11.3%	11.2%	=<12%= Green 12% to <15% =Amber >15% =Red
47	Career conversations (12 months) - formerly 'Performance review (12-month)'	8, 9	51.1%	48.5%	48.5%	56.2%	56.2%	61.0%	56.0%	57.2%	57.2%	56.8%	58.6%	58.0%	From May 2022 At or above trajectory = Green Below trajectory = Red

Appendix 5a – Specialty and tumour-site level performance

Table 1 – Performance against the RTT performance standard in December 2022, including the number of patients waiting over 18 weeks, the number of patients waiting over 52 weeks, and the average (mean) number of weeks patients have waited on the Trust's waiting list.

RTT specialty	Over 18 week waiters	Over 52 week waiters	Incomplete pathways	Incomplete pathways performance
General Surgery	229	38	399	42.6%
Urology	978	180	2005	51.2%
Trauma & Orthopaedics	1802	430	4969	63.7%
Ear, Nose & Throat (ENT)	1439	91	3159	54.4%
Ophthalmology	2307	191	4250	45.7%
Oral Surgery	1115	121	2462	54.7%
Plastic Surgery	0	0	3	100.0%
Cardiothoracic Surgery	8	0	30	73.3%
General Medicine	2	0	4	50.0%
Gastroenterology	971	11	2105	53.9%
Cardiology	1109	26	2407	53.9%
Dermatology	39	0	218	82.1%
Thoracic Medicine	506	1	1224	58.7%
Neurology	416	8	983	57.7%
Rheumatology	225	15	571	60.6%
Geriatric Medicine	82	0	433	81.1%
Gynaecology	865	117	2406	64.0%
Other – Medical Services	964	149	2109	54.3%
Other - Paediatric Services	373	12	1018	63.4%
Other - Surgical Services	2442	467	5461	55.3%
Other – Other Services	178	3	615	71.1%
Total	**16,050**	**1,860**	**36,831**	**56.4%**

Table 2 – Performance against the 62-day GP cancer standard in November 2022.

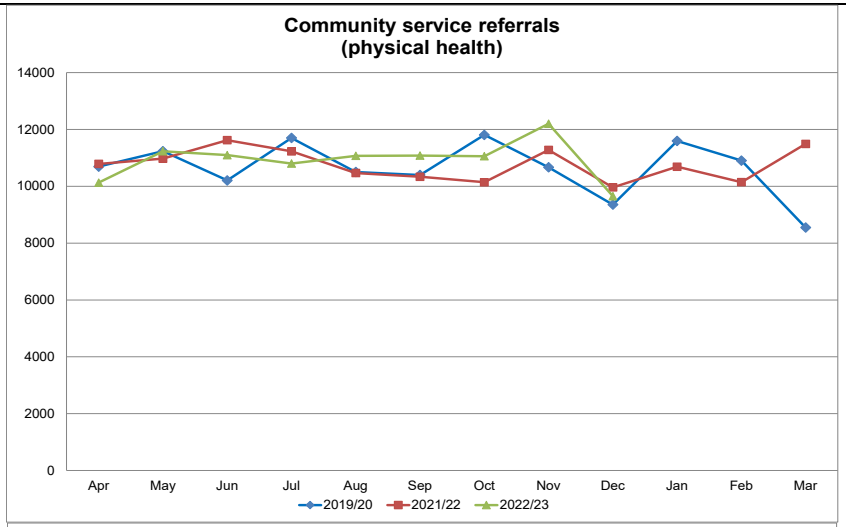
Tumour site	No of breaches	Trust performance
Breast	15.0	33.3%
Colorectal	8.0	42.9%
Gynaecology	7.0	26.3%
Haematology	2.0	73.3%
Head & Neck	1.0	77.8%
Lung	7.0	22.2%
Other	0.0	100.0%
Skin	1.0	50.0%
Upper GI	0.0	100.0%
Urology	15.5	55.1%
Total	**56.5**	**49.6%**

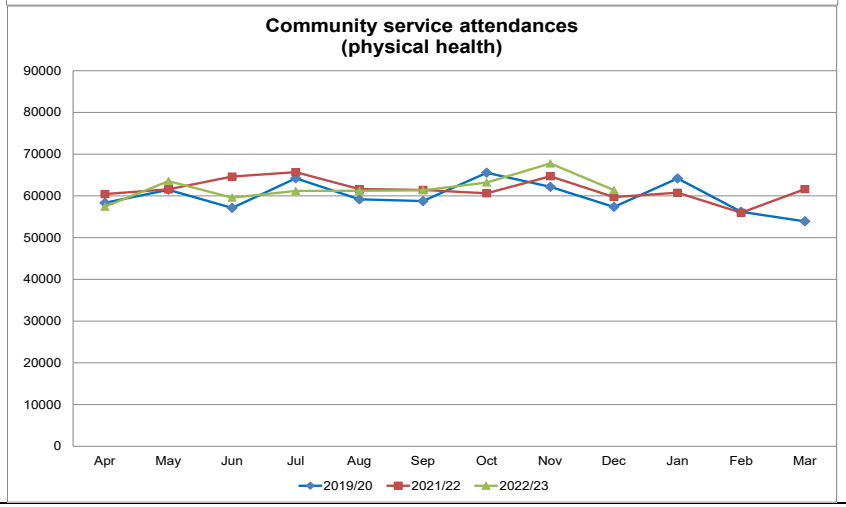
Ten patients were treated in November on or after day 104 (the national 'backstop'). Nine were assessed as having unavoidable delays. A breakdown of the breaches is as follows:

- Five patients had a complex pathway, including treatment plans changing, transferring to a different cancer pathway (i.e., a different type of tumour from the one originally referred for) and/or additional diagnostics tests being required.
- Three patients had some internal delays mainly due to capacity (one of which was assessed to have potentially avoidable), but were further delayed for unavoidable reasons, mainly due to a longer wait for a PET scan and other additional diagnostics undertaken by another provider.
- One patient's pathway was delayed for medical reasons (unfit for investigations).
- One pathway was delayed because of patient choice (delaying the first appointment), but there were further delays when the patient required additional investigations with other clinic teams.

Operational context

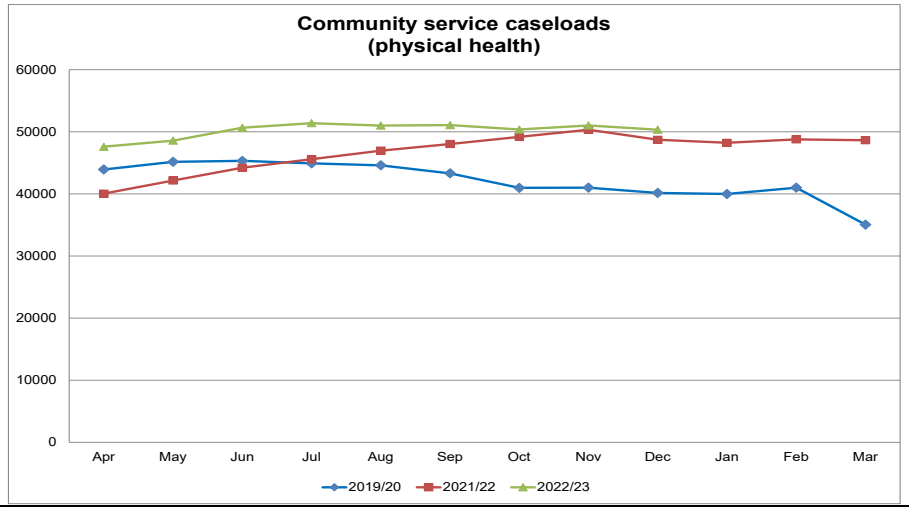
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





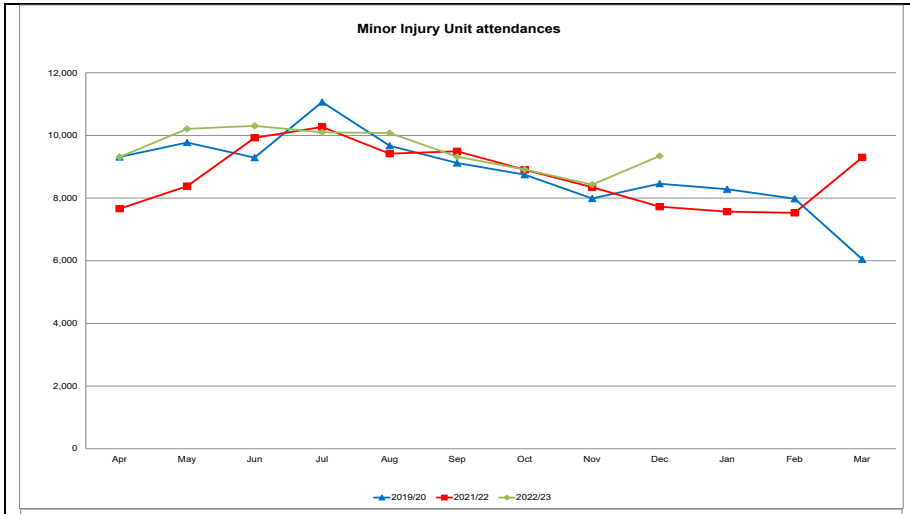
Summary:

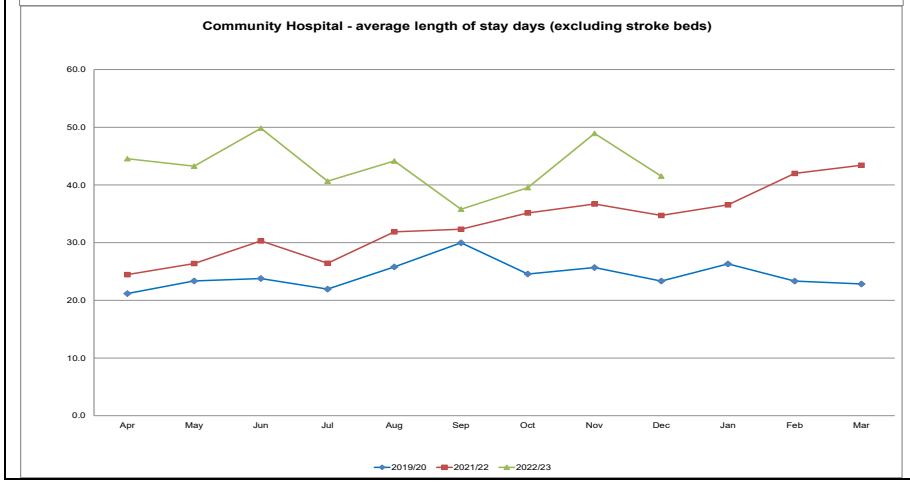
- Direct referrals to our community physical health services between 1 April and 31 December 2022 were 1.6% higher than in the same months of 2021 and 1.8% higher than the same months of 2019.
- Attendances for the same period were 0.7% lower than the same months of 2021 but 2.3% higher than the levels of 2019.
- Community service caseload levels as at 31 December 2022 were 3.3% higher than as at 31 December 2021, and were 25.3% above 31 December 2019 levels.



Operational context

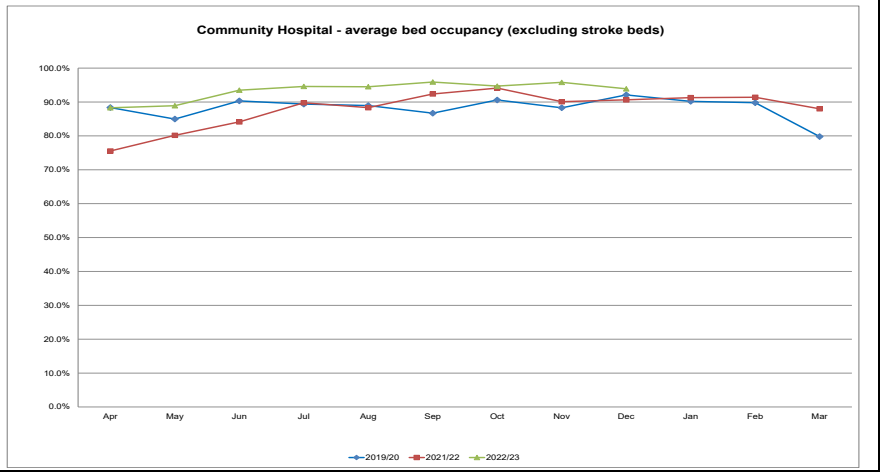
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





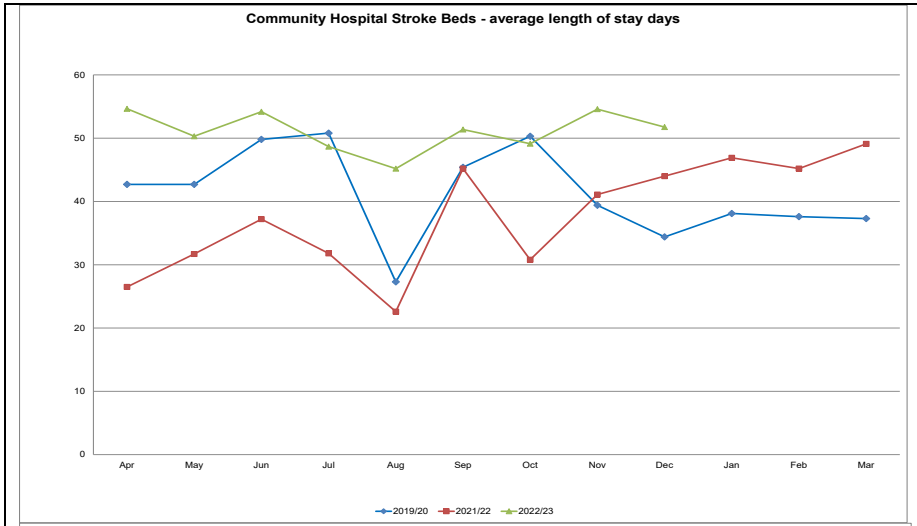
Summary:

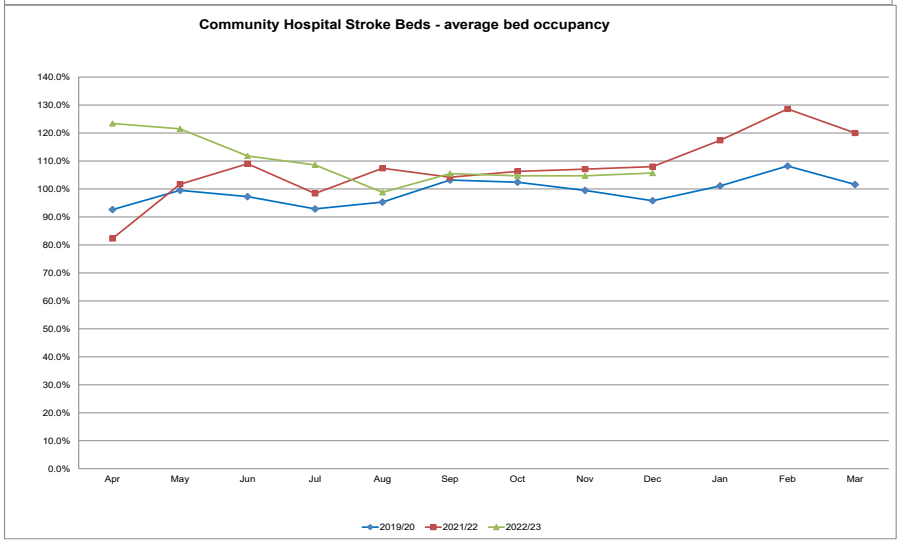
- Between 1 April and 31 December 2022, the number of Minor Injury Unit attendances was 7.3% higher than the same months of 2021 and 3.1% higher the same months of 2019. During December 2022, 93.9% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 95%.
- The average length of stay for non-stroke patients in our community hospitals in December 2022 was 41.5 days, a decrease compared to November 2022. A total of ten patients with stays longer than 100 days were discharged; the longest was 232 days for a patient at West Mendip community hospital.
- The community hospital bed occupancy rate for non-stroke patients in December 2022 remained high, at 93.9%, down from 95.8% in November 2022.



Operational context

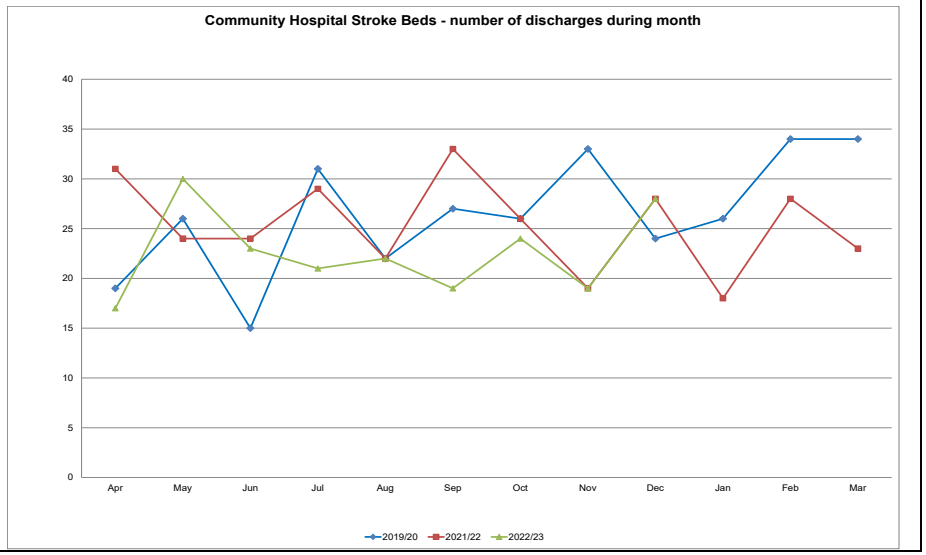
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





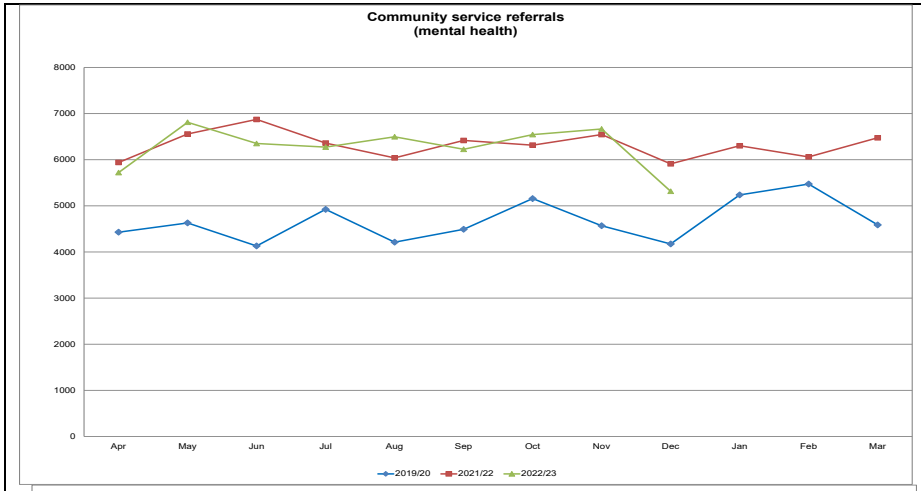
Summary:

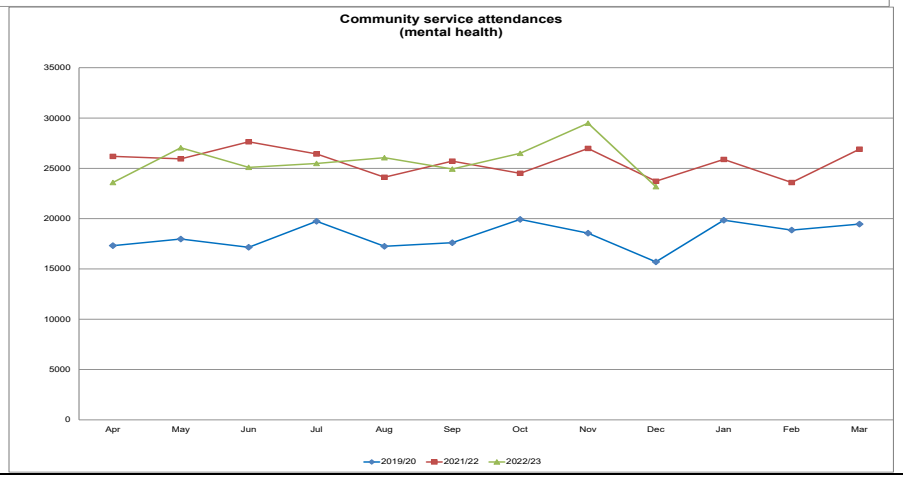
- The average length of stay for stroke patients in our community hospitals in December 2022 decreased to 51.8 days, from 54.6 days in November 2022. Two patients with stays longer than 100 days were discharged in December 2022, the longest being 248 days in respect of a patient at Williton community hospital.
- Stroke bed occupancy in December 2022 increased compared to November 2022.
- During December 2022 there were 28 discharges of stroke patients, up from 19 in November 2022. The monthly average number of stroke patients discharged from our community hospitals in 2021/22 was 25.



Operational context

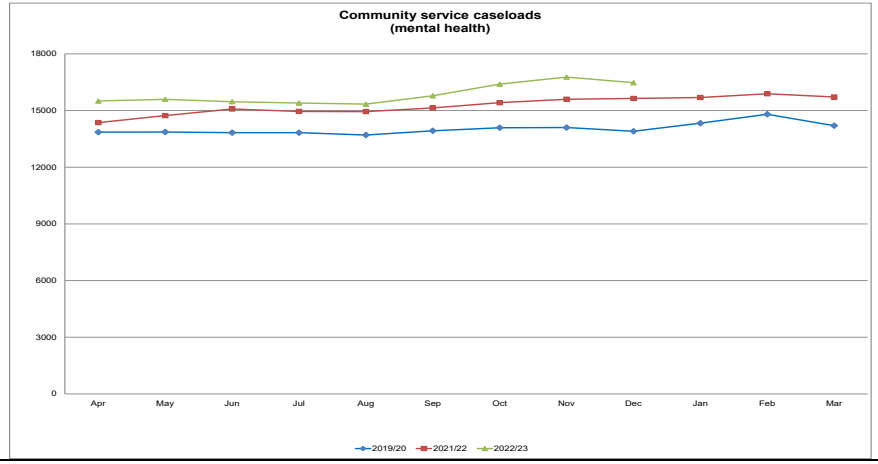
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





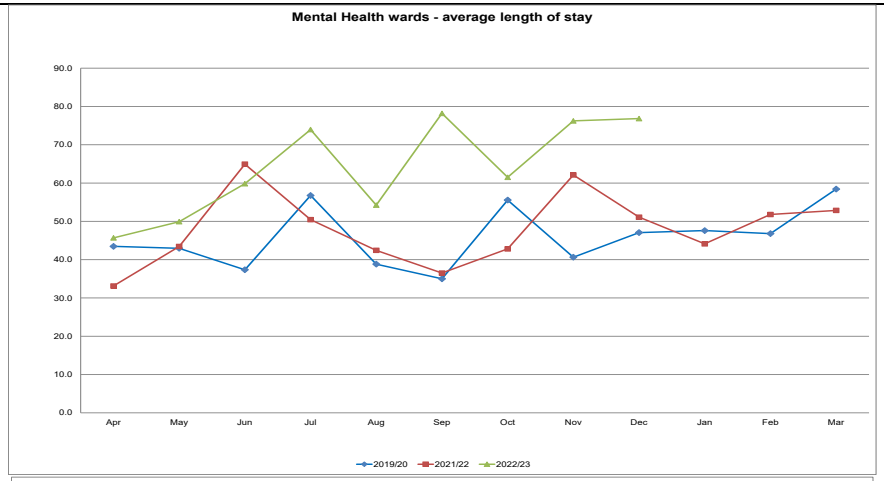
Summary:

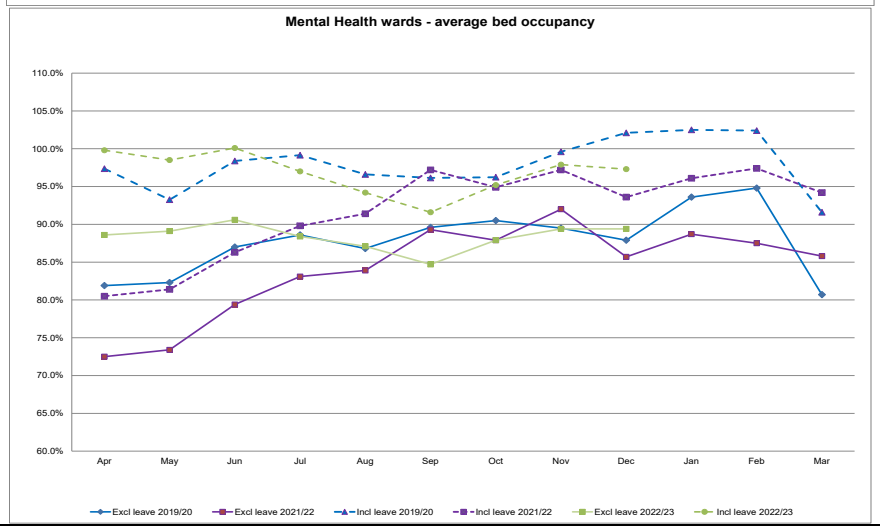
- Referrals to our community mental health services between 1 April and 31 December 2022 were 1.0% lower than in the same months of 2021 but 38.5% higher than the same months of 2019.
- Attendances for the same period were 0.1% lower than the corresponding months of 2021 but 43.5% higher than in 2019.
- Community mental health service caseloads as at 31 December 2022 increased by 5.3% when compared to 31 December 2021 and were 18.5% higher than as at 31 December 2019. It should be noted that investment in mental health services since 2019 has facilitated the expansion of some community mental health services.



Assurance and Leading Indicators

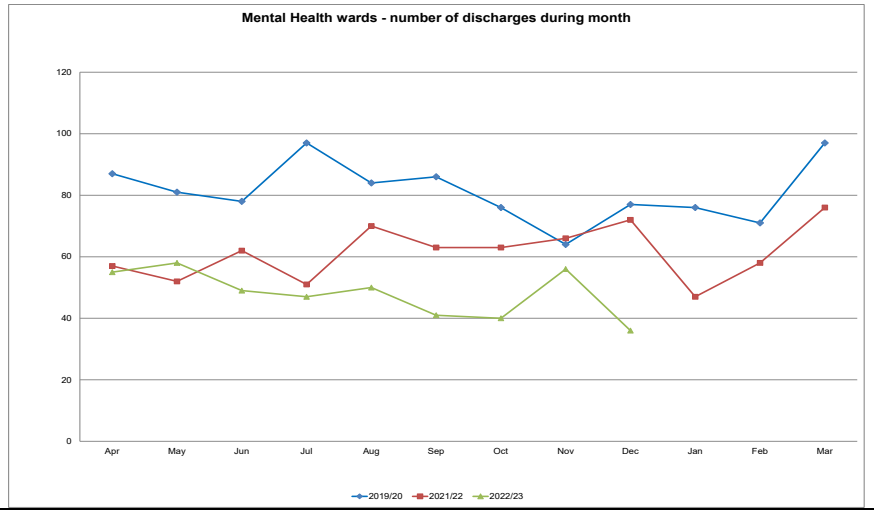
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





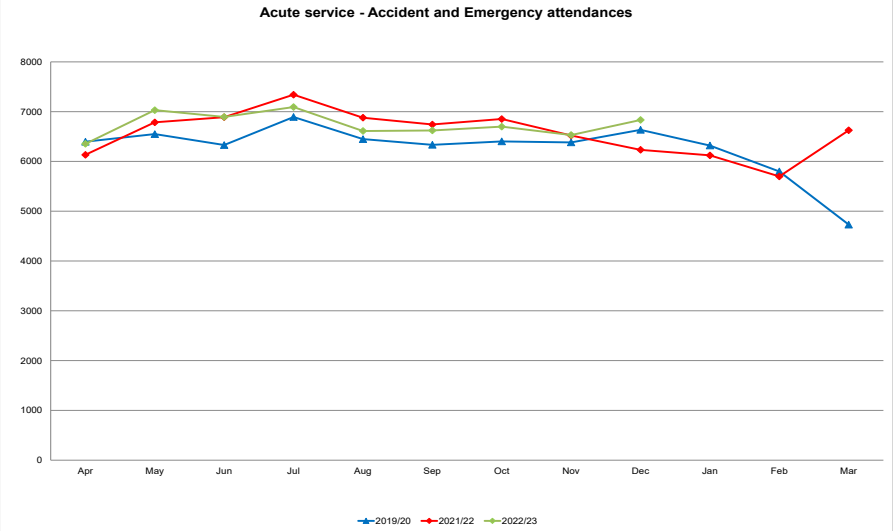
Summary:

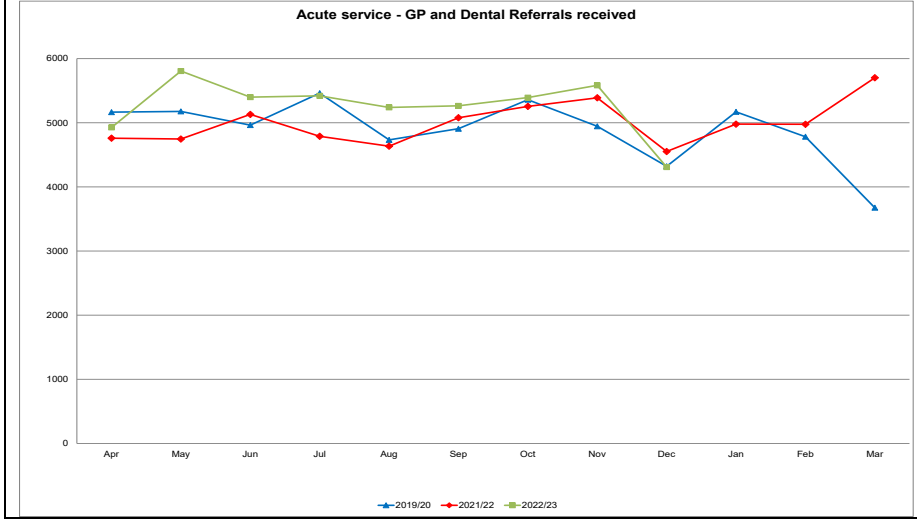
- The average length of stay in our mental health wards in December 2022 was 76.8 days, an increase compared to November 2022. seven patients discharged in December 2022 had lengths of stay of 100 days or more.
- The mental health bed occupancy rate in December 2022, based on excluding leave was unchanged from November 2022, whereas the rate including leave decreased.
- A total of 36 patients were discharged in December 2022, down from 56 in November 2022.



