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

NHS Somerset NHS Foundation Trust

SOMERSET NHS FOUNDATION TRUST
PUBLIC BOARD MEETING

A Public meeting of the Somerset NHS Foundation Trust Board will be held on **Tuesday 9 May 2023** at **9.00am** at the **Education Suite, South Petherton Community Hospital , Bernard Way, TA13 5EF**

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

Yours sincerely

COLIN DRUMMOND
CHAIRMAN SFT

AGENDA

		Action	Presenter	Time	Enclosure
1	**Welcome and Apologies for Absence**		Chairman	09:00	Verbal
2	**Questions from Members of the Public and Governors**		Chairman		Verbal
3	**Minutes of the Somerset NHS Foundation Trust's Public Board Meetings:** • Public Board - 7 March 2023 • Extra Ordinary Board - 20 March 2023	Approve	Chairman		Enclosure A Enclosure B
4	**Minutes of the Yeovil District Hospital NHS Foundation Trust's Board Meetings:** • Public Board - 7 March 2023 • Extra Ordinary Board - 20 March 2023	Approve	Chairman		Enclosure C Enclosure D
5	**Action Logs and Matters Arising**	Review	Chairman		Enclosure E
6	**Registers of Directors' Interests and Receive any Declarations of Interests relating to items on the Agenda**	Note & Receive	Chairman		Enclosure F
7	**Chairman's Remarks**	Note	Chairman		Verbal
8	**Chief Executive and Executive Directors' Report**	Receive	Peter Lewis	09:10	Enclosure G

ALL OBJECTIVES					
9	**Board Assurance Framework and Q4 2022/23 Corporate Risk Register Report**	Receive	Phil Brice	09:20	Enclosure H
OBJECTIVE 3 – Patient Story and Clinical Topic					
11	**Patient Story and Clinical Topic** *"A year in the life of Mike – a story of one man's journey through healthcare and challenging the norm"*	Receive	Fiona Green	09:40	Presentation
OBJECTIVE 2 – Provide the best care and support to people					
12	**Assurance Report of the Quality and Performance/Governance and Quality Assurance Committee meeting held on 29 March 2023**	Receive	Jan Hull	10:10	Enclosure J
13	**Learning from Deaths Framework: Mortality Review Progress Reports:** YDH & SFT	Receive	Paul Foster	10:15	Enclosure K Enclosure L
OBJECTIVE 4 – Reduce Inequalities					
14	**Assurance Report of the Mental Health Act Committee meeting held on 14 March 2023**	Receive	Alex Priest	10:20	Enclosure M
Coffee Break 10:25 - 10:35					
OBJECTIVE 6 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture					
15	**Assurance Report of the People Committee meeting held on 8 March 2023**	Receive	Graham Hughes	10:35	Enclosure N
16	**Guardian of Safe Working for Postgraduate Doctors Reports** • YDH • SFT	Receive	Dan Meron	10:40	Enclosure O Enclosure P
17	**Six-Monthly Wellbeing Guardian Report**	Receive	Graham Hughes	10:45	Enclosure Q
18	**Six-Monthly Inclusion Report**	Receive	Harriet Jones Kirstie Lord	10:55	Enclosure R

OBJECTIVE 8 – To develop a high performing organisation delivering the vision of the Trust

19	**Quality and Performance Exception Reports** • YDH • SFT	Receive	Pippa Moger	11:05	Enclosure S Enclosure T
20	**Reports on the Merger between Yeovil District Hospital NHS FT and Somerset NHS FT** • Merger update • NHSE Action Plan	Receive	David Shannon	11:15	Enclosure U1 Enclosure U2

OBJECTIVE 7: To live within our means and use our resources wisely

21	**Verbal report from the Finance Committee meeting held on 24 April 2023**	Receive	Kate Fallon	11:25	Verbal
22	**Assurance Report of the Audit Committee meeting held on 13 April 2023**	Receive	Barbara Gregory	11:30	Enclosure V
25	**Finance Reports** • YDH • SFT	Receive	Pippa Moger	11:35	Enclosure W Enclosure X
26	**Going Concern Statement**	Approve	Pippa Moger	11:45	Enclosure Y
27	**2023/24 Revenue Budget**	Approve	Pippa Moger	11:50	Enclosure Z

FOR INFORMATION

28	**Follow up questions from the Public and Governors**	Chairman	12:00	Verbal
29	**Any other Business**	All		Verbal
30	**Risks Identified**	All		Verbal
31	**Evaluation of the Effectiveness of the Meeting**	Chairman		Verbal

32 Items to be discussed at the Confidential Board Meetings

The items presented to the Confidential Board include: the Part B Chief Executive report; the Colleague Suspension and Exclusion report; the Independent Homicide report; the Symphony and Simply Serve quarterly highlight reports; the Simply Serve Strategy for 2023-28; the Board certification for the transfer of IT services; and minutes of the joint Finance/Financial Resilience and Commercial Committee meetings held in February and March 2023.

33 Withdrawal of Press and Public

To move that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

34 Date of Next Meeting 12:05

Tuesday 4 July 2023

SOMERSET NHS FOUNDATION TRUST (SFT)
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST (YDH)

PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST BOARD MEETING HELD ON 7 MARCH 2023 BY MS TEAMS

PRESENT

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

IN ATTENDANCE

Graham Hughes	Non-Executive Director, YDH
Paul Mapson	Non-Executive Director, YDH
Meridith Kane	Medical Director for Acute Hospitals
Fiona Reid	Director of Communications
Ben Edgar-Attwell	Deputy Director of Corporate Services
Emma Davey	Director of Patient Experience and Engagement
Charlie Davis	Consultant in Palliative Medicine
Catherine Leask	Consultant in Palliative Medicine
Jo Morrison	Consultant Gynaecological Oncology
Robert Lutyens	Nurse Consultant Palliative Care and End of Life
Kirstie Lord	Assistant Director People Services
Samantha Hann	Head of Health Safety and Risk
Caroline Sealey	Freedom to Speak Up Guardian
Alison Wootton	Deputy Chief Nurse SFT
Ria Zandvliet	Secretary to the Trust (minute taker)
Governors	
Ian Hawkins	Lead Governor, SFT/Governor, YDH
Kate Butler	Deputy Lead Governor, SFT

Jane Armstrong	Governor, SFT
Tony Robinson	Governor, YDH

1.	**APOLOGIES**
1.1	There were no apologies.
1.2	The Chairman advised that, following the establishment of a single executive team across both trusts, the SFT and YDH Boards have agreed to conduct their Board of Directors meetings as meetings held in common. The meetings will be chaired by the Chair of either SFT or YDH Chair on a rotation basis and Martyn Scrivens will be chairing this public Board meeting.
1.3	Martyn Scrivens welcomed all Board members, governors, colleagues and other attendees to the meeting and confirmed that both the SFT and YDH meetings were quorate.
2.	**QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS**
2.1	No questions from members of the public or governors had been received.
3.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 7 FEBRUARY 2023**
3.1	Jan Hull proposed, Barbara Gregory seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 7 February 2023 as a correct record.
4.	**MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 7 FEBRUARY 2023**
4.1	The approval of the minutes is reflected in the YDH minutes.
5.	**TO REVIEW THE ACTION LOGS AND MATTERS ARISING**
5.1	The Board received the action log and noted the completed actions.
5.2	There were no maters arising.
6.	**TO NOTE THE REGISTERS OF DIRECTORS' INTERESTS AND RECEIVE ANY DECLARATIONS OF INTERESTS RELATING TO ITEMS ON THE AGENDA**
6.1	The Board received the Register of Directors' interest. There were no changes to the register.
7.	**CHAIRMEN'S REMARKS**
7.1	Martyn Scrivens provided feedback from the Board to Board meeting with NHS England to discuss the proposed merger and advised that the meeting had been

	very positive and feedback about the merger had been encouraging. Martyn Scrivens commented that, based on the feedback received at the meeting, it was reasonable to assume that this will be the last public Board meeting of Yeovil District Hospital NHS Foundation Trust. Martyn Scrivens therefore thanked the Non-Executive and Executive Directors on the Board of Yeovil District Hospital NHS Foundation Trust (YDH) for their extra ordinary efforts in achieving this positive position. Martyn Scrivens further expressed the YDH Board's appreciation and thanks to the Governors.
7.2	Colin Drummond also thanked the YDH Board members and Governors for their fantastic work.
7.3	Colin Drummond provided feedback from a recent meeting with Helen Whately, Minister of State in the Department for Health and Social Care, and advised that he had highlighted the ongoing social care and primary care challenges and the work undertaken by the Trusts (including Sympony). Helen Whately was interested in primary care at scale and Colin Drummond had stressed the need for her to be clear about the "no criteria to reside" issues as resolving these issues will be critical due to the impact on all other services. Colin Drummond advised that the meeting had been positive and that the key challenges had been recognised.
7.4	**Non-Executive Directors Lead Roles** Colin Drummond presented the overview of Non-Executive Director lead roles which was received by the Board. He thanked the relevant Non-Executive Directors for taking on these roles.
8.	**CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT**
8.1	The Chief Executive presented the report which set out a number of significant and positive developments. The report was received by the Board.
8.2	The Chief Executive specifically highlighted the acquisition of surgical robots at both trusts and advised that the surgical robot at Musgrove Park Hospital (MPH) will be funded through a £1.5 million commitment from the Musgrove Park Hospital League of Friends. As a result of this commitment, equivalent capital funding for a surgical robot at YDH had been secured from NHS England. The Board agreed that this was an excellent outcome and thanked the League of Friends for their ongoing support.
8.3	The Chief Executive further highlighted the opening of the new Victoria Park health and wellbeing hub in Bridgwater. The hub, located in the former Victoria Park medical centre building, will provide a range of services for people of all ages, from pre-natal to end of life care. This was an excellent new development as the hub will work with the community, mental health, social care, pharmacy, hospital and voluntary services in the local area to meet the needs of individual patients.

8.4	**Junior Doctor industrial actions** The Chief Medical Officer provided an update on the junior doctor industrial actions scheduled for 13 to 16 March 2023 and advised that robust mitigating actions, led by Dr Meridith Kane, had been developed. The actions recognised the right of junior doctors to strike and were focussed on providing safe care and the highest level of activity as possible. The focus had been on a sustainable response so that actions will be in place in the case of further industrial action. The Chief Medical Officer advised that the actions were based on a collaborative approach, using devolved leadership and governance through service groups. This approach compared well with others trusts and a number of trusts had asked for copies of protocols and processes. He commended Meridith Kane and the medical leadership team on their excellent work. Meridith Kane advised that it was important to note that this was being treated as an extra ordinary event for remuneration and cover purposes to ensure equitable and appropriate rewards across acute and mental health inpatient services.
8.5	The Board discussed the report and commented/noted that: • Barbara Gregory queried whether critical mass for ensuring the delivery of safe services will be available. Meridith Kane advised that assurance had been received that critical mass will be available. The mitigating approach was not based on replacing junior doctors with consultants as the skill set of F1 and F2 level junior doctors was different from consultant skills sets. Mitigations have been identified at service group level and may not be the same for all services. A review of the needs for each service had been undertaken and consideration had been given as to which other staff groups have the required skill set. Meridith Kane advised that the approach used had been positive and learning will be identified and taken into account in workforce planning. Meridith Kane was asked to attend a future People Committee meeting to provide feedback on the learning identified. • February 2023 had focussed on kindness, civility and inclusion and Board members were encouraged to review the tools and resources. The next step will be to embed new values and behaviours. • Industrial actions and patient communications. External communications will clearly set out that the trusts will continue to be able to provide safe services and that anyone who needs help should seek help. It was expected that reactions to the patient communications may be mixed as a number of elective care activities had to be cancelled. It was noted that every affected patient will be contacted individually. Communications had been prepared and will be aligned with national guidance when received. • It was queried whether the morale of senior colleagues and registrars had been affected as a result of the expected industrial actions. Meridith Kane advised that senior consultants and registrars were supportive of the

	industrial actions and the mitigating approach was seen as a positive challenge. • The Victoria Park health and wellbeing hub was run by SFT jointly with the Bridgwater Bay Primary Care Network and staffing was provided through the PCN and the trust. The trust will focus on children and young people and families services as this best fits the local demographics. A community midwife will be based at the hub as well as a number of community services, including mental health and MSK services. • The frailty service at MPH had been reinstated. The service at YDH had been suspended over the last year in view of the need for escalation beds. In addition, it had only been possible to provide the service to a small cohort and, due to the criteria for frailty services, a larger cohort of patients were unable to receive the same level of services. A review of frailty services will be carried out on a countywide basis as it was recognised that frailty may not be just related to age. Post pandemic services were being restored, improvements had been made to services and pathways, and lessons had been learned. A number of alternatives to admission had been set up and looking after frail and elderly people in emergency services in a different way was welcomed. These initiatives were welcomed but it was queried how all the initiatives were linked and whether, if the initiatives were successful, whether they will be rolled out across the county. The Chief Operating Officer commented that a number of the initiatives had been set up by central government and all initiatives had been batched in a slightly different way. He felt that there was a clear oversight of the initiatives and advised that progress was being made in relation to ensuring simplicity and operational smoothness. He recognised that the initiatives could be further joined up and this was part of the work taking place. The Chief Operating Officer suggested including this on a future Board Development Day agenda. **Action: Chief Executive and Director of Corporate Services**.
9.	**PATIENT STORY AND CLINICAL TOPIC ON END OF LIFE SERVICES**
9.1	Charles Davis, Catherine Leask, Robert Lutyens and Jo Morrison joined the meeting for this agenda item.
9.2	The Chief Medical Officer welcomed colleagues from the end of life service to the meeting and expressed his thanks to the team for their ongoing excellent work.
9.3	Charlie Davis and colleagues provided the following overview of end of life services: • The background to end of life services. • The improvements made to the service over the last few years, including the changes to services during the Covid-19 period (65 different projects);

	the growth of the number of consultant wtes within the team; the ongoing merger conversations between the SFT and YDH nursing teams; the dedicated multi-disciplinary education team and the link into directorate type structure for end of life services. • The plan for end of life care – supportive, palliative, end of life care and bereavement care which is everyone's business and is supported, when needed, by specialists. Modest in its work in influencing culture – communication skills; discharge flows; STEP forms and process; caring for the most sick and needy. • The work taking place in South Somerset – joint working with oncology teams in Yeovil due to co-location of community palliative care and oncology at St Margaret's Hospice; the joint work with hospital and community medical teams enabling closer patient follow up regardless of location; pilot of end of life beds in an intermediate care home enabling end of life care for patients out of hospital; cross county end of life education. • The safety and governance aspects of supporting patients and professionals and oversight arrangements. These included relevant policies; updating medical guidance; and robust reporting arrangements. It was noted that the Care Quality Commission inspection had resulted in a "good" rating for safe services and this showed the excellent progress made. • The challenges identified as part of audits – improving end of life care on the wards at Musgrove Park Hospital; opportunities to recognise that a patient was sick enough to die; including carer feedback in consent/training programmes; data collection for the STEP service; data on the use of "Just In Case" medication in the community. • The work in acute and community services - the development of seven day working across both acute sites; the roll out of SIM education; the increased coordination and joint working between acute, community and community hospital services; and the development of bereavement support and feedback. • The challenges as identified from the "flow" in reach pilot and the end of life home care trial and particularly the finding that one in four end of life patients who want to go home will not leave hospital. It was noted that the "flow" pilot had been set up to explore the impact of the delays in social care packages.
9.4	Charlie Davis concluded by stating the importance of having the right people in the right place at the right time to be able to provide the right care.
9.5	The Board discussed the presentation and commented/noted that:

- The overview in terms of how the service had developed and how the different approaches used in the trials had made it more comfortable for patients and their families to deal with this difficult time of life was excellent.

- It was queried whether the application process for continuing care impacted on the ability to transfer patients, who wanted to go home to receive end of life care, to their home within a 24 hour period. Jo Morrison commented that the vision was to move away from a fast track referral process and to do what is the best for the patient with funding arrangements to be agreed separately from the transfer process. This vision will deliver the right care at the right time and will avoid patients being in the wrong place and cared for by the wrong people. Discussions were taking place with the Integrated Care Board on how to achieve this vision. Jo Morrison further highlighted that the trial had highlighted different arrangements in the two acute sites and these arrangements will be harmonised and an increase in resources will help to reduce the number of rejected referrals.

- The team was commended on their focus ensuring that the service was as supportive as possible to patients, their families and colleagues. It was queried at what point a decision was made as to when to start end of life. Charlie Davis commented that end of life did not relate to making a decision as to when someone was going to die but was very much focussed on communications with the patient and their family about the patient's prospects and being clear about expectations. It also related to shared decision making and clearly setting out the reason for treatment, the benefits and risks and being clear that the treatment may not work.

- Complaints about end of life services mainly related to communications and Emma Davey, Director of Patient Safety and Engagement, will be meeting with the end of life team to discuss how best to support people when they have made a complaint and how to manage expectations.

- The presentation provided a useful insight into end of life services and the importance of getting this right. There was a distinction between patients ill enough to die and end of life services. End of life services focussed on points of intervention to improve the quality of life for people in their final years and it was queried whether sufficient skills and resources were available within the team. The response to people ill enough to die will be different and clinical skills will need to be available across all services rather than held within the specialist end of life team.

  Charlie Davis agreed that the latter will require generalist and good communication skills. Audits had identified that although clinical teams were good at clinically recognising that patients were sick enough to die, the ability to discuss this with patients and family could be improved. Funding had been set aside to train a cohort of clinical staff in advanced communication skills. The training was aimed at senior clinicians and registrars' levels and will need to be repeated on a three yearly basis.

	• Clinical cultural change and a change in expectations will be required and it was queried what actions were being put in place to achieve this change in culture and expectations. Charlie Davis commented that any change will be challenging. Almost all of the complaints related to communication and this was the key area for investment in terms of time and resources. Clinicians will need to be provided with an education programme to ensure that they receive the right training and the uptake of training can be linked to the appraisal system. • The work carried out across the trusts by Charlie Davis and the team was excellent. Conversations about breaking the bad news were essential but the required skills were not taught routinely to medical students as part of their training. Learning to deal with bad news and bereavement therefore impacted heavily on junior doctors and medical students and this should also be considered as part of the wellbeing agenda. It was queried how the right training can be incorporated into the wellbeing agenda and mandatory training programme. The Chief of People and Organisational Development agreed to follow this up outside of the meeting. The Chief Nurse advised that education had a clear role in educating clinicians on how to share bad news, but this was also part of supervision and applied to all colleagues. Some professional groups had access to good quality supervision and it will be essential to ensure that colleagues from all professional groups have access to good quality supervision.
9.6	Martyn Scrivens thanked Charlie Davis and colleagues for the excellent presentation and for their commitment to high quality end of life services, patients and colleagues.
10.	**ASSURANCE REPORT OF THE QUALITY AND PERFORMANCE/ GOVERNANCE AND QUALITY ASSURANCE COMMITTEE MEETING HELD ON 25 JANUARY 2023**
10.1	Jan Hull presented the report which was received by the Board. She highlighted the areas of assurance received and the areas to be reported to the Board. These areas related to: • The recommendation for the Chief Executive to sign off the Year 4 MIS declarations for SFT and YDH. • The discussion in relation to the operational pressures - harm, morale injury and risks.
10.2	The Director of Corporate Services advised that a Health and Safety Executive re-inspection had taken place at YDH and it was expected that the findings of the re-inspection will be confirmed by 17 March 2023.

11.	**QUALITY AND PERFORMANCE REPORTS** **Group Board Overview Quadrant – YDH** **Quality and Performance Report – SFT**
11.1	The Chief Finance Officer presented the reports which were received by the Board. She provided an overview of the key performance challenges across both trusts which covered: acute referral to treatment (RTT) times; diagnostics; cancer services; urgent care – A&E 4 hour performance; ambulance handover times; community physical health services waiting times and activity; mental health waiting times and activity; children and young people's eating disorders; out of area placements; infection control; slips, trips and falls; mandatory training; sickness absence; turnover rates; career conversations.
11.2	The Board discussed the report and commented/noted that: • The 52 and 78 week waiting times performance showed an improved position across both trusts. • As at 31 January 2023, no YDH patients had waited 104 weeks or more to be seen and three SFT patients had waited 104 weeks due to clinical complexity. This number had reduced to two as at 28 February 2023 and the details of the two patients were noted. It was further noted that the end of year position will show one patient waiting over 104 weeks due to the minimum time frame between a Covid positive test and treatment. • The delays in the diagnostic pathways impacted on cancer waiting times performance. • Urgent care performance remained challenging with a significant increase in the number of ED attendances compared to the previous year. • Ambulance handover times had significantly improved during January 2023. • Overall performance continued to be challenging.
11.3	The Board acknowledged the areas of good performance and recognised the challenges and the actions being taken to address them.
12.	**UPDATE ON THE MERGER BETWEEN SOMERSET NHS FOUNDATION TRUST AND YEOVIL DISTRICT NHS FOUNDATION TRUST**
12.1	The Director of Strategy and Digital Development provided a verbal update and advised that good progress was being made in the preparations for the merger. A Board to Board challenge meeting with NHS England had taken place on 23 February 2023 and initial feedback had been positive. The merger risk rating will be issued mid March 2023 and the options will be either a Red, Amber or Green rating. A Green and Amber rating will allow the trusts to ask the Boards and Councils of Governors for approval to proceed with the merger. A meeting with the Boards and Councils of Governors had been set up for 20 March 2023.

12.2	The Director of Strategy and Digital Development advised that the current focus was on day one planning and this work was progressing well. The day one business critical and supporting day one critical projects were on track to be delivered by 1 April 2023 and a day one communications plan for stakeholders and the wider public was in place. It was noted that all business critical and supporting projects will be implemented on Monday 3 April 2023.
12.3	It was noted that the final due diligence report had not highlighted any new areas of concern.
12.4	Martyn Scrivens thanked the teams for their excellent achievement.
13.	**RISK MANAGEMENT STRATEGY**
13.1	Samantha Hann joined the meeting for this agenda item.
13.2	The Director of Corporate Services introduced the item and advised that the strategy reflected the outcome of a large project carried out over the last six months.
13.3	Samantha Hann presented the strategy which was received by the Board. She advised that the strategy outlined the trust's strategic approach to identifying and managing both opportunities and threats within its healthcare environment, and through adoption will help to create an environment which meets the needs of the trust's users, colleagues and other key stakeholders for the next three years. It was noted that the risk management policy will focus on how to operationalise the strategy.
13.4	The Board discussed the report and commented/noted that: • the risk appetite and risk tolerance statements for each of the strategic objectives was discussed at previous Board meetings and the statements had been included as attachments to the strategy. • A risk management policy will be developed and this will set out how to operationalise the strategy. The policy will further set out the responsibilities for executive directors and other key groups, as well as key definitions. • The risk objectives and building blocks to achievement had been colour coded and, as this had caused confusion with the usual RAG ratings colours, the colours will be changed. • The strategy will be circulated across the trust following Board approval together with the risk management policy. A progress report will be presented to the Board and Audit Committee on an annual basis. • The strategy was excellent and clearly showed that a lot of thought had been given to its content.

	• It was queried where service group risk registers were scrutinised. Samantha Hann advised that appendix three of the strategy included a flow chart of the process for the escalation of risks from "ward to Board" but this process will be defined in detail within the policy. In relation to service group risks, further work will need to be caried out with the service groups to define which risks will need to be escalated and the risks will be reassessed to determine whether they were organisational or service group risks. Oversight of service group risks will be through the senior operational group and oversight of corporate risks will be through the sub committees. In addition, oversight of service group risks will be provided through the executive team, triumvirate leads and senior management. The Director of Corporate Services advised that the triumvirate groups have been asked to join the Quality and Governance Assurance Committee on a regular basis to be able to review their governance and risk management processes and risks. This oversight process was welcomed and will provide assurance that risks were appropriately managed. • The first year of the strategy will require a significant focus on embedding the strategy and training colleagues. The second and third year will be the most critical year in terms of the implementation of the strategy. • The risk appetite and tolerance statements as set out in appendix four referred to unsafe practices not being tolerated and it was felt that this form of wording may not be well received by clinicians especially if they were required to implement new schemes, e.g. Hospital@Home, which will carry a level of risk. The Chief Medical Officer offered to review this wording and suggest more supportive wording. It was agreed to follow this up outside of the meeting. • A one page summary of the strategy will be welcomed. • The risk management system was based on a "bottom up" approach and it was suggested using a "top down" approach on an annual basis to review the risks to ensure that they reflected the key areas of concerns as discussed at Board and Committee level meetings. Samantha Hann commented that an annual Board development session will be scheduled to enable the Board to review the risks and ensure that the risks on the registers are consistent with expectations and Board and Committee discussions. The risk appetite and risk tolerance statements will also be reviewed on an annual basis. In addition to the Board level review, the Quality and Governance Assurance Committee will also review the risks at its planning meetings to check that the risks are in line with the Committee discussions and these checks will be undertaken on an ongoing basis.

