SOMERSET NHS FOUNDATION TRUST/
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

PUBLIC BOARD MEETINGS HELD IN COMMON

A Public meeting of the Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust Boards will be held in common on **Tuesday 7 February 2023** at **9.00am** by way of a Microsoft Team meeting – below the link.

Microsoft Teams meeting

Join on your computer, mobile app or room device

Click here to join the meeting

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

Yours sincerely

COLIN DRUMMOND
CHAIRMAN SFT

MARTYN SCRIVENS
CHAIRMAN YDH

A G E N D A

9.00	**1.**	**WELCOME AND APOLOGIES FOR ABSENCE**	**Joint**	
	2.	**QUESTIONS FROM MEMBERS OF THE PUBLIC AND GOVERNORS**	**Joint**	
	3.	**TO APPROVE THE MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 8 NOVEMBER 2022**	**SFT**	**Enclosure A**
	4.	**TO APPROVE THE MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 8 NOVEMBER 2022**	**YDH**	**Enclosure B**
	5.	**TO APPROVE THE MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 6 DECEMBER 2022**	**SFT**	**Enclosure C**
	6.	**TO APPROVE THE MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION**	**YDH**	**Enclosure D**

		TRUST'S PUBLIC BOARD MEETING HELD ON 6 DECEMBER 2022		
	7.	**TO APPROVE THE MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 20 JANUARY 2023**	**SFT**	**Enclosure E**
	8.	**TO APPROVE THE MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 20 JANUARY 2023**	**YDH**	**Enclosure F**
	9.	**TO REVIEW THE ACTION LOGS AND MATTERS ARISING**	**Joint**	**Enclosure G**
	10.	**TO NOTE THE REGISTERS OF DIRECTORS' INTERESTS AND RECEIVE ANY DECLARATIONS OF INTERESTS RELATING TO ITEMS ON THE AGENDA**	**Joint**	**Enclosure H**
	11.	**TO NOTE THE CHAIRMEN'S REMARKS** • **Board Committee Membership**	**Joint**	**Verbal** **Enclosure I**
9.15	**12.**	**TO RECEIVE THE CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT**	**Joint**	**Enclosure J**
ALL OBJECTIVES				
9.35	**13.**	**TO RECEIVE THE Q3 2022/23 BOARD ASSURANCE FRAMEWORK**	**Joint**	**Enclosure K**
9.50	**14.**	**TO RECEIVE THE Q3 2022/23 CORPORATE RISK REGISTER PROGRESS REPORT**	**Joint**	**Enclosure L**
OBJECTIVE 2: to provide the best possible care and support to people				
10.05	**15.**	**PATIENT STORY AND CLINICAL TOPIC ON THE TWIN CLINIC**	**Joint**	**Presentation**
10.35	**16.**	**TO RECEIVE THE ASSURANCE REPORT OF THE QUALITY AND PERFORMANCE/ GOVERNANCE AND QUALITY ASSURANCE COMMITTEE MEETINGS HELD ON 23 NOVEMBER 2022**	**Joint**	**Enclosure M**
10.45	**17.**	**Coffee Break**		
OBJECTIVE 8 – To develop a high performing organisation delivering the vision of the Trust				
10.55	**18.**	**CARE QUALITY COMMISSION INSPECTION REPORT**	**SFT**	**Enclosure N**

11.10	**19.**	**TO RECEIVE THE PERFORMANCE REPORTS** • **YDH** • **SFT**	**YDH** **SFT**	**Enclosure O** **Enclosure P**
11.30	**20.**	**UPDATE ON THE MERGER BETWEEN SOMERSET NHS FOUNDATION TRUST AND YEOVIL DISTRICT NHS FOUNDATION TRUST**	**Joint**	**Verbal**
OBJECTIVE 6 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture				
12.05	**21.**	**TO RECEIVE THE LEARNING FROM DEATHS FRAMEWORK: MORTALITY REVIEW PROGRESS REPORT** • **YDH** • **SFT**	**YDH** **SFT**	**Enclosure Q** **Enclosure R**
12.25	**22.**	**TO RECEIVE THE GUARDIAN OF SAFE WORKING FOR POSTGRADUATE DOCTORS REPORT** • **YDH** • **SFT**	**YDH** **SFT**	**Enclosure S** **Enclosure T**
12.45	**23.**	**TO RECEIVE THE ASSURANCE REPORT FROM THE PEOPLE/WORKFORCE COMMITTEE MEETINGS HELD ON 14 NOVEMBER 2022**	**Joint**	**Enclosure U**
OBJECTIVE 7: To live within our means and use our resources wisely				
12.50	**24.**	**TO RECEIVE THE FINANCE REPORTS** • **YDH** • **SFT**		**Enclosure V** **Enclosure W**
13.05	**25.**	**TO RECEIVE A VERBAL REPORT FROM THE FINANCIAL RESILIENCE COMMERCIAL COMMITTEE/FINANCE COMMITTEE MEETING HELD ON 30 JANUARY 2023**	**Joint**	**Verbal**
13.15	**26.**	**TO RECEIVE THE ASSURANCE REPORT OF THE AUDIT COMMITTEE MEETINGS HELD ON 17 JANUARY 2023**	**Joint**	**Enclosure X**
OBJECTIVE 4: Reduce Inequalities				
13.20	**27.**	**TO RECEIVE THE ASSURANCE REPORT OF THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON 13 DECEMBER 2022**	**SFT**	**Enclosure Y**

FOR INFORMATION				
13.25	**28.**	**FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS**	**Joint**	
	29.	**ANY OTHER BUSINESS**	**Joint**	
	30.	**RISKS IDENTIFIED**	**Joint**	
	31.	**EVALUATION OF THE EFFECTIVENESS OF THE MEETING**		
	32.	**ITEMS TO BE DISCUSSED AT THE CONFIDENTIAL BOARD MEETINGS** The items presented to the Confidential Board are items which are in draft format; are in pre submission stage; are related to specific patients or colleagues; are commercially sensitive (e.g contracts); are for strategic discussion; are otherwise required to be presented to the Confidential Board, e.g. due to regulatory requirements (approval of annual accounts and Quality Accounts); or the publicity on which would be prejudicial to the public interest. Every effort will be made to present items to the Public Board meeting.		
	33.	**WITHDRAWAL OF PRESS AND PUBLIC** To move that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.		
13.30	**34.**	**DATE FOR NEXT MEETING**		

2208SOMERSET NHS FOUNDATION TRUST (SFT)
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST (YDH)

PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST MEETING HELD ON MEETINGS HELD ON 8 NOVEMBER 2022 BY MS TEAMS

PRESENT

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

IN ATTENDANCE

Graham Hughes	Non-Executive Director, YDH
Paul Mapson	Non-Executive Director, YDH
Meridith Kane	Medical Director for Acute Hospitals
Sallyann King	Interim Director of Midwifery for Somerset (for item 17 only)
Xanthe Whittaker	Director of Elective Care (for item 23)
Paul Foster	Consultant Urologist/Clinical Director (for part of the meeting)
Janet Fallon	Guardian of Safe Working – SFT (for item 26 only)
John McFarlane	Guardian of Safe Working - YDH (for item 26 only)
Harriet Jones	Head of Inclusion (for item 27 only)
Kate Lindenau	Inclusion Co-ordinator, YDH (for item 27 only)
Alison Whitman	Lead Governor YDH
Virginia Membrey	Governor YDH
Steve Ashton	Governor YDH

Ian Hawkins	Lead Governor SFT/Governor YDH
Ria Zandvliet	Secretary to the Trust (minute taker)

The meeting was further attended by the following NHS England colleagues:

Beth Woolfson	Senior Manager, NHS England Provider Development
Neal Cleaver	Deputy Clinical Director, NHS England SW regional team
Kim Jones	Assistant Clinical Director, NHS England SW regional team
Serena Qayyum	Senior Manager, NHS England Provider Development
Jessica Crocker	Head of Financial Strategy and Transactions,

1.	**APOLOGIES**
1.1	There were no apologies.
1.2	The Chairman advised that, following the establishment of a single executive team across both trusts, the SFT and YDH Boards have agreed to conduct their Board of Directors meetings as meetings held in common. The meetings will be chaired by the Chair of either SFT or YDH Chair on a rotation basis and Martyn Scrivens will be chairing the Public Board meeting. Colin Drummond will be chairing this afternoon's meeting. The Chairman passed the chairmanship of the meeting over to Martyn Scrivens.
1.3	Martyn Scrivens welcomed all Board members, governors, colleagues and other attendees to the meeting and confirmed that both the SFT and YDH meetings were quorate.
1.4	Martyn Scrivens further welcomed the NHS England colleagues who had joined the meeting as observers in view of the finance and governance reviews which were currently being undertaken across both trusts as part of the proposed merger process. All NHS England colleagues introduced themselves.
2.	**QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS**
2.1	Colin Drummond advised that a letter with questions for the Board had been received from the League of Friends in Minehead. The letter highlighted: • The donation of a new 55" television DVD/and Blue Ray player to the inpatient ward. • The approval of a grant to enable the inpatient ward to purchase a reconditioned piano. • The approval of an application for grant aid to purchase a text book for the MSK physiotherapy department – vestibular rehabilitation book.

	• The approval of a grant for an "Operio-Sterile air zone unit".
2.2	The letter asked the Board to ensure the move of the MSK and ophthalmic surgery departments to Minehead Community Hospital. The letter further raised the lack of information in relation to the timing of the building works to allow for maxillofacial minor surgery to be undertaken at the hospital; and the delay in providing an update on progress made in relation to the Same Day Urgent Care provision project in West Somerset.
2.3	Colin Drummond thanked the League of Friends for their donations and grants and for the significant support they provide to the hospital. It was agreed that, as the questions did not relate to a specific agenda item, a formal written response will be provided to the League of Friends in Minehead outside of the Board meeting. It was clarified that although the letter referred to the trust leading the Same Day Urgent Care engagement exercise, this was not correct as this project was led by the Integrated Care Board and involved a wider range of providers and services. The Director of Corporate Services agreed to formally write to the League of Friends and reiterate the Board's thanks for everything the League of Friends does to support the hospital and patients in West Somerset. **Action: Director of Corporate Services.**
3.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 6 SEPTEMBER 2022**
3.1	Jan Hull proposed, Stephen Harrison seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 6 September 2022 as a correct record.
4.	**MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 6 SEPTEMBER 2022**
4.1	The approval of the minutes is reflected in the YDH minutes.
5.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 7 SEPTEMBER 2022**
5.1	Barbara Gregory proposed, Jan Hull seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 7 September 2022 as a correct record.
6.	**MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 7 SEPTEMBER 2022**
6.1	The approval of the minutes is reflected in the YDH minutes.

7.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 4 OCTOBER 2022**
7.1	Barbara Gregory proposed, Jan Hull seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 4 October 2022 as a correct record.
8.	**MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 4 OCTOBER 2022**
8.1	The approval of the minutes is reflected in the YDH minutes.
9.	**TO REVIEW THE ACTION LOGS AND MATTERS ARISING**
9.1	The Board received the action log and noted the completed actions.
9.2	In relation to the action to look into the reasons for the resignation of three radiology nurses at YDH, it was noted that the nurses had felt isolated from the wider nursing team within the hospital. This feedback was already being used to consider how best to retain radiology nurses and how to strengthen connections with the wider nursing team.
10.	**TO NOTE THE REGISTERS OF DIRECTORS' INTERESTS AND RECEIVE ANY DECLARATIONS OF INTERESTS RELATING TO ITEMS ON THE AGENDA**
10.1	The Board received the Register of Directors' interest. The Board noted the following changes to the register: • Pippa Moger – to change "Executive Director for SSL" to "Non-Executive Director for SSL". • Isobel Clements – to remove "Daughter works as a registered nurse in the Emergency department at MPH". • Kate Fallon – to add "Non-Executive Director Symphony Health Services"
10.2	Kate Fallon declared an interest in relation to the SFT Guardian of Safe working for post graduate doctors agenda item as her daughter produced and presented the report.
11.	**CHAIRMEN'S REMARKS**
11.1	Martyn Scrivens observed that both trusts continue to be under significant operational pressures both in terms of urgent care and elective recovery. With an expected increase in these pressures over the winter period, it will be important for Non-Executive Board members to be aware of these pressures and the challenges faced by the executive team and operational managers. Martyn Scrivens reminded executive directors to let non-executive board members know if there was anything they could do to help in managing these pressures.

11.2	Colin Drummond advised that two key system challenges severely impacted on bed capacity, four hour emergency department response times and on the ambulance handover times. These challenges related to delayed discharges of patients with "no criteria to reside"; and the fragility of primary care services. The trusts were working with the Integrated Care Board (ICB) and Somerset County Council to address these challenges. It was noted that the Chairman of the ICB will be meeting with governors from both trusts on 14 December 2022 to discuss the work of the ICB and a meeting between Non-Executive Directors of both trusts and the ICB had been set up in January 2023. These meetings will provide opportunities to keep a focus on those system challenges which severely impact on the delivery of services.
11.3	Kate Fallon provided feedback from her recent personal experience of using acute services and highlighted the humanity and kindness extended by all colleagues to their patients in spite of the pressures they were facing and irrelevant of the status of patients.
11.4	Martyn Scrivens commented that it was clear from the Leadership Quality Walkrounds that colleagues were committed to treating patients with dignity and respect and, on behalf of the Board, thanked colleagues for this commitment.
12.	**CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT**
12.1	The Chief Executive presented the report which was received by the Board. He advised that the report set out a number of significant and positive developments and specifically highlighted the approval at the October 2022 Extra-Ordinary Board meeting of the business case and additional documents for the proposed merger between Yeovil District Hospital (YDH) and Somerset (SFT) NHS Foundation Trusts.
12.2	The Chief Executive provided an update on the operating model and advised that the new operating model had now been implemented. Two acute site directors and six service group directors had been appointed and these appointments will support the integration of services. It was noted that Stacy Barron-Fitzsimons has been appointed into a different role and will therefore in future no longer attend the Board meetings. The Chief Executive thanked Stacey for her significant contributions to the work of YDH in her role as Director of Operations and wished her every success in her new role.
12.3	The Chief Executive referred to the letter received from NHS England and the additional actions identified to improve operational resilience and provided the following update: • Deliver on our ambitions to maximise bed capacity and support ambulance – the trusts generally performed relatively well in terms of ambulance handover times but, periodically, significant challenges were still being experienced resulting in a delay in handover times. Acute bed capacity was at full capacity and every possible space was being used for escalation beds. In addition, the single rooms in the Jubilee Building had

	over the last year been used as double rooms to be able to manage the bed pressures. • Ensure timely discharge and support people to leave hospital when clinically appropriate – this remained challenging in view of the large number of patients, 250+, with "no criteria to reside" across both YDH and SFT. This amounted to 25% of the total bed base and was a key factor of the bed capacity challenges. It was noted that additional social care capacity had been commissioned by the Integrated Care Board and the County Council and it was expected that the impact of this additional capacity will become visible over the next few weeks. The Chief Executive advised that, in addition to the delayed discharges, there was also concern about the blockage within intermediate care services where up to 200 patients were waiting for ongoing social care. Resolving this position will be one of the key priorities due to the impact on the overall patient flow. Consideration was being given as to what further actions could be taken internally but the key priority will be to address the patient flow challenges both within acute and community hospital services and within intermediate care services. • Better support for people in the community – the Chief Operating Officer (Mental Health, Families and Neighbourhoods) advised that all actions set out in the letter from NHS England were already being followed up. The community based falls response service had already been integrated into the Rapid Response Service and lifting equipment was available to the teams. Work had also taken place looking at options how to support ambulance services by taking suitable lower priority patients directly from the ambulance stack (patients waiting for an ambulance). Approximately 40% of ambulance calls were falls related and, from the end of November 2022, the Rapid Response Service will be able to respond to these calls; lift patients; carry out health checks; and put falls and rehabilitation services in place. This will reduce some of the pressures on ambulance services. Clear governance arrangements will be put in place to ensure that feedback on calls attended was fed back to the ambulance service. It was noted that the establishment of virtual wards was one of the highest priority programmes in the trust. As a mental health, community and acute services provider, SFT was well placed to take this work forward. It was expected that the virtual wards will go "live" early in 2023 and will remain in place post winter. A large number of staff had been appointed but there was a lead in time before the service can be fully operational. The capacity in the virtual wards will be equivalent to 280 beds and the capacity and the nature of patients covered will exceed the national requirement. It was noted that colleagues within the surgical and peri-operative teams were very enthusiastic about the potential of this service
12.4	The Board discussed the report and commented/noted that: • It was queried what the position was in terms of ambulance services appointing a mental health professional. It was noted that SFT was part of

a collaborative with the previous Bath, North Somerset and South Gloucestershire and Gloucestershire Clinical Commissioning Groups and a team of mental health professionals was embedded in the ambulance control centre with the aim to review the "stack" to see which patients would benefit from being transferred from the "stack" to mental health community services. It was noted that this scheme had been very successful and collaboration with neighbouring mental health providers had been excellent.

- It was queried what additional support can be provided to care homes to reduce a variation in ambulance conveyance rates. There was a variation in the use of ambulance services amongst care home and this could be due to a lack of confidence managing a patient within the care home and the stability of the care home team. The aim will be to identify those care homes with a higher conveyance rate and review what support will be needed and what support can be provided.

- A key area of concern nationally related to ambulance response times. The Chief Operating Officer (Hospital Services) advised that, for a long time, Somerset had taken the decision to hold risks within the hospitals and services to reduce ambulance response times. As a consequence, all possible escalation beds had been put in place and single rooms had to be used as double rooms. The ambulance response times had deteriorated in view of the bed capacity challenges and on 7 November 2022, a total of 91 ambulances had arrived at the emergency departments across both trusts with a lost ambulance response time of just over 16 hours. The current response times did not meet the required standards and discussions continued to take place with the ambulance service to improve the response times.

  In relation to the discharge pathways, the QI team will be working with the flow and discharge teams in acute and mental health services over the next few weeks to further explore areas which are not as effective as they can be and the actions to be taken to improve efficiency.

- The number of Covid-19 positive patients had reduced to 28 patients in MPH, 18 in YDH and three in community hospitals and over the last 24 hours no new Covid-19 positive patients had been reported. The number of patients and colleagues with flu were still low but it was expected that numbers will increase over the next few weeks.

- The smoke free pledge will be challenging to implement in mental health inpatient services. A Tobacco Reduction Programme Manager has recently been appointed and the approach to encourage patients to stop smoking will be adapted to individual patients and services. There will also be a focus on colleagues. Conversations were already taking place with patients about the support required.

- The work to support the ambulance stack was very positive and it was queried whether there were additional areas which could be targeted. The

	Chief Executive advised that a large number of calls related to falls and ambulance services were trying as much as possible to avoid conveying patients to hospitals. In view of the number of calls, targeting falls on the ambulance stack will be a good place to start. The Chief Operating Officer (Mental Health, Families and Neighbourhoods) commented that building capacity in the Hospital at Home scheme will be necessary to be able to reduce the stack. He highlighted the complexities of setting up the Hospital at Home scheme and the resulting lead in time required. The benefits of the scheme, once operational, will be significant. Martyn Scrivens advised that Symphony Health Services had a significant role to play in the Hospital at Home scheme and this can be explored at the December 2022 Board Development Session.
13.	**Q2 2022/23 BOARD ASSURANCE FRAMEWORKS**
13.1	The Director of Corporate Services presented the updated Q2 2022/23 Board Assurance Frameworks (BAF) for SFT and YDH which were received by the Board. The BAFs had been discussed by the Audit Committee, Executive Team and relevant sub Committees since the September 2022 Board meeting and there were no significant changes in levels of risk from the previous version.
13.2	The Director of Corporate Services advised that the overall assessment in terms of level of risk was consistent across both organisations and the highest risks identified within the Assurance Frameworks continued to relate to: • the impact of pressures and capacity shortfalls in social care and intermediate care (objectives 2, 3 and 8) • insufficient capacity to meet demand (objectives 7 and 8) • infrastructure investment and ageing estate (objectives 2 and 8) • the impact of pressures in primary care (objectives 2, 3 and 5) • workforce recruitment and retention (objectives 3 and 6) • the impact of the pandemic (objective 5) • delivery of financial plans (objectives 7 and 8).
13.3	The Director of Corporate Services advised that the BAFs clearly showed the pressures and challenges across both trusts and in the wider health system and the discussions at the Board meeting showed that the Board discussions were rightly focussed on the key areas of risk.
13.4	The Board discussed the Board Assurance Frameworks and commented/noted that:

	• The BAFs clearly showed progress made and the information was well presented. • A number of the strategic objectives and risks had been rated "Amber" and it was queried what this really meant. The Director of Corporate Services advised that the ratings reflected the level of gaps in assurances. An "Amber" rating reflected that there were some gaps in assurance whilst a "Red" rating indicated a lack of clear sources of assurance. Overall, in view of the difficult circumstances in which the trusts operated, the BAF showed good levels of assurance and progress made. • It was queried whether the number of "Amber" rated objectives will reduce prior to year end. The Director of Corporate Services advised that the aim was to have no "Red" ratings but it will not be possible to reduce all "Amber" rated objectives as some of these related to system issues and the ICB had a key role in mitigating system wide risks. In addition, in view of the current operational pressures and demand, the potential to mitigate risks will be limited. A number of strategies had been developed to address gaps in assurances but these strategies took a longer term view and are unlikely to resolve the gaps in assurances in 2022/23. • The pressures and challenges and the impact on the achievement of the strategic objectives were recognised and although the position felt uncomfortable, it was still within levels of tolerance. There were a number of risks within the strategic objectives which were outside of the trusts' control and although the reasons for the "red" and "amber" ratings for these risks will need to be understood, the trusts will not be able to mitigate these risks on its own. It was however stressed that the trusts were able to strongly influence the systemwide work and will need to make every possible effort to ensure that progress continued to be made. • Strengthening of controls; achievement of the strategic objectives; and strengthening of assurances were not the same and will need to be managed in different ways. • The risks relating to Symphony Health Services will be further discussed at the December 2022 Board Development Day as part of the wider discussion about SHS and primary care services.
13.5	The Board discussed the BAFs and welcomed the detailed updates.
14.	**Q2 2022/23 CORPORATE RISK REGISTER PROGRESS REPORTS**
14.1	The Director of Corporate Services presented the Q2 2022/232 Corporate Risk Register progress report which was received by the Board.
14.2	The Director of Corporate Services highlighted: • The common areas of risks identified across both trusts.

	• The total of 49 risks on the combined risk register – 30 SFT and 19 YDH risks – 16 of which scored 20 and above, with the majority of these risks relating to SFT. Details of these risks and the new risks were noted. • The four new risks relating to - Treatment Escalation Plans; Quality of Discharge Summaries; Shortage of Clinical Consumables; End of Life Pharmacy Robot – and the two risks which had increased – delivery of CIP; the poor condition of Shepton Mallet Community Hospitals Portakabin Units. • It was suggested including a quadrant diagram to be able to distinguish between the different type of risks e.g. which risks were subject to external factors and unavoidable. This will enable a clear overview of the clustering of risks. The Director of Corporate Services agreed to consider this as part of the 2023/24 corporate risk register. **Action: Director of Corporate Services**.
15.	**OVERVIEW OF REGULAR ITEMS TO THE BOARD**
15.1	Ria Zandvliet presented the report which was received by the Board.
15.2	The Director of Corporate Services advised that all items proposed to be presented to the Board had been mapped across the strategic objectives and, in addition, six monthly progress reports on the implementation of the key strategies had been included in the overview.
15.3	The Board discussed the report and commented/noted that: • The overview was helpful and comprehensive and demonstrated that the agenda for the Board meetings was driven by the Board Assurance Framework. • A number of items were allocated to the Part B Board meeting and it was noted that the default position was to present reports to the Part A Board meeting. Papers were only included on the Part B agenda if there was a genuine reason for doing so.
15.4	Stephen Harrison proposed, Jan Hull seconded and the Somerset NHS Foundation Trust Board approved the overview of regular agenda items to be presented to the post merger Board.
16.	**PATIENT STORY AND CLINICAL TOPIC ON THE INTEGRATION OF END OF LIFE SERVICES**
16.1	The Chief Medical Officer advised that, in view of operational pressures, this item will be deferred to a future meeting.

17.	**REPORT FOLLOWING THE INDEPENDENT INVESTIGATION INTO EAST KENT MATERNITY AND NEONATAL SERVICES**
17.1	Sallyann King, Interim Director of Midwifery for Somerset, joined the meeting for this agenda item.
17.2	Sallyann King provided an update on both SFT and YDH compliance with the recommendations set out in the Ockenden (The Independent Investigation into East Kent Maternity and Neonatal Service) report. She highlighted the overview of compliance for both trusts against the Ockenden 1 standards and it was noted that both trusts were fully compliant implementing the recommendations in the Ockenden 1 report except for: SFT – partial compliance with recommendation "twice daily consultant ward rounds"; and partial compliance for both SFT and YDH in relation to recommendation 7: informed consent.
17.3	In relation to compliance with the final Ockenden report, it was noted that the implementation of the Midwifery Continuity of Care recommendation had been put on hold as the plans were currently not achievable. It was noted that two continuity of care teams were in place at YDH but progress at Musgrove Park Hospital was less advanced. All other areas were compliant or were on plan to be completed according to plan.
17.4	Sallyann King further provided an overview of the findings of the independent investigation report; the key actions identified and the next steps. It was noted that the key actions were divided into the following categories: monitoring safe performance – finding signals among noise; standards of clinical behaviour – technical care is not enough; flawed teamworking – pulling in different directions; and organisational behaviour – looking good while doing badly.
17.5	The Board discussed the report and commented/noted that: • The ongoing focus on the Board agenda on maternity and obstetric services was welcomed and demonstrated the Board's commitment to maternity and obstetric services. • Somerset was a relatively simple system and this provided risks as well as opportunities for maternity services. Post merger there will be a single provider of maternity services in Somerset and it will be important to review performance as a "critical friend" and to seek feedback on performance from external partners and patients. • Maternity and obstetrics services posed the highest risks in terms of integration and both the Chief Nurse and Chief Operating Officer (Mental Health, Families and Neighbourhoods) will continue to work with the improvement team and the maternity services team on the integration of these services. Oversight was also provided by the Quality and Governance Assurance Committee. • The trusts were not complacent and recognised that a similar situation, as outlined in the report, could, in principle, occur in any service. Outcome

measures as well as soft signs and listening to colleagues and patients will be essential.

- Culture was a significant contributory factor to the findings identified in the independent report and it was queried whether any concerns about the culture, including a lack of compassion and colleagues working in silos, had been identified in the trusts. Sallyann King commented that culture was a concern as colleagues were tired and this could lead to poor behaviour and cultural anomalies. A focus on working as a team will provide colleagues with support and provide opportunities to raise any concerns. System and reporting processes had been put in place to help colleague to move to the next level.

- The estates environment remained a concern at SFT, and to a lesser extent at YDH.

- The merger was also a risk as the findings outlined in the independent report had occurred at times of merger. It will be essential to improve communications with the teams and allow the leadership team and the clinical care teams to share their concerns and feedback. It was noted that four integration champions had been appointed across both organisations – two midwifes and two clinical colleagues – and these champions were talking to colleagues to seek feedback. Sallyann King felt that the teams were open about their concerns and this enabled the concerns, where possible, to be addressed.

- Culture applied to all services and any concerns will need to be considered against the vision and values of the merged organisation going forward. The trusts were aware of the findings of the independent report and appropriate and meaningful actions were being considered.

- Senior obstetric and gynaecology colleagues had not attended any Board meetings and it was suggested inviting senior clinicians to future Board meetings. The Chief Medical Officer commented that senior clinical colleagues attended the Board meetings as part of the patient story and clinical topic agenda items and this will continue going forward.

- The Quality and Governance Assurance Committee had discussed maternity services at almost every formal and planning meeting and Sallyann King and colleagues from the midwifery team attended these meetings to provide updates. This will continue to be key area of focus of the Committee. A detailed discussion on cultural issues had taken place at the last planning meeting. The Board was provided with assurance that the Committee will continue to keep this under close review.
- Kate Fallon advised that both Alexander Priest and she were Safety Champions for both trusts and provided assurance to the Board that they both received significant levels of assurance in their role as Safety Champions.

17.6	The Board thanked Sallyann King for being so open and ambitious and providing an excellent service.
17.7	Sallyann King left the meeting.
18.	**ASSURANCE REPORT OF THE QUALITY AND PERFORMANCE/ GOVERNANCE AND QUALITY ASSURANCE COMMITTEE MEETING HELD ON 21 SEPTEMBER 2022**
18.1	Jan Hull, Chairman of the Quality and Governance Committee and Governance and Quality Assurance Committee, presented the report which was received by the Board. She particularly highlighted the Hospital at Home scheme and end of life services presentations.
18.2	Jan Hull further highlighted the risks to be reported to the Board. These risks related to: • Ophthalmology performance and the impact of broadband issues at YDH. • End of life care and the Somerset Treatment and Escalation Plans (STEP) digital solution. • Anaesthetics/critical care action plan at YDH. • Industrial actions.
18.3	Details of these risks were set out in the report and were noted.
18.4	The Board discussed the report and commented/noted that: • It was queried whether progress was being made in relation to the recruitment of intensivists. The Chief Medial Officer confirmed that an extensive action plan for the recruitment of new intensivist for the new integrated critical care services was in place. The action plan will cover the county as a whole, and the implementation of the action plan will ensure equity of standards and experience for patients. There was a good level of confidence that the workforce required to deliver integrated critical care services across the county can be recruited. • In relation to the broadband issue at YDH, it was queried whether Openreach had now addressed the broadband issues. The Director of Strategy and Digital Development commented that he expected that the work had been completed but agreed to check whether confirmation of completion of the final part of the works had now been received. **Action: Director of Strategy and Digital Development**.
18.5	Martyn Scrivens thanked the Committee for its work and the assurance provided.

19.	**ASSURANCE REPORT FROM THE QUALITY AND PERFORMANCE/ GOVERNANCE AND QUALITY ASSURANCE COMMITTEE ANNUAL REPORTS MEETINGS HELD ON 20 OCTOBER 2022**
19.1	Jan Hull, Chairman of the Quality and Governance Assurance Committee, presented the report which was received by the Board. She advised that annual reports from both trusts had been presented to the Committee and the reports outlined the fantastic work taking place across a wide range of services and further evidenced the increase in demand across all services; the ongoing pressures; and the focus on the integration of services.
19.2	Martyn Scrivens commended the teams on the excellent reports and the ability to see the reports of both trusts alongside each other was welcomed.
19.3	The Director of Corporate Services advised that the reports will be published on the Trust's website.
19.4	Martyn Scrivens welcomed the reports and thanked the authors of the reports and the teams for their fantastic work and commitment to their services.
20.	**EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE REPORT EPRR**
20.1	The Director of Corporate Services presented the joint report which was received by the Board. The Board noted that the self assessments showed substantive compliance for both trusts.
20.2	The Board discussed the reports and commented/noted that: • The reports and the levels of compliance were excellent; • It was queried whether, in view of the Covid-19 pandemic, any further actions can be taken to prepare for unexpected events. The Director of Corporate Services commented that emergency planning was based on the principle that there should not be anything for which we have not planned and that all scenarios should be considered. The occurrence of a possible pandemic had been included in EPRR planning for a very long time but the pandemic reacted in a different way than planned for and this was part of the process. The first step following the announcement of the pandemic was to set up a meeting and reflect on the actions to be taken. The emergency planning process was robust but a response may need to be fluid depending on the specifics of the emergency event. • It was queried whether the trusts continued to be engaged with the countywide gold command emergency planning arrangements. It was noted that the arrangements were being reviewed. Responsibility for emergency planning had been delegated to the Integrated Care System (ICS) and a Somerset based Local Health Resilience Partnership, led by the ICS, had been set up. This new arrangement was expected to strengthen the countywide processes.

	• A major incident plan for the post merger organisation was being developed and will be presented to a future Board meeting. • It was queried whether regular test of lines of communication and phone numbers were being undertaken. It was noted that this was regularly tested and an emergency planning exercise to test communication processes both internally and on a system wide basis, will be undertaken in the next week.
20.3	The Board agreed that the report provided significant assurance about the emergency planning processes. The Board noted the compliance ratings against the national EPRR Core Standards; the EPRR workstream activities to ensure the resilience of the post merger organisation; the new Category 1 status of the Somerset ICB and the establishment of the Somerset Local health Resilience Partnership.
22.	**QUALITY AND PERFORMANCE REPORTS** **Group Board Overview Quadrant – YDH** **Quality and Performance Report – SFT**
22.1	The Chief Finance Officer provided an overview of the key performance challenges across both trusts which covered: acute referral to treatment (RTT) times; diagnostics; intermediate care; cancer services; urgent care – A&E 4 hour performance; ambulance handover times; community physical health services waiting times and activity; mental health waiting times and activity, including the number of ligature incidents; children and young people's eating disorders; out of area placements; infection control; slips, trips and falls; mandatory training and sickness absence; turnover rates; career conversations.
22.2	The reports were received by the Board.
22.3	The Board discussed the report and commented/noted: • No patients were currently waiting over 104 weeks at YDH and the trajectory for SFT showed that the number of patients waiting over 104 weeks after the end of November 2022 will be minimal. • Diagnostic performance continued to improve at both YDH and SFT and the system performance levels of 77% were above the regional trajectory of 75% by 31 March 2023. This performance was particularly encouraging in view of the impact on the cancer and elective pathways. • YDH was in the top performing organisations nationally in relation to the four hour ambulance response times target. • Referrals into mental health services continue to be high and were causing additional pressures on the teams.

	• The continued strong performance in relation to children and young people eating disorders service was a significant achievement but as performance was reflected on a 12 month rolling basis, the excellent performance over the last few months would not result in the target levels being achieved until at least March 2023. • The number of pressure ulcers at SFT had significantly increased during July 2022 compared to the June 2022 position and there had been a gradual increase in the number of pressure ulcers over the last few months. This increase was not driven by a single factor and was complex. A number of improvement actions had been identified and were being implemented. It was noted that an update on the work undertaken to develop core standards of care, which every patient should receive, will be provided to the December 2022 Quality and Governance Assurance Committee. In addition, work was also being undertaken with the people team in relation to falls and pressure ulcer practice development. It was noted that the rate at YDH showed a continuing downwards trend. • The turnover rate remained consistent at 11% in SFT. The rate of 19.5% in YDH was high but was also consistent compared to the previous few months. The reasons for colleagues leaving the trusts continued to be explored in more detail and further information will be provided to the November 2022 People/Workforce Committee meetings. There was a particular concern about the turnover rate of administrative/clerical and additional clinical services colleagues in YDH and it was recognised that the proposed merger may play a factor in these colleagues leaving the trusts. A range of reasons had been identified and these will be kept under review. The second group with a high turnover rate were colleagues under the age of 25 leaving within 12 months of employment. Their reasons for leaving were not fully understood and further work will be undertaken to explore this in more detail. Martyn Scrivens welcomed the focussed work but also asked for a focus on retaining “rising stars”. The key two reasons seemed to relate to relocation and work/life balance and it was queried whether the same breakdown was available for SFT colleagues. It was noted that the same level of information was available but there was a need to strengthen both the levels of information received and the exit arrangements. • It was queried whether the delays in discharging patients who were medically fit to be discharged impacted on their condition and whether they would be more vulnerable to e.g. pressure ulcers. The Chief Nurse advised that it was well known that, especially older patients, will decondition the longer they stayed in hospital. Their muscle loss could lead to long term harm and immobility and patients were more likely to fall in hospital due to the unfamiliar environment and routines. The Chief Nurse commented that deconditioning was a real concern but work was taking place across both trusts to cohort some of the older patients

	together so that care can be provided in a different way. This was part of a large programme of work. The Chief Operating Officer (Hospital Services) advised that performance and actions continued to be reviewed in detail at the Quality and Governance Assurance Committee meetings. He acknowledged that there was an impact on patients' conditions when admitted to a hospital bed and it was therefore essential to rigorously review performance against all patient care indicators. Martyn Scrivens recognised the challenges caused by the delayed discharges and agreed that the position was difficult and unsatisfactory. He however stressed the need not to feel paralysed due to the operating conditions, but to remain on the front foot and take all possible actions the trusts could take to resolve the challenges.
22.4	The Board acknowledged the areas of good performance and recognised the challenges.
23.	**ELECTIVE RECOVERY PROGRAMME SELF DECLARATION - SFT**
23.1	Xanthe Whittaker, Director of Elective Services, joined the meeting for this agenda item.
23.2	The Board noted that a letter had been received from NHS England regarding the national elective recovery programme and that there was a requirement for the Board to submit a self declaration showing levels of compliance against the requirements set out in the letter.
23.3	The Chief Operating Officer (Hospital Services) provided an update on progress against the elective recovery programme and advised that, in his view, the trusts were performing well with strong performance in diagnostics and good progress being made in relation to RTT performance. However, there continued to be challenges, particularly in relation to the cancer treatment waiting times and bed occupancy levels and these will remain key areas of focus.
23.4	Xanthe Whittaker further advised that the position in relation to 104 week waiters was fragile and although the trajectory indicated that there will be no 104 week waiters after the end of November 2022, this will remain challenging as the cancellation of elective surgery will impact on the 104 week waiting list. However, the planning of the trajectory had been robust and credible plans had been submitted. The plan acknowledged some of the risks and challenges and the programme of work extended from day to day operational management focused on ensuring the right environment for patients, to the longer term management of demand. There had been a significant increase in the number of referrals, particularly in cancer services, and this had affected the two week waiting times performance. The referral rate had now reduced but the position remained challenging with a 20 to 40% increase in the number of referrals compared to pre-Covid.

23.5	In relation to the self declaration, the Chief Operating Officer (Hospital Services) advised that SFT had been classified as a Tier 2 trust in view of its projections. A robust programme of work was being implemented and, as part of the Board Development programme, the Board will receive updates on a number of elective services over the next few months. It was noted that the responses on the self declaration took account of the system wide implementation of the actions.
23.6	Xanthe Whittaker advised that the self declaration checklist included a number of best practice suggestions. She highlighted the actions in relation to colorectal services and advised that the trusts had already made good practice in this area and a colorectal referral hub to support primary care in requesting and managing FIT testing for patients with bowel problems. Meeting this requirement will therefore relatively easy for the trust, but other trusts may be in a different position.
23.7	The Board discussed the report and commented/noted that: • Areas of best practice will need to be considered in order to take the trust out of Tier 2 and it will be important to ensure that plans were realistic and achievable. • The elective recovery position was disappointing but good progress was being made. • It was queried how many elective surgery appointments had to be cancelled each week in both trusts. It was noted that the numbers varied significantly on a day to day basis but the typical number was six cancellations across both trusts. The aim was to prioritise long waiters alongside urgent patients for elective surgery and with the high number of patients waiting for a long time, it was difficult to cancel any surgery appointments. • The number of beds dedicated as elective surgery was small as the majority of beds were dedicated as emergency beds. However, the majority of elective activity was carried out as day surgery only. Elective patients requiring inpatient care were waiting longer as their surgery will be more complex and will require more theatre capacity. In addition, all clinical teams were aiming to optimise capacity and this was more difficult in a "stop and start" environment. • It was queried whether additional temporary agency staff will need to be employed to support the waiting list initiative. The Chief Operating Officer (Hospital Services) confirmed that additional staff continue to be required and, going forward, a strategic view will need to be taken in terms of the workforce in general and, particularly, workforce planning for the theatre environment. It was noted that temporary workforce capacity was created by using temporary staffing but also through additional shifts from existing colleagues.

23.8	The Board supported the self declaration and congratulated the teams on their excellent achievements in spite of the challenges faced. The Board particularly acknowledged Xanthe Whittaker's contributions.
23.9	Kate Fallon proposed, Barbara Gregory seconded and the Somerset NHS Foundation Trust Board approved the self declaration.
23.10	Xanthe Whittaker left the meeting.
24.	**UPDATE ON THE MERGER BETWEEN SOMERSET NHS FOUNDATION TRUST AND YEOVIL DISTRICT NHS FOUNDATION TRUST**
24.1	The Director of Strategy and Digital Development presented the report which was received by the Board. He advised that the business case to be submitted to NHS England had been approved at the October 2022 Extra Ordinary Board meeting. The version presented to the Board at today's meeting was the version to be publicly published.
24.2	The Director of Strategy and Digital Development set out the next steps including the work on the integration of services as set out in the patient benefits cases. He commented that other reports presented to the Board meeting already demonstrated closer working and progress in the integration of services. In relation to the next steps, it was noted that a Board to Board meeting between the trusts and NHS England's regional team will be scheduled in February 2023 and a recommendation whether to proceed with the merger will be issued in March 2023. This recommendation will be presented to both Boards and Council of Governors for approval.
24.3	The Board discussed the report and commented/noted that: • Communication will be important and an example of a misconception expressed by a Town Council was highlighted. As well as setting out what changes will be made following the merger, it will be equally important to communicate the areas which will not change, especially in relation to YDH services. The Chief Executive commented that he had been present at the Town Council meeting and there seemed to be a confusion between the merger and the consultation led by the ICB on the future of hyper acute stroke services. That misunderstanding was clarified but communication had not been sufficiently clear. • A communications plan had been developed and press releases will be issued. In addition, communications will be issued to a wide range of stakeholders through a number of different communication methods.
24.4	Jan Hull proposed, Alexander Priest seconded and the Somerset NHS Foundation Trust Board approved the publication of the business case.