Operational context

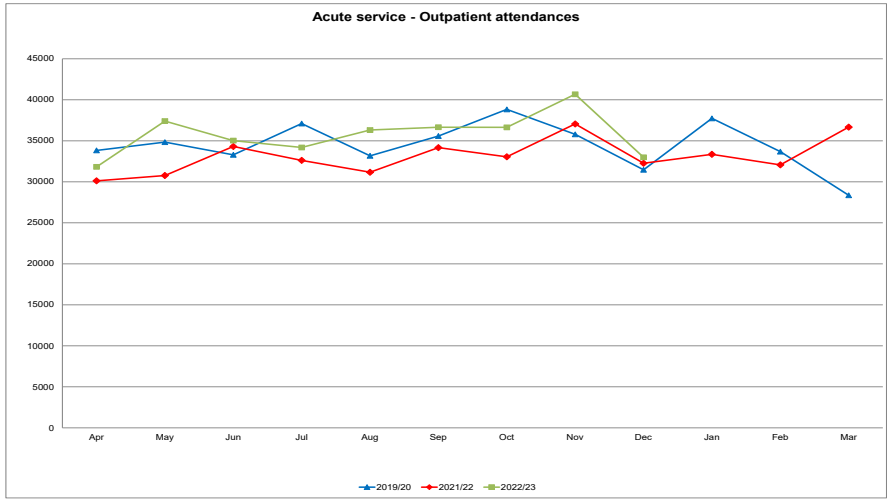
Acute services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





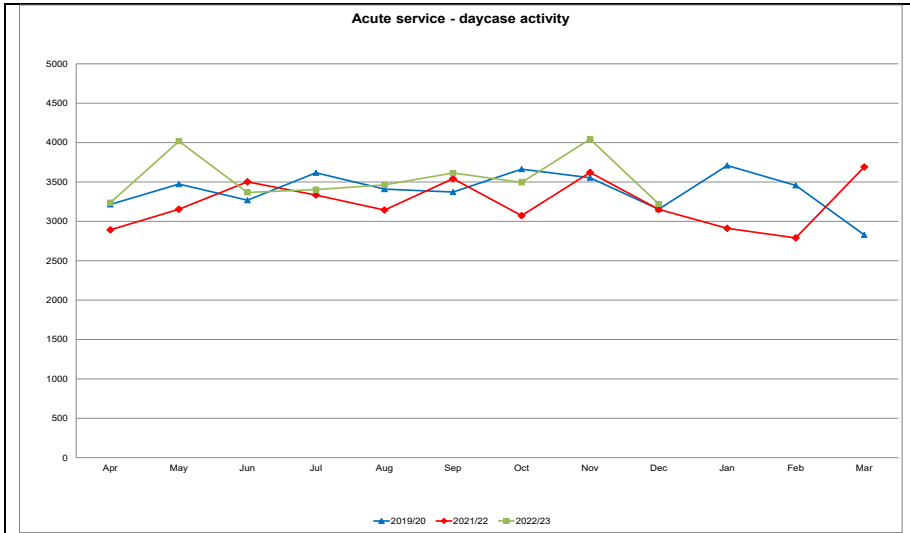
Summary:

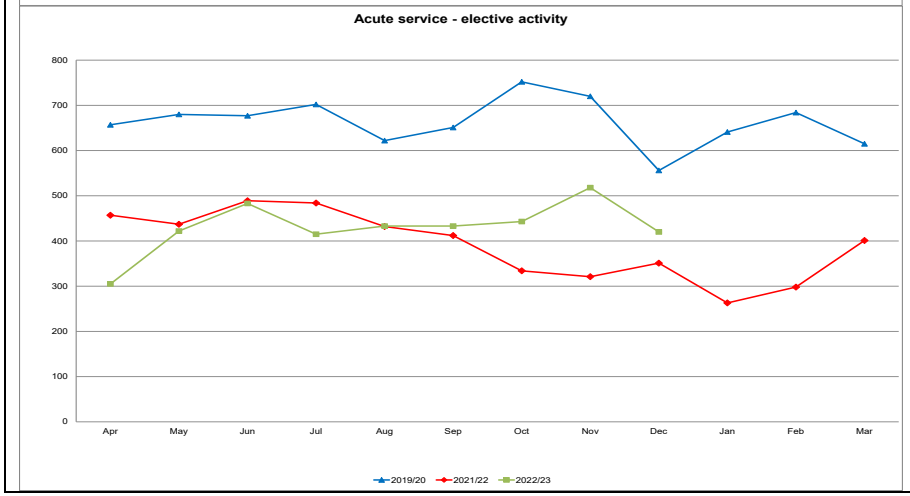
- Between 1 April and 31 December 2022 attendances to Accident and Emergency were 0.5% higher than the same months of 2021, and 3.9% higher than the same months of 2019. In December 2022, 39.6% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 95%.
- GP and Dental referrals between 1 April and 31 December 2022 were 6.8% higher than the same months of 2021, and 5.1% higher than the same months of 2019.
- Outpatient attendances for the same period were 8.9% higher than the same months of 2021, and 2.5% higher than the same months of 2019.



Operational context

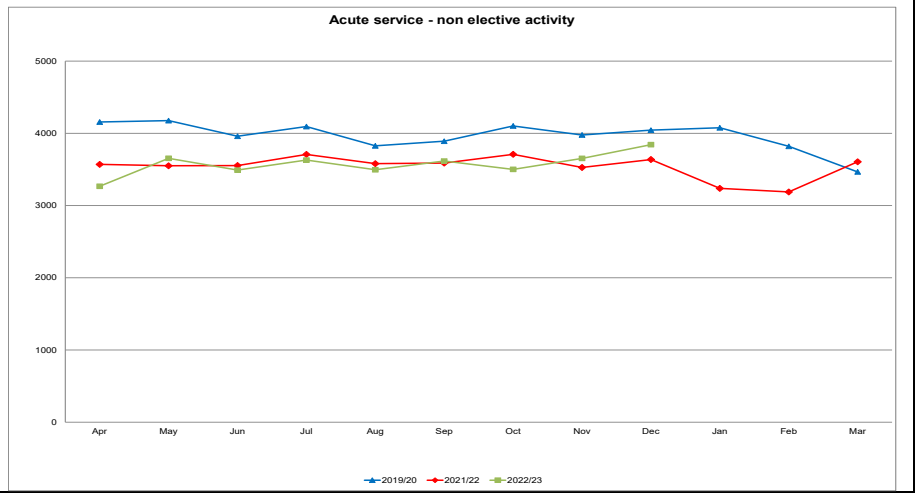
Acute services: This section of the report provides a summary of the levels of day case, elective, and non elective activity during the reporting period, compared to the previous months and prior year.





Summary:

- The number of day cases undertaken by our acute services between 1 April and 31 December 2022 increased by 8.3% compared to the same months of 2021 and was 3.7% higher than the same months of 2019.
- Over the same period elective admissions were 4.2% higher than the same months of 2021, but 35.6% lower than the same months of 2019, which reflects the significant operational pressures experienced at Musgrove Park Hospital over recent months.
- Non elective admissions between 1 April and 31 December 2022 were 8.9% higher than the same months of 2021 and were 2.5% higher than the same months of 2019.



Elective Recovery and Theatre Productivity

Somerset Foundation Trust

and

Yeovil District Hospital NHS Foundation Trust

January 2023

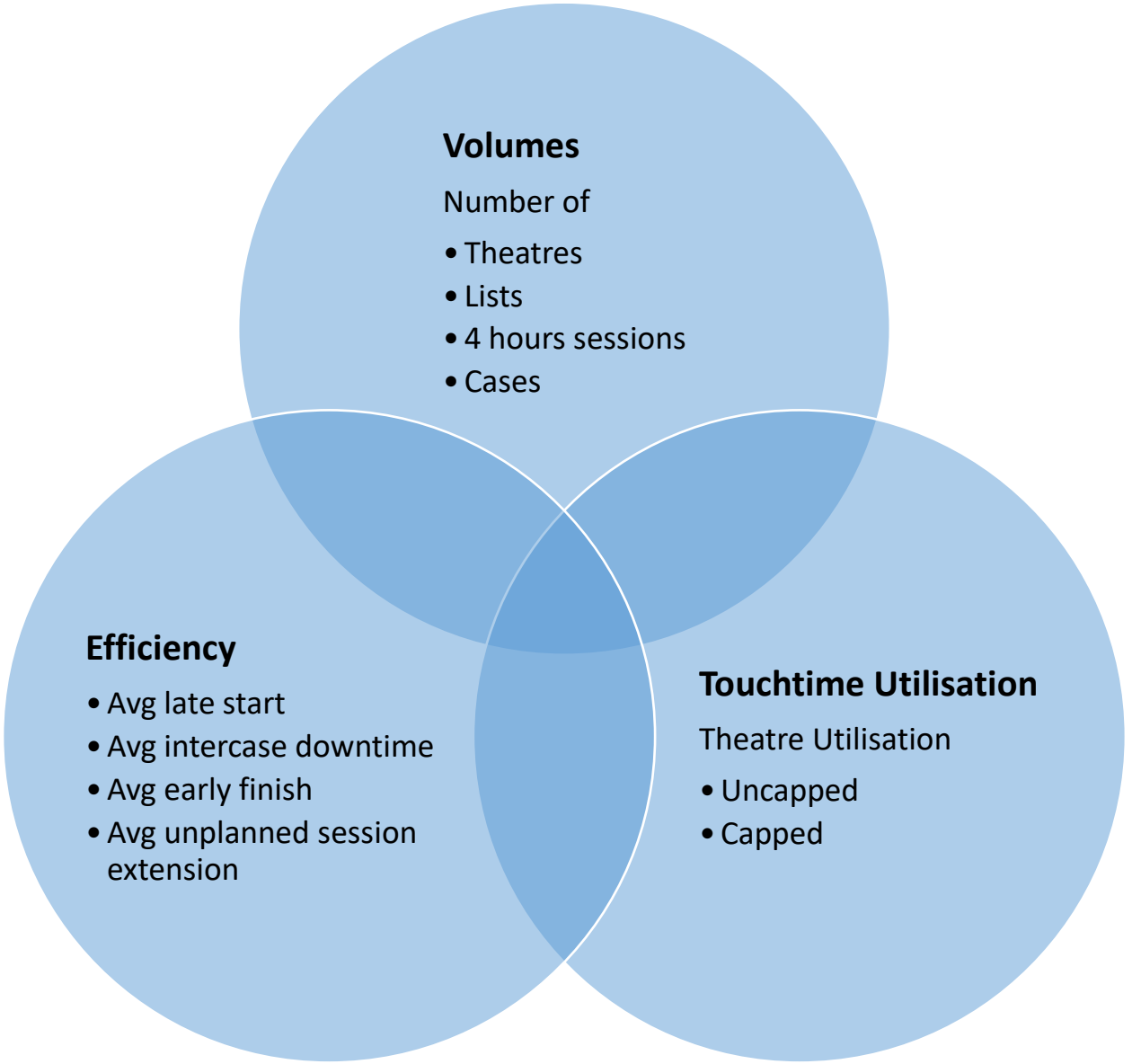
P Meldrum
Associate Director, Elective Recovery and Theatre Productivity

2023/24 Operational Planning Guidance

Elective Care

- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
- Deliver the system- specific activity target (agreed through the operational planning process)
- Increase productivity and meet the 85% day case and 85% capped theatre utilisation expectations, using GIRFT and moving procedures to the most appropriate settings
- Deliver 130% of pre-pandemic elective activity by 2024/25, after accounting for the impact of an improved care offer through system transformation, and advice and guidance.

Theatre Productivity



Touchtime Utilisation

This metric represents theatre time utilisation on actual surgery, touch time represents the time where the theatre team were actively engaged in operating. A high level of touch time utilisation could represent effective use of theatre time as well as efficiency in non-surgery activities such as set up and logistics.

Touch time utilisation over 85% is considered good practice.

Touchtime Metrics

Touchtime metrics are recorded by the clinical professionals whilst delivering care to their patients. This can result in estimated instead of actual times being recorded.

Key touchtime events:

- Into Anaesthetic Room
- Induction of Anaesthesia
- Into Theatre
- Incision
- Closure
- Out of Theatre
- Into Recovery

Touchtime Utilisation

Uncapped Theatre Utilisation, refers to the Touch Time being calculated on the total amount of time the surgical team were operating, irrespective of whether the session was unexpectedly extended.

Capped Theatre Utilisation, refers to the Touch Time being calculated on the total volume of time the surgical team were operating, within the planned session time only. This means any Touch time occurring within an unplanned session extension (after the planned session end time) is excluded from the calculation.

Touchtime Utilisation Methodology

Model Health System uses the following methodology when calculating Uncapped and Capped Theatre Utilisation

Uncapped Theatre Utilisation

Calculation (Total Touchtime / Planned Duration) * 100

Numerator

Touch Time = The amount of time the patient is being operated on.

[TouchTime Start] = in order of availability [Time Event: into anaes] or [Time Event: Induction]

[TouchTime End Uncapped] = in order of availability [Time Event: Into recovery], [Time event: Out of Theatre] or [Time event: Closure] + 10 minute.

[Total Touchtime] = Difference between [Start time] and [End time]

Denominator

Planned Duration = [Session Planned Duration]

Capped Theatre Utilisation

Calculation (Total Touchtime / Planned Duration) * 100

Numerator

Numerator Touch Time = The amount of time the patient is being operated on, the time difference between [TouchTime Start] and [TouchTime End Capped]

[TouchTime Start] = in order of availability [Time Event: into anaes] or [Time Event: Induction]

[TouchTime End Capped] = in order of availability [Time Event: Into recovery], [Time event: Out of Theatre] or [Time event: Closure] + 10 minute.

The [End Time] is automatically truncated, if the time extends past the [Session Planned End Time]

[Total Touchtime] = Difference between [Start time] and [End time]

Denominator

Planned Duration = [Session Planned Duration]

Touchtime Utilisation

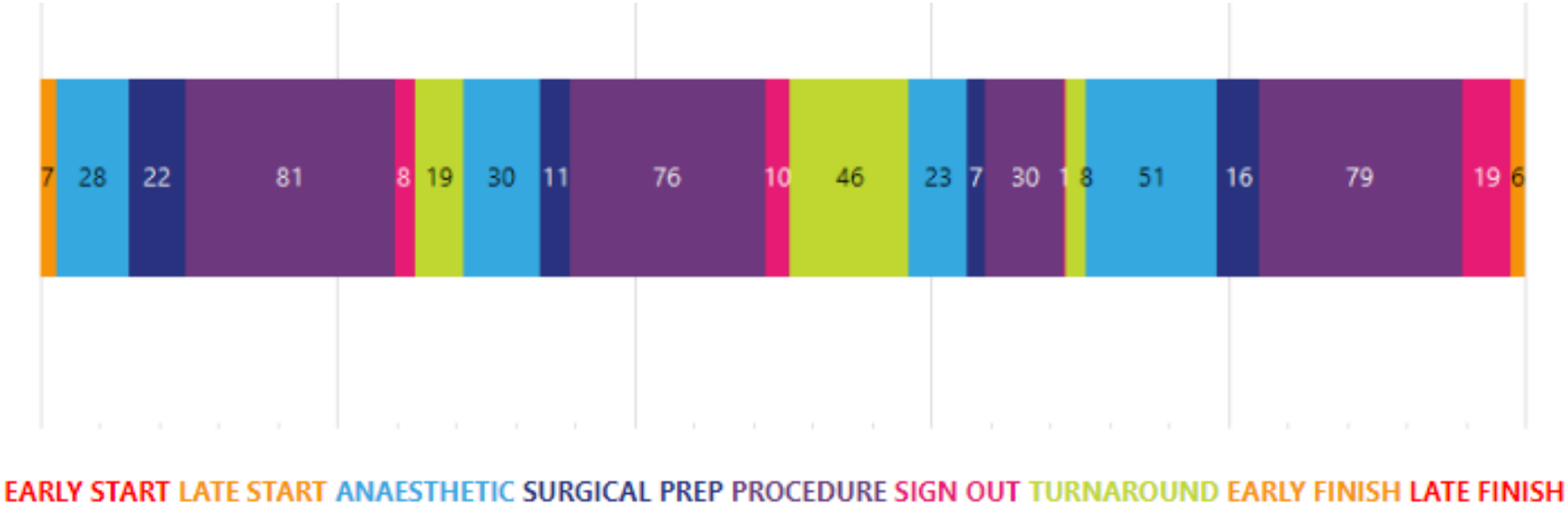
Sample operating list data:

Session Planned Start Time	Session Actual Start Time	Session Planned End Time	Session Actual End Time	Session Planned Duration
2022-06-13 08:30	2022-06-13 08:45	2022-06-13 17:30	2022-06-13 17:43	540
Late Start (mins)	00:07			
Unplanned Session Extension	00:13			

	Into Anaes	Induction	Into Theatre	Incision	Closure	Out of Theatre	Into Recovery	Touchtime
Patient 1	2022-06-13 08:37	2022-06-13 08:45	2022-06-13 09:05	2022-06-13 09:27	2022-06-13 10:48	2022-06-13 10:56	2022-06-13 10:56	02:11
Patient 2	2022-06-13 11:07	2022-06-13 11:35	2022-06-13 11:37	2022-06-13 11:48	2022-06-13 13:04	2022-06-13 13:14	2022-06-13 13:14	01:39
Patient 3	2022-06-13 13:50	2022-06-13 14:01	2022-06-13 14:13	2022-06-13 14:20	2022-06-13 14:50	2022-06-13 14:51	2022-06-13 14:51	00:49
Patient 4	2022-06-13 14:58	2022-06-13 15:00	2022-06-13 15:49	2022-06-13 16:05	2022-06-13 17:24	2022-06-13 17:43	2022-06-13 17:43	02:43
							Total Touchtime	444
							Capped Touchtime	431

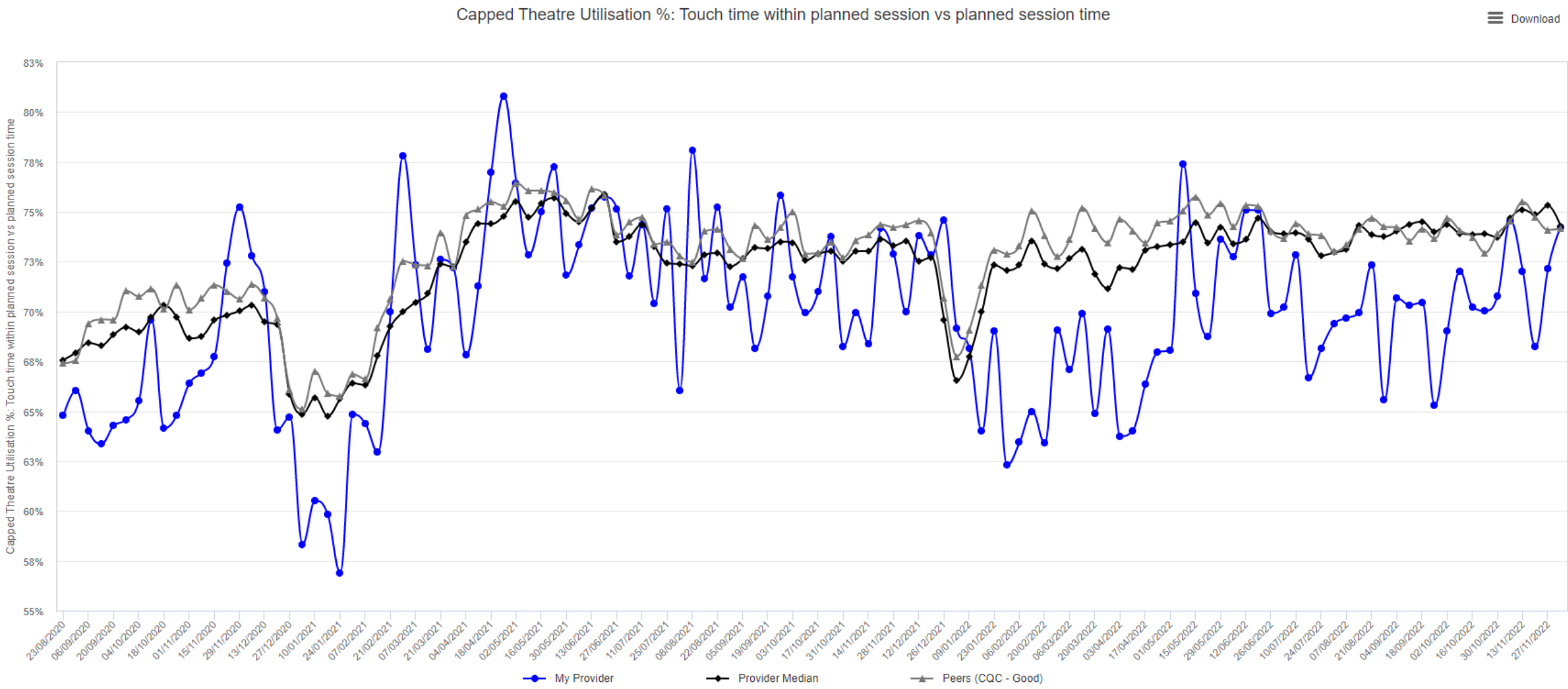
Touchtime Utilisation

Uncapped Theatre Utilisation %	**Total touchtime / Planned Duration**
	444 / 540 = 82.2%
Capped Theatre Utilisation %	**Total touchtime / Planned Duration**
	431 / 540 = 79.8%



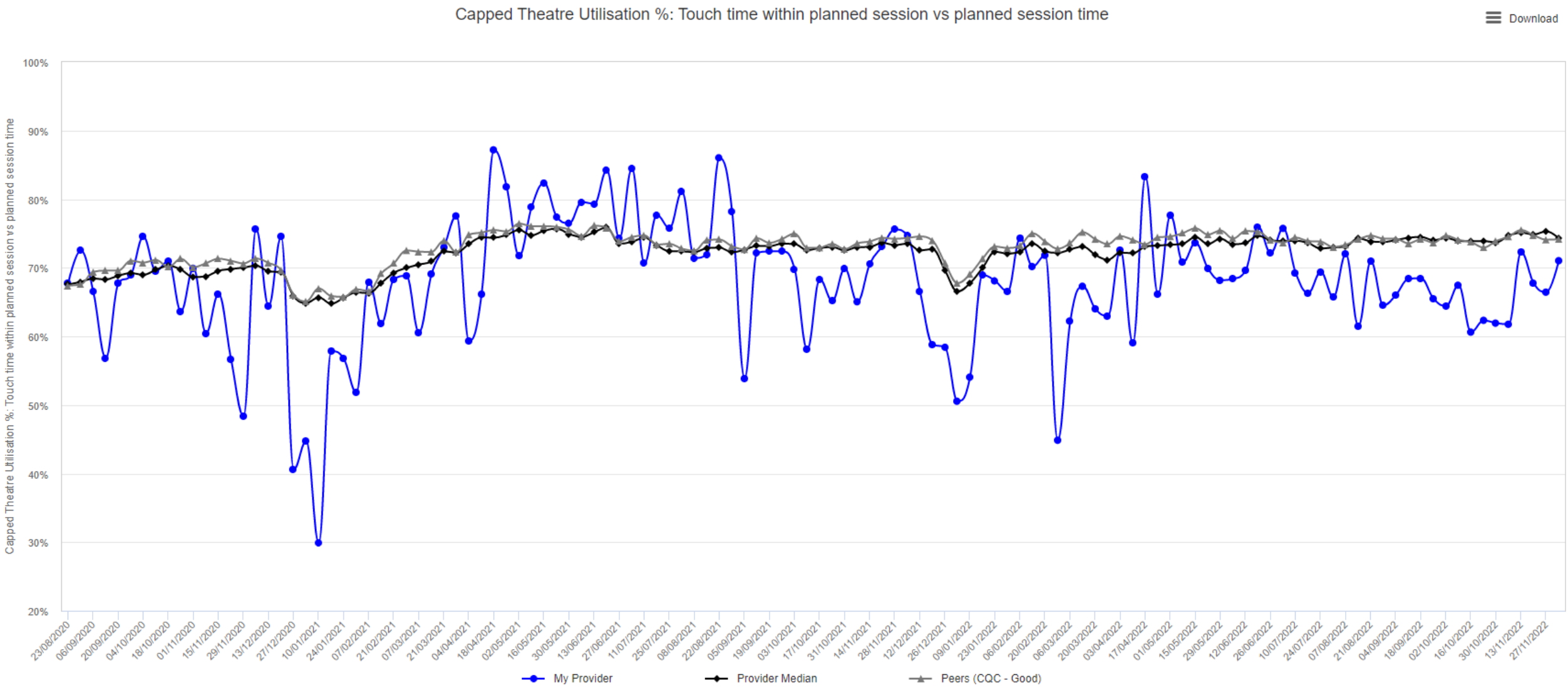
Capped Theatre Utilisation – SFT Performance

Latest published data 4th December 2022



Capped Theatre Utilisation – YDH Performance

Latest published data 4th December 2022



Theatre Productivity

Causes of reduced Theatre utilisation

Theatre utilisation factors	Causes of
Late starts	Not all patients can go to Surgical Admissions Lounge (SAL) /Clinical Decisions Unit (CDU) first because it is used for inpatients, so patients need to go to other wards prior to theatre (meaning patients are prepped for theatre in a less optimal/busy environment, surgeons and anaesthetist have a 'safari ward-round' visiting patients prior to going to theatre). Reallocating staff at short notice due to vacancies/sickness means list doesn't start on time. Loss of rigour/cadence following COVID leading to a lack of timeliness for theatre operating. Team leader not always identified to 'command' the running of the list; team leader not empowered to run the list.
Inter-case down-time	Loss of pre-COVID rigour to list management. High levels of agency staff with varying levels of productivity. Lists poorly planned to group similar types or side of procedure together.
Early finishes/ Low fill rates on the lists	Bed availability (no criteria to reside; COVID admissions; patient complexity/LOS). Some Surgeons and bookers hesitant to fully book lists as high level of cancellations owing to bed capacity results in having to cancel and rebook patients. Session length not reduced-down when patients cancelled, so the lists look like we are not fully booking a list. Complexity of cases – one large cases and can't fill the remaining few minutes. Cautious booking of theatre lists due to greater complexity of patients on the waiting list (lengths of wait/COVID decompensation). Clinical standardisation/variation (e.g. one anaesthetist/surgeon takes longer to do the same procedure than another). POAC capacity to provide enough patients to be able to add to the theatre list.
Numbers of lists/sessions	Bed availability (no criteria to reside; COVID admissions; patient complexity/LOS). Theatre staffing vacancies/sickness.

