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 7 May 2024** at **9.00am** in the Seminar Room at Minehead Community Hospital, Luttrell way, MINEHEAD, Somerset, TA24 6DF

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

Yours sincerely

COLIN DRUMMOND
CHAIRMAN

AGENDA

		Action	Presenter	Time	Enclosure
1.	**Welcome and Apologies for Absence**		Chairman	09:00	Verbal
2.	**Questions from Members of the Public and Governors**		Chairman		Verbal
3.	**Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 5 March 2024**	Approve	Chairman		Enclosure A
4.	**Minutes of the Extra-Ordinary Somerset NHS Foundation Trust's Public Board meeting held on 18 March 2024**	Approve	Chairman		Enclosure B
5.	**Action Logs and Matters Arising**	Review	Chairman		Enclosure C
6.	**Registers of Directors' Interests and Receive any Declarations of Interests relating to items on the Agenda**	Note and Receive	Chairman		Enclosure D
7.	**Chairman's Remarks**	Note	Chairman	09.10	Verbal
8.	**Chief Executive and Executive Directors' Report**	Receive	Peter Lewis	09:15	Enclosure E
ALL OBJECTIVES					

9.	**Q4 Board Assurance Framework and Corporate Risk Register Report**	Receive	Phil Brice	9.25	Enclosure F Enclosure G
OBJECTIVE 2 – Provide the best care and support to people					
10.	**Assurance Report of the Quality and Governance Assurance Committee meeting held on 27 March 2024**	Receive	Jan Hull	9.45	Enclosure H
11.	**Guardian of Safe Working for Postgraduate Doctors Quarterly Report**	Receive	Tom Rees	9.55	Enclosure I
OBJECTIVE 8 – To develop a high performing organisation delivering the vision of the Trust					
12.	**Quality and Performance Exception Report**	Receive	Pippa Moger	10.10	Enclosure J
OBJECTIVE 6 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture					
13.	**Assurance Report of the People Committee meeting held on 12 March 2024**	Receive	Kate Fallon	10.35	Enclosure K
14.	**Six monthly Health and Wellbeing Guardian Report**	Receive	Graham Hughes	10.40	Enclosure L
Coffee Break - 10.55 – 11.10					
OBJECTIVE 4 – Reduce Inequalities					
15.	**Patient Story - Facing the Outside and Finding my Feet**	Receive	Katey Davis/ Emma Clift/ Lorna Jones/ Marwisa Matsitsiro	11.10	Presentation
16.	**Assurance Report of the Mental Health Act Committee meeting held on 19 March 2024**	Receive	Alex Priest	11.40	Enclosure M
OBJECTIVE 7: To live within our means and use our resources wisely					
17.	**Finance Report**	Receive	Pippa Moger	11.45	Enclosure N
18.	**Verbal report from the Finance Committee meeting held on 29 April 2024**	Receive	Martyn Scrivens	12.00	Verbal

19.	**2024/25 Revenue Budget**	Approve	Pippa Moger	12.05	Enclosure O
20.	**Assurance Report from the Charitable Funds Committee meeting held on 26 January 2024**	Receive	Graham Hughes	12.20	Enclosure P
FOR INFORMATION					
21.	**Follow up questions from the Public and Governors**		Chairman	12.25	Verbal
22.	**Any other Business**		All		Verbal
23.	**Risks Identified**		All		Verbal
24.	**Evaluation of the Effectiveness of the Meeting**		Chairman		Verbal
25.	**Items to be discussed at the Confidential Board Meetings** The items presented to the Confidential Board include:				
26.	**Withdrawal of Press and Public** To move that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.				
27.	**Date of Next Meeting** Tuesday 2 July 2024			12.30	

PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 5 MARCH 2024 IN THE MOXON SUITE AT FROME COMMUNITY HOSPITAL, ENOS WAY, FROME, BA11 2FH

PRESENT

Colin Drummond	Chairman
Alexander Priest	Non-Executive Director
Martyn Scrivens	Non-Executive Director
Jan Hull	Non-Executive Director (for item 8 only through Teams)
Paul Mapson	Non-Executive Director
Kate Fallon	Non-Executive Director
Graham Hughes	Non-Executive Director
Inga Kennedy	Non-Executive Director
Tina Oakley	Associate Non-Executive Director (non-voting) (from item 8)
Peter Lewis	Chief Executive
Phil Brice	Director of Corporate Services (non-voting)
Andy Heron	Chief Operating Officer
Pippa Moger	Chief Finance Officer
David Shannon	Director of Strategy and Digital Development (non-voting)
Isobel Clements	Chief of People and Organisational Development
Hayley Peters	Chief Nurse (from item 12)
Daniel Meron	Chief Medical Officer

IN ATTENDANCE

Fiona Reid	Director of Communications
Katy Darvall	Consultant Vascular Surgeon and Mortality Lead (for item 9 only)
Ria Zandvliet	Secretary to the Trust

1. WELCOME AND APOLOGIES FOR ABSENCE

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

1.2. It was noted that apologies had been received from Barbara Gregory (Non-Executive Director) and that the Chief Nurse was delayed due to a serious incident.

2. QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS

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

3. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 6 FEBRUARY 2024

3.1. Kate Fallon proposed, Graham Hughes seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 6 February 2024 as a correct record with the following amendment:

- Paragraph 9.3 – to change “May 2424” to “May 2024”.

4. ACTION LOGS AND MATTERS ARISING

4.1. The Board received the action log and noted that the action relating to the acoustics of meeting venues will be considered at every meeting and that discussions about the loan of table microphones were taking place.

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

5.1. The Board received the Register of Directors’ interest and no changes to the register were received.

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

6. CHAIRMAN REMARKS

6.1. The Chairman provided feedback from the meeting between ICB and trust chairs and NHS England held on 28 February 2024. The key message was that ICBs and trusts have to think strategically both in the short and long term. Trusts were still expected to meet their targets and manage the ongoing internal and external pressures against short term financial allocations. The Chairman advised that he had highlighted the need for capital expenditure, especially for maternity services.

6.2. The Chairman advised that he had met with Amanda Pritchard, NHS England, and their Acting Head of Transformation in relation to EPR and digital development. Amanda Prichard understood the importance of the project and the approach taken by the trust in relation to the joint EPR work with Dorset; she expressed support for the view that the development of the trust’s EPR system should not be delayed because of delays in Dorset; and he invited her to visit the trust. He had also spoken with Ruth May, Chief Nursing Officer, re maternity capital investment and invited her to visit the trust to see the situation at MPH.

6.3. The Chairman further advised that NHS England's Chief Finance Officer (CFO) had highlighted the increase in the headcount in the NHS in general and the need to reduce headcounts. He had spoken to the CFO who was unclear how much of this increase in headcount was due to the increase in the number of patients categorised as "no criteria to reside".

6.4. Graham Hughes queried whether it will be helpful to follow up the conversation with Amanda Pritchard and Ruth May by email which the Chairman said he would do.

7. CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS REPORT

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

7.2. The Chief Executive particularly highlighted the EHR programme and advised that agreement with the ICB and trusts in Dorset had been reached to collaborate on the procurement of a unified electronic health record across Somerset and Dorset. A meeting of the Partnership Board had taken place and the options to be included in the business case had been agreed. Affordability of the programme remained a key challenge. It was noted that the business plan will be presented to the May 2024 Board meeting for approval.

7.3. The Chief Execuitve provided an update on the outcome of the ICB's consultation on stroke services. A decision was reached at the end of January 2024 and a public meeting had been set up jointly with Somerset Council for 1 March 2024 to enable the ICB to set out the rationale for their decision. There remained considerable concerns from Councillors and members of the public about the lack of a hyper acute unit in YDH. The Health Overview and Scrutiny Committee and members of groups, as well as individual members of the public, have written to the Secretary of State about the outcome of the consultation process. The programme plan will continue to be implemented pending the outcome of a potential review by the Secretary of State but the overall timeline had been extended due to the changes required in Dorchester.

7.4. The Chief Executive further highlighted: the visit on 4 March 2024 by the Chief Executive of the NHS Race and Health Observatory and the meeting with a large number of colleagues, including executive directors, to discuss how to enable inclusion, diversity, leadership across the organisation; and the letter received from Sir Jonathan Michael relating to the publication of the phase one inquiry report into David Fuller. It was noted that the trust will need to submit evidence to the inquiry in terms of its compliance with the mortuary and Human Tissue Authority standards. It was further noted that compliance against these standards was monitored through the Quality and Governance Assurance Committee.

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

- It was queried whether Dorset will be able to deliver their part of the programme. The Chief Executive advised that the ICB had been assured by the Dorset system and county hospital that they were committed to delivering

but that they were still working through the estate and recruitment details. It was queried what this commitment meant. The Chief Executive advised that they had committed to delivering the standard for hyper acute care for Somerset patients.

It was noted that the trust had sufficient consultant and allied health professional cover to deliver its part of the stroke programme but a new service model will be required to be able to effect change, particularly for the South Somerset patients who would otherwise have been admitted to YDH for the first part of their stroke treatment.

It was suggested that the consultation did not seem to have got across the clinical benefits for patients and lessons learned should be identified for future consultations. The Chief Executive advised that the clinical case and evidence was strong and this was set out at the public meetings. It was however understandable that members of the public had concerns.

In terms of risks, the performance report clearly showed challenges getting patients to a stroke unit within four hours due to the current configuration of stroke services in both acute hospitals. The short term recruitment risk had been mitigated as two additional doctors had been appointed. The new service model will enable the trust to deliver the stroke standards and improve care for patients.

These risks will need to be reviewed in the case of a delay in the process, e.g. as a result of Secretary of State intervention.

8. ASSURANCE REPORT OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING HELD ON 24 JANUARY 2024

8.1. Jan Hull joined the meeting for this agenda item.

8.2. Jan Hull presented the report which was received by the Board. She highlighted the areas of assurance received and the areas to be reported to the Board. The areas to be reported to the Board related to:

- The Maternity Incentive Scheme compliance declaration. The Committee signed off six out of the ten actions as being compliant with the MIS standards. Two actions were signed off as compliant with an action plan. This was a disappointing outcome and the Committee had considered what needed to be done to improve the oversight and governance of the process for the coming year. It was noted that the way evidence was gathered had been discussed at the February 2024 planning meeting.

- Assurance from the clinical support and specialist service group. The report provided significant positive assurance in terms of processes put in place by the service group and the strong focus on governance in meetings. Jan Hull highlighted the joint work between the service group and the patient

engagement team to streamline the complaints process and improve the response rates.

- Assurance from the SHS assurance report. This was the first report from Symphony Health Services (SHS). The aim of the report was to link SHS's governance processes to the Quality and Governance Assurance Committee. The focus of the first report was on governance processes and systems for providing governance oversight across practices. It was recognised that further work will be required but the report was a good starting point. The key risks discussed related to SHS's financial position and the lack of clarity about the SHS's strategic role in the wider system.

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

- Internal audit services had been used to test the MIS submission but it was not felt the right use of internal audit services on a routine basis. It was suggested that the Committee reviewed how evidence can be provided internally. Jan Hull agreed that, although the use of internal audit services had been helpful, it was not anticipated that internal audit services will be used going forward.

  The Director of Corporate Services advised that there had been some challenges in terms of the process. He advised that the advance notice of the year six requirements had now been received and a few amendments to the requirements had been made. An audit compliance tool had been published and aspects of three out of the four requirements for which the trust had not been compliant had been removed for year six. The advance notice further confirmed that Boards can delegate compliance oversight and sign off the compliance declaration to a sub committee.

- The SHS assurance report provided a good starting point. When presenting the report, Kerry White talked about delivery of the overarching objectives, including health surveillance. It was queried whether SHS related performance information can be included in the trust's quality and performance report. Kate Fallon advised that it was currently not easy to collect this information as individual practices were small practices and not strongly sighted on governance and collecting performance data. This was however work in progress.

- The Director of Corporate Services provided an update on the medical physics risk and advised that the trust was in the process of partnering with Oxford University Hospitals to provide medical physics cover. These partnering arrangements will come into effect in April 2024.

Tina Oakley joined the meeting.

- A working group had been set up, led by the chief nurse and chief operating officer, to address the fire safety risks identified at the maternity and neonatal intensive care unit at Musgrove Park Hospital. Monthly progress reports will be presented to the operational leadership team. There were

particular concerns in maternity services and this service had to work within a large number of governance frameworks and policy initiatives. A review of the governance arrangements was also taking place.

Jan Hull left the meeting.

9. LEARNING FROM DEATHS FRAMEWORK: MORTALITY REVIEW PROGRESS REPORT

9.1. Katy Darvall, Consultant Vascular Surgeon and Mortality Lead, joined the meeting for this agenda item. Katy Darvall presented the report which demonstrated the processes for learning from deaths and how this learning was shared and improvements made within the trust. Katy Darvall highlighted the key findings of the reviews and examples of learning.

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

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

- Statistics were presented at the end of the report and it was queried if the report could start with a snapshot of numbers and trends as this will help set the context and give an understanding of the key issues. Katy Darvall commented that the key aim of the report was to reflect learning. In terms of statistics, the trust was performing well and the overall trend was improving. Katy Darvall agreed to feed the data and trend issue back to the team for consideration for future reports. **Action: Katy Darvall**.

- The report showed a number of different approaches for different services and circumstances and it was queried whether the overall process was coherent and effective and whether assurance could be provided about the effectiveness of the overall process. Katy Darvall explained that the processes reflect national guidance. In terms of the learning from deaths process, the findings from the Structured Judgement Reviews and the opinion of clinicians could be amalgamated in an easier to read format. A large number of statistics were available but not all were helpful for an organisation like the trust. Granular data, by specialty, will be more helpful and it may be more helpful to include that data in the report.

- From a patient safety point of view, the report was well presented.

- Considerable progress had been made in the learning from deaths process and reporting and Katy Darvall and the team were thanked for their hard work.

- It was queried whether different actions should be taken in relation to the areas and performance showing above expected performance (i.e. higher than expected mortality). Katy Darvall advised that the number of areas showing above expected had reduced. The reason for the above

expected hospital standardised mortality ratio (HSMR). data was well understood and had been discussed in detail at previous Board meetings. In terms of the three community hospitals showing above expected hospital-level mortality index (SHMI) performance, clinical reviews of excess mortalities had been undertaken and no evidence of avoidability for any of the deaths reviewed had been identified. Any learning will be followed up with the relevant team. Katy Darvall highlighted the known compatibility issues with using existing mortality metrics (designed for acute services) at site level for community hospitals. As a result of these issues, it was suggested to stop using HSMR and SHMI at site level as a trigger of concern for community hospital deaths but to ensure that we consider other triggers for review.

- The incident reporting was working well and this provided a good level of assurance.

- In terms of the above expected HSMR performance, this was partly due to the guidance as to how palliative care should be coded. As the trust has historically used a different palliative care pathway, particularly through Musgrove Park Hospital, this impacted on coding but did not impact on the care provided to patients.

- It was queried whether the HSMR performance was expected to come back in line in the future or whether this was a permanent coding issue. Katy Darvall commented that the trust coded its palliative care correctly in line with its palliative care pathway. She advised that a number of patients are admitted to community hospitals for end of life care. Although they had a near 100% chance of passing away during the admission or shortly after it, the coding will show a 10/15% chance and these deaths resulted in an above expected performance.

- It was recognised that there was a level of complication because of the wide range of services provided by the trust. In spite of the metric issues, the trust was not complacent in terms of understanding the reasons for deaths in its acute services and embedding lessons learned. The depth of the analysis was important to provide assurance that processes are robust.

9.4. The Chairman thanked Katy Darvall for the excellent report and presentation. Katy Darvall left the meeting.

10. QUALITY AND PERFORMANCE EXCEPTION REPORT

10.1. The Chief Finance Officer presented the report which was received by the Board. She highlighted the areas of good performance and provided an overview of the key performance challenges across the trust.

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

- The number of incidents involving ligatures had been high during January 2024 and the 184 incidents related to 14 patients. Of these

incidents 50 related to one patient at Holford Ward and 77 of the incidents related to three patients at Rydon Ward 1.

- Compliance with the career conversations target was 69.1%, a slight increase from December 2023. Intensive work was being undertaken to understand the reported difficulties with updating the reporting system and to provide appropriate support and guidance. Service groups had been asked to review their performance and provide an updated trajectory. Progress will be closely monitored over the next few months. It was queried how the success of the career conversations was measured and the Chief of People and Organisational Development advised that the quality of career conversations was measured through the staff survey and the results of the 2023 staff survey were currently awaited.

- Performance against the ambulance handover times target showed a decrease. Work was taking place with the ambulance service to look at alternative pathways. It was queried whether the philosophy of taking patient risks in hospital rather than leaving them waiting in an ambulance will change as a result of the review of processes. The Chief Operating Officer confirmed that that philosophy will not change as it was felt that this was the right philosophy and in the best interest of patients. It was noted that, in terms of ambulance handover performance, the Somerset system was the best performing system in the South West. Hospital Ambulance Liaison Officers were embedded in emergency services and the impact these officers will have on handover performance will continue to be reviewed.

- It was queried whether the performance metrics were still fit for purpose for the merged trust and whether service groups were confident that the performance data reflected an accurate picture of performance. The Chief Operating Officer advised that, in his view, the report showed accurate performance data. In view of the size of the trust and the significant amount of detailed performance data, it was challenging to determine what level of performance details to include in the report to the Board. More detailed information was presented to the monthly service group finance and performance review meetings and there was opportunity to explore further the exceptions at both Service Group and Trust level through the Quality and Governance Assurance Committee. Martyn Scrivens confirmed that he had attended one of the service group meetings and commented that a total of 12 hours were spent on a monthly basis on the review of performance data at service group level. This provided him with significant assurance and he thanked the service groups for their rigorous reviews.

  A thorough scorecard review was undertaken on an annual basis and the aim has been to include site, as well as, mental health, and acute specific metrics. The annual review will take account of the requirements set out in the latest planning guidance and, where needed, the scorecard will be amended to take account of any changes reporting and monitoring needs.

- It was highlighted that the report and scorecard was presented to the Board to provide the Board with assurance but there were still a number of

data points missing with some fields indicating that data had not been collected, particularly relating to the YDH site. It was not clear where this data was reviewed and it was felt that this left questions about the assurance process for these metrics. The Director of Corporate Services offered to meet with Inga Kennedy to set out the assurance process in relation to the performance metrics. Inga Kennedy commented that it was helpful to discuss the assurance process but felt that it should be clearer where this information was reviewed.

- The report set out actions taken to try to reduce the number of "no criteria to reside" patients and it was queried how the effectiveness of e.g. the discharge actions will be measured. No criteria to reside had been identified as a social care issue, but it was important for the trust to be sure that it had taken all actions it could to reduce the number of "no criteria to reside" patients and that the measures taken were effective. The Chief Executive commented that the "no criteria to reside" metric related to a special cohort of patients, the majority of which had been classified as "no criteria to reside" as they were waiting for onward treatment or placement. There was however not a requirement for them to remain in an acute bed. 80% of inpatients do not require this onward care or placement and could be discharged to their own home. This cohort was equally important and the trust will need to be confident that it was doing everything it could to minimise delayed transfer of care whilst meeting the needs of all patients. There was a high focus on discharge in general and metrics such as length of stay and discharge dates continued to be closely reviewed. It was however not possible to reflect all the work taking place in the quality and performance report.

  The Chief Operating Officer advised that the majority of the work taking place related to operational activity, e.g. patient flow, pathway zero, carried out on a system wide basis, working closely with the ICB and Local Authority. A large proportion of the work taking place was not visible but there was a huge interest in the seven day flow work and a summit with the leadership team had recently taken place. A review of discharge performance in weekends had been conducted and improvements to weekend discharges are being implemented.

- Diagnostic performance at YDH had historically been lower and it was queried whether this required a structural change. The Chief Executive advised that performance was mainly affected by the backlog in endoscopy surveillance patients. This was a longstanding issue and work was taking place to reduce the backlog. However, overall performance will not change until the backlog has been cleared. The Chief Executive further highlighted that previously endoscopy surveillance patients had not been correctly recorded but this had now been addressed and had resulted in a reduction in the compliance rate. Addressing this will take time in view of capacity constraints.

11. ASSURANCE REPORT OF THE PEOPLE COMMITTEE MEETING HELD ON THE 17 JANUARY 2024

11.1. Kate Fallon, Chairman of the People Committee, presented the report which was received by the Board. Kate Fallon advised that this meeting had focussed on the remit of the Committee and the format of meetings going forward to ensure that the remit of the Committee covered the requirements of a larger trust.

11.2. Kate Fallon highlighted the following actions approved by the Committee:

- To move to ten meetings a year.
- To set up a small sub group led by Kate Fallon and Isobel Clements, with membership to include: Tina Oakley, James Phipps and Kirstie Lord, to discuss the agenda for the next six meetings.
- To present a report to the next meeting setting out the plan for future meetings and the process for gaining assurance from sub groups.

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

- The meetings will be split into strategic meetings and meetings focussed on deep dives into specific people related issues.
- It was queried whether the People Committee will be focussing on the recruitment challenges and the actions to be taken both as a trust and on a system wide basis. The Chief of People and Organisational Development advised that the agenda will be driven by the key risks, which relate to medical staffing, sickness and agency. The areas to be covered will be kept under close review.
- A large proportion of agency usage originates from Symphony Health Services and it was queried whether there was sufficient engagement with Symphony on the recruitment process. Kate Fallon commented that a portfolio job initiative had been brought in two to three years ago and this had encouraged candidates to apply for primary care positions. This work had shifted clinicians from doing locum work to taking on a substantive role.
- There was a close relation between workforce and finance and the impact of workforce decisions on the financial position will need to be closely monitored. It was suggested that quality impact assessments will need to be carried out for each programme and presented to the Quality and Governance Assurance Committee. It was noted that quality impact assessments were routinely presented to the Quality and Governance Assurance Committee to provide the Committee with the required assurance.

12. SIX MONTHLY ESTABLISHMENT REPORT

12.1. It was agreed to move this item down the agenda to await the arrival of the Chief Nurse.

13. SIX MONTHLY FREEDOM TO SPEAK UP REPORT

13.1. The Chief of People and Organisational Development presented the report which was received by the Board. Caroline Sealey particularly highlighted the increase in the number of Freedom to Speak Up cases; the key themes; the breakdown of the themes as well as the breakdown of staff groups reporting; the excellent compliance with the Freedom to Speak Up mandatory training module; the colleague satisfaction level with the service – 8.49 out of 9; and the actions being taken.

13.2. It was noted that elements of the report had been presented to the March 2024 Operational Leadership meeting.

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

- Locally the number of cases had increased 60% from quarter 1 to quarter 2 2023/24 and an increase was seen across all themes.
- A Freedom to Speak up internal audit had been undertaken and the findings from the audit were very positive and provided significant assurance about the Freedom to Speak Up process.
- One of the lessons learned was that difficult conversations with colleagues should to take place as early as possible so that any issues can be addressed as quickly as possible. Colleagues further continue to be reminded to be kind and follow policies and processes.
- The high percentage of colleagues who said that they would speak up again was excellent and was a good measure of the success of the service.
- A reference was made to a whistleblowing event by a consultant at a neighbouring trust and the importance was stressed of making sure that concerns, particularly by senior colleagues, were communicated to the Board in a timely manner.
- Compliance with Freedom to Speak Up follow up training will be a key area of focus for the next few months.
- The increase in cases was welcomed as it showed that colleagues felt able to raise their concerns. The total number of cases was however still a proportionally small number compared to the number of colleagues. It was noted that Freedom to Speak Up was only one of the speaking up routes and alternative routes were available; and that the number of cases compared well nationally, with the trust being in the top three organisations nationally during quarters 2 and 3 2023/24.

- A number of colleagues had indicated that they had been directed to the Freedom to Speak Up service by their manager. However, discussions with the line manager should be the default position, unless this was not possible in view of the concern.

- The Freedom to Speak Up Reflection Tool will be presented the April 2024 Board development day.

13.4. The Chairman commended Caroline Sealey for her excellent work.

14. FINANCE REPORT

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

- In January 2024, the Trust recorded a deficit of £0.696m, this was £1.790m adverse compared with the plan for the month. Cumulatively, the Trust is £5.758m in deficit, this is £2.325m adverse when compared with the planned position for the period. The in-month adverse variance resulted from the industrial actions in December 2023 and January 2024. Excluding the industrial action, the Trust was consistent with the H2 plan trajectory. It was noted that additional funding to cover the costs of the industrial actions will be allocated and it was expected that the forecast year end breakeven position will be achieved.