25.	**LEARNING FROM DEATHS FRAMEWORK: MORTALITY REVIEW PROGRESS REPORT**
	YDH
25.1	The discussion of this item is reflected in the YDH minutes.
	SFT
25.2	The Chief Medical Officer presented the report which demonstrated the processes for learning from deaths and how this learning was shared and improvements made.
25.3	The Board received the report and the issues identified as part of the investigations; the lessons learned, areas of improvement and actions taken were noted. The Board discussed the standardised mortality measures for the Trust as a whole and for the separate component parts of the Trust.
	Joint
25.4	The Board discussed the reports and commented/noted that: • The reports were focussed on emphasising the learning identified from the reviews and the changes made as a result of this learning. Details of the changes made were set out in the reports. • The Board discussed standardised mortality measures. SFT SHMR coding issues were well understood by the Board and were due to the Trust choosing to use a different End of Life pathway than the pathway used for End of Life coding. A recent discussion had taken place at the Finance Committee and the Committee was assured about the current position and work taking place to upskill the coding team. In the absence of accurate benchmarking information, the Board received assurance about the end of life pathway through the findings of the reviews carried out by the Medical Examiner. The Chief Medical Officer agreed that the benchmarking information was less concise as a result of the coding issues. A number of indicators had increased and it was expected that this may be due to statistical and environmental factors. In the absence of accurate benchmarking information, it was therefore essential to review as many deaths as possible to ensure that the end of life pathway remained appropriate. • The high number of reviews carried out was exceptional in view of the significant operational pressures, particularly in the medicine department where there were no outstanding unreviewed deaths. The findings of the reviews provided significant assurance that the deaths had not been caused by care or process issues. In addition, deep dives into certain causes of deaths provided additional assurance that the drift in SHMR/SHMI was not as a result of a drift in care provided but was due to other factors.

	• It was queried whether the SHMR coding issue was limited to Musgrove Park Hospital or also related to community hospitals. The Chief Medical Officer advised that the coding issue also related to community hospitals and NHS Digital had been requested on a number of occasions to remove community hospitals and the mental health components of deaths from the standard mortality indicators as national benchmarking was based on acute hospitals. The inclusion of community hospitals and other different care settings therefore increased the SHMI indicator. Deep dives into community hospital deaths had shown that good levels of care had been provided but as the models of care included end of life patients this affected the SHMI indicators. Feedback had now been received from NHS Digital that all sites other than Musgrove Park Hospital will be removed from the SHMI data and this will improve the accuracy of the SHMI data. • It was further queried when the statistical SHMR and SMHI anomaly will cease to show up. The Chief Medical Officer advised that some of the data anomalies related to the coding of end of life patients and the national definition of end of life care will not change. The Trust was not anticipating changing its end of life approach as it was felt that this approach was more patient focussed. The anomaly this created will need to be accepted. The remaining anomalies will change over time. As the indicators were based on six or 12 month rolling averages, there will be a few months' delay before improvement will become visible. National benchmarking was based on three years' worth of data and it will therefore take another three years for the national benchmarking to catch up with the changes. • The digital team had been going through a period of turnover and the coding team had been relatively inexperienced. This had now improved and the coding timelines were now being met. Work continued to take place to upskill the coding team but good progress was being made.
25.5	The Board thanked the teams for their excellent reports.
26.	**GUARDIAN OF SAFE WORKING FOR JUNIOR DOCTORS REPORT**
26.1	John McFarlane, Guardian of Safe Working YDH, and Janet Fallon, Guardian of Safe Working SFT, joined the meeting for this agenda item.
26.2	**YDH** The discussion of this item is reflected in the YDH minutes.
26.3	**SFT** Janet Fallon presented the report, which was received by the Board.

26.4	The Board discussed the report and commented/noted that: • The report provided evidence that the working hours for trainee doctors at SFT remained safe and that the process was working well. • The report reflected the pressures faced by trainee doctors working in acute areas of the Trust, with the majority of the exceptions originating from medical specialties, reflecting the pressure of work and staffing issues in medicine. • 162 exception reports had been received with the majority relating to the number of hours worked and this was a significant increase from the same period in 2022. However, more work will be needed to improve engagement from trainees and timely completion of reports by supervisors. • Seven immediate safety concerns had been raised regarding weekend working on the medical wards. • Pressure of work was impacting on educational opportunities for doctors, particularly in medicine. • The Chief Medical Officer advised that a few years ago changes had been made to the Post Graduate Trainee contracts and the contract included a requirement for organisations to ensure that junior doctors were sufficiently supported in managing pressures. He thanked both Janet Fallon and John McFarlane for their ongoing efforts ensuring that junior doctors were supported. • The Chief Medical Officer highlighted the improvements made, the changes required and supported the direction of travel. He reminded the Board of the investment in the medical junior doctor workforce by adding an additional layer of junior doctors into the surgical team and this had been as a result of the recommendations set out in a previous report. The actions identified in the report will result in further improvements and will ensure a better working environment for junior doctors. • It was queried whether it will be helpful to present a report to a future People/Workforce Committee meeting to obtain assurance about the relationships with staffing agencies and training and other checks carried out by the agencies. The Chief of People and Organisational Development advised that the trusts had good relationships with agencies and an update on these relationships and their pre employment processes will be presented to the January 2023 People/Workforce Committee. • It was queried what actions were being taken to reinforce the understanding amongst junior doctors that the reporting will result in change and that the reporting will not be seen as a question about their competence. Janet Fallon commented that a multi-pronged approach was being taken to reinforce this message and the benefits of reporting and the

	improvements made as a result of reporting were clearly highlighted. Feedback was also provided to the Doctors Forum on a bi-monthly/ quarterly basis and two-way conversations were taking place with representatives from the different specialties. New models of exception reporting were being introduced to try and encourage junior doctors to engage. Encouraging engagement will need to be an ongoing area of focus. • The Chief of People and Organisational Development commented that engagement with the staff survey was also challenging and there remained groups of colleagues who do not complete the survey as they do not see the benefits of the staff survey. Engagement was linked to leadership and culture and some colleagues may not provide feedback due to cultural differences and further work will need to be carried out to support colleagues in providing feedback.
26.5	The Board accepted the recommendations set out in the report
26.6	The Chairman thanked Janet Fallon and John McFarlane for their excellent report.
26.7	Janet Fallon and John McFarlane left the meeting.
27.	**SIX MONTHLY INCUSION REPORT**
27.1	Harriet Jones (Head of Inclusion) and Kate Lindenau (Inclusion Co-ordinator, YDH) joined the meeting for this agenda item.
27.2	Harriet Jones and Kate Lindenau presented the report which set out progress against the 2022 Workplace Race Equality Standard (WRES) report; the 2022 Workplace Disability Equality Standard (WDES) report; the key themes from the reports; and provided an overview of the new inclusion roadmap. The report was received by the Board.
27.3	Harriet Jones particularly highlighted: • The action plans in place to start building foundations for the trusts' approach to inclusion and to learn from good practices across the trusts. • The purpose of the road map to create inclusion by developing a framework, governance structures and ways of working to be able to define and measure impact and create sustainable and systemic change. • The key themes from the WRES and WDES reports.
27.4	The Board discussed the report and commented/noted that: • As Co-Chair of the Inclusion Steering Group, the Chief Operating Officer (Hospital Services) thanked Harriet Jones for her focus on helping the trusts to move the inclusion work forward onto the next stage and moving

from an opportunistic approach to a more strategic approach. He welcomed the extension of the inclusion work across both trusts and the focus of this work was encouraging and exciting.

- It was queried how colleagues representing a minority group felt about the inclusion work and impact on them. Harriet Jones advised that this was a difficult question to answer as the answer will be different for different colleagues. There was a shift in the way colleagues talk about inclusion and uncomfortable questions were being asked. The interest in the pilots had been overwhelming and this showed colleague's focus on inclusion. The key aim was to provide colleagues with the right tools and considerable progress was being made. Harriet Jones advised that she had spoken to colleagues from a different background and there was a feeling that systemic change was becoming visible. The focus on inclusion will need to be accelerated to speed up change.

- The roadmap was excellent and will help the Board to communicate what inclusion means for colleagues and the organisation. Further work will need to carried out and Harriet Jones will be able to support that work. In addition, a new Equality Delivery System and Diversity Standards will be published and it will be essential to work with system partners how to take that work forward.

- It was queried whether colleagues with disabilities felt comfortable coming forward about their disabilities and whether the actual rate was higher than the rate reported from the ESR system. Harriet Jones commented that some colleagues felt uncomfortable declaring their disability but a larger number of colleagues appeared not to know how to update their declaration on the ESR system. If a disability had been declared, conversations about possible adjustments could take place. The process for identifying adjustments will need to be clarified and checks will need to be carried out to ensure that the adjustments were the right adjustments for an individual colleague. This will be part of a wider piece of work.

- Measuring the evidence of focus and progress made will be critical but difficult to do. Staff surveys and quantitative data will give an indication but do not provide all the information. It was queried what methods will be used, other than the staff surveys, to capture valuable narratives and experience of colleagues to evidence the success of the focus on inclusion and how this will be acted upon. Harriet Jones commented that views from colleagues will be presented to the Inclusion Steering Group but, in addition, considerable work was taking place with the networks on how to collect and share information. Kate Lindenau commented that relationships with the networks were good and feedback was provided to the Steering Group to enable themes and actions to be identified and implemented.

- The roadmap aimed to create an inclusion governance structure but inclusion will need to be incorporated into the whole governance structure.

	Care will need to be taken that inclusion will not be limited to the inclusion governance structure.
27.5	The Board thanked Harriet Jones for the impact she had made since taking up her post and also thanked Kate Lindenau for her hard work.
28.	**THE HEALTHCARE WORKER FLU VACCINATION BEST PRACTICE MANAGEMENT CHECKLIST**
	YDH
28.1	The Chief Nurse presented the report which was received by the Board.
	SFT
28.2	The Chief Nurse presented the report which was received by the Board.
28.3	The Board discussed the SFT and YDH reports and commented/noted that: • The uptake at YDH was in line with the 2021/22 uptake to date whilst the SFT uptake was slightly ahead of the 2021 uptake. • There was a risk to the vaccination programme in view of a vaccination fatigue or a reluctance in the uptake of the Covid-19 vaccination by healthcare workers across both trusts and this may also affect the flu vaccination uptake. This was a complex issue and every effort was being made to try and understand the reasons for this reluctance and reassure colleagues. • Access to the vaccinations was being made as easily as possible and colleagues will continue to be encouraged to get vaccinated. • A reference was made to an article in the HSJ about a wrong vaccine being given to over 65s, but as this did not relate to the trusts, further information was not available. It was noted that over 65s will need a different flu vaccine than under 65s and the incident referred to in the article was likely to have related to vaccines provided in primary care services.
28.4	The Board reaffirmed its commitment to achieving the ambition of vaccinating all frontline healthcare workers (both clinical and non-clinical staff who have contact with patients).
29.	**ASSURANCE REPORT OF THE PEOPLE AND WORKFORCE COMMITTEE MEETINGS HELD ON 15 SEPTEMBER 2022**
29.1	Stephen Harrison presented the report which was received by the Board.
29.2	Stephen Harrison highlighted the areas for follow which related to the YDH turnover figures; the review of the work of the Cultural Board; the workforce corporate risks; and job planning. The Committee did not identify any risks or issues to be reported to the Board.

29.3	The Chief of People and Organisational Development highlighted the recent visit from the National Chief People Officer and the regional HR Director of the south west to the trust and they recognised the excellent progress being made in relation to the People Promise Exemplar Programme and the retention of colleagues across Somerset. They had commented that "a culture of positivity, high motivation for quality improvement was palpable" and their feedback was encouraging. A further visit will be arranged in 2023 to provide a further update on the work taking place.
29.4	The Chairman complimented Graham Hughes and Stephen Harrison for their ongoing focus on workforce.
30.	**FINANCE REPORTS** **Finance Report – YDH**
30.1	The discussion of this item is reflected in the YDH minutes.
	Finance Report - SFT
30.2	The Chief Finance Officer presented the financial report which was received by the Board. She highlighted the financial position: • An in-month deficit of £746,000 against a planned deficit of £211,000. A year to date deficit of £3.711 million which was £705,000 adverse to pan. It was noted that the in-month deficit was due to the Agenda for Change pay award paid in month; the continued additional costs experienced in relation to GP Direct Access activity and a stepped increase in bank and agency usage to cover substantive vacancies and costs associated with the additional bank holiday. • An increase in agency spend to cover vacancies. Agency spend for the year to date was £14 million which was £3.3 million above the same period in 2021/22. • An £878,000 cost improvement plan delivery against £728,000 planned efficiencies. It was noted that there remained a gap in cost improvement schemes of £2.3 million and the target of £14.181 million will be challenging to achieve due to the service pressures. • An underspend against the capital programme due to slippage of some of the schemes. It was noted that expenditure was expected to accelerate in the coming months. The highest risk related to the surgical build and discussions were taking place with NHS England to reprofile funding. • Risks going forward included the funding of the escalation capacity; the gap in efficiency schemes; and continued pressures in GP direct access and pathology testing costs.
30.3	The Board discussed both finance reports. It was queried whether it was expected that the year end breakeven forecast positions will be deliverable. The Chief Finance Officer advised that a review of the provider and system positions

	had taken place as the impact of one organisation not achieving its forecast position will affect the overall Somerset position. It was therefore not felt necessary to review the forecast system breakeven position.
31.	**VERBAL REPORT FROM THE FINANCIAL RESILIENCE COMMERCIAL COMMITTEE/FINANCE COMMITTEE MEETING HELD IN COMMON ON 1 NOVEMBER 2022**
31.1	Kate Fallon, Chairman of the joint Committee, provided feedback from the meetings held on 1 November 2022 and advised that one of the key discussions had focussed on the financial and planning uncertainty for 2023/24. It was expected that guidance will be issued by the end of December 2022.
31.2	A discussion had also taken place about slippage in the surgical centre build scheme due to supply chain challenges and the wider challenges faced by the construction industry.
31.3	The Committee had further received a presentation on reference costs and patient level costings for acute services and understanding these costs, and particularly the patient level costings, will significantly help operational transformation.
32.	**ASSURANCE REPORTS FROM THE AUDIT COMMITTEE MEETINGS HELD ON 12 OCTOBER 2022**
32.1	**YDH and SFT Audit Committee meetings held in common** Paul Mapson, Chair of the YDH Audit Committee, presented the report which was received by the Board.
32.2	Paul Mapson highlighted the areas of concern or for follow up which related to: • The areas of limited assurance findings of the YDH Health and Wellbeing audit. • The areas of limited assurance findings of the SFT Job Planning; Consultant Job Planning; Duty of Candour; Career Conversations; audit reports.
32.3	The Committee identified a risk in relation to the audits which had received limited audit assurance, the majority of which were workforce related.
33.	**ASSURANCE REPORT OF THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON 13 SEPTEMBER 2022**
33.1	Alexander Priest, Chair of the Mental Health Act Committee, presented the report which was received by the Board.
33.2	Alexander Priest highlighted the key areas of concern or for follow up which related to:

	• The delay in approving the Section 117 multi-organisational policy. • The staffing difficulties in the Approved Mental Health Professional (AMHP) Services over the summer period due to annual leave and retirements. • The lack of availability of AMHPs and Section 12 doctors. • The details of the paediatric ward data to be reported to the Committee. • The findings of the Parliamentary and Health Service Ombudsman (PHSO)- Local Government and Social Care Ombudsman (LGSCO) Launch Joint Public Interest Report on Section 117 Aftercare Provision.
33.3	The Committee did not identify any risks which will need to be reported to the Board.
34.	**FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS**
34.1	There were no follow up questions from the Public or Governors.
35.	**ANY OTHER BUSINESS**
35.1	There was no other business.
36.	**RISKS IDENTIFIED**
36.1	The Board did not identify any new risks which had not as yet been included on the risk register but reiterated the risks in relation to the capital programme; the operational pressures; the number of high risks and the ability to control these risks.
37.	**EVALUATION OF THE EFFECTIVENESS OF THE MEETING**
37.1	The Board agreed that the meeting had been long but a significant amount of information had been provided to the Board and all agenda items had been given effective consideration.
37.2	The Board agreed that the meeting had been very productive; well chaired and well balanced.
38.	**ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING**
38.1	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. These reasons related to contract confidentiality; commercially sensitive items; and draft reports.

39.	**WITHDRAWAL OF PRESS AND PUBLIC**
39.1	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.
40.	**DATE FOR NEXT MEETING**
40.1	7 February 2023

2208SOMERSET NHS FOUNDATION TRUST (SFT)
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST (YDH)

PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON

MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST MEETING HELD ON 8 NOVEMBER 2022 BY MS TEAMS

PRESENT

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

IN ATTENDANCE

Colin Drummond	Chairman - SFT
Barbara Gregory	Non-Executive Director – SFT
Kate Fallon	Non-Executive Director
Stephen Harrison	Non-Executive Director – SFT
Sube Banerjee	Non-Executive Director
Meridith Kane	Medical Director for Acute Hospitals
Sallyann King	Interim Director of Midwifery for Somerset (for item 17 only)
Xanthe Whittaker	Director of Elective Care (for item 23)
Paul Foster	Consultant Urologist/Clinical Director (for part of the meeting)
Janet Fallon	Guardian of Safe Working – SFT (for item 26 only)
John McFarlane	Guardian of Safe Working - YDH (for item 26 only)
Harriet Jones	Head of Inclusion (for item 27 only)
Kate Lindenau	Inclusion Co-ordinator, YDH (for item 27 only)
Alison Whitman	Lead Governor YDH
Virginia Membrey	Governor YDH
Steve Ashton	Governor YDH

Ian Hawkins	Governor YDH/Lead Governor SFT
Ria Zandvliet	Secretary to the Trust (minute taker)

The meeting was further attended by the following NHS England colleagues:

Beth Woolfson	Senior Manager, NHS England Provider Development
Neal Cleaver	Deputy Clinical Director, NHS England SW regional team
Kim Jones	Assistant Clinical Director, NHS England SW regional team
Serena Qayyum	Senior Manager, NHS England Provider Development
Jessica Crocker	Head of Financial Strategy and Transactions, NHSE England

1.	**APOLOGIES**
1.1	There were no apologies.
1.2	The Chairman advised that, following the establishment of a single executive team across both trusts, the SFT and YDH Boards have agreed to conduct their Board of Directors meetings as meetings held in common. The meetings will be chaired by the Chair of either SFT or YDH Chair on a rotation basis and Martyn Scrivens will be chairing the Part A Board meeting. Colin Drummond will be chairing this afternoon's meeting.
1.3	The Chairman welcomed all Board members, governors, colleagues and other attendees to the meeting and confirmed that both the SFT and YDH meetings were quorate.
1.4	The Chairman further welcomed the NHS England colleagues who had joined the meeting as observers in view of the finance and governance reviews which were currently being undertaken across both trusts as part of the proposed merger process. All NHS England colleagues introduced themselves.
2.	**QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS**
2.1	The Chairman advised that a letter with questions for the Board had been received from the League of Friends in Minehead. The letter highlighted: • The donation of a new 55" television DVD/and Blue Ray player to the inpatient ward. • The approval of a grant to enable the inpatient ward to purchase a reconditioned piano. • The approval of an application for grant aid to purchase a text book for the MSK physiotherapy department – vestibular rehabilitation book.

	• The approval of a grant for an "Operio-Sterile air zone unit".
2.2	The letter asked the Board to ensure the move of the MSK and ophthalmic surgery departments to Minehead Community Hospital. The letter further raised the lack of information in relation to the timing of the building works to allow for maxillofacial minor surgery to be undertaken at the hospital; and the delay in providing an update on progress made in relation to the Same Day Urgent Care provision project in West Somerset.
2.3	Colin Drummond thanked the League of Friends for their donations and grants and for the significant support they provide to the hospital. It was agreed that, as the questions did not relate to a specific agenda item, a formal written response will be provided to the League of Friends in Minehead outside of the Board meeting. It was clarified that although the letter referred to the trust leading the Same Day Urgent Care engagement exercise, this was not correct as this project was led by the Integrated Care Board and involved a wider range of providers and services. The Director of Corporate Services agreed to formally write to the League of Friends and reiterate the Board's thanks for everything the League of Friends does to support the hospital and patients in West Somerset. **Action: Director of Corporate Services.**
3.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 6 SEPTEMBER 2022**
3.1	The approval of the minutes is reflected in the SFT minutes.
4.	**MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 6 SEPTEMBER 2022**
4.1	Paul Mapson proposed, Alexander Priest seconded and the Board approved the minutes of the Yeovil District Hospital NHS Foundation Trust Public Board meeting held on 6 September 2022 as a correct record.
5.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 7 SEPTEMBER 2022**
5.1	The approval of the minutes is reflected in the SFT minutes.
6.	**MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 7 SEPTEMBER 2022**
6.1	Paul Mapson proposed, Graham Hughes seconded and the Board approved the minutes of the Yeovil District Hospital NHS Foundation Trust Public Board meeting held on 7 September 2022 as a correct record.
7.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 4 OCTOBER 2022**
7.1	The approval of the minutes is reflected in the SFT minutes.

8.	**MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 4 OCTOBER 2022**
8.1	Graham Hughes proposed, Paul Mapson seconded and the Board approved the minutes of the Yeovil District Hospital NHS Foundation Trust Public Board meeting held on 4 October 2022 as a correct record.
9.	**TO REVIEW THE ACTION LOGS AND MATTERS ARISING**
9.1	The Board received the action log and noted the completed actions.
9.2	In relation to the action to look into the reasons for the resignation of three radiology nurses at YDH, it was noted that the nurses had felt isolated from the wider nursing team within the hospital. This feedback was already being used to consider how best to retain radiology nurses and how to strengthen connections with the wider nursing team.
10.	**TO NOTE THE REGISTERS OF DIRECTORS' INTERESTS AND RECEIVE ANY DECLARATIONS OF INTERESTS RELATING TO ITEMS ON THE AGENDA**
10.1	The Board received the Register of Directors' interest. The Board noted the following changes to the register: • Pippa Moger – to change "Executive Director for SSL" to "Non-Executive Director for SSL". • Isobel Clements – to remove "Daughter works as a registered nurse in the Emergency department at MPH".
11.	**CHAIRMEN'S REMARKS**
11.1	The Chairman observed that both trusts continue to be under significant operational pressures both in terms of urgent care and elective recovery. With an expected increase in these pressures over the winter period, it will be important for Non-Executive Board members to be aware of these pressures and the challenges faced by the executive team and operational managers. Martyn Scrivens reminded executive directors to let non-executive board members know if there was anything they could do to help in managing these pressures.
11.2	Colin Drummond advised that two key system challenges severely impacted on bed capacity, four hour emergency department response times and on the ambulance handover times. These challenges related to delayed discharges of patients with "no criteria to reside"; and the fragility of primary care services. The trusts were working with the Integrated Care Board (ICB) and Somerset County Council to address these challenges. It was noted that the Chairman of the ICB will be meeting with governors from both trusts on 14 December 2022 to discuss the work of the ICB and a meeting between Non-Executive Directors of both trusts and the ICB had been set up in January 2023. These meetings will provide opportunities to keep a focus on those system challenges which severely impact on the delivery of services.

11.3	Kate Fallon provided feedback from her recent personal experience of using acute services and highlighted the humanity and kindness extended by all colleagues to their patients in spite of the pressures they were facing and irrelevant of the status of patients.
11.4	The Chairman commented that it was clear from the Leadership Quality Walkrounds that colleagues were committed to treating patients with dignity and respect and, on behalf of the Board, thanked colleagues for this commitment.
12.	**CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT**
12.1	The Chief Executive presented the report which was received by the Board. He advised that the report set out a number of significant and positive developments and specifically highlighted the approval at the October 2022 Extra-Ordinary Board meeting of the business case and additional documents for the proposed merger between Yeovil District Hospital (YDH) and Somerset (SFT) NHS Foundation Trusts.
12.2	The Chief Executive provided an update on the operating model and advised that the new operating model had now been implemented. Two acute site directors and six service group directors had been appointed and these appointments will support the integration of services. It was noted that Stacy Barron-Fitzsimons has been appointed into a different role and will therefore in future no longer attend the Board meetings. The Chief Executive thanked Stacey for her significant contributions to the work of YDH in her role as Director of Operations and wished her every success in her new role.
12.3	The Chief Executive referred to the letter received from NHS England and the additional actions identified to improve operational resilience and provided the following update: • Deliver on our ambitions to maximise bed capacity and support ambulance – the trusts generally performed relatively well in terms of ambulance handover times but, periodically, significant challenges were still being experienced resulting in a delay in handover times. Acute bed capacity was at full capacity and every possible space was being used for escalation beds. In addition, the single rooms in the Jubilee Building had over the last year been used as double rooms to be able to manage the bed pressures. • Ensure timely discharge and support people to leave hospital when clinically appropriate – this remained challenging in view of the large number of patients, 250+, with "no criteria to reside" across both YDH and SFT. This amounted to 25% of the total bed base and was a key factor of the bed capacity challenges. It was noted that additional social care capacity had been commissioned by the Integrated Care Board and the County Council and it was expected that the impact of this additional capacity will become visible over the next few weeks. The Chief Executive advised that, in addition to the delayed discharges, there was also concern about the blockage within intermediate care services where up to 200

	patients were waiting for ongoing social care. Resolving this position will be one of the key priorities due to the impact on the overall patient flow. Consideration was being given as to what further actions could be taken internally but the key priority will be to address the patient flow challenges both within acute and community hospital services and within intermediate care services. • Better support for people in the community – the Chief Operating Officer (Mental Health, Families and Neighbourhoods) advised that all actions set out in the letter from NHS England were already being followed up. The community based falls response service had already been integrated into the Rapid Response Service and lifting equipment was available to the teams. Work had also taken place looking at options how to support ambulance services by taking suitable lower priority patients directly from the ambulance stack (patients waiting for an ambulance). Approximately 40% of ambulance calls were falls related and, from the end of November 2022, the Rapid Response Service will be able to respond to these calls; lift patients; carry out health checks; and put falls and rehabilitation services in place. This will reduce some of the pressures on ambulance services. Clear governance arrangements will be put in place to ensure that feedback on calls attended was fed back to the ambulance service. It was noted that the establishment of virtual wards was one of the highest priority programmes in the trust. As a mental health, community and acute services provider, SFT was well placed to take this work forward. It was expected that the virtual wards will go "live" early in 2023 and will remain in place post winter. A large number of staff had been appointed but there was a lead in time before the service can be fully operational. The capacity in the virtual wards will be equivalent to 280 beds and the capacity and the nature of patients covered will exceed the national requirement. It was noted that colleagues within the surgical and peri-operative teams were very enthusiastic about the potential of this service
12.4	The Board discussed the report and commented/noted that: • It was queried what the position was in terms of ambulance services appointing a mental health professional. It was noted that SFT was part of a collaborative with the previous Bath, North Somerset and South Gloucestershire and Gloucestershire Clinical Commissioning Groups and a team of mental health professionals was embedded in the ambulance control centre with the aim to review the "stack" to see which patients would benefit from being transferred from the "stack" to mental health community services. It was noted that this scheme had been very successful and collaboration with neighbouring mental health providers had been excellent. • It was queried what additional support can be provided to care homes to reduce a variation in ambulance conveyance rates. There was a variation in the use of ambulance services amongst care home and this could be due to a lack of confidence managing a patient within the care home and

	the stability of the care home team. The aim will be to identify those care homes with a higher conveyance rate and review what support will be needed and what support can be provided. • A key area of concern nationally related to ambulance response times. The Chief Operating Officer (Hospital Services) advised that, for a long time, Somerset had taken the decision to hold risks within the hospitals and services to reduce ambulance response times. As a consequence, all possible escalation beds had been put in place and single rooms had to be used as double rooms. The ambulance response times had deteriorated in view of the bed capacity challenges and on 7 November 2022, a total of 91 ambulances had arrived at the emergency departments across both trusts with a lost ambulance response time of just over 16 hours. The current response times did not meet the required standards and discussions continued to take place with the ambulance service to improve the response times. In relation to the discharge pathways, the QI team will be working with the flow and discharge teams in acute and mental health services over the next few weeks to further explore areas which are not as effective as they can be and the actions to be taken to improve efficiency. • The number of Covid-19 positive patients had reduced to 28 patients in MPH, 18 in YDH and three in community hospitals and over the last 24 hours no new Covid-19 positive patients had been reported. The number of patients and colleagues with flu were still low but it was expected that numbers will increase over the next few weeks. • The smoke free pledge will be challenging to implement in mental health inpatient services. A Tobacco Reduction Programme Manager has recently been appointed and the approach to encourage patients to stop smoking will be adapted to individual patients and services. There will also be a focus on colleagues. Conversations were already taking place with patients about the support required. • The work to support the ambulance stack was very positive and it was queried whether there were additional areas which could be targeted. The Chief Executive advised that a large number of calls related to falls and ambulance services were trying as much as possible to avoid conveying patients to hospitals. In view of the number of calls, targeting falls on the ambulance stack will be a good place to start. The Chief Operating Officer (Mental Health, Families and Neighbourhoods) commented that building capacity in the Hospital at Home scheme will be necessary to be able to reduce the stack. He highlighted the complexities of setting up the Hospital at Home scheme and the resulting lead in time required. The benefits of the scheme, once operational, will be significant. Martyn Scrivens advised that Symphony Health Services had a significant role to play in the Hospital at Home scheme and this can be explored at the December 2022 Board Development Session.

13.	**Q2 2022/23 BOARD ASSURANCE FRAMEWORKS**
13.1	The Director of Corporate Services presented the updated Q2 2022/23 Board Assurance Frameworks (BAF) for SFT and YDH which were received by the Board. The BAFs had been discussed by the Audit Committee, Executive Team and relevant sub Committees since the September 2022 Board meeting and there were no significant changes in levels of risk from the previous version.
13.2	The Director of Corporate Services advised that the overall assessment in terms of level of risk was consistent across both organisations and the highest risks identified within the Assurance Frameworks continued to relate to: • the impact of pressures and capacity shortfalls in social care and intermediate care (objectives 2, 3 and 8) • insufficient capacity to meet demand (objectives 7 and 8) • infrastructure investment and ageing estate (objectives 2 and 8) • the impact of pressures in primary care (objectives 2, 3 and 5) • workforce recruitment and retention (objectives 3 and 6) • the impact of the pandemic (objective 5) • delivery of financial plans (objectives 7 and 8).
13.3	The Director of Corporate Services advised that the BAFs clearly showed the pressures and challenges across both trusts and in the wider health system and the discussions at the Board meeting showed that the Board discussions were rightly focussed on the key areas of risk.
13.4	The Board discussed the Board Assurance Frameworks and commented/noted that: • The BAFs clearly showed progress made and the information was well presented. • A number of the strategic objectives and risks had been rated “Amber” and it was queried what this really meant. The Director of Corporate Services advised that the ratings reflected the level of gaps in assurances. An “Amber” rating reflected that there were some gaps in assurance whilst a ”Red” rating indicated a lack of clear sources of assurance. Overall, in view of the difficult circumstances in which the trusts operated, the BAF showed good levels of assurance and progress made. • It was queried whether the number of “Amber” rated objectives will reduce prior to year end. The Director of Corporate Services advised that the aim was to have no “Red” ratings but it will not be possible to reduce all

	"Amber" rated objectives as some of these related to system issues and the ICB had a key role in mitigating system wide risks. In addition, in view of the current operational pressures and demand, the potential to mitigate risks will be limited. A number of strategies had been developed to address gaps in assurances but these strategies took a longer term view and are unlikely to resolve the gaps in assurances in 2022/23. • The pressures and challenges and the impact on the achievement of the strategic objectives were recognised and although the position felt uncomfortable, it was still within levels of tolerance. There were a number of risks within the strategic objectives which were outside of the trusts' control and although the reasons for the "red" and "amber" ratings for these risks will need to be understood, the trusts will not be able to mitigate these risks on its own. It was however stressed that the trusts were able to strongly influence the systemwide work and will need to make every possible effort to ensure that progress continued to be made. • Strengthening of controls; achievement of the strategic objectives; and strengthening of assurances were not the same and will need to be managed in different ways. • The risks relating to Symphony Health Services will be further discussed at the December 2022 Board Development Day as part of the wider discussion about SHS and primary care services.
13.5	The Board discussed the BAFs and welcomed the detailed updates.
14.	**Q2 2022/23 CORPORATE RISK REGISTER PROGRESS REPORTS**
14.1	The Director of Corporate Services presented the Q2 2022/232 Corporate Risk Register progress report which was received by the Board.
14.2	The Director of Corporate Services highlighted: • The common areas of risks identified across both trusts. • The total of 49 risks on the combined risk register – 30 SFT and 19 YDH risks – 16 of which scored 20 and above, with the majority of these risks relating to SFT. Details of these risks and the new risks were noted. • The four new risks relating to - Treatment Escalation Plans; Quality of Discharge Summaries; Shortage of Clinical Consumables; End of Life Pharmacy Robot – and the two risks which had increased – delivery of CIP; the poor condition of Shepton Mallet Community Hospitals Portakabin Units. • It was suggested including a quadrant diagram to be able to distinguish between the different type of risks e.g. which risks were subject to external factors and unavoidable. This will enable a clear overview of the clustering of risks. The Director of Corporate Services agreed to consider this as part of

	the 2023/24 corporate risk register. **Action: Director of Corporate Services**.
15.	**OVERVIEW OF REGULAR ITEMS TO THE BOARD**
15.1	Ria Zandvliet presented the report which was received by the Board.
15.2	The Director of Corporate Services advised that all items proposed to be presented to the Board had been mapped across the strategic objectives and, in addition, six monthly progress reports on the implementation of the key strategies had been included in the overview.
15.3	The Board discussed the report and commented/noted that: • The overview was helpful and comprehensive and demonstrated that the agenda for the Board meetings was driven by the Board Assurance Framework. • A number of items were allocated to the Part B Board meeting and it was noted that the default position was to present reports to the Part A Board meeting. Papers were only included on the Part B agenda if there was a genuine reason for doing so.
16.	**PATIENT STORY AND CLINICAL TOPIC ON THE INTEGRATION OF END OF LIFE SERVICES**
16.1	The Chief Medical Officer advised that, in view of operational pressures, this item will be deferred to a future meeting.
17.	**REPORT FOLLOWING THE INDEPENDENT INVESTIGATION INTO EAST KENT MATERNITY AND NEONATAL SERVICES**
17.1	Sallyann King, Interim Director of Midwifery for Somerset, joined the meeting for this agenda item.
17.2	Sallyann King provided an update on both SFT and YDH compliance with the recommendations set out in the Ockenden (The Independent Investigation into East Kent Maternity and Neonatal Service) report. She highlighted the overview of compliance for both trusts against the Ockenden 1 standards and it was noted that both trusts were fully compliant implementing the recommendations in the Ockenden 1 report except for: SFT – partial compliance with recommendation “twice daily consultant ward rounds”; and partial compliance for both SFT and YDH in relation to recommendation 7: informed consent.
17.3	In relation to compliance with the final Ockenden report, it was noted that the implementation of the Midwifery Continuity of Care recommendation had been put on hold as the plans were currently not achievable. It was noted that two continuity of care teams were in place at YDH but progress at Musgrove Park Hospital was less advanced. All other areas were compliant or were on plan to be completed according to plan.

17.4	Sallyann King further provided an overview of the findings of the independent investigation report; the key actions identified and the next steps. It was noted that the key actions were divided into the following categories: monitoring safe performance – finding signals among noise; standards of clinical behaviour – technical care is not enough; flawed teamworking – pulling in different directions; and organisational behaviour – looking good while doing badly.
17.5	The Board discussed the report and commented/noted that: • The ongoing focus on the Board agenda on maternity and obstetric services was welcomed and demonstrated the Board's commitment to maternity and obstetric services. • Somerset was a relatively simple system and this provided risks as well as opportunities for maternity services. Post merger there will be a single provider of maternity services in Somerset and it will be important to review performance as a "critical friend" and to seek feedback on performance from external partners and patients. • Maternity and obstetrics services posed the highest risks in terms of integration and both the Chief Nurse and Chief Operating Officer (Mental Health, Families and Neighbourhoods) will continue to work with the improvement team and the maternity services team on the integration of these services. Oversight was also provided by the Quality and Governance Assurance Committee. • The trusts were not complacent and recognised that a similar situation, as outlined in the report, could, in principle, occur in any service. Outcome measures as well as soft signs and listening to colleagues and patients will be essential. • Culture was a significant contributory factor to the findings identified in the independent report and it was queried whether any concerns about the culture, including a lack of compassion and colleagues working in silos, had been identified in the trusts. Sallyann King commented that culture was a concern as colleagues were tired and this could lead to poor behaviour and cultural anomalies. A focus on working as a team will provide colleagues with support and provide opportunities to raise any concerns. System and reporting processes had been put in place to help colleague to move to the next level. • The estates environment remained a concern at SFT, and to a lesser extent at YDH. • The merger was also a risk as the findings outlined in the independent report had occurred at times of merger. It will be essential to improve communications with the teams and allow the leadership team and the clinical care teams to share their concerns and feedback. It was noted that four integration champions had been appointed across both organisations – two midwifes and two clinical colleagues – and these champions were

	talking to colleagues to seek feedback. Sallyann King felt that the teams were open about their concerns and this enabled the concerns, where possible, to be addressed. • Culture applied to all services and any concerns will need to be considered against the vision and values of the merged organisation going forward. The trusts were aware of the findings of the independent report and appropriate and meaningful actions were being considered. • Senior obstetric and gynaecology colleagues had not attended any Board meetings and it was suggested inviting senior clinicians to future Board meetings. The Chief Medical Officer commented that senior clinical colleagues attended the Board meetings as part of the patient story and clinical topic agenda items and this will continue going forward. • The Quality and Governance Assurance Committee had discussed maternity services at almost every formal and planning meeting and Sallyann King and colleagues from the midwifery team attended these meetings to provide updates. This will continue to be key area of focus of the Committee. A detailed discussion on cultural issues had taken place at the last planning meeting. The Board was provided with assurance that the Committee will continue to keep this under close review. • Kate Fallon advised that both Alexander Priest and she were Safety Champions for both trusts and provided assurance to the Board that they both received significant levels of assurance in their role as Safety Champions.
17.6	The Board thanked Sallyann King for being so open and ambitious and providing an excellent service.
17.7	Sallyann King left the meeting.
18.	**ASSURANCE REPORT OF THE QUALITY AND PERFORMANCE/ GOVERNANCE AND QUALITY ASSURANCE COMMITTEE MEETING HELD ON 21 SEPTEMBER 2022**
18.1	Jan Hull, Chairman of the Quality and Governance Committee and Governance and Quality Assurance Committee, presented the report which was received by the Board. She particularly highlighted the Hospital at Home scheme and end of life services presentations.
18.2	Jan Hull further highlighted the risks to be reported to the Board. These risks related to: • Ophthalmology performance and the impact of broadband issues at YDH. • End of life care and the Somerset Treatment and Escalation Plans (STEP) digital solution. • Anaesthetics/critical care action plan at YDH.

	• Industrial actions.
18.3	Details of these risks were set out in the report and were noted.
18.4	The Board discussed the report and commented/noted that: • It was queried whether progress was being made in relation to the recruitment of intensivists. The Chief Medial Officer confirmed that an extensive action plan for the recruitment of new intensivist for the new integrated critical care services was in place. The action plan will cover the county as a whole, and the implementation of the action plan will ensure equity of standards and experience for patients. There was a good level of confidence that the workforce required to deliver integrated critical care services across the county can be recruited. • In relation to the broadband issue at YDH, it was queried whether Openreach had now addressed the broadband issues. The Director of Strategy and Digital Development commented that he expected that the work had been completed but agreed to check whether confirmation of completion of the final part of the works had now been received. **Action: Director of Strategy and Digital Development**.
18.5	The Chairman thanked the Committee for its work and the assurance provided.
19.	**ASSURANCE REPORT FROM THE QUALITY AND PERFORMANCE/ GOVERNANCE AND QUALITY ASSURANCE COMMITTEE ANNUAL REPORTS MEETINGS HELD ON 20 OCTOBER 2022**
19.1	Jan Hull, Chairman of the Quality and Governance Assurance Committee, presented the report which was received by the Board. She advised that annual reports from both trusts had been presented to the Committee and the reports outlined the fantastic work taking place across a wide range of services and further evidenced the increase in demand across all services; the ongoing pressures; and the focus on the integration of services.
19.2	The Chairman commended the teams on the excellent reports and the ability to see the reports of both trusts alongside each other was welcomed.
19.3	The Director of Corporate Services advised that the reports will be published on the Trust's website.
19.4	The Chairman welcomed the reports and thanked the authors of the reports and the teams for their fantastic work and commitment to their services.
20.	**EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE REPORT EPRR**
20.1	The Director of Corporate Services presented the joint report which was received by the Board. The Board noted that the self assessments showed substantive compliance for both trusts.