Utilisation improvements

Three key areas of focus

1. Reduce Late Starts by 50%, promoting Golden Patient and utilising Recovery space for patients who are 1st on the list

2. Reducing Inter procedure times to GIRFT recommended 15 mins

3. Filling operating lists to 100% capacity based on median operating case times

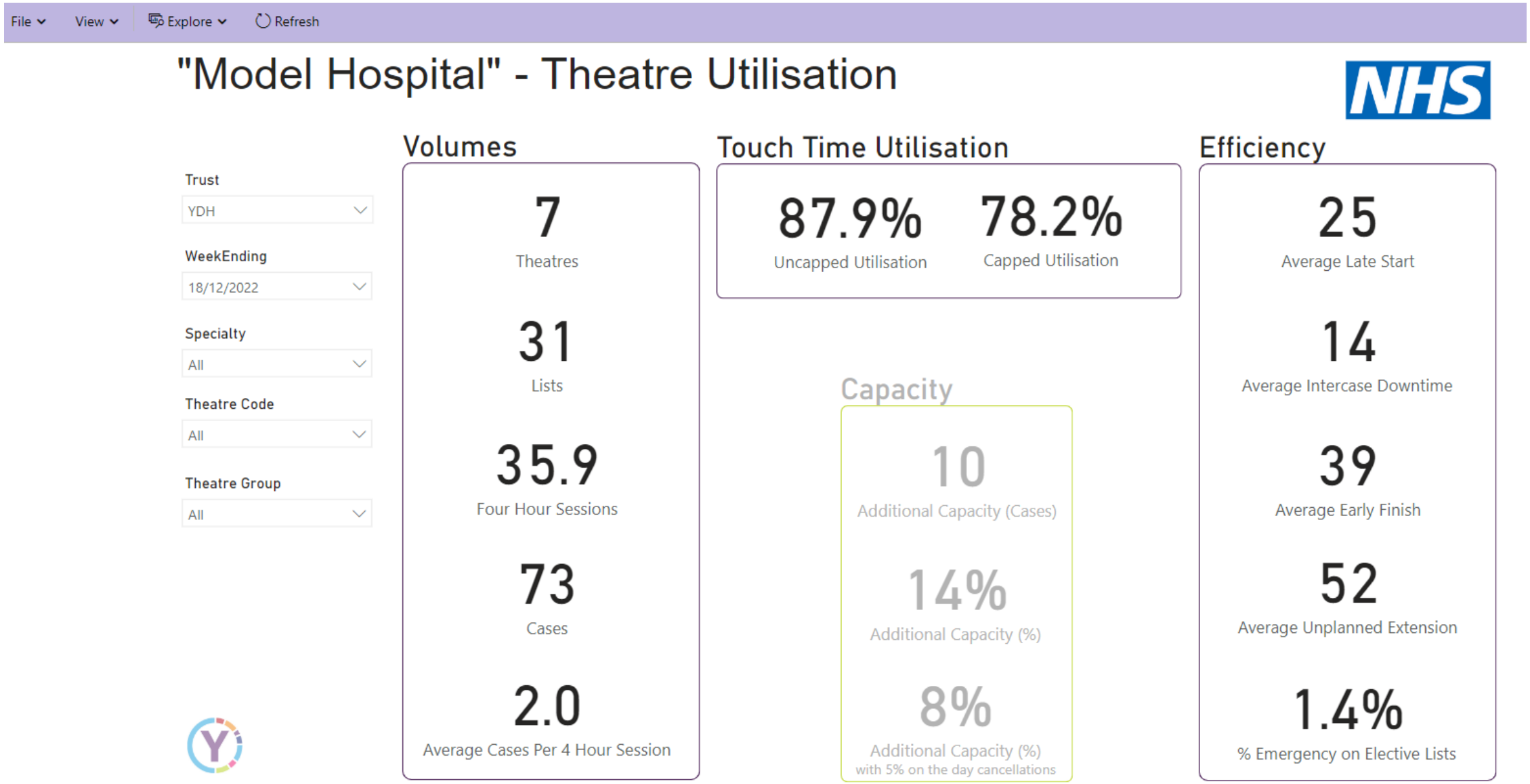
Summary of actions and projected timeline

- Promote the identification of the “Golden Patient” and use of recovery for all lists starts with Surgeons and Theatre Leads, through STEP Up, SOMC and Elective Recovery meetings on both sites – Closed 25/11/22
- Review inter-procedure times by Specialty/list and produce an action plan to re-establish the pre-COVID rigour to driving an operating list with Theatre Teams – Closed 02/12/22
- Review operating list bookings vs utilised to identify areas for improvement – Closed 02/12/22
- Through STEP UP and HVLC re-engage with Consultants to own their operating lists and work with the bookings teams to fill operating lists to >90% – Closed 09/12/22
- Engage with SD, AMDs, CDs to review unwarranted variation of Anaesthetic and Surgical procedures – Ongoing
- Review MHS data and correct with MHS where necessary – Ongoing
- Progress and support Step UP workstream actions – Ongoing

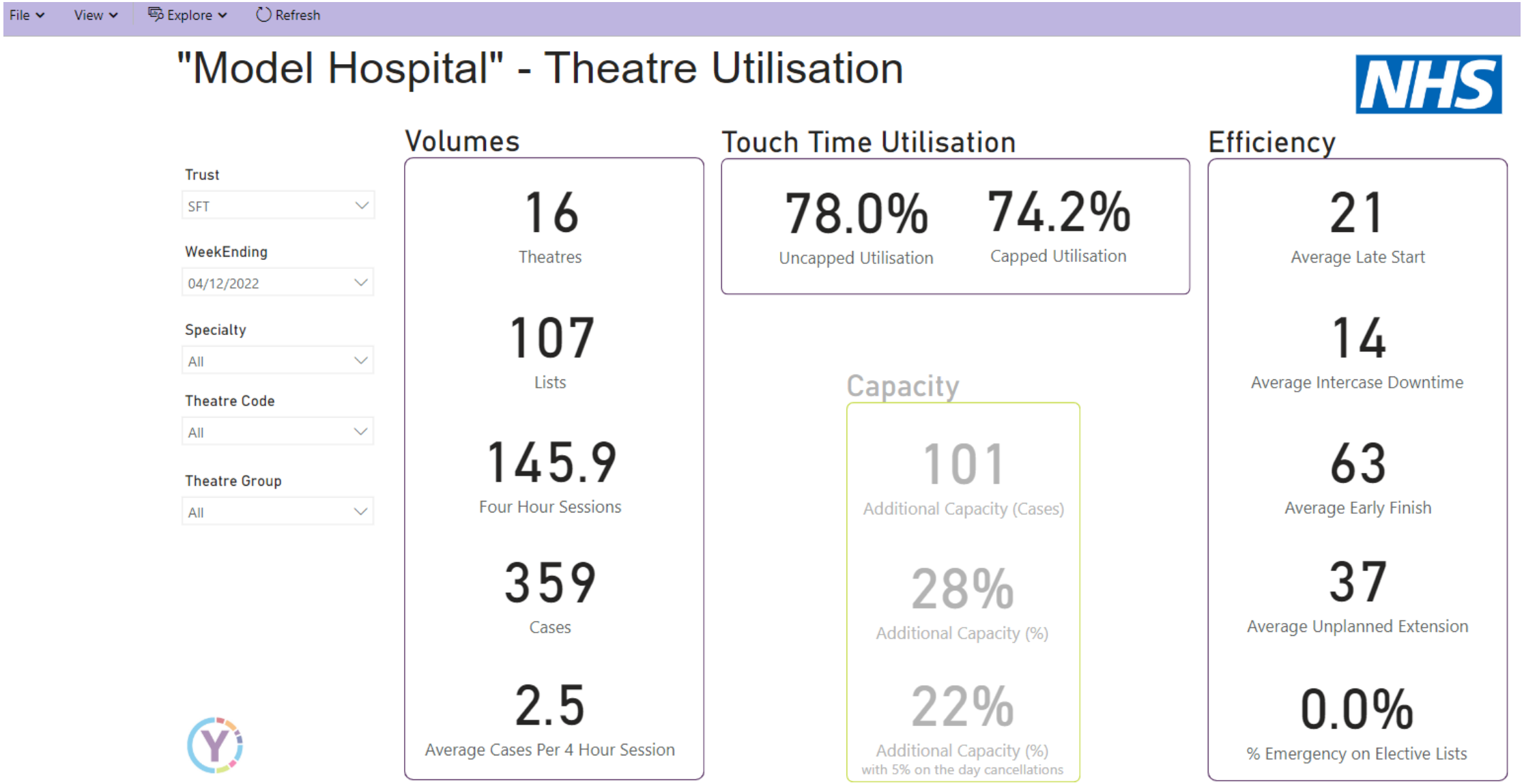
Summary of subsequent actions

- Theatre Productivity session planned for clinical staff this month, to increase engagement and improve data quality
- Right Procedure Right Place – SFT have now completed this exercise, YDH undertaking exercise Jan 2023
- Revise Theatre Scheduling meeting to drive up Theatre utilisation
- Mapping of day surgery sessions into Modular Day Theatre at YDH opening in April 2023
- Engage with SW Region providers to share best practices
- Support sought from SW Regional GIRFT Lead for Gynaecology to drive up day case procedures

Theatre Capped Utilisation - Dashboard

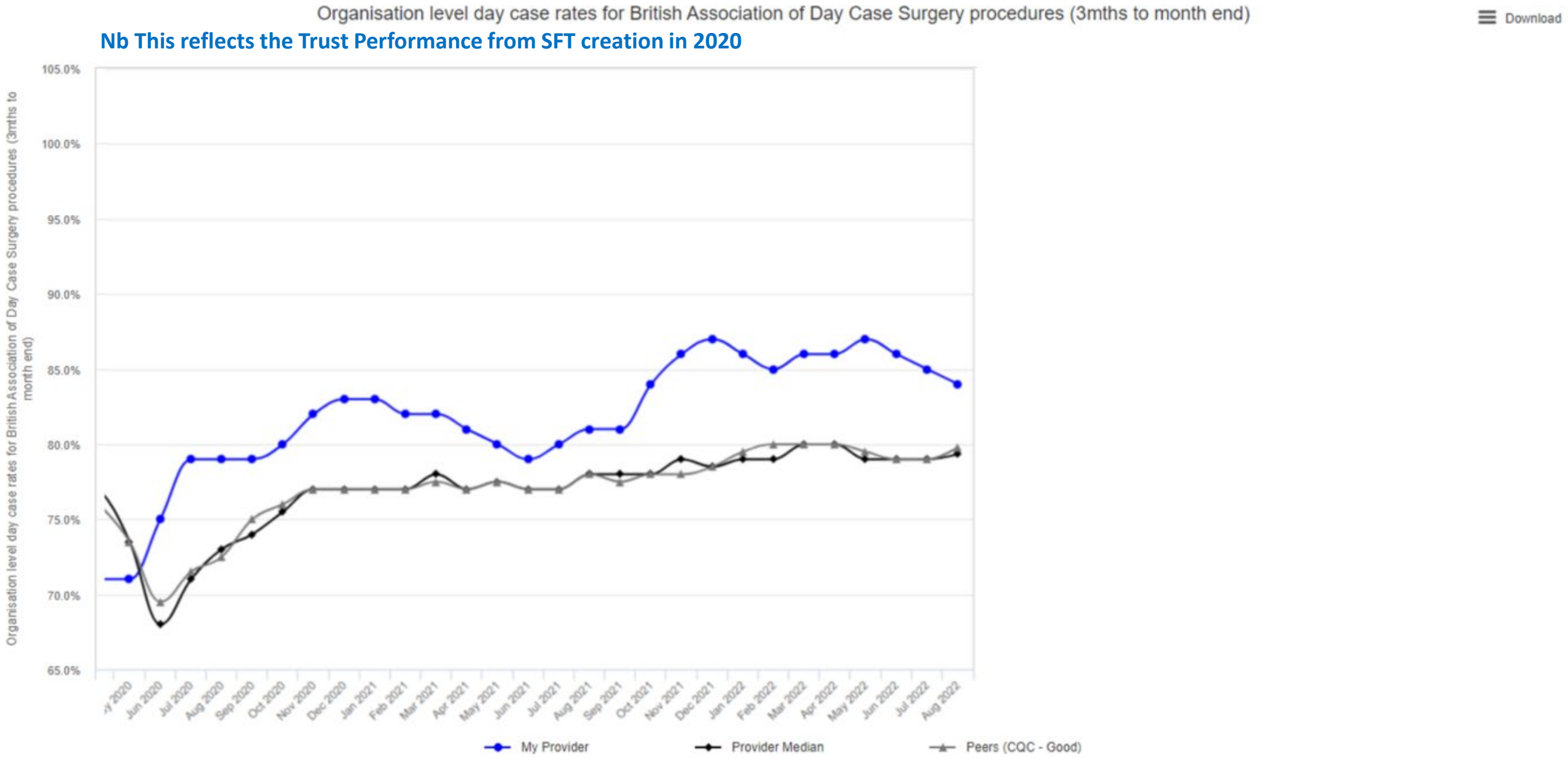


Theatre Capped Utilisation - Dashboard

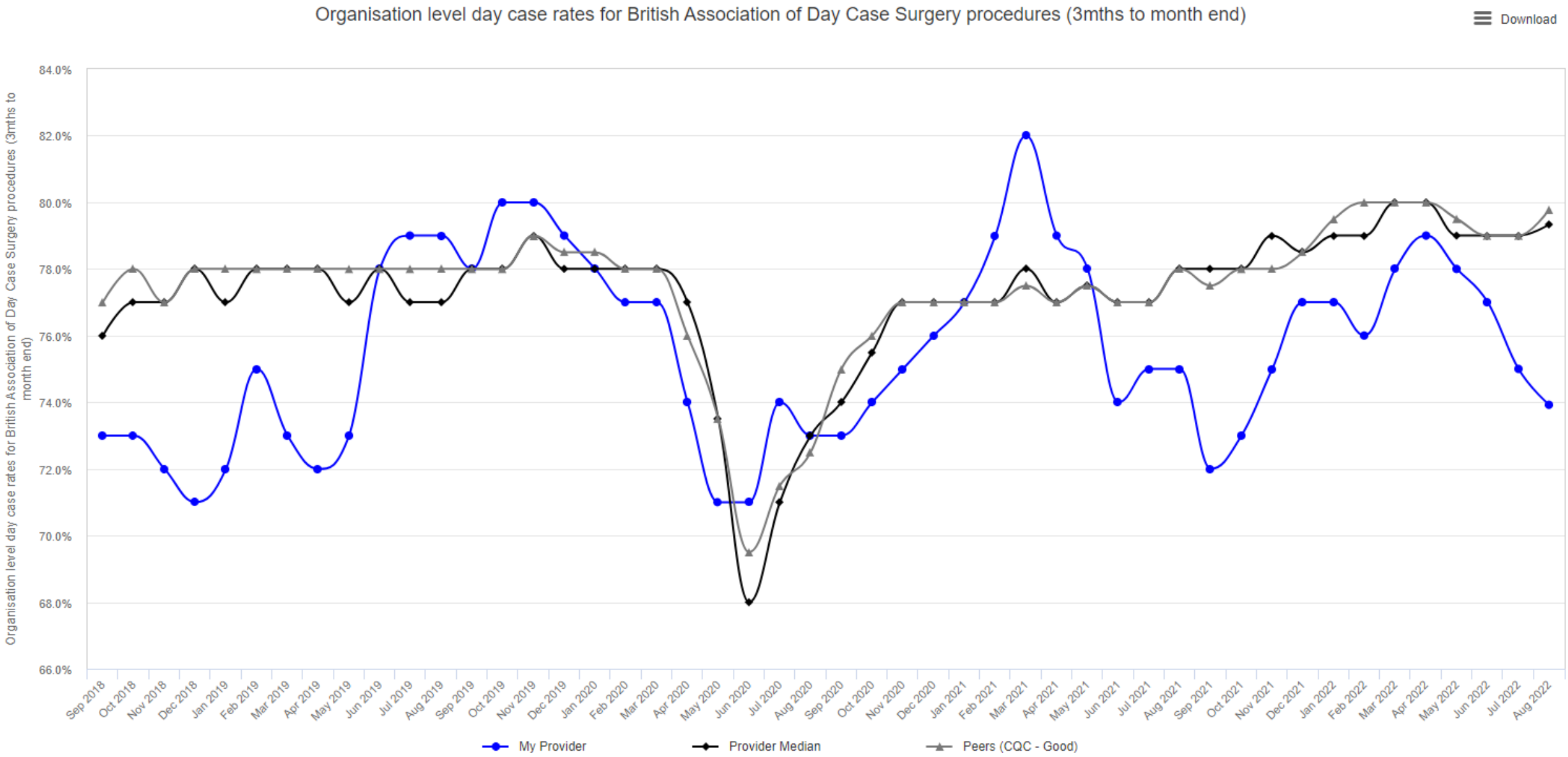


Daycase Rates – SFT

Nb This reflects the Trust Performance from SFT creation in 2020



Daycase Rates – YDH



Specialty Daycase Rates

MHS Latest: September 2022

Nb – this is a one month snapshot and the run chart is more informative of progress

Specialty	SFT	YDH	National Median
Organisation Level	84.4%	74.6%	79.2%
Breast Surgery	86.3%	80.4%	68.5%
ENT	87.0%	100.0%	86.3%
General Surgery	77.0%	63.0%	71.0%
Gynaecology	71.8%	46.6%	67.6%
Head and Neck	67.8%	100.0%	75.6%
Ophthalmology	98.8%	94.5%	98.7%
Orthopaedics	93.0%	69.3%	85.1%
Urology	85.8%	54.5%	66.3%
Vascular Surgery	62.1%	62.5%	83.1%

above National Median

below National Median

The RAG Rating is measured against the National Median by Specialty, for that given month and not against the NHSE ambition of 85%

YDH poor performance is a direct result of the DSU second stage recovery area (7 bays) being used to care for Urgent Care escalation, which adversely impacts on first stage recovery.

YDH Ophthalmology is a data anomaly where the intended management was Inpatient, but the patient was treated as a daycase. As per counting and coding procedures, Daycase patients with an intended management of Inpatient are not recognised as a Daycase

Work is ongoing to reduce the number of *'No Criteria to Reside'* patients and thereby reduce the impact of Urgent Care on Elective Care capacity.

Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Learning from Deaths/Mortality Report (Quarter 3) – YDH.
SPONSORING EXEC:	Dan Meron, Chief Medical Officer
REPORT BY:	Claire Bailey, Learning from Deaths Lead SFT Laura Walker, Head of Patient Safety and Learning SFT
PRESENTED BY:	Paul Foster, Medical Director YDH
DATE:	7 February 2023

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

Executive Summary and Reason for presentation to Committee/Board	YDH has implemented the required National Guidance on Learning from Deaths recommendations. The Mortality Report includes summary tables for the Trust, which should be presented to the Board on a quarterly basis. This is a requirement of the National Quality Board Guidance on Learning from Deaths March 2017 and the NHS Improvement Implementing the Learning from Deaths framework, key requirements for Trust Boards July 2017. This report reflects the ongoing progress with Medical Examiners identifying cases requiring further investigation through Mortality Reviews or Clinical Investigation and the difficulties experienced when demand exceeds capacity to complete Mortality Reviews.
Recommendation	The Board is asked to discuss the report.

Links to Joint Strategic Objectives (Please select any which are impacted on / relevant to this paper)
☒ Obj 1 Improve health and wellbeing of population
☒ Obj 2 Provide the best care and support to children and adults
☐ Obj 3 Strengthen care and support in local communities
☒ Obj 4 Reduce inequalities
☒ Obj 5 Respond well to complex needs

☒ Obj 6	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☐ Obj 7	Live within our means and use our resources wisely
☒ Obj 8	Develop a high performing organisation delivering the vision of the Trust

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

Details:

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

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

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

Equality

The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics

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

☐ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planning to mitigate any identified inequalities

Public/Staff Involvement History

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

N/A

Previous Consideration

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

The YDH Learning from Deaths report is developed in consideration with the Mortality Review Group and noted at the Clinical Outcomes Committee.

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

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

Q

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

MORTALITY REPORT- LEARNING FROM DEATHS

QUARTER 3 2022/2023

1. INTRODUCTION

1.1. In December 2016 the CQC report Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England, identified that learning from deaths was not given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. In March 2017 the National Quality Board published national guidance on learning from deaths to initiate a standardised approach to learning which includes a number of recommendations to be included into Trust's governance frameworks.

1.2. These recommendations included having a Director responsible for the learning from deaths agenda, a Non-Executive Director to take oversight of progress and implementing a systematic approach to identifying the deaths requiring review, with a robust methodology for case record reviews. Ongoing developments included specific guidance for NHS Trusts in working with families, published in July 2018 and the introduction of Medical Examiners who commenced their role in the Trust on 1st July 2020. The intention is to make sure that all deaths not investigated through the coronial process are subject to a degree of independent scrutiny, with increased transparency for the bereaved and an opportunity for them to raise concerns.

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

1.4. The report highlighted several challenges for Trusts in the future. These include:

- Monitoring and evolving the role of the Medical Examiner, providing continuous safety improvement, and responding to complaints and concerns.

- Developing systems to allow learning from deaths that have occurred outside of a hospital and for those under 18 years of age, with effective information sharing across NHS providers.

- Improving support for staff as agreed across national bodies, including NHS Improvement and the Healthcare Safety Investigation Branch to enable them to carry out robust reviews and investigations of deaths and serious incidents.

1.5. The Quarterly Learning from Deaths report confirms the Trust's position in relation to these challenges as well as documenting our progress with the evolving systems used to identify and learn from a patient's death. All in hospital deaths can provide information about the individual patient's care and management and this report details the learning that can be identified from many investigative sources.

1.6. The way we review a patient's death can take many forms with learning identified through several processes including but not exclusively those detailed below;

- External analysis of Mortality outcomes data through the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI)
- Scrutiny through the Medical Examiner service.
- Formal Structured Judgement Mortality Reviews.
- Coronial activity.
- Serious Incident Reviews.
- Complaints and Bereavement concerns.
- Learning Disability Reviews (LeDeR)
- Perinatal Mortality Reviews.
- Child Death Review processes.
- Review of COVID-19 related deaths.

1.7. Those cases reviewed through the above processes during Quarter 3 have allowed both local and Trust-wide learning to be identified and shared. Within this report we firstly highlight any specific learning and actions followed by more detail about each investigative process and identification of general themes as well as defining the number of reviews undertaken through each process.

1.8. Appendix 1 provides a summary of the reviews undertaken with comparative data from the previous year. These figures are updated at each subsequent Quarterly review period.

2. UPDATE ON THE MORTALITY REVIEW PROCESS

2.1. Since September 2022 the LfD team at SFT have been providing cover for the mortality review and coronial process at YDH. There are significant differences between the existing processes at both organisations. After a period of settling in, we have now met with key stakeholders from both organisations and have begun to plan how we can align these processes, ensuring that we draw on the strengths of each. The inquest process is now aligned and colleagues across both sites are being offered the same support.

2.2. Planning for the roll out of the Medical Examiner service across the whole of Somerset, is underway to include all deaths in the community, is and being led by Helen Gilliland, (Implementation Lead – Somerset Medical Examiner Service). This is still waiting implementation. Some of these developments have coincided with the LfD team working across both SFT and YDH ahead of the upcoming merger, resulting in an opportunity to review and standardise the referral process from the ME service to the LfD team. A digital referral form has been created for use by the ME service. We have now had sight of this and are due to give feedback.

2.3. Our clinical teams and services continue to face unprecedented demands and remain under significant pressure. During this reporting period, the monthly Mortality Review Group has been stood down due to consistently high levels of clinical acuity. This has resulted in further delays to the timely completion of mortality reviews. On the 16th December 2022, an extraordinary meeting was held with the LfD team and medical leadership team at YDH to agree an action plan in response to this. It was agreed that a priority list of required SJR's would be shared with the Associate Medical Directors for Urgent and Elective Care with a deadline for completion of 10th January.

3. LEARNING IDENTIFIED THROUGH THE MORTALITY REVIEW PROCESS

3.1. Previous reports have highlighted thematic concerns around the completion of Treatment Escalation Plans (TEP's), as well as the measures that were initiated to address these through organisational learning and the provision of additional training. There is some funding to teach doctors (at all levels) by equipping them with the tools to have challenging conversations about DNAR/TEP decisions and the importance of filling the forms in properly, with a face-to-face sim and feedback plus a video demonstrating good communications skills and phrases that can be used. There is also a narrated part of the video explaining the importance of filling each section on the TEP form. The progress of these improvement initiatives can be seen in the mortality reviews completed during this quarter.

3.2. Some reviews have highlighted excellence in this area. A patient, with known inoperable cancer, was admitted following a collapse at home. They were found to have raised inflammatory markers, and attempts were made to actively treat their infection. Sadly, their prognosis was poor, and they did not

recover from this infection. It was noted that the TEP was discussed and agreed with the patient and their family in the early stages of this admission. As a result, their End-of-Life care was well managed.

3.3. Other reviews have indicated that there is ongoing learning needed around this theme. A patient had been admitted due to dehydration associated with gastroenteritis. Approximately 1 week after admission, the patient sadly deteriorated, and a small bowel obstruction was noted on CT scan. A surgical review was requested. Concerns were raised as there were delays to this taking place. Whilst it was felt that an earlier surgical review wouldn't have made a difference to the outcome, the patient was known to have been very frail and there had been no discussion about TEP or ceiling of care until after this review had taken place. The review noted that earlier palliation may have resulted in an improved experience of End-of-Life care for the patient and their family.

ED mortality review summary

3.4. Despite considerable ongoing pressures in the department, Dr Joe Rowton, ED mortality lead in YDH, reviews all deaths in ED each month assessing the quality of care, the avoidability of the death and identifying any learning points. These summaries are shared with the ED seniors on a monthly basis and presented at the departmental clinical governance meeting. Deaths considered to be avoidable are subject to further scrutiny.

3.5. Between March and November 2022, there were 34 deaths in ED. 33 of these were judged unavoidable: 3 "anticipated deaths due to disease progression", 13 "deaths following cardiac or respiratory arrest which occurred before the patient's arrival in hospital", 16 "unexpected deaths despite known preventative measures taken in an adequate and timely fashion", and one "unexpected death" subject to ongoing significant event analysis.

3.6. Following review of a death during April of a patient presenting with massive GI haemorrhage and an out of hospital cardiac arrest, it was noted that the rapid infuser was not used for the multiple blood transfusions required. This was not felt to have affected the outcome for this patient but lead to immediate sharing of information amongst the team of the importance of using the rapid infuser as part of the management of massive haemorrhage, institution of training sessions for ED staff on how to set up and use the rapid infuser, and it has already been incorporated into monthly ED simulation training.

3.7. Further learning was shared amongst the team following unavoidable deaths in September and October around the importance of early decision making in terms of DNAR/TEP in elderly patients presenting with significant illness.

3.8. Also, in July, a death of a patient in the ambulance on the way to hospital (and confirmed by the ED doctor in the ambulance on arrival) was not documented on Trakcare. The importance of this documentation was shared with the wider ED team.

3.9. Following a recent meeting the SFT and YDH LfD team and medical leadership teams, these mortality reviews will be done using the structured judgement review (SJR) methodology going forwards as a further step towards streamlining mortality review processes across the new merged organisation.

4. INVESTIGATIVE PROCESSES UNDERTAKEN WITHIN THE QUARTER

4.1. The following sections of this report describe the investigative processes which have been used to identify the above learning. Where there has been activity within the reporting quarter this is included along with details of any more general themes identified. The Trust's Learning from Deaths Manager has responsibility for collating learning from all inpatient deaths whichever review method is used. Outcomes are reported through the Incident Investigation and Learning Group, Local Governance Meetings, the Mortality Review Group and the Clinical Outcomes Committee as well as being summarised within this quarterly report.

Standardised Mortality

4.2. Standard mortality ratios (SMRs) are the ratio between observed deaths and the estimated number of deaths. The Trust uses two measures of standardised mortality: summary hospital-level mortality index (SHMI) and hospital standardised mortality ratio (HSMR). SHMI and HSMR predict the estimated number of deaths differently by using different risk factors and methodologies.

Summary Hospital-Level Mortality Indicator (SHMI)

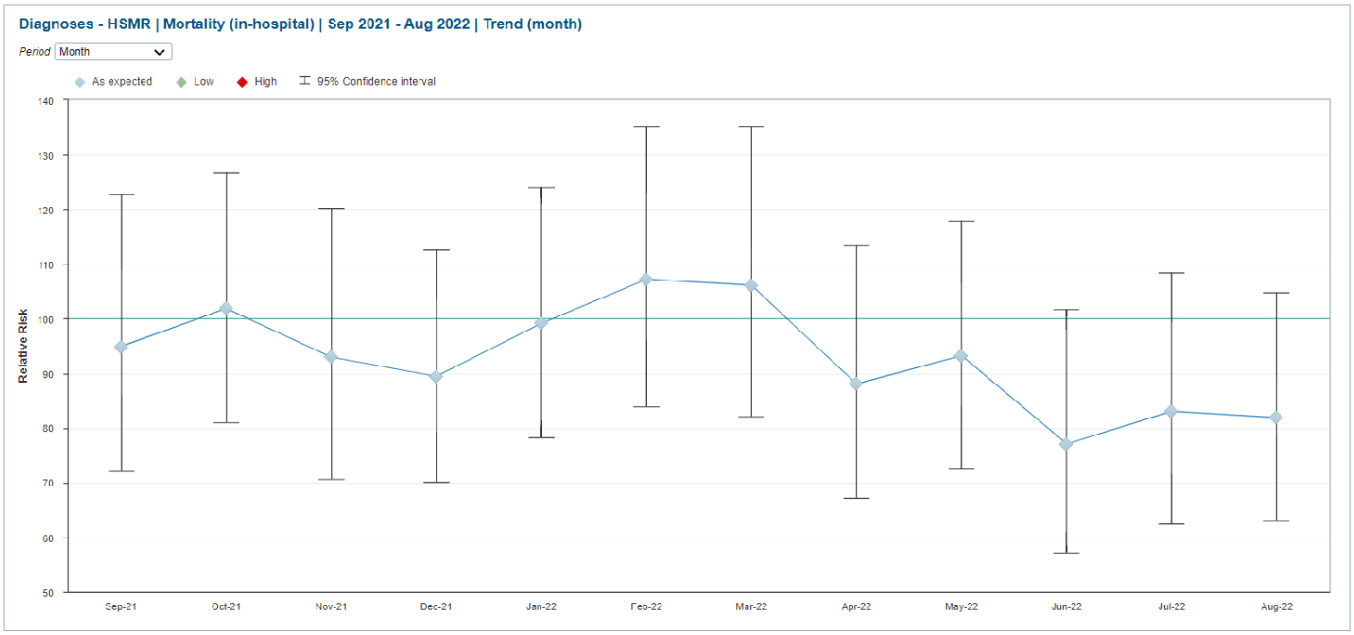
4.3. The number of deaths in hospital is captured through the Summary Hospital-Level Mortality Indicator (SHMI). This reports mortality at Trust level using a standard and transparent methodology, which is published quarterly as a National Statistic by NHS Digital. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. Our latest reported SHMI covering 12 months July 2021 to June 2022 is 95.26 which is within the expected range, with no diagnostic groups showing as an outlier.

Hospital Standardised Mortality Ratio (HSMR)

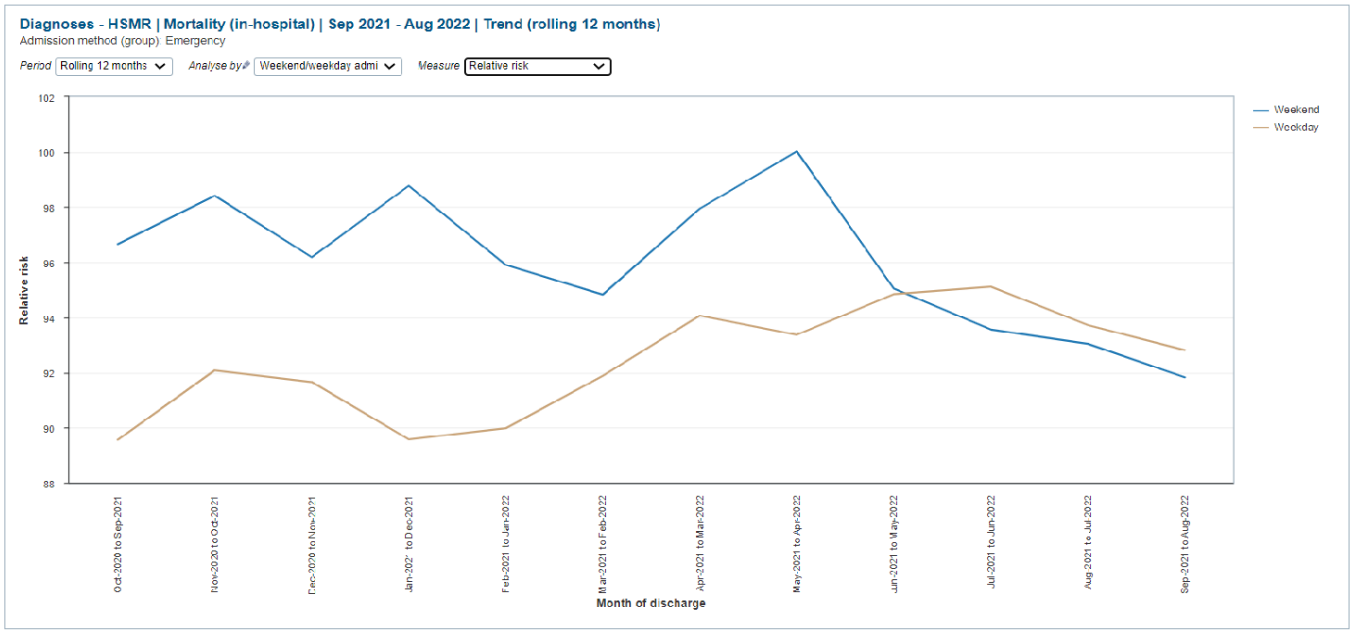
4.4. The Trust uses Dr Foster to support analytical review of outcomes data. There have been changes to the way that Dr Foster receives the national HES (Hospital Episode Statistics) data and this now comes directly from NHS Digital, improving filters and enhancing methodology to improve the accuracy of comorbidity and palliative code indicators and the predictive ability of the risk model.

4.5. Dr Foster outcomes data includes reporting of the Hospital Standardised Mortality Ratio (HSMR), which reviews a set number of indicators to inform understanding of quality and improvements in clinical care. The Trust HSMR for the latest reporting period 12 months from September 2021 to August

2022 is 92.9 which is statistically lower than expected. The rolling HSMR trend shows a level picture over the last 4 data points. The rolling HSMR 3-year trend shows that the HSMR has changed from a position of “within expected” to “lower than expected” for the last data period, having been within the expected range for the 6 periods prior. This is a different pattern compared to regional peers where the HSMR is continuing on an upward trajectory.



4.6. The Trust’s weekday HSMR is currently 92.8 with the weekend figure at 91.8 both are within the expected ranges. The Weekday rate had seen an increasing trend to the July 21 to June 22 data point but now shows a decreasing trend over the last 2 periods (July and August 22). The weekend rate trend continues to decline.