- Agency expenditure was £0.126m higher than December 2023 at £3.127m in January 2024.

- Cumulatively, savings of £22.738m have been delivered compared with the planned delivery of £25.350m at the end of January 2024, an under delivery of £2.612m. Of the savings delivered so far, 54% (£12.345m) are recurrent.

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

- In relation to industrial action, all systems will be performing above their ERF targets and income will be available to cover this element of loss associated with industrial action. The allocation for December 2023 and January 2024 will be £1.5 million and this will be sufficient to cover backfill costs.

- Being able to reduce waiting lists in spite of the episodes of industrial actions was an excellent achievement. The Chief Operating Officer advised that the responses to industrial action events have been well managed by Meridith Kane which lessened the impact on patients. He further highlighted the excellent senior medical leadership, the significant amount of planning required, and the focus on activities which could continue to be provided rather than on activities which should be stopped. Senior decision making at the right point in the pathway had a positive impact on patient flow in

emergency services but did not impact on the number of “no criteria to reside” beds.

- Ongoing junior doctor and consultant industrial actions will not be sustainable in the long term. The Chief Executive advised that learning from the industrial actions will need to be considered, including whether some actions taken to mitigate the impact of the industrial actions could be implemented on a more routine basis.

- It was queried whether more than expected activities were carried out in the private sector. The Chief Executive advised that, for many years, Somerset has had a high baseline percentage of planned activities carried out in the private sector. This impacted on the mix of activities carried out in acute services and had been identified as a driver of deficit. Conversations about the strategic view for Somerset were taking place with the Integrated Care Board (ICB). Considerable amount of money was spent in the private sector, but activities did not focus on patients waiting for a long time. Although the ICB commissioned services, patient choice was a key factor and this was not in control of the ICB or the trust.

  The demographics of the Somerset population further impacted on services as Somerset had a higher percentage of people over 75. A frailer population impacted on emergency services and the independent sector was unable to treat this group of patients.

15. VERBAL REPORT FROM THE FINANCE COMMITTEE MEETING HELD ON 26 FEBRUARY 2024

15.1. Martyn Scrivens, Chairman of the Committee, provided feedback from the meeting held on 26 February 2024 and advised that the Committee reviewed the finance report and discussed the capital programme.

16. CAPITAL PROGRAMME FOR 2024/25

16.1. The Director of Strategy and Digital Development presented the report which was received by the Board and highlighted the key allocations included in the capital programme.

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

- The team was commended on their management of the capital programme, especially as available capital varied on a monthly basis and making sure that capital was spent within the required timeframe could be challenging.

- The £1million allocation for stroke services reconfiguration was solely for the management of the reconfiguration of the service both in Somerset and Dorset. The allocation was expected to be spread over two financial years as the scheme had not as yet been fully developed and will not be

fully delivered in year. Upon the full development of the scheme, resources will be transferred to Dorset in line with the ICS plan.

- The EHR programme allocation will be subject to change depending on the progress made in relation to the development of the business case with Dorset.

- The level of backlog maintenance required across the organisation was high and it was queried whether the allocated funding will be sufficient. The Director of Strategy and Digital Development advised that backlog maintenance will continue to grow and cannot be fully covered by the capital programme. It had been possible to maintain the level of expenditure over the last few years and the main impact on backlog maintenance will be through the New Hospital Programme and other major capital schemes. A risk assessment had been carried out to identify the estate and facilities with the highest risks.

  The Director of Corporate Services advised that there remained a level of risk in the community estate due to the uncertainty about the wider strategy in relation to this estate and risk-based judgements will continue to need to be made.

- Large elements of expenditure will be required in future years to replace major equipment.

- the condition of the NHS estate in general was a concern and it was not felt that nationally sufficient capital was released to meet needs. It was queried whether the chairs can raise the impact of a failing estate on patients as part of their national meetings. The Chairman advised that he will continue to raise these concerns at the appropriate meetings.

16.3. Paul Mapson proposed, Jan Hull seconded and the Board approved the capital programme whilst noting that funding for the stroke service reconfiguration will need to be transferred to Dorset and noting that the capital programme still needs to be approved by the ICB.

17. ASSURANCE REPORT FROM THE AUDIT COMMITTEE MEETING HELD ON 10 JANUARY 2024

17.1. Paul Mapson presented the report which was received by the Board. He highlighted the areas of assurance received, the areas for follow up and the areas to be reported to the Board.

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

- The findings of the Personalised Care Audit Report (Quality and Governance Assurance Committee).

- The findings from the Procurement Audit Report (Finance Committee).

- The overdue internal audit recommendations (Operational Leadership Team).

17.3. The Board discussed the report and it was noted that the overdue internal audit recommendations had been raised at the recent Operational Leadership Team meeting.

12. SIX MONTHLY ESTABLISHMENT REPORT

12.1. In view of the absence of the Chief Nurse and Deputy Chief Nurse due to the serious incident at Yeovil District Hospital, the Chief Executive presented the report which was received by the Board.

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

- The report included a business case for paediatrics at Yeovil District Hospital and the Board noted that the business case will be reviewed as part of the wider business planning process. An assumption had been made about significant spending on paediatrics at Yeovil District Hospital. It was noted that the investment was expected to result in savings on agency expenditure.

- It was queried whether there was a good level of confidence that it will be possible to replace agency colleagues with substantive colleagues. The Chief Executive confirmed that he was confident that this can be achieved. Managing the staffing risk of the paediatric ward had been a longstanding issue.

- A number of patients on the paediatric ward had been admitted for eating disorders and supported feeding and it was queried whether there were partnerships which could be linked into to find out the reason for the eating disorder acuity. The Chief Executive advised that the key paediatric issues did not relate to the staffing model but to the demand for services. In terms of eating disorders, the Chief Operating Officer advised that the trust had a good relationship with SWEDA (Somerset and Wessex Eating Disorders Association). In relation to supported feeding, legally food was seen as a form of treatment for young eating disorder patients. There were safety issues relating to medically feeding young people and the aim was not to get to that position. The position at YDH and relationships with other organisations had significantly improved following the appointment of Claudine Brown as head of paediatric services and CAMHS.

- It was queried whether the shortage of psychologists was a concern. The Chief Operating Officer advised that there was a national shortage of psychologists due to the limitation of training places. This was a difficult profession to recruit to and this had been included as a workforce risk on the corporate risk register.

- The vacancy factors, fill rates and agency usage was generally good. It was noted that these figures included the use of agency colleagues. It was clarified that the overall agency costs pressure was not related to nursing services but was a medical staffing issue and included GPs.

- It was queried how the need to reduce overall staff numbers impacted on safe staffing requirements. The Chief Execuitve advised that this will be challenging. He advised that details of the planning guidance were currently not known but expecting core capacity to be maintained whilst reducing funding and staff did not align. The ability to reduce beds in a number of wards was depending on a resolution of the "no criteria to reside" challenges. The planning guidance and the actions to be taken will be reviewed once available.

12.3. Hayley Peters joined the meeting.

- It was queried what the benefits of the new safer nursing care tool were and whether this tool provide improved data. The Chief Nurse advised that two whole trust data captures had been completed but a further data cycle will be undertaken and reviewed to ensure the quality of the data. The first report will be available in September 2024 but more time will be required to be fully confident about the data. The tool was a national tool but there will be challenges in view of the different tools in mental health, acute, district nursing services etc.

- There was a high turnover of colleagues in theatres and the reasons for this turnover were known. This was however a concern and will be kept under close review.

12.4. Kate Fallon proposed, Pasul Mapson seconded and the Board approved the recommendations as set out in the report.

18. FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS

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

19. ANY OTHER BUSINESS

19.1. Graham Hughes advised that during Covid, the St Margaret's Hospice had moved to outpatient services only which enabled the trust to rent space at the Yeovil site for the oncology and haematology team. The charity had approved a request for funding to upgrade this space. Funding will be provided by the charity, but Graham Hughes wanted to raise this with the trust as it was a tenant on a full repairing lease expiring in 2027 and there could in future be a requirement to reinstate the work.

19.2. The Director of Strategy and Digital Development advised that this was a very low risk and the reality of moving services out of the hospice was low. In addition, it was

unlikely that any improvements to the space would need to be reinstated to their original condition.

19.3. The Board noted this and agreed that this was a good development and a good use of charitable funds.

19.4. The Chairman advised that this was Daniel Meron's last public Board meeting and on behalf of the Board, formally thanked him for his tremendous contributions to the work of the trust. Dan has made a significant impact during his four years with the trust and his enthusiasm and dedication will be missed.

20. RISKS IDENTIFIED

20.1. The Director of Corporate Services advised that no new risks had been identified during the meeting. He reiterated the risk in relation to a potential review of the stroke services consultation by the Secretary of State but it was noted that a wider stroke service risk had already been included on the corporate risk register.

21. EVALUATION OF THE EFFECTIVENESS OF THE MEETING

21.1. The Board agreed that the meeting had been productive. It had been possible to have more detailed discussions on some of the items due to a lighter agenda.

22. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

22.1. 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.

23. WITHDRAWAL OF PRESS AND PUBLIC

23.1. 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.

24. DATE FOR NEXT MEETING

7 May 2024

EXTRA ORDINARY PUBLIC BOARD MEETING

MINUTES OF THE EXTRA-ORDINARY SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 18 MARCH 2024 BY TEAMS

PRESENT

Colin Drummond	Chairman
Alexander Priest	Non-Executive Director
Martyn Scrivens	Non-Executive Director
Jan Hull	Non-Executive Director
Paul Mapson	Non-Executive Director
Kate Fallon	Non-Executive Director
Graham Hughes	Non-Executive Director
Inga Kennedy	Non-Executive Director
Tina Oakley	Associate Non-Executive Director (non-voting)
Peter Lewis	Chief Executive
Phil Brice	Director of Corporate Services (non-voting)
David Shannon	Director of Strategy and Digital Development (non-voting)
Isobel Clements	Chief of People and Organisational Development
Hayley Peters	Chief Nurse
Meridith Kane	Deputy Chief Medical Officer

IN ATTENDANCE

Ria Zandvliet	Secretary to the Trust (minute taker)

1. WELCOME AND APOLOGIES FOR ABSENCE

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

1.2. It was noted that apologies had been received from: Barbara Gregory (Non-Executive Director), Andy Heron (Chief Operating Officer), Pippa Moger (Chief Finance Officer) and Daniel Meron (Chief Medical Officer).

2. DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA

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

3. WITHDRAWAL OF PRESS AND PUBLIC

3.1. 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.

3.2. The Chairman advised that the focus of the Confidential Board meeting will be on the approval of the Draft Somerset System 2024/25 Plan and the Specialist Commissioning arrangements of Inpatient Perinatal Mental Health Beds.

4. DATE OF NEXT MEETING

4.1. 6 February 2024

SOMERSET NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETING HELD ON 5 MARCH 2024

AGENDA ITEM	ACTION	BY WHOM	DUE DATE	PROGRESS
9. Learning from Deaths Framework	To feed the data and trend issue back to the team for consideration for future reports	Katy Darvall	May 2024	Feedback on the data and trend issues have been fed back to the team.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Registers of Directors' Interests
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Colin Drummond, Chairman
DATE:	7 May 2024

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

Executive Summary and Reason for presentation to Committee/Board	The Registers of Interests are presented to the Board at every meeting and reflect the interests of Board members as at 26 February 2024.
Recommendation	The Board is asked to: • note the Register of Interests; • declare any changes to the Register of Interests; • declare any conflict of interests in relation to the agenda items.

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

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

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

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

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

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

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

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

REGISTERS OF DIRECTORS' INTERESTS

NON EXECUTIVE DIRECTORS	
Colin Drummond Chairman	• Honorary Vice President of Calvert Trust Exmoor (outdoor holidays for people with disabilities) – current • President of Wadham College Oxford 1610 Society • Deputy Lieutenant for Somerset • Worshipful Company of Water Conservators – Deputy Master
Jan Hull Non-Executive Director	• Trustee of the Dulverton Abbeyfield Society. • Formerly Managing Director of South, Central and West Commissioning Support Unit
Dr Kate Fallon Non-Executive Director (Senior Independent Director)	• Daughter is a Consultant at the Trust • Symphony Health Services Board member • Chairman Symphony Health Services
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 • Non-Executive Director at Torbay and South Devon Healthcare NHS Trust
Alexander Priest Non-Executive Director	• Chief Executive Mind in Somerset
Martyn Scrivens Non-Executive Director (Deputy Chairman)	• Non Executive Director and Chair of Audit Committee of Hampshire Trust Bank Limited • Wife works as a Bank Vaccinator for the Trust • Non-Executive Director and Chairman of Wesleyan Bank Limited, a 100% subsidiary of Hampshire Trust Bank Limited" (with effect from 28 February 2022) ▪ Member of the Boards of Directors of the Ardonagh Group – consisting of the following companies: – Ardonagh Holdco Limited (Jersey) – Ardonagh New Midco 1 Limited (Jersey)

	– Ardonagh Group Holdings Limited (UK) – Ardonagh New Midco 3 Limited (Jersey) – Ardonagh Midco 1 Limited (Jersey) – Ardonagh Midco 2 plc (UK) – Ardonagh Midco 3 plc (UK) – Ardonagh Finco plc (UK) • Director of Ardonagh International Limited
Graham Hughes Non-Executive Director	• Chairman of Simply Serve Limited • Parish Councillor of Babcary Parish Council
Paul Mapson Non-Executive Director	• Advisor to NHS Devon Health System
Inga Kennedy	• IJKennedy Healthcare Consultancy - Position - Director (however this Ltd Company is registered as not trading at this time. • Portsmouth Hospitals University Trust - Position - Non-Executive Director (end of term is Mar 24) • Isle of Wight NHS Trust - Position - Non-Executive Director (end of term is Mar 24)
Tina Oakley	• Son, Dr Tom Oakley, is Chief Executive Officer of a digital medical imaging company, Feedback plc.
EXECUTIVE DIRECTORS	
Peter Lewis Chief Executive (CEO)	• Member of the NHS Confederation Community Network Board • Management Board Member, Somerset Estates Partnership (SEP) Board • Director, Somerset Estates Partnership Project Co Limited
Phil Brice Director of Corporate Services	• Sister works for the Trust • Non-Executive Director of the Shepton Mallet Health Partnership • Shareholder Director of SSL
Isobel Clements Chief of People and Organisational Development	• Sister in law works in the pharmacy department at MPH • Nephew works as a physio assistant within MPH.
Andy Heron	• Wife works for Avon and Wiltshire Mental Health Partnership NHS Trust (and is involved in a sub contract for liaison and diversion services)

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

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Chief Executive/Executive Director Report
SPONSORING EXEC:	Peter Lewis, Chief Executive
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Peter Lewis, Chief Executive
DATE:	7 May 2024

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

Executive Summary and Reason for presentation to Committee/Board	The purpose of the report is to update the Board on the activities of the executive and senior leadership team and/or points of note which are not covered in the standing business and performance reports, including media coverage and any key legal or statutory changes affecting the work of the Trust. The report covers the period 24 February 2024 to 26 April 2024.
Recommendation	The Board is asked to note the report.

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

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

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

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

All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.
Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
The report includes a number of references to work involving colleagues, patients and system partners.

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

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

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

SOMERSET NHS FOUNDATION TRUST

CHIEF EXECUTIVE / EXECUTIVE DIRECTOR REPORT

1. ONE YEAR AS A MERGED TRUST

1.1. 1 April 2024 marked one year since we came together as a single trust providing mental health, LD, community, primary and acute hospital care services across Somerset.

1.2. We merged because we want to provide better care for everyone who accesses our services - and ensure that everyone in Somerset enjoys consistent access to high quality services irrespective of where they live. At the same time, we have focussed on supporting people to stay well, giving equal priority to mental and physical health, and delivering services in the most appropriate setting.

1.3. We are currently undertaking a post-transaction evaluation to assess how far we have come with our aims and ambitions and learning we can share from our merger and will be sharing this with NHS England, Somerset Integrated Care Board and publishing more widely later this year.

2. WELCOME TO DR MELANIE ISLES

2.1. On 1 April 2024 we also formally welcomed our new chief medical officer, Dr Melanie Iles. Melanie is an experienced leader, having worked as a medical director in different settings for over eight years, in an acute trust, for NHS Improvement and for NHS England at regional level. She is a paediatrician by background and was most recently NHS England's interim national chief clinical information officer, on secondment from her substantive role as NHS England's medical director and CCIO for the East of England region.

2.2. We also shared our thanks to Dr Dan Meron for his huge contribution as chief medical officer. Dan played a vital role in steering our legacy trusts through two mergers - focussed on what we can achieve in our clinical services for patients by coming together – and the pandemic.

3. PREVENTING FUTURE DEATHS REPORT

3.1. In April 2024, the inquest was held into the death of Cariss Stone, who died in Musgrove Park Hospital (MPH) in August 2019. She was transferred to MPH having been found unresponsive after having self-ligatured on Holford Ward at Wellsprings two days earlier.

3.2. Cariss was well known to our CAMHS, and adult mental health outpatient and inpatient services. On this occasion, she had been admitted to Holford Ward

in June 2019. An independent review of Cariss' care was undertaken by Dorset Health Care University NHS Trust. This found no clear single root cause for Cariss' sad death. However, some care concerns were identified, particularly around our observation policy and arrangements at that time, and an action plan was developed.

3.3. The facts of the case were determined by the jury under guidance from the coroner and they concluded that Cariss died by accident but deficiencies in the way that she was observed possibly contributed to her death.

3.4. Following the inquest, HM Coroner issued the Trust with a report under Regulation 28 – a Preventing Future Deaths report – on two points:

3.5. HM Coroner questioned whether nurses and healthcare assistants carried ligature cutters as these can be time critical in the removal of ligatures. HM Coroner advised that he had not had clear evidence on who carried these and if everyone did. He said he cannot make recommendations around this, but he would like the trust to respond to this.

3.6. HM Coroner acknowledged that the Trust's policy on observations had changed and he noted that the previously unsuitable observation chart had been revised. However, he did not feel he had heard sufficient evidence to give him sufficient comfort as to the safety of patients using the bathroom for instance. He understood the need for privacy and dignity but he wanted to know if the trust had assurance that this was balanced around the safety of the individuals in our care.

3.7. The Trust has 56 days from the date of the issue of the report to respond to these points and provide assurance to HM Coroner that these matters have been addressed.

3.8. Our thoughts, as always at these times, are with Cariss' family and friends and with our colleagues who knew and cared for Cariss over the time she was under our care.

4. WORK HAS BEGUN ON THE CONSTRUCTION OF THE YEOVIL DIAGNOSTIC CENTRE

4.1. In March 2024 we celebrated the start of building work on the Yeovil Diagnostic Centre with a breaking the ground ceremony. The modern state-of-the-art, stand-alone centre on the hospital site will benefit patients in Somerset and north west Dorset who will receive quicker diagnostic tests thanks to the additional capacity the centre will provide.

4.2. It will open in late 2024 and will provide over 70,000 diagnostic tests and outpatient appointments a year. Open seven days a week, it will provide radiology, endoscopy, cardiology and audiology diagnostic tests and

outpatient appointments. InHealth will provide radiology and endoscopy services. Our trust will provide all other diagnostic and outpatient services. Prime, our strategic estates partner, will design and build the centre in partnership with InHealth and the trust.

4.3. A press release about the opening is on our website and was sent to media.

5. OUR EMERGENCY DEPARTMENT PERFORMANCE IN MARCH

5.1. The Emergency Department performance across the NHS in England for March 2024 was published last week. This follows the NHS England ambition for at least 76% of patients in ED and Minor Injury Units to be admitted, transferred, or discharged within four hours during March.

5.2. Our teams worked incredibly hard, focussing both on the flow into, through and out of our hospitals. A summary of performance across England, and our performance comparatively was as follows:

- England performance was 74.2% within 4 hours.
- Our performance, and therefore the performance for the Somerset system, was 79.6%.
- Somerset was the third best performing system behind Kent and Medway (81.0%) and North West London (80.9%).
- As a provider we were 14th nationally out of those providers that have a type one unit.

5.3. Looking more closely at our comparative performance:

- 2.5% of our patients were not seen within 12 hours. This places us 8th best nationally. National average was 10.3%.
- At 2.5% we were also the best performing system with the next best at 3.5%. This is a very important measure given the research about harm linked to spending extended time in ED.
- Our type one performance was 65.2%, which means that we were ranked 40th for type one performance out of 122.
- It is also important for us to recognise that the performance of our teams came in a month when we saw record demand for urgent care within our services.

6. RESULTS FROM THE 2023 NHS STAFF SURVEY

6.1. The 2023 national NHS Staff Survey ran from September – December last year. Just over 53% of colleagues completed the survey, providing us invaluable insight into our colleagues' experiences of working at Somerset FT.

6.2. This was the first time that we participated in the survey as one organisation, following our merger in April. The survey questions were all aligned to the NHS People Promise, setting out the things that would most improve the working experience of everyone. Both legacy trusts started from good bases with high results, but this year's results have surpassed even the combined results of the previous year.

6.3. Our survey contractor, IQVIA, has been able to combine last year's results to this year's results, as well as benchmarking against our comparator group (trust's that we are most similar to) average. Presentational slides are attached to the report.

7. CHIEF EXECUTIVE OF NHS ENGLAND, AMANDA PRITCHARD, VISITS SOMERSET

7.1. Amanda Pritchard, chief executive of NHS England, visited Somerset on 12 April 2024 in response to an invitation from Colin Drummond. It was an opportunity for her to find out about integrated work in Somerset, the progress we have made to deliver care that is joined up across acute, mental health, community and primary care, and the further strides that can be made subject to investment in digital systems that will enable further clinical integration.

7.2. She began her visit at Musgrove Park Hospital (MPH) where we gave her an overview of our trust and talked through Open Mental Health, the Somerset Homeless Health Service, and our postmenopausal bleeding service as examples of how we are delivering and transforming services.

7.3. She also visited both our Emergency Department and Surgical Decisions Unit and spoke to colleagues from those teams, our psychiatric liaison team, and radiology team about our integrated working, use of AI, and our EPMA that is in use in both our acute hospitals, our community hospitals, with links to community pharmacies and GP practices in Somerset and plans to extend to our mental health units.

7.4. Colleagues from our integrated paediatrics and CAMHS service spoke to her about their service and their close links with children's services in Somerset, and we talked about the need for improved digital systems to support our Hospital@Home service.

7.5. It was a full programme that demonstrated the advantages of being an integrated trust, some of the real progress we have made to integrate and transform services and the digital challenges we face to go further.

8. BMA ACCEPTS GOVERNMENT'S OFFER ON PAY FOR CONSULTANTS IN ENGLAND AND PAY REVIEW BODY REFORM

8.1. The BMA recently announced that the BMA's consultants committee has accepted the Government's offer on pay for consultants in England and reform to the pay review body, the DDRB. This brings to an end the current dispute with the Government that has continued for over a year, during which consultants have taken unprecedented industrial action. BMA consultant members voted 83% for the offer in a referendum that took place between 14 March and 3 April, and following this the BMA's consultants committee has accepted the offer on behalf of the profession.

8.2. The full press release can be read on the British Medical Association's website.

8.3. Junior doctors in England remain in dispute with ministers over pay and have a fresh mandate to strike.

9. SOMERSET'S COMMITMENT TO CARERS 2024

9.1. In March 2024, the Somerset Board endorsed Somerset's Commitment to Carers 2024. A summary report on the Commitment to Carers is attached for information.

9.2. The Commitment is a statement acknowledging the invaluable contribution and challenges faced by unpaid carers. It outlines the values, principles and actions that health and social care services should adopt to ensure effective support for unpaid carers.

9.3. The Commitment aims to enhance the quality of life for carers and those they care for, by improving their experience of health and social care, and supporting them to access information and opportunities to keep healthy and live well while they carry out their vital caring roles. It reflects priorities identified through consultation and co-production with carers and those who work with and support carers.

9.4. The principles of the Commitment are also aligned with the Trust's and Somerset's system Clinical Care and Support Strategy in terms of enabling our communities to live well with healthier lives for longer and reduce inequalities and access to care and support services.

9.5. As a Trust we fully support and sign up this commitment; to embedding the priorities and practices in our services and service development; and to supporting and valuing the essential roles that carers, paid and unpaid, make to the support and wellbeing of our people in Somerset.

