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

NHS Somerset NHS Foundation Trust

SOMERSET NHS FOUNDATION TRUST
PUBLIC BOARD MEETING

A Public meeting of the Somerset NHS Foundation Trust Board will be held on **Tuesday 7 November 2023** at **9.00am** in the Conference Centre at Bridgwater and Taunton College, Taunton Campus, Wellington Road, Taunton TA1 5AX.

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

Yours sincerely

COLIN DRUMMOND
CHAIRMAN

AGENDA

		Action	Presenter	Time	Enclosure
1.	**Welcome and Apologies for Absence**		Chairman	09:00	Verbal
2.	**Questions from Members of the Public and Governors**		Chairman		Verbal
3.	**Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 5 September 2023**	Approve	Chairman		Enclosure A
4.	**Action Logs and Matters Arising**	Review	Chairman		Enclosure B
5.	**Registers of Directors' Interests and Receive any Declarations of Interests relating to items on the Agenda**	Note and Receive	Chairman		Enclosure C
6.	**Chairman's Remarks**	Note	Chairman		Verbal
7.	**Chief Executive and Executive Directors' Report**	Receive	Peter Lewis	09:10	Enclosure D
ALL OBJECTIVES					
8.	**Board Assurance Framework and Q2 2023/24 Corporate Risk Register Report** • **Board Assurance Framework** • **Corporate Risk Register**	Receive	Phil Brice	09:20	Enclosure E Enclosure F

OBJECTIVE 2 – Provide the best care and support to people					
9.	**Patient Story on the "Reay to go Acute Wards"**	Receive	Jannine Hayman	9.35	Verbal
10.	**Assurance Report of the Quality and Governance Assurance Committee meeting held on 27 September 2023**	Receive	Jan Hull	10.05	Enclosure G
11.	**Assurance Report from the Quality and Governance Assurance Committee meeting held on 6 October 2023**	Receive	Jan Hull	10.10	Enclosure H
12.	**Learning from Deaths Framework: Mortality Review Progress Report**	Receive	Daniel Meron	10.15	Enclosure I
OBJECTIVE 6 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture					
13.	**Assurance Report of the People Committee meeting held on 13 September 2023**	Receive	Jan Hull	10.25	Enclosure J
14.	**Guardian of Safe Working for Postgraduate Doctors Reports**	Receive	Daniel Meron	10.30	Enclosure K
10:40 – 10:55 Coffee Break					
15.	**Six Monthly Inclusion Report**	Receive	Harriet Jones	10.55	Enclosure L
16.	**Six Monthly Champion Wellbeing Report**	Receive	Graham Hughes	11.05	Enclosure M
17.	**Annual Medical Appraisal and Revalidation Report**	Approve	Daniel Meron	11.15	Enclosure N
OBJECTIVE 8 – To develop a high performing organisation delivering the vision of the Trust					
18.	**Quality and Performance Exception Report**	Receive	Pippa Moger	11.25	Enclosure O
OBJECTIVE 7: To live within our means and use our resources wisely					
19.	**Verbal report from the Finance Committee meeting held on 30 October 2023**	Receive	Martyn Scrivens	11.35	Verbal
20.	**Finance Report**	Receive	Pippa Moger	11.40	Enclosure P

21.	**Assurance Report from the Audit Committee meeting held on 11 October 2023**	Receive	Paul Mapson	11.50	Enclosure Q
OBJECTIVE 4 – Reduce Inequalities					
22.	**Assurance Report from the Mental Health Act Committee meeting held on 12 September 2023**	Receive	|Alexander Priest	11.55	Enclosure R
FOR INFORMATION					
23.	**Follow up questions from the Public and Governors**		Chairman	12.05	Verbal
24.	**Any other Business**		All		Verbal
25.	**Risks Identified**		All		Verbal
26.	**Evaluation of the Effectiveness of the Meeting**		Chairman		Verbal
27.	**Items to be discussed at the Confidential Board Meetings** The items presented to the Confidential Board include:				
28.	**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.				
29.	**Date of Next Meeting** Tuesday 6 February 2024			12.15	

PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 5 SEPTEMBER 2023 IN THE MOXON SUITE, FROME COMMUNITY HOSPITAL

PRESENT

Colin Drummond	Chairman
Barbara Gregory	Non-Executive Director
Alexander Priest	Non-Executive Director
Martyn Scrivens	Non-Executive Director
Sube Banerjee	Non-Executive Director
Jan Hull	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
Daniel Meron	Chief Medical Officer
David Shannon	Director of Strategy and Digital Development
Isobel Clements	Chief of People and Organisational Development
Hayley Peters	Chief Nurse

IN ATTENDANCE

Fiona Reid	Director of Communications
Paul Foster	Medical Director and Learning from Deaths Medical Lead (for item 12 only)
Caroline Sealey	Lead Freedom to Speak Up Guardian (for item 16 only)
Xanthe Whittaker	Director of Elective Care (for item 20 only)
Ria Zandvliet	Secretary to the Trust (minute taker)

1. WELCOME AND APOLOGIES FOR ABSENCE

1.1. It was noted that apologies had been received from Kate Fallon (Non-Executive Director) and Graham Hughes (Non-Executive Director).

1.2. The Chairman welcomed all Board members and attendees to the Board meeting and confirmed that the meeting was quorate. Colin Drummond particularly welcomed Tina Oakley, who was attending virtually, to the meeting. Pending approval from the Council of Governors, Tina Oakley will be joining the Trust as an Associate Non-Executive Director from 1 October 2023.

2. QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS

2.1. The following question had been received from Jane Armstrong:

"In view of the recent article in the Independent warning that scandals will be covered up as staff say whistleblowers are ignored, what assurance can the Board provide that whistleblowers are not ignored?"

It was agreed to respond to this question as part of the Chief Executive and Executive Directors report.

3. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 27 JUNE 2023

3.1. Barbara Gregory proposed, Sube Banerjee seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 27 June 2023 as a correct record.

4. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 4 JULY 2023

4.1. Alexander Priest proposed, Paul Mapson seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 4 July 2023 as a correct record.

5. ACTION LOG AND MATTERS ARISING

5.1. The Board received the action log and noted that no actions had been identified at the July 2023 Public Board meeting.

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

6.1. The Board received the Register of Directors' interest and noted the following change:

- Sube Banerjee – to add "Pro-Vice Chancellor for Medicine and Health Sciences at the University of Nottingham (from 1 November 2023)".

6.2. There were no declarations in relation to any of the agenda items and all Board members will be eligible to vote on any of the agenda items.

7. CHAIRMAN'S REMARKS

7.1. The Chairman provided an update on the recruitment of new Non-Executive Directors and advised that three new Non-Executive Directors have been appointed,

subject to formal ratification at the September 2023 Council of Governors meeting. It was anticipated that the Non-Executive Directors will be taking up their post on 1 October 2023. Induction meetings were being set up.

7.2. Colin Drummond further provided feedback from the visits by the Secretary of State for Health and Social Care and the Minister for Health and Social Care to Musgrove Park Hospital and advised that, although both the Secretary of State and the Minister supported the trust's bid for the New Hospital Programme, there was a requirement to reduce the overall cost of the programme and this may impact on the funding available for the trust.

7.3. Colin Drummond further highlighted the shocking events related to the Lucy Letby case and commented that the Quality and Governance Assurance Committee will be double checking that the trust is taking every possible action it could take to prevent such events happening at the trust.

8. CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT

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

8.2. The Chief Executive highlighted section eight of the report relating to the Lucy Letby events and advised that it will be important to reflect on the trust's position. Since those events, established Learning from Deaths and Freedom to Speak Up processes had been put in place and quarterly progress reports were included on the agenda. Although the findings of the trial were known, it was not known what had happened at trust level and this will be followed up as part of a statutory inquiry. The terms of reference for this inquiry were currently being agreed.

8.3. The Chief Executive commented that the trust will need to consider how it can make sure that everything possible was being done to support colleagues when they have concerns and further need to consider how these concerns were responded to. The trust's focus will continue to be on enabling colleagues to raise concerns and not on ignoring concerns and acting in a defensive way.

8.4. The Chief Executive highlighted the letter from NHS England issued on 18 August 2023 asking trusts to particularly review and strengthen, if needed, the Freedom to Speak Up arrangements. The trust already had a strong focus on Freedom to Speak Up and October had been dedicated as the Freedom to Speak up month. A progress report was presented to the Board on a quarterly basis and had been included on the agenda of today's meeting. The Freedom to Speak Up report included anonymous concerns and this was as a result of the trust having set up a WorkInConfidence system which enabled concerns to be raised anonymously. This system still enabled communication with the colleague who had raised a concern anonymously. One colleague who had raised an anonymous concern had come forward and has recently met with the Chief Executive and the Freedom to Speak Up Guardian after support to enable the colleague to come forward with their concerns had been put in place. A reluctance to come forward with any concerns or questions was a cultural issue and the right environment needs to be created for all colleagues

to feel comfortable raising concerns or asking questions. In terms of actions taken, the Chief Executive highlighted: the distribution of posters to encourage speaking up; and the open letter sent to parents at the neonatal units encouraging them to come forward if they have any concerns.

8.5. The Chief of People and Organisational Development advised that a Freedom to Speak Up Self Reflective Tool had been rolled out and the findings from this self assessment exercise will be presented to a future Board meeting.

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

- The trust had a good culture for raising concerns and regularly reviewed the number of concerns raised through the Freedom to Speak Up process.

- The learning from deaths report referred to the new Martha's rule which will give patients the right to a second opinion. This rule and the agreement of a pathway from Learning from Deaths to PALS and Complaints will help strengthen processes.

- Information was regularly triangulated through different processes and this included monthly meetings with staff side representatives.

- It was queried what the process was for checking unexpected deaths and ensuring that all unexpected deaths were reported. The Chief Medical Officer advised that a multi layered process for reporting and reviewing unexpected deaths was in place and statistical mortality information was reported to the Board on a quarterly basis. The information was also reviewed at Committee level. The standardised mortality rate for acute hospitals was within the expected range and this provided the trust with significant assurance. Almost all deaths in acute and mental health services, as well as in community hospitals, were reviewed and the review process will be rolled out to community services. The trust was ahead in terms of this review process and recognised the importance of reviewing individual deaths and identifying lessons learned. Evidence of learning and changes to practices as a result of the learning was included in the quarterly progress reports.

- Statistically, unexpected deaths can cluster in terms of time or geography and the trust had a good track record, especially in mental health services, of commissioning thematic reviews. This practice was already well established and, where needed, thematic reviews will continue to be carried out. None of the thematic reviews to date have highlighted any common themes but these reviews were important.

- The Quality and Governance Assurance Committee will be discussing processes further at its September 2023 meeting.

- The inquiry to be carried out was likely to identify cultural issues and it was expected that a number of recommendations will be made. These recommendations were likely to cover: culture; process for raising concerns; and process for responding to concerns.

- The latest round of industrial actions had highlighted some issues which had previously not been experienced by the trust and it had been increasingly difficult to cover services. The industrial actions had led to a significant loss of capacity and a large number of appointments had to be cancelled. The Chief Medical Officer agreed that it was increasingly difficult to ask colleagues to cover for colleagues during the industrial actions as colleagues were tired. The key aim will be to provide safe services but the combined junior doctors and consultant industrial actions later in the month will be particularly challenging and will impact on patients. The Chairman thanked all colleagues for their focus on patient care during these challenging times.

8.7. The Chairman agreed that the question posted by Jane Armstrong had been covered as part of the discussion of the report.

10. PATIENT STORY AND CLINICAL TOPIC – "RONNIE'S STORY"

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

10.2 Vanessa Tuff joined the meeting for this agenda item (via Teams).

10.3 The Chief Nurse introduced Vanessa Tuff and thanked her for attending the Board meeting to present Ronnie's story. The Chief Nurse advised that Ronnie would have wanted to be at the meeting in person but, due to the short notice and location, this was unfortunately not possible. The Chief Nurse highlighted the video about "Ronnie's Story" which had been created by the Learning and Development Department to be used as an educational tool to aid management and improvement work of sepsis and care of a deteriorating patient. The video was being widely used in a number of different forums to share learning. The video had also been shared with the Board members and all Board members had been asked to view the video in advance of the meeting.

10.4 The Chief Nurse advised that she was struck by Ronnie's story which had identified significant learning about sepsis and care of a deteriorating patient. There was an opportunity for the Board to learn what happens to services when the services are working under extra-ordinary pressure. This item was linked to a discussion as part of the Part B Board meeting about the reconfiguration of acute beds at Musgrove Park Hospital and Yeovil District Hospital. The purpose of the reconfiguration was to mitigate some of the risks faced by the trust over the last year and to try to ensure that patients receive care in the right place by the right people so that no other patient will experience the same issues as experienced by Ronnie. The Chief Nurse, on behalf of the Board, apologised to Ronnie and Vanessa Tuff for the standard of care Ronnie received but thanked them for the opportunity to learn from Ronnie's experience and share Ronnie's story. The Chief Nurse advised that she had agreed to write to Ronnie after the Board meeting to share how the video had been received by the Board.

10.5 Vanessa Tuff thanked the Chief Nurse for the apology. The main aim of sharing Ronnie's experiences was to identify learning and improve the standards of care for patients. Vanessa Tuff advised that she had worked at the trust for a long time and,

until the night in question, had full confidence in the services provided. Ronnie's experience was shocking and she was frustrated that she could not fix the issues for her dad. Ronnie was in a dangerous position during the night and this was due to a number of different factors. Vanesa Tuff advised that the video was a means of trying to look at the way the trust can educate itself and prevent anyone being in the same position as her dad. The video was made to help everyone else and Vanessa Tuff was pleased to hear that the video was being widely shared as part of the learning and development programme.

10.6 The Board discussed the story and commented/noted that:

- The Board thanked Ronnie for sharing his story and again apologised for his experiences.

- The video had been moving and it was suggested that the story may be more common than expected. Vanessa Tuff was able to view the story from both a family and colleague perspective and this was helpful.

- The Board was struck by how forgiving Ronnie was and how kindly he spoke of staff.

- It was queried what had caused this "perfect storm". Vanessa Tuff set out the reasons for the issues experienced which related to a high level of both medical and clinical colleague sickness absence in the Emergency Department; cover provided by colleagues from inpatient wards; lack of beds; and limited ability to provide timely treatment. Vanessa Tuff commented that all colleagues were struggling and did what they could in very difficult circumstances but were unable to deliver the care required at that particular night.

- The issues experienced on the night were not caused by anyone in particular but could have been the result of decisions taken by the executive team or Board over the last few years and Vanessa Tuff was asked what message she wanted to give the Board. Vanessa Tuff advised that she had met with the relevant matron following the night in question and recognised that difficult decisions had to be made. The key issue for her was remembering that there are people at the end of a decision-making process. She felt that the role of the colleague managing the Emergency Department was too broad as they also covered the patients in the corridor and the role has subsequently changed. Small improvements can make a significant difference.

- It was queried whether Vanessa Tuff had any recommendations to help prepare for a "perfect storm" and protect patients. Vanessa Tuff responded that as well as the issues already highlighted, some of the policies had not been followed, e.g. the sepsis policy, and there will need to be clear accountability when policies are not followed and the reasons why policies are not followed will need to be explored. In addition, on the night in question, paperwork was misplaced. Vanessa Tuff advised that when policies and processes do not work, the Board will need to ask questions as to why these processes and policies did not work.

- It was queried whether Vanessa Tuff had raised a formal complaint and, if so, whether she had been listened to. Vanessa Tuff advised that she had been clear from the onset that she did not want to submit a formal complaint as she did not want to turn this into a negative experience but use this as a learning opportunity.

- Although staffing levels in the Emergency Department had increased, nursing and medical staffing levels remained challenging. Some of the issues outlined in the story were as a result of last minute sickness but the key issue will be how to escalate and respond to these issues.

10.7 The Chief Executive thanked Vanessa Tuff again for joining the meeting and thanked Ronnie for sharing his story. The story had been helpful in terms of seeing the consequences of decisions taken. A reconfiguration of acute inpatient beds will be discussed at the Part B meeting and although it was essential to look at structural issues, consideration will also need to be given as to how to support colleagues at times of particular challenges and look at escalation processes.

9. Q2 2023/24 CORPORATE RISK REGISTER

9.1. The Director of Corporate Services presented the report which was received by the Board. The Director of Corporate Services highlighted the key risks on the risk register and advised that the highest rated risks related to: demand; waiting times; Symphony Healthcare Services not becoming financially self-sustaining; core numbers of Junior and Consultant medical workforce; inability to fill vacancies organisationally; and unsafe numbers of attendance in the Emergency Department.

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

- The process for reviewing emerging risks at Committee level was queried. An example was given of the unsupported infection control electronic case management system and it was queried whether this emerging risk should have been discussed at the Quality and Governance Assurance Committee. The Chief Nurse advised that this emerging risk had not been escalated to a Committee as it was felt that plans were in place to mitigate this risk. This risk had however now been escalated to the corporate risk register. Jan Hull advised that she will speak to Alison Wootton in relation to this risk and any follow up actions.