20.2	The Board discussed the reports and commented/noted that: • The reports and the levels of compliance were excellent; • It was queried whether, in view of the Covid-19 pandemic, any further actions can be taken to prepare for unexpected events. The Director of Corporate Services commented that emergency planning was based on the principle that there should not be anything for which we have not planned and that all scenarios should be considered. The occurrence of a possible pandemic had been included in EPRR planning for a very long time but the pandemic reacted in a different way than planned for and this was part of the process. The first step following the announcement of the pandemic was to set up a meeting and reflect on the actions to be taken. The emergency planning process was robust but a response may need to be fluid depending on the specifics of the emergency event. • It was queried whether the trusts continued to be engaged with the countywide gold command emergency planning arrangements. It was noted that the arrangements were being reviewed. Responsibility for emergency planning had been delegated to the Integrated Care System (ICS) and a Somerset based Local Health Resilience Partnership, led by the ICS, had been set up. This new arrangement was expected to strengthen the countywide processes. • A major incident plan for the post merger organisation was being developed and will be presented to a future Board meeting. • It was queried whether regular test of lines of communication and phone numbers were being undertaken. It was noted that this was regularly tested and an emergency planning exercise to test communication processes both internally and on a system wide basis, will be undertaken in the next week.
20.3	The Board agreed that the report provided significant assurance about the emergency planning processes. The Board noted the compliance ratings against the national EPRR Core Standards; the EPRR workstream activities to ensure the resilience of the post merger organisation; the new Category 1 status of the Somerset ICB and the establishment of the Somerset Local health Resilience Partnership.
22.	**QUALITY AND PERFORMANCE REPORTS** **Group Board Overview Quadrant – YDH** **Quality and Performance Report – SFT**
22.1	The Chief Finance Officer provided an overview of the key performance challenges across both trusts which covered: acute referral to treatment (RTT) times; diagnostics; intermediate care; cancer services; urgent care – A&E 4 hour performance; ambulance handover times; community physical health services waiting times and activity; mental health waiting times and activity, including the number of ligature incidents; children and young people's eating disorders; out of

	area placements; infection control; slips, trips and falls; mandatory training and sickness absence; turnover rates; career conversations.
22.2	The reports were received by the Board.
22.3	The Board discussed the report and commented/noted: • No patients were currently waiting over 104 weeks at YDH and the trajectory for SFT showed that the number of patients waiting over 104 weeks after the end of November 2022 will be minimal. • Diagnostic performance continued to improve at both YDH and SFT and the system performance levels of 77% were above the regional trajectory of 75% by 31 March 2023. This performance was particularly encouraging in view of the impact on the cancer and elective pathways. • YDH was in the top performing organisations nationally in relation to the four hour ambulance response times target. • Referrals into mental health services continue to be high and were causing additional pressures on the teams. • The continued strong performance in relation to children and young people eating disorders service was a significant achievement but as performance was reflected on a 12 month rolling basis, the excellent performance over the last few months would not result in the target levels being achieved until at least March 2023. • The number of pressure ulcers at SFT had significantly increased during July 2022 compared to the June 2022 position and there had been a gradual increase in the number of pressure ulcers over the last few months. This increase was not driven by a single factor and was complex. A number of improvement actions had been identified and were being implemented. It was noted that an update on the work undertaken to develop core standards of care, which every patient should receive, will be provided to the December 2022 Quality and Governance Assurance Committee. In addition, work was also being undertaken with the people team in relation to falls and pressure ulcer practice development. It was noted that the rate at YDH showed a continuing downwards trend. • The turnover rate remained consistent at 11% in SFT. The rate of 19.5% in YDH was high but was also consistent compared to the previous few months. The reasons for colleagues leaving the trusts continued to be explored in more detail and further information will be provided to the November 2022 People/Workforce Committee meetings. There was a particular concern about the turnover rate of administrative/clerical and additional clinical services colleagues in YDH and it was recognised that the proposed merger may play a factor in these colleagues leaving the trusts. A range of reasons had been identified and these will be kept under review. The second group with a high turnover rate were colleagues

	under the age of 25 leaving within 12 months of employment. Their reasons for leaving were not fully understood and further work will be undertaken to explore this in more detail. Martyn Scrivens welcomed the focussed work but also asked for a focus on retaining “rising stars”. The key two reasons seemed to relate to relocation and work/life balance and it was queried whether the same breakdown was available for SFT colleagues. It was noted that the same level of information was available but there was a need to strengthen both the levels of information received and the exit arrangements. • It was queried whether the delays in discharging patients who were medically fit to be discharged impacted on their condition and whether they would be more vulnerable to e.g. pressure ulcers. The Chief Nurse advised that it was well known that, especially older patients, will decondition the longer they stayed in hospital. Their muscle loss could lead to long term harm and immobility and patients were more likely to fall in hospital due to the unfamiliar environment and routines. The Chief Nurse commented that deconditioning was a real concern but work was taking place across both trusts to cohort some of the older patients together so that care can be provided in a different way. This was part of a large programme of work. The Chief Operating Officer (Hospital Services) advised that performance and actions continued to be reviewed in detail at the Quality and Governance Assurance Committee meetings. He acknowledged that there was an impact on patients’ conditions when admitted to a hospital bed and it was therefore essential to rigorously review performance against all patient care indicators. Martyn Scrivens recognised the challenges caused by the delayed discharges and agreed that the position was difficult and unsatisfactory. He however stressed the need not to feel paralysed due to the operating conditions, but to remain on the front foot and take all possible actions the trusts could take to resolve the challenges.
22.4	The Board acknowledged the areas of good performance and recognised the challenges.
23.	**ELECTIVE RECOVERY PROGRAMME SELF DECLARATION - SFT**
23.1	The discussion of this agenda item is reflected in the SFT minutes.
23.2	Xanthe Whittaker left the meeting.

24.	**UPDATE ON THE MERGER BETWEEN SOMERSET NHS FOUNDATION TRUST AND YEOVIL DISTRICT NHS FOUNDATION TRUST**
24.1	The Director of Strategy and Digital Development presented the report which was received by the Board. He advised that the business case to be submitted to NHS England had been approved at the October 2022 Extra Ordinary Board meeting. The version presented to the Board at today's meeting was the version to be publicly published.
24.2	The Director of Strategy and Digital Development set out the next steps including the work on the integration of services as set out in the patient benefits cases. He commented that other reports presented to the Board meeting already demonstrated closer working and progress in the integration of services. In relation to the next steps, it was noted that a Board to Board meeting between the trusts and NHS England's regional team will be scheduled in February 2023 and a recommendation whether to proceed with the merger will be issued in March 2023. This recommendation will be presented to both Boards and Council of Governors for approval.
24.3	The Board discussed the report and commented/noted that: • Communication will be important and an example of a misconception expressed by a Town Council was highlighted. As well as setting out what changes will be made following the merger, it will be equally important to communicate the areas which will not change, especially in relation to YDH services. The Chief Executive commented that he had been present at the Town Council meeting and there seemed to be a confusion between the merger and the consultation led by the ICB on the future of hyper acute stroke services. That misunderstanding was clarified but communication had not been sufficiently clear. • A communications plan had been developed and press releases will be issued. In addition, communications will be issued to a wide range of stakeholders through a number of different communication methods.
24.4	Graham Hughes <u>proposed,</u> Paul Mapson <u>seconded</u> and the Yeovil District NHS Foundation Trust Board approved the publication of the business case
25.	**LEARNING FROM DEATHS FRAMEWORK: MORTALITY REVIEW PROGRESS REPORT** **YDH**
25.1	The Chief Medical Officer advised that it had been intended that Paul Foster, Medical Director, would present the report but, due to the slippage of time, he had had to return to his clinical duties. The Chief Medical Officer presented the report and advised that the report reflected the ongoing progress with Medical Examiners identifying cases requiring further investigation through Mortality Reviews or Clinical Investigation and the difficulties experienced when demand exceeds capacity to complete Mortality Reviews.

25.2	The Board received the report and the issues identified as part of the investigations; the lessons learned, areas of improvement and actions taken were noted.
	SFT
25.3	The discussion of this agenda item is reflected in the SFT minutes.
	Joint
25.4	The Board discussed the reports and commented/noted that: • The reports were focussed on emphasising the learning identified from the reviews and the changes made as a result of this learning. Details of the changes made were set out in the reports. • The Board discussed standardised mortality measures. SFT SHMR coding issues were well understood by the Board and were due to the Trust choosing to use a different End of Life pathway than the pathway used for End of Life coding. A recent discussion had taken place at the Finance Committee and the Committee was assured about the current position and work taking place to upskill the coding team. In the absence of accurate benchmarking information, the Board received assurance about the end of life pathway through the findings of the reviews carried out by the Medical Examiner. The Chief Medical Officer agreed that the benchmarking information was less concise as a result of the coding issues. A number of indicators had increased and it was expected that this may be due to statistical and environmental factors. In the absence of accurate benchmarking information, it was therefore essential to review as many deaths as possible to ensure that the end of life pathway remained appropriate. • The high number of reviews carried out was exceptional in view of the significant operational pressures, particularly in the medicine department where there were no outstanding unreviewed deaths. The findings of the reviews provided significant assurance that the deaths had not been caused by care or process issues. In addition, deep dives into certain causes of deaths provided additional assurance that the drift in SHMR/SHMI was not as a result of a drift in care provided but was due to other factors. • It was queried whether the SHMR coding issue was limited to Musgrove Park Hospital or also related to community hospitals. The Chief Medical Officer advised that the coding issue also related to community hospitals and NHS Digital had been requested on a number of occasions to remove community hospitals and the mental health components of deaths from the standard mortality indicators as national benchmarking was based on acute hospitals. The inclusion of community hospitals and other different care settings therefore increased the SHMI indicator. Deep dives into community hospital deaths had shown that good levels of care had been

	provided but as the models of care included end of life patients this affected the SHMI indicators. Feedback had now been received from NHS Digital that all sites other than Musgrove Park Hospital will be removed from the SHMI data and this will improve the accuracy of the SHMI data. • It was further queried when the statistical SHMR and SMHI anomaly will cease to show up. The Chief Medical Officer advised that some of the data anomalies related to the coding of end of life patients and the national definition of end of life care will not change. The Trust was not anticipating changing its end of life approach as it was felt that this approach was more patient focussed. The anomaly this created will need to be accepted. The remaining anomalies will change over time. As the indicators were based on six or 12 month rolling averages, there will be a few months' delay before improvement will become visible. National benchmarking was based on three years' worth of data and it will therefore take another three years for the national benchmarking to catch up with the changes. • The digital team had been going through a period of turnover and the coding team had been relatively inexperienced. This had now improved and the coding timelines were now being met. Work continued to take place to upskill the coding team but good progress was being made.
25.5	The Board thanked the teams for their excellent reports.
26.	**GUARDIAN OF SAFE WORKING FOR JUNIOR DOCTORS REPORT**
26.1	John McFarlane, Guardian of Safe Working YDH, and Janet Fallon, Guardian of Safe Working SFT, joined the meeting for this agenda item.
26.2	**YDH** John McFarlane presented the report which was received by the Board.
26.3	The Board discussed the report and commented/noted that: • 53 exception reports had been received with the majority relating to the number of hours worked. In the majority of these instances, overtime payments had been made. • The report provided evidence that the working hours for trainee doctors at YDH remained safe. • Two immediate safety concern had been raised relating to the workload of new doctors on the surgical wards. These concerns had been reviewed by the rota team and resolved with appropriate induction and training. • The number of exceptions had significantly reduced compared with the same period in Q1 2022 and the numbers were now in the average range.

	Colleague absences had reduced resulting in fewer exception reports on surgical wards. • Medical ward exception reports have risen partly due to new doctors starting in August with delayed induction. • The reasons of the immediate safety concerns were noted and it was queried whether the training and induction issues were a wider concern and whether this could be addressed easily. John McFarlane advised that the concerns were expressed at the beginning of August 2022 at the start of a change over in junior doctors. A specific junior doctor had missed his induction and his assignment to the ward had been an administrative error and had been resolved. The induction had been rescheduled. John McFarlane stressed that this had not been a system error but a one off error.
26.4	The Chairman thanked John McFarlane for his excellent management of the Guardian of Safe Working process. **SFT**
26.5	The discussion of this agenda item is reflected in the SFT minutes.
26.6	The Chairman thanked Janet Fallon and John McFarlane for their excellent report.
26.7	Janet Fallon and John McFarlane left the meeting.
27.	**SIX MONTHLY INCUSION REPORT**
27.1	Harriet Jones (Head of Inclusion) and Kate Lindenau (Inclusion Co-ordinator, YDH) joined the meeting for this agenda item.
27.2	Harriet Jones and Kate Lindenau presented the report which set out progress against the 2022 Workplace Race Equality Standard (WRES) report; the 2022 Workplace Disability Equality Standard (WDES) report; the key themes from the reports; and provided an overview of the new inclusion roadmap. The report was received by the Board.
27.3	Harriet Jones particularly highlighted: • The action plans in place to start building foundations for the trusts' approach to inclusion and to learn from good practices across the trusts. • The purpose of the road map to create inclusion by developing a framework, governance structures and ways of working to be able to define and measure impact and create sustainable and systemic change. • The key themes from the WRES and WDES reports.

27.4	The Board discussed the report and commented/noted that: • As Co-Chair of the Inclusion Steering Group, the Chief Operating Officer (Hospital Services) thanked Harriet Jones for her focus on helping the trusts to move the inclusion work forward onto the next stage and moving from an opportunistic approach to a more strategic approach. He welcomed the extension of the inclusion work across both trusts and the focus of this work was encouraging and exciting. • It was queried how colleagues representing a minority group felt about the inclusion work and impact on them. Harriet Jones advised that this was a difficult question to answer as the answer will be different for different colleagues. There was a shift in the way colleagues talk about inclusion and uncomfortable questions were being asked. The interest in the pilots had been overwhelming and this showed colleague's focus on inclusion. The key aim was to provide colleagues with the right tools and considerable progress was being made. Harriet Jones advised that she had spoken to colleagues from a different background and there was a feeling that systemic change was becoming visible. The focus on inclusion will need to be accelerated to speed up change. • The roadmap was excellent and will help the Board to communicate what inclusion means for colleagues and the organisation. Further work will need to carried out and Harriet Jones will be able to support that work. In addition, a new Equality Delivery System and Diversity Standards will be published and it will be essential to work with system partners how to take that work forward. • It was queried whether colleagues with disabilities felt comfortable coming forward about their disabilities and whether the actual rate was higher than the rate reported from the ESR system. Harriet Jones commented that some colleagues felt uncomfortable declaring their disability but a larger number of colleagues appeared not to know how to update their declaration on the ESR system. If a disability had been declared, conversations about possible adjustments could take place. The process for identifying adjustments will need to be clarified and checks will need to be carried out to ensure that the adjustments were the right adjustments for an individual colleague. This will be part of a wider piece of work. • Measuring the evidence of focus and progress made will be critical but difficult to do. Staff surveys and quantitative data will give an indication but do not provide all the information. It was queried what methods will be used, other than the staff surveys, to capture valuable narratives and experience of colleagues to evidence the success of the focus on inclusion and how this will be acted upon. Harriet Jones commented that views from colleagues will be presented to the Inclusion Steering Group but, in addition, considerable work was taking place with the networks on how to collect and share information. Kate Lindenau commented that relationships with the networks were good and feedback was provided to

	the Steering Group to enable themes and actions to be identified and implemented. • The roadmap aimed to create an inclusion governance structure but inclusion will need to be incorporated into the whole governance structure. Care will need to be taken that inclusion will not be limited to the inclusion governance structure.
27.5	The Board thanked Harriet Jones for the impact she had made since taking up her post and also thanked Kate Lindenau for her hard work.
28.	**THE HEALTHCARE WORKER FLU VACCINATION BEST PRACTICE MANAGEMENT CHECKLIST** **YDH**
28.1	The Chief Nurse presented the report which was received by the Board.
	SFT
28.2	The Chief Nurse presented the report which was received by the Board.
28.3	The Board discussed the SFT and YDH reports and commented/noted that: • The uptake at YDH was in line with the 2021/22 uptake to date whilst the SFT uptake was slightly ahead of the 2021 uptake. • There was a risk to the vaccination programme in view of a vaccination fatigue or a reluctance in the uptake of the Covid-19 vaccination by healthcare workers across both trusts and this may also affect the flu vaccination uptake. This was a complex issue and every effort was being made to try and understand the reasons for this reluctance and reassure colleagues. • Access to the vaccinations was being made as easily as possible and colleagues will continue to be encouraged to get vaccinated. • A reference was made to an article in the HSJ about a wrong vaccine being given to over 65s, but as this did not relate to the trusts, further information was not available. It was noted that over 65s will need a different flu vaccine than under 65s and the incident referred to in the article was likely to have related to vaccines provided in primary care services.
28.4	The Board reaffirmed its commitment to achieving the ambition of vaccinating all frontline healthcare workers (both clinical and non-clinical staff who have contact with patients).

29.	**ASSURANCE REPORT OF THE PEOPLE AND WORKFORCE COMMITTEE MEETINGS HELD ON 15 SEPTEMBER 2022**
29.1	Stephen Harrison presented the report which was received by the Board.
29.2	Stephen Harrison highlighted the areas for follow which related to the YDH turnover figures; the review of the work of the Cultural Board; the workforce corporate risks; and job planning. The Committee did not identify any risks or issues to be reported to the Board.
29.3	The Chief of People and Organisational Development highlighted the recent visit from the National Chief People Officer and the regional HR Director of the south west to the trust and they recognised the excellent progress being made in relation to the People Promise Exemplar Programme and the retention of colleagues across Somerset. They had commented that "a culture of positivity, high motivation for quality improvement was palpable" and their feedback was encouraging. A further visit will be arranged in 2023 to provide a further update on the work taking place.
29.4	The Chairman complimented Graham Hughes and Stephen Harrison for their ongoing focus on workforce.
30.	**FINANCE REPORTS** **Finance Report – YDH**
30.1	The Chief Finance Officer presented the financial report which was received by the Board. She highlighted the financial position: • An in-month negative variance of £126,000 against a planned surplus of £22,000. The year to date was a negative variance of £450,000 against a planned deficit of £99,000. This adverse deficit was mainly driven by locum costs within Symphony Healthcare Services (SHS) due to the inability to recruit GPs and it was expected that this position will further deteriorate. Conversations will continue to take place with the ICB about the locum costs but also about the non-funded part of the GP pay award. The impact of the SHS deficit on the achievement of the forecast outturn had been recognised as a system risk. • Agency spend remained higher than plan and this was driven both by SHS locum and trust medical agency expenditure. Discussions had taken place with clinical divisions about the process for booking clinical agency shifts to ensure that the right levels of scrutiny and controls were in place. • A £2.255 million cost improvement plan delivery against £1.769 million planned efficiencies, of which 17% had been achieved recurrently. • An underspend against the capital programme due to a timing issue and it was expected that capital expenditure will increase in future months.

	• The year to date position included £1.526 million pay award funding above plan alongside an additional £379,000 reimbursement of Covid-19 costs (testing) incurred outside of the system funding envelope. • The key programme risks related to: the replacement of windows; the additional theatre and modular ward; the winter and escalation costs; the high level of agency spend; and the SHS locum costs.
30.2	**Finance Report - SFT** The discussion of this agenda item is reflected in the SFT minutes.
30.3	The Board discussed both finance reports. It was queried whether it was expected that the year end breakeven forecast positions will be deliverable. The Chief Finance Officer advised that a review of the provider and system positions had taken place as the impact of one organisation not achieving its forecast position will affect the overall Somerset position. It was therefore not felt necessary to review the forecast system breakeven position.
31.	**VERBAL REPORT FROM THE FINANCIAL RESILIENCE COMMERCIAL COMMITTEE/FINANCE COMMITTEE MEETING HELD IN COMMON ON 1 NOVEMBER 2022**
31.1	Kate Fallon, Chairman of the joint Committee, provided feedback from the meetings held on 1 November 2022 and advised that one of the key discussions had focussed on the financial and planning uncertainty for 2023/24. It was expected that guidance will be issued by the end of December 2022.
31.2	A discussion had also taken place about slippage in the surgical centre build scheme due to supply chain challenges and the wider challenges faced by the construction industry.
31.3	The Committee had further received a presentation on reference costs and patient level costings for acute services and understanding these costs, and particularly the patient level costings, will significantly help operational transformation.
32.	**ASSURANCE REPORTS FROM THE AUDIT COMMITTEE MEETINGS HELD ON 12 OCTOBER 2022**
32.1	**YDH and SFT Audit Committee meetings held in common** Paul Mapson, Chair of the YDH Audit Committee, presented the report which was received by the Board.
32.2	Paul Mapson highlighted the areas of concern or for follow up which related to: • The areas of limited assurance findings of the YDH Health and Wellbeing audit. • The areas of limited assurance findings of the SFT Job Planning; Consultant Job Planning; Duty of Candour; Career Conversations; audit reports.

32.3	The Committee identified a risk in relation to the audits which had received limited audit assurance, the majority of which were workforce related.
33.	**ASSURANCE REPORT OF THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON 13 SEPTEMBER 2022**
33.1	Alexander Priest, Chair of the Mental Health Act Committee, presented the report which was received by the Board.
33.2	Alexander Priest highlighted the key areas of concern or for follow up which related to: • The delay in approving the Section 117 multi-organisational policy. • The staffing difficulties in the Approved Mental Health Professional (AMHP) Services over the summer period due to annual leave and retirements. • The lack of availability of AMHPs and Section 12 doctors. • The details of the paediatric ward data to be reported to the Committee. • The findings of the Parliamentary and Health Service Ombudsman (PHSO)- Local Government and Social Care Ombudsman (LGSCO) Launch Joint Public Interest Report on Section 117 Aftercare Provision.
33.3	The Committee did not identify any risks which will need to be reported to the Board.
34.	**FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS**
34.1	There were no follow up questions from the Public or Governors.
35.	**ANY OTHER BUSINESS**
35.1	There was no other business.
36.	**RISKS IDENTIFIED**
36.1	The Board did not identify any new risks which had not as yet been included on the risk register but reiterated the risks in relation to the capital programme; the operational pressures; the number of high risks and the ability to control these risks.
37.	**EVALUATION OF THE EFFECTIVENESS OF THE MEETING**
37.1	The Board agreed that the meeting had been long but a significant amount of information had been provided to the Board and all agenda items had been given effective consideration.

37.2	The Board agreed that the meeting had been very productive; well chaired and well balanced.
38.	**ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING**
38.1	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. These reasons related to contract confidentiality; commercially sensitive items; and draft reports.
39.	**WITHDRAWAL OF PRESS AND PUBLIC**
39.1	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.
40.	**DATE FOR NEXT MEETING**
40.1	7 February 2023

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

PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST MEETING HELD ON 6 DECEMBER 2022 BY MS TEAMS

PRESENT

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

IN ATTENDANCE

Graham Hughes	Non-Executive Director, YDH
Paul Mapson	Non-Executive Director, YDH
Fiona Reid	Director of Communications
Meridith Kane	Medical Director for Acute Hospitals
Neil Murray	Strategic Accountant (for item 2)
Ian Boswall	Director of Redevelopment (for item 2)
Na'el Clarke	Director of Commercial Development (for item 3)
Ben Edgar-Attwell	Associate Director of Integration
Ria Zandvliet	Secretary to the Trust (minute taker)

1.	**WELCOME AND APOLOGIES**
1.1	It was noted that no apologies had been received.
1.2	The Chairman advised that, following the establishment of a single executive team across both trusts, the SFT and YDH Boards have agreed to conduct their Board of Directors meetings as meetings held in common. The meetings will be chaired by the Chair of either SFT or YDH Chair on a rotation basis and Colin Drummond will be chairing this meeting.
1.3	The Chairman welcomed all Board members and attendees to the meeting and confirmed that the meeting was quorate.
2.	**DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA**
2.1	There were no declarations of interest relating to items on the agenda.
3.	**ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING**
3.1	The Chairman advised that the main focus of the Confidential Board meeting will be on the YDH 2030 strategic outline case; and the commercial strategy and set out the reasons for including these items on the Confidential Board agenda.
4.	**WITHDRAWAL OF PRESS AND PUBLIC**
4.1	The Board moved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.
5.	**ANY OTHER BUSINESS**
5.1	There was no other business.
6.	**DATE OF NEXT MEETING**
6.1	7 February 2023

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

PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON

MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST MEETING HELD ON 6 DECEMBER 2022 BY MS TEAMS

PRESENT

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

IN ATTENDANCE

Colin Drummond	Chairman - SFT
Barbara Gregory	Non-Executive Director – SFT
Kate Fallon	Non-Executive Director - SFT
Stephen Harrison	Non-Executive Director – SFT
Sube Banerjee	Non-Executive Director - SFT
Meridith Kane	Medical Director for Acute Hospitals
Fiona Reid	Director of Communications
Neil Murray	Strategic Accountant (for item 2)
Ian Boswall	Director of Redevelopment (for item 2)
Na'el Clarke	Director of Commercial Development (for item 3)
Ben Edgar-Attwell	Associate Director of Integration
Ria Zandvliet	Secretary to the Trust (minute taker)

1.	**WELCOME AND APOLOGIES**
1.1	It was noted that no apologies had been received.

1.2	The Chairman advised that, following the establishment of a single executive team across both trusts, the SFT and YDH Boards have agreed to conduct their Board of Directors meetings as meetings held in common. The meetings will be chaired by the Chair of either SFT or YDH Chair on a rotation basis and Colin Drummond will be chairing this meeting.
1.3	Colin Drummond welcomed all Board members and attendees to the meeting and confirmed that the meeting was quorate.
2.	**DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA**
2.1	There were no declarations of interest relating to items on the agenda.
3.	**ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING**
3.1	Colin Drummond advised that the main focus of the Confidential Board meeting will be on the YDH 2030 strategic outline case; and the commercial strategy and set out the reasons for including these items on the Confidential Board agenda.
4.	**WITHDRAWAL OF PRESS AND PUBLIC**
4.1	The Board moved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.
5.	**ANY OTHER BUSINESS**
5.1	There was no other business.
6.	**DATE OF NEXT MEETING**
6.1	7 February 2023

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

PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON

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

PRESENT

Colin Drummond	Chairman
Jan Hull	Non-Executive Director (Deputy Chairman)
Barbara Gregory	Non-Executive Director
Stephen Harrison	Non-Executive Director
Alexander Priest	Non-Executive Director
Martyn Scrivens	Non-Executive Director
Sube Banerjee	Non-Executive Director
Kate Fallon	Non-Executive Director
Peter Lewis	Chief Executive
Matthew Bryant	Chief Operating Officer (Hospital Services)
Andy Heron	Chief Operating Officer (Mental Health, Families and Neighbourhoods)
Hayley Peters	Chief Nurse
David Shannon	Director of Strategy and Digital Development
Isobel Clements	Chief of People and Organisational Development

IN ATTENDANCE

Graham Hughes	Non-Executive Director, YDH
Paul Mapson	Non-Executive Director, YDH
Fiona Reid	Director of Communications
Meridith Kane	Medical Director for Acute Hospitals
Neil Murray	Strategic Accountant (for item 2)
Stuart Hill	Chief Information Officer (for item 2)
David Thomas	Chief Nurse Information Officer (for item 2)
Luke Gompels	Chief Clinical Information Officer (for item 2)
Gary Risdale	Programme Manager (for item 2)
Clive Radestock	Acting Managing Director SSL (for item 3 only)
Ben Edgar-Attwell	Associate Director of Integration
Ria Zandvliet	Secretary to the Trust (minute taker)

1.	**WELCOME AND APOLOGIES**
1.1	Apologies were received from: Phil Brice (Director of Corporate Services); Pippa Moger (Chief Finance Officer); and Daniel Meron (Chief Medical Officer).
1.2	The Chairman advised that, following the establishment of a single executive team across both trusts, the SFT and YDH Boards have agreed to conduct their Board of Directors meetings as meetings held in common. The meetings will be chaired by the Chair of either SFT or YDH Chair on a rotation basis and Martyn Scrivens will be chairing this meeting.
1.3	Martyn Scrivens welcomed all Board members and attendees to the meeting and confirmed that the meeting was quorate.
2.	**DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA**
2.1	There were no declarations of interest relating to items on the agenda.
3.	**ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING**
3.1	Martyn Scrivens advised that the main focus of the Confidential Board meeting will be on the Somerset TogethEHR digital outline business case; and the Ambulatory Breast Screening Unit and set out the reasons for including these items on the Confidential Board agenda.
4.	**WITHDRAWAL OF PRESS AND PUBLIC**
4.1	The Board moved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.
5.	**ANY OTHER BUSINESS**
5.1	There was no other business.
6.	**DATE OF NEXT MEETING**
6.1	7 February 2023

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

PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON

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

PRESENT

Martyn Scrivens	Non-Executive Director (Chairman)
Jan Hull	Non-Executive Director
Graham Hughes	Non-Executive Director
Alexander Priest	Non-Executive Director
Paul Mapson	Non-Executive Director
Peter Lewis	Chief Executive
Andy Heron	Chief Operating Officer (Mental Health, Families and Neighbourhoods)
Matthew Bryant	Chief Operating Officer (Hospital Services)
Hayley Peters	Chief Nurse
David Shannon	Director of Strategy and Digital Development
Isobel Clements	Chief of People and Organisational Development

IN ATTENDANCE

Colin Drummond	Chairman - SFT
Barbara Gregory	Non-Executive Director – SFT
Kate Fallon	Non-Executive Director - SFT
Stephen Harrison	Non-Executive Director – SFT
Sube Banerjee	Non-Executive Director - SFT
Meridith Kane	Medical Director for Acute Hospitals
Fiona Reid	Director of Communications
Mark Hocking	Deputy
Neil Murray	Strategic Accountant (for item 2)
Stuart Hill	Chief Information Officer (for item 2)
David Thomas	Chief Nurse Information Officer (for item 2)
Luke Gompels	Chief Clinical Information Officer (for item 2)
Gary Risdale	Programme Manager (for item 2)
Clive Radestock	Acting Managing Director SSL (for item 3 only)
Ben Edgar-Attwell	Associate Director of Integration
Ria Zandvliet	Secretary to the Trust (minute taker)

1.	**WELCOME AND APOLOGIES**
1.1	Apologies were received from: Phil Brice (Director of Corporate Services); Pippa Moger (Chief Finance Officer); and Daniel Meron (Chief Medical Officer).
1.2	The Chairman advised that, following the establishment of a single executive team across both trusts, the SFT and YDH Boards have agreed to conduct their Board of Directors meetings as meetings held in common. The meetings will be chaired by the Chair of either SFT or YDH Chair on a rotation basis and Martyn Scrivens will be chairing this meeting.
1.3	The Chairman welcomed all Board members and attendees to the meeting and confirmed that the meeting was quorate.
2.	**DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA**
2.1	There were no declarations of interest relating to items on the agenda.
3.	**ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING**
3.1	The Chairman advised that the main focus of the Confidential Board meeting will be on the Somerset TogethEHR digital outline business case; and the Ambulatory Breast Screening Unit and set out the reasons for including these items on the Confidential Board agenda.
4.	**WITHDRAWAL OF PRESS AND PUBLIC**
4.1	The Board moved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.
5.	**ANY OTHER BUSINESS**
5.1	There was no other business.
6.	**DATE OF NEXT MEETING**
6.1	7 February 2023

SOMERSET NHS FOUNDATION TRUST/YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON ON 6 NOVEMBER 2022

AGENDA ITEM	ACTION	BY WHOM	DUE DATE	PROGRESS
2. Questions from Members of the Public/Governors	To formally write to the Chairman of the League of Friends in Minehead to respond to the questions submitted to the Board.	Phil Brice	December	A written response has been provided.
14. Corporate Risk Register Progress Reports	To consider including a quadrant diagram to distinguish between the different type of risks in the 2023/24 corporate risk register.	Phil Brice	April	This will be considered for the 2023/24 Corporate Risk Register.
18. Assurance Report from the Quality and Governance Assurance Committee	To check whether confirmation of completion of the final part of the work to address the broadband issues at YDH had been completed.	David Shannon	November 2022	Confirmation was received at the November 2022 Confidential Board meeting that this work had been completed.

Somerset NHS Foundation Trust / Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	The Trust Board
REPORT TITLE:	Registers of Directors' Interests
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Chairman
DATE:	7 February 2023

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

Executive Summary and Reason for presentation to Committee/Board	The Registers of Interests are presented to the Board at every meeting and reflect the interests of Board members as at 31January 2023.
Recommendation	The Board is asked to: • note the Register of Interests; • declare any changes to the Register of Interests; • declare any conflict of interests in relation to the agenda items.

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

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

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

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

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

JOINT EXECUTIVE DIRECTORS	
Peter Lewis Chief Executive (CEO)	• Chief Executive, Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust • Member of the NHS Confederation Community Network Board • Management Board Member, Yeovil Strategic Estates (YEP) Partner Board • Director, YEP Project Co. Limited • Director, Yeovil Property Operating Company Limited
Phil Brice Director of Corporate Services	• Sister works for Somerset NHS Foundation Trust • Non-Executive Director of the Shepton Mallet Health Partnership • Director of Corporate Services, Yeovil District Hospital NHS Foundation Trust • Non-Executive Director of SSL
Matthew Bryant Chief Operating Officer (Hospital Services)	• Trustee for Hospiscare, Exeter • Visiting Specialist, Plymouth University Peninsula Medical School • Chief Operating Officer (Hospital Services), Yeovil District Hospital NHS Foundation Trust
Isobel Clements Chief of People and Organisational Development	• Chief of People and Organisational Development, Yeovil District Hospital NHS Foundation Trust
Andy Heron Chief Operating Officer (Neighbourhoods, Mental health and Families)	• 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 • Chief Operating Officer (Neighbourhoods, Mental health and Families), Yeovil District Hospital NHS Foundation Trust • Executive Director for SHS
Pippa Moger	• Stepdaughter works for Yeovil District Hospital NHS Foundation Trust • Son works for Somerset NHS Foundation Trust

Chief Finance Officer	• Director of the Shepton Mallet Health Partnership • Director of YEP Project Co Limited • Member of the Southwest Pathology Services (SPS) Board • Chief Finance Officer, Yeovil District Hospital NHS Foundation Trust • Non-Executive Director for SSL
Hayley Peters Chief Nurse	• Chief Nurse, Yeovil District Hospital NHS Foundation Trust
David Shannon Director of Strategy and Digital Development	• Member of the Southwest Pathology Services (SPS) Board • Daughter is employed as a healthcare assistant at Musgrove Park Hospital • Member of the Symphony Health Care Services (SHS) Board • Director of Symphony Health Services (SHS) • Wife works on a temporary contract within the recruitment department. • Director of YEP Project Co Limited • Director of Strategy and Digital Development, Yeovil District Hospital NHS Foundation Trust • Director Predictive Health Intelligence Ltd
Daniel Meron Chief Medical Officer	• Chief Medical Officer, Yeovil District Hospital NHS Foundation Trust

Somerset NHS Foundation Trust Non-Executive Directors	
Colin Drummond Chairman	• Honorary Vice President of Calvert Trust Exmoor (outdoor holidays for people with disabilities) – current • President of Wadham College Oxford 1610 Society • Deputy Lieutenant for Somerset • Worshipful Company of Water Conservators – Master
Jan Hull Non-Executive Director (Deputy Chairman)	• Trustee of the Dulverton Abbeyfield Society. • Formerly Managing Director of South, Central and West Commissioning Support Unit • Non-Executive Director Yeovil District Hospital NHS Foundation Trust

Dr Kate Fallon Non-Executive Director (Senior Independent Director)	• Daughter is a Consultant at Somerset NHS Foundation Trust • Symphony Health Services Board member • Daughter has been appointed as the Guardian of Safe Working Hours for Junior Doctors • Non-Executive Director Symphony Health Services
Stephen Harrison Non-Executive Director	• Trustee, YMCA Brunel Group • Trustee, Lawrence Centre, Wells • Governor, Wookey Primary School
Barbara Gregory Non-Executive Director	• RESEC Research into Elderly and Specialist Care Trustee. • Deloitte Associate – with effect from 6 February 2018. • Chair of the CNL (Chairs, Non Executive and Lay members) Faculty of HFMA • Director of AGRF
Alexander Priest Non-Executive Director	• Chief Executive Mind in Somerset • Non-Executive Director Yeovil District Hospital NHS Foundation Trust
Sube Banerjee Non-Executive Director	• Executive Dean, Faculty of Health, University of Plymouth • Hon Consultant in Psychiatry, Plymouth University Hospitals NHS Trust (unremunerated) • Visiting Professor, Brighton and Sussex Medical School (unremunerated) • Trustee and Patron, Alzheimer's Society (unremunerated) • Editor-in-chief, The International Journal of Geriatric Psychiatry • Director Cognitive Agility Ltd (personal consulting to governments and industry) • Association Member BUPA (unremunerated) • Trustee and Executive Board Member Medical Schools Council (unremunerated) • Board member University of Plymouth Enterprise Limited (unremunerated)
Martyn Scrivens Non-Executive Director	• Chairman Yeovil District Hospital NHS Foundation Trust • 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)
Yeovil District Hospital NHS Foundation Trust Non-Executive Directors	
Martyn Scrivens Chairman Non-Executive Director	• Non-Executive Director Somerset NHS Foundation Trust • Non Executive Director and Chair of Audit Committee of Hampshire Trust Bank Limited • Wife works as a Bank Vaccinator for the Trust • Non-Executive Director and Chairman of Wesleyan Bank Limited, a 100% subsidiary of Hampshire Trust Bank Limited" (with effect from 28 February 2022) • Member of the Boards of Directors of the Ardonagh Group – consisting of the following companies: – Ardonagh Holdco Limited (Jersey) – Ardonagh New Midco 1 Limited (Jersey) – Ardonagh Group Holdings Limited (UK) – Ardonagh New Midco 3 Limited (Jersey) – Ardonagh Midco 1 Limited (Jersey) – Ardonagh Midco 2 plc (UK) – Ardonagh Midco 3 plc (UK) – Ardonagh Finco plc (UK) •
Graham Hughes Non-Executive Director	• Chairman of Simply Serve Limited • Volunteer Advisor at Citizens Advice • Parish Councillor of Babcary Parish Council
Paul Mapson Non-Executive Director	• Advisor to Swansea Bay University Health Board • Advisor to NHS Devon Health System
Jan Hull Non-Executive Director	• Trustee of the Dulverton Abbeyfield Society. • Formerly Managing Director of South, Central and West Commissioning Support Unit

	• Non-Executive Director Somerset NHS Foundation Trust
Alexander Priest Non-Executive Director	• Chief Executive Mind in Somerset • Non-Executive Director Somerset NHS Foundation Trust

Somerset NHS Foundation Trust/Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Board Committee Membership
SPONSORING EXEC:	Colin Drummond, Chairman SFT
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Colin Drummond, Chairman SFT
DATE:	7 February 2023

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

Executive Summary and Reason for presentation to Committee/Board	Membership of all Board Committees has been reviewed to take account of the changes to the post merger Board. An overview of Board Committee membership, as well as an overview of the chairs for each of the committees, is included in this report.
Recommendation	The Board is asked to note Board Committee membership with effect from 1 April 2023.

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

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

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

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

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

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

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

BOARD COMMITTEE MEMBERSHIP

FROM 1 APRIL 2023

1. INTRODUCTION

1.1. Membership of all Board Committees has been reviewed to take account of the changes to the post merger Board.

2. BOARD COMMITTEE MEMBERSHIP

2.1. An overview of Board Committee membership with effect from 1 April 2023 is attached as Appendix A.

BOARD COMMITTEE CHAIRS

2.2. The chairs of each of the Committees will be as follows:

• Audit Committee	Barbara Gregory until 30/7/23 Paul Mapson from 1/8/23
• People Committee	Kate Fallon
• Quality and Governance Assurance Committee	Jan Hull
• Finance Committee	Martyn Scrivens
• Mental Health Act Committee	Alexander Priest
• Charitable Funds Committee	Barbara Gregory until 30/9/23 Graham Hughes from 1/10/23
• Nomination and Remuneration Committee	Colin Drummond Kate Fallon

APPENDIX A

Board Committee membership with effect from 1 April 2023

	Jan Hull	**Kate Fallon**	**Barbara Gregory**	**Alexander Priest**	**Sube Banerjee**	**Graham Hughes**	**Paul Mapson**	**Martyn Scrivens**
End date of appointment ([1] or [2] reflects end of 1st or 2nd term of office)	July 2024[2]	May 2024[2]	July 2024[2]	March 2026[2]	June 2024[1]	March 2202[1]	March 2026[1]	March 2024[1]
Audit Committee			√	√			√	√
People Committee	√	√				√		√
Quality and Governance Assurance Committee	√	√				√		√
Finance		√	√	√			√	√
Mental Health Act	√			√	√			
Charitable Funds			√	√	√	√		
Nomination and Remuneration	√	√	√	√	√	√	√	√

NHS Somerset NHS Foundation Trust

NHS Yeovil District Hospital NHS Foundation Trust

Somerset NHS Foundation Trust / Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	The Trust Board
REPORT TITLE:	Chief Executive/Executive Director Report
SPONSORING EXEC:	Chief Executive
REPORT BY:	Executive Directors
PRESENTED BY:	Chief Executive
DATE:	7 February 2023

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

Executive Summary and Reason for presentation to Committee/Board	The purpose of the report is to update the Boards on Chief Executive and Executive Director activities and/or points of note which are not covered in the standing business and performance reports and this update is for information. The report covers the period November, December 2022 and January 2023.
Recommendation	The Boards are asked to note the report.