9.6. The Somerset Carers Strategic Partnership Board will oversee the ongoing review and development of this work, including a performance monitoring

framework to assess the effectiveness of the Commitment. This will include ensuring that Carers continue to have opportunities to review and re-fresh the Commitment outcomes, priorities and recommendations.

10. REPORT - HEALTH INEQUALITIES IN 2040: CURRENT AND PROJECTED PATTERNS OF ILLNESS BY DEPRIVATION IN ENGLAND

10.1. The Health Foundation's Real Centre has published a report exploring how patterns of diagnosed ill health vary by socioeconomic deprivation in England. It is the second report from a research programme led by the Health Foundation's Real Centre in partnership with the University of Liverpool. Key findings from the report are:

- On current trends, inequalities in health will persist over the next two decades: people in the 10% most deprived areas can expect to be diagnosed with major illness a decade earlier than people in the 10% least deprived areas.

- A small group of long-term conditions contribute to most of the observed health inequalities, out of which chronic pain, type 2 diabetes and anxiety and depression are projected to increase at a faster rate in the 10% most deprived areas by 2040.

- These conditions are typically managed in primary care, underlining the need to invest in general practice, particularly in the most deprived areas, and community-based services and focus on prevention and early intervention.

- Inequalities in working-age ill health is also projected to persist. 80% of the increase in the number of working age people living with major illness between 2019 and 2040 (from 3 million to 3.7 million) will be concentrated in more deprived areas.

- Action focused on risk factors linked to major illness is essential but insufficient on its own to tackle health inequalities. Making progress on inequalities in major illness will also require long-term effort across government and the economy to address the underlying causes of health inequality, such as poor housing, low income, and insecure employment.

11. SUCCESS OF LOCAL NURSING AND MIDWIFERY DEGREE COURSES RECOGNISED WITH A QUEEN'S ANNIVERSARY AWARD

11.1. Peter Lewis joined partners from Bridgwater and Taunton College (BTC) at the Queen's Anniversary Prizes celebrations in London, with our Chief Nurse Hayley Peters.

11.2. As part of the awards ceremony, current nursing apprentices Telma Da Silva, Chris McCarthy and Millie Hollie visited Buckingham Palace with a team from University Centre Somerset (UCS), the higher education arm of Bridgwater and Taunton College (BTC). Her Majesty the Queen presented the team with a Queen's Anniversary award to recognise the college's outstanding achievements in developing responsive and effective nursing education pathways to address the shortage of qualified nurses in Somerset.

11.3. BTC is the first further education college in the country to gain consent from the Nursing & Midwifery Council and a university partner to deliver nursing degrees locally, opening up much needed additional healthcare career and training routes for all ages and helping to respond to our local workforce challenges.

11.4. These new career routes are just some of the ways that we are working in partnership with BTC to help develop new training opportunities and progression routes to help our colleagues to upskill and progress in their careers and provide new ways to start a career in healthcare. Congratulations to everyone who has been involved in the programme.

12. PREDICTIVE HEALTH INTELLIGENCE PARTNERSHIP SHORTLISTED FOR HSJ DIGITAL AWARDS

12.1. The Predictive Health Intelligence partnership between our trust, consultant gastroenterologist Dr Tim Jobson, and health information and IT expert Neil Stevens, has been shortlisted for two Health Service Journal Digital awards in the categories of 'Driving Change through Data and Analytics' and 'Generating Impact in Population Health through Digital'.

12.2. Funded by the National Institute for Health and Care Research, the Predictive Health Intelligence team has developed a new way of reviewing existing blood tests and finding people who have no symptoms but could be at risk of developing liver disease.

12.3. As part of this, they created a search engine – called hepatoSIGHT – that allows clinicians to identify people who may be at risk, quickly and easily. It's simple to use, requiring no manuals or training, and is designed to be as intuitive and easy-to-use as Rightmove or AirBnB.

12.4. Patients identified are not necessarily ill, but by looking at their historic blood tests, they fall into a category where they are more likely to develop an illness in the years ahead. It is similar to the screening programmes already in place for breast or bowel cancer: the trick is to find people before they are ill.

12.5. Before PHI was set up, many patients presenting to hospital with liver disease had already had blood tests (either with their GP or in hospital) which indicated a need to investigate further for a liver problem. However, one off abnormal blood tests do not necessarily indicate a problem. Now we can see

the trend in results over a number of years, it's possible to pick up those potentially at risk.

12.6. We will find out whether this innovative example of preventative health is successful at the HSJ Digital Awards ceremony in June.

13. TOTAL HIP REPLACEMENT DAY CASE PROCEDURE WINS HEALTH SERVICE JOURNAL PARTNERSHIP AWARD

13.1. A total hip replacement procedure, that can now be done without the patient needing an overnight hospital stay, has won a prestigious Health Service Journal Partnership Award.

13.2. The procedure has been available at both Musgrove Park and Yeovil hospitals for almost two years, where it is performed by each hospital's respective trauma and orthopaedic teams. It means a patient is assessed, operated on, and discharged from hospital on the same day, back to their home environment to continue their rehabilitation and recovery. And for other patients who do need a stay in hospital for clinical reasons, the average length of stay has halved from an average of four days, to just two days.

13.3. It took home first prize at the prestigious national HSJ Partnership Awards in the 'Best Elective Care Recovery Initiative' category, alongside Johnson & Johnson MedTech, who partnered with the hospitals to deliver this solution to optimise hospital productivity. The full media release can be viewed on our website.

14. NEW SERVICE GIVES LIFELINE TO BEDBOUND PATIENTS NEEDING TREATMENT FOR STIFF MUSCLES

14.1. Creating stronger links between services across Somerset for the benefit of our colleagues is one of the cornerstones of why we came together a year ago as one trust. One of those teams that spans much of our trust is our spasticity service, which was set up ahead of the first merger in 2020.

14.2. Many of our neurological patients whose muscles stiffen or tighten often need to come into hospital for regular botulinum toxin injections from our spasticity service colleagues to help maintain their range of movement and optimise the effectiveness of therapy interventions. It affects patients with multiple sclerosis and other neurological or brain conditions, as well as those who've had a stroke.

14.3. The botulinum toxin injections are given under the guidance of an ultrasound at our acute stroke units at Musgrove Park or Yeovil District hospitals, and in an outpatient setting at Dene Barton and South Petherton community hospitals. This works fine for patients who can travel to these areas, but for those who are housebound or struggle to travel to a hospital setting, they can

find it impossible to get their injections, sadly leading to their condition deteriorating. This has all changed thanks to an incredible donation by the South Petherton Hospital League of Friends, who have purchased a portable ultrasound machine that can be used at both the South Petherton and Williton community hospital stroke rehabilitation units, and even more importantly, in a patient's own home or place of residence.

15. NATIONAL SPEAKING UP REVIEW INTO EXPERIENCES OF OVERSEAS-TRAINED WORKERS

15.1. The National Guardians Office has announced that it will conduct a Speak Up Review into experiences of overseas-trained workers. This is an area that we ourselves have been debating, and we have volunteered to take part in this review. We have no further details at present, but I will share any updates as and when I have them.

16. CARE QUALITY COMMISSION REPORT – SOMERSET FT FEATURES AS POSITIVE CASE STUDY

16.1. The Care Quality Commission have published the latest 'Monitoring the Mental Health Act' report using a good practice reference that describes the outstanding practice of our 'specialist community mental health teams for children and young people', as found in the CQC's September 2022 inspection.

16.2. The report references the importance of early intervention as set out in the 2019, NHS long term plan, to improve access to children and young people's mental health services over 10 years.

'*Separate to our monitoring work, our inspection of Somerset Foundation NHS Trust highlighted how investment in early intervention can significantly improve outcomes for children and young people.*

We found outstanding practice relating to the trust's specialist community teams, which had implemented a number of strategies to decrease their wait times. This included, for example, working in partnership with voluntary sector organisations, investing in early intervention such as the mental health in schools team, and upskilling staff so more could deliver therapy.

We found that their efforts over the past 4 years have resulted in achieving a no wait list for children and young people to access the service, and a decrease in referrals. As a result, caseloads for staff were lower and there were also better outcomes for those who did not meet the criteria to access the service.'

16.3. The full report can be found on the CQC website.

17. USE OF THE CORPORATE SEAL

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

17.2. The seal register entries over the period 1 January 2024 to 30 April 2024 are set out in the attached appendix.

18. MEDIA COVERAGE

18.1. Over the period 24 February 2024 to 26 April 2024, there has been the following media coverage:

- Coverage of the incident at Yeovil District Hospital in the early hours of 5 March 2024. The coverage reported that two people are charged with murder following the death of the baby at YDH of a suspected skull fracture. The coverage came from the charge in Bristol Crown Court and is as we would expect. The statement that the trust released is on our website.

- Coverage on ITV West Country about Mark Catton's recruitment to the trust via the Department of Work and Pensions' Sector-based Work Academy Programme (SWAP). Job rejections left man with sight problems feeling 'on the scrapheap' | ITV News West Country

- Interviews with Holly Larcombe, Retention and People Promise Manager, and Sandra Webb, Head of Future Workforce Supply, in response to research conducted by the University of Bath which suggests that nearly half of NHS staff in England are looking for jobs elsewhere with half showing symptoms of burnout. Holly and Sandra discuss the support we provide for colleagues. Charlie Taylor - 25/04/2024 - 25/04/2024 - BBC Sounds (1.08:35 into programme).

- Coverage of our Somerset Preschool Lifestyle Activity and Skills for self Help (SPLASH) service. This is a is a weight management service where doctors, dietitians, and psychologists support children aged 0-4 years – one of very few of its kind in the country. The service first started as a trial in April 2022, but proved so successful that it has now been given permanent funding.

- Coverage on our sleep apnoea service at Yeovil Hospital. Dr Phil Raines, our respiratory medicine consultant and clinical lead for our sleep apnoea service at YDH, took to the airwaves as he joined BBC Radio Somerset's Simon Parkin for a chat about all things 'sleep'. You can listen back here (1:08:25 into programme) or you can read the article on our website: Spotlight on our sleep apnoea service at Yeovil District Hospital - Somerset NHS Foundation Trust (somersetft.nhs.uk)

- Coverage on our pioneering use of AI software to transform prostate cancer diagnosis. Mr Neil Trent, our consultant urologist, was live on BBC Radio Somerset on Tuesday 19 March to talk about the launch of a groundbreaking way of supporting doctors to diagnose prostate cancer using the latest artificial intelligence (AI) in Somerset.

  We have joined forces with Cambridge-based technology company, Lucida Medical, as the first NHS trust in the UK to introduce its AI tool, called Pi, to work alongside teams of radiologists. With support from charities Macmillan Cancer Support and Prostate Cancer Research, the Pi tool is being introduced at both Yeovil and Musgrove Park hospitals to assist radiologists in detecting clinically significant prostate cancer, using an AI technique that looks at a prostate MRI scan. You can read the story on our website: We're pioneering the use of AI software to transform prostate cancer diagnosis - Somerset NHS Foundation Trust (somersetft.nhs.uk)
- Six-part series featuring our colleagues on BBC Radio Somerset's Asian Show. The interviews are available on the following links:

  Andru Debbarman, admin team leader in our day surgery centre at Musgrove Park Hospital.
  Soomi Khokhar, a staff nurse on the intensive care unit at Musgrove Park Hospital.
  Saleema Airaz, a clinical skills trainer.
  Soni Shakya, a senior tissue viability nurse.
  Lakshme Vasanthan, infection prevention and control nurse.
  Jennifer Pereira, a junior sister at Bridgwater Community Hospital.

- Connecting the Dots – a new Somerset FT podcast series – in March 2024, we launched a new podcast series designed to enable closer working and engagement between primary and secondary care. targeted towards our primary care partners. The podcast follows on from the Connecting the Dots engagement meetings and newsletter. The first episode features Dr Andrea Trill, Somerset FT medical director for integrated and primary care, along with special guest Dr Jon Upton – a GP at St James Medical Centre, in Taunton and a GPwER (GP with extended responsibility) in dermatology and dermatology lead at the ICB.

  This very first podcast explores the development of our new dermatology service in Somerset, and we hope it answers some of the questions that our primary and secondary care colleagues may have. Connecting the Dots - episode 1

- Somerset Emotional Wellbeing podcast **-** in the latest episode of the Somerset Emotional Wellbeing podcast, Allyship, our hosts Dr Peter Bagshaw and Dr Kate Staveley are joined by Sun Sander-Jackson and Isobel Clements from our trust to discuss what allyship is, why it is important to consider what a person might want from an ally before

acting, and how you can best support people of all backgrounds both in work, and in life.

- Coverage following on from a survey by the Office for National Statistics (ONS) that shows almost 10 million people in England could be on an NHS waiting list. NHS Providers shared that The Guardian and The Telegraph reported the ONS survey showing that almost 10 million people across England could be waiting for an NHS appointment or treatment, 2 million more than previously estimated.

  The study found that 21% of patients were waiting for a hospital appointment or to start receiving treatment on the NHS, equating to 9.7 million people. In January the waiting list stood at 7.6 million, according to official NHS statistics.

19. NATIONAL DEVELOPMENTS

19.1. **NHS England publishes planning guidance for 2024/5 -** planning guidance for 2024/5.

19.2. NHS providers published the ***Good quality regulation: How CQC can support trusts to deliver and improve*** report. The report outlines key areas for improvement to enhance support and constructive engagement between CQC and trusts.

19.3. In response to feedback from trust leaders indicating declining confidence in the regulatory body, NHS Providers has conducted extensive research to identify the characteristics of effective quality and safety regulation. Read the full report. NHS Providers chief executive Sir Julian Hartley said: "Effective regulation should not only ensure high-quality healthcare services but also support providers in their journey towards improvement and innovation." Read the full statement.

CQC's Community Mental Health Survey 2023

19.4. The Care Quality Commission (CQC) published its Community Mental Health Survey 2023, which received feedback from 14,770 people who received treatment for a mental health condition between 1 April and 31 May 2023. This report shows that overall people's experiences of NHS mental health services provided in the community are poor. Most notably with regard to, quality of care, crisis care, support while waiting, planning and involvement in care, and support with other areas of life.

19.5. NHS Providers has produced a briefing that summarises the key findings, areas identified by the CQC for improvements, and sets out the provider organisation's view.

Analysis of NHS waiting times and the challenge of returning them to pre-pandemic levels

19.6. The Institute for Fiscal Studies (IFS) has analysed NHS waiting times and judges it most likely that waiting lists will start to fall consistently but slowly from the middle of 2024, but that it is very unlikely they will reach pre-pandemic levels over the next four years.

19.7. NHS Providers has responded with the following statement from its chief executive Sir Julian Hartley.

"Trust leaders across hospital, mental health and community services are working flat out to reduce record-high waiting times and waiting lists.

"But their efforts are thwarted by a perfect storm of squeezed funding in the NHS, the fallout of the pandemic, severe workforce shortages and strikes.

"Despite incredibly tough circumstances, trusts have made vital progress in tackling care backlogs, including delivering a record number of tests and checks and seeing cancer patient referrals more quickly.

"But trust leaders want to go further and faster. As resolving industrial action would remove one of the biggest blockers to bearing down on care backlogs, the government and health unions must urgently find a way to agree a pay deal.

"Sustained government investment in NHS capital and digital infrastructure, as well as social care reform, are also vital enablers for trusts to cut waiting lists and give patients the timely care they deserve."

NHS Providers briefing: A picture of health: delivering the next generation NHS

19.8. Ahead of the next general election, NHS Providers has published a briefing, A picture of health: delivering the next generation NHS, outlining five shared commitments focused on working with the government to deliver the next generation NHS and create a picture of health that is responsive, effective and continuously improving.

Report on *The state of NHS Communications*

19.9. NHS Providers published a report titled The state of NHS communications. Produced by NHS Providers, NHS Confederation, and the Centre for Health Communications Research, it explores the findings of a national survey of senior NHS communicators and provides insight into the diversity of NHS communications leaders, their capacity and resources, ways of working and what they regard as their key challenges.

19.10. The key findings from the survey are:

- The most senior NHS communications leaders are likely to be female, white, have an undergraduate degree, and three quarters have a

specific communications qualification.

- Like the wider communications profession, the NHS has an ambition to improve the ethnic diversity of its communications workforce. This survey indicates the profession is going backwards, with less than 5% of the most senior NHS communicators from an ethnic minority background. In addition, almost two thirds (61%) say they do not have a communications workforce that is representative of the local communities they serve.

- Turning to gender, 72% of the most senior communicators are women compared to 28% who are men. However, a higher proportion of those senior communicators who are men (31%) are on the NHS' highest pay band (VSM) compared to the proportion of women (20%).

- With NHS finances under strain, it is not surprising that over a quarter (26%) say their budgets for staff have been cut over the past year, with a third (34%) reporting a reduction in non-pay budgets. Many referred to significant upheaval caused by restructuring.

- Training and development budgets are being hit: almost two thirds say they do not have adequate training budgets, increasing the risk that communications staff won't be supported to learn new skills and maximise their potential. This may have an impact on retention, which is a problem given four in 10 (39%) say they find it difficult to fill vacancies.

- Just under half report directly into their chief executive; less than half (46%) are on the executive team; while the vast majority (78%) are not on their organisation's board.

Analysis of latest British Social Attitudes Survey shows lowest satisfaction with the NHS

19.11. There has been widespread coverage recently of analysis by The King's Fund and Nuffield Trust of the latest British Social Attitudes Survey.

19.12. The top three findings from the analysis are that:

- The 2023 survey recorded the lowest levels of satisfaction since the survey began in 1983 – only 24% of the public are satisfied with the NHS, and only 13% are satisfied with social care.

- Despite low levels of public satisfaction, a large majority of the public still support the principles of the NHS.

- 48% of the public would support the government increasing taxes and spending more on the NHS.

19.13. In response, NHS Providers said:

"Relentless challenges facing the NHS and social care have inevitably impacted public satisfaction with these services.

"Rising demand, inadequate funding and a shortage of resources have created immense strain on the system for years. This chronic pressure has been intensified by the pandemic, further financial constraints and industrial action.

"However, it's crucial to recognise that public support for the fundamental principles of the NHS is unwavering.

"Despite the obstacles, trust leaders and their teams are steadfast in their commitment to restoring services and delivering high-quality care. Efforts are underway to tackle backlogs, prioritise the most urgent treatments and improve access to care across various specialties.

"But these findings make clear that ahead of a general election, politicians must prioritise the sustainability of the NHS. We need to see sustained investment, including by fully funding the long-term workforce plan and resolving the damaging and disruptive industrial disputes.

"What's more, these efforts must be bolstered by long-overdue reform of social care, which is intrinsically linked to the NHS. Social care workers need to be adequately paid, with working conditions improved, to better support the vital role they play in delivering care."

NHS Providers – guide to tackling health inequalities

19.14. NHS Providers has launched a comprehensive guide for NHS trust board members to tackle health inequalities, *Reducing health inequalities: A guide for NHS trust board members*. It is a practical resource, designed to help NHS trust board members drive down unjust differences in health outcomes in their local communities, enabling them to champion health equity and create positive change. The guide covers a wide range of topics, from operational and clinical service delivery to the role of NHS trusts as anchor institutions and employers of NHS staff. It also provides a vision of what effective action on health inequalities entails and suggests objectives for board members to implement within their trusts.

Spotlight on the role of community partners and system providers play *Supporting people living with frailty*

19.15. Hosted by NHS Providers and NHS Confederation, the Community Network spotlights the pivotal role community providers and system partners play *Supporting people living with frailty*.

19.16. The new report, including case studies, looks at innovation by community providers, the importance of scaling up services for an ageing population and the support needed to do so.

19.17. In addition, NHS Providers senior policy officer Hannah Hayes explains how community providers are working to ensure people with frailty can receive the right care in the right place following an urgent incident.

Nuffield Trust report *Preventing people with a learning disability from dying too young*

19.18. The Nuffield Trust has published a report titled *Preventing people with a learning disability from dying too young* which examines a set of five key health care services in England that people with a learning disability should have access to. The purpose of the report was to understand how well these service are working for people with learning disabilities and whether they are able to get the support they need.

19.19. The report looks at obesity, cancer screening, mental health, annual health checks, and early diagnosis. This is the first time that evidence has been brought together on these important measures of prevention for this group of people.

19.20. The report found evidence that people with a learning disability are not always able to get equitable preventive support:

- People with a learning disability are more likely than the rest of the population to be obese, particularly in teenage years and into young adulthood.
- Over the past five years, there has consistently been a 15 percentage-point difference in breast cancer screening rates and a 36 percentage-point difference in cervical cancer screening rates between people with a learning disability and the rest of the population.
- Cancer is often diagnosed at a later stage for people with a learning disability than for the rest of the population. These late diagnoses are sadly often made in an emergency at the hospital. Cancer rates seem to be lower in people with a learning disability aged 55 and over than in the rest of the population of the same age. This seems to show that cancer diagnoses for people with a learning disability are being missed.
- Only around 26% of people with a learning disability in England are on the learning disability register. If people are not on this register, they may not be able to get annual health checks or Covid-19 and flu vaccinations.
- People with a learning disability are more likely to have mental health problems. But access to good mental health treatments is often poor. People with a learning disability are less likely to be referred for talking therapies and more likely to be prescribed psychotropic medicines for psychosis, depression, and epilepsy than other people. More than 30,000 adults with a learning disability are taking psychotropic

medicines even though they do not have a diagnosis of the conditions the medicines are prescribed for.

- Many opportunities for support that could help to stop people with a learning disability from getting health problems are being missed as a result of disjointed care, and information and communication that are not well suited to the people they are being provided to.