- It was queried why the risk relating to “ongoing sustainable pressure to colleagues in the trust” had reduced. It was noted that the overall workforce risks – safe staffing; nursing vacancies - had increased but it was felt correct to reduce this risk as concerns about morale and ongoing workforce pressures reported to the People Committee had reduced. It was recognised that this risk will be subject to change.

- It was queried how the high level risks were moderated. The Director of Corporate Services advised that governance arrangements had been developed and service groups carried out a risk assessment for each risk

relevant to their service group. A moderation process was in place and risks were also discussed at the service group's quality outcomes finance and performance (QOFP) meetings. Samantha Hann as Deputy Director of Governance also further reviewed the overall risks and assessed the organisational impact. This bottom up approach was welcomed.

11. ASSURANCE REPORT OF THE GOVERNANCE AND QUALITY ASSURANCE COMMITTEE MEETING HELD ON 26 JULY 2023

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

- The summary of the families and young people service group report including the excellent joint leadership between CAMHS and Paediatrics.
- The estates and fire safety risks.
- The work of the Acute Home Treatment Team and the importance of the service as we move towards winter.
- The correlation of workforce and infrastructure risks across the three committees.
- The assurance in relation to the Maternity Incentive Scheme.

11.2. The Board agreed that the items discussed at the meeting provided assurance in relation to objectives two to five of the Board Assurance Framework.

12. LEARNING FROM DEATHS FRAMEWORK: MORTALITY REVIEW PROGRESS REPORT

12.1. Paul Foster joined the meeting for this agenda item. Paul Foster presented the report which demonstrated the processes for learning from deaths and how this learning was shared and improvements made within the trust. Paul Foster highlighted the key findings of the reviews and examples of learning.

12.2. 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.

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

- A lead Medical Examiner had been appointed and their role will be to lead the ME system and to support implementation of the expansion of ME coverage to include primary care reviews and improve consistency of the referrals.
- As some Medical Examiners (ME) are employees of the trust, it was queried how the trust can be assured that the MEs were robust and impartial. The

Chief Medical Officer stressed that although the ME service was hosted by the trust, the MEs worked to the regional ME and not to the Chief Medical Officer. This reporting process provided assurance in relation to the independence of the MEs.

- Perinatal deaths were reviewed using the Perinatal Mortality Review Tool (PMRT). This tool facilitated a standardised and robust review of all eligible perinatal deaths. Paul Foster confirmed that any deaths not meeting the PMRT criteria were also reviewed but this review was not the review methodology described in PMRT framework. The eligible reviews were notified to a national independent programme. The Chief Nurse advised that the Health Care Safety Investigation Board also independently investigated incidents of neonates meeting certain thresholds.

- The Chief Medical Officer advised that a system was being set up to review mortality on a system wide footprint and joint work was taking place with the Integrated Care Board and the regional team to design ways of looking at mortality on a population basis, including primary and secondary care services. A system wide process for reviewing mortality will be transformational and the implementation of such a process will be a credit to Somerset.

- The Quality and Governance Assurance Committee received a written report and a presentation on the maternity incentive scheme at every meeting. The report covered information on neonatal and perinatal deaths and serious incidents.

- The learning from deaths governance processes were different on both acute sites and it was queried what progress had been made aligning processes. Paul Foster advised that good progress was being made and the clinical lead for governance was reviewing processes. The aim was to have a single system which disseminated areas of best practices from both processes. A single system will make the governance process more robust and will ensure that actions are logged and completed. The Chief Medical Officer advised that discussing mortality reports at committee level had been a significant improvement and enabled more time for in-depth scrutiny of the report and strengthened Non-Executive Director oversight.

12.4. The Board agreed that the report provided significant assurance about the rigour of the review process.

12.5. Paul Foster left the meeting.

13. 2022/23 QUALITY REPORTS AND QUALITY ACCOUNTS

13.1. The Director of Corporate Services presented the reports which were received by the Board. The Director of Corporate Services advised that there was a requirement to produce Quality Accounts for both legacy organisations but, as in previous years, there was no requirement for an external audit opinion on the Quality Accounts.

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

- The 2022/23 quality improvement priorities will remain in place for 2023/24 to reset and refresh the priorities in view of the new service groups and operational and clinical leads.

- Progress will be monitored within the Board Assurance Framework but the programmes will be delivered at team and/or service group level.

- The new quality strategy will be presented to the Quality and Governance Assurance Committee and to the Board at a later date.

- Stakeholder feedback had been included in the SFT report and feedback in relation to the YDH report will be circulated when available. Feedback received to date had been very positive.

13.3. Paul Mapson proposed, Barbara Gregory seconded and the Board agreed that the reports accurately reflected performance against the objectives. The Board approved the signing of the reports by the Chairman and Chief Executive.

14. ASSURANCE REPORT OF THE PEOPLE COMMITTEE MEETING HELD ON 25 JULY 2023

14.1. Jan Hull presented the report which was received by the Board. She highlighted the areas of assurance received and the areas to be reported to the Board. The impact of integration of the workforce had been identified as an area to be reported to the Board.

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

- The level of medical workforce vacancies was a concern and, in view of the impact on other services, these vacancies were discussed at all committee meetings. It was queried whether the recruitment approach was sufficiently creative and innovative. The Chief of People and Organisational Development advised that the market was challenging and the approach will need to continue to be reviewed. She assured the Board that innovative work was taking place.

  The Chief Medical Officer advised that recruitment remained challenging and the same issues were experienced across all trusts. Rurality was an additional factor in Somerset which impacted on recruitment. Overseas recruitment was currently taking place and two recruitment pipelines had been identified which were less densely competitive. The Chief Medical Officer felt that further actions can be identified and this included the development of a long term clinical workforce strategy. It will be important to consider whether there are medical posts which do not require a medical doctor and which can be filled from the existing workforce.

- It was queried whether the merger had resulted in recruitment opportunities and whether evidence of an increase in recruitment as a result of the merger was available. The Chief Medical Officer advised that it was difficult to compare the pre and post merger positions as no counter factual was available. There had been some successful recruitment to posts which had previously been difficult to fill. The philosophy of the merged organisation was different and this enabled competing in a different market.

14.3. The Board agreed that the report provided assurance in relation to objective six of the Board Assurance Framework.

15. GUARDIAN OF SAFE WORKING FOR POSTGRADUATE DOCTORS REPORTS

15.1. The Chief Medical Officer presented the report which was received by the Board. It was noted that the report had been discussed at the People Committee meeting.

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

- The total number of exception reports had remained unchanged, in spite of the industrial actions. This provided assurance that the pressures from the industrial actions had not compromised clinical safety and significantly impacted on junior doctors.

- The majority of exception reports originated from the medical directorate and related to deviation from the usual working hours practice.

- The numbers of exception reports within the general surgery directorate at YDH showed a higher than expected increase and it was noted that this increase was due to an increase in pressures during industrial actions but was also due to an increase in awareness of exception reporting. The Chief Medical Officer advised that the increase in reporting was welcomed as increased reporting better reflected the pressures faced by medical colleagues and enabled improvement actions to be identified and implemented. A number of improvements have been made as a result of the issues raised in exception reports and subsequent data showed that the improvements had been effective.

- It was queried whether, in view of the pressures highlighted in the patient story there had been an expectation that an incident was raised by medical colleagues working in the Emergency Department on the night in question. The Chief Medical Officer advised that the medical service group traditionally generated more exception reports and he would have expected exception reports from junior doctors covering the wards during that week. The patient story referred to a patient who had been delayed in the emergency department due to a lack of inpatient beds and this reflected pressures on the wards. Medical colleagues in the emergency department were more senior and would be less inclined to raise exception reports as they were more able to manage the pressures. The majority of exception reports were generated

by F1s and this reflected a difference in culture and experience and was in line with the conditions of the junior doctor contract.

- It was noted that 51 exceptions remained outstanding and progress will be included in the next progress report.

16. SIX MONTHLY FREEDOM TO SPEAK UP GUARDIAN PROGRESS REPORT

16.1. Caroline Sealey, Freedom to Speak Up Guardian, joined the meeting and presented the report which was received by the Board. Caroline Sealey advised that the report covered pre merger data and had therefore been split into two separate sections. Caroline Sealey highlighted: the national data and the 25% increase in reported Freedom to Speak Up cases; the local data and the key themes; the breakdown by staff groups; the areas of concern; and the actions taken to raise awareness of Freedom to Speak Up.

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

- Mandatory training compliance for substantive colleagues was over 90%. Compliance for bank colleagues was 46.1%. This low compliance rate was principally due to inaccurate mapping and it was expected that more accurate data will be available by the end of the year.

- An internal audit had been carried out and the audit provided substantial assurance for both design and effectiveness and this finding provided significant assurance. Caroline Sealey was complimented on the excellent findings of this audit.

- October 2023 had been identified as Freedom to Speak Up month and the focus will be on reducing barriers to speaking up.

- A discussion had taken place about protected characteristics of colleagues using Freedom to Speak Up as it was felt that the ethnicity profiles of colleagues speaking up did not reflect the ethnicity profiles of particularly the nursing and health care professional workforce. Work was being carried out with colleagues on the Aspiring Leaders programme in relation to conversations with overseas colleagues to gain insight into their experience.

- The Freedom to Speak Up service does ask colleagues for their demographic information when speaking up, but colleagues were not required to provide this information and the data set was too small to draw any conclusions. Caroline Sealey did feel that there was an under representation of colleagues from a minority ethnicity background and advised that she was working closely with the inclusion team and the multi-cultural network to look at barriers and encouraging colleagues to come forward with any concerns either through the Freedom to Speak Up services or through other routes.

- The Freedom to Speak Up programme for October included drop in sessions with the inclusion team and walkrounds and any colleague was

welcome to join the drop in session or speak to the Freedom to Speak Up colleagues during the walkrounds.

- The freedom to speak up process was well embedded across the former SFT and work was taking place to increase visibility of the service at YDH. Caroline Sealey advised that there was now one single system across the organisation with colleagues from all sites having access to the same system.

- "Missing voices" and "quiet places" were important areas to target for feedback and it was queried what actions can be taken to ensure that these areas were covered. Caroline Sealey advised that the Freedom to Speak Up service tried to focus on areas of lower engagement, e.g. estates and facilities and medical colleagues, and training was being provided to increase visibility.

- A lack of visibility of board members and senior managers had been raised as a concern on multiple occasions and colleagues felt that the lack of visibility was impacting on how services were run. The Chairman advised that Board members would be happy to join walkarounds if this was felt to be helpful. It was agreed to follow this up outside of the meeting.

- Colleagues speaking up felt that this had been a good experience and it will be important to ensure that colleagues feel able to speak up in the setting where they feel most comfortable. The freedom to speak up service was therefore one route for speaking up but other routes were also available.

16.3. The Chairman thanked Caroline Sealey for her excellent work.

16.4. Caroline Sealey left the meeting.

17. SIX MONTHLY STAFFING ESTABLISHMENT REPORT

17.1. Alison Wootton, Deputy Chief Nurse, joined the meeting.

17.2. Alison Wootton presented the report which was received by the Board. Alison Wootton highlighted the key challenges and risks and particularly, the number of escalation beds; the high pressures on emergency care; and the industrial actions. Alison Wootton further highlighted: the reduction in colleague sickness levels; and the reduction in the number of escalation beds.

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

- Emergency department specific data was not included in the report but detailed data on fill rates; vacancies; and sickness levels etc, was available and reviewed by Alison Wootton on a regular basis.

- Good progress was being made recruiting new staff but until all new staff were in post the position will remain challenging.

- Closing the vacancy gap will continue to be a key area of focus. During the pandemic, it had not been possible to recruit overseas nurses but good progress was being made. The Chief Nurse acknowledged the excellent work by the recruitment team and the service group to fill vacancies in areas of supply.

- The team had been successful recruiting mental health nurses and overall recruitment and retention work had resulted in all vacancies in inpatient wards being filled. International recruitment had also focussed on midwives and children and adolescent mental health nurses and new colleagues will be taking up their post in the autumn.

17.4. The Board accepted the reassurance that the trust is taking all actions to try and ensure safe staffing levels in all ward areas and that, where this is not possible, escalation and actions are followed to try and mitigate the risks of working with a compromised level of staffing. The Board approved the report for publication on the public website as per requirements.

17.5. Alison Wootton left the meeting.

20. ELECTIVE RECOVERY OUTPATIENT CHECKLIST

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

20.2. Xanthe Whittaker joined the meeting and presented the report which was received by the Board.

20.3. Xanthe Whittaker highlighted the letter received from NHS England on 4 August 2023 in relation to outpatient transformation including the self assessment checklist which will need to be completed and submitted by 30 September 2023.

20.4. Xanthe Whittaker highlighted the checklist and advised that the trust was largely performing well against the actions set out in the checklist. Further work will need to be carried out in some areas and the actions to be taken to achieve compliance had been included in the checklist.

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

- The key actions set out in the letter related to: setting an ambition that no patient in the 65 week “cohort” will be waiting for a first outpatient appointment after 31 October 2023; revisiting the plan on outpatient follow up reduction to identify more opportunities for transformation; and maintaining an accurate and validated waiting list.

- Follow up appointments was one area where further work was required and this was a key area of focus at the senior leadership forum meetings. It was noted that the activity levels were significantly higher than those delivered in 2019/20 and the process for the follow up of care and the ongoing management of patients will need to be reviewed.

- The self assessment checklist provided significant assurance about outpatient performance.

- The benefit of the validation of patients who have been waiting over 12 weeks was queried. Xanthe Whittaker advised that previously it had been decided not to contact patients that early on in the process as it was not felt to be beneficial and may set incorrect waiting times expectations. Patients were now being contacted and every effort was being made to clearly word the questions to be asked of patients as part of the validation process. Patients continued to be asked whether they wished to be treated by a different provider who may have able to offer an earlier appointment. The percentage of patients taking up this offer was increasing.

  Xanthe Whittaker advised that that the table in the appendices set out the rationale for not previously contacting patients and advised that the wording in this section will be strengthened to better reflect the concerns in relation to patient expectations.

  The Board agreed that the principle of contacting patients to validate the waiting list was the right one.

- In relation to the action to reduce follow up appointments by 25%, the most effective way will be to discharge patients back to primary care but this will put additional pressure on primary care services. Xanthe Whittaker advised that the best way to reduce follow up appointments will be to reduce unnecessary follow ups and this will be a key area of focus. Unnecessary follow ups were mainly related to more junior clinicians not feeling confident discharging patients. When discharging patients, this could be accompanied by information on what to do in certain circumstances with the option to self refer back into the service if needed. This approach will have the potential to release capacity.

20.6. Jan Hull proposed, Martyn Scrivens seconded and the Board approved the declaration of assurance.

20.7. Xanthe Whittaker left the meeting.

18. QUALITY AND PERFORMANCE REPORTS

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

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

- From 1 October 2023 cancer reporting will be based on new standards and the report will be amended to reflect these new standards.

- Ligatures – a large number of the ligatures could be attributed to two patients for whom ligatures were used as a way to express their level of distress. Consideration had been given as to whether or not the inpatient unit was the right environment to manage their distress and one of the patients had been transferred to Holford PICU.

- It was queried whether the reference to the nursing vacancy challenges referred to in the report was in contradiction to the improvements highlighted in the staffing establishment report. The Chief Finance Officer advised that the vacancies referred to in the quality and performance report reflected vacancies in more specialised areas as identified in the corporate risk register.

- Levels of Covid infections were increasing and a strategy for the management of Covid over the winter period had been developed. The infection prevention and control team was working hard to reduce the risk of beds being lost as a result of infections on the ward. The Chief Operating Officer advised that Covid infections were well managed by the infection prevention and control team.

- Performance against the "percentage of stroke patients directly admitted to an acute stroke ward without four hours" standard continued to be challenging but performance had slightly improved, particularly at Yeovil District Hospital. It was noted that the findings from the consultation on stroke services led by the Integrated Care System were still awaited.

19. MERGER UPDATE

19.1. The Director of Strategy and Digital Development presented the report which was received by the Board.

19.2. The Board discussed the update and commented/noted that:

- All day one and day 100 tasks had been completed and good progress was being made in relation to the remaining corporate tasks.

- Overall good progress was being made on the integration of clinical services and a significant reconfiguration was currently being undertaken. It was recognised that full integration will take longer to complete due to the operational and capacity challenges. It was noted that completion dates for all projects had been agreed as part of the Post Transaction Implementation Plan.

- Although the merger has been completed at organisational level, the integration of services and teams was still ongoing at service group and team level and this impacted on colleagues. It was important to recognise colleagues' concerns.

19.3. The Chairman thanked the Director of Strategy and Digital Development and the integration team for their ongoing focus on achieving the benefits of the merger.

21. VERBAL REPORT FROM THE FINANCE COMMITTEE MEETING HELD ON 1 SEPTEMBER 2023

21.1. Martyn Scrivens, Chairman of the Committee, provided feedback from the meeting held on 1 September 2023 and advised that the Committee reviewed the finance report for July 2023. The report showed a continuation of the key challenges experienced over the last year, particularly relating to agency spend and achievement of the cost improvement programme.

21.2. The Committee further reviewed the digital and finance risks register but had not identified any particular concerns to be reported to the Public Board.