	• The relationship between the organisational and ICS based risks was queried, and in particular whether the Trust was purposely holding system risks to reduce the risks to the population of Somerset. An example of such a risk was offloading patients from ambulances as soon as possible after arrival rather than having patients waiting in ambulances. This put pressure on the emergency department but was in the best interest of the patient and the ambulance service. It was further highlighted that a large part of services provided were provided in the community and it was queried whether an organisational approach to risk was the best approach or whether the approach should be a population based approach. Samantha Hann advised that discussions were taking place with the ICS about system risks. Their risk management approach was not as mature as the trust's approach and the trust was working with the ICS to look at the system risks and identify the best way to manage these risks. This work was still ongoing and further meetings will be set up to further discuss the system risks management approach and relationships. Samantha Hann further advised that discussions were also taking place with neighbourhood teams about how to identify, manage and report risks in the community. The Director of Corporate Services advised that the starting point will need to be those risks which are within the remit of the trust. In view of the shared clinical and care strategy and clinical objectives, those risks should align with the system risks and this should be the starting point for the ICS. The same applied to finance and workforce risks as there was significant overlap between the Trust and system risks. The Chief Executive advised that there was a difference between organisational risks and risks to the organisation and one of the strategic objectives was based on population health. The key issue was how the ICB had a view across the system risks and the relative risks across partners and this view was currently not available. The trust will also need to find a way of linking with the County Council, primary care and the ambulance service to review shared risks and risks impacting on other providers as the key focus should be on what is best for the population of Somerset. • It was queried whether it was appropriate for the risk management strategy to be shared with the ICB. The Chief Executive advised that it will be helpful to share the strategy with the ICB and a range of information has already been pro-actively shared with the ICB. The calibration of risks however still needs to be agreed. All organisations were assessing risks against the same risk matrix and the ICS should be able to review the risks and determine the areas of priority across the system. Although the risk rating will be consistent across all organisations, the delivery and management of the risks will be different for different organisations. • It was stressed that risks which were not in control of the Trust should not be on the Trust's risk register and should be owned by the ICS.

13.5	Jan Hull proposed, Kate Fallon seconded and the Somerset NHS Foundation Trust Board approved the risk management strategy.
13.6	Samantha Hann left the meeting.
14.	**SIX MONTHLY FREEDOM TO SPEAK UP PROGRESS REPORT**
14.1	Caroline Sealey, Freedom to Speak Up Guardian, joined the meeting and presented the report which was received by the Board. Caroline Sealey highlighted the establishment of a joint speaking up service across both trusts and the aligning of services in preparation for the merger. It was noted that the service model consisted of two full time guardians and an additional guardian was appointed in December 2022.
14.2	The Board discussed the report and commented/noted that: • A total of 71 concerns had been raised at SFT over the period April 2022 to September 2022 with 19 concerns raised at YDH over the same period. • The majority of the concerns had been raised by nursing, midwifery, admin and clerical colleagues. The majority of these concerns contained an element of bullying/harassment or inappropriate attitudes/behaviours. • The reduction in the number of concerns raised, 20+% for both trusts compared to the previous two quarters, may reflect an improving culture where colleagues feel safe to raise concerns via other routes. Caroline Sealey was confident that the reduction was not due to a lack of reporting as considerable work had taken place to raise the profile of the freedom to speak up work and the alternative routes available. It was recognised that there may be specific groups of colleagues who will find it more challenging to speak up due to cultural differences and work was taking place with ensure that they feel able to speak up. • The national benchmarking data for 2021/22 showed the following trends: increase in the number of cases with patient safety/quality or bullying or harassment elements; increase in the number of cases where detriment was indicated; and reduction in the number of cases anonymously. • It was queried whether two full time guardians will be sufficient to ensure visibility across the acute sites. Caroline Sealey commented that the service was wider than the acute sites and also covered the full range of mental health and community services across the county. In view of the wide range of services covered, it was difficult to be visible in all locations but every effort will be made to have an ongoing presence at YDH. The Chief of People and Organisational Development commented that the freedom to speak up work was not limited to the guardians and many colleagues and senior managers can offer and signpost support. The guardians will make every effort to see as many colleagues as possible in person but it was also important to ensure that the work of the guardians was linked to the people strategy. Caroline

	Sealey further advised that the respectful resolution training will provide clarity and will allow concerns to be identified at an early stage. • The number of bullying or harassment cases was a concern and there should be zero tolerance for bullying or harassment. An example was highlighted where, some time ago, bullying and harassment concerns had been identified during night shifts in more isolated units and it was queried how assurance can be provided about the culture during night shifts. Caroline Sealey advised that the first walkround had included night shift colleagues and this will continue to be an area of focus. The Chief Nurse commented that she regularly completed night shifts and this provided an element of assurance about the culture. Caroline Sealey commented that the perception of bullying or harassment can be different for different groups, but colleagues submitting a claim will be supported and appropriate actions will be taken. These actions do take account of the wishes of the colleagues raising the concerns. • The response times as set out in paragraph 3.7 were excellent but it was queried whether the response times related to acknowledging or resolving the concerns. Caroline Sealey advised that the response times related to the timing within which a meaningful response had been provided.
14.3	Martyn Scrivens thanked Caroline Sealey for the excellent and encouraging report. The report provided positive assurance that colleagues feel able to speak up.
14.4	Caroline Sealey left the meeting.
15.	**SIX MONTHLY STAFFING ESTABLISHMENT REPORT**
15.1	Alison Wootton, Deputy Chief Nurse SFT, joined the meeting.
15.2	Alison Wootton presented the report which was received by the Board. Alison Wootton highlighted the key challenges and risks and particularly the ongoing impact of Covid-19, the number of escalation beds; the industrial actions; and the continued pressures on the workforce.
15.3	The Board discussed the report and commented/noted that: • Safe staffing levels had been reviewed as detailed in the report and have broadly been found to meet the standards and guidance. • There remained disruption and challenges to service delivery requiring a focus on a dynamic approach to monitor and oversee staffing. • Some services had vulnerabilities that required ongoing and close monitoring as well as action to mitigate and deliver safe care. There was directorate level ownership and oversight of these risks and issues and there was a clear and accessible escalation process to raise concerns if the risk was considered inadequately managed or mitigated.

	• A number of measures in the primary care and neighbourhoods directorate were showing red in spite of fill rates showing 111%. Alison Wootton advised that the measures were based on 100% of normal staffing levels and even at 111% staffing levels, further staff was required e.g to cover escalation beds. 30 escalation beds had been opened in community hospitals and further additional staff was required. Additional RGNs had been appointed but shift gaps were more difficult to fill because of the rurality of the majority of the community hospitals. • It was queried why the YDH fill rate generally seemed to be lower than the SFT fill rate. Alison Wootton advised that the YDH and SFT data may not be like for like comparisons as the information was provided by different teams. Generally it may be more difficult to fill shift gaps at YDH in view of the more limited temporary staffing pool in Yeovil. • It was queried whether there was a point at which services were declared unsafe. Alison Wootton advised that risks were balanced on a day by day basis and generally a balance could be achieved. In the case of e.g. only one RGN on a shift in a community hospital, discussions will take place with the RGN to check whether, and if so what, additional support will need to be put in place. Martyn Scrivens advised that this explanation provided assurance about the management of shift gaps. • The report showed more full time wtes than budgeted wtes and it was queried whether this was due to non budgeted escalation staffing requirements. Alison Wootton advised that some services had seen an over recruitment as the international recruitment feed was healthy. It was better to maintain the recruitment feed on an ongoing basis to avoid any gaps in recruitment and this had resulted in some over recruitment. A further reason was that both trusts were running the equivalent of an extra 6.5 wards of escalation beds which required additional staffing. Over recruitment can be used to support other services when needed. Barbara Gregory advised that the size of the non budgeted whole-time equivalents (wtes) had been raised at the recent Finance Committee and different ways for managing the additional wtes may need to be considered to ensure that there was clear budgetary oversight. • It was queried how many patients had been identified as having “no criteria to reside” and it was noted that there were approaching 200 patients to whom this criteria applied across both trusts. A reduction in the number of patients waiting for ongoing care will reduce the need for escalation beds. • The midwife to birth ratio was broadly in line with the national recommendation of 1:28. The Chief Nurse advised that the ratio depended on the operating model but generally a ratio of 1:28 or better was being achieved. The Chief Nurse advised that the ratios did not reflect the considerable pressures midwifery services were experiencing. It was noted that the SFT home birth service had been suspended for three months due to a reduction in staffing levels in community teams as a result of vacancies

	and sickness absence and, where possible, women were cared for by the YDH home birthing team.
15.4	The Board accepted the assurance set out in the report that the trusts were taking all actions to try and ensure safe staffing levels in all ward areas and that, where this was not possible, escalation and actions were followed to try and mitigate the risks of working with a compromised level of staff.
15.5	Martyn Scrivens thanked Alison Wootton and her team for their excellent work.
16.	**STAFF SURVEY 2022 REPORT**
16.1	The Chief of People and Organisational Development advised that the staff survey report was embargoed until 9 March 2023 and will therefore be presented to the May 2023 meeting.
17.	**ASSURANCE REPORT OF THE PEOPLE AND WORKFORCE COMMITTEE MEETINGS HELD ON 30 JANUARY 2023**
17.1	Stephen Harrison presented the report which was received by the Board.
17.2	Stephen Harrison advised that no areas of concern or follow up, or significant risks or issues to be reported to the Board had been identified. Stephen Harrison advised that the main focus at the meeting had been on nurse recruitment and the Committee received and discussed the five year nursing vacancy forecast. The discussion provided the Committee with significant assurance about workforce planning. Graham Hughes agreed that the presentation and discussion had been interesting and productive and it will be helpful to share the presentation with Board members.
17.3	The Board discussed the report and commented/noted that: • Workforce demand and supply planning as well as assumptions for all staff groups will need to be tested and it was suggested following this up at a future Board development day. The Chief of People and Organisational Development advised that the People Committee will be carrying out deep dives into all staff groups over the next few months. • The Chief Nurse advised that the nursing workforce planning forecast as presented to the Committee had been a resource intensive exercise and the frequency of presenting this information to the Committee will need to be considered. She advised that workforce planning for occupational and physio therapists was in an advanced stage but less progress had been made in relation to smaller professional groups. The five year forecast was based on a number of assumptions and it will be helpful to test the assumptions in the next few years. The Chief Medical Officer advised that workforce planning for medical staff was more difficult but a multi disciplinary heatmap exercise was being undertaken and will be presented to a future Quality and Governance

	Assurance Committee planning meeting. Medical workforce planning will need to be linked to the future clinical inpatient and community service model.
17.4	Martyn Scrivens thanked Stephen Harrison and Graham Hughes for their ongoing leadership of the Committee.
18.	**FINANCE REPORTS**
	Finance Report – YDH
18.1	The discussion of this item is reflected in the YDH minutes.
	Finance Report - SFT
18.2	The Chief Finance Officer presented the financial report which was received by the Board. She highlighted the financial position: • An in-month surplus of £888,000 against an in-month surplus plan of £25,000. A year to date deficit of £2.067 million which was breakeven to plan. • Agency spend for the year to date was £26.1 million which was £8.0 million above the same period in 2021/22 – in month agency spend showed a reduction. • A cumulative £9.953 million cost improvement plan delivery against an end of year plan of £14.181 million. It was expected that there will be a £1.2 million shortfall in the delivery of the 2022/23 cost improvement programme. • An underspend against the capital programme due to slippage of some of the schemes. Further schemes have been identified to ensure the capital resources are fully utilised by year end. • Risks going forward included the funding of the escalation capacity; and staffing challenges.
18.3	The Board discussed both reports and commented/noted that: • The finance reports had been discussed in detail at the recent Finance Committee meetings. • A large part of agency expenditure related to medical agency and it was queried whether robust recruitment plans were in place and whether the recruitment issues were restricted to specific specialities. It was noted that the recruitment challenges relating to Symphony practices and the high use of locums was recognised. The Chief Medical Officer advised that the processes for managing medical vacancies had been aligned across both trusts and this work had identified possibilities for transformation. It was recognised that some of the specialties will be difficult to recruit to and progress was being made at a slower speed. In addition, some agency staff was required to staff the escalation beds. It was expected that the further development of Hospital@Home and other admission avoidance

	schemes, as well as improvement in social care staffing challenges, will reduce the need for agency staff. The Chief of People and Organisational Development advised that a deep dive into the agency position will be undertaken at the People/Workforce Committee meetings to be held in common on 8 March 2023. This will enable a clear understanding of the key drivers for agency staff across all services. Significant work will also be undertaken over the coming month on identifying areas where recruitment had not been successful in spite of a number of recruitment campaigns and alternative options will be identified. • The escalation budget was proportionately high compared to the basic directorate budgets and was in addition to the directorate budgets. It was queried whether the value for money aspect of the use of the escalation budget had been considered and what processes were in place to manage and oversee the budget. The Chief Operating Officer advised that there had been a need to use escalation beds to be able to provide safe services and deliver the elective recovery programme. A programme of work on planning bed requirements for 2023/24 was currently taking place and this will include a review of current beds, surge beds etc as well as a review of management and control processes. The significant financial expenditure associated with staffing additional beds was recognised and this was a key area of focus. • Work was taking place to ensure that a common set of financial and workforce data from the ledger and ESR will be available for discussion at the Finance Committee meetings from April 2023 onwards. To date there had been a mismatch between the data on the ledger and ESR and this made it more difficult to match the data. • In view of higher activity and demand levels compared to 2019/20, it was not envisaged that escalation beds can currently be fully eliminated. However relevant discussions were taking place and workforce, financial and operational plans will need to be triangulated. • The first task will be to understand the drivers and to then approach this in a systemic way. The Chief Operating Officer advised that the teams were committed and motivated to get services back into pre Covid-19 shape as soon as possible.
18.4	The Board recognised the financial challenges and welcomed the actions being taken to address the financial pressures.
19.	**CAPITAL PROGRAMME FOR 2023/24**
19.1	The Director of Strategy and Digital Development presented the report which was received by the Board. It was noted that the capital envelope for the merged organisation will be £33.059 million, which was an overcommitment of 5% above

	the system allocation and this overcommitment can be managed through the year. The details of the capital schemes for 2023/24 were noted.
19.2	The Board discussed the report and commented/noted that: • The scale of the capital programme recognised the level of internal funding available in the system. It was noted that an additional £3 million capital funding will be allocated to the system if a 2022/23 financial breakeven position will be achieved. • A number of the schemes were existing schemes and were carried forward into 2023/24. • The scale of the programme carried a level of risk and there continued to be challenges in terms of the supply chain and construction industry from a supplier and material perspective. • Resources had been identified for the majority of the schemes but business case for some of the schemes will need to be developed and approved due to the level of investment required. • In view of the overcommitment, it was queried whether a plan was being developed to address the overcommitment, e.g. through slippage of schemes. The Director of Strategy and Digital Development advised that the overcommitment had been included to avoid a delay in schemes due to the need for Board approval during the year. The capital programme was reviewed on a quarterly basis and any slippages on schemes will be identified and elements for future schemes can be brought forward as and when required. • Confirmation of funding from the New Hospital Programme was still awaited and due to the impact on other builds, e.g. maternity unit, it was queried whether public or political awareness of the delay in confirmation of funding will need to be raised regionally and nationally. It was noted that the Trust, together with another 32 hospitals had been waiting for confirmation of participation in the scheme for one year and due to the state of some of the facilities at Musgrove Park Hospital, this delay was disappointing. Colin Drummond advised that he had raised the delay with the local MP and was doing everything he could to continue to raise awareness of the delay and impact. The Chief Executive advised that actions were being taken and, if needed, consideration will be given as to how to increase the focus on the environmental impact of the delay.
19.3	Kate Fallen <u>proposed</u>, Colin Drummond <u>seconded</u> and the Somerset NHS Foundation Trust Board approved the capital programme for 2023/24.

20.	**VERBAL REPORT FROM THE FINANCIAL RESILIENCE COMMERCIAL COMMITTEE/FINANCE COMMITTEE MEETING HELD IN COMMON ON 24 FEBRUARY 2023**
20.1	Kate Fallon, Chairman of the joint Committee, advised that all issues discussed at the meeting held in common on 24 February 2023 had already been covered under previous agenda items.
21.	**CHANGES TO THE CONSTITUTION**
	YDH
21.1	The discussion of this item is reflected in the YDH minutes.
	SFT
21.2	The Director of Corporate Services presented the report and advised that the constitution for the post merger organisation had been reviewed by NHS England as part of the review of the merger business case and two small amendments have been requested. The Board received the report.
21.3	Kate Fallon proposed, Stephen Harrison seconded and the Somerset NHS Foundation Trust Board approved the changes to the constitution as set out in the report. The Board that noted that the Council of Governors will be asked to approve the changes to the constitution at their meeting to be held on 9 March 2023.
22.	**FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS**
22.1	There were no follow up questions from the Public or Governors.
23.	**ANY OTHER BUSINESS**
23.1	Colin Drummond advised that this was Stephen Harrison's last public Board meeting and thanked Stephen for his significant contributions to the Trust as well as to Taunton and Somerset NHS Foundation Trust prior to the merger in 2020. He advised that Stephen had been dedicated and committed to the work of the Trust and was a sound and balanced contributor to Board and Committee meetings. Colin Drummond reiterated his thanks on behalf of the Board and wished Stephen every success for the future.
23.2	Stephen Harrison commented that his time on the Board, and previous Board, had been an interesting time and was encouraged by the progress made and the vision going forward.
23.3	Martyn Scrivens, on behalf of the Yeovil District Hospital NHS Foundation Trust Board, also wished Stephen every success for the future.
	Patient Stories
23.4	Emma Davey advised that she had taken up her post as Director of Patient Safety and Engagement and one of her roles will be to identify patient stories for Board

	meetings. Emma Davey asked Board members to advise her of any topics for future Board meetings.
24.	**RISKS IDENTIFIED**
24.1	The Board did not identify any new significant risks which had not as yet been included on the risk register but highlighted the discussion in relation to end of life services and the financial position.
25.	**EVALUATION OF THE EFFECTIVENESS OF THE MEETING**
25.1	The Board agreed that the meeting had been very effective with a wide range of topics covered.
25.2	The Director of Corporate Services advised that a more formal effectiveness review of the Board and Committees will be carried out over the next few months.
26.	**ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING**
26.1	The Chairman highlighted the items for discussion at the confidential Board meeting and set out the reasons for including these items on the Confidential Board agenda.
27.	**WITHDRAWAL OF PRESS AND PUBLIC**
27.1	The Board moved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.
28.	**DATE FOR NEXT MEETING**
28.1	9 May 2023

SOMERSET NHS FOUNDATION TRUST (SFT)
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST (YDH)

EXTRA ORDINARY PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST BOARD MEETING HELD ON 20 MARCH 2023 BY MS TEAMS

PRESENT

Colin Drummond	Chairman
Jan Hull	Non-Executive Director/Deputy Chairman
Barbara Gregory	Non-Executive Director
Stephen Harrison	Non-Executive Director
Alexander Priest	Non-Executive Director
Martyn Scrivens	Non-Executive Director
Sube Banerjee	Non-Executive Director
Kate Fallon	Non-Executive Director
Peter Lewis	Chief Executive
Phil Brice	Director of Corporate Services
Andy Heron	Chief Operating Officer
Hayley Peters	Chief Nurse
Daniel Meron	Chief Medical Officer
David Shannon	Director of Strategy and Digital Development
Isobel Clements	Chief of People and Organisational Development

IN ATTENDANCE

Graham Hughes	Non-Executive Director, YDH
Paul Mapson	Non-Executive Director, YDH
Fiona Reid	Director of Communications
Ben Edgar-Attwell	Deputy Director of Corporate Services
Ria Zandvliet	Secretary to the Trust (minute taker)
Victoria Keilthy	Director of Integration

1.	**WELCOME AND APOLOGIES**
1.1	Apologies were received from: Pippa Moger (Chief Finance Officer).
1.2	The Chairman advised that, following the establishment of a single executive team across both trusts, the SFT and YDH Boards have agreed to conduct their Board of Directors meetings as meetings held in common. The meetings will be chaired by the Chair of either SFT or YDH Chair on a rotation basis and Colin Drummond will be chairing this meeting.

1.3	The Chairman welcomed all Board members and attendees to the meeting and confirmed that the meeting was quorate.
2.	**DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA**
2.1	There were no declarations of interest relating to items on the agenda.
3.	**ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING**
3.1	The Chairman advised that the focus of the Confidential Board meeting will be on the merger progress update; approval of the merger transaction; and approval of the merger transaction agreement for signature. The Chairman set out the reasons for including these items on the Confidential Board agenda.
4.	**WITHDRAWAL OF PRESS AND PUBLIC**
4.1	The Board moved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.
5.	**ANY OTHER BUSINESS**
5.1	There was no other business.
6.	**DATE OF NEXT MEETING**
6.1	9 May 2023

SOMERSET NHS FOUNDATION TRUST (SFT)
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST (YDH)

PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON

MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST (YDH) BOARD MEETING HELD ON 7 MARCH 2023 BY MS TEAMS

PRESENT

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

IN ATTENDANCE

Colin Drummond	Chairman - SFT
Barbara Gregory	Non-Executive Director – SFT
Kate Fallon	Non-Executive Director
Stephen Harrison	Non-Executive Director – SFT
Sube Banerjee	Non-Executive Director
Meridith Kane	Medical Director for Acute Hospitals
Fiona Reid	Director of Communications
Ben Edgar-Attwell	Deputy Director of Corporate Services
Charlie Davis	Consultant in Palliative Medicine
Catherine Leask	Consultant in Palliative Medicine
Jo Morrison	Consultant Gynaecological Oncology
Robert Lutyens	Nurse Consultant Palliative Care and End of Life
Kirstie Lord	Assistant Director People Services
Samantha Hann	Head of Health Safety and Risk
Caroline Sealey	Freedom to Speak Up Guardian
Alison Wootton	Deputy Chief Nurse SFT
Ria Zandvliet	Secretary to the Trust (minute taker)

Governors

Ian Hawkins	Lead Governor, SFT/Governor, YDH
Kate Butler	Deputy Lead Governor, SFT
Jane Armstrong	Governor, SFT

	Tony Robinson	Governor, YDH

1.	**APOLOGIES**
1.1	There were no apologies.
1.2	The Chairman advised that, following the establishment of a single executive team across both trusts, the SFT and YDH Boards have agreed to conduct their Board of Directors meetings as meetings held in common. The meetings will be chaired by the Chair of either SFT or YDH Chair on a rotation basis and Martyn Scrivens will be chairing this public Board meeting.
1.3	The Chairman welcomed all Board members, governors, colleagues and other attendees to the meeting and confirmed that both the SFT and YDH meetings were quorate.
2.	**QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS**
2.1	No questions from members of the public or governors had been received.
3.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 7 FEBRUARY 2023**
3.1	The approval of the minutes is reflected in the SFT minutes.
4.	**MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 7 FEBRUARY 2023**
4.1	Graham Hughes proposed, Martyn Scrivens seconded and the Board approved the minutes of the Yeovil District Hospital NHS Foundation Trust Public Board meeting held on 7 February 2023 as a correct record.
5.	**TO REVIEW THE ACTION LOGS AND MATTERS ARISING**
5.1	The Board received the action log and noted the completed actions.
5.2	There were no maters arising.
6.	**TO NOTE THE REGISTERS OF DIRECTORS' INTERESTS AND RECEIVE ANY DECLARATIONS OF INTERESTS RELATING TO ITEMS ON THE AGENDA**
6.1	The Board received the Register of Directors' interest. There were no changes to the register.
7.	**CHAIRMEN'S REMARKS**
7.1	The Chairman provided feedback from the Board to Board meeting with NHS England to discuss the proposed merger and advised that the meeting had been very positive and feedback about the merger had been encouraging. Martyn

	Scrivens commented that, based on the feedback received at the meeting, it was reasonable to assume that this will be the last public Board meeting of Yeovil District Hospital NHS Foundation Trust. The Chairman therefore thanked the Non-Executive and Executive Directors on the Board of Yeovil District Hospital NHS Foundation Trust (YDH) for their extra ordinary efforts in achieving this positive position. Martyn Scrivens further expressed the YDH Board's appreciation and thanks to the Governors.
7.2	Colin Drummond also thanked the YDH Board members and Governors for their fantastic work.
7.3	Colin Drummond provided feedback from a recent meeting with Helen Whately, Minister of State in the Department for Health and Social Care, and advised that he had highlighted the ongoing social care and primary care challenges and the work undertaken by the Trusts (including Sympony). Helen Whately was interested in primary care at scale and Colin Drummond had stressed the need for her to be clear about the "no criteria to reside" issues as resolving these issues will be critical due to the impact on all other services. Colin Drummond advised that the meeting had been positive and that the key challenges had been recognised.
	Non-Executive Directors Lead Roles
7.4	Colin Drummond presented the overview of Non-Executive Director lead roles which was received by the Board. He thanked the relevant Non-Executive Directors for taking on these roles.
8.	**CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT**
8.1	The Chief Executive presented the report which set out a number of significant and positive developments. The report was received by the Board.
8.2	The Chief Executive specifically highlighted the acquisition of surgical robots at both trusts and advised that the surgical robot at Musgrove Park Hospital (MPH) will be funded through a £1.5 million commitment from the Musgrove Park Hospital League of Friends. As a result of this commitment, equivalent capital funding for a surgical robot at YDH had been secured from NHS England. The Board agreed that this was an excellent outcome and thanked the League of Friends for their ongoing support.
8.3	The Chief Executive further highlighted the opening of the new Victoria Park health and wellbeing hub in Bridgwater. The hub, located in the former Victoria Park medical centre building, will provide a range of services for people of all ages, from pre-natal to end of life care. This was an excellent new development as the hub will work with the community, mental health, social care, pharmacy, hospital and voluntary services in the local area to meet the needs of individual patients.
	Junior Doctor industrial actions
8.4	The Chief Medical Officer provided an update on the junior doctor industrial actions scheduled for 13 to 16 March 2023 and advised that robust mitigating

	actions, led by Dr Meridith Kane, had been developed. The actions recognised the right of junior doctors to strike and were focussed on providing safe care and the highest level of activity as possible. The focus had been on a sustainable response so that actions will be in place in the case of further industrial action. The Chief Medical Officer advised that the actions were based on a collaborative approach, using devolved leadership and governance through service groups. This approach compared well with others trusts and a number of trusts had asked for copies of protocols and processes. He commended Meridith Kane and the medical leadership team on their excellent work. Meridith Kane advised that it was important to note that this was being treated as an extra ordinary event for remuneration and cover purposes to ensure equitable and appropriate rewards across acute and mental health inpatient services.
8.5	The Board discussed the report and commented/noted that: • Barbara Gregory queried whether critical mass for ensuring the delivery of safe services will be available. Meridith Kane advised that assurance had been received that critical mass will be available. The mitigating approach was not based on replacing junior doctors with consultants as the skill set of F1 and F2 level junior doctors was different from consultant skills sets. Mitigations have been identified at service group level and may not be the same for all services. A review of the needs for each service had been undertaken and consideration had been given as to which other staff groups have the required skill set. Meridith Kane advised that the approach used had been positive and learning will be identified and taken into account in workforce planning. Meridith Kane was asked to attend a future People Committee meeting to provide feedback on the learning identified. • February 2023 had focussed on kindness, civility and inclusion and Board members were encouraged to review the tools and resources. The next step will be to embed new values and behaviours. • Industrial actions and patient communications. External communications will clearly set out that the trusts will continue to be able to provide safe services and that anyone who needs help should seek help. It was expected that reactions to the patient communications may be mixed as a number of elective care activities had to be cancelled. It was noted that every affected patient will be contacted individually. Communications had been prepared and will be aligned with national guidance when received. • It was queried whether the morale of senior colleagues and registrars had been affected as a result of the expected industrial actions. Meridith Kane advised that senior consultants and registrars were supportive of the industrial actions and the mitigating approach was seen as a positive challenge.