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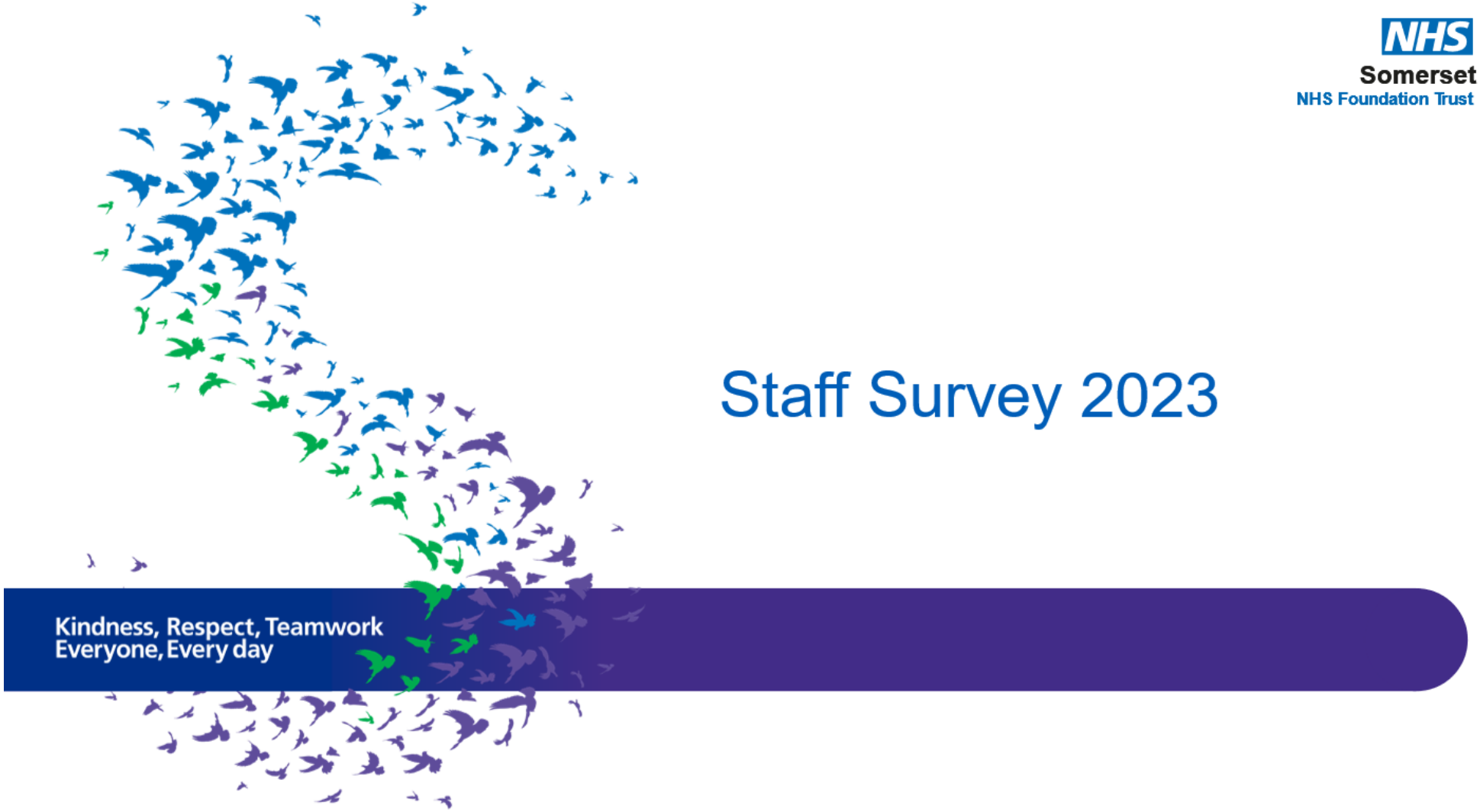
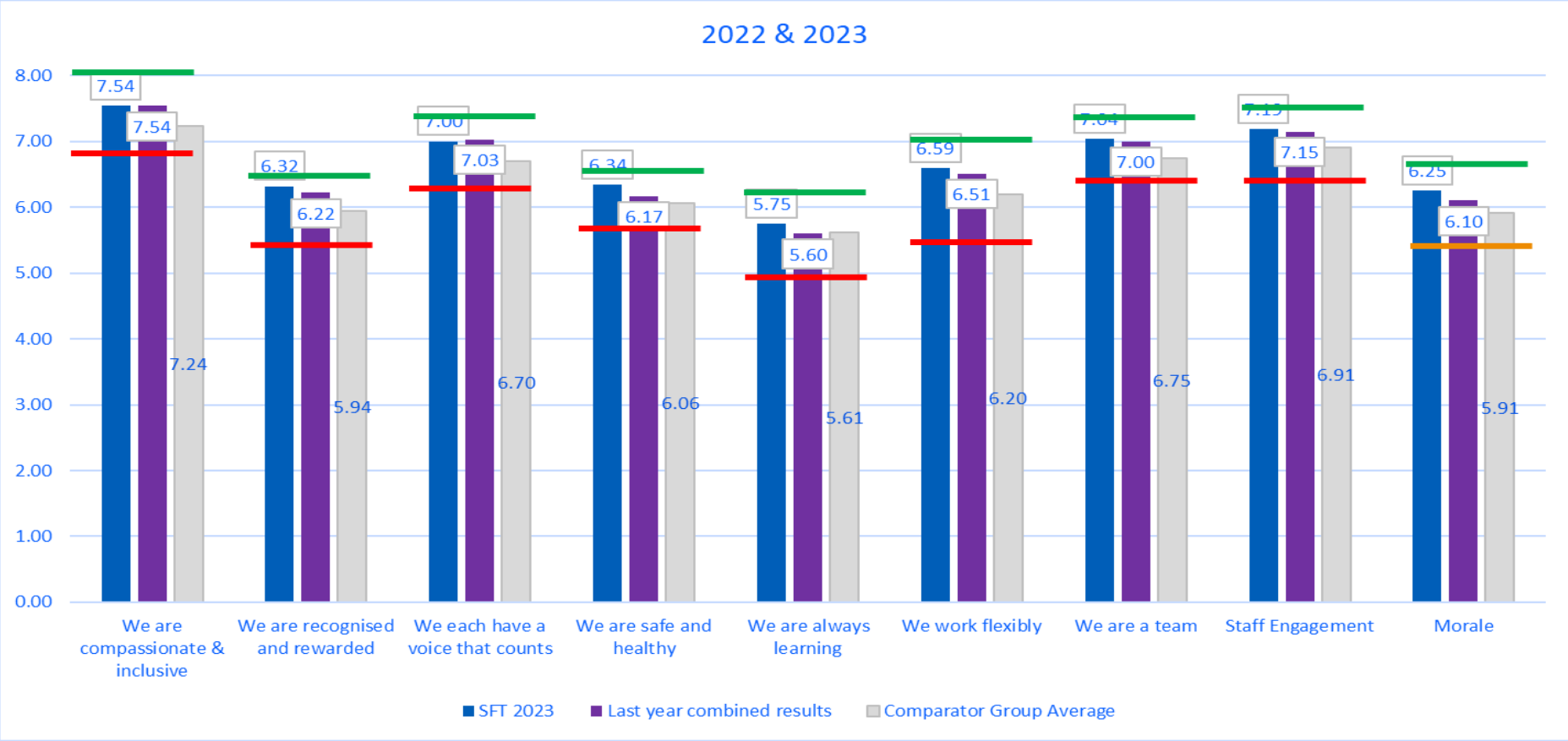
Staff Survey 2023



People Promise Elements and Themes



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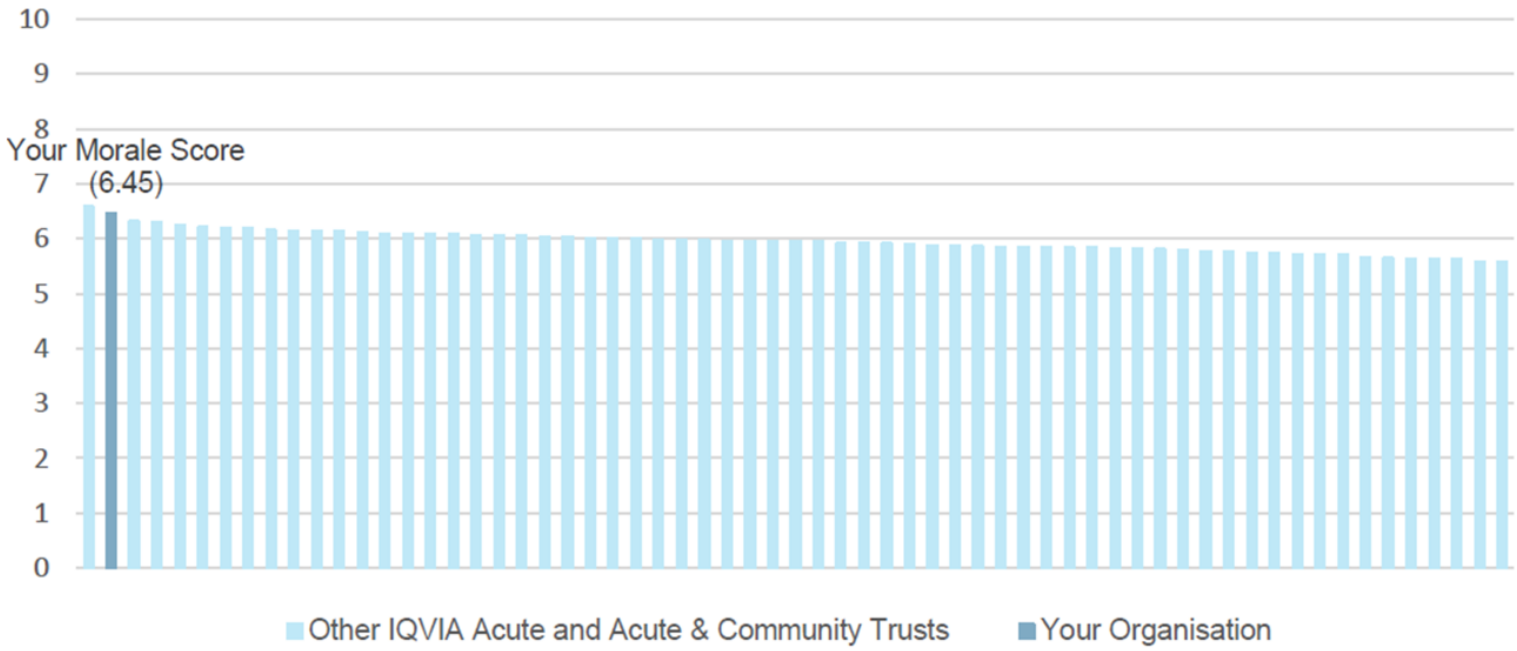
Morale



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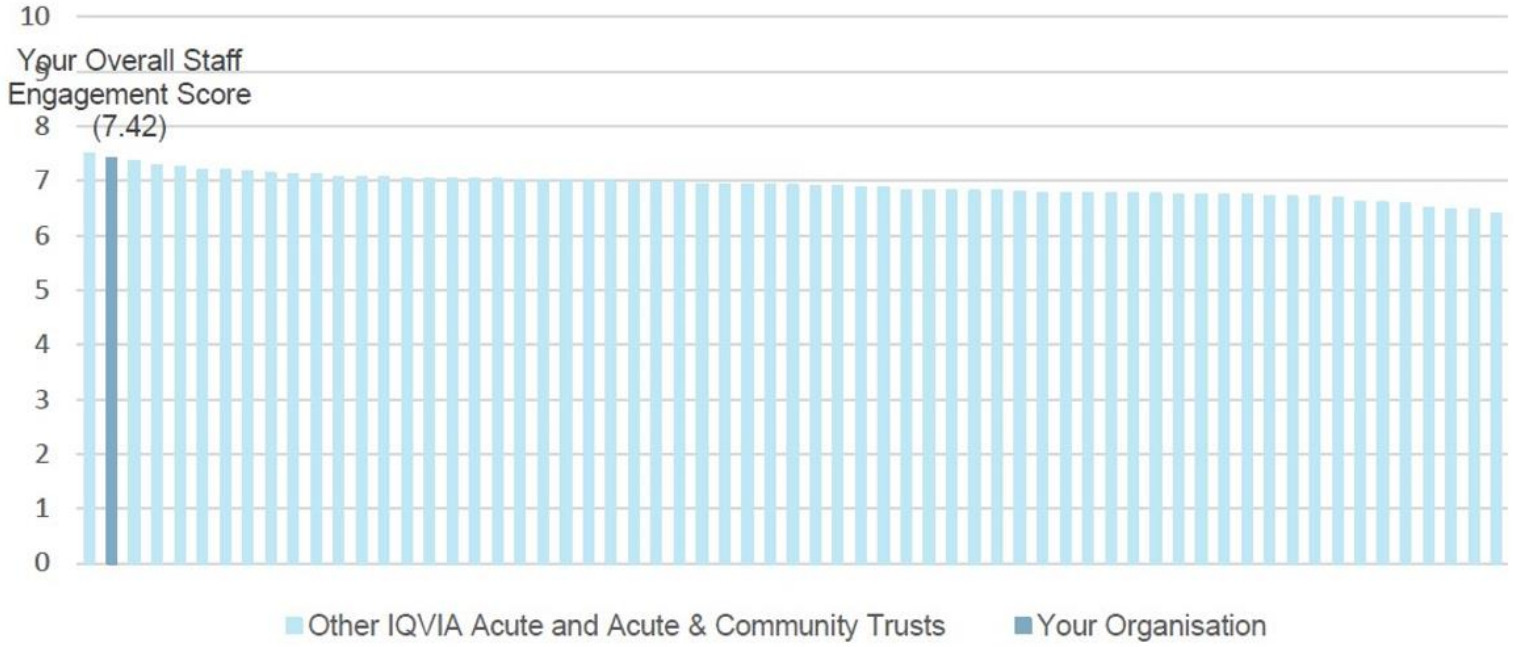
Staff Engagement



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NHS Somerset NHS Foundation Trust

People Promise Theme / Sub Theme	Staff Survey Q3 Oct-22	NQPS Q4 Jan-23	NQPS Q1 Apr-23	NQPS Q2 Jul-23	Staff Survey Q3 Oct-23	NQPS Q1 Jan-24
Engagement	7.15	Pre-merger	6.53	6.85	7.19	6.80
Motivation	7.18	Pre-merger	6.82	6.79	7.26	6.77
Involvement	7.13	Pre-merger	6.34	6.61	7.30	6.66
Advocacy	7.14	Pre-merger	6.45	7.15	7.18	6.97

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Unwanted Sexual Behaviour

Somerset NHS Foundation Trust

Q17a In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From patients / service users, their relatives or other members of the public.

% of staff saying they experienced at least one incident of unwanted behaviour of a sexual nature out of those who answered the question

SFT 2023	9.38%
Responses	6832

Comparator Group Scores

Best result	0.93%
Average result	7.73%
Worst result	14.39%

Q17a In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From staff / colleagues.

% of staff saying they experienced at least one incident of unwanted behaviour of a sexual nature out of those who answered the question

SFT 2023	3.54%
Responses	6821

Comparator Group Scores

Best result	1.44%
Average result	3.82%
Worst result	5.73%

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Vision

Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture

Action

Care for our people – through the creation of the Culture Board we will triangulate our intelligence ensuring that the wellbeing of our colleagues is at the core of what we do

Develop our People – listen to colleagues, understand our business needs to create a successful culture of retaining, investing and growing our own talent to meet the needs of the Trust

Compassionate & Inclusive Leadership – inclusion and our values to be at the heart of what and how we develop our leaders and culture within our organisations

Retain and attract talent – by investing in creating a culture we are proud of, developing our people we will not only retain our colleagues but be an exemplar site for attracting colleagues

Learning and transforming - to adopt QI methodology to our programmes of work, learning and collaborating with each other and recognising our successes we will begin to transform the way in which we work

Success

Hero Measure - Retention

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Since Last Year

Inclusion Roadmap
Introduction of Inclusion Roadmap, to fix the system and not the people.

Ally ship Training
Development of Trust wide training to support and encourage all colleagues to become allies

Colleague Networks
Continued development of colleague networks to provide support and a voice to a range of different groups, including our multicultural network and Women's network

Revised Interview Process
Pilot within Nursing groups of providing interview questions prior to interview to even the opportunity for all.

Retirement Support
Promotion of national pension seminars and Trust wide information

Recognition Awards
Introduction of merged Trust recognition awards and celebrations, to include thank you cards, Monthly Somerset Star & awards events

Introduction of Wagestream
Colleagues are really valuing the opportunity to receive the payments for Bank shifts much sooner than they would have via the normal process.

Freedom to Speak Up
Dedicate FTSU Guardian support across all SFT & YDH sites

ESR Exit Questionnaire
Introduction of revised leavers process and ESR exit questionnaire

Stay Conversations
Introduction of Stay Conversations across teams

'Dig Deeper, Look Closer, Think Bigger' multicultural event which explored the barriers of speaking up, allyship and our approach to inclusion

New Starters review
Review of new starters experience, in order to shape the future Local Induction and Trust introduction programmes

Wellbeing Conversations
Roll out of Wellbeing conversation across the Trust, to encourage leaders and managers to have regular and meaningful conversations.

Sexual Safety Charter
Working group developed to introduce Sexual Safety charter

Winter Wellbeing Seminar
Online seminar to support colleagues, with a focs on retention. Sessions included menopause, 3 key conversations, emotional intelligence, 'own oxygen mask first'

Menopause focus
Including online resources, training and a virtual monthly 'Menopause meet up'. The Trust is in the process of developing a formal Menopause Policy.

Preceptorship Development
Integration of the merged Trust preceptorship programmes utilising national framework. The Trust has now been awarded the Gold Quality Mark

Legacy Mentors
Lead role and 5 Legacy Mentor's recruited to support early career nurses

Schwartz Rounds
A combination of online and in person events taken place and arranged to support learning and open culture

Scope for Growth
In the process of developing a plan to introduce the S4C Career Development tool, with pilot teams and areas identified.

Chief Nurse Core Standards
A set of bite size training, to refresh knowledge and skills in key areas.

Introduction of flexible working programme

Flexible Working Training
To include myth busting, advertising with flex and opening the conversation up with your team

Promotion campaign
Promotional posters and videos of how we are getting it right

Flexible Working dashboard
Developed to include information of par time workers, broken down into banding, service group, age, gender etc. Includes information on retire and return and has space for applications when ESR Self service applications introduced

TED Survey Tool
Roll out of TED Survey tool across selected teams, with positive feedback

Speaking Own language Guidance
Guidance introduced to provide clarity and support to teams around speaking own languages in teams and clinical areas

Coaching development
Reviewing coaching offering to develop coaches to be able to provide career coaching support

Retention Action Group
Developed to ensure representation from all staff groups and service areas, to engage with retention activity and plans.

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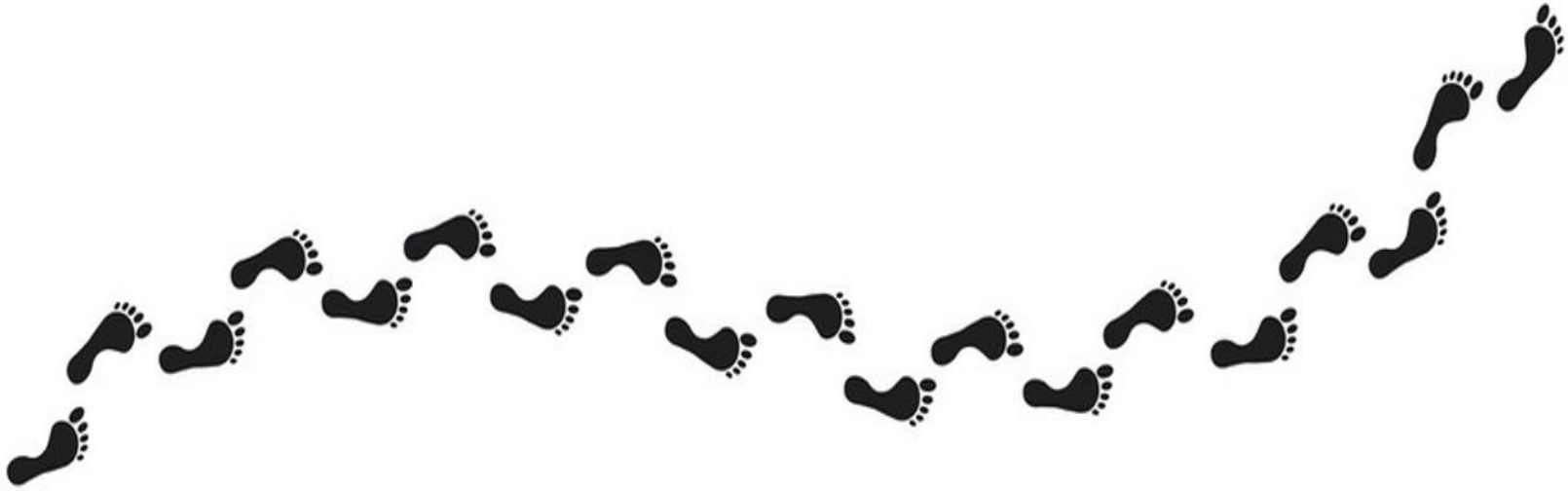
Next Steps



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SOMERSET NHS FOUNDATION TRUST

SEAL REGISTER

1 JANUARY 2024 – 30 APRIL 2024

Date of Sealing	No. of Seal	Nature of Document	First Signatory	Second Signatory
10 January 2024	66	Underlease, Flat 9, Cannonsgrove Halls of Residence	Phil Brice	David Shannon
29 January 2024	67	Project Agreement – Yeovil Diagnostic Centre – SFT – Somerset Estates Partnership - InHealth	David Shannon	Peter Lewis
01 March 2024	68	Lynton Health Centre, Deed of Guarantee and Indemnity	Phil Brice	Pippa Moger
01 March 2024	69	Lynton Health Centre – Deed of Termination of Deed of Guarantee and Indemnity	Phil Brice	Pippa Moger
8 April 2024	70	Burnham and Berrow Medical Centre, Deed of Guarantee and Indemnity and Release	David Shannon	Peter Lewis
30 April 2024	71	Deed of Termination of Deed of Guarantee and Indemnity – Lynton Health Centre	Peter Lewis	David Shannon

Somerset's Commitment to Carers 2024

Valuing and supporting unpaid carers

Summary report: March 2024

Evolving Communities

healthwatch Somerset

Somerset Council

NHS Somerset

Introduction

Somerset's Commitment to Carers 2024 is a statement, aligned with the 2015 and 2022 Care Acts, acknowledging the invaluable contribution and challenges faced by unpaid carers. It outlines the values, principles and actions that health and social care services should adopt to ensure effective support for unpaid carers.

It was presented to the Somerset Board for their endorsement and will influence health and social care strategies, service commissioning and development. The Somerset Carers Strategic Partnership Board (SCSPB) will oversee ongoing review and development of this work.

The Commitment aims to enhance the quality of life for carers and those they care for, by improving their experience of health and social care, and supporting them to access information and opportunities to keep healthy and live well while they carry out their vital caring roles. It reflects priorities identified through consultation and co-production with carers and those who work with and support carers.

Priorities for unpaid carers

To enhance the lives of unpaid carers in Somerset, those who commission, provide and support health and social care services should embed the following priorities into all aspects of their work.

Enable, support and empower unpaid carers, including young carers, to:

- Recognise and address their own health and wellbeing needs.
- Take adequate breaks from caring roles and, if needed, let go of their caring responsibilities by choice.
- Easily access information, education, training, health and care support.
- Have an active role in decisions that affect their lives, including service development.

Develop and embed new approaches

- Build carer aware, friendly and inclusive cultures and environments, including employment and decision-making.
- Establish and require diverse and inclusive partnership working between the health and social care system and unpaid carers.
- Facilitate and implement joined up working practices recognising and supporting unpaid carers as experts by experience. For example, 'People Who Matter' in mental health, 'Making It Real' carers and social services and 'No Wrong Door' with young carers.

Create and facilitate social opportunities

- Build a strong, resilient and sustainable social network for unpaid carers.
- Develop and support access to diverse social opportunities.
- Enable and support carers' opportunities for learning and training.
- Develop choice and access to social prescribing activities for unpaid carers.

Recommended actions

To embed the Commitment to Carers priorities into working practices, health and social care services should adopt the following principles and actions.

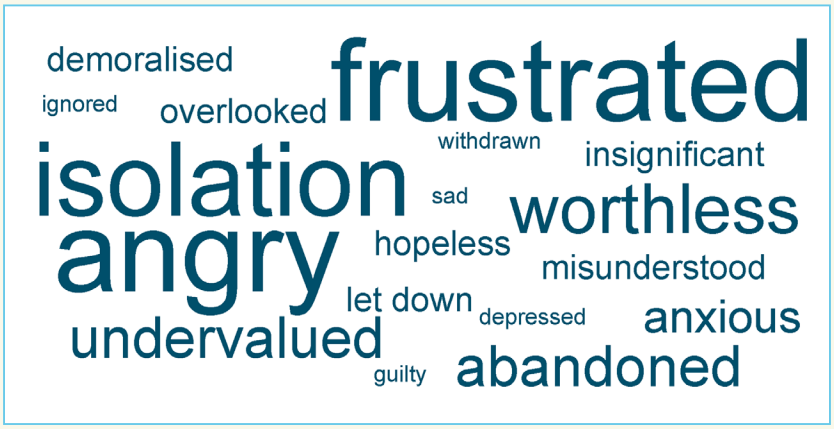
- **Respect and value carers:** Treat carers with respect and compassion, value their contribution and include them in the Triangle of Care conversations.
- **Ensure quality support:** Make sure unpaid carers receive great support and take prompt action to address terrible support, putting things right and ensuring positive changes for all carers in the future.

- **Enhance communication for joined-up working:** Improve communication and information sharing across the health and social care system, to ensure joined-up working and provision for carers (including co-ordination of the different types of carers assessments).
- **Identify carers in primary care:** Use standardised SNOMED codes in primary care services, including GP practices, to identify unpaid carers, and have proactive Carers Champions.
- **Develop opportunities to integrate support:** Use the introduction of universal personalised care and social prescribing link workers to find ways to join up health and wellbeing frameworks (including Green Care, Active Health and Wellbeing, Creative Health and Culture Frameworks) with existing community, NHS and social care partnerships, to increase capacity and improve prevention and treatment of negative health and wellbeing outcomes.
- **Focus on young carers:** Provide special focus and additional resources to support young carers who are overlooked and consider implementing the No Wrong Door policy or approach.
- **Build awareness and access to support:** Improve communication with carers to raise awareness of the support that's available and to encourage and help them to access that support. (The new recommendations from 'Preparing to care' can inform this future development.)
- **Provide accessible information:** Make information and communication accessible for disadvantaged, under-served and diverse communities, adopting the Accessible Information Standard to include people with a disability, impairment or sensory loss, those whose first language is not English, and those who are unable to use digital options.
- **Involve unpaid carers in service improvement:** Seed fund and resource pilot projects for unpaid carers, including young carers, to contribute to health and social care service improvement.
- **Preserve and use local knowledge:** Ensure digital data driven projects complement and do not discount or override, local knowledge which is one of the most valuable resources for gaining insight about carers.
- **Extend social opportunities for carers:** Develop, promote and support a rich and varied menu of in person and online social opportunities for Somerset's diverse community of carers.
- **Create a joint governance framework:** The Integrated Care Board (ICB), Integrated Care System (ICS) and SCSPB should create a joint governance framework, structure and process, based on the Maturity Matrix and the CQC quality markers - requiring partnership and joint working between the NHS, social care, Somerset Council, community and voluntary organisations and unpaid carers. Impact should be documented and used to make a business case for ongoing support for unpaid carers.
- **Oversight and reporting:** The SCSPB should oversee delivery of the Commitment to Carers, establishing an annual reporting mechanism and biannual review to evaluate progress and impact and guide development.
- **Establish a carer aware culture:** Embed a 'Think Carer' approach in discussions and decisions at all levels, championed by individual members of the Somerset Board and ICB/ ICS and ensure carer representation throughout the system.
- **Professional development:** Service providers and commissioners should adopt professional development and quality improvement practices to support and drive the Commitment to Carers.
- **Promote the Commitment to Carers:** The Commitment to Carers should be widely promoted and used throughout the health and care system as a model for best practice in supporting unpaid carers.