22. FINANCE REPORTS

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

- An in-month deficit of £0.903 million against an in-month deficit of £0.578 million.
- A year to date deficit of £6.218 million against a planned deficit position of £5.059 million.
- An in-month agency spend of £2.839 million which was £0.748 million above the agency cap.
- An agreed cost improvement plan of £33.8 million and the delivery of £2.195 million cost improvements in July 2023 against a forecast delivery of £2.366 million.
- A year to date capital expenditure of £12.0 million against a plan of £12.4 million.

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

- The in-month position had been affected by industrial actions and had resulted in additional costs of £325,000.
- Loss of income due to industrial action will be included in the figures from August 2023 onwards.

23. ASSURANCE REPORT FROM THE AUDIT COMMITTEE MEETINGS

Meetings held on 7 and 27 June 2023
Meeting held on 12 July 2023

23.1. Paul Mapson presented the reports which were received by the Board. Paul Mapson advised that he had taken over as Chair of the Committee from 1 August 2023. He highlighted the areas of assurance received and advised that one area to be reported to the Board had been identified at the June 2023 meeting:

- The challenges in relation to the MEA process and the recommendation to review MEA valuation assumptions by a committee and management group prior to year end.

23.2. The following areas to be reported to the Board had been identified at the July 2023 meeting:

- The declarations of interests compliance rate (Executive Team).
- The limited opinion for both design and design effectiveness in relation to consultant job planning (Executive Team).
- The environmental sustainability report and the need for staff and cultural engagement to be able to deliver the Green Plan. (Executive Team).
- The overdue workforce related internal audit recommendations (People Committee).

24. ASSURANCE REPORT FROM THE CHARITABLE FUNDS COMMITTEE MEETING HELD ON 12 JULY 2023

24.1. Barbara Gregory presented the report which was received by the Board. She highlighted the areas of assurance received and advised that two areas for follow up had been identified. These related to the review of the ethical policy and the review of the 25th anniversary appeal projects.

24.2. No issues have been identified to be reported to the Board.

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

- The breast cancer appeal at YDH was still open for donations and any additional funding received will be used to support the overall programme. Donations were still being received and the Committee will make a decision as to when to close the appeal at a future meeting.

24.4. The Chairman thanked the fundraising teams for their excellent work.

25. ASSURANCE REPORT FROM THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON 13 JUNE 2023

25.1. Alexander Priest presented the report which was received by the Board. He highlighted the areas of assurance received, the areas for follow up and the areas to be reported to the Board. The capacity of the AMHP team and impacts on the undertaking of Mental Health Act assessments; and the number of out of area placements had been identified as an area to be reported to the Board.

26. FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS

26.1. There were no follow up questions from members of the public or, specifically, Governors.

27. ANY OTHER BUSINESS

27.1. There was no other business.

28. RISKS IDENTIFIED

28.1. The Board identified a risk in relation to: the patient story and the staffing pressures in the emergency department. The Board noted that this risk had been included on the Corporate Risk Register.

29. EVALUATION OF THE EFFECTIVENESS OF THE MEETING

29.1. The Board agreed that the meeting had been productive with a wide range of topics covered in detail, including the patient story.

30. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

30.1. 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.

31. WITHDRAWAL OF PRESS AND PUBLIC

31.1. 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.

32. DATE FOR NEXT MEETING

7 November 2023

SOMERSET NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETINGS HELD ON 5 SEPTEMBER 2023

AGENDA ITEM	ACTION	BY WHOM	DUE DATE	PROGRESS
No actions to be followed up by the Board were identified at the meeting				

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Registers of Directors' Interests
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Colin Drummond, Chairman
DATE:	7 November 2023

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

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

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

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

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

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

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

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

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

REGISTERS OF DIRECTORS' INTERESTS

NON EXECUTIVE DIRECTORS	
Colin Drummond Chairman	• Honorary Vice President of Calvert Trust Exmoor (outdoor holidays for people with disabilities) – current • President of Wadham College Oxford 1610 Society • Deputy Lieutenant for Somerset • Worshipful Company of Water Conservators – Master
Jan Hull Non-Executive Director	• Trustee of the Dulverton Abbeyfield Society. • Formerly Managing Director of South, Central and West Commissioning Support Unit
Dr Kate Fallon Non-Executive Director (Senior Independent Director)	• Daughter is a Consultant at the Trust • Symphony Health Services Board member • Daughter has been appointed as the Guardian of Safe Working Hours for Junior Doctors • Non-Executive Director Symphony Health Services
Barbara Gregory Non-Executive Director	• RESEC Research into Elderly and Specialist Care Trustee. • Deloitte Associate – with effect from 6 February 2018. • Chair of the CNL (Chairs, Non Executive and Lay members) Faculty of HFMA • Director of AGRF
Alexander Priest Non-Executive Director	• Chief Executive Mind in Somerset
Sube Banerjee Non-Executive Director	• Visiting Professor, Brighton and Sussex Medical School (unremunerated) • Trustee and Patron, Alzheimer's Society (unremunerated) • Pro-Vice Chancellor for Medicine and Health Sciences at the University of Nottingham (from 1 November 2023) • Hon Professor, Faculty of Health, University of Plymouth (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)
Martyn Scrivens Non-Executive Director (Deputy Chairman)	• Non Executive Director and Chair of Audit Committee of Hampshire Trust Bank Limited • Wife works as a Bank Vaccinator for the Trust • Non-Executive Director and Chairman of Wesleyan Bank Limited, a 100% subsidiary of Hampshire Trust Bank Limited" (with effect from 28 February 2022) ▪ Member of the Boards of Directors of the Ardonagh Group – consisting of the following companies: – Ardonagh Holdco Limited (Jersey) – Ardonagh New Midco 1 Limited (Jersey) – Ardonagh Group Holdings Limited (UK) – Ardonagh New Midco 3 Limited (Jersey) – Ardonagh Midco 1 Limited (Jersey) – Ardonagh Midco 2 plc (UK) – Ardonagh Midco 3 plc (UK) – Ardonagh Finco plc (UK)
Graham Hughes Non-Executive Director	• Chairman of Simply Serve Limited • Parish Councillor of Babcary Parish Council
Paul Mapson Non-Executive Director	• Advisor to NHS Devon Health System
James Phipps	• Smartech Energy Limited and Smartech Holdings Limited – shareholder and advisory board member • Left Handed Giant Limited – Shareholder • Creative Nature Limited – shareholder and advisor • Betty Blossom Limited – director (family investment vehicle)
Inga Kennedy	• IJKENNEDY HEALTHCARE CONSULTANCY - Position - Director (however this Company Ltd is registered as not trading at this time. • Portsmouth Hospitals University Trust - Position - Non-Executive Director (end of term is Mar 24) • Isle of Wight NHS Trust - Position - Non-Executive Director (end of term is Mar 24)

Tina Oakley	None to declare
EXECUTIVE DIRECTORS	
Peter Lewis Chief Executive (CEO)	• Member of the NHS Confederation Community Network Board • Management Board Member, Yeovil Strategic Estates (YEP) Partner Board • Director, YEP Project Co. Limited
Phil Brice Director of Corporate Services	• Sister works for the Trust • Non-Executive Director of the Shepton Mallet Health Partnership • Non-Executive Director of SSL
Isobel Clements Chief of People and Organisational Development	None to declare
Andy Heron Chief Operating Officer/Deputy Chief Executive	• Wife works for Avon and Wiltshire Mental Health Partnership NHS Trust (and is involved in a sub contract for liaison and diversion services) • Director of the Shepton Mallet Health Partnership • Executive Director for SHS
Pippa Moger Chief Finance Officer	• Stepdaughter works at Yeovil District Hospital • Son works for the Trust • Director of the Shepton Mallet Health Partnership • Director of YEP Project Co Limited • Member of the Southwest Pathology Services (SPS) Board • Non-Executive Director for SSL
Hayley Peters Chief Nurse	None to declare
David Shannon Director of Strategy and Digital Development	• Member of the Southwest Pathology Services (SPS) Board • Daughter is employed as a healthcare assistant at Musgrove Park Hospital • Member of the Symphony Health Care Services (SHS) Board • Director of Symphony Health Services (SHS) • Wife works within the Neighbourhood's Directorate. • Director of YEP Project Co Limited • Director Predictive Health Intelligence Ltd

Daniel Meron Chief Medical Officer	• Visiting Professor, Peninsula Medical School, University of Plymouth

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Chief Executive/Executive Director Report
SPONSORING EXEC:	Chief Executive
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Chief Executive
DATE:	5 September 2023

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

Executive Summary and Reason for presentation to Committee/Board	The purpose of the report is to update the Board on the activities of the executive and senior leadership team and/or points of note which are not covered in the standing business and performance reports, including media coverage and any key legal or statutory changes affecting the work of the Trust. The report covers the period September and October 2023.
Recommendation	The Board is asked to note the report.

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

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

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

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

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

Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
The report includes a number of references to work involving colleagues, in particular the work on sexual safety and the various workstreams relating to equality, diversity and inclusion.

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

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

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

SOMERSET NHS FOUNDATION TRUST

CHIEF EXECUTIVE / EXECUTIVE DIRECTOR REPORT

1. WELCOME TO OUR NEW NON-EXECUTIVE DIRECTORS

1.1. On 1 October 2023, we welcomed three new non-executive directors – Inga Kennedy CBE, Tina Oakley and James Phipps - to our trust. They joined our Trust Board on 1 October 2023 as non-voting associate members, before becoming full voting non-executive directors in 2024 on the planned retirement of three of our current non-executives.

1.2. Inga, Tina and James bring outstanding and diverse high-level experience and a deep commitment to the values of the NHS. Inga was previously Head of the Medical Service/Medical Director General of the Royal Navy. Tina has held a range of senior HR roles at British Airways, Amazon, and other blue-chip companies. James is a successful entrepreneur and philanthropist.

1.3. Our Trust is integrated and provides acute, community, mental health and learning disability services and approximately a quarter of primary care in Somerset. It is also one of the largest trusts in the south west. We are delighted that we have three very experienced people who joined our Trust Board. By joining initially as non-voting associates, we will ensure a seamless transition for our Trust Board.

2. REPORT INTO SEXUAL MISCONDUCT IN SURGERY AND OUR RESPONSE

2.1. On 12 September 2023 a report was published which has exposed the truly shocking extent of reported sexual misconduct by colleagues within the UK surgical workforce. The publications by the Working Party on Sexual Misconduct in Surgery included research that found that two-thirds of women (63.3 per cent) reported having been the target of sexual harassment from colleagues, along with almost a quarter of men (23.7 per cent).

2.2. Clearly the behaviour and culture that is described goes against everything that we are trying to achieve within our trust. We are considering what we do to respond proportionately to both understand what we know about the cultures within our trust, what further work we need to do to understand this, and the actions we may need to take.

2.3. In the immediate aftermath of the report's publication, we have written to all doctors within our trust to pledge our support to any colleagues who witnesses or is the victim of behaviour that makes them feel uncomfortable and to outline to them a variety of routes that they can use to speak out. We have also communicated how we are working hard to build a culture in which every colleague has a voice that is valued and heard, and that values everyone.

We know that this culture enhances safety and improves safety and experience for patients and colleagues.

3. OUR TRUST SIGNS UP TO SEXUAL SAFETY CHARTER

3.1. Our trust has signed up to the sexual safety charter launched by NHS England. It commits us to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce.

3.2. For the first time, the NHS Staff Survey, which was launched in September 2023, asks colleagues how many times, they have been the target of unwanted behaviour of a sexual nature in the workplace. This will help us and other NHS organisations to understand the prevalence of sexual misconduct and we will be looking at the results very closely.

3.3. A working group will be convened to look at this issue, understand the position within our trust and the action that we need to take to continue to build a culture in which every colleague has a voice that is valued and heard, and that values everyone.

4. REGIONAL EQUALITY, DIVERSITY AND INCLUSION STRATEGY

4.1. The Trust recently received a letter from NHS England setting out the next steps with respect to implementing the Regional Equality, Diversity and Inclusion Strategy titled “Leading for Inclusion”.

4.2. The purpose of the strategy is to create a culture where people feel valued and heard, helping them to be their best selves at work through developing leaders to be compassionate and inclusive. All while recruiting, training, and retaining a more diverse workforce that has fair representation, focusing on disabilities, Race, Ethnicity, and LGBTQ+).

4.3. The work to implement the regional strategy is aligned to the NHS People Promise – we are compassionate and inclusive, we all have a voice that counts, and we are recognised and rewarded.

4.4. The Trust welcomes, and is committed to, the regional strategy and focus on equality, diversity and inclusion and supports the ambitions of the strategy, which are aligned to the Trust’s inclusion activities.

5. SOMERSET NHS COLLEAGUES TO SHOWCASE READY TO GO UNITS AT NEW SCIENTIST CONFERENCE

5.1. A team of colleagues from our trust are spreading the word about our ‘Ready to Go Units’ at a prestigious science conference held in London in October 2023.

5.2. Dr James Gagg, one of our emergency medicine consultants and associate medical director for our medical services group, is part of the team who travelled to the New Scientist Live to showcase how colleagues on the units are giving medically-fit patients that more intensive rehabilitation before they return home from hospital.

"It's a real honour for our trust to be asked to exhibit our work on such a prestigious platform as New Scientist Live," he said. "It very much follows the widespread local and national media coverage in early 2023 that showed our approach to developing the best way of caring for a group of patients, who are appropriate to be discharged from hospital, but are waiting for care in the community.

"We set up our two Ready to Go Units – in Musgrove Park and Yeovil hospitals – with a reablement focus very much in mind. Our colleagues set about creating a space that didn't resemble a traditional hospital ward but is more a place where patients can develop a routine more akin to that at home as well as getting additional therapy whilst awaiting a safe discharge.

"The ethos of the units is to get patients dressed and out of bed, as well as taking part in physiotherapy exercises and other activities that will make their everyday life much easier at home. Data shows that almost nine in ten of our patients cared for on the units were up, washed and dressed every day – a great effort.

"There are two main areas that we want to celebrate and showcase at the event, the first being how we've worked hard as an organisation to identify the problem and use quality improvement methodologies to come up with innovative solutions.

"The problem in this case was how we could do our best for those patients who are medically-fit to be discharged from hospital but are waiting for an onward care package or social care placement – we wanted to avoid giving them unnecessary medical care or allow them to decondition by lying in bed and not moving.

"The quality improvement processes that we have at the trust allowed us to make this happen, and on the units themselves, 88% of colleagues reported that they'd had a good day at work – bucking the national trend.

"The other side, of course, is the actual care of the patient and how we're learning more about why getting people out of bed and doing activities and exercises, and involving other organisations, such as Age UK, has a huge benefit for our patients. It also reduces the level of care they might need once they're back home and increasing their independence.

"While this is a great solution to the problem, and 15% of all patients left the unit with greater independence, the ultimate aim is for those patients not to be in hospital in the first place with care available in the community, closer to their home.

6. SYMPHONY HEALTHCARE SERVICES SHOWCASED AS A CASE STUDY IN NHS PROVIDERS REPORT TITLED *THE CONTRIBUTION OF AT SCALE PRIMARY CARE TO SYSTEM WORKING*

6.1. Symphony is a case study in a report by NHS Providers which looks at the role and contribution of at scale primary care providers to system working.

6.2. The report sets out how there are many different approaches to delivering primary care at scale, but common aims include: efficiencies, new ways of working above the provision of core general practice to improve quality or integrate care, and collaboration with other practices and healthcare providers to improve patient care or share resources.

6.3. The development of policy has driven consideration of the benefits of collaboration and working at scale and the case studies in this briefing bring these ideas to life and demonstrate the ways in which larger scale primary care providers are, and can be, integral to NHS services working together in neighbourhoods, in place-based partnerships and in systems.

6.4. The case study about Symphony describes the group's focus on skills and expertise that has involved the centralisation and standardisation of key functions. This approach has realised an estimated £500,000 in savings while improving processes and support to practices.

7. UPDATE ON INDUSTRIAL ACTION

7.1. For the first time, junior doctors and consultants took joint action, and since strikes began, the national cumulative total of acute inpatient and outpatient appointments rescheduled has now exceeded 1 million.

7.2. In September 2023, the British Medical Association announced that it has re-balloted junior doctors to extend its mandate for strike action by junior doctors in England. 98 percent of junior doctors, from a turnout of 71% voted to continue industrial action. The ballot has renewed the BMA's mandate for six months until 29 February 2024.

7.3. The BMA announced new strike dates for both junior doctors and consultants with both groups striking on the same days for the first time.

7.4. Junior doctors took industrial actions on 20, 21 and 22 September 2023 and on 2, 3 and 4 October 2023. Consultants took industrial actions on 19 and 20 September and 2, 3 and 4 October 2023. A "Christmas Day" level of staffing from both groups was provided on the four days impacted by the joint actions.

7.5. The September 2023 actions resulted in 129,913 inpatient and outpatient appointments having to be rescheduled.

8. CELEBRATING BLACK HISTORY MONTH

8.1. On 5 October 2023 colleagues from across our trust came together for a thought-provoking event to celebrate Black History Month, organised by our Multicultural Network and supported by our Freedom to Speak Up Guardians. It was a wonderful celebration of culture, diversity and allyship – something we strive to have at the forefront of how we work.