4.7. The COVID pandemic has resulted in a change in patient activity which has reduced the denominator data and the variation in the number of observed deaths in some diagnoses groups. This trend is monitored within the monthly data report. Currently if all Covid-19 activity is removed from the HSMR the figure reduces to 90.5, which is statistically lower than expected, weekday HSMR decreases to 90.4 which is statistically lower than expected, and weekend HSMR reduces to 89.5 which is statistically within the expected range.

Mortality Alerts

4.8. CUSUM is short for cumulative sum and an alert occurs when the number of deaths, readmissions, or activity within the Trust in a cohort of patients with the same coded condition, (taking account of their comorbidities) is higher than anticipated. There was 1 new CUSUM Mortality Alert reported by Dr Foster in Quarter 3. The alert was in relation to the diagnosis group “other perinatal conditions”, where there were 2 observed deaths, both had a P95 still birth coding. There will be a request for these cases to be looked at within their speciality due to the low number.

4.9. CUSUM Mortality alerts are reviewed firstly by identifying the number of patients in the cohort to ascertain if monitoring or review is appropriate. Where there are small numbers, the data may be subject to change. If a review is commissioned, the accuracy of the codes allocated to their case is interrogated. If this does not show any issues an assessment of care and management from the patient records is completed. This allows us to ascertain why the alert has occurred and to identify any actions that should be taken to address any issues with the management of this group of patients. This process may result in the coding for the patient spell being amended if their main documented condition or cause of death has changed since their admission. Reviews are carried out through the Mortality Review Group or by the clinical teams involved, with the outcome fed back through the Clinical Outcomes Committee.

The Medical Examiner service

4.10. The introduction of the Medical Examiner Role in 2020 has helped to formalise our Mortality Review Processes. The current challenges and development include:

- There is an expectation for all patients who die in the hospital to have an initial notes review by the Medical Examiner. This scrutiny enables identification of any issues for referral to Learning from Deaths for further review. However, there have been challenges with achieving scrutiny of all deaths. Additional Medical Examiner sessions have been recruited and these changes are beginning to be reflected in the number of case reviews undertaken.

- A discussion also occurs with the doctor responsible for completing the Medical Certificate of Cause of Death (MCCD). This prompts learning

for the individual doctor and can serve to reduce the possibility of the documented cause of death being rejected by the Registrar's Office.

- There will also be a conversation between the Medical Examiner Officer or Medical Examiner and the patient's Next of Kin to explore any care concerns that they may have. This allows the team to identify any potential issues and to address these at an early stage.

- Where a cause of death has not been identified or this fits within the coronial rules an initial Coroner's referral is made to determine if further investigation will be required.

- Active collaboration with the Medical Examiner service at Somerset Foundation Trust to provide a seamless cross-country process is ongoing. The appointment of a dedicated lead with the responsibility for the rollout of integrated systems to include scrutiny of all community deaths and in the future evolving the role of the Medical Examiner to include scrutiny of all neo-natal and child deaths.

Formal Structured Judgement Mortality Reviews - the three stage process

4.11. In addition to the above overview reporting mechanisms it is important to provide a formal system to review the care and management of any patient who dies within the Trust. The Trust's Learning from Deaths Manager holds responsibility for ensuring robust systems are used to identify and share learning from any death within the hospital.

4.12. The Structured Judgement Review Tool (SJR) from the Royal College of Physicians has been adapted to facilitate its use throughout the hospital. Formal mortality reviews are undertaken with data analysis used to inform improvements in care and provide reports to the Board.

4.13. The Mortality Review Group and the Learning from Deaths Manager oversee reviews of the management and care of all patients who have died within the hospital. A three-stage process is used with those patients requiring a formal review identified through the formal Medical Examiner interventions at the time of completing the death certification.

- Mortality review 1 - An initial assessment completed by the Medical Examiner enables early identification of any case where a potential problem exists. For example, where the cause of death does not follow from the admission diagnosis or where a potential omission in care or poor management is identified. Any such case is referred to the Specialty Team or the Mortality Review group who are responsible for undertaking a detailed mortality review to identify any concerns and to ensure learning for improvement. This system ensures that all patient deaths are subject to an initial review of their management and care, with a small number going forward for a full formal Mortality or Clinical review.

- Mortality Review 2 - Cases identified for this type of review will undergo a full review via speciality Morbidity and Mortality meetings with presentation of any significant findings at local Clinical Governance Sessions. Outcomes from these meetings, in particular any learning and actions taken will be recorded through the Learning from Deaths Manager within the Structured Judgement Review tool. The SJR tool summarises each review with an avoidability score. This is used to determine whether the information identified during the review, shows any evidence that the patient's death could have been avoided if different actions had been taken or the circumstances had been different. Any investigation undertaken outside of this process, for instance Serious Untoward Incident Investigations where death has occurred will now include an avoidability score as part of the investigation summary. This ensures all patient in hospital deaths can be categorised depending on the level of avoidability in each individual case regardless of the investigative process.

  There are some groups of patients who will automatically be subject to a Mortality Review 2, regardless of any findings identified by the Medical Examiner. These are where the number of deaths in the specialty is small, where the patient had a Learning Disability and where there is evidence of a hospital acquired COVID-19 infection which has been cited as the cause or contributed to the death.

- Mortality Review 3 - The third stage of the process involves the referral of any patient whose Mortality review has identified a degree of avoidability greater than 50% to the Mortality Review Group for verification and action. The Medical Examiner may also refer cases direct for this level of review. These cases may also include those where an incident investigation has been undertaken which does not cover the patient's death or where a case has been referred for a formal coroner's inquest.

Quarter 3 Review Outcomes

- Quarter 3 saw 182 of our 242 inpatient deaths (75%) scrutinised by the Medical Examiner. These would be classified as a Mortality Review at level 1 as described above. When compared to Quarter 2, the total number of Mortality Reviews completed at level 1 has increased from 166, however the overall percentage has decreased from 85%.

- 19 deaths were referred for a Mortality Review at level 2. Clinical activity within the Trust has resulted in the need to cancel the Mortality Review Group since August 2022. To ensure that these reviews, as well as the 15 outstanding from Quarter 2, do not fall too far outside of the desired timeframes, we have arranged for these reviews to be completed by colleagues outside of the Mortality Review Group setting. To date, 12 of these reviews have been completed. For those reviews undertaken using the Structured Judgement Tool in Quarter 2, 10 were judged to be unavoidable and the remaining 2 were judged to have

slight evidence of avoidability. Both noted delays to diagnosis and treatment.

Learning Disability Deaths

4.14. All deaths where a patient has been confirmed as having a Learning Disability are reported in line with national requirements and reviewed as part of the Trust's formal process with a subsequent referral externally for a full LeDeR review. Seven patients with a Learning Disability have been identified as needing a review in the quarter. These cases have been referred for a LeDeR review in line with Trust policy.

Perinatal and Child Death reviews

Neonatal and Maternal Deaths

4.15. CNST requires that cases and actions reviewed using the **Perinatal Mortality Review Tool (PMRT)** are reported to Trust Board quarterly. The PMRT facilitates a comprehensive, robust and standardised review of all perinatal deaths from 22+0 gestations (excluding terminations) to 28 days after birth; as well as babies who die after 28 days following neonatal care. Review is undertaken by a multidisciplinary panel of clinicians which has to include a panel member who is external to the unit.

4.16. The web-based tool presents a series of questions about care from pre-conception to bereavement and follow-up care. The factual information is entered in advance of a multidisciplinary panel of internal and external peers (allowing for a 'Fresh eyes' perspective) review of cases. The tool is used to identify required learning with action plans generated, implemented and monitored.

4.17. Reviews undertaken and the findings are detailed in the Trust's Quarterly Maternity Quality Report.

Paediatric Deaths

4.18. The Child Death Overview Panel reviews all child deaths. 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.

Review of COVID-19 related deaths

4.19. The Trust is required to maintain processes to investigate and learn from cases where COVID-19 has been identified as hospital acquired and listed as the cause of death or a contributory factor.

4.20. The South West Regional Healthcare Setting Outbreak Framework from NHS England and NHS Improvement guidance states that where there is any evidence that the COVID-19 infection may have been hospital-acquired and a death has resulted, there is scope for learning. If the infection was acquired due to issues in healthcare provision, such as non-compliance with IPC processes this is potentially a Serious Incident.

4.21. The Mortality processes and Medical Examiner Role link closely with the Post Infection Review (PIR) process which, in agreement with the CCG and following the Outbreak Framework, requires a serious incident review for all cases where a lapse in care has been identified.

4.22. The Trust has developed processes to identify any care and service delivery problems within the group of patients where a COVID-19 infection has contributed to or caused their death. Where a patient has COVID-19 identified as a cause of death documented on their death certificate a review is undertaken to determine if there were any lapses in care. Those cases where a lapse is identified a serious incident review is commissioned. No reports have been completed in the quarter.

Coronial Activity

4.23. The newly substantively appointed Senior Coroner Mrs Samantha Marsh has requested statements from staff in relation to the death of an inpatient or where the patient had a recent admission or procedure that could be relevant to their death. 9 new instructions were received relating to deaths in quarter 3. There have been no inquests with staff required to attend, and no pre-inquest hearings have been conducted during this quarter.

Serious Incident Reviews, Complaints and Bereavement concerns.

4.24. One reported case in Quarter 3 resulted in a Serious Incident Investigation being commissioned concerning a patient who died whilst under our care. This incident was a never event due to incorrect blood products being administered to the patient. The initial review has clarified that the incident did not contribute to the patient's death in any way. An additional two cases from a previous reporting period remain under review. Additional details will not be available until these investigations are complete.

Appendix 1

This table is a summary of the number of deaths in month against the number reviewed using the investigative processes available. Please note there is a delay in accurate reporting of in-quarter reviews due to the time frames of external surveillance data from Dr Foster and the mortality review process . This table will be updated quarterly.

2021-	2022-

	Jul	Aug	Sep	Q2 Total	Oct	Nov	Dec	Q3 Total	Jan	Feb	Mar	Q4 Total	April	May	June	Q1 Total	July	Aug	Sept	Q2 Total	Oct	Nov	Dec	Q3 Total
Total deaths in the Trust (including ED deaths)	68	71	62	**201**	87	71	82	**240**	86	88	79	**234**	82	83	64	**229**	62	72	61	**195**	68	71	103	**242**
Number subject to a Level 1 Mortality Review	49	47	25	**121**	38	35	39	**112**	64	63	54	**181**	49	53	41	**143**	53	58	55	**166**	68	58	56	**182**
Number referred for a Level 2/3 Mortality Review	6	4	3	**13**	5	3	10	**18**	9	8	6	**23**	12	8	5	**25**	7	3	6	**16**	9	5	7	**21**
Number of completed Level 2/3 Reviews	5	3	1	**9**	5	3	5	**9**	8	6	4	**18**	9	0	2	**11**	12	2	3	**17**	0	0	2	**2**
Number investigated as a Serious Incident	0	0	0	**0**	0	0	1	**1**	0	1	0	**1**	0	0	0	**0**	1	0	1	**2**	0	0	1	**1**
Learning Disability deaths	0	1	0	**1**	0	0	0	**0**	1	0	0	**1**	2	0	0	**2**	2	0	2	**4**	3	1	3	**7**
Bereavement concerns	0	0	1	**1**	0	1	2	**3**	0	1	0	**1**	1	0	0	**1**	3	0	0	**3**	0	1	1	**2**
Coroner's Inquest investigations	2	2	1	**5**	4	2	4	**9**	1	1	3	**6**	1	4	2	**7**	2	2	6	**10**	4	3	2	**9**
Number thought more likely than not to be due to	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**

problems with care																							

It should be noted that scrutiny of all patient deaths by the Medical Examiner and the resultant change in process means that comparative data is not yet available for all types of investigative review. Where available retrospective data has been added to the above chart.

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Learning from Deaths (2022/23 Quarter 3) SFT
SPONSORING EXEC:	Dr Daniel Meron, Chief Medical Officer
REPORT BY:	Laura Walker, Head of Patient Safety and Learning Dr Matthew Hayman, Deputy Chief Medical Officer (Trust medical lead for LfD) Claire Bailey, Learning from Deaths Lead Gary Filer, Quality and Safety Analyst
PRESENTED BY:	Dr Matthew Hayman, Deputy Chief Medical Officer (Trust medical lead for LfD)
DATE:	7 February 2023

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

Executive Summary and Reason for presentation to Committee/Board	The learning from deaths framework published by NHS Improvement places a number of requirements on NHS trusts, including to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public Board meetings. This report demonstrates the processes in place for how Somerset FT learn from deaths, how this learning is shared, and how improvements are made.
Recommendation	The Board is asked to discuss the report.

Links to Joint Strategic Objectives (Please select any which are impacted on / relevant to this paper)	
☒ Obj 1	Improve health and wellbeing of population
☒ Obj 2	Provide the best care and support to children and adults
☐ Obj 3	Strengthen care and support in local communities
☒ Obj 4	Reduce inequalities
☒ Obj 5	Respond well to complex needs

☒ Obj 6	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☐ Obj 7	Live within our means and use our resources wisely
☒ Obj 8	Develop a high performing organisation delivering the vision of the Trust

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

Details:

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

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

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

Equality

The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics

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

☐ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planning to mitigate any identified inequalities

Public/Staff Involvement History

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

N/A

Previous Consideration

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

Quarterly Report

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

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

R

SOMERSET NHS FOUNDATION TRUST

LEARNING FROM DEATHS FRAMEWORK

1. MORTALITY PROCESS UPDATE

1.1 The Medical Examiner's office had 449 deaths reported to them between October and December 2022. Of these, 43 were Community Hospital Deaths. 93.5% of the 449 deaths were scrutinized by the Medical Examiner team. The Medical Examiner 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.

1.2 During October to end of December we have had five coroner's inquests heard with witnesses present plus two pre inquest review hearings. During this quarter 28 inquests were opened by HMC requiring statements from colleagues in SFT. This compares to 29 in Q1 and 42 in Q2. Mrs Samantha Marsh has now been appointed as Senior Coroner for Somerset and we continue to work closely with her and her office.

1.3 The twice weekly 72-hour review meetings enable a rapid, pan-organisational discussion of deaths where the Medical Examiner has raised significant concerns and/or an incident report has been raised about an unexpected death. 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. The advantage of having senior members of the organisation at these meetings is both for senior awareness and to facilitate any immediate actions that may be required. These meetings continue to 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? Operational pressures have resulted in an inevitable delay in the scheduling of some of these meetings as the priority has been to preserve their supportive ethos by ensuring that they remain appropriately attended. Overall, the meetings have been very successful and facilitate a positive environment for open discussion, which in turn optimizes the potential for learning. Within this reporting period, 25 deaths have been referred for the 72-hour meeting process, of which 3 will be further subject to the Serious Incident Review process, 8 more will be subject to a Structured Judgement Review (SJR), and 6 have yet to been discussed. In the remaining cases, no further formal review was required, and learning arose through the 72-hour process that was shared with the clinical teams.

1.4 Our clinical teams and services continue to face unprecedented demands and remain under significant pressure. Despite this, M&M meetings are still regularly taking place, although there are delays to the completion of SJR's in some areas of the organization. Our patient safety and governance leads continue to support the LfD agenda by maintaining oversight of the completion of SJR's in their directorates. The patient safety and governance leads have been instrumental in ensuring that we do not return to having a significant backlog of outstanding reviews.

1.5 There has been an increase in a broad range of respiratory illnesses circulating in our local communities. We have seen an increase in the numbers of both patients and colleagues with these viruses and are monitoring the impact of this on the organisation. Whilst covid-19 is still present, we continue to see a reassuring picture of less severe illness and death attributable to this infection. Our predominant concern is now seasonal flu as we are seeing an increase in severe illness resulting in admission to ICU. Given its current severity, there are risks associated with nosocomial spread. IP&C measures continue to be in place, which goes some way towards mitigating this risk. However, given the demands on capacity across our inpatient facilities, we are no longer able to cohort patients, which previously proved an effective safeguard against nosocomial spread of covid during the early waves of the pandemic. We continue to mitigate risk where possible and there is ongoing review of our IP&C decisions and balance between patient care and cohorting of individuals.

1.6 As mentioned in previous reports, our approach to cases where a patient contracted covid-19 in hospital and later died now involves a thematic review to draw out any learning. Working closely with our colleagues in Infection Prevention and Control (IP&C), we have identified clinical areas where nosocomial spread resulted in an outbreak of covid-19 for thematic reviews. To date, we have completed reviews up until March 2022, and have not identified any breach of infection control measures. We have identified 1 case where we will commission a more detailed review to ascertain if there is any learning. We will shortly complete a similar thematic review for the period between March and September 2022.

1.7 Maternity services provide a report shared with the Trust Board each quarter that includes details of any perinatal deaths, what has been reviewed and the subsequent action plans. The report provides evidence that the Perinatal Mortality Review Tool (PMRT) has been used to review eligible perinatal deaths and that the required standards have been met. In December 2021, the maternity governance team implemented a monthly PMRT meeting to enable regular review of cases with a multidisciplinary team (MDT) and an external representative. The maternity governance team have implemented a joint action plan for each month's review of cases (unless a serious incident) and have highlighted any common actions to help identify themes from reviews. All finalised reports and subsequent action plans are shared with the parents according to their wishes. There were 4 perinatal deaths eligible to be notified to MBRRACE-UK with only one of these cases meeting criteria for PMRT review in this reporting period. 3 concerned medical terminations, and

there was 1 neonatal death. All reviews and notifications have met the expected timescales.

2. LEARNING, IMPROVEMENT, AND CHANGE

2.1 The importance of providing high-quality, personalised care at the end of life is well recognised. At SFT, improving our approach to end-of-life care is a priority. Although there are acknowledged challenges for some areas with delivering this, there other areas that demonstrate excellence. Several reviews recently undertaken by the orthopaedic team have highlighted the benefits of early recognition of the dying patient, meaning that the right support was given not only to the patient but also to their families and loved ones. In one such case, a patient who had a hemiarthroplasty following a fall and was awaiting a nursing home placement, sadly developed symptoms of pneumonia. Although the patient was not at that time formally deemed end of life, plans for this were made in case of further deterioration. When the patient deteriorated later that evening, the out of hours medic was able to enact this plan, ensuring that the patient's comfort was prioritised with no delays. The next of kin was updated throughout. The Trust Mortality Lead has further reviewed these cases and reflected to the Speciality Lead that these examples of excellent care could be used as learning points that feed into common themes for improvement across the trust and will be asked to share these at an upcoming Mortality Steering Group (MSG) meeting.

2.2 Colleague concerns were raised via an incident report and a referral for review by the ME service following the death of a patient known to the vascular team. This patient had been admitted in an emergency due to a deteriorating limb, which was found to be critically ischaemic. Treatment options were discussed with the patient, and bypass surgery was agreed in accordance with the patient's preference to avoid limb amputation. The patient had been made aware that this would be a high-risk procedure. There were no issues during the surgery and the patient returned to the ward. On the following day the patient was found unresponsive. Resuscitation was initiated and plans were made to return the patient to surgery upon discovery of significant perioperative bleeding. Sadly, the resuscitation attempts were unsuccessful. Concerns were raised that there would have been significant delays in transferring the patient back to theatre as it would not have been possible to move the patient out of the room on the bed, nor was there an available trolley nearby to transfer the patient on to. This was discussed initially at a 72-hour meeting and immediate learning was drawn from this discussion. It was agreed that this should be included in an ongoing piece of work around ensuring that patients are cared for in the most appropriate place. In this (and similar) cases, this would be in a room or ward area where the bed could be easily removed. However, it was acknowledged that at times of heightened acuity, this has not always been possible. Therefore, measures have been put in place to ensure that more trolleys are available in areas that are now being used for post-operative patients. An SJR was also completed to consider if this issue had an impact on the sad death of this patient. It was found that the overall care of this patient was good, and when the sudden

deterioration was noted, both the surgical and resuscitation teams were called and swiftly attended. Arrangements for emergency surgery were rapidly made and was deemed to demonstrate excellent care, however they could not transfer the patient as the team were unable to restore cardiac output. Although the issue with the delay in accessing a trolley did not impact on the sad death of this patient, crucial learning was derived from this event that could impact on the outcome for another patient.

2.3 It was identified that we had an issue with the delivery of chemotherapy medication through some pump devices which resulted in incomplete delivery of medication. There was no alert in the medical records to show that there had been an issue with delivery of the medication and therefore further medication was prescribed and administered in line with protocol. It was identified that there was no standardised process to document pump failure and how much of the intended treatment had been administered. This has led to the development of a SOP to support staff, as well as an update to the electronic prescribing system used for chemotherapy. Staff can now record the percentage amount of chemotherapy administered, making it clear where this differs to the percentage amount prescribed. All staff have been briefed on these changes and local education has been provided.

2.4 Following the unexpected death of a patient who was being supported by one of our mental health Home Treatment Teams, a 72-hour meeting was convened. The patient had a history of psychotic disorder, and although there were no acute mental health concerns, there were known risks around self-neglect and poor diabetes management. It was felt that there was clear evidence of excellence throughout the care given to this patient, despite the sad outcome. Even though the patient was reluctance to engage, when concerns were raised by other professionals and the patient's neighbours, the Home Treatment Team responded in a timely manner with phone calls and ad hoc home visits, as well as attempts to contact friends and family members. They escalated appropriately to the police on several occasions to request welfare checks. On one such occasion, the patient required admission to an acute hospital as they were found in a severely frail state having not eaten for several days. Throughout, there was evidence of joined up working between the Home Treatment Team, the Psychiatric Liaison Team, the patient's GP as well as the care team supporting the patient's spouse, who themselves was acutely mentally unwell. Sadly, despite these efforts the patient was found deceased at home by the Home Treatment Team. This excellence has been shared with the teams involved and highlighted within the directorate.

3. MORTALITY REVIEWS

		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
Community hospital	**Deaths**	15	24	20	13	10	13	24	19	13	28	21	14	22	15
	ME Reviews	12	19	17	12	10	12	23	19	8	23	15	11	17	15
	Reviews	4	5	0	0	0	0	0	1	1	0	0	1	0	0
	Stage 2	1	4	0	0	0	0	0	1	1	0	0	1	0	0
Contact with MH services in the last 6 months	**Deaths***	5	6	1	3	3	4	9	4	8	1	8	3	7	4
	ME Reviews	1	0	0	0	0	1	0	0	0	0	0	0	0	1
	Reviews	5	6	1	3	3	4	9	4	8	1	8	3	7	4
	Stage 2	3	3	0	3	2	2	7	3	7	1	6	2	5	4
Learning disabilities	**Deaths****	1	1	0	2	0	1	3	1	2	1	1	0	1	2
	LeDeR	1	1	0	2	0	1	2	1	2	1	1	0	1	2
	Stage 2**	1	1	0	2	0	1	2	1	2	1	1	0	0	0
Acute inpatients	**Deaths**	185	101	133	114	140	149	107	108	126	115	108	119	112	172
	ME Reviews	185	101	128	114	140	132	102	104	126	113	101	112	106	159
	Reviews	17	15	20	11	14	19	9	5	6	4	4	1	0	0

*MH death that meets criteria of being seen by MH services within 6 months prior to death
**All LD deaths who have been referred to the LFD team

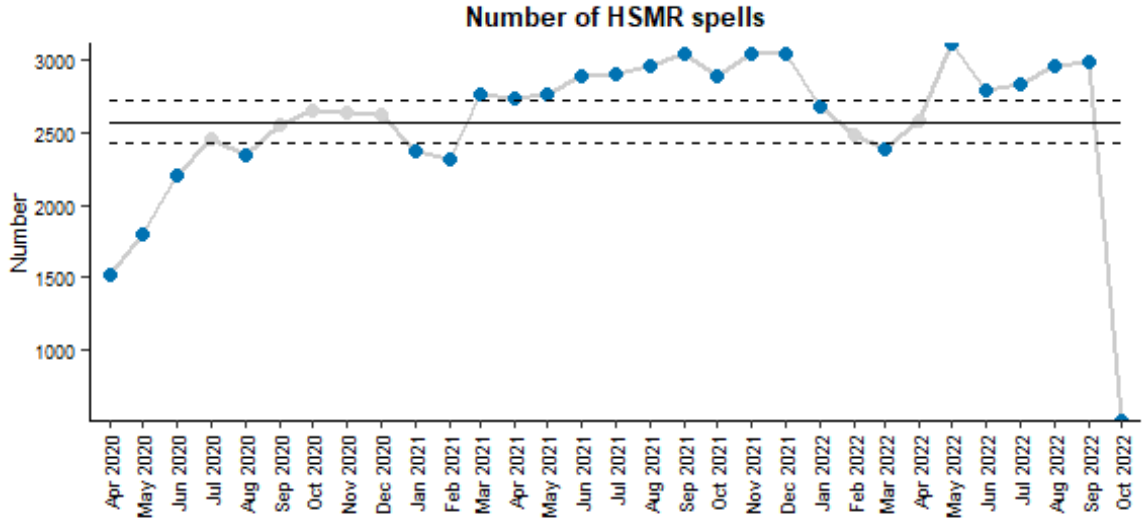
4. STANDARDISED MORTALITY

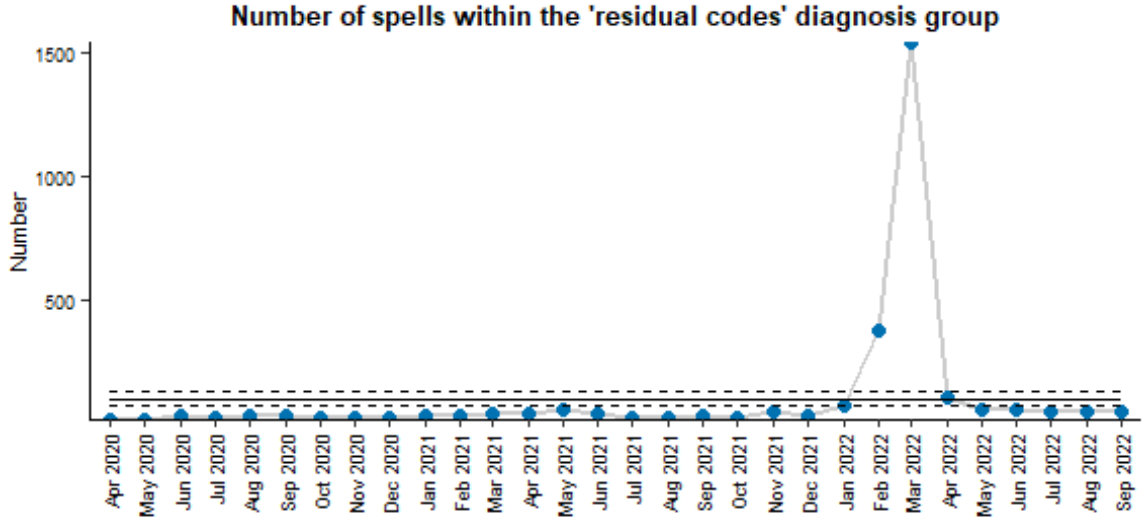
4.1 Standardised mortality ratios (SMRs) are the ratio between observed deaths and the estimated number of deaths. The Trust uses two measures of standardised mortality: summary hospital-level mortality index (SHMI) and hospital standardised mortality ratio (HSMR). SHMI and HSMR predict the estimated number of deaths differently by using different risk factors and methodologies.

4.2 The source of the data is Healthcare Evaluation Data which uses hospital episode statistics (HES) to calculate the indicators. Patients who have signed up to the national opt out programme are not included in the HES data but are included in the NHS Digital data. This is approximately 5% of spells. SHMI HES is used rather that the NHS digital dataset as the SHMI using HES data is more up-to-date and able to be broken down to patient level, however results vary.

4.3 The latest NHS Digital SHMI publication includes the 12 months to July 2022 and reports Somerset FT to have an 'as expected' SHMI value of 107.9.

4.4 The HSMR indicators have been published with data to October 2022, however the data provided by this Trust is incomplete and therefore October 2022 has been excluded from this analysis. There is evidence to suggest there are a higher number of uncoded spells than normal throughout 2022, with a significantly higher number in February and March 2022.





4.5 Covid 19 has affected activity and mortality rates in a significant way which is not fully represented in the SHMI and HSMR models. SHMI exclude all spells with a suspected or confirmed diagnosis of covid in any position, as well as any patient with mention of covid on the death certificate. HSMR does not include spells where primary diagnosis on admitting episode is confirmed or suspected covid, but may include spells with a confirmed or suspected covid diagnosis is in other positions.

