SOMERSET NHS FOUNDATION TRUST
PUBLIC BOARD MEETING

A Public meeting of the Somerset NHS Foundation Trust Board will be held on **Tuesday 2 July 2024** at **9.00am** in the Wheeldon Room at the Westlands Entertainment Venue, Westbourne Close, Yeovil, Somerset, BA20 2DD.

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 7 May 2024**	Approve	Chairman		Enclosure A
4.	**Minutes of the Extra-Ordinary Somerset NHS Foundation Trust's Public Board meeting held on 4 June 2024**	Approve	Chairman		Enclosure B
5.	**Minutes of the Extra-Ordinary Somerset NHS Foundation Trust's Public Board meeting held on 25 June 2024**	Approve	Chairman		Enclosure C
6.	**Action Logs and Matters Arising**	Review	Chairman		Enclosure D
7.	**Registers of Directors' Interests and Receive any Declarations of Interests relating to items on the Agenda**	Note and Receive	Chairman		Enclosure E
8.	**Chairman's Remarks**	Note	Chairman	09.10	Verbal
9.	**Fit and Proper Person Test Report**	Receive	Chairman	9.15	Enclosure F

10.	**Chief Executive and Executive Directors' Report**	Receive	Peter Lewis	09:20	Enclosure G
ALL OBJECTIVES					
11.	**2024/25 Q1 Board Assurance Framework and Corporate Risk Register Report**	Receive	Phil Brice	9.30	Enclosure H Enclosure I
OBJECTIVE 2 – Provide the best care and support to people					
12.	**Care Quality Commission Maternity Services Inspection Report and Action Plan**	Receive	Phil Brice	9.45	Enclosure J
13.	**Assurance Report of the Quality and Governance Assurance Committee meeting held on 29 May 2024**	Receive	Jan Hull	10.05	Enclosure K
14.	**Learning from Deaths Framework: Mortality Review Progress Report**	Receive	Melanie Iles	10.10	Enclosure L
OBJECTIVE 6 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture					
15.	**Assurance Report of the People Committee meeting held on 14 May 2024**	Receive	Kate Fallon	10.20	Enclosure M
Coffee Break - 10.25 – 10.40					
OBJECTIVE 4 – Reducing Inequalities					
16.	**Patient Story – "Gaining Control – delivering a patient and family centred approach to haematology care"**	Receive	Gail Rawbone/ Toni Hall	10.40	Verbal
OBJECTIVE 6 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture and OBJECTIVE 4 – Reducing Inequalities					
17.	**Inclusion Progress Report**	Receive	Phil Brice/ Isobel Clements	11.10	Enclosure N
OBJECTIVE 8 - Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies					
18.	**Quality and Performance Exception Report**	Receive	Pippa Moger	11.25	Enclosure O

OBJECTIVE 7: To live within our means and use our resources wisely					
19.	**Finance Report**	Receive	Pippa Moger	11.45	Enclosure P
20.	**Standing Financial Instructions and Standing Orders – Procurement Changes**	Approve	Pippa Moger	12.00	Enclosure Q
21.	**Verbal report from the Finance Committee meeting held on 24 June 2024**	Receive	Martyn Scrivens	12.10	Verbal
FOR INFORMATION					
22.	**Follow up questions from the Public and Governors**		Chairman	12.15	Verbal
23.	**Any other Business**		All		Verbal
24.	**Risks Identified**		All		Verbal
25.	**Evaluation of the Effectiveness of the Meeting**		Chairman		Verbal
26.	**Items to be discussed at the Confidential Board Meetings** The items presented to the Confidential Board include:				
27.	**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.				
28.	**Date of Next Meeting** Tuesday 3 September 2024			12.30	

PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 7 MAY 2024 IN THE SEMINAR ROOM AT MINEHEAD COMMUNITY HOSPITAL, LUTTRELL WAY, MINEHEAD, SOMERSET, TA24 6DF

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
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)
Hayley Peters	Chief Nurse
Melanie Iles	Chief Medical Officer

IN ATTENDANCE

Kirstie Lord	Assistant Director People Services
Katey Davis	Specialist Screening Nurse, LD (for item 15)
Marwisa Matsitsiro	Cancer Screening Nurse, LD Team (for item 15)
Emma Clift	Specialist Occupational Therapist, LD East (for item 15)
Lorna Jones	Primary Liaison Nurse, LD (for item 15)
Sally Bryant	Director of Midwifery
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); Tina Oakley (Associate Non-Executive Director (non-voting)) and Isobel Clements (Chief of People and Organisational Development).

2. QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS

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

3. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 5 MARCH 2024

3.1. Paul Mapson proposed, Jan Hull seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 5 March 2024 2024 as a correct record.

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

4.1. Graham Hughes proposed, Martyn Scrivens seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 18 March 2024 as a correct record.

5. ACTION LOGS AND MATTERS ARISING

5.1. The Board received the action log and noted that the comments relating to the learning from deaths framework report had been fed back to the team for consideration in future reports.

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

6.1. The Board received the Register of Directors' interest and no changes to the register were received.

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

7. CHAIRMAN REMARKS

7.1. The Chairman advised that the Non Executive and Executive Director performance reviews had been completed. Objectives over the last few years had very much focussed on the mergers and objectives for 2024 will need to refocus on the vision going forward. It was noted that an overview of the trust's vision will be presented to the June 2024 Council of Governors meeting.

8. CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS REPORT

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

8.2. The Chief Executive particularly highlighted the “Preventing Future Deaths” report and advised that a Regulation 28 Notice had been issued. The Trust will have 56 days from the date of the issue of the report to respond to the points set out in the notice and to provide assurance that the points raised had been addressed.

8.3. The Chief Executive further highlighted: the staff survey results; the Somerset’s Commitment to Carers; the report on health inequalities in 2040; and the awards.

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

- The year one post merger evaluation report will be presented to the June 2024 Board Development Day and the meeting will be attended by NHS England representatives. A further year two review will be produced in 2025. It was noted that progress against the finance and quality governance action plan will also be presented to the June Board Development Day.

- ED performance for March was 79.6% and it was queried whether this performance related to just acute services or included MIU performance. It was noted that this figure reflected performance by type 1 units but did not reflect type 1 attendances. This distinction was made due to the different ED configurations in the country with not all areas having access to MIUs resulting in more patients being seen in their ED services. It was recognised that this differentiation made it more difficult to compare performance but the total measure tried to show performance on a like for like basis.

  The Chief Executive advised that the trust compared well in terms of national benchmarking and the Somerset system was the third best performing system in the country.

  It was queried whether this ED performance was as a result of additional work and if so, whether lessons have been learned so that performance can be maintained. The Chief Executive advised that the higher level of focus on ED services had made a difference. Performance for April 2024 has been maintained at the March 2024 level.

  The Chief Operating Officer agreed that the higher level of focus on meeting the four hour ED target had made a difference but felt that it will not be possible to maintain this level of focus on an ongoing basis as this could impact on performance in other areas. The Chief Operating Officer advised that patient flow out of ED remained a considerable factor impacting on performance and one of the options which could be considered was to look at co-locating an urgent treatment centre at the front door. He reassured the Board that all ED colleagues were committed to maintaining this level of performance.

  It was stressed that the human aspect relating to ED performance must not be forgotten and, if a patient had to wait on a trolley for some time for a bed to become available, every effort will need to be made to ensure that they are as comfortable as they can be during their wait. A deep dive of ED services will be presented to the Quality and Governance Assurance Committee and the

Committee had previously also discussed the patient flow challenges and actions being taken.

The Chief Nurse highlighted the considerable pressures and patient flow issues at Yeovil District Hospital and advised that work was taking place to reduce these pressures.

The Chief Operating Officer advised that the high number of patients in ED, specifically at YDH, was a concern. Some of the issues experienced in EDs related to mental health and children and adolescents mental health services (CAMHS) but due to the benefits of the merger and the work on the mental health and CAMHS services pathways long mental or CAHMS related waits were now rare.

9. BOARD ASSURANCE FRAMEWORK AND Q3 2023/24 CORPORATE RISK REGISTER REPORT

Board Assurance Framework (BAF)

9.1. The Director of Corporate Services presented the report which was received by the Board. He advised that it had been intended to present the 2024/25 BAF to the May Board meeting but this will now be presented to the July 2024 Board meeting following the review planned for the strategic session.

9.2. The Director of Corporate Services highlighted the key risks on the BAF which continued to relate to: workforce shortages; core numbers of junior and consultant medical workforce; access to primary care/increased ED demand; lack of pace of system-wide changes to address deficit; and insufficient capacity to meet demand. Five out of the eight strategic objectives showed risk appetite levels beyond the levels agreed for these objectives. It was noted that the risk appetite statements will be discussed as part of the strategic session.

Corporate Risk Register

9.3. The Director of Corporate Services presented the report which was received by the Board. The highest areas of risk on the register related to: pressures in social care, intermediate care and primary care; insufficient capacity to meet demand; workforce recruitment and retention; ageing estate – acute and community; and financial position. Details of these risks, as well as changes in risk levels, and new risks were set out in the report.

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

- the strategic objectives allocated to the People Committee, Finance Committee and Quality and Governance Assurance Committees had been reviewed at their recent meetings.

- There were a total of 30 risks on the CRR of which seven scored 20 or above. A detailed deep dive into medical workforce had been undertaken at the recent People Committee meeting and the level of risks had been reduced in

view of the mitigations put in place. The risk in relation to a failure to deliver the financial plan had now been reduced to 20.

- The Quality and Governance Assurance Committee had undertaken a deep dive into pressure ulcers and further assurance had been received. It was recognised that this was a difficult area to resolve.

- The risk register did not take account of the findings of the recent Care Quality Commission inspection of maternity services and any resulting risks will be considered after the inspection report has been published.

- A new risk had been included relating to delays to core system upgrades. Although it had been anticipated to phase system upgrades, this had not been possible due to supply and capacity issues. Upgrades will be rolled out over the next three months. The highest risk relating to the replacement of the pathology lab ordering system as this will impact on all systems, including on primary care systems. Plans for the upgrades were being developed and the business continuity process will be activated within the next few weeks. The Director of Strategy and Digital Development advised that the upgrades were essential and did not conflict with the longer term electronic health record objective.

- The risk relating to the unsafe number of ED attendances had reduced from 25 to 20 but elsewhere in the report the risk relating to ED overcrowding had increased from 16 to 20 and this seemed at odds for seemingly similar risks. The Chief Nurse advised that these were high level risks and significant details will be underneath these risks. She expected that these risks related to the two different acute sites. With the move to a single risk management system it will now be easier to see all risks and combine risks where needed.

- Devolved governance was a fantastic principle but this could lead to similar risks for different service areas and these risks will need to be combined on the risk register. It was recognised that further work on devolved governance and understanding where risks can be managed, and that the corporate risk register was used appropriately, will be required.

- The People Committee had received significant assurance about medical workforce recruitment but it was recognised that some specialties will always be more difficult to recruit to than other areas. International recruitment had now been extended to include medical recruitment but retention will need to be a key area of focus.

  The Chief Operating Officer highlighted the following questions which will need to be considered: can the process be improved in terms of recruitment and markets for recruitment; can the process itself be simplified; can the process in operational services be carried out in a different way; is the skills mix configuration correct; and have lessons learnt be identified. It was highlighted that it was particularly difficult to recruit rheumatology consultants and this will be taken forward as part of the productive care programme.

- The requirement to reduce overall workforce numbers nationally was highlighted and it was commented that this may require a change in attitude relating to redevelopments and transformation. Going forward, it may be more challenging to recruit new people into new environments.

- Assurance about new medical student numbers will need to be sought from the deaneries and the trust will need to ensure that there are sufficient students and that they are placed in services where there was a workforce gap. The Chief Medical Officer advised that the number of medical students coming through the medical schools was increasing but there was pressure on students to go to the Exeter medical school and this could impact on the trust. An extra six F1s have been placed this year but it was not always possible for students to be placed in areas with medical workforce gaps. The Chief Executive advised that the short term challenge was to have sufficient capacity to support medical students from the two universities. The number of students will further increase from 2026. Although it was recognised that more medical students were required, there was currently not the infrastructure and medical staff to support more students.

10. ASSURANCE REPORT OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING HELD ON 27 MARCH 2024

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

- The discussion in relation to the risk appetite levels and the recommendation for the risk appetite and risk tolerance levels for the strategic objectives allocated to the committee to remain at their current levels.

- The positive and negative assurance in relation to maternity services, including the ongoing work and challenges in relation to the triage process at Musgrove Park Hospital.

- The surgical services assurance report.

- The decontamination lead arrangements.

- Estates and Project Safety

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

- Considerable work was taking place in relation to the implementation of the triage process. Sally Bryant advised that the triage service had now been launched at Musgrove Park Hospital and women were now receiving evidence based risk triage. She set out the details of the triage process and advised that the service had been launched using posters and social media posts. Sally Bryant further advised that safety walkrounds had been carried out and feedback indicated that staff were happy with the new triage

process and that women felt that they were receiving good care. Sally Bryant recognised that further work was required, but the launch of the service was a positive step forward.

- There remained considerable pressures and risk in maternity services, some of which were due to the environment. It was queried whether further information on progress in relation to the New Hospital Programme and the build of a new maternity unit was available. The Director of Strategy and Digital Development advised that, pending confirmation of the New Hospital Programme, site maintenance clearance and site enablement work can be carried out and a business case for this work was being prepared. It was expected that the business case will be presented to the Board for approval by September 2024. It was expected that a positive planning determination for the first phase – the new multi-storey car park - will be received soon.

  The Director of Strategy and Digital Development set out the challenges as a result of the constant moving timeline as well as changes within the national New Hospital Programme team. The national programme business case had been presented to the Business Review Group and this will enable the programme to move to its next phase. Confirmation of the approval of the programme was awaited as well as confirmation what this approval meant in terms of releasing funding and timescales for the programme.

  The Director of Strategy and Digital Development further highlighted the updating of the Strategic Outline Case (SOC) and the work in relation to the assurance process. Elements of the SOC will need to be reviewed on an ongoing basis until September/October 2024 when the work will progress to the development of the Outline Business Case (OBC). There was concern that the timeline kept changing which will result in an increase in the overall funding requirement.

16. ASSURANCE REPORT OF THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON 19 MARCH 2024

16.1. It was agreed to bring this item forward on the agenda.

16.2. Alexander Priest presented the report which was received by the Board. He 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:

- Mental Health Act assessments – an audit had been carried out and a shared interface group with the Local Authority had been set up.

- Right Care Right Person – an internal steering group to assess the impact of Right Care Right Person had been set up.

16.3. The Chairman thanked Alexander Priest for the update and thanked the Committee for its work.

13. ASSURANCE REPORT OF THE PEOPLE COMMITTEE MEETING HELD ON 12 MARCH 2024

13.1. It was agreed to bring this item forward on the agenda.

13.2. Kate Fallon, Chairman of the People Committee, presented the report which was received by the Board. The risk relating to the overall establishment against the workforce cap and the financial impact on the overall financial position had been identified as an area to be reported to the Board.

13.3. Kate Fallon advised that the Committee had observed mixed signals about workforce. Hearing from colleagues about their experiences provided significant assurance and significant learning was being identified as part of the colleague stories. One of the suggestions expressed at the meeting related to medical recruitment and the need to be a more flexible employer and accommodate the need of people where appropriate. It was further commented that middle managers should act more flexibly and be enabled to make changes in the best interest of their service.

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

- The establishment against the workforce cap and the financial impact on the overall financial position will need to be reviewed by the People Committee but also by the Finance Committee, and, where necessary, the Quality and Governance Assurance Committee. It was noted that cover across the Finance and People Committees had now been set up to provide clear links between the committees and in addition, the level of information to be provided to the committees had been agreed. This information will enable the committees to clearly triangulate workforce and financial information. It was stressed that, where needed, triangulation should also take place at the Quality and Governance Assurance Committee.

13.5. The Chairman thanked Kate Fallon for the update and thanked the Committee for its work.

20. ASSURANCE REPORT FROM THE CHARITABLE FUNDS COMMITTEE MEETING HELD ON 26 JANUARY 2024

20.1. It was agreed to bring this item forward on the agenda.

20.2. Graham Hughes, Chairman of the Charitable Funds Committee, presented the report which was received by the Board. He highlighted the areas of assurance received and particularly highlighted: the £25,000 donation to each acute site from the Glastonbury Festival; the £351,000 legacy; the transfer of £770,000 from the current account to the investment account; and the development of the fundraising policy.

20.3. Graham Hughes advised that no areas for follow up or areas to be reported to the Board had been identified.

20.4. The Chairman thanked Graham Hughes for the update and thanked the Committee for its work.

12. QUALITY AND PERFORMANCE EXCEPTION REPORT

12.1. It was agreed to bring this item forward on the agenda.

12.2. The Chief Finance Officer presented the report which was received by the Board. She highlighted the areas of good performance and provided an overview of the key performance challenges across the trust. The key areas of under-performance against targets and areas of concern related to: No Criteria to Reside within acute beds which continued to impact on patient flow; the percentage of people waiting under six weeks for a diagnostic test; and the percentage of ambulance handovers completed within 30 minutes of arrival at the Emergency Departments.

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

- The trust was an outlier nationally and regionally in relation to the number of no criteria to reside beds. The position had improved over the last few weeks but a number of immediate actions will need to happen to be able to make a significant impact on the position and some of these actions will come at a cost.

- Mental health performance was excellent especially considering the 30% increase in activity levels on a year by year basis. The trust was historically one of the best performing trusts in relation to inappropriate placements out of area but the number of days spent in inappropriate placements had increased since February. One of the reasons related to a patient not being appropriate for placement on the mixed sex PICU but a further patient was now waiting for high secure care. It was queried whether there were plans for a PICU ward.

  The Chief Operating Officer advised that it was unusual to operate a mixed sex PICU ward but due to the small number of female patients requiring a PICU it was difficult to provide a female only PICU. In terms of actions being taken, where appropriate, a partnership with the South West Provider Collaborative will be considered and a new strategy for managing patients with complex needs had been drafted. Consideration was being given to opening a new high care unit in Yeovil and combine this with the new approach to managing patients with complex needs. A percentage of patients with complex needs will be women and consideration can be given whether it will be possible to maximise the number of women in a PICU. If a female PICU was not viable, private care outside of Somerset remained an option but this was not a preferred option as the trust was not in control of care provided privately. The new opportunities on the Summerlands site in Yeovil will need to be reviewed.

- The majority of stroke patients were not admitted to stroke beds but it was noted that the stroke figures included patients admitted with stroke like

symptoms. As a stroke diagnosis remained a possibility patients had to be treated as having a stroke until a stroke diagnosis had been ruled out.

- YDH had increased theatre efficiency for dental surgery for children resulting in an increase in the number of children treated in each session and it was queried whether lessons had been identified and whether further efficiencies can be achieved. The Chief Executive advised that this related to the use of YDH theatres for community dental services but YDH did not provide a significant number of sessions. Some lessons had been learned about the logistics getting patients from the community into YDH. Due to the way theatres were configured, they were not always used to their full potential.

  The Chief Operating Officer further advised that work was taking place with some specialities around theatre efficiency. In relation to dental services, the majority of the patients had complex dental issues and, in view of the psychological impact on children, it was important to make as best use of theatre time as possible. It was however also essential for more theatre capacity to become available in Dorset. It was suggested that this would be a good topic for a deep dive by the Quality and Governance Assurance Committee.

- Infection control performance was good but C.Diff numbers showed an increase despite a low usage of antibiotics. The Chief Nurse advised that performance was in line with other trusts and all C.Diff incidents were reviewed for learning. There were no concerns about the usage of antibiotics within the hospitals and the increase in the number of C. Diff incidents was not fully understood other than that this followed a national trend. The Chief Nurse suggested to further review this at the Quality and Governance Assurance Committee.

- The number of falls resulting in moderate harm showed an increase at YDH and this will need to be kept under review.

- Pressures ulcer data for February and March 2024 was not available due to the need to validate the data. This data will be included in the next report.

- It was queried whether data on the storage of medicines at YDH was available and, if not, how assurance can be obtained that medicines were stored correctly. The Director of Corporate Services advised that this data was not historically collected but the Chief Pharmacist will be attending the Quality and Governance Assurance Committee to discuss medication incidents and this can be extended to include medicine storage issues at MPH and YDH.

- The reference to a threshold of expected infectious disease cases was felt to be misleading and not a sound measure. It was suggested that a trendline would provide a more accurate picture of performance. It was queried whether there was an aspiration to eradicate E.Coli infections and, if is, why the target was not more ambitious.

- It was queried whether having limited NHS dental services in Somerset and Dorset created unmet needs and therefore impacted on the waiting list for children requiring dental surgery. The Chief Operating Officer advised that he was not aware of evidence in this respect but recognised that it was difficult to access NHS dentistry in Somerset and in other parts of the country. The Chief Executive advised that there was a link between deprivation and inequalities and child dental health and it was essential to focus on health inequalities. It was suggested that the waiting list was reducing as young children and teenagers were not visiting dentists and therefore did not get onto the waiting list. The Chief Executive advised that health inequalities was part of the population health agenda which was being taken forward by the Somerset Integrated Care Board (ICB).

  It was highlighted that the dentistry allocation has been underspent for the last two years and it was noted that there was a national underspend due to patients not being able to access services. It was agreed that not spending money on preventing dental decay in under 5s was a missed opportunity. The Chief Operating Officer advised that the ICB and Local Authority had set up a working group to explore this in more detail and identify opportunities to work together.

14. SIX MONTHLY HEALTH AND WELLBEING GUARDIAN REPORT

14.1. It was agreed to bring this item forward on the agenda.

14.2. Graham Hughes, Non-Executive Director wellbeing champion, presented the report which was received by the Board. He particularly highlighted:

- The NHS staff survey results which indicated that colleagues with long term conditions appeared at greater risk in terms of their overall wellbeing; that allied health professionals across the trust and colleagues in nursing and midwifery and mental health and learning difficulties services were represented as more highly at risk of burnout; that new colleagues or those from a younger age category were at greater risk of burnout; and that colleagues from a BME background reported more MSK problems. Further work will be required to understand the implications and causes which can be used to inform future strategy development for the trust.

- The top three reasons for sickness absence and the actions being taken including at service level.

- Areas to highlight: the high demand in P4U physiotherapy services; the waiting list in the colleague support service; the need for multi-purpose spaces for taking breaks, holding confidential and wellbeing interventions.

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

- The sign up to the Sexual Safety Charter.

- That overall sickness absence due to S10 – anxiety/stress/depression/other psychiatric illnesses – had flatlined overall but remained high in mental health and community services. A waiting list for colleague support services was a concern and it was queried whether additional funding was available to provide additional psychiatric support. Kirstie Lord advised that the causes of stress were not fully understood and a deep dive into the data was being undertaken to understand the drivers for this sickness absence. Investment into the colleague support service will be ongoing but the findings of the deep dive will need to be reviewed to be able to identify a solution.

- It was queried whether national work on the management of stress, which would help in terms of understanding the data, was taking place. Kirstie Lord advised that an increase in reporting was quite often accompanied by a focus on the topic and the trust's performance was in line with national performance. Progress was being made in ensuring that colleagues felt safe talking about mental health but no national support in terms of how to address stress in the workplace was available. It was noted that the South West group for health and wellbeing guardians had been disbanded but Graham Hughes was hopeful that the group will be reinstated.

- The Chief Operating Officer advised that during a visit to community mental health teams in the Bridgwater and Taunton areas it became apparent that there had been an increase in referrals from people who in the past would not have classified themselves as having mental health problems. They were now prepared to use language such as anxiety or mental problems and, if this applied to the wider society, it was expected that this also applied to colleagues.

- Service groups now presented progress reports to the Quality and Governance Assurance Committee and it was heartening to see that the reports covered health and wellbeing of the team or service. This focus on health and wellbeing had not previously been seen in reporting.

- Mental health and MSK issues were two key reasons for sickness absence. Work was taking place nationally on accessing treatments on the NHS app at an early stage.

- It was queried whether resilience training was being considered. Kirstie Lord advised that there was no evidence that training was a key solution. Colleagues within the trust covered multi generations and an area of focus for 2024 was understanding the needs of the different generations. In addition, a deep dive was being undertaken at service group level to understand the people issues and this will help to provide greater assurance about the actions being taken at service group level.

  It was agreed that there were many factors impacting on health and wellbeing and resilience was a different issue. The NHS was a different place to work in and capacity issues were a key challenge. Colleagues may not be as resilient but workloads and capacity issues in acute services was complex. It

was stressed that irrelevant of the approach taken, the key focus should be on what makes a difference.

14.4. The Board thanked the wellbeing team for their excellent work and further thanked Graham Hughes for his continued focus on wellbeing.

15. PATIENT STORY - FACING THE OUTSIDE AND FINDING MY FEET

15.1. It was agreed to bring this item forward on the agenda.

15.2. Katey Davis, Marwisa Matsitsiro, Emma Clift and Lorna Jones joined the meeting for this agenda item. They highlighted the story of Stephen, a 69 year old patient who was diagnosed with moderate learning disabilities at birth. Stephen had autism, type 1 diabetes, non functional hearing, and was unable to communicate verbally. Katey Davis highlighted Stephen's poor living conditions, the lack of proper furniture and his resulting pressure sores; his risks of UTIs and sepsis; and the misunderstanding by carers as a result of them not understanding his communication issues and learning disability condition. Stephen's physical health had significantly deteriorated over time resulting in him not leaving him room for many months.

15.3. Katey Davis advised that the screening liaison nursing team was an integral part of the community learning disability service providing a specialist service to people with a learning disability.

15.4. Lorna Jones shared an overview of Stephen's journey by Thomasz, Locality Manager for Dimensions, and advised that Stephen's journey with the team started in October 2023 to assist him in accessing diabetic retinopathy screening. By that time he had been housebound for 12 months which had impacted on his health. The team who visited Stephen at the home to take him to a diabetic retinopathy appointment were upset about his situation and a safeguarding referral due to neglect was acted upon immediately. Following a conversation with his GP, Stephen was admitted to MPH with sepsis. Following his stay at MPH, Stephen returned to his care setting but, thanks to a newly appointed locality manager, measures had been put in place to ensure his safety and continued support with his ongoing physical challenges. Arrangements had been put in place to enable him to communicate with staff, his room had been cleaned and carpet replaced. A shower was due to be installed in the next week.

15.5. The diabetic retinopathy screening was completed successfully with Katey provided him with support and ensuring that reasonable adjustments had been made. Katey Davis advised that she continued to support Stephen following his discharge and conducted a further four visits to complete the screening process. She highlighted the significant improvements to Stephen's living situation but also to his personal care.

15.6. Katey Davis advised that a quality assurance review of the care setting had been carried out by social services and it was recognised that the home had made significant improvements.

15.7. The screening service had supported 51 patients all of whom had successfully completed their screening and this was an excellent achievement and thanks to the work of the team. Katey Davis advised that the national screening uptake by people with learning disabilities was 45% and thanks to the engagement and hard work by the team, the trust was now achieving an uptake of 50%. Every effort will continue to be made to further increase the uptake.

15.8. Katey Davis concluded by thanking the Board for listening to the story and asked for people with learning disabilities to be recognised when attending acute services as they want the same access to health services as all other patients.

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

- The story was very moving and sad to listen to.

- The presentation clearly showed that colleagues, who by seeing and challenging things that are not right, and by advocating for people who cannot advocate for themselves, are able to make improvements. Excellent services were now provided and the team was thanked for their excellent work.

- It was queried whether the safeguarding issue had triggered a Care Quality Commission (CQC) review. Katey Davis advised that a CQC review had not taken place for some time due to Covid. A quality assurance review had highlighted some issues and these were resolved within 24 hours. A new locality manager had been appointed and all patients were now able to access the required health care.

- It was queried whether it was part of the team's role to encourage all screening services to make reasonable adjustments as part of their standard practice. Katey Davis advised that she was working closely with all screening teams and in particular the breast and bowel screening teams were already doing excellent work. Patients with learning disabilities were less aware of their bodies and may not come forward with any symptoms.

- Improvements will be required at primary care level as 26 of the GP practices were not engaging with the screening service. A large number of GPs still viewed learning disabilities as a mental health issue and on one occasion downs syndrome had been listed as the cause of death on a death certificate. Reasonable adjustments will be required both in terms of needs and language used. If GPs are able to register their patients more accurately on a learning disability register, this will help. The Chief Executive commented that it was not acceptable that 26 of the practices did not engage with the service.

- The age threshold for screening programmes will need to change as people with learning disabilities had a lower life expectancy due to physical health care issues not being identified at an early stage. Katey Davis advised that a change in thresholds had been requested but in the absence of a national change in pathways, pilots can be undertaken e.g. for lung screening or infections, and local pathways can be adjusted where needed. Katey Davis advised that she had spoken with local teams about setting up

pilots. She highlighted that there had been seven deaths of people with learning disabilities in the last year due to bowel cancer and screening will help to provide treatment as early as possible.

- Katey Davis advised that data should be closely monitored – people with learning disabilities were dying 20 years earlier due to a lack of access to health care and screening and learning disabilities was not a cause of death.

- Concerns were raised that the primary care learning disability registers were not up to date as considerable work on registers had taken place during the covid vaccination programme.

- The governance arrangements for the care provider were a concern and any packages of care should be subject to an annual review by the Local Authority. It was queried whether there was a relationship between the Local Authority and the team in relation to annual reviews. Katey Davis advised that Stephen had 12 hours of care, most of which were used for his diabetic management. She did not have details on how this care was used as giving insulin itself did not total up to 12 hours. She advised that the team was not provided with access to details of the care package. Any questions from the team had to be directed to the adult social care team. It was noted that the team did have access to RiO.

- There was a focus on annual health screening in Sedgemoor and although screening was a good start, it was known that people with learning disabilities had poor access to health care. She was personally committed to improving the life expectancy for people with learning disabilities. She felt that if no changes were made, life expectancy for this group of patients will remain at 62.

- Lorna Jones advised that work was being carried out with GPs on the learning disability registers and carrying out annual health checks. She previously worked at a GP practice as a practice nurse and did carry out annual health checks for people with learning disabilities. However, the quality of health checks may not be consistent across all practices and the quality may very much depend on the person carrying out the health check.

- A letter had been received recently about the mandated flagging of people with learning disabilities on all health care systems. This will be followed up with the digital team and the ICB.

- The liaison work with acute nurses was important and an integrated team was in place at YDH. The team was small and a resource gap had been identified. A business case was being prepared.

- Katey Davis reiterated the excellent work taking place, including the work with village agents and social prescribers.

15.10. The Board thanked Katey Davis and the team for their excellent work and considerable progress made.

11. GUARDIAN OF SAFE WORKING FOR POSTGRADUATE DOCTORS QUARTERLY REPORT

11.1. It was noted that Tom Rees, Guardian of Safe Working – MPH, was unable to attend the meeting due to a clinical emergency and the Chief Medical Office therefore presented the report which was received by the Board.

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

- The Yeovil site will continue with their monthly Junior Doctor Forum meetings (JDF) to help discuss ideas and concerns raised. It was noted that the Taunton site will continue with quarterly JDFs.

- Junior doctors have been reminded at JDFs to close off exception reports and that overtime payment should not be issued unless the Post Graduate doctor has agreed with the outcome and closed the exception report.

- The increase in general surgery exception reports at the Taunton site. It was noted that the majority of the exception reports were due to overtime. The out of hours issue raised in a small number of reports had now been resolved.

- The low number of exception reports generated at weekends may be resolved by the implementation of the NHS@work software which may help automate exception report data. It was noted that there was an expectation that exception report numbers may increase after the implementation of the software.

- The data gave the impression that more senior clinicians did not do overtime and it was queried whether this was correct. The Chief Executive advised that an update had been provided to the recent Operational Leadership Team meeting and it was felt that the reporting from senior clinicians will increase as this reporting will come through different systems. In addition, there was a different culture with more senior clinicians feeling that they do not need to report overtime as part of their post. This lack of reporting did not mean that they did not work over their contracted hours but reflected their perception that they did not need to report this overtime.

- Concerns were expressed that senior clinicians did not report on the quality of their training. The Chief Executive advised that other sources of information to gather that information were available, e.g. the GMC survey. These surveys also provided insight at service level and any concerns were escalated through the deaneries.

17. FINANCE REPORT

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

- The end of year surplus of £23,000 which was a small favourable position compared with the breakeven plan.

- The submission of the draft accounts to NHS England and to the external auditors, and the external audit to be undertaken over the period 29 April 2024 to 28 June 2024.

- The total agency expenditure for 2023/24 of £36.784 million; the total medical locum expenditure of £10.8 million; the reduction in total agency expenditure but the increase in medical agency and medical locums spend compared to 2022/23.

- The delivery of the cost improvement programme of £31.931 million and the delivery of 51% of these savings on a recurrent basis. This level of overall savings was below the target set out in the merger business case but was higher compared to 2022/23.

- The delivery of £79.668 million capital expenditure against a plan of £79.698 million.

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

- The outturn position reflected a significant amount of work all year to mitigate a number of risks and manage a complex financial plan.

- The Board thanked the Chief Finance Officer and the team for the excellent end of year results which had been achieved despite considerable pressures and challenges.

- It was recognised that the management of the 2024/25 financial position will be challenging.

18. VERBAL REPORT FROM THE FINANCE COMMITTEE MEETING HELD ON 29 APRIL 2024

18.1. Martyn Scrivens, Chairman of the Committee, advised that both the finance report and 2024/25 revenue budget report had been included on the agenda as separate items and there was no further feedback.

19. 2024/2025 REVENUE BUDGET

19.1. The Chief Finance Officer presented the report which was received by the Board.

19.2. The Chief Finance Officer advised that the final version of the 2024/25 plan had been approved at the Finance Committee meeting held on 29 April 2024 and had subsequently been submitted to NHS England. She advised that the revenue budget was a summary of the plan and the report set out both the budget at group level and by service group, corporate services and other budgets.

19.3. The total wte reflected in the budget equalled the value of wtes as at October 2023 and reflecting the information in this way was a requirement of the planning submission. Due to the focus on wtes nationally, detailed and robust reporting arrangements will be put in place and data will be included in the monthly finance Board reports.

19.4. The Chief Finance Officer advised that the cost improvement programme (CIP) amounted to £64.3 million and the breakdown of the savings were set out in the report. Services continued to develop their CIP plans using a combination of traditional CIP schemes and productivity and transformational opportunities identified as part of the Productive Care Programme. Progress will continue to be monitored by the Finance Committee.

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

- One of the national priorities was a focus on quality and safety and it was queried whether a system wide process for funding schemes was in place. The Chief Finance Officer advised that an internal process was in place and system wide discussions had also taken place. Some mainly safety related business cases had been approved to proceed. It was noted that some investment will be available.

- The CIP was very ambitious and it was queried whether the same level of recurrent versus non recurrent schemes was being anticipated. It was noted that the schemes had not been fully worked up as yet to be able to determine the level of recurrent and non recurrent schemes. The budget was based on a 50:50 recurrent versus non recurrent split as it was recognised that the productive care programme will take some time to produce efficiencies.

- It will not be possible to spend cash reserves on capital expenditure and capital expenditure is restricted to the system capital financial envelope.

- The inclusion of the column showing the CIP target compared to total spend by service area was welcomed. A comparison against the 2023/24 CIP target and spend will be helpful in identifying trends.

- It was queried how system wide savings will be monitored. It was noted that the SFT CIP performance will be included in the finance report to the ICB Finance Committee alongside the ICB CIP performance. The ICB CIP savings had not as yet been scoped but once performance information was available, this will be presented to the Finance Committee.

- The stretch target was not expected to create an additional burden on the provider or system budget but achievement of this target was expected to be based on transformation and different ways of working.

- Frustration was expressed about the time taken and lack of progress made in respect of identifying the system wide saving requirements. The Chief Executive advised that although the planning process started a few months ago, the numbers in the initial version of the plan, and specifically

the stretch targets, were not deliverable. The system plan had only recently been approved. Further work continued to take place and feedback will be provided to the Finance Committee.

- Progress on the productive care programme will be presented to the Finance Committee as part of the CIP progress report. In view of the transformation work, it will also be helpful to present progress to a Board development day or strategic session.

- It was queried how the plan aligned with other system partner plans and whether the ICB will require other system partners to compliment other partners' plans. The Chief Executive advised that there will be interdependencies and it will be important to capture risks that may impact on the trust's plan and ensure that the interdependencies will be delivered. The ICB has set five key priorities for 2024/25 but details were not yet known.

- The Chief Operating Officer highlighted "no criteria to reside" as one of the priorities and advised that progress was being made. In terms of admission prevention, the trust will be able to work with primary care on working differently which could have a significant impact both from a financial and quality perspective. It will be key to develop a system-wide programme with real deliverables.

- Headcounts will need to be closely monitored and a clear oversight process was in place.

19.6. Martyn Scrivens proposed, Paul Mapson seconded and the Board approved the 2024/25 revenue budget. The Board complimented the Chief Finance Officer and the team on their excellent work in producing the budget.

21. FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS

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

22. ANY OTHER BUSINESS

22.1. There was no other business.

23. RISKS IDENTIFIED

23.1. The Director of Corporate Services advised that areas of risk raised during the meeting related to: dental, including primary care dental services; infection prevention and control; digital; ED; recruitment; wellbeing and stress management; and aspects of the patient story e.g. learning disability register and health care access for people with learning disabilities.

24. EVALUATION OF THE EFFECTIVENESS OF THE MEETING

24.1. The Board agreed that the meeting had been productive. The patient story had been very good with lengthy discussions.

25. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

25.1. 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.

26. WITHDRAWAL OF PRESS AND PUBLIC

26.1. 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.

27. DATE FOR NEXT MEETING

27.1. 2 July 2024

EXTRA ORDINARY PUBLIC BOARD MEETING

MINUTES OF THE EXTRA-ORDINARY SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 4 JUNE 2024 IN THE BOARDROOM AT YEOVIL DISTRICT HOSPITAL, YEOVIL

PRESENT

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

IN ATTENDANCE

Peter Harvey	Matron, Frome Community Hospital
Ria Zandvliet	Secretary to the Trust

1. WELCOME AND APOLOGIES FOR ABSENCE

1.1. Colin Drummond welcomed everyone to the meeting. It was noted that apologies had been received from: Martyn Scrivens (Non-Executive Director); Tina Oakley (Non-Executive Director) and Barbara Gregory (Non-Executive Director).

1.2. It was noted that Peter Harvey was in attendance as he was shadowing Hayley Peters as part of his development programme.

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 EHR business case; update on the New Hospital Programme and approval of the build of a new multi-storey car park.

4. DATE OF NEXT MEETING

4.1. 2 July 2024

EXTRA ORDINARY PUBLIC BOARD MEETING

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

PRESENT

Colin Drummond	Chairman
Paul Mapson	Non-Executive Director
Kate Fallon	Non-Executive Director
Graham Hughes	Non-Executive Director
Martyn Scrivens	Non-Executive Director
Peter Lewis	Chief Executive
Phil Brice	Director of Corporate Services (non-voting)
Andy Heron	Chief Operating Officer
Pippa Moger	Chief Finance Officer

IN ATTENDANCE

Ben Edgar-Attwell	Deputy Director of Corporate Services
Chris Upham	Assistant Director of Finance
Meridith Kane	Deputy Chief Medical Officer
Ria Zandvliet	Secretary to the Trust

1. WELCOME AND APOLOGIES FOR ABSENCE

1.1. Colin Drummond welcomed everyone to the meeting. It was noted that apologies had been received from: Barbara Gregory (Non-Executive Director); Alexander Priest (Non-Executive Director); Inga Kennedy (Non-Executive Director); Tina Oakley (Non-Executive Director); David Shannon (Director of Strategy and Digital Development); Isobel Clements (Chief of People and Organisational Development); Hayley Peters (Chief Nurse); and Melanie Iles (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 2023/24 annual accounts and annual report.