8.2. Each year in October we highlight the months of Freedom to Speak Up and Black History, and this year, we are 'breaking barriers' across the trust. Inviting everyone to dig deeper, look closer, and think bigger about the meaningful action we can all take to make our trust a fair, safe, and inclusive environment for everyone.

8.3. We know that there is still work to be done to improve our approach to inclusion across our trust, but the event both celebrated what we have achieved so far together and shone a light on what needs to be done.

8.4. We had the pleasure of being joined by guest speaker, Michelle Cox. Her story was a reminder of the importance of speaking up, being brave, and the work that needs to be done to break barriers. Personal stories from colleagues across the trust were shared, and everyone who attended were given the chance to reflect on their own experiences.

Reflections from our Multicultural Network lead, Tayo Evans
"I would like to express, on behalf of the multicultural network, gratitude for all executives that were present and supported us. We learnt so much from them and we are truly grateful. Hayley and Bel made the trust so proud. As Michelle Cox mentioned, we were one of the first trusts that reached out to her when she was going through her tribunal to offer our support, and she shared the letter that Hayley and Bel sent to our network members to express their support.

I want to encourage all our colleagues to embrace our diverse community and continue to learn from one another. There is beauty in working together as the diverse team that we are.

Our multicultural network is for all cultures that come together to work in Somerset NHS Foundation Trust. We are always happy to welcome ideas from all on working together and making things better for us all in providing outstanding care".

9. SUPPORTING FAMILIES THROUGH BABY LOSS IN SOMERSET

9.1. This year marks the 21st year of Baby Loss Awareness Week in the UK – a week for everyone to come together to remember and commemorate all of the much-loved, and much-missed babies.

9.2. Our team of bereavement lead midwives across the trust provide support to families after the loss of their babies, within our maternity units. The team is made up of lead bereavement midwife, Lucy Blackmore, Yeovil-based midwife, Lorna Straker-Nesbit, and Musgrove Park-based midwife, Jo Beebee.

9.3. The team is open to hearing from anyone across the trust who would like more information or support.

10. RCN SURVEY – FIVE YEARS ON: ARE WE ACHIEVING PARITY BETWEEN MENTAL AND PHYSICAL HEALTH?

10.1. To mark World Mental Health day on 13 October 2023, the Royal College of Nursing (RCN) has published its latest survey to establish members' views on the progress in clinical settings towards achieving greater mental health equality. The RCN last conducted its survey on parity of esteem between mental and physical health in 2018, but then sought the views of members working in mental health settings.

10.2. This year's survey of 4,000 nursing staff found that mental health remains "the poor relation in the NHS" and that NHS services are not treating people holistically by joining up physical and mental health care.

10.3. NHS Providers has responded to the findings of the survey with the following statement.

11. LABOUR WARD AT MUSGROVE PARK TO PILOT EMERGENCY ROLE ALLOCATION SYSTEM

11.1. The new emergency role allocation (ERA) system is an innovative digital bell system designed by one of our midwives Caroline Lacy, inpatient matron at Yeovil District Hospital.

11.2. Currently, when an emergency occurs, clinicians pull a physical emergency buzzer. This alerts colleagues to the emergency, and they attend the area to establish what the emergency is before leaving the area to call or find other colleagues, retrieve equipment, or to complete any other actions needed before returning to the emergency.

11.3. The new system enables clinicians to alert the wider team digitally to the emergency and define what the emergency is. This means that colleagues can self-allocate roles/actions before entering the area of the emergency, saving time and responding to the emergency more efficiently.

11.4. Over the last two years, our maternity colleagues have been testing the ERA system as part of their in-situ emergency simulations, and during this time have provided valuable feedback on usability, acceptability, and effectiveness.

The team is excited that the benefits of the systems will now be available in real-time in the clinical setting.

12. HAND AND WRIST SURGERY INTRODUCED AT MINEHEAD COMMUNITY HOSPITAL

12.1. People in Minehead and West Somerset are now able to access many types of hand and wrist surgery at their local community hospital. It follows the introduction of a nerve block technique, where a patient's whole arm can be numbed before surgery, so they can be operated on under local anaesthetic without needing to travel to Musgrove Park or Yeovil hospitals.

12.2. Patients are assessed by their clinician to determine if they are suitable to have an operation at Minehead Hospital, as not all patients will meet the clinical criteria.

12.3. The technique is traditionally used at Musgrove Park and Yeovil hospitals for hand and wrist operations, where the option of a general anaesthetic is available if required.

12.4. After careful consideration by our theatre, anaesthetic and safety teams, for those patients who meet certain pre-operative criteria, it has been possible to develop this service at Minehead Hospital without needing the safety net of a general anaesthetic.

12.5. By running this at Minehead Hospital, we are not only reducing the time that patients need to wait for their operation, but are lowering the risk of an operation being cancelled due to other higher priority emergency operations. This is so much more convenient for people in this rural area of Somerset.

13. THANK YOU TO EVERYONE WHO ATTENDED OUR ANNUAL MEMBERS' MEETING AND ANNUAL GENERAL MEETING

13.1. The Annual General Meeting and Members' Meeting took place on 20 September 2023 and, on behalf of the trust, the Chairman thanks everyone who attended the annual events.

13.2. The meeting received an overview of 2022/3 and reflections for 2023/4 as well as the YDH and SFT 2022/23 annual accounts and annal reports. This overview was followed by a very engaging session from our Child and Adolescent Mental Health Services (CAMHS) describing their journey from a service that was rated "requires improvement" in 2018 by the Care Quality Commission (CQC) to one that was rated "outstanding" in 2023. The meeting further received a very thought provoking and interesting presentation on our homelessness and rough sleeper service.

14. USE OF THE CORPORATE SEAL

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

14.2. The seal register entries over the period 1 April 2023 to 1 November 2023 are set out in the attached appendix.

15. MEDIA COVERAGE

15.1. Over the period September to October 2023, there has been the following media coverage:

- ***Media coverage of our new radiotherapy superficial x-ray unit***
  Below links to the BBC Radio Somerset coverage on 22 September 2023 about our new radiotherapy superficial x-ray unit. This was part of a wider package of comms that also included social media posts, press release and Our News/Intranet articles. Jo Penman, head of radiotherapy; Stephen McCormick, head of radiotherapy physics; and Paul Always, chair of SURE, were interviewed.

  Breakfast: Charlie Taylor - 22/09/2023 - BBC Sounds (1:26.45 into programme)

  Drive: Afternoons on BBC Radio Somerset - With Caroline Martin (22/09/2023) - BBC Sounds (3:34.20 into programme)

- ***Media coverage of our new post menopausal bleeding service***
  below a link to the coverage about our new post menopausal bleeding service. It was part of a wider communications and advertising campaign that includes social media posts, press release, web article, internal Our News article, along with an advertising package with Heart FM, buses, and others Both David Milliken, consultant gynaecological oncologist, and Heather Fryer, colposcopy sister, were interviewed by BBC Radio Somerset and Heart FM. Links to available coverage are below.

  BBC Radio Somerset: Charlie Taylor - 27/09/2023 - BBC Sounds (1.09:00 into programme).
  BBC News Online: Somerset womb cancer detection service launches - BBC News

- Early October 2023, the communications team worked on coverage about a research study by one of our clinical nurse researchers, Ana-Maria Toth, into the potential benefits of hypnosis for patients following a colectomy. Coverage on ITV West Country includes an interview with Ana, as well as consultant surgeon Ed Smyth, and patient Patsy, whose procedure was also filmed. This is part of a wider package of

comms that included an article in Our News and social media posts.

- **Coverage in the British Medical Journal (BMJ)**
  Andrew Stevenson, consultant trauma and orthopaedic surgeon at our trust and co-chair of the Royal College of Surgeons of England's sustainability in surgery group, is interviewed for an article in the BMJ titled How to make "single use" surgical items more sustainable about the work that has been done, and the challenges, to make choices about use of more sustainable products in surgery.

- **Coverage expected in the Sunday Times on 29 October 2023**
  We are expecting coverage in Sunday Times on 29 October 2023 about the research project study led by clinical nurse researcher Ana-Maria Toth, into the potential benefits of hypnosis for patients following a colectomy. It is expected to be part of a wider piece that looks at hypnotism in general, at patients who are turning to hypnotherapy as an alternative to traditional therapies and counselling, and the move towards using hypnotherapy in clinical settings. Our study is looking at the potential effectiveness of hypnotism in addition to pain relief.

16. NATIONAL DEVELOPMENTS

NHS monthly performance statistics show record number of people waiting

16.1. The monthly performance statistics published by the NHS in September 2023 show that nearly 7.7 million people were on NHS waiting lists at the end of July.

16.2. NHS Providers, which represents NHS hospital, mental health, community, and ambulance services that treat patients and service users in the NHS, has issued the following statement in response.

"It's extremely *concerning to see the waiting list hit another record high amid escalating pressure on the NHS, including A&Es facing their busiest summer since 2019.*

"Trust leaders remain focused on improving timely patient care and have managed to reduce ambulance response times for the third month in a row.

"However, challenges including severe staff shortages, capacity constraints – including of beds and equipment – and ongoing strikes are hindering vital progress on performance targets.

"This impacts the whole system, including hospital, ambulance, mental health and community services.

"Nearly one million appointments have had to be postponed due to the strikes since December, which significantly hampers trusts' efforts to bear down on backlogs.

"With more strikes on the horizon, including coordinated action between junior doctors and consultants for the first time, even greater disruption looms.

"It's vital the government and unions re-open talks to find a resolution to the pay dispute."

NHS Providers materials – race equality and allyship video series My journey as a white ally - update

Video series – My journey as a white ally

16.3. As part of its insight report, trust leaders asked NHS Providers to support white chairs and chief executives to have conversations about race, helping them develop a greater understanding of what it means to be anti-racist

16.4. Through these events and resources, NHS Providers has shared how white leaders are, as a result of their personal buy in, enabling conversations about race, fostering safe spaces, and developing in their role as allies.

16.5. The full series is available here. In the latest episode NHS Providers spoke to Andy Callow, chief digital and information officer at Nottingham University Hospitals NHS Trust.

NHS Providers - race equality programme

16.6. NHS Providers Race Equality Programme team recently spoke to Dom Patterson, founder and managing director of Seventeen Seconds, specialists in organisational development for the NHS.

16.7. In the interview Dom speaks about Culture in Health, an educational programme run by Seventeen Seconds, designed to help develop culturally competent trust leaders who would in turn be better equipped to support their internationally educated workforce. The full interview is available here.

Ipsos Mori research into public perceptions of health and social care

16.8. The Health Foundation has published the results of research by Ipsos Mori into the public's perception of health and social care. The latest briefing is from the fourth wave of the Health Foundation's public perceptions research with Ipsos Mori tracks the public's views on health and social care in the UK every six months.

16.9. The highlights are that:

- 4 out of 5 people (80%) support additional funding for the NHS.
- Top priorities for the health service remain addressing the pressure or workload on staff (40%), increasing the number of staff in the NHS (39%) and improving waiting times for routine services such as diagnostic tests or operations (34%).
- Only 1 in 20 (6%) think the government has the right policies for social care.
- The public's top priorities for social care are improving pay and conditions for staff (42%), making it easier for health and social care services to work together (37%), increasing support for people who

provide care for friends or family members who need support who are not paid (32%) and increasing the number of staff in social care (32%).

- Just 16% of the public think the government has the right policies to improve public health.

NHS Providers response to Sir Keir Starmer's speech at the Labour Party conference

16.10. In response to Labour Party leader Sir Keir Starmer's speech at the Labour Party conference this week, Sir Julian Hartley, chief executive of NHS Providers, said:

"An NHS fit for the future needs long-term plans and support rather than short-term fixes.

"Record-high numbers of patients are on waiting lists. Trusts have succeeded in tackling the longest waits for care but continue to face ever-growing demand.

"Any attempts to address backlogs are of course welcome, including the announcement by the Labour Party leader of a £1.1bn investment earlier this week to cut waiting times by asking NHS staff to work evening and weekend shifts.

"But it's vital that we address the underlying issues facing healthcare. Waiting times were getting longer before the pandemic after years of underfunding and chronic staff shortages. Today there are 125,000 unfilled jobs across the NHS, leaving staff with heavy workloads and one in four absences due to anxiety, stress and depression.

"More national investment in public health and prevention, and in social care, is vital as well as substantially more capital spending to help ease pressure on stretched hospital, ambulance, mental health and community services and staff.

"Meanwhile the NHS is heading into a demanding winter with the threat of more strikes hanging over it.

"Trust leaders need to be able to spend their time ensuring that patients get first-class care and bearing down on care backlogs, not planning to cope with strikes. The government and unions must find a way to break the deadlock."

Care Quality Commission publishes its annual State of Care Report

16.11. On 20 October 2023 the Care Quality Commission (CQC) published its annual State of Care Report. The report is the CQC's annual assessment of health care and social care in England, which looks at trends, shares examples of good and outstanding care, and highlights where care needs to improve.

Diversity and inclusion in the NHS

16.12. During the week of 20 October 023, there have been two publications discussing diversity and inclusion in the NHS.

Secretary of State for Health and Social Care, Steve Barclay, has written to Integrated Care Boards (ICBs) in which he expresses concern that many local organisations are recruited into dedicated equality, diversity, and inclusion roles. In response Roger Kline, research fellow at Middlesex, writes an open letter to Steve Barclay, published in the BMJ that describes the importance of supporting the NHS workforce and the role that equality and diversity plays in supporting colleagues to deliver excellent care.

NHS Providers report – *Enabling wellbeing within trusts*

16.13. NHS Providers has published a report titled" Enabling wellbeing within trusts" featuring six trusts from across the sectors who are investing in targeted interventions to support the physical, mental and emotional wellbeing of their workforce. These case studies highlight some of the local initiatives trusts have delivered to support their colleagues through the current challenges of working in the NHS.

NHS Provides guide to addressing racial discrimination in disciplinaries

16.14. NHS Providers has launched a new guide *Closing the gap: a guide to addressing racial discrimination in disciplinaries* in partnership with leading healthcare law firm Hempsons. It aims to support board members to have an increased awareness and understanding of the NHS racial disciplinary gap and provides practical advice and examples of how the gap can be reduced.

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SOMERSET NHS FOUNDATION TRUST

SEAL REGISTER

1 APRIL 2023 to 31 OCTOBER 2023

Date of Sealing	No. of Seal	Nature of Document	First Signatory	Second Signatory
17 April 2023	53	Deed of Amendment and Restatement of south West Pathology Services LLP Members' Agreement	David Shannon	Isobel Clements
1 June 2023	54	Deed of Variation relating to a deed of variation and an agreement for lease of premises known as Rutherford Diagnostic Centre	David Shannon	Daniel Meron
29 June 2023	55	Lease of first floor of Taunton diagnostic Centre	David Shannon	Pippa Moger
12 July 2023	56	Yeovil Diagnostic Centre service contact	David Shannon	Peter Lewis
17 July 2023	57	Lease of car parking spaces at Victoria Gate	David Shannon	Isobel Clements
18 August 2023	58	Lease of first floor at Rutherfords Diagnostic Centre – deed of warranty	David Shannon	Peter Lewis
4 September 2023	59	Engrossment Lease for Cannonsgrove Hall of Residence	David Shannon	Phil Brice
13 September 2023	60	Diagnostic Centre Retrospective Licence to sub-Let	David Shannon	Pippa Moger
13 September 2023	61	The Exchange Lease Renewal	David Shannon	Pippa Moger
24 October 2023	62	Wincanton Engrossment documents	Peter Lewis	David Shannon

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	2023/24 Q2 Board Assurance Framework
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
PRESENTED BY:	Phil Brice, Director of Corporate Services
DATE:	7 November 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	Somerset NHS Foundation Trust (SFT) has identified eight strategic objectives, which remain the long term aims for the newly merged organisation. The five clinical objectives are aligned with the system clinical aims which also form the basis for the clinical model. These sit alongside our financial, people and organisational objectives. The Board Assurance Framework (BAF) A revised Assurance Framework has been developed to clearly outline the highest risks to the Trust in achieving these objectives; the plans in place to manage and mitigate these and to provide the Committees and Board with a summary of key plans and strategies supporting their delivery. Common areas of risk identified across objectives are: • Workforce shortages/retention/turnover/recruitment • Insufficient capacity to meet demand • Failure to secure the necessary infrastructure • Sub-optimal links between primary care and SFT services • Access to primary care / increasing ED demand / fragility of primary care • Personalised care not getting required focus • Lack of understanding of shared accountability / resourcing
Recommendation	The Board is asked to: • Review the Board Assurance Framework and note

	the actions being taken to address the risks identified • Consider the objectives reserved to the Board in respect of the key controls and assurances and any further assurances that may be required in respect of any individual areas of risk.

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

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

Equality and Inclusion **The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.** **How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?**
The needs and impacts on people with protected characteristics have not been considered as part of this report but are considered as part of the mitigating actions taken at service group level.

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

2023/24 Q2 BOARD ASSURANCE FRAMEWORK

1. PURPOSE OF THE REPORT

1.1 To present the 2023/24 Q2 SFT Board Assurance Framework to the Board of Directors.

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 Revisions have been made to the Assurance Framework for 2023/24 in order to focus the Committees and Board on the key risks, controls and assurance, and the plans in place to mitigate the risks. In addition, the Assurance Framework provides the Committees and Board with a summary of key plans and strategies supporting their delivery.