Overall position

Measure	Period	RR	LCL	UCL	Banding
SHMI	Oct 21 - Sep 22	109.4	104.5	114.6	**Above expected**
HSMR	Oct 21 - Sep 22	133.4	126.1	141.0	**Above expected**

Position for admission on weekdays

Measure	Period	RR	LCL	UCL	Banding
SHMI	Oct 21 - Sep 22	107.6	102.1	113.4	**Above expected**
HSMR	Oct 21 - Sep 22	129.8	121.6	138.4	**Above expected**

Position for admission on weekends

Measure	Period	RR	LCL	UCL	Banding
SHMI	Oct 21 - Sep 22	116.0	105.2	127.6	**Above expected**
HSMR	Oct 21 - Sep 22	145.5	129.8	162.6	**Above expected**

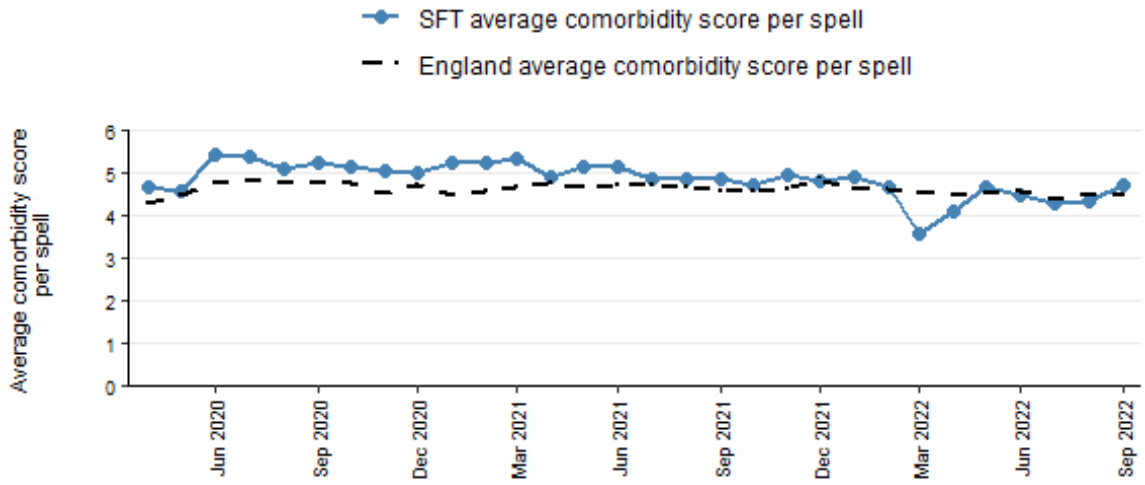
Outliers at site level:

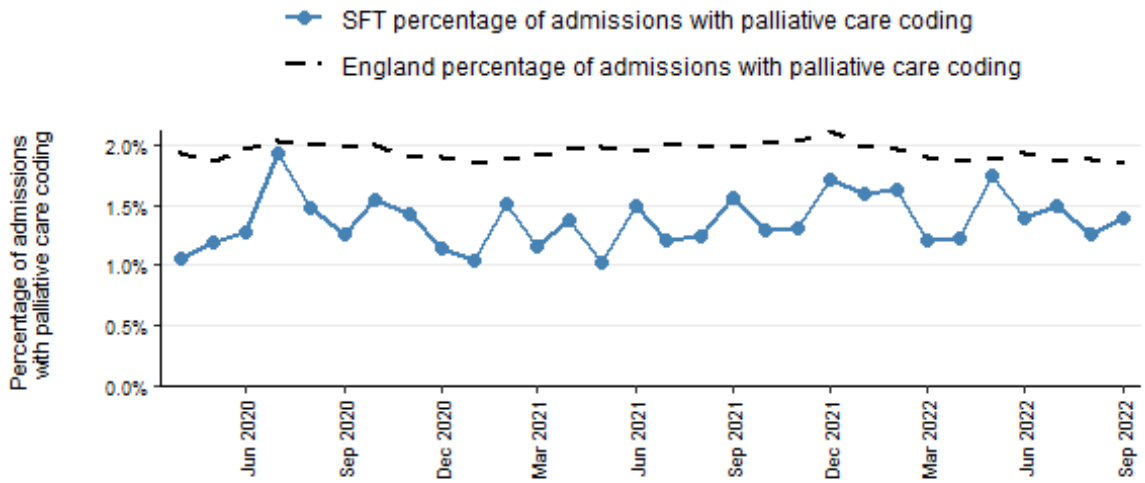
Treatment site	SHMI (Sep 21-Aug 22)	HSMR (Sep 21-Aug 22)
RH5A8 - MUSGROVE PARK HOSPITAL	**Above expected** 108.1 (95% CI: 103.0 - 113.3) Excess deaths: 126.9	**Above expected** 131.1 (95% CI: 123.6 - 138.9) Excess deaths: 269.6
RH5G5 - FROME COMMUNITY HOSPITAL	**Above expected** 173.4 (95% CI: 117.0 - 247.6) Excess deaths: 12.7	**Above expected** 195.9 (95% CI: 126.8 - 289.2) Excess deaths: 12.2
RH5K6 - BRIDGWATER COMMUNITY HOSPITAL	As expected 116.5 (95% CI: 60.1 - 203.5) Excess deaths: 1.7	**Above expected** 229.0 (95% CI: 104.5 - 434.8) Excess deaths: 5.1
RH5F9 - CREWKERNE HOSPITAL	**Above expected** 270.8 (95% CI: 147.9 - 454.4) Excess deaths: 8.8	As expected 149.8 (95% CI: 68.3 - 284.3) Excess deaths: 3.0

4.6 As described in previous reports, thematic reviews of the community hospital outliers have demonstrated that there were no clinical concerns with the care that the patients received, but that we would continue to monitor this situation. As demonstrated above, we continue to see above expected deaths at some of our community hospitals. Of note, Bridgwater Community Hospital is flagging above expected deaths for the first time. With the support of colleagues from our Primary Care and Neighbourhoods Directorate, we are in the process of conducting a further thematic review and will report the outcome in due course. Oversight by the medical examiner of all inpatient deaths provides an independent review of 93.5% deaths in the trust. Although there is an upward trend in MPH and in some of the community hospitals there have been no concerns raised by the ME service. Internally ongoing mortality reviews and the twice weekly 72 hour meetings allow for oversight of deaths and any concerning trends will be identified there. Nationally there is an upward trend in mortality and recent evidence suggests that this will be an ongoing trend due in part to the aging population.

Clinical coding – Comorbidities & palliative care
Source: SHMI (Oct 21-Sep 22)

Measure	Trust	Percentile	England
Average comorbidity score per spell (SHMI)	4.54	47th (57.5 of 122)	4.57
Percentage of discharges with palliative care coding (SHMI)	1.44%	23rd (27.5 of 122)	1.94%





4.7 **Effect of palliative care adjustment**
The standard indicator for SHMI does not include an adjustment for palliative care coding in its models whereas the standard indicator for HSMR does. In addition to the standard indicators, HED published additional indicators with or without the adjustment for palliative care.

4.8 For both measures, the ratio of observed to expected deaths is above the expected range whether palliative care adjustment is included or not.

Source	With palliative care adjustment	Without palliative care adjustment
SHMI (Oct 21-Sep 22)	126.9 (95% CI: 121.1 - 132.8) **Above expected**	109.4* (95% CI: 104.5 - 114.6) **Above expected**
HSMR (Oct 21-Sep 22)	133.4* (95% CI: 126.1 - 141) **Above expected**	118.7 (95% CI: 112.2 - 125.5) **Above expected**

*Standard indicator

5. PLANS FOR THE FUTURE

5.1 The trust's internal auditor has reviewed the Trust's Learning from Deaths process in January 2022. They found a substantial level of assurance over the design of the process and rated the effectiveness as moderate. An action plan has been in place to address the recommendations that were outlined. The only outstanding actions relate to adding the Structured Judgement Review template to a digital platform.

5.2 In September 2022, the process for this was mapped out using our current risk and learning platform, Radar, by Claire Bailey (LfD Lead), Katy Darvall (Trust Mortality Lead) and Paula Wiggins (Radar System Lead). There have been some delays to implementing and going live with this process as conversations have started between SFT and YDH, who use a different risk and learning platform, Ulysses, about how these processes can align within the forthcoming merged organisation.

5.3 At YDH, the Structured Judgement Review template has already been added to a digital platform, but this is not one that is supported by Ulysses and is not suitable for use by the merged organisation.

5.4 In October 2022, there was a system meeting with both suppliers and key stakeholders from governance, management and clinical teams from both organisations to look at the currently available platforms. A decision has not yet been reached as to which platform will be adopted by the merged organisation. Whilst we await the outcome of this, the Radar System Lead has built the form and its associated workflows for Radar. Once this has been finalised by the supplier, we will proceed to trial a live version of this form. We expect to be in a position to do this early in the new year.

5.5 In addition to the above, we have begun to review the work of the national Learning from Deaths forum called Better Tomorrow, who have developed an updated version of the SJR tool, called SJR*Plus*, as well as a digital platform to support this. To date, they have updated the existing review tools for Acute and Mental Health settings and have further plans to develop a new tool for use in Community settings. Whilst our engagement with this forum is still in the early stages, we are looking at this work with interest.

5.6 Planning for the roll out of the Medical Examiner service across the whole of Somerset, to include all deaths in the community, is being led by Helen Gilliland (Implementation Lead – Somerset Medical Examiner Service). These developments have coincided with the LfD team working across both SFT and YDH ahead of the upcoming merger. This has resulted in an opportunity to review and standardise the referral process. A digital referral form has been created for use by the ME service. We have now had sight of this and are due to give feedback.

5.7 As mentioned in previous reports, since September 2022 the LfD team at SFT have been providing cover for the mortality review and coronial process at YDH. There are significant differences between the

existing processes at both organisations. After a period of settling in, we have now met with key stakeholders from both organisations and have begun to plan how we can align these processes, ensuring that we draw on the strengths of each. The inquest process is now aligned and colleagues across both sites are being offered the same support.

5.8 In our Mental Health and Learning Disability Directorate, the mortality review process has, up until now, been overseen by SIRG. Beginning in January 2023, the Directorate will embark on a project to develop a separate mortality review process for deaths that don't meet the threshold for SIRG. By building on the M&M meeting model, which is widely used in our acute settings, the Directorate will become more aligned with the rest of the organisation through enabling clinical teams to be more engaged with the process. As Older Person's Mental Health sits within our Primary Care and Neighbourhoods Directorate, collaboration has been required to ensure that relevant learning is shared between the directorates.

5.9 These conversations have led to our Primary Care and Neighbourhoods Directorate identifying a need to undertake a separate review of their processes around mortality, and an acknowledgement that it has been uniquely challenging for them to implement a standardised approach. These challenges have, in part, arisen from the wide variety and expansion of services that this Directorate holds. Furthermore, because of the pressures seen across the whole organisation since the start of the pandemic, there has been a marked change in the clinical acuity that many of their services now manage. This review will be supported by the LfD team to ensure that any learning is captured and disseminated in line with the LfD policy.

Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Guardian Of Safe Working For Postgraduate Doctors Quarterly Report
SPONSORING EXEC:	Daniel Meron, Chief Medical Officer
REPORT BY:	John McFarlane, Guardian of Safe working for Yeovil
PRESENTED BY:	Daniel Meron, Chief Medical Officer
DATE:	7 February 2023

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

Executive Summary and Reason for presentation to Committee/Board	This report covers the period October to December 2022. The report shows that there is robust evidence that the working hours for trainee doctors at YDH remain safe. The following findings are drawn to the attention of the Board: • Exception report numbers almost double the average in the quarter mainly in general medicine during December due to the volume of admissions and pressure on discharging patients. • ISC high number (10) due to junior doctors feeling overwhelmed at times
Recommendation	The Board is asked to discuss the report.

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

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

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

Equality The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics
☒ This report has not been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
☐ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planning to mitigate any identified inequalities

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
N/A

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

YDH
Guardian of Safe Working Hours

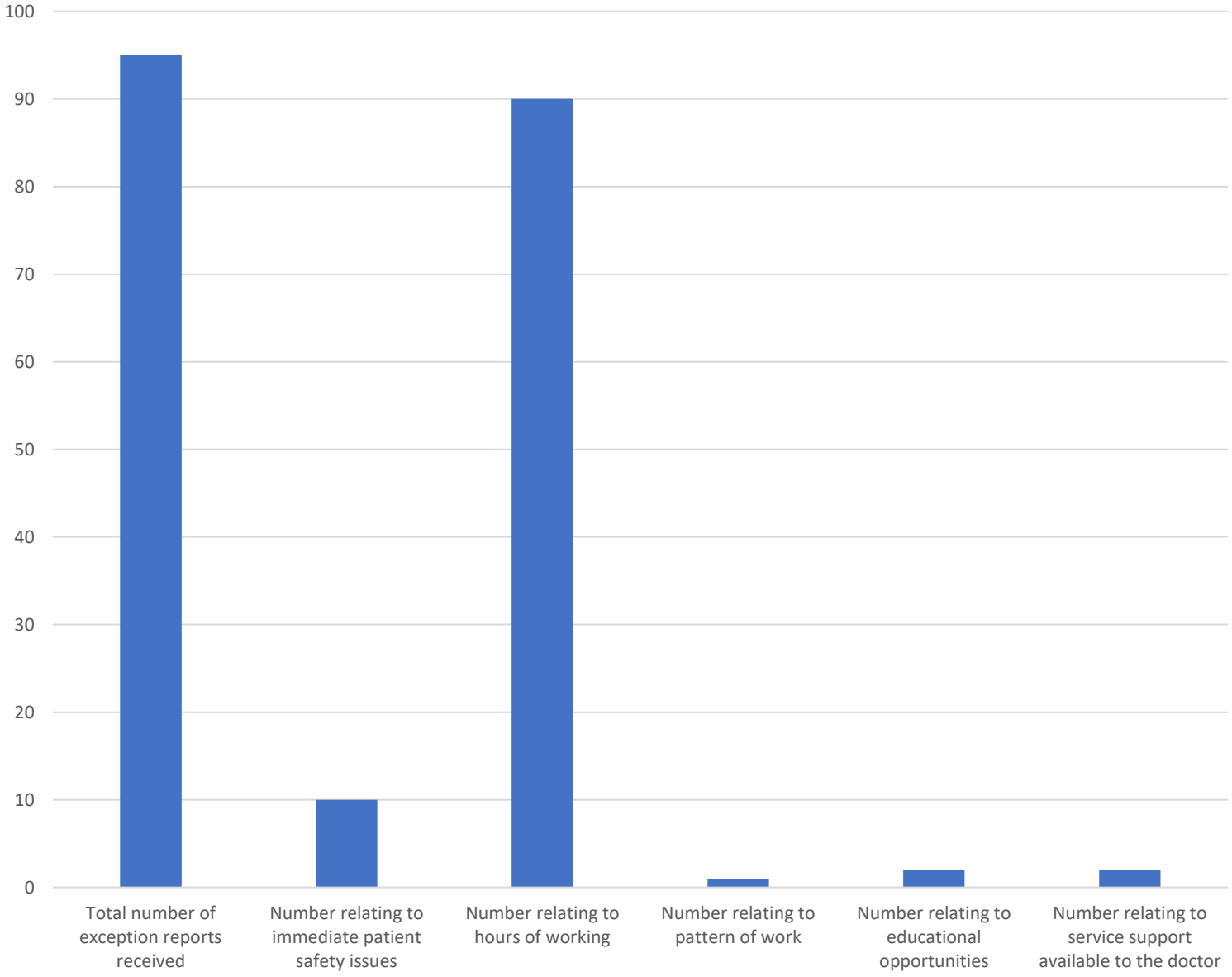
Quarterly Report
October to December 2022

Exception Reports at YDH – Historical Perspective

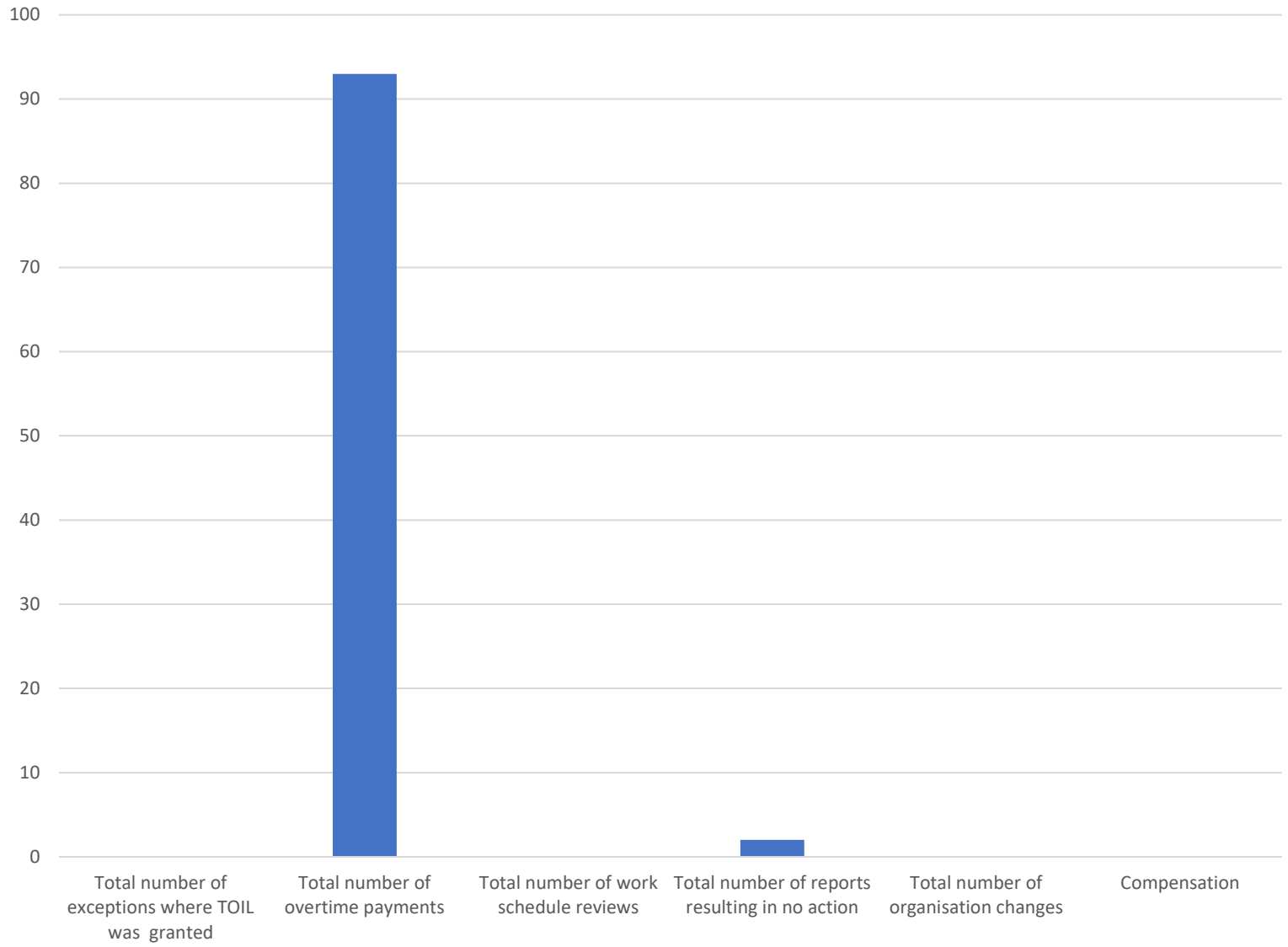
- Allocate was introduced to Yeovil District Hospital NHS Foundation Trust in 2016.

- From 06th December 2016 up until the current reporting date we have received a total of:
  - 1241 Exception Reports (Allocate Total Count)
  - This represents an average of ~ 50 Reports per Quarter
  - Of the reports raised
    - 1096 have related to Hours (95%)
    - 35 have related to Educational Issues
    - 18 have related to Service Provision Issues

95 exception reports



Nearly all resulting in overtime payments



Exception reports for the quarter by rota

- Gen surgery: 10

- Gen medicine: 69
- Cardiology : 7

- Orthopaedics: 8
- Obs and Gynae : 1

Immediate Safety Concerns

In the past three months there has been 10 Exception Report that was raised by the originator as being of “Immediate Safety Concern” (ISC)

On investigation these were found to be as follows:

All in general medicine

6 were due to junior doctors in general medicine feeling unsafe in their practice due to the volume of work

4 described as ISC in error

ISC junior doctor comments

- We all had to review patients that required a senior review over the weekend as we understandably weren't able to pull the registrar off the acute medical take to assist us. This has left us all feeling very concerned for our patient's safety and quality of care they received over the weekend as we feel like we weren't able to give all our patients the time they required to be reviewed.

- On this day, the ward was already short staffed while overfilled. Only three doctors were allocated for that day. We were not able to complete the essential jobs until 19:30. All three had to stay until then. The constant pressure to discharge patients on top of this, frankly, made me feel unsafe working for the day, as I was worried that essential jobs might be missed.
- I was not even able to eat lunch until 16:50, and only then it was a ten minute break.

- Today the EAU was staffed with only 3 junior doctors, and additional help did not arrive until after 1 pm. Even consultant had to start reviewing patients to help us. We were not able to carry out MDT meeting until 3 pm, only after which we could start doing the jobs. This extra hour worked was only possible because we did not have our allowed 30 min breaks. So, it is two exceptions.
- I believe that for a ward like the EAU to have only this many doctors puts patients at risk as well.

ISC actions

- The hospital was well stretched on those days with unprecedented admissions and work load and staffing in turn did not match up - the rota team were aware and did their best, having brought in 7 locums to cover areas in need , but still fell short
- Foundation Programme Director made aware and has drafted a letter to all juniors warning them of impending redeployment for periods of 48-72 hours, should the situation demand it

Guardian of Safe Working Fines

- **There have been no fines imposed at YDH in this Reporting Period**

  - *The secondary limits that attract a fine are*
  - ***a doctor working more than an average of 48 hours per week in any 3 month period***
  - ***a doctor working more than an absolute maximum of 72 hours in any given week***
  - ***a doctor getting less than getting 8 hours rest between shifts***
  - ***a doctor missing more than 25% of rest breaks in any 4 week period.***

- *(Historically there have been no fines imposed at YDH since the start of Exception Reporting)*

Summary

Summary

- Exception report numbers almost double the average in the quarter mainly in general medicine during December due to the volume of admissions and pressure on discharging patients
- ISC high number (10) due to junior doctors feeling overwhelmed at times

Summary

There is robust evidence that the working hours for trainee doctors at YDH remain safe, as they relate to the 2016 T&Cs and the hours limits set out by those T&Cs.

Somerset NHS Foundation Trust/Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Guardian of Safe Working for Postgraduate Doctors Quarterly Report – February 2023
SPONSORING EXEC:	Chief Medical Officer
REPORT BY:	Janet Fallon, Guardian of Safe Working Lee-Ann Toogood, Medical Workforce Manager
PRESENTED BY:	Janet Fallon, Guardian of Safe Working
DATE:	7 February 2023

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

Executive Summary and Reason for presentation to Committee/Board	This report covers 14 October 2022 to 6 January 2023. We are seeing an upward trend in exception reporting, with very high numbers from doctors in medical specialties. Exception reports relating to missed educational opportunities have increased. We are monitoring the number and details of Immediate Safety Concerns raised in the Trust. Steps have been taken to address concerns regarding medical weekend on-call working, and the situation remains under close review. We continue to see excellent engagement from postgraduate doctors via the exception reporting system and Postgraduate Doctor Forum. Rota management remains a challenge across directorates.
Recommendations	To continue to support safe working practices across the Trust by engagement with the exception reporting process and Postgraduate Doctor Forum

	To support innovation and improvement in rota management

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

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

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

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QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING – February 2023

1. EXECUTIVE SUMMARY

1.1. This report covers the period 14 October 2022 to 6 January 2023.

- We are seeing an upward trend in exception reporting, with very high numbers from doctors in medical specialties
- Exception reports relating to missed educational opportunities have increased
- We are monitoring the number and details of Immediate Safety Concerns raised in the Trust
- Steps have been taken to address concerns regarding medical weekend on-call working, and the situation remains under close review
- We continue to see excellent engagement from postgraduate doctors via the exception reporting system and Postgraduate Doctor Forum
- Rota management remains a challenge across directorates

2. INTRODUCTION

2.1. The data presented below is to allow the Board to assess the current risks to the provision of safe patient care posed by rota gaps and vacancies, and patterns of exception reporting by postgraduate doctors in training. This is followed by a qualitative summary of issues arising and actions take to address these.

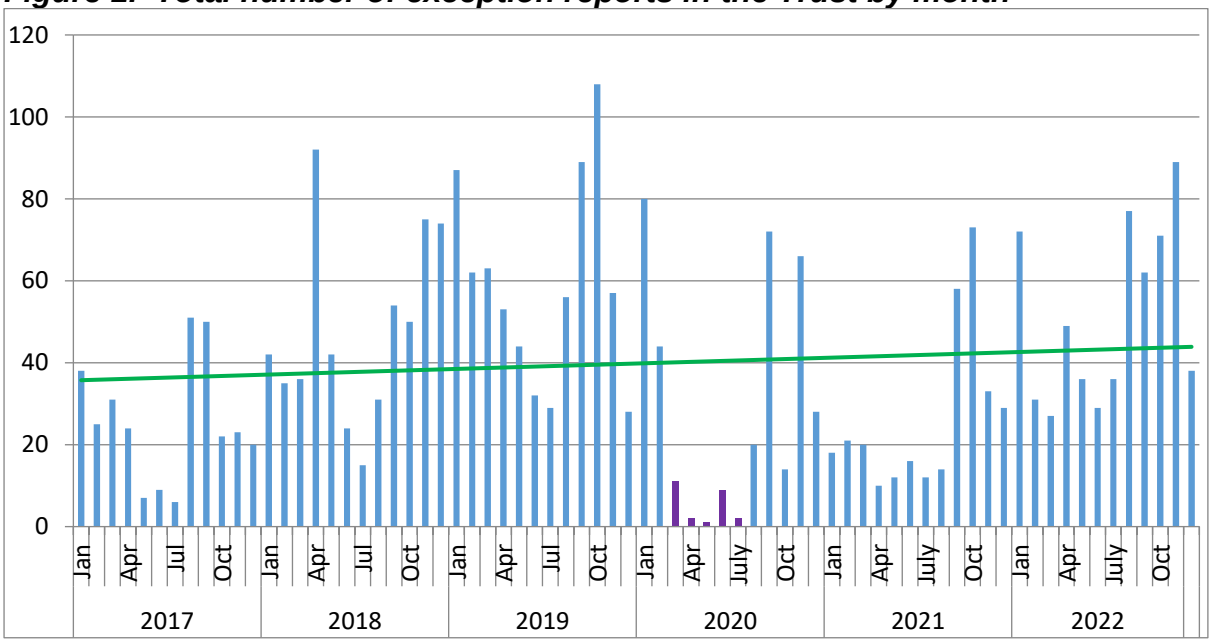
3. EXCEPTION REPORT DATA:

Number of doctors/dentists in training on 2016 TCS (total):	263
Job plan allocation for Guardian of Safe Working:	1.5 PAs
Job plan allocation for Educational Supervisors per trainee:	0.125 PAs

Exception reporting since the introduction of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016

3.1. As of 06/01/23 - Total of 2810 exception reports since implementation of 2016 TCS (December 2016). The overall cost of exception report overtime is £47,735.05. The monthly breakdown of exception reporting is shown in *Figure 1*.

Figure 1. Total number of exception reports in the Trust by month



3.2. **Exception reports this quarter** - please find the information in brackets from the previous quarterly report for comparison:

Table 1: Exception reports per specialty

Specialty	No. exceptions raised	No. exceptions closed	No. exceptions outstanding	Type
Acute & General Medicine	112 *(98)*	78	34	Hours 80 Educational 28 Service Support 1 Pattern 3
Anaesthetics	0 *(1)*	0	0	
DCT Trainees	0 *(0)*	0	0	
ENT	0 *(0)*	0	0	
General Surgery	16 *(14)*	6	10	Hours 16
O&G	1 *(0)*	0	1	Hours 1
Oncology/ Haematology	13 *(29)*	13	0	Hours 13
Paediatrics	6 *(3)*	2	4	Hours 6
Psychiatry	11 *(4)*	0	11	Hours 4 Educational 4 Service Support 2 Pattern 1
Trauma & Ortho	7 *(1)*	3	4	Hours 3 Educational 2 Service Support 2
Urology	6 *(2)*	0	6	Hours 6
Vascular	2 *(1)*	1	0	Hours 2
Total	**174 *(162)***	**104**	**70**	

Table 2: Exception reports per trainee grade

Grade of trainee	No. exceptions raised
F1	97 *(85)*
F2	26 *(56)*
CT1-2 / ST1-2	44 *(9)*
ST3+	7 *(12)*
Total	**174 *(162)***

Table 3: Exception reports relating to number of trainees and rota gaps per specialty

Specialty	Grade	No. of trainees	Rota gaps (average WTE)	Exception reports per grade	Exception reports per specialty
Anaesthetics/ ICU	ST3+	9	**1.1**	0	0
	CT1/2	0	**0.4**	0	
	F1/F2	1	0	0	
Emergency Medicine	ST3+	8	**0.8**	0	0
	CT1/2	14	**1.8**	0	
	F2	2	**1.9**	0	
	F1	1	0	0	
Medicine (including Neurology & Haem / Onc)	ST3+	16	**1.0**	2	112
	CT1/2	15	**0.2**	32	
	F2	15	0	16	
	F1	19	**1**	72	
Obs & Gynae	ST3+	8	**0**	1	1
	ST1/2	10	**0**	0	
Ophthalmology	ST1-3	5	0	0	0
Paediatrics	ST	18	**2.6**	1	1
	F2	1	**0**	0	
Psychiatry	ST4+	7	2.2	9	11
	CT1-3	16	**1.2**	0	
	F2	2	0	0	
	F1	3	0	2	
T&O	ST3+	7	0	0	7
	CT1/2	1	0	0	
	F2	8	0	7	
Surgery	ST3+	7	0	0	23
	CT1/2	11	**1.4**	0	
	F2	1	0	0	
	F1	11	0	23	

Qualitative summary of exception reports

3.3. We have seen an increase in the number of exception reports submitted compared with last quarter. The majority of these came from doctors in medical specialties, with high numbers relating to work on the Acute Medical Unit and general medical on-all shifts. The number of exception reports relating to missed educational opportunities has increased

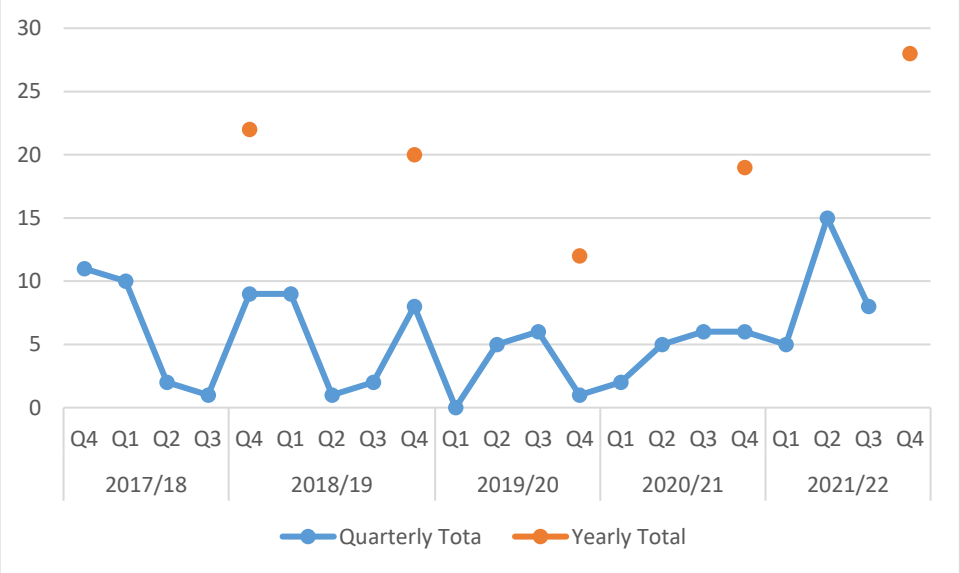
from 19 in the same quarter last year to 34 this quarter. These trends reflect the pressure of work in acute specialties across the trust, most noticeably in medicine, and highlight the impact this has on the quality of the working environment and educational opportunities for our post-graduate doctors.

Immediate safety concerns (ISCs)

3.4. Eight ISCs were raised this quarter, five of which relate to work in medical specialties. These included incidents relating to medical on-call weekend ward cover shifts, concerns regarding safe levels of minimum staffing on the wards and the impact of managing acutely unwell patients. Two ISCs were flagged by doctors in Trauma & Orthopaedics, relating to weekend on-call shifts with a heavy workload for the F2 doctors covering the wards and acute admissions, whilst senior members of the team are operating in emergency theatre. One ISC was raised in Paediatrics, relating to a busy night shift with unwell patients and insufficient time for natural breaks. Qualitative summaries of all ISCs highlight that the doctors in question took appropriate action, prioritising the most unwell patients and escalating their concerns to senior colleagues.

3.5. The overall number of ISCs this quarter is lower than last quarter, but higher than the average for Q3 compared with previous years. We have seen more ISCs so far this year than in previous years.