Links to Board Assurance Framework and Corporate/Directorate Risk Register
(Please select any which are impacted on / relevant to this paper)

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

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

The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics
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☐ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planning to mitigate any identified inequalities

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
The report includes proposals for a public consultation on the future of acute-based stroke services in Somerset together with a number of projects and developments built on patient and carer feedback, including the patient hubs, the Anya maternity app and the personalised care educational programme.

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

CHIEF EXECUTIVE / EXECUTIVE DIRECTOR REPORT

1. PUBLIC CONSULTATION ON THE FUTURE OF ACUTE HOSPITAL-BASED STROKE SERVICES IN SOMERSET TO START ON MONDAY

1.1. At its meeting on 26 January 2023, Somerset's Integrated Care Board agreed to run a public consultation on the future of acute hospital-based stroke services in Somerset. The consultation led by Fit For My Future (FFMF) will begin on Monday 30 January and run for 12 weeks until midnight on Monday 24 April 2023. To find out more about the proposals and how to respond to the consultation, please visit http://www.somersetics.org.uk/stroke.

1.2. Our colleagues in stroke services in both Yeovil Hospital and Musgrove Park Hospital have been involved in the engagement on the future of stroke services in Somerset and sessions will be held with them as part of the consultation.

1.3. Below is background information describing why the consultation is taking place and what it is on. Once the consultation has begun, we will provide links to the FFMF website and notice of consultation events and feedback mechanisms.

What is the consultation on?

1.4. The consultation is on the future configuration of acute hospital-based stroke services, which includes hyper acute stroke and acute stroke services. This is the specialist hospital care people receive in the first few days and weeks after a stroke.

1.5. Acute hospital-based stroke treatment in Somerset currently takes place at:

- Musgrove Park Hospital, Taunton
- Yeovil District Hospital, Yeovil.

1.6. Some people who live in Somerset may receive stroke care at other hospitals in neighbouring counties. Only the two hospitals in Somerset are part of these proposals.

1.7. This consultation does not include the support and rehabilitation that is provided when patients are discharged from hospital following a stroke. Patients would continue to receive community rehabilitation stroke care, provided in the local community as they would do now. No changes are being proposed to the stroke rehabilitation services provided at South Petherton Community Hospital or Williton Community Hospital. The early supportive discharge at home scheme where rehabilitation is provided in your home would continue to be offered.

1.8. An evaluation process by clinicians, staff, people with lived experience and community and voluntary sector organisations, identified that hyper acute stroke services would be better delivered from one hospital site in Somerset, instead of two. They also concluded that if hyper acute services were to be consolidated and in future delivered from a hyper acute stroke unit at only one hospital site in Somerset, Musgrove Park Hospital in Taunton was the only solution that could feasibly deliver a high quality, safe, and clinically sustainable hyper acute service. On this basis, the evaluation identified two potential options for future acute stroke services in Somerset.

1.9. The consultation is therefore asking for views on the following proposals:

- To provide hyper acute stroke services at one hyper acute stroke unit in Somerset and, if that is the right way forward, that the unit be located at Musgrove Park Hospital in Taunton

- To provide acute stroke services at either:

  - Two acute stroke units one at Musgrove Park Hospital, Taunton and one at Yeovil District Hospital; or

  - One acute stroke unit, which would need to be located at the same hospital as the hyper acute stroke unit proposed to be Musgrove Park Hospital, Taunton.

Option A	**Option B**
A single hyper acute stroke unit at Musgrove Park Hospital, Taunton	
An acute stroke unit at **both** Musgrove Park Hospital and Yeovil District Hospital.	A **single** acute stroke unit at Musgrove Park Hospital, Taunton.

Urgent stroke care best practice

1.10. Stroke doctors emphasise that to get the best possible outcomes, patients need to be seen by stroke specialists in a hyper acute stroke unit, even if that means a longer journey to reach the right hospital. These services should be available 24 hours a day, seven days a week.

1.11. National standards and best practice guidance on hyper acute stroke units state they should be:

- Run by a multi-disciplinary team of specialist stroke staff (that is, a team with a mix of professionals such as consultant doctors, radiologists, occupational therapists and physiotherapists, specialist stroke nurses, speech therapists, dietitians and so on).

- Treating at least 500 confirmed stroke patients each year. This is to ensure the staff see enough patients to maintain their competency levels and build their expertise.

- Open 24 hours a day, seven days a week with access at all times to brain scanning equipment and clot-busting drugs (thrombolysis) and the consultant cover to review scans and provide thrombolysis.

- Admitting people quickly onto the unit avoiding waits in A&E.

- Offering patients and carers high quality information and support.

1.12. Neither of our hyper acute stroke units consistently work in this way in Somerset. By reorganising our hyper acute stroke services, we could offer better stroke care for our patients.

1.13. By changing the way stroke services in Somerset are organised we could:

- Make sure that everyone has access to our specialist teams and treatments 24 hours a day, 7 days a week.

- Meet the national standards for stroke care.

- Support staff better, attract and retain the specialist staff needed.

- Make the best use of resources to create a service fit for the future.

- Save more lives and help more people live well after stroke.

1.14. The proposals were reviewed by an independent Clinical Senate, a group of clinicians from outside of the area, who agreed that it would benefit patients and
services.

2. MAJOR INCIDENT ON TUESDAY 17 JANUARY

2.1. Our trusts played a part in a major incident on 17 January 2023 after a bus carrying 70 Hinckley C workers overturned on the A39 Quantock Road in icy weather early in the morning. The major incident rooms at Musgrove Park Hospital and Yeovil Hospital were opened and virtual meetings were held jointly to ensure we were prepared to treat those who needed it and we could offer support across our trusts' services.

2.2. In total 54 patients were triaged at the scene by South Western Ambulance Service and patients were treated at the Minor Injuries Unit in Bridgwater and at the Emergency Department at Musgrove Park Hospital. A small number of patients were taken to Southmead Hospital in Bristol.

2.3. We are conducting a post incident review to ensure that we capture learning and what worked well to feed into the system-wide debrief.

3. DEVELOPMENT OF NEW SERVICES

3.1. At the same time as working through an ongoing period of unprecedented demand for NHS services, we have introduced a number of measures and new services that we believe will help manage demand for NHS services, and support people in Somerset better.

Patient Hub

3.2. We have entered into a partnership with technology company Netcall to develop a Patient Hub, which enables patients to control their appointments digitally instead of contacting our trusts. The first phase of Patient Hub will begin at the end of January 2023 for Somerset FT patients and will be later rolled out to Yeovil Hospital patients too.

3.3. We are using Patient Hub to ask patients whether they would still like to proceed with the appointments they are waiting for. We know that patients' symptoms can sometimes resolve over time, or patients can opt to be treated elsewhere, so that they no longer wish to remain on our waiting lists. This will help us to reduce delays for all our patients, by ensuring we are only offering appointments to patients who need them.

Mental Health Walk In

3.4. A new high street centre recently opened in Bridgwater that promises support for people with mental health challenges.

3.5. Based in the town centre, people can walk into the Fore Street hub to access the mental health support they need. It is part of the innovative Open Mental Health alliance between the NHS in Somerset and a number of voluntary sector organisations – which work together to ensure that people with mental health difficulties get the right support at the right time.

3.6. People can access the hub either via their GP, another healthcare practitioner, or via a self-introduction. Depending on a person's needs, support would then be provided either by the NHS or by one of the wide range of third sector partners, including, for example, Citizen's Advice, Age UK Somerset or Second Step, a community mental health charity.

New health and care hub in Taunton

3.7. In January 2023, we opened a new health and care hub in Taunton for children and young people who need emotional and mental health support. The hub at the Horizon Centre, run in partnership by Somerset FT and Young Somerset, offers a range of healthcare appointments, giving children and young people better access to the care they need, in a more relaxed setting. A multi-disciplinary team of NHS professionals are working at the hub alongside a range of voluntary and third sector organisations involved in the care of children and young people.

4. MERGER UPDATES

Outcome of the quality governance and financial governance reviews of our merger

4.1. NHS England (NHSE) carried out a review of the quality governance and financial arrangements of both trusts as part of their review of the proposed merger.

4.2. The purpose of the quality governance review is to assess the extent to which Boards have the information and skills required to identify and address quality risks and will continue to do so in the enlarged organisation. The purpose of the financial governance review is to assess the extent to which Boards are aware (and would become aware in the future) of any financial issues, will be able to address financial issues when they arise, and will be able to deliver financial improvement following the transaction.

4.3. NHSE conducted its reviews of quality and financial governance against its published domains in NHS England's Assuring and supporting change – Statutory transactions, including mergers and acquisitions. For both reviews, NHSE considered our current processes and proposals for future processes in the merged trust.

4.4. Overall, this review is a very positive assessment for us with some very useful recommendations.

Patient benefits case published on our websites

4.5. The patient benefits case that sets out the expected benefits for patients, their families and carers of our planned merger between Somerset FT and YDH is published on both trusts' websites and intranets alongside the full business case.

4.6. The patient benefits case was one of a suite of documents that was signed off by both Trust Boards and shared with our regulator NHS England for review. It includes out our vision for Somerset, model of care, the aims of our clinical strategy and case studies of services which are priority areas for change, either because of pressing staffing challenges, or because by coming together we can better serve an underserved cohort of patients.

Update on operating model for our merged trust

4.7. Over the last few months, we have carried out work to agree the operating model for our merged trust.

4.8. After considering the current models in place in both our trusts, looking at models elsewhere, and engaging with colleagues and teams, we agreed that we would have six service groups (our new name for directorates or divisions). These will be:

- Children, Young People and Families Service Group
- Clinical Support and Cancer Service Group
- Medical Service Group
- Mental Health and Learning Disabilities Service Group

- Neighbourhoods and Community Service Group
- Surgical Service Group.

4.9. In addition, there will be a hospital site director at both Yeovil District Hospital and Musgrove Park Hospital, who will work alongside a site-based medical director and site nursing director to ensure the safety and day-to-day operational leadership of each acute site. There will also be a system lead for elective care as we have now.

4.10. Each service group will be led by a service group director, associate medical director and an associate director of patient care. The service group directors for each service group are in their designate roles to prepare for our new working arrangements from 1 April 2023, when we are planning to merge our trusts.

5. YDH AND SFT 2030 PROGRAMMES

5.1. A lot of work is continuing to ensure that the buildings from which we provide care are fit for purpose and support us to provide the best possible care. This work is contained in our YDH 2030 and Musgrove 2030 programmes.

5.2. At its meeting on 20 January 2023, the Trust Board approved the construction of the ambulatory breast care unit at YDH and entering into a contract with the contractor pending final approval by the local authority. The dedicated breast cancer unit will bring breast care services, which are currently spread around the hospital, into one place.

5.3. At the same time, our Musgrove 2030 programme is making good progress. If you have visited the Musgrove site recently you will see that parts of the Old Building have been demolished to make way for the new surgical centre. Over recent years we have seen the development of a new surgical decisions unit, therapies centre, expanded critical care unit, refurbished birthing centre, and hospital kitchen among others.

6. MATTHEW BRYANT

6.1. As you may know, Matthew Bryant has been appointed as the Chief Executive Officer of Dorset County Hospital NHS Foundation Trust and Dorset Healthcare University NHS Foundation Trust. Many congratulations to Matthew on his appointment and we are wishing him all the best in his new role.

6.2. Matthew has made a huge contribution to both our trusts in his role as Chief Operating Officer for Hospital Service. This includes his work, with colleagues, to integrate acute, community and mental health services; his leadership in bringing Somerset FT and YDH together; and his focus on supporting acute services through the pandemic, recovering services and reducing waiting times for our patients.

6.3. Matthew's final day with us will be 24 February 2023.

7. DISCHARGE SUPPORT BY SOCIAL CARE COLLEAGUES

7.1. During January 2023, we welcomed social work colleagues who support the discharge of patients from beds within our services to Yeovil District Hospital (YDH) and the team will be visiting Musgrove Park Hospital next week. Over the three days that they were in YDH, the experienced social work team shared their knowledge with clinical colleagues and reviewed patients who were medically fit to leave hospital. There were a number of areas of learning that will help us to discharge patients from hospital services in Somerset and support them in the community.

8. MATERNITY SERVICES

App trial helps to support new parents in Somerset

8.1. Parents of new babies in Somerset are now benefiting from an app which supports with feeding and parenting in the first 1001 days after birth. The Anya app, from LatchAid Ltd, is being offered at a premium level until 30 April 2023 to support with pregnancy, parenting, and infant feeding, in partnership with both of our trusts.

8.2. The new app contains the interactive 3D 'LatchAid' animation tool, which coaches mums on how to position and attach their baby for breastfeeding. It was made by Dr. Chen Mao Davies, founder and CEO of LatchAid, after her own experiences breastfeeding her baby. The tool helps show mothers how to latch their newborn in a visual way and has previously shown to double exclusive breastfeeding rates at six eight weeks in an NHS pilot with 12 NHS trusts in areas where it was rolled out.

8.3. The premium access differs from the free version in that it will allow parents to submit as many questions as they like to the 'Anya AI virtual supporter', and allows them to attend drop-in webinars with specialists. The Anya chat function, created with trusted information from specialists, can answer questions, direct to tailored articles, videos and webinars, and signpost to healthcare help when needed. Premium users can also access more breastfeeding positions in the LatchAid 3D tool, with new animations showing how to hold the baby, the baby's hunger cues, and how the baby's tongue moves during feeding.

8.4. The premium access comes as part of a SBRI Healthcare Health Inequalities in Maternity Care funding competition to develop additional features and content in the app, to tackle healthcare inequalities in maternity care.

8.5. By June, the project will aim to have a clear understanding of how the Anya app can best reach and support underserved communities to address inequalities, while improving wider breastfeeding rates and other health outcomes.

8.6. After a three month trial of the premium access, users will then move to the free version, which will still provide access to resources and the basic LatchAid tool, but will limit users to five questions per day to the Anya AI virtual supporter.

8.7. It comes after the success of a recent project to improve the way we deliver parental education in Musgrove's Somerset Neonatal Intensive Care Unit (SNICU), which looks after babies born from 28 weeks who need further care, and has featured in the prestigious Infant Journal, the leading UK publication for the multidisciplinary team that cares for vulnerable sick or premature babies in their first year of life.

8.8. Parents can download the Anya app on IOS or Android via their app store, or the SNICU directory of resources at https://linktr.ee/snicu. Please do encourage any patients with new babies to download the app and make use of the premium features available.

South West Neonatal Network launch virtual tours of units

8.9. We understand that it is a difficult time for new parents when their newborn needs specialist medical care as well as nerve-wracking when they do not know what to expect. One of the main anxieties for families who have babies in neonatal units or families whose babies will be moved to one of these units, is that they do not know what the units look like on the inside or how to find their way through it.

8.10. As we wanted to support our patients further, with the hard work of many hospitals in the South West and neonatal teams, South West Neonatal Network has now released virtual tours of the neonatal units.

8.11. You can watch the short virtual tours about the different units, find out where everything is along with other information whether it is a question about the parking, the local public transport to it, or simply where you can find the nearest cup of tea.

8.12. Yeovil Hospital and Somerset FT are included in these tours so if you would like more information, the links are as follows: Musgrove Park Hospital, Yeovil District Hospital.

9. SOMERSET RECEIVES LEVELLING UP FUNDING TO ESTABLISH TRAINING ACADEMY FOR HEALTH AND SOCIAL CARE

9.1. Somerset has received nearly £20 million of Levelling Up funding to establish the Somerset Training Academy for Health and Social Care by regenerating an at-risk, Grade II listed historic former community hospital in the centre of Bridgwater and re-purposing a vacant public building in Minehead.

10. CHIEF NURSE RESEARCH FELLOWS ANNOUNCED

10.1. The Chief Nurse Fellowship programme was launched by Hayley Peters, Chief Nurse, alongside our clinical research teams at both trusts, allowing successful colleagues to be released from their roles for one day a fortnight to complete their own service-based research projects over the course of a year, supported by mentoring from the Somerset Clinical School.

10.2. A huge well done to the following colleagues across both Somerset FT and Yeovil Hospital for being accepted into the Chief Nurse Fellowship programme for this year:

- Charlotte Fellows – immunisation nurse, Somerset FT
- Ian Angell – immunisation team lead, SAINT, Somerset FT
- Eleanora Forbes – neonatal nurse, SCBU, Yeovil Hospital
- Reshma Thomas – deputy sister, Dunkery Stroke Unit, Somerset FT
- Katie Ross – community nurse, Creech Medical Centre, Somerset FT
- Siobhan Warne – clinical supervision project lead/lead PNA, Somerset FT
- Cecilia Cole – staff nurse, ITU, Yeovil Hospital
- Beth Hawken – neonatal nurse, SCBU, Yeovil Hospital
- Alice Bevan – sonographer team lead, Somerset FT
- Rebecca Kendall – nurse, Fielding ward, Somerset FT
- Philippa Quinn – birth centre and community midwife team leader, Somerset FT
- Tessa Dean – research midwife, Somerset FT
- Makhosi Ndebele – practice development lead, Somerset FT
- Martin Chapman – clinical service manager, psychiatric intensive care, Wellsprings Hospital site, Somerset FT
- Oluwafemi Alo – registration nurse, stroke rehab unit, Williton Community Hospital, Somerset FT

11. MEDIA COVERAGE

Work with The Times

11.1. The NHS and social care in Somerset worked with a reporter from The Times to outline the pressures that our services are under and some of the innovative solutions that we have put in place to manage those pressures. The reporter spent two days in Somerset and either visited or spoke to colleagues in a range of services including a GP surgery in Taunton, home care, the Taunton Diagnostic Centre, Hospital@Home, the ready to go ward at Musgrove Park, the surgical decisions unit, and Emergency Department at Musgrove Park.

Focus on health and social care in Somerset on the BBC

11.2. On Thursday 8 December 2022 there was a focus on the Today programme on how the NHS and social care in Somerset are working within a very challenging environment but are at the same time developing innovative approaches and ways of working.

11.3. The Today programme visited a range of services within Somerset and spoke to a range of colleagues and services providing care in different settings in our county. The programme included:

- An interview with chief executive of NHS Somerset, Jonathan Higman (33 minutes into the recording).

- An interview with colleagues from the Somerset ambulance doctor scheme, which provides GP services as part of the ambulance service and helps keep 85% of the patients they treat at home.

- A look at how the colleagues and services within the Somerset NHS Foundation Trust are managing patient flow through Musgrove Park Hospital including developing services such as the "ready to go units" and Somerset's Hospital@Home service. This section (beginning at 2 hours 10 minutes into the programme) includes interviews with Dr James Gagg, associate medical director for the medicine service group; Clare Boobyer-Jones, director of allied health and psychology professions; and Dr Charlie Davis, clinical lead for the Hospital@Home service and the associate medical director for our neighbourhoods and community services group.

- A visit to the reablement unit at Gotton Manor care home in Taunton. This section (beginning at 2 hours 45 minutes into the programme) includes interviews with Mel Lock, director of adult services for Somerset County Council, and colleagues from Harbour Healthcare which runs the care home.

11.4. At the same time as hosting Radio 4, we have also worked with BBC Points West to provide our local BBC with the same access to information about how our colleagues and services in Somerset are working. As part of this and article was published online and coverage appeared in the television news bulletins.

11.5. This media work is part of our approach to supporting colleagues and our services by describing the challenges they face and showcasing their innovative approaches and professionalism through our communications. At the same time it enables our patients and the people of Somerset more generally to understand the pressures we face and the actions we are taking, so that they can be our partners in working through this difficult situation.

BBC Countryfile to feature Somerset FT and YDH midwives

11.6. On 15 January 2023 both our trusts were on prime-time national television as the weekly Countryfile series on BBC One focuses on the amazing work done by midwives across Somerset.

11.7. Over a couple of weeks back in the autumn, the Countryfile team followed a handful of our midwives and families, who gave an honest reflection on the very real challenges that teams face working in a rural county like Somerset, and the current pressures within the NHS.

11.8. The programme showcased our midwives and described the importance of standalone midwife-led birthing centres, with footage of our midwives at Bracken Birthing Centre and Mary Stanley Birthing Unit, as well as the Yeovil home birth service, and why it is important that we offer choice for women and their families. The programme further set out the current staffing challenges across midwifery in the UK and the pressures faced by midwives whilst still providing excellent care.

12. AWARDS

Recognition in the HSJ Partnership Awards 2023

12.1. A project that aimed to end non-urgent bleep use - and has saved our postgraduate doctors in training over 90 minutes a shift - has been recognised in national awards for the second time.

12.2. This work by Infinity Health and Somerset FT, "banishing the bleep out of hours – saving 91 minutes of clinical time per person per shift" is a finalist in the "best acute sector partnership with the NHS in the HSJ Partnership Awards 2023. It was previously shortlisted for this year's HSJ Awards.

12.3. More information about this project and what it achieved is here.

Personalised care educational programme in national award shortlist

12.4. A pioneering educational programme led by the NHS in Somerset has been shortlisted for a prestigious Health Service Journal Partnership award.

12.5. It follows a range of feedback from patients and colleagues alike that show how personalised conversations and health coaching skills are giving people a voice when it comes to the health and social care services they need to help keep themselves well.

12.6. The programme has been extended across Somerset into every 'neighbourhood' – single points of access for health and social care professionals in every local community that assess patients on the support they may need to help keep them safe, well and happy in their own homes.

12.7. The programme aims to meet objectives of the NHS Long Term Plan, which were developed between colleagues working in health and care, alongside people with lived experience. This includes personalised care becoming part of the way services work, giving people choice and control over their health and care, based on what matters to people and their individual strengths and needs, starting with a 'what matters to you' conversations.

12.8. The programme was created in collaboration by health and social care professionals in the south west, and crucially, people with lived experience.

12.9. So far 130 people have been trained, which includes 20 trainers or facilitators. In a survey of participants, 97% of people told us that their experience of the learning programme was 'Excellent' (81%) or 'Good' (16%).

13. USE OF THE CORPORATE SEAL

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

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

NATIONAL DEVELOPMENTS

14. PUBLICATION OF THE TERMS OF REFERENCE FOR PATRICIA HEWITT'S REVIEW OF INDEPENDENT REVIEW OF INTEGRATED CARE SYSTEMS

14.1. The Department of Health and Social Care has published the terms of reference of the independent review by Patricia Hewitt, former Secretary of State for Health, that will consider how the oversight and governance of integrated care systems (ICSs) can best enable them to succeed, balancing greater autonomy and robust accountability with a particular focus on real time data shared digitally with the Department of Health and Social Care, and on the availability and use of data across the health and care system for transparency and improvement. NHS Providers has published a media statement in response.

15. NHS PROVIDERS BRIEFING ON SPECIALISE SERVICES AND SYSTEM WORKING

15.1. NHS Providers has published a briefing *Specialised services and system working: Risks and opportunities.*

15.2. NHS England (NHSE) is progressing plans to change how specialised services – a portfolio of around 150 services accessed by people often with rare or complex health needs – are commissioned. From April 2023, NHSE plans to give local systems a bigger role in planning and shaping many specialised services. This will be enabled through two routes – either by NHSE working with ICBs to jointly commission services or by NHSE delegating responsibility and budgets to ICBs for those services.

15.3. The NHS Providers briefing aims to outline the changes NHSE plans to implement from April 2023; and provide some preliminary analysis of the benefits and risks inherent in greater system leadership of specialised services. It is informed by extensive engagement with both trusts and NHSE.

16. NHS ENGLAND PUBLISHES DETAILS OF THE NHS OPERATIONAL PLANNING GUIDANCE FOR 2023/4

16.1. NHS England has published details of the NHS Operational Planning Guidance for 2023/4 which sets out priorities for the next financial year,

including recovering core services, improving productivity and renewing focus on delivering the long term plan.

16.2. Alongside the operational planning guidance, NHS England also published:

- 2023/25 NHS Payment Scheme consultation documents
- NHS standard contract consultation
- 2023/24 CQUIN.

17. GUIDANCE ON THE DEVELOPMENT OF FIVE-YEAR JOINT FORWARD PLANS FOR ICBS AND THEIR PARTNER TRUSTS

17.1. NHS England has also published guidance for integrated care boards (ICBs) and their partner trusts and foundation trusts on the development of five-year joint forward plans (JFPs).

17.2. The guidance covers specific statutory requirements that the plans must meet, such as setting out how an ICB and its partner trusts will meet the health needs of its population. The guidance also sets out how JFPs should be produced, including conducting consultations, involving health and wellbeing boards, and the role of NHSE.

17.3. ICBs and their partner trusts have a duty to prepare a first JFP before the beginning of 2023/24. However, for this first year of the process, NHSE has said it expects systems to produce a version by 31 March, but consultation on further versions can continue beyond that date, in time for a final plan by 30 June.

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

SEAL REGISTER
FINANCIAL YEAR 2022/23

Date of Sealing	No. of Seal	Nature of Document	First Signatory	Second Signatory
27/05/2022	517	MSCP – Deed of Rectification – Resigning of 2018 docs	Peter Lewis Chief Executive Officer	Pippa Moger Chief Finance Officer
27/05/2022	518	MSCP – Deed of Rectification – RPI Clause	Peter Lewis Chief Executive Officer	Pippa Moger Chief Finance Officer
16/06/2022	519	Deed of Guarantee + Indemnity – Buttercross Health Centre - SHS	Peter Lewis Chief Executive Officer	Pippa Moger Chief Finance Officer
16/06/2022	520	Deed of Covenant – Buttercross Health Centre - SHS	Peter Lewis Chief Executive Officer	Pippa Moger Chief Finance Officer
16/06/2022	521	Deed of Termination + Guarantee + Indemnity – SHS Ilchester Surgery	Peter Lewis Chief Executive Officer	n/a
16/06/2022	522	Deed of Termination of Deed of Covenant - Buttercross Health Centre	Peter Lewis Chief Executive Officer	n/a
16/06/2022	523	Deed of Termination of Guarantee + Indemnity – Buttercross Health Centre	Peter Lewis Chief Executive Officer	n/a
23/12/2022	524	Section 278 Agreement re. Red Lion Lane Closure	Pippa Moger Chief Finance Officer	Hayley Peters Chief Nurse
23/12/2022	525	Section 278 Agreement re. Red Lion Lane Closure	Pippa Moger Chief Finance Officer	Hayley Peters Chief Nurse
23/12/2022	526	Section 278 Agreement re. Red Lion Lane Closure	Pippa Moger Chief Finance Officer	Hayley Peters Chief Nurse

SOMERSET NHS FOUNDATION TRUST

SEAL REGISTER

1 MARCH 2022 to 31 OCTOBER 2022

Date of Sealing	No. of Seal	Nature of Document	First Signatory	Second Signatory
10 March 2022	27	Lease and Licence Unit 1, Watermargyue, Lufton Way, Yeovil	Daniel Meron	David Shannon
16 March 2022	28	Glanville house, Bridgwater	Peter Lewis	David Shannon
16 March 2022	29	Reversion Lease of Frome Enterprise Resource Centre	David Shannon	Peter Lewis
21 March 2022	30	Reversion Lease of Millstream House, Taunton	Peter Lewis	Phil Brice
21 March 2022	31	Renewal Lease of Canford Health with Dorset Dental	Phil Brice	Peter Lewis
21 March 2022	32	Renewal Lease of the Browning Centre with Dorset Dental	Phil Brice	Peter Lewis
31 March 2022	33	Agreement for Lease First Floor Diagnostic Centre, Blackbrook Park	David Shannon	Daniel Meron

10 June 2022	34	Lease of the medical centre at the Springboard Centre, Victoria Park, Bridgwater	Hayley Peters	Matthew Bryant
4 August 2022	35	Lease of Quantock View Dental Centre	Pippa Moger	Isobel Clements
10 August 2022	36	Pre Construction Services Agreement – Dorset Dental	Peter Lewis	Phil Brice
10 August 2022	37	Planning and Highways Agreement Dancing Lane, Wincanton	Peter Lewis	Phil Brice
26 August 2022	38	Agreed lease for Room 2, Ground floor, and Room 17, second floor at The Exchange, Express Park, Bridgwater.	David Shannon	Phil Brice
6 October 2022	39	Supplemental Lease of part of Canford Health, Health Clinic, Cullifiord Crescent	Hayley Peters	Isobel Clements
6 October 2022	40	Supplemental Lease of part of the Browning Centre, 7 Shelley road, Boscombe	Hayley Peters	Isobel Clements
14 October 202	41	24 Hoveland Lane, Taunton, TA1 5DE	Hayley Peters	David Shannon
14 October 2022	42	Letter of Indemnity from the Trust re first floor EWA (CMS draft 13/10/22)	David Shannon	Hayley Peters
20 October 2022	43	Letter of Indemnity from the Trust re first floor of Diagnostic Centre - revised	David Shannon	Isobel Clements

27 October 2022	44	Taunton Diagnostic Centre Alliance Medical Group parent company guarantee and Direct Agreement Deed of Variation	Peter Lewis	Pippa Moger
16 November 2022	45	Poole Dentistry contract documents	David Shannon	Phil Brice
28 November 2022	46	Deed of Variation to the Letter of Indemnity – Diagnostic Centre	David Shannon	Isobel Clements
13 December 2022	47	Deed of Variation – First Floor TDC	David Shannon	Peter Lewis
20 December 2022	48	Lease Tower Street, Taunton	David Shannon	Andy Heron
23 January 2023	49	Creech Medical Centre Land Registry	David Shannon	Isobel Clements
27 January 2022	50	Swingbridge House, Taunton	David Shannon	Phil Brice
30 January 2023	51	Section 106 – Dancing Lane, Wincanton	David Shannon	Phil Brice

Somerset NHS Foundation Trust/Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Board of Directors in common
REPORT TITLE:	Q3 2022/23 Board Assurance Framework
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Director of Corporate Services Associate Director of Integrated Governance
PRESENTED BY:	Director of Corporate Services
DATE:	7 February 2023

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

Executive Summary and Reason for presentation to Committee/Board	The Board Assurance Framework has been developed to consider the highest risks to the Trust in achieving its eight strategic objectives; the plans in place to manage and mitigate these and to provide the Board with a summary of key plans and strategies supporting their delivery. Common areas of risk identified across objectives remain: • pressures in social care and intermediate care • insufficient capacity to meet demand • infrastructure investment and ageing estate • pressures in primary care • workforce recruitment and retention • the impact of the pandemic • delivery of financial plans
Recommendation	The Board is asked to: • review the Board Assurance Framework and note the actions being taken to address the risks identified; • and consider the objectives and risks reserved to the Board.

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

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

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

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

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

2022/23 Q3 BOARD ASSURANCE FRAMEWORK

1. PURPOSE OF THE REPORT

1.1 To present the current Board Assurance Framework for 2022/23 to the Board.

2. BOARD ASSURANCE FRAMEWORK

2.1 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.

2.2 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.

2.3 A review of the Trust's strategic objectives was undertaken at the April 2022 Board Development Day. The eight strategic objectives have been agreed in common across the two trusts as the long term aims for our merger and integration. The five clinical objectives are aligned with the system clinical aims which form the basis for the clinical model, and which are set out in the Strategic Outline Case for our merger.

2.4 These objectives sit alongside our financial and people objectives as the core strategies for the merging organisations. They are supported by a range of supporting strategies and transformation plans that are also identified in the sections of the Assurance Framework.

3. ASSURANCE FRAMEWORK GOVERNANCE ARRANGEMENTS

3.1 The Audit Committees are 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.

3.2 The Audit Committees oversee the effectiveness of the above processes at each of its meetings. The Audit Committees reviewed the Assurance Frameworks at their meeting on 17 January 2023.

3.3 The joint Quality and Governance Assurance Committee has responsibility for oversight of the clinical strategy objectives (2, 3, 4 and 5). The People (SFT) and Workforce (YDH) Committees have responsibility for oversight of people objective (6) and the Finance (SFT) and the Financial Resilience and Commercial (YDH) Committees have responsibility for oversight of the finance objective (7). Objectives 1 and 8 are reserved to the Boards.

3.4 The Assurance Framework is also reviewed at the Executive Team meeting on a regular basis.

4. GAPS IN CONTROL AND ASSURANCE

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

- the impact of pressures and capacity shortfalls in social care and intermediate care (objectives 2, 3 and 8)
- insufficient capacity to meet demand (objectives 7 and 8)
- infrastructure investment and ageing estate (objectives 2 and 8)
- the impact of pressures in primary care (objectives 2, 3 and 5)
- workforce recruitment and retention (objectives 3 and 6)
- the impact of the pandemic (objective 5)
- delivery of financial plans (objectives 7 and 8)

4.2 The current level of activity being faced by the Trusts across all of their services continues to impact significantly the steps to deliver all objectives and mitigate the risks. Recent Board and system-level discussions on the pressures in primary care, social care and other providers and their impact on the Trusts' achievements of our clinical and corporate objectives will continue to be reviewed.

4.3 Gaps in controls and assurance are identified in a number of objectives and actions to address these are identified in some and in development for others. The Boards and their sub-committees should consider if there are any further assurances that may be required in respect of any individual areas of risk.

4.4 Within the summary of each objective there is reference to key supporting strategies and transformation plans that are essential to the achievement of the objective. The Boards and their sub-committees should consider the progress against these strategies and plans as part of their assurance review of the objectives.

4.5 A summary of actions to address the key risks is set out in the Assurance Framework but each is supported by an action plan to address the issues raised and the response is co-ordinated by the nominated lead executive director.

4.6 During the report period, executive leads have reviewed all strategic risks with the Head of Risk, Health and Safety to ensure that all risks are mapped to the risks on the Corporate Risk Register, in line with the findings from the CQC well led report.

5. CONCLUSION

5.1 Progress is being made identifying actions to address any gaps in controls and assurances but the position around delivery of the core strategic objectives remains extremely challenging in the context of operational pressures within the trust and in social care and primary care across the county; and increasingly, workforce issues in a number of core services.

6. RECOMMENDATION

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

DIRECTOR OF CORPORATE SERVICES

BOARD ASSURANCE FRAMEWORK SUMMARY

SOMERSET NHS FOUNDATION TRUST

Quarter 3 2022/23

Ref	Executive Owner	Corporate Objective	Overseeing Committee	Highest Risk	Change	Strength of Controls	Change	Strength of Assurance	Change	Strategy Progress	Change
1	PL	Improve the health and wellbeing of the population	Board	16	↑	A	→	A	↑	A	→
2	HP	Provide the best care and support to people	GQAC	25	→	A	→	G	→	A	→
3	AH	Strengthen care and support in local communities	GQAC	25	→	A	→	A	→	A	→
4	MB	Reduce inequalities	GQAC	15	↑	A	→	A	→	A	→
5	DM	Respond well to complex needs	GQAC	20	↑	R	↓	R	→	A	→
6	IC	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture	Workforce	20	↑	A	→	A	→	A	→
7	PM	Live within our means and use our resources wisely	FRCC	16	→	A	→	A	→	R	→
8	PL	Develop a high performing organisation delivering the vision of the trust	Board	25	→	A	→	A	→	A	→

Board Assurance Framework 2022-23

SOMERSET NHS FOUNDATION TRUST

Exec owner(s)

David Shannon

Corporate Objective

1. Improve the health and wellbeing of the population

Overseeing Committee

Board(s)

Date of last Committee review

Nov-22

Key Performance Indicators

Diabetes: HbA1C checks	Oct-22	100%		Addiction (Smoking and Alcohol)			Suicide/Self harm Prev: MH staff	Dec-22	211	
28 day cancer faster diagnosis	Nov-22	63.0%		Cultural engagement - tbc			Suicide/Self harm Prev: non-MH	Dec-22	117	

Top 3 risks to achieving this objective	Score (LxC)	Risk Reference
1 Population Health may not get the focus required	1 4 x 3 = 12	1 SFT 1613 / YDH 986
2 Approach to Population Health may be unco-ordinated	2 2 x 4 = 8	2 SFT 1615 / YDH 987
3 Lack of understanding of shared accountability and resourcing	3 4 x 4 = 16	3 SFT 1616 / YDH 988

Associated risks on CRR

SFT - 7, 8, 9, 12, 277, 326, 372, 534, 673, 842, 862, 923, 1004, 1016, 1046, 1310, 1343, 1356, 1513, 1542, 1577

YDH - 49, 83, 100, 372, 652, 687, 864, 874

Key controls currently in place to manage the risk to achieving this objective

Somerset ICS has committed to Population Health Transformation and the Somerset Population Health Transformation Board has been created - and developed the key priorities agreed with system partners (highlighted in KPI)
ICS Action learning Set in place to support PHM development - concluded in September 2022
ICS Data and Analytic learning set in place to support data development - Place PHM programme to be embeded in ICS analytics programme
ICS data development group in place to support the data development - data strategy agreed to support analytics from March 2023
There is a stock-take undertaken of all population health programmes undertaken by the Programme Board
The Trust Board public agendas will feature a section dedicated to population health and reducing health inequalities on a regular baisis.

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)

Progress on key performance indicators set by the Poulation Health Transformation Board and progress in tackling inequality in referrals and the waiting list during 2022/23 presented to the board on a regular basis (+)
Limited Board and committee oversight to date (-)
Population Health Transformation Board established with cross system senior involvement and attendance
Trust population health working group to be established (-)
Oversight of flagship Quality Account priorities and clinical strategy through Quality and Governance Committee (+)

Strength of controls	Significant gaps in current controls	Strength of assurance	Areas where further assurance is required
Amber	Engagement and resourcing plan in development but not confirmed	**Amber**	Detailed implementation plan for priorities Engagement plan for programme Board KPI metrics not yet concluded and basline and improvement

Key transformation plans and strategies to achieve objective

	Strategy	Owner	Assessment of Progress
1	Population Health Transformation priorities: - Tobacco reduction - Suicide prevention - Healthy weight - Positive steps (peri-operative care)	David Shannon/Dan Meron	**Amber**
2	Population Health data and analytics programme	David Shannon	**Amber**
3	Dementia Strategy	Helen McEvansonya	**Green**

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress
A	Development of year one actions	DS / DM	Nov-22	System agreed priorities for year 1 and 2 linked to inequatlities programme. WS Leads appointed Y1 objectives and milestones in development
B	Development of communication and engagement plan	DS / DM	Nov-22	Comm's and Engagement Lead appointed, Y1 plan in development
C	Resource and implementaion plan developed and agreed	DS	Nov-22	Initial resource plans to be submitted to Nov PHM board

4				D	Set and Monitor Short and Long Term KPI Measures	DS/DM	Jan-23	KPI Agreed baseline and improvement measures
5				E				

Board Assurance Framework 2022-23

SOMERSET NHS FOUNDATION TRUST

Exec owner(s)

Hayley Peters

Corporate Objective

2. Provide the best care and support to people

Overseeing Committee

GQAC / Q&G

Date of last Committee review

Dec-22

Key Performance Indicators

Ambulance handover hours lost>15m	Dec-22	1672	↓	Cancelled operations	Dec-22	2.3%	↑	
Patient initiated follow up (PIFU)	Dec-22	3.9%	↓	Falls resulting in harm per 1000 days	Dec-22	2.32	↓	
C Diff monthly cases	Dec-22	2	=					
Pressure Ulcers per 1000 bed days	Nov-22	0.27	↑					

Top 3 risks to achieving this objective	Score (LxC)	Risk Reference
1 Access to primary care / increasing ED demand	1 4 x 4 = 16	1 SFT 372 & 673 & 923 / YDH 236 & 21
2 Social care capacity shortfalls	2 5 x 5 = 25	2 SFT 831 & 842 & 1513 / YDH 331
3 Age of acute and community estates	3 5 x 4 = 20	3 SFT 3 & 534

Associated risks on CRR

SFT - 2, 3, 4, 7, 8, 9, 12, 82, 277, 326, 343, 366, 372, 399, 534, 588, 673, 690, 831, 842, 862, 923, 1004, 1016, 1046, 1150, 1214, 1310, 1329, 1343, 1356, 1400, 1408, 1470, 1482, 1491, 1505, 1510, 1512, 1513, 1519, 1542, 1577

YDH - 21, 45, 49, 83, 100, 236, 331, 372, 515, 652, 687, 728, 729, 772, 864, 868, 874, 925, 947, 961

Key controls currently in place to manage the risk to achieving this objective

A range of schemes with partners to address demand issues.
Hospital @ Home programme of work.
Continued development and implementation of the clinical strategy.
A range of recruitment and retention plans as part of the People Strategy.
Risk assessed capital and backlog maintenance programmes, focussing on high priority areas. Additional national funding utilised in 2020/21 to support high risk areas.
Integrated performance reporting.
Estates programme of work across Community, Mental Health and Acute Estate overseen by Strategic Estates Group
Approval of Digital and Estates Strategies

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)

CQC Inspection reports (+/-). CQC Insight reports (includes SHMI) (+)
GST assurance processes (IQAB, Care Essentials, etc.), reported via Quality and Governance Committee (+/-).
National Patient Surveys (+). MPH 6 Facet condition survey (-).
Benchmarking Model Hospital and MH national benchmarking data. GIRFT reports and intelligence
Oversight of flagship Quality Account priorities and clinical strategy through Quality and Governance Committee (+)
National Staff Survey (+)
SOC due diligence reports (+)
Internal audit programme (+/-)

Strength of controls

Amber

Significant gaps in current controls

Poor availability of primary care data & business intelligence.
Poor availability of social care demand/capacity information to forecast with confidence

Strength of assurance

Green

Areas where further assurance is required

Key transformation plans and strategies to achieve objective

	Strategy	Owner	Assessment of Progress
1	Estate Strategy - Musgrove 2030/YDH 2030	David Shannon	Green
2	Digital Strategy	David Shannon	Green

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress
A	Continue to strengthen strategic, professional, tactical & operational workforce plans, both Somerset system focus and Trust specific.	IC	Mar-23	Workforce planning priorities being progressed and monitored through the People Board; detailed SBAR available
B	Develop data and BI capacity and delivery for primary care	DS	Mar-23	ICS data development programme in place (inform programme) Data platform to be in place by March 2023. Creation of data science team to support evaluation.