2.4 A review of the Trust's strategic objectives was undertaken by the Board of Directors at a Board Development Day in April 2023, where it was agreed that the eight strategic objectives previous set remain the long term aims for the newly merged organisation.

2.5 The five clinical objectives are aligned with the system clinical aims which also form the basis for the clinical model. These sit alongside our financial, people and organisational objectives.

2.6 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 Committee is responsible for reviewing the levels and effectiveness of the assurances that the Board received in respect of the risks identified, ensuring that these are relevant and timely, and that the overall system of internal control is effective.

3.2 The Audit Committee oversee the effectiveness of the above processes at each of its meetings.

3.3 The Quality and Governance Committee has responsibility for oversight of the clinical strategy objectives (2, 3, 4 and 5). The People Committee has responsibility for oversight of people objective (6) and the Finance Committee has responsibility for oversight of the finance objective (7). Objectives 1 and 8 are reserved to the Board.

3.4 The BAF was reviewed and considered by the relevant committees at the following meetings:

Audit Committee – 12 July 2023, 11 October 2023
Quality and Governance Committee – 28 June 2023, 26 July 2023, 25 October 2023
People Committee – 25 July 2023, 13 September 2023, 8 November 2023
Finance Committee – 31 July 2023, 30 October 2023
Board – 4 July 2023

3.5 The Assurance Framework is also reviewed by the Executive Team on a regular basis.

3.6 Following the review of the BAF at the Audit Committee, amendments will be made to the BAF during Q3 to provide further clarity on targets and timeframes for plans and strategies against the key risks.

4. GAPS IN CONTROL AND ASSURANCE

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

- Workforce shortages (objective 3)
- Inability to fill vacancies across organisation (objective 6)
- Insufficient capacity to meet demand (objective 8)
- Failure to secure the necessary infrastructure (objective 8)
- Retention and turnover of colleagues (objective 6)

- Sub-optimal links between primary care and SFT services (objective 5)
- Personalised care doesn't get required focus (objective 5)
- Access to primary care / increasing ED demand / fragility of primary care (objectives 2 and 3)
- Lack of understanding of shared accountability/resourcing (objective 1)

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 Board 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 Board 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 All strategic risks have been reviewed by the Deputy Director of Integrated Governance and 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 continues to be 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.

5.2 There has been some reduction in the highest risks across a small number of objectives as outlined within the report.

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.

DEPUTY DIRECTOR OF CORPORATE SERVICES

BOARD ASSURANCE FRAMEWORK SUMMARY

Quarter 2 2023/24

	Highest Risk	Assurance ratings
⇧	Highest risk rating increased	Assurance increased
⇔	Highest risk rating remained the same	Assurance remained the same
⇩	Highest risk rating decreased	Assurance decreased

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

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

Key Performance Indicators

Diabetes: HbA1C checks	Jun	100% ⇔	Addiction (smoking/Alcohol) YDH IP		62% ⇧	Suicide/Self harm prev: MH Staff	361 ⇧
Suicide/Self harm prev: non-MH		177 ⇧	28 day cancer faster diagnostic	Jul	79.4% ⇧	Number of pats enrolled to Periop	104 ⇧

	Key Risks	Risk Reference	Current Risk						Target Risk					
	(High Consequence risks that may stop us achieving the objective)	*(From corporate risk register)*	*Con*		*Lik*		*RS*		*Con*		*Lik*		*RS*	
1	Population Health may not get the focus required	R1613/U986	3	x	4	=	12		3	x	3	=	9	
2	Approach to Population Health may be uncoordinated	R1615/U987	4	x	2	=	8		4	x	2	=	8	
3	Lack of understanding of shared accountability/resourcing	R1616/U988	4	x	4	=	16		4	x	3	=	12	

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

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

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

Key Performance Indicators

Ambulance handover hrs lost >15m	Jul	11358 ⇧	Cancelled operations		⇔	C.Diff year to date cases		18 ⇩
Patient Initiated follow up (PIFU)		8.2% ⇧	Falls resulting harm per 1000 days	Jun	0.37 ⇩	Pressure ulcers per 1000 bed days	Jun	0.87 ⇧
Acute Home Treatment caseload		66 ⇩	Pats waiting social wk assessment		54 ⇧	End of Life pat discharges <24hrs	Jun	70.0% ⇩

	Key Risks *(High Consequence risks that may stop us achieving the objective)*	Risk Reference *(From corporate risk register)*	Current Risk Con	Lik	RS	Target Risk Con	Lik	RS
1	Access to primary care / increasing ED demand	R673	4 x	4 =	16	4 x	4 =	16
2	Shortfalls in Social Care capacity	R831/U331 & R1513	5 x	3 =	15	4 x	3 =	12
3	Age of acute and community estates	R1789	5 x	3 =	15	4 x	2 =	8

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

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Launch programme to EPJP and prevent deconditioning across all sites	HP	Jul-23	On Plan
Development of Quality and Patient Strategy	HP	Oct-23	On Plan
Ward Accreditation - revised programme to be developed	HP	Jul-23	On Plan
Leadership quality walkarounds	PB/HP	Jul-23	On Plan
Development of the Chief Nurse Core Standards	HP	Jul-23	On Plan

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

Key Performance Indicators

Pats ref to Acute Home Treatment	179 ⇩	Adm. Prevented by Rapid Resp/AHT	365 ⇩	Urgent Community response <2hrs	Jun	91.0% ⇩
PCNs with integrated models	1 ⇔	Increase Open MH attendances	22,575 ⇧	Integrated family hub launch		1 ⇔

	Key Risks (*High Consequence risks that may stop us achieving the objective*)	Risk Reference (*From corporate risk register*)	Current Risk Con	Lik	RS	Target Risk Con	Lik	RS
1	Workforce shortages	U925, R1329, R1624/U994, R179	4	5	20	4	3	12
2	Fragility of Primary Care	R673	4	4	16	4	4	16
3	Shortfalls in Social Care capacity	R831/U331 & R1513	5	3	15	4	3	12

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

Actions to Improve Controls and Assurance (*Required for any areas assessed Amber or Red*)	Lead	Target Date	Progress Summary
Action plan to address low levels of referral activity into H@H	AH/TE/CD	15.06.23	On Plan
Intermediate Care Strategy development reporting to Neighbourhood & PC Programme Board	PM/AH	12.07.23	Behind Schedule
KPIs/metrics monitored and actions taken via the QOFP process	PM/AH	01.03.23	On Plan

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

Key Performance Indicators

Prot characteristics data complete	May	98.9% ⇔	Ethnicity equity of access:acute RTT		tbc	Ethnicity equity of access: cancer		Equal ⇔
Ethnicity equity of access: MH		Equal ⇔	Reduce elective waits - pats with LD	Mar	19w ⇧	Healthy life expect. gap: high-low	2020	13.3y ⇔

	Key Risks (*High Consequence risks that may stop us achieving the objective*)	Risk Reference (*From corporate risk register*)	Current Risk Con	Lik	RS	Target Risk Con	Lik	RS
1	System and Trust strategy not fully developed	R1620/U991	5	3	15	4	2	8
2	Data quality issues leading to poor information	R1616/U992	4	4	16	4	3	12
3	Historical funding/resource gaps including in MH & LD	R1622/U993	3	4	12	3	3	9

Controls (*What we have in place to support delivery of the objective*)	Assurance (*Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*)	Outcome of assurance	Assessment (*See assessment guidance*)
Plans & Strategies			
Open Mental Health	Internal Audit - Mental Health (January 2023)	Positive	
Digital Strategy - population health data	Digital Board/Board review	Neutral	Green
	CQC Inspection - (September 2022)	Positive	
Processes for Delivering Plans			
Equality Impact Assessment	None	Negative	
Master Patient Index programme	Data Quality reports	Neutral	Amber
Elective Recovery inequalities programme	Board reports	Positive	
Oversight Arrangements for Governance & Engagement			
System Quality Governance Committee	CQC Inspection/Insight	Positive	
Quality & Governance Assurance Committee	Board Assurance Reports	Neutral	Amber
Population Health Management Committee	Board Reports	Neutral	

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

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

Key Performance Indicators

CYP Eating Disorders - Urgent	100% ⇔	CYP Eating Disorders - Routine	97.3% ⇧	Reduce time in ED: intensity users	Jun	64,386	⇧
Dementia diagnosis rate-Symphony	54.8% ⇧	Persistent physical symptoms prog.	Yes ⇔	Time to assessment in CYPNP		81w	⇩
Homeless service: annual referrals	760 ⇧	Personalised convs/health coaching	187 ⇧				

	Key Risks (High Consequence risks that may stop us achieving the objective)	Risk Reference (From corporate risk register)	Current Risk Con		Lik		RS	Target Risk Con		Lik		RS
1	Sub-optimal links between primary care & SFT services	R1951	4	x	4	=	16	4	x	2	=	8
2	Personalised care doesn't get required focus	R1952	4	x	4	=	16	4	x	2	=	8
3	Failure to deliver EHR	R1953	4	x	3	=	12	4	x	2	=	8

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

Actions to Improve Controls and Assurance (Required for any areas assessed Amber or Red)	Lead	Target Date	Progress Summary
Development of oversight and reporting governance with ICB/ICP	DM	Oct-23	Behind Schedule
Reviewing dementia diagnosis rates split by symphony practices	DM	Oct-23	On Plan

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

Key Performance Indicators

Retention: % in post >12months	83.0% ⇧	Pulse Engagement	6.5% ⇔	Inclusion: % B8S reg.disabled	2.8% ⇩
Pulse Advocacy measure	6.5% ⇩	Inclusion: % B8s who are female	58.7% ⇔	Inclusion: % B8s ethnic minority	20.3% ⇔

	Key Risks (*High Consequence risks that may stop us achieving the objective*)	Risk Reference (*From corporate risk register*)	Current Risk Con	Lik	RS	Target Risk Con	Lik	RS
1	Core numbers of junior & consultant medical workforce	R1329	4	5	20	3	4	12
2	Not improving retention rate of colleagues especially in support to	R1880	4	4	16	3	3	9
3	Reduced colleague resilience	R1944	4	4	16	3	3	9

Controls (*What we have in place to support delivery of the objective*)	Assurance (*Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*)	Outcome of assurance	Assessment (*See assessment guidance*)
Plans & Strategies			
People Strategy 2023-2028 with defined year 1 deliverables	People Strategy KPIs	Positive	
People Promise Exemplar programme	National Staff survey results - people promise areas	Positive	Green
Inclusion Roadmap	WDES/WRES/gender pay gap/EDS	Positive	
Processes for Delivering Plans			
Year 1 deliverables charter	Highlight reports	Neutral	
Retention roadmap	Internal audit due Q3 23/24	Neutral	Amber
Values and behaviourial framework	Pulse survey/ FTSU, H&W, career conversation and absence interna	Positive	
Oversight Arrangements for Governance & Engagement			
People Committee	People Committee strategy commitments assurance deep dives	Positive	
People Governance Committee	Year 1 deliverables highlight reports and project charters	Neutral	Amber
Cultural Strategy Group	Cultural Maturity Review - internal audit	Positive	

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

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

Key Performance Indicators

Financial position v plan (YTD)	1.5m ad ⇩	% of CIP identified as recurrent	45% ⇧	Agency v plan (YTD)	2.6m ad ⇩

	Key Risks *(High Consequence risks that may stop us achieving the objective)*	Risk Reference *(From corporate risk register)*	Current Risk Con	Lik	RS	Target Risk Con	Lik	RS
1	Failure to identify & deliver sufficient recurrent CIP	R6/U738	5 x 3 =	15		5 x 2 =	10	
2	Lack of pace of system-wide changes to address deficit	R1855	5 x 3 =	15		3 x 3 =	9	
3	The Trust fails to deliver the elective activity trajectory	R1859	4 x 3 =	12		4 x 2 =	8	

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

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Challenge set to obtain 75% recurrent CIP in 23/24 planning	PM	Mar-24	Behind Schedule
Identify further efficiencies/improve productivity using available benchmarking, GIRFT etc.	PM	Dec-23	Behind Schedule
Work with Social Care to increase capacity in care market to reduce delays and increased costs	AH	Sep-23	Behind Schedule
Quarterly review of underlying position to be presented to Finance Committee	PM	Quarterly	On Plan
Strengthen arrangement between People and Finance Committees regarding workforce reporting	PM / IC	Nov-23	On Plan

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

Key Performance Indicators

A&E 4-hour standard		76.0% ⇩	78 week acute RTT waiters		66 ⇩	6 week diagnostics		76.9% ⇩
62 day cancer waiting time	Jul	71.2% ⇧	Mental health 6 week waiting time		92.8% ⇩	Community waiters >18 weeks		3,862 ⇧

	Key Risks (*High Consequence risks that may stop us achieving the objective*)	Risk Reference (*From corporate risk register*)	Current Risk Con		Lik		RS	Target Risk Con		Lik		RS
1	Insufficient capacity to meet demand	R4	5	x	4	=	20	4	x	4	=	16
2	Failure to secure the necessary infrastructure	R1611/U984 & R1624/U994	4	x	4	=	16	4	x	2	=	8
3	Failure to realise benefits of merger & service integration	R1612/U985	4	x	3	=	12	3	x	2	=	6

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

Actions to Improve Controls and Assurance (*Required for any areas assessed Amber or Red*)	Lead	Target Date	Progress Summary
Development and delivery of system bed capacity review/plan	AH		
Implement new national patient choice strategy	XW	Mar-24	On Plan
System to participate in Right Procedure Right Place (surgery) programme	FC	Mar-24	On Plan
Model/plan to address elective capacity shortfall (65 weeks)	XW	Sep-23	On Plan
Develop and implement business case(s) for Community Diagnostic Programme	DS	Sep-23	On Plan

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Corporate Risk Register Report
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Samantha Hann, Deputy Director of Integrated Governance
PRESENTED BY:	Phil Brice, Director of Corporate Services
DATE:	7 November 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: … ***receive and review the Corporate Risk Register via the Board Assurance Committees*** *and the Assurance Framework quarterly, which identify the principal risks and any gaps in assurance regarding those risks* Each Board Assurance Committee will receive the Corporate Risk Register report with the specific risks assigned to them. The Committees will formally review and scrutinise the risks within their remit. These reports will be received at least once a quarter together with the Board Assurance Framework. The highest areas of risk for the organisation are: • pressures in social care; intermediate care; and primary care • insufficient capacity to meet demand • workforce recruitment and retention • aging estates - acute and community • financial position
Recommendation	The report covers those risks detailed on the Somerset Foundation Trust Corporate Risk Register on 30 October 2023. The report focuses on the high risks scoring 15+ on the risk matrix and includes corporate risks and service group risks. The Board are asked to note the report and the risks identified.

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

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

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

CORPORATE RISK REGISTER REPORT

1. INTRODUCTION

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

Board Assurance Framework

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

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

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

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

Corporate Risk Register

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

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

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

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

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

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

2. PURPOSE OF THE REPORT

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

2.2 This risk report aims to provide details of the key risks detailed on the Trust's Corporate Risk Register on 30 October 2023.

2.3 The report also includes the corporate risks identified by Simply Serve Limited (SSL) which is a wholly owned subsidiary of SFT. These risks are either shown as additional corporate risks for SFT (Risks U1047 & U1056) or mapped into existing SFT corporate risks (Risks U1050 & U1051).

3. CORPORATE RISK REGISTER

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

- Risk 004 Demand
- Risk 0012 Waiting Times
- Risk 0497 Symphony Healthcare Services not becoming financially self-sustaining
- Risk 1329 Core numbers of Junior and Consultant medical workforce

New Risks

3.2 There have been three new risks added to the Corporate Risk Register since the last report presented to the Board sub-committees on 2 October 2023:

- Risk R1968 - Failures in referral pathways to specialities from Primary Care increasing Emergency Department attendances

- Risk R1984 - Inability to recruit applicants within timely manner on the applicant tracking system (ATS)

- Risk R1985 - Poor data quality in Electronic Staff Record (ESR)

Increased Risks

3.3 There have been no risks which have increased since the last report presented to the Board sub-committees on 2 October 2023 which have been included on the Corporate Risk Register.

Risks which have Reduced

3.4 There have been no risks which have reduced since the last report presented to the Board sub-committees on 2 October 2023 from the Corporate Risk Register.

Risks which have been Archived

3.5 There has been one risk which has been archived from the Corporate Risk Register since the last report presented to the Board sub-committees on 2 October 2023:

- Risk U1042/R1799 – Inability to fill vacancies – organisationally

Service Group & Corporate Function Risks

3.6 A number of additional risks scoring 15 or more continue to be identified at Service Group and departmental levels. These risks have been linked to risks on the Corporate Risk Register as shown in Appendix 1. The movement of these risks since the last report presented to the Board sub-committees on 2 October 2023 has also been included within Appendix 1.