	• The Victoria Park health and wellbeing hub was run by SFT jointly with the Bridgwater Bay Primary Care Network and staffing was provided through the PCN and the trust. The trust will focus on children and young people and families services as this best fits the local demographics. A community midwife will be based at the hub as well as a number of community services, including mental health and MSK services. • The frailty service at MPH had been reinstated. The service at YDH had been suspended over the last year in view of the need for escalation beds. In addition, it had only been possible to provide the service to a small cohort and, due to the criteria for frailty services, a larger cohort of patients were unable to receive the same level of services. A review of frailty services will be carried out on a countywide basis as it was recognised that frailty may not be just related to age. Post pandemic services were being restored, improvements had been made to services and pathways, and lessons had been learned. A number of alternatives to admission had been set up and looking after frail and elderly people in emergency services in a different way was welcomed. These initiatives were welcomed but it was queried how all the initiatives were linked and whether, if the initiatives were successful, whether they will be rolled out across the county. The Chief Operating Officer commented that a number of the initiatives had been set up by central government and all initiatives had been batched in a slightly different way. He felt that there was a clear oversight of the initiatives and advised that progress was being made in relation to ensuring simplicity and operational smoothness. He recognised that the initiatives could be further joined up and this was part of the work taking place. The Chief Operating Officer suggested including this on a future Board Development Day agenda. **Action: Chief Executive and Director of Corporate Services**.
9.	**PATIENT STORY AND CLINICAL TOPIC ON END OF LIFE SERVICES**
9.1	Charles Davis, Catherine Leask, Robert Lutyens and Jo Morrison joined the meeting for this agenda item.
9.2	The Chief Medical Officer welcomed colleagues from the end of life service to the meeting and expressed his thanks to the team for their ongoing excellent work.
9.3	Charlie Davis and colleagues provided the following overview of end of life services: • The background to end of life services. • The improvements made to the service over the last few years, including the changes to services during the Covid-19 period (65 different projects); the growth of the number of consultant wtes within the team; the ongoing merger conversations between the SFT and YDH nursing teams; the

	dedicated multi-disciplinary education team and the link into directorate type structure for end of life services. • The plan for end of life care – supportive, palliative, end of life care and bereavement care which is everyone's business and is supported, when needed, by specialists. Modest in its work in influencing culture – communication skills; discharge flows; STEP forms and process; caring for the most sick and needy. • The work taking place in South Somerset – joint working with oncology teams in Yeovil due to co-location of community palliative care and oncology at St Margaret's Hospice; the joint work with hospital and community medical teams enabling closer patient follow up regardless of location; pilot of end of life beds in an intermediate care home enabling end of life care for patients out of hospital; cross county end of life education. • The safety and governance aspects of supporting patients and professionals and oversight arrangements. These included relevant policies; updating medical guidance; and robust reporting arrangements. It was noted that the Care Quality Commission inspection had resulted in a "good" rating for safe services and this showed the excellent progress made. • The challenges identified as part of audits – improving end of life care on the wards at Musgrove Park Hospital; opportunities to recognise that a patient was sick enough to die; including carer feedback in consent/training programmes; data collection for the STEP service; data on the use of "Just In Case" medication in the community. • The work in acute and community services - the development of seven day working across both acute sites; the roll out of SIM education; the increased coordination and joint working between acute, community and community hospital services; and the development of bereavement support and feedback. • The challenges as identified from the "flow" in reach pilot and the end of life home care trial and particularly the finding that one in four end of life patients who want to go home will not leave hospital. It was noted that the "flow" pilot had been set up to explore the impact of the delays in social care packages.
9.4	Charlie Davis concluded by stating the importance of having the right people in the right place at the right time to be able to provide the right care.
9.5	The Board discussed the presentation and commented/noted that: • The overview in terms of how the service had developed and how the different approaches used in the trials had made it more comfortable for patients and their families to deal with this difficult time of life was excellent.

	• It was queried whether the application process for continuing care impacted on the ability to transfer patients, who wanted to go home to receive end of life care, to their home within a 24 hour period. Jo Morrison commented that the vision was to move away from a fast track referral process and to do what is the best for the patient with funding arrangements to be agreed separately from the transfer process. This vision will deliver the right care at the right time and will avoid patients being in the wrong place and cared for by the wrong people. Discussions were taking place with the Integrated Care Board on how to achieve this vision. Jo Morrison further highlighted that the trial had highlighted different arrangements in the two acute sites and these arrangements will be harmonised and an increase in resources will help to reduce the number of rejected referrals. • The team was commended on their focus ensuring that the service was as supportive as possible to patients, their families and colleagues. It was queried at what point a decision was made as to when to start end of life. Charlie Davis commented that end of life did not relate to making a decision as to when someone was going to die but was very much focussed on communications with the patient and their family about the patient's prospects and being clear about expectations. It also related to shared decision making and clearly setting out the reason for treatment, the benefits and risks and being clear that the treatment may not work. • Complaints about end of life services mainly related to communications and Emma Davey, Director of Patient Safety and Engagement, will be meeting with the end of life team to discuss how best to support people when they have made a complaint and how to manage expectations. • The presentation provided a useful insight into end of life services and the importance of getting this right. There was a distinction between patients ill enough to die and end of life services. End of life services focussed on points of intervention to improve the quality of life for people in their final years and it was queried whether sufficient skills and resources were available within the team. The response to people ill enough to die will be different and clinical skills will need to be available across all services rather than held within the specialist end of life team. Charlie Davis agreed that the latter will require generalist and good communication skills. Audits had identified that although clinical teams were good at clinically recognising that patients were sick enough to die, the ability to discuss this with patients and family could be improved. Funding had been set aside to train a cohort of clinical staff in advanced communication skills. The training was aimed at senior clinicians and registrars' levels and will need to be repeated on a three yearly basis. • Clinical cultural change and a change in expectations will be required and it was queried what actions were being put in place to achieve this change in culture and expectations. Charlie Davis commented that any change will be challenging. Almost all of the complaints related to communication and

	this was the key area for investment in terms of time and resources. Clinicians will need to be provided with an education programme to ensure that they receive the right training and the uptake of training can be linked to the appraisal system. • The work carried out across the trusts by Charlie Davis and the team was excellent. Conversations about breaking the bad news were essential but the required skills were not taught routinely to medical students as part of their training. Learning to deal with bad news and bereavement therefore impacted heavily on junior doctors and medical students and this should also be considered as part of the wellbeing agenda. It was queried how the right training can be incorporated into the wellbeing agenda and mandatory training programme. The Chief of People and Organisational Development agreed to follow this up outside of the meeting. The Chief Nurse advised that education had a clear role in educating clinicians on how to share bad news, but this was also part of supervision and applied to all colleagues. Some professional groups had access to good quality supervision and it will be essential to ensure that colleagues from all professional groups have access to good quality supervision.
9.6	The Chairman thanked Charlie Davis and colleagues for the excellent presentation and for their commitment to high quality end of life services, patients and colleagues.
10.	**ASSURANCE REPORT OF THE QUALITY AND PERFORMANCE/ GOVERNANCE AND QUALITY ASSURANCE COMMITTEE MEETING HELD ON 25 JANUARY 2023**
10.1	Jan Hull presented the report which was received by the Board. She highlighted the areas of assurance received and the areas to be reported to the Board. These areas related to: • The recommendation for the Chief Executive to sign off the Year 4 MIS declarations for SFT and YDH. • The discussion in relation to the operational pressures - harm, morale injury and risks.
10.2	The Director of Corporate Services advised that a Health and Safety Executive re-inspection had taken place at YDH and it was expected that the findings of the re-inspection will be confirmed by 17 March 2023.
11.	**QUALITY AND PERFORMANCE REPORTS** **Group Board Overview Quadrant – YDH** **Quality and Performance Report – SFT**
11.1	The Chief Finance Officer presented the reports which were received by the Board. She provided an overview of the key performance challenges across both trusts which covered: acute referral to treatment (RTT) times; diagnostics; cancer

	services; urgent care – A&E 4 hour performance; ambulance handover times; community physical health services waiting times and activity; mental health waiting times and activity; children and young people's eating disorders; out of area placements; infection control; slips, trips and falls; mandatory training; sickness absence; turnover rates; career conversations.
11.2	The Board discussed the report and commented/noted that: • The 52 and 78 week waiting times performance showed an improved position across both trusts. • As at 31 January 2023, no YDH patients had waited 104 weeks or more to be seen and three SFT patients had waited 104 weeks due to clinical complexity. This number had reduced to two as at 28 February 2023 and the details of the two patients were noted. It was further noted that the end of year position will show one patient waiting over 104 weeks due to the minimum time frame between a Covid positive test and treatment. • The delays in the diagnostic pathways impacted on cancer waiting times performance. • Urgent care performance remained challenging with a significant increase in the number of ED attendances compared to the previous year. • Ambulance handover times had significantly improved during January 2023. • Overall performance continued to be challenging.
11.3	The Board acknowledged the areas of good performance and recognised the challenges and the actions being taken to address them.
12.	**UPDATE ON THE MERGER BETWEEN SOMERSET NHS FOUNDATION TRUST AND YEOVIL DISTRICT NHS FOUNDATION TRUST**
12.1	The Director of Strategy and Digital Development provided a verbal update and advised that good progress was being made in the preparations for the merger. A Board to Board challenge meeting with NHS England had taken place on 23 February 2023 and initial feedback had been positive. The merger risk rating will be issued mid March 2023 and the options will be either a Red, Amber or Green rating. A Green and Amber rating will allow the trusts to ask the Boards and Councils of Governors for approval to proceed with the merger. A meeting with the Boards and Councils of Governors had been set up for 20 March 2023.
12.2	The Director of Strategy and Digital Development advised that the current focus was on day one planning and this work was progressing well. The day one business critical and supporting day one critical projects were on track to be delivered by 1 April 2023 and a day one communications plan for stakeholders and the wider public was in place. It was noted that all business critical and supporting projects will be implemented on Monday 3 April 2023.

12.3	It was noted that the final due diligence report had not highlighted any new areas of concern.
12.4	The Chairman thanked the teams for their excellent achievement.
13.	**RISK MANAGEMENT STRATEGY**
13.1	Samantha Hann joined the meeting for this agenda item.
13.2	The Director of Corporate Services introduced the item and advised that the strategy reflected the outcome of a large project carried out over the last six months.
13.3	Samantha Hann presented the strategy which was received by the Board. She advised that the strategy outlined the trust's strategic approach to identifying and managing both opportunities and threats within its healthcare environment, and through adoption will help to create an environment which meets the needs of the trust's users, colleagues and other key stakeholders for the next three years. It was noted that the risk management policy will focus on how to operationalise the strategy.
13.4	The Board discussed the report and commented/noted that: • the risk appetite and risk tolerance statements for each of the strategic objectives was discussed at previous Board meetings and the statements had been included as attachments to the strategy. • A risk management policy will be developed and this will set out how to operationalise the strategy. The policy will further set out the responsibilities for executive directors and other key groups, as well as key definitions. • The risk objectives and building blocks to achievement had been colour coded and, as this had caused confusion with the usual RAG ratings colours, the colours will be changed. • The strategy will be circulated across the trust following Board approval together with the risk management policy. A progress report will be presented to the Board and Audit Committee on an annual basis. • The strategy was excellent and clearly showed that a lot of thought had been given to its content. • It was queried where service group risk registers were scrutinised. Samantha Hann advised that appendix three of the strategy included a flow chart of the process for the escalation of risks from "ward to Board" but this process will be defined in detail within the policy. In relation to service group risks, further work will need to be caried out with the service groups to define which risks will need to be escalated and the risks will be

reassessed to determine whether they were organisational or service group risks.

Oversight of service group risks will be through the senior operational group and oversight of corporate risks will be through the sub committees. In addition, oversight of service group risks will be provided through the executive team, triumvirate leads and senior management.

The Director of Corporate Services advised that the triumvirate groups have been asked to join the Quality and Governance Assurance Committee on a regular basis to be able to review their governance and risk management processes and risks.

This oversight process was welcomed and will provide assurance that risks were appropriately managed.

- The first year of the strategy will require a significant focus on embedding the strategy and training colleagues. The second and third year will be the most critical year in terms of the implementation of the strategy.

- The risk appetite and tolerance statements as set out in appendix four referred to unsafe practices not being tolerated and it was felt that this form of wording may not be well received by clinicians especially if they were required to implement new schemes, e.g. Hospital@Home, which will carry a level of risk. The Chief Medical Officer offered to review this wording and suggest more supportive wording. It was agreed to follow this up outside of the meeting.

- A one page summary of the strategy will be welcomed.

- The risk management system was based on a “bottom up” approach and it was suggested using a “top down” approach on an annual basis to review the risks to ensure that they reflected the key areas of concerns as discussed at Board and Committee level meetings. Samantha Hann commented that an annual Board development session will be scheduled to enable the Board to review the risks and ensure that the risks on the registers are consistent with expectations and Board and Committee discussions. The risk appetite and risk tolerance statements will also be reviewed on an annual basis.

  In addition to the Board level review, the Quality and Governance Assurance Committee will also review the risks at its planning meetings to check that the risks are in line with the Committee discussions and these checks will be undertaken on an ongoing basis.

- The relationship between the organisational and ICS based risks was queried, and in particular whether the Trust was purposely holding system risks to reduce the risks to the population of Somerset. An example of such a risk was offloading patients from ambulances as soon as possible after arrival rather than having patients waiting in ambulances. This put

	pressure on the emergency department but was in the best interest of the patient and the ambulance service. It was further highlighted that a large part of services provided were provided in the community and it was queried whether an organisational approach to risk was the best approach or whether the approach should be a population based approach. Samantha Hann advised that discussions were taking place with the ICS about system risks. Their risk management approach was not as mature as the trust's approach and the trust was working with the ICS to look at the system risks and identify the best way to manage these risks. This work was still ongoing and further meetings will be set up to further discuss the system risks management approach and relationships. Samantha Hann further advised that discussions were also taking place with neighbourhood teams about how to identify, manage and report risks in the community. The Director of Corporate Services advised that the starting point will need to be those risks which are within the remit of the trust. In view of the shared clinical and care strategy and clinical objectives, those risks should align with the system risks and this should be the starting point for the ICS. The same applied to finance and workforce risks as there was significant overlap between the Trust and system risks. The Chief Executive advised that there was a difference between organisational risks and risks to the organisation and one of the strategic objectives was based on population health. The key issue was how the ICB had a view across the system risks and the relative risks across partners and this view was currently not available. The trust will also need to find a way of linking with the County Council, primary care and the ambulance service to review shared risks and risks impacting on other providers as the key focus should be on what is best for the population of Somerset. • It was queried whether it was appropriate for the risk management strategy to be shared with the ICB. The Chief Executive advised that it will be helpful to share the strategy with the ICB and a range of information has already been pro-actively shared with the ICB. The calibration of risks however still needs to be agreed. All organisations were assessing risks against the same risk matrix and the ICS should be able to review the risks and determine the areas of priority across the system. Although the risk rating will be consistent across all organisations, the delivery and management of the risks will be different for different organisations. • It was stressed that risks which were not in control of the Trust should not be on the Trust's risk register and should be owned by the ICS.
13.5	Graham Hughes <u>proposed</u>, Paul Mapson <u>seconded</u> and the Yeovil District Hospital NHS Foundation Trust Board approved the risk management strategy.
13.6	Samantha Hann left the meeting.

14.	**SIX MONTHLY FREEDOM TO SPEAK UP PROGRESS REPORT**
14.1	Caroline Sealey, Freedom to Speak Up Guardian, joined the meeting and presented the report which was received by the Board. Caroline Sealey highlighted the establishment of a joint speaking up service across both trusts and the aligning of services in preparation for the merger. It was noted that the service model consisted of two full time guardians and an additional guardian was appointed in December 2022.
14.2	The Board discussed the report and commented/noted that: • A total of 71 concerns had been raised at SFT over the period April 2022 to September 2022 with 19 concerns raised at YDH over the same period. • The majority of the concerns had been raised by nursing, midwifery, admin and clerical colleagues. The majority of these concerns contained an element of bullying/harassment or inappropriate attitudes/behaviours. • The reduction in the number of concerns raised, 20+% for both trusts compared to the previous two quarters, may reflect an improving culture where colleagues feel safe to raise concerns via other routes. Caroline Sealey was confident that the reduction was not due to a lack of reporting as considerable work had taken place to raise the profile of the freedom to speak up work and the alternative routes available. It was recognised that there may be specific groups of colleagues who will find it more challenging to speak up due to cultural differences and work was taking place with ensure that they feel able to speak up. • The national benchmarking data for 2021/22 showed the following trends: increase in the number of cases with patient safety/quality or bullying or harassment elements; increase in the number of cases where detriment was indicated; and reduction in the number of cases anonymously. • It was queried whether two full time guardians will be sufficient to ensure visibility across the acute sites. Caroline Sealey commented that the service was wider than the acute sites and also covered the full range of mental health and community services across the county. In view of the wide range of services covered, it was difficult to be visible in all locations but every effort will be made to have an ongoing presence at YDH. The Chief of People and Organisational Development commented that the freedom to speak up work was not limited to the guardians and many colleagues and senior managers can offer and signpost support. The guardians will make every effort to see as many colleagues as possible in person but it was also important to ensure that the work of the guardians was linked to the people strategy. Caroline Sealey further advised that the respectful resolution training will provide clarity and will allow concerns to be identified at an early stage. • The number of bullying or harassment cases was a concern and there should be zero tolerance for bullying or harassment. An example was highlighted where, some time ago, bullying and harassment concerns had been identified

	during night shifts in more isolated units and it was queried how assurance can be provided about the culture during night shifts. Caroline Sealey advised that the first walkround had included night shift colleagues and this will continue to be an area of focus. The Chief Nurse commented that she regularly completed night shifts and this provided an element of assurance about the culture. Caroline Sealey commented that the perception of bullying or harassment can be different for different groups, but colleagues submitting a claim will be supported and appropriate actions will be taken. These actions do take account of the wishes of the colleagues raising the concerns. • The response times as set out in paragraph 3.7 were excellent but it was queried whether the response times related to acknowledging or resolving the concerns. Caroline Sealey advised that the response times related to the timing within which a meaningful response had been provided.
14.3	The Chairman thanked Caroline Sealey for the excellent and encouraging report. The report provided positive assurance that colleagues feel able to speak up.
14.4	Caroline Sealey left the meeting.
15.	**SIX MONTHLY STAFFING ESTABLISHMENT REPORT**
15.1	Alison Wootton, Deputy Chief Nurse SFT, joined the meeting.
15.2	Alison Wootton presented the report which was received by the Board. Alison Wootton highlighted the key challenges and risks and particularly the ongoing impact of Covid-19, the number of escalation beds; the industrial actions; and the continued pressures on the workforce.
15.3	The Board discussed the report and commented/noted that: • Safe staffing levels had been reviewed as detailed in the report and have broadly been found to meet the standards and guidance. • There remained disruption and challenges to service delivery requiring a focus on a dynamic approach to monitor and oversee staffing. • Some services had vulnerabilities that required ongoing and close monitoring as well as action to mitigate and deliver safe care. There was directorate level ownership and oversight of these risks and issues and there was a clear and accessible escalation process to raise concerns if the risk was considered inadequately managed or mitigated. • A number of measures in the primary care and neighbourhoods directorate were showing red in spite of fill rates showing 111%. Alison Wootton advised that the measures were based on 100% of normal staffing levels and even at 111% staffing levels, further staff was required e.g to cover escalation beds. 30 escalation beds had been opened in community hospitals and further additional staff was required. Additional RGNs had

	been appointed but shift gaps were more difficult to fill because of the rurality of the majority of the community hospitals. • It was queried why the YDH fill rate generally seemed to be lower than the SFT fill rate. Alison Wootton advised that the YDH and SFT data may not be like for like comparisons as the information was provided by different teams. Generally it may be more difficult to fill shift gaps at YDH in view of the more limited temporary staffing pool in Yeovil. • It was queried whether there was a point at which services were declared unsafe. Alison Wootton advised that risks were balanced on a day by day basis and generally a balance could be achieved. In the case of e.g. only one RGN on a shift in a community hospital, discussions will take place with the RGN to check whether, and if so what, additional support will need to be put in place. Martyn Scrivens advised that this explanation provided assurance about the management of shift gaps. • The report showed more full time wtes than budgeted wtes and it was queried whether this was due to non budgeted escalation staffing requirements. Alison Wootton advised that some services had seen an over recruitment as the international recruitment feed was healthy. It was better to maintain the recruitment feed on an ongoing basis to avoid any gaps in recruitment and this had resulted in some over recruitment. A further reason was that both trusts were running the equivalent of an extra 6.5 wards of escalation beds which required additional staffing. Over recruitment can be used to support other services when needed. Barbara Gregory advised that the size of the non budgeted whole-time equivalents (wtes) had been raised at the recent Finance Committee and different ways for managing the additional wtes may need to be considered to ensure that there was clear budgetary oversight. • It was queried how many patients had been identified as having “no criteria to reside” and it was noted that there were approaching 200 patients to whom this criteria applied across both trusts. A reduction in the number of patients waiting for ongoing care will reduce the need for escalation beds. • The midwife to birth ratio was broadly in line with the national recommendation of 1:28. The Chief Nurse advised that the ratio depended on the operating model but generally a ratio of 1:28 or better was being achieved. The Chief Nurse advised that the ratios did not reflect the considerable pressures midwifery services were experiencing. It was noted that the SFT home birth service had been suspended for three months due to a reduction in staffing levels in community teams as a result of vacancies and sickness absence and, where possible, women were cared for by the YDH home birthing team.
15.4	The Board accepted the assurance set out in the report that the trusts were taking all actions to try and ensure safe staffing levels in all ward areas and that, where

	this was not possible, escalation and actions were followed to try and mitigate the risks of working with a compromised level of staff.
15.5	The Chairman thanked Alison Wootton and her team for their excellent work.
16.	**STAFF SURVEY 2022 REPORT**
16.1	The Chief of People and Organisational Development advised that the staff survey report was embargoed until 9 March 2023 and will therefore be presented to the May 2023 meeting.
17.	**ASSURANCE REPORT OF THE PEOPLE AND WORKFORCE COMMITTEE MEETINGS HELD ON 30 JANUARY 2023**
17.1	Stephen Harrison presented the report which was received by the Board.
17.2	Stephen Harrison advised that no areas of concern or follow up, or significant risks or issues to be reported to the Board had been identified. Stephen Harrison advised that the main focus at the meeting had been on nurse recruitment and the Committee received and discussed the five year nursing vacancy forecast. The discussion provided the Committee with significant assurance about workforce planning. Graham Hughes agreed that the presentation and discussion had been interesting and productive and it will be helpful to share the presentation with Board members.
17.3	The Board discussed the report and commented/noted that: • Workforce demand and supply planning as well as assumptions for all staff groups will need to be tested and it was suggested following this up at a future Board development day. The Chief of People and Organisational Development advised that the People Committee will be carrying out deep dives into all staff groups over the next few months. • The Chief Nurse advised that the nursing workforce planning forecast as presented to the Committee had been a resource intensive exercise and the frequency of presenting this information to the Committee will need to be considered. She advised that workforce planning for occupational and physio therapists was in an advanced stage but less progress had been made in relation to smaller professional groups. The five year forecast was based on a number of assumptions and it will be helpful to test the assumptions in the next few years. The Chief Medical Officer advised that workforce planning for medical staff was more difficult but a multi disciplinary heatmap exercise was being undertaken and will be presented to a future Quality and Governance Assurance Committee planning meeting. Medical workforce planning will need to be linked to the future clinical inpatient and community service model.