What carers told us

[**Source:** Based on responses from the co-production workshop, September 2023]

What does terrible support feel like?



What does great support feel like?

For more information

To find out more about Somerset's Commitment to Carers and to request a copy of the full report, contact:

- **Somerset Council Adults Commissioning Team**
  Email commissioningteammailbox@somerset.gov.uk or phone 0300 123 2224
- **Somerset Carers Strategic Partnership Board**
  Email info@healthwatchsomerset.co.uk or online healthwatchsomerset.co.uk
- **Somerset Carers Service**
  Email: carers@somersetrcc.org.uk or online somersetcarers.org

Somerset's Commitment to Carers 2024 was co-produced and created through the Somerset Carers Engagement Project, which was delivered by Evolving Communities - a Community Interest Company that specialises in stakeholder engagement and insight to drive improvements in health and social care. We achieve this at a national, regional and local level by delivering local Healthwatch services, community engagement partnerships and consultancy services

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Any enquiries regarding this publication should be sent to us at info@evolvingcommunities.co.uk.

You can download this publication from evolvingcommunities.co.uk.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	2023/24 Q4 Board Assurance Framework
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
PRESENTED BY:	Phil Brice, Director of Corporate Services
DATE:	7 May 2024

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

Executive Summary and Reason for presentation to Committee/Board	Somerset NHS Foundation Trust (SFT) has identified eight strategic objectives, which remain the long term aims for the newly merged organisation. The five clinical objectives are aligned with the system clinical aims which also form the basis for the clinical model. These sit alongside our financial, people and organisational objectives. The Board Assurance Framework (BAF) An Assurance Framework has been developed to clearly outline the highest risks to the Trust in achieving these objectives; the plans in place to manage and mitigate these and to provide the Committees and Board with a summary of key plans and strategies supporting their delivery. The highest risks to the strategic objectives are currently: • Workforce shortages (objective 3) – 20 • Core numbers of junior and consultant medical workforce (objective 6) – 20 • Access to primary care / increasing ED demand (objective 2) – 20 • Lack of pace of system-wide changes to address deficit (objective 7) – 20 • Insufficient capacity to meet demand (objective 8) – 20 Further information on the current risk position is outlined below.

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

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

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

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

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

Details: N/A

Equality and Inclusion

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

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

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

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

Public/Staff Involvement History

How have you considered the views of service users and / or the public in relation to the

issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Public or staff involvement or engagement has not been required for the attached report.

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

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

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

SOMERSET NHS FOUNDATION TRUST

2023/24 Q4 BOARD ASSURANCE FRAMEWORK

1. PURPOSE OF THE REPORT

1.1 To present the 2023/24 Q4 SFT Board Assurance Framework to the Board of Directors in line with the governance and monitoring arrangements outlined within Appendix 1 of this report.

2. CURRENT POSITION

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

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

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

- Access to primary care / increasing ED demand (objective 2) – **20**
- Age of acute and community estates (objective 2) – **15**
- Shortfalls in Social Care capacity (objectives 2 & 3) – **16**

F

- Workforce shortages (objective 3) – **20**
- Fragility of Primary Care (objective 3) – **16**
- Core numbers of junior and consultant medical workforce (objective 6) – **20**
- Not improving retention rate – nursing/estates/facilities/admin roles (objective 6) – **16**
- Reduced colleague resilience (objective 6) – **16**
- Failure to identify & deliver sufficient recurrent CIP (objective 7) – **15**
- Lack of pace of system-wide changes to address deficit (objective 7) – **20**
- The Trust fails to deliver the elective activity capacity (objective 7) – **15**
- Insufficient capacity to meet demand (objective 8) – **20**
- Failure to secure the necessary infrastructure (objective 8) – **16**

2.3 The workforce risks recorded under objectives 3 and 6 were reviewed by a deep dive session within the People Committee on 3 April where the risks were reduced from a 25 to a 20 due to the mitigations and actions in place.

3. 2023/24 PROGRESS AGAINST ACTIONS TO IMPROVE CONTROLS AND ASSURANCE

3.1 A summary of the actions taken to improve controls and assurance against the strategic objectives is included as Appendix 1 to this report. This outlines progress against those actions identified on the BAF for each strategic objective.

4. PROPOSED AMENDMENTS FOR THE 2024/25 BAF TEMPLATE

4.1 It is proposed that for the 2024/25 BAF, further amendments would be made to the template to enhance the reporting and oversight arrangements. These proposals will be presented to the Board in May 2024.

5. CONCLUSION

5.1 Whilst the Trust continues to carry a significant number of high strategic risks that are over and above the level of risk it is willing accept within its Risk Appetite Statement, there has been some progress made to reduce the level of risk to within appetite levels across objectives 1 and 4 as illustrated within this report.

5.2 There is a mixed level of assurance across the strategic objectives, although it has been demonstrated that there has been progress made against the identified actions as outlined within Appendix 2 to this report.

5.3 Due to the nature of the wider NHS, a number of the highest rated risks are residual strategic or operational risks that the Trust may not be able to directly influence. Consideration should be made as to whether or not further mitigations can be identified.

5.4 Progress continues to be made across the identified actions to address any gaps in controls and assurances with a number of key actions completed. However, the position around delivery of the core strategic objectives remains extremely challenging in the context of operational pressures within the Trust and in social care and primary care across the county; and increasingly, workforce issues in a number of core services.

6. RECOMMENDATION

6.1 The Board is asked to review the Board Assurance Framework, note the actions being taken to address the risks identified, and consider the objectives and risks reserved to the Board. The Board is also asked to note the plans to make amendments to the template for the 2024/25 iteration of the report.

DEPUTY DIRECTOR OF CORPORATE SERVICES

BOARD ASSURANCE FRAMEWORK SUMMARY

Quarter 4 2023/24

Ref	Executive Owner	Corporate Objective	Overseeing Committee	Risk Appetite		Highest Risk		Plans & Strategies		Policies & Processes		Oversight Arrangements	
1	DS	Improve the health and wellbeing of the population	Board	G	Seek 15-16	12	⇔	G	⇔	A	⇔	A	⇔
2	HP	Provide the best care and support to people	Quality & Governance Assurance Committee	R	Open 12	20	⇧	A	⇩	A	⇔	G	⇔
3	AH	Strengthen care and support in local communities	Quality & Governance Assurance Committee	R	Seek 15-16	20	⇔	G	⇔	G	⇔	A	⇔
4	PB	Reduce inequalities	Quality & Governance Assurance Committee	G	Seek 15-16	12	⇩	A	⇔	A	⇔	R	⇩
5	MI	Respond well to complex needs	Quality & Governance Assurance Committee	G	Seek 15-16	12	⇩	A	⇩	G	⇧	G	⇧
6	IC	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture	People Committee	R	Seek 15-16	20	⇔	A	⇔	A	⇧	A	⇔
7	PM	Live within our means and use our resources wisely	Finance Committee	R R	Financial Manag - Open 12 Commercial - Seek 15-16	20	⇧	A	⇔	A	⇔	A	⇔
8	PL	Develop a high performing organisation delivering the vision of the trust	Board	R	Seek 15-16	20	⇔	A	⇔	G	⇔	A	⇔

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

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

Key Performance Indicators

Diabetes: HbA1C checks	Dec	100% ⇔	Addiction (smoking/Alcohol) IP	Dec	28% ⇩	Suicide/Self harm prev: MH Staff	381 ⇩
Suicide/Self harm prev: non-MH		237 ⇧	28 day cancer faster diagnostic	Jan	70.8% ⇩	Number of pats enrolled to Periop	155 ⇧

	Key Risks	Risk Reference	Current Risk						Target Risk					
	(High Consequence risks that may stop us achieving the objective)	*(From corporate risk register)*	*Con*		*Lik*		*RS*		*Con*		*Lik*		*RS*	
1	Population Health may not get the focus required	R1613	3	x	4	=	12		3	x	3	=	9	
2	Approach to Population Health may be uncoordinated	R1615	4	x	2	=	8		4	x	2	=	8	
3	Lack of understanding of shared accountability/resourcing	R1616	4	x	3	=	12		3	x	2	=	6	

Controls	Assurance		Assessment
What we have in place to support delivery of the objective	*Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	*(See assessment guidance)*
Plans & Strategies			
Somerset Health and Care Strategy	ICS System Assurance Forum	Positive	
ICS Population Health Strategy		Neutral	Green
Smoking Cessation and Perioperative care programme		Positive	
Processes for Delivering Plans			
ICS Action learning set to support PHM development completed	Priorities developed for ICS aligned with core20 plus 5	Positive	
Development of Pop Health integrated dataset data group	Compliance with regional and national programmes	Negative	Amber
Hypertension Flagship for ICS		Neutral	
Oversight Arrangements for Governance & Engagement			
ICS Health Transformation Board	Progress on KPIs presented to Board on regular basis	Positive	
ICS Data Development Group	Overview of Programme to Board Development Session	Neutral	Amber
Trust Data and Population Health Insights Group	Oversight off flagship priorities & clinical strategy - QGAC	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Oversight of priority progammes - Smoking Cessation, Periop care & Suicide prevention	DS	Oct-23	Complete
Insights group to focus on neighbourhood / PCN service access	DS	Jul-23	Complete
Development & implementation of resource plan - Training and Development Sessions	DS	Apr-24	On Plan
Trust Support to ICS priorities	DS / DM	Apr-24	Complete
Trust involvement of Reagional data strategy and secure data environmen	DS	Mar-24	Complete

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

Key Performance Indicators

Ambulance handover hrs lost >15m	10400 ⇩	Cancelled operations	Dec	3.7% ⇩	C.Diff year to date cases		83 ⇩
Patient Initiated follow up (PIFU)	7.4% ⇩	Falls resulting harm per 1000 days		0.13 ⇧	Pressure ulcers per 1000 bed days	Jun	0.87 ⇧
Acute Home Treatment caseload	73 ⇩	Pats waiting social wk assessment		18 ⇧	End of Life pat discharges <24hrs	Jan	85% ⇧

	Key Risks *(High Consequence risks that may stop us achieving the objective)*	Risk Reference *(From corporate risk register)*	Current Risk Con		Lik		RS	Target Risk Con		Lik		RS
1	Access to primary care / increasing ED demand	R372, R1811, R551, R673, R1709	4	x	5	=	20	4	x	2	=	8
2	Shortfalls in Social Care capacity	R2273 & R1513	4	x	4	=	16	4	x	3	=	12
3	Age of acute and community estates	R1789	5	x	3	=	15	4	x	2	=	8

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	Outcome of assurance	Assessment *(See assessment guidance)*
Plans & Strategies			
Clinical Strategy	CQC Inspection / Insight Reports	Negative	
Digital and Estates Strategies	National Patient Surveys / Staff Survey	Positive	Amber
Recruitment and Retention Plans	Model Hospital/GIRFT/national benchmarking data	Neutral	
Processes for Delivering Plans			
Continued development and implementation of Clinical Strategy	Due diligence reports	Positive	
Risk assessed capital and backlog maintenance programmes	Internal audit programme	Neutral	Amber
Hospital @ Home Programme			
Oversight Arrangements for Governance & Engagement			
Integrated performance reporting	GST assurance processes (IQAB, Care Essentials etc.) QGAC	Neutral	
Strategic Estates Group	Oversight off flagship priorities & clinical strategy - QGAC	Positive	Green
Maternity Neonatal Action Group			

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Ward Accreditation programme - building Ward2Board measurement dashboard for input wards	HP	Jul-23	Significantly Behind Schedule
Delivery of Quality Strategy Work Plan - Year One, including measurement of delivery	HP	May-24	On Plan
Chief Nurse Core Standards - First release complete - preping second release of 3 core standards	HP	Ongoing	On Plan
The introduction of 'Martha's Rule' – phase 1, adult general beds and paediatrics	HP	Jul-24	On Plan
Publication of the research strategy and delivery plan	HP	Mar-24	Complete
Delivery of the action plan following the internal audit for Personalised Care	CB-J	Dec-24	On Plan

Ward leadership reset week - June 2024	HP/AW	Jun-24	On Plan

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

Key Performance Indicators

Pats ref to Acute Home Treatment	167 ⇩	Adm. Prevented by Rapid Resp/AHT	369 ⇩	Urgent Community response <2hrs	Jan	91.1% ⇧	
PCNs with integrated models	4 ⇔	Increase Open MH attendances	23130 ⇩			⇔	

	Key Risks (*High Consequence risks that may stop us achieving the objective*)	Risk Reference (*From corporate risk register*)	Current Risk Con		Lik		RS	Target Risk Con		Lik		RS
1	Workforce shortages	R2044, R1624, R1815, R1880, R2	5	x	4	=	20	4	x	3	=	12
2	Fragility of Primary Care	R673	4	x	4	=	16	4	x	4	=	16
3	Shortfalls in Social Care capacity	R2273 & R1513	4	x	4	=	16	4	x	3	=	12

Controls (*What we have in place to support delivery of the objective*)	Assurance (*Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*)	Outcome of assurance	Assessment (*See assessment guidance*)
Plans & Strategies			
Trust/ICS workforce strategy and integration	ICS System Assurance Forum	Neutral	
Acute Home Treatment	Regional oversight of implementation and peformance	Positive	Green
Processes for Delivering Plans			
Integration pilot underway in North Sedgmoor - 2 more planned	SEND Improvement Board oversight of implementation	Neutral	
New Hospital@Home services under development	Deep Dive outcomes - YDH and MPH	Positive	Green
New A&EDB working group to develop UTCs for Yeovil & Taunton	A&EDB and Trust Board oversight internally within SFT	Positive	
Oversight Arrangements for Governance & Engagement			
Regular Service Group F&P/QOFP meetings	Trust Board Quadrant Report	Neutral	
Intermediate Care Board with KPI monitoring	Intermediate Care performance report - weekly	Neutral	Amber
System Neighbourhood Board & A&E DB co-chaired by COO	Trust Board Quadrant Report		

Actions to Improve Controls and Assurance (*Required for any areas assessed Amber or Red*)	Lead	Target Date	Progress Summary
Action plan to address low levels of referral activity into H@H	AH/TE/CD	Jun-23	Complete
Intermediate Care Strategy development reporting to Neighbourhood & PC Programme Board	PM/AH	Jul-23	Significantly Behind Schedule
KPIs/metrics monitored and actions taken via the QOFP process	PM/AH	Mar-23	Complete

Exec Owner	Corporate Objective	Overseeing Committee
Phil Brice	**4. Reduce inequalities**	Quality & Governance Assurance Committee

Key Performance Indicators

Prot characteristics data complete	Oct	98.7% ⇧	Ethnicity equity of access:acute RTT	Equal ⇔	Ethnicity equity of access: cancer	Dec	Equal ⇔
Ethnicity equity of access: MH		Equal ⇔	Reduce elective waits - pats with LD	Equal ⇔	Healthy life expect. gap: high-low	2020	13.3y ⇔

	Key Risks *(High Consequence risks that may stop us achieving the objective)*	Risk Reference *(From corporate risk register)*	Current Risk Con		Lik		RS	Target Risk Con		Lik		RS
1	System and Trust strategy not fully developed	R1620	5	x	2	=	10	4	x	2	=	8
2	Data quality issues leading to poor information	R1616	4	x	3	=	12	3	x	2	=	6
3	Historical funding/resource gaps including in MH & LD	R1622	3	x	4	=	12	3	x	3	=	9

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Plans & Strategies			
Open Mental Health	Internal Audit - Mental Health (January 2023)	Positive	
Digital Strategy - population health data	Digital Board/Board review	Neutral	Amber
Stolen Years flagship	QGAC annual review	Positive	
Processes for Delivering Plans			
Equality Impact Assessment	None	Negative	
Master Patient Index - data quality review	Data Quality reports	Neutral	Amber
Elective Recovery inequalities programme	Board reports	Positive	
Oversight Arrangements for Governance & Engagement			
System Quality Governance Committee	CQC Inspection/Insight	Negative	
Quality & Governance Assurance Committee	Board Assurance Reports	Neutral	Red
Population Health Management Committee	Board Reports	Neutral	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Review Equality Impact assessment process and effective monitoring at all levels	PB	Jul-23	Complete
Development of strategy to incorporate of deprivation/exclusion markers into trust data	DS	Mar-24	Behind Schedule
Review NHSE Statement of Information on Health Inequalities to meet provider actions	PB	Apr-24	Behind Schedule

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

Key Performance Indicators

CYP Eating Disorders - Urgent	- ⇔	CYP Eating Disorders - Routine	96% ⇩	Reduce time in ED: intensity users	Dec	64,508 ⇧
Dementia diagnosis rate-Symphony	55.1% ⇔	Persistent physical symptoms prog.	Yes ⇔	Time to assessment in CYPNP		89 wks ⇩
Homeless service: annual referrals	724 ⇧	Personalised convs/health coaching	Dec 242 ⇧			

	Key Risks (High Consequence risks that may stop us achieving the objective)	Risk Reference (From corporate risk register)	Current Risk Con	Lik	RS	Target Risk Con	Lik	RS
1	Sub-optimal links between primary care & SFT services	R1951	4 x 3 = 12			4 x 2 = 8		
2	Personalised care doesn't get required focus	R1952	4 x 2 = 8			4 x 2 = 8		
3			x = 0			x = 0		

Controls (What we have in place to support delivery of the objective)	Assurance (Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.))	Outcome of assurance	Assessment (See assessment guidance)
Plans & Strategies			
Digital strategy for delivery of EHR	Internal monitoring	Positive	
Somerset Health and care strategy	ICS System Assurance Forum	Neutral	Amber
Dementia and Delirium strategy	Internal monitoring	Positive	
Processes for Delivering Plans			
Clinical priority prog. eg high service use, homeless, eating disorders	Compliance with national and regional programmes	Positive	
Support to ICS Personalised care strategy planning	Internal monitoring, audit	Positive	Green
Connecting Dots developments	Internal monitoring, GP provider board	Neutral	
Oversight Arrangements for Governance & Engagement			
Accountabilty Framework process/meetings	Reports to QGAC	Positive	
Symphony board	Oversight reports for ICB, Primary Care Board etc.	Neutral	Green
	Progress on KPIs presented to Board on regular basis	Positive	

Actions to Improve Controls and Assurance (Required for any areas assessed Amber or Red)	Lead	Target Date	Progress Summary
Development of oversight and reporting governance with ICB/ICP	DM	Oct-23	Behind Schedule
Reviewing dementia diagnosis rates split by symphony practices	DM	Oct-23	Complete
Personalised care audit for SFT commissioned. CBJ taking lead on response to audit	CBJ	Dec-23	Complete
PL and AT have set up quarterly meetings with PCN leads	AT	Dec-23	Complete
SFT Personalised care improvement group established	CBJ	Mar-24	Complete

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

Key Performance Indicators

Retention: % in post >12months	81.0% ⇧	Pulse Engagement	6.8% ⇧	Inclusion: % B8S reg.disabled	Dec	3.1% ⇧
Pulse Advocacy measure	6.8% ⇧	Inclusion: % B8s who are female	Dec	58.7% ⇩	Inclusion: % B8s ethnic minority	Dec	20.9% ⇧

	Key Risks	Risk Reference	Current Risk							Target Risk					
	(High Consequence risks that may stop us achieving the objective)	*(From corporate risk register)*	*Con*		*Lik*		*RS*			*Con*		*Lik*		*RS*	
1	Core numbers of junior & consultant medical workforce	R2044, R2306, R2307	5	x	4	=	20			4	x	3	=	12	
2	Not improving retention rate - nursing/estates/facilities/admin role	R1880	4	x	4	=	16			3	x	3	=	9	
3	Reduced colleague resilience	R1944	4	x	4	=	16			3	x	3	=	9	

Controls	Assurance		Assessment
What we have in place to support delivery of the objective	*Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	*(See assessment guidance)*
Plans & Strategies			
People Strategy 2023-2028 with defined year 1 deliverables	People Strategy KPIs / year 1 deliverables / NQPS	Neutral	
People Promise Exemplar programme Retention Roadmap	NHS Staff Survey Results	Positive	Amber
Inclusion workforce plan	Internal audit / NHS Staff Survey / NQPS / WDES / WRES / Gender I	Neutral	
Processes for Delivering Plans			
Year 1 deliverables work	Highlight reports	Neutral	
Retention roadmap	Internal audit - Moderate findings	Neutral	Amber
Oversight Arrangements for Governance & Engagement			
People Committee	People Committee strategy commitments assurance deep dives	Neutral	
People Services Governance Committee	Year 1 deliverables highlight reports and project charters	Neutral	Amber
Cultural Strategy Group	Cultural Maturity Review - internal audit / Report to OLT/ Report to	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Implement governance arrangements for people strategy year 1 deliverables	IC	Jul-23	Complete
Develop listening strategy to support an improvement in uptake rate of people pulse	IC	Mar-24	Behind Schedule
Undertake retention internal audit	IC	Dec-23	Complete
Strengthen the link between colleague experience and patient experience through intrinsically linking expe	IC	Dec-23	Complete
Strengthen the link between colleague experience and learning	IC	Dec-23	Behind Schedule

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

Key Performance Indicators

Financial position v plan (YTD)	B/even ⇧	% of CIP identified as recurrent	54% ⇩	Agency v plan (YTD)	7.5m ad ⇩

	Key Risks (*High Consequence risks that may stop us achieving the objective*)	Risk Reference (*From corporate risk register*)	Current Risk Con	Lik	RS	Target Risk Con	Lik	RS
1	Failure to identify & deliver sufficient recurrent CIP	R6	5 x	3 =	15	5 x	2 =	10
2	Lack of pace of system-wide changes to address deficit	R960	5 x	4 =	20	3 x	3 =	9
3	The Trust fails to deliver the elective activity trajectory	R1859	5 x	3 =	15	3 x	3 =	9

Controls (*What we have in place to support delivery of the objective*)	Assurance (*Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*)	Outcome of assurance	Assessment (*See assessment guidance*)
Plans & Strategies			
Finance Strategy - reduce underlying deficit to breakeven by 26/27	Oversight of Strategy through Finance Committee	Neutral	
Financial Plans for 2023/24	Financial oversight reports to Finance Committee	Neutral	Amber
Processes for Delivering Plans			
System wide discussions to manage available resources	Internal and external audit programme	Positive	
	HFMA Financial Sustainbility Checklist results	Positive	Amber
Oversight Arrangements for Governance & Engagement			
Control and oversight of CIP through Accountability Frameworks	Financial oversight reports to Finance Committee	Neutral	
System Finance Assurance Group	Key Financial Systems Internal Audit Report	Positive	Amber

Actions to Improve Controls and Assurance (*Required for any areas assessed Amber or Red*)	Lead	Target Date	Progress Summary
Challenge set to obtain 75% recurrent CIP in 23/24 planning	PM	Mar-24	Behind Schedule
Productive Care Programme launched for 24/25 & 25/26 CIP planning	AH/ PM	Apr-24	On Plan
Work with Social Care to increase capacity in care market to reduce delays and increased costs	AH	Mar-24	Behind Schedule
Quarterly review of underlying position to be presented to Finance Committee	PM	Quarterly	On Plan
Strengthen arrangement between People and Finance Committees regarding workforce reporting	PM / IC	May-24	On Plan

Exec Owner	Corporate Objective	Overseeing Committee
Peter Lewis	**8. Deliver a high performing organisation delivering the vision of the Trust**	Board

Key Performance Indicators

A&E 4-hour standard		74.2% ⇧	78 week acute RTT waiters		48 ⇧	6 week diagnostics		78.2% ⇧
62 day cancer waiting time	Dec	64.9% ⇩	Mental health 6 week waiting time		96.6% ⇩	Community waiters >18 weeks		3,367 ⇧

	Key Risks (High Consequence risks that may stop us achieving the objective)	Risk Reference (From corporate risk register)	Current Risk Con	x	Lik	=	RS	Target Risk Con	x	Lik	=	RS
1	Insufficient capacity to meet demand	R4	5	x	4	=	20	4	x	4	=	16
2	Failure to secure the necessary infrastructure	R1611 & R1624	4	x	4	=	16	4	x	2	=	8
3	Failure to realise benefits of merger & service integration	R1612	3	x	3	=	9	3	x	2	=	6

Controls (What we have in place to support delivery of the objective)	Assurance (Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.))	Outcome of assurance	Assessment (See assessment guidance)
Plans & Strategies			
People Strategy (including Cultural Board and Inclusion plans)	National Staff Survey results	Positive	
Green Plan	Environmental Maturity Audit	Negative	Amber
Digital Strategy and EHR programme	External Review through NHSE/CQC liaison meetings	Neutral	
Processes for Delivering Plans			
Colleague Health, Wellbeing and Resilience programmes	National Staff Survey results	Positive	
Values into Action workshops			Green
Merger Integration Programme	Merger updates to Board/NHSE review and approval of plans	Positive	
Oversight Arrangements for Governance & Engagement			
Accountability Frameworks (QOFP) & System Performance Group	Quarterly Reports to Board (Finance, F2SU, GoSW, LfDs etc.)	Positive	
Elective Care Board (ECB)	SW Regional weekly elective recovery report	Neutral	Amber
Intermediate Care Programme Board	Board Quadrant Reports	Neutral	

Actions to Improve Controls and Assurance (Required for any areas assessed Amber or Red)	Lead	Target Date	Progress Summary
Development and delivery of system bed capacity review/plan	AH	Nov-23	Complete
Implement new national patient choice strategy	XW	Mar-24	Complete
System to participate in Right Procedure Right Place (surgery) programme	FC	Mar-24	Complete
Model/plan to address elective capacity shortfall (65 weeks)	XW	Sep-23	Complete
Implement plans for sustainability governance review	PB	Oct-23	On Plan

Appendix 1

1. BOARD ASSURANCE FRAMEWORK

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

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

2. ASSURANCE FRAMEWORK GOVERNANCE ARRANGEMENTS – MOVE TO APPENDIX

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

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

2.3 The strategic objectives/BAF were reviewed and considered by the relevant committees at the following meetings:

Audit Committee	12 July 2023 11 October 2023 10 January 2024
Quality and Governance Assurance Committee	28 June 2023 26 July 2023 25 October 2023

	20 December 2023 28 February 2024
People Committee	25 July 2023 13 September 2023 8 November 2023 12 March 2024
Finance Committee	31 July 2023 30 October 2023 29 January 2024
Board	4 July 2023 7 November 2023 6 February 2024

2.5 Deep dives of the five clinical aims and objectives were completed, with strategic objectives 1 and 2 reviewed at the meeting of the Quality and Governance Assurance Committee held on 20 December 2023. Objectives 3 and 5 were reviewed at the Quality and Governance Assurance Committee held on 28 February 2024. Objective 4 was reviewed at the Quality and Governance Assurance Committee held on 24 April 2024.