3.7 Since the last report presented to the Board sub-committees on 2 October 2023, there have been a number of risks at Service Group and departmental levels which have increased, reduced or archived:

Risk Number	Risk Description	Reduced / Archived
Risk R346	Inability to provide consistent consultant cover for Somerset Neuro Rehabilitation Unit	Increased from 6 ⇨ 16
Risk R1630	Insufficient Learning Disability Liaison Team establishment	Increased from 6 ⇨ 16
Risk R654	Ligature Points on the ward pose a risk to patients	Reduced from 15 ⇨ 10
Risk U1013 / R1809	Lack of outpatient room availability for patients within Dietetic Services	Reduced from 15 ⇨ 9
Risk R1112	Insufficient Orthotist cover	Reduced from 16 ⇨ 12
Risk R1749	Lack of out of hours medical cover at SNRC	Reduced from 16 ⇨ 12
Risk R1871	Delays in accessing the out of hours radiology reporting service	Reduced from 16 ⇨ 8
Risk R1894	Insufficient Sonographer workforce	Reduced from 16 ⇨ 12

Risk Number	Risk Description	Reduced / Archived
Risk R1910	Insufficient medical cover – Willow Ward	Reduced from 15 ⇨ 8
Risk R497	Lack of continuity within medical team on Barrington Ward	Risk Archived
Risk R1825	Referrals rates for the ADHD service exceed the capacity of the service	Risk Archived
Risk R1826	Inability to meet screening referral times within ADHD service	Risk Archived

Emerging Risks

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

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

3.10 Since the last report presented to the Board sub-committees on 2 October 2023, there have been five emerging risks which have been added to the service group and departmental risk registers with a score of 12 which will be closely monitored and mitigating action plans developed:

Risk Number	Risk Description
R1965	Yeovil Dental Access Centre building not fit for purpose
R1971	Lack of transition pathways and processes for young people with a learning disability
R1975	Inconsistent service provision for patients and court colleagues due to insufficient Court Practitioner staffing establishment
R1983	Loss of Computer Room 1 at MPH site due to vibration damage to fibre optic network caused by floor levelling works in SSD building
R1988	Use of escalation beds in Exmoor annex

4. RISK MANAGEMENT ARRANGEMENTS UPDATE

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

4.2 The Trust continues to manage two Risk Management Systems – RADAR and Ulysses. The Trust is currently undergoing a pre-market engagement process to review the Trust's Risk Management System with a stakeholder engagement event being held on 13 November 2023 with stakeholders across clinical and

corporate teams. A contract will be awarded in December 2023 to the provider of the Risk Management System the Trust will use from April 2024.

4.3 Following the stakeholder engagement event, the Governance Support Team will commence an intensive implementation programme across the whole of the organisation to train colleagues in the use of the system. Specifically in relation to the risk registers, the Risk team will work with Risk Owners to ensure all risks are moved to the risk register which will remain in place following April 2024. This will further cement the work that has been underway for some time to review the risks on the current risk registers ensuring the risks are live and have been reviewed recently.

4.4 The Risk Management Policy is under development with key stakeholders across the Trust with input from the Service Groups and Corporate Teams. This will be finalised when a decision has been made on the Risk Management system that will be in place across the Trust from 1 April 2024.

5 CONCLUSION

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

6 RECOMMENDATION

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

Corporate Risk Register 30 October 2023

NHS Somerset NHS Foundation Trust

People Committee

20 R1329 Core numbers of Junior and Consultant medical workforce

16 U0189/R1879 Failure to achieve mandatory training levels

16 U0925/R1880 Retention and turnover of staff

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

16 R1815 Vacancies and absence rates within nursing and AHP teams

16 R1944 Reduced colleague resilience due to prolonged impact of integration

16 R1985 NEW Poor data quality in Electronic Staff Record (ESR)

15 R1984 NEW Inability to recruit applicants within timely manner on the applicant tracking system (ATS)

Financial Committee

20 U0497 SHS not becoming self-sustaining

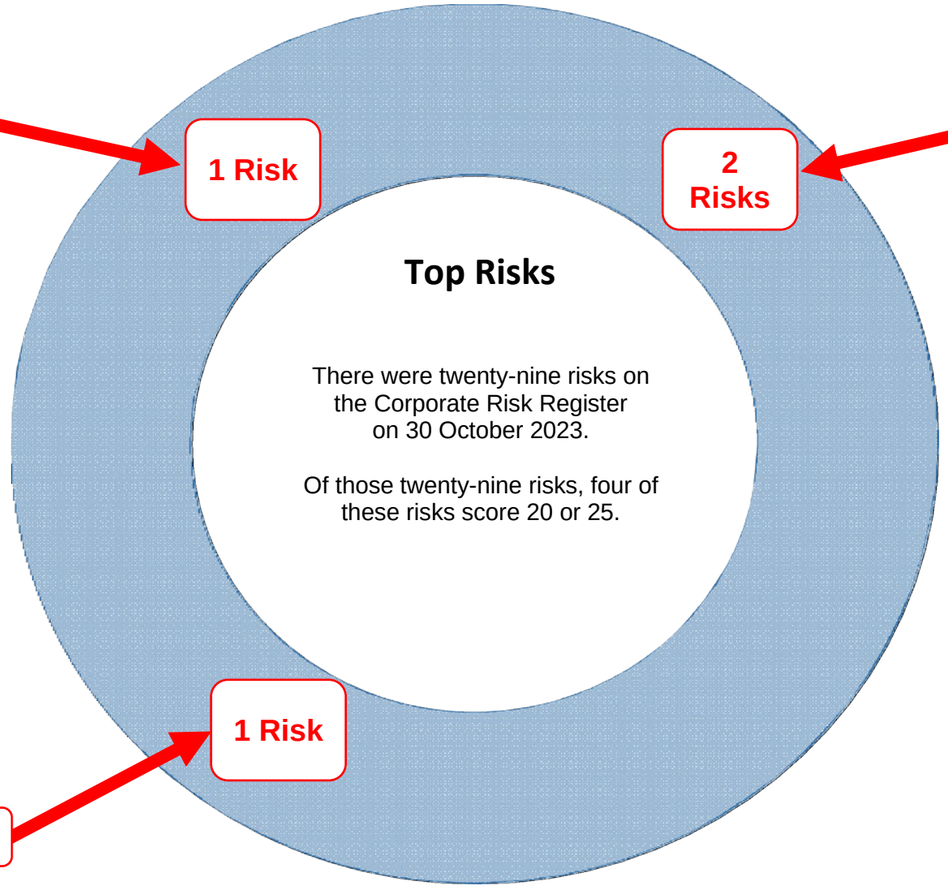
16 R1611/U0984 Failure to secure necessary infrastructure – physical & digital (funding)

16 U1056 Non-delivery of service provision KPIs by Contractor

15 R0006/U0738 Delivery of CIP 2023/24

15 U1047 Reduction of funding into SSL budget to meet service requirements

15 R1855 Failure to deliver financial plan



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

Quality & Governance Committee

20 R0004 Demand

20 R0012 Waiting Times

16 R0007/U100 Referral to Treatment Times

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

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

16 R1238 Fire Compartmentation

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

16 R1852 Unsupported infection control electronic case management system

16 R1952 Lack of prioritisation for further development of personalised care

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

15 R0831/U331 Insufficient intermediate care capacity

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

15 R1789 Unsafe premises and environment

15 R1958 Inability to meet organisational responsibilities under Multi Agency Public Protection Arrangements (MAPPA)

15 R1968 NEW Failures in referral pathways to specialities from Primary Care and Emergency Department referrals

Appendix 1

QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R0004	20	⇔	Demand

Service Group / Corporate Function Risks 15+

U021/ R1811	25	⇔	Unsafe numbers of attendances in Emergency Department
R0372	20	⇔	Overcrowding in Emergency Department
R1077	20	⇔	Cancellation of elective activity due to insufficient number of theatre slots for trauma lists to meet demand
R0560	16	⇔	Insufficient capacity to meet demand for Endocrine weight management service
R0953	16	⇔	Increased demand impacting on patient flow within the Trust
R1362	16	⇔	Insufficient theatre capacity for Urology cases to meet demand
R1504	16	⇔	Referral rates into Children & Young People's Neurodevelopment Service
R1597	16	⇔	No dedicated theatre list for elective caesareans leading to delays and poor patient experience
R1649	16	⇔	Insufficient capacity to meet demand in heart failure nurse led service
R1709	16	⇔	Increase in Primary Care in Minehead sending patients with primary care conditions to Minehead MIU
R1830	16	⇔	Unprecedented levels of referrals into radiotherapy which cannot be met by treatment capacity
R0293	15	⇔	Insufficient capacity to meet demand for CT scanning
R0562	15	⇔	Insufficient capacity to meet demand in diabetes specialist podiatry service
R1004	15	⇔	Inability to meet demand for elective surgery to reduce admitted backlogs
U1023	15	⇔	Inability to meet demand for immunotherapy
R1948	15	⇔	Inability to meet demand in Trauma and Orthopaedics to reduce admitted backlog

U83	16	⇔	Product shortages and/or significant delays of supply due to unpredictable market

R1955	16	⇔	Insufficient freezer storage capacity for patient food at MPH to successfully prepare in the event of delays or cancellations of supply

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Service Group / Corporate Functions - Children, Young People & Families; Clinical Support and Cancer; Medical; Mental Health & Learning Disabilities; Neighbourhoods; Surgical; Corporate Functions; SFT Trustwide Corporate Risk: SSL Risk SHS Risk

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

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QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R0012	20	⇔	Waiting Times
R0007 / U100	16	⇔	Referral to Treatment Times
R0673	16	⇔	Impact of the current capacity and future resilience of Primary Care in Somerset on the Trust
R1238	16	⇔	Fire Compartmentation

Service Group / Corporate Function Risks 15+

R0009	16	⇔	Diagnostic Waiting Times Performance
R1813	15	⇔	Lack of service contract leading to increase in waiting times – Neurophysiology
R1972	15	NEW	Increased wait time for patients due to insufficient clinic capacity and staffing to cover clinics
U1039	16	⇔	Backlog of patients requiring endoscopy surveillance procedure
R1731	16	⇔	Failure to meet both National Cervical Screening Program and National Cancer Waiting Times standards within Grace Centre
R1951	16	⇔	Sub-optimal links between primary care and SFT services due to siloed working
R1664	20	⇔	Evacuation of patients - Jubilee Building
R1774	20	⇔	Evacuation of patients - SNICU
R1820	20	⇔	Evacuation of patients – Maternity (MPH)
R1694	16	⇔	Evacuation of patients – TOR Ward
U45	15	⇔	Evacuation of patients - Wards 6 to 9
R1746	15	⇔	Evacuation of patients – lack of appropriate equipment to support vertical evacuation in community hospitals
R1897	15	⇔	Patient outcomes potentially compromised due to current evacuation plan for Neonatal Unit

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QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R1513	16	⇔	Community & Adult Social Care provision for mental health and learning disability patients
R1852	16	⇔	Unsupported infection control electronic case management system
R1952	16	⇔	Lack of prioritisation for further development of personalised care
R0326	15	⇔	No coordinated approach to the transition of children and young people with complex care needs
R0831 / U331	15	⇔	Insufficient intermediate care capacity

Service Group / Corporate Function Risks 15+

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QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R1789	15	⇔	Unsafe premises and environment

Service Group / Corporate Function Risks 15+

R1849	20	⇔	Outbreak of Carbapenemase-producing organisms (CPO) due to an environmental reservoir of CPO
R1927	20	⇔	Failure of Air Handling Units (AHUs) in Ophthamlic Theatre suite
R1954	20	⇔	Loss of Switchboard, paging systems and emergency alarm systems due to SSD Flooring works
R1956	20	⇔	Resilience of radio network infrastructure due to works on the MPH site
U1031/ R1808	16	⇔	Lack of cell salvage equipment in maternity
R1256	16	⇔	Contamination due to water droplets/aerosols from toilets/macerators/drains due to poor ventilation
R1297	16	⇔	Lack of safe access to steam control valves serving the heating & hot water heat exchangers for the day surgery building
R1562	16	⇔	Non-compliance of statutory maintenance of thermostatic mixing values
R1570	16	⇔	Management of the Asbestos Register
R1648	16	⇔	Poor water quality and potentially unsafe water systems at project handovers
R1668	16	⇔	Cath lab cardiac arrest call bell system not fit for purpose
R1883	16	⇔	Insufficient CCTV security system in place
U1088	16	NEW	Loss of waste compound at YDH due to planned site developments
R0170	15	⇔	Insufficient clinic space availability for the Trauma & Orthopaedic service
U1029/ R1810	15	⇔	Lack of ability to manage US waiting list and support clinical specialties with service developments/improvement due to reduction of US rooms as a result of reconfiguration
R1043	15	⇔	Bed driving devices that are not fit for purpose to transport patients
U1063	15	⇔	Inability to place PICC/midlines for outpatients and hospital at home patients due to lack of clinic space
R1299	15	⇔	Loss of high voltage supply and resilience due to additional load for new surgical centre

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QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R1620 / U991	15	⇔	Failure to achieve our objective of reducing healthcare inequalities
R1958	15	⇔	Inability to meet organisational responsibilities under Multi Agency Public Protection Arrangements
R1968	15	NEW	Failures in referral pathways to specialities from Primary Care increasing Emergency Department attendances

Service Group / Corporate Function Risks 15+

R1300	15	⇔	Air conditioning maintenance not undertaken to the correct legislative standards
R1346	15	⇔	Inability to develop support site development due to electrical supplier unable to increase our maximum demand for a long period of time
R1567	15	⇔	Helipad barriers - non-compliance with current electrical regulations
R1670	15	⇔	Lack of physical space within the department to accommodate clinical functions
R1686	15	⇔	Treatment room on Blake Ward is no longer fit for purpose for ENT emergencies
R1741	15	⇔	Inability for nursing staff to hear patient call bells
R0534	15	⇔	Poor condition of Shepton Mallet Community Hospital Portakabin Units
R1892	15	⇔	Inability to provide patient meals due to failure of the patient catering freezer
R1907	15	⇔	Potential closure of the obstetric service due to insufficient maintenance programme to maintain the integrity of the estate
R1987	15	NEW	Lack of robust process to ensure blood glucose monitors across community teams are calibrated accurately

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PEOPLE COMMITTEE

Somerset NHS Foundation Trust

Corporate Risks 15+

R1329	20	⇔	Core numbers of Junior and Consultant medical workforce

Service Group / Corporate Function Risks 15+

U1092	20	NEW	Lack of Permanent GPs at Wincanton Health Centre
R1150	20	⇔	Orthogeriatric medical staffing
R1762	20	⇔	Inability to recruit to medical vacancies – Holford & St Andrews
R346	16	↑	Inability to provide consistent consultant cover for Somerset Neuro Rehabilitation Unit
R0530	16	⇔	Somerset Lipid Service is not adequately developed and resourced
R0956	16	⇔	Rheumatology medical staffing
R1413	16	⇔	Multiple longstanding vacancies within the Clinical and Medical Consultant oncology service
R1505	16	⇔	Dental workforce challenges
R1700	16	⇔	Need to recruit and train a further Consultant in ERCP (Endoscopic Retrograde Cholangiopancreatography)
R1701	16	⇔	Increased risk of amputation for patients with Diabetic Foot due to delays in identification or management of ulceration
R1819	16	⇔	Significant shortages in the sonographer work force impacting on the obstetric service
U515 / R1900	15	⇔	Inability to retain and recruit critical care consultant intensivists
U864	15	⇔	Inability to support the additional 10 escalation beds at La Fontana Care Home in Martock
R0999	15	⇔	Inability to recruit substantive Orthodontic consultant
R1943	15	⇔	Nuclear Medicine Service workforce

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PEOPLE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

U189 / R1879	16	⇔	Failure to achieve mandatory training levels
U925 / R1880	16	⇔	Retention and turnover of staff
R1624 / U994	16	⇔	Failure to secure necessary infrastructure – physical and digital (workforce)

Service Group / Corporate Function Risks 15+

R0131	16	⇔	Training and validation of pressure ulcers acquired in the Community
R1875	15	⇔	Safeguarding Unborn Baby and Children Supervision compliance
R0564	16	⇔	Inequitable service provision to teams/localities across Somerset - Physiologists
U1051	16	⇔	Lack of skilled and unskilled colleagues to deliver services
R1295	16	⇔	Insufficient numbers of skilled personnel in Estates to maintain 24/7 response
R1812	16	⇔	Inability to recruit Sterile Services Technicians
R583	16	⇔	Insufficient resource to cover core clinical system support out of hours
R1258	16	⇔	Unmet organisational expectations of Digital Services and missed opportunities to innovate and improve services
R1616 / U988	16	⇔	Lack of analytic support and visibility of data to manage population health
U1073	15	⇔	Inability to audit and review Sepsis and deteriorating patient records due to lack of resource
R1389	15	⇔	Backlog of clinical correspondence - Neurology admin team

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PEOPLE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