Figure 2. ISC reporting – quarterly and yearly totals



3.6. **Fines**

No fines were issued during this quarter.

Work schedule reviews

3.7. 12 exception reports have been escalated to level 1 work schedule review this quarter. 10 of these reports related to missed educational opportunities for doctors on the Acute Medical Unit. This has been raised with the Director of Medical Education. For this cohort of doctors, study leave opportunities have been arranged in lieu of missed teaching sessions. A further level 1 work schedule review related to pressure of work on one of the Care of the Elderly wards, and in this case overtime payment was arranged.

3.8. **Bank and agency data**

Specialty	Shifts Requested	Worked as Bank/ Internal Cover	Worked as Agency	Hours Requested	Worked as Bank/ Internal Cover	Hours worked as Agency
Accident & Emergency	373	154	219	3822	1695.5	2126.5
AMU/GIM	361	49	312	2968.89	380.25	2588.64
Anaesthetics	1	1	0	2	2	0
ENT	6	6	0	38	38	0
Gastroenterology	11	11	0	83	83	0
General Surgery	5	5	0	35	35	0
Maxillo-Facial	15	15	0	174	174	0
Obstetrics & Gynaecology	53	6	47	549	59.5	489.5
Ophthalmology	4	4	0	34.5	34.5	0
Peadiatrics	8	8	0	55.5	55.5	0
Respiratory	34	4	30	573.08	21	252.08
Trauma & Orthopaedics	15	15	0	161.5	161.5	0
Community Services	190	0	190	1517.84	0	1517.84
Grand Total	1072	274	798	9679.8	2705.3	6974.6

Request Grade	Shifts Requested	Worked as Bank/ Internal Cover	Worked as Agency	Hours Requested	Worked as Bank/ Internal Cover	Hours Worked as Agency
F1	0	0	0	0	0	0
F2	52	52	0	417.75	417.75	0
ST1/2	504	466	38	4820.42	3969.42	851
ST3+	461	337	124	4218.09	2947.59	1275.5
Grand Total	965	803	162	9038.51	6917.01	2126.5

4. ISSUES ARISING

Medical weekend working

4.1. Previous reports have highlighted an increasing number of ISCs relating to medical weekend on-call shifts. In response to this, a working group was drawn together to address these issues, supported by the Medical Director, Head of Medical Services, Medical Consultants, Chief Registrar and Hospital Out of Hours (HOOH) Practitioners.

4.2. A change to the HOOH Co-ordinator cover for weekend days was suggested, moving this service from the surgical directorate to the medical directorate. This change was implemented for a trial period starting in December ’22. Initial qualitative feedback from the HOOH Co-ordinators and postgraduate doctors has been positive. No immediate safety concerns have been raised since this change was implemented.

4.3. It should be noted that the ISCs raised by doctors regarding weekend working in Trauma & Orthopaedics were submitted prior to the change in HOOH Co-ordinator cover. No exception reports have been submitted regarding weekend working in either General Surgery or Trauma & Orthopaedics since this change has been implemented. Close monitoring of weekend exception report data is ongoing and quantitative evaluation of the impact of these developments is planned for the near future.

4.4. A new on-call “huddle” has been introduced on weekends at 2pm in the Academy, allowing for on-call doctors to meet and discuss their workload and any specific issues with the medical registrar and HOOH team. This is open to doctors from all specialties and has been well attended.

Postgraduate Doctor Forum (PDF)

4.5. Our last PDF was held in December and was well attended by postgraduate doctors of various grades and specialties. The agenda included Fatigue & Facilities funding allocation, Doctors’ Mess updates, recent exception reporting data and the planned introduction of representatives for specialties and to mirror faculty roles.

Rota management

4.6. On-call rotas in a number of specialties were published later than the minimum 6 week notice period mandated by the Terms & Conditions of Service. This was highlighted by the trainee BMA representative and Industrial Relations Officer. This was flagged to the relevant managers and rota co-ordinators for immediate action. This highlights the ongoing complexities of rota management across the Trust. As highlighted in previous reports, innovation and improvement in rota design and implementation are required to meet acceptable standards as outlined in the contract and the BMA Good Rostering Guide.

5. SUMMARY

- We are seeing an upward trend in exception reporting, with very high numbers from doctors in medical specialties
- Exception reports relating to missed educational opportunities have increased
- We are monitoring the number and details of Immediate Safety Concerns raised in the Trust
- Steps have been taken to address concerns regarding medical weekend on-call working, and the situation remains under close review
- We continue to see excellent engagement from postgraduate doctors via the exception reporting system and Postgraduate Doctor Forum
- Rota management remains a challenge across directorates

6. RECOMMENDATIONS

6.1. The Boards are asked:

- To continue to support safe working practices across the Trust by engagement with the exception reporting process and Postgraduate Doctor Forum
- To support innovation and improvement in rota management

Janet Fallon, Guardian of Safe Working

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Assurance Report from the People Committee meetings held in common on 14 November 2022
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Stephen Harrison and Graham Hughes, Chairmen of the People Committees
DATE:	7 February 2023

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the People and Workforce Committee meetings held in common on 14 November 2022 and the assurance received by the Committees. The meeting was conducted as a video conference call. The Committees received assurance in relation to: • Colleague Story – Occupational Therapy Project • Allied Health and Professionals (AHP) Workforce Deep Dive • Cultural Board • Retention Roadmap • Industrial Action Briefing • Risk Appetite and Risk Tolerance • Violence and Aggression Programme Update • Learning Item – Review of Bank Incentivisation Schemes

	The Committees identified the following area for follow up: • Sickness Absence and Turnover • Review of the Boar Assurance Framework • Workforce (Corporate Risk Register) • Violence and Aggression Programme Update – Freedom to Speak Up update • Internal Audit follow up No issues have been identified to be followed up by other Committees or to be reported to the Board. The Committees are able to provide the Boards with assurance that the items discussed at the meeting provide significant assurance in relation to addressing gaps in controls and assurances for objective six of the Board Assurance Framework.
Recommendation	The Board is asked to discuss the report and note the areas of assurance and follow up.

Links to Joint Strategic Objectives (Please select any which are impacted on / relevant to this paper)
☐ Obj 1 Improve health and wellbeing of population
☐ Obj 2 Provide the best care and support to children and adults
☐ Obj 3 Strengthen care and support in local communities
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☐ Obj 5 Respond well to complex needs
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☐ Obj 8 Develop a high performing organisation delivering the vision of the Trust

Implications/Requirements (Please select any which are relevant to this paper)					
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Equality The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics					

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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]
Feedback from the meeting is presented to every meeting.

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

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

SOMERSET NHS FOUNDATION TRUST (SFT)

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST (YDH)

ASSURANCE REPORT FROM THE PEOPLE COMMITTEES

1. PURPOSE

1.1. The report sets out the items discussed at the meetings held in common on 14 November 2022, the assurance received by the Committees and any areas of concern identified.

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

2. ASSURANCE RECEIVED

2.1. **Colleague Story – Occupational Therapy Project**
The Committee receive an update from Rebecca Keating, Head of Occupational Therapy, on the workforce challenges within occupational therapy services.

2.2. The Committee noted the work undertaken to understand the workforce position within the team and the engagement with regional and national agencies to understand the actions which can be taken to ensure timely access to occupational therapy services. The Committee noted the improvements made in relation to recruitment, retention, transformation; communication; and the increase in return to practice opportunities.

2.3. The Committee further received an update from Nicola Mead, Clinical Specialist Occupational Therapist for Stroke, on the difficulties retaining colleagues due to the feeling that career development and engagement in service development were limited. The Committee noted the use of ESR data and the development of an Early Warning RAG Tool to identify opportunities for improving retention.

2.4. The Committee was assured by the work taking place to transform the occupational therapy service delivery model across both trusts, including the focus on clear roles and strong professional identities, and the development of a new primary care occupational therapy service, but recognised the challenges faced by the service. The Committee noted the development of a two year recruitment, retention and engagement programme plan by the Occupational Therapy Improvement Board.

Allied Health and Professionals (AHP) Workforce Deep Dive

2.5. The Committee received an update on the AHP workforce position; challenges faced by the AHPs; the work carried out to increase recruitment and internal promotion opportunities; the data accuracy review to support workforce planning; the development of an AHP promotion

booklet; and the establishment of workstreams with the AHP Council and Faculty to address the five key areas of focus in the national AHP strategy.

2.6. The Committee was assured by the work being undertaken across Somerset but recognised the challenges faced by AHP services. The Committee further noted that funding for the Faculty and AHP development lead role within the Faculty will come to an end and that ongoing funding will be discussed with the Chief Finance Officer.

Cultural Board

2.7. The Committee discussed the revised Terms of References for the Cultural Board and noted that the Terms of References took account of the new People Strategy and proposed merger. The Committee approved the Terms of Reference subject to a number of changes.

Retention Roadmap

2.8. The Committee received the retention roadmap which set out the current position in relation to retention data and the focus for the next year.

Industrial Action Briefing

2.9. The Committee received an update on the preparations for industrial actions and received assurance that, although disruptions were expected, the trusts were in a strong position to support and respond to the strike actions.

Risk Appetite and Risk Tolerance

2.10. The Committee received an update in relation to the development of a risk appetite and risk tolerance statement as part of the wider risk management strategy and framework for the post merger organisation. The Committee particularly discussed the risk appetite and risk tolerance for the strategic objective assigned to the People Committee – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning cultures".

2.11. The Committee agreed that level four would be the right risk appetite level for strategic objective six.

Violence and Aggression Programme Update

2.12. The Committee received an update in relation to the implementation of the Violence and Aggression Programme and noted that: an interim violence and aggression policy had been developed; a training and education framework had been explored; consideration was being given as to where violence and aggression reduction sits across the whole system and how much the trusts can influence this work to ensure that good practices become embedded; engagement had taken place with colleagues and feedback provided to the Inclusion Group; and that a project was taking place in relation to culture civility and inclusion.

Learning Item

2.13. The Committee received an update from Dee Barber, Head of Workforce and Employment, on her review of the bank incentivisation scheme at YDH. The Committee noted the findings of this review and the

recommendation to moving away from an incentivisation to a reward scheme with a focus on rewarding colleagues accepting bank shifts six to eight weeks in advance.

3. AREAS OF CONCERNS/FOLLOW UP

Sickness Absence and Turnover

3.1. The Committee discussed the proposals for monitoring performance against the standards and agreed that, although it was important to have oversight of performance, the use of the word “target” could have a negative connotation. The Committee therefore suggested using the concept of an expected range and to review the KPIS as part of the wider People Strategy KPI review.

Review of the Board Assurance Framework

3.2. The Committee noted the areas with gaps in assurances, which related to: violence and aggression; governance of inclusion; pulse check and career conversations. Reports relating to these areas had been covered at the meeting.

Workforce (Corporate Risk Register)

3.3. The Committee received the combined workforce risk register and noted that there were currently 53 risks on the combined register scoring 15 and above, an increase of seven risks, with 12 of these risks scoring 20 and above.

Violence and Aggression Programme Update

3.4. The Committee asked for a Freedom to Speak Guardian update on colleague civility to be presented to the Committee on an annual basis.

Internal Audit Follow Up

3.5. The Committee received the YDH health and wellbeing internal audit report and noted the findings of the audit report. The Committee received assurance that a number of the recommendations were already being implemented and that an update will be presented to the January 2023 Committee meeting, together with the findings of the SFT health and wellbeing audit report.

3.6. The Committee further received the SFT performance appraisals (career conversations) internal audit report and noted the findings of the audit report. The Committee noted the concerns expressed at the Audit Committee about the timeframe for implementing the recommendations but was assured that actions will be implemented as soon as possible but that some actions will take a longer period of time to fully implement due to the integration of the career conversations and talent management work following the merger. The Committee noted that an action plan to take these recommendations forward had been developed.

3.7. The Committee expressed concerns about the potential for duplication of schemes and projects and asked for an overview of all projects to be presented to the January 2023 Committee meeting.

4. ISSUES REQUESTED TO BE FOLLOWED UP BY OTHER COMMITTEES

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

5. ASSURANCE FRAMEWORK

5.1. The Committee received the following assurance in relation to strategic objective six:

- Review of the incentivisation bank schemes at YDH.
- The preparations for the industrial actions.
- The work on reducing violence and aggression.
- The focus on retention of colleagues.
- The colleague story and the workforce planning deep dive.

Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Yeovil District Hospital NHS Foundation Trust Finance Report – Month 9
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Deputy Chief Finance Officer
PRESENTED BY:	Chief Finance Officer
DATE:	7 February 2023

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

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

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

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

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

Equality The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics
☒ This report has/has not been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
☐ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planning to mitigate any identified inequalities

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
N/A

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

YDH | Consolidated Financial Performance

Month 9 - December 2022

1 Group I&E page 2

2 I&E detail pages 3-4

3 Group staff expenditure page 5

4 Group agency expenditure page 6

5 Medical page 7

6 Nursing page 8

7 Operating Expenditure page 9

8 Subs NEW page 10

9 Income and Contracting pages 11-12

10 Trust CIP Summary page 13

Executive summary

In month, the Group reported a £0.234m surplus which was in line with the plan. Year to date the Group has a £0.133m deficit which is also consistent with the plan.

Services continue to be under significant pressure from high levels of demand and difficulties in discharging patients in a timely manner. Funding for escalation (£1.6m) was included in the YDH block contract and although year to date expenditure is already c£0.9m above this level, winter funding from the ICB of £0.5m has been recognised to date to help with this. There is an ongoing process in place with the ICB to fund the unplanned costs of escalation/winter from system contingencies until year end. Overachievement of CIP against the year to date trajectory is also partially offsetting pressures. Agency costs continue to be high in December, with the sustained pressure the hospital is seeing in non elective activity and staffing.

Risks to our overall outturn are considered with the ICB as part of the system financial oversight process. A number of commissioner and provider risks (e.g. further winter escalation) are noted with identified mitigations in place.

The Trust is forecasting to achieve £4.563m in CIP (in line with plan). However, of this only £1.058m (23%) is recurrent. Work will continue to support groups to mitigate any residual risks in their plans and increase the level of recurrent delivery.

The capital programme continues to be behind plan. This is due primarily to slippage on externally funded schemes (Salix, Breast Care Unit & Modular theatre). Although significant expenditure is planned in the second half of the year, it is now forecast that the PDC funded theatre 5 plan will not be achieved in this year. NHSE have agreed to rephase the funding for this scheme in line with our revised plans.

Performance on a financial trajectory basis	1.	In Month	The Group reported an in month surplus of £0.234m against a planned surplus of £0.234m, and is therefore in line with the plan in month.
		YTD	The Group deficit year to date is £0.133m compared with a planned deficit of £0.133m, and is therefore consistent with the plan.
Cash	2.	The total cash balance and working cash balance at the 31st December was £27.060m. The year end forecast position £25.196m.	
Capital	3.	YTD	Gross capital expenditure YTD was £8.840m (no MES additions) versus planned £13.845m (£15.065m including MES). The plan will be revised after agreement by NHSE to reprofile funding for the theatre scheme.
CIP performance	4.	YTD	£3.924m has been delivered compared with £3.078m of planned efficiencies; of which 21% have been achieved recurrently. The Trust is forecasting to achieve it's CIP target at year end.

Group I&E - Summary

December 2022			£'000'	YTD			Annual Plan
Actual	Plan	Variance fav/(adv)		Actual	Plan	Variance fav/(adv)	
22,095	20,380	1,715	Operating Income	188,222	180,221	8,001	240,404
(14,458)	(13,226)	(1,232)	Staff Expenditure	(123,756)	(118,468)	(5,289)	(158,123)
(7,394)	(6,530)	(863)	Operating Expenditure	(62,425)	(59,292)	(3,133)	(78,750)
243	**623**	**(381)**	**Operating I&E**	**2,040**	**2,461**	**(421)**	**3,530**
(9)	(389)	380	Non-Operating Expenditure	(2,173)	(2,594)	421	(3,531)
234	**234**	**(0)**	**Adj to Financial Improvement Trajectory (FIT) Basis**	**(133)**	**(133)**	**0**	**(0)**
383	1,462	(1,079)	Donated Assets and other adjustments excluded from FIT	5,148	10,406	(5,258)	11,819
617	**1,696**	**(1,080)**	**I&E surplus/(deficit)**	**5,015**	**10,273**	**(5,258)**	**11,819**

Key headlines:

Operating Income - The year to date position includes £2.289m of pay award funding above plan and an additional £1.045m reimbursement of COVID-19 costs (testing) incurred outside of the system funding envelope. Other reimbursements for extra escalation/winter costs in YDH and higher SHS income (£2.204m fav) have also been seen, including part of £1m further funding newly agreed by the ICB towards SHS pressures. An underperformance on high cost drugs is matched by underspends in high cost drugs expenditure YTD.

Staff Expenditure - SHS costs remain higher than plan due to primary care operational pressures which have been funded by increased ICB support. Agency and bank premium costs relating to escalation capacity/activity continue to drive adverse variances across the group, offset in part by income reimbursement as described above. Total variance due to cost of back-dated pay award YTD is £2.563m offset by income stated above giving net adverse variance £0.274m YTD.

Operating Expenditure - year to date favourable variances continue to be seen in IT and recruitment services. Adverse variances include COVID-19 impact of £0.569m YTD due to testing costs which are offset by income. Additional overspends driven by escalation, inflation, non COVID pathology testing, in tariff funded drugs and impact of non-elective demand on elective expenditure, and one-off system costs.

Group I&E - Detail

December 2022			£'000'	YTD			Annual Plan
Actual	Plan	Variance fav/(adv)		Actual	Plan	Variance fav/(adv)	
16,753	16,020	733	NHS Acute Income	147,118	143,986	3,132	191,970
2,756	2,222	534	NHS Primary Care Income	20,894	16,469	4,425	22,180
359	425	(67)	Non NHS Clinical Income	2,480	4,193	(1,713)	5,536
2,155	1,713	442	Other Income	16,685	15,098	1,587	20,242
72	0	72	Top Up income	1,045	476	569	476
22,095	**20,380**	**1,715**	**Total Operating Income**	**188,222**	**180,221**	**8,001**	**240,404**
(4,361)	(3,964)	(397)	Medical Staff Expenditure	(37,420)	(35,529)	(1,891)	(47,441)
(5,770)	(4,981)	(789)	Nursing Staff Expenditure	(47,614)	(44,377)	(3,237)	(59,310)
(4,327)	(4,281)	(46)	Other Staff Expenditure	(38,722)	(38,561)	(161)	(51,372)
(14,458)	**(13,226)**	**(1,232)**	**Total Staff Expenditure**	**(123,756)**	**(118,468)**	**(5,289)**	**(158,123)**
(1,869)	(1,770)	(99)	Drugs	(16,598)	(16,169)	(429)	(21,299)
(1,616)	(1,386)	(230)	Clinical Supplies & Services	(13,803)	(12,689)	(1,114)	(16,847)
(3,908)	(3,374)	(534)	Other Operating Expenditure	(32,024)	(30,435)	(1,590)	(40,604)
(7,394)	**(6,530)**	**(863)**	**Total Operating Expenditure**	**(62,425)**	**(59,292)**	**(3,133)**	**(78,750)**
243	**623**	**(381)**	**Total Operating I&E**	**2,040**	**2,461**	**(421)**	**3,530**
(9)	(389)	380	Non-Operating Expenditure	(2,173)	(2,594)	421	(3,531)
234	**234**	**(0)**	**Adj to Financial Improvement Trajectory (FIT) Basis**	**(133)**	**(133)**	**0**	**(0)**
383	1,462	(1,079)	Donated Assets	5,148	10,406	(5,258)	11,819
0	0	0	Other adjustments excluded from FIT	0	0	0	0
617	**1,696**	**(1,080)**	**I&E surplus/(deficit)**	**5,015**	**10,273**	**(5,258)**	**11,819**

COVID-19 Financial Summary (excl SHS)

Included with Plan

COVID19 Related Expenditure £'000	2022/23 YTD												
	Annual Plan	Plan YTD	Actual M1	Actual M2	Actual M3	Actual M4	Actual M5	Actual M6	Actual M7	Actual M8	Actual M9	Actual YTD	Variance YTD (adverse)/ favourable
Medical Staff Expenditure	982	737	58	96	73	83	129	93	98	96	98	824	(87)
Nursing Staff Expenditure	1,780	1,340	164	119	178	176	143	131	140	131	149	1,329	11
Other Staff Expenditure	522	303	81	35	23	25	26	24	24	23	25	287	16
Total Staff Expenditure	**3,284**	**2,379**	**302**	**250**	**274**	**283**	**298**	**248**	**263**	**250**	**272**	**2,439**	**(60)**
Drugs	2	1	0	0	0	0	0	0	0	0	0	1	1
Clinical Supplies & Services	14	10	0	0	1	0	0	0	9	0	0	10	1
Other Operating Expenditure	231	173	4	(1)	4	24	2	2	1	1	2	37	136
Total Non-Staff Operating Expenditure	**247**	**185**	**4**	**(1)**	**5**	**25**	**2**	**2**	**9**	**1**	**2**	**48**	**137**
Total	**3,531**	**2,564**	**306**	**249**	**279**	**308**	**299**	**250**	**272**	**250**	**274**	**2,487**	**78**

Outside of Envelope

COVID19 Expenditure to be Reimbursed £'000	2022/23									
	Actual M1	Actual M2	Actual M3	Actual M4	Actual M5	Actual M6	Actual M7	Actual M8	Actual M9	Actual YTD
Nursing Staff Expenditure	0	0	0	0	0	0	0	0	0	0
Other Staff Expenditure	0	0	0	0	0	0	0	0	0	0
Clinical Supplies & Services	246	301	79	178	68	(17)	52	66	72	1,045
Total	**246**	**301**	**79**	**178**	**68**	**(17)**	**52**	**66**	**72**	**1,045**

Key headlines:

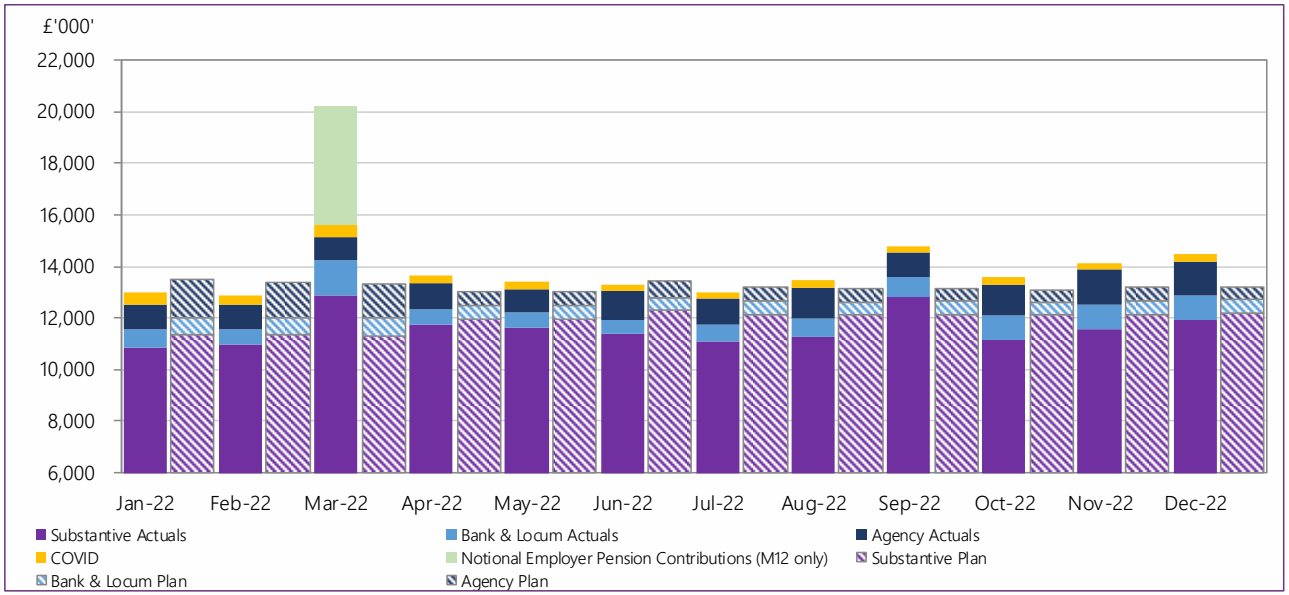
Costs in relation to COVID-19 continue to be reviewed across the trust and system to confirm what additional planned expenditure can be removed aligned to the relaxation in infection prevention and control measures. The level of specific Covid funding the system will receive in 2023/24 have significantly reduced from 2022/23 levels.

Outside of envelope is completely reimbursable from NHSE and relates to COVID testing.

Group staff expenditure

December 2022

vs Plan in month	£1.232m adverse
vs Plan YTD	£5.289m adverse

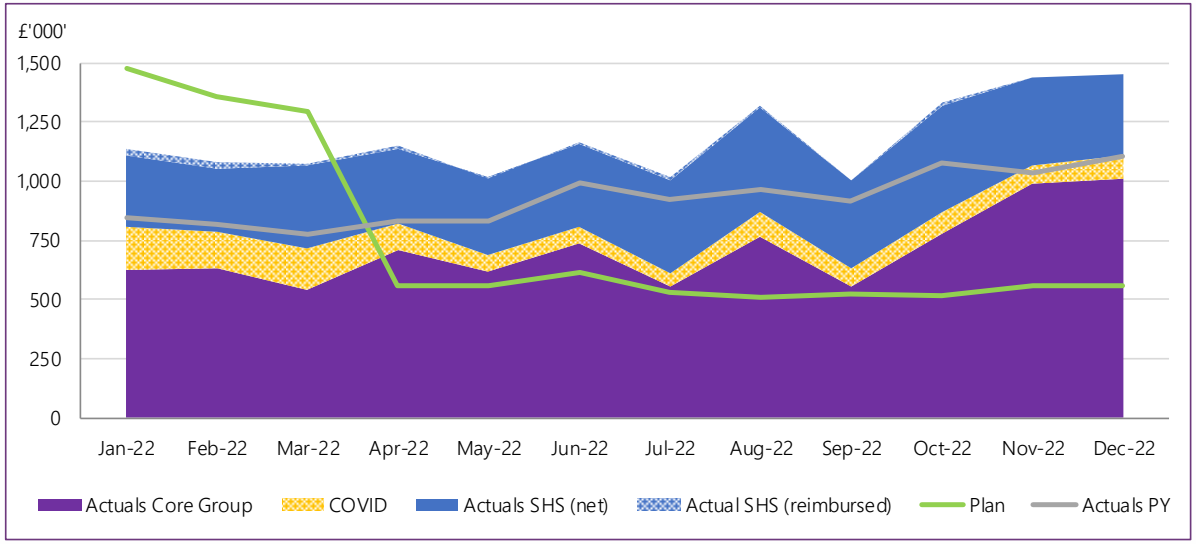


December 2022			£'000'	YTD			Comments	Annual Plan
Actual	Plan	Variance fav/(adv)		Actual	Plan	Variance fav/(adv)		
4,361	3,964	(397)	Medical	37,420	35,529	(1,891)	See medical analysis on following slides.	47,441
5,770	4,981	(789)	Nursing	47,614	44,377	(3,237)	See nursing analysis on following slides.	59,310
1,656	1,418	(238)	Sci, Theraputic & Technical	13,897	12,831	(1,066)	Higher costs in SHS (pharmacists), and ODPs with underspends in homefirst therapists.	17,082
383	314	(70)	Ancillary	3,326	2,822	(504)	Position largley driven by housekeeping and agency premium in month and YTD alongside impact of pay award in YTD.	3,758
2,288	2,550	262	Estates, Admin & Clerical	21,498	22,908	1,410	Fav across various areas largely SHS (£0.100m in month, £0.863m YTD), senior managers in HR and IT.	30,532
14,458	**13,226**	**(1,232)**	**Total Pay**	**123,756**	**118,468**	**(5,289)**		**158,123**

Group agency expenditure

December 2022

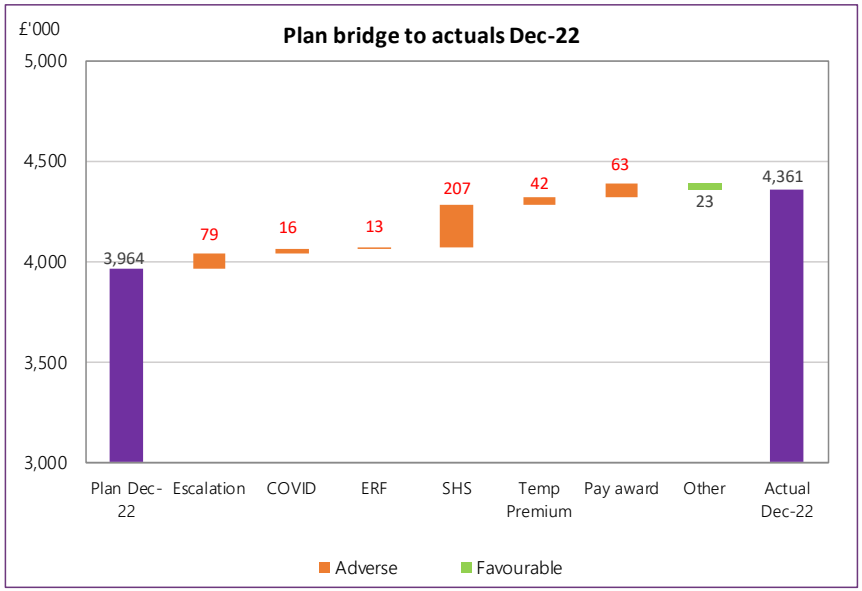
Group plan YTD	£4.922m
Actuals vs Plan YTD	£5.884m adv
Actuals vs prior year YTD	£6.33m over

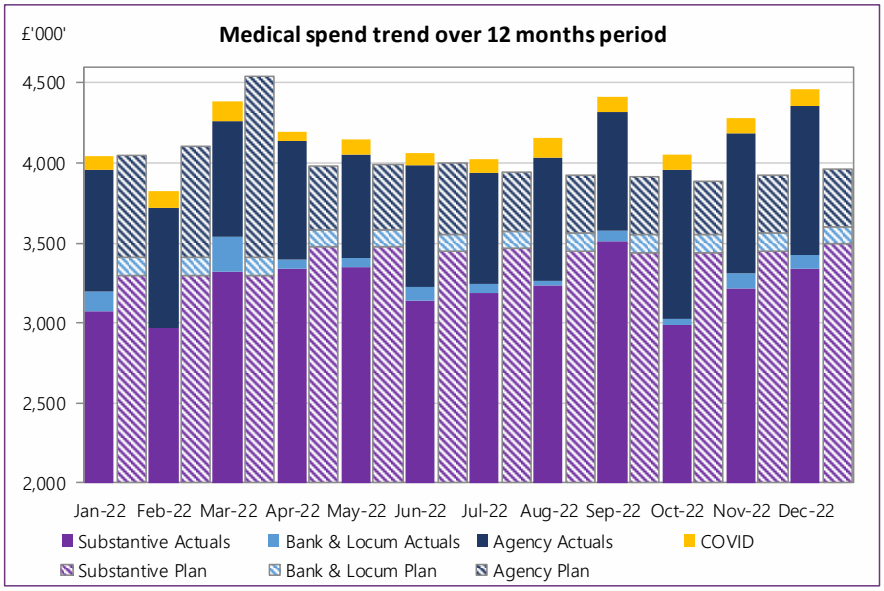


	Variance to Plan fav/(adv)	
£'m	In month	YTD
Nursing	(0.092)	(0.710)
Medical	(0.557)	(3.920)
Other Pay	(0.222)	(1.254)
Total	**(0.870)**	**(5.884)**

December 2022			£'000'	YTD		
Actual	Plan	Variance fav/(adv)		Actual	Plan	Variance fav/(adv)
643	250	(394)	Medical	4,436	2,244	(2,192)
207	171	(37)	Nursing	1,606	1,370	(236)
166	12	(154)	Other Pay	839	116	(722)
1,017	***432***	***(585)***	***YDH total***	***6,881***	***3,730***	***(3,151)***
68	0	(68)	Other Pay	510	0	(510)
68	***0***	***(68)***	***SSL total***	***510***	***0***	***(510)***
288	125	(163)	Medical	2,920	1,192	(1,728)
55	0	(55)	Nursing	474	0	(474)
0	0	0	Other Pay	22	0	(22)
343	***125***	***(218)***	***SHS total***	***3,415***	***1,192***	***(2,223)***
1,428	**557**	**(870)**	**Group Total**	**10,806**	**4,922**	**(5,884)**

Group medical spend





Plan bridge to Actuals YTD	£'000'
Plan	**35,529**
Escalation	373
COVID	86
ERF	(8)
SHS	1,639
Temp Premium	(398)
Other	(367)
Actual Dec-22	**37,419**
Variance to Plan	**(1,890)**

Key headlines:

Note that month 12 21/22 includes year end provisions for annual leave due to employees and outstanding professional/study leave.