17.4	The Chairman thanked Stephen Harrison and Graham Hughes for their ongoing leadership of the Committee.
18.	**FINANCE REPORTS**
	Finance Report – YDH
18.1	The Chief Finance Officer presented the financial report which was received by the Board. She highlighted the financial position: • An in-month surplus of £283,000 in line with the plan. The year to date was a negative variance of £150,000 in relation to the plan. • Agency spend remained higher than plan and this was driven both by SHS locum and trust agency expenditure due to an increase in non elective activity and sickness absence. • A £4.345 million cost improvement plan delivery against £3.565 million planned efficiencies, of which 22% had been achieved recurrently. • An underspend against the capital programme. The programme will be revised after agreement by NHS England to reprofile funding for the theatre schemes. • Risks going forward included the funding of the escalation capacity; and staffing challenges.
	Finance Report - SFT
18.2	The discussion of this item is reflected in the SFT minutes.
18.3	The Board discussed both reports and commented/noted that: • The finance reports had been discussed in detail at the recent Finance Committee meetings. • A large part of agency expenditure related to medical agency and it was queried whether robust recruitment plans were in place and whether the recruitment issues were restricted to specific specialities. It was noted that the recruitment challenges relating to Symphony practices and the high use of locums was recognised. The Chief Medical Officer advised that the processes for managing medical vacancies had been aligned across both trusts and this work had identified possibilities for transformation. It was recognised that some of the specialties will be difficult to recruit to and progress was being made at a slower speed. In addition, some agency staff was required to staff the escalation beds. It was expected that the further development of Hospital@Home and other admission avoidance schemes, as well as improvement in social care staffing challenges, will reduce the need for agency staff.

	The Chief of People and Organisational Development advised that a deep dive into the agency position will be undertaken at the People/Workforce Committee meetings to be held in common on 8 March 2023. This will enable a clear understanding of the key drivers for agency staff across all services. Significant work will also be undertaken over the coming month on identifying areas where recruitment had not been successful in spite of a number of recruitment campaigns and alternative options will be identified. • The escalation budget was proportionately high compared to the basic directorate budgets and was in addition to the directorate budgets. It was queried whether the value for money aspect of the use of the escalation budget had been considered and what processes were in place to manage and oversee the budget. The Chief Operating Officer advised that there had been a need to use escalation beds to be able to provide safe services and deliver the elective recovery programme. A programme of work on planning bed requirements for 2023/24 was currently taking place and this will include a review of current beds, surge beds etc as well as a review of management and control processes. The significant financial expenditure associated with staffing additional beds was recognised and this was a key area of focus. • Work was taking place to ensure that a common set of financial and workforce data from the ledger and ESR will be available for discussion at the Finance Committee meetings from April 2023 onwards. To date there had been a mismatch between the data on the ledger and ESR and this made it more difficult to match the data. • In view of higher activity and demand levels compared to 2019/20, it was not envisaged that escalation beds can currently be fully eliminated. However relevant discussions were taking place and workforce, financial and operational plans will need to be triangulated. • The first task will be to understand the drivers and to then approach this in a systemic way. The Chief Operating Officer advised that the teams were committed and motivated to get services back into pre Covid-19 shape as soon as possible.
18.4	The Board recognised the financial challenges and welcomed the actions being taken to address the financial pressures.
19.	**CAPITAL PROGRAMME FOR 2023/24**
19.1	The Director of Strategy and Digital Development presented the report which was received by the Board. It was noted that the capital envelope for the merged organisation will be £33.059 million, which was an overcommitment of 5% above the system allocation and this overcommitment can be managed through the year. The details of the capital schemes for 2023/24 were noted.

19.2	The Board discussed the report and commented/noted that: • The scale of the capital programme recognised the level of internal funding available in the system. It was noted that an additional £3 million capital funding will be allocated to the system if a 2022/23 financial breakeven position will be achieved. • A number of the schemes were existing schemes and were carried forward into 2023/24. • The scale of the programme carried a level of risk and there continued to be challenges in terms of the supply chain and construction industry from a supplier and material perspective. • Resources had been identified for the majority of the schemes but business case for some of the schemes will need to be developed and approved due to the level of investment required. • In view of the overcommitment, it was queried whether a plan was being developed to address the overcommitment, e.g. through slippage of schemes. The Director of Strategy and Digital Development advised that the overcommitment had been included to avoid a delay in schemes due to the need for Board approval during the year. The capital programme was reviewed on a quarterly basis and any slippages on schemes will be identified and elements for future schemes can be brought forward as and when required. • Confirmation of funding from the New Hospital Programme was still awaited and due to the impact on other builds, e.g. maternity unit, it was queried whether public or political awareness of the delay in confirmation of funding will need to be raised regionally and nationally. It was noted that the Trust, together with another 32 hospitals had been waiting for confirmation of participation in the scheme for one year and due to the state of some of the facilities at Musgrove Park Hospital, this delay was disappointing. Colin Drummond advised that he had raised the delay with the local MP and was doing everything he could to continue to raise awareness of the delay and impact. The Chief Executive advised that actions were being taken and, if needed, consideration will be given as to how to increase the focus on the environmental impact of the delay.
19.3	Graham Hughes <u>proposed</u>, Martyn Scrivens <u>seconded</u> and the Somerset NHS Foundation Trust Board approved the capital programme for 2023/24.
20.	**VERBAL REPORT FROM THE FINANCIAL RESILIENCE COMMERCIAL COMMITTEE/FINANCE COMMITTEE MEETING HELD IN COMMON ON 24 FEBRUARY 2023**
20.1	Kate Fallon, Chairman of the joint Committee, advised that all issues discussed at the meeting held in common on 24 February 2023 had already been covered under previous agenda items.

21.	**CHANGES TO THE CONSTITUTION**
	YDH
21.1	Ben Edgar-Attwell joined the meeting for this agenda item.
21.2	Ben Edgar-Attwell presented the report and highlighted the proposal to include a provision for email voting and the change to the quoracy requirements. The report was received by the Board.
21.3	Graham Hughes proposed, Paul Mapson seconded and the Yeovil District Hospital NHS Foundation Trust Board approved the changes to the constitution as set out in the report. The Board that noted that the Council of Governors will be asked to approve the changes to the constitution at their meeting to be held on 10 March 2023.
	SFT
21.4	The discussion of this item is reflected in the YDH minutes.
22.	**FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS**
22.1	There were no follow up questions from the Public or Governors.
23.	**ANY OTHER BUSINESS**
23.1	Colin Drummond advised that this was Stephen Harrison's last public Board meeting and thanked Stephen for his significant contributions to the Trust as well as to Taunton and Somerset NHS Foundation Trust prior to the merger in 2020. He advised that Stephen had been dedicated and committed to the work of the Trust and was a sound and balanced contributor to Board and Committee meetings. Colin Drummond reiterated his thanks on behalf of the Board and wished Stephen every success for the future.
23.2	Stephen Harrison commented that his time on the Board, and previous Board, had been an interesting time and was encouraged by the progress made and the vision going forward.
23.3	The Chairman, on behalf of the Yeovil District Hospital NHS Foundation Trust Board, also wished Stephen every success for the future.
	Patient Stories
23.4	Emma Davey advised that she had taken up her post as Director of Patient Safety and Engagement and one of her roles will be to identify patient stories for Board meetings. Emma Davey asked Board members to advise her of any topics for future Board meetings.
24.	**RISKS IDENTIFIED**
24.1	The Board did not identify any new significant risks which had not as yet been included on the risk register but highlighted the discussion in relation to end of life services and the financial position.

25.	**EVALUATION OF THE EFFECTIVENESS OF THE MEETING**
25.1	The Board agreed that the meeting had been very effective with a wide range of topics covered.
25.2	The Director of Corporate Services advised that a more formal effectiveness review of the Board and Committees will be carried out over the next few months.
26.	**ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING**
26.1	The Chairman highlighted the items for discussion at the confidential Board meeting and set out the reasons for including these items on the Confidential Board agenda.
27.	**WITHDRAWAL OF PRESS AND PUBLIC**
27.1	The Board moved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.
28.	**DATE FOR NEXT MEETING**
28.1	9 May 2023

SOMERSET NHS FOUNDATION TRUST (SFT)
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST (YDH)

EXTRA ORDINARY PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON

MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST MEETING HELD ON 20 MARCH 2023 BY MS TEAMS

PRESENT

Martyn Scrivens	Non-Executive Director (Chairman)
Graham Hughes	Non-Executive Director
Alexander Priest	Non-Executive Director
Paul Mapson	Non-Executive Director
Jan Hull	Non-Executive Director
Peter Lewis	Chief Executive
Phil Brice	Director of Corporate Services
Andy Heron	Chief Operating Officer
Hayley Peters	Chief Nurse
Daniel Meron	Chief Medical Officer
David Shannon	Director of Strategy and Digital Development
Isobel Clements	Chief of People and Organisational Development

IN ATTENDANCE

Colin Drummond	Chairman - SFT
Barbara Gregory	Non-Executive Director – SFT
Kate Fallon	Non-Executive Director - SFT
Stephen Harrison	Non-Executive Director – SFT
Sube Banerjee	Non-Executive Director - SFT
Fiona Reid	Director of Communications
Ben Edgar-Attwell	Deputy Director of Corporate Services
Ria Zandvliet	Secretary to the Trust (minute taker)
Victoria Keilthy	Director of Integration

1.	**WELCOME AND APOLOGIES**
1.1	Apologies were received from: Pippa Moger (Chief Finance Officer).
1.2	The Chairman advised that, following the establishment of a single executive team across both trusts, the SFT and YDH Boards have agreed to conduct their Board of Directors meetings as meetings held in common. The meetings will be chaired by the Chair of either SFT or YDH Chair on a rotation basis and Colin Drummond will be chairing this meeting.

1.3	Colin Drummond welcomed all Board members and attendees to the meeting and confirmed that the meeting was quorate.
2.	**DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA**
2.1	There were no declarations of interest relating to items on the agenda.
3.	**ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING**
3.1	Colin Drummond advised that the focus of the Confidential Board meeting will be on the merger progress update; approval of the merger transaction; and approval of the merger transaction agreement for signature. Colin Drummond set out the reasons for including these items on the Confidential Board agenda.
4.	**WITHDRAWAL OF PRESS AND PUBLIC**
4.1	The Board moved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.
5.	**ANY OTHER BUSINESS**
5.1	There was no other business.
6.	**DATE OF NEXT MEETING**
6.1	9 May 2023

SOMERSET NHS FOUNDATION TRUST/YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON ON 7 MARCH 2023

AGENDA ITEM	ACTION	BY WHOM	DUE DATE	PROGRESS
ACTIONS FROM THE MEETINGS HELD ON 6 NOVEMBER 2022				
14. Corporate Risk Register Progress Reports	To consider including a quadrant diagram to distinguish between the different type of risks in the 2023/24 corporate risk register.	Phil Brice	April	This will be considered for the 2023/24 Corporate Risk Register.
ACTIONS FROM THE MEETINGS HELD ON 7 FEBRUARY 2023				
9. Future Community Hospitals model of care	To include a discussion on the future model of community hospital care on the schedule for a future Board Development Day.	Ria Zandvliet	February 2023	This item has been included on the Board development programme.
13. Board Assurance Framework	To give an update on the work in relation to strategic objective 1 – improving the health and wellbeing of the population – and the actions taken by ICB and Local Authority to a future Board Development Day.	Peter Lewis	To be confirmed	The item has been included on the Board development programme.

ACTIONS FROM THE MEETINGS HELD ON 7 MARCH 2023					
8.	**Chief Executive and Executive Directors report**	To include an overview of the different initiatives relating to services for frail people on the agenda of a future Board Development Day	Peter Lewis/ Phil Brice	TBC	This item has been included on the planner for future Board Development Days.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Registers of Directors' Interests
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Chairman
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	The Registers of Interests are presented to the Board at every meeting and reflect the interests of Board members as at 1 May 2023.
Recommendation	The Board is asked to: • note the Register of Interests; • declare any changes to the Register of Interests; • declare any conflict of interests in relation to the agenda items.

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

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

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

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

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

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

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

F

REGISTERS OF DIRECTORS' INTERESTS

EXECUTIVE DIRECTORS	
Peter Lewis Chief Executive (CEO)	• Member of the NHS Confederation Community Network Board • Management Board Member, Yeovil Strategic Estates (YEP) Partner Board • Director, YEP Project Co. Limited
Phil Brice Director of Corporate Services	• Sister works for Somerset NHS Foundation Trust • Non-Executive Director of the Shepton Mallet Health Partnership • Non-Executive Director of SSL
Isobel Clements Chief of People and Organisational Development	None to declare
Andy Heron Chief Operating Officer/Deputy Chief Executive	• Wife works for Avon and Wiltshire Mental Health Partnership NHS Trust (and is involved in a sub contract for liaison and diversion services) • Director of the Shepton Mallet Health Partnership • Executive Director for SHS
Pippa Moger Chief Finance Officer	• Stepdaughter works for Yeovil District Hospital NHS Foundation Trust • Son works for Somerset NHS Foundation Trust • Director of the Shepton Mallet Health Partnership • Director of YEP Project Co Limited • Member of the Southwest Pathology Services (SPS) Board • Non-Executive Director for SSL
Hayley Peters Chief Nurse	None to declare

David Shannon Director of Strategy and Digital Development	• Member of the Southwest Pathology Services (SPS) Board • Daughter is employed as a healthcare assistant at Musgrove Park Hospital • Member of the Symphony Health Care Services (SHS) Board • Director of Symphony Health Services (SHS) • Wife works on a temporary contract within the recruitment department. • Director of YEP Project Co Limited • Director Predictive Health Intelligence Ltd
Daniel Meron Chief Medical Officer	None to declare

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

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

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

NHS Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Chief Executive/Executive Director Report
SPONSORING EXEC:	Chief Executive
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Chief Executive
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	The purpose of the report is to update the Board on the activities of the executive and senior leadership team and/or points of note which are not covered in the standing business and performance reports, including media coverage. The report covers the period March and April 2023.
Recommendation	The Boards are asked to note the report and to approve the NHS Provider Self Declaration pending feedback from Governors.

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

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

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

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

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
The report includes a summary relating to industrial action and the staff survey results.

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

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

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

SOMERSET NHS FOUNDATION TRUST

CHIEF EXECUTIVE / EXECUTIVE DIRECTOR REPORT

1. WELCOME TO OUR NEW TRUST

1.1. On 1 April we became one trust and welcomed all colleagues across all our sites and services to the new organisation.

1.2. In addition, we launched the trust's new website, rolled out merged communications channels for all colleagues, merged social media channels for the trust, and shared the news direct with stakeholders and through press statements and interviews. The merger was covered on BBC Points West, BBC Radio Somerset, BBC online and in the Somerset Gazette.

1.3. The welcome letter to all colleagues is set out below:

Dear colleagues,

Welcome to our new Somerset NHS Foundation Trust. After a number of years of working very closely together, we have now merged our trusts and become one organisation.

It is my great pleasure to welcome you all. Together we now provide services across community, mental health and learning disability services in the county and into Dorset, and services from both Yeovil District Hospital and Musgrove Park Hospital and a quarter of Somerset's GP practices.

We are privileged to touch the lives of hundreds of thousands of people each year and I know how much this means to you, and how you strive to do your best for them, wherever you work and whatever your role.

Celebrating where we have come from
Both of our legacy trusts have a proud history and both are rated good overall by the Care Quality Commission. Even as we look to our future together, I'd like to recognise and celebrate where we've come from.

Through its vanguard programme Yeovil District Hospital NHS Foundation Trust brought together primary care and acute services to benefit people with complex needs and provide greater support to people to manage their own conditions. Our previous Somerset NHS Foundation Trust was one of the first organisations to integrate mental health and learning disability services, community and acute services in one organisation.

Together we saw the opportunity to go further - and we began our work to merge. This is a complex process and I know how hard colleagues, teams and services have worked to get to this point and will continue to work to realise the benefits of being one trust. Thank you.

Why we have come together and our future
We merged because we want to provide better care for everyone who accesses our services and ensure that all the people we serve enjoy consistent access to high quality services irrespective of where they live. At the same time, supporting people to stay well, giving equal priority to mental and physical health, and delivering services in the most appropriate setting, will also help us to further improve care for our patients and make better use of our resources.

I strongly believe that we have a stronger future together and can deliver more for the local population as one trust. We have worked particularly closely together on our recovery of services following the COVID-19 pandemic and have many examples of how our services have come together to support one another, increase resilience, provide a more equitable service across the county and at the same time improve services for patients and families.

Examples of teams coming together are:

- *Our specialist dementia and delirium teams have come together to provide a service across Somerset and improve support for patients and colleagues. Colleagues from YDH have led the way with a team of specialist dementia and delirium professionals that has supported patients on the inpatient wards at Yeovil Hospital for the last eight years. Last year a similar service was set up in our community hospital inpatient units and the wards at Musgrove Park Hospital. Coming together has enabled the team to strengthen its knowledge and resilience as one team for Somerset, which will benefit patients with dementia and their families.*

- *People who are homeless or who sleep rough can potentially only live until their mid-40s – around 30 years less than average. Our homeless and rough sleepers service is working together with teams across both of our legacy trusts, and the wider Somerset healthcare system, to bridge the gaps and ensure this group of patients get equal access to the physical and mental health care they need.*

- *Our maternity team was one of the first to come together under a single leadership team, introducing joint roles and shared pathways to provide a more equitable service across Somerset. Together they are tackling recruitment challenges, supporting colleagues to progress and using our resources in the best possible way to provide the right care at the right time to our women and pregnant people.*

Supporting you
As one trust, including our subsidiaries in SHS and SSL, we employ more than 13,000 colleagues and we want to continue to improve your experience of work. The results of the most recent NHS Staff Survey show how well our legacy trusts have done in comparison with other trusts but also where we have more work to do.

One of the central preparations for our new organisation was the development of our values – Kindness, Respect and Teamwork – which we developed together and you see reflected visually in our communications. Our people strategy includes five commitments to care for and develop our colleagues, retain and attract talent, continue to develop compassionate and inclusive leadership and to continue to learn and transform.

We have launched the new recognition framework that will recognise and thank colleagues for their work and have launched the new learning management system for the trust.

My commitment is to continue to work with my senior leadership team and with the Trust Board and its subcommittees to support colleagues to develop in their roles, perform them to the best of their ability, and to stay healthy and well, so that together we can support and care for our patients, service users and their families.

Peter Lewis
Chief Executive

2. UPDATE ON INDUSTRIAL ACTION

Agenda for Change pay offer

2.1. On 2 May, the NHS Staff Council - made up of health unions, employers and Government representatives – accepted the Government's pay offer of a 5% pay rise with an additional one-off sum of at least £1,655.

2.2. The Royal College of Nursing (RCN) has not accepted the pay offer and has warned that it will continue to pursue strike action. Another ballot of its members will be required as its six month mandate expired at the end of their strike action on 1 May 2023.

2.3. Unite has also rejected the pay offer.

Industrial Action

2.4. We will continue to plan collaboratively, with our values of Kindness, Respect and Teamwork in the forefront of our minds, as we plan for and manage the impact of any further industrial action across our services.

Impact of industrial action by junior doctors

2.5. Data showing the impact of the recent industrial action from 11 – 15 April by junior doctors indicates that, at a national level, over four days there were 195,000 cancellations. At the peak of the action, there were 27,361 colleagues not at work due to industrial action. In the previous junior doctors' strike, there were 175,000 cancellations across three days.

3. LAUNCH OF THE SOMERSET TOGETHEHR PROGRAMME

3.1. We recently launched the Somerset TogethEHR programme which is working towards a single integrated health record across our services. The EHR is an electronic health record system providing one digital patient record, giving a complete picture of the health of every person in Somerset. This patient record will be accessible across different health care settings, in our case all service groups across both trusts.

3.2. Our ambition is to continue the momentum of digital and data transformation both trusts have invested in, with an inclusive approach to all services groups and sites. The development of an EHR is a key enabler in the merger and underpins our clinical care and support strategy and digital strategy.

3.3. The EHR will maximise the opportunities for the newly merged trust to come together as one team, use digital and data to enhance the delivery of care, provide one patient record for everyone no matter their previous health care experience and give our community greater opportunity to achieve better health outcomes. This will touch everyone within the trusts - clinical, administrative and support teams, as well as patients and their families and support networks.

3.4. This is an exciting digital programme that will involve all colleagues as well as patients, their families and support networks.

4. VERY POSITIVE NHS STAFF SURVEY RESULTS FOR BOTH TRUSTS

4.1. The results of the 2022 NHS Staff Survey have been released and are overwhelmingly positive for both trusts.

4.2. The survey, which was conducted throughout October and November 2022, provides feedback on the nine elements and themes of the NHS People Promise and both trusts have ranked near the top of these elements within our comparator group, with YDH receiving the best scores nationally in five of the elements. The Health Service Journal has run articles about the national results and its coverage ranks YDH and Somerset FT first and second for acute trusts in order of colleagues “agreeing” or “strongly agreeing” they would recommend it as a place to work.

4.3. SSL also conducted a survey and this highlighted colleagues’ pride in their service as well as good working relationships with managers.

4.4. The surveys confirmed feedback that we have previously received and that have informed the development of five commitments within our people strategy; caring for our people, developing our people, compassionate and inclusive leadership, retaining and attracting talent, and learning and transforming.

4.5. While we are really pleased with these results, which demonstrate our strong position ahead of our merger, we also know it won’t feel the same for all colleagues. We have been analysing the detail to understand how the results may vary for colleagues across the various protected characteristics, as well as by service areas, sites and professional group.

4.6. The full results of both surveys can be found on the following link view results these can be found at Results | Working to improve NHS staff experiences | NHS Staff Survey (nhsstaffsurveys.com)

5. UPDATE ON REBRANDING OUR CHARITIES

Background

5.1. We developed brand options to represent the new family of charities post-merger. We used the same agency as the trust and have ensured that the charity brands are compatible with the trust visual identity. We consulted all colleagues across all sites and a cross section of our supporters, including individuals, organisations, groups and companies, and the heart-shaped logo was preferred by around 80% of those who responded.

Where we are now

5.2. We have a full set of brand guidelines including logos.

Somerset NHS Charity

Love Musgrove

Yeovil Hospital Charity

5.3. This allows us to maintain existing supporters and start growing the new parent brand, Somerset NHS Charity, with greater focus on supporting community healthcare projects.

Next steps

5.4. We are now bringing the brand to life by creating leaflets, banners, digital assets etc. Because Somerset NHS Charity does not currently exist, and is a completely new brand, we are planning a launch event, which we are hoping can take place in early June.

6. DISCHARGE TO ASSESS HELPS 8,300 PATIENTS RETURN HOME IN FIRST THREE YEARS

6.1. Over 8,300 people have been helped to regain their independence at home following a stay in hospital thanks to Somerset's Discharge to Assess service.

6.2. The service, which is funded jointly by Somerset FT and Somerset County Council's adult social care team, celebrates its third birthday this month – with colleagues and patients proud of its success.

6.3. It was initially formed from the NHS and council's response to the COVID-19 pandemic – a time when it was vital to help people stay at home.

6.4. It means our patients can return home much quicker than before, reducing the need to wait in hospital for a long-term care package.

6.5. Clare Brolly, our operational flow manager at the Discharge to Assess team, explains how the service works.

"When a patient is admitted to one of our hospitals, they are assessed by a multidisciplinary team of health and social care professionals who will look at whether their care could be managed at home with a little extra support.

"*We use a number of resources to support patients to return home which may include therapy, reablement care, or equipment. As part of this, we work with patients in their home to carry out a holistic assessment, where we review their abilities and needs to understand how to help them to recover.*

"We also provide a period of rehabilitation, centred around the persons recovery goals, which helps to reduce the chance of them being re-admitted to hospital, or needing further care at our community hospitals.

"Many of our patients don't need further support following care from our service, but for those who do, we help to identify the type of longer-term care that may be needed, or other support, such as from the voluntary sector.

"Colleagues in our Discharge to Assess team have learned so much in its first three years, we listen to our patients and colleagues about what works well and where we need to improve, and always strive to give the best service we can."

7. HOUSEKEEPING TEAM AT YDH CELEBRATES PERFECT SCORE FOR CLEANLINESS

7.1. The results of the national Patient-Led Assessments of the Care Environment (PLACE) have been published.

7.2. The inspection involved local people known as patient assessors visiting inpatient sites across the trust to assess how the environment supports the provision of clinical care. The assessment covers a range of areas including; privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia or with a disability.

7.3. While the trust's sites received good scores across the board, the Yeovil Hospital team was top in the category of "small" hospital and one of only eight NHS hospitals across England to receive a maximum 100% score for cleanliness.

7.4. The assessments take place every year, and results are published to help drive improvements in the care environment. The results show how hospitals are performing both nationally and in relation to other hospitals providing similar services.

8. CELEBRATING OUR MIDWIVES ACROSS SOMERSET AND BEYOND

8.1. On Friday 5 May, we are celebrating the fantastic work of our midwives across Somerset, through the International Day of the Midwife.

8.2. Supporting families through one of life's biggest moments is a huge job, but our maternity colleagues have taken it all in their stride – and done so brilliantly, too. Over the last 12 months (April 2022 to March 2023), our midwifery teams have delivered a whopping 4,229 babies - including 59 sets of twins!

8.3. A lot has happened for the maternity service since last year's celebrations, and our director of midwifery, Sallyann King, reflects on the changes, achievements, and hopes for the future. She said: "*International Day of the Midwife is always a great opportunity to take a moment to celebrate the work of our midwives. I also like to think about the maternity wider team, because we couldn't do what we do without them.*

8.4. "We have had such an amazing year, bringing our teams and services together, launching our new digital platform for colleagues to access records, and an app for patients to access their notes, as well as winning awards and all the work that goes on behind the scenes to make these things happen. But reflecting on the year's stats is a real reminder that behind every single number is a person, and a family. Each and every day our midwives are making a difference, having a huge impact on lives across Somerset, and sometimes beyond, at such a special, life-changing time.

8.5. "I would like to wish all our midwives a very happy International Day of the Midwife and take the opportunity to say a heartfelt thank you! Knowing we have such a fantastic and dedicated team here in Somerset makes me exceptionally proud and I can't wait to see what more we can achieve."