2.6 These updates included an overview and update on progress against the flagship/Quality Account programmes of work within the relevant areas.

Appendix 2 - BAF - Summary of identified actions

Ref	Executive Owner	Overseeing Committee	Corporate Objective & full actions as identified on the BAF	2023/24 Q1	Q2	Q3	Q4
1	DS	Board	**Improve the health and wellbeing of the population**				
			Oversight of priority programmes - Smoking cessation, preri-operative care and suicide prevention.	On Plan	On Plan	Complete	Complete
			Insights group to focus on neighbourhood / PCN service access.	On Plan	On Plan	Complete	Complete
			Development and implementation of resource plan for SFT - Training and Development Sessions	On Plan	On Plan	Behind Schedule	On Plan
			Trust Support to ICS priorities	Behind Schedule	On Plan	On Plan	Complete
			Trust involvement of Reagional data strategy and secure data environment		On Plan	On Plan	Complete
2	HP	Quality & Governance Assurance Committee	**Provide the best care and support to people**				
			Launch programme to EPJP and prevent deconditioning across all sites	On Plan	On Plan		
			Delivery of Quality Strategy Work Plan - Year One, including measurement of delivery	On Plan	On Plan	On Plan	On Plan
			Ward Accreditation programme - building Ward2Board measurement dashboard for input wards	On Plan	On Plan	Significantly Behind Schedule	Significantly Behind Schedule
			Leadership quality walkarounds	On Plan	On Plan	Complete	
			Chief Nurse Core Standards - First release complete - preping second release of 3 core standards	On Plan	On Plan	On Plan	On Plan
			The introduction of 'Martha's Rule' – phase 1, adult general beds and paediatrics			On Plan	On Plan
			Publication of the research strategy and delivery plan			On Plan	Complete
			Production of a detail workplan following internal audit for Personalised Care			On Plan	Complete
			Delivery of the action plan following the internal audit for Personalised Care				On Plan
			Ward leadership reset week - June 2024				On Plan
3	AH	Quality & Governance Assurance Committee	**Strengthen care and support in local communities**				
			Action plan to address low levels of referral activity into Hospital@Home	On Plan	On Plan	Complete	Complete
			Intermediate Care Strategy development reporting to Neighbourhood & PC Programme Board	Behind Schedule	Behind Schedule	Behind Schedule	Significantly Behind Schedule
			KPIs/metrics monitored and actions taken via the QOFP process	On Plan	On Plan	Complete	Complete
4	PB	Quality & Governance Assurance Committee	**Reduce inequalities**				
			Review Equality Impact assessment process and effective monitoring at all levels	On Plan	Behind Schedule	Significantly Behind Schedule	Complete
			Development of strategy to incorporate of deprivation/exclusion markers into trust data	On Plan	On Plan	On Plan	Behind Schedule
			Review NHSE Statement of Information on Health Inequalities to meet provider actions			On Plan	Behind Schedule
5	MI	Quality & Governance Assurance Committee	**Respond well to complex needs**				
			Development of oversight and reporting governance with ICB/ICP	Behind Schedule	Behind Schedule	Behind Schedule	Behind Schedule
			Personalised care audit for SFT commissioned	On Plan	On Plan	Complete	Complete
			Reviewing dementia diagnosis rates split by symphony practices			Complete	Complete
			PL and AT have set up quarterly meetings with PCN leads			On Plan	Complete
			SFT Personalised Care Improvement Group established				Complete
6	IC	People Committee	**Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture**				

			Implement governance arrangements for people strategy year 1 deliverables	On Plan	On Plan	Complete	Complete
			Develop listening strategy to support an improvement in uptake rate of people pulse	On Plan	On Plan	On Plan	Behind Schedule
			Undertake retention internal audit	On Plan	On Plan	Complete	Complete
			Strengthen the link between colleague experience and patient experience through intrinsically linking experience and learning	On Plan	On Plan	Complete	Complete
			Strengthen the link between colleague experience and learning	On Plan	On Plan	On Plan	Behind Schedule
7	**PM**	Finance Committee	**Live within our means and use our resources wisely**				
			Challenge set to obtain 75% recurrent CIP in 23/24 planning	Behind Schedule	Behind Schedule	Behind Schedule	Behind Schedule
			Identify further efficiencies/improve productivity using available benchmarking, GIRFT etc.	Behind Schedule	Behind Schedule		
			Work with Social Care to increase capacity in care market to reduce delays and increased costs	Behind Schedule	Behind Schedule	Behind Schedule	Behind Schedule
			Quarterly review of underlying position to be presented to Finance Committee	On Plan	On Plan	On Plan	On Plan
			Strengthen arrangement between People and Finance Committees regarding workforce reporting		On Plan	On Plan	On Plan
			Productive Care Programme launched for 24/25 & 25/26 CIP planning			On Plan	On Plan
8	**PL**	Board	**Develop a high performing organisation delivering the vision of the trust**				
			Development and delivery of system bed capacity review/plan			Complete	Complete
			Seek additional elective capacity via insourcing and other system facilities	On Plan			
			System to participate in Right Procedure Right Place (surgery) programme	On Plan	On Plan	On Plan	Complete
			Model/plan to address elective capacity shortfall (65 weeks)	Behind Schedule	On Plan	Complete	Complete
			Develop and implement business case(s) for Community Diagnostic Programme	On Plan	On Plan		
			Implement new national patient choice strategy		On Plan	Complete	Complete
			Implement plans for sustainability governance review			On Plan	On Plan

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Corporate Risk Register Report
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Samantha Hann, Deputy Director of Integrated Governance
PRESENTED BY:	Phil Brice, Director of Corporate Services
DATE:	7 May 2024

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

Executive Summary and Reason for presentation to Committee/Board	The Board of Directors are ultimately responsible and accountable for the comprehensive management of risks faced by the Trust. They will: … ***receive and review the Corporate Risk Register via the Board Assurance Committees*** *and the Assurance Framework quarterly, which identify the principal risks and any gaps in assurance regarding those risks* Each Board Assurance Committee will receive the Corporate Risk Register report with the specific risks assigned to them. The Committees will formally review and scrutinise the risks within their remit. These reports will be received at least once a quarter together with the Board Assurance Framework. The highest areas of risk for the organisation are: • Pressures in social care; intermediate care; and primary care • Insufficient capacity to meet demand • Workforce recruitment and retention • Aging estates - acute and community • Financial position
Recommendation	The report covers those risks detailed on the Somerset Foundation Trust Corporate Risk Register on 29 April 2024 The report focuses on the high risks scoring 15+ on the risk matrix and includes corporate risks and service group risks. The Board are asked to note the report and the risks identified.

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

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

Equality The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
There are no proposals or matters which affect any persons with protected characteristics directly within this report. Any risks where there are proposals or matters which may affect any persons with protected characteristics would be included within the mitigating action plans held within the individual risk assessments referred to within this report.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

CORPORATE RISK REGISTER REPORT 25 MARCH 2024

1. INTRODUCTION

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

2. PURPOSE OF THE REPORT

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

2.2 This risk report aims to provide details of the key risks detailed on the Trust's Corporate Risk Register on 29 April 2024 and the changes since the last report to the Board of Directors on 27 December 2023.

2.3 The report also includes the corporate risks identified by Simply Serve Limited (SSL) which is a wholly owned subsidiary of SFT. These risks are either shown as additional corporate risks for SFT (Risk R2333) or mapped into existing SFT corporate risks (Risk R2409).

3. CORPORATE RISK REGISTER

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

- Risk 0960 Failure to deliver financial plan (25)
- Risk 0004 Demand (20)
- Risk 0006 Delivery of CIP 2024/25 (20)
- Risk 0012 Waiting Times (20)
- Risk 0862 Use of escalation beds across SFT (20)
- Risk 2044 Vacancies and absence rates within senior doctor workforce (20)
- Risk 2192 Symphony Healthcare Services not becoming financially self-sustaining (20)

3.2 There have been nine risks scoring 15 or above which have been removed from the Corporate Risk Register as they are Service Group / Corporate Function risks. They do not currently map into a risk on the Corporate Risk Register that scores 15 or above. These risks are shown on page 5 of Appendix 1.

New Risks

3.3 There have been eleven new risks added to the Corporate Risk Register since the last report to the Board of Directors on 27 December 2023:

Risk Reference	Risk Description
Extract taken from Corporate Risk Register Report dated 8 February 2024	
Risk 2157	Inefficient use of resources due to no automated radiation dose management software available to proactively monitor radiation doses, diagnostic reference levels and identification of equipment outliers
Risk 2211	Ward medicine storage on MPH site non-compliant with CQC standards
Extract taken from Corporate Risk Register Report dated 4 March 2024	
Risk 2231	Lack of sub-specialty service provision for patients on biologics and disease modifying antirheumatic drugs (DMARDS)
Risk 2235	Inability to prevent potential harm to children born to parents who are taking oral valproate as well as the potential impact on the parents caring for a child who has suffered harm by valporate due to new guidance not being full implemented across the Trust
Risk 2257	Non-compliance with National Bed Rails Patient Safety Alert
Extract taken from Corporate Risk Register Report dated 25 March 2024	
Risk 2306	Vacancies and absence rates within trainee doctor workforce
Risk 2307	Current medical workforce establishment not mapped to year on year increasing demand
Risk 2320	Decontamination techniques and processes not being followed due to lack of training
Extract taken from Corporate Risk Register Report dated 29 April 2024	
Risk 2376	Delays to core system upgrades which are critical to support business needs and improve patient safety
Risk 2413	Inability to proceed with planned go live of new ordercomms system
Risk 2462	Lack of knowledge, skill and resource to demonstrate compliance with national guidance and legislation for decontamination due to not having a dedicated decontamination lead in place

Increased Risks

3.4 There have been five risks which have increased since the last report to the Board of Directors on 27 December 2023. Two of these risks (Risk 0006 & Risk 0960) were already on the Corporate Risk Register:

Risk Reference	Risk Description
Extract taken from Corporate Risk Register Report dated 8 February 2024	
Risk 0960	Failure to deliver financial plan
Risk 1827	Lack of unified policy and approach for the management of colleague personal files
Extract taken from Corporate Risk Register Report dated 25 March 2024	

Risk 2273	Insufficient intermediate care capacity
Extract taken from Corporate Risk Register Report dated 29 April 2024	
Risk 0006	Delivery of CIP 2024/25
Risk 0960	Failure to deliver financial plan

Risks which have Reduced

3.5 There have been six risks which have reduced since the last report to the Board of Directors on 27 December 2023. Although Risk 2044 has reduced, this remains on the Corporate Risk Register:

Risk Reference	Risk Description
Extract taken from Corporate Risk Register Report dated 8 February 2024	
Risk 0326	No coordinated approach to the transition of children and young people with complex care needs
Risk U1056	Non-delivery of service provision KPIs by Contractor
Risk 1968	Failures in referral pathways to specialities from Primary Care increasing Emergency Department attendances
Extract taken from Corporate Risk Register Report dated 4 March 2024	
Risk 1952	Lack of prioritisation for further development of personalised care
Extract taken from Corporate Risk Register Report dated 29 April 2024	
Risk 2044	Vacancies and absence rates within senior doctor workforce
Risk 1999	Inability to undertake Mental Health Act Assessments in a timely manner by AMHPs

Risks which have been Archived

3.6 There has been one risk which has been archived from the Corporate Risk Register since the last report to the Board of Directors on 27 December 2023:

Risk Reference	Risk Description
Extract taken from Corporate Risk Register Report dated 8 February 2024	
Risk 1855	Failure to deliver financial plan *(this risk has been replaced by Risk R0960 referred to in Section 3.4 above)*

Risk Appetite & Risk Tolerance

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

3.7 It is important for the Board and the Board Assurance Committees are aware of the risks that fall outside of the set risk appetite levels and to use this information to focus their discussions on these risks. Further information on risk appetite and risk tolerance can be found in Appendix 3.

Service Group & Corporate Function Risks

3.8 A number of additional risks scoring 15 or more continue to be identified at Service Group and departmental levels. These risks have been linked to risks on the Corporate Risk Register as shown in Appendix 1. The movement of these risks since the last report on 27 December 2023 has also been included within Appendix 1.

3.9 Since the last report on 27 December 2023, there have been a number of risks at Service Group and departmental levels which have increased, reduced or archived, the detail of which has been included in Appendix 4.

Emerging Risks

3.10 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.

3.11 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.

3.12 Since the last report on 27 December 2023, there has been forty-five 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. These have been included within Appendix 5.

4. RISK MANAGEMENT ARRANGEMENTS UPDATE

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

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

4.3 Specifically in relation to the risk register element of the system, the Risk team have progressed well with the work with risk owners to ensure all risks are reviewed and moved from Ulysses to Radar before 1 May 2024. This work further cements the work that has been underway for some time to review the risks on the current risk registers ensuring the risks are live and have been reviewed recently. The next stage of this work is to review the risks on Radar to ensure these meet the standard as specified within the Riks Management Policy.

4.4 A baseline assessment of the risks on the Trust's risk register will be undertaken during Quarter 1 2024/25 against the KPIs set out in the Risk Management Strategy. This will be presented to the Audit Committee in July 2024 as part of the monitoring of the implementation of the Strategy.

4.5 The draft Risk Management Policy is currently out for consultation with stakeholders across the Trust and the Subsidiary organisations. This has been presented to the Audit Committee in draft form in April 2024 and will be virtually approved by the Audit Committee following any feedback from stakeholders by the end of May 2024.

4.6 BDO undertook a Risk Maturity Audit in December 2023 reviewing the Trust's risk management arrangements. The final report was presented to the Audit Committee in April 2024. The overall maturity assessment was rated as:

	Risk Governance	Risk Assessment	Risk Mitigation	Reporting and Review	Continuous Improvement
Current	Defined	Defined	Defined	Defined	Managed
Target	Managed	Managed	Managed	Managed	Enabled

4.7 There were eleven recommendations, all of which were accepted by the Trust. Recommendations 1-10 were highlighted by the Trust to BDO during the audit as work that was scheduled to be progressed during late 2023/24 and 2024/25. Management responses were provided to the recommendations and an action plan created which will be monitored through the BDO Internal Audit Follow Up report which is presented quarterly to the Audit Committee.

5 CONCLUSION

5.1 The Trust continues to respond and manage to an exceptionally high level of risk. There has been progress in mitigating a number of risks but the position remains challenging due to workforce challenges and operational pressures within the Trusts and in social care and primary care across the County.

6 RECOMMENDATION

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

Corporate Risk Register 29 April 2024

NHS Somerset NHS Foundation Trust

People Committee

20 R2044 REDUCED Vacancies and absence rates within senior doctor workforce

16 R1624 Failure to secure necessary infrastructure (workforce)

16 R1815 Vacancies and absence rates within nursing and AHP teams

16 R1827 INCREASED Lack of unified policy and approach for the management of colleague personal files

16 R1880 Retention and turnover of staff

16 R1944 Reduced colleague resilience due to prolonged impact of integration

16 R2307 NEW Current medical workforce establishment not mapped to year on year increasing demand

15 R2306 NEW Vacancies and absence rates within trainee doctor workforce

15 R2320 NEW Decontamination techniques and processes not being followed due to lack of training

Financial Committee

25 R0960 INCREASED Failure to deliver financial plan

20 R0006 INCREASED Delivery of CIP 2024/25

20 R2192 SHS not becoming self-sustaining

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

15 R2333 Reduction of funding into SSL budget to meet service requirements

Quality & Governance Committee

20 R0004 Demand

20 R0012 Waiting Times

20 R0862 Use of escalation beds across SFT

16 R0007 Referral to Treatment Times

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

16 R1238 Fire Compartmentation

16 R1852 Unsupported infection control electronic case management system

16 R2131 Product shortages and/or significant delays of supply due to unpredictable market

16 R2273 INCREASED Insufficient intermediate care capacity

16 R2376 NEW Delays to core system upgrades which are critical to support business needs and improve patient safety

16 R2413 NEW Inability to proceed with planned go live of new ordercomms system

15 R1542 Insufficient Medical Physics Expertise leading to all radiation services ceasing

15 R1789 Unsafe premises and environment

15 R2053 Increased risk of harm due to development of episode of care pressure ulcers

15 R2257 NEW Non-compliance with National Bed Rails Patient Safety Alert

15 R2462 NEW Lack of knowledge, skill and resource to demonstrate compliance with national guidance and legislation for

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

Appendix 1

QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R0004	20	Demand
SO8	⇔	

Service Group / Corporate Function Risks 15+

R0372	20	↑	Overcrowding in Emergency Department
R1811	20	↓	Unsafe numbers of attendances in Emergency Department
R2035	20	↑	Inability to meet demand for virtual macular reviews within the Ophthalmology service
R2229	20	NEW	Insufficient capacity to meet demand in the Rheumatology service
R0560	16	⇔	Insufficient capacity to meet demand for Endocrine weight management service
R1597	16	⇔	No dedicated theatre list for elective caesareans leading to delays and poor patient experience
R1649	16	⇔	Insufficient capacity to meet demand in heart failure nurse led service
R1709	16	⇔	Increase in Primary Care in Minehead sending patients with primary care conditions to Minehead MIU
R1830	16	⇔	Unprecedented levels of referrals into radiotherapy which cannot be met by treatment capacity
R1831	16	NEW	Unsustainable radiotherapy service due to demand and staffing issues
R2185	16	↑	Inability to provide patient care and treatment in a timely manner due to increased demand and staffing challenges - Hamdon Medical Centre
R2260	16	NEW	Increased demand and acuity of patients within Community Urgent Care (CUC) service
R2450	16	NEW	Inability to maintain service delivery due to demand on the epilepsy service and workforce issues
R2466	16	NEW	Inability to provide adequate care and treatment at Highbridge Medical Centre due to increased demand and reduced capacity
R0562	15	⇔	Insufficient capacity to meet demand in diabetes specialist podiatry service
R1060	15	↓	Insufficient capacity to meet demand for bowel cancer screening
R1362	15	⇔	Insufficient theatre capacity for Urology cases to meet demand

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QUALITY & GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust

Corporate Risks 15+

R0012	20		Waiting Times
SO2	⇔		
R862	20		Use of escalation beds across SFT
SO2	⇔		
R0007	16		Referral to Treatment Times
SO8	⇔		
R0673	16		Impact of the current capacity and future resilience of Primary Care in Somerset on the Trust
SO3	⇔		

Service Group / Corporate Function Risks 15+

R0009	16	⇔	Diagnostic Waiting Times Performance
R2228	16	NEW	Increased wait time for Rheumatology patients due to issues with outsourced provider of care
R2467	16	NEW	Backlog of unprocessed patient documents leading to delay in patient treatment and waiting times
R1813	15	⇔	Lack of service contract leading to increase in waiting times – Neurophysiology
R2063	15	⇔	Increased wait time for category 2 (P2) Urology patients due to lack of theatre capacity
R2050	16	⇔	Community hospital winter pressures bed escalation
R2267	16	⇔	Use of escalation areas and cancellation of elective activity on YDH site
R2230	16	NEW	Backlog of Rheumatology patients awaiting follow ups
R2272	16	⇔	Backlog of patients requiring endoscopy surveillance procedure

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QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R1238	16	⇔	Fire Compartmentation
SO8			
R1852	16	⇔	Unsupported infection control electronic case management system
SO2			
R2131	16	⇔	Product shortages and/or significant delays of supply due to unpredictable market
SO2			
R1542	15	⇔	Insufficient Medical Physics Expertise leading to all radiation services ceasing
SO8			

Service Group / Corporate Function Risks 15+

R1664	20	⇔	Evacuation of patients – Jubilee Building
R1774	20	⇔	Evacuation of patients – SNICU
R1820	20	⇔	Evacuation of patients – Maternity (MPH)
R1746	15	⇔	Evacuation of patients – lack of appropriate equipment to support vertical evacuation in community hospitals
R1897	15	⇔	Patient outcomes potentially compromised due to current evacuation plan for Neonatal Unit
R2094	15	⇔	Evacuation of patients – Wards 6 to 9
R2102	15	↑	Loss of storage and logistics areas due to open fire barriers in ceiling voids (YDH)
R1955	16	⇔	Insufficient freezer storage capacity for patient food at MPH to successfully prepare in the event of delays or cancellations of supply

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QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R2273	16	Insufficient intermediate care capacity
SO3	↑	

R2376	16	Delays to core system upgrades which are critical to support business needs and improve patient safety
SO8	NEW	

R2413	16	Inability to proceed with planned go live of new ordercomms system
SO8	NEW	

Service Group / Corporate Function Risks 15+

R1703	16	↑	Lack of social worker provision increasing the length of stay in intermediate care beds

R2013	20	↔	Inability to track and access patient referral information if the upgrade to the digital surgical decision unit patient tracker is delayed

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QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R1789	15	Unsafe premises and environment
SO2	⇔	