Risk budgets in the Clinical SBUs are underspent in month 9 due to a reduction in premium temporary staffing costs.

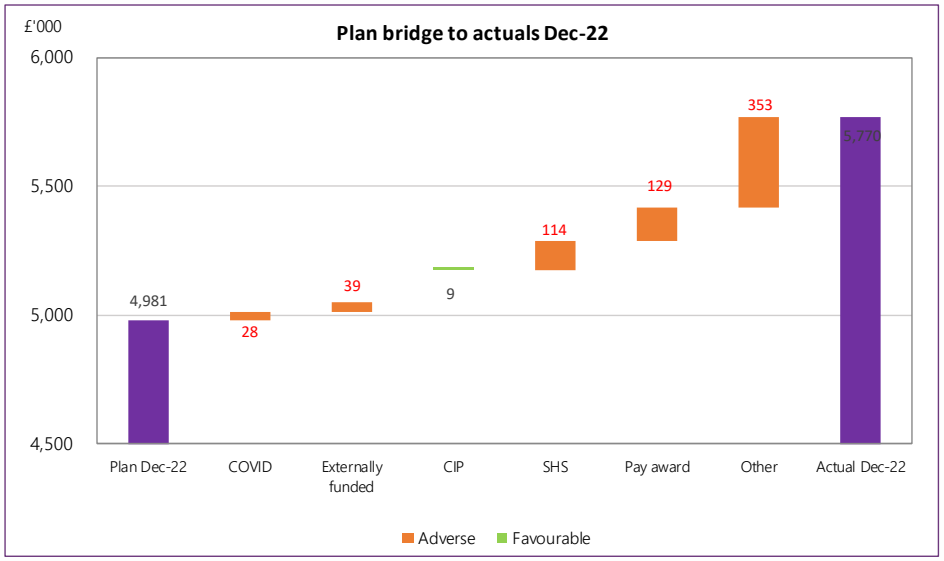
COVID related spend in month was £0.098m (£0.824m YTD), and is adverse to plan due to backfilling staff on sickness leave.

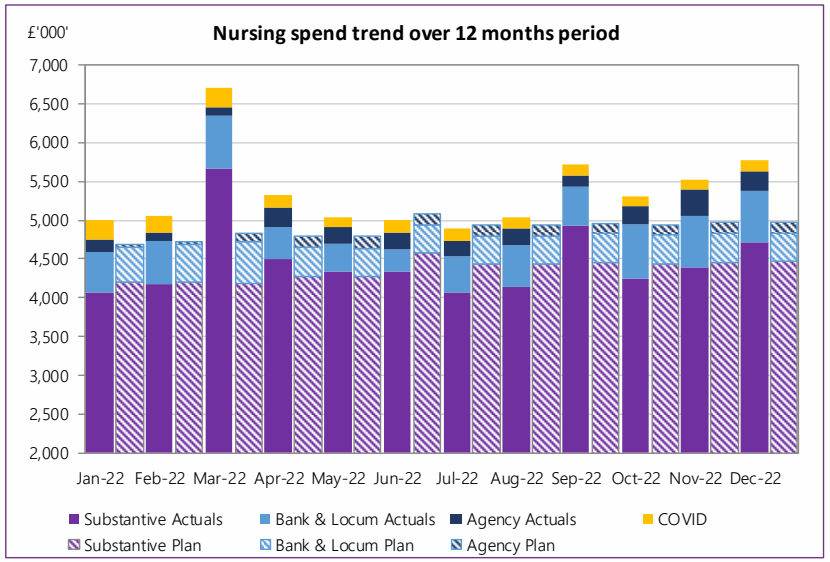
ERF relates to the continuation of 21/22 ERF schemes not in the plan.

£0.373m of additional medical staff shifts were incurred YTD to manage the escalation and acuity of patients being seen on the wards.

SHS includes GP vacancy locum cover and costs incurred due to increased demand.

Group nursing spend





Plan bridge to Actuals YTD	£'000'
Plan	**44,377**
COVID	(11)
Externally funded	364
Escalation	552
CIP	(268)
SHS	894
Pay award	1,150
Other	557
Actual Dec-22	47,615
Variance to Plan	**(3,238)**

Key headlines:

Note that month 12 21/22 includes increases in year end provisions for outstanding annual leave and a wellbeing day due to employees as well as outstanding professional/study leave cover and enhancements due.

COVID - expenditure for the additional shifts in ED has been allocated to COVID up to the plan level. Increase in backfill of shifts for COVID related sickness and isolation in month.

Externally funded - This includes income for midwifery posts, secondments, recharges for CAMHS and variances offset by income e.g. overseas recruitment.

Escalation - costs incurred above budget for staffing Jasmine, CDUP, FAU Escalation and AEC. Additional winter schemes for AAUP, Clinical Site Managers and KW.

CIP - overachievement in nursing YTD, predominantly non recurrent vacancy factor and COVID reduction for swabbing clinic.

SHS - includes nurse practitioner vacancy locum cover and costs incurred due to increased demand.

Pay award - budget allocated for the pay award, over and above the 2% set at planning. Mostly offset by additional income.

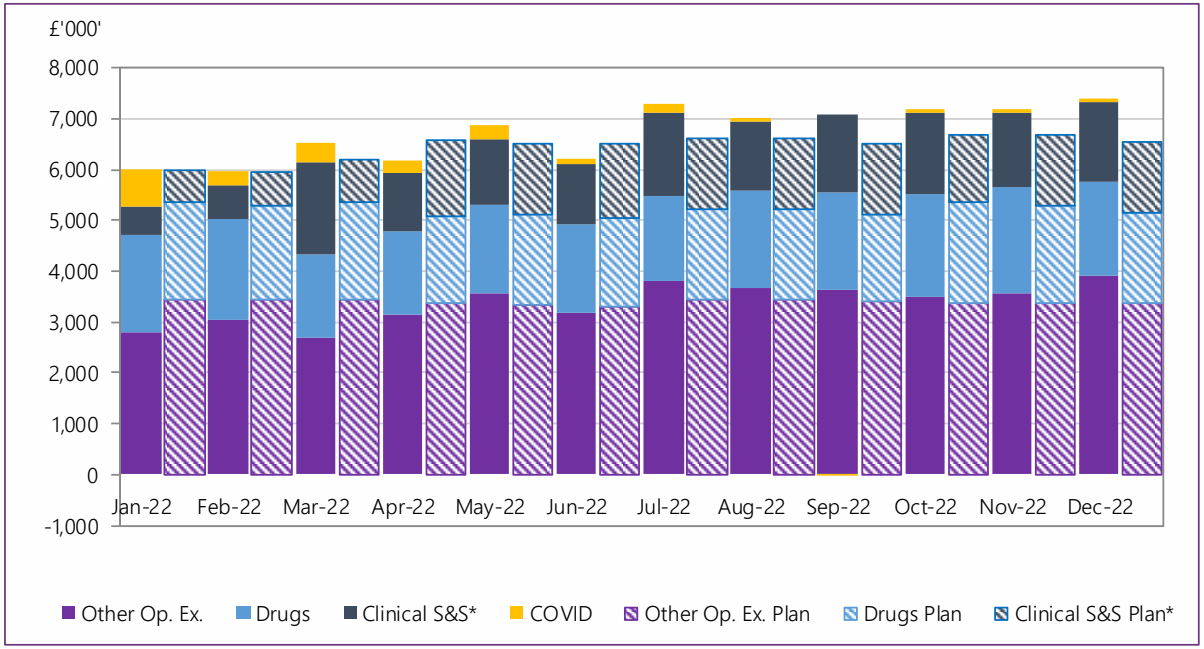
Other - expenditure remains high in ED, General Wards, Theatres, ICU, Ward 10 and Midwifery. Agency and bank usage has reduced in month but remains above plan, with the main changes in booking reasons due to a reduction in shifts due to vacancies. £0.155m movement in month for the provision of outstanding leave for the additional bank holiday to be taken before end March 23.

Group operating expenditure

December 2022

vs Plan in month	£0.863m adverse
vs Plan YTD	£3.133m adverse

£'m	Variance to Plan fav/(adv) In month	YTD
Clinical Supplies & Services	(0.230)	(1.114)
Drugs	(0.099)	(0.429)
Other Operating Expenditure	(0.534)	(1.590)
Total	**(0.863)**	**(3.133)**



*From Apr-22 category changed to allign to NHSE/I reporting, 2021/22 months data relates to consumables only

Key headlines:

Clinical Supplies & Services - Overspends in pathology testing (excl COVID costs) still seen from high non-elective demand. Variance also includes private patient medical LLP costs (offset by income) and £0.569m adverse YTD from virus testing expenditure funded by additional income outside the funding envelope.

Drugs - YTD underspend on high cost/pass-through drugs matched by lower income. Remaining adverse variance is reflecting increased activity and escalation areas causing higher than planned spend on in-tariff funded drugs.

Other Operating Expenditure - adverse variances include provisions (catering) driven by escalation and prices, high non-elective activity impact on elective recovery expenditure and one-off system costs in year to date. Underspends continue within recruitment (overseas recruitment, offset by lower income), IT software and rents (due to recategorisation of leases).

All Commissioners Activity & Income

Table based on full PBR for actual activity and income for all commissioners.
Will not reconcile to the financial position of the Trust which reflects the block income arrangements in place.

ACTIVITY					December 2022	INCOME £'000'				
2022/23 Annual Plan	2022/2023 YTD Plan	YTD Actual	YTD Variance fav/(adv)	% variance against plan		2022/23 Annual Plan	2022/2023 YTD Plan	YTD Actual	YTD Variance fav/(adv)	% variance against plan
					Split by Commissioner					
1,133,099	846,003	1,019,265	173,262	20.5%	Somerset (Including NCA activity)	*162,457*	121,939	124,248	2,309	1.9%
54,603	40,835	41,570	736	1.8%	Dorset	*19,891*	14,928	14,927	(0)	(0.0%)
18,338	13,709	16,620	2,911	21.2%	NHS England (Including Military) Activity	*4,266*	3,195	4,015	820	25.7%
					NHS England (Including Military) Drugs	*8,074*	6,082	6,304	222	3.6%
1,206,040	**900,547**	**1,077,455**	**176,908**	**19.6%**	**Total All Activity**	**194,689**	**146,143**	**149,494**	**3,351**	**2.3%**

** Note: the table is reflective of a PbR position and does not consider Commissioner activity challenges, however these changes would not be financially material. This activity is costed at 2022/23 final tariff and includes all additional inflation changes.*

Key headlines:

Indicative Activity Plans (IAPs) have been submitted to all CCGs broadly aligned to trajectories submitted for the Trust wide activity plans. Further metrics were used for waiting lists and Emergency Care that are not reflected fully in these IAPs. Work will be carried out with CCGs to develop these plans throughout 2022/23.

Block contracts have been agreed system wide, however further associated activity from in-year businesses planning, safety, COVID and ESRF is monitored through the associated Elective & Urgent Care Delivery Boards to help inform work on 2023/24 plans.

YTD activity is 176,908, 19.6% over plan, with income £3.351m, 2.3% over indicative plan. This activity variance is mainly due to pathology overachievement of 161,745 to date. Income key variances are emergency excess beddays of £2.053m and critical care discharges of £0.783m over plan to date. Income has also been updated to the latest consultation tariff to include adjustment for pay inflation and NI reduction.

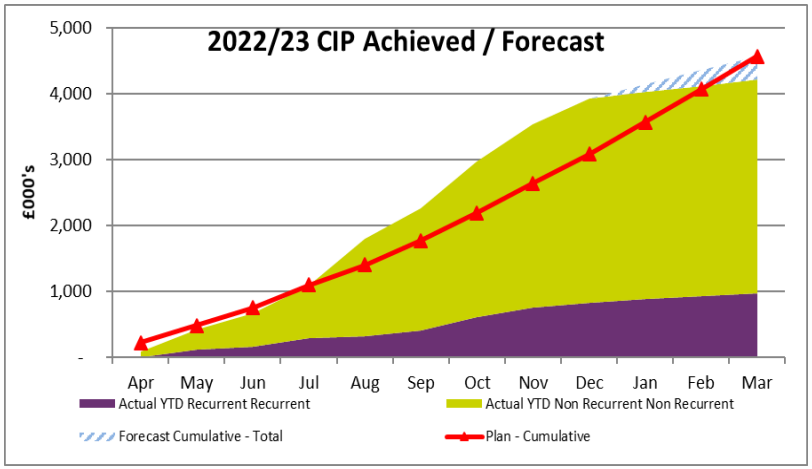
Group activity summary

December 2022			YTD		
Actual	Plan	Variance fav/(adv)	POD (groups)	Actual	Plan	Variance fav/(adv)
1,079	1,359	(280)	Daycase	11,984	12,773	(789)
127	222	(95)	Electives	1,384	2,086	(702)
2,210	2,219	(9)	Non-Elective	18,789	19,681	(892)
4,017	4,164	(147)	Outpatient Firsts	42,698	39,145	3,553
10,006	10,199	(193)	Outpatient F-Up	99,782	95,870	3,912
97,766	78,180	19,586	Other	902,818	730,992	171,826
115,205	**96,343**	**18,862**	**Total**	**1,077,455**	**900,547**	**176,908**

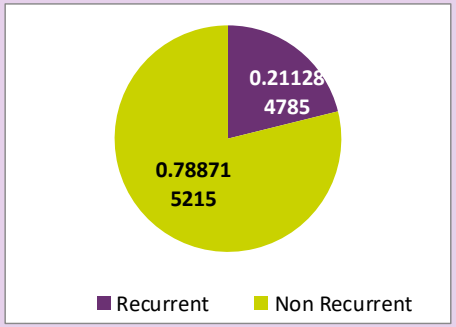
Key notes:

1. Excess beddays activity NOT included.
2. Maternity deliveries have been included.
3. Outpatient procedures included as FA/Fup attendance
4. Non-face to face attendances included as FA/Fup

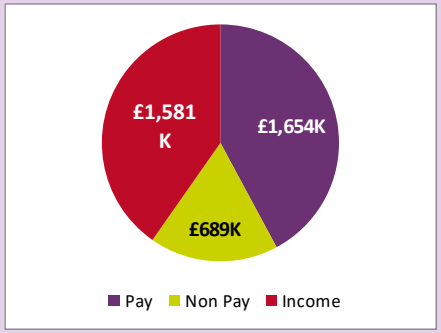
Trust CIP summary



Recurrent v Non Recurrent Savings (YTD)



Savings type (YTD)



Category	In Month					Year To Date						Forecast Outturn			
	Actual Recurrent	Actual Non Recurrent	Total Achieved	Plan	Variance	Actual Recurrent	Actual Non Recurrent	Total Achieved	Plan	Variance	Full Year Plan	FOT recurrent	FOT non recurrent	Forecast outturn total	Variance - Forecast outturn v Plan
Corporate	41	197	238	81	157	520	738	1,258	615	643	878	642	834	1,476	599
Elective Care	11	34	45	116	(71)	169	513	682	718	(36)	1,138	184	633	817	(321)
Urgent Care	6	55	61	150	(90)	39	1,173	1,212	893	319	1,400	54	1,248	1,303	(98)
SHS	0	(16)	(16)	35	(51)	0	367	367	441	(74)	546	0	367	367	(179)
SSL	14	55	70	61	9	102	303	405	411	(6)	600	177	423	600	(0)
Total	**72**	**325**	**397**	**443**	**(46)**	**829**	**3,095**	**3,924**	**3,078**	**846**	**4,562**	**1,058**	**3,505**	**4,563**	**1**

Forecast outturn is £1.058m recurrent CIP (23%) vs a £4.562m plan, however it was assumed within the plan that £3.562m would be delivered recurrently (therefore 30% FOT is against that plan)

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Somerset NHS Foundation Trust Finance Report – Month 9
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Assistant Directors - Financial Management/Financial Servs Deputy Chief Finance Officer
PRESENTED BY:	Chief Finance Officer
DATE:	7 February 2023

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

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

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

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

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

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

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
N/A

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

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

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

SOMERSET NHS FOUNDATION TRUST

FINANCE REPORT TO 31 DECEMBER 2022

1. SUMMARY

1.1 In December 2022, the Trust recorded a surplus of £0.409m which was in-line with the plan for the month. Cumulatively, the Trust has a deficit of £2.955m, which is £0.863m adverse to plan.

1.2 Escalation costs in month were £1.238m and have been funded by the Integrated Care Board (ICB) from system contingency monies. As anticipated, costs in December 2022 showed a marked increase (£0.223m) which reflected the unprecedented level of pressure on services throughout the month. There is an ongoing process in place with the ICB to agree and fund the impact of escalation for the remainder of the financial year.

1.3 Vacancies, sickness and escalation continue to drive very high levels of agency and locum usage. December expenditure was £3.2m, an increase of £0.3m on November levels. Cumulatively the Trust has spent £22.8m on agency and locums which is £6.4m above the equivalent 2021/22 period.

1.4 Capital expenditure is £22.5m cumulatively compared with the plan of £37.7m. Spend continues to fall behind plan although the reprofiling of central funding for the Surgical Centre has recently been confirmed by NHSE which removes the risk of a significant undershoot on this scheme in year and pressure in subsequent years. Further schemes have been identified to ensure the capital resources are fully utilised by year end.

1.5 The CIP shortfall continues to reduce and work is continuing with services to close the remaining gap.

1.6 Appendix 1 provides an executive summary of key financial information.

2. INCOME AND EXPENDITURE

2.1 Table 1 below sets out the summary income and expenditure account to 31 December 2022: -

Table 1: Income and Expenditure Summary

Statement of Comprehensive Income	Annual Plan £000	Current Month 9			Year to date		
		Plan £000	Actual £000	Fav./ (Adv.) Variance £000	Plan £000	Actual £000	Fav./ (Adv.) Variance £000
Income							
NHS clinical income	594,754	49,560	55,564	6,004	446,048	472,374	26,327
Non-NHS clinical income	3,165	264	249	(15)	2,375	2,511	136
Non-clinical income	37,628	3,133	5,110	1,976	28,226	39,203	10,976
Total operating income (excl STF)	**635,547**	**52,957**	**60,923**	**7,966**	**476,648**	**514,088**	**37,439**
Employee expenses	(436,147)	(35,840)	(40,021)	(4,181)	(328,836)	(344,564)	(15,728)
Drugs	(37,828)	(3,214)	(4,213)	(999)	(28,495)	(35,487)	(6,992)
Clinical Supplies	(34,557)	(2,936)	(3,562)	(626)	(26,032)	(28,143)	(2,110)
Non-clinical supplies	(86,070)	(7,142)	(9,569)	(2,427)	(64,654)	(79,906)	(15,252)
PFI expenses	(3,753)	(313)	(318)	(5)	(2,815)	(2,817)	(2)
Depreciation charges	(27,646)	(2,304)	(2,170)	133	(20,735)	(20,056)	678
Total operating expenses	**(626,000)**	**(51,749)**	**(59,853)**	**(8,104)**	**(471,567)**	**(510,973)**	**(39,406)**
EBITDA	**9,547**	**1,208**	**1,069**	**(138)**	**5,082**	**3,115**	**(1,967)**
Other income	189	16	183	167	141	1,542	1,401
PDC dividend expense	(7,461)	(622)	(675)	(53)	(5,596)	(5,732)	(137)
Other financing costs	(1,893)	(174)	(97)	77	(1,372)	(2,217)	(844)
Overall Surplus/(Deficit) after PSF	**381**	**428**	**481**	**53**	**(1,745)**	**(3,292)**	**(1,547)**
Adjustments to control total	**(381)**	**(19)**	**(72)**	**(53)**	**(347)**	**336**	**683**
Adjusted Financial Performance	**0**	**409**	**409**	**(0)**	**(2,092)**	**(2,955)**	**(863)**

2.2 The total cost of escalation in month was £1.2m, this was higher than November 2022 and cumulatively totals £6.7m. Escalation costs are primarily the staffing costs of supporting the additional capacity required to manage the ongoing demand and patient flow issues and associated activity driven costs such as pathology, radiology and soft facilities management (laundry, cleaning, catering etc).

2.3 Non pay variances relate predominantly to pass-through and cancer drugs, imaging, pathology, radiology, and diagnostic hub activity – much of which is either offset by additional funding or will be included within the revised block contract.

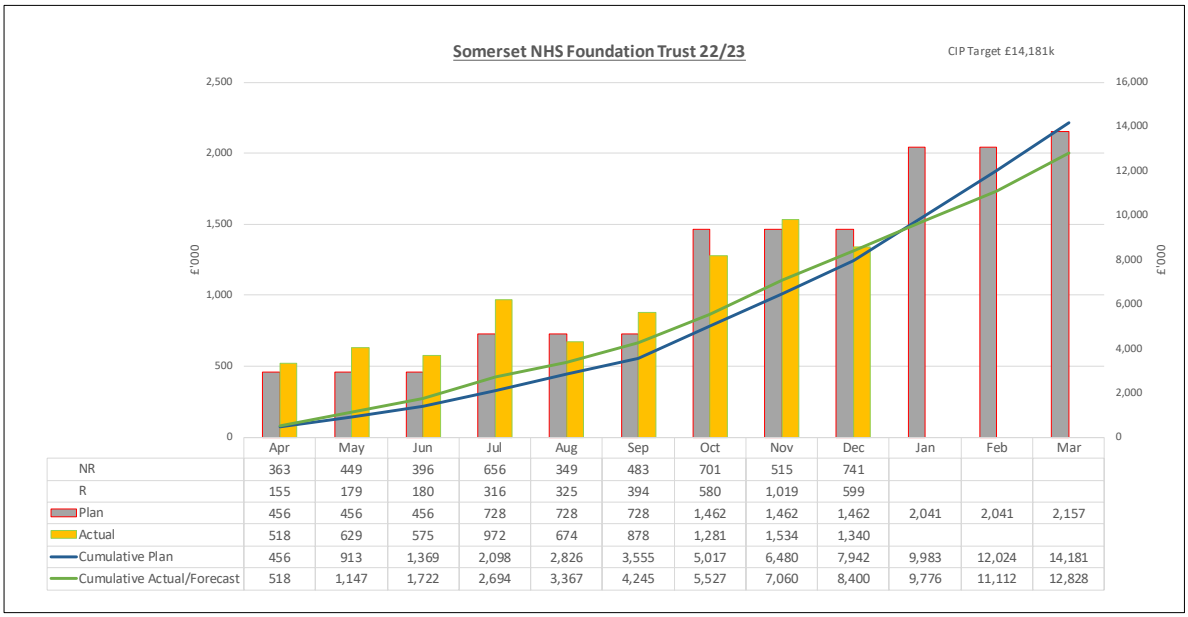
3. COST IMPROVEMENT PROGRAMME

3.1 The Trust has a CIP plan of £14.181m for the year, identifying schemes of this level has been challenging for services as they continue to recover from Covid but also face the day-to-day operational pressures which have been present all year.

3.2 The plan under-achieved in month with savings of £1.340m delivered compared with the plan of £1.462m. Cumulatively, the trust has delivered £8.4m of savings, with £3.7m of recurrent schemes. Through continual reviews the overall forecast outturn has increased by £0.2m to project an annual outturn of £12.8m, with recurrent schemes increasing slightly by £0.050m.

3.3 The December and cumulative CIP performance is shown in Chart 1 below: -

Chart 1: CIP Summary



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NR	363	449	396	656	349	483	701	515	741			
R	155	179	180	316	325	394	580	1,019	599			
Plan	456	456	456	728	728	728	1,462	1,462	1,462	2,041	2,041	2,157
Actual	518	629	575	972	674	878	1,281	1,534	1,340			
Cumulative Plan	456	913	1,369	2,098	2,826	3,555	5,017	6,480	7,942	9,983	12,024	14,181
Cumulative Actual/Forecast	518	1,147	1,722	2,694	3,367	4,245	5,527	7,060	8,400	9,776	11,112	12,828

3.4 The performance to date and forecast delivery by area is set out in Table 2 below: -

Table 2: CIP Detail & Forecast

Somerset NHS Foundation Trust

Cost Improvement Programme 22/23 Trustwide

Directorate	Current Year Plan	Plan to Date	Actual to Date			Projected Out-turn			Forecast Variance	
			R	NR	TOTAL	R	NR	TOTAL	R Shortfall	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Integrated & Urgent Care Directorate	2,088	1,128	166	842	1,008	222	1,046	1,268	(1,866)	(820)
Surgical Directorate	3,090	1,668	450	809	1,259	815	1,169	1,984	(2,275)	(1,106)
Clinical Support & Specialist Services Directorate	2,022	1,254	309	782	1,091	562	1,460	2,022	(1,460)	(0)
MH&LD Directorate	1,157	625	509	183	692	679	568	1,247	(478)	90
Families Directorate	1,307	706	443	776	1,219	653	782	1,435	(653)	129
Operational Management	411	222	88	338	426	118	369	487	(294)	77
Estates	787	425	343	125	467	662	125	787	(125)	0
Primary Care & Neighbourhoods Directorate	1,540	832	396	637	1,034	631	909	1,540	(909)	0
Director of Corporate Governance	160	86	59	48	108	79	80	160	(80)	0
Director of Finance	183	99	66	52	118	150	52	202	(33)	19
Director of Nursing	101	55	25	34	59	40	61	101	(61)	0
Director of People	242	131	53	25	79	71	171	242	(171)	0
Director of Strategic Development	513	277	337	0	337	541	0	541	28	28
Central	582	437	101	401	502	134	679	813	(448)	231
	14,181	**7,942**	**3,346**	**5,054**	**8,400**	**5,357**	**7,472**	**12,828**	**(8,825)**	**(1,353)**

3.5 Clinical areas and corporate functions continue to review their plans to reduce the gap and work will continue Trust wide to identify further opportunities to fully close the remaining gap of £1.353m. It is acknowledged that the remaining savings will predominantly be non-recurrent in nature.