9. CONSTRUCTION BEGINS ON NEW BREAST CANCER UNIT AS FUNDRAISING EFFORTS CONTINUE

9.1. We are excited to announce that work is now underway to build our new Breast Cancer Unit at Yeovil Hospital.

9.2. Our breast care team treats and cares for over 2,000 new patients and more than 3,000 follow up patients every year at the Yeovil site. The new unit is a huge milestone in the project and, with £2.3m of the £2.5 million target already achieved, we have been given the go-ahead to begin the construction work while fundraisers continue to support us.

9.3. More women and men are surviving breast cancer today but there are also more people being diagnosed than ever before with one in seven women being diagnosed with breast cancer in their lifetime.

9.4. For the first time, this new Breast Cancer Unit will mean patients can receive all of their tests in one, purpose-built facility making the experience much less stressful at what is often a very difficult time.

9.5. James Kirton, Head of Charity, said, “We have raised over £2.3 million so far and we would like to thank each and every member of our wonderful community. It will be fantastic to see this money transformed into ‘bricks and mortar’. Without the effort and enthusiasm of all of our supporters and donors, we would not be able to turn this ambition into a reality for our patients.

9.6. “We have had people being strapped to the top of planes wing-walking, running marathons, selling cakes, eating cakes, shaving beards and much, much more. Fundraising brings out the best and the bravest in everyone. We have worked with people right across the region, including local companies, schools, groups and many wonderful organisations. Please stick with us for a few more months!”

9.7. The new unit will bring all of the relevant services together. Patients can have their clinical examination, an ultrasound scan, a mammogram, a biopsy, a prosthesis fitting, an appointment with a doctor and an appointment with a specialist nurse all in one place, which will help improve patient experience.

9.8. The unit is being built next to our Women’s Hospital building and will include:

- A dedicated counselling space for difficult conversations
- A changing room, designed specifically to ensure patient privacy and dignity are paramount
- A fitting room for bras and prostheses
- A comfortable waiting area, away from other busy outpatient areas and treatment rooms
- Art and natural light to make the atmosphere as relaxing as possible
- A mammography room
- An ultrasound room

- A wellbeing room for support groups and wellbeing activities

9.9. Although building work is finally underway, our fundraising efforts still have some way to go. The fundraising team can be contacted on 01935 383020 or by emailing YeovilHospitalCharity@somersetft.nhs.uk.

10. NEW COURSE DEVELOPMENT FOR INTERNATIONAL ODPS AND ANAESTHETIC NURSES

10.1. Our international recruitment team, Yeovil International Recruitment, has been working hard over the past year to develop a brand new training course to help ease the transition for our international Operating Department Practitioners (ODPs) and anaesthetic nurses.

10.2. The team has developed a five day course to support all new international arrivals. This will help to ensure that all new recruits are up to UK standards and will give our international recruits confidence in their practise when they arrive in a new country. The course is a mix of theory and practical scenarios. Candidates are tested in high-pressure scenarios replicating real-life situations that can happen in an operating theatre setting.

10.3. As well as being able to offer the whole course to other trusts, which will generate income for the trust, we will also be able to assist UK ODPs and anaesthetic nurses to gain some CPD points towards their HCPC registration evidence.

10.4. The international recruitment team has developed the course content and worked hard behind the scenes to get it accredited by the Association for Periperative Practice, which is a major achievement. Congratulations to the team!

11. DELIVERING TRAUMA-INFORMED MATERNAL MENTAL HEALTH CARE IN SOMERSET

11.1. For almost 15 months, our new maternal mental health service has been supporting people in Somerset with their mental health, providing a specific area of support to those following the loss of a baby, or a traumatic experience related to pregnancy, birth, or post-natally.

11.2. So far, the team has supported over 100 people, caring for around 50 patients at any one time. To coincide with the national Maternal Mental Health Awareness Week, they are now officially launching the service, hoping to raise awareness of how they can support those in need.

11.3. The team works side-by-side with our existing perinatal mental health service, and is part of the NHS Long-Term Plan to combine maternity, reproductive health, and psychological therapy for anyone experiencing moderate to

severe or complex mental health difficulties – directly arising from, or related to, their maternity experience.

11.4. Together, the teams will listen to the person referred to the service, to understand what would be helpful for them and their family at that time, and into the future. Our service lead for the perinatal and maternal mental health services, Debbie Bunce, explains how we're ensuring that patients can access compassionate care, at whatever level of support they require. She said: "Supporting people who have mental health needs from the loss of a baby, or from a traumatic experience related to maternity care, can require a different type of support that wasn't previously offered by perinatal services.

12. THIRD ROOM OPENS AT BRIDGWATER HOSPITAL'S ENDOSCOPY UNIT

12.1. Patients in Somerset who need an endoscopy are benefitting from shorter waiting times, thanks to a third operating room that has been running at our endoscopy unit at Bridgwater Community Hospital since October 2022.

12.2. It means that we now have a total of eight endoscopy rooms across Somerset – three at Bridgwater Hospital, three at Musgrove Park Hospital, and two at Yeovil District Hospital – which treat around 1,500 patients every month.

13. SOMERSET NHS FOUNDATION TRUST BOARD DECLARATIONS RELATING TO THE PROVIDER LICENCE AND THE HEALTH AND SOCIAL CARE ACT

13.1. NHS foundation trusts are required to make the following declarations after the end of the 2022/23 financial year:

- systems for compliance with licence conditions – in accordance with General condition 6 of the NHS provider licence;
- availability of resources and accompanying statement – in accordance with the Continuity of service condition 7 of the NHS provider licence;
- Corporate Governance Statement – in accordance with the FT 4 condition of the NHS provider licence
- certification on training of Governors – in accordance with s151(5) of the Health and Social Care Act.

13.2. The Trust is not required to submit the declarations to NHS England but the Board is required to sign off the declarations and publish the self certifications.

13.3. In view of the new Provider Licence which came into effect on 1 April 2023, self declarations will no longer be required to be published from 2023/24 onwards but different licence compliance monitoring arrangements may be put in place by the ICB.

13.4. The Trust intends to also make positive confirmations on all declarations.

13.5. The Board is required to seek the views of Governors in relation to Conditions 4 and 6 and the certification on training of Governors. Due to the earlier date of the Board meeting, Governors views will be sought by email.

13.6. Details of the declarations are attached to the report and it is proposed that the declarations are approved pending feedback from Governors and that any significant changes to the declarations are approved by the Board by email following the receipt of any comments from Governors.

14. USE OF THE CORPORATE SEAL

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

14.2. The seal register entries for both trusts are set out in the attached appendices.

15. MEDIA COVERAGE

Our trust in the Health Service Journal

15.1. As part of our communications to support our merger to create our new trust, Peter did an interview with the HSJ that has resulted in two pieces published.

15.2. The first article focussed on the priority to deliver acute care at home at a much greater scale than the current virtual ward and remote monitoring programmes across the NHS. The article is available for Health Service Journal readers on the following link CEO of double-merger trust targets 'powerful' shift to out-of-hospital care | News | Health Service Journal (hsj.co.uk)

15.3. The second article was the HSJ's "daily insight" opinion piece and focussed on the merger and the opportunity to deliver truly integrated care across Somerset due to the uniqueness of the Somerset system. The article is available for Health Service Journal readers on the following link Daily Insight: Bludgeoned into balance | Daily Insight | Health Service Journal (hsj.co.uk)

Ready to go unit

15.4. Following on from the in depth look into pressures and solutions by BBC Radio 4/Points West/Radio Somerset and The Times recently, we hosted a crew from ITV Westcountry at Musgrove Park Hospital as part of a similar themed planned media package. ITV also visited Bluebird Care and Taunton Vale GP Practice's telemedicine centre.

£15m funding boost for additional theatre and new ward at Yeovil Hospital

15.5. Mr Paul Foster, Site Medical Director at Yeovil Hospital, was interviewed by BBC Radio Somerset's Drive presenter Matt Faulkner, speaking about the great investments we're seeing in Somerset, including the £15m additional theatre and new ward at Yeovil Hospital as well as the surgical unit in Taunton, the new day theatre in Yeovil and two robots that will soon arrive in the county.

15.6. All of these changes will benefit patients and reduce the time they have to wait – which we know has been an issue post pandemic. The interview mentioned the people behind the scenes working hard to secure investments that will make services in Somerset sustainable for the future, with patients benefiting from equitable care whatever their postcode in Somerset or North Dorset.

16. NATIONAL DEVELOPMENTS

NHS Providers briefing on the UK Covid-19 Inquiry Preliminary Hearing on Module 1

16.1. On 25 April 2023, the UK Covid-19 Inquiry (the Inquiry) held its third preliminary hearing on module 1 which will examine Government planning and preparedness. It will scrutinise Government decision-making relating to planning from June 2009 to January 2020 and seek to identify lessons that can be learnt.

16.2. NHS Providers briefing sets out the key issues discussed in the hearing and where core participants are pressing for changes to the provisional outline of scope. The briefing is available on the following link Next day briefing: UK Covid-19 Inquiry, preliminary hearing on module 1, 25 April 2023 - NHS Providers

Government publishes Patricia Hewitt's independent review of integrated care systems

16.3. The Government has published the independent review of integrated care systems that the Rt Hon Patricia Hewitt was commissioned to lead in November 2022. The review is available on the following link Hewitt Review: an independent review of integrated care systems - GOV.UK (www.gov.uk).

16.4. NHS Providers' briefings is available on the following link On the day briefing: The Hewitt Review - NHS Providers

Government publishes Policy paper: Next steps to put people at the heart of care

16.5. This week the Government has published the policy paper – Next steps to put people at the heart of care – which follows on from the publication of the white paper in December 2021. The paper is available on the following link Adult social care system reform: next steps to put People at the Heart of Care - GOV.UK (www.gov.uk)

SOMERSET NHS FOUNDATION TRUST

NHS PROVIDER LICENCE DECLARATIONS

1. GENERAL CONDITIONS 6 – SYSTEMS FOR COMPLIANCE WITH LICENCE CONDITIONS

1.1 Paragraphs 1 and 2 of General Conditions 6 state that:

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

   (a) the Conditions of this Licence;

   (b) any requirements imposed on it under the NHS Acts, and;

   (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

   (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and;

   (b) regular review of whether those processes and systems have been implemented and of their effectiveness.

1.2 The Trust is intending to declare full compliance with the following statement:

"Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution**."**

2. GENERAL CONDITIONS 6 – SYSTEMS FOR COMPLIANCE WITH LICENCE CONDITIONS

2.1 The Trust is intending to declare full compliance with the following statement*:*

"The Board declares that the Licensee continues to meet the criteria for holding a licence."

3. CONTINUITY OF SERVICES CONDITION 7 – AVAILABILITY OF RESOURCES

3.1 The Trust is required to make one of the following statements:

EITHER

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

3.2 The Trust will declare compliance with statement 3a. The basis for this compliance statement is the achievement of the 2022/23 year end break even position consistent with the plan, the rigorous cost improvement programmes, the merger and the ongoing integration of services, and the presentation of the budgets for 2023/24 to the May 2023 Board meeting.

4. CONDITION FT4 - CORPORATE GOVERNANCE STATEMENT

4.1 It was recommended that the Board declares compliance with the standards marked in italics below. The sources of evidence for the standards are set out in Appendix 1.

4.2 *The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS*.

4.3 *The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.*

4.4 *The Board is satisfied that the Trust has established and implements*

(a) Effective board and committee structures;

(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and

(c) Clear reporting lines and accountabilities throughout its organisation.

4.5 *The Board is satisfied that the Trust has established and effectively implements systems and/or processes:*

(a) To ensure compliance with the Trust's duty to operate efficiently, economically and effectively;

(b) For timely and effective scrutiny and oversight by the Board of the Trust's operations;

(c) To ensure compliance with health care standards binding on the Trust including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;

(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Trust's ability to continue as a going concern);

(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;

(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and

(h) To ensure compliance with all applicable legal requirements.

4.6 *The Board is satisfied that the systems and/or processes referred to above should include but not be restricted to systems and/or processes to ensure:*

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;

(d) that it receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

4.7 *The Board is satisfied that there are systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.*

5. TRAINING OF GOVERNORS

5.1 The Trust is required to confirm compliance with the following statement:

"The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role."

5.2 The Trust is intended to declare full compliance with the above statement on the basis that a development programme has been put in place by way of Governor Development Days. The agenda for the Development Days is set by Governors and takes account of the skills and knowledge needs of Governors. Governors are also invited to attend specific training events, including NHS Providers events.

Appendix 1 – Sources of assurance for Condition FT4 – Corporate Governance Statement

Text of the Statement	Evidence / Sources of assurance on which Board members may choose to rely
The board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services to the NHS.	• Internal Audit (BDO) and External Audit (KPMG) plans include full range of audits to give assurance in this area (via Audit Committees to Board) • Annual Governance Statement. • Head of Internal Audit Opinion. • Annual Audit Letter 2021/22. • Monthly quality, performance, and finance reports to the Board. • Board Assurance Framework and Corporate Risk Register. • Care Quality Commission inspection reports and action plans. • Financial Plan 2022/23. • Implementation of new service group structures. • Risk Management strategy and risk management system • Merger between YDH and SFT
The board has regard to such guidance on good corporate governance as may be issued by NHS England/ Improvement from time to time.	• Processes in place to ensure this is flagged (usually via Audit Committees), with back up provided by regular updates on new guidance from internal and external audit. • New guidance is also flagged through NHS Providers.
The board is satisfied that the Trust implements: (a) effective board and committee structures (b) clear responsibilities for its board, for committees reporting to the board and for staff reporting to the board and those committees (c) clear reporting lines and accountabilities throughout its organisation.	• Review of the effectiveness of the Board, and the use of Development Days to strengthen the strategic focus of the Board. • Assurance reports from the Committees to the Board. • The Trust's Constitution (including Standing Orders). • Standing Financial Instructions. • Scheme of Delegation. • Review of the Committee structure and Terms of References in preparatio0n for the merger. • Board of Directors' Terms of References and review of compliance with the Terms of References • Committee Governance structure • Governance related audit reports • Board and Committee meetings held in common

Text of the Statement	Evidence / Sources of assurance on which Board members may choose to rely
The board is satisfied that Somerset NHS Foundation Trust effectively implements systems and/or processes: (a) to ensure compliance with the licence holder's duty to operate economically, efficiently and effectively (b) for timely and effective scrutiny and oversight by the board of the licence holder's operations (c) to ensure compliance with healthcare standards binding on the licence holder including, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions (d) for effective financial decision-making, management and control including, but not restricted to, appropriate systems and/or processes to ensure the licence holder's ability to continue as a going concern (e) to obtain and disseminate accurate, comprehensive, timely and up-to-date information for board and committee decision-making (f) to identify and manage (with, but not restricted to, forward plans) material risks to compliance with the conditions of its licence (g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery (h) to ensure compliance with all applicable legal requirements.	• Well-led reviews (3 years) and action plan. • Review of Board and committee effectiveness. • Committee and Governance Group terms of reference. • Constitutional documents (standing orders, standing financial instructions, scheme of reservation and delegation and Constitution). • Governance framework, including internal audit of governance processes. • Internal audit plan, reports and opinion. • External audit plan and Annual Audit Letter. • Counter-fraud work plan and reports. • Risk management processes (including corporate risk register, board assurance framework and risk management strategy). • Regular Board and committee meetings' cycle (e.g. Audit Committee, and Quality and Governance Assurance Committee, Finance Committee oversight and progress reports from the Committees to the Board). • Operational plan, business action plan and monitoring arrangements. • Performance reports to the Board (monthly) • Staffing establishment reports, including review of staffing arrangements, to the Board. • Financial performance report to the Board (monthly) and to the Finance Committee; approval of the revenue and capital budgets by the Board and close monitoring arrangements of the cost improvement programme. • Performance monitoring process and review by the directorates. • Patient experience reports to the Council of Governors and Quality and Governance Assurance Committee, including patient story to the Board. • Implementation of the People Strategy. • Annual report, quality report, annual account and annual governance statement. • System working • Integration of services and teams between SFT and YDH • Merger between YDH and SFT

Text of the Statement	Evidence / Sources of assurance on which Board members may choose to rely
	• CQC inspection report ('Good' overall) and action plan; Care Quality Commission Mental Health Act compliance reports. • Going Concern statement to the Audit Committee and Board. • Performance review meetings with regulators. • System financial plan. • Leadership Walkrounds.
The board is satisfied: (a) there is sufficient capability at board level to provide effective organisational leadership on the quality of care provided (b) the board's planning and decision-making processes take timely and appropriate account of quality of care considerations (c) accurate, comprehensive, timely and up-to-date information on quality of care is collected (d) it receives and takes into account the accurate, comprehensive, timely and up-to-date information on quality of care (e) Somerset NHS Foundation Trust including its board actively engages on quality of care with patients, staff and other relevant stakeholders, and takes into account, as appropriate, views and information from these sources (f) there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues, including escalating them to the board where appropriate.	• Annual performance review of the Chief Executive by the Chairman; • Annual performance review of each Executive Director by the Chief Executive and feedback provided to the Remuneration Committee. • Annual personal development plan agreed for the Chief Executive and Executive Directors. • Annual review of the Chairman by the Council of Governors and Board members. • Annual review of Non-Executive Directors by the Chairman and Nomination and Remuneration Committee. • Chief Medical Officer and Chief Nurse as Executive members of the Trust Board.

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

SEAL REGISTER
FINANCIAL YEAR 2022/23

Date of Sealing	No. of Seal	Nature of Document	First Signatory	Second Signatory
27/05/2022	517	MSCP – Deed of Rectification – Resigning of 2018 docs	Peter Lewis Chief Executive Officer	Pippa Moger Chief Finance Officer
27/05/2022	518	MSCP – Deed of Rectification – RPI Clause	Peter Lewis Chief Executive Officer	Pippa Moger Chief Finance Officer
16/06/2022	519	Deed of Guarantee + Indemnity – Buttercross Health Centre - SHS	Peter Lewis Chief Executive Officer	Pippa Moger Chief Finance Officer
16/06/2022	520	Deed of Covenant – Buttercross Health Centre - SHS	Peter Lewis Chief Executive Officer	Pippa Moger Chief Finance Officer
16/06/2022	521	Deed of Termination + Guarantee + Indemnity – SHS Ilchester Surgery	Peter Lewis Chief Executive Officer	n/a
16/06/2022	522	Deed of Termination of Deed of Covenant - Buttercross Health Centre	Peter Lewis Chief Executive Officer	n/a
16/06/2022	523	Deed of Termination of Guarantee + Indemnity – Buttercross Health Centre	Peter Lewis Chief Executive Officer	n/a
23/12/2022	524	Section 278 Agreement re. Red Lion Lane Closure	Pippa Moger Chief Finance Officer	Hayley Peters Chief Nurse
23/12/2022	525	Section 278 Agreement re. Red Lion Lane Closure	Pippa Moger Chief Finance Officer	Hayley Peters Chief Nurse
23/12/2022	526	Section 278 Agreement re. Red Lion Lane Closure	Pippa Moger Chief Finance Officer	Hayley Peters Chief Nurse
29/03/2023	527	Deed of Guarantee + Indemnity - Leases - Burnham and Berrow SHS	Peter Lewis, Chief Executive	Pippa Moger, Chief Finance Officer
29/03/2023	528	Deed of Guarantee + Indemnity - Leases - Burnham and Berrow SHS	Peter Lewis, Chief Executive	Pippa Moger, Chief Finance Officer
29/03/2023	529	Deed of Guarantee + Indemnity - Licence - Burnham and Berrow SHS	Peter Lewis, Chief Executive	Pippa Moger, Chief Finance Officer
29/03/2023	530	Deed of Guarantee + Indemnity - Licence - Burnham and Berrow SHS	Peter Lewis, Chief Executive	Pippa Moger, Chief Finance Officer
29/03/2023	531	Asset Transfer Agreement - Burnham and Berrow SHS	Peter Lewis, Chief Executive	Pippa Moger, Chief Finance Officer
29/03/2023	532	Asset Transfer Agreement - Burnham and Berrow SHS	Peter Lewis, Chief Executive	Pippa Moger, Chief Finance Officer
29/03/2023	533	Asset Transfer Agreement - Burnham and Berrow SHS	Peter Lewis, Chief Executive	Pippa Moger, Chief Finance Officer
29/03/2023	534	Asset Transfer Agreement - Burnham and Berrow SHS	Peter Lewis, Chief Executive	Pippa Moger, Chief Finance Officer

SOMERSET NHS FOUNDATION TRUST

SEAL REGISTER

1 APRIL 2022 to 1 APRIL 2023

Date of Sealing	No. of Seal	Nature of Document	First Signatory	Second Signatory
10 June 2022	34	Lease of the medical centre at the Springboard Centre, Victoria Park, Bridgwater	Hayley Peters	Matthew Bryant
4 August 2022	35	Lease of Quantock View Dental Centre	Pippa Moger	Isobel Clements
10 August 2022	36	Pre Construction Services Agreement – Dorset Dental	Peter Lewis	Phil Brice
10 August 2022	37	Planning and Highways Agreement Dancing Lane, Wincanton	Peter Lewis	Phil Brice
26 August 2022	38	Agreed lease for Room 2, Ground floor, and Room 17, second floor at The Exchange, Express Park, Bridgwater.	David Shannon	Phil Brice
6 October 2022	39	Supplemental Lease of part of Canford Health, Health Clinic, Cullifiord Crescent	Hayley Peters	Isobel Clements
6 October 2022	40	Supplemental Lease of part of the Browning Centre, 7 Shelley road, Boscombe	Hayley Peters	Isobel Clements

14 October 202	41	24 Hoveland Lane, Taunton, TA1 5DE	Hayley Peters	David Shannon
14 October 2022	42	Letter of Indemnity from the Trust re first floor EWA (CMS draft 13/10/22)	David Shannon	Hayley Peters
20 October 2022	43	Letter of Indemnity from the Trust re first floor of Diagnostic Centre - revised	David Shannon	Isobel Clements
27 October 2022	44	Taunton Diagnostic Centre Alliance Medical Group parent company guarantee and Direct Agreement Deed of Variation	Peter Lewis	Pippa Moger
16 November 2022	45	Poole Dentistry contract documents	David Shannon	Phil Brice
28 November 2022	46	Deed of Variation to the Letter of Indemnity – Diagnostic Centre	David Shannon	Isobel Clements
13 December 2022	47	Deed of Variation – First Floor TDC	David Shannon	Peter Lewis
20 December 2022	48	Lease Tower Street, Taunton	David Shannon	Andy Heron
23 January 2023	49	Creech Medical Centre Land Registry	David Shannon	Isobel Clements
27 January 2022	50	Swingbridge House, Taunton	David Shannon	Phil Brice
30 January 2023	51	Section 106 – Dancing Lane, Wincanton	David Shannon	Phil Brice
20 February 2023	52	Transfer and deed of release Glastonbury Dental Access Centre	David Shannon	Phil Brice

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Board Assurance Framework and Corporate Risk Register Report
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Samantha Hann, Deputy Director of Integrated Governance
PRESENTED BY:	Phil Brice, Director of Corporate Services
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	The Board of Directors are ultimately responsible and accountable for the comprehensive management of risks faced by the Trust. They will: • agree the strategic objectives and review these on an annual basis • identify the principal risks which may prevent the Trust from achieving its key objectives • receive and review the Corporate Risk Register via the Board Assurance Committees and the Assurance Framework quarterly, which identify the principal risks and any gaps in assurance regarding those risks • support the Trust's risk management programme • review the Risk Management Strategy at regular intervals but as a minimum once every 3 years • approve Assurance Committee terms of reference annually Each Board Assurance Committee will receive Corporate Risk Register reports with the specific risks assigned to them. The Committees will formally review and scrutinise the risks within their remit. These reports will be received at least once a quarter together with the Board Assurance Framework. The highest areas of risk for the organisation are:

	• pressures in social care and intermediate care • insufficient capacity to meet demand • workforce recruitment and retention • aging estates - acute and community • financial position The final version of the Assurance Framework for 2022/23 was presented to the Audit Committee in April 2023 and will be presented to the relevant sub-committees in respect of individual objectives. A revised Assurance Framework for Q1 2023/24 will be presented to the Board at its meeting in July 2023.
Recommendation	The Board is asked to note the report and the risks identified.

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

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

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

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER REPORT

1. INTRODUCTION

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

Board Assurance Framework

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

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

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

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

1.6 At its development session in April 2023, the Board agreed that its eight strategic objectives remained appropriate and would form the basis of the Board Assurance Framework for 2023/24. The final version of the Assurance Framework for 2022/23 was presented to the Audit Committee in April and will be presented to the relevant sub-committees in respect of individual objectives.

1.7 The revised Assurance Framework for 2023/24 is being developed to reflect the comments from the development session and will take into account the new corporate risk register for the merged trust; the single set of controls; assurances and KPIs now in place; the focus on key strategies to deliver the organisation's objectives and the work currently underway with the NHS

Somerset Integrated Care Board to develop system risk and assurance mechanisms.

1.8 A revised Assurance Framework for Q1 2023/24 will be presented to the Board at its meeting in July 2023.

Corporate Risk Register

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

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

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

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

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

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

2. PURPOSE OF THE REPORT

2.1 To present the Corporate Risk Register to the Board.

2.2 This risk report aims to provide details of the key risks detailed on the Trust's Corporate Risk Register on 1 April 2023.