4. DATE OF NEXT MEETING

4.1. 2 July 2024

SOMERSET NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETINGS HELD ON 7 MAY 2024, 4 JUNE 2024 AND 25 JUNE 2024

AGENDA ITEM	ACTION	BY WHOM	DUE DATE	PROGRESS
MEETNG HELD ON 7 MAY 2024				
No actions were identified at the meeting held on 7 May 2024				
MEETING HELD ON 4 JUNE 2024				
No actions were identified at the meeting held on 4 June 2024				
MEETNG HELD ON 25 JUNE 2024				
No actions were identified at the meeting held on 25 June 2024				

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

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

Details: N/A

Equality and Inclusion

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

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

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

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

Public/Staff Involvement History

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

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

Previous Consideration

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

The report is presented to every Board meeting.

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

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

REGISTERS OF DIRECTORS' INTERESTS

NON EXECUTIVE DIRECTORS	
Colin Drummond Chairman	• Honorary Vice President of Calvert Trust Exmoor (outdoor holidays for people with disabilities) – current • President of Wadham College Oxford 1610 Society • Deputy Lieutenant for Somerset • Worshipful Company of Water Conservators – Deputy Master
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 Non-Executive Director	• IJKennedy Healthcare Consultancy - Position - Director (however this Ltd Company is registered as not trading at this time. • Portsmouth Hospitals University Trust - Position - Non-Executive Director (end of term is Mar 24) • Isle of Wight NHS Trust - Position - Non-Executive Director (end of term is Mar 24)
Tina Oakley Non-Executive Director	• Son, Dr Tom Oakley, is Chief Executive Officer of a digital medical imaging company, Feedback plc.
EXECUTIVE DIRECTORS	
Peter Lewis Chief Executive (CEO)	• Member of the NHS Confederation Community Network Board • Management Board Member, Somerset Estates Partnership (SEP) Board • Director, Somerset Estates Partnership Project Co Limited
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 Chief Operating Officer/Deputy Chief Executive	• Wife works for Avon and Wiltshire Mental Health Partnership NHS Trust (and is involved in a sub contract for liaison and diversion services) • Director of the Shepton Mallet Health Partnership • Executive Director for SHS
Pippa Moger Chief Finance Officer	• Stepdaughter works 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:	Fit and Proper Person Annual Submission
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Ria Zandvliet, Secretary to the Trust
DATE:	2 July 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 Fit and proper Person Test (FPPT) Framework was published by NHS England on 2 August 2023 in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT. A report on the changes to the new Fit and Proper Person Framework was presented to the February 2024 Board meeting. This report sets out the actions taken to ensure that Board and deputy director level appointments, meet the requirements of the Fit and Proper Person Framework.
Recommendation	The Board is asked to accept the assurance that all Board members and deputy directors meet the Fit and Proper Persons requirements. The Board is further asked to approve the signing and submission of the Fit and Proper Person Annual Submission to NHS England.

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

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

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

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

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

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
This report has not previously been considered.

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

FIT AND PROPER PERSON ANNUAL SUBMISSION

1. BACKGROUND

1.1. The Fit and proper Person Test (FPPT) Framework was published by NHS England on 2 August 2023 in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT. The Framework takes account of the guidance produced by the Care Quality Commission "Regulation 5: Fit and Proper Persons: Directors Information for NHS Bodies" published in March 2015.

1.2. The purpose of the Framework is to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS.

1.3. The Framework applies to the board members of NHS organisations, irrespective of voting rights or contractual terms. The Trust has chosen to include deputies who will be covering for Board members within the scope of the FPPT Framework.

1.4. A report on the new Fit and Proper Person Framework, setting out the changes to the process and additional requirements, was presented to the February 2024 Board meeting.

2. ANNUAL CHECKS AND SELF-ATTESTATIONS

2.1. The FPPT process was undertaken during May and June 2024 and the following checks were carried out:

- Social Media – Facebook, Instagram, X, and Tiktok
- Employment Tribunal Judgement
- Disqualified Charity Trustee Register
- Insolvency Register
- Disqualified Director Register

2.2. Evidence of all checks is placed on file and will be included onto the electronic staff record.

2.3. In addition to the above checks, Board members and designated deputies were required to sign a self attestation declaring compliance with the Fit and Proper Person requirements.

2.4. With the exception of one self attestation not having been signed, no concerns about relevant Directors' fitness or ability to carry out their duties or information about a director not being of good character have been identified as part of the checks or brought to the attention of the Chairman. The

reasons for the self attestation not being signed are known to the Chairman and the relevant Board member will be leaving the Trust at the end of their term of office on 31 July 2024.

2.5. The Chairman therefore provide the Board with assurance that all relevant Directors and Deputy Directors meet the requirements of the new Fit and Proper Persons Test Framework.

3. FIT AND PROPER PERSON SUBMISSION TEMPLATE

3.1. The Trust is required to submit an annual submission and attached the proposed submission to NHS England.

4. RECOMMENDATIONS

4.1. The Board is asked to accept the assurance that all Board members and Directors as specified in the Fit and Proper Person Policy continue to meet the Fit and Proper Persons requirements.

4.2. The Board is further asked to approve the signing and submission of the Fit and Proper Person Annual Submission to NHS England.

SECRETARY TO THE TRUST

Appendix 5: Annual NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
Somerset NHS Foundation Trust	Colin Drummond	1 October 2023 to 30 June 2024

Part 1: FPPT outcome for board members including starters and leavers in period

Role	Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Board Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Number of Board Member References completed and retained
Chair/NED board members	12	9	1	None	2	2
Executive board members	9	8	0	None	1	1
Partner members (subsidiary)	2	2	0	None	0	0
Dedicated deputy directors	5	5	0	None	0	0
Total	28	24	1		3	3

**** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.***

Have you used the Leadership Competency Framework as part of your FPPT assessments for individual board members?	No but this will be used for 2024/25 appraisals.	No

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
Board level review	February 2024	A review of the process itself was undertaken to take account of the new and extended process and a report was presented to the February 2024 Board meeting. The implementation of the process will be considered as part of the internal audit process.	The key actions related to: adjusting internal processes to ensure that they met the requirements of the FPPT process, including liaising with the recruitment and workforce to clarify responsibilities.	April 2024

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR Somerset NHS Foundation Trust October 2023 to June 2024					
For the SID/deputy chair to complete:					
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No	
	Senior Independent Director	Kate Fallon		Yes	
For the chair to complete:					
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:			
	9 – Yes 1 - No	The NED involved has not been able to sign the self attestation due to reasons known to me but all other checks have been completed satisfactory. The NED involved will be leaving the trust at the end of the term of office on 31 July 2024.			
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:			
	Yes	Some of the DBS checks are being renewed either due to certificates number not being available (it is known that DBS check for all executive directors were carried out in September 2022) or due to a DBS check being expired. This process is still taking place but as the self attestations have been signed, which state that the Board member is compliant with the FPPT requirements, it is felt that the signed self attestation will be sufficient to sign off this submission. The DBS results will be checked once received and the dates of the checks added to ESR.			
As Chair of Somerset NHS Foundation Trust, I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.					
Chair signature:					
Date signed:					
For the regional director to complete:					
Name:					

Signature:	
Date:	

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:	2 July 2024

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

Executive Summary and Reason for presentation to Committee/Board	The purpose of the report is to update the Board on the activities of the executive and senior leadership team and/or points of note which are not covered in the standing business and performance reports, including media coverage and any key legal or statutory changes affecting the work of the Trust. The report covers the period 27 April 2024 to 26 June 2024.
Recommendation	The Board is asked to note the report and approve the proposed compliance statement for the Continuity of Services Condition 7 – availability of resources.

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

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

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

Details: N/A
Equality and Inclusion The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
There are a range of issues covered in the report that highlight work we are doing and/or national initiatives in relation to equality, diversity and inclusion.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.
Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
The report includes a number of references to work involving colleagues, patients and system partners.
Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The report is presented to every Board meeting.

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

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

SOMERSET NHS FOUNDATION TRUST

CHIEF EXECUTIVE / EXECUTIVE DIRECTOR REPORT

1. PUBLICATION OF CARE QUALITY COMMISSION REPORTS INTO OUR MATERNITY SERVICES

1.1. On 10 May 2024, the Care Quality Commission (CQC) published three reports regarding the maternity services we provide (Musgrove Park Hospital; Yeovil District Hospital; Bridgwater Community Hospital). These illustrate that we have fallen short of the standards we expected to be delivering and we want to say sorry to our families that use these services and to our hard-working colleagues. Peter Lewis, Chief Executive provided the following statement.

"We are committed to improve so that we provide an excellent service that supports women, birthing people, and families in Somerset. We have made significant changes since the inspection and will continue to do so. We have strengthened our processes to provide ongoing review of quality, performance and governance including developed a strong audit and policy programme to drive continual improvements in our services. All guidance and policies that were highlighted have been reviewed and updated and we have increased scrutiny and governance around our policy processes ensuring these are available to all colleagues. We have reviewed and mapped all mandatory training, strengthened our oversight, and significantly improved our compliance.

At Musgrove Park Hospital's maternity unit, we have put in place a new evidence-based, standardised triage process to risk assess and prioritise care based on clinical need and reconfigured the ward to facilitate safe and effective clinical oversight of our service users. We immediately sourced emergency equipment at Musgrove Park and Yeovil District Hospital.

The CQC report for Musgrove Park's maternity service highlights issues that are as a result of the poor condition of the building. We are planning to replace this as part of the national New Hospitals Programme but have already made improvements specifically around safety and security.

The inspectors noted an open culture, good engagement with local communities to make improvements and plan services, good team working, and that colleagues felt valued and supported. We have a lot of work to do, but this does give us good foundations on which to build.

We are here to support all those using our maternity services. If you have any questions, or concerns, would like more information, or to speak to someone about our service, please speak to your midwife. We are here to help and support you."

1.2. The inspection reports have been included as separate agenda items along with the action plan we have developed to address the shortcomings identified by CQC.

2. OUR ACUTE HOSPITALS ARE APPROVED TO TAKE PART IN THE FIRST PHASE OF MARTHA'S RULE PROGRAMME

2.1. We have received confirmation that both Yeovil District Hospital and Musgrove Park Hospital have been accepted to be in the first phase of a regional pilot programme, to support the national development and implementation of Martha's Rule. A total of 143 hospitals are taking part in the national programme.

Background

2.2. Thirteen-year-old Martha Mills died in 2021 after developing sepsis in hospital, where she had been admitted with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to promptly, and in 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier.

2.3. In response to this, and other cases related to the management of deterioration, the Secretary of State for Health and Social Care and NHS England committed to implement 'Martha's Rule'; to ensure the vitally important concerns of the patient and those who know the patient best are listened to and acted upon.

Three components of Martha's rule

1. All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient.

2. All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about the patient's condition. This is Martha's Rule.

3. The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

3. SYNNOVIS CYBERATTACK

3.1. You will have seen in the media that Synlab, a private pathology provider that works with the NHS, was the victim of a ransomware cyberattack. It has affected the systems at the Synnovis joint venture IT systems, resulting in

interruptions to many of its pathology services.

3.2. NHS hospitals and services in London, including King's College Hospital, Guy's and St Thomas' (including the Royal Brompton and the Evelina London Children's Hospital) and primary care are among those affected. It is resulting in delays to patient care.

3.3. Our pathology provider is Southwest Pathology Services (SPS) who partner with Synlab, but our laboratory systems are separate and hosted by the trust. We are not affected by the cyberattack, but it is of course vital that we remain vigilant. The source of the attack has not yet been disclosed by NHS England (NHSE) or the national cyber security centre, but we remain in contact with Synlab and NHSE to ensure we can quickly respond to any issues.

4. MAINTAINING FOCUS AND OVERSIGHT ON QUALITY OF CARE AND EXPERIENCE IN PRESSURISED SERVICES

4.1. The Trust received a letter on 26 June 2024 about the actions required to maintain focus and oversight on quality of care and experience in pressured services.

4.2. This letter is in response to a recent Channel 4 Dispatches documentary, filmed in the Emergency Department at Royal Shrewsbury Hospital about the impact of these pressures on patients. The documentary provided a stark example of what it means for patients when patients are not treated with kindness, dignity and respect.

4.3. All trusts have been asked to assure themselves that they are working with system partners to do all they can to:

- Provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence.

- Maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility.

5. MERGER - QUALITY AND FINANCIAL GOVERNANCE REVIEW

5.1. The Trust Board was joined at its Development Day meeting held on 4 June 2024 by a team from NHS England to discuss the one year review of the merger between Somerset NHS Foundation Trust and Yeovil District Hospital Trust from 1 April 2023. The team was particularly interested in the progress made in relation to the quality and financial governance actions.

5.2. The feedback received from the NHS England team has been positive. The team indicated that they observed a positive level of interaction and discussion between Board members and observed the overall understanding amongst Board members of the challenges that the organisation had both overcome, and those which remained. Given the substantial progress described, and the supporting comprehensive measures put in place, the team was confident that the Trust has adequately addressed the quality and financial governance recommendations and confirmed that no further action will be taken by the NHS England's Regional Quality Team in relation to these recommendations.

5.3. The full feedback letter is attached to the report.

6. OUR ACUTE HOSPITALS WILL PROVIDE ACCESS TO PERSONALISED CANCER VACCINE AS PART OF NATIONAL TRIAL

6.1. Yeovil District Hospital (YDH) and Musgrove Park Hospital (MPH) are part of a trial of personalised cancer vaccines following the launch of a world-leading NHS trial "matchmaking" service to help find new life-saving treatments.

6.2. NHSE announced that it has treated its first patient in England with a personalised vaccine against their bowel cancer, in a clinical trial part of NHS England's new Cancer Vaccine Launch Pad (CVLP). The study is one of several vaccine trials that will be taking place in NHS trusts across the country to treat different types of cancer through NHS England's new Cancer Vaccine Launch Pad (CVLP) scheme, which makes it easier to identify and fast-track patients who want to take part in these trials.

6.3. Through the CVLP, people with cancer who are receiving treatment from the NHS in England can be assessed to see if they might be eligible to join a cancer vaccine clinical trial, and then referred to a hospital that is running a trial. Our acute hospitals are part of the CVLP.

7. YEOVIL HOSPITAL CELEBRATES IMPORTANT NEW OPERATING THEATRE MILESTONE

7.1. The fifth theatre at Yeovil District Hospital (YDH) celebrated an important milestone with a topping out ceremony on Friday 14 June 2024. The theatre, which is expected to specialise mainly in orthopaedic operations, is set to open in summer 2025, with a new 20-bedded ward to accommodate the patients operated on in the new theatre, also opening next year.

7.2. At the event Cara Hatcher, senior operating department practitioner, tightened the last bolt, and Colin Drummond, chairman, Mr Matthew Hall, orthopaedic consultant, Steve Power, head of acute capital delivery, and James Powell, project director and south operational lead from Morgan Sindall, said a few words. A press release will be issued after the election (in line with guidelines during the pre- election period).

7.3. The creation of the fifth theatre and 20-bedded ward are very important developments which will support us to address the predicted growth in the number of patients who will need our care in the future and has been possible thanks to NHS England's elective care recovery fund, which was allocated to NHS trusts following the pandemic to support us to bring down waiting lists.

8. UPCOMING INDUSTRIAL ACTION

8.1. The BMA has announced that junior doctors will strike for five days in the run up to the general election from 7am on 27 June until 7am on 2 July. This includes the weekend when the Glastonbury Festival takes place, for which YDH is the principal receiving hospital, and we are working through the impact of this. We have resumed our planning for industrial action, using the same processes that we have used successfully before, respecting colleagues' right to take industrial action and ensuring our services run safely during industrial action.

9. PEOPLE PROMISE EXEMPLAR PROGRAMME

9.1. Two years ago, our trust was one of 23 organisations selected to join the People Promise Exemplar Programme, a nationwide programme aiming to improve colleagues' experiences at work.

9.2. The People Promise programme covers many actions, all working together to improve colleagues' experiences, and the infographic below illustrates some examples of the improvements made since the beginning of the Exemplar programme.

10. RETIREMENT OF PHIL BRICE, DIRECTOR OF CORPORATE SERVICES

10.1. Phil Brice, our Executive Director of Corporate Services, is retiring shortly and returning in the autumn to a new part-time role.

10.2. Phil has a huge amount of knowledge, having worked in the NHS in Somerset for many years, and we have benefited from this as well as his calm, thoughtful and measured approach.

10.3. The very good news is that Phil will continue to work for us after enjoying the summer off, but he will return in a new role of Director of Quality Assurance and Involvement. His last day in our trust in his current role will be Friday 5 July and he will return on 1 October 2024.

11. COLLEAGUES PART OF PANEL DISCUSSION AT NHS CONFEDERATION CONFERENCE

11.1. Isobel Clements and Jackee Phillips, Assistant Director of Patient Care for our medical services group, attended the NHS Confed event in Manchester on Thursday 13 June 2024. They were invited to be panel members for a

discussion on “Delivering the NHS Long Term Workforce Plan: supporting our workforce to stay and stay well”.

11.2. This was an opportunity for us both to describe the journey that our trust has been on through our work as People Promise exemplar site between April 2022 and April this year.

11.3. Isobel Clements talked about our merger process to create our trust, the focus of our trust’s people strategy focus - particularly about the environment that leaders create. Jackee brought our strategic focus to life in the examples she gave about how her service group supports colleagues, particularly overseas colleagues, to thrive and belong in our organisation.

11.4. The feedback we received was very positive and it was a pleasure to have many individuals come and speak to them following the panel discussion, wanting to know more about the work that we have done and our focus on our colleagues.

12. CONTINUITY OF SERVICES CONDITION 7 – AVAILABILITY OF RESOURCES

12.1. As part of its Provider Licence, the Trust is required to make one of the following statements:

EITHER

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

OR

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

OR

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

12.2. It is proposed to declare compliance with statement 3a which is in line with the Going Concern statement approved by the Board at its May 2024 meeting. The Board will be required to approve this compliance statement.

13. PRIDE MONTH

13.1. Throughout June 2023, we celebrated Pride Month, by sharing colleague stories and experiences, as part of our wider awareness campaign – 'More to Me'.

13.2. 'More to Me' was about highlighting and understanding what makes each and every one of us unique; our values, our interests, our attributes – because there's more to us all, than meets the eye…

14. INTERNATIONAL HR DAY

14.1. On 20 May 2024, we recognised the hard work and dedication of our colleagues working in people services as part of International HR Day.

14.2. Every year, the European Association for People Management announces a theme for International HR Day. This year the themes were:•

- Championing Ethical Tech & AI Integration
- Redefined Future Workplaces
- Excellence in People Leadership
- Continuous Investment in Skills & Education

14.3. There is no doubt that the people team is the driving force behind making the trust a great place to work. We know that when colleagues are happy and satisfied, they are more engaged and productive, and are more likely to stay

with us in the longer-term. Our People Strategy provides us with the focus and vision for bringing this to life and recognising the part that everyone plays, day to day in its delivery.

15. VOLUNTEERS WEEK

15.1. We celebrated Volunteers' Week (3-9 June) which is an opportunity to recognise, celebrate, and thank our incredible volunteers for all they contribute to our trust, colleagues, and patients.

15.2. Sporting their bright orange polos and beaming with infectious smiles, our volunteers are the heart and soul of the trust. From supporting patients, to keeping our hospital sites looking inviting and presentable, our network of dedicated volunteers personify our values, and are a vital asset to the day to day running of each of our sites.

15.3. Contributing their time, energy and compassion, our volunteers not only support patients by providing warm meals and a listening ear, but they support our colleagues too – giving them more time to provide quality care to our patients and service users.

"Volunteers have a tremendous impact on every aspect of the trust, and we're very lucky to have them as a resource," says Sarah Cherry, volunteers' manager.

"They impact everything from talking to patients and encouraging them to eat and drink, to supporting them in finding their way around the site. They're there to free up our colleagues to allow them the time and space to care effectively.

"The volunteers have a wealth of knowledge and life experience that they bring to their roles – whether they're 16 or 96!" adds Julie Foot, patient experience coordinator.

"Volunteers are the icing on the cake and they complement our colleagues greatly. They give their time to us – freely and enjoyably – so it's only right we show our appreciation."

16. CELEBRATING OUR COLLEAGUES AT OUR VERY OWN OSCAS

16.1. We celebrated the very best work across our trust at the Our Somerset Colleague Awards (OSCAs) event on Friday 14 June 2024. As part of the celebration, we saw videos that gave us insights into the work of the shortlisted colleagues and teams, and we celebrated the winners in each of our 12 categories.

16.2. The event was the culmination of many months of work that began with nominations opening in early February this year. We received over 400 nominations and our judging panel had a very difficult job to pick deserving winners in each category.

16.3. The OSCAs are part of our reward and recognition framework that enables us to recognise and thank colleagues for their good work and consists of everyday champions and our monthly Somerset Stars. We are continuing to encourage colleagues to recognise and thank the deserving work that they see around them every day.

17. MEDIA COVERAGE

17.1. Over the period 27 April 2024 to 26 June 2024, there has been the following media coverage:

- Coverage on BBC Points West and local radio about a complaint that we have received and responded to from a patient who was an ICU patient at YDH in November 2021 and was recruited to the GenOMICC research study which aims to find the genetic factors that determine outcome in critical illness.

- ***Somerset's reservist programme -*** Below are links to coverage about Somerset's reservist programme. BBC Radio Somerset: https://www.bbc.co.uk/sounds/play/p0ht1ktk (1.09:40 into programme - interview with orthotics reservist Kevin Boseley; 2.10:00 into programme - interviews with orthotics manager Nina Darke and reservists programme lead Charlene Craig).

- ***NHS Providers blog: NHS trusts making strides on integrating physical and mental health***
  Work within our trust is highlighted in a blog by Emily Gibbons, policy officer for mental health, that looks at work trusts and their partners are doing to improve physical support for people with severe mental illness (SMI), who often face some of the most significant stigma and health inequalities. The information about our trust focusses on our trust as one of the first trusts in England to provide community, mental health, learning disability and acute hospital services, with a clinical strategy in which responding well to complex needs and reducing inequities (including between physical and mental health) is a central aim. It highlights how we are identifying vulnerable patients on waiting lists, such as those with a learning disability or with a mental health referral, and how we are providing physical health checks for those with severe mental illness.

18. NATIONAL DEVELOPMENTS

Tim Ferris rejoins NHSE to advise on technology spending

18.1. It was reported in the HSJ that Tim Ferris, who was NHS England's transformation director from May 2021 until the summer last year, is helping NHSE plan for how the £3.4bn for NHS technology pledged in the most recent government budget should be prioritised.

18.2. The HSJ reports that:

- Dr Ferris's work now includes advising chief finance officer Julian Kelly on digital productivity and efficiency, and advising on how to maximise research data opportunities, including in genomics.
- During his tenure at NHSE, Dr Ferris created the managed convergence policy which encouraged NHS providers in integrated care systems to use the same tech systems.
- He set targets for trusts' roll-out of patient engagement portals, while plans for expansion of the NHS App were also pushed forward under his leadership of the transformation directorate.
- He also oversaw the merging of NHSX, NHS Digital and Health Education England into NHS England, in a process which has lasted more than two years.

18.3. In April 2024, a paper by Dr Ferris, titled *Unit cost and hope: Increased NHS resilience through tech-enabled transformation* was published in the Future Healthcare Journal.

19. NHS ENGLAND PUBLISHES LATEST PUBLIC ATTITUDES RESEARCH

19.1. NHS England Transformation Directorate has published research into public attitudes to data in the NHS and social care.

19.2. This research gives insight into how the public feels about data use and identifies six distinct attitudinal groups. To inform the engagement, NHS England surveyed over 2,200 individuals about their attitudes towards health and care data use. This was supplemented with qualitative research, including in depth interviews and group discussions.

19.3. The findings will help make sure this engagement effectively addresses the differing needs, attitudes and concerns that exist across the population regarding health and care data.

NHS England South West

To: Dr Peter Lewis, CEO
Peter.Lewis@Somersetft.nhs.uk
Mr Colin Drummond, Chairman
Colin.Drummond@somersetft.nhs.uk

cc. Mark Cooke
Neal Cleaver

NHS England
South West House
Blackbrook Park Avenue
Taunton
Somerset
TA1 2PX

24 June 2024

Dear Peter and Colin

Assurance on Quality Governance Recommendations

I am writing to you to thank you for the invitation to join your Trust Board meeting on 4 June 2024. I was joined at the meeting by Neal Cleaver, Deputy Clinical Quality and Improvement Director and Kim Jones, Assistant Clinical Quality and Improvement Director. The purpose of our attendance was to discuss the 'One Year Review of the merger of Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust'. We were specifically keen to understand the progress in relation to the six Quality Governance Recommendations that were detailed to you following our due diligence checks prior to the transaction (Letter of 21 December 2022).

The recommendations under review were within the domains of Leadership and Behaviours, and Data and Reporting, as detailed below:

Quality Governance Domain 1: Leadership and Behaviours

1. **Non-Executive Directors Succession Planning**: We heard that the Trust has successfully completed the recruitment of Associate Non-Executive Directors, ensuring there are no gaps in the skills and experience needed at the Board level. This process concluded in August 2023, with the Associate Non-Executive Directors commencing their roles in October 2023 and becoming full Non-Executive Directors in 2024. The Board identified that it has a focus on Equality and Diversity, and that the skills mix required is reviewed at the time of any recruitment to take account of changing circumstances.
2. **Quality Governance Framework**: A comprehensive review of the Trust's Quality Governance Framework has been completed. This review was conducted as part of the Trust's regular corporate governance processes to ensure it remains effective and fit for purpose. The findings were presented to the Board in May 2024, and this paper had been made available to us in NHSE. We were able to discuss with you how the Board will maintain oversight and responsibility for patient safety under a 'devolved'

governance structure, and you explained the process and routes for escalation. We briefly reflected on the most recent CQC Maternity inspection report and concerns raised at the System Quality Group in relation to paediatric services; although this meeting was not specifically in relation to those, you were able to explain the mechanisms for those concerns to be raised, and how those were being progressed.

3. **Board Development Days**: The Trust has continued to conduct Board development days, which have provided oversight of the Post-Transaction Integration Plan (PTIP) milestones and integration plans. Integration updates have been consistently reported to the Programme Board in 2023/24 and have now transitioned into Business as Usual (BAU) reporting for 2024/25.

Quality Governance Domain 2: Data and Reporting

4. **Data Quality Improvement**: Significant advances have been made to enhance data quality within the Trust. These initiatives have improved data quality. The Quality and Performance reports identify exceptions using Statistical Process Control, as outlined in “Making Data Count”, and these include guidance on how to interpret SPC charts.
5. **Risk Management Framework**: You confirmed that the Trust has now moved to a single system ‘Radar’ across the merged organisation. Although there were some minor issues to be resolved, this has in the majority gone well. The Trust has developed and implemented the Risk Management Framework, including the revised Policy. The Framework includes a clear escalation route from departmental levels to the Corporate Risk Register. Although we were not able to test the effectiveness of the escalation route, we were assured that the internal audit of risk register controls had been completed.
6. **Internal Audit of Risk Register Controls**: An internal audit of the Risk Register controls was conducted in Q3 2023/24, and the results had been presented to the Audit Committee in April 2024. This process has confirmed to the Trust Board the robustness of the risk management controls. We discussed the option of applying external audit to this process to further provide assurance to Trust Board.

We observed a positive level of interaction and discussion between your Non-Executive Directors and Executive Team. It was good to observe the overall understanding amongst your team of the challenges that the organisation had both overcome, and those which remained, and this formed part of the overall evaluation.

Given the substantial progress described, and the supporting comprehensive measures put in place, we were confident that the Trust has adequately addressed these six recommendations. Consequently, no further action will be required from NHS England’s Regional Quality Team regarding these recommendations.

As is standard in situations where there has been an NHS organisational merger, there will in due course be a nationally led post-merger review process. This will reflect on all aspects of the merger, beyond the quality recommendations discussed above, and the region will work alongside you and the ICB, as well as the national NHSE team, when that is scheduled.

We were able to ascertain that you do not require any additional support from the NHS England Regional Quality Team. However, should this change, then please do not hesitate to contact NHSE for support.

We reflected that we have appreciated the ongoing collaboration with the Trust and look forward to continuing our joint efforts to maintain the highest standards of quality governance.

Please do not hesitate to contact me if you require any further information or clarification.

Yours sincerely,

Dr Michael J Marsh
Regional Medical Director & CCIO
Higher Level Responsible Officer
South West Region
NHS England

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	2024/25 Q1 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:	2 July 2024

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

Executive Summary and Reason for presentation to Committee/Board	Somerset NHS Foundation Trust (SFT) has identified eight strategic objectives, which remain the long term aims for the newly merged organisation. The five clinical objectives are aligned with the system clinical aims which also form the basis for the clinical model. These sit alongside our financial, people and organisational objectives. The Board Assurance Framework (BAF) An Assurance Framework has been developed to clearly outline the highest risks to the Trust in achieving these objectives; the plans in place to manage and mitigate these and to provide the Committees and Board with a summary of key plans and strategies supporting their delivery. The highest risks to the strategic objectives are currently: • Access to primary care / increasing ED demand (objective 2) – 20 • Workforce shortages (objective 2) – 20 • Workforce shortages (objective 3) – 20 • Vacancies within doctor workforce (objective 6) – 20 • Failure to identify and deliver sufficient recurrent CIP (objective 7) – 20 • Lac of pace of system-wide changes to address deficit (objective 7) – 20 • Risk of EHR business case is not approved or delays to process (objective 8) - 20 Further information on the current risk position is outlined below.

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

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

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

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

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

Details: N/A

Equality and Inclusion

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

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

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

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

Public/Staff Involvement History

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

2024/25 Q1 BOARD ASSURANCE FRAMEWORK

1. PURPOSE OF THE REPORT

1.1. To present the 2024/25 Q1 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. Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies	R	Seek 15-16	20

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

- Access to primary care / increasing ED demand (objective 2) – 20
- Workforce shortages (objective 2) – 20
- Workforce shortages (objective 3) – 20
- Vacancies within doctor workforce (objective 6) – 20

- Failure to identify and deliver sufficient recurrent CIP (objective 7) – 20
- Lack of pace of system-wide changes to address deficit (objective 7) – 20
- Risk of EHR business case is not approved or delays to process (objective 8) - 20

3. AMENDMENTS TO THE 2024/25 BAF TEMPLATE

3.1. The BAF has been amended to include the following amendments:

- The summary page to include space for 'Hero'/aspirational measures against the corporate objectives. The process to identify these measures is still underway to ensure their suitability and measurability. The will be included within the Q2 BAF.

- Each objective now has space for the inclusion of the Risk Appetite and the current position against this.

- The controls and assurance section has been amended to include Risk Controls.

4. CONCLUSION

4.1. The Trust continues to carry a significant number of high strategic risks that are over and above the level of risk it is willing accept within its Risk Appetite Statement, there has been some progress made to reduce the level of risk to within appetite levels across objectives all objectives.

4.2. 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.

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

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

5. RECOMMENDATION

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

DEPUTY DIRECTOR OF CORPORATE SERVICES

BOARD ASSURANCE FRAMEWORK SUMMARY

Quarter 1 2024/25

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

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

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

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

Diabetes: HbA1C checks	100% ⇔	Diabetes: pats on hybrid closed loops	93 ⇧	Smoking status: acute IP	Feb	25.2% ⇧		
Smoking quit rates: Mental health IP	⇧⇩	28 day cancer faster diagnostic	79% ⇩	Suicide/Self harm prev: MH Staff		381 ⇧⇩		
Suicide/Self harm prev: non-MH	237 ⇔							

	Key Risks (High Consequence risks that may stop us achieving the objective)	Risk Reference (From corporate risk register)	Current Risk Con		Lik		RS	Target Risk Con		Lik		RS
1	Population Health may not get the focus required	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

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

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

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

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

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

Incidents involving ligatures	49 ⇩	Patient Initiated follow up (PIFU)		8.1% ⇧	Ambulance handover hrs lost >15m		10694 ⇩
Infection control measure tbc	⇧⇩	Falls per 1000 days		6.78 ⇩	Pressure ulcers per 1000 bed days		1.24 ⇧
End of Life pat discharges <24hrs	75.0% ⇔	Acute Home Treatment caseload	May	71 ⇧	No criteria to reside: % of acute beds		20% ⇩

	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	R1811, R372, 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
4	Workforce shortages	R2044, R1624, R1815, R1880, R2306, R	5	x	4	=	20	4	x	3	=	12

Open 12	**Risk Appetite**	Red - above risk appetite level

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

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

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

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

Adm. Prevented by Rapid Resp/AHT	376 ⇩	Pats admitted to Acute Home Treatmt	195 ⇩	Increase Open MH attendances	22297 ⇧
Increase numbers of self-referrals	⇧⇩	Urgent Community response <2hrs	95.9% ⇧	Treatmt Escalation Plans measure tbc	

	Key Risks *(High Consequence risks that may stop us achieving the objective)*	Risk Reference *(From corporate risk register)*	Current Risk Con		Lik		RS	Target Risk Con		Lik		RS
1	Workforce shortages - Primary Care	TBC	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

Risk Appetite

Seek 15-16	Red - above risk appetite level

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

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

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

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

Prot characteristics data completeness			Maternity: continuity of care hi risk tbc	⇧⇩		Ethnicity equity of access:acute RTT	Equal	⇔
Ethnicity equity of access: cancer	Mar	Equal ⇔	Ethnicity equity of access: MH	Equal	⇔	Screening for people with LD - tbc		⇧⇩
Safeguarding children measure tbc		⇧⇩						

	Key Risks (*High Consequence risks that may stop us achieving the objective*)	Risk Reference (*From corporate risk register*)	Current Risk Con		Lik		RS	Target Risk Con		Lik		RS
1	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

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

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

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

Develop and improve Healthcare Inequalities data and evidence eg ethnicity data.	DS / MI	Apr-25	Behind Schedule

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

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

CYP Eating Disorders - Routine	97%	Reduce time in ED: intensity users	67273 ⇧	Time to assessment in CYPNP	85 wks ⇧
Time to assessment: adults with ASD	⇧⇩	MH bed days: Cmplex emotionl needs	⇧⇩	Personalised care planning tbc	⇧⇩
Dementia diagnosis rate-Symphony	54.6% ⇩	Homeless service: annual referrals	746 ⇧		

	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	

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

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

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

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

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

Retention: rolling 12 months	89.0% ⇩	Pulse Engagement		6.8 ⇔	Pulse Advocacy		6.8 ⇔
Learning measure tbc	⇧⇩	Inclusion: % Band 8a+ who are female	Mar	58.1% ⇩	Retention: leavers <5yrs service tbc		⇧⇩

	Key Risks (*High Consequence risks that may stop us achieving the objective*)	Risk Reference (*From corporate risk register*)	Current Risk Con		Lik		RS	Target Risk Con		Lik		RS
1	Vacancies within doctor workforce	2044, 2307, 2306	5	x	4	=	20	4	x	3	=	12
2	Retention rate for some colleague groups	1880	4	x	4	=	16	3	x	3	=	9
3	Reduced colleague resilience	1944	4	x	4	=	16	3	x	3	=	9

Risk Appetite

Seek 15-16	Red - above risk appetite level

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

Actions to Improve Controls and Assurance (*Required for any areas assessed Amber or Red*)	Lead	Target Date	Progress Summary
Stengthen the link between colleague experience and learning through a revised learning strategy & KPI	IC	Dec-24	Behind Schedule
Implement formal monitoring arrangements of the inclusion workforce plan and improve visibility	IC	Sep-24	On Plan
Explore colleague experience from different generational perspective & develop response plan	IC	Aug-24	On Plan
Review next steps for retention focus now the exemplar programme has ended	IC	Aug-24	On Plan

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

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

Financial position v plan (YTD)	May	B/even ⇔	% of CIP identified as recurrent	May	24% ⇩	Agency v plan (YTD)	May	37k fav ⇧
No criteria to reside: % of acute beds		20% ⇩	Performance v workplan trajectory		⇧⇩			

	Key Risks (*High Consequence risks that may stop us achieving the objective*)	Risk Reference (*From corporate risk register*)	Current Risk Con	Lik	RS	Target Risk Con	Lik	RS
1	Failure to identify & deliver sufficient recurrent CIP	R6	5 x 4 = 20			5 x 3 = 15		
2	Lack of pace of system-wide changes to address deficit	R960	5 x 4 = 20			4 x 3 = 12		
3	The Trust fails to deliver the elective activity trajectory	R1859	5 x 3 = 15			3 x 3 = 9		

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

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

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

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

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

Research: active trials / studies open	TBC	Quality Improvmt: colleagues trained	TBC	% of reports available via self-service	TBC ⇧
Number of services using Netcall	TBC ⇔	Electronic Health Record on track	⇧	WTEs freed up: Robotic Process Auto	TBC ⇧
New Hospital Programme on Track	⇩				

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

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

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

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

Appendix 1

1. BOARD ASSURANCE FRAMEWORK

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

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

2. ASSURANCE FRAMEWORK GOVERNANCE ARRANGEMENTS

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

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

2.3 The strategic objectives/BAF are reviewed and considered by the relevant committees. Objectives 2-5 were reviewed at the Quality and Governance Assurance Committee at the meeting held on 26 June 2024. Review and oversight of Objectives 1 and 8 is to be completed by the Board on 2 July and the remaining objectives are due to be reviewed at the respective committees in the July 2024 meetings.

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:	2 July 2024

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

Executive Summary and Reason for presentation to Committee/Board	The Board of Directors are ultimately responsible and accountable for the comprehensive management of risks faced by the Trust. They will: … ***receive and review the Corporate Risk Register via the Board Assurance Committees*** *and the Assurance Framework quarterly, which identify the principal risks and any gaps in assurance regarding those risks* Each Board Assurance Committee will receive the Corporate Risk Register report with the specific risks assigned to them. The Committees will formally review and scrutinise the risks within their remit. These reports will be received at least once a quarter together with the Board Assurance Framework. The highest areas of risk for the organisation are: • pressures in social care; intermediate care; and primary care • insufficient capacity to meet demand • workforce recruitment and retention • aging estates - acute and community • financial position
Recommendation	The report covers those risks detailed on the Somerset Foundation Trust Corporate Risk Register as at 3 June 2024 The report focuses on the high risks scoring 15+ on the risk matrix and includes corporate risks and service group risks. The Board is asked to discuss and note the report and the risks identified.

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

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

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

Equality

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

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

There are no proposals or matters which affect any persons with protected characteristics directly within this report. Any risks where there are proposals or matters which may affect any persons with protected characteristics would be included within the mitigating action plans held within the individual risk assessments referred to within this report.

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

Public/Staff Involvement History

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

Not applicable

Previous Consideration

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

The Corporate Risk Register is presented to the Board and the Board Assurance Committees on a quarterly basis.

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

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

SOMERSET NHS FOUNDATION TRUST

CORPORATE RISK REGISTER REPORT 3 JUNE 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 3 June 2024 as shown within Appendix 1.

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

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

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

3. CORPORATE RISK REGISTER

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

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

New Risks

3.2 There have been no new risks added to the Corporate Risk Register since the last report on 29 April 2024.

Increased Risks

3.3 There have been no risks which have increased since the last report on 29 April 2024.

Risks which have Reduced

3.4 There have been three risks which have reduced since the last report on 29 April 2024 - Risk 960 remains on the Corporate Risk Register:

- Risk 960 – Failure to deliver financial plan
- Risk 2333 – Reduction of funding into SSL budget to meet service requirements
- Risk 2376 – Delays to core system upgrades which are critical to support business needs and improve patient safety

Risks which have been Archived

3.5 There have been two risks which have been archived from the Corporate Risk Register since the last report on 29 April 2024:

- Risk 1542 – Insufficient Medical Physics Expertise leading to all radiation services ceasing
- Risk 2131 – Product shortages and/or significant delays of supply due to unpredictable market

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 4.

Emerging Risks

3.8 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.

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

4. RISK MANAGEMENT ARRANGEMENTS UPDATE

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

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 that is now underway is to review the risks on Radar to ensure these meet the standard as specified within the Risk 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 following consultation with stakeholders across the Trust and the Subsidiary organisations has been virtually approved by the Audit Committee on 3 June 2024. This will be disseminated across the organisation in June and uploaded to the Trust's policies and procedures section on Radar.