4. CASH FLOW AND BALANCE SHEET

4.1 The Trust ended the month with cash balances of £50.4m at 31 December and is forecasting a year-end balance of £45.4m as set out in table 3 below: -

Table 3: Monthly cash flow

Monthly cash flow and forecast	Dec YTD £000	Jan £000	Feb £000	Mar £000
	Actual	Plan		
Opening Cash Balance	46,253	50,416	51,506	52,095
Surplus/(Deficit) from operations	1,122	753	1,776	2,850
Non-cash flows in operating surplus/(deficit)	2,006	2,451	2,722	569
Operating cash flows before movements in working capital	3,128	3,204	4,497	3,419
Increase/(decrease) in working capital	5,049	(1,159)	(673)	(6,126)
Net cash inflow/(outflow) from operating activities	8,177	2,045	3,824	(2,707)
Capital expenditure	(3,109)	(2,333)	(2,710)	(2,865)
Net cash inflow/(outflow) before financing	5,068	(288)	1,115	(5,572)
Net cash inflow/(outflow) from financing activities	(905)	1,378	(527)	(1,131)
Net increase/(decrease) in cash and cash equivalents	4,163	1,090	588	(6,703)
Closing cash balance	**50,416**	**51,506**	**52,095**	**45,391**

4.2 The Statement of Financial Position is shown in Table 4 below: -

Table 4: Statement of financial position as at 31 December 2022

Statement of Financial Position	Opening Balance 1st April 2022 incl IFRS16	Current Month Actual	Movement in Year	Balance at end of Previous Period	Current Month Actual	Movement	Forecast Outturn	2022/23 Plan	Variance from Plan - Increase / (Reduction)
	£000	£000	£000	£000	£000	£'000	£'000	£'000	£'000
Non Current Assets									
Intangible Assets	20,338	19,868	(471)	19,712	19,868	156	19,882	16,694	3,188
Property, Plant and Equipment, Other	302,139	305,676	3,537	304,294	305,676	1,382	321,805	329,793	(7,988)
On SoFP PFI Assets	21,747	23,304	1,557	23,429	23,304	(125)	23,862	22,107	1,755
Right of Use Assets	28,997	26,393	(2,604)	26,666	26,393	(273)	25,282	25,849	(567)
Investments in Joint Ventures	797	1,026	229	975	1,026	52	1,023	797	226
Other investments/financial assets	161	14	(146)	14	14	0	14	161	(147)
Trade & other Receivables >1Yr	2,669	2,534	(135)	2,555	2,534	(21)	2,555	2,669	(114)
Non Current Assets	**376,849**	**378,815**	**1,966**	**377,645**	**378,815**	**1,170**	**394,423**	**398,070**	**(3,647)**
Current Assets									
Inventories	5,723	7,366	1,642	6,744	7,366	622	6,744	5,723	1,021
Trade and other receivables: NHS receivables	11,399	13,683	2,285	11,591	13,683	2,093	18,591	18,420	171
Trade and other receivables: non-NHS receivables	9,316	11,231	1,915	22,987	11,231	(11,755)	15,987	9,295	6,692
Non Current Assets Held for Sale	15	15	0	15	15	0	0	0	0
Cash	58,729	50,416	(8,313)	46,253	50,416	4,163	45,391	40,025	5,366
Total Current Assets	**85,182**	**82,712**	**(2,470)**	**87,590**	**82,712**	**(4,878)**	**86,713**	**73,463**	**13,250**
Current Liabilities									
Trade and other payables: non-capital	(61,641)	(58,785)	2,856	(58,764)	(58,785)	(21)	(60,897)	(61,529)	632
Trade and other payables: capital	(21,749)	(7,151)	14,599	(7,117)	(7,151)	(34)	(14,617)	(13,948)	(669)
Deferred Income	(6,893)	(21,018)	(14,125)	(24,506)	(21,018)	3,488	(24,506)	(6,893)	(17,613)
Other Liabilities - Other	(259)	(259)	0	(259)	(259)	0	(259)	(259)	0
Borrowings	(7,072)	(5,316)	1,756	(5,415)	(5,316)	99	(4,397)	(6,932)	2,535
Provisions <1yr	(850)	(896)	(47)	(875)	(896)	(21)	(863)	(852)	(11)
Current Liabilities	**(98,464)**	**(93,425)**	**5,039**	**(96,936)**	**(93,425)**	**3,511**	**(105,539)**	**(90,413)**	**(15,126)**
Net Current Assets	**(13,282)**	**(10,713)**	**2,569**	**(9,347)**	**(10,713)**	**(1,366)**	**(18,827)**	**(16,950)**	**(1,877)**
Long Term Liabilities									
Loans >1yr	(47,996)	(44,755)	3,240	(45,412)	(44,755)	656	(44,328)	(41,754)	(2,574)
Provisions >1yr	(3,282)	(3,248)	34	(3,248)	(3,248)	0	(3,248)	(3,182)	(66)
Deferred Income >1yr	(2,200)	(2,006)	194	(2,027)	(2,006)	22	(1,941)	(1,941)	(0)
Total Long Term Liabilities	**(53,478)**	**(50,009)**	**3,468**	**(50,687)**	**(50,009)**	**678**	**(49,517)**	**(46,877)**	**(2,640)**
Net Assets Employed	**310,089**	**318,093**	**8,004**	**317,611**	**318,093**	**482**	**326,080**	**334,244**	**(8,164)**
Tax Payers Equity									
Public Dividend Capital	212,588	224,028	11,440	224,028	224,028	0	229,341	236,356	(7,015)
Revaluation Reserve	77,595	77,595	0	77,595	77,595	0	77,595	77,595	0
Other Reserves	(2,325)	(2,471)	(146)	(2,471)	(2,471)	0	(2,471)	(2,325)	(146)
I&E Reserve	22,231	18,941	(3,290)	18,460	18,941	482	21,615	22,618	(1,003)
Total Tax Payers Equity	**310,089**	**318,093**	**8,004**	**317,611**	**318,093**	**482**	**326,080**	**334,244**	**(8,164)**

5. CAPITAL

5.1 Year to date, capital expenditure is £22.5m compared with the plan of £37.7m, resulting in slippage of £15.2m.

5.2 NHS England (NHSE)/Department of Health and Social Care (DHSC) has granted approval to reprofile the externally funded Surgical Centre scheme. This means current and future years funding will be adjusted to reflect the revised delivery trajectory. This is good news and will avoid a significant financial pressure in future years.

5.3 Robust discussions are being held with capital budget managers to refresh forecast assumptions and determine where slippage can be redeployed to faciliate additional/alternative purchases in year to ensure we maximise the overall envelope. This will happen across YDH and SFT jointly. On this basis, the Trust is

still expecting to fully deliver schemes which will utilise all of the available capital envelope.

5.4 The capital programme summary is set out in table 5 below:-

Table 5: Capital Programme as at 31 December 2022

Acute Programme	Plan £000	Revised Budget £000	YTD Plan £000	YTD Actual £000	Variance v plan £000	FOT
Site Risks / Plant & Equipment	254	254	211	121	(90)	1,261
Site and Service Development	1,200	1,206	1,105	1,469	364	1,640
Total Acute	**1,454**	**1,460**	**1,317**	**1,590**	**274**	**2,901**
Community/Mental Health Programme						
Site Risks / Plant & Equipment	300	265	228	54	(174)	265
Site and Service Development	5,663	6,202	4,693	2,660	(2,033)	5,620
Total Community/Mental Health	**5,963**	**6,467**	**4,921**	**2,714**	**(2,207)**	**5,885**
Trustwide	**£000**	**£000**	**£000**	**£000**	**£000**	
Site Risks / Plant & Equipment	8,642	8,442	6,484	3,563	(2,920)	8,453
Site and Service Development	6,374	6,299	5,156	2,671	(2,485)	5,413
Trustwide	**15,016**	**14,741**	**11,640**	**6,234**	**(5,405)**	**13,866**
Total Internal Capital Envelope	**22,433**	**22,668**	**17,877**	**10,538**	**(7,339)**	**22,652**
Additional Capital Schemes	**£000**	**£000**	**£000**	**£000**	**£000**	
STP 3 - Surgical Centre	20,841	13,350	15,631	10,158	(5,473)	13,350
NHP	1,060	1,060	795	588	(207)	1,060
Cyber Security	94	94	94	99	5	94
MRI Upgrade	0	86	0	86	86	85
Mri Simulator	0	25	0	0	0	25
Digital Maturity	711	0	533	0	(533)	0
Wessex House	0	153	0	132	132	153
Pathology Network	0	964	0	0	0	964
Diagnostic Network	0	397	0	0	0	397
PFI MES Funded IFRIC 12	1,903	1,903	1,427	432	(995)	1,903
Somerset CYP Crisis Accom	0	624	0	4	4	624
Salix	1,062	1,195	797	248	(548)	1,195
Donated	710	710	525	191	(334)	710
Total Additional Schemes	**26,381**	**20,561**	**19,802**	**11,939**	**(7,863)**	**20,560**
Lease Renewals	21	21	14	14	0	35
TOTAL TRUST PROGRAMME	**48,835**	**43,250**	**37,693**	**22,491**	**(15,202)**	**43,247**

6. RISKS AND OUTTURN

6.1 Operational pressures continue to cause the Trust to run high levels of additional escalation capacity to manage urgent care, flow and winter pressures. This has again generated significant additional costs in month which have been funded non-recurrently by the ICB through use of system contingency funds.

6.2 Staffing challenges continue to create financial pressure. Although there is some offset with vacancy savings of substantive posts, the premium cost of agency staff being used in many services more than exceeds this. The monthly directorate review process continues to review the measures and actions being taken to reduce agency usage

6.3 Closure of the CIP gap remains a challenge, but we continue to make progress and are expecting to close the gap and deliver the full plan this year.

6.4 The ICB remain supportive of the Trust should we not be able to mitigate the financial risks by year end.

7. RECOMMENDATION

7.1 The Board is requested to discuss the financial performance for the month ending 31 December 2022.

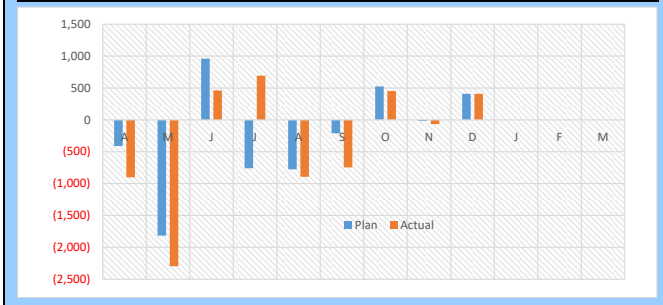
CHIEF FINANCE OFFICER

Appendix 1

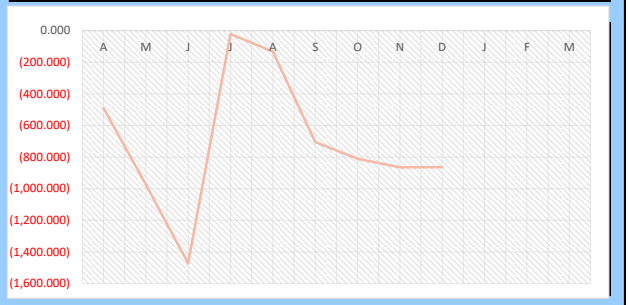
EXECUTIVE SUMMARY AT 31 DECEMBER 2022

Financial Performance	Annual Plan	Current Month 9			Year to date		
		Budget £m	Actual £m	Variance £m	Plan	Actual	Fav/(Adv) Variance
Income	635.5	52.96	60.92	7.96	476.65	514.09	37.44
Expenditure	-626.0	-51.75	-59.85	-8.10	-471.57	-510.97	-39.40
Operating Surplus/(Deficit)	**9.54**	**1.21**	**1.07**	**-0.14**	**5.08**	**3.12**	**-1.96**
Financing costs	-9.16	-0.78	-0.59	0.19	-6.83	-6.41	0.42
Overall Surplus/(Deficit) for the period	**0.38**	**0.430**	**0.48**	**0.05**	**-1.75**	**-3.29**	**-1.54**
Adjustments to financial performance	-0.38	-0.02	-0.07	-0.05	-0.35	0.33	0.68
Adjusted financial performance Surplus/(Deficit)	**0.00**	**0.41**	**0.41**	**0.00**	**-2.10**	**-2.96**	**-0.86**

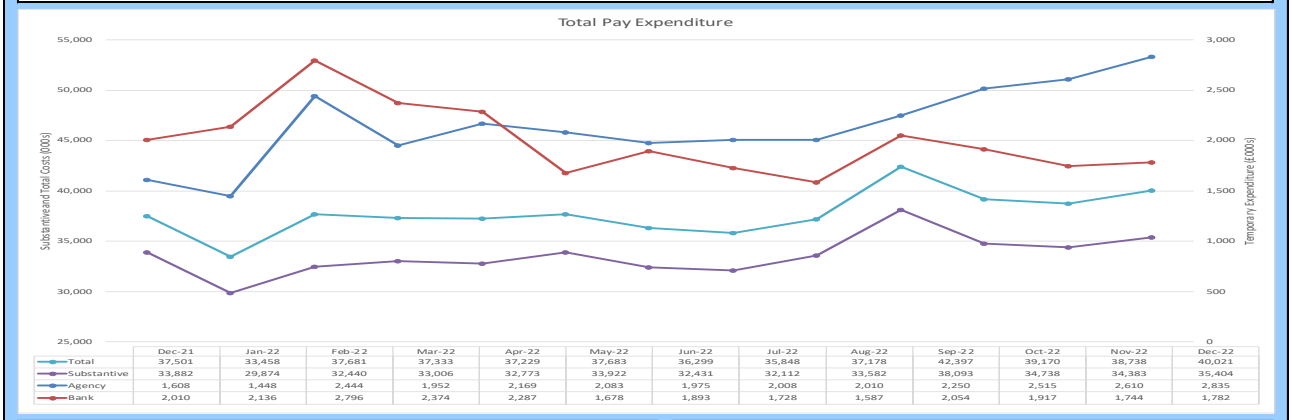
MONTHLY FINANCIAL PERFORMANCE



YEAR TO DATE VARIANCE FROM PLAN

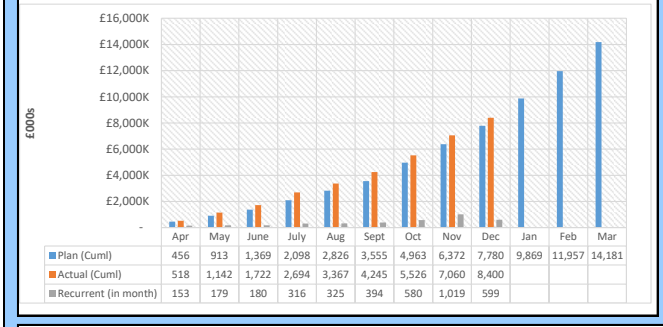


TOTAL PAY EXPENDITURE



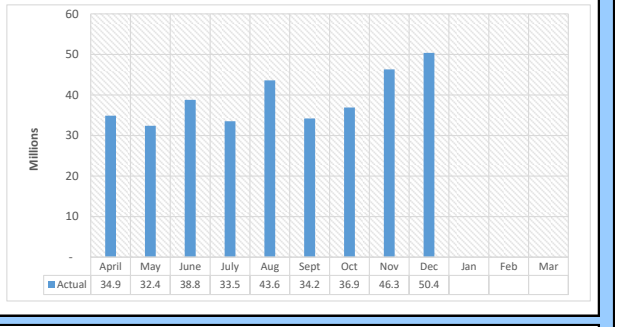
	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Total	37,501	33,458	37,681	37,333	37,229	37,683	36,299	35,848	37,178	42,397	39,170	38,738	40,021
Substantive	33,882	29,874	32,440	33,006	32,773	33,922	32,431	32,112	33,582	38,093	34,738	34,383	35,404
Agency	1,608	1,448	2,444	1,952	2,169	2,083	1,975	2,008	2,010	2,250	2,515	2,610	2,835
Bank	2,010	2,136	2,796	2,374	2,287	1,678	1,893	1,728	1,587	2,054	1,917	1,744	1,782

CIP DELIVERY



	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Plan (Cuml)	456	913	1,369	2,098	2,826	3,555	4,963	6,372	7,780	9,869	11,957	14,181
Actual (Cuml)	518	1,142	1,722	2,694	3,367	4,245	5,526	7,060	8,400			
Recurrent (in month)	153	179	180	316	325	394	580	1,019	599			

CASH BALANCE



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Actual	34.9	32.4	38.8	33.5	43.6	34.2	36.9	46.3	50.4			

COMMENTARY

- A revised financial plan was agreed at the Joint Board meeting on 20 June 2022. The revised plan now means that the system and each organisation will have a balanced position. Escalation pressures continue to have a significant impact on financial performance.

Somerset NHS Foundation Trust/Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Assurance report from the SFT and YDH Audit Committee meetings held in common on 17 January 2023.
SPONSORING EXEC:	Barbara Gregory and Paul Mapson, Chairmen of the Audit Committees
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Barbara Gregory and Paul Mapson, Chairmen of the Audit Committees
DATE:	67 February 2023

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the Audit Committee meetings held on 17 January 2023 and the assurance received by the Committees.
Recommendation	The Board is asked to note the assurance provided and the area of concern identified by the Audit Committees.

Links to Board Assurance Framework and Corporate/Directorate Risk Register (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)

X

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

Details:

Equality

The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics

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

☐ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planning to mitigate any identified inequalities

Public/Staff Involvement History

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

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 assurance report is presented to the Board after every meeting.

Reference to CQC domains (Please select any which are relevant to this paper)

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

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

X

SOMERSET NHS FOUNDATION TRUST/
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

AUDIT COMMITTEE MEETINGS HELD IN COMMON ON 17 JANUARY 2023

1. PURPOSE

1.1 The report sets out the items discussed at the meetings held on 17 January 2023, the assurance received by the Committee and any areas of concern or follow up identified.

2. ASSURANCE RECEIVED

YDH Counter Fraud Progress Report

2.1 The Committees received the counter fraud progress report and noted the proactive work, investigations and performance against the functional standards.

2.2 The Committees noted the proactive exercise in relation to checking attendance of booked temporary ward staff and the reporting of non attendance and the findings of this exercise provided the Committees with significant assurance.

2.3 The Committees agreed that the report provided significant assurance about the work of the counter fraud service.

SFT Counter Fraud Progress Report

2.4 The Committees received the counter fraud progress report and noted the proactive work, investigations and performance against the functional standards.

2.5 The Committees discussed the findings from the proactive work in relation to mandate fraud, and in particular requests to change suppliers' bank account detail, and agreed that the actions taken provided the Committees with assurance.

SFT Counter Fraud Recommendations Tracker

2.6 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.

National Proactive Exercise – Covid-19 Post Event Assurance

2.7 The Committees received the joint report and noted the findings of the national exercise. The Committees agreed that the findings had not highlighted any areas of concern.

Internal Audit progress report - YDH

2.8 The Committees received the internal audit progress report and agreed that good progress was being made.

2.9 The Committees received the internal audit recommendations follow up report and noted that no recommendations were overdue.

2.10 The Committees agreed that the report provided significant assurance.

Key Financial Systems – SFT and YDH

2.11 The Committees received the audit report and noted that the report provided substantial assurance for design and design effectiveness.

2.12 The Committees agreed that the findings provided significant assurance.

HFMA Financial Sustainability audit report – SFT and YDH

2.13 The Committees received the internal audit reports and agreed that the findings demonstrated a good level of understanding and awareness.

2.14 The Committees agreed that the audits had not identified any areas of concern and this provided the Committees with significant assurance.

Internal Audit progress report - SFT

2.15 The Committees received the internal audit progress report and agreed that good progress was being made.

2.16 The Committees agreed that the report provided significant assurance.

Health and Wellbeing - SFT

2.17 The Committees received the audit report and noted that the report provided moderate assurance for design and design effectiveness.

2.18 The Committees agreed that the findings and the actions being taken to address the recommendations provided the Committees with good assurance.

Cyber Security - SFT

2.19 The Committees received the audit report and noted that the report provided substantial assurance for design and moderate assurance for design effectiveness.

2.20 The Committees agreed that the findings and the implementation of the medium priority recommendation provided the Committees with significant assurance.

Clinical Validation of Waiting Lists - SFT

2.21 The Committees received the audit report and noted that the report provided moderate assurance for design and design effectiveness.

2.22 The Committees agreed that the findings and the actions identified to implement the recommendations provided the Committees with good assurance.

Mental Health Review - SFT

2.23 The Committees received the audit report and noted that the report provided moderate assurance for design and design effectiveness.

2.24 The Committees agreed that the findings and the actions identified to implement the recommendations provided the Committees with good assurance. The Committees agreed to ask the Mental Health Act Committee to review the audit report.

Internal audit follow up report - SFT

2.25 The Committee received the internal audit recommendations follow up report and noted that all 2021/22 recommendations had been completed.

YDH and SFT External Audit Progress Report and Technical Update

2.26 The Committees received the external audit progress report and noted the work completed since October 2022 and the work to be completed over the next quarter.

Audit Plan 2022/23 – YDH and SFT

2.27 The Committees received the YDH and SFT audit plans.

Losses and Special Payments – SFT and YDH

2.28 The Committees received the losses and special payments report and noted the reasons for the losses and special payments.

2.29 The Committees agreed that the reports did not highlight any areas of concern.

Single Quotation/Tender Waiver Action report

2.30 The Committees received the single quotation/tender waiver action report and noted the single quotation and tender waiver actions and the reasons for these actions.

3. AREAS OF CONCERN/FOLLOW UP

Board Assurance Framework

3.1 The Committees discussed the Board Assurance Frameworks (BAF) and noted that the actions had been updated.

3.2 The Committees noted that the majority of the RAG ratings had remained unchanged and that this was a reflection of the ongoing pressures. The Committees further noted that there was a duplication of risks as the same risks were included on the SFT and YDH BAFs. The BAFs and risks will be aligned following the merger.

3.3 The Committees agreed that, due to the number of amber and red rated strategic risks, the Committees were only able to provide the Board with limited assurance about the management of strategic risks.

Corporate Risk Register

3.4 The Committees noted the significant number of high risks on the Corporate Risk Register and noted the details of these risks.

3.5 The Committees noted the work being undertaken to review the risks across both risk registers with the aim to moving to a single risk register from the date of the merger.

3.6 The Committees received an update on the development of the risk management framework and noted that the framework will be available in draft format by 31 January 2023. Discussions were also taking place about the development of an ICS system risk register.

3.7 The Committees noted that the finance risks will be discussed at the next Finance Committee meeting and it was expected that a number of the finance risks can be reduced in view of an improved financial position.

3.8 The Committees agreed that the risk register provided assurance about the management of the majority of risks but the Committee felt that the level of assurance about the workforce and pay controls and risks was limited.

3.9 The Committees discussed the role of the People Committee in reviewing workforce related controls and risks and agreed that the Committee was more strategically focussed. The Committees agreed that, although oversight could be provided by both the People and Quality and Governance Assurance Committees, it will be important to be clear about the oversight arrangements.

SFT Counter Fraud Progress Report

3.10 The Committees noted the exercise undertaken to check agency invoices and rates charged by agencies and noted the significant overcharging particular by one agency. The Committees noted the difference in controls between YDH and SFT and further noted that more checks will be carried out over the next year. The Committees agreed that the split between timesheet and invoice approval processes was a concern and noted that actions will be taken to address these control issues.

National Proactive Exercise – Purchase Orders (POs) s versus non Purchase Orders

3.11 The Committees received the joint report and noted that the data was based on 2019/20 and therefore did not reflect the improvements made to processes over the last 12 months.

3.12 The Committees noted that both PO and non PO invoices were subject to robust checks.

3.13 The Committees agreed that it will not be practical for POs to be set up for all expenditure, e.g. utilities, but assurance will need to be provided that current practices were appropriate. The Committees noted that this will be followed up with SSL and with the Finance Committee.

Payroll Overpayment - SFT

3.14 The Committees received the audit report and noted that the report provided moderate assurance for design and limited assurance for design effectiveness.

3.15 The Committees noted that the main reason for overpayments related to the late submission of termination forms to payroll. The Committees asked for information on outstanding payments and amounts paid to be provided to the next Audit Committee meeting.

3.16 The Committees expressed their concern about these findings and, as the reason for the overpayments was workforce related, agreed to share the audit report with the People Committee.

4. RISKS

4.1 The Committees identified the following risks to be reported to the Board:

- the number of amber and red rated strategic risks
- the high number of workforce related risks
- the gaps in agency invoice checking controls
- the late submission of colleague termination forms to payroll

CHAIRMEN OF THE AUDIT COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	The Trust Board
REPORT TITLE:	Assurance Report from the Mental Health Act Committee meeting held on 13 December 2022
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Alexander Priest, Chairman of the Mental Health Act Committee
DATE:	7 February 2023

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the Mental Health Act Committee meeting held on 13 December 2022 and the assurance received by the Committee. The meeting was conducted as a video conference call. The Committees received assurance in relation to: • the Mental Health Lead report • the update on MCA, DoLs and LPS • the update on the Approved Mental Health Professional (AMHP) Services • the update from Sawn Advocacy • the Care Quality Commission Compliance Visits • CAMHs out of area placements • Out of Area Treatment for Somerset Patients • Complaints and Issues • The review of the Section 17 Leave Policy

	• The Risk Register The Committees identified the following areas of concern or follow up: • Mental Health Lead report – follow up in relation to the SAR review finding – recording of assessments • the update on the Approved Mental Health Professional (AMHP) Services – timing of assessments and bed capacity • Update from the ICB Commissioning Manager – the delays in the development and approval of the Section 117 funding policy • Out of Area Treatment Somerset (OATS) patients – the mixed sex safety issues in a mixed PICU ward • Clinical Audit planning – recommendations for the internal audit plan for 2023/24 The Committee identified the following risks or issues to be reported to the Board and/or Board Committees • Mental Health bed pressures and delayed discharges • Timing for assessment under the MHA taking into consideration bed availability • A review is required into the mitigations for admission of patients with sexual safety issues onto a mixed PICU.
Recommendation	The Board is asked to note the assurances and the areas for follow up identified by the Committee. The Board is further asked to note the risks or issues to be reported to the Board.

Links to Joint Strategic Objectives (Please select any which are impacted on / relevant to this paper)
☐ Obj 1 Improve health and wellbeing of population
☐ Obj 2 Provide the best care and support to children and adults
☐ Obj 3 Strengthen care and support in local communities
☒ Obj 4 Reduce inequalities

☐ Obj 5	Respond well to complex needs
☒ Obj 6	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☐ Obj 7	Live within our means and use our resources wisely
☐ Obj 8	Develop a high performing organisation delivering the vision of the Trust

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

Details:

Equality

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

☐ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planning to mitigate any identified inequalities

Public/Staff Involvement History

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

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 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

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 13 December 2022, the assurance received by the Committee and any areas of concern identified.

2. ASSURANCE AND UPDATES RECEIVED

Mental Health Lead report

2.1. The Committee received the report of the Mental Health Lead and noted:

- The publication of the Care Quality Commission annual report and the publication of NHS official statistics about the use of the Mental Health Act.
- The reinstatement of face to face tribunals for patients requesting this.
- The good progress made in relation to training, including hospital managers panel chair training, and the ongoing network and support arrangements for ward colleagues.
- The recording of detentions in acute services and the follow up of these recordings to ensure that referrals were made to Advocacy services and that checks on the provision of S132 information were conducted.
- The ongoing work in relation to improving the recording of Section 17 leave.
- The number of overdue Second Opinion Appointed Doctor (SOAD) requests and the need to improve processes to avoid any overdue requests.
- The delay in the development of the S117 protocol and standard operating processes.
- That the average detention rate had remained stable over the last six months.
- The improvement in the number of Section 136 patients being transferred directly to mental health wards. The Committee further noted the control room triage work undertaken by Avon and Wiltshire NHS Foundation Trust (AWP) in the Bristol area and the positive impact on the diversion rate. The Trust used a

different model to respond to Section 136s but a conversation about the model used by AWP had been requested.

2.2. The Committee agreed that the report provided significant assurance about the work taking place and compliance with the Act and Code of Practice.

Update on MCA, DoLs and LPS

2.3. The Committee received the report and agreed that the report provided positive assurance.

2.4. The Committee approved an extension to the date of the existing Mental Capacity Assessment policy.

Update on Approved Mental Health Professional (AMHP) Services

2.5. The Committee noted that the AMHPs had moved to a new contract and rota which provided more equitable cover across the week.

2.6. The Committee noted that the new secure transport provision had been put in place and that this will require time to become fully embedded. Response timescales were improving and the relationship was developing but there remained challenges accessing secure transport and a meeting with the transport provider had been set up.

Swan Advocacy

2.7. The Committee received an update from Swan Advocacy and noted the positive progress made in how advocacy services were working in Somerset.

2.8. The Committee noted that no themes or issues to be raised with the Committee had been identified. The Committee received significant assurance about the work of Swan Advocacy in supporting patients.

Care Quality Commission MHA Compliance Visits

2.9. The Committee received the report on the St Andrews Ward MHA compliance visit and noted that no compliance actions had been identified and that the report included really positive comments from patients.

2.10. The Committee received the report on the Rydon Ward 2 MHA compliance visit and noted the positive feedback as well as the challenges relating to capacity assessments; translating risk assessments; and meaningful activities and engagement with patients on the ward. The Committee was assured by the work taking place to address the issues, especially the appointment of two new occupational therapists.

2.11. The Committee noted that the Care Quality Commission's report into adult mental health inpatient services will be published in January 2023.

CAMHS

2.12. The Committee received an update on child and adolescent mental health services (CAMHS) out of area placements and noted that three CAMHS patients had been placed out of area into specialist eating disorder

services. The report provided the Committee with significant assurance.

Out of Area Treatment Somerset (OATS) patients

2.13. The Committee received a report on the number of OATS patients and noted that numbers remained low. 14 patients were currently detained under the MHA and placed out of county under a planned admission.

2.14. The Committee agreed that the report provided significant assurance about the process for preventing and monitoring patients with mental health issues having to be placed out of area. The Committee noted the reasons for the out of area placements.

Complaints and Issues

2.15. The Committee received the report setting out the complaints and issues received and resolved by the Trust in relation to patients under the MHA during the period 1 September 2022 to 5 December 2022 and noted that three new complaints had been received during this period. The Committee noted that three complaints remained open.

2.16. The Committee noted that access to Section 17 leave was a factor in two of the complaints and the details of all complaints were noted.

2.17. The Committee further discussed the Independent Investigation into a homicide and noted that the report will be published in early 2023.

2.18. The Committee agreed that the report provided significant assurance about the complaints and PALs and serious investigation processes.

Section 17 Leave Policy

2.19. The Committee received an update on the review of the Section 17 leave policy and noted the changes to the policy. The Committee further noted that the policy did not cover times of acuity when patients will not be able to go out as much as they would want and noted that this can be covered by way of an escalation process.

Risk Register

2.20. The Committee received the Mental Health and Learning Disability directorate risk register and noted the high rated risks. The Committee noted that staffing remained the key challenge but that this was an improving position.

2.21. The Committee noted the actions taken to mitigate risks.

3. AREAS OF CONCERNS/FOLLOW UP

Update on MCA, DoLs and LPS

3.1. The Committee received an update on the findings of the Safeguarding Adults Review (SAR) and noted that the findings will be presented to the Safeguarding Committee and to the Quality and Governance Assurance Committee. The Committee further noted that the recommendations set out in the SAR had been implemented. The

Committee agreed that the review findings provided positive assurance about the assessment but negative assurance about the recording of the assessment. The Committee asked for a progress report to be presented to the next Committee meeting.

Update on Approved Mental Health Professional (AMHP) Services

3.2. The Committee noted the challenges faced by AMHPs to secure inpatient beds for mental health patients due to the delays in discharges and the potential increase in the number of patients having to be transferred to an out of area placement.

3.3. The Committee noted the ongoing challenges faced by AMHPs when assessing detained patients on a Section 136 in the emergency department and further noted the bed capacity challenges and the impact this could have on the timing of the assessment. The Committee noted that assessments of patients not requiring an inpatient bed could be undertaken quicker than assessments requiring an inpatient bed.

Update from the ICB Commissioning Manager

3.4. The Committee did not receive a formal update but noted that Section 117 funding was discussed at the complex case panel on a weekly basis. The panel included representatives from the local authority, ICB and SFT. The Committee noted the potential different funding decisions for detained and non detained patients.

3.5. The Committee noted the delays in the development and approval of the Section 117 funding policy and protocol and the lack of a local framework and clear guidance. The Committee further noted the work taking place within the ICB to develop a system approach.

Out of Area Treatment Somerset (OATS) patients

3.6. The Committee noted that three patients were currently inappropriately placed in out of areas placements due to challenges placing patients in a mixed sex PICU ward. A review into the mitigations for admission of patients with sexual safety issues onto a mixed PICU will need to be undertaken and a report on processes and frameworks in place to ensure the safety of all patients on a mixed sex ward will be presented to the next Committee meeting.

Clinical Audit Planning

3.7. The Committee noted that Section 132 compliance, Section 17; and Capacity and Consent had been audited in 2022. The Committee noted that all recommendations from the Section 132 audit had been implemented and that work on the implementation of the Section 17 and Capacity and Consent recommendations was ongoing.

3.8. The Committee agreed to recommend that Capacity; Discharge Planning; and Section 17 audits were included in the 2023/24 audit plan.

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

4.1 The Committee identified the following risks or issues to be reported to the Board and/or Board Committees

- Mental Health bed pressures and delayed discharges
- Timing for assessment under the MHA taking into consideration bed availability
- A review is required into the mitigations for admission of patients with sexual safety issues onto a mixed PICU.

Alexander Priest
CHAIRMAN OF THE MENTAL HEALTH ACT COMMITTEE