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

Service Group / Corporate Function Risks 15+

R1396	20	⇔	Insufficient nursing establishment funding in cardiac cath lab
R0306	16	⇔	Lower Paediatric Diabetic Senior Nurse to patient ratio in comparison to other SouthWest regional Units
R0440	16	⇔	Inability to provide a robust, continuous streamlined service for direct current cardioversion patients
R0513	16	⇔	Limited provision of specialist neurological rehabilitation and neuropsychiatry service
U868 / R1755	16	⇔	Insufficient Clinical Nurse Specialist cover – Gynaecology oncology
U886 / R1856	16	⇔	Lack of radiology nursing cover
R0916	16	⇔	Insufficient critical care Rehabilitation establishment
U1070	16	⇔	Lack of funding for Paediatric physiotherapy out of hours
R1148	16	⇔	Theatres do not have the required safe staffing numbers in the establishment to deliver the service
R1324	16	⇔	High levels of vacancies and absences across community and urgent care teams
R1491	16	⇔	Inability to provide endoscopists to meet capacity for colonoscopy lists
R1625	16	⇔	Paediatric high dependency unit staffing
R1630	16	↑	Insufficient Learning Disability Liaison Team establishment
R1679	16	⇔	Weight Management Service staffing
R1706	16	⇔	Cath Lab staffing establishment due to vacant posts
R1798	16	⇔	Insufficient Weight Management Dietitian staffing due to vacancies
R1993	16	NEW	Insufficient resource within Asthma service
U772 / R1759	15	⇔	Anaesthetic Practitioner on Call Service Provision

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PEOPLE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R1944	16	⇔	Reduced colleague resilience due to prolonged impact of integration
R1985	16	NEW	Poor data quality in Electronic Staff Record (ESR)
R1984	15	NEW	Inability to recruit applicants within timely manner on the applicant tracking system (ATS)

Service Group / Corporate Function Risks 15+

U1022/ R1758	15	⇔	Significant staffing vacancies in the Emergency Department - nursing and ENPs
U1040	15	⇔	Lack of Occupational Therapy staffing causing delays in patients receiving timing treatment
R1301	15	⇔	Wards under resourced and insufficient skill mix of staff – Nurses & HCAs
R1450	15	⇔	Insufficient staffing to manage continuous growth in demand for ultrasound services (antenatal and general ultrasound services)

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FINANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

U497	20	⇔	SHS not becoming self-sustaining
R1611 / U984	16	⇔	Failure to secure necessary infrastructure – physical & digital (funding)
U1056	16	⇔	Non-delivery of service provision KPIs by Contractor

Service Group / Corporate Function Risks 15+

R1310	20	⇔	No automated and cross organisation treatment escalation plans process
R1343	20	⇔	Quality of Discharge Summaries
R1840	20	⇔	Inability to fund new electronic health record with shortfall in national allocation
R0003	16	⇔	Insufficient investment to reduce levels of backlog maintenance
R0336	16	⇔	Replacement Viewpoint (Colposcopy system) across Grace and Gynae Oncology Services
U1050	16	⇔	Insufficient investment from main contractor to reduce levels of backlog maintenance
R1419	16	⇔	Inability to financially support Yeovil Dental Access Centre
R1926	15	⇔	Increase in capital cost and delivery timeline for on premise datacentre for new EHR

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FINANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+				Service Group / Corporate Function Risks 15+
R0006 / U738	15	⇔	Delivery of CIP	
U1047	15	⇔	Reduction of funding into SSL budget to meet service requirements	
R1855	15	⇔	Failure to deliver financial plan	

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Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 27 September 2023
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Jan Hull, Chairman of the Quality and Governance Assurance Committee
DATE:	7 November 2023

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the Quality and Governance Assurance Committee meeting held on 27 September 2023. The Committee received assurance in relation to: • The Corporate Risk Register – oversight of the risks; risk management system procurement process; identification of new merging risks • Verdict in the Trial of Lucy Letby – the strong speaking up and whistleblowing culture and the positive internal audit findings • The progress made implementing the fire safety actions • The sustainability progress report • The development of the Quality Strategy • The assurance report from the medical services group • The devolved governance arrangements versus centralised governance. • The update in relation to the Maternity Incentive Scheme Year Five safety actions • The Learning from Deaths progress report

	The Committee identified the following areas of concern or for follow up: • The Corporate Risk Register – the update on the risk management process to a future Committee meeting; the delay in the connection to the Learning from Patient Events national system; and the presentation of the SSL governance arrangements internal audit findings to the January 2024 Committee meeting • The Verdict in the Trial of Lucy Letby – NHS England letter to trusts – the actions to be taken and the review of governance arrangements following the completion of a public enquiry at a future date • Quality Strategy – the presentation of the strategy to a future Committee meeting • The recent tragic stillbirths at YDH The Committee identified the following areas to be reported to the Board: • The assurance in relation to the fire safety actions • The devolved governance arrangements versus centralised governance • The stillbirths at YDH • The assurance in relation to the achievement of the Maternity Incentive Scheme year five safety actions standards • The medical services assurance report in terms of the progress made whilst recognising the size of the working group and the upcoming winter pressures challenges.
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Quality and Governance Assurance Committee. The Board is further asked to note the areas to be reported to the Board.

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

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

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

Equality and Inclusion

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

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

The needs and potential impacts on people with protected characteristics are considered by each individual service group as part of their update to the Committee. The Committee reviews data presented to the Committee and will raise any queries if required.

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

Public/Staff Involvement History

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

Staff involvement takes place through the regular service group and topic updates.

Previous Consideration

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

The report is presented to the Board after every formal meeting.

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING HELD ON 27 SEPTEMBER 2023

1. PURPOSE

1.1. The report sets out the items discussed at the formal meeting held on 27 September 2023, along with the assurance received by the Committee and any areas of concern identified. The meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

Corporate Risk Register

2.1. The Committee received the up-to-date combined Corporate Risk Register report and noted that there were currently 24 corporate risks on the risk registers of which five scored 20 or above. The Committee noted the new emerging risk relating to the impact of the integration on collleagues, including changes to leadership and changes in roles.

2.2. The Committee noted: the progress made in mitigating a number of service group and corporate risks; the implementation of a quarterly workforce risk review process and the presentation of the findings of this review to the People Committee; and the roll out of this review process for other risks.

2.3. The Committee received an update on the risk management procurement process and timeline and noted that the pre-market engagement procurement exercise for a single risk management system will commence at the end of September 2023. A stakeholder engagement event will be scheduled for November 2023 and it was hoped that a contract can be awarded by the end of November 2023.

2.4. The Committee received an update on a new emerging risk relating to the number of positive Covid-19 infections on inpatient wards and the impact on inpatient services and bed capacity. The Committee was briefed on the proposed approach to the new variation outbreak which it supported.

Verdict in the Trial of Lucy Letby – NHS England letter to Trusts

2.5. The Committee discussed the letter received from NHS England following the Lucy Letby's trial. The case has created shockwaves throughout the NHS and the Committee agreed that consideration will need to be given as to how to provide the Board with assurance about the trust's processes.

2.6. The Committee noted that the letter from NHS England set out a number of initial actions in relation to Freedom to Speak Up and whistleblowing processes and the actions were noted.

2.7. In terms of processes already in place, the Committee agreed that the trust had a strong speaking up and whistleblowing culture with quarterly reports provided to the Board. The findings of recent whistleblowing and freedom to speak up internal audits had been positive with substantial assurance both for design and design effectiveness.

Fire Safety

2.8. The Committee received an update on the actions taken in relation to the SNICU (Somerset Neonatal ICU), Maternity and Trustwide recommendations reported to the July 2023 Committee meeting.

2.9. The Committee noted the progress made and particular areas to note were: the discussion with the Dorset and Somerset Fire and Rescue Service in relation to the clinical risks versus the fire safety risks and the timeline for implementing the actions; the work with the fire engineer and consultancy to look at developing retrospective fire strategies across the trust; the re-instatement of the Fire Safety Committee; and the development of a new fire safety policy.

2.10. The Committee further noted that the fire service has indicated that they will be writing to the Chief Executive in relation to their concerns about on-site storage issues. The Committee discussed the on-site storage issues and noted that these issues mainly related to Musgrove Park Hospital. Health and safety arrangements will be reviewed as part of the integration work and health, safety and fire will continue to be a standing item on the agenda of the Operational Leadership Team meeting.

2.11. The Committee agreed that the update provided assurance about the progress made.

Sustainability

2.12. The Committee received an update on sustainability and the development of the governance processes to support implementation of the Green Plan.

2.13. The Committee noted that an environmental maturity internal audit had recently been undertaken and this audit provided useful benchmarking information and identified a number of recommendations. A further re-audit will be undertaken in 2024.

2.14. The Committee further noted that an action plan has been developed and the actions were noted. The Committee particularly noted the establishment of a Strategic Sustainability Group to oversee the implementation of the internal audit actions but also to oversee progress in relation to the Green Plan; and the establishment of the Green Care Action Group which will feed into the Strategic Sustainability Group.

2.15. The Committee was assured that work was also taking place on a systemwide basis to look at opportunities for joint working across the system.

2.16. The Committee agreed that the report provided excellent assurance and noted that six monthly updates will be presented to the Committee.

Quality Strategy

2.17. The Committee received an update on the development of the Quality Strategy and the approach used to develop the strategy.

2.18. The Committee noted that the strategy will set out a programme of clear aspirations to improve the quality of care for patients in Somerset and will include a plan to deliver the quality priorities. The Committee noted that the strategy will be one of the supporting strategies to deliver the strategic objectives set out in the Board Assurance Framework.

2.19. The Committee noted: the approach taken to develop the strategy; and the focus on governance of quality and safety and quality improvement. The Committee further noted that the strategy will support devolved governance arrangements and that it will be important to ensure that all governance plans are developed with quality in mind and are aligned with the strategy.

2.20. The Committee noted that oversight arrangements of the Quality Strategy will be aligned with risk management processes and will feed into the Board Assurance Framework. In addition, the topic assurance reports will be linked to the Care Quality Commission standards and to the Quality Strategy as it develops.

Service Group Assurance Report – Medical Services

2.21. The Committee received the assurance report from the medical service group and noted the key highlights from the report, including the focus on integrating governance arrangements across all medical services; the intention to use the Patient Safety Incident Response Framework as the model for the integrated governance reporting arrangements; and the expected winter pressures.

2.22. The Committee also noted: the establishment of the service group Governance Committee as a forum to discuss the service group risks and areas such as shared learning and patient stories, incidents and themes; the need for a two way flow of information and clear structures; the support to the formal complaints team as part of the test of change process; the need to bring some learning from the complaints process into the assurance report to be able to demonstrate changes made as a result of lessons learned identified as part of the complaints process; the need to review and strengthen the patient engagement elements; the improved position in relation to the management of complaints.

2.23. The Committee further discussed the large size and complexity of the service group and the management of the service group risks and governance arrangements through devolved governance arrangements. Discussions were currently taking place about what central support to provide to the service groups, and how to provide this support, but devolved governance

arrangements were essential as centralised arrangements will move oversight further away from the front line.

2.24. The Committee agreed that the report provided the Committee with good assurance about the work and focus of the Service Group.

Maternity Incentive Scheme (MIS)

2.25. The Committee received an update on progress made in relation to achieving the year five requirements of the MIS.

2.26. The Committee noted the progress in relation to safety actions 9 (claims, actions from investigations and the joint Perinatal Surveillance dashboard) and 10 (HSIB and Early notification cases interim bi-annual report); the actions being taken to implement a new diabetes testing standard within the Saving Babies Lives Safety Action; and the potential issue in relation to Safety Action 4 – clinical workforce planning relating to compensatory rest.

2.27. The Committee received an update on the implementation of BadgerNet and noted the difficulties in relation to the data entry process and obtaining data and audit data. The Committee received assurance that work was taking place to address the data challenges.

2.28. The Committee agreed that the report provided good assurance in terms of progress made but asked for obstetricians to be invited to future meetings as their leadership and support will be essential to achieving the safety actions.

Learning from Deaths Report

2.29. The Committee received the 2023/24 Q1 progress report and noted that the report recognised the significant progress made and highlighted the collaborative working across all services.

2.30. The Committee further noted: the positive movement in engagement for mortality reviews across the organisation and the difference this engagement has made for learning outcomes and assurances about outlier data; the need to review the process for engaging with bereaved families and the Duty of Candour process when the review process changes over to the Patient Safety Incident Response Framework.

2.31. The Committee agreed that the report, and the evolution of the approach to learning from deaths, provided the Committee with significant assurance

3. AREAS OF CONCERN OR FOLLOW UP

Corporate Risk Register

3.1. The Committee discussed the risk management process, risk register and the findings of the self assessment. The Committee noted that a further update on the risk management process will be presented to the Committee following the completion of the planned risk maturity audit.

3.2. The Committee received an update on the trust's connection to the Learning from Patient Safety Events (LfPSE) national system and noted that, due to the different recording of LfPSE within the current two risk management systems, it had been agreed to delay the connection until the risk management system procurement process has been concluded. The Committee supported this decision.

3.3. The Committee further noted the launch of the new governance framework and the completion of the Simply Serve Limited (SSL) internal audit. The internal audit report will be presented to the October 2023 Audit Committee meeting and the findings will be shared with the Committee as part of the January 2024 assurance report by the SSL leadership team.

Verdict in the Trial of Lucy Letby – NHS England letter to Trusts

3.4. The Committee discussed the letter received from NHS England following the Lucy Letby's trial. The Committee agreed that the case was truly shocking and that consideration will need to be given as to how to provide the Board with assurance about the trust's processes.

3.5. The Committee noted that a public enquiry will be carried out to establish the actions of the relevant trust and senior management responses and the findings of this public enquiry will provide a clear framework for actions to be taken by all trusts.

3.6. The Committee noted that the letter from NHS England set out a number of initial actions in relation to Freedom to Speak Up and whistleblowing processes and the actions were noted.

3.7. In terms of processes already in place, the Committee agreed that the trust had a strong speaking up and whistleblowing culture with quarterly reports provided to the Board. The findings of recent whistleblowing and freedom to speak up internal audits had been positive with substantial assurance both for design and design effectiveness.

3.8. The Committee discussed the service group assurance reports in relation to their risk and governance arrangements and agreed that consideration will need to be given as to how these risks and governance arrangements are reported to the Board and sub Committees and where clinical oversight of these risks rest.

3.9. The Committee further discussed the actions to be carried out and noted that: the Board and sub Committees will need to review data presented to the Board or Committee to ensure that the data was fit for purpose; the roll out of the Patient Safety Incident Response Framework will be key; further actions can be taken in terms of the patient/carer voice and acting upon themes identified; a review of the data outlier arrangements was being carried out and that processes across the organisation were being aligned; work on aligning the culture across the organisation was taking place and that the Leadership

Quality Walkrounds will help to get a better feel of the culture across the whole organisation. Finally, the Committee noted that a Freedom to Speak Up Self Reflection will be carried out and that the findings will be presented to the December 2023 Board Development Day.

3.10. The Committee agreed that overall processes were felt to be good but recognised that governance arrangements will need to be reviewed after the publication of the public enquiry findings.

Quality Strategy

3.11. The Committee asked for the Quality Strategy to be presented to the Committee once fully developed to be able to discuss the oversight arrangements.

Any Other Business

3.12. The Director of Midwifery advised the Committee of the recent three antenatal stillbirths at YDH and noted that this number of stillbirths was highly unusual. The Committee noted their concern and recognised the impact the stillbirths have on the families and colleagues. A review of each of the stillbirths will be undertaken, and reported to the Committee.

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

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

- The assurance in relation to the fire safety actions
- The benefits of devolved governance arrangements versus centralised governance
- The stillbirths at YDH
- The assurance in relation to the achievement of the Maternity Incentive Scheme year five safety actions standards
- The medical services assurance report in terms of the progress made whilst recognising the size and complexity of the service group and the upcoming winter pressures challenges.

5. BOARD ASSURANCE FRAMEWORK (BAF)

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

- **Objective 2** – safe, high quality care: positive assurance in relation to the Quality Strategy, fire safety and sustainability items.

- **Objective 8** – develop a high performing organisation delivering the vision of the trust: the nature of the organisation we are creating and the links to the quality strategy, sustainability, and learning from deaths items.

5.2 The Committee agreed that, based on the service group assurance reports, it was getting stronger assurance in relation to patient engagement and experience and felt that patient engagement and experience now had higher strategic visibility across the organisation.

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

Jan Hull
CHAIRMAN OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 6 October 2023
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Jan Hull, Chairman of the Quality and Governance Assurance Committee
DATE:	7 November 2023

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out details of the annual reports discussed at the Quality and Governance Assurance Committee meeting held on 6 October 2023. The Committee received assurance in relation to: • Safeguarding Adults - YDH • Safeguarding Adults - SFT • Safeguarding Children – YDH • Safeguarding Children – SFT • Emergency Planning, Response and Resilience (EPRR) • Patient Experience (including Complaints and PALS) – YDH • Patient Experience (including Complaints and PALS) – SFT • Infection Prevention and Control – SFT • Infection Prevention and Control – YDH • Information Governance – SFT and YDH

	• Health and Safety (including Fire Safety and Security for YDH The Committee has not identified any particular areas of concern to be reported to the Boar but wants to highlight the excellent levels of assurance received
Recommendation	The Board is asked to note the assurances received, the issues discussed and recognise the excellent work in place across the trust.