3	Hospital @ Home Progamme Board and associated sub-groups, with strong operational & clinical engagement internally and externally	Andy Heron	Red
4	Quality and Patient Safety Strategy	Hayley Peters/Phil Brice	Amber
5	ICB / system winter summit held August 2022, five key actions in addition to Intermediate Care programme of work. 1. care home inreach support at scale 2. POC reduction and inc. bedded care capacity 3. inc OPMH capacity 4. Increase PC urgent capacity by decreasing LTC routine reviews 5. Hospital @ Home	Hayley Peters/Dan Meron/Andy Heron/Matthew Bryant	Amber
6	End of Life Care (Last 1,000 days)	Charlie Davis	Amber

C	H@H Programme Board adheres to formal programme management methodology including the maintainance of a comprehensive programme risk register with mitigations	AH	Reviewed every two weeks by the Programme Board	Complete and ongoing
D	Ward accrediation pilot	HP	Mar-23	Two wards at panel in August, stocktake of metrics required before next panel. 9/1/23 Stocktake delayed due to CNO team restructure and organisational pressures, planned before end January.
E	Leadership quality walkarounds	PB/HP	Sep-22	Schedule of visits across all sites to be published in September commencing from 12/09/2022; 9/1/23 - programme underway and full programme in place for 2023
F	Launch programme to EPJP and prevent deconditioning across SFT & YDH	HP	Mar-23	Programme leads identfied, supportfrom improvement team, first meeting. 9/1/23 Readyto Go Wards x 2 @MPH & YDH, challenging model with pressures, improvement support in place
G	Development of the Chief Nurse Core Standards	HP	Mar-23	Resource identified, weekly huddle set up, core standards being agreed
H	CPD investment to address care priorities	HP	Mar-23	Scoping exercisecompleted, areas identified. 9/1/23 - review of priorities planned for end Jan 2023
I	Quality and Patient Safety Strategy	HP	Jan-23	Delayed due to CNO restructure and organisational pressures; draft outline to be delivered by end Jan 23

Board Assurance Framework 2022-23

SOMERSET NHS FOUNDATION TRUST

Exec owner(s)

Andy Heron

Corporate Objective

3. Strengthen care and support in local communities

Overseeing Committee

GQAC / Q&G

Date of last Committee review

Dec-22

Key Performance Indicators

Patients referred to NHS@Home	Dec-22	50	↑	Adm. prev by Rapid Resp/NHS@Home	Dec-22	307	↑	Urgent community response <2hr	Dec-22	83.4%	↑
PCNs with integrated models	Dec-22	2	=	Psychiatric readmission rate	Dec-22	5.5%	↓	Integrated family hub launch	Dec-22	0	=

Top 3 risks to achieving this objective	Score (LxC)	Risk Reference
1 Workforce shortages	1 4 x 4 = 16	1 SFT 366 & 1329 & 1408 / YDH 236
2 Primary care fragility	2 4 x 4 = 16	2 SFT 673 / YDH 236
3 Social care capacity shortfalls	3 5 x 5 = 25	3 SFT 831 & 842 & 1513 / YDH 331

Associated risks on CRR

SFT - 2, 3, 4, 7, 8, 9, 12, 277, 326, 366, 534, 588, 673, 690, 831, 842, 923, 1016, 1046, 1310, 1343, 1408, 1470, 1505, 1510, 1513, 1519, 1542, 1577

YDH - 236, 331, 652, 728, 729, 864, 874, 947

Key controls currently in place to manage the risk to achieving this objective

Trust/ICS workforce strategy and integration.
System Neighbourhood Board co-chaired by COO.
Intermediate Care Board with associated KPI monitoring.
Joint Head of Intermediate Care appointment made with SCC.
Integration pilot underway in the North Sedgemoor area with plans for two more integration projects in the South Somerset and Bridgwater areas.
New Hospital@Home services under development for respiratory and frailty for implementation during 2022/23 with remedial diagnostic and action plan in development to address current low level of referrals
Regular directorate focussed Finance and Performance & QOFP meetings in place to review performance and delivery of Trust strategy in local communities.
Significant additional investment in domicilliary care capacity and intermediate care beds now agreed and being implemented in accordance with winter resilience planning.

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)

Trust Board Quadrant report (+/-)
Weekly intermediate care performance report circulated to Exec Team with daily capacity/demand information underpinning this and circulated (+/-)
The mental health benchmarking club (+/-)
SEND Improvement Board oversight of neuro-developmental disorder assessment service implementation (+/-)
Regional oversight of Hospital@Home implementation and performance against trajectories (+/-)
ICS System Assurance Forum

Strength of controls

Amber

Significant gaps in current controls

Poor availability of primary care data & business intelligence
Poor availability of social care demand/capacity information to forecast with confidence

Strength of assurance

Amber

Areas where further assurance is required

Oversight of delivery of intermediate care strategy
Development and delivery of primary care strategy

Key transformation plans and strategies to achieve objective

	Strategy	Owner	Assessment of Progress
1	Hospital @ Home	Andy Heron	**Red**
2	Pilot integration project for North Sedgemoor with further integration projects underway for Somerset West and Bridgwater PCN areas	Kerry White Andy Heron	**Green**

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress
A	i) H@H Programme Board adheres to formal programme management methodology including the maintainance of a comprehensive programme risk register with mitigations ii) Action plan being developed to address the currently low levels of referral activity into H@H in both the frailty and respiratory services	i) AH ii) AH/ TE/CD	i) Reviewed every 2 weeks by the Prog. Board ii) Jan - 23	i) Complete and ongoing ii) Currently under urgent development
B	Further level of risk management now underway via face to face meetings with the PCN in North Sedgemoor chaired by COO/CEO SHS.	AH	Aug-22	In place and under continuing review

3	Intermediate Care strategy and transformation plan	Mel Lock Andy Heron Somerset DoFs	**Amber**	C	Intermediate Care strategy development now reporting to Neighbourhood & Primary Care Programme Board chaired by COO/Director ASC	AH / ML	Apr-22	In place and under continuing review
4	Open Mental Health (including stolen years)	Jane Yeandle Andy Heron	**Green**	D	Key performance/workforce metrics routinely monitored via the QOFP process	PM / AH	Mar-23	In place and under continuing review
5	Strategy developed (under leadership of SEND Improvement Board) for children and young people with neuro developmental disorders.	Alison Ficarotta Andy Heron	**Green**	E				

Board Assurance Framework 2022-23

SOMERSET NHS FOUNDATION TRUST

Exec owner(s)

Matthew Bryant

Corporate Objective

4. Reduce inequalities

Overseeing Committee

GQAC / Q&G

Date of last Committee review

Dec-22

Key Performance Indicators

>65s accessing Open Mental Health	Dec-22	150	↓	Reduce elective waits for ppl with LD	Oct-22	17.5 wks	↑	Continuity of carer: eth.min/depr		
IAPT referrals for long term condition	Dec-22	197	↓	Prot characteristics data completeness	Jul-22	98.8%	↑		Jul-22	

Top 3 risks to achieving this objective

1 System and Trust strategy not fully developed
2 Data quality issues leading to poor information
3 Historical funding/resource gaps including in MH & LD

Score (LxC)

1 3 x 5 = 15
2 2 x 4 = 8
3 4 x 3 = 12

Risk Reference

1 SFT 1620 / YDH 991
2 SFT 1621 / YDH 992
3 SFT 1622 / YDH 993

Associated risks on CRR

SFT - 277, 326, 673, 842, 1016, 1046, 1310, 1343, 1513, 1577

YDH - 45, 874, 961

Key controls currently in place to manage the risk to achieving this objective

Development of a three year trust strategy that is aligned with ICS and sets out the approach to use the principles of our clinical model to actively address healthcare inequalities (by end of quarter 3)
Introduction of inequalities data to trust datasets to identify issues and start to measure impact (to be included in board reports by end of quarter 2)
Commencement/continuation of a range of projects at service level (work already underway)
Monitoring of resource/investment between physical and mental health to support parity of esteem (ongoing)
Approval of digital strategy with focus on digital inequalities as on of the main aims

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)

Regular updates on development of trust strategy (+/-)
Monthly Board updates from PDC (+)
Monthly Quality and Performance reports, including seeing data changes (+)
Progress against clinical model milestones (- / +)
Feedback from Healthwatch / CVAG / PALS / Triangle of Care (+ /-)
CQC Inspection reports (+/-). CQC Insight reports (includes SHMI) (+)
Mental Health Act Committee monitoring and reports (+)
Oversight of flagship Quality Account priorities and clinical strategy through Quality and Governance Committee (+)

Strength of controls

Amber

Significant gaps in current controls

Governance oversight process

Strength of assurance

Amber

Areas where further assurance is required

Development of strategy + preparedness for adoption of deprivation/exclusion markers into trust data

Key transformation plans and strategies to achieve objective

	Strategy	Owner	Assessment of Progress
1	Open Mental Health - with a focus on reaching out to disadvantaged populations	Jane Yeandle	Green
2	Review support arrangements for our LD population accessing physical health services	Andy Heron	Amber

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress
A	Develop focused governance approach for this aspect of organisational strategy	PB	Sep-22	Board sub-committee arrangements defined and approved October 2022 Board. Schedule of board reporting presented to the November board.
B	Ensure development of strategy, in partnership with ICS	DS	Dec-22	Population health steering board being developed with ICB to oversee production of strategy. Focus of work on Core20Plus and reflecting new requirements for Children Core20

3	Maternity strategy - deliver plan to achieve continuity of carer for >35% of pregnant woment from an ethnic minority background/deprived areas	SallyAnn King	**Amber**	C	Development of community and neighbourhood initiatives focussed on inequalties	AH	Dec-22	Core part of Hospital at Home programme (eg focus on protected characteristics) + communities with deprivation. This is ongoing as part of this work.
4	Digital Strategy - alignment	David Shannon	**Green**	D	Develop way of monitoring trust activity underway	DS	Jan-23	Changes made to elective reporting at board (completed). Review of Board reporting to include metrics on a regular (6montly) basis
5	Elective Recovery - reduce inequalties as part of elective recovery plans	Xanthe Whitaker	**Amber**	E	Include as a focus for teams developing delivery plans for implementation of clinical model	MB	Sep-22	This will be built into the process for developing plans at service level via the CIT. Completed.
				F	Inequalities analysis on cancer; introduction of vulnerable patients prioritisation; interventions to address higher DNA rates for patients from more socially deprived areas.	XW	Mar-23	Cancer analysis underway; DNA interventions being piloted; vulnerable patient prioritisation approachnow neing implemented.

Board Assurance Framework 2022-23

SOMERSET NHS FOUNDATION TRUST

Exec owner(s)

Dan Meron

Corporate Objective

5. Respond well to complex needs

Overseeing Committee

GQAC / Q&G

Date of last Committee review

Dec-22

Key Performance Indicators

CYP Eating Disorders - urgent	Dec-22	84.2%	↓	CYP Eating Disorders - routine	Dec-22	91.1%	↓	Reduce time in ED: Hi intensity users	Sep-22	44,487 hrs	↑
Dementia diagnosis rate	Oct-22	53.5%	↑	Persistent physical symptoms progrm	Dec-22			Anticipatory care measure tbd			
Time to diagnosis in SEND tbd	Nov-22	66 weeks	↓								

Top 3 risks to achieving this objective

1 Failure to sufficiently deliver the clinical model
2 Insufficient capacity in primary care
3 Impact of pandemic on our population and services

Score (LxC)

1 3 x 4 = 12
2 4 x 4 = 16
3 4 x 5 = 20

Risk Reference

1 SFT 1617 / YDH 989
2 SFT 673 / YDH 236
3 SFT 2 / YDH 100

Associated risks on CRR

SFT - 2, 4, 7, 8, 9, 12, 326, 372, 673, 831, 842, 862, 923, 1004, 1016, 1046, 1310, 1343, 1356, 1513, 1519, 1542, 1577

YDH - 21, 45, 49, 83, 100, 331, 652, 687, 874, 961

Key controls currently in place to manage the risk to achieving this objective

Clinical strategy delivery governance, including specific flagships delivery governance (Independent Lives, Function First, Connecting Us, Ageing Well)
QOFPA process and meetings
SHS reports
Representation at ICB
Representation at primary care board
Representation at SEND improvement Board
Population health management system programme
Elective care delivery programme
Colleague wellbeing agenda

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)

Integration Programme Board (+/-)
Reports to Q&GC (+/-)
Oversight reports for ICB, primary care board, SEND improvement board, population health (+/-) management board, elective care delivery board (+/-)

Strength of controls

Red

Significant gaps in current controls

Clinical strategy delivery governance now undefined
Flagships are variable in maturity
Weak controls for primary care risk.

Strength of assurance

Red

Areas where further assurance is required

System level monitoring and reporting within the ICS

Key transformation plans and strategies to achieve objective

	Strategy	Owner	Assessment of Progress
1	Hospital @ Home	Andy Heron	**Red**
2	Ageing Well (Anticipatory care)	Alex Murray	**Red**

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress
A	Work with the ICB and ICP to develop oversight and reporting governance	DM	Mar-23	Outline governance framework established subject to further review
B	Develop governance structure for clinical strategy delivery across the two trusts	MK	Sep-22	Oversight of delivery scheduled through Q&GC/GQAC and Programme Board

3	Persistent physical symptoms in children and adults, including neuro rehab projects	Julie Jones	**Amber**	C	Newly developed neurdevelopmental assessment service - performance levels montored by QOFP internally and SEND IB externally	AH	Feb-23	In place and ongoing
4	Dementia Strategy	Helen McEvansonya	**Green**					
5	Homelessness pathway	Karen George	**Green**	D				
5	SEND pathway	Andy Heron	**Green**	E				

Board Assurance Framework 2022-23

SOMERSET NHS FOUNDATION TRUST

Exec owner(s)

Isobel Clements

Corporate Objective

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

Overseeing Committee

People

Date of last Committee review

Dec-22

Key Performance Indicators

Vacancy levels	Dec-22	6.6%	Sickness rates	Dec-22	6.1%	Mandatory training	Dec-22	91.9%
Stress / anxiety days lost	Dec-22	306	Staff turnover	Dec-22	11.2%	Cultural measure tbd		

Top 3 risks to achieving this objective

1 Workforce supply / vacancy levels

2 Retention / turnover

3 Culture / leadership

Score (LxC)

1 5 x 4 = 20

2 4 x 4 = 16

3 3 x 4 = 12

Risk Reference

1 SFT 399 & 1329 & 1408 / YDH 236

2 YDH 925

3 SFT 1618 / YDH 990

Associated risks on CRR

SFT - 2, 3, 4, 7, 8, 9, 12, 82, 277, 326, 343, 366, 372, 399, 534, 588, 673, 690, 842, 862, 923, 1004, 1046, 1150, 1214, 1310, 1329, 1343, 1400, 1408, 1470, 1491, 1505, 1510, 1512, 1513, 1519, 1542, 1577

YDH - 21, 45, 49, 100, 236, 372, 515, 652, 687, 728, 729, 772, 864, 868, 874, 925, 947, 961

Key controls currently in place to manage the risk to achieving this objective

People Strategy commoitments agreed that reflect the national people plan, people promise priorities and HR/OD futures work.Commitments are - Care for our People, Develop our People, Compassionate & Inclusive leaders, Retain & attract talent, Learning & transformation - work on measures/KPI's in progression and year 1 deliverables. Values & behavioural framework in place, work commenced ahead of merger on bulding these into the employees work cycle, attraction, recruitment etc Local workforce plans in place, system wide workforce plans in development that support the LTP. Leadership forums in place (approx 100 senior leaders & exec) , have met twice to discuss environment being created in support of strategic objective.

Continued focus on colleague health, wellbeing & resilience, priority focus on financial wellbeing & civility. Continued focus & priority on the development of an inclusive workplace. Work to eliminate voilence & aggression, feedback from S/S - working group estalished to support directorates and teams in developing strategy & priority actions to eliminate, inc training and development.
Overseas recruitment campaigns x 8 now in place and working well ensuring a strong International pipeline into the providers and Somerset. Exemplar national people promise site primary focus retention.

Benchmarking work underway, enabling a better understanding of the data & in turn actions to address high turnover.

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)

Oversight of People Strategy via People Committee (+/-) Cultural Maturity reviews (BDO) (+) Freedom to Speak up caseload/feedback, ER (Including Employment Tribunal) caseload, OD caseload and intervention.
Monthly Quality and Performance Reports (+/-), Sickness, Turnover, Retention KPI's, Trade Union feedback loops.
Networks feedback via cultural board.
National Staff Survey (+) Engagement scores
Pulse (+) - newly launched . Postgraduate doctor surveys.

Strength of controls

Amber

Significant gaps in current controls

Further work required to support colleagues exposed to violence and aggression
Uptake of quarterly pulse is currently poor, career conversation uptake poor, reset required to ensure all colleagues understand the value and link this to retention.

Strength of assurance

Amber

Areas where further assurance is required

Strategic oversight of violence and aggression/inclusion
Gap analysis of cultural engagement requirements
Leadership survey completed, focus on engagement built into leadership forum focus for 2023.

Key transformation plans and strategies to achieve objective

Strategy	Owner	Assessment of Progress

Additional key actions required to mitigate risks or improve assurance

Action	Lead	Target Date	Progress

1	People Strategy - Values engagement & build. Values being built into the whole employee lifecycle in readiness for merger on 1 April 2023.	Isobel Clements	**Green**	A	Review governance arrangements for the development of an inclusive culture. Extend across YDH.	IC	Apr-23	Revised proposal & TofR to Nov People Committee. First new style Cultural Board planned for January. reporting arrangements strenthened.
2	People Strategy - 5 Commitments agreed - the development of yearly road maps, measures and KPIs underway.	Isobel Clements	**Green**	B	System workforce team, structure, committee and plans to be reviewed when system Director of Workforce Stategy is appointed	IC	Mar-23	Team development planned across system/provider.
3	People Strategy - continue to strengthen workforce plans, both Somerset system focus and Trust specific.	Isobel Clements	**Green**	C	Work underway to further consider & improve uptake of pulse for colleagues to feedback on engagement etc	IC	Apr-23	Engagement work continues, aligned to national & regional focus.
4	People Strategy - national future Human Resources & Organisational Development vision for 2030, ongoing work to consider model of people services within Somerset.	Isobel Clements	**Green**	D	NHSI/E - Cultural/engagement requirements - gap analysis underway to ensure all engagement activity in place for April 2023.	IC	Apr-23	Gap analysis undertaken, continued actions continue re engagement. Leader survey completed, need to focus on uptake, further leadership forums planned.
5	Violence Prevention and Reduction Strategy	Isobel Clements/Hayley Peters/Phil Brice	**Amber**	E	Develop Violence Prevention and Reduction Strategy, including monitoring arrangements and measures	IC/HP /PB	Apr-23	Interim Strategy in place. Staff survey 2022 findings to feed into this work.

Board Assurance Framework 2022-23

SOMERSET NHS FOUNDATION TRUST

Exec owner(s)

Pippa Moger

Corporate Objective

7. Live within our means and use our resources wisely

Overseeing Committee

FRCC / Finance

Date of last Committee review

Dec-22

Key Performance Indicators

Financial position v plan (YTD)	Dec-22	£0.9m adv	↓	% of CIP identified as recurrent	Dec-22	41.8%	↓	Agency v plan (YTD)	Dec-22	£10.3m adv	↓

Top 3 risks to achieving this objective

1. Failure to identify & deliver sufficient recurrent CIP
2. Increasing demand leading to increased costs.
3. Lack of pace of system-wide changes to address deficit.

Score (LxC)

1 3 x 5 = 15
2 4 x 4 = 16
3 3 x 4 = 12

Risk Reference

1 SFT 6
2 SFT 4 & 372 / YDH 21 & 49
3 FIN001

Associated risks on CRR

SFT - 3, 4, 6, 7, 8, 9, 12, 277, 326, 372, 534, 673, 831, 842, 862, 923, 1004, 1016, 1046, 1329, 1356, 1482, 1510, 1513, 1542, 1577

YDH - 21, 45, 49, 83, 100, 331, 372, 652, 687, 737, 864, 874, 916, 947

Key controls currently in place to manage the risk to achieving this objective

Financial control systems and processes.
System wide discussions to ensure overall system position is managed within available resources.
Control and oversight of CIP through Quality, Outcomes, Finance and Performance process and CIP Review Group.
Financial Strategy being developed to reduce the underlying deficit to break even by 2026/27

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)

Internal and external audit programme (+).
Financial oversight via Finance Committee (+/-).
System Finance Assurance Group (+/-).
HFMA Financial Sustainability Checklist (+)

Strength of controls

Amber

Significant gaps in current controls

Further savings to be identified via CIP and other schemes

Strength of assurance

Amber

Areas where further assurance is required

Oversight of actions to address underlying deficit

Key transformation plans and strategies to achieve objective

	Strategy	Owner	Assessment of Progress
1	Finance Strategy - clear plan of work programmes required to reduce the underlying deficit each year	Pippa Moger	Amber
2	Clinical Strategy - developed sufficiently to model what the cost of future models of care	Hayley Peters / Dan Meron	Red
3	Workforce strategy - ensuring pipeline of recruitment and retention and new roles to reduce reliance on agency and manage costs	Isobel Clements	Green
4	Digital Strategy - Developed to ensure productivity can be maximised therefore reducing the growth required in costs	David Shannon	Green
5	Estates Strategy - Plan on how estate could / will be reduced over 5 year period to reduce costs	David Shannon	Green

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress
A	Ongoing work to identify additional CIP schemes which are recurrent	PM	Dec-22	Unpalatable CIP schemes prepared and reviewed with implementation taking place. The majority are NR in nature though
B	Identify additional opportunities, through the use of available benchmarking, Model Hospital, GIRFT,etc. to identify further efficiencies and improve productivity	PM	Apr-23	Work started to identify opportunities and 2023/24 CIP will focus on those
C	Working with social care on increasing capacity in care market to reduce patients being delayed and increased costs being incurred through escalation	AH/MB	Mar-23	Additional capacity sourced and delays slowly reducing
D	Finance strategy working group to be set up to ensure focus on the strategic changes required	PM	Mar-23	
E	Challenge set to obtain 75% recurrent CIP in 2023/24 planning	PM	Mar-24	

Board Assurance Framework 2022-23

SOMERSET NHS FOUNDATION TRUST

Exec owner(s)

Peter Lewis

Corporate Objective

8. Develop a high performing organisation delivering the vision of the trust

Overseeing Committee

Board(s)

Date of last Committee review

Nov-22

Key Performance Indicators

A&E 4-hour standard	Dec-22	70.5%	78 week acute RTT waiters	Dec-22	257	6-week diagnostics	Dec-22	78.8%
2-week cancer waiting time	Nov-22	51.9%	Mental health 6w waiting times	Dec-22	89.0%	Community waiters>18 weeks	Dec-22	4,102

Top 3 risks to achieving this objective

1 Insufficient capacity to meet demand in all services Acute, Community, Mental Health, Intermediate Care)
2 Failure to secure the necessary infrastructure
3 Failure to realise the benefits of merger and service integration

Score (LxC)

1 5 x 5 = 25
2 4 x 4 = 16
3 3 x 4 = 12

Risk Reference

1 SFT 4 & 372 & 831 / YDH 21 & 49 & 331
2 SFT 1611 & 1624 / YDH 984 & 994
3 SFT 1612 / YDH 985

Associated risks on CRR

SFT - 2, 4, 6, 7, 8, 9, 12, 277, 326, 372, 673, 831, 842, 862, 864, 923, 1004, 1016, 1310, 1343, 1356, 1482, 1510, 1513, 1519, 1542, 1577

YDH - 21, 45, 49, 83, 100, 331, 372, 652, 687, 737, 864, 874, 916

Key controls currently in place to manage the risk to achieving this objective

Elective performance monitored fortnightly System Performance Group and through Directorate QOFP process. Additional weekly meetings held with directorates/specialties for cancer and RTT according to the scale of risk.
Directorate Governance, F&P and QOFP processes
COVID Recovery Co-ordination Group reports and plans
Intermediate Care Programme Board
Oversight of the activities of the Somerset Collaboration Hub through the system-wide Collaboration Forum
People Strategy overseen through People/Workforce Committees
Colleague Health, Wellbeing & Resilience programmes.
Inclusion Strategies.
Values into Action workshops
Digital Board
Merger Programme Board

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)

Quarterly Finance Committee reports (+)
Quarterly reports to Trust Board on Learning from Deaths (+)
Quarterly report to Trust Board on Freedom to Speak up (+)
National Freedom to Speak Up Guardian Report (+)
National Staff Survey (+)
Internal Audit of Cultural Maturity (+)
Performance monitored through QPOF process (+ /-).
Monthly Quality and Performance reports (+ / -)
External review through NHSI/CQC liaison meetings (+ / -)
Merger Updates to Board (+)
Merger Updates to Board (+) NHSE review of Merger plans and preparedness

Strength of controls

Amber

Significant gaps in current controls

Insufficient capacity to meet demand
Capital resources to support infrastructure requirements

Strength of assurance

Amber

Areas where further assurance is required

System level monitoring and reporting within the ICS

Key transformation plans and strategies to achieve objective

	Strategy	Owner	Assessment of Progress
1	Merger Business Case	David Shannon	**Green**
2	Elective Recovery Programme	Matthew Bryant	**Amber**

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress
A	System Bed Capacity Plan	AH/MB	tbc	Funding agreed by Region. Delivery trajectory now being set.
B	Additional elective capacity being sought via insourcing and use of other System's facilities (e.g. Exeter Nightingale)	XW	Mar-23	Contracts in place. Additional capacity continues to be sought/identified.

3	People Strategy - Values engagement & build	Isobel Clements	**Green**	C	System to participate in Right Procedure Right Place (surgery) programme	FC	Dec-22	Programme developing well. Recent positive review by national lead for High Volume Low Complexity (HVLC) / Get It Right First Time (GIRFT); modelling being undertaken to understand impact on bed requirements.
4	Digital Strategy	David Shannon	**Green**	D	NHSI/E - Cultural/engagement requirements - gap analysis underway to ensure all engagement activity in place for April 2023.	IC	Sep-22	Gap analysis undertaken, continued actions continue re engagement. Leader survey completed, need to focus on uptake, further leadership forums planned.
5	Communications and Engagement Strategy	Fiona Reid	**Amber**	E	Implementation of waiting list initiative work to reduce the number of long waiters and shorten waiting times for community 18 week waiters	LC	Mar-23	
				F	Elective capacity shortfall (78 weeks) modelled/understood and plan in place.	XW	Nov-22	Significant reductions in 78-week cohort delivered to date (better than trajectory). On track to deliver plan (300 at March 23)

BOARD ASSURANCE FRAMEWORK SUMMARY

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

Quarter 3 2022/23

Ref	Executive Owner	Corporate Objective	Overseeing Committee	Highest Risk	Change	Strength of Controls	Change	Strength of Assurance	Change	Strategy Progress	Change
1	PL	Improve the health and wellbeing of the population	Board	16	↑	A	→	A	↑	A	→
2	HP	Provide the best care and support to people	GQAC	25	→	A	→	G	→	A	→
3	AH	Strengthen care and support in local communities	GQAC	25	→	A	→	A	→	A	→
4	MB	Reduce inequalities	GQAC	15	↑	A	→	A	→	A	→
5	DM	Respond well to complex needs	GQAC	20	↑	R	↓	R	→	A	→
6	IC	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture	Workforce	20	↑	A	→	A	→	A	→
7	PM	Live within our means and use our resources wisely	FRCC	16	→	A	→	A	→	R	→
8	PL	Develop a high performing organisation delivering the vision of the trust	Board	25	→	A	→	A	→	A	→

Board Assurance Framework 2022-23

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

Exec owner(s)

David Shannon

Corporate Objective

1. Improve the health and wellbeing of the population

Overseeing Committee

Board(s)

Date of last Committee review

Nov-22

Key Performance Indicators

Diabetes: HbA1C checks	Oct-22	100%	↑	Addiction (Smoking and Alcohol) - from 2023			Suicide/Self harm Prev: MH staff	Dec-22	211 ↑
28 day cancer faster diagnosis	Nov-22	67.7%	↓	Colleagues attending Public Health management training - from Mar 23			Suicide/Self harm Prev: non-MH	Dec-22	117 ↑

Top 3 risks to achieving this objective

1 Population Health may not get the focus required
2 Approach to Population Health may be unco-ordinated
3 Lack of understanding of shared accountability and resourcing

Score (LxC)

1 4 x 3 = 12
2 2 x 4 = 8
3 4 x 4 = 16

Risk Reference

1 SFT 1613 / YDH 986
2 SFT 1615 / YDH 987
3 SFT 1616 / YDH 988

Associated risks on CRR

SFT - 7, 8, 9, 12, 277, 326, 372, 534, 673, 842, 862, 923, 1004, 1016, 1046, 1310, 1343, 1356, 1513, 1542, 1577

YDH - 49, 83, 100, 372, 652, 687, 864, 874

Key controls currently in place to manage the risk to achieving this objective

Somerset ICS has committed to Population Health Transformation and the Somerset Population Health Transformation Board has been created - and developed the key priorities agreed with system partners
ICS Action learning Set in place to support PHM development - concluded in September 2022
ICS Data and Analytic learning set in place to support data development - Place PHM programme to be embeded in ICS analytics programme
ICS data development group in place to support the data development - data strategy agreed to support analytics from March 2023
The Trust Board public agendas will feature a section dedicated to population health and reducing health inequalities on a regular baisis.

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)

Progress on key performance indicators set by the Poulation Health Transformation Board and progress in tackling inequality in referrals and the waiting list during 2022/23 presented to the board on a regular basis (+)
Limited Board and committee oversight to date (-)
Population Health Transformation Board established with cross system senior involvement and attendance
Trust population health working group to be established (-)
Oversight of flagship Quality Account priorities and clinical strategy through Quality and Governance Committee (+)

Strength of controls

Amber

Significant gaps in current controls

Engagement and resourcing plan in development but not confirmed

Strength of assurance

Amber

Areas where further assurance is required

Detailed implementation plan for priorities
Engagement plan for programme Board
KPI metrics not yet concluded and basline and improvement

Key transformation plans and strategies to achieve objective

	Strategy	Owner	Assessment of Progress
1	Population Health Transformation priorities: - Tobacco reduction - Suicide prevention - Healthy weight - Positive steps (peri-operative care)	David Shannon/Dan Meron	Amber
2	Population Health data and analytics programme	David Shannon	Amber
3	Dementia Strategy	Helen McEvansonya	Green

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress
A	Development of year one actions	DS / DM	Nov-22	System agreed priorities for year 1 and 2 linked to inequatlities programme. WS Leads appointed Y1 objectives and milestones in development
B	Development of communication and engagement plan	DS / DM	Nov-22	Comm's and Engagement Lead appointed, Y1 plan in development
C	Resource and implementaion plan developed and agreed	DS	Nov-22	Initial resource plans to be submitted to Nov PHM board

4				D	Set and Monitor Short and Long Term KPI Measures	DS/DM	Jan-23	KPI Agreed baseline and improvement measures
5				E				

Board Assurance Framework 2022-23

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

Exec owner(s)

Hayley Peters

Corporate Objective

2. Provide the best care and support to people

Overseeing Committee

GQAC / Q&G

Date of last Committee review

Dec-22

Key Performance Indicators

Ambulance handover hours lost>15m	Dec-22	764	↓	Cancelled operations	Dec-22	0.3%	↑	C Diff monthly cases	Dec-22	0	↑
Patient initiated follow up (PIFU)	Dec-22	12.7%	↓	Falls res in harm/1000 bed days	Dec-22	0.33	↓	Press. Ulcers/1000 bed days	Dec-22	1.18	↑

Top 3 risks to achieving this objective	Score (LxC)	Risk Reference
1 Access to primary care / increasing ED demand	1 4 x 4 = 16	1 SFT 372 & 673 & 923 / YDH 236 & 21
2 Social care capacity shortfalls	2 5 x 5 = 25	2 SFT 831 & 842 & 1513 / YDH 331
3 Age of acute and community estates	3 5 x 4 = 20	3 SFT 3 & 534

Associated risks on CRR

SFT - 2, 3, 4, 7, 8, 9, 12, 82, 277, 326, 343, 366, 372, 399, 534, 588, 673, 690, 831, 842, 862, 923, 1004, 1016, 1046, 1150, 1214, 1310, 1329, 1343, 1356, 1400, 1408, 1470, 1482, 1491, 1505, 1510, 1512, 1513, 1519, 1542, 1577

YDH - 21, 45, 49, 83, 100, 236, 331, 372, 515, 652, 687, 728, 729, 772, 864, 868, 874, 925, 947, 961

Key controls currently in place to manage the risk to achieving this objective

A range of schemes with partners to address demand issues.
Hospital @ Home programme of work.
Continued development and implementation of the clinical strategy.
A range of recruitment and retention plans as part of the People Strategy.
Risk assessed capital and backlog maintenance programmes, focussing on high priority areas. Additional national funding utilised in 2020/21 to support high risk areas.
Integrated performance reporting.
Estates programme of work across Community, Mental Health and Acute Estate overseen by Strategic Estates Group.
Approval of Digital and Estates Strategies

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)

CQC Inspection reports (+/-). CQC Insight reports (includes SHMI) (+)
GST assurance processes (IQAB, Care Essentials, etc.), reported via Quality and Governance Committee (+/-).
National Patient Surveys (+). MPH 6 Facet condition survey (-).
Benchmarking Model Hospital and MH national benchmarking data. GIRFT reports and intelligence
Oversight of flagship Quality Account priorities and clinical strategy through Quality and Governance Committee (+)
National Staff Survey (+)
SOC due diligence reports (+)
Internal audit programme (+/-)

Strength of controls

Amber

Significant gaps in current controls

Poor availability of primary care data & business intelligence.
Poor availability of social care demand/capacity information to forecast with confidence

Strength of assurance

Green

Areas where further assurance is required

Key transformation plans and strategies to achieve objective

	Strategy	Owner	Assessment of Progress
1	Estate Strategy - Musgrove 2030/YDH 2030	David Shannon	Green
2	Digital Strategy	David Shannon	Green

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress
A	Continue to strengthen strategic, professional, tactical & operational workforce plans, both Somerset system focus and Trust specific.	IC	Mar-23	Workforce planning priorities being progressed and monitored through the People Board; detailed SBAR available
B	Develop data and BI capacity and delivery for primary care	DS	Mar-23	ICS data development programme in place (inform programme) Data platform to be in place by March 2023. Creation of data science team to support evaluation.

3	Hospital @ Home Progamme Board and associated sub-groups, with strong operational & clinical engagement internally and externally	Andy Heron	**Red**
4	Quality and Patient Safety Strategy	Hayley Peters/Phil Brice	**Amber**
5	ICB / system winter summit held August 2022, five key actions in addition to Intermediate Care programme of work. 1. care home inreach support at scale 2. POC reduction and inc. bedded care capacity 3. inc OPMH capacity 4. Increase PC urgent capacity by decreasing LTC routine reviews 5. Hospital @ Home	Hayley Peters/Dan Meron/Andy Heron/Matthew Bryant	**Amber**
6	End of Life Care (Last 1,000 days)	Charlie Davis	**Amber**

C	H@H Programme Board adheres to formal programme management methodology including the maintainance of a comprehensive programme risk register with mitigations	AH	Reviewed every two weeks by the Programme Board	Complete and ongoing
D	Ward accrediation pilot	HP	Mar-23	Two wards at panel in August, stocktake of metrics required before next panel. 9/1/23 Stocktake delayed due to CNO team restructure and organisational pressures, planned before end January.
E	Leadership quality walkarounds	PB/HP	Sep-22	Schedule of visits across all sites to be published in September commencing from 12/09/2022; 9/1/23 - programme underway and full programme in place for 2023
F	Launch programme to EPJP and prevent deconditioning across SFT & YDH	HP	Mar-23	Programme leads identfied, supportfrom improvement team, first meeting. 9/1/23 Readyto Go Wards x 2 @MPH & YDH, challenging model with pressures, improvement support in place
G	Development of the Chief Nurse Core Standards	HP	Mar-23	Resource identified, weekly huddle set up, core standards being agreed
H	CPD investment to address care priorities	HP	Mar-23	Scoping exercisecompleted, areas identified. 9/1/23 - review of priorities planned for end Jan 2023
I	Quality and Patient Safety Strategy	HP	Jan-23	Delayed due to CNO restructure and organisational pressures; draft outline to be delivered by end Jan 23

Board Assurance Framework 2022-23

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

Exec owner(s)

Andy Heron

Corporate Objective

3. Strengthen care and support in local communities

Overseeing Committee

GQAC / Q&G

Date of last Committee review

Dec-22

Key Performance Indicators

Patients referred to NHS@Home	Dec-22	50	↑	Adm. prev by Rapid Resp/NHS@Home	Dec-22	307	↑	Urgent community response <2hr	Dec-22	83.4%	↑
PCNs with integrated models	Dec-22	2	=	Psychiatric readmission rate	Dec-22	5.5%	↓	Integrated family hub launch	Dec-22	0	=

Top 3 risks to achieving this objective	Score (LxC)	Risk Reference
1 Workforce shortages	1 4 x 4 = 16	1 SFT 366 & 1329 & 1408 / YDH 236
2 Primary care fragility	2 4 x 4 = 16	2 SFT 673 / YDH 236
3 Social care capacity shortfalls	3 5 x 5 = 25	3 SFT 831 & 842 & 1513 / YDH 331

Associated risks on CRR

SFT - 2, 3, 4, 7, 8, 9, 12, 277, 326, 366, 534, 588, 673, 690, 831, 842, 923, 1016, 1046, 1310, 1343, 1408, 1470, 1505, 1510, 1513, 1519, 1542, 1577

YDH - 236, 331, 652, 728, 729, 864, 874, 947

Key controls currently in place to manage the risk to achieving this objective

Trust/ICS workforce strategy and integration.
System Neighbourhood Board co-chaired by COO.
Intermediate Care Board with associated KPI monitoring.
Joint Head of Intermediate Care appointment made with SCC.
Integration pilot underway in the North Sedgemoor area with plans for two more integration projects in the South Somerset and Bridgwater areas.
New Hospital@Home services under development for respiratory and frailty for implementation during 2022/23 with remedial diagnostic and action plan in development to address current low level of referrals
Regular directorate focussed Finance and Performance & QOFP meetings in place to review performance and delivery of Trust strategy in local communities.
Significant additional investment in domicilliary care capacity and intermediate care beds now agreed and being implemented in accordance with winter resilience planning.
Deep Dive work being undertaken on site at YDH w/c 09/01/23 and at MPH w/c 23/01/23

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)

Trust Board Quadrant report (+/-)
Weekly intermediate care performance report circulated to Exec Team with daily capacity/demand information underpinning this and circulated (+/-)
The mental health benchmarking club (+/-)
SEND Improvement Board oversight of neuro-developmental disorder assessment service implementation (+/-)
Regional oversight of Hospital@Home implementation and performance against trajectories (+/-)
ICS System Assurance Forum

Strength of controls

Amber

Significant gaps in current controls

Poor availability of primary care data & business intelligence.
Poor availability of social care demand/capacity information to forecast with confidence

Strength of assurance

Amber

Areas where further assurance is required

Oversight of delivery of intermediate care strategy
Development and delivery of primary care strategy

Key transformation plans and strategies to achieve objective

	Strategy	Owner	Assessment of Progress
1	Hospital@Home Progamme Board and associated sub-groups	Andy Heron	**Red**
2	Pilot integration project for North Sedgemoor with further integration projects underway for Somerset West and Bridgwater PCN areas	Kerry White Andy Heron	**Green**

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress
A	i) H@H Programme Board adheres to formal programme management methodology including the maintainance of a comprehensive programme risk register with mitigations ii) Action plan being developed to address the currently low levels of referral activity into H@H in both the frailty and respiratory services	i) AH ii) AH/ TE/CD	i) Reviewed every 2 weeks by the Prog. Board ii) Jan - 23	i) Complete and ongoing ii) Currently under urgent development
B	Further level of risk management now underway via face to face meetings with the PCN in North Sedgemoor chaired by COO/CEO SHS.	AH	Aug-22	In place and under continuing review

3	Intermediate Care strategy and transformation plan	Mel Lock Andy Heron Somerset DoFs	**Amber**
4	Open Mental Health (including stolen years)	Jane Yeandle Andy Heron	**Green**
5	Strategy developed (under leadership of SEND Improvement Board) for children and young people with neuro developmental disorders.	Alison Ficarotta Andy Heron	**Green**

C	Intermediate Care strategy development now reporting to Neighbourhood & Primary Care Programme Board chaired by COO/Director ASC	AH / ML	Apr-22	In place and under continuing review
D	Key performance/workforce metrics routinely monitored via the QOFP process	PM / AH	Mar-23	In place and under continuing review
E				

Board Assurance Framework 2022-23

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

Exec owner(s)

Matthew Bryant

Corporate Objective

4. Reduce inequalities

Overseeing Committee

GQAC / Q&G

Date of last Committee review

Dec-22

Key Performance Indicators

>65s accessing Open Mental Health	Dec-22	150	↓	Reduce elective waits for ppl with LD	Nov-22	18.3 wks	↑	Continuity of carer: eth.min/depr	Nov-22	86% ↑
IAPT referrals for long term condition	Dec-22	197	↓	Prot characteristics data completeness	Jul-22	96.9%	↑		Jul-22	

Top 3 risks to achieving this objective

1 System and Trust strategy not fully developed
2 Data quality issues leading to poor information
3 Historical funding/resource gaps including in MH

Score (LxC)

1 3 x 5 = 15
2 2 x 4 = 8
3 4 x 3 = 12

Risk Reference

1 SFT 1620 / YDH 991
2 SFT 1621 / YDH 992
3 SFT 1622 / YDH 993

Associated risks on CRR

SFT - 277, 326, 673, 842, 1016, 1046, 1310, 1343, 1513, 1577

YDH - 45, 874, 961

Key controls currently in place to manage the risk to achieving this objective

Development of a three year trust strategy that is aligned with ICS and sets out the approach to use the principles of our clinical model to actively address healthcare inequalities (by end of quarter 3)
Introduction of inequalities data to trust datasets to identify issues and start to measure impact (to be included in board reports by end of quarter 2)
Commencement/continuation of a range of projects at service level (work already underway)
Monitoring of resource/investment between physical and mental health to support parity of esteem (ongoing)
Approval of digital strategy with focus on digital inequalities as on of the main aims

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)

Regular updates on development of trust strategy (+/-)
Monthly Board updates from PDC (+)
Monthly Board Quadrant reports, including seeing data changes (+)
Progress against clinical model milestones (- / +)
Feedback from Healthwatch / CVAG / PALS / Triangle of Care (+ /-)
CQC Inspection reports (+/-). CQC Insight reports (includes SHMI) (+)
Mental Health Act Committee monitoring and reports (+)
Oversight of flagship Quality Account priorities and clinical strategy through Quality and Governance Committee (+)

Strength of controls

Amber

Significant gaps in current controls

Governance oversight process

Strength of assurance

Amber

Areas where further assurance is required

Development of strategy + preparedness for adoption of deprivation/exclusion markers into trust data

Key transformation plans and strategies to achieve objective

	Strategy	Owner	Assessment of Progress
1	Open Mental Health - with a focus on reaching out to disadvantaged populations	Jane Yeandle	**Green**

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress
A	Develop focused governance approach for this aspect of organisational strategy	PB	Sep-22	Board sub-committee arrangements defined (Q&G), schedule of board reporting approved at the October 2022 Board. Schedule of board reporting presented to the November board.