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 is asked to review the Corporate Risk Register.

Corporate Risk Register 3 June 2024

NHS Somerset NHS Foundation Trust

People Committee

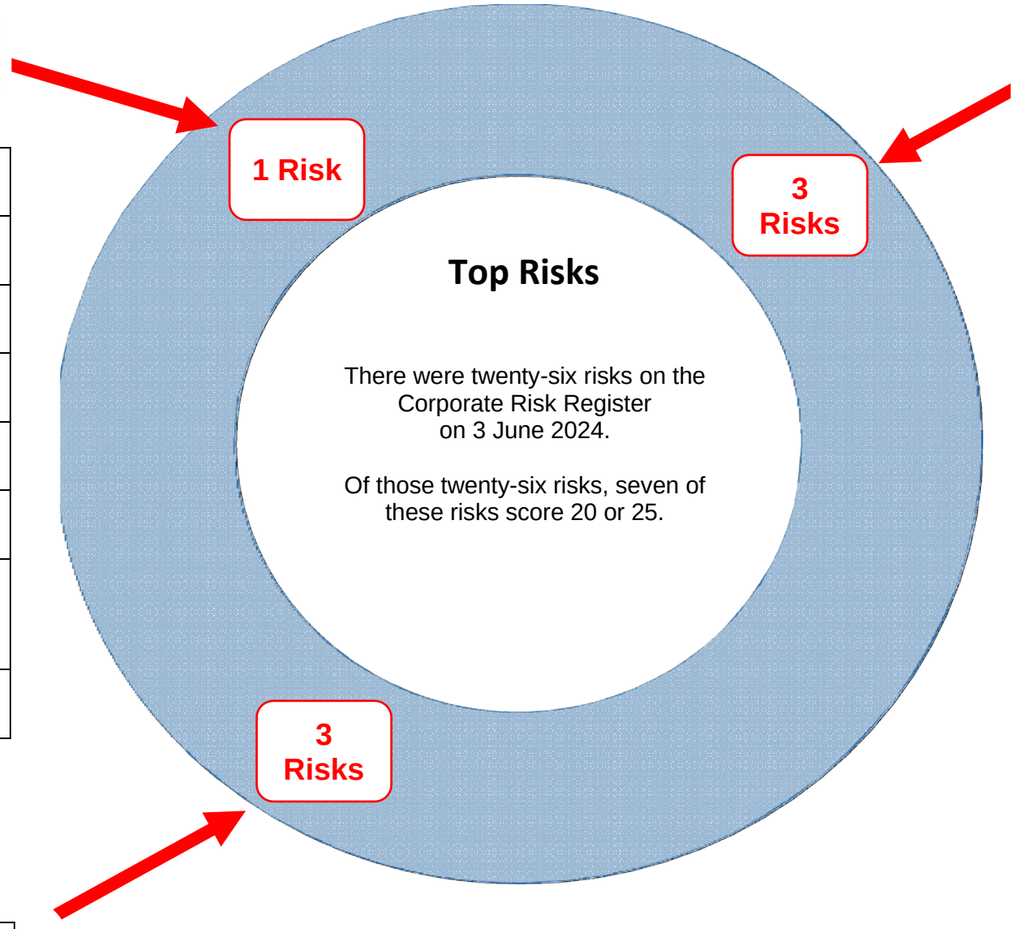
20	R2044	Vacancies rates within senior doctor workforce
⇔	SO6	

16	R1624	Failure to secure necessary infrastructure (workforce)
⇔	SO6	
16	R1815	Vacancies and absence rates within nursing and AHP teams
⇔	SO6	
16	R1827	Lack of unified policy and approach for the management of colleague personal files
⇔	SO6	
16	R1880	Retention and turnover of staff
⇔	SO6	
16	R1944	Reduced colleague resilience due to prolonged impact of integration
⇔	SO6	
16	R2307	Current medical workforce establishment not mapped to year on year increasing demand
⇔	SO6	
15	R2306	Vacancies rates within trainee doctor workforce as a result of national shortage of trainees; Deanery allocations; and the structure of run throughs
⇔	SO6	
15	R2320	Decontamination techniques and processes not being followed due to lack of training
⇔	SO6	

Financial Committee

20	R0006	Delivery of CIP 2024/25
⇔	SO7	
20	R0960	**REDUCED** Failure to deliver financial plan
⇓	SO7	
20	R2192	SHS not becoming self-sustaining
⇔	SO7	

16	R1611	Failure to secure necessary infrastructure – physical & digital (funding)
⇔	SO7	



Quality & Governance Committee

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

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

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

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

7. BOARD ASSURANCE FRAMEWORK & CORPORATE RISK REGISTER

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

Board Assurance Framework

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

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

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

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

Corporate Risk Register

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

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

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

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

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

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

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

8. VALIDATION OF RISKS

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

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

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

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

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

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

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

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

9. RISK APPETITE AND RISK TOLERANCE

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

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

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

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

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

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

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

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

Figure 1

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

Figure 2

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

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Care Quality Commission (CQC) Maternity Services Inspection Reports and Action Plan
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Phil Brice, Director of Corporate Services
PRESENTED BY:	Phil Brice, Director of Corporate Services
DATE:	2 July 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 Care Quality Commission (CQC) carried out an inspection of the Trust's maternity services at Musgrove Park Hospital (MPH), Yeovil District Hospital (YDH) and at Bridgwater Community Hospital on 20 and 21 November 2023. The inspection reports were published on 10 May 2024. The services were assessed against the CQC's "safe" and "well led" standards and the CQC has rated the Trust's maternity services at MPH and YDH as "requires improvement". Based on the evidence provided, the CQC was unable to rate maternity services at Bridgwater Community Hospital. The Trust was required to provide an action plan to address the concerns raised in the inspection reports and a comprehensive action plan was submitted to the CQC on 7 June 2024. Progress against the action plan will be monitored through the Quality and Governance Assurance Committee.
Recommendation	The Board is asked to note the findings of the maternity services inspection and discuss the inspection reports and action plan.

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

☒ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture ☒ Obj 7 Live within our means and use our resources wisely ☒ Obj 8 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

Equality and Inclusion
The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
The needs and impact on people with protected characteristics will be considered as part of the implementation of the action plan by the maternity services.
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 and members of the public have engaged with the CQC as part of their inspection.

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 reports have been considered at the June 2024 Quality and Governance Assurance 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

Somerset NHS Foundation Trust

Musgrove Park Hospital

Inspection report

Musgrove Road
Taunton
TA1 5DA
Tel: 01823333444

Date of inspection visit: 20 and 21 November 2023
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Musgrove Park Hospital

Requires Improvement 

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Musgrove Park Hospital.

We inspected the maternity service at Musgrove Park Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

Musgrove Park Hospital provides maternity services to the population of Taunton and Somerset.

Maternity services included a Triage Ward with 4 beds and a side room; Antenatal Ward (Willow Ward) which included 4 induction of labour beds, 6 antenatal beds and 1 side room with en-suite facility; a midwifery led alongside birthing centre (Bracken Birth Centre) which included 2 pool rooms with en-suite facilities and 6 postnatal beds; a Postnatal Ward (Fern Ward) which had 11 beds across 2 bays, 2 transitional care beds in a shared bay and accommodation for up to 5 parents whose babies were on special care. There was a labour ward with 7 birthing rooms, 1 of which had a birthing pool and a procedure room; 2 recovery beds and 1 theatre. In the last year approximately 3000 babies were born at Musgrove Park Hospital.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

Our rating of this hospital went down. We rated it as requires improvement because:

- Our rating of Inadequate for maternity services changed the ratings for the hospital overall. We rated maternity services as inadequate in both safe and well-led.

We also inspected 2 other maternity services run by Somerset NHS Foundation Trust. Our reports are here:

- Yeovil District Hospital - https://www.cqc.org.uk/location/RH5O4

- Bridgwater Community Hospital - https://www.cqc.org.uk/location/RH5K6
  How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.

We visited triage, labour ward, the antenatal and postnatal wards, transitional care, and the Bracken Birth Centre.

We spoke with 8 doctors, 10 midwives, 2 support workers, 7 women and birthing people and their birthing partners and/or relatives. We received 12 responses to our give feedback on care posters which were in place during the inspection.

Our findings

We reviewed 7 patient care records and 9 medicines records.

Following our onsite inspection, we spoke with senior leaders within the service; we also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Inadequate ↓↓

Our rating of this service went down. We rated it as inadequate because:

- Staff were not always up to date with training and key skills and there was a lack of effective oversight from leaders.
- Not all staff had been trained to the appropriate level to protect women and birthing people from abuse.
- Women and birthing people presenting to triage were not appropriately risk assessed and prioritised based on the presenting risk. Staff did not have a standardised, evidence-based risk assessment guidance to follow in the triage area.
- The service did not control infection risk well as the environment was unsuitable.
- There was a lack of adequate emergency equipment across the service.
- The service did not always have enough midwifery staff to ensure the safety of women and birthing people. The service did not have an effective local audit programme to ensure the quality and safety of the service.
- Learning from incidents was not always embedded.
- Leaders did not operate effective governance systems. They did not always manage risk, issues, and performance well. They did not consistently monitor the effectiveness of the service. Though staff were committed to improving services, they did not always have the skills and resources to do so.
- Staff did not have access to up-to-date policies and procedures to support them in their role. However:
- The service engaged well with women and birthing people and the community to plan and manage services.
- There was a positive culture amongst the staff team who were keen to improve the service.
- The service had a safeguarding team who were available to offer support to staff when needed.

Following this inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this action as we believed a person would or may be exposed to the risk of harm if we had not done so.

Is the service safe?

Inadequate ↓

Mandatory training

The service did not make sure everyone completed and kept up to date with mandatory training.

Maternity

Staff were not always up to date with their mandatory training. The trust target for compliance was 90%. Records showed low compliance rates for training modules. For example, 16% of midwives had completed reduced fetal movements training, 24% of midwives had completed diabetes training, and 26% of midwives had completed, equity and personalised care training.

Following the inspection the trust advised us that the data they had supplied during the inspection was for e-learning training and did not reflect face-to-face training compliance. The trust said that following the trust merger they had decided to enhance some areas of training with face-to-face training and that these face-to-face training sessions would be completed by staff within the next 2 years, from April 2023.

Moving and handling training for midwives and midwifery support workers (MSW), was delivered by way of completion of a booklet and included pool evacuation training over a 2-year rolling programme. Data showed 67% of midwives and 78% of MSWs had completed this training. There was a risk not all staff knew how to safely evacuate women and birthing people from the birthing pool in an emergency.

The service made sure staff received practical obstetric multi-professional training (PROMPT). Data showed 93% of midwives, 91% of MSW and 88% of medical staff had completed this training. Training was also above the trust target of 90% for smoking cessation, , pre-term birth, bereavement care and infant feeding.

Data showed 88% of all staff had completed fetal monitoring training, and 98% of required staff had completed neonatal life support training.

Student midwives had access to a practice development midwife as well as a preceptorship midwife once they had qualified. The service supported a programme of international midwives who would join the service as a band 4 midwife support worker until they had successfully completed their Objective Structured Clinical Examination (OSCE's) at which point they would join newly qualified midwives on the preceptorship programme for 12 months.

A nurse associate was the professional development lead for midwifery support workers, staff told us they were supported to develop in their role and access relevant training.

Managers allocated staff time away from clinical duties to complete the training, midwives were allocated a study week once a year with 7.5 training days rostered, this was overseen by the practice development team.

Safeguarding

Not all staff understood how to protect women and birthing people from abuse. Staff had not received training at a level appropriate to their role to ensure they knew how to recognise and report abuse.

The trust was already aware that staff were not trained to the correct level in safeguarding adults in line with national guidance. Following the inspection, the service leaders told us the named safeguarding midwife, supported by the safeguarding learning and development lead would urgently review training and map relevant staff to Level 3 safeguarding adult training. 85% of staff had been trained to level 2 safeguarding adults training. The National Safeguarding Intercollegiate Guidelines state that all registered health care staff risk assessing women and birthing people should complete training to level 3 in adult safeguarding.

Maternity

Staff were required to complete children's safeguarding training up to level 3. At the time of the inspection 80% of midwives and 37% of doctors had completed this training. This was below the trust target of 90%. There were no action plans shared with us to how the service was going to improve staff compliance for children's safeguarding training. At the last inspection of this service in March 2020 we found safeguarding training for medical staff was below the trust target.

There was a mandatory field on the electronic record system to record at every contact whether the woman and birthing people had been asked about domestic abuse.

Where safeguarding concerns were known, women and birthing people had birth plans with input from the safeguarding team. However, on the day of inspection staff did not always access this information or demonstrate knowledge of how to effectively manage and communicate safeguarding concerns between the team to mitigate potential risk.

Staff told us that they would speak to the safeguarding leads if they had concerns and spoke positively about a dedicated team of midwives who supported women with additional needs. Care records detailed where safeguarding concerns had been escalated in line with local procedures and whilst we saw that safeguarding alerts were on the electronic records system not all staff were aware of these and were reliant on verbal information being handed over.

The named and deputy named midwife for safeguarding, offered quarterly and as and when needed safeguarding supervision to their team of midwives as well as annual safeguarding supervision to the wider midwifery team.

There were systems and processes in place to ensure information is shared with other professionals such as GPs and health visitors.

We were told that the safeguarding team worked closely with the local authority and contributed to groups within the local authority safeguarding team and were part of the Southwest safeguarding network. They told us they were respected and listened to and that there was an escalation policy in place in case of professional disagreements.

Staff followed the baby abduction policy and undertook regular baby abduction drills. However, we found that the unit was not secure, some of the issues we found had been highlighted during a baby abduction drill 2 months prior to the inspection. Insufficient action had been taken at the time of inspection to ensure ward areas, windows and doors were secured and monitored. Following the inspection, we raised our concerns, and the trust took immediate action to improve security. They provided assurance that security across maternity has been reviewed and upgraded with windows and doors identified as part of the inspection, were secured.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. We saw how interpreting and translation services were used to ensure women were supported to understand what was happening during a procedure. This was done with care and compassion.

Staff followed safe procedures for children visiting the ward.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Equipment and the premises were not always visibly clean.

Maternity

The maternity service was situated in an old building that required numerous repairs and maintenance.

The integrity of the building impacted on how well these areas could be effectively cleaned; however, the service did not have an effective plan for managing the infection control risk this presented.

Medical equipment was not always stored correctly. For example, we found single use emergency equipment was not in its packaging. We also found medical equipment that was out of date and coated in dust. Chairs were also found to be torn which impacts how effectively these could be cleaned. This was raised with the trust who took action to remove and replace these.

On the Bracken Birth Centre, we found paint and white spirit stored in an open cupboard in a day room which was used by new mothers and children. Under the requirements of the Control of Substances Hazardous to Health (COSHH) regulations these need to be stored safely and securely. This posed a risk to people and children visiting the birth centre and were immediately removed when we highlighted and requested this.

Staff did not always follow infection control principles including following the correct uniform policy and storage of towels and linen. We observed staff wearing jumpers in clinical areas and not all staff were bare below the elbows. We observed domestic staff not using personal protective equipment correctly, specifically the use of gloves when moving between different clinical areas.

Leaders completed regular infection prevention and control, hand hygiene and bare below the elbow audits; however, these had not picked up the issues we found on inspection. Data showed hand hygiene audits were scheduled monthly, however, there was no audits completed between April and June 2023 on the antenatal clinic, or in May 2023 on the Bracken Birth Centre after compliance of 71% in April 2023. No hand hygiene or bare below the elbow audits were completed on the labour ward in September or October 2023 however where audits were completed over the last year compliance was consistently above 90%. The service had implemented an action plan to address the shortfalls identified in audits and these were discussed at monthly cleaning standards meetings.

The service had completed an audit on surgical site infections and readmissions between November 2022 and March 2023 and found the percentage of readmissions due to infection or inpatients being treated for infection from caesarean sections was 0.9% and 5% reported an infection following a caesarean section. Actions were put in place to further improve this position.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always ensure people were kept safe. However, staff managed clinical waste well.

The building was not fit for purpose due to its age, layout, and design. A new build was expected in the future meanwhile the service leaders had tried to reconfigure the layout to work within the limitations, but more work was needed to mitigate risk. We saw water damage to the building, plaster that had come away from the walls and flooring that needed replacing had been secured by hazard floor tape. We heard from staff, women, and birthing people how the environment made it difficult to effectively regulate the temperature and ventilation within the service.

The maternity unit was not fully secure and because of the limited security there was free movement within the maternity service which could not be effectively monitored. We raised this with the service following the inspection and the trust took action to address the issues.

Maternity

There was no process in place for the provision of a second theatre team or dedicated theatre team available in an obstetric emergency. There was a lack of comprehensive and robust procedures or guidance for staff on how to manage a situation in which simultaneous emergencies may occur. There was only 1 theatre within maternity which was the primary facility for all caesarean sections (both elective and emergency). The service had converted a labour room on the labour ward into a "procedure room," this was primarily for repairing of perineal tears and cervical sutures, however, should there be obstetric emergencies at the same time, the procedure room was available for use as a second operating theatre. There were plans to improve the procedure room further with changes to the layout of the room. On the day of inspection, we found the procedure room door had no lock to secure the room, allowing free access from the labour ward. This presented a risk in terms of infection prevention and control and to the privacy and dignity of the woman or birthing person in the room.

We found gaps in the daily and weekly safety checks of specialist equipment which staff were required to complete. For example, there were 8 days in one month that the daily resuscitation equipment checks which is used for babies had not been completed. Over a six-month period, there were 8 weeks that both the emergency boxes used during a diabetic emergency and a pre-eclampsia emergency were not completed.

There was not enough emergency equipment available to cover the number of birthing beds and areas across the footprint of the service. For example, there were not enough resuscitaires which are used to provide lifesaving resuscitation to babies. There was also not enough adult and baby emergency equipment for the size and footprint of the service. Leaders had not identified this and were unaware of issues; for example, one resuscitaire was unusable as it had a broken wheel, we raised our concerns with the trust who completed a risk assessment, provided guidance for staff on what to do in an emergency and ordered more equipment for maternity services.

The service did not ensure the safe, secure, and effective storage and management of expressed breast milk (EBM). We found that fridges and freezers used to store EBM were not clean, de-frosted and the temperature of the fridge and freezers were not monitored and recorded. We also found contents of the fridge were not properly recorded and there was out of date milk stored. This posed a risk to babies drinking this milk. The trust was aware that the fridge and freezer currently used were not sufficient and were awaiting replacements, although no mitigation was in place to manage the presenting risk. We raised this with the trust as a concern and they provided assurance that this would be addressed and the process for safe management would be reviewed.

The birth partners of women and birthing people were supported to attend the birth and provide support. We saw how partners with babies on transitional care were supported to stay overnight with pull out beds provided. The service also offered accommodation within the hospital for those parents who had babies on special care but themselves were medically fit.

Due to the small, open bay style wards (Nightingale wards) there was limited space and privacy for women, birthing people. This was raised as a concern as part of the give feedback on care by people using the service. Staff told us that there were limited rooms to allow for private conversation on the wards which led to staff at times using offices when conversations with women and birthing people required for privacy away from the ward.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply and a standard operating procedure on how to clean the pool after use.

The service ensured there was a birthing evacuation net in each room that had a birthing pool. There was a portable ultrasound scanner, sufficient cardiotocograph machines and observation monitoring equipment. However, data provided showed that not all equipment had been checked and tested to ensure it was safe.

Equipment was not always serviced regularly. We reviewed equipment testing compliance data and compliance rates for equipment testing and servicing was 60% for 2023.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Assessing and responding to risk

Staff did not always complete and update risk assessments or take action to remove or minimise risks.

The service did not use an evidence-based, standardised risk assessment tool for maternity triage. There was a lack of guidance for staff around how to risk assess, manage, and escalate risk within maternity triage. The maternity triage policy (version 1, issued 14 August 2019) was out of date as of the 14 August 2022 and did not reflect current practice. Waiting times to be seen and reviewed by a midwife and/or medical professional were not recorded in a standardised way and there was no system to ensure that women and birthing people were seen in order of medical priority based on presenting symptoms and risk rather than time of arrival. Whilst staff could explain that certain symptoms, such as reduced fetal movements would be prioritised, this was based on clinical judgment of an individual midwives rather than a standardised approach. Staff used multiple recording systems to document the attendance of women and birthing people in triage, which made it difficult to effectively monitor and audit processes. The triage area consisted of an open bay with 4 beds and a side room and a waiting area in the main reception. However, there was no allocated oversight by an appropriate clinician, of women and birthing people waiting to be seen, whose condition could potentially deteriorate.

A snapshot audit of the workflow through triage was carried out between May 2022 and July 2022 by a midwife. We were told this was shared with leaders, however there was no evidence that action was taken to act on the concerns presented and recommendations to use a standardised risk assessment triage process. Staff told us they were keen to improve on how triage was working and had ideas of how to improve this; however, there was no evidence that this was being supported and progressed by leaders within the service. Audits of maternity triage had not been carried out and this wasn't included on the risk register for Musgrove Park Hospital.

There was a policy in place which outlined the process for induction of labour. However, staff told us that they needed more guidance around when delays occur and that delays could lead to women and birthing people becoming upset. Staff told us induction of labour was managed by the labour ward coordinator and the consultant on the day, who would prioritise women and birthing people based on clinical judgement of risk; this information was displayed for the team on a white board in a side room.

The service did not have separate theatre lists for elective caesareans and emergency caesareans, this approach could lead to delays in those women and birthing people having an elective caesarean and doctors told us this led to an inconsistent experience for women having an elective caesarean. We saw delays in elective caesarean sections had been incident reported.

Maternity

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 7 MEOWS records and found staff correctly completed them and had escalated concerns to senior staff. However, the service did not complete audits in this area.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks. For example, staff used the fresh eyes approach to carry out fetal monitoring safely and effectively. Leaders carried out an audit for February-October 2023 rather than regular quarterly audits to see how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). The data presented for that time period covered 105 records on the labour ward and the Bracken Birth Centre. Results showed the correct method of fetal monitoring was carried out in 97% of cases, CTG was interpreted correctly in 89% of cases, false assurance from misinterpretation of CTGs occurred in 6% of cases and there was a delay in acting on a pathological CTG in 6% of cases. Fresh eyes were completed hourly in 95% of cases. The service staff told us results from this audit were due to be presented at an audit meeting in January 2024, where an action plan would then be put in place.

Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns. There was a team of midwives who would provide support for women and birthing people requiring additional support throughout their pregnancy to offer a level of continuity which included mental health support. Staff told us this worked well in terms of ensuring consistency, oversight, and improved communication.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Shift changes and handovers included key information to ensure medical background and risk was discussed, however, more detail was required around known safeguarding concerns. Staff were given very brief details and signposted to access the electronic records.

Staff had 2 consultant-led, multi-disciplinary handovers each day to ensure all staff were up to date with key information. The handover shared information using a format which described the situation, background, assessment, recommendation for each person. We did not witness any areas of learning shared as part of the midwifery handover process, but this was part of the medical handover.

Staff completed newborn assessment observation and early warning score forms (NEWS) on their electronic records system. We saw 1 example of this which was fully completed and escalated appropriately. The British Association of Perinatal Medicine recommend the use of Newborn Early Warning Trigger and Track (NEWTT) as best practice and the service told us they were aware of this and working towards implementing NEWTT.

Leaders did not provide clinicians with guidance by way of a policy or have oversight of staff compliance in relation to NEWS. The service did not audit staff use of the NEWS tool and there was no specific policy in place to guide staff on when and how to use the tool. Following raising our concerns a retrospective audit of NEWS between January 2022 and December 2023 on the services electronic records system was undertaken. This showed 71% of babies who required NEWS forms due to being under observation had one recorded, and 69% of those under observation and requiring escalation to the paediatrics team had one recorded. We were told, further audits were scheduled for 2024 and findings were to be discussed at the maternity and neonatal governance meeting. At the time of inspection, despite a Healthcare Safety Investigation Branch safety recommendation at Yeovil district hospital in August 2023, (following the merger in April 2023) there was no action plan to improve the compliance of NEWS observations at any of the trust's other sites.

Maternity

Service leaders had not carried out a ligature risk assessment in line with an NHS National Patient Safety Alert which was issues in 2020 as they were not aware these were required within the maternity department. Following the inspection, the service told us they would complete this, review the relevant policies and ensure a standard operating procedure was put in place. The service also ordered ligature cutters.

The service provided transitional care service for babies who required additional care, the aim of transitional care is to avoid the separation of mum and baby. This was located on a separate corridor opposite the postnatal ward. We spoke to families whose babies were receiving care on the transitional ward and they spoke highly of the care and support they had received. They told us how midwives were quick to respond to the call bells and paediatricians provided support for their babies and completed regular checks.

Staff completed risk assessments prior to discharging women and birthing people into the community, however there were incident reports of failures to communicate with third-party organisations of the birth and discharge of babies where this was required.

Midwifery Staffing

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. Staff did not always have the right skills and training to keep women safe from avoidable harm and to provide the right care and treatment. The service did not always make sure all staff were competent for their roles. Not all staff had received an appraisal of their performance or support with their development.

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. Staff told us low numbers mainly impacted wards other than the labour ward and lack of staff made them feel unsafe.

The service monitored maternity staffing through reporting on the number of times staffing levels were or were not sufficient to meet the needs of women and birthing people (acuity) each week to the monthly maternity and neonatal governance meeting. Data showed in July 2023, acuity was met 66% of the time, in August 2023 72% of the time and September 2023 55% of the time. The figures reflect the number of staff in reported positions at regular intervals throughout the day. The trust told us that staff would be deployed to different areas across the service to meet the rising acuity and complexity across the service.

The service did not effectively report and monitor maternity ‘red flag’ staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 ‘Safe midwifery staffing for maternity settings. A midwifery ‘red flag’ event is a warning sign that something may be wrong with midwifery staffing. Five of the 9 red flag incident categories were reported on in the last 12 months. These included 12 incidents of delayed or cancelled time critical activity, 17 incidents of missed or delayed care, 2 incidents of missed medication during an admission, 1 incident of delayed recognition of and action on abnormal vital signs and no incidents of a midwife being unable to provide continuous 1:1 care during established labour. This is a total of 32 red flags over 12 months. There is limited assurance on the accuracy of the number of documented red flags as there was no effective tool in place at the time of inspection to record red flags. The service told us that they would be implementing an evidenced based tool designed for maternity care, which was in use at Yeovil District Hospital, in January 2024 to ensure a more effective way to report and monitor red flag incidents.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in November 2021. This review recommended the service needed 154.44

whole-time equivalent (WTE) midwives, compared to the funded establishment of 149.07 WTE, indicating an additional investment of 7.94 WTE staff. Investment was secured following the birth rate plus recommendations and recruitment was successful in closing the identified gap. The trust told us they were over recruited to both midwifery roles and midwifery support worker roles, however there remained 1.1 WTE vacancies at this location. The service had recruited 9 new starters in October 2023; which included 8 preceptees & 1 Band 6 for community; with a further 8 WTE, band 6 midwifery roles being advertised. However, staff told us that midwifery shortages impacted the service and recruitment was on-going.

Managers moved staff according to the number of women and birthing people in clinical areas however this often left wards short staffed. Staff told us the labour ward was prioritised and they were expected to work flexibly at short notice, sometimes in areas they do not normally work. The trust told us this was to reduce clinical risk in response to demand. The maternity escalation plan had 4 alert levels: green – normal working, amber – persistent excess pressure, red – severe and prolonged excess pressure, and black – unit closed to admissions and patients diverted to neighbouring trusts. There was a supernumerary labour co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. Data showed the labour ward coordinator was always supernumerary in July, August, and September 2023. However, acuity was only formally recorded on the labour wards and so did not always take into account the pressures experienced in triage, antenatal and postnatal areas.

Managers requested bank staff familiar with the service and made sure all bank staff had a full induction and understood the service.

The service made sure some staff were competent for their roles. Staff did not always receive a yearly appraisal.

Midwifery staff compliance with mandatory appraisals did not meet the trust target of 92% for any staff groups. As of 1 November 2023, compliance across departments ranged between 33% and 80% with an average of 47.5% of staff receiving an appraisal.

The service had recruited and supported 8 international midwives to work at the service. Additional training, competency assessment and support by way of supernumerary working was provided until they were signed off as competent to work independently.

From the information provided it was not clear that all other midwives had been assessed as competent following training provided.

The trust had specialist midwives such as a bereavement lead, safeguarding and audit midwife that covered both Musgrove Park Hospital and Yeovil District hospital. There were other specialist midwifery roles such as infant feeding, digital lead, governance and screening leads who were based at the service in Musgrove Park hospital.

A practice development team supported midwives. The team included 3 practice development lead midwives.

The chief nurse reported in the September 2023 six monthly staffing report to the trust board that 21 of the student midwives who trained at the trust had been successfully recruited to the service with planned start dates in October 2023.

The service did not have enough medical staff with the right qualifications, skills, training, and experience to provide the right care and treatment. There was no process or procedure around the induction of locum doctors.

Maternity

The service did not have enough medical staff. At the time of inspection, the service had 13 obstetric and gynaecology consultants which included 1 locum. There were also 9 specialist registrars, which included 1 locum and 8 GP trainee doctors. The service always had a consultant on call during evenings and weekends and any gaps were a result of sickness. However, the sustainability of the 1 in 12 consultant on-call rota to enable the daily evening ward round on labour ward was on the risk register since December 2022. The service told us they had recruited 2 obstetric consultants who were due to start in March 2024. The service was holding 2 consultant led ward rounds per day as required.

The service had 2 locum doctors at the time of inspection (1 consultant and 1 specialist registrar) but did not have a formal procedure to monitor compliance with recruitment or to ensure a formal induction had taken place and was evidenced. However, the locum doctor on duty during the inspection told us they were well supported and had received a comprehensive induction. The service leaders created an action plan to address this following the inspection.

The service monitored whether a consultant was called when needed (as per the service escalation policy) and whether consultants attended those obstetric emergencies. In August 2023, the attendance was 8 out of 9 of the obstetric emergencies requiring a consultant. However, in 1 case a consultant did not attend a post-partum haemorrhage, over 2 litres as according to the records they believed it was under control. Doctors and staff we spoke to told us they knew when a consultant should attend and there were no issues experienced by them.

Consultant job plans did not allow for obstetric consultants at both hospital sites to take the recommended 11 hours of compensatory rest following on-call activity and there was an expectation that individual staff would use their discretion, however there were no systems to provide cover in these circumstances.

Medical staff including junior doctors, told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop.

The service had a lack of rest facilities for those doctors working on call overnight and it was unclear if action was being taken to address this.

Records

Staff kept detailed records of women and birthing people's care and treatment. Electronic records were clear, up to date, stored securely. However, paper records were not well managed or secure and not all staff found records easy to navigate. The service did not regularly carry out documentation audits.

The trust used a combination of paper and electronic records. We reviewed 7 electronic records and found records were mainly clear and complete. However, ethnicity was not always recorded correctly and often stated British only. Some ethnic groups of women and birthing people are at higher risk and disproportionately experience poorer outcomes, it is therefore important this is correctly recorded, risk assessed and reviewed. Some parts of the records were still in paper form, and these were not stored securely, we raised this with the service at the time and they told us they would address this.

The service introduced an electronic patient records system in February 2023. There had been no documentation audits since this was introduced. Following the inspection, trust leaders told us a formal audit of maternity documentation was scheduled for March 2024. Not all staff were confident in navigating and understanding the functions on the electronic

records. For example, the system allowed for flags to indicate where there were additional needs around mental health or safeguarding and not all staff were aware of these. The service told us staff training was on-going and we saw guidance documents had been provided and training sessions scheduled. We also saw newsletters with updates and areas of focus from the digital team.

Women and birthing people's care record was on a secure electronic care record system used by all staff involved in the woman's care. Each episode of care was recorded by health professionals and was used to share information between care givers. Women and birthing people were able to view their own medical records online.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records.

The service had digital midwifes who was able to support staff when needed with any issues relating to the electronic records systems.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However not all medicines were stored safely.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had electronic prescription charts for medicines that needed to be administered during their admission. We reviewed 9 prescription charts and found staff had correctly completed them.

Staff reviewed each woman's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

Some medicines which were to be taken "when required" (also known as PRN) were documented on the electronic record as a regular medication, and so the medication record showed this medication as being late or missed. We were assured that midwives were clear and were checking which medicines were regular, and which were PRN, but the administration record did not accurately reflect this.

The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was variation. However, we found anaesthetic agents that could be misused by the public in the room which were not secured. This was raised with the trust at the time of our inspection and steps were taken to secure access to the room and medicines within the room. Checks have also been reviewed to ensure oversight.

Some medication doses are prescribed based on the persons weight, the electronic medication record did not record the person's weight, and this was recorded a separate electronic system, this increases the risk of the wrong dose being given. The trust told us this function was available on the EPMA. However, this function was not being utilised at the time of inspection.

The trust did not have a system in place to monitor staff's competencies around medicines management. Staff completed an e-learning course on medicines management.

Incidents

The service did not manage safety incidents well. Staff recognised and reported incidents and near misses and managers investigated incidents. However, lessons were not always learnt and shared with the whole team and the wider service. When things went wrong, staff did not always apologise and give women and birthing people honest information and suitable support.

The service had not learnt from an incident which occurred in May 2023 where there were simultaneous emergencies overnight and a second theatre team were not able to be sourced from the main theatres. There was poor communication, management and escalation which led to significant delays in women and birthing people receiving care and treatment. At the time of the incident and at the time of the inspection, there was no clear guidance for midwives and theatre staff around protocol in this situation, escalation or roles and responsibilities. Leaders could not be assured that should such a situation happen again staff would be able to manage this more effectively. We raised this as a concern with the service and whilst leaders had drafted a standard operating procedure this was not yet finalised and signed off and did not provide sufficient detail to guide staff. Leaders told us they recognised the importance of providing greater clarity and accountability around the staffing provision for theatres.

Staff did not always effectively carry out duty of candour. There was no evidence that duty of candour was met in several cases we reviewed as part of the inspection. Within investigation reports the service had explicitly documented that duty of candour had not been completed. These were documented to be followed up by individual staff members, however we found that there was no further update provided to evidence completion.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. Leaders reviewed the number of incidents reported, type and grade of the impact at monthly maternity and neonatal (MatNeo) governance meetings. For example, the September 2023 MatNeo governance meeting showed the highest reported incident was undetected small for gestational age (SGA) babies with 13 incidents of birth below 10th centile out of 94 total incidents; and the October 2023 data showed 14 incidents of birth below the 10th centile out of a total of 82 incidents. There was no evidence from the minutes and actions provided that the high number of incidents was being reviewed to identify trends and themes and to improve detection rate. The service acknowledged there were capacity issues within the obstetric sonography, (which is one way to detect SGA babies) and this is a recorded risk on the risk register. However, SGA detection rates was not included within the impact of this risk and so it is unclear whether this has been identified as a causational factor.

We reviewed 223 incidents reported in the 3 months before inspection there were concerns around how these were categorised as some incidents were incorrectly categorised. The trust told us leaders reviewed all incidents across maternity irrespective of level of harm, this included incidents such as PPH and stillbirths. However, we saw no evidence by way of minutes or actions plans from these meetings.

At the monthly maternity and neonatal (MatNeo) governance meetings leaders monitored progress with rapid review reports, root cause analysis reports, perinatal mortality reviews and cases reported to the Maternity and Neonatal Safety Investigation Programme (MNSI). Whilst an overview and update were provided, actions and timeframes for actions to be completed were not always evidenced and so it was difficult to track progress.

Maternity

The service did not always complete incident investigations in a timely way. At the time of inspection there were 6 serious incidents open over 60 days for maternity service. Of these, four addressed a theme relating to shoulder dystocia. The service had four shoulder dystocia incidents in 4 months (May to August 2022). A joint action plan was created to address them in September 2022. However, there were still actions that had not been completed within the time frames set with limited updates included.

We did not identify from any evidence submitted that managers reviewed incidents potentially related to health inequalities.

Managers did not share learning with their staff about never events that happened elsewhere. There was little evidence of shared learning from the trust's other maternity service, Yeovil District Hospital and there were missed opportunities to implement learning and drive quality across both sites.

The service had an incident reporting and management policy for staff to follow which set out actions staff must take along with roles and responsibilities.

Managers had identified from investigation reports that the support and de-briefs offered to staff and the process around this was not embedded or effective and this was added to an action plan to address. However, the date for completion was documented as July 2023 and this was not yet completed. Staff told us that they could ask for support from their direct line manager, and this would be facilitated. They also told us they had good support from their peers.

Is the service well-led?

Inadequate 

Leadership

There was a newly established leadership team in maternity services. The maternity leadership team for the trust was formed as part of the trust merger in April 2023. Some leaders had been in post for only 2 weeks before the inspection. Leaders were not always visible to staff. Executive leaders did not demonstrate an understanding and effectively manage the priorities and issues the service faced.

Maternity services at the trust were managed as part of the service group for children, young people, and families. This included services such as child and adolescent mental health services (CAMHS) women's sexual health and maternity services.

The service group had a senior leadership quinumvirate for the Children Young People & Families service group, consisting of the that consisted of the service group director, the director of midwifery (DOM), an associate director of patient care for the service group, the associate medical director for obstetrics and gynaecology, sexual health and dental, who was a vascular surgeon and the associate medical director for paediatrics and CAMHS, who was a paediatric and neonatal doctor. The trust told us that MPH also had a dedicated quadrumvirate, with membership consisting of: Head of Midwifery, Clinical Lead Obstetrician, Clinical Lead Neonatologist and Service Operations manager.

Actions from senior leadership team meetings were not tracked effectively. The quadrumvirate leadership team told us they met every 2 weeks. There were no minutes to these meetings, but they kept an action tracker of actions agreed. This tracker showed all items as completed. However, not all items had a date that they were completed and 1 item marked as green stated it needed further action.

The director of midwifery (DOM) reported to the safety champions twice a month. There were 3 board level safety champions, which were the chief nurse and 2 non-executive directors. The safety champions then reported up to the board. The DOM informed us that they attended the Quality & Governance Assurance Committee (Q&GAC) meeting on a regular basis. We were told this a board level committee, chaired by a non-executive director with a number of board members present. The board devolved responsibility for monitoring quality in maternity on behalf of the board. The DOM does not attend the board itself, information on maternity is presented by the non-executive chair of Q&GAC, supported by the Chief Nurse

We reviewed the maternity safety champion meeting minutes for the last 5 meetings and found that there was poor attendance from the Trust board level safety champions. From meetings held in May 2023, July 2023, August 2023, September 2023, and October 2023 there was only 1 occasion out of 5 when 2 safety champions and the DOM were present. This at times led to the meeting not being quorate, which was minuted but led to no improvement in attendance. We also saw that the effectiveness of the meetings was questioned, attendees noted improvements were needed around learning shared at the meeting, but this led to no evidenced improvements in this area. Those in attendance were unable at times to progress actions due to lack of attendance from key members. We also spoke with the 3 board safety champions. They were consistently positive about the assurance they received about the service and did not demonstrate an awareness of the challenges in the service. The service could therefore not be assured of the effectiveness in the board safety champions being cited on maternity issues and driving quality and safety improvements.

We saw maternity briefing reports for the quality and governance assurance committee (Q&GAC) which was a subcommittee to the board. Areas of concern would then be highlighted for escalation and discussion at the public board meeting. It was not clear from the Q&GAC briefing minutes provided who attended those meetings, or if there was an overarching action plan to track progress. The reports were discussed at board level and staffing within maternity was included as part of overall staffing discussions. We also saw that the board had reviewed the risk register which included risks over 15 which also sat on the corporate risk register, this included risks around theatres and estates with maternity. The board could not be properly cited on issues around audits, poor attendance at meetings (which impacted compliance with the maternity incentive scheme) poor compliance with training and appraisals as these were not included in the Q&GAC meetings. The service had poor oversight of the issues faced. Discussion at service group level were held monthly at a Quality, Outcome, Finance and Performance (QOFP) meetings. However, there was no evidence of how this information was escalated or shared outside of this meeting.