3. CORPORATE RISK REGISTER

3.1 There are currently 22 risks on the Corporate Risk Register detailed within the circle heat map, seven of which score 20 or 25:

- Risk 831/331 Insufficient intermediate care capacity
- Risk 003 Estate - Acute
- Risk 004 Demand
- Risk 007/100 Referral to Treatment Times
- Risk 0012 Waiting Times
- Risk 0497 Symphony Healthcare Services not becoming financially self-sustaining
- Risk 1329 Core numbers of Junior and Consultant medical workforce

New Risks

3.2 There has been one new risk added to the Corporate Risk Register during March 2023:

- Risk 1669 – the challenges with the clinical pharmacy service workforce

Increased Risks

3.3 There have been no risks which have increased within March 2023 which have been included on the Corporate Risk Register.

Risks which have Reduced

3.4 There has been one risk which has been reduced and removed from the Corporate Risk Register during March 2023:

- Risk 1542/817 - Insufficient Medical Physics Expertise leading to all radiation services ceasing – Risk reduced from 20 (high risk) to 10 (moderate risk) as there has been an agreed extension of the service secured until 31 December 2023

Risks which have been Archived

3.5 There has been one risk which has been archived on the Trust's Risk Register during March 2023:

- Risk 0002 - Risk associated with Covid19 Pandemic – Risk reduced as no longer relevant. The impact of the pandemic is included within other risks where applicable

Service Group & Corporate Function Risks

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

Emerging Risks

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

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

3.9 During March 2023, there has been eight emerging risks which have been added to the service group and departmental risk registers with a score of 12 which will be closely monitored and mitigating action plans developed:

- Risk U1009 – Unavailability of staff resource to support the proposed increased activity for the service expansion on the Yeovil Hospital (YH) site and support for additional SFT Community devices due to the expansion of services to include; medical device management for YH Modular Theatre; YH Fifth Theatre; Modular Ward; CDC; and North Somerset SFT Community Devices
- R1650 – Medical staffing configuration within mental health and learning disability service group
- R1652 – Lack of air conditioning within the post mortem room
- R1660 – Children and Young people respiratory programmes at risk of not being optimised in the community due to insufficient capacity to match demand
- R1663 – Slip, trips and fall risk and overloading of electrical supplies due to use of escalation beds
- R1666 – Insufficient capacity within the Home Enteral Tube Feeding team to meet demand
- R1674 – Insufficient capacity within bereavement services to meet service requirements
- R1676 – Inability to consistently staff community midwifery services to support choice of place of birth

4. RISK MANAGEMENT ARRANGEMENTS UPDATE

4.1 The Board on 7 March 2023 were asked to approve the draft Risk Management Strategy and the draft Risk Appetite and Risk Tolerance Statement. Both documents had been developed following discussions at Board meetings and Board Sub-Committee meetings throughout 2022/23. Both documents were approved and disseminated to the senior service leads throughout the organisation.

4.2 Work continues to implement the aligned risk management processes. The Board will be kept up-to-date on a regular basis through this report on the progress with the implementation plan included within the Trust's Risk Management Strategy.

4.3 The Trust continues to manage two Risk Management Systems – RADAR and Ulysses. During 2023/24, the Trust will undertake a review of the systems and their functionality and a decision will be made on the system that will be in sole use by the Trust for 2024/25.

5. CONCLUSION

5.1 There has been progress in mitigating a number of risks but the position remains challenging due to workforce challenges and operational pressures within the Trusts and in social care and primary care across the County.

6. RECOMMENDATION

6.1 The Board is asked to note the Corporate Risk Register.

Appendix 1

QUALITY & GOVERNANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R0831 / U331	25	⇔	Insufficient intermediate care capacity

R0003	20	⇔	Estate - Acute

Service Group / Corporate Function Risks 15+

R0890	20	⇔	Inability to convert model box room to provide required clinical space to meet service requirements
R1548	20	⇔	End of life aspect isolators and air handling units
R1256	16	⇔	Staff and areas becoming contaminated due to water droplets/aerosols from toilets, macerators, drains due to poor ventilation
R1297	16	⇔	Lack of safe access to steam control valves serving the heating & hot water heat exchangers for the day surgery building
R1313	16	⇔	The high voltage ring supply to Duchess, Queens and Jubilee is compromised
R1562	16	⇔	Non-compliance of statutory maintenance of thermostatic mixing values
R1570	16	⇔	Management of the Asbestos Register
R1648	16	⇔	Poor water quality and potentially unsafe water systems at project handovers
R1668	16	NEW	Cath lab cardiac arrest call bell system not fit for purpose
R1299	15	⇔	Loss of high voltage supply and resilience due to additional load for new surgical centre
R1300	15	⇔	Air conditioning maintenance not undertaken to the correct legislative standards
R1346	15	⇔	Inability to develop support site development due to electrical supplier unable to increase our maximum demand for a long period of time
R1567	15	⇔	Helipad barriers - non-compliance with current electrical regulations
R1670	15	NEW	Lack of physical space within the department to accommodate clinical functions

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

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

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

Appendix 1

QUALITY & GOVERNANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R0004	20	⇔	Demand

Service Group / Corporate Function Risks 15+

U21	25	⇔	Unsafe numbers of attendances in Emergency Department
U49	20	⇔	Increased demand – opening of escalation areas
R1004	20	⇔	Inability to provide sufficient theatre capacity for elective operating
R1077	20	↑	Cancellation of elective activity due to insufficient number of theatre slots for trauma lists to meet demand
R1649	20	⇔	Insufficient capacity to meet demand in heart failure nurse led service
R0277	16	⇔	Activity within community midwifery impacting on prioritisation of safeguarding
R0293	16	⇔	Insufficient capacity to meet demand for CT scanning
R0372	16	⇔	Overcrowding in Emergency Department
R0551	16	⇔	Overcrowding in Acute Medical Unit
R0847	16	⇔	Increased bed capacity - doubling up beds in single rooms
R0953	16	⇔	Increased demand impacting on patient flow within the Trust
R1134	16	⇔	Non-compliance with stroke standards due to increased demand
R1312	16	⇔	Use of escalation beds for additional capacity
R1362	16	⇔	Insufficient theatre capacity for Urology cases to meet demand
R1504	16	⇔	Referral rates into Children & Young People's Neurodevelopment Service
R1389	15	⇔	Increased demand in neurology causing delays in typing and sending to onward care providers clinical correspondence
R1450	15	⇔	Significant and continuous growth in demand for Ultrasound services
R1587	15	⇔	Super surge additional beds being set up in medical wards

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

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

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

Appendix 1

QUALITY & GOVERNANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

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

Service Group / Corporate Function Risks 15+

R0009	16	⇔	Diagnostic Waiting Times Performance
U687	16	⇔	Inability to comply with Cancer standards due to lack of outpatient capacity
R0008 / U652	15	⇔	Deteriorating cancer performance & inability to meet cancer standards
R1664	20	⇔	Evacuation of patients - Jubilee Building
U45	15	⇔	Evacuation of patients - Wards 6 to 9
U961	15	⇔	Evacuation of patients - AEC

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

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

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

Appendix 1

QUALITY & GOVERNANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

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

Service Group / Corporate Function Risks 15+

R1672	20	NEW	Use of rooms on site not fit for purpose – Rydon Ward
R0534	15	⇔	Poor condition of Shepton Mallet Community Hospital Portakabin Units
R0654	15	⇔	Ligature Points on the ward pose a risk to patients
R1214	15	⇔	Lack of speech and language therapy provision for patients with upper airway disorders

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

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

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

Appendix 1

PEOPLE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R1329	20	⇔	Core numbers of Junior and Consultant medical workforce
U189	16	⇔	Failure to achieve mandatory training levels

Service Group / Corporate Function Risks 15+

R0644	20	⇔	Reduced echocardiography service due to staffing issues
R1150	20	⇔	Orthogeriatric medical staffing
R1599	20	⇔	Recommended 1:6 staffing for Interventional Radiology not currently achievable due to current establishment
U236	16	⇔	Reduced GP cover within SHS Practices
R0343	16	⇔	Inability to recruit to vacant Neurology Consultant posts
R0530	16	⇔	Somerset Lipid Service is not adequately developed and resourced
R0999	15	↓	Inability to recruit substantive Orthodontic consultant
R1491	16	⇔	Inability to provide endoscopists to meet capacity for colonoscopy lists
R1662	16	⇔	Inability to provide consistent Consultant cover for Somerset Neuro Rehabilitation Unit
U515	15	⇔	Inability to retain and recruit critical care consultant intensivists
U864	15	⇔	Inability to support the additional 10 escalation beds at La Fontana Care Home in Martock (SHS)
R1671	15	NEW	Insufficient substantive staffing for the Breast Surgery Pre-Operative Assessment Clinic
R0131	16	⇔	Training and validation of pressure ulcers acquired in the Community

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

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

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

Appendix 1

PEOPLE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R0690 / U728	16	⇔	Ongoing unsustainable pressure to colleagues in the Trust / staff resilience
U925	16	⇔	Retention and turnover of staff
R1624 / U994	16	⇔	Failure to secure necessary infrastructure (workforce)
R1669	15	NEW	Clinical Pharmacy Service Workforce Challenge

Service Group / Corporate Function Risks 15+

U729	16	⇔	Violence & aggression towards Practice Staff
R1519	15	⇔	Inability to review and lead on governance due to staffing levels
R1581	16	⇔	Clinical Coding backlog due to loss of qualified and experienced colleagues
R1295	16	⇔	Insufficient numbers of skilled personnel in Estates to maintain 24/7 response
R1616 / U988	16	⇔	Lack of analytic support and visibility of data to manage population health

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

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

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

Appendix 1

PEOPLE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

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

Service Group / Corporate Function Risks 15+

R0399	20	⇔	Increased vacancy rate in Occupational Therapy across the organisation
R0440	20	⇔	Inability to provide a robust, continuous streamlined service for direct current cardioversion patients
R0205	16	⇔	HCA Vacancies
R0366	16	⇔	Ongoing shortfall in staffing levels within the District Nursing Teams
R0513	16	⇔	Limited provision of specialist neurological rehabilitation and neuropsychiatry service
R0781	16	⇔	High staffing vacancy percentage and shortfall of therapy staff for the stroke rehab units and community stroke rehab service
U868	16	⇔	Insufficient Clinical Nurse Specialist cover for gynaecology cancer patients
R0969	16	⇔	Speech and language therapy input in our Stroke Rehabilitation Centres are well below the national average
R1112	16	↑	Insufficient Orthotist cover
R1148	16	⇔	Theatres do not have the required safe staffing numbers in the establishment to deliver the service
R1400	16	⇔	Significant nursing and support staff vacancies on the Paediatric ward
R1520	16	⇔	Inability to recruit into staff vacancies - midwifery
R1625	16	⇔	Paediatric high dependency unit staffing
R1653	16	⇔	Loss of therapy colleagues due to Athena Therapy contract ending
U772	15	⇔	Anaesthetic Practitioner on Call Service Provision
R1422	15	⇔	Vacancies across clinical posts in children's therapy services
R1512	15	⇔	Lack of qualified Resuscitation Team staff

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

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

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

Appendix 1

FINANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

U497	20	⇔	SHS not becoming self-sustaining
R1611 / U984	16	⇔	Failure to secure necessary infrastructure (funding)
R006	15	⇔	Delivery of CIP

Service Group / Corporate Function Risks 15+

R1310	20	⇔	No automated and cross organisation treatment escalation plans process
R1343	20	⇔	Quality of Discharge Summaries
R0336	16	⇔	Replacement Viewpoint (Colposcopy system) across Grace and Gynae Oncology Services
R1016	16	⇔	Clinical Coding backlog – loss of income
R1482	16	⇔	End of Life Pharmacy Robot
R0421	15	⇔	End of life overhead hoist
R1046	15	⇔	Rio disaggregation (separation of systems)
R1215	15	⇔	Pharmacy Worksheet and labelling system does not link to either Mosaiq ePrescribing or Trust PAS systems and is non-compliant with guidance

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

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

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

Corporate Risk Register 1 April 2023

Somerset NHS Foundation Trust

People Committee

20 R1329 Core numbers of Junior and Consultant medical workforce

16 U0189 Failure to achieve mandatory training levels

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

16 U0925 Retention and turnover of staff

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

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

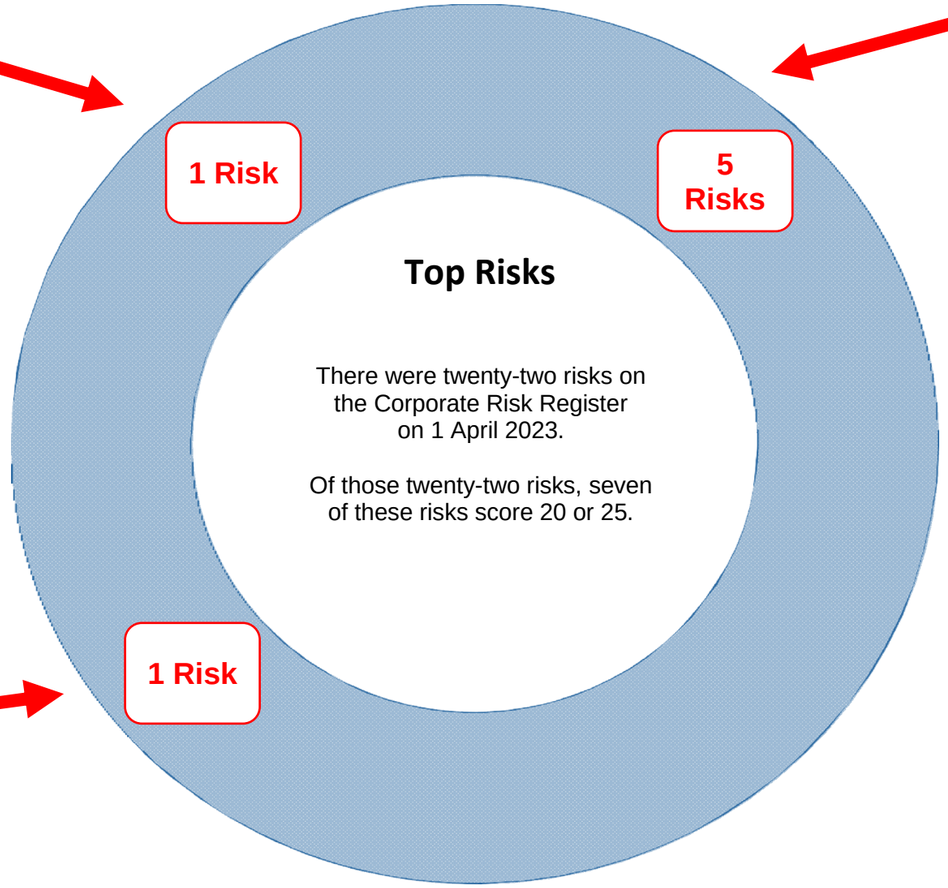
15 R1669 Clinical Pharmacy Service Workforce Challenge

Financial Committee

20 U0497 SHS not becoming self-sustaining

16 R1611/U0984 Failure to secure necessary infrastructure (funding)

15 R0006 Delivery of CIP 2022/23



Quality & Governance Committee

25 R0831/U331 Insufficient intermediate care capacity

20 R0003 Estate – Acute

20 R0004 Demand

20 R0007/U100 Referral to Treatment Times

20 R0012 Waiting Times

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

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

16 R1016 Fire Compartmentation

16 R1473 Estate – Community

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

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

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

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

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held in common on 29 March 2023
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Jan Hull, Chairman of the Quality and Governance Assurance Committee
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the Quality and Governance Assurance Committee meeting held on 29 March 2023. The Committee received assurance in relation to: • The junior doctor industrial actions • The YDH Health and Safety Executive Improvement Notice • The merger risk rating • Medical Physics and Radiation Protection • The development of the Quality Strategy • The SFT Care Quality Commission Action Plan • The major incident planning arrangements in the new merged organisation • The Maternity Incentive Scheme (MIS) The Committee identified the following areas of concern or for follow up: • The outbreak of Carbapanemase-producing

	Enterobacterales • A serious incident in mental health services • Quality and safety for people with learning disabilities • The Corporate Risk Register • The SFT Home Birth Services The Committee identified the following area to be reported to the Board: • The Learning Disabilities Services review • The suspension of SFT Home Birth Services • The preparation for Junior Doctor Industrial Action • The CQC Action Plan • The Major Incident Plan documentation and assurance of day one actions
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Quality and Governance Assurance Committee. The Board is further asked to note the areas to be reported to the Board.

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

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

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETINGS HELD IN COMMON ON 29 MARCH 2023

1. PURPOSE

1.1. The report sets out the items discussed at the formal meetings held on 29 March 2023, along with the assurance received by the Committees and any areas of concern identified. The meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

Junior doctor Industrial Action

2.1 The Committees received an update on the latest 72 hour industrial action and noted that the strike had been managed well across both trusts and that the thorough planning had enabled 95% of elective care activity to be undertaken during the 72 hour period. The Committee further noted that lessons learned will be identified to inform the planning for the further 96 hour strike from 11 to 15 April 2023. The particular planning challenges for the 96 hour strike were noted.

YDH Health and Safety Executive Improvement Notice

2.2 The Committees noted that the requirements of the Improvement Notice had now been met. The Committees thanked the team leading the improvement work for their excellent work.

Merger Risk Rating

2.3 The Committees noted that the merger risk rating had been received from NHS England and the amber rating will enable approval for the merger to be sought from the Boards and Council of Governors.

Medical Physics and Radiation Protection

2.4 The Committees received an update on the recruitment to the senior vacant posts and noted that extended cover for both nuclear medicine and overall radiation protection had been secured from the current provider until December 2023. This arrangement will enable the continuation of current services whilst a further recruitment campaign for a senior leadership team will be undertaken.

Development of the Quality Strategy

2.5 The Committees received a presentation on the development of the Quality Strategy and noted that the strategy will reflect the diversity of the services we provide with attention to minority services in line with the health inequalities and population health objectives and will be linked to the Care Quality

Commission essential standards, system strategy and other relevant strategies.

2.6 The Committees noted the involvement of service groups; the emphasis on co-design with members, governors, patient groups and service users; the governance arrangements for the delivery of the strategy; and the expected timeline for the production of the strategy.

SFT Care Quality Commission (CQC) – Action Plan

2.7 The Committees received and noted the action plan to address the issues identified in the CQC inspection report. The Committees noted that the action plan will be shared with the CQC at the liaison meeting to be held on 6 April 2023.

Major Incident Planning Arrangements in new merged organisation

2.8 The Committees received an overview of the major incident planning arrangements for the new merged organisation and noted that, as a Category 1 responder, emergency preparedness, resilience and response (EPRR) will be a core function of the merged organisation.

2.9 The Committees noted the day one tasks – co-ordinated on-call system; tactical major incident plans; and fully operational hospital control rooms – and concluded that the integration of the on-call system ahead of the merger; the approval of the tactical major incident plans and the fully operational hospital control rooms provided the Committees with significant assurance. In addition, the Committees agreed that the testing of the major incident plans and emergency planning arrangements following the recent coach crash provided additional assurance.

Maternity Services Incentive Scheme (MIS)

2.10 The Committees received an update on the scheme and noted that the year five requirements had not yet been received. The Committees noted that the Safety Action 4 – requirement for a duty anaesthetist to be available for the obstetrics unit 24 hours day – standard had been met across both trusts.

3. AREAS OF CONCERN OR FOLLOW UP

Outbreak of Carbapenemase-producing Enterobacterales (CPE) Update

3.1. The Committees received an update on the outbreak of CPE at Yeovil District Hospital (YDH) and noted the actions taken to identify the source of the outbreak and the deep cleaning of the wards.

Serious Incident in mental health services

3.2. The Committees received details of a serious incident in mental health services and noted that a 72 hour review was being undertaken.

Quality and Safety in Learning Disabilities

3.3. The Committees received a presentation on the experience of a patient with

learning disabilities using physical health services. The Committees noted that a wider review of the support and care for people with a learning disability diagnosis was being undertaken and that this review also focussed on reasonable adjustments and support for people to access the same physical healthcare support as patients without a learning disability diagnosis.

3.4. The Committees noted that a number of concerns had been raised by learning disability services frontline colleagues mainly relating to the quality and safety of the provision of services for people with learning disabilities and the timely allocation of social workers to undertake assessments and reviews. The Committees noted the key themes; the escalation and discussion of these concerns with the relevant Local Authority leads; and the proposed developments to improve support and quality of services.

3.5. The Committees further noted: the work undertaken by the Integrated Care Board (ICB) to review primary care learning disability registers to identify people with learning disabilities: the system wide conference/workshop arranged for later in the year to focus on the system's responsibility for this vulnerable group of people; the establishment of the Leadership Governance and Improvement Group; the involvement of Experts by Experience; and the establishment of a SFT Learning Disability Improvement Board/Forum following the system wide conference/workshop so that the work of this board/forum can be aligned to the system approach.

Corporate Risk Register

3.6. The Committees received the up-to-date combined Corporate Risk Register report and noted that there were currently 66 risks on the risk registers – 42 on the SFT risk register and 24 on the YDH risk register – with 19 risks scoring 20 or 25. The Committees noted the details of the risks and recognised that although progress in mitigating risks had been made, the management of the risks remained challenging due to the operational pressures.

3.7. The Committees noted that a number of risks were duplicated across both trusts and the number of risks will therefore decrease following the establishment of a single post merger risk register.

SFT Home Birth Services

3.8. The Committees received a briefing on the decision to suspend SFT's home birth service for a period of three months due to a significant deficit in community midwifery staffing.

3.9. The Committees noted the reasons for the community midwifery staffing shortages and the impact on 17 women due to give birth at home or at the birth centre. The Committees noted that recruitment will continue and that it was expected that a number of midwives will return from sickness absence during this three month period. The position will be kept under close review and, if possible, the service will be reinstated at the earliest opportunity.

3.10. The Committees raised concerns about the high level of sickness absence and asked for assurance that everything was being done to understand the reasons for the sickness absence and to support colleagues.

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

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

- The Learning Disabilities Services review.
- The suspension of SFT Home Birth Services.
- The preparation for Junior Doctor Industrial Action.
- The CQC Action Plan.
- The Major Incident Plan documentation and assurance of day one actions.

5. BOARD ASSURANCE FRAMEWORK (BAF)

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

- The LD review discussion focussed particularly on **Objective 4** around health inequalities but also linked to all the **clinical strategy objectives**, providing elements of both positive and negative assurance.
- The development of the Quality Strategy relates to **Objective 2** in terms of safe high-quality care but also links across all of the **clinical strategy objectives**.
- Maternity Incentive Scheme and Home Birth services relates to **Objective 2** and provided both negative and positive assurance.
- A number of items link into strategic **Objective 8** and these relate to the CQC action plan, NSHE approval, HSE improvement notice being lifted and Major Incident Plans approval.

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

Jan Hull
CHAIRMAN OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Learning from Deaths (Quarter 4) YDH
SPONSORING EXEC:	Daniel Meron, Chief Medical Officer
REPORT BY:	Laura Walker, Head of Patient Safety and Learning Claire Bailey, Learning from Deaths Lead
PRESENTED BY:	Laura Walker, Head of Patient Safety and Learning
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	The Trust has implemented the required recommendations in implementing the National Guidance on Learning from Deaths. 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.
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	x Legislation	☐ Workforce	☐ Estates	☐ ICT	x Patient Safety/ Quality
Details: N/A					

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

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

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The report is presented to the Board on a quarterly basis. The YDH Learning from Deaths report is also noted at the Clinical Outcomes Committee where the SMR data is discussed.

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

MORTALITY REPORT
LEARNING FROM DEATHS

QUARTER 4 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 4 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 were significant differences between the existing processes at both organisations. Plans for aligning the processes, including those for referrals, departmental mortality meetings, Trust level mortality surveillance and sharing of learning, as well as the development of

a single digital platform for hosting mortality reviews for the merged organisation are ongoing.

2.2. The statutory medical examiner system, where all deaths that are not taken for investigation by the coroner will be subject to independent scrutiny by a medical examiner, was expected to commence in April 2023. This has been delayed nationally. The roll out of this across Somerset is being led by Helen Gilliland (Implementation Lead – Somerset Medical Examiner Service). To date, 11 out of 61 GP practices are engaged. This is fewer than anticipated, with delays to uptake attributed to perceived delays to the service becoming statutory as scheduled. It has also been confirmed that Helen Gilliland's role as Lead Bereavement and Medical Examiner Officer will be extended to oversee the service at YDH. We look forward to working closely with Helen to review and develop the pathway, ensuring that processes are fully aligned.

2.3. As we recover from the aftereffects of the covid-19 pandemic, the need for an increased bed base continues to impact on our clinical teams and services. There has been a rise in elective care activity in a proactive effort to improve patient outcomes by addressing waiting lists. We have also seen an increase in patients remaining in hospital for longer than was anticipated due to challenges with sourcing appropriate care. Not only are these delays to discharge detrimental for patient flow, but our patients are also at increased risk of poorer outcomes due to deconditioning. In response to this, we have opened dedicated "ready-to-go" wards, where the focus of care is on supporting independence. During the pandemic, the responsibility for completing mortality reviews was managed by the Mortality Review Group to support clinical teams. However, there is now an expectation that completion of mortality reviews and dissemination of learning will be undertaken at a departmental level, and we are supporting colleagues to ensure that these are completed to a high standard and in a timely manner.

3. LEARNING IDENTIFIED THROUGH THE MORTALITY REVIEW PROCESS

3.1. During this period, several reviews have been completed looking at the care given to our patients with a Learning Disability. It is known that people with a Learning Disability die earlier, and may not receive the same quality of care, as the general public. These reviews have highlighted excellence in the overall quality of care given, with themes of good family involvement in care decisions, recognition of the need to make reasonable adjustments, and appropriate use of the mental capacity act. In one case, the patient had been deemed to be medically safe for discharge within a few weeks of admission. Following a best interest meeting, the patient remained in hospital whilst an appropriate care setting was sought. Sadly, before this could happen, they deteriorated rapidly and died. It was noted that this deterioration was quickly recognised by the clinical team. Despite not being in the familiar, home environment that had been hoped for, the patient received good End of Life care with evidence of consideration of pain control in response to the body language of a non-verbal patient.