2	Review support arrangements for our LD population accessing physical health services	Andy Heron	**Amber**
3	Maternity strategy - deliver plan to achieve continuity of carer for >35% of pregnant woment from an ethnic minority background/deprived areas	SallyAnn King	**Amber**
4	Digital Strategy - alignment to	David Shannon	**Amber**
5	Elective Recovery - reduce inequalties as part of elective recovery plans	Xanthe Whitaker	**Amber**

B	Ensure development of strategy, in partnership with ICS	DS	Dec-22	Population health steering board being developed with ICB to oversee production of strategy. Focus of work on Core20Plus and reflecting new requirements for Children Core20
C	Development of community and neighbourhood initiatives focussed on inequalties	AH	Dec-22	Core part of Hospital at Home programme (eg focus on protected characteristics) + communities with deprivation. This is ongoing as part of this work.
D	Develop way of monitoring trust activity underway	DS	Jan-23	Changes made to elective reporting at board (completed). Review of Board reporting to include metrics on a regular (6montly) basis
E	Include as a focus for teams developing delivery plans for implementation of clinical model	MB	Sep-22	This will be built into the process for developing plans at service level via the CIT. Completed.
F	Inequalities analysis on cancer; introduction of vulnerable patients prioritisation; interventions to address higher DNA rates for patients from more socially deprived areas.	XW	Mar-23	Cancer analysis underway; DNA interventions being piloted; vulnerable patient prioritisation approach now being implemented

Board Assurance Framework 2022-23

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

Exec owner(s)

Dan Meron

Corporate Objective

5. Respond well to complex needs

Overseeing Committee

GQAC / Q&G

Date of last Committee review

Dec-22

Key Performance Indicators

CYP Eating Disorders - urgent	Dec-22	84.2%	↓	CYP Eating Disorders - routine	Dec-22	91.1%	↓	Reduce time in ED: Hi intensity users	Nov-22	24,431 hrs	↓
Dementia diagnosis rate	Oct-22	53.5%	↑	Persistent physical symptoms progrm	Dec-22			Anticipatory care measure tbd			
Time to diagnosis in SEND tbd	Nov-22	66 weeks	↓								

Top 3 risks to achieving this objective

1 Failure to sufficiently deliver the clinical model
2 Insufficient capacity in primary care
3 Impact of pandemic on our population and services

Score (LxC)

1 3 x 4 = 12
2 4 x 4 = 16
3 4 x 5 = 20

Risk Reference

1 SFT 1617 / YDH 989
2 SFT 673 / YDH 236
3 SFT 2 / YDH 100

Associated risks on CRR

SFT - 2, 4, 7, 8, 9, 12, 326, 372, 673, 831, 842, 862, 923, 1004, 1016, 1046, 1310, 1343, 1356, 1513, 1519, 1542, 1577

YDH - 21, 45, 49, 83, 100, 331, 652, 687, 874, 961

Key controls currently in place to manage the risk to achieving this objective

Clinical strategy delivery governance, including specific flagships delivery governance (Independent Lives, Function First, Connecting Us, Ageing Well)
Accountability Framework process and meetings
SHS reports
Representation at ICB
Representation at primary care board
Representation at SEND improvement Board
Population health management system programme
Elective care delivery programme
Colleague wellbeing agenda

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)

Integration Programme Board (+/-)
Reports to GQAC (+/-)
Oversight reports for ICB, primary care board, SEND improvement board, population health (+/-) management board, elective care delivery board (+/-)

Strength of controls

Red

Significant gaps in current controls

Clinical strategy delivery governance now undefined
Flagships are variable in maturity
Weak controls for primary care risk.

Strength of assurance

Red

Areas where further assurance is required

System level monitoring and reporting within the ICS

Key transformation plans and strategies to achieve objective

	Strategy	Owner	Assessment of Progress
1	Hospital @ Home	Andy Heron	Red
2	Ageing Well (Anticipatory care)	Alex Murray	Red
3	Persistent physical symptoms in children and adults, including neuro rehab projects	Julie Jones	Amber

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress
A	Work with the ICB and ICP to develop oversight and reporting governance	DM	Mar-23	Outline governance framework established subject to further review
B	Develop governance structure for clinical strategy delivery across the two trusts	MK	Sep-22	Oversight of delivery scheduled through Q&GC/GQAC and Programme Board
C	Newly developed neurdevelopmental assessment service - performance levels montored by QOFP internally and SEND IB externally	AH	Feb-23	In place and ongoing

	Dementia Strategy	Helen McEvansonya	Green					
	Homelessness pathway	Karen George	Green	D				
6	SEND pathway	Andy Heron	Green	E				

Board Assurance Framework 2022-23

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

Exec owner(s)

Isobel Clements

Corporate Objective

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

Overseeing Committee

People

Date of last Committee review

Dec-22

Key Performance Indicators

Vacancy levels	Dec-22	4.6%	Sickness rates	Dec-22	5.0%	Mandatory training	Dec-22	85.9%
Stress / anxiety days lost	Dec-22	608	Staff turnover	Dec-22	19.5%	Cultural measure tbd		

Top 3 risks to achieving this objective

1 Workforce supply / vacancy levels

2 Retention / turnover

3 Culture / leadership

Score (LxC)

1 5 x 4 = 20

2 4 x 4 = 16

3 3 x 4 = 12

Risk Reference

1 SFT 399 & 1329 & 1408 / YDH 236

2 YDH 925

3 SFT 1618 / YDH 990

Associated risks on CRR

SFT - 2, 3, 4, 7, 8, 9, 12, 82, 277, 326, 343, 366, 372, 399, 534, 588, 673, 690, 842, 862, 923, 1004, 1046, 1150, 1214, 1310, 1329, 1343, 1400, 1408, 1470, 1491, 1505, 1510, 1512, 1513, 1519, 1542, 1577

YDH - 21, 45, 49, 100, 236, 372, 515, 652, 687, 728, 729, 772, 864, 868, 874, 925, 947, 961

Key controls currently in place to manage the risk to achieving this objective

People Strategy commoitments agreed that reflect the national people plan, people promise priorities and HR/OD futures work.Commitments are - Care for our People, Develop our People, Compassionate & Inclusive leaders, Retain & attract talent, Learning & transformation - work on measures/KPI's in progression and year 1 deliverables. Values & behavioural framework in place, work commenced ahead of merger on bulding these into the employees work cycle, attraction, recruitment etc Local workforce plans in place, system wide workforce plans in development that support the LTP. Leadership forums in place (approx 100 senior leaders & exec) , have met twice to discuss environment being created in support of strategic objective.

Continued focus on colleague health, wellbeing & resilience, priority focus on financial wellbeing & civility. Continued focus & priority on the development of an inclusive workplace. Work to eliminate voilence & aggression, feedback from S/S - working group estalished to support directorates and teams in developing strategy & priority actions to eliminate, inc training and development.

Overseas recruitment campaigns x 8 now in place and working well ensuring a strong International pipeline into the

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)

Oversight of People Strategy via People Committee (+/-) Cultural Maturity reviews (BDO) (+) Freedom to Speak up caseload/feedback, ER (Including Employment Tribunal) caseload, OD caseload and intervention.

Monthly Quality and Performance Reports (+/-), Sickness, Turnover, Retention KPI's, Trade Union feedback loops.

Networks feedback via cultural board.

National Staff Survey (+) Engagement scores

Pulse (+) - newly launched . Postgraduate doctor surveys.

Strength of controls

Amber

Significant gaps in current controls

Further work required to support colleagues exposed to violence and aggression

Uptake of quarterly pulse is currently poor, career conversation uptake poor, reset required to ensure all colleagues understand the value and link this to retention.

Strength of assurance

Amber

Areas where further assurance is required

Strategic oversight of violence and aggression/inclusion

Gap analysis of cultural engagement requirements

Leadership survey completed, focus on engagement built into leadership forum focus for 2023.

Key transformation plans and strategies to achieve objective

	Strategy	Owner	Assessment of Progress
1	People Strategy - Values engagement & build. Values being built into the whole employee lifecycle in readiness for merger on 1 April 2023.	Isobel Clements	**Green**

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress
A	Review governance arrangements for the development of an inclusive culture. Extend across YDH.	IC	Apr-23	Revised proposal & TofR to Nov People Committee. First new style Cultural Board planned for January. reporting arrangements strenthened.

2	People Strategy - 5 Commitments agreed - the development of yearly road maps, measures and KPIs underway.	Isobel Clements	Green	B	System workforce team, structure, committee and plans to be reviewed when system Director of Workforce Stategy is appointed	IC	Mar-23	Team development planned across system/provider.
3	People Strategy - continue to strengthen workforce plans, both Somerset system focus and Trust specific.	Isobel Clements	Green	C	Work underway to further consider & improve uptake of pulse for colleagues to feedback on engagement etc	IC	Apr-23	Engagement work continues, aligned to national & regional focus.
4	People Strategy - national future Human Resources & Organisational Development vision for 2030, ongoing work to consider model of people services within Somerset.	Isobel Clements	Green	D	NHSI/E - Cultural/engagement requirements - gap analysis underway to ensure all engagement activity in place for April 2023.	IC	Apr-23	Gap analysis undertaken, continued actions continue re engagement. Leader survey completed, need to focus on uptake, further leadership forums planned.
5	Violence Prevention and Reduction Strategy	Isobel Clements/Hayley Peters/Phil Brice	Amber	E	Develop Violence Prevention and Reduction Strategy, including monitoring arrangements and measures	IC/HP /PB	Sep-22	Interim Strategy in place. Staff survey 2022 findings to feed into this work.

Board Assurance Framework 2022-23

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

Exec owner(s)

Pippa Moger

Corporate Objective

7. Live within our means and use our resources wisely

Overseeing Committee

FRCC / Finance

Date of last Committee review

Dec-22

Key Performance Indicators

Financial position v plan (YTD)	Dec-22	0m	⇩	% of CIP identified as recurrent	Dec-22	23%	⇩	Agency v plan (YTD)	Dec-22	£5.9m adv	⇩

Top 3 risks to achieving this objective

1. Failure to identify & deliver sufficient recurrent CIP
2. Increasing demand leading to increased costs.
3. Lack of pace of system-wide changes to address deficit.

Score (LxC)

1 3 x 5 = 15
2 4 x 4 = 16
3 3 x 4 = 12

Risk Reference

1 SFT 6
2 SFT 4 & 372 / YDH 21 & 49
3 FIN001

Associated risks on CRR

SFT - 3, 4, 6, 7, 8, 9, 12, 277, 326, 372, 534, 673, 831, 842, 862, 923, 1004, 1016, 1046, 1329, 1356, 1482, 1510, 1513, 1542, 1577

YDH - 21, 45, 49, 83, 100, 331, 372, 652, 687, 737, 864, 874, 916, 947

Key controls currently in place to manage the risk to achieving this objective

Financial control systems and processes.
System wide discussions to ensure overall system position is managed within available resources.
Control and oversight of CIP through Accountability Framework process.
Financial Strategy being developed to reduce the underlying deficit to break even by 2026/27

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)

Internal and external audit programme (+).
Financial oversight via Finance Committee (+/-).
System Finance Assurance Group (+/-).
HFMA Financial Sustainability Checklist (+)

Strength of controls

Amber

Significant gaps in current controls

Further savings to be identified via CIP and other schemes

Strength of assurance

Amber

Areas where further assurance is required

Oversight of actions to address underlying deficit

Key transformation plans and strategies to achieve objective

	Strategy	Owner	Assessment of Progress
1	Finance Strategy - clear plan of work programmes required to reduce the underlying deficit each year	Pippa Moger	Amber
2	Clinical Strategy - developed sufficiently to model what the cost of future models of care	Hayley Peters / Dan Meron	Red
3	Workforce strategy - ensuring pipeline of recruitment and retention and new roles to reduce reliance on agency and manage costs	Isobel Clements	Green
4	Digital Strategy - Developed to ensure productivity can be maximised therefore reducing the growth required in costs	David Shannon	Green
5	Estates Strategy - Plan on how estate could / will be reduced over 5 year period to reduce costs	David Shannon	Green

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress
A	Ongoing work to identify additional CIP schemes which are recurrent	PM	Dec-22	Unpalatable CIP schemes prepared and reviewed with implementation taking place. The majority are NR in nature though
B	Identify additional opportunities, through the use of available benchmarking, Model Hospital, GIRFT,etc. to identify further efficiencies and improve productivity	PM	Apr-23	Work started to identify opportunities and 2023/24 CIP will focus on those
C	Working with social care on increasing capacity in care market to reduce patients being delayed and increased costs being incurred through escalation	AH/MB	Mar-23	Additional capacity sourced and delays slowly reducing
D	Finance strategy working group to be set up to ensure focus on the strategic changes required	PM	Mar-23	
E	Challenge set to obtain 75% recurrent CIP in 2023/24 planning	PM	Mar-24	

Board Assurance Framework 2022-23

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

Exec owner(s)

Peter Lewis

Corporate Objective

8. Develop a high performing organisation delivering the vision of the trust

Overseeing Committee

Board(s)

Date of last Committee review

Nov-22

Key Performance Indicators

A&E 4-hour standard	Dec-22	63.4%	78 week acute RTT waiters	Dec-22	58	6-week diagnostics	Dec-22	69.4%
2-week cancer waiting time	Nov-22	59.4%	Mental health 6w waiting times	Dec-22	89.0%	Community waiters>18 weeks	Dec-22	4,102

Top 3 risks to achieving this objective

1 Insufficient capacity to meet demand in all services Acute, Community, Mental Health, Intermediate Care)
2 Failure to secure the necessary infrastructure
3 Failure to realise the benefits of merger and service integration

Score (LxC)

1 5 x 5 = 25
2 4 x 4 = 16
3 3 x 4 = 12

Risk Reference

1 SFT 4 & 372 & 831 / YDH 21 & 49 & 331
2 SFT 1611 & 1624 / YDH 984 & 994
3 SFT 1612 / YDH 985

Associated risks on CRR

SFT - 2, 4, 6, 7, 8, 9, 12, 277, 326, 372, 673, 831, 842, 862, 864, 923, 1004, 1016, 1310, 1343, 1356, 1482, 1510, 1513, 1519, 1542, 1577

YDH - 21, 45, 49, 83, 100, 331, 372, 652, 687, 737, 864, 874, 916

Key controls currently in place to manage the risk to achieving this objective

Elective performance monitored fortnightly System Performance Group and through Directorate QOFP process. Additional weekly meetings held with directorates/specialties for cancer and RTT according to the scale of risk.
Accountability processes and governance framework
COVID Recovery Co-ordination Group reports and plans
Intermediate Care Programme Board
Oversight of the activities of the Somerset Collaboration Hub through the system-wide Collaboration Forum
People Strategy overseen through People/Workforce Committees
Colleague Health, Wellbeing & Resilience programmes.
Inclusion Strategies.
Values into Action workshops.
Digital Board
Merger Programme Board

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)

Quarterly Finance Committee reports (+)
Quarterly reports to Trust Board on Learning from Deaths (+)
Quarterly report to Trust Board on Freedom to Speak up (+)
National Freedom to Speak Up Guardian Report (+)
National Staff Survey (+)
Internal Audit of Cultural Maturity (+)
Performance monitored through Accountability Framework process (+ /-).
Board Quadrant reports (+ / -)
External review through NHSI/CQC liaison meetings (+ / -)
Merger Updates to Board (+)
Merger Updates to Board (+) NHSE review of Merger plans and preparedness

Strength of controls

Amber

Significant gaps in current controls

Insufficient capacity to meet demand
Capital resources to support infrastructure requirements

Strength of assurance

Amber

Areas where further assurance is required

System level monitoring and reporting within the ICS

Key transformation plans and strategies to achieve objective

	Strategy	Owner	Assessment of Progress
1	Merger Business Case	David Shannon	Green
2	Elective Recovery Programme	Matthew Bryant	Amber

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress
A	System Bed Capacity Plan	AH/MB	tbc	Funding agreed by Region. Delivery trajectory now being set.
B	Additional elective capacity being sought via insourcing and use of other System's facilities (e.g. Exeter Nightingale)	XW	Mar-23	Contracts in place. Additional capacity continues to be sought/identified.

3	People Strategy - Values engagement & build	Isobel Clements	**Green**	C	System to participate in Right Procedure Right Place (surgery) programme	FC	Dec-22	Programme developing well. Recent positive review by national lead for High Volume Low Complexity (HVLC) / Get It Right First Time (GIRFT); modelling being undertaken to understand impact on bed requirements.
4	Digital Strategy	David Shannon	**Green**	D	Elective capacity shortfall (78 weeks) modelled/understood and plan in place.	XW	Nov-22	Significant reductions in 78-week cohort delivered to date (better than trajectory). On track to deliver plan (300 at March 23)
5	Communications and Engagement Strategy	Fiona Reid	**Amber**	E				

Somerset NHS Foundation Trust/Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Joint Corporate Risk Register Report
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Deputy Director of Integrated Governance
PRESENTED BY:	Director of Corporate Services
DATE:	7 February 2023

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

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

Recommendation	The report covers those risks detailed on the Somerset Foundation Trust (SFT) and Yeovil District Hospital NHS Foundation Trust (YDH) corporate risk registers on 10 January 2023. The report focuses on the high risks scoring 15+ on the risk matrix. The Board are asked to note the report and the risks identified.

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

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

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

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
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 (SFT)
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST (YDH)

CORPORATE RISK REGISTER REPORT 10 JANUARY 2023

1. PURPOSE OF THE REPORT

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

2. JOINT RISK MANAGEMENT ARRANGEMENTS

2.1 This risk report aims to provide details of the key risks detailed on the Trust's corporate risk registers on 10 January 2023. The report focuses on those risks scoring 15+ on the risk matrix.

2.2 Following the joint Board discussion in April 2022, work is underway to implement newly aligned risk management processes across SFT & YDH in advance of the planned merger. As part of alignment, there have been minor changes to the current risk scoring tools, and the format for future risk register reports is being updated. This work is being led by Samantha Hann, who has been appointed as the Head of Risk across both organisations. A joint Risk Management Framework is being developed during 2022/23.

2.3 In the joint Board meeting in July 2022, the Board were updated on the progress with the alignment work which included the purpose of developing a risk management framework; examples of possible risk management vision statements; draft risk management aims for the new organisation; the building blocks and key actions which would be required to achieve the aims; the measures which will evidence the aims and vision are being achieved; the risk management policy and what this will include; and next steps for the Board and the Risk team.

2.4 In September 2022, the joint Board held a seminar session where the Board discussed and approved the risk management vision and risk management aims for the new organisation. The majority of the session focused on a discussion on the possible risk appetite and risk tolerance approaches that could be used by the new organisation. The risk appetite and risk tolerance approaches were approved by the joint Board and it was agreed within Quarter 3 2022/23, the Board sub-Committees would review the strategic objectives within their remit and recommend to the Board the risk appetite levels. The Board would be asked to approve the recommendations and set the risk appetite levels for strategic objectives 1 and 8 in February 2023.

2.5 The Board sub-Committees have met on the following dates and reviewed and discussed the risk appetite level for the strategic objectives under their remit for recommendation to the Board of Directors:

- People Committee on 14 November 2022 discussed strategic objective 6
- Quality & Governance Committee on 23 November 2023 discussed strategic objectives 2, 3, 4 & 5
- Financial Committee on 6 January 2023 discussed strategic objective 7

3. JOINT CORPORATE RISK REGISTER

3.1 There are currently sixty-five risks on the combined corporate risk register. Forty-four of these risks are on the SFT corporate risk register and twenty-one on the YDH corporate risk register. This is an increase in the number of risks on both the SFT and YDH corporate risk registers since Quarter 2 2022/23 due to the unprecedented levels of demand on the Trusts and an ongoing review of Directorate risk registers at SFT (see section 3.5).

3.2 Of the sixty-five risks on the combined corporate risk register, twenty-one of those risks score 20 or 25. The top twenty-one risks to the organisations are:

- Risk 0021 Unsafe numbers of attendances in the Emergency Department (YDH)
- Risk 0331 Insufficient intermediate care capacity (YDH)
- Risk 0831 Insufficient intermediate care capacity (SFT)
- Risk 0002 Risk associated with Covid19 Pandemic (SFT)
- Risk 0003 Aging Estate (SFT)
- Risk 0004 Demand (SFT)
- Risk 0007 Referral to Treatment Times (SFT)
- Risk 0012 Waiting Times (SFT)
- Risk 0049 Increased demand – opening of escalation areas (YDH)
- Risk 0100 Breach of RTT standards (YDH)
- Risk 0372 Overcrowding in ED (SFT)
- Risk 0372 Patients being lost to follow up/not enough capacity to be seen in the designated follow up regime leading to preventable sight loss (YDH)
- Risk 0399 Increased vacancy rate in Occupational Therapy (SFT)
- Risk 0947 Capital schemes not being completed within their original timescales (YDH)
- Risk 1004 Inability to provide sufficient theatre capacity for elective operating (SFT)
- Risk 1150 Orthogeriatric medical staffing (SFT)
- Risk 1310 Treatment Escalation Plans (SFT)
- Risk 1329 Core numbers of Junior and Consultant medical workforce (SFT)
- Risk 1343 Quality of Discharge Summaries (SFT)
- Risk 1408 Staffing across Community Urgent Care (Minor Injuries Units) (SFT)
- Risk 1542 Insufficient Medical Physics Expertise leading to all radiation services ceasing (SFT) (*Please note this risk is currently being updated on the YDH risk register to mirror the risk assessment undertaken at SFT*)

4. SFT CORPORATE RISK REGISTER

4.1 The corporate risk register attached is a summary format produced from the “Radar” risk management system.

4.2 The Governance Support Team has worked with the suppliers of the Radar system to design and implement a format and workflows for the risk register in Radar that allows production of an interactive risk register, with drill down enabled to allow examination of the details of existing controls, actions, etc.

4.3 There are currently forty-four risks on the SFT corporate risk register:

- one risk is rated 25 (intermediate care)

- Fourteen risks are rated 20 (overall Covid risk; the condition of the estate; increasing demand; RTT risks; waiting times; core numbers of Junior and Consultant medical workforce: OT vacancy rate; overcrowding in ED; treatment escalation plans; quality of discharge summaries; inability to provide sufficient theatre capacity for elective operating; Orthogeriatric medical staffing; staffing across Community Urgent Care - Minor Injuries Units; and insufficient Medical Physics Expertise leading to all radiation services ceasing)

- Nineteen risks are rated 16 (diagnostic waiting times; district nurse staffing; colleague pressures; primary care provision; community podiatry vacancies; community social care provision for complex young people; escalation beds; end of life pharmacy robot; shortage of clinical consumables; inability to provide endoscopists to meet capacity for colonoscopy lists; inability to recruit vacant Neurology consultant posts; significant nursing and support staff vacancies on the Paediatric ward; Dental Service workforce; community care and Adult Social Care provision for Learning Disability patients; continued pressures on BI service teams; lack of SLT provision for patients with upper airway disorders; activity within community midwifery impacting on prioritisation of safeguarding; patients waiting in Ambulances outside of ED; and Clinical Coding backlog)

- Ten risks are rated 15 (disaggregation of RIO; cancer standards; nurse and AHP shortages; delivery of CIP; poor condition of Shepton Mallet Community Hospital Portakabin Units; no coordinated approach to the transition of children and young people with complex care needs; lack of qualified Resuscitation Team staff; high use of bank and agency staffing; Community Rehab Service (CRS) low staffing levels; and insufficient time to undertake governance processes).

4.4 There have been eleven new risks added and five risks which have increased during Quarter 3 2022/23 to date. The risks which have reduced within the quarter and been archived are included within the main report.

4.5 A number of additional risks scoring 15 or more continue to be identified at Directorate and Departmental levels. The majority of these have been linked to the corporate risks on escalation and staffing, but work is currently on-going to update processes, to ensure new risks scoring 15 or more are formally reviewed, with timely input from the Governance Support Team.

5. YDH CORPORATE RISK REGISTER

5.1 The corporate risk register attached is a summary format manually extracted from the “Ulysses” risk management system.

5.2 The report includes where applicable new risks added within Quarter 3 2022/23 and the risks which have reduced or have been archived during Quarter 3 2022/23.

5.3 There are currently twenty-one risks on the YDH corporate risk register:

- two risks are rated 25 (intermediate care; and unsafe numbers of attendance in the Emergency Department)

- four risks are rated 20 (escalation areas open due to demand; breach of RTT standards; patients lost to follow up/not enough capacity to be seen; and capital schemes not being completed within their original timescales)

- seven risks are rated 16 (GP cover within SHS Practices; staff resilience (SHS); violence & aggression towards Practice staff (SHS); product shortages/significant delays of supplies; inability to comply with cancer standards due to outpatient capacity; retention and turnover of staff; and insufficient Clinical Nurse Specialist cover (Gynaecology))

- eight risks are rated 15 (deteriorating cancer performance; inability to support additional escalation beds (SHS); inappropriate environment to safely manage mental health patients; inability to retain and recruit critical care consultant intensivists; failure to control costs; Anaesthetic Practitioner on call service provision; levels of dependency of patients in beds risking delay in evacuation of AEC in the event of a fire; and evacuation of patients on wards 6 to 9

5.5 There are a number of emerging risks which have been added to the risk register within Quarters 3 2022/23 with a score of 12 which will be closely monitored and mitigating action plans developed:

- Risk 926 – Industrial strike action (this risk is also an emerging risk for SFT and added on RADAR as Risk-1494)
- Risk 931 – Lack of capacity to cover endoscopy lists in week due to lack of endoscopist cover
- Risk 937 – No podiatry service provision. No band 7 advanced practitioner podiatry cover available to cover Maternity leave of current post holder leaving end of October.
- Risk 944 – Lack of Uro-oncology cover from 16 December 2022. Reducing to one Uro clinic per week covered by SFT
- Risk 945 – Reduced consultant gynae-oncology cover from December leading to no cover in February 2023
- Risk 948 – Loss of power to IT comms rooms housing core network switches and fibre links for the main site
- Risk 968 – Delays in diagnosis and treatment due to backlog of echocardiology appointments

5.6 The YDH risk register, including the Corporate Risk Register, is a YDH Group risk register and therefore risks in relation to the two Subsidiary Companies of YDH - Simply Serve Limited and Symphony Healthcare Services - will be included within the report.

6. CONCLUSION

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

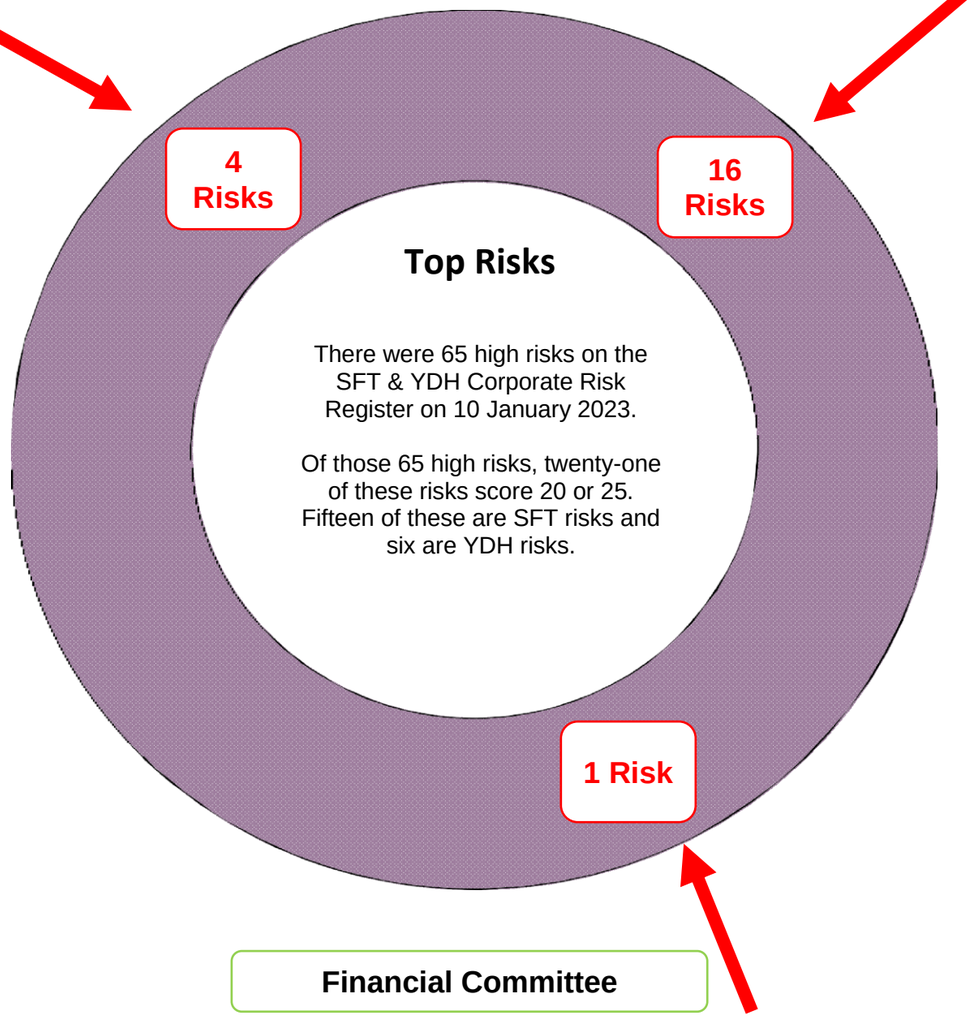
7. RECOMMENDATION

7.1 The Board of Directors are asked to review the Corporate Risk Registers.

SFT & YDH Corporate Risk Register 10 January 2023

People Committee

20 S 0399 Increased vacancy rate in Occupational Therapy across the organisation
20 S 1150 Orthogeriatric medical staffing
20 S 1329 Core numbers of Junior and Consultant medical workforce
20 S 1408 Staffing across Community Urgent Care (Minor Injuries Units)
16 Y 0236 Reduced GP cover within SHS Practices
16 S 0343 Inability to recruit to vacant Neurology Consultant posts
16 S 0366 Ongoing shortfall in staffing levels within the District Nursing Teams
16 S 0588 High vacancy rates in Community Podiatry services
16 S 0690 Ongoing unsustainable pressure to colleagues in the Trust
16 Y 0728 Reduced staff resilience including staff burn out (SHS)
16 Y 0729 Violence & aggression towards Practice Staff (SHS)
16 Y 0868 Insufficient Clinical Nurse Specialist cover (Gynaecology)
16 Y 0925 Retention and turnover of staff
16 S 1214 Lack of SLT provision for patients with upper airway disorders
16 S 1400 Significant nursing and support staff vacancies on the Paediatric ward
16 S 1491 Inability to provide endoscopists to meet capacity for colonoscopy lists
16 S 1505 Inability to deliver Dental Service due to workforce challenges
15 S 0082 Nurse and AHP Staffing Shortage
15 Y 0515 Inability to retain and recruit critical care consultant intensivists
15 Y 0772 Anaesthetic Practitioner On Call Service Provision
15 S 1470 Community Rehab Service (CRS) low staffing levels
15 S 1510 High use of bank and agency staffing
15 S 1512 Lack of qualified Resuscitation Team staff



20 Y 947 Capital schemes not being completed within their original timescales
15 S 006 Delivery of CIP 2022/23
15 Y 737 Failure to control costs

Key: **Risk Score = 15-25** **S = SFT Risks** **Y = YDH Risks** **01 = Unique Risk Reference**

Quality & Governance Committee

25 Y 0021 Unsafe numbers of attendances in ED
25 Y 0331 Insufficient intermediate care capacity
25 S 0831 Insufficient intermediate care capacity
20 S 0002 Risks associated with Covid 19 Pandemic
20 S 0003 Aging Estate
20 S 0004 Demand
20 S 0007 Referral to Treatment Times
20 S 0012 Waiting Times
20 Y 0049 Increased demand – opening of escalation areas
20 Y 0100 Breach of RTT standards
20 S 0372 Overcrowding in ED
20 Y 0372 Patients being lost to follow up/not enough capacity to been seen in the designated follow up regime leading to preventable sight loss
20 S 1004 Inability to provide sufficient theatre capacity for elective operating
20 S 1310 Treatment Escalation Plans
20 S 1343 Quality of Discharge Summaries
20 S 1542 Insufficient Medical Physics Expertise leading to all radiation services ceasing
16 S 0009 Diagnostic Waiting Times Performance
16 Y 0083 Product shortages and/or significant delays of supply due to unpredictable market
16 S 0277 Activity within community midwifery impacting on prioritisation of safeguarding
16 S 0673 Current capacity and future resilience of primary care in Somerset
16 Y 0687 Inability to comply with Cancer standards due to lack of outpatient capacity
16 S 0842 Community social care provision for complex young people
16 S 0862 Escalation Beds
16 S 0923 Patients waiting in Ambulance outside of ED
16 S 1016 Clinical Coding backlog
16 S 1356 Shortage of Clinical Consumables
16 S 1482 End of Life Pharmacy Robot
16 S 1513 Community care and Adult Social Care provision for Learning Disability patients
16 S 1577 Continued pressures on BI service teams
15 S 0008 Cancer Standards
15 Y 0045 Evacuation of patients on wards 6 to 9
15 S 0326 No coordinated approach to the transition of children and young people with complex care needs
15 S 0534 Poor condition of Shepton Mallet Community Hospital Portakabin Units
15 Y 0652 Deteriorating cancer performance & inability to meet cancer standards
15 Y 0864 Inability to support the additional 10 escalation beds at La Fontana Care Home in Martock (SHS)
15 Y 0874 Inappropriate environment to safely and appropriately manage mental health patients and patients with behavioural issues
15 Y 0961 Levels of dependency of patients in beds risking delay in evacuation of AEC in the event of a fire
15 S 1046 Rio disaggregation (separation of systems)
15 S 1519 Insufficient time to undertake governance processes

SFT Corporate Risk Register List Report - 10 January 2023

Report Date: **10-Jan-2023**

Filters: Categories: **Corporate Risk**
Current Score: **15 - 25**

Reference	Category	Scope / Location	Description	Owner	Last review	Next review	Original score	Current score	Risk response	Target score	Latest comment
RSK-000831	Corporate Risk	Intermediate Care	If social care are unable to commission sufficient capacity/obtain sufficient workforce and deliver in line with system plans and to meet demand in a timely way then we will see patients delayed in acute and community hospital beds. This will lead to adverse outcomes for individual patients, high occupancy rates (which also lead to poor outcomes for a much larger group of patients), a need for escalation beds, compromising colleague experience in a significant way and resulting in high levels of unplanned overspend. It will cause poor ED performance, and cancellation of elective patients causing further patient safety risks, as well as a reputation and regulatory risk associated with this.	Matthew Bryant	30-Aug-2022	29-Sep-2022	25	25	Treat	15	
RSK-000003	Corporate Risk	Organisation	Aging Estate - if the Trust is not able to invest sufficiently in backlog maintenance on the acute hospital site, then there is a risk to the sustainability of high quality care in some specialties.	David Shire	28-Dec-22	31-Mar-23	20	20	Tolerate	20	
RSK-000007	Corporate Risk	Organisation	RTT - if we do not have sufficient capacity and resource currently allocated to meet the demand for non-admitted and admitted care then waiting times will continue to lengthen.	Matthew Bryant	30-Aug-2022	31-Oct-2022	16	20	Treat	20	There is an active programme of system-wide actions to support long term recovery, which includes the shared use of capacity across the system, ways of re-routing demand to available capacity, full use of available Independent Sector capacity, and ways of managing demand differently.
RSK-000004	Corporate Risk	Organisation	Demand - if demand for services continues to increase in-line with demographic trends then the Trust will not have sufficient capacity.	Peter Lewis	10-Jan-22	01-Apr-22	20	20	Tolerate	16	
RSK-000002	Corporate Risk	Organisation	COVID - Risks associated with Covid 19 Pandemic.	Peter Lewis	30-Aug-2022	29-Sep-2022	25	20	Tolerate	15	
RSK-000012	Corporate Risk	Organisation	Waiting Times - if we are unable to provide sufficient capacity to enable us to meet clinically acceptable waiting times for patients for non-admitted and admitted care, including follow up intervals then this has the potential to impact on the clinical outcomes for patients.	Matthew Bryant	30-Aug-2022	31-Oct-2022	20	20	Treat	15	
RSK-001329	Integrated & Urgent Care	Acute Medical Wards	Inability to staff within core numbers of junior and consultant medical workforce, reliance on bank and agency. Patient safety risks, care and quality at risk, health and well being concerns for workforce.	Julie Thomas	03-Jul-2022	30-Nov-2022	20	20	Treat	12	
RSK-001408	Neighbourhoods & Primary Care	MIU	Staffing across Community Urgent Care (Minor Injuries Units) - Frequent closures, patients arriving at community hospitals for MIU closed at short notice, staff travelling/moving between sites at short notice, staff stress and fatigue	Michael Paynter	06-Dec-22	31-Jan-23	16	20	Treat	12	Risk score increased from 16 to 20 on 13 October 2022
RSK-001310	Corporate Risk	Organisation	Treatment Escalation Plans - There is no automated process for treatment escalation plans so they are not easily accessible/communicated or readily available between services/organisations in Somerset. If a clinician does not know the details of an existing treatment escalation plan, then they are likely to give poor, dangerous, or potentially criminal, care to patients	Charles Davis	20-Nov-22	31-Mar-23	20	20	Treat	9	
RSK-001343	Corporate Risk	Organisation	Quality of discharge summaries due to lack of Pharmacy input - risks to patient safety, risk of readmission, impact on primary care	Andrew Prowse	02-Oct-2022	31-Oct-2022	20	20	Treat	9	New Risk Added following audit undertaken
RSK-000372	Integrated & Urgent Care	Emergency Department	Overcrowding in ED - Where there is overcrowding in the department there is a risk to patient safety and clinical management. This can be caused by delays in hospital admissions/bed allocation, increased numbers of unwell patients presenting thought IFD/minors (walk ins/self presenting), high volumes/batching of ambulance arrivals, capacity to accommodate patient volume including availability of examination rooms for arriving patients. Compromising patient care leads to poorer outcomes - increased morbidity and mortality due to e.g. departmental crowding, ambulance arrivals not able to be offloaded, walk in patients spending considerable time in the waiting areas before being seen, staff stress, compromised infection control, patients being managed in non-clinical areas, delays in patients receiving treatment and care including medications. Delays in ambulance handovers - leading to further queuing of ambulances outside ED.	Toby Stockton	16-Dec-22	15-Jan-23	20	20	Treat	9	