The figures presented to the board did not match up with data we received around incidents for the service or from the data supplied from the maternity and neonatal (MatNeo) governance meetings. In the board papers, figures showed that there had been no babies born in an unexpected poor condition between the months of October 2022 and September 2023. The combined MatNeo governance meeting showed data from August 2022 to September 2023 where there had been 5 occasions where therapeutic cooling of babies was needed, on 4 of these occasions' babies needed to be transferred to a specialist unit in another hospital trust. There was also a missed opportunity to provide the board with regular key safety performance information such as delayed induction of labour and meeting national guidance for

emergency caesarean sections. Following the inspection the trust advised us that at the time of the inspection the MatNeo governance meeting was not covering both hospital sites. This meeting did not cover Yeovil District hospitals maternity service. This was not clear when reviewing the documentation, nor was it clear from the board papers if the executive board had oversight of the maternity service at both hospitals

Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis as part of their role as safety champions but not all staff were familiar with the senior leadership team.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

There was a systems strategy, combining maternity and neonates' The strategy had been written in 2023 after the recommendations from the Ockenden 2020 and 2022 reports. Also, with the merger between Somerset Foundation Trust and Yeovil District Hospital in mind. They had a vision for what they wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Staff could explain the vision and what it meant for women and birthing people and babies. The progress and oversight of the strategy was monitored at a systems level.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and planned to revise the 3-year delivery plan to include these recommendations.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Staff told us they felt respected, supported, and valued by their managers and peer. Staff were positive about the direction that the service was going in following the trust merger and were keen to have a new hospital building as they acknowledged the limitation the current site posed. Staff told us they felt able to speak to leaders about difficult issues and when things went wrong.

The service prioritised staff wellbeing. The service was part of the NHS National Health and Wellbeing Offer for Maternity Services. Findings from a visit and survey of staff in January 2023 found a highly motivated team with a positive culture. Areas for improvement included staffing, workload, and space for rest breaks. Staff spaces for rest break had been documented on the risk register and staff spoke positively about the changes made to shift patterns and the flexibility this offered. The service also recognised staff achievements in the regular governance meetings.

However, the service had not responded to the latest NHS staff survey. We requested the most recent maternity staff survey and associated action plans. The service submitted an action plan relating to 2021 NHS staff survey for Yeovil District Hospital only and not Musgrove Park Hospital.

Maternity

The CQC maternity survey requested feedback from people who gave birth in February 2023 (and January 2023 for smaller trusts). Questionnaires were sent out between April and August 2023; responses were received from 165 people at Somerset NHS Foundation Trust. The survey showed that Somerset NHS Foundation Trust scored “about the same” in comparison to other trusts in all areas. However, they scored “better than expected” for clear communication and “somewhat better than expected” for kind and understanding care and partner length of stay.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples’ care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this. People using the service spoke highly of the staff that had cared for them and the support they received.

The trust had an equality and impact assessment tool that was used when creating and reviewing policies and procedures and all policies and guidance included an equality and diversity statement. The use of the assessment tool had been discussed at board meetings and the board felt more should be done to ensure that the tool was used to assess reports prior to them going to board. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints, identified themes, and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. We reviewed the trusts responses to the last three complaints and found complainants questions were responded to in detail and a full apology given. Staff could give examples of how they used women and birthing people's feedback to improve daily practice.

We did not see evidence of leaders exploring and understanding how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. There was no evidence that incidents were reviewed in relation to whether ethnicity or health inequalities may have impacted outcomes.

Governance

Leaders did not operate effective governance processes to monitor and improve the quality of the service. Leaders did not have clear oversight of the service.

The service did not have an effective program of regular local audits to ensure the safety and quality of the service was monitored and processes to learn from incidents were not effective.

The service did not have effective governance processes. The governance structure did not always support the flow of information from front line staff to senior leaders and vice versa. Governance and safety champion meetings took place but were not always well attended by senior leaders. We saw discrepancies in information about key safety and performance metrics at a service level to information and key safety and performance metrics discussed at executive board level.

Maternity

We reviewed the last three meeting minutes of the governance meetings and the combined maternity and neonatal governance meetings. We found that the number and type of incidents were broken down, the risk register was discussed, and issues such as complaints, training, acuity, guidelines, and safeguarding were also discussed. However, there was a lack of clear action and accountability from these meetings to drive improvement.

Maternity quality surveillance data reviewed at this meeting was minimal and only included raw data of the numbers of PPH incidents, shoulder dystocia, 3rd and 4th degree tears rather than statistical process charts to map trends over time. Further work was needed to make the information presented more meaningful and provide context.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. The service had completed an audit of WHO checklists between April 2022 and March 2023. Findings from the audit were collated in October 2023 and were due to be presented at the audit meeting in December 2023, where an action plan would then be formulated. That was a delay of 7 months from the completion of the audit to implementing an action plan. Leaders told us any concerns would be highlighted and shared at the monthly maternity and neonatal governance meeting, but we saw no evidence of this happening. The WHO checklist audit showed that there were 1094 cases that went through maternity theatres and 88% of these cases were compliant with completing the checklist. Trends around incomplete checklists were similar to those found the previous year. The trust had 2 serious incidents which related to theatres in a six-month period. Following the inspection, we were advised that actions implemented at Yeovil District Hospital had also been embedded at Musgrove Park Hospital. However, we did find this during our inspection. Frequent and timely audits and actions were not in place following these incidents to share findings and drive quality improvements.

Data and key performance metrics discussed at governance meetings was not up to date information and provided a snapshot in time rather than over regular intervals, there were long delays before this was shared at meetings and actions put in place. For example, WHO audit data was collected and reported on yearly (April 2022-March 2023) and there was significant delay between completion of the audit, to creation of an action plan (October 2023) and sharing that information with the wider team (December 2023).

The evidence provided as part of the inspection which documents the process for reviewing neonatal deaths was not in line with national guidance. We reviewed 2 mortality reviews from the November 2023 meeting and found the Perinatal Mortality Review Tool (PMRT), a nationally recognised methodology to review baby deaths was not used to grade the severity of these incidents. There was no reference to the parents' views being sought in the reviews. We raised this as a concern with the trust and they assured us that the process was being followed, including meeting the recommended timeframes. They told us this information was documented in the final reports; we saw 1 example of a final report however, we cannot be assured this process was followed in all reviews.

The service did not ensure staff had access to up-to-date policies, procedures, and guidance. Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust merged to form one organisation in April 2023. Following the merger governance teams were in the process of reviewing and aligning policies between the two locations. From the 12 policies and procedures requested for trust, 5 were out of date (Recognition of the severely ill woman, Sepsis, Triage and Prevention and management of postpartum Haemorrhage-(PPH)).

Despite incidents occurring leaders did not have effective governance processes to ensure timely access to emergency obstetric theatre staff from the main hospital site. We requested, and did not receive, audits of timeliness of decisions

for knife to skin for caesarean sections. The service had acknowledged from a thematic review, that there was an issue with the categorisation of caesarean sections and staff told us there were still issues in this area. Staff also told us they were concerned that there wasn't a separate elective and emergency caesarean list. The service had not taken action to assure themselves of their performance in this area.

Leaders did not have effective oversight of training compliance and competencies or appraisal rates. This had not improved since the last inspection in March 2020.

The service did not carry out regular audits to gain assurance and oversight of staff compliance with guidance and documentation or take timely action to share findings and drive improvement.

Leaders had not completed quarterly audits of MEOWS records to check they were fully completed and escalated appropriately and so the service cannot be assured that national tools are appropriately used and escalated. We saw action plans with recommendations from Healthcare Safety Investigation Branch (HSIB) now known as Maternity and Newborn Safety Investigations (MNSI), dated September 2022 which stated, "MEOWS charts were not utilised within triage and labour care settings impacting recognition and escalation of abnormal observations". Whilst we saw and staff told us these tools were now in use in these areas, the service had not taken appropriate and timely action to assure themselves of compliance and effectiveness in relation to the use of MEOWS.

Management of risk, issues, and performance

Leaders and teams did not use effective systems to manage performance. They did not always identify and escalate relevant risks and issues or take actions in a timely manner to reduce their impact.

There were significant failures in audit systems and processes. Out of the 8 audits requested by CQC only 1 was completed regularly. The service had not audited the use of Modified Early Obstetric warning score (MEOWS), triage, handover tool (Situation Background Assessment (SBAR)), World Health Organisation theatre checklist (WHO), NEWS or the electronic care records system.

When improvements had been made at the service, they were not monitored to ensure they were fully implemented or that best practice were being followed. For example, a maternity electronic record system was implemented in February 2023. However, there had been no audits of the system to ensure staff were using the system effectively. In governance meetings leaders identified a decrease in incident reporting but could not assure themselves whether this was due to changes to the electronic care records or poor record keeping.

Leaders had not effectively mitigated known risks. For example, there was no elective caesarean surgical list at Musgrove Park Hospital and so women and birthing people could face unnecessary delays in going to theatre. This was listed on the MPH risk register as high risk (16), however there were no "controls (actions) outstanding" or "controls implemented" listed.

The service had not recognised safety risks that were identified during the inspection. For example, leaders at the service had not recognised that the service had insufficient resuscitaires to meet the needs of the service based on number of birthing rooms, nor had they completed risk assessments for areas of the service that did not have immediate access to a resuscitaire. Following the inspection and our feedback, the service acted by ordering more resuscitaires and putting risk assessments in place.

Maternity

Managers monitored the top five risks at the monthly combined maternity and neonatal governance meetings. As of September 2023, the top recorded risks in maternity were the lack of robust maintenance programme to maintain the maternity building, significant shortages in the sonography department (staff who carry out ultrasound scans) and that the service had access to one obstetric theatre (and one procedure room). These risks were mere not effectively mitigated at the time of inspection. For example, the maternity building risk was only recorded since August 2023 despite being a long-standing risk and the mitigation recorded was 'business continuity planning.'

The sonography staffing risk had been recorded on the risk register since March 2021 and the mitigating actions were vague 'secure funding for additional capacity to meet current and future demand' and it was not clear what the current progress was to mitigate this risk.

The lack of access to a second obstetric theatre risk was recorded since March 2021 but there were no mitigating actions.

The service took part in national audits. Data was obtained and reported at trust level to the National Maternity Dashboard. Results across all metrics were within expected limits and so the trust was not considered an outlier. For example, the rolling 6-month average rate for perineal trauma (also referred to as 3rd and 4th degree tears) in March 2023 was 37.2 per 1,000 births across the trust against the national average of 27 per 1,000 births. The rolling 6-month average rate in March 2023 of post-partum haemorrhage of 1500 mls or above, was 44 per 1,000 births across the trust, against the national average of 29 per 1,000 births. The rate on a rolling 6-month basis in March 2023 for the number of pre-term babies born per 1000 births was 54.7 which is lower than the national average of 63 per 1000 births.

The service provided briefing reports as part of the maternity incentive scheme on their progress with Saving Babies Lives Care Bundle Version 3 (SBLCBv3). Version 3 was published in May 2023 and all NHS maternity providers are responsible for implementation by March 2024. The aim of SBLCBv3 is to provide detailed information to providers and commissions on how to reduce perinatal mortality across England. It identifies six areas of care and uses evidence based/best practice to drive improvement.

As part of the Maternity Incentive Scheme reporting process, progress is reported by way of self-assessment by the trust and then by the LMNS (local maternity and neonatal system) validated assessment status. The trust report dated 11 October 2023 outlined that all 6 elements were fully implemented for 34% of the interventions (LMNS validated assessment status). However, the service had self-assessed that they had fully implemented 41% of the interventions. Many of the LMNS suggested improvement activity was in relation to audits to lack of guidelines and pathways.

The trust was eligible to claim additional funding by the NHS Resolution Clinical Negligence Scheme for Trusts (CNST). The last maternity update to trust board in November 2023 showed the service met 10 out 10 CNST safety standards. They held monthly maternity incentive scheme (MIS) meetings to review compliance. The service had employed a cross-site project lead midwife for MIS year 5 whose role was to support with gathering evidence and preparing reports required for submission to the trust Quality and Governance Committee (Q&GC).

Information Management

The service did not always collect reliable data or analyse it in a timely manner. Staff could not always find the data they needed, in easily accessible formats. The information systems were not always integrated and secure. However, data or notifications were consistently submitted to external organisations as required.

Maternity

The service did not always collect reliable data, and it was not always evident that the service leaders had analysed the data in a timely manner. For example, in relation to audits and red flags. We also saw that information presented in the MatNeo Governance meeting did not correlate with what was presented to the board.

They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

The electronic patient records system was not yet fully integrated and records such as Cardiotocography (CTG's) and NEWS records were not yet computerised.

On the day of inspection staff supporting inspectors to access information from patient care records had difficulty navigating the system and accessing data.

Data or notifications were consistently submitted to external organisations as required.

Engagement

There was a limited approach to sharing information with and obtaining the views of staff and people who used

the service. Leaders did not respond to feedback in a timely way in order to improve services.

Following the inspection the service introduced rostered midwifery days for staff to meet with senior leaders to ask questions and discuss current issues. Midwives had access to Professional midwifery advocates and a recruitment and retention lead for support. The national health and wellbeing team at NHS England had visited both sites of the trust in January 2023, the aim is to support trust to improve and develop a program of improved health and well-being for maternity staff. Following the inspection the trust shared a summary of the feedback from listening events that was shared with staff. Immediate actions taken included; introducing measures to make health and wellbeing initiatives more accessible with a more proactive and preventative approach, and a re-vamp of existing rest areas. However, issues around rest spaces were raised at the time of the inspection. No further action plans were shared around on-going work from this visit.

Staff were enthusiastic about the service and the potential for improvement. A monthly maternity matters meeting was held in which staff would receive updates and there were opportunities for question-and-answer sessions with leaders.

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. The service listened to the feedback provided from women and birthing people about the use of electronic records. Feedback was also collected by the MNVP from women and birthing people around their experience of breastfeeding as part of the breastfeeding strategy, however it was unclear what the next steps were based on the action plans shared.

The trust and the MNVP had developed an informed decision-making tool and were in the process of drafting a 'care outside of guidance' guideline. This is when women or birthing people choose to birth in an environment not recommended by clinicians.

The trusts' pace of change in terms of co-production with the MNVP could be improved. For example, some actions were behind schedule such as, supporting the development of birthplace choices across Somerset and enhancing use of personalised care plans.

Maternity

The MNVP issued ‘star awards’ to midwives who they had received especially positive feedback about. We saw that midwives had been nominated for ‘star awards.’

The MNVP had completed a ’15 steps review’ of Musgrove Park Hospital in March 2023. Numerous recommendations were made, themes included the environment not being welcoming, comfortable or fit for purpose, including being cluttered, better and clearer signage and information needed, ensuring this is also in an accessible format and infection control issues. Whilst the trust commented that steps would be taken to work towards the recommendations, we asked for but did not receive evidence of an action plan. We also found similar issues which were identified in the 15 steps in March 2023 at the time of our inspection 8 months later.

We requested but did not receive an action plan following the 2022 NHS staff survey, only the 2021 NHS staff survey was provided from the previous year.

Support for trainee doctors could be improved. Results from the 2023 General Medical Council National Trainee Survey (GMC NTS), which trainee doctors complete in relation to the quality of training and support received; were compatible with the national average scores in 14 indicators. However, the results were worse than national average (but not an outlier), for four indicators (‘reporting systems,’ ‘handover,’ ‘induction’ and ‘regional teaching’) which all reduced from the 2022 survey.

Feedback from women and birthing people showed care, especially in relation to postnatal care could be improved. The CQC Maternity Survey results for 2023 showed, in comparison to other trusts, Somerset NHS Foundation Trust scored about the same for 50 questions, ‘better than expected’ for one question and ‘worse than expected’ for no questions. For six questions there was a ‘statistically significant decrease’ in scores when compared to 2021 results, the majority of these related to postnatal care.

We received 18 responses to our give feedback on care posters which were in place during the inspection. Of these responses 8 were positive feedback and 10 raised concerns about the service. Positive feedback related to the friendly and supportive staff and concerns raised about the service related to feeling listened to, the environment, pain relief and communication.

Learning, continuous improvement and innovation

There was limited evidence of learning and continuous improvement.

There was limited evidence of how learning from incidents had been fed into training to improve outcomes. Staff told us that there was shared learning they could access electronically and the opportunity to attend monthly drop-ins, but the uptake from staff was not clear.

Staff at Musgrove Park Hospital were involved in the PERIPrem initiative, which was a package of care aiming to reduce the number of pre-term births and also improve the outcome for those babies born prematurely.

They also took part in a staff coaching pilot, to improve staff engagement and satisfaction with their work. This showed positive results for those that took part, but it was unclear whether this was going to be rolled out to other staff and adopted across the service.

Maternity

The service did not have a quality improvement champion to coordinate and drive improvement, we also saw no evidence of training initiatives around quality improvement. We saw how steps had been taken to improve communication with staff such as white boards in staff areas with governance and other key information about risk and performance. Staff also told us how the new system for sharing new guidance was working well.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:
Maternity

- The service must ensure they apply and demonstrate compliance with Duty of Candour requirements. Regulation 20.
- The service must ensure staff are up to date with maternity mandatory training modules. Regulation 12(1)(2) (c)
- The service must ensure the security of the unit is reviewed in line with national guidance. Regulation 12 (1) (2) (a) (d)
- The service must ensure staff are up to date with the appropriate level of safeguarding training in line with national guidance. Regulation 12(1)(2) (c)
- The service must ensure that policies are available, up to date and reviewed in accordance with the review date. Regulation 17 (1) (2)
- The service must ensure all staff must receive annual appraisals. Regulation 18 (2) (a)
- The service must ensure that staff adhere to infection, prevention and control policies and procedures. Regulation 12 (2) (h)
- The service must ensure medicines and breast milk is stored safely and securely. Regulation 12 (2) (f)
- The service must ensure there are risk assessments for women and birthing people presenting to the triage service and best practice is considered to mitigate any identified risk. Regulation 12(2)(a)(b)

Action the trust SHOULD take to improve:

- The service should ensure the monitoring of incidents by ethnicity to evaluate incidents and clinical outcomes to ensure equality in maternity care.
- The service should consider providing additional support to staff around the use of electronic patient records.
- They should consider how ‘medicines as required’ (PRN) medicines and patient weight is recorded on the electronic medicines record.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 3 other CQC inspectors, and 2 midwifery specialist advisors and a Specialist obstetric advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.

Somerset NHS Foundation Trust

Yeovil District Hospital

Inspection report

Yeovil District Hospital
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Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Yeovil District Hospital

Requires Improvement 

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Yeovil District Hospital.

We inspected the maternity serviced at Yeovil District Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

Yeovil District Hospital provides maternity services to the population of Yeovil in South Somerset, North and West Dorset, and the Mendips.

Maternity services include an outpatient department, maternity assessment unit, triage, maternity ward for antenatal and postnatal care (Freya Ward), delivery suite, two maternity theatres, bereavement suite, antenatal clinics and an ultrasound department. Between April 2022 to March 2023 there were 1259 births at Yeovil District Hospital.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

This was the first time we inspected Yeovil District Hospital maternity services since merger of the two organisations. Our rating of this hospital went down. We rated it as requires improvement because:

- Our rating of inadequate for maternity services changed ratings for the hospital overall. We rated safe as inadequate and well-led as Inadequate.

We also inspected 2 other maternity services run by Somerset NHS Foundation Trust. Our reports are here:

- Musgrove Hospital – https://www.cqc.org.uk/location/RH5A8
- Bridgwater Community Hospital - https://www.cqc.org.uk/location/RH5K6

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.

We visited triage, the labour ward, the antenatal and postnatal wards.

We spoke with 18 staff including obstetric medical staff, midwives of different seniority, support staff and 2 women and birthing people. We received 2 responses to our give feedback on care posters which were in place during the inspection.

Our findings

We reviewed 9 patient care records, 6 observation and escalation charts and 5 medicines records.

Following our onsite inspection, we spoke with senior leaders within the service; we also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Inadequate ↓↓

ur rating of this service went down. We rated it as inadequate because:

- Not all staff had sufficient training to recognise and understand how to protect women and birthing people from abuse and manage safety well.
- There was not enough emergency equipment to safely care for babies.
- The service did not always control infection risk well. Not all staff followed infection control principles because they were not adhering to the trust's uniform policy. Nor did all staff adhere to hand hygiene principles when entering clinical areas prior to administering care. Audits were not used to monitor hand hygiene and cleaning at the service.
- The service did not always have enough medical staff. There were gaps in rotas which were covered by locum doctors and there was only 1 consultant led ward round a day, other ward rounds were led by a registrar.
- Leaders did not operate effective governance systems. They did not always manage risk, issues, and performance well. They did not consistently monitor the effectiveness of the service. Though staff were committed to improving services, they did not always have the skills and resources to do so.
- There was a lack of meaningful conversations and information regarding maternity services at executive board level.

However:

- The service had a safeguarding team who were available to offer support to staff when needed.
- The service acted and ordered additional emergency equipment to keep babies safe.
- The service was well maintained and visibly clean with effective signage in all areas.
- Staff worked together as a big team to cover areas where women and birthing people needed support.
- The service engaged well with women and birthing people and the community to plan and manage services.

Following this inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this action as we believed a person would or may be exposed to the risk of harm if we had not done so.

Is the service safe?

Inadequate ↓↓

Our rating of safe went down. We rated it as inadequate.

Maternity

Mandatory training

The service did not ensure all staff kept up to date with all aspects of mandatory training and key skills.

Midwifery staff did not always keep up to date with all of their mandatory training nor were they always meeting the trust target of 90% compliance. For example, midwifery staff were 24% compliant with diabetes training, 25% compliant with equality and personalised care training, 61% compliant with fetal growth restriction training and 88% compliant with reduced fetal movement training. Low compliance in training rates could lead to midwives being out of date with new guidance and practices and lead to potential risks to women and birthing people and their babies. However, for other mandatory training modules such neonatal life support midwives were 92% compliant. The service provides staff with multi-professional simulated obstetric emergency training. (PROMPT) Compliance for PROMPT training ranged from 100% compliance for obstetricians and consultant anesthetists to 87% for midwives.

Following the inspection the trust advised us that the data they had supplied during the inspection was for e-learning training and did not reflect face to face training compliance. The trust said that following the trust merger they had made a decision to enhance some areas of training with face to face training and that these face to face training sessions would be completed by staff within the next 2 years, from April 2023.

There was not a process for how managers monitored mandatory training. However, staff completed training in day sessions so as not to disrupt staffing on the unit. We were told matrons would work clinically to cover staff for them to be able to complete their training and that the service tried not to pull staff off their training to work clinically.

Student midwives had access to a practice development midwife as well as a preceptorship midwife once they had qualified. The service supported a programme of international midwives who would join the service as a band 4 midwife support worker until they had successfully completed their Objective Structured Clinical Examination (OSCE's) at which point they would join newly qualified midwives on the preceptorship programme for 12 months.

Safeguarding

Staff had not received training at a level appropriate to their roles on how to recognise and report abuse. However, staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so.

We identified and the trust were already aware that staff were not trained to the correct level in safeguarding children and adults in line with national guidance. Following the inspection, the service leaders told us the named Safeguarding Midwife, supported by the Safeguarding Learning and Development Lead would urgently review training and map this to Level 3 Safeguarding adult training. We were informed that midwifery staff had been trained to level 2 safeguarding adults training. However, we did not receive compliance rates for this training. The National Safeguarding Intercollegiate Guidelines state that all staff risk assessing women and birthing people should complete training to level 3 in adult safeguarding.

Following the inspection, we received data for the staff that had completed level 2 safeguarding adults training. This data showed that 10 members of staff had never completed level 2 safeguarding training, whilst some of these staff were new to the service some had been with the service over 6 months and 1 member of staff without level 2 safeguarding adults training had been with the service since March 2022.

Maternity

Staff were required to complete children's safeguarding training up to level 3. At the time of the inspection, 82% of midwives had completed this training and 50% of doctors. This was below the trust target of 85%. There were no action plans shared with us to show how the service was going to improve their compliance for children's safeguarding training.

Leaders did not have effective oversight of safeguarding. Safeguarding was a quarterly agenda item at the monthly Maternity Governance meetings. We reviewed October 2023 meeting minutes where safeguarding was an agenda item and found training compliance was not discussed.

Staff we spoke with were able to demonstrate they knew how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act and understood their responsibilities to make referrals to the local authority. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice.

Staff asked women and birthing people about domestic abuse, at booking and at regular intervals during the antenatal period of care. There was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans in place with input from the safeguarding team.

The service safeguarding team had worked on joining together with the Musgrove Park Hospital safeguarding team before the merger of Somerset Partnership NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust in April 2023.

The safeguarding team was part of a trust wide safeguarding advisory services structure. There was a named midwife for safeguarding, and a deputy named midwife for safeguarding, who were part of a team of midwives who supported women and birthing people who required extra nurturing due to being identified as vulnerable or who have a range of identified social needs. These safeguarding midwives had access to support from the trust leads for safeguarding adults and children as well as a domestic abuse lead. The team held a caseload of women and birthing people as well as supporting the wider maternity team by being on call to offer safeguarding support to staff on the wards.

The named and deputy named midwife for safeguarding, offered quarterly and as and when needed safeguarding supervision to their team of midwives as well as annual safeguarding supervision to the wider midwifery team.

Staff used an electronic records system where they could place an alert on the system to make other staff aware of safeguarding concern for woman or birthing person and their babies.

There were systems and processes in place to ensure information is shared with other professionals such as GPs and health visitors.

We were told that the safeguarding team worked closely with the local authority and contributed to groups within the local authority safeguarding team and were part of the Southwest safeguarding network. They told us they were respected and listened to and that there was an escalation policy in place in case of professional disagreements.

Staff followed safe procedures for children visiting the ward.

The service had a newborn security guidelines policy which at the time of inspection was being updated. This policy had been issued in November 2018 and had been due to be reviewed in November 2020 and was therefore overdue review.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection and had further plans for another drill to be undertaken in January 2024.

Cleanliness, infection control and hygiene

Staff did not always use effective control measures to protect women and birthing people, themselves, and others from infection. However, they did keep equipment and the premises visibly clean.

During the inspection we observed not all staff were bare below the elbow whist in clinical areas, nor did all staff adhere to hand hygiene principles when entering clinical areas before administering care.

At the time of the inspection, the maternity service did not complete audits to monitor if staff were bare below the elbow and hand hygiene compliance audits. This meant leaders could not be assured that staff were followed infection control principles. Leaders informed us they did daily walk rounds of the service and would discuss these principles with staff that were observed not to be acting appropriately. Leaders told us there were plans to start hand hygiene and 'bare below the elbow' audits.

Maternity service areas were clean and had suitable furnishings which had been kept clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use.

Domestic staff were available on the ward areas, and we saw them undertaking their duties. Safe colour coded cleaning equipment items were used, and waste was handled correctly.

During the inspection we asked 3 staff if they knew who in the service was the lead for infection prevention control. These 3 staff were not aware of who the lead was. Following the inspection the trust advised us that they did not have specific champions for infection prevention control and that this is the responsibility for the relevant manager of each area.

Environment and equipment

The design, maintenance and use of facilities and premises mostly kept people safe. Staff managed clinical waste well. However, not all areas of the service had sufficient emergency equipment available.

The service was accommodated over 3 floors of the women's hospital at Yeovil District Hospital. All areas of the service had clear effective signage.

Situated on the ground floor were antenatal clinics, ultrasound facilities, day care services, Consultant, and specialist midwife services. There was a separate room where staff were able to facilitate private conversations with women and birthing people, this room was furnished in a non-clinical way making for a supportive environment.

Maternity

The waiting area for antenatal clinics was shared with the gynaecology clinics. This conflicted with national guidance (Health Building Note – Maternity care facilities) where it is advised that waiting areas should be subdivided into separate waiting spaces.

The 1st floor housed an operating theatre and recovery room, used for elective caesarean sections and gynaecology procedures. The theatre was appropriately equipped, containing all equipment needed in an emergency. There were 4 slots a week for elective caesarean sections.

On the 2nd floor there was a dedicated triage service and the maternity ward (Freya ward). The triage area was for women and birthing people who presented with pregnancy related concerns. Triage consisted of 2 assessment rooms, 2 side rooms and a treatment area suitable for 2 women or birthing people and a waiting area. The waiting area had good visibility so that staff would be aware if a woman or birthing person became unwell whilst waiting to be seen or for a follow up review.

The maternity ward (Freya Ward) consisted of 3,4-bedded bay areas and 2 side rooms. Women and birthing people who required both postnatal and antenatal care were looked after on Freya Ward. As well as babies who required transitional care. Freya Ward was adjacent to the special care baby unit (SCBU). There was only 1 neonatal resuscitaire available on the 2nd floor of the service. This resuscitaire was located in the special care baby unit. The door joining SCBU to Freya ward was a locked door and meant that the resusciataire was not easily and immediately available if required. Freya Ward had some emergency equipment that could be used on a baby in an emergency, but this equipment was not stored correctly which meant there was a risk the equipment could be tampered with. There was not an appropriate alternative safe space to resuscitate a baby in the absence of a neonatal resuscitaire. In triage there was some adult and baby emergency equipment but no safe space for use or storage. This was reported to the trust who took action to ensure there was a further resuscitaire available for use across Freya Ward and the triage area.

Located on the 3rd floor was the labour ward an emergency theatre and a bereavement suite. There was no theatre recovery room on the delivery suite. Women and birthing people needing care following an emergency procedure would be cared for in a birthing room.

The labour ward consisted of 6 birthing rooms all with ensuite facilities. There were 2 neonatal resuscitaire for the 6 birthing rooms. There was a risk that if all rooms were in use there would not be enough neonatal resuscitaire. Staff carried out daily safety checks of specialist equipment. There were some gaps in checks. However, the majority of checks were carried out.

Across the corridor from the labour ward was a birthing room with a birthing pool, the birthing pool was staffed when needed and available for women and birthing people who were low risk and assessed as appropriate for a water birth. There was a resuscitaire available for the room with a birthing pool.

Also across the corridor was a bereavement room. This room was furnished to be less clinical with a pull-down double bed and a sitting area. Due to location of the bereavement room women and birthing people who were using this facility did not have to go through the main labour ward and would not hear other women and birthing people who were giving birth or newborn babies crying.

Call bells in all areas of the service were accessible to women and birthing people if they needed support and staff responded quickly when called.

Call bells in shower rooms and toilets were via a red cord. These had not been risked assessed for a ligature risk and as a result, were not encased in suitable material to minimise being used for this purpose. A National Patient Safety Alert was issued around ligature and ligature point risk assessment tools and policies in March 2020. The expectation on the response to this was to ensure risk assessments were undertaken and responded to. However, the service had not taken appropriate risk assessments to ensure staff were aware of ligature risks. This was raised with the service during the inspection who agreed that risk assessments need to be put in place.

The design of the environment mostly followed national guidance. The maternity unit was fully secure with a monitored entry and exit system. On the day of the inspection, the secure exit system was not fully working. Leaders had acted promptly and appointed security personnel outside of the labour ward.

Medical equipment was not always serviced when it should have been. Records show that compliance for equipment testing was 85.8% across maternity services at the hospital. There was a risk that equipment currently in use was not safe or working effectively.

For staff visitors and women and birthing people to move between the 3 floors of the service there were 2 lifts, both lifts were large enough to accommodate a hospital bed. On the day of the inspection one of the lifts was broken, this had been reported and was awaiting repair. We were shown the guidance for staff to follow in the case of a lift failure. However, this guidance document should have been reviewed in September 2023, 2 months before the inspection. The birth partners of women and birthing people were supported to attend the birth and provide support.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Signage in all areas of the service was clear and easy to follow. On the delivery suite we saw signage saying welcome to “labour ward” in several different languages.

During the inspection there was maintenance underway and windows in the maternity service were being replaced. Contractors were liaising with staff to ensure the privacy of women and birthing people.

Assessing and responding to risk

Staff did not always utilise tools to identify if women and birthing people were at risk of deterioration and therefore there was a risk, they would not recognise concerns or act appropriately.

The service used a nationally recognised tool to identify women and birthing people at risk of deterioration. Staff used the Modified Early Obstetric Warning Score (MEOWS) to assess women and birthing people. We reviewed 6 MEOWS records and found staff had only fully completed 2 out of the 6. At the time of the inspection, there were no audits to monitor staff compliance with completing, scoring and escalating appropriately when a MEOWS showed deterioration in a woman or birthing persons condition. This meant that the trust did not have oversight of the effectiveness of staff’s use of the tool. It also meant that women and birthing people were at risk of staff not identifying that their health was deteriorating if staff had not noticed or documented the signs of deterioration. We brought this to the attention of leaders at the trust and have been advised audits will begin in December 2023.

The service currently complete newborn assessment observation and early warning score forms (NEWS) on their electronic records system. The service did not audit the use of the NEWS tool. Following raising our concerns a

retrospective audit of NEWS on the services electronic recoding system was undertaken. This showed 49.6% compliance rate of NEWS forms. Further audits were scheduled for 2024 and findings were to be discussed at the maternity and neonatal (MatNeo) governance meeting. The service did not share if an action plan was developed and implemented to improve the compliance of NEWS observations.

Women and birthing people who presented at maternity triage were assessed using a recognised, standardised risk assessment tool and pathway. An initial assessment would determine a categorisation of red, orange, yellow, or green, which guided staff to which women and birthing people needed ongoing care immediately, their prioritisation for follow up care which could include being seen by a doctor, or if they could be discharged home.

The service had looked at their available space and moved their day assessment area to the ground floor with the antenatal clinic to create a workable triage space.

The triage service was staffed by 1 midwife and a maternity support worker (MSW) and on the day of the inspection there was also a student midwife. The midwife was expected to answer phone calls as well as assessing and monitoring women and birthing people. We were told that when the midwife was not available the calls would be answered by either the student midwife or the MSW. If the call was not answered by staff in triage, it would be transferred to a phone on the labour ward. We were told that unqualified staff did not give advice, they would take the details of the caller and the midwife would return the call. Unless it was obvious that the woman or birthing person needed to be seen immediately in which case, they would be asked to come into the unit.

At the time of the inspection, telephone calls were taken in the clinical area by the midwife who was working on triage. This was not in line with national guidance and had led to incidents reported nationally by Healthcare Services Investigation Branch. There were plans to combine the telephone triage line with Musgrove Park Hospital's maternity services and would ensure the telephone triage service would be staffed during high acuity hours between 7.30am and 8pm, and away from the clinical area.

In October 2023 there was an external review of triage in the maternity service. Feedback included positive feedback and where improvements could be made.

Positive feedback from their visit including, staff embracing the standardised care system, areas had been split into an excellent triage area, with an appropriate space for unscheduled attendees, good clinical oversight and the creation of a midwife-led clinic in the day assessment area away from triage for scheduled appointments and staff training.

During the inspection we found that due to staff training and competencies some scheduled appointments were still taking place in the triage area. For example, iron infusions (treatment for women and birthing people with low iron levels) were taking place in triage as the staff had the skills set and arrangements had not been made for a more appropriate place for these infusions to be administered. Additionally, the triage midwife on shift during the inspection had been called away to the outpatient clinic to give a patient a vaccine as the staff in clinic did not have the skills to do so.

The maternity triage service closed at 7.45pm, after this time women and birthing people needing the triage service wereseen on the labour ward. The service had not added additional staff on labour ward to cover triage. There was a risk that women and birthing people who use the triage service out of hours would not be seen within 15 minutes in accordance with national guidance.

Maternity

The service had not completed audits of the safety and effectiveness of the maternity triage. Leaders and staff did not have oversight and could not be assured that women and birthing people were seen within the timescales set out in the assessment tool or that all women and birthing people were all assessed and prioritised correctly.

Staff on the labour ward used the 'fresh eyes' approach to carry out fetal monitoring safely and effectively. We reviewed care records and could see that 'fresh eyes' observations were carried regularly every hour in line with national guidance and documented by labour ward staff.

We reviewed a draft report with data from July – September 2023 which was written following the inspection and mentioned CQC's review of care records during the inspection. The report stated that a review of the 'fresh eye' approach showed the 'fresh eyes' approach was used in 141 out of 145 occasions. However, this was a draft report and was not currently part of the services audit programme. The draft report stated there had been a delay in the audit due to the implementation of an electronic maternity records system and anticipation of changes to CTG guidelines. Leaders could not be assured of regular oversight of staff compliance with fetal monitoring at the service.

The service had a fetal monitoring action plan. However, this action plan did not comment on a 'fresh eyes' approach during induction of labour and was reliant on the trust updating their CTG guidelines.

Misinterpretation of intrapartum CTGs was on the service's risk register as the service had been using 3 classification tools. The mitigation for this known risk was to implement intrapartum fetal monitoring guidelines with a target date of November 2023.

The service provided transitional care for babies who required additional care.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the woman's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection, we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to- date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation for each person.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third party organisations were informed of the discharge.

Midwifery Staffing

Maternity

Staffing levels did not always match the planned numbers and staff did not always have the right skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment. The service did not always make sure all staff were competent for their roles. Not all staff had received an appraisal of their performance or support with their development.

Staff were allocated to the different areas of the service daily depending on the acuity in each area. Managers moved staff according to the needs of the service. We were told by leaders that there were currently no midwifery vacancies at the service. The chief nurse reported in the September 2023 six monthly staffing report to the trust board that 21 of the

student midwives who trained at the trust had been successfully recruited to the service with planned start dates in October 2023.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Between 1 July and 20 December 2023, the service reported 21 red flag incidents. These included 10 occasions where there was more than 2 hours delay in admission for an induction of labour and the beginning of the procedure and 7 occasions where the supernumerary status of the labour ward coordinator was not achieved. Red flags were reported and discussed at trust board and Quality and Governance Assurance Board sub-committee.

Managers accurately calculated and reviewed the number and grade of midwives and maternity support workers, needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in December 2021. This review recommended 67.04 whole-time equivalent (WTE) Band 3 to 8 compared to the funded staffing of 65.45 WTE, a shortfall of 1.59 WTE staff.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. They worked closely with a matron who had wider oversight of the services. Due to the occasions where it had not been possible for the labour ward coordinator to achieve supernumerary status, it was discussed at the September 2023 board meeting.

We asked the service for information regarding their use of agency and staff sickness rates. However, we did not receive this information.

The trust had specialist midwives such as a bereavement lead, safeguarding and audit midwife that covered both Musgrove Park Hospital and Yeovil District hospital. There were other specialist midwifery roles such as infant feeding, digital, governance and screening leads who were based at the service in Yeovil District hospital.

The service had recruited 2 international midwives both had passed their Objective Structured Clinical Examinations (OSCE's) and were working in Band 5 preceptorship roles.

Staff told us they worked as one big team and that senior and specialist midwives worked clinically when needed, or to cover for midwives to take their breaks and attend training. Due to the way managers allocated staff, they were all familiar with areas within the service and did not feel they were asked to work in an area they were unfamiliar with.

Band 5 preceptorship midwives told us that the service was a supportive, friendly environment. They received monthly catch ups from the preceptorship lead and benefitted from a buddy system.

The service had its own bank staff who were familiar with the service and made sure all bank and agency staff had a full induction and understood the service. shifts that needed to be covered were done so by staff from wither the continuity of carer team or by bank staff who already work at the service.

The service did not always make sure all staff were competent for their roles. Not all staff had received an appraisal of their performance or support with their development.

Staff told us they felt supported by their managers. However, when we reviewed data on the number of staff that had received an appraisal only 50.5 % of midwives had received an annual appraisal within the last 12 months prior to our inspection.

The service had a practice development lead and a practice development midwife who supported staff with training. The practice development team had won an award for their work around 'Implicit Bias' in maternity care 2022. This award was around their approach of treatment and recognising signs of deterioration in babies of all skin colours and was won after they entered a competition to gain funding for resuscitation dummies in different skin colours to support staff's understanding of monitoring vital signs.