3.2. Key learning that has come out of HSIB (Healthcare Safety Investigation Branch) maternity investigations shared during 2022/2023 includes:

- Following the review of a neonatal resuscitation, it was identified that there were inaccuracies on the timings documented. The department is therefore

developing and trialling a neonatal resuscitation proforma to improve record keeping.

- There is ongoing learning regarding CTG interpretation and appropriate use of conservative measures such as IV fluids.

- There is ongoing civility work within maternity to encourage a positive culture and escalation of concerns as highlighted as an issue in some cases.

- Robust processes are now in place for support for staff and de-briefs following incidents in practice, including immediate de-briefs, After Action Reviews and Professional Midwifery Advocate (PMA) sessions available as 1 to 1 sessions or group.

3.3. The investigation into the death of a patient who had attended for elective surgery has identified that there were missed opportunities to identify and respond to VTE (Venous Thromboembolism) risk. A representative from the surgical directorate now attends the VTE committee, where this case has been discussed. This group have reviewed the Trust policy against NICE guidelines, which will be shared back with the directorate.

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 Lead 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. Mortality data intelligence is provided by Dr Foster Intelligence on a monthly basis. This provides the Trust with the Standardised Hospital-Level Mortality Indicator (SHMI), Hospital Standardised Mortality Ratio (HSMR), Standardised Mortality Ratio (SMR) and highlights any cumulative alerts (CUSUM) associated with mortality. There is also additional data around palliative care coding and Covid-19 associated mortality. There have been changes to the way that Dr Foster Intelligence receives the national HES (Hospital Episode Statistics) data, which 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.

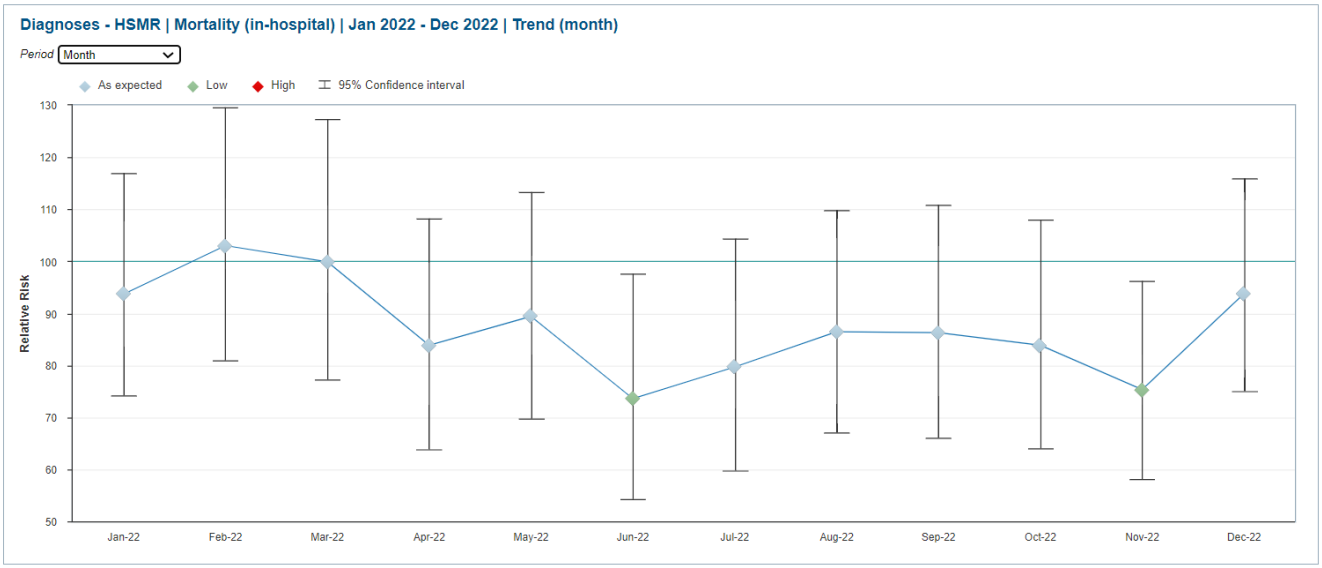
<u>Summary Hospital-Level Mortality Indicator (SHMI)</u>

4.3. The Summary Hospital-Level Mortality Indicator (SHMI) 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 based on average England figures, given the characteristics of the patients treated there.

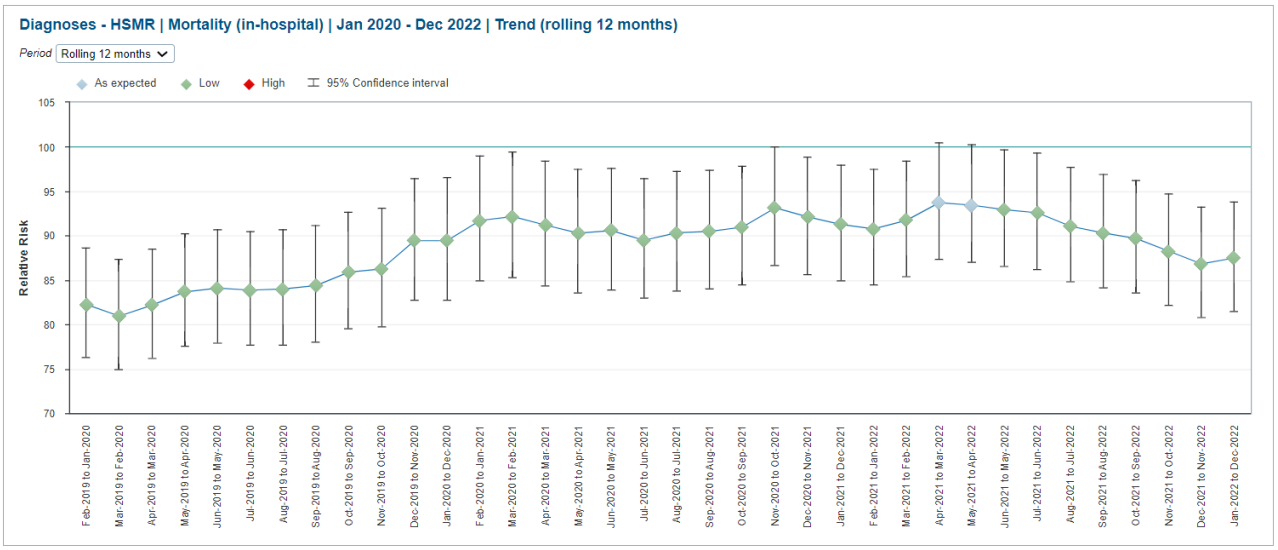
4.4. Our latest reported SHMI covering 12 months November 2021 to October 2022 is 89.34 whilst this is a decrease from the previous data period, this is still within the expected range. No diagnostic groups are showing as outliers when using NHS Digital's control limits, however *Congestive heart failure, non-hypertensive*, is statistically higher than expected when using the more sensitive 95% Confidence Intervals. Katy Darvall, the Trust Mortality Lead from SFT working in an extended role across YDH, has completed an initial clinical review of these cases. She has identified a sample of cases from these deaths that warrant further review and is awaiting the patient level data. We will report any findings from these reviews in due course.

Hospital Standardised Mortality Ratio (HSMR)

4.5. The Hospital Standardised Mortality Ratio (HSMR) 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 January 2022 to December 2022 is 87.5 which is statistically lower than expected.

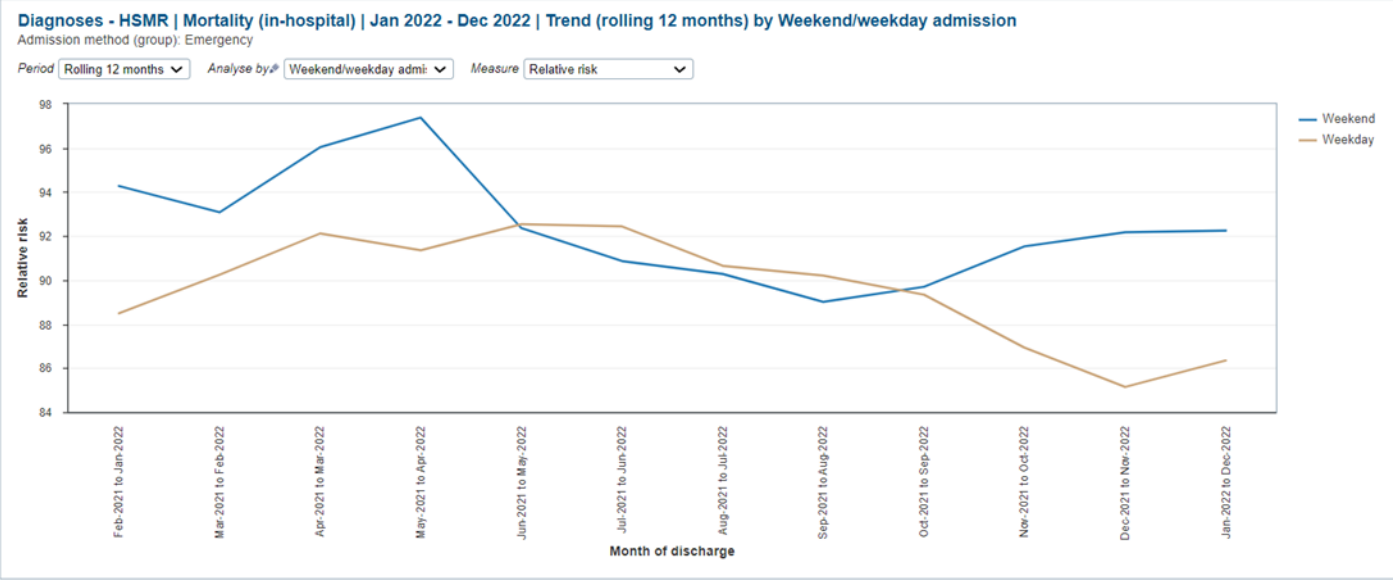


4.6. The rolling HSMR 3-year trend shows that the HSMR is on a downward trajectory and has been statistically lower than expected for the last 8 consecutive periods.



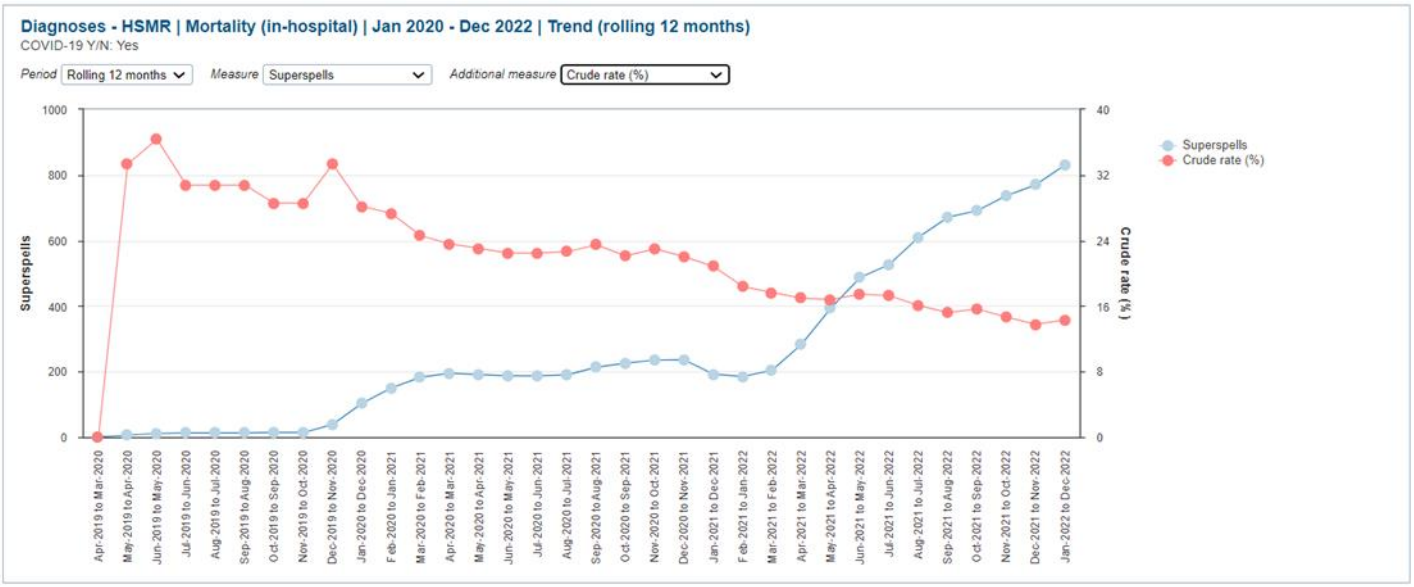
4.7. When compared to its regional peers (of 14 acute, non-specialist Trusts), YDH is the only Trust to be statistically lower than expected.

4.8. The Trust's weekday HSMR is currently 86.3 and remains statistically lower than expected. The weekend figure at 92.2 and remains within the expected range. The Weekday rate had seen a declining trend, but there has been an upturn over the last rolling 12-month period. The weekend rate shows an upward trend over the last four periods.



4.9. Further analysis has highlighted that there are two diagnosis groups within the emergency weekend admissions cohort, *noninfectious gastroenteritis* and *intestinal obstruction without hernia* that may be driving this increase. We will continue to monitor this.

4.10. 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 85.4, which is statistically lower than expected. The volume of superspells coded with covid-19 in secondary diagnosis position has increased over the last 11 rolling data periods. Crude rates for the covid-19 cohort have continued to fall.



Mortality Alerts

4.11. 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.

4.12. 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.

4.13. In our Quarter 3 report, we highlighted that there had been a CUSUM mortality alert in relation to the diagnosis group “other perinatal conditions”, where there had been 2 observed deaths between September 2021 and August 2022, both with a P95 still birth coding. This has been reviewed by the maternity governance lead, who has reported that both were notified and reviewed within the appropriate timeframes. There were care issues identified in 1 case. These were not thought to have made a difference for the outcome for the baby, but some might have made a difference for the mother. Appropriate actions plans were put in place.

There was 1 new CUSUM Mortality Alert reported by Dr Foster in Quarter 4. The alert was in relation to the diagnosis group *hyperplasia of prostate*, where there was 1 observed death versus and expected death of 0. Following discussion at CLOC (Clinical Outcomes Committee), we will request a further review of this death.

The Medical Examiner service:

4.14. 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 review of the notes 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

4.15. 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 Lead holds responsibility for ensuring robust systems are used to identify and share learning from any death within the hospital.

4.16. 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.

4.17. The Mortality Review Group and the Learning from Deaths Lead 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 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. 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.

<u>Quarter 4 Review Outcomes</u>

4.18. Quarter 4 saw 276 of our 288 inpatient deaths (96%) scrutinised by the Medical Examiner. These would be classified as a Mortality Review at level 1 as described above. When compared to Quarter 3, the total number of Mortality Reviews completed at level 1 has increased from 242 and the overall percentage has also increased from 75%. From cases referred by the ME, a potential theme is emerging around deaths on the recently established Ready to Go wards. We will continue to monitor this.

4.19. Following changes made by the ME service to their recording process, it was identified that there was no longer a referral process for altering Learning from Deaths to potential cases for review. Whilst this has been resolved going forwards, there has been a delay in requesting reviews as we need to retrospectively identify cases that should have been referred. 25 referrals have now been identified through this process, which are being triaged for appropriateness for further review. There has been some progress this quarter with completing outstanding mortality reviews from previous reporting periods, although there are still 25 pending.

Learning Disability Deaths

4.20. 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. Three 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

4.21. 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.

4.22. 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.

4.23. There were two perinatal deaths eligible to be notified to MBRRACE-UK with both cases meeting criteria for PMRT review in this reporting period. Both were antepartum stillbirths and were notified within the expected timeframe. The first case has undergone PMRT review within the expected timeframe and no issues were identified with care. The second review is scheduled for April, again this will be within the expected timeframe. More details are in the Trust's Quarterly Maternity Quality Report.

Paediatric Deaths

4.24. 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.

4.25. 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.

4.26. 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.

4.27. 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.

4.28. 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

4.29. 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. 14 new instructions were received relating to deaths in quarter 4, compared to 9 new instructions in quarter 3.

4.30. There was one inquest held with witnesses involving an unexpected death following planned surgery. The death was concluded to be unavoidable by the coroner and all three witnesses provided clear and helpful evidence to enable the family and the coroner to understand what had happened. No further learning was identified for the trust.

Serious Incident Reviews, Complaints and Bereavement concerns.

4.31. Three reported cases in Quarter 4 resulted in a Serious Incident Investigation being commissioned concerning a patient who died whilst under our care. An additional three 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												2022-2023											
	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**	**Jan**	**Feb**	**Mar**	**Q4 Total**
Total deaths in the Trust (including ED deaths)	87	71	82	**240**	86	88	79	**234**	82	83	64	**229**	62	72	61	**195**	68	71	103	**242**	108	99	81	**288**
Number subject to a Level 1 Mortality Review	38	35	39	**112**	64	63	54	**181**	49	53	41	**143**	53	58	55	**166**	68	58	56	**182**	106	95	75	**276**
Number referred for a Level 2/3 Mortality Review	5	3	10	**18**	9	8	6	**23**	12	8	5	**25**	7	3	6	**16**	9	5	7	**21**	15	3	7	**25**
Number of completed Level 2/3 Reviews	5	3	5	**9**	8	6	4	**18**	9	0	2	**11**	12	2	3	**17**	0	0	2	**2**	14	1	5	**20**
Number investigated as a Serious Incident	0	0	1	**1**	0	1	0	**1**	0	0	0	**0**	1	0	1	**2**	0	0	1	**1**	0	2	1	**3**
Learning Disability deaths	0	0	0	**0**	1	0	0	**1**	2	0	0	**2**	2	0	2	**4**	3	1	3	**7**	1	0	2	**3**
Bereavement concerns	0	1	2	**3**	0	1	0	**1**	1	0	0	**1**	3	0	0	**3**	0	1	1	**2**	1	1	2	**4**
Coroner's Inquest investigations	4	1	4	**9**	1	2	3	**6**	1	4	2	**7**	2	2	6	**10**	4	3	2	**9**	3	3	8	**14**
Number thought more likely than not to be due to problems with care	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**

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 th

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Learning from Deaths (Quarter 4) SFT
SPONSORING EXEC:	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:	Laura Walker, Head of Patient Safety and Learning
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	The 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	x Legislation	☐ Workforce	☐ Estates	☐ ICT	x Patient Safety/ Quality

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

LEARNING FROM DEATHS FRAMEWORK

1. MORTALITY PROCESS UPDATE

1.1 The Medical Examiner's office had 475 deaths of patients under the care of SFT reported to them between January and March 2023. Of these, 437 were within the acute hospital, 37 were within our community hospitals, and 1 death was in our mental health inpatient settings (this death was expected). 96% of the 475 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 January to the end of March we have had 6coroner's inquests heard with witnesses present. A further 36 read-only inquests were concluded. During this quarter there were 38 new enquiries from the coroner concerning deaths of patients known to SFT services. This compares to 29 in Q1, 42 in Q2 and 28 in Q3.

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, 32 deaths have been referred for the 72-hour meeting process, of which 1 will be further subject to the Serious Incident Review process, 11 will be subject to a Structured Judgement Review (SJR), 5 will be looked at locally within the specialty teams and 10 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 As we recover from the aftereffects of the covid-19 pandemic, the need for an increased bed base, and the challenges associated with this, continue to impact on our clinical teams and services. There has been a rise in elective care activity in a proactive effort to improve patient outcomes by addressing waiting lists. We have also seen an increase in patients remaining in hospital for longer than needed due to challenges with sourcing appropriate care. Not only are these delays to discharge detrimental for patient flow, but our patients are also at increased risk of poorer outcomes due to deconditioning. In response to this, we have opened dedicated “ready-to-go” wards, where the focus of care is on supporting independence. Whilst these have been a success, with examples of patients leaving hospital requiring a less intensive package of care than was intended prior to their stay on these wards, we have seen some unexpected death on these wards. The medical examiner service has been asked to highlight deaths of patients who were considered to be medically safe for discharge. Specialty M&M meetings are still regularly taking place, although there are delays to the completion of SJR’s and dissemination of learning in some areas of the organization. Our service group patient safety and governance leads continue to support the LfD agenda by maintaining oversight of the completion of SJR’s in their directorates.

1.5 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, reviews have been completed up until March 2022, and have not identified any breach of infection control measures that were in place at that time. Colleagues from IP&C are completing a more detailed review of 1 case as this is thought to potentially relate to a change in strategy around isolation. We await the outcome of this review. We have discussed and agreed our ongoing strategy for reviewing nosocomial covid deaths with colleagues from IP&C, who will continue to complete thematic reviews of clinical areas where there has been an outbreak. In addition to this, the Learning from Deaths Lead will highlight individual cases for further review where the family/carer or staff have raised concerns, as well as where the patient’s death has been directly attributed to nosocomial covid infection.

1.6 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. A monthly PMRT meeting is held to enable regular review of cases with the multidisciplinary team (MDT) and an external representative. A joint action plan for each month’s review of cases (unless a serious incident) enables the maternity governance team to highlight any common actions and identify themes from reviews. All finalised reports and subsequent action plans are shared with the parents according to their wishes. In this reporting period, there were 3 perinatal deaths eligible to be notified to MBRRACE-UK all of which met the

criteria for PMRT review. 1 concerned a late miscarriage, and there were 2 intrauterine deaths. All reviews and notifications have met the expected timescales.

2 LEARNING, IMPROVEMENT, AND CHANGE

2.1 The ME service highlighted the death of a patient who had been admitted to a medical ward with known type 2 respiratory failure. They noted that this patient had not been managed using scale 2 oxygen monitoring, despite this being requested by the medical team. A SJR was completed by the specialty team, who acknowledged that the request for scale 2 oxygen monitoring was not fulfilled but they did not think that this contributed to the patient's death. They identified learning around the prescription of oxygen, and that this needs to be in line with the most appropriate oxygen scale target for the patient's underlying medical condition. They noted that there was a failure in communication of this but could not pinpoint how or where this broke down. To explore this further, they have introduced an audit of current practice. Not only will this measure compliance with national standards, but it can also help the team to identify specific areas for further improvement.

2.2 In a complaint from the family of a patient who died on one of our Care of the Older Person wards, it was described that, throughout the patient's admission they were called by the wrong name, despite attempts by the family to correct this. This caused distress and confusion to the patient and their family. The team have introduced a new document "what matters to me", which highlights patients' preferences. The activity facilitators on the wards will support patients and their families to complete these to help all staff to deliver individualised care.

2.3 A SJR was completed by the vascular team concerning the death of a patient who died during emergency surgery to repair a ruptured abdominal aortic aneurism. It was felt that the overall, this patient received poor care, with evidence of care issues that may have contributed to their death and probable avoidability. This sad event has resulted in learning for surgical and Emergency Department teams. It was identified that a large AAA (regardless of whether this is shown to be ruptured on CT) needs to be flagged to the on-call vascular consultant at the earliest opportunity. Teaching on "vascular surgical emergencies" is now delivered to all surgical trainees. It was highlighted to the ED team that there had been a lack of clinical suspicion of AAA. To highlight the need for awareness of key risk factors and signs/symptoms of AAA, a lightning learning poster has been shared with the team in ED via their SharePoint page.

2.4 A RCA was completed following the sad death by suicide of a patient known to our mental health services.. This patient had a long history of sporadic engagement with services, marked by difficulties with alcohol dependency, behavioural problems, deliberate self-harm, suicidality, and PTSD. The investigation highlighted that in accordance with the dual diagnosis policy, a

MDT should have been held to consider appropriate crisis and contingency plans. However, this did not take place as the patient was discharged due to disengagement. This has led to the development of the “no response” SOP. Through this, there is now a clear and consistent process for CMHS staff to follow in the event of a patient disengaging from treatment of not attending a planned appointment.