RSK-001004	Surgical Care	Surgical Care - Management Team	Inability to provide sufficient theatre capacity for elective operating with an appropriate post-op bed base to meet demand - Patients may be at risk of harm due to increased waiting times for elective procedures and the Trust will not meet national performance targets	Fred Cock	20-Sep-2022	01-Dec-2022	20	20	Treat	9	21/09/22 QOFP review with NF - Sept 2022 - Step up programme still in progress. Ongoing bed have led to cancellations. Agreed to review in December 2022.
RSK-001150	Surgical Care	Orthopaedics	Orthogeriatric medical staffing - Inability to deliver safe and efficient Orthogeriatric service and failing to achieve BEST Practice Tariff due to recruitment and retention of orthogeriatric medical staffing. Patients' care will be compromised resulting potentially in death or major permanent incapacity.	Beatrix Hajdu-Howe	18-Oct-2022	23-Nov-2022	20	20	Treat	8	Risk Review: 19/10/22 Risk discussed again at Governance Huddle due to scoring being a 20 agreed risk score remains high. Will review the risk monthly through Huddle.
RSK-000399	Corporate Risk	Therapies	Increased vacancy rate in Occupational Therapy across the organisation impacting on patient outcomes and flow	Rebecca Keating	29-Dec-22	03-Apr-23	15	20	Treat	8	
RSK-001542	Clinical Support & Specialist Services	Organisation	The current RPA cover (with RRPPS) for SFT, YDH, and Alliance PET will cease on 31st March 2023. This will mean that, unless resolved, the Trust will have insufficient Medical Physics Expertise available and will therefore need to cease all use of radiation services or continue operating whilst non-compliant with radiation protection legislation.	Toni Hall	10-Dec-22	31-Jan-23	25	20	Treat	5	New Risk Added
RSK-000673	Corporate Risk	Organisation	Issues with the current capacity and future resilience of primary care in Somerset are significantly impacting on capacity across the Trust in areas already under pressure (including ED, MIUs, district nursing, etc.)	Andy Heron	17-May-22	30-Jun-22	16	16	Tolerate	16	
RSK-001214	Clinical Support & Specialist Services		Unable to provide a new service for patients with upper airway disorders as the severe asthma clinic does not currently have SLT provision	Karen Dockings	01-Dec-22	27-Jan-23	9	16	Treat	16	Risk increased
RSK-000009	Corporate Risk	Organisation	Diagnostic Waiting Times Performance - if we continue to experience growth in demand greater than our ability to supply capacity for key diagnostic modalities, then we will fail to meet national standards.	Matthew Bryant	30-Aug-2022	31-Oct-2022	16	16	Treat	12	
RSK-000366	Corporate Risk	District Nurses	There is an ongoing shortfall in staffing levels within the District Nursing Teams.	Mary Martin	03-Jan-23	10-Jul-23	16	16	Treat	12	There is no change to the risk assessment as the teams remain in OPEL 3 with work undone. Priority is given to priority one patients. Deferring work every day or most days is a red flag and is escalated daily. (13-Oct-2022)
RSK-000690	Corporate Risk	Organisation	Ongoing unsustainable pressure to colleagues in the Trust	Isobel Clements	15-Mar-22	31-May-22	16	16	Treat	12	
RSK-000842	Families	CAMHS	Lack of appropriate community social care provision for complex young people presenting in psychological distress - This can at times lead to extreme pressure on acute and community health services, disrupting the safety of services and impacting on staff wellbeing. Frequent family/care breakdown leading to increased risk of corporate care or admission to acute and psychiatric hospitals. Frequent inappropriate admissions to acute hospital beds with no clear and timely onward care options. Impact on patient experience leads to increased expressions of emotions, risk of self-injury and accidental incidents. This can lead to incidents of restraint which would otherwise not occur. Increased levels of stress, sickness and poor staff retention.	Mark Conway	05-Jan-23	03-Apr-23	12	16	Tolerate	12	
RSK-000923	Integrated & Urgent Care		Patients waiting in Ambulances Outside ED due to lack of capacity within department leading to patient harm	Toby Stockton	16-Dec-22	31-Jan-23	12	16	Treat	12	Risk increased
RSK-001505	Families	Dental	Dental workforce Challenges - Inability for the service to deliver commissioned activities	Zillah Morris	05-Dec-2022	30-Dec-2022	12	16	Treat	12	New Risk Added
RSK-000862	Corporate Risk	Acute Hospital Wards	Escalation Beds - risks to patient safety and patient experience from increased need for escalation beds at MPH, including doubling up in single rooms in the Jubilee Building	Alison Wootton	02-Oct-2022	31-Jan-2023	16	16	Tolerate	10	Escalation bed numbers have reduced but still many open so risk continues.
RSK-001356	Corporate Risk	Organisation	Issues with clinical supplies - Shortage of clinical consumables affecting care and treatment of patients	Karen Tyler	22-Jul-22	22-Jul-22	16	16	Treat	9	New Risk Added
RSK-001513	Mental Health & Learning Disabilities		Pressure relating to community care provision and Adult Social Care provision is impacting on Learning Disability patients accessing appropriate social care and support in a timely manner and meaning care providers are not adhering to health care plans (including eating and drinking plans) or providing commissioned levels of care.	Thomas Clifford	09-Jan-23	10-Feb-23	20	16	Treat	6	New Risk Added
RSK-000277	Families		If the current activity continues in community midwifery then there is a risk that the safeguarding will not be prioritised by the existing workforce at the detriment to unborn babies, vulnerable women & families.	Dawn Sherry	14-Dec-24	31-Jan-23	12	16	Treat	6	Risk increased

RSK-000588	Corporate Risk	Podiatry	Community podiatry services are under significant pressure due to high levels of demand and high vacancy rates.	Anthony Joyce	13-Dec-22	31-Jan-23	16	16	Treat	4	
RSK-001482	Clinical Support & Specialist Services	Organisation	Pharmacy Robot: Risk of - Significant faults or complete system shut down which would mean Pharmacy are unable to process medication orders in a timely manner Due to - Existing pharmacy robot is now 16 years old and at the end of its life. Normal life of robot is 10-12 years. Significant faults being reported frequently Resulting in - Delayed discharges which impact on operational flow, delayed medications to inpatients including critical medications, increased length of stays for inpatients, patient safety risks, colleagues being called back from the wards to support the Pharmacy team if Business Continuity plans need to be enacted	Andrew Prowse	02-Oct-2022	04-Jan-2023	16	16	Treat	4	New Risk Added
RSK-000343	Integrated & Urgent Care	Neurology	The demand on the neurology department at MPH does not meet the capacity available due to the inability to recruit to the x 3 vacant consultant posts and therefore the service has an ever-increasing backlog of work across both MPH and YDH.	Imogene Spink	16-Dec-22	31-Jan-23	9	16	Treat	4	
RSK-001016	IT & Digital		Clinical Coding Backlog of around 13,000 uncoded episodes. This could have a reputational risk that uncoded data is not being submitted via SUS and national indicators such as SHIMI will be incorrect.	Nigel Holland	04-Jan-23	31-Jan-23	12	16	Treat	3	Risk increased
RSK-001400	Families	Paediatric Inpatients	Significant nursing and support staff vacancies on the Paediatric ward - Recognition that even when full staffed the Paediatric ward does not have equitable staff across all shifts and is not meeting Royal College of Nursing (RCN 2018) standards for safe staffing. The Paediatric Assessment Unit is not open on the weekends and this impacts the number of admissions to the ward and staff to patient ratios.	Sarah Davies	07-Dec-22	31-Jan-23	16	16	Treat	2	
RSK-001491	Surgical Care	Endoscopy	Inability to provide endoscopists to meet capacity for colonoscopy lists - Colonoscopy's will continue to breach the national target for 2WW pathways.	Laura Jones	10-Oct-2022	13-Nov-2022	16	16	Treat	1	New risk added 11/10/2022. 26/09/22 Risk discussed at Governance Huddle
RSK-001577	IT & Digital		Continued pressures on BI service teams will prevent necessary work to enable the integration of reporting processes for the new merged Trust. Incorrect information could be submitted nationally and locally	Nigel Holland	04-Jan-23	31-Jan-23	16	16	Treat	1	New Risk Added
RSK-000008	Corporate Risk	Organisation	Cancer Standards - if we continue to fail to meet the 62-day referral from GP Cancer Standard, then this could result in adverse patient experience.	Matthew Bryant	30-Aug-2022	31-Oct-2022	16	15	Treat	15	Patients are continuing to be prioritised for cancer treatment, in line with the national prioritisation codes and timescales established during Covid. Patients treated for a colorectal cancer made-up 50% of all the breaches of the 62-day standard. A review has been undertaken of the colorectal pathway and a working group has been established to identify interventions.
RSK-001046	Corporate Risk	Safeguarding	Rio disaggregation (separation of systems) - key risk is missing key information that informs safeguarding action or risk assessment	Richard Painter	24-Mar-22	03-Aug-22	15	15	Tolerate	15	
RSK-001510	Mental Health & Learning Disabilities	Organisation	High use of bank and agency staffing due to increased levels of long-term & short term staff sickness and high acuity of patients on increased observations.	Amanda Fear	09-Dec-22	09-Jan-23	15	15	Treat	15	New risk added 2 November 2022
RSK-000534	Corporate Risk	Outpatient Dept - Shepton Mallet Community Hospital	Shepton Mallet Community Hospital - Old portakabin units used for clinical services as OPD facility are in poor condition, expensive to maintain & run (Heating costs, poor windows, heating via Oil fired boilers). Part of roof also needs to be supported. Potential for ceiling in clinical area (not currently in use) to collapse. Impact on patient, staff environment, services being managed within units and health and safety risks	Neil Hughes	20-Sep-2022	30-Mar-2023	12	15	Treat	15	These building are leased from NHS Property Services to Practice Plus (formerly Care UK Ltd) and subsequently sub-let to Somerset NHS FT. Somerset NHS FT have notified Practice Plus (Contractual Route) that the building are unfit for clinical use without substantial investment required. Next opportunity to evoke a break clause is 2nd May 2023 and lease expires 27th April 2028. This fits into FFMF (Fit for my Future) workstream. Reported to current lease holder representing Trust Landlord (Practice Plus) and escalated to NHS Property Services (Landlord)

RSK-000006	Finance Team	Organisation	The Trust cannot deliver CIP plans for 2022/23	Mark Hocking	22-Aug-22	29-Sep-22	20	15	Treat	10	The Trust delivered the requirement level of savings in H1 and has plans in place to delivery the required level of savings in H2 to ensure the overall target is achieved.
RSK-000082	Corporate Risk	Organisation	Nurse and AHP Staffing Shortage and increased activity across all services - Risk of impact on quality of patient care and increased pressure on colleagues	Alison Wootton	31-Oct-2022	31-Dec-2022	20	15	Treat	8	This risk is linked to an increasing number of risks in individual departments across acute wards and community services.
RSK-001512	People Team	Organisation	Significant lack of qualified Resuscitation Team staff. Service provision does not meet demand.	Jessica Purdy	08-Nov-2022	08-Dec-2022	15	15	Treat	6	New risk Added
RSK-000326	Families	Paediatric Community Nursing Team	No coordinated approach to the transition of CYP (children and young people) with complex care needs - continue to risk causing significant harm to this highly vulnerable cohort of young people.	Mary Trotman	04-Sep-2022	08-Jan-2023	15	15	Treat	4	
RSK-001470	Neighbourhoods & Primary Care	IRT	Community Rehab Service (CRS) low staffing levels due to difficulty with recruitment and retention issues	Helen Hutchinson	05-Dec-22	31-Jan-23	15	15	Treat	4	
Risk-001519	Families		If there is no allocated time for a consultant neonatologist and neonatal nurse to review and lead on governance, then there is a risk that cases, incidents, investigations and reports are not reviewed by the whole multidisciplinary team which could impact on the appropriate action and escalation being taken and how learning from these incidents are shared	Nicola Van-Eerde	11-Nov-22	31-Jan-23	15	15	Treat	2	New Risk Added

RISKS WHICH HAVE REDUCED DURING QUARTER 3 2022/23

RSK-000015	Corporate Risk	Dental Services	Dorset Dental General Anaesthetic Paediatric List - if the waiting list exceeds waiting targets then health outcomes and patient experience will be adversely affected	Zillah Morris	28-Oct-22	30-Nov-22	15	12	Treat	9	Risk reduced from 15 to 12
RSK-000017	Corporate Risk	Community Hospitals Wards	Community Hospital staffing levels - if the current problems with community staffing levels and the national and local recruitment market for nurses persists, there is a risk of failing to meet safer staffing levels in Community Hospitals.	Norma Coombes	11-Nov-22	11-Feb-23	15	12	Treat	3	Risk reviewed and score reduced from 15 to 12
RSK-001088	Surgical Care	Ophthalmology	IF: the backlog of the reviewing virtual glaucoma notes is not reduced THEN: patients are at an increased risk of sustaining sight loss	Helen Evans	24-Oct-22	01-Dec-22	16	9	Treat	6	Risk reduced from 16 to 9 following discussion at Governance huddle
RSK-001487	Clinical Support & Specialist Services	Organisation	National shortage of Alteplase which is used for thrombolysis in stroke patients - the impact of supply shortages may mean that some patients who are eligible for thrombolysis may not receive the life changing treatment	Rebecca Halley	23-Nov-22	31-Dec-22	15	9	Treat	6	Risk reduced from 15 to 9
RSK-001087	Neighbourhoods & Primary Care	Older Persons Mental Health - South Somerset	Increasing vacancies and inability to recruit to older persons mental health team leading to increased waiting times, reduction in service provision, reduced clinical support, low staff morale	Sharon Phillips	25-Nov-22	05-Dec-22	16	8	Treat	2	Risk reduced from 16 to 8

RISKS WHICH HAVE ARCHIVED DURING QUARTER 3 2022/23

RSK-000018	Neighbourhoods & Primary Care	MIU	Minor Injury Service ACP staffing deficit - If the Difficulties in recruitment and retention of Advanced Clinical Practice Roles countywide persist then there is a risk of not delivering a safe and/or effective service	Alyson Rees	19-Sep-2022	06-Oct-2022	16	16	Treat	8	Risk closed on 5 October 2022. Reason: duplicate risk. amalgamated into RSK001408

YDH Corporate Risk Register 10 January 2023

Total number of high risks (15+) Risk Number, Board Assurance Committee & Risk Description (QGC – Quality Governance Committee, FC – Finance Committee, PC – People Committee)		Movement of Risk Since Last Reviewed & Date Last Updated	Main Specialty / Second Specialty Risk Lead & Risk Owner	Current Score					Target Score				
				L	x	C	=		L	x	C	=	
331 QGC	Risk of: Continued high level of over 21 day length of stay and those patients waiting for care at alternative providers Due to: Insufficient intermediate care capacity as social care is unable to commission sufficient capacity/obtain sufficient workforce and deliver in line with system plans and meet demand in a timely way; insufficient community hospital provision; and at times insufficient specialist treatment centres for complex patients Resulting in: Patients not cared for in the most appropriate place; delay in patients onward care and treatment; adverse outcomes for individual patients; high occupancy rates leading to poorer outcomes for larger groups of patients; reduction in patient flow; Trust's ability to maintain performance standards; financial risk to opening additional escalation areas; compromised colleague experience; poor Emergency Department (ED) performance; cancellation of elective patients; patient safety risks; and reputational and regulatory risks to the organisation ***Update at last review - Work ongoing to address. Discharge Steering Group has been established to review delayed discharges and associated harm. Incidents will be submitted to reflect outcomes. Escalation process for length of stay is now in progress which will be monitored with a tracker. This should be live by mid-September. Reviewing patients 14 days and over that are not medically fit to look at what is outstanding to aid a quicker discharge where possible. Every Wednesday over 14 length of stay reviews are undertaken by Ward Matrons. Any complex patients continue to be identified so social care can be involved as early as possible. Reviewing intermediate care capacity as a system to improve flow. Risk reviewed by QGC on 21 September 2022 and agreed risk score remains at 25. The issues outside of the control of the organisation and within the wider Somerset System were discussed and an update provided by the ICB Chief Nurse who was in attendance at the meeting.***	⇔ 12/12/2022	Patient Flow / Clinical Trustwide Risk Lead – Michele Brown Executive Lead – Matthew Bryant	5	x	5	=	25	2	x	5	=	10
21 QGC	Risk of: Delays for patients and potential patient safety issues together with the co-ordination and ability to escalate can be compromised Due to: Overcrowding in the ED with unsafe numbers of attendances Resulting in: Delays in treatment and patients potentially being at risk of the reported worsened clinical outcomes when in ED for longer than 4 hours ***Update at last review - Increased risk score due to extreme and unprecedented levels of escalation. Managing over 80 patients in the ED at one time at points and exceeding previous highest number of daily attendances. Acuity also is at its highest with a particular increase in risk of the acuity of the walk-ins as well as significant delays in offloading ambulances. These both add to increase in delays in initial assessment and therefore treatment. Have had to utilise our Minor Injuries Assessment (MIA) area for increased acuity patients as well as using fracture clinic to increase our footprint to be able to manage the demands that are in ED. These areas are not fully set up to take this type of patients cohort. Nurse staffing has been increased significantly to support the increase in demands/acuity and space. Further pressure is added with challenges with equipment/consumables when managing such high demands. This includes, beds/trollies/oxygen/medications/oxygen masks/syringes.***	↑ 29/12/2022	Emergency Department / Patient Flow Risk Lead – Sarah Riley Executive Lead – Matthew Bryant	5	x	**5**	=	**25**	3	x	2	=	6
100	Risk of: Breaching National RTT Standards at Aggregate and Specialty Level Due to: Performance deterioration following the direct impact of COVID, the residual "catch up" in referrals missed during the pandemic period and lack of elective beds is resulting in long waits for elective patients – especially those classed as P4 'routine'. Operational limitations include the lack of available beds for planned care due to increasing numbers of medically fit patients unable to be discharged	⇔ 22/12/2022	Clinical Trustwide Risk Lead – Alex Talbott	5	x	4	=	20	4	x	3	=	12

YDH Corporate Risk Register 10 January 2023

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				L	x	C	=		L	x	C	=	
QGC	Resulting in: Patients waiting longer than expected resulting in poorer health outcomes ***Update at last review - Over Summer and Autumn the RTT percentage has increased to 70%+. Recovery is continuing with a new Standard Operating Procedure (SOP) in place on the Kingston Wing, which is aiding bed availability for all surgical specialities. ENT RTT has risen to >52% from <39%, T&O RTT is rising from <39% to mid 40's in November/December. Gynaecology are holding at ~65%. Risks remain in the outlook into 2023 (bed availability, patient illness, staff sickness), but the overall trajectory is one of improvement throughout the rest of 2022/23 with 75% RTT possible by the end of March 2023.***		Executive Lead – Matthew Bryant										
947 FC	Risk of: Externally funded capital schemes not being completed within their original timescales Due to: Slippage in design/delivery/construction Resulting in: A risk that there will be a funding shortfall in future years that will impact on other priorities ***New Risk Added***	New Risk Added 15/11/2022 15/11/2022	Finance Risk Lead – Mark Hocking Executive Lead – Pippa Moger	5	x	4	=	20	3	x	3	=	9
49 QGC	Risk of: Increased demand resulting in escalation areas being opened and cancellation of elective activity due to bed capacity Due to: Increased emergency admissions and acuity of patients Resulting in: Risks to quality of care; risks include falls, pressure ulcers, medication errors, staff sickness, detrimental impact on staffing as a result of increase of bed occupancy and medical outliers ***Update at last review – Risk remains due to the continued increased in no reason to residue numbers; number of attendances; daily use of super surge beds in use; escalation areas permanently opened; overcrowding and stacking in ED on a daily basis, all of which increase the patient safety risks and risks to staff resilience. However do now have two ready to go units for medically fit patients. This will free up some of the medical workforce so that they are able to concentrate on higher acuity patients. Work load will be less stretched to cover escalation areas***	⇔ 08/12/2022	Patient Flow / Clinical Trustwide Risk Lead – Mel Smith Executive Lead – Matthew Bryant	5	x	4	=	20	2	x	3	=	6
372 QGC	Risk of: Preventable sight loss Due to: Patients being lost to follow up or not enough capacity to be seen in the designated follow up regime Resulting in: Patients losing their sight ***Update at last review - Hub is up and running with broadband now. To complete new hub, receptionist position to be in post. Backlog waiting list is improving and projection is positive with anticipated zero waiters by March 2023, therefore the risk should be able to be archived within Quarter 4 2022/23.***	⇔ 22/12/2022	Ophthalmology Risk Lead – Becky Whittaker Executive Lead – Matthew Bryant	5	x	4	=	20	2	x	3	=	6
868 PC	Risk of: Poor patient support and experience during cancer diagnosis and giving bad news. Inconsistent post operative support and recognition of complications which delays appropriate referral to relevant services Due to: Insufficient Clinical Nurse Specialist cover (CNS) Resulting in: Single point of failure, no cover for leave and absence. Poor patient experience with the potential for delay in treatment. Lack of equity in care across county for gynaecology cancer patients ***Update at last review – Likelihood of risk has increased due to the follow up of a patient missed because CNS did not have viability of her pathway as unable to be present at breaking bad news due to workload. Request for funding submitted to McMacmillan - outcome expected in January 2022***	↑ 01/12/2022	Gynaecology Risk Lead – Liz King Executive Lead – Andy Heron	**4**	x	4	=	**16**	3	x	4	=	12

YDH Corporate Risk Register 10 January 2023

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				L	x	C	=		L	x	C	=	
925 PC	Risk of: Increasing retention and turnover of staff, which was already exceeding national benchmarks across all staff groups and in all areas clinical and non-clinical Due to: Cost of living crisis; employee choice particularly for lower banded roles; staff morale; merger; burn out; ongoing pay award discussions; pandemic; collapse of social care; reputation working in health and social care; and re-evaluating work/life balance Resulting in: Loss of organisational memory; financial costs (use of agency staff due to the increased need to use temporary workforce); staff not being able to pick up additional shifts; organisational performance; morale; and increased pressurised working environment for staff ***New Risk Added – Following discussion at People Committee. Risk updated in December following confirmation from the RCN that strike action will be taken in the New Year which could further impact on staff morale and relationships.***	New Risk Added 13/10/2022 02/12/2022	Human Resources / Trustwide Risk Lead – Sharon Baxter Executive Lead – Isobel Clements	4	x	4	=	16	3	x	3	=	9
83 QGC	Risk of: Product shortages and/or significant delays of supply Due to: Unpredictable market - manufacturing and shipping delays due to worldwide events Resulting in: Unable to source alternatives, resulting in cancellation of procedures and colleagues not having the correct products to carry out their jobs ***Risk being managed by SSL*** ***Update at last review - This risk remains the same, the current market continues to be extremely volatile and monitoring of supply issues continues***	⟺ 08/12/2022	Procurement / Finance - SSL Risk Lead – Katie Mattravers Executive Lead – Pippa Moger	4	x	4	=	16	2	x	3	=	6
236 PC	Risk of: Reduced GP cover within SHS practices Due to: Lack of both permanent and locum GPs in the system Resulting in: Reduced service provision, lack of patient continuity and increased cost ***Risk being managed by SHS*** ***Update at last review - Bank pool of GPs is in place however similar pools are being created across the Country so work is being undertaken to ensure the organisation remains competitive and retains GPs. The vacancy rates continue to be monitored through individual Practice scorecards and any areas of particular concern are escalated. The organisation is looking to expand the number of training Practices across the whole of SHS. There are currently 16 contracts. Recruitment campaigns continue. New Workforce Recruitment Manager in post who will support with the recruitment campaigns increasing the focus on social media***	⟺ 13/06/2022	General Practice Risk Lead – Zoe Turner Executive Lead – Kerry White	4	x	4	=	16	2	x	3	=	6
687 QGC	Risk of: Inability to comply with time standards to see patients within 2 weeks, urgent, 4 weeks and routine 6 weeks. Inability to follow up patients from first appointment in the clinically requested outcomed timeframe. Patients being lost in the administrative process and having their wait time extended. Due to: Lack of outpatient capacity as outpatient demand filled with two week wait (2WW) and urgent new and pre assessment patients on ongoing treatment. Currently outpatient capacity is at 50% of the required capacity. Resulting in: Delayed diagnosis, failure to meet targets, poor patient experience, poor staff well being; delays to treatment; pre assessments; and surveillance, treatment not being provided at optimal intervals, overbooked clinics resulting in reduced clinic slots and/or overrunning clinics, delayed ward reviews at YDH as a result of overbooked clinics, potential of reoccurrence of cancer for patients and/or early diagnosis of the progression in cancer because if the cancer is treated earlier then this can potentially be treatable and poor patient experience. ***Update at last review - Temporary transfer of YDH outpatient haematology activity to Musgrove Park***	⟺ 01/12/2022	Haematology / Cancer Services Risk Lead – Sharon Cable Executive Lead – Matthew Bryant	4	x	4	=	16	2	x	3	=	6

YDH Corporate Risk Register 10 January 2023

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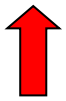
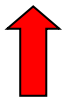
				L	x	C	=		L	x	C	=	
	Hospital (MPH) continues to ensure safe running of the service.												
728 P C	Risk of: Reduced staff resilience including staff burn out Due to: Stress/anxiety related to workplace pressures, increased demand on services, impact of the pandemic on staff resilience to cope, changes in personal circumstances for staff e.g. financial impacts, anxiety of contracting COVID19 Resulting in: Sickness absence, low morale, high turnover, early retirement, challenging behaviours towards colleagues and patients as unable to manage emotions and behaviours, instability within the working environment ***Risk being managed by SHS*** ***Update at last review – risk remains high due to increased and sustained demand and pressure on staff.***	 30/09/2022	General Practice / Human Resources Risk Lead – Zoe Turner Executive Lead – Kerry White	4	x	4	=	16	2	x	3	=	6
729 P C	Risk of: Violence and aggression towards Practice staff including verbal abuse impacting on staff wellbeing Due to: Patients and members of the public demonstrating unacceptable or criminal behaviour towards Practice staff Resulting in: Increasing stress levels in staff, impacting on sickness levels, psychological harm to staff, low morale, high turnover, early retirement ***Risk being managed by SHS*** ***Update at last review - Reviewing CCTV coverage at all Practices. For Practices without CCTV, this will be added to the site. Incident forms continue to be submitted by staff. De-escalation training has been offered to staff using the YDH Academy. Reviewing mandatory training for cohorts of staff and ensuring this is included for all patient facing roles. Due to providing Covid vaccinations, there has been contact by anti-vaccine groups which has contributed to this risk.***	 30/09/2022	General Practice / Human Resources Risk Lead – Zoe Turner Executive Lead – Kerry White	4	x	4	=	16	2	x	3	=	6
737 F C	Risk of: Not delivering in year Financial Improvement Trajectory Due to: Failure to control costs Resulting in: Breach of financial targets and duties of the organisation and potential regulatory and audit action ***Update at last review – Year to date plan adverse and operational pressures creating additional financial risk to plan.***	 05/11/2022	Finance Risk Lead – Mark Hocking Executive Lead – Pippa Moger	**5**	x	3	=	**15**	3	x	3	=	9
772 P C	Risk of: Main Theatre being unable to cover required Anaesthetic Practitioner on-call service provision Due to: Multi-factorial challenges including staff health and well being, covid vulnerable staff risk assessments, travelling time, self rostering, recruitment and retention of anaesthetic practitioners Resulting in: Small pool of anaesthetic practitioners covering all anaesthetic on call shifts across a seven day period impacting upon staff health and well being ***Update at last review – Risk increased due to increasing theatre staffing issues***	 22/12/2022	Theatre Services / Main Theatres Risk Lead – Julie Vickery Executive Lead – Matthew Bryant	**5**	x	3	=	**15**	3	x	3	=	9
515	Risk of: Inability to provide 24/7 intensivists Consultant cover which prevent YDH meeting Guidelines for the Provision of Intensive Care Services (GPICS) standards Due to: Inability to retain and recruit critical care consultant intensivists Resulting in: Current vacancies and under establishment to create a split rota enabling the ICU to be GPICS		Critical Care / ICU Risk Lead –	5	x	3	=	15	2	x	3	=	6

YDH Corporate Risk Register 10 January 2023

Total number of high risks (15+) Risk Number, Board Assurance Committee & Risk Description (QGC – Quality Governance Committee, FC – Finance Committee, PC – People Committee)		Movement of Risk Since Last Reviewed & Date Last Updated	Main Specialty / Second Specialty Risk Lead & Risk Owner	Current Score					Target Score				
				L	x	C	=		L	x	C	=	
PC	compliant. Also prevents the unit meeting training requirements and therefore we do not receive senior trainee doctors. Impacts on staff morale ***Update at last review - Risk remains, however, active recruitment campaign for 6 additional intensivists is current with one Locum Pure Intensivist commencing post in January 2023. A business case is being presented to Finance Committee in January 2023***	08/12/2022	Magnus Teig Executive Lead – Dan Meron										
652 QGC	Risk of: Deteriorating cancer performance and inability to meet cancer standards Due to: Capacity issues within radiology and endoscopy to undertake timely diagnostics; limited outpatient capacity especially for skin; urology - lack of LATP (transperineal (TP) biopsy) lists; increase in referrals across all cancer pathways Resulting in: Delays in patient pathways; delays in diagnosis and treatment for patients which could result in poorer patient outcomes and patient harm; inability to meet 2WW, 62, 28 and 31 day standards; adverse patient experience; regulatory action; loss of reputation ***Update at last review - Monthly joint service improvement groups between YDH & SFT in place to implement rapid diagnostic service (RDS) in prostrate, colorectal & gynaecology. New Patient Tracking List and Dashboards are in development. Harm reviews continue to be undertaken for any patients treated over 104 day. Joint Cancer Services workforce in place across SFT & YDH providing a countywide service.***	⇔ 08/12/2022	Cancer Services Risk Lead – Rosie Edgerley Executive Lead – Matthew Bryant	5	x	3	=	15	2	x	3	=	6
874 QGC	Risk of: Patient harm in the Emergency Department (ED) and patients harming staff Due to: Inappropriate environment to safely and appropriately manage mental health patients and patients with behavioural issues Resulting in: Greater risk to these patients, risk of harm physically and mentally to patients and staff. Poor outcomes due to YDH Emergency Department not being a mental health unit with dedicated mental health staff ***Update at last review - ED leads have recently had a meeting with Mental Health Lead to address recent incidents that have occurred and have pulled together a plan to manage high risk patients that self harm within the department. Situations are increasing. Psychiatric Liaison team also support the team including out of hours and are now permanently based in ED. Continue to see high volumes and in particular, high acuity with this cohort patients. Increasing intensity for staff when managing these patients, plus managing high levels of escalation consistently. Emotional support for team is ongoing and looking for external support now as members of staff are showing signs of distress.***	⇔ 29/12/2022	Emergency Department Risk Lead – Sarah Riley Executive Lead – Matthew Bryant	5	x	3	=	15	3	x	2	=	6
941 QGC	Risk of: Permanent pacemaker battery depletion in house bound patients Due to: Inability of CID staff to travel to patients' homes Resulting in: Potential unnoticed and unrecorded battery depletion - if battery runs out and pacemaker dependent this could result in death. ***New Risk Added***	New Risk Added 10/11/2022 10/11/2022	Cardiology Risk Lead – Ashley Davidson Executive Lead – Matthew Bryant	3	x	5	=	15	1	x	5	=	5
961	Risk of: Levels of dependency of patients in beds within the department previously AEC with the risk of the delay in evacuation in the event of fire compromising the area Due to: Current occupation outside of the fire strategy for the area with no ability to carry out Progressive Horizontal	New Risk Added	Fire / AEC Risk Lead –	3	x	5	=	15	1	x	5	=	5

YDH Corporate Risk Register 10 January 2023

Total number of high risks (15+) Risk Number, Board Assurance Committee & Risk Description (QGC – Quality Governance Committee, FC – Finance Committee, PC – People Committee)		Movement of Risk Since Last Reviewed & Date Last Updated	Main Specialty / Second Specialty Risk Lead & Risk Owner	Current Score					Target Score				
				L	x	C	=		L	x	C	=	
QGC	Evacuation Resulting in: Delay and exposure to potential fire and smoke inhalation due to a one way evacuation strategy in place in a department no designed for in-patient use with lack of Progressive Horizontal Evacuation ***New Risk Added***	30/12/2022 30/12/2022	Adrian Pickles Executive Lead – Matthew Bryant										
45 QGC	Risk of: Delay in evacuating patients cross level on the wards 6 to 9 of the main hospital building exposing patients to unacceptable fire safety risk Due to: The numbers of patients on a ward, including on boarding patients, to move cross level away from a fire as well as the dependency levels of patients requiring bed movement would delay progress past the acceptable tolerable level to be exposed to heat sources or smoke. Staffing gaps on wards will affect the time to evacuate patients cross level as well as the amount of equipment with potential to block corridors. Resulting in: Unacceptable delay of evacuation with potential life risk of multiple patients ***Update at last review – Fire Risk Assessment review with the additional patients placed on corridors in wards (on-boarding) has increased the fire evacuation risk of not being able to quickly evacuate patients. Safety walk around taking place and departments being decluttered from additional equipment and Christmas decorations being removed***	 30/12/2022	Fire / Clinical Trustwide Risk Lead – Adrian Pickles Executive Lead – Matthew Bryant	**5**	x	3	=	**15**	1	x	3	=	3
864 QGC	Risk of: Inability to support the additional 10 escalation beds at La Fontana Care Home in Martock. Due to: Lack of GP and care home resource to provide the necessary care for the additional patients Resulting in: Poor patient experience, impact on staff resilience, clinical patient safety risks ***Risk being managed by SHS*** ***Update at last review - 10 beds were agreed which could be supported however an additional 10 escalation beds is unsustainable due to the lack of resource. Agreement still to be reached between the ICB, SHS & YDH on future plans to support the patients and care providers.***	 11/11/2022	General Practice Risk Lead – Zoe Turner Executive Lead – Kerry White	5	x	3	=	15	1	x	3	=	3

YDH Quarter 3 2022/23 Corporate Risk Register

Number of high risks (15+) that have <u>REDUCED</u> during Qtr 3 2022/23		Movement of Risk and Date Last Updated	Main Specialty / Second Specialty Risk Lead & Risk Owner	Current Score on 10 January 2023					Quarter 2 2022/23 Risk Score				
				L	x	C	=		L	x	C	=	
405 Q G C	Risk of: Inability to safely deliver the Acute Oncology Service (AOS) with the required nursing skills and expertise to manage this cohort of patients Due to: There is 0.6 WTE of a current funded 3.83 WTE operational to provide a 7 day service Resulting in: Patient safety concerns for inpatients as there will be no team to coordinate patients care such as advising on antibiotics, managing the Trust's Metastatic Spinal Cord Compression (MSCC) pathway, which can result in potential paralysis if not managed and coordinating ongoing treatment for patients; inability to follow up patients virtually after early discharge or following contacting the cancer helpline managed by SFT, ensuring attendance at AEC or ED is avoided; inability to provide training to ward nurses and ED staff on the management of our patients who have specialist care needs: potential impact on the wellbeing of the 0.6WTE currently in post; and continued non-compliance with mandatory national audits such as neutropenic sepsis and MSCC audit that require upload to quality dashboard on a monthly basis. ***Risk reduced - There is currently in place a speciality Dr who is covering ward rounds 4 days a week and a consultant for the 5th day. Speciality Dr has contact with a Consultant to discuss cases when required. Plan is to cover weekends eventually. Recruited to 2 vacancies within the nursing team with band 6 chemo nurse also supporting the team as a result the risk score has been reduced.***	↓ 17/10/2022	Oncology Risk Lead – Sharon Cable Executive Lead – Matthew Bryant	**3**	x	4	=	**12**	4	x	4	=	16
738 F C	Risk of: Not delivering in year Financial Improvement Trajectory Due to: Failure to deliver savings Resulting in: Breach of financial targets and duties of the organisation and potential regulatory and audit action ***Update at last review - CIP progress reviewed & forecast updated as a result, likelihood of risk reduced.***	↓ 15/11/2022	Finance – YDH Risk Lead – Mark Hocking Executive Lead – Pippa Moger	**4**	x	3	=	**12**	5	x	3	=	15
847 P C	Risk of: Undiagnosed Familial Hypercholesterolaemia (FH) (affecting 1 in 250 people) and other Lipid disorders, particularly pancreatitis due to hypertriglyceridaemia Due to: The retirement and departure of Consultant Clinical Chemist at SFT and a national shortage of trained clinical chemists has led to replacement by a (non-medically trained) Clinical Biochemist. This leaves only one Lipidologist across Somerset, at YDH, with lipidology a non-job planned aspect of their direct clinical care. Resulting in: Insufficient clinical capacity to assess patients; build-up of waiting list in Lipid and Endocrine clinics; preventable admissions for pancreatitis; insufficient clinical capacity to prescribe and deliver anti-FH therapies for appropriate patients; insufficient administrative support to maintain patient database for overarching governance of service; overwhelming capacity shortfall resulting in low staff morale and individual burnout; adverse outcomes in statutory audits will negatively affect SFT/YDH reputation; possible preventable cardiovascular deaths; negative impact on general medical service; financial risk if lipid work including FH referred elsewhere. ***Update at last review - Risk score reduced as GP WER in place to reduce the waiting list business case approved with funding to release current Consultant.***	↓ 22/11/2022	Endocrinology / Outpatients Risk Lead – Alex Bickerton Executive Lead – Matthew Bryant	**3**	x	**3**	=	**9**	4	x	4	=	16

YDH Quarter 3 2022/23 Corporate Risk Register

Number of high risks (15+) that have REDUCED during Qtr 3 2022/23		Movement of Risk and Date Last Updated	Main Specialty / Second Specialty Risk Lead & Risk Owner	Current Score on 10 January 2023					Quarter 2 2022/23 Risk Score				
				L	x	C	=		L	x	C	=	
912 P C	Risk of: Unsafe care for stroke patients and not meeting Deanery expectations for trainees Due to: Inability to secure substantive consultant Resulting in: Inadequate stroke ward cover, particular issues with Fridays and annual leave / sickness; cancellation of follow up clinics; risk to thrombolysis service; further decline in SSNAP performance. ***Update at last review - Locum now in post and cross county discussion continues regarding the future of Stroke Services including medical workforce risk score therefore reduced.***	↓ 22/11/2022	Stroke Risk Lead – Charlotte Cumberbatch Executive Lead – Dan Meron	**2**	x	**3**	=	**6**	4	x	4	=	16

YDH Quarter 3 2022/23 Corporate Risk Register

	Number of high risks (15+) that have been **ARCHIVED** during Qtr 3 2022/23	Main Specialty / Second Specialty Risk Lead & Risk Owner	Date Archived
941 QGC	Risk of: Permanent pacemaker battery depletion in house bound patients Due to: Inability of CID staff to travel to patients' homes Resulting in: Potential unnoticed and unrecorded battery depletion - if battery runs out and pacemaker dependent this could result in death. ***Risk archived 03/01/23 - Arrangement in place with FAST to bring patients onsite for pace maker checks. There is criteria in place for eligible patients and this is coordinated in line with angio runs to MPH so at no additional cost to Trust***	Cardiology Risk Lead – Ashley Davidson Executive Lead – Matthew Bryant	03/01/2023

Somerset NHS Foundation Trust/Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	The Trust Board
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held in common on 23 November 2022
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Jan Hull, Chairman of the Quality and Governance Assurance Committee
DATE:	7 February 2023

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

Executive Summary and Reason for presentation to Committee/Boardtr	The attached report sets out the items discussed at the Quality and Governance Assurance Committee meeting held on 23 November 2022. The Committee received assurance in relation to: • Feedback from the NHS England Review meetings • The Corporate Risk Register • Actions taken in response to the letter regarding quality and safety of mental health, learning disability and autism inpatient services • Compliance with the SFT and YDH Maternity Incentive Schemes (MIS) • Midwifery Continuity of Carer – the ability to move to more flexible local arrangements • Progress made in relation to the Maternity Transformation Project • Initial feedback from the Care Quality Commission inspection

	The Committee identified the following areas of concern or for follow up: • The Health and Safety Executive Improvement Notice relating to the use of safer medical sharps in theatres • The deteriorating patients internal audit findings • The draft Independent Homicide Review report • The discharge medication process – a further progress report to be provided to a future meeting • The risk appetite and tolerance levels for strategic objectives 2 to 5 The Committee identified the following area to be reported to the Board: • Health and Safety Executive Improvement Notice (paragraph 3.1) • Deteriorating Patients internal audit findings (paragraph 3.4) • Update on the Homicide reports including the Duty of Candour audit and review (paragraphs 3.7 and 3.11) • Strategic objectives risk tolerance levels (paragraph 3.14)
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Quality and Governance Assurance Committee.