Medical staffing

There was not always enough medical staff with the right qualifications, skills, training, and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment. However, recruitment had been on going. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service always had a consultant on call during evenings and weekends. We were told by medical staff that there was not always a consultant present for the 2nd ward round each day, where there were gaps the ward round was led by a registrar. This was not in line with Ockenden recommendations made in February 2021, which recommended that there must be a minimum of twice daily consultant led ward rounds. This meant the service did not always have a good skill mix and availability of medical staff on each shift. Following the inspection the trust shared data regarding consultant presents at ward rounds. This showed there were some gaps. However, the majority of times when the ward round was not in full attendance this was due to none attendance of anesthetist. The trust also shared a consultant obstetrician job plan which stated the consultant coved the 2nd ward round as part of their hot week duties.

The service had vacancies for medical staff. There were 3 vacant registrar posts of which 2 posts had been filled put the post holders had not yet started at the service. Medical staff we spoke to said gaps in the rota were covered by locum doctors.

Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work.

The service had an induction handbook for doctors on rotation at the service covering maternity and gynaecology. As well as a locum induction checklist, that was to be completed on the first shift for any new locums working at the service.

Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop. Junior doctors told us that they knew who to escalate concerns to.

Maternity

Records

Staff mostly kept detailed records of women and birthing people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

The service had started using an electronic recording system specifically designed for use in maternity services in February 2023. Some staff were still getting used to the system. We reviewed 9 electronic records. Most women and birthing people's notes were comprehensive, and all staff could access them easily. However, we found that not all records were fully completed. It was not always recorded where additional risk factors in pregnancy were identified as high risk and required additional monitoring. These risk factors varied from high body mass index to social factors. The lack of documentation of these risks put women and birthing people at risk of not receiving the correct treatment.

Leaders had not audited the use of the electronic recording system in the time since it was implemented in February 2023. This meant that leaders could not be assured of the quality of recording. We were told that there were plans to audit the electronic records in March 2024.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

The service had a digital midwife who was able to support staff when needed with any issues relating to the electronic records system.

The trust had previously used a different patient administration system (PAS) and it had been identified that when transferring data from PAS to the maternity electronic records system, that women and birthing people's ethnicity was not being accurately recorded. This had led to a project by the digital team to review and implement changes.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had electronic prescription charts for medicines that needed to be administered during their admission. We reviewed 7 prescription charts and found staff had correctly completed them.

Staff reviewed medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

Staff completed medicines records accurately and kept them up-to-date. The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct

temperature. The temperature of the clinic room where medicines were stored was monitored by the pharmacy team. To Take Out (TTO'S) in the medicines cupboard on Freya ward were dated the month before the inspection. These medicines were given to staff who returned to the pharmacy Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to act if there was variation.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services.

Staff completed e learning courses on medicine management. The trust did not monitor staff's ongoing competencies around medicines management.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents; Incidents were not always correctly categorised. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. However, there was not effective systems in place to ensured that actions from safety alerts and lessons learned were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. The service had an incident reporting and management policy for staff to follow which set out actions staff must take along with roles and responsibilities.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. The governance lead for midwifery had oversight of daily incidents and serious incidents. Incidents were discussed at weekly maternity governance meetings, and monthly at Maternity and Neonatal (MatNEO) governance meetings. However, the grading of incidents had not been minuted at these meetings.

We reviewed 115 incidents reported in the 3 months before inspection. The leaders could not be assured all were fully reviewed to promote investigation and improvement such as for obstetric haemorrhage. However, those graded as serious incidents did have a thorough investigation with a 72 hour review and were also discussed at the trust serious incident review group. We reviewed 2 such incident review reports. These reports showed involvement and views of the women, birthing people and the families in the incidents. Managers shared duty of candour and draft reports with the families for comment. However, actions from reviews were not always clear or had an assigned owner to carry out any actions.

Learning was shared with staff by email on a learning from incident review forms. Staff met to discuss the feedback and look at improvements to the care of women and birthing people as part of their perinatal meetings for all staff, at Band 6/7 meetings as well as using governance boards across the service. However, there was often a delay between the completion of the audits and creating an action plan to make improvements. Any action staff were asked to undertake was not followed up with an audit therefore leaders could not be assured that staff were making changes or that the proposed changes had been effective.

There were 2 'never events' at the service in the 3 months prior to the inspection, in maternity theatres. 'Never events' are incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Maternity

These events had been investigated and action taken to improve systems in the maternity theatres. These actions included improvements made to the use of World Health Organisation (WHO) surgical safety check list and procedures used to trigger action in cases of massive obstetric haemorrhage (MOH). However, there had been no audits undertaken on how effective these changes had been.

We did not identify any evidence that managers reviewed incidents potentially related to health inequalities.

Managers debriefed and supported staff after any serious incident. We were told debriefs looked at what went well as well as where things could be improved and supporting staff.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

Leadership

There was a newly established leadership team in maternity services. The maternity leadership team for the trust was formed as part of the trust merger in April 2023. Some leaders had been in post for only 2 weeks before the inspection. Leaders had not prioritised audits to ensure the quality of the service. Some leaders were more visible than others. Executive leaders did not always understand and manage the priorities and issues the service faced.

Maternity services at the trust were managed as part of the service group for children, young people, and families. This included services such as child and adolescent mental health services (CAMHS) women's sexual health and maternity services.

The structure of the senior leadership team did not support effective clinical oversight of maternity services. The service group had a quadrumvirate that consisted of the director of midwifery (DOM), an associate director of patient care for the service group, the associate medical director for obstetrics and gynaecology, sexual health and dental, who was a vascular surgeon and a paediatric and neonatal doctor. There was not a dedicated triumvirate/quadrumvirate for maternity services.

Actions from senior leadership team meetings were not tracked effectively. The quadrumvirate leadership team told us they met every 2 weeks. There were no minutes to these meetings, but they kept an action tracker of actions agreed. This tracker showed all items as completed. However, not all items had a date that they were completed and 1 item marked as green stated it needed further action.

The associate director of patient care for the service group and the director of midwifery (DOM) reported to the safety champions twice a month. There were 3 board level safety champions, which were the chief nurse and 2 non-executive directors. The safety champions then reported up to the board. The DOM informed us that they attended board level quality and safety meetings where they presented maternity information, and that they attended board meetings 3-4 times a year. However, on review of the public board meetings for the year of 2023 the DOM was not listed as attending, we did not receive minutes for the quality and safety meetings.

Maternity

We reviewed the maternity safety champion meeting minutes for the last 5 meetings and found that there was poor attendance from the Trust board level safety champions. From meetings held in May 2023, July 2023, August 2023, September 2023, and October 2023 there was only 1 occasion out of 5 when 2 safety champions and the DOM were present. This at times led to the meeting not being quorate, which was minute but led to no improvement in attendance. We also saw that the effectiveness of the meetings was questioned, attendees noted improvements were needed around learning shared at the meeting, but this led to no evidenced improvements in this area. Those in attendance were unable at times to progress actions due to lack of attendance from key members. We also spoke with the 3 board safety champions. They were consistently positive about the assurance they received about the service and did not demonstrate an awareness of the challenges in the service. The service could therefore not be assured of the effectiveness in the board safety champions being cited on maternity issues and driving quality and safety improvements.

We saw maternity briefing reports for the quality and governance assurance committee (Q&GAC) which was a subcommittee to the board. Areas of concern would then be highlighted for escalation and discussion at the public board meeting. It was not clear from the Q&GAC briefing minutes provided who attended those meetings, or if there was an overarching action plan to track progress. The reports were discussed at board level and staffing within maternity was included as part of overall staffing discussions. We also saw that the board had reviewed the risk register which included risks over 15 which also sat on the corporate risk register, this included risks around theatres and estates with maternity. The board could not be properly cited on issues around audits, poor attendance at meetings (which impacted compliance with the maternity incentive scheme) and poor compliance with training and appraisals as these were not included in the Q&GAC meetings and the service had poor oversite of the issues faced.

The figures presented to the board did not match up with data we received around incidents for the service or from the data supplied from the combined maternity and neonatal (MatNeo) governance meetings. In the board papers, figures showed that there had been no babies born in an unexpected poor condition between the months of October 2022 and September 2023. The combined MatNeo governance meeting showed data from August 2022 to September 2023 where there had been 5 occasions where therapeutic cooling of babies was needed, on 4 of these occasions' babies needed to be transferred to a specialist unit in another hospital trust. There was also a missed opportunity to provide the board with regular key safety performance information such as delayed induction of labour and meeting national guidance for emergency caesarean sections. Following the inspection the trust advised us that at the time of the inspection the MatNeo governance meeting was not covering both hospital sites. This meeting did not cover Yeovil District hospitals maternity service. This was not clear when reviewing the documentation, nor was it clear from the board papers if the executive board had oversight of the maternity service at both hospitals.

Executive leaders were not always visible in maternity services. Staff told us the head of maternity was visible and approachable in the service for women and birthing people and staff. However, when asked about visibility of the director of midwifery, who covering both Yeovil District Hospital and Musgrove Park Hospital, and the executive leadership team not all staff felt they were as visible. However, staff told us they were well supported by their line managers, ward managers and matrons.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Maternity

There was a systems strategy, combining maternity and neonates' The strategy had been written in 2023 after the recommendations from the Ockenden 2020 and 2022 reports. Also, with the merger between Somerset Foundation Trust and Yeovil District Hospital in mind. They had a vision for what they wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Staff could explain the vision and what it meant for women and birthing people and babies. The progress and oversight of the strategy was monitored at a systems level.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. However, it was not clear that leaders and staff understood and knew how to apply processes in the strategy and there were no systems in place to monitor progress.

Culture

Most staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

We received mixed feedback on how well staff were supported. Most staff felt respected, supported, and valued and said that there was a good working relationship between staff groups. However, some staff told us that they felt more could be done to support junior staff, that the culture at the service could be hierarchical and that consultants were felt on occasions to be dismissive during professional disagreements. Most staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. Staff at the service said that they benefitted from working across the service as one big team. Most staff, but not all said that the merger with Musgrove Park Hospital had been a positive move.

The service had recognised culture at the service to be of concern. Poor culture had been added to the risk register. The risk register stated that there was an action plan in place with a target date of January 2024. Leaders were planning to monitor staff feedback from a range of sources such as exit interviews, freedom to speck up and reviews of incidents.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

The trust had an equality and impact assessment tool that was used when creating and reviewing policies and procedures. This assessment tool had been discussed at board meetings where the outcome had been, more should be done to ensure that the tool is used to assess reports prior to them going to board. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. Staff understood the policy on complaints and knew how to handle them.

Maternity

Managers investigated complaints, identified themes, and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. We reviewed the trusts responses to the last three complaints and found complainants questions were responded to in detail and a full apology given. Staff could give examples of how they used women and birthing people's feedback to improve daily practice.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

We did not see evidence of leaders exploring and understanding how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. There was no evidence that incidents were reviewed in relation to whether ethnicity or health inequalities may have impacted outcomes.

Governance

Leaders did not operate effective governance processes throughout the service. Leaders did not have clear oversight of the service. However, leaders made referrals to partner organisations when this was required.

The service did not have an effective program of regular local audits to ensure the safety and quality of the service was monitored and processes to learn from incidents were not effective.

The service did not have effective governance processes. The governance structure did not always support the flow of information from front line staff to senior leaders and vice versa. Governance and safety champion meetings took place but were not always well attended by senior leaders. We saw discrepancies in information about key safety and performance metrics at a service level to information and key safety and performance metrics discussed at executive board level.

We reviewed the last three meeting minutes of the governance meetings and the combined maternity and neonatal governance meetings. We found that the number and type of incidents were broken down, the risk register was discussed, and issues such as complaints, training, acuity, guidelines, and safeguarding were also discussed. However, there was a lack of clear action and accountability from these meetings to drive improvement.

Data and key performance metrics discussed at governance meetings was often a year old and therefore we were not assured any themes and trends were actioned or responded to quickly.

Maternity quality surveillance data reviewed at this meeting was minimal and only included raw data of the numbers of PPH incidents, shoulder dystocia, 3rd and 4th degree tears rather than statistical process charts to map trends over time. Further work was needed to make the information presented more meaningful and provide context.

Governance meetings were not always attended by the head of midwifery or the director of midwifery. It was unclear if this meant that actions could not be decided upon as some items had actions whereas others did not.

The service did not have effective systems in place to ensure staff received regular supervision and appraisals. Required staff training had not been completed by all staff. Ineffective systems had led to staff not being asked to complete safeguarding level 3 adults training, due to a lack of oversight of the training mapping. Systems for ensuring the safety, oversight, maintenance, and monitoring of equipment were not effective.

Maternity

Leaders at the service had not recognised the need and their responsibility to ensure the oversight of quality at the service. As well as not ensuring an effective audit programme was in place, there was no effective process for reviewing and updating policies and guidelines. Senior leaders were not always present at governance meetings or invited to present information regarding the service at executive board meetings. Following the inspection, we were advised that the trust had devolved responsibility for oversight on maternity governance issues to the Quality and Governance Assurance Committee. We were told senior leaders were always present to discuss the reports in detail at these meetings. However, the data we received for these meetings did not state who was present at the meetings or what escalation the Quality and Governance Assurance Committee would follow regarding information of concern.

The maternity safety champions covered maternity and neonatal services on both Yeovil District Hospital and Musgrove Park Hospital sites. However, the visit to Yeovil District Hospital was not regular with the last recorded visit as July 2023 with 2 safety walk rounds of the maternity services. However, there was a safety champions' board displayed in the service advising staff of who the safety champions were as well as information on the next walk round.

The director of midwifery (DOM) reported to the safety champions twice a month. There were 3 board level safety champions, which included the chief nurse and 2 non-executive directors. The safety champions then reported up to the board. We were told that the DOM attended board level quality and safety meetings where they presented at board meetings 3-4 times a year.

Maternity safety champions were not effective in their role in improving 'floor to board' communication. We reviewed 5 notes and actions from maternity safety champion meetings between May and October 2023. There was only 1 occasion out of 5 when 2 safety champions and the DOM were present.

We raised our concerns about the governance of the service following the inspection. Leaders told us they would review their systems for oversight within maternity to ensure oversight of the training and appraisal position improved and staff were clear on their accountabilities.

Management of risk, issues, and performance

Leaders and teams did not used effective systems to manage performance. They did not always identify and escalated relevant risks and issues or take actions in a timely manner to reduce their impact.

The service did not have an effective program of regular local audits to ensure the safety and quality of the service was monitored and processes to learn from incidents were not effective.

There were significant failures in audit systems and processes. Audits we would expect a service to undertake for leaders to have oversight of key safety and performance metrics were not being regularly undertaken. For example, the service had not audited the use of Modified Early Obstetric Warning Score (MEOWS), newborn assessment observation and early warning score forms (NEWS), triage, handover tool Situation Background Assessment (SBAR), World Health Organisation theatre checklist (WHO) or the electronic records system.

When improvements had been made at the service, they were not monitored to ensure they were fully implemented or that best practice were being followed. For example, a maternity electronic record system was implemented in February 2023. However, there had been no audits of the system to ensure staff were using the system effectively. In governance meetings leaders could not assure themselves that a drop in reporting was not down to poor record keeping. In September 2023 and in October 2023, it was recognised in the maternity governance meeting minutes that staff may not always be recording information correctly on the electronic patient record system and that audits may be pulling the

information from several places. However, despite the electronic patent record system being in place since February 2023 there had been no audit of how well the system had been implemented or the quality of the record keeping. We discussed this with the service during the inspection process and were advised that the trust's governance team would support the maternity governance team to develop a more coordinated approach to auditing.

Risks were not always identified by leaders through the service's incident management systems. When risks were identified the service did not always act promptly to take action. The service had not recognised safety risks that were identified on inspection. For example, leaders at the service had not recognised that the service had insufficient resuscitaires to meet the needs of the service based on number of birthing rooms, nor had they completed risk assessments for areas of the service that did not have immediate access to a resuscitaire. Following the inspection and our feedback, the service acted by ordering more resuscitaires and putting risk assessments in place.

The service had a risk register which identified a risk score, risk lead and owner. Risks were reviewed. However, the register did not state when the risk had first been added which meant we were not able to assess how well the service managed these risks. Following the inspection the trust told us that their risk register does include the dates that risks are added to the register. However, this information was not shared with us.

The service took part in national audits. Data was obtained and reported at trust level to the National Maternity Dashboard. Results across all metrics were within expected limits and so the trust was not considered an outlier. For example, the rolling 6-month average rate for perineal trauma (also referred to as 3rd and 4th degree tears) in March 2023 was 37.2 per 1,000 births across the trust against the national average of 27 per 1,000 births. The rolling 6-month average rate in March 2023 of post-partum haemorrhage of 1500 mls or above, was 44 per 1,000 births across the trust, against the national average of 29 per 1,000 births. The rate on a rolling 6-month basis in March 2023 for the number of pre-term babies born per 1000 births was 54.7 which is lower than the national average of 63 per 1000 births.

Information Management

The service collected reliable data. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. However, service did not always analyse it in a timely manner.

The service collected reliable data, but there was not always evidence that the service leaders had analysed the data in a timely manner. They had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

Staff could find the data they needed.

The information systems were integrated and secure.

Data or notifications were consistently submitted to external organisations as required.

Engagement

Leaders and staff engaged with women and birthing people. They collaborated with partner organisations to help improve services for women and birthing people.

Maternity

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. The MNVP told us they felt embedded into the service, that leaders at the service were approachable and that they felt listened to. They told us that they had worked with the trust on 2 main projects. These projects were on personalised care and bereavement care.

The service made available interpreting services for women and birthing people. Staff were able to tell us of times when interpreting services had been used. However, it was mainly a telephone service that was utilised.

Leaders understood the needs of the local population. They were able to inform us of their local demographic and had continuity of carer teams in postcode areas where they were most needed.

We received 2 responses to our give feedback on care posters which were in place during the inspection. Of these responses we had a mixed response 1 both positive and mixed response.

Learning, continuous improvement and innovation

Learning from incidents was shared with staff. Improvements needed to be made to the way in which leaders at the service recognised and encouraged staff to use quality improvement methods and to participate in research.

When things went wrong the service looked at incidents and identified learning on how they could improve and added situations from the incidents to their training programme. There was a learning board in the labour ward office where information on the emergency of the month was shared. Information on learning was also shared by email to all staff.

We were given details of a local maternity and neonatal systems (LMNS) funded project that had supported staff with empowering, resolving problems and improving access to support. We did not however see any evidence of quality improvement meetings where those involved would look at ways in which they could improve their service through quality improvement methodologies.

The service did not have a quality improvement champion to coordinate and develop quality improvement initiatives. For example, an improvement at the service was where leaders had put in place white boards to ensure a live count of swabs used during birth in birthing rooms and theatres. However, this had not been followed up with an audit of how effective this new process was or if staff were using the process correctly. Additionally, this new way of working had not been shared with or taken on by Musgrove Park Hospital, another maternity service within the same trust. Following the inspection, we were advised that these improvements had been embedded at Musgrove Park Hospital. However, we observed to not be the case during our inspection.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies.

Outstanding practice

We found the following areas of outstanding practice:

The service had won an Award for the introduction of ‘Implicit Bias’ and training recognising signs of babies being unwell by using resuscitation dummies of different skin colour.

Maternity

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:
Maternity

- The service must ensure staff are up to date with maternity mandatory training modules, including adult and children's safeguarding training at level 3. Regulation 12 (1) (2) (c)
- The service must ensure staff accurately complete, and document modified early obstetric warning scores and newborn assessment observation and early warning score forms in order to identify and escalate women and birthing people and babies at risk of deterioration. Regulation 12 (2) (a) (b)
- The service must ensure effective risk and governance systems are implemented which supports safety and quality care. Regulation 17 (1) (2)
- The service must ensure that policies are up to date and reviewed in accordance with the review date. Regulation 17 (1) (2)
- The service should ensure all staff must receive annual appraisals. Regulation 18 (2) (a)
- The service must ensure electrical equipment is properly maintained. Regulation 15 (1) (e)

Action the trust SHOULD take to improve:

- The service should ensure that all staff adhere to the uniform policy to maintain effective infection prevention control.
- The service should consider a review of arrangements for twice daily consultant led ward round to comply with national guidance.
- The service should consider monitoring incidents by ethnicity to evaluate incidents and clinical outcomes to ensure equality in maternity care.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 2 other CQC inspectors, 2 midwife specialist advisors and an obstetric specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care

Somerset NHS Foundation Trust

Bridgwater Community Hospital

Inspection report

Bower Lane
Bridgwater
TA6 4GU
Tel: 01278436555

Date of inspection visit: 20 and 21 November 2023
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this location	Insufficient evidence to rate
Are services safe?	**Insufficient evidence to rate**
Are services well-led?	**Insufficient evidence to rate**

Our findings

Overall summary of services at Bridgwater Community Hospital

Insufficient evidence to rate

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Bridgwater Community Hospital.

We inspected the Mary Stanley midwife-led unit at Bridgwater Community Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

The Mary Stanley midwife-led unit at Bridgwater Community Hospital provides maternity services to the population of Bridgewater, Minehead, Glastonbury and the surrounding areas.

Maternity services include a midwifery-led birthing centre with 2 birthing rooms both with birthing pool rooms. At the time of inspection, one birthing room was used as a clinic room and the other was set up for births. Between October 2022 and October 2023, 5 babies were born at the Mary Stanley midwife-led unit at Bridgwater Community Hospital.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

We had not previously rated this hospital. We did not have sufficient evidence to rate the hospital overall. We rated maternity services requires improvement in safe and well-led.

We also inspected 2 other maternity services run by Somerset NHS Foundation Trust. Our reports are here:

- Musgrove Park Hospital - https://www.cqc.org.uk/location/RH5A8
- Yeovil District Hospital - https://www.cqc.org.uk/location/RH5O4

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.

We visited the two birthing rooms at Mary Stanley midwife-led unit.

We spoke with 2 midwives.

We reviewed 2 patient care records and 2 observation and escalation charts.

Following our onsite inspection, we spoke with senior leaders within the service; we also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

Our findings

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Requires Improvement

We rated it as requires improvement because:

- The service had high rates of staff sickness. Staffing levels impacted on the sustainability of the birth centre service which had been suspended between February and July 2023.
- Equipment was not always maintained safely.
- Leaders did not monitor waiting times to ensure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets.
- There were ineffective processes for learning from incidents.
- Leaders did not operate effective governance systems. They did not always manage risk, issues, and performance well. They did not consistently monitor the effectiveness of the service.
- The birth centre did not have a specific vision or strategy.

However:

- Staff had training in key skills and worked well together for the benefit of women and birthing people.
- Staff understood how to protect woman and birthing people from abuse, and managed safety well.

Is the service safe?

Requires Improvement

We had not previously rated this service. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff completed professional obstetric multidisciplinary training (PrOMPT) training once a year. The service made sure that staff received multi-professional simulated obstetric emergency training. As of 22 November 2023, 93% of midwives and 91% of midwifery support workers who worked at Musgrove Park Hospital or Bridgwater Community Hospital had completed yearly PrOMPT training.

The mandatory training was comprehensive and met the needs of woman and birthing people and staff. Training included skills and drills training and neonatal life support. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for woman and birthing people and babies. Training data for staff who worked at Mary Stanley Birth Centre was not separated from staff at Musgrove Park Hospital as community midwives worked across the two sites.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Maternity

Safeguarding

Staff understood how to protect woman and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Training records showed that staff had completed both Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines. Across maternity services at the trust 80% of staff had completed level 3 safeguarding training as of 20 November 2023.

Community staff had access to regular safeguarding supervision. The birth centre lead offered safeguarding supervision sessions every month. Staff had to attend 4 supervision sessions a year and this was monitored by the safeguarding team.

Cleanliness, infection control and hygiene

The service did not always control infection risk effectively.

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Wards had recently been refurbished to the latest national standards. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning audits showed between April and October 2023 the Mary Stanley Unit consistently scored above 98% in cleaning monthly audits. However, in room 1 we found thick dust under the bed and at the bottom of a machine to assess vital signs. We raised this with the birth centre lead at the end of inspection.

Leaders did not complete regular hand hygiene audits at the Mary Stanley midwife led unit. Data showed hand hygiene audits were completed every month in all other maternity areas within the trust.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply. We saw staff recorded on checklists that water outlets were flushed three times to reduce risk of legionella.

The birth centre manager was aware of processes for managing and controlling the risk of legionella including regular flushing of taps on the birth centre. We saw that staff completed checklists to confirm taps were flushed 3 times a week.

Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned. Staff used ‘I am clean’ stickers to show equipment was clean and ready for use.

Environment and equipment

Maintenance of equipment did not always keep people safe. However, staff were trained to use equipment and managed clinical waste well.

Electrical equipment was not properly maintained. Several items of equipment were out of date for electrical safety testing. For example, an examination lamp in birthing room 1 was due electrical safety testing in July 2022. We reviewed compliance for equipment testing at the Mary Stanley unit and this was 30.6%. We raised this with the birth centre lead following the inspection and they told us electrical safety testing would be completed as soon as possible.

Staff did not have immediate access to a defibrillator for adult resuscitation on the birth centre. The community matron had recorded this as a risk on the maternity risk register since March 2023. Staff had access to adult resuscitation equipment and a defibrillator that was stored on the adjacent ward that provided medical care and rehabilitation to older adults. The trust updated the risk assessment following the inspection.

Maternity

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system.

Staff carried out daily safety checks of specialist equipment. Records showed the neonatal resuscitaire was checked daily.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the birth centre there was access to a hoist noodle-shaped floats for pool evacuation.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins.

Assessing and responding to risk

Key information was not always shared effectively when care was handed over to other healthcare professionals. However, staff completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration.

Staff did not always share key information to keep women and birthing people safe when handing over their care to others. An incident occurred in August 2023 when midwife to midwife handover did not occur when a woman was transferred from the Mary Stanley birth unit to the Bracken Birth Centre at the main hospital site by ambulance. A midwife did not travel in the ambulance to supervise the transfer and did not call the main hospital site to handover the care. This was not in line with the trust policy and there was a risk of the woman deteriorating in transit without access to a midwife.

Leaders did not monitor waiting times to ensure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 2 MEOWS records and found staff correctly completed them. However, managers did not audit use of MEOWS at Mary Stanley midwife-led unit and could therefore not be assured that deterioration of women and birthing people was escalated and acted upon in a timely manner.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed the criteria for use of the birth centre and found they were in line with national guidance. We reviewed 2 records which showed staff risk assessed women and birthing people at each antenatal appointment and ensured criteria for use of the birth centre were met. However, the service did not complete audits on this.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. The service had not completed a ligature risk assessment of the unit.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly.

Maternity

Midwifery Staffing

Staffing levels did not always match the planned numbers putting the safety of woman and birthing people and babies at risk.

High levels of staff sickness and staff vacancies impacted on the sustainability of the birth centre service. The home birth service and births at the Mary Stanley Birth Centre were suspended for over 4 months from February 2023 to the end of July 2023. The chief nurse reported in the September 2023 six monthly staffing report to the trust board that 21 of the student midwives who trained at the trust had been successfully recruited to the service with planned start dates in October 2023.

Managers moved staff according to the number of woman and birthing people in clinical areas. The maternity escalation plan had 4 alert levels: green – normal working, amber – persistent excess pressure, red – severe and prolonged excess pressure, and black – unit closed to admissions and patients diverted to neighbouring trusts. Community midwives were part of the escalation plan and would support on Bracken Birth Centre the alongside midwifery unit at Musgrove Park Hospital when needed. If the escalation alert level was anything other than green the homebirth service would be reduced, and the provision intrapartum care (during labour) would be suspended at Mary Stanley midwife-led birth centre as staff would be redeployed to maternity services at the main hospital site. The Mary Stanely midwife-led unit was closed to births for five months between February 2023 and July 2023 when it re-opened to births. During the planned closure two women had booked to birth at the Mary Stanley unit and these women were offered to birth at the alongside midwifery led unit Bracken birth centre instead.

The birth centre was staffed by community midwifery staff. Two midwives needed to be available to facilitate a birth at the birth centre. The availability of community midwifery staff impacted on the sustainability of the Mary Stanley midwife-led unit. The birth centre lead midwife or community matron adjusted staffing levels daily according to the needs of woman and birthing people. Band 7 midwives met every week to discuss staffing across the maternity service.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They completed a maternity safe staffing workforce review in line with national guidance in November 2021. This review recommended the service needed 40.06 whole-time equivalent (WTE) midwives Band 4 to 8 to run community services including home births and births at Mary Stanley birth centre. As reported in the October 2023 maternity and neonatal governance report, the trust had an 8% vacancy rate for community midwives (4.4 WTE midwives) required.

Compliance with annual appraisals was below the trust target.

Managers supported staff to develop through appraisals of their work however, data showed not all community midwifery staff received an appraisal yearly. The compliance rate with completion of appraisals for community midwifery staff was 58.6% as of November 2023 against a trust target of 92%.

Records

Staff kept detailed records of woman and birthing people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used electronic records. We reviewed 2 records and found they were clear and complete.

The service did not complete documentation audits at the time of inspection.

Maternity

When women and birthing people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Staff locked computers when not in use.

Medicines

There was a risk medicines were not always stored under the correct conditions. The service used systems and processes to safely prescribe, administer and record.

Safety of storage of medicines could be improved. At the time of inspection staff did not monitor and record fridge temperatures. Staff stored medicines in a locked fridge in the staff office that could only be accessed by authorised staff. Medicines we checked were in date and stored at the correct temperature. However, due to the lack of monitoring there was a risk medicines were not stored under the correct conditions.

Staff had access to emergency medicines boxes in both birthing rooms to support management of post-partum haemorrhage and cord prolapse. The items in all four boxes checked were in date for use.

No controlled drugs were stored on the Mary Stanley unit. For pain relief women and birthing people had access to birth pools and oral over the counter painkillers only. Women and birthing people requesting high levels of pain relief, for example an epidural, would be transferred to the obstetric unit at Musgrove Park Hospital.

Incidents

Processes for learning from incidents were ineffective.

The birth centre lead was not aware of any incidents that had occurred at the Mary Stanley Standalone Birth Centre in the past year.

Following the inspection, we requested the incidents that had occurred at Mary Stanley Birth Centre in the past year. One clinical incident occurred in August 2023 when a woman was transferred to the Bracken Birth Centre alongside midwifery-led unit.

The transfer was not managed in line with the trust guidance on ‘criteria for transfer to labour ward from the birth centres (maternity)’ as in this incident the woman was not accompanied by a midwife in the ambulance and there was no midwife-to-midwife handover either in person or by phone. The woman was transferred from Mary Stanley unit to the Bracken Birth Centre at Musgrove Park Hospital. This was also not in line with the trust guidance which only outlined processes for transfer to the labour ward at Musgrove Park Hospital. It was not clear from the incident report if the trust guidance had been followed in terms of ensuring the labour ward co-ordinator was informed of the transfer or if an obstetrician was informed of the transfer within 15 minutes of the woman’s arrival.

Is the service well-led?

Requires Improvement

We had not previously rated this service. We rated it as requires improvement.

Maternity

Leadership

Local leaders had the skills and abilities to run the service. They supported staff to develop their skills and take on more senior roles. They were visible and approachable in the service for woman and birthing people and staff. However, executive leaders did not always understand and manage the priorities and issues the service faced.

Maternity services at the trust came under a service group for children, young people and families. This included services such as child and adolescent mental health services (CAMHS), women's sexual health and maternity services.

The maternity leadership team for the trust was formed as part of the trust merger in April 2023. The structure of the senior leadership team did not support effective clinical oversight of maternity services. The service group had quadrumvirate that consisted of the director of midwifery (DOM), the associate medical director for obstetricians and gynaecology, sexual health and dental, who was a vascular surgeon by background and the associate director of patient care for the service group. There was not a dedicated triumvirate for maternity services.

Maternity board level safety champions were not effective in their role in improving 'floor to board' communication. We reviewed 5 notes and actions from maternity board level safety champion meetings. These meetings were in May 2023, July 2023, August 2023, September 2023 and October 2023 there was only 1 occasion out of 5 when 2 safety champions and the DOM were present. As part of the inspection, we spoke with the 3 board level safety Champions.

Mary Stanley midwife led unit at Bridgwater Hospital was managed by a Band 7 birth centre lead who was supported by a Band 8 community matron who was based in the community.

Local leaders were visible and approachable in the service for woman and birthing people and staff. Leaders were well respected, approachable, and supportive. The chief nurse, director of midwifery and deputy director of midwifery had visited the birth centre.

Vision and Strategy

There was no clear vision for the Mary Stanley midwife-led unit at Bridgwater Community Hospital.

There was a vision and strategy for the trust maternity and neonatal services 2023 – 2027. The priorities included: personalised care, quality & safety, improving health, wellbeing, and our future. However, the Mary Stanley midwife led unit was not specifically included in this strategy and staff were not aware of the vision for the unit.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of woman and birthing people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where woman and birthing people, their families and staff could raise concerns without fear.

Staff we spoke with were positive about working at the trust.

The service had received no complaints in relation to Mary Stanley Birth Centre in the past year.

Governance

Leaders did not operate effective governance processes to ensure oversight of the birth centre.

Maternity

The trust had poor oversight of activity levels at Mary Stanley birth unit. The community matron and birth centre lead were unable to tell us how many births there had been at the standalone midwifery-led unit in the past year. We requested this information following the inspection and the trust told us 3 babies had been born between December 2022 and November 2023 at the Mary Stanley Birth Centre. The figures provided did not match up with the number reported on the trust maternity dashboard. For example, the trust told us one baby had been born at the Mary Stanley Birth Centre in August 2023, but the maternity dashboard reported 0 babies were born at the standalone midwifery led unit in August 2023. Similarly the trust told us 0 babies were born at the Mary Stanley unit in March 2023 and the unit was closed, but the maternity dashboard reported 1 baby was born at the standalone midwifery led unit in March 2023.

The trust did not have effective oversight of whether the Mary Stanley unit was open or closed to births. The birth centre lead told us if a birth could not be facilitated at Mary Stanley unit due to staffing levels, this would be reported as an incident. However, the service did not monitor how many births were facilitated at the alongside midwifery-led unit at Musgrove Park Hospital when people's choice to use the Mary Stanley Birth Centre could not be met.

Managers did not formally audit transfers out of the standalone midwifery led birth centre to the main hospital site. We requested transfer audits for the past year and the service provided details of one transfer that had occurred in the past year out of 3 births. We were not confident the service had oversight of all transfers as the information provided by the trust did not include the transfer during labour of a woman whose record we reviewed during the inspection.

The service also did not audit whether the criteria for use of the birthing centre were met at the time of labour. This was not in line with the trust's policy, 'criteria for transfer to labour ward from the birth centres (Maternity) version 2 which was due for review in May 2023. This stated all transfers from the birth centres to the obstetric units needed to be incident reported.

Staff did not always have access to up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. For example, the guidance on 'criteria for transfer to labour ward from the birth centres (maternity)' was six months out of date at the time of inspection and was due for review in May 2023.

The birth centre lead met with other band 7 senior midwives every week to discuss safety and performance.

Management of risk, issues, and performance

There was little understanding or management of risks and issues, and there were significant failures in performance management and audit systems.

The service did not have an effective program of regular local audits to ensure the safety and quality of the service is monitored and processes to learn from incidents were not effective**.**

There were significant failures in audit systems and processes. The service had not audited the use of Modified Early Obstetric warning score (MEOWS), handover tool Situation Background Assessment (SBAR), or the electronic records system.

There was one recorded risk in relation to Mary Stanley Birth Centre on the maternity risk register. The recorded risk was in relation to the lack of a defibrillator on the birth centre. There were no recorded mitigations to this risk, but it was observed on inspection that staff had access to the defibrillator on the adjacent ward.

Maternity

Risks were not always effectively mitigated. For example, there was a recorded risk in relation to transferring women and birthing people to the main hospital from the Mary Stanley Birth Centre to the main hospital site which had been a recorded risk since March 2021. The risk of delayed transfer was not monitored or mitigated effectively as the service did not regularly review capacity and demand in the ambulance service and the impact this may have on the safety of the homebirth and standalone midwifery led unit service.

Managers monitored risk across maternity services on the maternity services risk register. Top risks across maternity services were safe midwifery staffing, and shortages of sonography (ultrasound scanning) staff. These risks were mitigated by ongoing midwifery recruitment and seeking further funding for sonography staffing.

The service did not effectively audit clinical outcomes for women and birthing people who delivered their babies at the standalone birth centre. The maternity dashboard did not include any clinical outcomes data in relation to the Mary Stanley standalone birth centre at Bridgwater Community Hospital.

Information Management

Staff could find the data they needed. The information systems were integrated and secure.

The information systems were integrated and secure**.** The service used an electronic record system.

Engagement

There was a limited approach to engaging with people who used the service.

The service encouraged but received limited feedback from women, birthing people, and families. No complaints were received about the Mary Stanley Birth Centre in the past year.

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. The MNVP visited Mary Stanley birth centre in July 2023 and made recommendations including making the environment more calming, updating noticeboards and putting up information on active birth positions.

Learning, continuous improvement and innovation

There was limited evidence of quality improvement and innovation.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action the service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Maternity

- The service must ensure where responsibility for the care and treatment of women and birthing people is transferred to timely sharing of information and care planning takes place . Regulation 12 (2) (i)
- The service must ensure electrical equipment is properly maintained. Regulation 15 (1) (e)

Maternity

- The service must ensure there are effective processes for learning from incidents. Regulation 17 (1) (2) (a)
- The service must ensure there are effective processes for amending the homebirth and midwifery-led unit provision at times of increased demand on ambulance services to ensure timely transfer to the obstetric-led maternity unit is not delayed. Regulation 17 (1) (2) (a)
- The service must ensure there are governance systems to consistently monitor the effectiveness of the service including local audits and processes to learn from incidents. Regulation 17 (2) (a) (b) (e))
- The service should ensure all midwifery staff receive a yearly appraisal. Regulation 18 (2) (a)

Action the service SHOULD take to improve:

- The service should ensure clinical outcomes data in relation to the the Mary Stanley free standing birth unit at Bridgwater Community Hospital is included in the maternity dashboard.
- The service should ensure medicines are stored at the correct temperature.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and midwife specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.

Action plan to respond to areas for improvement from CQC Maternity Inspection Reports (3 reports published 10 May 2024)	Date Created	15th May 2024

Plan Owner:	Sally Bryant, Director of Midwifery Phil Brice, Director of Corporate Services (CQC Nominated Individual)	**Date last updated: (and version no)**	07 June 2024 V10
Core implementation Group:	Maternity Leadership Triumvirate Heads of Midwifery and Matrons Executive Directors (support) Director of Integrated Governance, Governance Support Team (support)	**Next review due by** **Group / Committee:**	12 June 2024 Maternity and Neonatal Governance Meeting, reporting to CYP and Families Service Group Governance Meeting

Links to key documents

- Inspection reports: Yeovil District Hospital, Musgrove Park Hospital, Bridgwater Community Hospital, all published 10 May 2024
- CQC Section 29A Warning Notice letter, January 2024 and CQC Section 31 letter of intent November 2023
- CQC letter of acceptance of improvements to date, no further regulatory action, May 2024
- CQC template – Report on actions
- 'Demonstrating improvement' summary briefings addressing key requirements of Warning Notice letter (these are cross-referenced throughout the action plan)
- Associated actions plans and programmes (triage, clinical audit for example)
- Associated risk assessments on risk register (triage and guideline management for example)

Notes on action plan structure and status tracking

- The actions are organised according to the areas for improvement within the three separate reports for each inspected location. Where actions are repeated within the reports, the actions have been defined once and *apply to the whole service*. This is indicated via cross-referencing within the relevant sections.