3 MORTALITY REVIEWS

		Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Community hospital	**Deaths**	13	10	13	24	19	13	28	21	14	22	15	8	11	18
	ME Reviews	12	10	12	23	19	8	23	15	11	17	15	8	11	18
	Reviews	0	0	0	0	1	1	0	0	1	0	0	0	0	1
	Stage 2	0	0	0	0	1	1	0	0	1	0	0	0	0	1
Contact with MH services in the last 6 months	**Deaths***	3	3	4	9	4	8	1	8	3	7	4	4	3	4
	ME Reviews	0	0	1	0	0	0	0	0	0	0	1	0	0	1
	Reviews	3	3	4	9	4	8	1	8	3	7	4	4	3	4
	Stage 2	3	2	2	7	3	7	1	6	2	5	4	4	3	4
Learning disabilities	**Deaths****	2	0	1	3	1	2	1	1	0	1	2	2	1	2
	LeDeR	2	0	1	2	1	2	1	1	0	1	2	2	1	2
	Stage 2**	2	0	1	2	1	2	1	1	0	1	2	2	1	2
Acute inpatients	**Deaths**	114	140	149	107	108	126	115	108	119	112	172	167	128	142
	ME Reviews	114	140	132	102	104	126	113	101	112	106	159	159	126	138
	Reviews	18	14	19	9	8	11	6	10	10	8	9	6	1	0

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

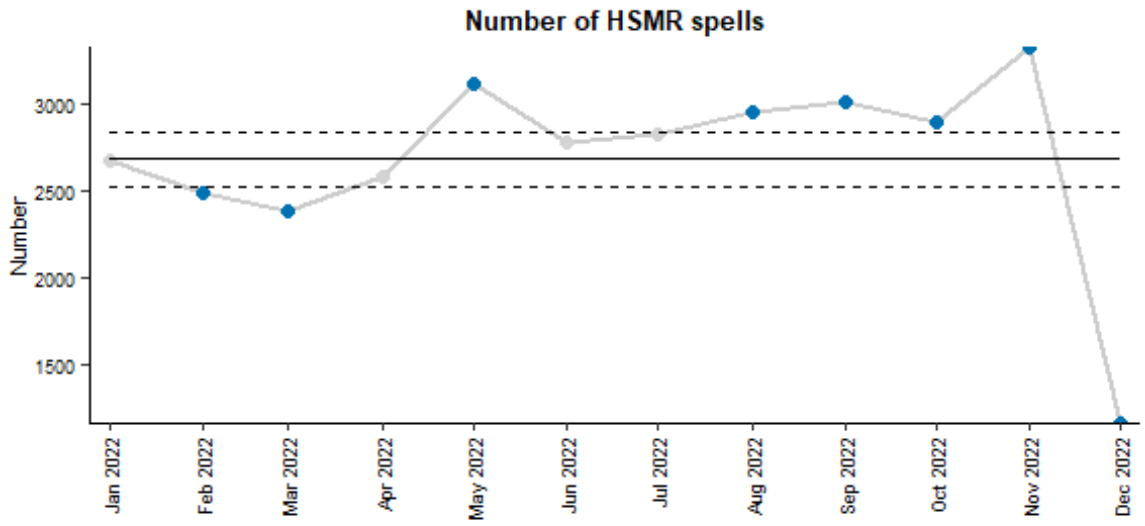
4 STANDARDISED MORTALITY

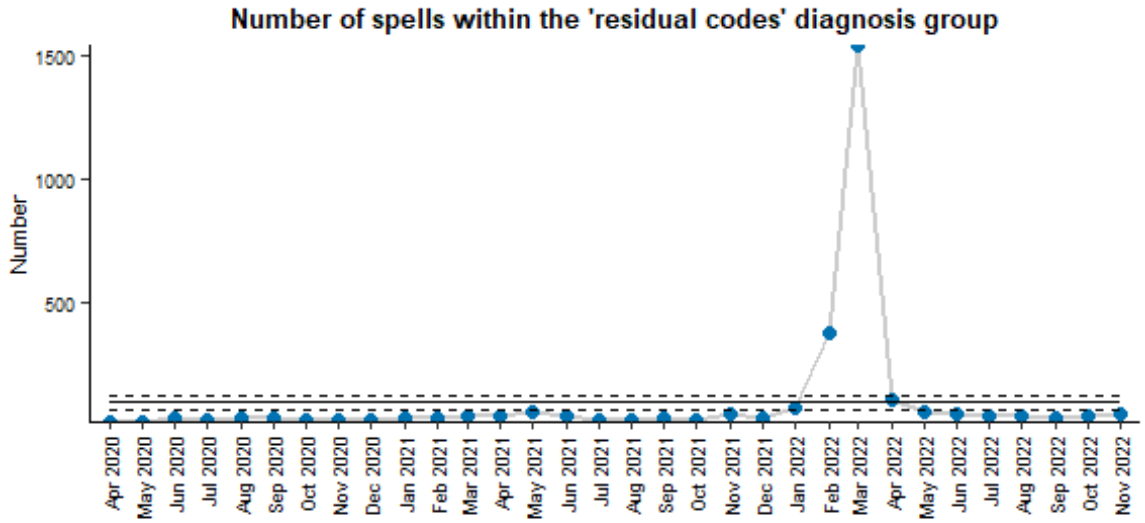
4.1 Standardised mortality ratios (SMRs) are the ratio between observed deaths and the estimated number of deaths. The Trust uses two measures of standardised mortality: summary hospital-level mortality index (SHMI) and hospital standardised mortality ratio (HSMR). SHMI and HSMR predict the estimated 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 October 2022 and reports Somerset FT to have 'as expected' SHMI value equivalent to 106.66.

4.4 The HSMR indicators have been published with data to December 2022, however the data provided by this Trust is currently incomplete and therefore December 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 suspect covid diagnosis in other positions.

Overall position

Measure	Period	RR	LCL	UCL	Banding
SHMI	Dec 21 - Nov 22	107.5	102.6	112.6	**Above expected**
HSMR	Dec 21 - Nov 22	128.2	120.7	136.0	**Above expected**

Position for admission on weekdays

Measure	Period	RR	LCL	UCL	Banding
SHMI	Dec 21 - Nov 22	105.8	100.3	111.6	**Above expected**
HSMR	Dec 21 - Nov 22	123.1	114.9	131.8	**Above expected**

Position for admission on weekends

Measure	Period	RR	LCL	UCL	Banding
SHMI	Dec 21 - Nov 22	113.5	102.8	125.0	**Above expected**
HSMR	Dec 21 - Nov 22	145.6	129.1	163.6	**Above expected**

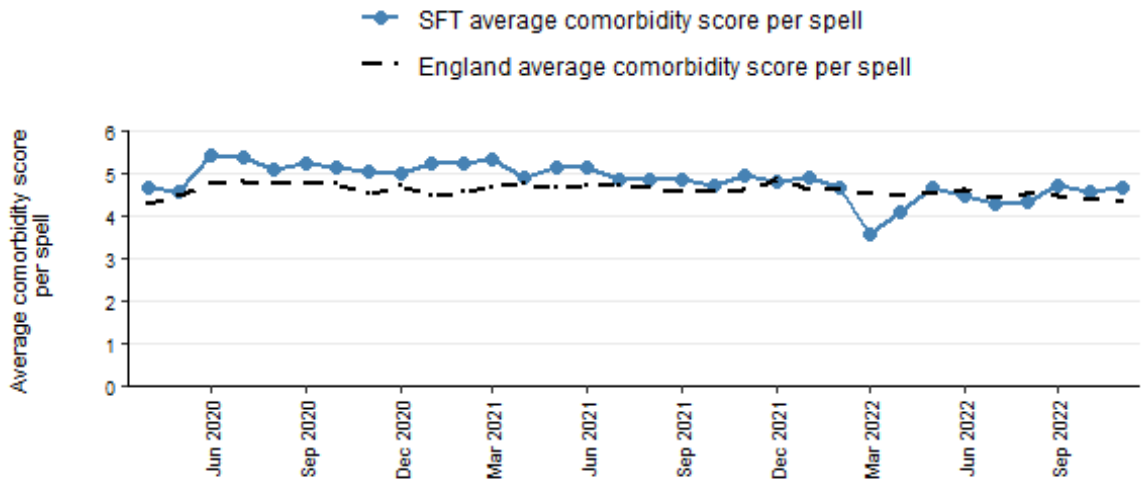
Outliers at site level

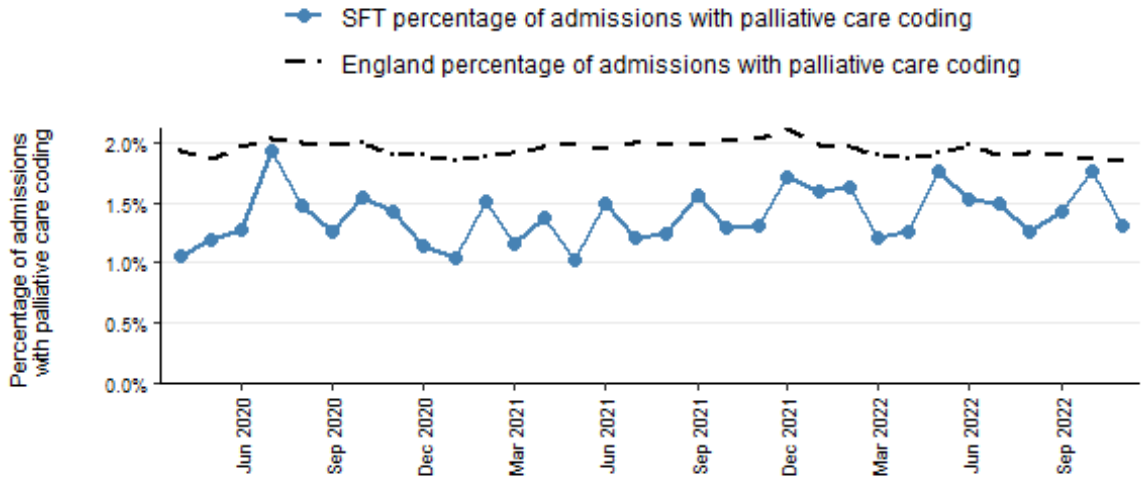
Treatment site	SHMI (Dec 21-Nov 22)	HSMR (Dec 21-Nov 22)
RH5A8 - MUSGROVE PARK HOSPITAL	**Above expected** 105.6 (95% CI: 100.6 - 110.8) Excess deaths: 87.9	**Above expected** 125.7 (95% CI: 118.1 - 133.7) Excess deaths: 206.3
RH5G5 - FROME COMMUNITY HOSPITAL	**Above expected** 176.0 (95% CI: 120.4 - 248.5) Excess deaths: 13.8	**Above expected** 182.0 (95% CI: 115.3 - 273.0) Excess deaths: 10.4
RH5F9 - CREWKERNE HOSPITAL	**Above expected** 248.7 (95% CI: 135.8 - 417.3) Excess deaths: 8.4	As expected 137.9 (95% CI: 59.4 - 271.8) Excess deaths: 2.2

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. Bridgwater Community Hospital, which flagging above expected deaths during the Quarter 3 reporting period, has now returned to within expected ranges. 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 deaths in the trust. 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 (Dec 21-Nov 22)

Measure	Trust	Percentile	England
Average comorbidity score per spell (SHMI)	4.5	45th (55 of 122)	4.54
Percentage of discharges with palliative care coding (SHMI)	1.50%	24th (29 of 122)	1.93%





Effect of palliative care adjustment

4.7 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 (Dec 21-Nov 22)	123 (95% CI: 117.4 - 128.8) **Above expected**	107.5* (95% CI: 102.6 - 112.6) **Above expected**

Source	With palliative care adjustment	Without palliative care adjustment
HSMR (Dec 21-Nov 22)	128.2* (95% CI: 120.7 - 136) **Above expected**	115.6 (95% CI: 108.9 - 122.7) **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. 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. 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.

5.2 Whilst considering a digital platform for the merged organisation, we have been reviewing the work of the national Learning from Deaths forum called Better Tomorrow. They 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 developed a new tool for use in Community settings. This is due to go live shortly. Unfortunately, the platform in its current form does not support Trust's to access more than 1 version of the tool, meaning that it has limited applications for integrated Trusts such as ours. Whilst we will adopt the updated SJR templates, we will not be using the national platform.
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.

5.3 The Radar System Lead has built the acute trust SJR form and the associated workflows for Radar. Alongside colleagues in our bereavement team, who have been using Radar for their workstreams, we are due to meet with the Director of Integrated Governance and the Radar System Lead to determine whether we can extend our respective workstreams to include YDH clinical areas after the two Trusts merge. If this is possible, we will continue our development work of the SJR template.

5.4 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). To date, 11 out of 61 GP practices are engaged. This is fewer than anticipated, with delays to uptake attributed to perceived delays to the service becoming statutory in April 2023. At the time of writing this report, we have not been updated as to how long this is likely to be delayed. It has also been confirmed that Helen Gilliland's role as Lead Bereavement and Medical Examiner Officer will be extended to oversee the service at YDH. The LfD team at SFT have been working across both SFT and YDH since September 2022. We look forward to working closely with Helen to review and develop the pathway, ensuring that processes are fully aligned.

5.5 As we move towards merger, we have begun to think about how we can support the new service groups with Learning from Deaths. This has presented us with an opportunity to review how Mortality and Morbidity meetings are organised by the specialties and ensure that there are optimal opportunities to disseminate learning. There is a balance to be struck between implementing standardised processes for consistency, and appreciating the nuances and needs of different specialities. We will work closely with AMD's, safety and governance leads and mortality leads on this.

5.6 In our Mental Health and Learning Disability Directorate, the mortality review process has, up until now, been overseen by SIRG. The Directorate has embarked 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. We are due to meet with key stakeholders from this directorate to support this transition.

5.7 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. The Head of Patient Safety and Learning is due to meet with the ADPC for this directorate to take this forward.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Mental Health Act Committee meeting held on 14 March 2023
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Alexander Priest, Chairman of the Mental Health Act Committee
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the Mental Health Act Committee meeting held on 14 March 2023 and the assurance received by the Committee. The meeting was conducted as a video conference call. The Committees received assurance in relation to: • the Mental Health Lead report • the update on MCA, DoLs and LPS • CAMHs out of area placements • Out of Area Treatment for Somerset Patients • Policies and Procedures • Complaints and Issues • The review of the directorate risk register The Committee identified the following areas of concern or for follow up: • the update from the ICB Commissioning Manager • the Care Quality Commission Compliance Visits

	• Mixed PICU issues and approaches to keep patients within Somerset • Complaints and Issues • National Partnership Agreement The Committee did not identify any areas to be reported to the Board and/or Board Committees.
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Mental Health Act Committee. The Board is further asked to note the areas to be reported to the Board.

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

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

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

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

Details: N/A

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

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

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON 14 MARCH 2023

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 14 March 2023, 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 separation of assessments for capacity for admission and for treatment.
- The focus on casework support particularly relating to forensic patients and the training needs identified.
- The increase in training requests for wider clinical groups.
- The review of the provision of advocacy services against NICE guidelines and the good progress made achieving the requirements.
- The development of draft guidelines for staff in implementing S.117.
- The mapping exercise for the Electronic Health Record and the additional recording information requirements in relation to Mental Health Act assessments and S.117. The Committee asked for assurance that rigorous processes regarding legal responsibilities are considered in the electronic health records.
- The limited progress made in relation to radar reporting due to the lack of availability of the radar team and the focus on the Electronic Health Record mapping exercise.
- That no complaints about the MHA Administration service had been received in the last quarter whilst a number of compliments and thanks had been received.
- The increase in the number of S.136s and the work taking place with

the Police to ensure the accuracy of the data. The Committee noted that the Police still presented patients under a S.136 to the acute emergency departments for a physical health check instead of to a S.136 suite.

- The report referred to a patient being admitted to a 'wrong' bed as set out on the MHA papers, but upon hearing the reasons for the change in admitting ward, the Committee was assured that the right process had been followed to ensure that the needs of the patient were met.

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 noted the slippage in training rates from 94.2% for level 1 and 83% for level 2 MCA and DoLs training to 92.4% and 79.5% respectively. The weighted compliance rate for the merged Trust was expected to be 82% and 70% respectively as this training was currently not mandatory at YDH. The Committee noted that an e-learning package mapped to the Somerset mental capacity framework was being developed.

2.4. The Committee noted that an announcement regarding the implementation of Liberty Protection Safeguards (LPS) had been delayed and was now expected at the end of March 2023. The Committee further noted the work taking place to prepare for the implementation of the code of practice.

2.5. The Committee received an update on the publication of the "Susan" Safeguarding Adults Review and noted that all recommendations set out in the report had been met.

CAMHS

2.6. The Committee received an update on child and adolescent mental health services (CAMHS) out of area placements and noted that one CAMHS patients had been placed out of area into a medium secure unit. The Committee further noted that work was already in hand to bring the patient back to Somerset as soon as possible. The report, and the focus on repatriating patients as soon as possible, provided the Committee with significant assurance.

Out of Area Treatment Somerset (OATS) patients

2.7. The Committee noted that there were no inappropriate out of area placements and commended the team for the level of detail in the report which they considered to reflect a patient centric approach.

Policies and Procedures

2.8. The Committee approved the Section 5(4) and 5 (2) Policy and the Hospital Managers' Scheme of Delegation.

Complaints and Issues

2.9. 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 December 2022 to 28 February 2023 and noted that three new complaints had been received during this period. The Committee noted that two other complaints remained open.

2.10. The Committee noted that the environment and Section 17 leave were common themes in the new complaints and the details of all complaints were noted.

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

Risk Register

2.12. The Committee received the Mental Health and Learning Disability directorate risk register and noted the high rated risks. The Committee noted that the staffing and bed availability risks had improved; that St Andrews Ward was expected to open in the Autumn; and that the Pyrland Wards will be included in the annual ligature review of inpatient wards.

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

3. AREAS OF CONCERNS/FOLLOW UP

Update from the ICB Commissioning Manager

3.1. The Committee noted that the financial allocation for 2023/24 had not yet been received but the aim will be to fund all areas covered in the mental health investment standard. The Committee noted that some other funding sources may be available and that funding details will be shared with the Committee when available.

Care Quality Commission MHA Compliance Visits

3.2. The Committee received the report on the Ash Ward MHA compliance visit and noted that the report was very positive with positive feedback from carers and other stakeholders. Three areas for action had been identified, relating to sharing the outcomes of the inspection with patients, linking risk assessments into care planning and communication regarding SOAD decisions. The Committee noted the challenges relating to the SOAD process and variation in referral practices and noted that the SOAD process will be reviewed and that feedback will be provided to the next meeting.

Mixed sex PICU issues and approaches to keep patients within Somerset

3.3. The Committee received an update on the review regarding single sex accommodation within the Trust and the county wide review into mixed sex PICU accommodation. The Committee noted that a proposal following the

country wide review was being developed and that this proposal will be reviewed when available.

3.4. The Committee noted that the Trust only had one PICU and that, if moving to a single sex PICU, more patients will need to be placed out of county or a ward will need to be repurposed into a female only PICU ward.

3.5. The Committee discussed the challenges of trans people being admitted to single sex wards and noted that discussions were taking place and that work will be undertaken to look into specific streams of care. The Committee noted that there had been a recent increase in the number of patients wishing to change how they identify themselves. The Committee further noted that the electronic patient record did not allow the easy retrieval of information relating to sex at birth and gender of patients and this will be followed up with the digital team.

Complaints and Issues

3.6. The Committee noted that the Independent Investigation into a homicide report was expected to be published in May 2023.

3.7. The Committee noted that a review of duty of candour in relation to homicide was being undertaken and that this review will particularly focus on engagement with families of victims.

3.8. The Committee received an update in relation the quality assessment review regarding a historic homicide and noted that the draft findings of the review were currently with the ICB. The implications for the Trust and ICB will be reviewed upon receipt of the report.

National Partnership Agreement

3.9. The Committee noted that the Police are working to establish a national partnership agreement with the aim to reduce the amount of police intervention in mental health. The agreement was expected to be published at the end of March 2023.

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

4.1 The Committee did not identify any specific issues or risks to be reported to the Board and/or Board Committees

Alexander Priest
CHAIRMAN OF THE MENTAL HEALTH ACT COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the People Committee meetings held in common on 8 March 2023
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Graham Hughes, Chairman of the People Committee
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the People and Workforce Committee meetings held in common on 8 March 2023 and the assurance received by the Committees. The meeting was conducted as a video conference call. The Committees received assurance in relation to: • The colleague story – Sector Based work Academy Programme (SWAPs) • The Review of the Board Assurance Framework (BAF) • The Staff Survey findings • The focus on Agency Scrutiny • The Higher Specialist Scientist Training (HSST) and scientist roles • The Director Report and the improvement in the retention of nursing colleagues • The review of the people and workforce risks on the Corporate Risk Register

	The Committees identified the following aeras for follow up: • Learning item in relation to a recent tribunal about racist discrimination through all internal processes of an organisation 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
☐ Obj 4 Reduce inequalities
☐ Obj 5 Respond well to complex needs
✓ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☐ Obj 7 Live within our means and use our resources wisely
☐ Obj 8 Develop a high performing organisation delivering the vision of the Trust

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

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST (SFT)

ASSURANCE REPORT FROM THE PEOPLE COMMITTEES

1. PURPOSE

1.1. The report sets out the items discussed at the meetings held in common on 8 March 2023, 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

Colleague Story – Sector Based Work Academy Programme (SWAPs)

2.1. The Committee received an update on the pre-employment scheme to support those in unemployment, on a low income or facing redundancy into work. The Committee noted that the scheme was one of the two known schemes in the country operating at this scale, with the Somerset scheme having the highest throughput. Out of the 174 people who completed the SWAP course, 107 were now in work.

2.2. The Committee received a story from a colleague who had completed the course on advice of the Job Centre and noted how the closure of his own business had impacted on his mental health and how completing the course had enabled him to become employed as a healthcare assistant. The Committee noted that the programme had been an excellent doorway into employment and had changed his life.

2.3. The Committee noted that administration colleagues who had completed the course were finding it more difficult to obtain a job within the Trust due to the current labour market and more experienced candidates applying. It was suggested considering better guidance to raise awareness of SWAP candidates throughout the Trust or to consider guidance to shortlist a certain percentage of SWAP candidates for suitable posts. This will be further considered outside of the People Committee meetings.

2.4. The Committee noted that the programme had not yet been implemented on a system wide basis, but a Proud to Care programme was also available which supported individuals into social care roles across Somerset. However, due to the pay differentials between health and social care, more candidates were attracted to the NHS scheme.

2.5. The Committee agreed that the early career support will help to maintain high retention rates. The Committee noted that funding for training had been provided through the Department of Work and Pensions but the remainder of the programme was funded through health care development and the mass

vaccination programme. This funding had significantly reduced and sustainability will need to be evidenced through cost avoidance due to improved retention rates and avoidance of re-recruitment costs.

2.6. The Committee noted that the first training session had now been scheduled at Yeovil District Hospital.

Review of the Board Assurance Framework (BAF)

2.7. The Committee discussed the relevant sections of the Board Assurance Framework and noted that the BAF had been updated to reflect feedback and discussions at the recent Board meeting and the changes in the risk ratings were noted.

2.8. The Committee noted that the BAF now better reflected current progress.

Staff Survey Highlights

2.9. The Committee received an update on the staff survey results and noted the response rates and context and challenges experienced at the time of the survey.

2.10. The Committee noted that both trusts compared favourably with its comparator groups and the excellent results for the People Promise elements as well as for the People Promise themes - staff engagement and morale - were noted. The Committee noted that “We are compassionate and inclusive” was the highest ranking theme across both trusts.

2.11. The Committee noted that there had been a reduction in the scores for diversity and equality for both trusts and that the drivers for this decrease were being explored.

2.12. The Committee further noted that the data will be cross referenced to the system level data.

2.13. The Committee discussed the morale scores for YDH. Although YDH had the best overall score on the morale theme, the small reduction from 2021/22 was statistically a significant reduction and the Committee queried whether this reduction was in line with the national average. The Committee noted that this will be further explored and feedback provided to the next meeting.

2.14. The Committee asked for future results to be presented in a bar chart so that the Trust’s position will be more easily visible. The Committees further asked for a narrative as to whether or not a higher score was a good or not as good result as this was not always clear at first sight.

2.15. The Committee agreed that the staff survey findings were excellent and the findings provided the Committee with significant assurance.

Agency Scrutiny

2.16. The Committee received an update on the review of agency expenditure and noted that the trusts' performance was in line with regional performance but regional performance was high compared to the remainder of the country.

2.17. The Committee noted the detailed findings and the actions being taken by the operational teams to reduce the current spend. The Committees further noted the actions taken by the medical workforce team.

2.18. The Committee discussed the electronic rostering system for medical colleagues and noted that it had been difficult to find a suitable software supplier for a medical rostering system. A system had been developed by another trust, working with NHSE, and the success of this system will be closely monitored.

2.19. The Committee noted the increase in demand for non-medical temporary staffing over the last few years, particularly in community hospitals and mental health services, and further noted details of this increase; the increase in vacancies; the increase in demand for enhanced care requests; and the actions being taken to manage non-medical agency expenditure.

2.20. The Committee discussed the position in relation to Emergency Nurse Practitioners and agreed that the merger will provide an opportunity to look at alternative ways of working with different staff groups. The Committee agreed that long term workforce planning will be essential.

2.21. The committee noted local workforce plans existing within services but that this needed to be bought together for stronger visibility and scrutiny at people committee at the future date.

2.22. The committee also raised the issue of better alignment of data and workforce information between the finance and people committee. There was an agreement for the chairs and lead executives (& deputies) of both committees to scope this out further. This will be reported back through both committees in due course.

Higher Specialist Scientist Training (HSST) and Roles

2.23. The Committee received an update on the Higher Specialist Scientist Training and their current roles within the Trust. The Committees noted the details of the training programme; the skill set of the healthcare scientists and the need for sufficient clinical consultants scientist posts to be able to fully utilise the skill set of this group of colleagues.

2.24. The Committee recognised the importance raising the profile of the training programme and the skills of the scientists and asked for the update to be presented to a future Quality and Governance Assurance Committee planning meeting.

Director Report

2.25. The Committee received the report and noted the improvements in the retention of nursing colleagues.

Workforce (Corporate Risk Register)

2.26. The Committee discussed the workforce risks and noted the work taking place to align the risks on both risk registers. The Committee noted that as part of the alignment of risks, a meeting had been set up to review the people/workforce risks; to carry out a data cleanse to remove duplicate risks; and to ensure that full risks assessments of all risks had been carried out.

3. AREAS OF CONCERNS/FOLLOW UP

Learning Item

3.1. The Committee discussed the article relating to a recent tribunal where a nurse in NHSE was subjected to racist discrimination through all internal processes in the organisation. The Committee agreed that the article provided an opportunity for colleagues and the trust to reflect whether this could happen in the trust.

3.2. The Committee noted that an update on the work to avoid discrimination will be presented to a future 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 assurance on strategic objective six in the following areas:

- workforce planning
- Improvement in retention
- People Promise elements – Staff Survey 2022 results
- Education - Colleague story on the Sector Based Work Academy Programme and the Higher Specialist Scientist Training
- Review of medical and non-medical agency staff