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

☒ Obj 8 Develop a high performing organisation delivering the vision of the Trust

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

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

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

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

Reference to CQC domains (Please select any which are relevant to this paper)					
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☐ Well Led	
Is this paper clear for release under the Freedom of Information Act 2000?				☒ Yes	☐ No

SOMERSET NHS FOUNDATION TRUST
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETINGS HELD IN COMMON ON 23 NOVEMBER 2022

1. PURPOSE

1.1. The report sets out the items discussed at the formal meetings held on 23 November 2022, along with the assurance received by the Committees and any areas of concern identified. The meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

NHS England Review Meetings

2.1 The Committees received an update on the governance review carried out by NHS England as part of their assessment of the merger business case. The Committees received assurance that feedback to date about processes; the effectiveness of processes; and the work on the risk appetite and risk tolerance approach, had all been positive. An exercise had been undertaken to follow through a risk from establishment of the risk to Board oversight and it will be helpful to follow the same approach to see how risks on the Board Assurance Framework feed into the Corporate Risk Register and Committee oversight.

Corporate Risk Register

2.2 The Committees received the up-to-date combined Corporate Risk Register report and noted that there were currently 56 risks on the risk registers – 38 on the SFT risk register and 18 on the YDH risk register – with 19 risks scoring 20 or 25. The Committees noted the details of the risks and recognised that although progress in mitigating risks had been made, the management of the risks remained challenging due to the operational pressures.

2.3 The Committees noted that a mapping exercise of the risks on directorate risk registers scoring 15 or above is being undertaken to check how these risks feed into the risks on the Corporate Risk Register.

2.4 The Committees noted that there were no new risks but the impact of the industrial actions had been added as an emerging risk. The Committees received assurance about the mitigating actions already being taken to minimise the impact of industrial actions.

Quality and Safety of Mental Health, Learning Disability and Autism Inpatient Services

2.5 The Committees received an update on the trust's response to the letter from Claire Murdoch, National Mental Health Director, in response to the

BBC Panorama programme on the care and treatment of mental health inpatients across the country.

2.6 The Committees received assurance about the implementation of the action plan and noted that good progress was being made to ensure compliance with the recommendations set out in the letter. The Committees noted that responsibility for the "care, education and treatment reviews and independent care education and treatment reviews" action rested with the Integrated Care Board and that national guidance was still awaited.

2.7 The Committees agreed that the update provided substantial assurance about levels of compliance with the five areas highlighted in the letter.

Maternity Services – SFT Maternity Incentive Scheme (MIS)

2.8 The Committees received an update on compliance with the MIS and noted that it was expected that the trust will be able to declare full compliance with all safety actions. The Committees accepted the recommendations within the MIS report.

Maternity Services - YDH Maternity Incentive Scheme (MIS)

2.9 The Committees received an update on compliance with the MIS and noted the possible impact of the supernumerary status of the labour ward coordinator on the ability to declare compliance with safety action 5.

2.10 The Committees further noted the current areas of non-compliance in relation to safety action 6 and 8.

2.11 The Committees accepted the recommendations within the MIS report.

MIS Safety Action 9 – Midwifery Continuity of Carer (MCoC) – YDH and SFT

2.12 The Committees received an update on the requirement set out in the Ockenden report to implement a Maternity Continuity of Care model by March 2024.

2.13 The Committees noted that, in view of the continued workforce challenges, the target date had been removed and trusts will be able to develop local plans which should focus on retention and growth of the workforce and take account of local population; current staffing; more specialised models of care required by some women; and current ways of working supporting the whole maternity team to work to their strengths.

2.14 The Committees noted that maternity services across both trusts worked to different models of care and that a review of the workforce and services will be undertaken to explore the type of service that can be achieved and sustained as a continuity model for the future.

2.15 The Committees agreed that the flexibility for local plans will provide significant assurance as this model can take account of the rural nature of Somerset.

Maternity Transformation Project (MTP)

2.16 The Committees received an update on the project and accepted the content of the report as assurance of the progress made in relation to the Maternity Transformation Programme and Ockenden 1 compliance.

Care Quality Commission Inspection

2.17 The Committees discussed the findings of the draft inspection report and noted the review of factual accuracy currently underway. The final report will be formally published by the Care Quality Commission.

3. AREAS OF CONCERN OR FOLLOW UP

Health and Safety Executive (HSE) Improvement Notice - YDH

3.1. The Committees received an overview of the findings and actions required, particularly in relation to the use of safer medical sharps in theatres, and noted these findings.

3.2. The Committees noted the work already taking place to address the actions and was assured that the actions will be implemented across both trusts.

3.3. The Committees noted that the action plan will be presented to a future Committee meeting and that the implementation of the action plan will be overseen by the YDH Quality Assurance Committee.

Deteriorating Patients Internal Audit findings

3.4. The Committees received an overview of the findings of the internal audit which had been commissioned to review the post implementation benefits of the electronic system used to record electronic patient observations. The Committees noted that the audit had been undertaken whilst colleagues were still working under Covid-19 restrictions and that this had affected the process for rolling out the electronic system.

3.5. The Committees noted the six key findings of the audit and the actions already put in place to address the findings.

3.6. The Committees were assured that the audit had also identified areas of positive developments and learning. The Committees noted that, in view of the number of key findings, an executive director-led oversight group will be established to review the implementation of the action plan.

Mental Health Services – Independent Homicide Review

3.7. The Committees received an update on the work undertaken regarding the reviews of a series of homicides that occurred in 2019 and 2020.

3.8. The Committees noted the draft findings of the Independent Homicide Review report in relation to Mr X, including the recommendations for improvement which focussed on: family engagement; capacity assessments; Regulation 28 Protocol; records management; and SI quality assurance.

3.9. The Committees noted that the investigation had been well conducted; that the findings were felt to be a fair assessment; and that the draft report overall was positive and described that reasonable choices had been taken at the time of the incident but that the post incident actions could be improved.

3.10. The Committees noted that the Independent Investigation Report will be formally published in early 2023 and that a formal action plan will be produced. The Committees received assurance that significant work had already taken place to improve the pathway and post incident responses to homicides; and that a Homicide Review Group had been set up to review actions plans from previous investigations; to strengthen assurance processes; and to review the process for managing homicides.

3.11. The Committees noted that a Duty of Candour audit and a review of family engagement in three homicide incidents had been commissioned. The Committees noted the findings of the Duty of Candour audit and the work taking place to improve duty of candour in the event of a homicide. The Committees further noted the peer review work regarding oversight of homicide incidents.

Discharge Medication Process – Update

3.12. The Committees received an update on the discharge medication process and noted the different pharmacy discharge models across both trusts and that the model used at YDH will also be rolled out across SFT. The implications of this change in discharge medication mode; the impact on resourcing; the benefits; and risks of this model were noted.

3.13. The Committees were assured about the actions being taken; noted the risks and asked for an update on the roll out of the first phase to be provided in Spring 2023.

Risk Appetite and Tolerance – Strategic Objectives 2 - 5

3.14. The Committees discussed the risk appetite and risk tolerance levels for strategic objectives two to five and agreed that the risk tolerance level for strategic objectives three, four and five should be set at 4 (seek).

3.15. The Committees agreed to further discuss the risk tolerance level for strategic objective two at the December 2022 planning meeting.

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

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

- Health and Safety Executive Improvement Notice (paragraph 3.1)
- Deteriorating Patients internal audit findings (paragraph 3.4)
- Update on the Homicide reports including the Duty of Candour audit and review (paragraphs 3.7 and 3.11)

- Strategic objectives risk tolerance levels (paragraph 3.14)

5. BOARD ASSURANCE FRAMEWORK (BAF)

5.1 The Committees agreed that it had received assurance in respect of all areas of the strategic objectives.

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

Jan Hull
CHAIRMAN OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Care Quality Commission (CQC) inspection report - SFT
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Director of Corporate Services
PRESENTED BY:	Director of Corporate Services
DATE:	7 February 2023

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

Executive Summary and Reason for presentation to Committee/Board	The CQC has published its report of the inspection it undertook on 6, 7, 8, 28 and 29 September 2022 The CQC team carried out a short notice announced inspection of the trust's acute wards for adults of working age and psychiatric intensive care unit, specialist community mental health services for children and young people and community end of life care services of the trust as part of their continual checks on the safety and quality of healthcare services. The CQC further inspected the well-led key question for the trust overall. The CQC has rated the trust's community mental health services for children and young people (CAMHS) as outstanding and our community end of life services and our acute wards for adults of working age and psychiatric intensive care unit as good overall. The CQC praised the trust's work and said "it is a remarkable achievement to merge trusts at the beginning of a national pandemic and yet Somerset NHS Foundation Trust has continued to maintain the good quality of service that we had come to expect from both Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust". The CQC inspection team found outstanding practice which it highlights in the report and includes the CAMHS team's work and approach to eliminating waiting times for the service and the work of community end of life team to

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consider the specific needs of patient groups and better meet their needs.

As part of its consideration of how “well-led” the trust is, the CQC observed a number of meetings and met leaders across the trust. The CQC also spoke to a range of patients, carers and colleagues about our services during their inspection, as detailed in their report. The CQC’s inspection team noted that:

- The trust has a clear vision and set of values that colleagues understand.
- The trust has well-embedded clinical leadership.
- The senior leadership team demonstrated a high level of awareness of the priorities and challenges facing the trust and how these were being addressed.
- Overall leaders had the skills and abilities to run the service, were visible and approachable for patients and colleagues and supported colleagues to develop their skills and take on more senior roles.
- Leaders operated effective governance processes and colleagues at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn.
- Leaders and colleagues actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services and collaborate with partner organisations to help improve services for patients.
- Colleagues feel respected, supported and valued.
- We promote equality and diversity in our daily work.
- Colleagues are focussed on the needs of our patients.

The CQC inspection report also provides some valuable insights about where we can improve, most notably at a trust-wide level by reviewing how we increase representation of black and minority ethnic colleagues in some areas and address the issues that black and minority ethnic colleagues report about bullying and harassment.

Within the services that it inspected, the QCQ also highlighted issues for us to address which we are following up. We have taken immediate action to rectify the specific

	environmental issues within our mental health wards. We are also making wider improvements with the development of a new ward in Yeovil and the refurbishment of Rowan ward which cares for adults of working age who are experiencing an acute mental health problem. We are grateful to those teams and individuals who welcomed the CQC team, described their work including what they are proud of and how they are addressing the challenges they face.
Recommendation	The Board is asked to discuss the findings of the inspection and to note that an action plan to address the recommendations set out in the report will be developed.

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

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

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☒ This report has/has not been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
☐ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planning to mitigate any identified inequalities

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

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

Inspection report

Musgrove Park Hospital
Taunton
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Date of inspection visit: 06 September - 08 September 2022, 28 September and 29 September 2022
Date of publication: 23/01/2023

Ratings

Overall trust quality rating	Good
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Outstanding** ☆
Are services responsive?	**Good**
Are services well-led?	**Good**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Somerset NHS Foundation Trust (SFT) is the first NHS trust on the English mainland to provide community, mental health, and acute hospital services. The trust was formed with the formal merger of Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust which took place on 1 April 2020. At our last comprehensive inspection of the Taunton and Somerset trust in January 2020 (the report published in March 2020) we rated the trust overall as good, with a requires improvement rating for safe. Caring was rated as outstanding. The other key questions of effective, responsive well led were rated as good. At our last comprehensive inspection of Somerset Partnership in October 2018 (published in January 2019) we rated the trust overall as good, with a requires improvement rating for safe. Effective, caring responsive and well led were rated as good.

The trust is working towards a planned merger with Yeovil District Hospital NHS Foundation Trust (YDH) to bring the trusts together to create a new, single organisation which will be responsible for running Yeovil District Hospital and Musgrove Park Hospital, the community hospitals in Somerset, all community, mental health and learning disability services in the county with population coverage of 20% of GP practices in Somerset. The two trusts are overseen by a joint board. The merger is due to complete in April 2023.

We carried out this short notice announced inspection of acute wards for adults of working age and psychiatric intensive care unit (PICU), specialist community mental health services for children and young people and community end of life care services of this trust as part of our continual checks on the safety and quality of healthcare services. We also inspected the well-led key question for the trust overall. At our last inspection we rated the trust good overall.

During this inspection we inspected three of the Trust's core services and rated one outstanding and two as good. We also undertook an inspection of how 'well-led' the trust was. We rated the trust as good overall. We rated each of the key questions. We rated safe as requires improvement; effective, responsive, and well-led as good, and we rated caring as outstanding.

The trust provides the following services:

Our findings

Mental health services

Acute wards for adults of working age and psychiatric intensive care units (PICU's)

Long stay/rehabilitation mental health wards for working age adults

Forensic inpatient / secure wards

Child and adolescent mental health wards

Wards for older people with mental health problems

Community-based mental health services for adults of working age

Mental health crisis services and health-based places of safety

Specialist community mental health services for children and young people

Community-based mental health services for older people

Community mental health services for people with a learning disability or autism

Community health services

Community nursing services or integrated care teams, including district nursing, community matrons and specialist nursing service

Community health services for children, young people and families

Community health inpatient services

Community end of life care

Community dental services

Community sexual health services

Urgent Care

Acute hospital services

Urgent and emergency services

Medical care (including older people's care)

Surgery

Our findings

Critical care

Maternity

Services for children and young people

End of life care

Outpatients

Our rating of the trust stayed the same. We rated them as good because:

- We rated effective and responsive as good, caring as outstanding and safe as requires improvement. We rated 'well-led' for the trust overall as good. In rating the trust, we took into account the existing ratings of the 22 previously inspected services not inspected during this inspection.
- We rated 1 of the 3 core services we inspected as outstanding and 2 as good.
- We rated specialist community mental health services for children and young people as outstanding overall, with caring and responsive rated outstanding. This had improved from the overall rating of requires improvement given at our last inspection. We rated acute wards for adults of working age and psychiatric intensive care units as good. This rating was unchanged since our last inspection. We rated community end-of-life care as good in every domain, this was an improvement as we rated the safe domain as requires improvement at our last inspection.
- During the core services inspections we saw that staff treated people with compassion and kindness, respected their privacy and dignity and understood people's individual needs. Services were inclusive, took account of patients' preferences and their individual needs. People had their communication needs met and information was shared in a way that could be understood.
- The strategy provided a focus for the work being done by the trust to prepare for the merger with Yeovil District Hospital NHS Trust and to meet the needs of local populations.
- We found that despite the challenges of the pandemic, the trust had adapted, learnt, and continued to make positive progress. We found that the trust had addressed all the areas where improvements were recommended in the specialist community mental health services for children and young people at the previous inspection. This had a positive impact for people who use services and staff working for the service.
- Staff were well supported by supportive and competent leaders across the organisation. Leaders were well supported with their career development and the provider had improved its approach to succession planning for senior leadership posts.
- We found a positive culture across the trust. Staff told us that they felt proud to work for the trust and we heard many examples of how they put the people who use services at the centre in their work. The senior leaders including the non-executive directors were open, friendly and approachable. They had worked hard during the pandemic to engage with services in person and remotely. People and teams were able to speak honestly and reflect on where improvements were needed and how this could be achieved.
- The non-executive directors provided high quality, effective leadership and delivered support and appropriate challenge to the senior executives. They all had experience as senior leaders in a range of organisations and brought skills from other sectors including NHS acute care, health organisation directorships, social care, education and local government.

Our findings

- The senior leadership team demonstrated a high level of awareness of the priorities and challenges facing the trust and the local health environment, and how they could address these and influence change in the system. The trust had well embedded clinical leadership.
- The trust's governance system effectively provided assurance and helped keep patients safe. It helped the organisation deliver its key transformation programmes and priorities outlined in the annual business plan.

However:

- There were still outstanding maintenance, refurbishment and repair issues on acute wards for adults of working age and psychiatric intensive care units to ensure they provided a therapeutic environment. The outstanding issues had been logged on the trust system by staff, but repairs had not been completed. The specific issues are described in the core service reports.

How we carried out the inspection

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

Before the inspection we reviewed a range of information we held about the services.

During our inspection of the three core services, the inspection teams:

- reviewed records held by the CQC relating to each service
- visited seven wards and ten community team bases across Somerset. We looked at the quality of the ward environments, management of the clinic rooms, and observed how staff were caring for patients
- interviewed the ward manager and/or matron for each ward or service
- reviewed 69 patient care and treatment records
- interviewed 31 patients and 13 relatives of patients
- looked at a range of policies and procedures related to the running of the service
- spoke with the Peer Support worker
- spoke with an independent mental health advocate
- looked at a range of policies, procedures and other documents relating to the running of each service
- spoke with 46 staff members including nurses, clinical practice leads, end of life coordination team, district nursing teams, rapid response service, staff proving care on community inpatient ward. support workers, occupational therapists, occupational therapy students, clinical psychologists, associate psychologists, health care assistants, activities coordinator
- spoke with 18 senior members of staff including the professional lead for the PMVA (Prevention Management of Violence and Aggression) team
- spoke with medical teams across the services including the palliative consultant leadership team, consultant psychiatrists and doctors. We also spoke to members of the LARCH team and End of life education team
- observed eight multi-disciplinary meetings, two home visits and one assessment.

Our findings

The well led inspection team comprised one executive reviewer who was an executive of an NHS mental health and community health provider, two specialist advisors with professional experience in executive roles and board-level governance, one CQC head of hospital inspection, two CQC inspection managers and three colleagues from NHS England.

What people who use the service say

Acute wards for adults of working age and psychiatric intensive care units

Patients felt safe and their relatives confirmed their family member receiving care and treatment was safe.

Patients knew the reasons for their admission and the conditions of their stay. They knew their rights and how they applied to them. For example, their right to leave.

Relatives felt informed of important events and where appropriate were invited to reviews. Some relatives raised concerns about the closure of St Andrews and how this would impact on their visiting

Patients overall gave positive feedback about the staff and relatives praised staff for their patience. Some relatives had observed staff shortages when they visited. Patients in Rydon 2 said there was a lack of meaningful activities, and the activities room was often closed.

Patients felt confident to approach the staff with complaints and gave us examples of complaints they made with support of their advocates.

Patients knew about their care and treatment but were not provided with copies of their care plan.

Patients knew the routines of the ward and said the meals were of a good standard

Specialist community mental health teams for children and young people

Parents and carers gave very positive feedback about CAMHS (Child and Adolescent Mental Health Services) services. Parents and carers said that every single service responded to them in a timely way, that their children were assessed, and appropriate therapy offered quickly.

Children and young people said their appointments were flexible; they could request a digital appointment and appointments always ran on time.

Parents and carers said that communication was good. They said that staff were supportive, kind, and caring. Parents and carers said that staff always made sure they understood what was happening, they had a very open dialogue with staff and that their opinion was always sought.

Parents and carers said they were reassured by staff and included in reviews and assessments. They said that care plans were done together as a family, and they received written copies regularly.

Young people said they were fully involved in their care and understood what was going on.

Our findings

Community end of life care

Patients and families knew how to complain and felt they could raise concerns without fear of prejudice.

Patients and families described staff very positively. Some carers had fundraised following the death of patients as they had wanted to give something back to the services that they felt had cared for their loved ones very well.

Patients and families were positive about the support they received from staff, their religious and cultural needs were respected and supported.

Patients and families were supported to give feedback on their treatment and the service.

Outstanding practice

We found the following outstanding practice:

Specialist community mental health teams for children and young people

- CAMHS teams had implemented a number of strategies to decrease their wait times to access the service. This included working in partnership with voluntary sector organisations, investing in early intervention such as the mental health in schools team, developing new teams such as the intensive support team, upskilling staff so more could deliver therapy, successful recruitment into vacant posts and investment into alternative placements for young people rather than hospital admission. Their efforts over the past four years have resulted not only in achieving a no wait list for children and young people to access the service, a decrease in referrals and therefore caseloads for staff but also better outcomes for those who did not meet the criteria to access the service.
- Staff adopted multi-disciplinary working within teams and with external agencies instinctively. Staff worked openly with the voluntary sector, schools, and other local healthcare agencies to actively provide early intervention support for children and young people. Staff ensured that pathways between services were clear and well used. Staff worked within other services to provide training and support for professionals and families.
- Participation was high on this service's agenda. The young people participation group continued to provide a platform for young people to give feedback about the services they received. Young people were involved in the development of services, from choosing furniture to sitting on recruitment panels. Managers had adapted systems to better include the voice of the young person within care records. The service had also set up a parent's participation group which provided advice and support and provided training sessions for parents.
- Equality and diversity were embedded into the culture of the teams. Staff embraced an inclusive culture where requirements for adjustments to the working environment were well thought of ahead of time.
- An annual review of the service's 'jigsaw project,' where young people were offered an alternative placement to hospital, showed a 65% reduction in readmission of young people to acute wards.

Community end of life care

Our findings

- Staff had developed training and safe protocols to allow family members to administer some medicines to help treat common end of life symptoms. This meant that carers did not have to wait for home visits by a nurse or doctor to respond to breakthrough symptoms, which was especially helpful for them during the evening or out of hours. All carers were required to be signed off as competent and had access to an out of hours help line for advice and to inform staff if they had administered the medication.
- Through the services wider programme of quality improvement projects looking specifically at end-of-life care, teams had considered the specific experiences of patient groups and made improvements to the way they worked to better meet these needs. For example, teams noted that patients living with motor neurone diseases were being asked to attend multiple different appointments with specialists across different services and teams, for example SALT (speech and language therapists), Physio etc. This required patients to travel to multiple different clinics. During the covid-19 pandemic staff set up a pilot model for patients with motor neurone disease where they would have one virtual Multi-Disciplinary Team call where professionals across services would dial in to one call. Staff had received good feedback from patients.

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:

We told the trust that it must take action to bring services into line with legal requirements. This action related to one service.

Acute mental health services for adults of working age and psychiatric intensive care units

- The trust must ensure that staff attend training that meet the needs of patients. Staff must attend training to manage situations where patients place themselves and others at risk of harm. Staff must be supported through regular individual supervision. Regulation 18
- The trust must ensure repairs are carried out in a timely manner to ensure patients have their care and treatment in an environment that maximises their recovery. Regulation 12
- The trust must ensure risks are assessed and action plans devised on how the risk is to be managed or reduced. Regulation 12

Action the trust SHOULD take to improve:

Acute mental health services for adults of working age and psychiatric intensive care units

- The trust should ensure that activities in Rydon One and Rydon 2 are regular, planned, and meaningful.
- The trust should ensure care planning systems are fully embedded and are holistic
- The trust should consider reviewing staffing levels to ensure patients have their escorted leave as prescribed.

Specialist Community Mental Health Services for Children and Young People

Our findings

- The trust should ensure that managers carry out environmental risk assessments for the clinical areas in which young people are seen. This should include a ligature point risk assessment.
- The trust should consider refurbishment at Priory House in Wells.
- The trust should ensure all supervision is recorded.
- The trust should work with young people in the participation group to make actions more visible to them.
- The trust should consider increasing the capacity for staff to have access to clinical spaces.
- The trust should ensure that all clinical rooms are sound proofed.

Community End of Life Care

- The trust should ensure records kept regarding patient care reflect the level of care delivered.
- The trust should continue work towards increasing local uptake and completion of Treatment Escalation Plan forms to ensure these forms are easily accessible to staff and patients are able to engage with this process if they wish.
- The trust should consider making End of life Care training mandatory for teams that are likely to deliver this care.

Is this organisation well-led?

Our comprehensive inspections of organisations have shown a strong link between the quality of overall management of a provider and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a provider manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

With a view towards future integration, the trust had employed a joint Director of Pharmacy with its neighbouring NHS trust. The director of pharmacy reported to the Chief Medical Officer. There were clear lines of accountability and a route to board.

The trust had well embedded clinical leadership. There were two medical directors, one with a lead for mental health and the other with the lead for physical health.

Interviews held with the trust leadership team demonstrated a high level of awareness of the priorities and challenges facing the trust and how these were being addressed. People were able to speak with insight about the importance and complexities of the work with stakeholders, the development of new models of care and the workforce challenges.

Our findings

The trust board recognised the importance of visiting services in order to understand the challenges they were facing and to inform their assurance work. Executive board members also had a programme of visits, which had continued throughout the pandemic. Systems were in place to ensure that the findings of these visits were shared with the board and that action was taken to address any issues raised by the team that was visited. Most staff commented on the approachability of senior leaders in the trust. They told us they had good access to leaders and felt they had a good understanding of the challenges in their service.

Leadership development opportunities were available for staff who were aspiring to be managers as well as existing managers. During the inspections, we heard many positive examples from staff who had accessed development opportunities.

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 strategy sets out the mission 'to deliver outstanding care through a culture of listening, learning and continuous improvement'. The trust had five clinical strategic objectives which had been developed and well embedded throughout the trust. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a clear vision and a set of values which staff understood. The trust vision is 'to be an organisation that gets it right for our patients, carers, colleagues and communities through an inclusive culture of partnership, learning and continuous improvement.' Leaders were well sighted on the ambition of the strategy and there was a focus on aligning the strategy with both local and national priorities.

The director of pharmacy had developed a pharmacy transformation programme to move towards integration of services across Somerset and to improve collaboration. The transformation programme described plans to restructure the pharmacy department to align with the trust service group structure, clinical and operational developments, efficiencies, workforce development, pharmacy department modernisation, digital medicines, aseptic services, and medicines governance. For example, operational actions included improving the quality of medicines information supplied when patients were discharged from services.

The trust was developing its work on population health.

There were already many examples of where the trust was working with partners including the third sector to meet the needs of local communities.

Culture

The leadership demonstrated strong strategic focus, which was values driven. The senior leaders including the non-executive directors were open, compassionate, and approachable. They had worked hard during the pandemic to engage with services in person and remotely.

Throughout the well led review we heard from people about the culture of the trust which was positive, and person centred. Staff felt respected, supported, and valued and told us they felt proud to work for the trust. They were focused on the needs of patients receiving care. The trust promoted equality and diversity in daily work and provided opportunities for career development. The trust had an open culture where patients, their families and staff could raise concerns without fear. People and teams were able to speak honestly and reflect on where improvements were needed and how this could be achieved. Freedom to speak up arrangements had been further developed and were well used.

Our findings

The 2021 NHS staff survey indicated that the trust scored better than average when compared to other trusts for indicators relating to morale, opportunities for progression, staff engagement, safe environment (bullying & harassment) and equality diversity and inclusion. 82.5% of colleagues living with disabilities felt that the Trust provided adequate adjustment. However, the trust scored worse than average for indicators relating to appraisal.

The trust had produced a joint WRES annual report and action plan in cooperation with YDH ahead of the planned merger. The data showed that although the trust had scored better than average in most indicators in the staff survey Black and minority ethnic colleagues were reporting significant issues around bullying and harassment and abuse. The trust had taken steps to ensure staff were empowered to speak up, challenge or report incivility and harassment in the workplace. The trust had committed to review SFT and YDH dignity at work / bullying and harassment policies taking the best practice from each trust to create a consistent combined policy and process.

Representation of Black and minority ethnic staff was low in non-clinical roles and varied between different staff groups, reducing in higher band roles. The trust had identified the need for a significant review of recruitment process and practices to ensure inclusive recruitment principles were embedded. The trust had developed and implemented training for recruitment managers to guide them through inclusive practice and bias mitigation strategies, this was being monitored to ensure it was fully embedded throughout the trust. There were actions planned for consultation with staff networks to explore the 2022 staff survey findings.

The board were committed to equality and inclusion. There was an active focus on equality, diversity and inclusion represented at board level. The trust had set itself a goal to become an anti-racist organisation. The trust had continued to recognise the importance of the staff networks, and they had strengthened since the last well led review. There were six staff networks who met regularly; Multicultural Network, Lived Experience Network, Women's Network, Carers' Network, Armed Forces Network and LGBT+ Network. The networks all felt supported by the trust with regular links with the chief executive and executive sponsors. The trust had set up 'conversation café' sessions for each member of executive team to meet with every Network Lead to hear colleague feedback, understand their priorities and challenges.

There were ongoing discussions with the Multicultural Network focusing on what else the trust needed to do to support Black and minority ethnic development into leadership roles.

Pharmacy staff felt supported each other to maintain their wellbeing. Limited workforce meant they often felt pressured, but they had tools in place to prioritise workload. They were supported to have breaks and work flexibly. Pharmacy staff described how the new director of pharmacy had visited different services across the whole trust and ran workshops to understand how people worked and their concerns. Staff felt this created an open environment and provided assurance about ongoing roles and structure. Pharmacy staff were aware of the trust whistleblowing policy, and how to contact the Freedom to Speak Up Guardians.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Board meetings were well led and appropriately structured. The Board was very aware of the need to use part two of the board meeting appropriately. This was mainly used to discuss individual incidents and patient safety.

The trust was organised into six clinical directorates.

Our findings

- Integrated and urgent care – including A&E, minor injuries services, community hospital beds and medical beds at Musgrove Park Hospital
- Mental health and learning disability services
- Primary care and neighbourhoods
- Surgical care
- Clinical support and specialist services
- Families and paediatric care – including Child and Adolescent Mental Health Services (CAMHS) and maternity services.

The trust had devolved governance and leadership arrangements as an essential part of the leadership structure, which they called senior leadership operational management. The committee structure for the trust supported high level board reporting, with lines of accountability and reporting mechanisms which were fit for purpose. There was a method of reporting, debating and challenging safety, risk, effectiveness, practice and performance issues and topics and this fits well with the trust's approach to implementing an organised accountability framework.

The Board Assurance Framework (BAF) for 2022-23 covers most of the required elements, however some of the risk descriptions were not described as risks and there was no clear articulation of target dates for the risks and some of the actions for the mitigation were out of date. The working format is in line with what is needed and is in easy read format. The heat map was a positive addition for board use.

The non-executive directors (NEDS) and executive directors provided high quality, effective leadership. Non-executive board members had a wide range of skills and experience. They all had experience as senior leaders in a range of organisations and brought skills such as a knowledge of finance, organisational development, legal, fire service, research, real estate, human resources, working in partnership and transforming services. The non-executive directors were well supported and provided appropriate challenge to the trust board.

An established medicines governance system was in place with a clear reporting structure. The medicines governance committee (MGC) was a multidisciplinary group chaired by the deputy medical officer and reported to the quality and governance committee, a sub-board group. The drugs and therapeutics committee had primary care, medicines formulary and integrated care board representation in order to decide which new medicines might be suitable for use. The trust had established medicines optimisation groups that reported to MGC.

There were robust arrangements to ensure that the trust discharged its specific powers and duties according to the provisions of the Mental Health Act 1983 (MHA).

The trust continued to have a process in place to manage the investigation of serious incidents.

The trust had robust arrangements for safeguarding adults and children. There was a clear governance structure for reporting to the trust board, with identified leads for child and adult safeguarding. Safeguarding matters were reported to a safeguarding committee, which in turn reported to the quality assurance committee and to board in an annual report. The chief nurse was the executive lead for safeguarding, with a director of safeguarding in post. The merger of YDH and SFT provides the opportunity to create a single Integrated Safeguarding Service. There was a combined team of 40 staff in YDH and SFT who would form the new integrated safeguarding service. From August 2022 a newly created Domestic Abuse lead post and Domestic Abuse Researcher role provided a cross county service.

Our findings

The Safeguarding Service planned to integrate with YDH Safeguarding team from November 2022, six months ahead of the trusts formally merging. This will ensure a single safeguarding service to support health providers including public health and primary care.

Management of risk, issues and performance

The trust was well-informed on areas of risk, and these were clearly articulated by members of the board. Team risk registers fed into directorate risk registers and then into a trust risk register where corporate risks were identified. The risks were all rated and actions to address them were in place. Concerns raised during the inspection correlated with what was on the risk register.

There was a clearly outlined merger strategy and financial benefits focused on corporate service savings of £22m across various directorates. Good engagement and alignment from directorate leads in planning, savings focused on removing duplication rather than cutting resources. Scoping of clinical service synergies and opportunities between Yeovil and Musgrove specialities has commenced, but merger business case does not rely on clinical service savings.

There was a positive system finance approach, leadership, and relationship with the Integrated Care Board (ICB) counterpart. There was an underlying deficit for the system, root causes of which were shared 50/50 between the trust and ICB.

The Chief Finance Officer (CFO) had developed strong joint finance team leadership and governance capabilities in advance of merger with YDH. A robust, inclusive quality impact assessment process was in place with clinical leadership sign-off for cost saving plans.

The CFO as an executive team member was knowledgeable and engaged in the wider organisation participation of Trust values development and supporting current mission and vision development for the merged organisation. The CFO was well supported by experienced non-executive directors (NEDs) at SFT and in joint finance committees from YDH NEDs. Several executive and non-executive directors had NHS finance backgrounds. A proactive approach was taken to achieve flexibility in system capital limits and external funding. Financial governance, culture and understanding was strong across the trust and joint working arrangements had improved financial governance at YDH from a prior inadequate use of resources rating in 2019.

The trust continued to be financially stable and had strong financial expertise among the executives and nonexecutive directors (NEDS).

The organisation had identified that it needed to achieve consistency in governance arrangements post-merger and plans were in place to revisit these.

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

It was recognised that medicines safety risks lacked assurance across the trust. A workforce plan was in place to recruit a senior pharmacist to the medicines safety officer role. Pharmacy and medicines optimisation risks were reported on a departmental risk register, with high scoring risks escalated to the trust risk register. Risks were regularly reviewed, and controls implemented to reduce ongoing risk.

Our findings

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The pharmacy transformation programme identified that there was significant fragmentation in the way medicines were prescribed across the trust, with a mix of electronic and paper prescribing being used. Actions were identified to roll out the same electronic prescribing and medicines administration as is deployed in the acute setting to community hospitals and mental health units and used to integrate electronic discharge systems to allow referrals on discharge to community pharmacies.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust had worked in partnership to develop the Open Mental Health collaboration with Local Authority, primary care and Voluntary Community and Social Enterprise (VCSE) partners. This model was built on the ethos of person first and 'record once, report light' and was aligned with the ambitions of the Long-Term Plan and Community Mental Health Services (CMHS) Framework. The partnership developed a coproduced Open Mental Health standard operating procedure with combination of traditional pathways and innovative approaches.

Patient engagement was central to the work of the trust. There were good examples of co-production, for example in the specialist community mental health services for children and young people. The trust had worked with people with lived experience to better understand their experience of care when they attend the Emergency Department in mental health distress.

The director of pharmacy engaged with other pharmacy leaders in the system to improve the safety and quality of medicines optimisation in Somerset. Plans included development of a single medication record for the Somerset population with a better interface between primary care and secondary care prescribing systems.

The trust had made a significant contribution through its delivery of the vaccination programme in Somerset, delivering 1.5 million COVID-19 vaccinations as of September 2022.

Large scale engagement was undertaken with staff across both Somerset and Yeovil trusts to establish the vision and mission which will be in place post-merger.

The trust had continued its arrangements to work with trade unions including the joint staff committee. Trade union representatives said they recognised that staff engagement had increased linked to the pandemic and that the trust had worked to be supportive for example with staff who needed to shield.

The trust managed complaints effectively. The complaints process was overseen and managed by a central complaints team. The investigation of complaints was led by appropriate locality managers with support from the central team. Information on how to complain was on the trust website. Information in relation to PALS was also available on the trust website. During our core service inspections, we saw that information on how to make a complaint was available locally.

Our findings

The trust had a complaints policy in place that was recently revised (May 2022). Following some concerns arising from a complaint this policy was reviewed, and the trust commissioned an internal audit of complaints handling. The audits analysis of all complaints raised between 1 September 2021 and 31 May 2022 showed an average response time of 52 days which exceeded the trust's target but was within national guidelines of 60 days. The audit made recommendations around training for investigators, appropriate storage of documentation relating to complaint investigations, monitoring of action plans and re-introducing complaints and concerns workshop which had been paused during the pandemic. The trust had accepted each of these recommendations and had plans to ensure implementation and embedding.

Learning, continuous improvement and innovation

The use of a quality improvement approach was central to the work of the trust. All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. The trust carried out Quality Improvement Grand Rounds hosted by executive directors with presentations by staff members. Prior to the pandemic the quality improvement team led approximately 70% of the projects with 30% engagement and support of front-line staff. Now 70% of projects work is done by front-line staff and the quality improvement team offer a support function.

The trust had established a Chief Nurse Research Fellow scheme, which enabled twenty-two registered general and mental health nurses, midwives, and allied health professionals to concentrate on gaining clinical research trials experience and embedding this in clinical practice.

Pharmacy staff across the trust felt that they had good access to development opportunities, although the pharmacy procurement team felt their opportunities to external development were limited currently due to workforce pressures.

The trust had worked in partnership with Somerset Integrated Care System and Bridgwater and Taunton College (University Centre Somerset) to support the college to gain Nursing and Midwifery Council approval to deliver registered nursing degrees. This ground-breaking development had enabled Somerset residents to access career pathways into nursing and was supporting a system wide approach that linked learner numbers to workforce plans.

The trust was awarded the Health Service Journal Mental Health Trust of the Year in November 2021.

The trust was named employer of the year in the English Veterans awards and the Chair of the Armed Forces and Veteran Colleague Network was awarded a role model of the year award and awarded advocate of the year in the Ex-Forces in Business Awards 2022.

The trust was recognised for the support it gives to armed forces communities and awarded The Defence Employer Recognition Scheme (ERS) gold status. To qualify for the gold award, organisations must show that they provide 10 extra paid days leave for reservists, and have supportive HR policies in place for veterans, reserves, cadet force adult volunteers and spouses and partners of those serving in the armed forces.

The trust has Veteran Aware accreditation, is signed up to the Armed Forces Covenant, which promises to ensure that those who serve or have served in the armed forces, and their families, are treated fairly. The trust also pledged to help the armed forces community access careers in the NHS, by signing up to the Step into Health initiative. This provides a dedicated path into an NHS career for all service leavers, reservists, veterans, cadet force adult volunteers and their families.

Our findings

The trust homelessness nursing team was shortlisted for the Royal Society of Public Health (RSPH) 2022 award for 'health and wellbeing'. The team provide healthcare and support for anyone who is homeless in Somerset that has a health need.

The trust maternity team received an extension to their UNICEF gold standard baby-friendly accreditation in June 2022. Baby Friendly accreditation is a nationally recognised mark of quality care for babies and mothers, awarded to organisations that can show evidence that they provide the best possible care for new families. The team is the only NHS trust maternity service in the South West to have the accreditation, which they have held for four years.

The trust was accredited as an international centre of excellence for bariatric surgery for the fourth successive year by the Surgical Review Corporation in 2022.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Jan 2023	Good ➔➔ Jan 2023	Outstanding ↑ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Good	Outstanding	Good	Good	Good
Mental health	Good	Good	Good	Good	Good	Good
Community	Requires Improvement	Good	Outstanding	Good	Good	Good
Overall trust	Requires Improvement ➔➔ Jan 2023	Good ➔➔ Jan 2023	Outstanding ↑ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Musgrove Park Hospital	Requires improvement Mar 2020	Good Mar 2020	Outstanding Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Overall trust	Requires Improvement ➔➔ Jan 2023	Good ➔➔ Jan 2023	Outstanding ↑ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Musgrove Park Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Mar 2020	Good Mar 2020	Outstanding Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Services for children & young people	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Critical care	Requires improvement Mar 2020	Good Mar 2020	Outstanding Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
End of life care	Good Dec 2017	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
Outpatients and diagnostic imaging	Good Dec 2017	Not rated	Good Dec 2017	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017
Surgery	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
Urgent and emergency services	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
Maternity	Requires improvement Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Overall	Requires improvement Mar 2020	Good Mar 2020	Outstanding Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement ➔➔ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023
Long stay or rehabilitation mental health wards for working age adults	Good Jan 2019	Good Jan 2019	Outstanding Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
Wards for older people with mental health problems	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Community-based mental health services of adults of working age	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Mental health crisis services and health-based places of safety	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
Specialist community mental health services for children and young people	Good ↑ Jan 2023	Good ➔➔ Jan 2023	Outstanding ↑ Jan 2023	Outstanding ↑↑ Jan 2023	Good ↑ Jan 2023	Outstanding ↑↑ Jan 2023
Community-based mental health services for older people	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
Community mental health services for people with a learning disability or autism	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Outstanding Jun 2017	Good Jun 2017
Child and adolescent mental health wards	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
Overall	Good	Good	Good	Good	Good	Good

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community end of life care	Good ↑ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023	Good ➔➔ Jan 2023
Community health services for adults	Requires improvement Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Community health services for children and young people	Good Dec 2015	Good Dec 2015	Good Dec 2015	Good Dec 2015	Good Dec 2015	Good Dec 2015
Community health inpatient services	Good Jan 2019	Good Jan 2019	Outstanding Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
Community dental services	Requires improvement Dec 2015	Good Dec 2015	Outstanding Dec 2015	Requires improvement Dec 2015	Requires improvement Dec 2015	Requires improvement Dec 2015
Overall	Requires Improvement	Good	Outstanding	Good	Good	Good

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.