- Status colours indicate the following position

  Green Complete
  Blue On-plan according to timeframe
  Amber Challenges / slippage according to timeframe
  Red Significant barriers to achieving the action – may not be achieved

Yeovil District Hospital

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
MUST 1 **The service must ensure staff are up to date with maternity mandatory training modules, including adult and children's safeguarding training at level 3. Regulation 12 (1) (2) (c) (S29A)** **Note –** Developments since inspection set out within separate summary briefing – available.				
1. Staff to be mapped to identify those who require safeguarding adults level 3 training	KH/SL/AD/KM	Achieved 09/04/24	All staff (RM & Medical) currently mapped however, some discrepancies regionally re workforce considered appropriate to include. Guidance has been interpreted differently across trusts.	
2. Staff to be mapped to identify those who require medicines management training.	KH/SL/AD/KM	14/06/24	Staff mapped.	
3. Mapping for other associate training modules: medical devices, medical gases, anti-D, transfusion.	KH/SL/AD/KM	28/06/24	Staff asked to complete yearly medical devices update. Medical gases mapping in progress. Anti-D and transfusion: mapping complete Matron confirming frequency of training requirements with module Leads.	
4. Establish process for all line managers to register monthly to confirm teams are up to date with required training.	KH/SL/AD/KM	14/06/24	Processes established.	
5. All staff training compliance rates including medical staff to be presented, broken down into staff groups and site specific to MatNeo Gov as standing monthly agenda item for oversight, assurance and escalation of any issues.	AD/SL/CL	28/06/24	Training compliance and appraisal compliance trajectories captured in tracker. Work to validate some data ongoing.	

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
			New cross site MatNeo Gov TOR's, reporting schedule and Agenda developed to include monthly oversight of training compliance data with quarterly training report.	
MUST 2 **The service must ensure staff accurately complete, and document modified early obstetric warning scores and newborn assessment observation and early warning score forms in order to identify and escalate women and birthing people and babies at risk of deterioration. Regulation 12 (2) (a) (b) (S29A)**				
1. Conduct focussed review via Maternity and Neonatal Governance meeting to ensure a clear understanding of the problem and determine specific interventions that contribute to the improvements. This to be revisited in line with audit data.	AD/SL/CL	31/07/2024	New cross site MatNeo governance meeting with associated reporting schedule in place first meeting 12/6/24. Audit programme standing agenda item for oversight.	
2. Targeted communications to all colleagues with role in documentation of MEOWS and NEWS within the system, to promote improved capture and data quality.	AD/SL/CL	30/06/2024	Plan to share via MatNeo monthly newsletter plus targeted meetings and safety huddles.	

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
3. Ensure audits completed on regular basis as part of rolling audit programme: specifically NEWS;MEOWS. All to be presented at MatNeo Governance for oversight.	AD/SL/FS	30/09/24	Audit programme developed. Some work required to ensure prioritisation of audits is appropriate. New cross site MatNeo Gov TOR's, reporting schedule and agenda developed to include monthly oversight of audit data with monthly audit report.	
4. NEWS audits to be included in rolling audit programme and reported. Broken down into months to allow comparison and action plans with identified accountable persons and timeframes for completion to address any identified shortfalls in place.	AD/SL/FS	30/07/24	NEWS audits already in place and within programme. Mar-Dec 2023 audit presented at MatNeo Governance. Planning form for 2024 audit submitted target date for completion of first (Q1) summary report: 30-07-24.	
5. MEOWS audits to be included in rolling audit programme and reported. Broken down into months to allow comparison and action plans with identified accountable persons and timeframes for completion to address any identified shortfalls in place.	AD/SL/FS	30/07/24	MEOWS audit already in place and within programme. Collection tool designed and in use. Audit periods and report dates set. Initial data available indicates / confirmed a continued need to improve – interventions to improve to be considered as per action 1, above.	

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
MUST 3 **The service must ensure effective risk and governance systems are implemented which supports safety and quality care. Regulation 17 (1) (2) (S29A)** **Note –** Developments since inspection set out within separate summary briefing – available.				
1. Review of existing governance systems and processes	ST/JC/JT	01/5/24	Review complete and signed off at MNAG meeting (exec oversight).	
2. Mapping of existing governance reporting schedule, data presentation and forum for presentation	ST/CW	01/05/24	Review complete and signed off at MNAG meeting (exec oversight).	
3. Develop new governance structure to support effective risk governance systems to be in place to support safety and quality of care	ST/SB/JC/JT	12/06/24	New governance structure developed. Shared with MNAG (exec oversight) and Governance team. New Cross site joint governance meeting with TOR's, reporting schedule, agenda developed. Plan to go live first meeting 12/6/24.	
4. Develop new governance reporting schedule with agreed data presentation, forum for presentation and clearly defined reporting route	ST/SB/JC/JT	23/05/24	Reporting schedule developed with data presentation forum agreed by Service governance leads (MDT) and corporate governance team input.	
5. Commence meetings of newly integrated Maternity and Neonatal Governance Meeting (two former meetings combined)	SB	12/06/24	Arranged and date set for 12/06/24.	
MUST 4 **The service must ensure that policies are up to date and reviewed in accordance with the review date. Regulation 17 (1) (2) (S29A)** **Note –** Developments since inspection set out within separate summary briefing – available.				

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
1. Ensure the 3 named guidelines requested by CQC for YDH are in date: newborn security, escalation of maternity services and management of PPH and MOH	AD/SL/FS	30/04/24	Newborn security- Ratification in May Escalation of maternity services - complete for both sites with the adoption of the Southwest Maternity Escalation Policy OPEL Postpartum Haemorrhage (PPH) incorporating massive obstetric haemorrhage (MOH) updated in November for one year until Nov 24.	
2. Include guidelines and policy review in reporting schedule for new joint cross site governance meeting reporting schedule for oversight, assurance and escalation of any issues.	ST/SB/JC/JT	24/05/24	New cross-site joint governance meeting with TOR's, reporting schedule (including monthly policy and guideline report) agenda developed. Plan to go live first meeting 12/6/24.	
3. Continued development of lead roles to oversee and drive guideline review and production, including in context of merger.	SB/CL/FS	30/09/24	Conversations held between DoM and current Lead Obstetrician to recognise position and consider onward approach.	
4. Further review of risk assessment to ensure clarity about mitigation of risk during the period where guidelines are published and in need of review.	SB/ST/LA	30/06/24	Existing risk assessment may need strengthening to ensure that mitigation includes the use of current national best practice guidance as a reference for clinicians to inform	

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
			consistent /safe practice.	
MUST 5 **The service should ensure all staff must receive annual appraisals. Regulation 18 (2) (a) (S29A)** **Note –** Developments since inspection set out within separate summary briefing – available.				
1. All staff appraisal compliance rates including medical staff to be presented, broken down into staff groups and site specific to MatNeo Gov as standing monthly agenda item for oversight, assurance, and escalation of any issues.	FS/AD/SL	12/06/24	Appraisal compliance trajectories captured in tracker. Work to validate some data ongoing. New Cross site joint governance meeting with TOR's, reporting schedule (including appraisal compliance rates) agenda developed. Plan to go live first meeting 12/6/24.	
MUST 6 **The service must ensure electrical equipment is properly maintained. Regulation 15 (1) (e) (S29A)**				
1. Standardise the way the F2 database is used across the organisation, to support monitoring of routine maintenance.	PD/DW	31/03/25	Project has commenced to move to one F2 database, with key changes already implemented to align risk categorisation.	
2. Standardise the way compliance is reported with maintenance schedules.	PD/DW	31/05/24	Reporting is now standardised (although this will continue to require a manual step until database is fully merged).	
3. Ensure Medical Electronics resource is assigned appropriately to address maintenance needs for the Maternity service, based on level of risk.	PD/DW	31/07/24	Resource is assigned across the organisation to ensure delivery of KPIs based on level of risk. This will be	

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
			reviewed to address any gaps identified once service level reports have been fully developed.	
4. Provide Maternity and Neonatal services with clear maintenance compliance / status reports – in an agreed, standardised format – on a regular basis.	PD/DW	31/07/24	Draft report to be produced for June, to be finalised after user feedback.	
5. Ensure Maternity and Neonatal service leads have clear contact and escalation routes within the Medical Electronics team to address areas of concern.	PD/DW	30/06/24	Details to be confirmed as part of initial compliance / status report.	
6. Ensure all colleagues within Maternity and Neonatal services are aware of requirements around electrical equipment maintenance.	AD/SL	30/06/24	Cascading via team meetings.	
7. Conduct regular checks of compliance within the service using checklist and address any issues identified.	Matrons	30/07/24	Checks in place on both acute sites - work now underway to standardise and agree reporting routes.	
SHOULD 1 **The service should ensure that all staff adhere to the uniform policy to maintain effective infection prevention control.**				
1. Matrons to conduct weekly walkabout to include spot checks on adherence to the uniform policy.	Matrons	30/04/24	Weekly matron walkabouts on site reported to senior RM team via exception at monthly senior RM/RN team meeting.	
2. Review current policy content and position with respect to clarity of / integration of uniform policies as currently published.	AD	30/06/24	HOM working with Matrons to review and integrate.	
SHOULD 2 **The service should consider a review of arrangements for twice daily consultant led ward round to comply with national guidance.**				
1. Conduct review to ensure consultants are being appropriately job planned to deliver twice daily ward rounds.	JEC	31/07/24	Further to review to date, 11 of 12 consultants have in job	

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
			plans and deliver this. Review to be completed and reported to Maternity and Neonatal Governance for assurance.	
2. Conduct ongoing monitoring and oversight of ward round compliance.	JEC/CL/FS	31/07/24	CSLs working with HOMS to agree best process for monitoring compliance.	
SHOULD 3 **The service should consider monitoring incidents by ethnicity to evaluate incidents and clinical outcomes to ensure equality in maternity care.**				
1. Ethnicity data recording included in incident review pro-forma.	ZP/AS	30/04/24	Ethnicity data capture included in incident proforma.	
2. Quarterly PSIRF report to be included in governance reporting schedule to include data on ethnicity and to highlight any themes/ learning from incidents related to ethnicity.	ZP/AS	31/07/24	Ethnicity data capture included in incident proforma- quarterly report of PSIRF themes included in governance reporting schedule. Plan to commence reporting in July.	

Musgrove Park Hospital

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
MUST 6 **The service must ensure they apply and demonstrate compliance with Duty of Candour requirements. Regulation 20. (S29A)** **Note –** Links to overall governance developments since inspection set out within separate summary briefing – available.				
1. Review and develop governance roles within the service – with attention on the responsibilities for ensuring Duty of Candour is enacted in line with requirements and can be demonstrated clearly in the records held.	SB/ST	31/07/24	The roles within the service for providing support for governance processes have been defined and agreed, with job descriptions in development.	
2. Develop the governance structure to enable clear arrangements for shared / devolved ownership of delivering on all processes for incident response and learning, including Duty of Candour, ensuring multidisciplinary involvement.	SB/ST	30/06/24	Discussions continue, to engage fully with all relevant leaders / members of the multidisciplinary team.	
3. Review the development of competencies for relevant colleagues in Duty of Candour, alongside other governance requirements.	SB/ST	31/07/24	Discussions to review relevant training and awareness – raising are commencing currently. This links with them attending the training as set out in 4. Further team training can be arranged via GST. This would benefit from a MDT approach.	
4. Review and align Duty of Candour processes with recent developments to safety event response, including PSIRF.	SB/ST	31/07/24	A number of midwives have attended the trust wide DoC training run by GST (note - this builds on training provided to some of the team in October 2023).	

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
5. DOC audits to be included in rolling audit programme. Broken down into months to allow comparison and action plans with identified accountable persons and timeframes for completion to address any identified shortfalls in place.	AD	24/05/24	Audit programme developed to include DOC audits. Meeting in diaries for 29/5/24. New cross site MatNeo Gov TOR's, reporting schedule and Agenda developed to include monthly oversight of audit data with monthly audit report.	
MUST 7 **The service must ensure staff are up to date with maternity mandatory training modules. Regulation 12(1)(2) (c) (S29A)** **Note –** Developments since inspection set out within separate summary briefing – available.				
Actions as set out under MUST 1 (YDH), above				
MUST 8 **The service must ensure the security of the unit is reviewed in line with national guidance. Regulation 12 (1) (2) (a) (d)**				
1. Immediate interventions taken in accordance with the CQC letter indicating intent under Section 31 (November 2023) – delivery of remedial improvements to the estate including window opening restrictors / fire door fixtures.	AS/DS/ HoM	Achieved	Assurance provided to CQC, demonstrating the response to immediate concerns. Evidence of action accepted by inspection team.	
2. Enhanced security guard presence to maintain surveillance of the Unit as an interim provision, (pending full establishment of the dedicated security team).	AS/ HoMs	30/06/24	Additional patrols commencing in line with increased numbers in the security team.	
3. Incorporate unit security improvements, through installation of swipe access system, into the planning and installation of new fire doors.	KK	30/09/24 (Indicative, pending fire door tendering)	3 of the 5 door sets are complete within SNICU but we are waiting for the remaining 2 doors to be fitted as our installers are programmed to fit new	

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
			doors to Head & Neck Theatres (Queens Building) as well as a 60-minute door set outside of Head & Neck Theatres next then, once that is complete, they will fit the remaining 2 doors in SNICU. Swipe system hardware has begun to be installed – works currently in progress. Tender for the fire doors has been issued. Date set for submission review (19 June 2024), with a view of appointment towards the end of June beginning of July 2024.	
4. Recruit dedicated security team for the maternity unit – ensuring that security and fire safety is considered in establishing these roles.	KK	30/09/24	5 of the 6 security guards have been recruited and are going through the recruitment process and will have various start dates. All will need to complete their training, currently in progress, but patrols in maternity are being gradually increased as the resource is put in place (see above).	

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
5. Develop safe processes for the operation of the newly formed security arrangements, including safe working procedures, induction and familiarisation with the unit for the newly recruited team.	KK/AD	30/09/24	Discussion with security lead and IP Matron in place to agree processes.	
6. Continue to respond to the security visit recommendations via review of the recommendations tracker and engage actively with the ongoing programme, overseen by the Strategic Security Management Meeting.	SL/AD	30/06/24	The most recent round of updating for security visit recommendations is due by 11 June 2024. The open recommendations include swipe access installation and CCTV installation. Review is currently in progress to respond.	
MUST 9 **The service must ensure staff are up to date with the appropriate level of safeguarding training in line with national guidance. Regulation 12(1)(2) (c) (S29A)** **Note –** Developments since inspection set out within separate summary briefing – available.				
Actions as set out under MUST 1 (YDH), above				
MUST 10 **The service must ensure that policies are available, up to date and reviewed in accordance with the review date. Regulation 17 (1) (2) (S29A)** **Note –** Developments since inspection set out within separate summary briefing – available.				
1. Ensure the 4 named guidelines requested by CQC for MPH are in date: (Recognition of the severely ill woman, Sepsis, Triage, Prevention and management of postpartum Haemorrhage-PPH).	AD/SL/CL	30/04/24	EMC Enhanced maternity care and recognition of the severely ill woman - ratification in May. Triage -ratification in May Sepsis - ratification in May Prevention and management of postpartum	

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
			Haemorrhage PPH - updated in November for one year until Nov 24. Plan to align the guideline for both units.	
Further service-wide actions as set out under MUST 4 (YDH), above				
MUST 11 **The service must ensure all staff must receive annual appraisals. Regulation 18 (2) (a) (S29A)**				
Actions as set out under MUST 5 (YDH), above				
MUST 12 **The service must ensure that staff adhere to infection, prevention and control policies and procedures. Regulation 12 (2) (h)**				
1. Matrons to conduct weekly walkabout to include spot checks on adherence to the uniform policy/ infection prevention and control policies and procedures.	Matrons	30/04/24	Weekly matron walkabouts on site reported to senior RM team via exception at monthly senior RM/RN team meeting.	
2. Review of processes for providing hand hygiene audit data and ensuring oversight of process and visibility / response to findings.	SB/SL/AD	30/06/24	Review complete. Oversight being addressed as part Mat Neo Governance meeting developments (IPC included in schedule of reports) and development of reviewed audit roles.	
3. Ensure representation on / engagement with the Infection Control Committee – overseeing compliance and audit outcomes at Trust level.	SL/AD	31/05/24	Attendance by HOMs is achieved.	
4. Review of feedback mechanisms in conjunction with IPC team, ensuring any data contribution issues are addressed.	SL/VY	30/06/24	Potential development to be explored.	

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
MUST 13 **The service must ensure medicines and breast milk is stored safely and securely. Regulation 12 (2) (f)**				
1. Order new fridges for milk storage	LC	31/05/24	New fridges in place.	
2. Develop new SOP for the storage of expressed breast milk	PQ	31/01/24	SOP produced and published: 'Infant Milk Fridges on Maternity Wards - Storage and Management of Expressed Breastmilk and Formula Feeds'. Monitoring process in place for milk being stored appropriately, labelled correctly and in date.	
3. Procure and install new medicines storage cabinets for Bracken Birthing Centre	LC/PQ	Complete	Cabinets in place.	
4. Confirm / ensure that monitoring for Room 9 anaesthetic fridge and trolley is undertaken monthly	SL	31/07/24	SOP is in place with monitoring defined – full operation of the monitoring to be ensured.	
5. Confirm / ensure that daily checks for Room 9 medicines storage are undertaken.	SL	31/07/24	SOP is in place with monitoring defined – full operation of the monitoring to be ensured.	
MUST 14 **The service must ensure there are risk assessments for women and birthing people presenting to the triage service and best practice is considered to mitigate any identified risk. Regulation 12(2)(a)(b) (S29A)** **Note –** Developments since inspection set out within separate summary briefing – available.				

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
1. Review current triage service and risk assessment process	AD/LC	31/03/24	Review complete. Concluded that service does not adhere to best practice. Recommend implementation of BSOTS.	
2. Reconfiguration of waiting area to ensure visual oversight of women and birthing people waiting triage assessment	SD/LC	25/03/24	Waiting area reconfigured to provide triage waiting area within triage area of ward facilitating visual oversight of all women and birthing people in triage waiting area.	
3. BSOTS SOP to be developed to support consistent evidence-based guidance to support effective prioritisation and assessment of women and birthing people calling the triage telephone line with implementation supported by staff training programme	CL/SD/LC	09/04/24	10/04/24 New SOP and targeted training programme in place to ensure all staff are able to log and record triage line call time, reason for call and essential clinical information. Clinical decisions then supported by action cards based on the BSOTS.	
4. Remove risk to inconsistency of telephone triage management due to human error at times of high acuity or low staffing	SD/LC	TBC – contingent on business case review outcome	Phone line moved to office to minimise distraction. Staffing reconfigured to support additional RM to cover triage telephone - needs long term increase in establishment to embed. Uplift in business case developed for 2nd theatre & triage delivery. Submitted to execs and supported. Submitted to	

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
			triple lock process 13/6/24.	
5. Create one single point of documentation for triage calls/ attendances/ ongoing clinical care	SD/LC/PE	09/04/24	All triage calls documented in Badgernet under "BSOTS Triage Contact" as one single point of documentation.	
6. Remove day care from triage area	SD/LC	09/04/24	Day care removed from triage and delivered on the AN ward in dedicated day care area.	
7. Consistent recording of triage clinical documentation in EPR	SD/LC	09/04/24	All triage activity recorded in BadgerNet EPR.	
8. Audit of triage performance – in line with audit timeframe / plan defined	SD/LC	30/09/24 (Report target date)	Audit plan developed, with first round of data collection due in by end July. Plan for audit each month with quarterly reporting of performance to MatNeo Gov.	
9. Review of obstetric staffing to identify additional capacity required to support effective and robust triages services	JC/CL	09/04/24	22/4/24 Review complete. Business case developed to support additional obstetric and midwifery staffing required to deliver robust and sustainable triage as well as staffing provision for a second theatre. Submitted to execs and supported. Submitted to triple lock process 13/6/24.	

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
10. Recruit to identified obstetric staffing	JEC/JT	TBC – contingent on business case review outcome	Business case developed to support additional obstetric and midwifery staffing required to deliver robust and sustainable triage as well as staffing provision for a second theatre. Submitted to execs for and supported. Submitted to triple lock process 13/6/24.	
11. Review of midwifery and MSW staffing to identify additional capacity required to support effective and robust triages services	SD/LC/AD	09/04/24	Review Complete. Additional staffing required identified. Business case developed to support additional obstetric and midwifery staffing required to deliver robust and sustainable triage as well as staffing provision for a second theatre. Submitted to execs and supported. Submitted to triple lock process 13/6/24.	
12. Recruit to identified midwifery and MSW staffing	AD/SL	TBC – contingent on business case review outcome	Business case developed to support additional obstetric and midwifery staffing required to deliver robust and sustainable triage as well as staffing provision for a second theatre. Submitted to execs and supported. Submitted to triple lock	

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
			process 13/6/24.	
SHOULD 4 **The service should ensure the monitoring of incidents by ethnicity to evaluate incidents and clinical outcomes to ensure equality in maternity care.**				
Actions as set out under SHOULD 3 (YDH), above				
SHOULD 5 **The service should consider providing additional support to staff around the use of electronic patient records.**				
1. Commence continuous programmed audit of BadgerNet data completeness	BB/PE	12/06/24	Badgernet data completeness audit now programmed and being completed monthly by digital lead midwives. Initial pilot complete, quarterly reporting to commence to Maternity and Neonatal Governance meeting.	
2. Share Badgernet comms to all staff outlining additional support available	BB/PE	12/06/24	Monthly newsletters in place. Email out early June to Band 7s & and 8s asking for data quality issues found during audit. YDH given 30 min slot on a mandatory study day to commence form July. Planning of mini teaching session on LWs in response to issues identified in data completeness reports.	
3. Ensure that the digital expertise within the service is readily available to all colleagues	BB/PE	30/06/24	The digital team are contactable – presence of digital midwives in	

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
			ward areas now routine.	
4. Oversight of digital records system including staff support to ensure user success via Digital Oversight Group	BB/PE	31/07/24	Digital Oversight Group becoming established.	
5. Engage other specific teams in the use of Badgernet, focussing on identified areas of challenge / opportunity.	BB/PE	31/08/24	Hazard workshop held regarding diabetes clinic with agreement to support team to transition to Badgernet for this element of the service.	
SHOULD 6 **They should consider how 'medicines as required' (PRN) medicines and patient weight is recorded on the electronic medicines record.**				
1. Review of BadgerNet recording of medicines and patient weight to understand current position	BB/PE	03/06/24	Digital Lead Midwives confirmed that both patient weight and all medicines are recorded in BadgerNet EPR.	
2. Share Badgernet comms to all staff outlining additional support available	BB/PE	12/06/24	Monthly newsletters in place. Email out early June to Band 7s & and 8s asking for data quality issues found during Audit. YDH given 30 min slot on a mandatory study day to commence form July. Planning of mini teaching session on LW's in response to issues identified in data completeness reports.	

Bridgwater Community Hospital – Mary Stanley Free Standing Birthing Unit

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
MUST 14 **The service must ensure where responsibility for the care and treatment of women and birthing people is transferred, that timely sharing of information and care planning takes place. Regulation 12 (2) (i)**				
1. Review of ambulance transfer guideline	SL/PB	14/06/24	Ambulance transfer guideline –live – approved Dec 2023.	
2. All community transfers to acute unit to be reviewed by Community Matron with any learning/ incident identified taken to weekly MDT review meeting for MDT discussion and agreement on any necessary actions.	PB	14/06/24	BCH MSFSBU birth service currently suspended pending options appraisal. Transfer arrangement to be considered in options appraisal.	
3. All transfers to acute unit to be reviewed to identify any themes and this data used to inform an options appraisal of the viability of the MSFSBU	SB	30/09/24	BCH MSFSBU birth service currently suspended pending options appraisal. Transfer arrangement to be considered in options appraisal.	
4. Review of existing guideline for home/ community birth including SOP for communication with the ambulance service.	SL/PB	14/06/24	Community Matron reviewing guidance with community team leads.	
5. Share update communication to all staff who attend home/ community birth relating to emergency transfer and communication with the ambulance service.	SL/PB	14/06/24	Community Matron reviewing guidance with community team leads. Updated communication relating to transfer to be shared following review.	
MUST 15 **The service must ensure electrical equipment is properly maintained. Regulation 15 (1) (e) (S29A)**				

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
Actions as set out under MUST 6 (YDH), above				
MUST 16 **The service must ensure there are effective processes for learning from incidents. Regulation 17 (1) (2) (a) (S29A)**				
Actions as set out under MUST 3 (YDH), above, addressing risk and governance systems. Specific additional actions (whole service) as below:				
1. Develop communication channel to permit learning for incidents to be shared across the whole service.	ST/SB/JC/JT	12/06/24	Governance "newsletter" developed to share leaning form incidents across all settings.	
2. Review departmental meeting structures across SFT to align where appropriate and to ensure a consistent approach across site. This structure to be agreed at senior level and Terms of Reference agreed.	SB/CSLs	31/08/24	Review commenced.	
3. Continue to embed processes for sharing learning in line with Trust guidance (for example PSIRF, LFPSE). Such information is to be shared regularly at SFT MatNeo Governance meetings to ensure senior oversight.	Gov Lead Midwives	30/11/24	Review of current processes underway.	
4. Continue to embed dissemination of relevant learning (i.e. from incidents, case reviews) via the Practice Development Team through mandatory study days, PROMPT, ad hoc simulations, in line with the SFT three-year training plan.	Practice Dev teams	30/06/24	3-year plan in place.	
5. Identify process for sharing learning from excellence and sharing of case examples across SFT to all maternity staff. This includes patient and family feedback and MNVP data.	Gov Lead Midwives	31/08/24	Review of current processes underway.	
6. Develop pathway for sharing learning with wider teams (encompassing both consultant team and midwifery team) within the service group.	Gov Lead Midwives/ FS/KM	30/09/24	Review of current processes underway.	
MUST 17 **The service must ensure there are effective processes for amending the homebirth and midwifery-led unit provision at times of increased demand on ambulance services to ensure timely transfer to the obstetric-led maternity unit is not delayed. Regulation 17 (1) (2) (a)**				
1. Review of existing guideline for home/ community birth including SOP for communication with the ambulance service.	SL/PB	14/06/24	Community Matron reviewing guidance with community team leads	

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
2. Share update communication to all staff who attend home/ community birth relating to emergency transfer and communication with the ambulance service.	SL/PB	14/06/24	Community Matron reviewing guidance with community team leads. Updated communication relating to transfer to be shared following review.	
MUST 18 **The service must ensure there are governance systems to consistently monitor the effectiveness of the service including local audits and processes to learn from incidents. Regulation 17 (2) (a) (b) (e) (S29A)** **Note –** Developments since inspection set out within separate summary briefing – available.				
Actions as set out under MUST 3 (YDH), above, addressing risk and governance systems. Specific additional actions addressing clinical audit (whole service) as below:				
1. Hold multidisciplinary discussions to appraise the emerging clinical audit programme and ensure full agreement of priority topics for inclusion within the programme.	FS/CL/KM/ AD/SL/BD	30/06/24	With the programme having been formed largely on the basis of mapped drivers for audit, and with midwifery team input, there is a pressing need for the proposed programme to be fully owned and agreed by all in the MDT, notable obstetric colleagues. Initial review meeting held 29/05/24, with follow up set for 07/06/24.	
2. Identify and agree the routes for reporting on each individual audit programmed, with consideration to the level of visibility / oversight required and the need for front line clinical team engagement to make improvements on the basis of audit findings.	AD/SL	30/06/24	Review conducted at weekly programme meeting to propose the most appropriate forum for receipt / review of audit reports – many are proposed to route to Labour Ward Forum for the required MDT	

Action What specific actions will be taken to address the issue(s)	Lead by:	Achieve by:	Progress update / notes	Status
			engagement and awareness. Escalation criteria to be defined to determine which audits take priority for full visibility at Maternity and Neonatal Governance Meeting. DOM and CSL working on development of new clinical excellence forum.	
MUST 19 **The service should ensure all midwifery staff receive a yearly appraisal. Regulation 18 (2) (a) (S29A)**				
Actions as set out under MUST 5 (YDH), above				
SHOULD 7 **The service should ensure clinical outcomes data in relation to the Mary Stanley free standing birth unit at Bridgwater Community Hospital is included in the maternity dashboard.**				
1. All clinical outcome date in relation to the Mary Stanley FSBU to be included in the maternity dashboard	CL/ZP/PB	31/08/24	New dashboard in development to include Mary Stanley FSBU clinical outcome data. Task and finish group established.	
SHOULD 8 **The service should ensure medicines are stored at the correct temperature.**				
1. Confirm / ensure that daily checks for medicines storage are undertaken.	PB/SA	31/07/24	Standard approach agreed across service (see MUST 13 above) – roll out for MSFBU contingent on options appraisal of (see MUST 14).	

Action **What specific actions will be taken to address the issue(s)**	**Lead by:**	**Achieve by:**	**Progress update / notes**	**Status**
2. Confirm / ensure that monitoring for medicines storage is undertaken monthly	PB/SA	31/07/24	Standard approach agreed across service (see MUST 13 above) – roll out for MSFBU contingent on options appraisal of (see MUST 14).	

Measures of success - How will we know the issue(s) have been addressed?	
Monitoring method (e.g. audit, spot check, document produced):	**What issues / action in the plan does this cover?**
Example: Spot check of five wards	**1, 3, 4**

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 29 May 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:	2 July 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 29 May 2024. The Committee received assurance in relation to: • The actions taken in response to the MHRA bed rails alert • The revision of the Leadership Quality Walkrounds action plan template • The Corporate Risk Register – the reduction in the risk rating for risks allocated to the Committee; and the update in relation to the risk management processes • The Neighbourhood and Community Services assurance report • The Learning from Deaths progress report • The progress made in relation to the trust's response to the maternity services Care Quality Commission inspection report • The update on the work in relation to the Section29A warning notice The Committee identified the following areas of concern or for follow up:

	• The Regulation 28 Preventing Future Deaths Notice • The Maternity and Perinatal Incentive Scheme (MPIS) Year 6 – the new requirements of safety action 9; the review of the Perinatal Quality Surveillance Tool dashboard; the review of the reporting arrangements; and the request to carry out a risk assessment for the delivery of the scheme • Impact of the junior doctor industrial action • The Joint Targeted Area Inspection The Committee identified the following areas to be reported to the Board: • The assurance from the neighbourhood and community service group progress report • The assurance in relation to the trust's response to the Care Quality Commission's maternity service inspection. • The work in relation to Maternity and Perinatal Incentive Scheme (MPIS) Year 6
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Quality and Governance Assurance Committee. The Board is further asked to note the areas to be reported to the Board.

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

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

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING HELD ON 29 MAY 2024

1. PURPOSE

1.1. The report sets out the items discussed at the formal meeting held on 29 May 2024, along with the assurance received by the Committee and any areas of concern identified. The meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

MHRA Bed Rails Alert

2.1. The Committee received an update on the progress made actioning the alert and noted that two actions remained outstanding. The Committee noted the progress in relation to the development of a training programme and the longer term people and space capacity issues in relation to the maintenance of beds. The Committee recognised that good progress had been made and noted that it was expected that the full action plan will be signed off by September 2024.

Leadership Quality Walkrounds (LQW)

2.2. The Committee noted that the LQW action plan template had been revised and that positive feedback on the use of this new template had been received.

Corporate Risk Register

2.3. The Committee received the up-to-date combined Corporate Risk Register report and noted that there were currently 30 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. The Committee recognised the significant finance and cost improvement programme delivery risks and the possible impact this could have on decision making and on quality and safety in general.

2.4. The Committee received an update on the risks allocated to the Committee and particularly discussed and noted the improvements in the following risks: demand and waiting times; escalation beds; fire safety policy and strategy and the fire safety risks on the acute sites; the supply chain risk although noting the need to review this risk in view of increasing medication availability issues.

2.5. The Committee further received an update on the progress made in relation to risk management processes and noted that the draft risk management policy was currently out for consultation; and that the roll out of the Learning from Patient Safety Events to RADAR had been successful.

2.6. The Committee noted the MIU-related risks on the neighbourhood and community services risk register and noted that these risks mainly related to workforce, sickness absence and triage. The Committee received an update on the actions being taken to mitigate these risks and was assured that the service group had clear oversight of these risks and that mitigating actions were being taken.

Service Group Assurance Report – Neighbourhood and Community Services

2.7. The Committee received the assurance report from the neighbourhood and community services group and noted the key highlights from the report, including: the focus on culture that promotes growth and reflects the trust values; the monthly governance meetings which included representatives from all services within the service group; the escalation process for governance related issues outside of the monthly meetings; the review of learning responses; the significant improvements made in reducing the number of unmanaged incidents; the implementation of quality walkrounds in parts of the service as a proactive ongoing method of peer review; and the successful implementation of Patient Safety Incident Response Framework (PSIRF) and Learning from Patient Safety Events (LFPSE) and the focus on learning. The Committee recognised the diversity of the service group's portfolio.

2.8. The Committee noted the focus on encouraging joint ownership of governance and the positive risk maturity audit findings. The Committee further noted the progress made in relation to co-production and the appointment of a peer support worker in the Long Covid and Homeless and Rough Sleepers services.

2.9. The Committee received an update on the key challenges, including the integration of the stroke services into the service group and the impact on the baseline data and risk register.

2.10. The Committee discussed the number of incidents reported and noted that incident reporting was low compared to the number of attendances and contacts and that focussed work was taking place to increase reporting. The Committee further noted the quick, open and honest response by the service group to any concerns raised either through the complaints process or through Care Opinion. The Committee discussed the low number of complaints compared to the number of contacts and the comparatively lengthy time taken to respond to the complaints. The Committee noted that the complex nature of the complaints was one of the reasons for delays in responding.

2.11. The Committee further noted the development of the service group's patient engagement plan and the presentation of the group's people plan to the next People Committee meeting. The Committee received assurance that retention and sickness absence were key areas of focus.

2.12. 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.

Learning from Deaths Report

2.13. The Committee received an update on the work in relation to learning from deaths including: the delay of the implementation of the next phase of the roll out of the Medical Examiner service to September 2024 and the development of local arrangements to meet the requirements for the statutory service; the seven cases identified for further review; the core function of the mortality surveillance group and the review of the group's terms of references; and feedback from the first meeting of the system-wide mortality meeting chaired by the ICB.

2.14. The Committee further noted: the coroner enquiries; the conclusion of inquests; the revision of the summary hospital level mortality indicator to include Covid deaths; and the learning identified.

2.15. The Committee offered Non-Executive Director support to the mortality surveillance group which was welcomed and this will be further discussed.

Maternity Services Update – Care Quality Commission Inspection Report

2.16. The Committee received the CQC maternity services inspection report and noted that a formal response to the required actions was being prepared and would be presented to the July planning meeting. The Committee further noted that, at a meeting with the local CQC relationship team, the team had confirmed that they were satisfied with the progress already made. A further meeting will be set up for July 2024 and it was expected that a re-inspection will be carried out in the autumn.

Maternity and Neonatal Action Group (MNAG) Report

2.17. The Committee received an update on the work in relation to the CQC's Section 29A Warning Notice and noted that the group will maintain robust oversight of the timely implementation of the actions.

3. AREAS OF CONCERN OR FOLLOW UP

Regulation 28 Preventing Future Death Notice

3.1. The Committee received an update on the notice issued by the Coroner following the conclusion of a jury inquest regarding the death of an inpatient on Holford Ward in 2019. The Committee noted details of the concerns raised in the notice which related to the implementation of the level two observation policy and the lack of ligature cutters for all staff and further noted that a formal written response to the notice was being prepared.

Maternity and Perinatal Incentive Scheme (MPIS) Year 6

3.2. The Committee received an update on progress made and noted the following: the establishment of a MIS huddle to help oversee the planning, running and delivery of the scheme; the identification of leads for every safety action; the establishment of monthly safety action leads meetings to provide a forum for leads to discuss progress made in meeting the scheme requirements; the development of a reporting schedule; the development of an additional reporting schedule for evidence; and the work to embed PSIRF within maternity and neonatal services.

3.3. The Committee further noted that information on compliance with safety action 9 will be presented to every Committee meeting. Due to changes in this safety action for year six, additional development work will be required and the current tool and the dashboard will need to be reviewed to be able to provide assurance about all safety action 9 requirements. Details of the work taking place were noted.

3.4. The Committee has received and reviewed a report on maternity and neonatal quality and safety including a review of the Perinatal Quality Surveillance Tool dashboard, presented by the Director of Midwifery. The report covered staffing data, training compliance, culture and PSIRF themes. It was noted that the themes are also being reviewed via a dedicated Triangulation meeting held monthly and attended by the multi-disciplinary team (MDT) and the MNVP (Maternity and Neonatal Voices Partnership). This new group will provide a quarterly report to the MatNeo Governance meeting. The themes will also be overseen through the board safety champions through their monthly review meetings. The Committee noted the work that the Maternity and Neonatal safety champions are undertaking including how the group are working with the perinatal leadership team to provide oversight of safety and quality of services including progress with the culture improvement plan.

3.5. In particular, the Committee noted the work being undertaken to review recent incidents of impacted fetal head (IFH) across both acute sites. The MDT has reviewed the incidents and is following PSIRF methodology to consider the learning. The Committee will monitor the outcomes of these reviews.

3.6. Further work is being done to enhance the dashboard and the reporting to the Committee which will inform reporting to the Board in September.

3.7. The Committee agreed that sight of the reporting schedule of when different elements will be presented, and the detailed thematic review work that has been undertaken, was helpful and noted the work being undertaken on the maternity improvement plan. The Committee asked for a risk assessment to be undertaken to consider the competing pressures of delivering the requirements of the scheme, the response to the Care Quality Commission reports and the overall improvement plan, to consider the resources required to achieve these.

Junior Doctor Industrial Action

3.8. The Committee noted that a further round of industrial actions had been announced for the period 27 June to 1 July which coincided with the Glastonbury Festival.

Joint Targeted Area Inspection (JTAI)

3.9. The Committee received feedback from a recent national inspection with a focus on safeguarding serious youth offending by violence and knife crime. The report will take the form of a thematic review and will be circulated to the Somerset system.

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

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

- The assurance from the neighbourhood and community service group progress report.
- The assurance in relation to the trust's response to the Care Quality Commission's maternity service inspection.
- The work in relation to Maternity and Perinatal Incentive Scheme (MPIS) Year 6

5. BOARD ASSURANCE FRAMEWORK (BAF)

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

- Objective 2 – the Committee recognised the significant negative assurance in relation to the CQC maternity reports in both safe and well led domains, alongside the actions in place to seek to address the shortcomings identified.
- Objective 3 – the report from the Neighbourhoods and Community service group report provided largely positive assurance about the governance structures supporting the development of community and neighbourhoods programmes.
- Objective 4 – the Learning from Deaths report identified positive assurance in respect of learning. However, the Preventing Future Deaths report highlighted issues to be addressed in terms of supporting patients with serious mental illness.
- Objective 5 – the report from the Neighbourhoods and Community service group report provided largely positive assurance in relation to

the management of complex care and end of life care in community settings.

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

Jan Hull
CHAIRMAN OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Learning from Deaths Report Q4 2023/24
SPONSORING EXEC:	Melanie Iles, Chief Medical Officer
REPORT BY:	Claire Bailey, Learning from Deaths Lead Laura Walker, Head of Patient Safety and Learning Gary Filer, Quality and Safety Lead Analyst
PRESENTED BY:	Dr Paul Foster
DATE:	2 July 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 National Guidance on Learning from Deaths (National Quality Board, March 2017) and the Implementing Learning from Deaths framework, key requirements for Trust Boards (NHS Improvement, July 2017), places a number of requirements on NHS Trusts. This includes the need to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public Board meetings. This report also demonstrates the processes in place for how Somerset FT learn from deaths and how this learning is shared and improvements are made.
Recommendation	The Board is asked to discuss this report.

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

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

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

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

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

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

Equality and Inclusion

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

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

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

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

Public/Staff Involvement History

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

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

Previous Consideration

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

The report is reviewed by the Quality Governance and Assurance Committee and Operational Leadership Group.