Service Group / Corporate Function Risks 15+

R1849	20	⇔	Outbreak of Carbapenemase-producing organisms (CPO) due to an environmental reservoir of CPO
R1954	20	⇔	Loss of Switchboard, paging systems and emergency alarm systems due to SSD Flooring works
R1956	20	⇔	Resilience of radio network infrastructure due to works on the MPH site
R2029	20	⇔	Lift failures at Frome Community Hospital
R1256	16	⇔	Contamination due to water droplets/aerosols from toilets/macerators/drains due to poor ventilation
R1297	16	⇔	Lack of safe access to steam control valves serving the heating & hot water heat exchangers for the day surgery building
R1562	16	⇔	Non-compliance of statutory maintenance of thermostatic mixing values
R1570	16	⇔	Management of the Asbestos Register
R1648	16	⇔	Poor water quality and potentially unsafe water systems at project handovers
R2146	16	NEW	Systematic failure of nurse call system supplying Jubilee building due to unsupported obsolete system
R2245	16	NEW	Failure of intercom system at Bridgwater Hospital
R2251	16	NEW	Inability to review site specific pre-planned maintenance (PPM) due to new CAFM system which operates with SFG20 HTM compliant generic PPM software, not site specific
R2259	16	NEW	Condition and security of Shepton Mallet Community hospital site
R0534	15	⇔	Poor condition of Shepton Mallet Community Hospital Portakabin Units
R1043	15	⇔	Bed driving devices that are not fit for purpose to transport patients

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QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

Service Group / Corporate Function Risks 15+

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
R1686	15	⇔	Treatment room on Blake Ward is no longer fit for purpose for ENT emergencies
R1741	15	⇔	Inability for nursing staff to hear emergency bells
R1845	15	↑	Breach of national Bereavement Care Service Standards due to lack of space for the Bereavement service on the YDH site
R1892	15	⇔	Inability to provide patient meals due to failure of the patient catering freezer
R1907	15	⇔	Potential closure of the obstetric service due to insufficient maintenance programme to maintain the integrity of the estate
R2037	15	⇔	Road collisions due to the disrepair of the car park at Frome Community Hospital
R2054	15	↓	Risk of injury from deterioration of Boiler House
R2066	15	NEW	Functionality of nurse call bells
R2302	15	⇔	Inability to place PICC/midlines for outpatients and hospital at home patients due to lack of clinic space
R2381	15	NEW	Lack of assurance provided by the Beacon Centre that there is a robust water safety regime in place
R2388	15	NEW	Closure of boiler house and loss of services due to eroded structural beam - MPH
R2456	15	NEW	Inability to undertake annual servicing and testing of patient beds due to resource constraints
R2458	16	NEW	Condition of estate at Shepton Mallet Community Hospital

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QUALITY & GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust

Corporate Risks 15+

R2053	15	Increased risk of harm due to development of episode of care pressure ulcers
SO2	⇔	
R2257	15	Non-compliance with National Bed Rails Patient Safety Alert
SO8	⇔	
R2462	15	Lack of knowledge, skill and resource to demonstrate compliance with national guidance and legislation for decontamination due to not having a dedicated decontamination lead in place
SO8	NEW	

Service Group / Corporate Function Risks 15+

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NHS Somerset NHS Foundation Trust

Service Group / Corporate Function Risks 15+

Not Mapped to a Risk on the Corporate Risk Register

R2408	20	NEW	Risk to patients of deterioration due to delays in ambulance transfers from MIUs
R1660	16	⇔	Children's respiratory management programmes not being optimised in the community due to being unable to provide treatments that are needed; colleagues working in isolation; lack of equipment and specialist training and lack of escalation pathway
R2211	16	NEW	Ward medicine storage on MPH site non-compliant with CQC standards
R2231	16	NEW	Lack of sub-specialty service provision for patients on biologics and disease modifying antirheumatic drugs (DMARDS)
R2423	16	NEW	Compromised patient safety due to document management processes not being followed correctly
R0363	15	⇔	Patient outcomes and treatments not recorded in a timely and accurate way whilst in Emergency Department
R2235	15	NEW	Inability to prevent potential harm to children born to parents who are taking oral valproate as well as the potential impact on the parents caring for a child who has suffered harm by valporate due to new guidance not being full implemented across the Trust
R2438	15	NEW	Unavailability of fit for purpose defibrillators due to the defibrillators no longer being supported by the manufacture if they require repair

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PEOPLE COMMITTEE

Somerset NHS Foundation Trust

Corporate Risks 15+

R2044	20	⇩	Long standing vacancies within some specialities where there are chronic national shortages within the senior doctor workforce
SO6			

Service Group / Corporate Function Risks 15+

R1762	20	⇔	Inability to recruit to medical vacancies – Holford & St Andrews
R1943	20	⇧	Nuclear Medicine Service workforce
R0530	16	⇔	Somerset Lipid Service is not adequately developed and resourced
R0956	16	⇧	Consultant vacancies in Rheumatology
R1413	16	⇔	Multiple longstanding vacancies within the Clinical and Medical Consultant oncology service
R1505	16	⇔	Dental workforce challenges
R1700	16	⇔	Need to recruit and train a further Consultant in ERCP (Endoscopic Retrograde Cholangiopancreatography)
R2079	16	⇧	Insufficient clinical workforce to ensure timely diagnosis of Familial Hypercholesterolaemia (FH) and other lipid disorders
R2247	16	NEW	Inability to meet the demand on Urology services due to upcoming workforce challenges
R2359	16	NEW	Consultant vacancies within SWISH (Sexual Health) Services
R0999	15	⇔	Inability to recruit substantive Orthodontic consultant
R2168	15	⇩	Lack of specialised care for elderly patients that require orthopaedic-geriatric care due to lack of consultant cover

R1880	16	⇔	Retention and turnover of colleagues
SO6			

R1295	16	⇔	Insufficient numbers of skilled personnel in Estates to maintain 24/7 response

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PEOPLE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

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

Service Group / Corporate Function Risks 15+

R2378	20	NEW	Insufficient staffing establishment within the community urgent care service
R0440	16	⇔	Inability to provide a robust, continuous streamlined service for direct current cardioversion patients
R0513	16	⇔	Limited provision of specialist neurological rehabilitation and neuropsychiatry service
R0916	16	⇔	Insufficient critical care rehabilitation establishment
R1148	16	⇔	Theatres do not have the required safe staffing numbers in the establishment to deliver the service
R1491	16	⇔	Inability to provide endoscopists to meet capacity for colonoscopy lists
R1630	16	⇔	Insufficient Learning Disability Liaison Team establishment
R1798	16	⇔	Insufficient Weight Management Dietitian staffing due to vacancies
R2064	16	⇔	Inability to staff theatre services on the YDH site due to registered and non-registered staffing vacancies
R2210	16	NEW	Insufficient Learning Disability Liaison team establishment
R2227	16	NEW	Insufficient staffing resource within the Adult Speech and Language service to meet demand on the general medical wards in both acute hospitals
R2255	16	NEW	Insufficient staffing levels across the Stroke Rehabilitation units at Williton and South Petherton
R2379	16	NEW	Inability to monitor cardiac device patients due to staffing levels
R2226	15	NEW	Insufficient OT establishment on wards leading to increased length of stay for patients
R2299	15	⇔	Significant staffing vacancies in the Emergency Department - nursing and ENPs
R2362	15	↑	Non-compliance with staffing levels for children and young people's services at YDH due to the establishment on the paediatric ward not meeting RCN requirements for bed spaces on the ward
R2369	15	⇔	Lack of Occupational Therapy staffing causing delays in patients receiving timing treatment

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PEOPLE COMMITTEE

Somerset NHS Foundation Trust

Corporate Risks 15+

R1624	16	↔	Failure to secure necessary infrastructure – physical and digital (workforce)
SO6			

R1827	16	↑	Lack of unified policy and approach for the management of colleague personal files
SO6			

R1944	16	↔	Reduced colleague resilience due to prolonged impact of integration
SO6			

Service Group / Corporate Function Risks 15+

R1389	16	↑	Backlog of clinical correspondence - Neurology admin team
R2083	15	↔	Inability to audit and review Sepsis and deteriorating patient records due to lack of resource

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PEOPLE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R2307	16	Current medical workforce establishment not mapped to year on year increasing demand
SO6	NEW	

R2306	15	Vacancies and absence rates within trainee doctor workforce
SO6	NEW	

R2320	15	Decontamination techniques and processes not being followed due to lack of training
SO6	NEW	

Service Group / Corporate Function Risks 15+

R2006	15	⇔	Inability to fill required number of Dental Core Trainee posts within the Maxillo-Facial department

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FINANCE COMMITTEE

Somerset NHS Foundation Trust

Corporate Risks 15+

R0960	25	↑	Failure to deliver financial plan
SO7			
R0006	20	↑	Delivery of CIP
SO7			
R2192	20	↔	SHS not becoming self-sustaining
SO7			
R1611	16	↔	Failure to secure necessary infrastructure – physical & digital (funding)
SO7			
R2333	15	↔	Reduction of funding into SSL budget to meet service requirements
SO7			

Service Group / Corporate Function Risks 15+

R1859	15	↑	Failure to deliver elective activity trajectory
R1919	15	↑	Increasing costs to existing digital system contracts due to incumbent awareness of the Trust's EHR procurement and need to make short term contract extensions
R1343	20	↔	Quality of Discharge Summaries
R1840	20	↔	Inability to fund new electronic health record with shortfall in national allocation
R0003	16	↔	Insufficient investment to reduce levels of backlog maintenance
R1419	16	↔	Inability to financially support Yeovil Dental Access Centre
R2409	16	↔	Insufficient investment from main contractor to reduce levels of backlog maintenance

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7. BOARD ASSURANCE FRAMEWORK & CORPORATE RISK REGISTER

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

Board Assurance Framework

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

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

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

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

Corporate Risk Register

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

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

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

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

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

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

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

8. RISK APPETITE AND RISK TOLERANCE

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

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

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

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

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

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

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

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

Figure 1

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

Figure 2

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

Appendix 4

Service Group and Departmental Risks which have Increased, Reduced or been Archived Since 27 December 2023

Since 27 December 2023, there have been a number of risks at Service Group and departmental levels which have increased, reduced or been archived as shown below:

Extract taken from Corporate Risk Register Report dated 8 February 2024		
Risk Reference	**Risk Description**	**Reduced / Archived**
Risk R2035	Inability to meet demand for virtual macular reviews within the Ophthalmology service	Increased from 12 → 20
Risk R0956	Consultant vacancies in Rheumatology	Increased from 9 → 16
Risk R2168	Lack of specialised care for elderly patients that require orthopaedic-geriatric care due to lack of consultant cover	Increased from 9 → 16
Risk R0551	Overcrowding in Acute Medical Unit on MPH site	Increased from 12 → 16
Risk R0969	Insufficient speech and language therapy input in the Trust's Stroke Rehabilitation Centres due to current establishment	Increased from 12 → 16
Risk R1060	Insufficient capacity to meet demand for bowel cancer screening	Increased from 12 → 16
Risk R1703	Lack of social worker provision increasing the length of stay in intermediate care beds	Increased from 12 → 16
Risk R1859	Failure to deliver elective activity trajectory	Increased from 12 → 15
Risk R2102	Loss of storage and logistics areas due to open fire barriers in ceiling voids (YDH)	Increased from 12 → 15
Risk U0021 / R1811	Unsafe numbers of attendances in Emergency Department	Reduced from 25 → 20
Risk R2054	Risk of injury from deterioration of Boiler House	Reduced from 25 → 15
Risk R1310	No automated and cross organisation treatment escalation plans process	Reduced from 20 → 12
Risk U1092 / R2184	Lack of Permanent GPs at Wincanton Health Centre	Reduced from 16 → 12
Risk R1324	High levels of vacancies and absences across community and urgent care teams	Reduced from 16 → 12
Risk R1551	Insufficient Psychologist staffing due to vacant posts	Reduced from 16 → 12

Appendix 4

Service Group and Departmental Risks which have Increased, Reduced or been Archived Since 27 December 2023

Risk R1731	Failure to meet both National Cervical Screening Program and National Cancer Waiting Times standards within Grace Centre	Reduced from 16 → 12
Risk R1808	Lack of cell salvage equipment in maternity	Reduced from 16 → 12
Risk R1972	Increased wait time for patients due to insufficient clinic capacity and staffing to cover clinics	Reduced from 15 → 12
Risk R0564	Inequitable service provision to teams/localities across Somerset - Physiologists	Reduced from 16 → 9
Risk U1051	Lack of skilled and unskilled colleagues to deliver services	Reduced from 16 → 9
Risk R1966	Insufficient staffing within the vaccination team due to vacant posts as a result of the delay in the publication of the National Vaccination Strategy	Reduced from 16 → 9
Risk U0515 / R1900	Inability to retain and recruit critical care consultant intensivists	Reduced from 15 → 9
Risk U0868 / R1755	Insufficient Clinical Nurse Specialist cover – Gynaecology oncology	Reduced from 16 → 8
Risk R1396	Insufficient nursing establishment funding in cardiac cath lab	Reduced from 20 → 6
Risk R1679	Weight Management Service staffing	Reduced from 16 → 6
Risk R1706	Cath Lab staffing establishment due to vacant posts	Reduced from 16 → 6
Risk U1023 / R2189	Inability to meet demand for immunotherapy	Reduced from 15 → 6
Risk U1105	Electrical and fire risk from damaged mattress electric cables	Risk Archived
Risk U1120	Capacity and demand within Symphony Practices	Risk Archived
Risk R1301	Wards under resourced and insufficient skill mix of staff – Nurses & HCAs	Risk Archived
Risk R1567	Helipad barriers – non-compliance with current electrical regulations	Risk Archived
Risk R1694	Evacuation of patients – TOR Ward	Risk Archived
Risk R2016	Collapse of the Parkside floor leading to access to the Ward being lost	Risk Archived
Risk R2024	Failure of the boiler house electrical distribution board due to age and works required after recent boiler house flood	Risk Archived

Appendix 4

Service Group and Departmental Risks which have Increased, Reduced or been Archived Since 27 December 2023

Extract taken from Corporate Risk Register Report dated 4 March 2024		
Risk Reference	**Risk Description**	**Reduced / Archived**
R0372	Overcrowding in Emergency Department	Reduced from 20 → 16
R2079	Insufficient clinical workforce to ensure timely diagnosis of Familial Hypercholesterolaemia (FH) and other lipid disorders	Increased from 12 → 16
R1088	Increased wait time due to backlog in the virtual glaucoma patient reviews	Increased from 9 → 16
U0934	Non-compliance with staffing levels for children and young people's services at YDH due to the establishment on the paediatric ward not meeting RCN requirements for bed spaces on the ward	Increased from 12 → 15
R1845	Breach of national Bereavement Care Service Standards due to lack of space for the Bereavement service on the YDH site	Increased from 12 → 15
R1919	Increasing costs to existing digital system contracts due to incumbent suppliers awareness of the Trust's EHR procurement and need to make short term contract extensions	Increased from 12 → 15
R1450	Insufficient staffing to manage continuous growth in demand for ultrasound services (antenatal and general ultrasound services)	Reduced from 20 → 12
R1951	Sub-optimal links between primary care and SFT services due to siloed working	Reduced from 16 → 12
R1670	Lack of physical space within the department to accommodate clinical functions	Reduced from 15 → 10
R1987	Lack of robust process to ensure blood glucose monitors across community teams are calibrated accurately	Reduced from 15 → 8
R0969	Insufficient speech and language therapy input in the Trust's Stroke Rehabilitation Centres due to current establishment	Risk Archived
R2051	Inability to recruit stroke consultants at YDH	Risk Archived
R2197	Impact of using the gym as an escalation area on stroke and neuro patients	Risk Archived

Appendix 4

Service Group and Departmental Risks which have Increased, Reduced or been Archived Since 27 December 2023

Extract taken from Corporate Risk Register Report dated 25 March 2024		
Risk Reference	**Risk Description**	**Reduced / Archived**
R0372	Overcrowding in Emergency Department	Increased from 16 → 20
R1943	Nuclear Medicine Service workforce	Increased from 15 → 20
R1060	Insufficient capacity to meet demand for bowel cancer screening	Reduced from 16 → 15
R1117	Responsiveness of Approved Mental Health Professionals (AMHPs) service out of hours for mental health patients within the Emergency Departments	Reduced from 16 → 12
R2110	Significant long term absence rates within rapid response team	Reduced from 16 → 12
R1088	Increased wait time due to backlog in the virtual glaucoma patient reviews	Reduced from 16 → 9
R2129	Loss of waste compound at YDH due to planned site developments	Reduced from 16 → 8
R0131	Training and validation of pressure ulcers acquired in the Community	Risk Archived

Extract taken from Corporate Risk Register Report dated 29 April 2024		
Risk Reference	**Risk Description**	**Reduced / Archived**
R1389	Backlog of clinical correspondence - Neurology admin team	Increased from 12 → 16
R2185	Inability to provide patient care and treatment in a timely manner due to increased demand and staffing challenges - Hamdon Medical Centre	Increased from 9 → 16
R2168	Lack of specialised care for elderly patients that require orthopaedic-geriatric care due to lack of consultant cover	Reduced from 16 → 15
R0551	Overcrowding in Acute Medical Unit on MPH site	Reduced from 16 → 12
R2188	Reduced GP cover within SHS Practices	Reduced from 16 → 12
R2216	Global shortage of Gastrografin used for bowel prep in CT colonography examinations	Reduced from 16 → 12
R2363	Lack of funding for Paediatric Physiotherapy out of hours	Reduced from 16 → 12

Appendix 4

Service Group and Departmental Risks which have Increased, Reduced or been Archived Since 27 December 2023

R2239	Lack of staff across the Older Persons service in Mendip due to vacancies and sickness across the service	Reduced from 16 → 9
R0293	Insufficient capacity to meet demand for CT scanning	Reduced from 15 → 12
R1856	Lack of radiology nursing cover	Reduced from 15 → 10
R2157	Inefficient use of resources due to no automated radiation dose management software available to proactively monitor radiation doses, diagnostic reference levels and identification of equipment outliers	Reduced from 15 → 6
R1668	Cath lab cardiac arrest call bell system not fit for purpose	Risk Archived
R2116	Failure of battery management system (Mortuary and Cath Lab – MPH site)	Risk Archived
R2248	Inability to recruit to HCA vacancies	Risk Archived
R2288	Inability to recruit Ophthalmology Sister posts	Risk Archived

Emerging Risks on the Service Group & Corporate Function Risk Registers Since 27 December 2023

Since 27 December 2023, there has been forty-five 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.

Extract taken from Corporate Risk Register Report dated 8 February 2024	
Risk Reference	**Risk Description**
Risk R2091	Lack of compliance with National recommendations for blood transfusions with regards to training and audit
Risk R2092	Haematology patient follow up backlog
Risk R2113	Vacancies within the staffing establishment for the Specialist Community Forensic Team
Risk R2164	Inadequate staffing resource in the SLT team assigned to managing deteriorating conditions in the Community due to increasing caseloads and complexity of caseloads
Risk R2169	Lack of digital resource to implement Pathpoint on the YDH site which will result in the Trust being unable to meet the NHS mandate to pre-screen and optimist all patients waiting for major/inpatient elective surgery by April 2024
Risk R2171	Injury to catering teams due to blocked access in covered walkway on MPH site when accessing and exiting Main Kitchen
Risk R2176	Out of hours prescribers do not have access to key clinical systems within the community leading to missed, duplicate or incorrect medicines administration

Extract taken from Corporate Risk Register Report dated 4 March 2024	
Risk Reference	**Risk Description**
Risk R2214	Failure of the boiler house soft water plant on MPH site due to plant condition, obsolete parts/spares and repairs and remedial works required
Risk R2215	Inability to achieve Improving Quality in Physiological Services (IQIPS) UKAS accreditation in Audiology services
Risk R2233	Failure of the medical gas alarms due to an obsolete system which is no longer supported by the manufacturer
Risk R2238	Patients admitted to areas not designated for Older Persons Mental Health due to programme of works to create two safer bedrooms on Pyrland Ward 1 and the need to close beds to undertake the works
Risk R2241	Patients potentially not receiving physical health monitoring due to the lack of agreement by Primary Care to meet NICE guidance for Trust patients open to the Eating Disorder service
Risk R2244	Failure to digitise insulin prescribing at MPH due to the lack of deployed digital CBG capture and feed into ePMA
Risk R2258	Failure in the power supply to the main Pharmacy fridge resulting in delays in treating patients and financial impact on the Trust

Extract taken from Corporate Risk Register Report dated 25 March 2024	
Risk Reference	**Risk Description**
R2271	Insufficient resource (nursing, anaesthetics and clinic space) to meet demand for complex vascular patients

Emerging Risks on the Service Group & Corporate Function Risk Registers Since 27 December 2023

R2287	Inability to attract applicants to replace retiring colleagues – Orthoptics service
R2293	Delayed communication and follow up care with specialties and/or primary care following an AEC episode of care due to significant delays in discharge summaries being completed as a result of capacity and workload pressures
R2317	Reduced service and potential delays for patients due to reduction in Cardiac Physiologists at YDH who can ensure patients with magnetic resonance (MR) conditional cardiac devices are put into the appropriate mode for MRI scans

Extract taken from Corporate Risk Register Report dated 29 April 2024	
Risk Reference	**Risk Description**
R2324	Delay in treatment due to oncology outpatient dieticians being called to cover inpatient services as a result of low staffing numbers
R2342	Inadequate speech and language therapy staffing resource on the acute stroke unit at YDH
R2345	Shortage of medication due to medication supply chain issues
R2351	Inability to provide sufficient on call cover due to shortage of registrars – DSC
R2380	Lack of kit availability for regular lists when maintenance is required which reduces the number of cases able to be seen and treatment for patients is delayed – DSC and GRACE
R2382	Inability to manage our assets/asset management system due to limited resource and investment to operationally manage the system
R2383	Lack of robust water safety management/legionella risk assessment strategy
R2384	Water quality issues due to a reduction in the current management regime for water safety on residential properties
R2389	Reduced staff wellbeing due to inability to take breaks and leave work on time - MIUs
R2391	Vehicle/pedestrian accidents due to increased use of electrical vehicular movement across the sites
R2393	Inability to book patients directly from 111 – Minehead Community Hospital
R2397	Inability to evacuate bay due to broken bay doors - MPH
R2398	Insufficient establishment of uro-oncology clinical nurse specialist cover at YDH to meet the requirements of the service
R2399	Safeguarding referrals not being followed up due to shift patterns and lack of process - MIUs
R2407	Delayed assessment and equipment provision for out of area funded residents in Somerset – Learning Disabilities
R2411	Inability to ensure patients receive clinical assessment by a registrant within 15 minutes of arrival at MIUs
R2415	Failure of electrical power and lighting circuits due to age of infrastructure leading to loss of clinical services - MPH
R2416	Slips, trips and falls risk due to exposed/broken manholes - MPH
R2420	Insufficient bathroom facilities for patient cohort leading to either patients unable to use the facilities or injuries - Parkside
R2424	Injuries to patients/colleagues/carers due to inadequate changing space in cubicles to use the hydrotherapy hoist and unable to use the overhead tracking for hoist
R2440	Increased waiting lists due to no paediatric nursing service for Dermatology in Somerset

Appendix 5

Emerging Risks on the Service Group & Corporate Function Risk Registers Since 27 December 2023

R2441	Lack of capacity and workforce to support the number of follow up appointments required for Dermatology services
R2444	Backlog of clinical correspondence – Dermatology (MPH)
R2452	Loss of patient data due to migration to EMIS system for GPWeR services – Dermatology (MPH)
R2457	Insufficient system and process for out of hours medics to undertake tasks leading to patient safety being compromised
R2464	Incidents not reported in a timely manner - SHS
R2465	Premises not fit for purpose - Yeovil Health Centre

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 27 March 2024
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Jan Hull, Chairman of the Quality and Governance Assurance Committee
DATE:	7 May 2024

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the Quality and Governance Assurance Committee meeting held on 27 March 2024. The Committee received assurance in relation to: • The Corporate Risk Register – progress in relation to a single risk management system and findings of the internal audit risk maturity report. • Annual Risk Appetite discussion. • Surgical Care Service Group assurance report. • Leadership Walkround 2023/24 Report. • Maternity Services update – Maternity Incentive Scheme (MIS) Year 6. The Committee identified the following areas of concern or for follow up: • Corporate Risk Register – risks. • Maternity Services update – ongoing work in relation to the triage process. • Maternity and Neonatal Action Group Report.

	The Committee identified the following areas to be reported to the Board: • Risk Appetite levels agreement. • Positive and Negative assurance re Maternity Services. • Surgical Services assurance report. • Decontamination Lead. • Estates and Project Safety.
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Quality and Governance Assurance Committee. The Board is further asked to note the areas to be reported to the Board.