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

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

SOMERSET NHS FOUNDATION TRUST

LEARNING FROM DEATHS REPORT – QUARTER 4 2023-2024

1. BACKGROUND AND PURPOSE

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

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

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

2. UPDATE ON THE MORTALITY REVIEW PROCESS

2.1. We continue to work closely with our colleagues in the Bereavement and Medical Examiner's teams to support each other with our alignment and development of processes. The next phase of the national roll out of the Medical Examiner Service, in which Medical Examiners will provide independent scrutiny to all non-coronial deaths without exception, was expected to commence in April 2024, however, it has now been confirmed that these changes will come into force on 9th September 2024. Helen Waldon, the Lead Bereavement and Medical Examiner Officer and Implementation Lead for the Somerset Medical Examiner Service, has been developing the local arrangements to meet the requirements set out for the statutory service. To date, 47 out of 62 GP practices in the catchment area are referring deaths to the Medical Examiner service. In this reporting period, there has been a noted increase in activity. The team have completed reviews on 215 community deaths, compared to 149 in Quarter 3 and 99 in Quarter 2.

We continue to see an impact of this roll-out, with the Medical Examiner team sharing feedback about SFT care for patients who have died in the community, giving us further opportunities to learn and improve our services.

2.2. As described in the previous report, we have developed a clearer pathway for the escalation of concerns raised by families or carers of our deceased patients. This pathway is now in operation. During this reporting period, the ME service flagged 7 such deaths. We have requested a Structured Judgement Review for 2 of these deaths and colleagues in the Patient Experience Team have agreed to ask the clinical team to respond to the concerns raised in 3 of these deaths. For the remaining 2 deaths, it was felt that there were elements for both Learning from Deaths and Patient Experience to take forwards.

2.3. Colleagues in our Mental Health and Learning Disability Service Group have changed their process for requesting and allocating SJR's. This had previously been held within the Mental Health Serious Incident Review Group (MHSIRG). Following the move away from the Serious Incident Framework to the Patient Safety Incident Response Framework (PSIRF), this meeting has been stood down. In its place, a new series of meetings have been devised. On a weekly basis, there is a Mental Health Incident Governance Group. This acts as a screening meeting for all newly reported incidents and/or deaths. Outcomes for incidents and/or deaths that will be taken down the PSIRF pathway will be overseen by the Mental Health and Learning Disability Incident Group. Outcomes for deaths that will be subject to SJR as per the Learning from Deaths criteria, will be discussed at an SJR review meeting. In a similar way to the Morbidity and Mortality (M&M) meetings that happen on our acute sites, this new meeting will move the review of deaths and any subsequent learning, closer to the clinical teams.

2.4. The core function of the Mortality Surveillance Group (MSG) is to ensure that we have strategic level oversight and can provide assurances that our processes maximise learning from the deaths of people in our care. On 22/03/2024, Paul Foster, Laura Walker and Claire Bailey met to review the Terms of Reference for MSG. Commencing June 2024, it was agreed that we would move to quarterly meetings, in line with the Learning from Deaths reporting schedule. It was hoped that this would support the intended purpose of this meeting as well as provide structure and facilitate attendance.

2.5. The Patient Safety Incident Response Framework (PSIRF) was formally launched across the trust on 01/01/2024. This quarter has been a transition period towards full implementation on 01/04/2024. PSIRF will positively impact on the way we learn from deaths, by maximising opportunities to learn when a death does not meet the criteria for either a PSII or SJR. During this quarter, there have been a small number of deaths for which the new learning response tools, such as SWARM huddles and After Action Reviews, have been used. As use of these tools becomes more established, we expect to be able to report on the outcomes of these reviews.

2.6. Aligning with the implementation of PSIRF, there are also changes underway to how patient safety incidents will be reported. From 01/05/2024, Learning from Patient Safety Events (LfPSE) will replace the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS). The LfPSE service supports a learning culture within the Trust and across the wider healthcare system by collecting information that is better suited to improvement. LfPSE expands the types of events that can be reported to enable staff to report outcomes, risks, and good care as well as incidents. With respect to deaths, this will offer greater clarity between deaths that are responded to using the PSIRF pathway, which are thought to relate to a patient safety incident, and deaths that are responded to using the LFD pathway, which are thought to relate to an unexpected poor outcome.

2.7. On 24/01/2024, Laura Walker attended the first system-wide mortality meeting chaired by the ICB. The aim of these meetings is to share intelligence and thematic learning to identify trends in the data and opportunities for further learning. In this meeting, representatives from Adult Social Care (ASC) and Public Health England (PHE) presented data around population health and health inequalities, using figures based on the number of deaths in placements funded by ASC. They reported that the monthly average number has remained generally stable over the last 5 years, with the exception of a spike in deaths during the 2020-2021 period. This is presumed to be related to the covid pandemic. There are plans to extend this meeting to include feedback from the ME service, Coroner's Inquests and Regulation 28 Reports, as well as Child Death Reviews.

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

3.1. **Examples of learning:**

- An SJR was completed by colleagues in our Older Person's Mental Health team following the death of a patient with known bipolar disorder. Having been stable for many years, the patient was referred to their GP for an urgent assessment due to concerns that physical health investigations had triggered a relapse in their mental health. This was reported as escalating low mood, suicidal thoughts, and self-neglect. Sadly, the patient died of natural causes before the team were able to complete their assessment. The outcome scores on the SJR described the care as poor with care failings that may have contributed to the patient's death. This has been discussed at the Neighbourhoods Service Group Governance Meeting, and the following learning is being taken forwards:

    - A countywide triage process is being introduced to ensure that there is a consistent approach to managing outstanding referrals.

    - The process for managing staff absence will be reviewed to ensure that appointments are reallocated.

- Training for staff around recognising and responding to delirium.

- A patient was admitted under the care of one of our medical teams for treatment of a lower respiratory tract infection, infected leg ulcers and acute kidney infection. During the admission, the patient deteriorated with worsening acute kidney infection, and they developed hyperkalaemia. Sadly, they went into cardiac arrest and died despite resuscitation attempts. There were concerns raised about the management of hyperkalaemia. The rapid review process was initiated, and an RCA investigation was undertaken. One of the recommendations from this investigation was for hyperkalaemia management to be included in ongoing training for medical and nursing staff. This resulted in a project to develop a hyperkalaemia simulation on our medical wards. This training has identified further process gaps as it became clear that some staff struggled to access the current treatment guidelines on the intranet. The search function has now been improved, for instance, alternative spellings can now be used. In addition, a QR code has been introduced and widely advertised to raise awareness of how to find policies and guidelines on the intranet.

- The Medical Examiner Service highlighted the death of a patient who had been admitted to one of our surgical wards after presenting to ED with abdominal pain and vomiting. It was quickly recognised by the clinical team that there was a high mortality risk, with or without any surgical intervention. The options were discussed with the patient and their family, and the patient decided that they wanted to be discharged home with palliative care support. Discharge was arranged within 24 hours and the patient died peacefully in their own home on the following day. This case was shared with the End of Life (EOL) team. It was identified that the EOL Homecare Project was instrumental in the patient being supported to die in the place of their choice. This project started in November 2022 and aimed to improve patient and carer experience, as well as hospital flow, by reducing the time for discharge from hospital for EOL care from 6.3 days to less than 24 hours. This case is a clear example of the success of this project but has also shown some further learning that may improve the experience of EOL care. For instance, the discharge summary suggested that the patient be returned to hospital if their NG tube required reinsertion, however had this been needed, this could have been managed in the community by the District Nurse service. This has been shared with the team, as this could have been clarified by a specialist review by the palliative care team ahead of discharge from hospital.

- At a recent inquest into the death of a patient who died on one of our care of the older persons wards, significant learning was described. It was heard that the patient was prescribed medication to treat a potentially life-threatening infection. This specific medication is available in different formulations, however the doses for the different preparations are not the same. There was a dosing error which resulted

in an overdose of medication being administered. Whilst this did not contribute to his death, there has been considerable learning from this incident to prevent a recurrence. Locally, changes have been made to the electronic prescribing and administration (ePMA) system so that this medication can only be prescribed by formulation, with limits placed on the maximum prescribable dose. There has been teaching provided for pharmacy staff in relation to this incident. The incident has been reported to the British National Formulary, requesting changes to the monograph for this medication to provide greater clarity.

- An SJR was completed following the death of a patient who was under the care of our trauma and orthopaedic team. The patient was admitted after falling at home and was found to have sustained a fractured neck of femur. Surgery was agreed, and it was noted that a TEP form was completed. The patient, their family and the clinical team agreed that the patient would not be for resuscitation. The surgery itself was successful, however the patient deteriorated with symptoms of sepsis. Despite treatment, the patient sadly died following a cardiac arrest. Their family had raised concerns that they believed that the “do not resuscitate” decision was only for during the operation. The review found that the TEP decision was appropriate given the patient’s multiple co-morbidities but acknowledged that there was some learning for the team around how these decisions are communicated to our patients and their families. Arrangements have been made for simulation training to be delivered.

- A patient with severe heart failure was being care for on one of our inpatient wards. The patient fell whilst trying to mobilise to the toilet and sustained a subdural haemorrhage. Sadly, the patient deteriorated rapidly, and it was recognised that this was a terminal event. Palliative care was started, and they died the following day. This death was taken through the rapid review process and whilst immediate learning for the team was identified through this process it was agreed that an SJR would be requested. It was identified that there was a delay in requesting a CT head following the fall. Although this did not affect the outcome for this patient, this case was shared with the team to highlight the need to follow NICE guidelines when a patient is suspected to have a head injury following a fall. It was also noted that neurological observations were not documented correctly. A package of training for neurological observations has been delivered to the nursing team by one of the clinical skills facilitators.

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

- **Scrutiny through the Medical Examiner service**
  There is an expectation that all patients who die in our bedded care settings have an initial review of the notes completed by the Medical Examiner. Whilst the Medical Examiner service is independent of SFT, this scrutiny enables early identification of any case where a potential problem exists, for example where a potential omission in care or poor management is identified, or where the bereaved raise a significant concern. These are then referred to Learning from Deaths for consideration for further review. The Medical Examiner also ensures the appropriate direction of deaths to the coroner. Medical practitioners have a duty to report deaths to a coroner for which they are unable to ascertain the cause of death, the cause of death is unnatural, or the death occurred in custody or state detention, e.g., whilst under a section of the Mental Health Act.

  The Medical Examiner's office had 687 deaths of patients under the care of SFT reported to them between January and March 2024. Of these, 632 were within our acute hospitals, 54 were within our community hospitals, 0 deaths were in our mental health inpatient settings and 1 was under the care of our hospital at home team. 98% of the 687 deaths were scrutinized by the Medical Examiner team. In total, 50 deaths were highlighted to Learning from Deaths.

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

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

  During this reporting period 10 inpatient deaths met the criteria for SJR. These deaths were flagged by the Medical Examiner service, who raised concerns about the care that one of these patients received. To

date, 4 SJR's has been completed and shared with LeDeR. There were no reported incidents associated with the deaths of these patients.

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

  Within this reporting period, 7 deaths have been discussed at rapid review meetings. 1 of these deaths met the criteria for internal review using a PSIRF tool, 2 deaths will be subject to a Structured Judgement Review, and 2 cases will be looked at internally using the Perinatal Mortality Review Tool (PMRT). For the remaining 2 deaths, no further internal review was required, and it was identified that all learning had already been actioned.

- **PALS and complaints**
  During this quarter, 13 PALS queries and 5 formal complaints have been raised concerning the deaths of patients in our care. Common themes are around poor communication (including breaking bad news and supporting the bereaved), inadequate discharge planning, delays to treatment and concerns about care and treatment at the end of life.

- **Maternal and Perinatal Deaths**
  There have been no maternal deaths during this reporting period.

  Eligible perinatal deaths are reviewed using the Perinatal Mortality Review Tool (PMRT). A monthly PMRT meeting is held to enable regular review of cases with the multidisciplinary team (MDT) and an external representative, allowing for a 'fresh eyes' perspective. A joint action plan for each month's review of cases (unless being investigated as a patient safety incident) enables the maternity governance team to highlight any common actions and identify themes from reviews. All finalised reports and subsequent action plans are shared with the parents according to their wishes. In this reporting period, there were 8 perinatal deaths that were eligible for PMRT. In 4 cases, PRMT processes are ongoing, and all are on track for completion within expected timescales. There has been a death that has triggered the PMRT process, however this is on hold pending completion of external processes. There were 3 further cases that triggered PMRT processes, which will be led by other NHS Trusts. As antenatal and/or postnatal

care was provided by SFT services, we will be involved in these reviews as there may be learning opportunities for our services.

A theme has been identified relating to the maternity triage service and provision, and it has been recognised that there are safety issues with the current process. Plans are underway to move to a different triage model, BSOTS (Birmingham Symptom-specific Obstetric Triage System), a validated system to improve safety and care.

- **Paediatric Deaths**
  Reviews of these deaths are mandatory and undertaken by the Child Death Overview Panel (CDOP). Notification of a child death to the local Safeguarding Children Board is made at the time of any agency becoming aware of the death of a child. Where the death occurs within the hospital, responsibility for completing this notification is usually undertaken by the paediatrician managing the case.

  During this reporting period, there have been no paediatric deaths of children who were under the care of SFT at the time of their death.

- **Coronial activity**
  During this reporting period, there were 56 new enquiries from the coroner concerning the deaths of patients known to SFT. Formal statements have been requested for all cases.

  Several inquests pending from previous reporting periods have been concluded during this quarter. This includes 47 read-only inquests, and 12 inquests heard with witnesses called. There have been 4 pre inquest review hearings heard for inquests that are due to be heard at a later date. There have been no prevention of future deaths reports since July 2022 at legacy SFT and November 2021 at legacy YDH.

3.3. Standardised mortality

Summary Hospital-level Mortality Indicator (SHMI), December 2022 - November 2023
Source: NHS England (April 2024)
Note: All sub-national counts have been rounded to the nearest five, with SHMI values calculated from the unrounded values.

Trust level

Trust	Provider spells	Observed deaths	Expected deaths	SHMI value
Somerset NHS FT	77,420	2,930	2,910	1.0081 As expected

Site level *Acute hospitals and exceptions*

Site	Provider spells	Observed deaths	Expected deaths	SHMI value
Musgrove Park Hospital	52,830	1,730	1,760	0.9827 As expected
Yeovil District Hospital	22,710	1,045	1,030	1.0166 As expected

Diagnosis group *Reported groups by exception*

Diagnosis group	Provider spells	Observed deaths	Expected deaths	SHMI value
Septicaemia (except in labour), Shock	1,355	270	325	0.8332 **Lower than expected**

Visual life adjusted display (VLAD) – recent alerts

No recent alerts

Standard mortality ratios from HED

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

3.4. This report refers to two measure of standardised mortality: summary hospital-level mortality index (SHMI) and hospital standardised mortality ratio (HSMR). For information regarding these indicators please refer to the quick guide in Appendix A.

Trust level

Trust	SHMI (Jan 23 – Dec 23)	HSMR (Feb 23 – Jan 24)
Somerset NHS FT	100.5 (As expected) 95% CI: 96.8 - 104.3 Observed: 2,790 Expected: 2,777 Spells: 73,778	107.1 (Above expected) 95% CI: 102.2 - 112.2 Observed: 1,774 Expected: 1,656 Spells: 50,453

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

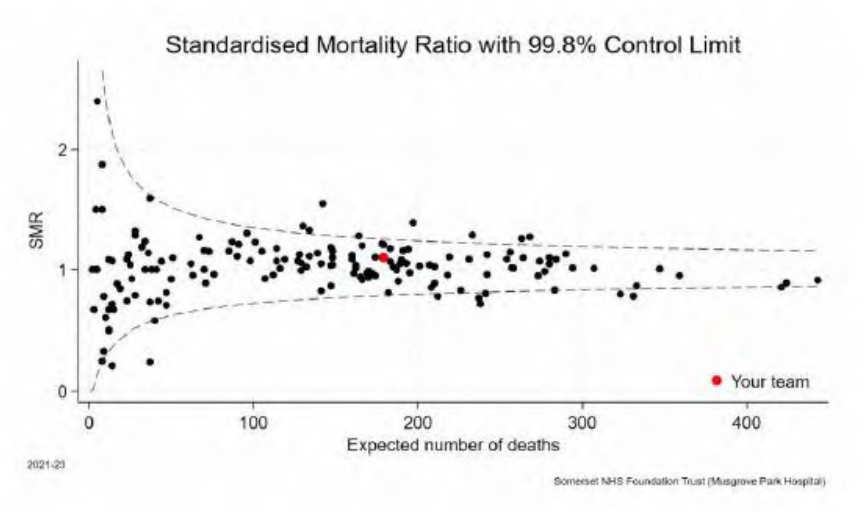
Site	SHMI (Jan 23 – Dec 23)	HSMR (Feb 23 – Jan 24)
Musgrove Park Hospital	97.2 (As expected) 95% CI: 92.5 - 102.0 Observed: 1,643 Expected: 1,691 Spells: 50,961	113.6 **(Above expected)** 95% CI: 106.5 - 121.0 Observed: 959 Expected: 844 Spells: 31,871
Yeovil District Hospital	103.2 (As expected) 95% CI: 97.0 - 109.8 Observed: 1,010 Expected: 978 Spells: 21,118	95.3 (As expected) 95% CI: 88.5 - 102.4 Observed: 728 Expected: 764 Spells: 16,685

Plans for reviews in response to Standardised Mortality Data:

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

Sentinel Stroke National Audit Programme

3.6. We have recently had sight of the Sentinel Stroke National Audit Programme (SSNAP) stroke mortality report results for patients admitted to our MPH site between April 2021 and March 2023. Unlike Dr Foster data, a case mix adjustment has been applied to the data to adjust for patient characteristics that influence mortality (stroke severity, age etc) which shows that we are not an outlier for mortality (SMR – 1.10 observed 197 expected 179). This will be discussed further at the next MSG.



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

Appendix 1

NHS Somerset NHS Foundation Trust

		2022/2023								2023/2024										
		Jan	Feb	Mar	Q4 total	April	May	June	Q1 total	July	Aug	Sept	Q2 total	Oct	Nov	Dec	Q3 total	Jan	Feb	Mar	Q4 total
ACUTE INPATIENTS*	Total deaths (including ED)	275	227	223	725	182	203	202	587	157	183	156	502	187	171	233	591	236	195	201	632
	Total Scrutinised by ME	264	221	213	699	182	199	190	571	157	183	156	502	175	168	207	550	231	193	195	619
	SJR's requested by LfD	24	12	16	52	12	9	8	29	14	10	12	36	10	9	10	29	10	9	7	26
	SJR's completed	56	25	31	112	23	16	23	62	23	27	18	68	19	15	16	50	3	6	5	14
	Problems in care**	6	2	1	9	5	2	1	8	0	2	2	4	0	0	0	0	0	0	0	0
	Serious Incident/PSIRF***	0	1	0	1	0	0	0	0	0	0	0	0	1	0	0	1	1	1	0	2
	Learning Disabilities: internally all deaths in acute inpatient settings are subject to review or investigation																				
	Total deaths	3	1	3	7	3	0	2	5	4	0	2	6	1	1	2	4	3	2	5	10
	Review/investigation completed	3	1	3	7	2	0	2	4	4	0	2	6	0	1	1	2	0	1	3	4
COMMUNITY HOSPITAL	Total deaths	16	16	21	53	22	22	16	60	19	18	29	66	24	22	17	63	19	15	20	54
	Total scrutinised by ME	8	11	18	37	22	19	15	56	19	18	29	66	24	22	17	63	19	15	20	54
	SJR's requested by LfD	0	0	1	1	0	1	1	2	1	0	2	3	0	1	0	1	0	0	0	0
	SJR's completed	0	0	1	1	0	1	1	2	1	0	2	3	0	1	0	1	0	0	0	0
	Problems in care**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incident/PSIRF***	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MENTAL HEALTH	Total deaths (reported as incident)	6	9	9	24	5	10	6	21	8	10	3	21	4	9	6	19	10	4	9	23
	Total scrutinised by ME	0	0	1	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0
	SJR's requested by LfD	2	6	7	15	1	5	3	9	1	0	2	3	2	2	1	5	3	0	2	5
	SJR's completed	2	5	7	14	1	5	3	9	1	0	1	2	0	2	0	0	0	0	0	0
	Problems in care**	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
	Serious Incident/PSIRF***	0	1	0	1	0	1	0	1	1	0	0	1	0	0	1	1	2	0	1	3
COMMUNITY SERVICES	SJR's requested by LfD	0	0	0	0	0	0	1	1	0	0	0	0	1	0	0	1	0	0	0	0
	SJR's completed	2	2	1	5	0	0	1	1	0	0	0	0	1	0	0	1	0	0	0	0
	Problems in care**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incident/PSIRF process initiated	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total deaths subject to Coroner's Inquests		19	19	27	65	17	30	16	63	11	12	9	32	14	19	17	50	23	17	16	56

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

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the People Committee meeting held on 14 May 2024
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Kate Fallon, Chairman of the People Committee until 1 June 2024
DATE:	2 July 2024

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the People Committee meeting held on 14 May 2024 and the assurance received. The meeting was conducted as a video call. The Committee received assurance in relation to: • The colleague story in relation to their development journey and the induction of overseas workers. • The review of the Board Assurance Framework • The update on the progress in relation to the workforce inclusion plan for 2023-2028 • The learning item in relation to the work to prepare for the new Care Quality Commission inspection regime. • The Director's report The Committee identified the following areas for follow up: • The Corporate Risk Register – the key risks for the People Committee and the overall risks • A further updated of the work of the Culture Strategy Group/Colleague Experience Group

	The Committee did not identify any specific risks which will need to be presented to the Board but the Committee agreed that the workforce risks remained an area for ongoing focus. The Committee is able to provide the Board with assurance that the items discussed at the meeting provide significant assurance in relation to addressing gaps in controls and assurances for objective six of the Board Assurance Framework.
Recommendation	The Board is asked to discuss the report and note the areas of assurance and follow up.

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

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

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

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

Details:

Equality and Inclusion

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

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

The colleague story and learning item are ways of identifying potential impacts on colleagues with protected characteristics and any lessons learned will be followed up.

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST (SFT)

ASSURANCE REPORT FROM THE PEOPLE COMMITTEE

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 14 May 2024, the assurance received by the Committee and any areas of concern identified.

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

2. ASSURANCE RECEIVED

Colleague story – Development Journey

2.1. The Committee received a story from a colleague who had recently embarked on a new matron role to cross cover cardiology on both acute sites. The colleague shared her journey and the journey from one of her colleagues.

2.2. The stories showed that the journeys had not been easy and had required a lot of hard work. Both colleagues had been grateful for the opportunity to grow their careers. The Committee further noted: the drive and ambition through the development journeys; the challenge in relation to culture for overseas colleagues; the lack of a diverse workforce being reflected in the leadership team; the improvements made in relation to equality and diversity; and the challenge maintaining a healthy work/life balance when having a young family.

2.3. The Committee welcomed the philosophy that championing and instilling culture, trust and respect could be done at individual level; that an individual's behaviour demonstrates how colleague support each other; and that every colleague had the same rights and abilities irrespective of their ethnicity and race.

2.4. The Committee discussed the journeys and noted: the increased awareness around the diverse workforce and the opportunities available to all colleagues; the consideration of increasing flexibility for clinical colleagues in relation to their working patterns; the work in relation to reducing cultural barriers and the focus on induction of international educated colleagues; the need for all colleagues to understand different cultures and values; and the suggestion to provide a platform and a safe place for colleagues to share their views.

Review of Board Assurance Framework (BAF)

2.5. The Committee received the updated Board Assurance Framework in relation to strategic objective six and agreed that no changes were required to the Q4 update.

2.6. The Committee further received the draft BAF for Q1 2024/25 and noted the changes to the key performance indicators; the inclusion of a rolling retention rate indicator; the development of a retention indicator for colleagues with less than five years of service to be able to understand and monitor trends; and the development of a learning culture indicator.

Inclusion Update

2.7. The Committee received the workforce inclusion plan for 2023 to 2028 and noted that the plan had been sectioned by themes to ensure that all areas were covered; that the timelines aligned with the people strategy; and that accountable for the plan rested with senior colleagues rather than the inclusion team to be able to embed an approach that makes inclusion everyone's responsibilities and to ensure that systemic change is led by the appropriate leaders and teams.

2.8. The Committee further noted: that a new inclusive leadership content in senior nurse away days will be piloted; that some service groups were further ahead in terms of inclusion than other service groups but that inclusion was now a stronger area of focus in all service groups; and that consideration was being given as to what future support can be provided to the service groups.

2.9. The Committee was advised that the Care Quality Commission assessment now included a well led review for workforce equality, diversity and inclusion and further work will be required to provide evidence and ensure regular monitoring.

Learning Item

2.10. The Committee received an update on the new Care Quality Commission (CQC) approach to regulation which aimed to be a more flexible, responsive, and transparent method of quality assessment. The Committee noted that the new approach was based on a regular assessment of quality based on a defined set of evidence sources and that the approach will include quality statements and evidence, including from patients.

2.11. The Committee received an overview of the quality statements for safe and effective staff and workforce wellbeing and enablement and noted that six of the total eight quality statements will sit within the People Committee remit. The Committee further received an update on the work taking place to prepare for the new approach to ensure that the organisation, at all levels, will be ready to demonstrate compliance with the newly defined quality statements, in line with the evidence-focussed assessment methodology.

2.12. The Committee recognised the challenges raising awareness of this approach across the wide range of services and noted that ownership for the majority of well led aspects will rest with the Committee but with a link to the service groups. The Committee noted that further work will be required to review the statement and look at what "good" looks like.

Director Report

2.13. The Committee received the report and noted*:* the people services senior team's work in relation to productivity; the restructuring of the people services and the focus on priorities going forward; the concerns in relation to the clinical colleague sickness rate and the work to streamline the sickness absence reporting by clinical colleagues; the key sickness absence themes which related to both clinical and non clinical colleagues – stress, anxiety and depression and viruses; and that a discussion on workforce planning as part of the productive care programme work will be presented to the July 2024 meeting.

2.14. The Committee further discussed the wider productive care programme, which was aimed at transforming the way services are provided and noted that the full detailed plans will be presented to the May 2024 Finance Committee meeting.

Assurances Received

2.15. The Committee agreed that assurances had been provided in following areas:

- Assurance around the inclusion plan
- The colleague story gave assurance around the induction of the overseas workforce which was encouraging.

3. AREAS OF CONCERNS/FOLLOW UP

Corporate Risk Register – Key risks for the People Committee

3.1. The Committee discussed the key risks relating to the People Committee and noted the risks relating to: senior medical vacancies; the retention rate; colleagues' resilience and the need to review this risk following a discussion at the Culture Strategy Group meeting; the nursing and Allied Health Professional (AHP) workforce and the review of this risk by the service groups; discrimination and the actions being taken to improve the controls and assurances. The Committee noted that the nursing and AHP risk was a high scoring risk and, if not reducing, will need a stronger focus.

3.2. The Committee noted that exit data in relation to colleagues leaving due to the relationship with their line manager was currently not being captured but that this was linked to the implementation of the five year strategy. The Committee received assurance that work on retention was taking place and that a deep dive will be presented to the next meeting.

Corporate Risk Register

3.3. The Committee received the updated corporate risk register and noted*:* the reduction in the senior medical vacancy risk; the closing of the medical physics expertise risk as a service was now in place; the new risk in relation to vulnerability for the medical physics service during the recruitment process;

the approval of the risk appetite statement “seek” for strategic objective six; and the risk in relation to trans inclusive care.

3.4. The Committee further noted: the approval of the risk management policy at the next Audit Committee meeting; the establishment of an operational working group to review processes and develop a unified approach to personnel files as well as developing a staff record policy; the review of the senior medical workforce risks and the addition of a narrative on the risk assessment to reflect the impact of the geography of the hospital sites in relation to training sites on trainee numbers.

3.5. The Committee further discussed: the link between the general GP staff shortages risk and the risk relating to the Hamdon Medical Centre – although the general staffing risk had reduced, the staffing shortages at Hamdon Medical Centre remained a significant risk; the decontamination techniques and processes risk and the mitigating actions being taken – there was a high focus on this risk but a stable leadership and robust oversight of processes will be required to be able to reduce this risk; and the engagement of the business partners with service groups to be able to obtain feedback on people services support.

Work of the Culture Strategy Group

3.6. The Committee received an update on the work of the Culture Strategy Group and noted: the challenge in relation to the amount of information presented to the Group; the considerable progress made including the more robust focus on inclusion; the Group’s reporting structure; the challenge utilising the meeting time to understand the data, and in particular performance data; the proposal for the Group to solely focus on colleague experience; and to align the terms of reference to the Care Quality Commission’s quality statements.

3.7. The Committee further discussed the Group’s workload and agreed that it will be important for the Group to focus on a small number of topics particularly in relation to colleague experience. As culture was monitored by the Operational Leadership Team and the Board, the Committee agreed to change the name of the group to “Colleague Experience Group”.

3.8. The Committee asked for a further update to be provided to the November 2024 meeting.

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

4.1. The Committee did not identify any specific risks which will need to be presented to the Board but the Committee agreed that the workforce risks remained an area for ongoing focus.

5. ASSURANCE FRAMEWORK

5.1. The Committee received the assurance on strategic objective six in the following areas:

- Assurance around the inclusion plan
- The colleague story gave assurance around the induction of the overseas workforce which was encouraging.

Somerset NHS Foundation Trust	
REPORT TO:	Board
REPORT TITLE:	Inclusion Progress Report
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development Phil Brice, Director of Corporate Services
REPORT BY:	Harriet Jones, Head of Inclusion Isobel Clements, Chief of People and Organisational Development Phil Brice, Director of Corporate Services
PRESENTED BY:	Isobel Clements, Chief of People and Organisational Development Phil Brice, Director of Corporate Services
DATE:	2 July 2024

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

Executive Summary and Reason for presentation to Committee/Board	This paper outlines a proposal for the next stage of Inclusion across Somerset NHS Foundation Trust (SFT). We commenced our focus on this agenda within our workforce but this broader focus would ensure an evidence-based and systemic approach to inclusion is applied not only to our workforce, but also the engagement, access and outcomes for our patients, as well as our organisational ways of working and processes. This paper describes the Board's role in enabling inclusion to be fully embedded across SFT, holding teams to account on their inclusion objectives, and ensuring we make measurable progress. The paper outlines proposals for development and training to support the Board in prioritising and embedding inclusion in their remit. The paper takes into account the Care Quality Commission's Quality Statements framework and its emphasis on capable, compassionate and inclusive leadership and on workforce equality, diversity and inclusion. The paper also acknowledges the Trust's responsibilities as a provider of mental health services in respect of the patient and carer race equality framework (PECRF). Finally, this paper also describes a proposed reporting and monitoring framework to Board for inclusion.

Recommendation	The Board to consider the proposals around Board development on inclusion. The Board is asked to approve the proposals for implementation of the PCREF. The Board is asked to discuss and approve the proposed monitoring and reporting arrangements described above.

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

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

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

Equality and Inclusion

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

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

The paper outlines how SFT will develop and extend our approach to inclusion, which is informed by leading research and practice. Our aim is to ensure our work has a positive and measurable impact on people with protected characteristics – extending our focus from our workforce to include our patients and wider organisational impact.

The attached workforce plan (appendix) outlines data-informed actions that are designed to remove and reduce systemic inequalities and improve outcomes for colleagues 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.
The inclusion workforce plan has been developed with input from the colleague networks and building on feedback through staff survey and other sources. The aim is that developments of patient and carer facing involvement will be co-produced.

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 attached Workforce Inclusion Plan has been reviewed and discussed 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

SOMERSET NHS FOUNDATION TRUST

INCLUSION PROGRESS REPORT

1. BACKGROUND AND PURPOSE

1.1 Over the past two years, we have been working hard to embed an impactful, systemic approach to inclusion across SFT. We have made progress, seeing a change in conversations, actions taken, and engagement across the trust. As planned through our strategic approach, this activity has largely focused on our workforce as the place to embed compassionate and inclusive leadership.

1.2 We are now at the point where we are looking to build on this platform to apply this approach to everything we do as a Trust, including the provision of inclusive and accessible care for all our patients, and embedding inclusion across all organisational processes.

1.3 This paper outlines a proposal for the future scope and focus for inclusion across SFT, as well as a description of the Board's role in supporting this work to progress and be fully embedded. This will take into account the Care Quality Commission's (CQC) Single Assessment Framework and the NHS England Patient and Carer Race Equality Framework (PCREF). We also describe a proposed reporting and monitoring framework for inclusion at Board level.

2. A WIDER FOCUS FOR INCLUSION

2.1 We are proposing a shift in scope and focus to build on the platform of inclusion we have established and to encompass fully our duties and responsibilities as a public sector organisation and provider of healthcare services. The diversity and experience of our colleagues remains a priority, but we are currently missing opportunities to apply a systemic approach to inclusion to other strategic objectives.

Care Quality Commission Single Assessment Framework

2.2 In 2023, CQC launched its new strategy and single assessment framework. The new assessment framework has a specific and general focus on people's human rights when they receive health and care services with a view to preventing failures in care that are often related to risks to human rights and to ensure people receive good care.

2.3 The quality statements in the assessment framework are aligned to human rights principles. These FREDA principles are:

- fairness
- respect

- equality
- dignity
- autonomy.

2.4 The Health and Social Care Act regulations are also designed to be compliant with human rights law. Legal compliance requirements include, for example, with the Equality Act 2010 and Human Rights Act 1998. We recognise that it is a priority to protect and promote people's human rights.

2.5 In particular, the CQC's new approach includes two evidence categories that underpin the principles of inclusion and human rights:

People's experience of health and care services: This means CQC will listen to and gather people's experiences of care as evidence and this will directly inform their assessments of the quality of care.

Feedback from staff and leaders: This CQC will listen more closely to experiences of frontline staff and take action sooner to protect the rights of people using services and staff.

2.6 CQC has a number of Quality Statements which set out specific expectations of trusts in respect of equality, diversity and inclusion. These include:

- Equity in access
- Equity in experiences and outcomes
- Person-centred care
- Treating people as individuals
- Capable, compassionate and inclusive leadership
- Workforce diversity, equality and inclusion

Patient and carer race equality framework

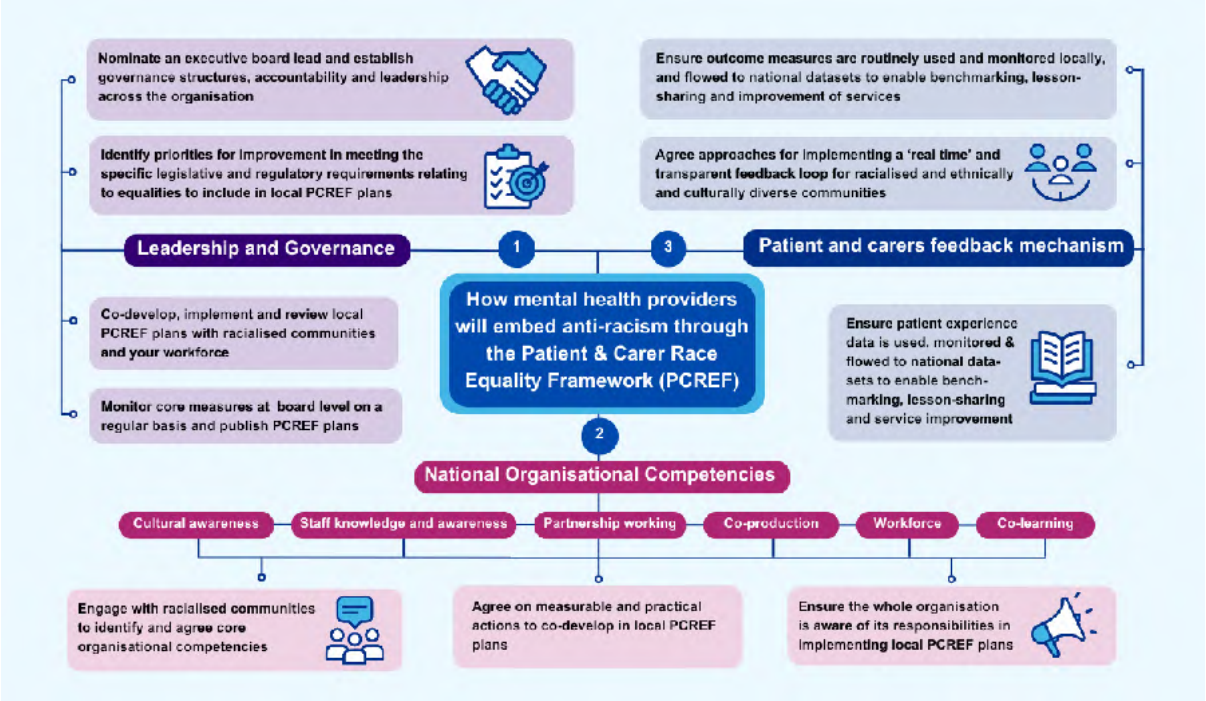
2.7 NHS England has launched an anti-racism framework: the Patient and carer race equality framework (PCREF), for all NHS mental health trusts and mental health service providers to embed across England. This is a mandatory framework intended to support trusts and providers to become actively anti-racist organisations by ensuring that they are responsible for co-producing and implementing concrete actions to reduce racial inequalities within their services. This will become part of CQC inspections. The PCREF will support improvement in three main domains:

- Leadership and governance: trusts' boards will be leading on establishing and monitoring concrete plans of action to reduce health inequalities

- Data: new data set on improvements in reducing health inequalities will need to be published, as well as details on ethnicity in all existing core data sets.

- Feedback mechanisms: visible and effective ways for patients and carers to feedback will be established, as well as clear processes to act and report on that feedback.

2.8 The anti-racism framework is designed to promote a new dimension of co-production, where individuals and communities are at the heart of the design and implementation of the services they need.



2.9 The NHSE guidance sets out key steps that trusts needs to take to embed anti-racism through the PCERF with an expectation that these are in place by March 2025:

Leadership and governance

- Nominate an executive board lead and establish governance structures, accountability and leadership across the organisation.

- Co-develop, implement and review local PCREF plans with racialised communities and your workforce.

- Identify priorities for improvement in meeting the specific legislative and regulatory requirements relating to equalities to include in local PCREF plans.

- Monitor core measures at Trust Board level on a regular basis and publish PCREF plans.

National organisational competencies

- Engage with racialised communities to identify and agree core organisational competencies.

- Agree on measurable and practical actions to co-develop in local PCREF plans.

- Ensure the whole organisation is aware of its responsibilities in implementing local PCREF plans.

Patient and carer feedback mechanism

- Ensure patient experience data is used, monitored and flowed to national data-sets to enable bench- marking, lesson-sharing and service improvement.

- Ensure outcome measures are routinely used and monitored locally, and flowed to national datasets to enable benchmarking, lesson-sharing and improvement of services.

- Agree approaches for implementing a 'real time' and transparent feedback loop for racialised and ethnically and culturally diverse communities.

2.9 A draft strategy has been developed (Appendix 1) which outlines 6 priorities for embedding inclusion across all areas of work at SFT. These priorities are:

- An innovative approach to culture change

- People policies and processes that drive inclusion

- Patient care that is inclusive and addresses health inequalities

- Physical and digital environments that are accessible and inclusive

- Communication and engagement that is representative and inclusive

- Governance processes that embed inclusion in all that we do

2.10 For this scope and focus of approach to be successful, we also need to reconsider the role and purpose of an inclusion team. We are currently piloting a new model within two people services teams. We are aiming to embed expertise and support to these teams locally, to enable them to lead on inclusion actions and improvements themselves. The aim is to build expertise and confidence in inclusion within teams, rather than a small team of experts being seen as responsible for all inclusion actions. Based on the review of this pilot, we will look to amend and extend this approach across SFT.

3. THE ROLE OF BOARD, AND BOARD DEVELOPMENT

3.1 Research on impactful inclusion strategies consistently points to leadership engagement and commitment as a driving principle. This aligns with the CQC quality statements and what good looks like in respect of capable, compassionate and inclusive leaders. However, bringing this to life can be challenging, and often requires additional development and discussion amongst the Board to agree an approach that works for their own organisation.

3.2 Effectively leading on inclusion requires Boards to hold teams and managers accountable on trust-wide inclusion priorities, and to ensure inclusion is considered across all areas of the Board's work.

3.3 It is recommended that any development for Board should focus on the following three areas:

- **The diversity of Board**: Research has shown a link between the diversity of Boards and the success and innovation of organisations[1] [2]. Any development should include conversations around how diverse our current Board is, what we should be aiming for, and identifying research-informed and systemic steps we can take to ensure our Board becomes more diverse over time.