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

Implications/Requirements (Please select any which are relevant to this paper)					
☐ Financial	☐ Legislation	☐ Workforce	☐ Estates	☐ ICT	☒ Patient Safety/ Quality
Details: N/A					
Equality and Inclusion **The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.** **How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?**					

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING HELD ON 27 MARCH 2024

1. PURPOSE

1.1. The report sets out the items discussed at the formal meeting held on 27 March 2024, along with the assurance received by the Committee and any areas of concern identified. The meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

Corporate Risk Register

2.1. The Committee received the up-to-date combined Corporate Risk Register report and noted that there were currently 32 corporate risks on the risk registers of which seven scored 20 or above. The Committee noted the details of these risks, including the three new risks.

2.2. The Committee further received an update on the progress made in relation to a single risk management system and noted that work on the intensive implementation programme to develop RADAR as the trust's risk management system across the trust continued. Good progress was being made on the work with risk owners to ensure that all risks were reviewed and, where needed, moved to RADAR before 1 April 2024; and significant training on the use of RADAR continued to be provided. The Committee noted the delay in the transfer of Learning from Patient Safety Events to RADAR from 1 April 2024 to 1 May 2024.

2.3. The Committee noted that the internal audit risk maturity report had been received and will be presented to the April 2024 Audit Committee meeting. Overall, the audit findings were positive with the trust scoring "managed" for continuous improvement. This was a significant achievement as not many trusts received this score. The Trust had been assessed as "Defined" for the other four domains. The Committee agreed that this audit findings provided positive assurance.

Annual Risk Appetite Discussion

2.4. The Committee reviewed the risk assessment level for strategic objectives 2, 3, 4 and 5 to determine whether the risk appetite levels were still appropriate.

2.5. The Committee noted that the current risk appetite levels had resulted in a large number of red rated risks being held on the Corporate Risk Register as it had been agreed previously to tolerate a level of risk for three out of the four strategic objectives falling under the remit of the Committee. The Committee

noted the recommendation to keep the risk appetite levels at their current levels as it was recognised that large projects carry a degree of risk.

2.6. The Committee discussed the risk appetite levels and noted that the period of post merger structural change had been completed and that the next step was to look at transformation, quality and service improvement which will come with a degree of risks. The Committee agreed to recommend to the Board that the risk appetite levels remain unchanged.

2.7. The Committee further noted that the risk maturity audit had highlighted the need to consider how risk appetite will work in service groups and projects as risk appetite levels may be different in different services. The Committee noted that this could be built into the productive care development programme. In addition, it was suggested that risk appetite will need to be considered on a routine basis as part of the transformation process.

Service Group Assurance Report – Surgical Care

2.8. The Committee received the assurance report from the surgical care service group and noted the key highlights from the report, including: the change in the service group structure and the clear lines of accountability for governance and the measures in place to embed learning; the appointments to the Associate Medical Director for Surgery and Deputy Associate Director of Patient Care posts; the restructuring of the governance team; the improvements in relation to the group's complaints process which had resulted in the embedding of proactive projects with the aim to reduce the number of complaints.

2.9. The Committee noted that the establishment of the service group governance team had been fundamental in transforming the way governance was carried out and addressing the risks that were developing due to the lack of clarity about the previous governance processes. The team had also built more robust pathways for governance processes leading to better oversight of service group activities. This model was now also being developed in other service groups.

2.10. The Committee noted that clinical engagement was one of the challenges in creating a governance team within a service group and it was suggested testing the level of clinical engagement and ownership of governance.

2.11. The Committee agreed that the service group had made good progress over the last 12 months and that the report provided the Committee with significant assurance about the service group's governance processes.

Leadership Quality Walkround 2023-24 Report

2.12. The Committee received the report including the action plans from each of the visits.

2.13. The Committee noted that during July to December 2023 32 visits had been arranged but that seven had to be stood down for a number of different

reasons. The visits covered a wide range of services and were well received by colleagues. The Committee noted the key areas of concerns which related to: staffing, recruitment and retention; ageing estates and facilities backlog; and IT/Digital transformation.

2.14. The Committee further noted that planning for the 2024/25 visits had commenced and that Governors will be invited to attend all planned visits as an observer.

2.15. The Committee discussed the level of detail in the action plans and noted that the report was a high level report which set out the key themes to ensure that the Committee was focussing on the right issues. The aim of the visits was to gain "soft intelligence" and did not take the form of an inspection with timetabled action plans. The action plans were shared with the relevant teams to ensure that they were aware of the issues raised. The Committee noted that the action plan feedback template will be reviewed to take account of comments made at the meeting.

2.16. The Committee agreed that the key themes identified have been a key area of focus by the Committee and this provided the Committee with assurance.

Maternity Services Update – Maternity Incentive Scheme (MIS) Year 6

2.17. The Committee received an update on the Year 6 MIS requirements and noted that a summary of the expected changes had now been received and that an initial review of the changes had not highlighted any significant areas of concern at this stage.

2.18. The Committee noted that MIS will be included within the portfolio of work for a new governance lead role and that the Governance Support Team will support the initial set up of the scheme by devising a reporting timetable, map scheme deadlines and engage in meetings with safety action leads to promote the scheme and discuss requirements. The Committee noted that the maternity service will be responsible for delivering and monitoring progress against the scheme with oversight from the leadership team and wider service group.

2.19. The Committee further noted: the quality assurance process; the process for reviewing evidence; the consideration of the evidence tracker/compliance audit tool to be used; and the commissioning of an internal audit to provide additional assurance.

2.20. The Committee agreed that the report provided a good level of assurance about the MIS governance process going forward.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. The Committee discussed the following risks, which had been discussed at the recent Quality Assurance Group, in more detail:

- Decontamination lead risk – this was a new risk and oversight had been allocated to the Committee in view of the patient safety element. The risk related to training and impact on patient safety and the risk will be reviewed to ensure that it was properly recorded.

  The Committee noted the current Decontamination Lead arrangements and agreed that, although the immediate risks were largely mitigated, the interim arrangements were not sustainable in the long term especially considering the significant post merger decontamination requirements.

  The Committee further noted that a review of the decontamination processes across both acute sites will be undertaken by the Authorised Engineers. A review was undertaken on an annual basis but this review had been brought forward to be able to provide assurance about processes and the management of this risk. The Committee noted that further discussions on the decontamination challenges and resources were taking place at the Operational Leadership Team meetings.

- Fire safety risk – good progress was being made in terms of the strategy and processes in relation to compartmentation. There was a requirement for capital investment and this will be discussed as part of the capital funding prioritisation process.

- Discharge medication – a Situation, Background, Assessment, Recommendation (SBAR) report will be presented to the April 2024 Committee meeting and an item on a wider medication review will be included on the agenda of a future meeting.

- Medical physics – an arrangement with Oxford University Hospitals will come into effect from 1 May 2024.

- Mental Health Act Assessments – this risk had been discussed at the recent Mental Health Act Committee meeting. An audit had been undertaken which had raised some concerns but, due to the lack of a Local Authority representative at the meeting, the findings will be followed up at the next Mental Health Act Committee meeting.

- Intermediate care risk – Peter Lewis had been appointed as the system wide lead for “no criteria to reside” and there was confidence that work to address the intermediate care risk will now progress.

- Risks in relation to the quality of the estate – a report on the quality of premises had been received by the Quality Assurance Group and the maintenance backlog risk will need to be reviewed in light of the prioritisation in the capital programme.

3.2. The Committee agreed that it was well sighted on the majority of these risks but the scoring of a number of risks was increasing, e.g. surgical build and the implications of the on-site work, and the Committee asked for a progress report to be presented to a future planning meeting. The Committee noted that a capital projects internal audit had been commissioned and that the findings will be shared with the Committee when available.

Maternity Services Update – Triage Process

3.3. The Committee received a presentation on the triage process within maternity services and how triage was provided across the organisation.

3.4. The Committee noted the triage system recommended by the Royal College of Gynaecologists – Birmingham Symptom specific Obstetrics (BSOTS); the workflow challenges at Yeovil District Hospital prior to the introduction of a triage system; the different arrangements in place at Musgrove Park Hospital (MPH) including the need for day care elements as part of the triage process; the challenges removing the day care elements in order to introduce BSOTS due to the estate design and the need for a space for the day assessment service; the actions being taken to address the triage challenges; the expected implementation of the MPH triage system on or before 6 May 2024; and the business case for test of change with telephone triage phone calls.

3.5. The Committee noted that a risk assessment will be carried out which will describe how to implement some interventions to reduce risks over time and which will make a real difference to the service.

Maternity and Neonatal Action Group (MNAG) report

3.6. The Committee received a report on the establishment of the Maternity and Neonatal Action Group in February 2024 to provide oversight to the children, young people and families service group in response to: the Care Quality Commission's inspection in 2023; the issues identified as part of the Maternity Incentive Scheme submission; and the fire safety and security concerns within the maternity and neonatal unit at MPH.

3.7. The Committee noted the membership of the group and reporting arrangements and further noted two issues which required escalation to the Committee. The Committee noted that these issues related to: the temporary suspension of the Mary Stanley Unit following the move of the neonatal resuscitaire to the delivery suite at MPH and the future of this unit given the changing profile of acuity of women birthing on a planned pathway; and the reduction in neonatal capacity pending the completion of planned fire safety infrastructure work.

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:

- Risk Appetite levels agreement
- Positive and Negative assurance re Maternity Services
- Surgical Services assurance report
- Decontamination Lead
- Estates and Project Safety

5. BOARD ASSURANCE FRAMEWORK (BAF)

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

- Discussion re Risk Appetite and how this impacts on the BAF.
- Positive assurance around devolved governance arrangements within surgical services with the caveats and challenges that were raised as part of the discussion.
- Positive assurance in the context of maternity services and progress made.

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

Jan Hull
CHAIRMAN OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust/Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Guardian of Safe Working for Postgraduate Doctors Quarterly Report 4
SPONSORING EXEC:	Melanie Iles, Chief Medical Officer
REPORT BY:	Tom Rees (TST) and John McFarlane (YDH), Guardian of Safe Working; Lee-Ann Toogood, Medical Workforce Manager
PRESENTED BY:	Tom Rees, Guardian of Safe Working
DATE:	7 May 2024

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

Executive Summary and Reason for presentation to Committee/Board	This report covers quantitative and qualitative summary of exception report data generated between 13 January 2024 and 10 April 2024 across Somerset NHS Foundation Trust.
Recommendations	Yeovil will continue monthly Junior Doctor Forum meetings (JDF) which helps discuss ideas and concerns raised. Taunton will continue with quarterly JDFs. Junior doctors were reminded at JDF to close off exception reports – strictly speaking overtime payment should not be issued unless Post Graduate doctor has agreed with outcome and closed exception report. Uptick in exception reports at Taunton in general surgery. Most due to overtime, but some because of an out of hours issue which should now be resolved. Numbers will be monitored going forwards. Low numbers of exception reports generated at weekends may be resolved by NHS@work software which may help automate a lot of the exception report data. Expectation that exception report numbers may increase when software is implemented.

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

☐ Obj 4	Reduce inequalities
☐ Obj 5	Respond well to complex needs
☒ Obj 6	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☐ Obj 7	Live within our means and use our resources wisely
☒ Obj 8	Develop a high performing organisation delivering the vision of the Trust

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

Details:

Equality and Inclusion

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

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

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

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

Public/Staff Involvement History

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

Not applicable for this report.

Previous Consideration

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

The report is presented to the Board on a quarterly basis. The report has been reviewed by the People Committee.

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

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

CONTENTS	

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

1. INTRODUCTION

1.1. This report covers and comprises quantitative and qualitative data on working patterns and associated exception reports for postgraduate doctors in training across the Trust.

1.2. Exception reports are a mandatory requirement of the 2016 Junior Doctor Contract. All doctors on this contract should report any hours worked above their standard contract via the software provided by the hospital in order to be awarded time off in lieu (TOIL) or additional payment where TOIL cannot be accommodated.

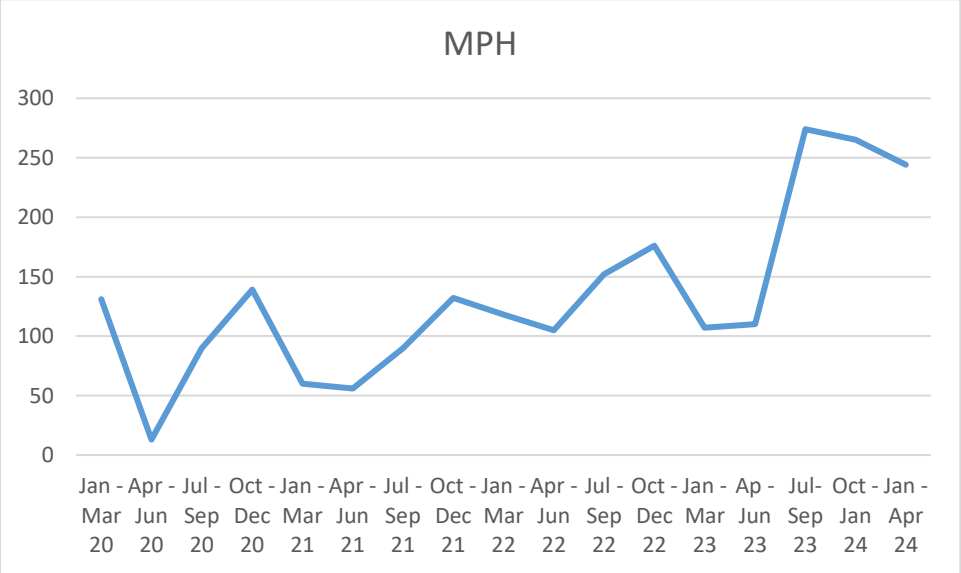
2. EXCEPTION REPORT DATA

Number of doctors/dentists in training on 2016 TCS (total):	424
Job plan allocation for Guardian of Safe Working: (1.5 legacy SFT, 1 YDH)	2.5 PAs
Job plan allocation for Educational Supervisors per trainee:	0.125 PAs

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

2.1. As of 12/01/2024 - Total of exception reports since implementation of 2016 TCS (December 2016). 3307 for Taunton and for Yeovil 1489. The overall cost of exception report overtime is £93,426.17

Figure 1 Quarterly total for exception reporting



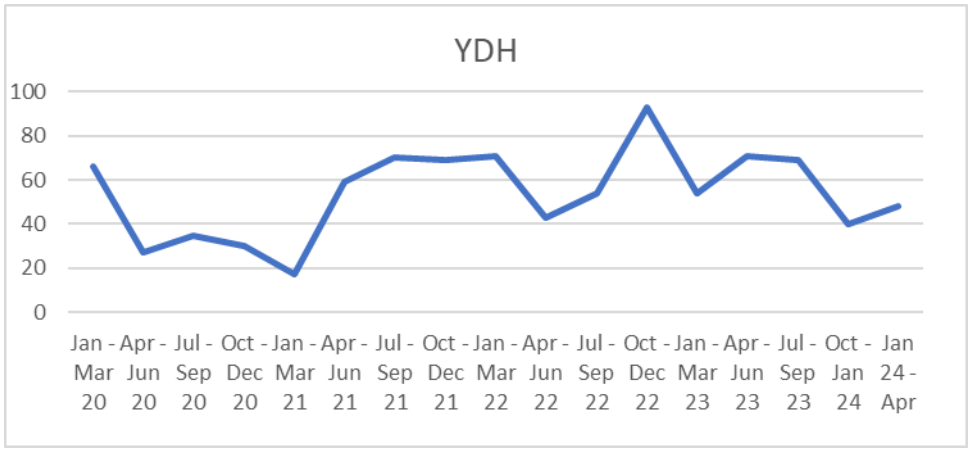
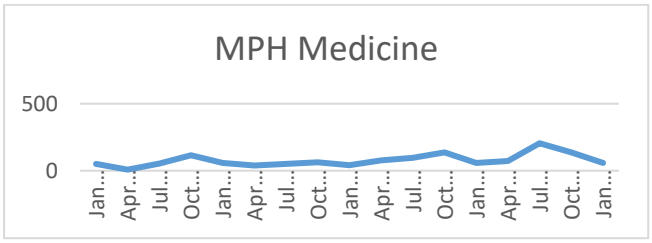
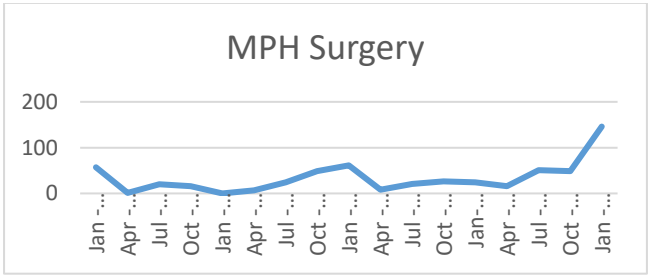
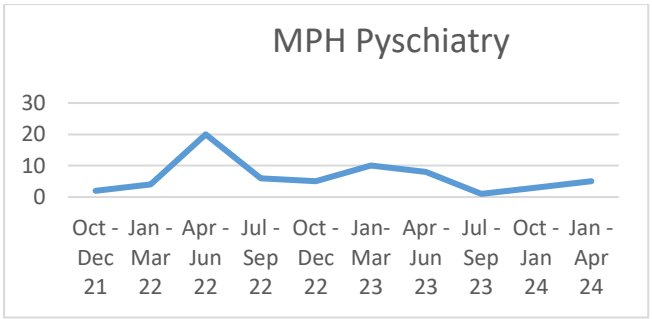
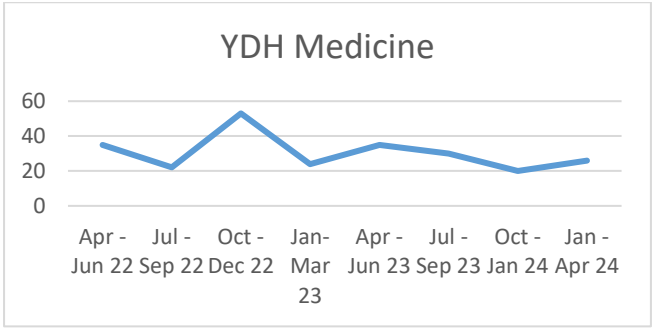


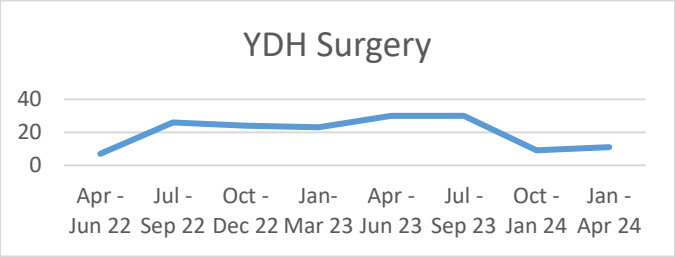
Figure 2 Exception Report Trends by Specialty











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

Table 1: Exception reports per specialty

Specialty	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**	**Type**
Acute & General Medicine	MPH 65 (137) YDH 25 (20)	35 17	30 8	Hours MPH 56 YDH 22 Educational MPH 6 Service Support YDH 3 Pattern YDH 1
Anaesthetics	1 *(0)*	1	0	Pattern MPH 1
DCT Trainees	0 *(0)*	0	0	
Emergency Medicine	MPH 2 (3) YDH 1 (0)	2	0	Hours 2 MPH 1 YDH
ENT	0 *(10)*	0	10	
General Surgery	MPH 146 *(49)* YDH 11 (9)	112 11	34 0	Hours YDH 6 MPH 143 Pattern MPH 1 Educational MPH 2 YDH 5
O&G	MPH 9 (1) YDH 0 *(1)*	1 0	8 0	Hours MPH 9
Oncology/ Haematology	MPH 3 *(1)*	0	3	Hours MPH 3
Paediatrics	MPH 13 *(10)*	7	3	Hours MPH 13 Pattern MPH 1
Psychiatry	MPH 5 *(3)*	2	3	Hours MPH 3 Pattern MPH 2
Trauma & Ortho	MPH 0 *(5)* YDH 11 (10)	0 11	0 0	Hours YDH 11
Urology	MPH 0 *(6)*	0	0	
Vascular	0 *(0)*	0	0	
Total	**292**	**198**	**94**	

Table 2: Exception reports per trainee grade

Grade of trainee	No. exceptions raised Taunton	No. exceptions raised Yeovil
F1	117	33
F2	18	12
CT1-2 / ST1-2	103	3
ST3+	6	0
Total	**244**	**48**

Locum Agency and Bank Spend to cover Post Graduate Doctors in Training

Division	Pay Gross (No VAT)	Commission Gross (No VAT)	VAT	Booking Gross (No VAT)
CYP & Families Services	£330,443.82	£25,114.48	£36,454.94	£400,997.12
Medical Services	£1,469,789.43	£104,010.23	£157,716.52	£1,717,958.33
Medicine	£63,479.12	£5,344.00	£5,567.99	£74,293.07
Mental Health and LD	£315,139.80	£28,415.55	£22,385.32	£377,063.70
Neighbourhood Services	£23,820.00	£1,985.00	£5,161.00	£25,805.00
Primary Care & Neighbourhoods	£261,099.76	£21,130.40	£41,989.88	£304,627.93
Surgical Services	£149,500.37	£9,066.00	£5,155.30	£176,851.29
Grand Total	£2,613,272.29	£195,065.65	£274,430.95	£3,077,596.44

Qualitative summary of exception reports

2.3. Uptick in exception reports generate at Taunton from surgery this quarter which has historically had a stable number. This will be monitored going forward. Most generated from an out of hours issue that arose and took a while to be resolved within surgery. Others relate to overtime. Exception reports in medicine appear down in absolute numbers as we come out of winter months which we see on historical trends.

Immediate safety concerns (ISCs)

2.4. No ISC at Yeovil.

2.5. Single ISC generated at Taunton AMU night shift due to a rota gap that was not filled, a busy shift due to multiple unwell patients, including the need for the Registrar to help out on the wards. F1 felt unsupported on AMU and unsafe. TR to discuss with rota coordinator on the nature of the rota gap and ways to mitigate against this in the future.

Fines

2.6. No fines were issued during this quarter.

Work schedule reviews

2.7. There were no work schedule reviews this quarter.

3. ISSUES ARISING

Postgraduate Doctor Forum (PDF)

3.1. Yeovil continues to provide a monthly forum which is well attended. The most recent meeting discussed learning opportunities and the subject of virtual teaching sessions when off-site was raised with associated exception reports. The education team feels strongly that remote teaching via Teams is not productive or well engaged by students and declined to reinstate this. We also reflected on a questionnaire on induction processes and quality of teaching, with advice given on teaching leads for each sub-specialty.

3.2. Taunton conducts quarterly PDFs. We did discuss increasing the frequency to be inline with Yeovil, and conducted a poll of junior doctors. There was no appetite for increasing the frequency at this stage so quarterly forums will continue. We discussed the obvious increase in exception reports generated around August changeover. The feeling was reduced efficiency was due to administrative tasks and finding and implementing protocols. We will look at a way of having a bank of information to easily find protocols etc. TR reminded juniors to agree/disagree with exception reports and close off exception reports to 'complete the loop'.

Rota management

3.3. At Yeovil issues were raised about new F1s starting on nights and weekends, this will be reviewed and checked at the next handover period.

Weekend working

3.4. We discussed the low exception reports generated on weekends in Taunton at our JDF – the main barriers were not wanting to stay late to complete exception reports. New software may alleviate this issue.

4. SUMMARY

4.1. Yeovil continues to benefit from an increase in junior doctor staffing with exception report numbers continue on a low trend in all sub-specialties, 48 this quarter, below average since 2016 (50). The majority are coming from F1s, and the forums are helpful to review any concerns raised.

4.2. Exception reports generated from Taunton remain high but have reduced this quarter. We have seen an uptick in exception reports from general surgery which will be monitored. One would hope with continued recruitment into the clinical fellow program, and with an increase in staff numbers, exception reports will reduce.

5. RECOMMENDATIONS

5.1. Yeovil will continue monthly JDF which helps discuss ideas and concerns raised. Taunton will continue with quarterly JDFs.

5.2. Junior doctors were reminded at JDF to close off exception reports – strictly speaking overtime payment should not be issued unless PG doctor has agreed with outcome and closed exception report.

5.3. Uptick in exception reports at Taunton in general surgery. Most due to overtime, but some because of an out of hours issue which should now be resolved. Numbers will be monitored going forwards.

5.4. Low numbers of exception reports generated at weekends may be resolved by NHS@work software which may help automate a lot of the exception report data. Expectation that exception report numbers may increase when software is implemented.

Tom Rees and John McFarlane Guardian of Safe Working