- **The inclusivity of Board**: Research has evidenced[3] that diversity alone is not enough - to gain the benefits of diversity, the Board needs to be an inclusive environment where everyone can contribute, bring different perspectives, and inform decision making. Development should cover research-informed practice that Board could adopt to ensure all members are able to contribute and engage in decision making. This should include honest conversations around how inclusive our Board currently feels, what practices work well, and what may need to change in order for Board to be fully inclusive in how it functions and interacts.

- **Board commitment, engagement and leadership of inclusion**: Finally, research highlights[4] that for an organisation to make progress against it's stated inclusion goals and strategies, work needs to be driven and supported at Board level and spread throughout the organisation. Attention is needed to assess how inclusion can be fully embedded across all Board activities and decision making, and where further development and support is needed for members of Board to fully understand and lead a systemic approach to inclusion.

3.4 Given the focus and importance of this area of work and the specific requirement within PCREF, the Board should nominate a single executive lead for inclusion – covering the full range of protected characteristics and inclusion.

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[1] Strengthening-NHS-board-diversity-report.pdf (nhsconfed.org)
[2] Research: Firms with Diverse Boards Achieve Higher ESG Ratings (hbr.org)
[3] Is Your Board Inclusive — or Just Diverse? (hbr.org)
[4] The inclusion imperative for boards | Deloitte Insights

4. MONITORING ARRANGEMENTS

4.1 The inclusion team currently reports to Board every 6 months. The current reporting arrangements cover two key updates:

- **Workforce Inclusion Report** – SFT's first Workforce Inclusion Report was presented to Board in November 2023. This was the first holistic report covering workforce diversity and inclusion data, and a workforce inclusion plan. This will now be an annual Board report. The purpose of the report is to track progress over time, identify our priority areas for action, and develop a clear understanding of the systemic drivers of inequality including workplace behaviours, processes, or policies that need improving. The report brings together mandatory reporting frameworks (including the WDES, WRES and gender pay gap) that focus on individual protected characteristics, along with additional demographic information and data sets not covered by these reporting frameworks. The report also includes an update against our workforce inclusion plan 2023-2028. The workforce inclusion plan has been updated and was presented and discussed by People Committee in May 2024. The approved version of the workforce inclusion plan is attached as Appendix 2. This will be updated, and progress will be reported, every year as part of the annual workforce inclusion report to Board.

- **Inclusion Progress Update** (this paper) – The aim of the progress update is to present a narrative of key strategic priorities, areas of progress, and proposed changes.

4.2 It is proposed that once a broader scope for inclusion has been agreed and embedded, an additional report should be added to our annual reporting cycle to Board. This third report would present all relevant inclusion data relating to our patients, taking account of the PCERF requirements and the NHS Equality Delivery System. This would ensure we adopt a data-driven approach to systemic changes focusing on patient engagement, access, and outcomes and will complement the future reporting arrangements in relation to patient, carer and colleague experiences.

5. RECOMMENDATION

5.1 The Boad to consider the proposals around Board development on inclusion.

5.2 The Board to nominate a dedicated executive lead for this agenda and specifically for PCREF.

5.3 The Board to discuss and approve the proposed monitoring and reporting arrangements described above.

Isobel Clements, Chief of People and Organisational Development
Phil Brice, Director of Corporate Services

APPENDIX 1: DRAFT SFT INCLUSION STRATEGY

Our vision is to be a Trust where everything we do has been designed to be fully inclusive and to create equitable outcomes for all. We will have a truly inclusive culture, where every colleague knows that their unique skills and abilities are valued, and where each member of our community has equitable opportunities, knows they belong, and that they are heard. Our patients will receive accessible and inclusive care, informed by demographic data, insight, and the voices of our community.

Our approach is how we create change. Our actions will address the cultures, behaviours, policies, and processes that create or maintain inequality. Our approach is to design for inclusion and to 'fix the system'.

The principles that enable us to 'fix the system' are:

- We are evidence-based: detailed data analysis and meaningful consultation enables us to identify where action is needed and to track impact over time.

- We work in partnership: we offer expertise to leaders and teams to embed inclusion into all our organisational strategies, policies, processes, and ways of working.

- We are innovative: we take brave and research-informed actions.

- We empower: inclusion is everyone's responsibility. We provide our colleagues with the skills to drive inclusion in their own teams and in their work.

Our priorities:

1. An innovative approach to culture change

The culture of our organisation impacts both colleagues and the community we serve. However, changing organisational culture is notoriously difficult. As our organisation has grown, we need to adopt a research-based and innovative approach to culture change at a larger scale. Our actions will focus on changing behaviours at organizational, team, and interpersonal levels so that all areas of our trust are truly inclusive.

- Address discrimination and bullying. This includes setting and communicating expectations on behaviours we do and don't expect at SFT, with effective processes to enable accountability, including clear mechanisms for speaking up, and for responding to and addressing behaviours.

- Reduce and respond to violence and abuse. This includes creating safe environments where violence and aggression are less likely to occur, ensuring our reporting mechanisms lead to action, providing skills to de-escalate, and ensuring effective post-incident support.

- Our Board, Executive and senior leaders prioritise inclusion, set the tone on expected behaviours, and lead by example.

- Inclusion and cultural competency to be embedded as key principles of leadership development and leadership expectations. We will have effective development, support, and accountability mechanisms to bring these principles to life.

- Build the skills, capability, and accountability across SFT to ensure inclusion is considered and embedded in all that we do.

2. People policies and processes that drive inclusion

How we recruit, support, and develop our workforce has direct impacts on retention and experience. Our people policies and processes must be designed with inclusion in mind, to ensure we meet the needs of our diverse colleague community, as well as ensuring inclusive application and outcomes.

- Recruitment processes that are fully inclusive and accessible. We will need to think differently about how we design roles, how we advertise, how we select candidates, and provide an inclusive induction process. We will look to the emerging research on inclusive, skills-based, recruitment to design a process that is fit for purpose.

- Policies that are designed to be inclusive and accessible. We will track the application and impacts of all our policies to ensure equitable outcomes.

- Reduce existing gender and race pay gaps and identify mechanisms to prevent the creation of new pay gaps. Work towards analysing our pay data to identify any gaps relating to disability and sexuality.

- Development and progression options that meet the needs of our diverse community. This includes addressing identified barriers to progression for diverse groups through workforce data and consultation.

- People services colleagues who are confident to provide inclusive services, advice, and support.

3. Patient care that is inclusive and addresses health inequalities

Ensure our systems, processes and policies relating to patient care consider and effectively support diverse communities, with the aim of reducing health inequalities.

- Embed a structure and process for diverse and inclusive co-production.

- Ensure inclusion is embedded within all policies and processes relating to patient care.

- Progress projects and supportive policies to address identified gaps, including specific focus on Trans-inclusive care, neurodiverse-inclusive care, and providing reasonable adjustments.

- Make the most of opportunities as an integrated Trust - learn from the expertise of colleagues and teams across our Trust to inform our approach to

inclusive care. For example, working with and learning from the expertise of the autism service and learning disability services.

- Build confidence and expertise amongst colleagues to support patients from diverse communities.

4. Physical and digital environments that are accessible and inclusive

Our physical and digital environments can have a huge impact on our experience at work or as a patient. Our digital systems, buildings, way finding, signage, outdoor spaces and travel options should all be planned and designed with accessibility and inclusion as driving principles.

- Embed inclusion within all capital development strategies, design briefs, and developments

- Develop an improvement strategy for providing accessible and inclusive spaces across all existing SFT sites

- Digital platforms should be procured and developed to be fully accessible, and designed to reflect the diversity of our population

- Digital systems should enable us to report, measure and analyse trends relating to diversity and inclusion, and this data should be used to inform service and process design.

5. Communication and engagement that is representative and inclusive

Our tone of voice, organisational identity, and the images we use should represent the diversity of our community. How we engage, consult, and listen to colleagues and patients should seek out and respond to quiet voices.

- Create mechanisms for seeking, hearing, and responding to diverse voices from our colleague community and the wider Somerset community.

- Develop clear guidance on how we can communicate internally and externally in an inclusive and accessible way, including our organisational tone of voice, the language we use, the stories we tell, and the images used

- Communicate effectively so that we can keep people updated and involved in the progress we're making and how to support inclusion

- Build a reputation that evidences SFT is innovative, brave, and making tangible progress towards inclusion.

6. Governance processes that embed inclusion in all that we do

Our governance mechanisms are opportunities to embed practices that ensure inclusion isn't a 'nice to have' but an essential part of how we work. We need useful, meaningful, and accessible diversity data and insight in the right places and at the right time to inform policy development, change processes, and improvements.

- Provide meaningful diversity data and insight that drives improvement for inclusion for patient care and workforce data.

- Equip colleagues with the skills and tools to interpret and respond to diversity data relating to the experience of patients and colleagues, effective patient care, and workforce.

- Embed inclusion in department, service group and organisational governance processes.

- Embed the use of People Impact Assessments to ensure policies, change, and improvement processes lead to equitable outcomes.

- Build the skills, understanding and governance processes that support the new CQC framework, which has inclusion threaded throughout.

- Ensure inclusion is a core part of processes and improvement models including QI methodology and models for understanding our productivity and impact.

- Establish clear accountabilities for inclusion outcomes and progress, including appropriate representation at meetings and forums. This should be role modelled at Board level and embedded across local governance structures.

- Work with our partner organisations in Somerset and beyond to build and support a culture of proactively seeking the views and acting on feedback from patients, carers, communities and colleagues to ensure different groups can take part and all voices are heard.

A new model for the inclusion team

To achieve the above, we need a new model for how an inclusion team collaborates with, and influences, teams across the Trust. In line with research and best practice on impactful inclusion strategies; actions and accountabilities should be owned across the organisation, rather than by an inclusion team. The role of a central inclusion team should primarily be an advisory and consultancy function.

We're proposing that we establish a trust-wide community of practice. This would involve colleagues from relevant teams joining inclusion to develop their skills and understanding, to develop and manage projects relating to inclusion, and to share their new inclusion expertise with their teams locally. The intended outcome would be actions are held and driven locally, with support from the inclusion team, and that inclusion skills are spread across teams and service groups.

This model is being trialled over the next 8 months – with Sun being embedded as part of the OD and Leadership team, and Kate being embedded within the HR Advisory team.

APPENDIX 2: PEOPLE COMMITTEE PAPER, MAY 2024

WORKFORCE INCLUSION PLAN 2023-2028

1 BACKGROUND AND PURPOSE

1.1 SFT's first Inclusion Workforce Report was presented to Board in November 2023. This was the first holistic report covering workforce diversity and inclusion data, and a workforce inclusion plan. This will now be an annual Board report.

1.2 The purpose of the report is to track progress over time, identify our priority areas for action, and develop a clear understanding of the systemic drivers of inequality including workplace behaviours, processes, or policies that need improving.

1.3 The report brings together mandatory reporting frameworks (including the WDES, WRES and gender pay gap) that focus on individual protected characteristics, along with additional demographic information and data sets not covered by these reporting frameworks.

1.4 The workforce inclusion plan responds to the data presented, as well as research and best practice on inclusion. The timeframe for this workforce plan aligns with the SFT People Strategy (2023-2028).

2 THE WORKFORCE INCLUSION PLAN

2.1 Since the original workforce inclusion plan was presented at Board, the plan has been reviewed, and accountabilities and timescales have been added. The final version is presented below.

2.2 It is expected that the plan will develop each year as we track impact over time, and actions will be added or amended as new priorities emerge from our data.

2.3 Accountabilities within the workforce inclusion plan have deliberately identified senior colleagues rather than accountability sitting with the inclusion team. This is to embed an approach that makes inclusion everyone's responsibility, and ensuring systemic change is led by the appropriate leaders and teams.

2.4 The role of the inclusion team will be to offer support, coaching, and advise to teams as they implement the actions outlined in the workforce inclusion plan.

2.5 Timeframes have been agreed with all relevant stakeholders and teams. Timeframes have been set that reflect the current priorities for each team and align with ongoing deliverables under the People Strategy.

3 MONITORING ARRANGEMENTS

3.1 We are proposing the following governance and monitoring arrangements for the workforce inclusion plan, to ensure there is effective oversight of implementation and tracking of impact:

- The People Governance Group will provide regular oversight of the delivery of actions within the workforce inclusion plan, identify where progress is not being made against agreed timeframes, and identify additional support that may be needed for teams to progress actions.

- Updates on progress against the workforce inclusion plan will be presented to People Committee eery 6 months. This will provide assurance to People Committee on progress and impact made, but also identify where further work is needed across the Trust.

- An updated against the plan will be part of the annual inclusion workforce report to Board.

4 RECOMMENDATION

4.1 The People Committee is asked to review and approve the workforce inclusion plan.

4.2 The People Committee is also asked to consider and agree the proposed monitoring arrangements for the workforce inclusion plan described above.

HARRIET JONES
HEAD OF INCLUSION

WORKFORCE INCLUSION WORKPLAN 2023-2028

Action	What we know	Accountability	Timeframe	Strategic and Reporting Links	May 2024 progress update
Key Theme 1: Recruitment					
Procure and embed an Applicant Tracking System (ATS) that enables us to: 1. Undertake a detailed analysis of diversity recruitment data at application, interview, and appointment stages. 2. Ensure we provide an accessible and inclusive hiring process by design. 3. Extend anonymised hiring practices where possible. 4. Ensure the Disability Confident guaranteed interview scheme works in practice.	There is a lack of reliable or accurate data on our recruitment process – impacting our ability to undertake an analysis of diversity trends. The data we do have, suggests a white candidate is more likely to be appointed in comparison to a BAME candidate. The Disability Confident Audit identified that the guaranteed interview scheme does not work in practice due to issues with our current ATS.	- Belinda Lock / Debs Matthewson / Noella Rowton (Resourcing and Supply)	- New ATS in place by June 2024 - Review of inclusion impacts of ATS quarterly (analysis of impact to lead to new actions)	- People Strategy - Retain and attract talent - WRES Metric 1 & 2 - WDES Metric 1 & 2 - Disability Confident	New ATS procurement process undertaken in Q3 2023, with new provider identified. Requirements relating to inclusion were defined and embedded as a core part of the procurement process.
Move towards a skills-based model of hiring. 1. Provide development and up-skilling for recruitment team to understand and implement an inclusive and skills-based approach to hiring. 2. Work with external experts to develop a skills-based model that is designed to be fully inclusive and accessible.	Research suggests skills-based hiring is the most effective model for addressing bias in recruitment and ensuring equitable outcomes.	- Belinda Lock / Debs Matthewson / Noella Rowton (Resourcing and Supply)	- Engage consultant to support the design of an inclusive assessment centre model - July 2024 - Inclusive and skills-based recruitment development for recruitment team - July 2024 - Skills-based and inclusive assessment centre in place by Dec 2024 - Revisit recommendations from RoleMapper – January 2025	- People Strategy - Retain and attract talent - WRES Metric 1 & 2 - WDES Metric 1 & 2	Diagnostic review undertaken in partnership with RoleMapper. This identified opportunities for improvement across our recruitment process, and recommendations for revamping our process for creating job descriptions, adopting a structured job architecture, and moving to skills-based hiring.
Embed inclusive recruitment processes and tools that improve applicant experience and equitable outcomes. For example, these include, but not limited to: 1. Ensure we are equipped to provide reasonable adjustments at every stage of the recruitment process. 2. Explore alternative methods of selection as well as or instead of a traditional interview. 3. Pilot providing skills-based and inclusive interview questions in advance to all candidates. 4. Ensure the use of AI tools in recruitment mitigate bias.	Skills-based hiring, and the new ATS will make significant improvements to our recruitment process, and our ability to embed inclusive practice. However, there will be other mechanisms that we need to explore and embed within our process. Recommendations from the Disability Audit identified the need to improve our recruitment process to be more accessible and to provide appropriate adjustments. While there are numerous benefits to using AI in recruitment, emerging research highlights the risks to embedding bias within processes if AI tools aren't designed or	- Belinda Lock / Debs Matthewson / Noella Rowton (Resourcing and Supply)	- Assess the provision of reasonable adjustments - March 2025 (following implementation of reasonable adjustments policy, and the Work Well program). - Develop bank of interview questions for hiring managers to use and share with candidates before the interview – from Sept 2024. Review impact for	- People Strategy - Retain and attract talent - WRES Metric 2 - WDES Metric 2 - Disability Confident	Improvements have been made to the recruitment process to explicitly promote reasonable adjustments during recruitment. More work is needed to up-skill hiring managers and the recruitment team on supporting these adjustments. Pilots are being run locally where interview questions are being provided in advance. Initial feedback from internationally education colleagues, and those with disabilities, has indicated that this has been very helpful in preparing for interviews. We will continue to assess the impact and whether this could become standard practice.

Action	What we know	Accountability	Timeframe	Strategic and Reporting Links	May 2024 progress update
	assessed from an inclusion perspective. This is something that will need to be considered throughout future pilots and applications of AI.		pilot groups in March 2025.		The trust has signed up to the Work Well program via the DWP, and this work initiated in March 2024. This ensures adjustments are provided in the recruitment process through advice and support from external assessors.
Review and update the SFT recruitment website to reflect diversity and inclusion, including a focus on: 1. The diversity of images used 2. Information on accessibility and reasonable adjustments 3. Information on the culture of inclusion at the trust, the progress being made, and colleague networks	Opportunities for improvement were identified through the Disability Confident Audit, this included promoting the trust as an inclusive employer, and providing information on arranging reasonable adjustments throughout the recruitment process.	- Belinda Lock / Debs Matthewson / Noella Rowton (Resourcing and Supply) - Lisa Pyrke (Comms)	- Complete – Review and audit of website completed, with improvements made in March 2024. - Review website content March 2025.	- People Strategy - Retain and attract talent - WRES Metric 2 - WDES Metric 2 - Disability Confident	The recruitment website was reviewed and updated in Q2-3 2023, and again in Q1 2024 following a review. Significant improvements have been made, with positive feedback received from colleagues, and positive feedback in the Rainbow Badge results report.
Develop training for recruitment managers that fully embeds content on inclusive practice and bias mitigation strategies at every stage of the recruitment process.	While the new ATS will enable more inclusive approaches and techniques for hiring, there will still be a need for development for hiring managers.	- Belinda Lock / Debs Matthewson / Noella Rowton (Resourcing and Supply)	- Training on new system rolled out from July 2024 - Ongoing improvement and development of training reviewed annually.	- People Strategy - Retain and attract talent - WRES Metric 2 - WDES Metric 2 - Rainbow Badge	The recruitment team have built tips on inclusive practice into current training provided for hiring managers. A review of training will be undertaken in line with the launch of the new ATS platform. The new ATS has been designed to promote inclusive practice and behaviours. One example is that hiring managers cannot post a role until they have completed the basic training – which will include content on inclusion.
Key Theme 2: Retention and Progression					
Take steps to improve the progression and retention for internationally educated colleagues. This will include, but is not limited to: 1. Understand the needs of internationally educated colleagues in different staff groups, including nurses, midwives, AHPs, and doctors. 2. Improvements to the induction and onboarding process. 3. Develop and implement Cultural Competency training for managers of culturally diverse teams. 4. Ensure colleagues are not charged as international students when completing qualifications. 5. Review opportunities to support colleagues applying for their right to	The majority of BAME colleagues are employed at band 5 – 41% of colleagues at band 5 are BAME. Representation then falls significantly to 12% at band 6. In comparison to 2021, the representation of BAME colleagues has increased from 14%. There has also been an increase across most bands, including an increase from 31% to 41% at band 5, and from 9% to 12% at band 6. In medical and Dental roles, BAME colleagues are more highly represented in SAS roles (51%), compared to 22% in consultancy roles. Representation has not changed at consultant level since 2021.	- Lou Netto / Wendy Powell (Experience & Learning) - Alison Wooton (Senior care team) - Noella Rowton (Medical Workforce Strategic Development)	- Working group to be established to develop a plan for this work – in place by June 2024. - Cultural Competency training in place from September 2024, with regular impact reviews. - Review of impact and lessons learned from DAL programme – July 2024.	- WRES Metric 1 - People Strategy – Retain and attract talent	A scoping exercise has been completed, compiling all data and feedback available to help us understand the barriers to progression and retention for international colleagues. This will inform the activities and priorities of the working group. Several Cultural Competency training offerings have been piloted, with a view to adopting a model to roll out across SFT. The training is intended to support managers, especially those who support internationally educated colleagues. 6 colleagues took part in the 2023/24 DAL programme – this is the Developing Aspirant Leaders (DAL) Programme for ethnic minority nurses and midwives, run by

Action	What we know	Accountability	Timeframe	Strategic and Reporting Links	May 2024 progress update
remain visa (this comes at a significant financial cost to colleagues). 6. Review of the DAL programme, and opportunities to apply positive aspects to internal training. 7. Opportunities to support internationally educated doctors to become consultants. 8. Consider how we meaningfully acknowledge and value experience gained oversees before joining the NHS.					NHS England. 4 colleagues are part of the 2024/25 cohort. Progress to date was shared at the 2023 Black History Month event, and a session provided opportunities for attendees to feedback on further improvements needed and priorities. Guidance on languages spoken at work has been developed and communicated. Our annual leave policy was amended following feedback from internationally educated colleagues that they were not being supported to take longer periods of leave to travel home.
Review and improve our reasonable adjustments policy and process.	This was a key finding from the BDO Disability Confident Audit. In 2022, the NHS staff survey showed that almost a third of colleagues with a disability do not have a reasonable adjustment in place to enable them to carry out their work. This could equate to roughly 1200 people without an adjustment in place. A large number of ongoing HR cases and tribunal cases relate to disability, and often a lack of reasonable adjustments discussed and when offered they were not all fully considered or understood. We also recognised a significant increase in concerns being raised via the Lived Experience and Neurodiversity Networks.	- Lou Netto (Experience & Learning)	- New policy and process ratified and in place by May 2024. - Comms plan implemented throughout 2024. - Training in place by October 2024. - Review of impact of policy and process April 2025. - Pilot programmes supporting neurodiverse colleagues implemented April-July 2024, and reviewed in August 2024.	- Disability Confident - WDES Metric 8 - People Strategy – Retain and attract talent	A working group undertook a holistic review of the reasonable adjustment process. A new policy has been finalised, a central fund for reasonable adjustments has been created, and training has been held for the HR Advisor Team. Toolkits and guides for colleagues and managers have also been published on our intranet. Initial comms has been launched, with further plans for future reminders throughout 2024. Following feedback from the Neurodiversity network, we have identified a number of pilot programmes to address gaps in our OH advice, or to pilot approaches that support individuals and their managers to identify suitable adjustments.
Ensure career conversations enable colleagues to effectively plan for their progression, with development opportunities provided by their manager and centrally via People Services. Ensure this is designed to meet the needs of all colleague groups and demographics.		- Debs Matthewson (Resourcing and Supply)	- Year 2 people strategy deliverable – review impact and progress in March 2025	- People Strategy – Develop our people	As part of the implementation of the people strategy, a year 1 deliverable group was established focusing on retention. In its first year, this group has been primarily focusing on the 'Scope for Growth' framework for career support and development. The need to improve and review the appraisal process has led to this being a focus of a deliverable group throughout year two of the people strategy.
Review our parental leave provisions, with a particular focus on:	A relatively low number of colleagues are accessing parental and paternity leave. There were no records of colleagues	- Lou Netto (Experience & Learning)	- New policy developed and communicated by June 2024.	- People Strategy - Care for our people - Rainbow Badge	A review of the parental leave policy has begun. This will include a full people impact

Action	What we know	Accountability	Timeframe	Strategic and Reporting Links	May 2024 progress update
1. Colleagues are encouraged and feel able to access shared parental and paternity leave. 2. Our policies are explicitly inclusive of LGBTQ+ families. 3. There are clear mechanisms and guidance for keeping in touch and up to date during parental leave. 4. There is a clear process and guidance to support a smooth and successful return from parental leave.	accessing shared parental leave. However, our BAME colleagues are more likely to access these provisions. Within our Rainbow Badge assessment report, the trust scored 0 out of 5 for the review of policies relating to parental leave, as they were not seen to be explicitly inclusive of LGBTQ+ families. The Women's Network undertook a survey of colleagues who had recently taken parental leave in 2021. This was developed into a series of actions that need to be adopted and reviewed within people services.		- Review of impact of policy June 2025.		assessment, the alignment of legacy SFT and YDH policies.
Develop and implement guidance for colleagues who are transitioning. This guidance should include information for the individual and their manager.	As part of the rainbow badge scheme, there was a clear recommendation that the Trust finalises and publishes the draft guidance that has been developed. Feedback has been provided by the LGBT Foundation. Anecdotal feedback from colleagues who are transitioning is that there is very little information or advice available, and managers are unsure how best to support.	- Lou Netto (Experience & Learning)	- New guidance developed and communicated by June 2024. - Comms, information, and training in place by October 2024. - Review impact of guidance June 2025.	- Rainbow Badge	This guidance has been drafted, and consultation has been undertaken with members of the LGBTQ+ network, relevant stakeholders, and managers. The guide is due to be reviewed by the people policy group in May 2024.
Investigate within-band pay gaps, particularly gaps within senior roles. Analysis might include: 1. Analysis of starting salaries to explore whether the negotiation process establishes a pay gap. 2. Gender and race distribution across banding pay points.	There are some gender and race pay gaps within bands, particularly at band 8D and above, and within several Medical and Dental roles.	- Kirstie Lord (Strategy and Profession Development)	- Report on existing data by demographic groups to be presented to pay assurance committee - July 2024 - Further actions developed in response to analysis – September 2024.	- Gender Pay Gap	We report our gender pay gap annual as a national requirement. These reports have shown little significant changes in our pay gap over the past three years. While we are required to report annually on our gender pay gap, for the past three years we have also analysed our data to understand our race pay gap.
Ensure any future Clinical Excellence Award scheme is implemented and designed to be inclusive, so further pay gaps are not created.	The historic CEA scheme has created a legacy gender pay gap of 30.2%. This compares to the current scheme, where CEAs are shared equally between consultants.	- Noella Rowton (Medical Workforce Strategic Development)	- To commence when guidance is provided on any new national CEA scheme.	- Gender Pay Gap	
Establish a pay assurance committee to oversee pay agreements outside of Agenda for Change processes.	Research shows that discretionary payments and negotiated pay are often where gender and race pay gaps are established and exacerbated.	- Isobel Clements (Chief People Officer)	- Complete - committee in place from April 2024 - Mechanisms for monitoring data by	- Gender Pay Gap	Committee and terms of reference established April 2024.

Action	What we know	Accountability	Timeframe	Strategic and Reporting Links	May 2024 progress update
1. Monitor data to understand whether pay offers are applied equitably, or if pay gaps are established. 2. Review and develop policies associated with discretionary pay to ensure equitable processes and outcomes.			demographics – July 2024 - Review of policies – September 2024 - Annual review of committee data – from April 2025 onwards		
Implement mechanisms, including an exit survey, to understand: 1. People's reasons for leaving the trust and whether this differs across demographic groups. 2. The length of service when someone leaves, to understand whether the rate of retention and turnover differs across demographic groups.	Our leavers data doesn't indicate that any demographic group is more likely to leave than others. However, we aren't sure what contributes to people's decision to leave.	- Lou Netto (Experience & Learning)	- Review available data and success of new mechanisms – August 2024 - Further action developed following review – September 2024	- People Strategy - Retain and attract talent	The trust introduced a new exit survey in 2023, which we hope will enable a detailed analysis and understanding of people's reasons for leaving, and whether this differs by demographic group.
Key Theme 3: Leadership					
Partner with Executive Team to develop specific inclusion actions and priorities for each member of the Executive Team.	Research and best practice show the importance of senior leaders visibly taking accountability for, and implementing, actions relating to inclusion.	- Peter Lewis (CEO) & Isobel Clements (Chief People Officer)	- SMART objectives finalised and agreed by June 2024 - Objectives communicated across SFT from September 2024 - Objectives reviewed May 2025 - Progress communicated in June 2025	- People Strategy - Compassionate and inclusive leadership	Each member of the Executive has identified at least 1 inclusion objective. Some members of the Executive Group have also asked their senior teams to develop their own inclusion objective.
Ensure our leadership development programmes build compassionate and inclusive leadership skills across our organisation. Actions would include: 1. Develop and roll out leadership expectations that embed inclusive practice 2. Review and redesign leadership development programme to reflect the new leadership expectations 3. Identify further development needs for leaders around inclusion and inclusive practice	Research on successful inclusion strategies consistently highlights the role crucial leaders and managers play in creating and maintaining an inclusive culture.	- Lou Netto (Experience & Learning)	- Leadership expectations developed – May 2024 - Leadership expectations communicated and embedded throughout 2024 - Review leadership development program – December 2024. - Ongoing review of impact of leadership expectations – December 2024 onwards.	- People Strategy - Compassionate and inclusive leadership - WDES Metric 6	An approach to inclusive leadership development was piloted at the senior nurse away days, reaching 300+ colleagues.
Implement mechanisms for collecting and analysing the diversity of key decision-making committees, as a minimum, this would include:	WDES and WRES data indicates that some data is missing relating to the diversity of Board.	- Ria Zandvliet (Secretary to the Trust)	- Mechanisms for monitoring in place by December 2024.	- WRES metric 9 - WDES metric 10	Members of Board have been asked to update their information within ESR to improve accuracy of demographic data reporting.

Action	What we know	Accountability	Timeframe	Strategic and Reporting Links	May 2024 progress update
1. Trust Board 2. Board sub-committees 3. Governors			- Actions developed based on data – March 2025.		
Key Theme 4: Workplace Culture					
Develop and progress a Trust-wide strategy on violence and aggression, which addresses the variation of experience for colleagues from diverse groups. This strategy will focus on: 1. Governance - including our reporting mechanisms, support options post-incident, and understanding our data on experiences of violence 2. Environment – including our approach to providing security, pilots of body cams, and ensuring Trust environments are designed with safety in mind 3. Behaviour – building de-escalation skills and a trauma informed approach across the trust, setting the tone of the behaviours that are expected, and clear processes and support if these expectations are not met.	Our 2022 staff survey indicated that: - BAME and LGB colleagues were more likely to report experiencing physical violence from patients or service users. - Female, BAME, disabled and LGB colleagues were more likely to report experiencing harassment, bullying or abuse from patients or service users. - Disabled colleagues were less likely to report their experience of violence compared to colleagues with no disability. - A lower proportion of colleagues had made a report of their experience of harassment, compared to physical violence.	- Dave Thomas (Senior care team / topic lead for violence and aggression) - Wendy Powell (Experience & Learning)	- Trust-wide strategy in place with agreed actions by September 2024.	- WRES Metric 5 - WDES Metric 4 - People Strategy - Care for our people	Dave Thomas is now topic lead for this project, with a working group in place to support the development of a new policy and trust-wide strategy. A working group has been established within people services to progress the 'behaviour' workstream, as a deliverable group as part of the people strategy. Radar reports are being monitored by ADPCs and are being discussed in regular governance meetings at Service Group level.
Develop an Inclusion 101 training box set. Short videos will give people the information they need to feel confident with the basics of inclusion. Development needs that have already been identified include: 1. What are pronouns and why are they important? 2. What is a reasonable adjustment and why are they important? 3. What is a People Impact Assessment and how do I use the PIA Tool? Following the development of the above topics, review available data and insight to identity further information and training needs.	Conversations with teams and managers has highlighted a need for basic information and training to improve people's confidence to have conversations around inclusion. This information would impact interactions with colleagues and with patients.	- Lou Netto (Experience & Learning)	- Training and information in place for initial development needs – by January 2025 - Review of future training needs – February 2025.	- People Strategy - Develop our people	
Develop effective, just, and restorative policies, processes and guidance relating to bullying, harassment and discrimination.	Within the rainbow badge assessment, SFT scored 1 out of a total 4 points on questions relating to discrimination, bullying or harassment policies.	- Lou Netto (Experience & Learning)	- Policies are to be reviewed throughout 2024.	- People Strategy - Care for our people - WDES Metric 4 - Rainbow Badge	One of the deliverable groups for year one of the people strategy focused on developing principles for just and restorative policies and processes, this work is still

Action	What we know	Accountability	Timeframe	Strategic and Reporting Links	May 2024 progress update
					ongoing and will influence work to review and improve our policies. A member of the inclusion team is partnering with the HR Advisory team to support the review of all our policies to ensure inclusion is fully embedded, and meaningful people impact assessments are completed.
Develop informative and effective guidance and processes in relation to sexual safety.	The 2023 staff survey included specific questions on sexual safety for the first time. Data from this survey highlighted: - 9.6% of colleagues had experienced unwanted sexual behaviour from patients or visitors - Demographic groups more likely to have experienced unwanted sexual behaviour from patients included colleagues aged 16-20 and 21-30, women, colleagues with a disability, and LGBT colleagues. - 2.5% of colleagues had experienced unwanted sexual behaviour from a colleague - Demographic groups more likely to have experienced unwanted sexual behaviour from colleagues include colleagues aged 16-20 and 21-30, LGBT colleagues, and colleagues with a disability.	- Lou Netto (Experience & Learning)	- Review progress against pledges from sexual safety charter July 2024	- People Strategy - Care for our people	The Trust has signed up to the NHS sexual safety charter, which includes a commitment to 10 key actions. A working group has been established to plan the Trust's implementation of this charter.
Review our opportunities for speaking up to ensure they are inclusive and colleagues from all demographic groups feel safe to access these options.	The 'Too Hot to Handle' report published in 2024 highlighted a number of concerns in speaking up mechanisms for colleagues experiencing racism across the NHS. There are a number of recommendations for us to review and consider locally.	- Lou Netto (Experience & Learning)	- Review in June 2024 – based on data from productive people services process - Plan for next steps – August 2024.	- People Strategy - Care for our people	
Review our wellbeing offerings to ensure they are accessible and inclusive, and meet the needs of diverse demographic groups.	Staff survey data highlights that: - disabled colleagues, LGB and male respondents were less positive about the Trust's action on health and wellbeing. - LGB and disabled colleagues were significantly more likely to report that they had felt unwell as a result of work-related stress.	- Lou Netto (Experience & Learning)	- Review in June 2024 – based on data from productive people services process - Plan for next steps – August 2024.	- People Strategy - Care for our people	
Procure and embed an Occupational Health provision that is fully inclusive and supports the reasonable adjustments process.	The work undertaken on the reasonable adjustments policy and process highlighted a number of concerns around our OH provision, and whether the current provision enables practical and effective advice,	- Lou Netto (Experience & Learning)	- New OH provision in place by Jan 2025	- People Strategy - Care for our people	Inclusion principles, and requirements around reasonable adjustment support have been embedded within the tender documents for the OH service.

Action	What we know	Accountability	Timeframe	Strategic and Reporting Links	May 2024 progress update
	recommendations and support for colleagues with disabilities and long-term health conditions.				
Roll out allyship training across SFT 1. Allyship training co-delivered by each member of the Executive Team 2. Allyship training co-delivered by the OD & Leadership team 3. Allyship training content fully embedded within the leadership development program		- Lou Netto (Experience & Learning)	- Complete – co-delivery with Exec completed 2023/24 - Co-delivery with OD – competed by December 2024 - Embed within LDP – December 2024	- People Strategy - Care for our people	Allyship training was piloted with the Executive Group late in 2022. Each member of the Executive has co-delivered these workshops, which were open to all SFT colleagues. Feedback on these sessions has been positive. To upskill and promote allyship within the People Services team, all members of the People Services team have been offered tailored allyship training, delivered by the Chief of people and organisational development and inclusion team. Over 60 people have attended, and the training has received excellent feedback. Bespoke inclusive leadership and allyship sessions have also been held for 300+ senior nurse and AHP colleagues.
Key Theme 5: People systems and governance					
Ensure there is a consistent and accurate record of colleagues entering formal processes. Review diversity data of colleagues going through processes including: 1. Formal capability processes 2. Formal disciplinary processes 3. Referrals to bodies including the NMC and GMC	Research suggests that bias often increases the likelihood of underrepresented groups entering formal processes. Initial data from the WRES suggests BAME colleagues may be more likely to be involved in formal disciplinary processes. However, numbers are very small, there are concerns around data accuracy, and that data is not currently reflective of all formal processes in place.	- Lou Netto (Experience & Learning) - Kirstie Lord (Strategy and Profession Development) - Alison Wooton (Senior care team / COAG chair) - Melanie Iles (Chief Medical Officer / ROAG chair)	- Data collation methods in place by July 2024 - Review of data November 2024 then annually.	- WDES Metric 3 - WRES Metric 3 - People Strategy - Care for our people	
Improve completion rates for demographic data in ESR.	Completion rates are particularly low for disability and sexuality. To improve our understanding of trends, we need to improve the completeness and accuracy of our data.	- Mike Scott (Strategy and Profession Development)	- Comms plan developed - May 2024 - Comms plan implemented throughout 2024 - Review progress – October 2024 then every 6 months	- All strategies and reports	A letter to colleagues with missing data in ESR has been drafted and will be sent out. Since 2021, completion rates have slightly improved, which we believe is a result of the move to ESR self-service. For example, 28% of colleagues had not answered demographic questions relating to disability in 2021, compared with 20% in 2023.
Ensure our people services digital solutions are designed to drive equitable outcomes, and to be fully inclusive and accessible	The deliverable group focusing on people services digital solutions found that 90% of people services digital systems had not have a people impacts assessment completed (or equivalent).	- Mike Scott (Strategy and Profession Development)	- People services digital board – in place by May 2024. - Annual review of actions and progress – May 2025 onwards.	- People Strategy – Learning and transforming	A people services digital strategy has been developed and includes actions for improving the accessibility of our digital systems, and ensuring systems are designed to be fully inclusive.

Action	What we know	Accountability	Timeframe	Strategic and Reporting Links	May 2024 progress update
Ensure strategic workforce plans and people plans at all levels of the organisation are informed by inclusion data and insight, and include actions designed to improve equality and inclusion outcomes. Review support and development for people partners and service groups to support colleagues to achieve this.		- Kirstie Lord (Strategy and Profession Development)	- Development plan in place by July 2024. - Annual review of people plans at people committee – May 2024 onwards	- People Strategy – Learning and transforming	People committee review of people plans – on agenda for June 2024 meeting. QOFP review of productive care plans – on agenda for May 2024.
Our workforce reporting provides meaningful and actionable data relating to diversity demographics and trends. 1. Diversity demographics are included within monthly workforce reporting 2. Diversity demographics are included in productive care reports 3. Development of Power BI to make data more accessible 4. Upskilling for colleagues to respond to diversity and inclusion data	We have access to demographic data within ESR, the NHS staff survey, and other core people services systems. However, this data is not always reported or accessible. This data is crucial for informing PIAs, local people plans, and productivity plans.	- Mike Scott (Strategy and Profession Development)	- Productive care reports – complete – demographics included from April 2024 onwards - Monthly workforce reporting – demographics included from September 2024 - Transition workforce data to Power BI reporting – from April 2025 - Development and training – ongoing, review in April 2025.	- People Strategy – Learning and transforming	Demographic data is not included within productive care reports. High-level demographic data is part of monthly workforce reports, further work is needed to explore the data that can be provided to meet planning needs locally. Initial development conversations have been held with people services teams around interpreting and responding to diversity data.
Embed People Impact Assessments across all people services processes, including the development of new strategies, policies, systems and organisational change processes.	The People Impact Assessment tool has replaced the previous Equality Impact Assessment form. The intention to provide guidance and support for colleagues so they can consider inclusion from the start of process, rather than the EIA form being a tick-box exercise at the end of a process.	- Isobel Clements (Chief People Officer)	- PIAs embedded within people strategy work – ongoing since April 2023 - PIAs completed for all new people policies – ongoing from April 2024 onwards - PIAs embedded within org change policy and processes – December 2024 - Review impacts and improvements – April 2025	- People Strategy – Learning and transforming	People Impact Assessments have been embedded within the year 1 people strategy deliverables. This has highlighted areas where further development may be needed.