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

Implications/Requirements (Please select any which are relevant to this paper)					
☐ Financial	☐ Legislation	☐ Workforce	☐ Estates	☐ ICT	☒ Patient Safety/ Quality
Details: N/A					
Equality and Inclusion **The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.** **How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?**					
The needs and potential impacts on people with protected characteristics are considered by each individual service group as part of their update to the Committee. The Committee reviews data presented to the Committee and will raise any queries if required.					
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.					

Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Staff involvement takes place through the regular service group and topic updates.

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

ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING

ANNUAL REPORTS – 2022/23

1. PURPOSE

1.1 The report sets out a summary of discussions relating to the following annual reports which were considered by the Quality and Governance Assurance Committee at a meeting held on 6 October 2023, in line with the delegated authority from the Trust Board:

- Safeguarding Adults - YDH
- Safeguarding Adults - SFT
- Safeguarding Children – YDH
- Safeguarding Children – SFT
- Emergency Planning, Response and Resilience (EPRR)
- Patient Experience (including Complaints and PALS) – YDH
- Patient Experience (including Complaints and PALS) – SFT
- Infection Prevention and Control – SFT
- Infection Prevention and Control – YDH
- Information Governance – SFT and YDH
- Health and Safety (including Fire Safety and Security for YDH)

2. SAFEGUARDING ADULTS 2022/23 – YDH – PRESENTED BY RICHARD PAINTER, DIRECTOR OF SAFEGUARDING

2.1 The report provided the Committee with both assurance and evidence that Yeovil District Hospital NHS Foundation Trust fulfilled its statutory responsibilities to adults at risk of abuse, set against the guidance within the Care and Support Statutory Guidance 2020.

2.2 The areas of compliance covered in the report on which assurance was given included:

- Safeguarding Adults – the Care Act 2014
- Mental Capacity Act (MCA) 2005 and Codes of Practice
- Deprivation of Liberty Safeguards (DoLS) and Code of Practice and preparation for the Liberty Protection Safeguards
- PREVENT – section 26 of the Counter Terrorism and Security Act 2015
- Domestic Abuse Act 2021
- Domestic Violence Crime and Victims Act (2004(- Part 1(9)
- Equality Act (2010)
- Human Rights Act 1998
- Modern Slavery Act 2015

2.3 The Committee particularly noted:

- The integration of the YDH and SFT teams ahead of the formal merger.
- The number of contacts and the low percentage of contacts being converted into referrals to adult and children's social care. The majority of the contacts were requests for advice and guidance and supporting staff with strategy discussions and meetings on behalf of others within the hospital.
- That safeguarding training compliance remained challenging and that this may be more of a concern once the compliance data has been remapped against the Intercollegiate guidance. The key issues related to the release of colleagues to attend training.
- The work scheduled to raise the importance of safeguarding adults and children training and the statutory responsibilities.
- The supervision and levels of supervision offered by the safeguarding team to staff groups across the trust.
- The safeguarding adult reviews, domestic homicide reviews and safeguarding children practice reviews undertaken as part of the safeguarding partnerships arrangements. The Committee noted that no major failures had been identified as part of the reviews.

2.4 The Committee agreed that the report provided significant assurance and approved the report.

3. SAFEGUARDING ADULTS – SFT - PRESENTED BY HEATHER SPARKS, NAMED PROFESSIONAL FOR SAFEGUARDING ADULTS

3.1 The report provided the Committee with both assurance and evidence that Somerset NHS Foundation Trust is fulfilling its statutory responsibilities to adults at risk of abuse, set against the guidance within the Care and Support Statutory Guidance 2020.

3.2 The areas of compliance covered in the report on which assurance was given included:

- Safeguarding Adults – the Care Act 2014
- Mental Capacity Act (MCA) 2005 and Code of Practice
- Deprivation of Liberty Safeguards (DoLS) and Code of Practice and preparation for the Liberty Protection Safeguards
- PREVENT – section 26 of the Counter Terrorism and Security Act 2015
- Domestic Abuse Act 2021
- Domestic Violence Crime and Victims Act (2004(- Part 1(9)
- Multi-Agency Public Protection Arrangements - MAPPA (Criminal Justice Act, 2003)
- Equality Act (2010)
- Human Rights Act 1998
- Modern Slavery Act 2015

3.3 The Committee particularly noted:

- The increase in demand.
- That safeguarding level 3 training compliance remained challenging due to the competing demands of colleagues needing to provide and prioritise patient care. In addition, YDH colleagues had not been mapped to the level 3 training and compliance levels will be impacted during 2023/24. The current compliance rate was 69.2% against a target of 85%.
- The higher number of safeguarding adults reviews and domestic homicide reviews compared to the previous year. The main themes appear to be a correlation between domestic abuse and suicidal

ideation and work has taken place with the mental health teams and suicide prevention lead to look at options to raise awareness.

- The identification of sexual incidents on both mental health and acute inpatient wards which have resulted in a number of safeguarding referrals, some of which have resulted in Section 42 safeguarding enquiries.

- The establishment of a Sexual Safety Best Practice Group to help address the issues of sexual safety of patients and colleagues. A Sexual Safety Policy is being developed and sexual safety information leaflets and posters will be developed for patients and colleagues.

- The fragmented clinical systems and the pressure on teams which create a risk in terms of the way information was managed across the trust. It was suggested that an interim recording solution was developed prior to the single Electronic Health Record being delivered to manage the large number of contacts by the Safeguarding Duty Team.

- The development of consultation clinics to help staff making referrals to ensure that they are providing the appropriate information when completing SBARs. The positive impact of these clinics was already visible.

3.4 The Committee agreed that the report provided significant assurance and approved the report.

4. SAFEGUARDING CHILDREN – YDH - PRESENTED BY RICHARD PAINTER, DIRECTOR OF SAFEGUARDING

4.1 The report provided the Committee with both assurance and evidence that Yeovil District Hospital NHS Foundation Trust fulfilled its statutory responsibilities to protect children's right to live in safety, free from abuse and neglect; to protect children from maltreatment in order to prevent the impairment of children's health and development; to work with other organisations to prevent and stop the risks and experience of abuse or neglect. This included working with Somerset Safeguarding Children Partnership.

4.2 The areas of compliance covered in the report on which assurance was given, included:

- The Children Acts 1989 and 2004

- United Nations Convention on the Rights of the Child (UNCRC)

- Every Child Matters (2004 and 2015)

- National Service Framework for Children (2004)
- Working Together to Safeguard Children (2018)
- Intercollegiate Document (2019) Safeguarding Children and Young People: Roles and Competencies for Health Care Staff
- Children and Social Work Act (2017)
- CONTEST – Counter Terrorism Strategy (2018)
- Modern Slavery Act (2015)
- Domestic Abuse Act (2021)
- Domestic abuse Statutory Guidance (July 2022)

4.3 This included compliance with the Safeguarding and Protection of unborn Babies and Children Policy; the Safeguarding Clinical Supervision Policy; the Court Procedures for Safeguarding Unborn Babies and Children Policy (2021); Safeguarding Children and Young People from Child Exploitation Policy (2022).

4.4 The Committee particularly noted:

- The increase in referrals to just under 700 contacts and the challenges faced by the team managing this increase.
- The lack of a central recording system for contacts and the successful implementation of a single point of contact and single database covering both adults and children services.
- The number of contacts converting into referrals to external agencies and the recording of the referrals in patient records.
- The decline in training compliance but a compliance rate above the 85% target. The impact of the training remapping exercise may impact on this compliance rate.
- The refresh of the Safeguarding Operational Group with the aim to provide the necessary assurance to demonstrate that the trust is meeting its obligations for regulation with the Care Quality Commission in relation to safeguarding.

4.5 The Committee agreed that the report provided significant assurance and approved the report.

5. SAFEGUARDING CHILDREN – SFT - PRESENTED BY NIOCOLE MITCHELL, NAMED NURSE FOR SAFEGUARDING CHILDEN

5.1 The report provided the Committee with both assurance and evidence that Somerset NHS Foundation Trust fulfilled its statutory responsibilities to protect children's right to live in safety, free from abuse and neglect; to protect children from maltreatment in order to prevent the impairment of children's health and development; to work with other organisations to prevent and stop the risks and experience of abuse or neglect. This included working with Somerset Safeguarding Children Partnership.

5.2 The areas of compliance covered in the report on which assurance was given, included:

- The Children Acts 1989 and 2004
- Every Child Matters
- Children and Social Work Act (2017)
- CONTEST – Counter Terrorism Strategy (2018)
- Domestic Abuse Act (2021)
- Female Genital Mutilation Act (2003)
- Modern Slavery Act (2015)
- Serious Crime Act (2015)
- The Health and Care Bill 2021
- United Nations Convention on the Rights of the Child (UNCRC

5.3 This included compliance with the Safeguarding and Protection of unborn Babies and Children Policy; the Safeguarding Clinical Supervision Policy; the Court Procedures for Safeguarding Unborn Babies and Children Policy (2021); Safeguarding Children and Young People from Child Exploitation Policy (2022).

5.4 The Committee particularly noted:

- The increase in non-accidental injuries (NAIs) to young babies which was in line with national trends. The team works closely with public health nursing colleagues and primary care to try to identify these children in advance of injuries happening.
- That further work was being carried out in relation to hidden children and what constitutes a sufficient welfare check. This

work was carried out in response to a serious incident of severe parental neglect involving an infant under one whose birth was not registered with parents living off grid. The excellent work of the Homeless and Rough Sleeper Team in identifying that this child was at risk was recognised.

- The focus on transition and the appointment of a new Child Exploitation and Transition lead.

- The compliance rates for Level 3 Safeguarding Children and Supervision training and the scheduling of additional training to increase training uptake.

- The increase in the number of referrals whilst the level of Children's Social Care (CSC) involvement in cases had stayed steady. The Local Authority did not have an official Multi-agency Safeguarding Hub (MASH) but the team was working closely with Local Authority colleagues to work at the lowest threshold of interventions. It will be important to have a support structure in place to ensure that colleagues are not holding risks to children, themselves or the organisation unnecessarily.

- The ambition of the service to strengthen patient and public service user involvement. The current focus was on helping the service with the voice of parents from maternity services but it was the ambition of the service to develop this further. Service user feedback was provided by teams and captured and used to shape services.

- The audit work which provided significant assurance.

- The positive feedback from the Care Quality Commission Inspection in 2022 in relation to the duty structure which is being used as an exemplar across the country.

5.5 The Committee agreed that the report provided significant assurance and approved the report.

6. EMERGENCY PLANNING RESILIENCE AND RESPONSE (EPRR) – SFT AND YDH - PRESENTED BY ANGELA TURNER, HEAD OF RESILIENCE

6.1 The report provided the Committee with assurance that both trusts were fulfilling their statutory responsibilities with regard to emergency planning and civil contingencies, and that the merged trust is substantially compliant with the NHSE core standards for EPRR.

6.2 The Committee noted in particular:

- The completion of the post merger NHSE EPRR Annual Assurance Self Assessment against the national EPRR core standards and the submission of the self assessment to the Somerset Integrated Care Board (ICB). The self assessment had been agreed by the ICB and showed full compliance against all core standards. The Committee agreed that this was an excellent achievement especially in view of the merger and non-compliance in the previous year.

- The integration of all plans but with some site specific adaptions.

- The overarching Major Incident Plan and the tactical plans for acute sites.

- The examples of good practice identified by the ICB relating to: the exceptionally strong partnership working across systemwide EPRR teams in Somerset; heatwave planning; the approach to the ongoing industrial action in all areas; and the engagement of all colleagues to maintain the critical services.

- The focus of the deep dive assessment on training and exercising arrangements and the substantial assurance received. The one area where compliance had not been received was not applicable to EPRR.

- The expected challenges over the winter period and the evidence of preparedness and resilience as demonstrated in the self assessment against the core EPRR standards.

- The successful testing of business continuity procedures through live situations, such as the Cannington coach crash and the IT outage.

- The opportunity Symphony and the close working with the ICB provides to develop links with primary care.

- The CBRN audits undertaken on 26 September 2023, the findings of which were still awaited.

6.3 The Committee agreed that the report provided significant assurance and approved the report.

7. PATIENT EXPERIENCE AND ENGAGEMENT – SFT AND YDH - PRESENTED BY EMMA DAVEY, DIRECTOR OF PATIENT EXPERIENCE AND ENGAGEMENT, AND CAROLINE TAYLOR, HEAD OF PATIENT EXPERIENCE

7.1 The report set out an overview of the area of work for 2022/23 and Trust's activity in relation to patient experience, PALS and complaints and the opportunities for learning and service improvement.

7.2 The Committee noted that 2022/23 had been another busy year for the patient experience, engagement, and involvement team with significant steps taken to fundamentally change not only the structure of the team in terms of roles, but to also lay the foundations for total service reconfiguration to enable the service to support the delivery of the objectives outlined in the Board Assurance Framework (BAF) as well as the Trust's quality strategy and to fulfil our public involvement duty as outlined in the NHS Act 2006.

7.3 The Committee noted in particular:

- The vacancy position at the time of the merger – 15% vacancy factor at the legacy YDH and 32% at SFT.

- The increase in the number of complaints and complexity of complaints, but the overall low number of formal complaints received for both legacy organisations compared to the significant number of patient contacts.

- The 16% increase in the number of complaints, 61% increase in the number of compliments; the 22% decrease in the number of PALS enquiries at SFT; and the referral of 16 complaints to the Parliamentary and Health Service Ombudsman – although none of those that had to date been investigated had been upheld. The key themes of all complaints related to: communication/information; staff attitude; general medical treatment; and access to services.

- The 41% increase in the number of complaints, 37% increase in the number of compliments and the 4% decrease in the number of PALS enquiries at YDH; and the referral of three complaints to the Parliamentary and Health Service Ombudsman, two of which had been upheld in part. The key themes of all complaints related to: communication; clinical treatment; patient care; and admission and discharges.

- The full service review which was being undertaken to ensure an improved process across the merged organisation.

- The change to the process to include resolution meetings and the increase in the uptake of resolution meetings.

- The work to develop a single Friends and Family Test reporting and data management platform.

- The completion of the formal consultation process to restructure the legacy SFT and YDH Patient Experience and Engagement teams in October 2023; the additional investment secured as a result of the reconfiguration to create new key roles to support the team; the

current vacancy rate of 26%; and the recruitment campaign to fill these vacancies by December 2023.

- The upcoming changes to processes as a result of the implementation of the Patient Safety Incident Response Framework.

- The two different risk reporting platforms where complaints data was held and the lack of the ability to produce a dashboard directly from the systems. Work was taking place to develop a scorecard/dashboard for the team.

7.4 The Committee agreed that the report provided good assurance and approved the report.

8. INFECTION PREVENTION AND CONTROL – SFT - PRESENTED BY VAL YICK, LEAD NURSE FOR INFECTION PREVENTION AND CONTROL, AND ALISON WOOTTON, DEPUTY CHIEF NURSE

8.1 The Committee received the report for Somerset NHS Foundation Trust which provided an overview of the infection prevention and control activity during the year and assurance on investigation and learning from outbreaks.

8.2 The Committee noted in particular:

- The integration of the teams.

- There was one Trust attributed Methicillin Resistant Staphylococcus aureus (MRSA) bloodstream infections in 2022/23, compared to four in the previous year. Following review of the cases, no lapses in care that may have contributed to the infection were identified.

- There were 49 Trust apportioned cases of Clostridium difficile infection compared to 46 in the previous year. This comprised of 34 hospital onset cases and 15 community onset cases where the patient had an overnight stay in the Trust in the preceding 28-days.

- There were 48 Trust attributed Methicillin Sensitive Staphylococcus aureus (MSSA) bloodstream infections compared to 35 in the previous year.

- There were 11 norovirus outbreaks in 2022/23.

- There were 439 inpatients with influenza in the Trust and five outbreaks in inpatient wards.

- There were 461 inpatients with Respiratory Syncytial Virus (RSV), during the winter, the majority of which were children.

- With regard to Covid-19, between April 2022 and March 2023 there was a total of 2,386 inpatients with PCR confirmed Covid-19 across the Trust, 64% of which were not attributable to the Trust. There were 128 inpatient ward outbreaks of Covid-19.

- The Post Infection Review and the purpose and reasons for the review, including the alignment with the Patient Safety Incident Review Framework.

- The improvement work around Methicillin Staph aureus E Coli blood stream infections related to peripheral cannulas and urinary catheters and the reduction in blood stream infections as a result of this work and the introduction of a new skin cleaning product.

- The following areas of work: the continuous programme of surgical site surveillance and findings of the surveillances; the work to be taken forward in relation to: restoring services which had been stopped following the Covid-19 pandemic; achieving more sustainability and reducing unnecessary waste relating to personal protective equipment; the investigation of the water valve issues at Musgrove Park Hospital in view of risk of Legionella; the concerns in relation to the presence of Legionella at the Beacon Ward and actions taken; the risk in relation to the increased use of IVs in the community and the work with the Hospital at Home and community teams to raise awareness of infection risks.

8.3 The Committee recognised the continued pressure on the team; the excellent levels of assurance received by the reports; and the ongoing need to adapt to changes in guidance and working closely with clinical and operational colleagues to explain the changes and provide a level of assurance.

8.4 The Committee agreed that the report provided significant assurance and approved the report.

9. INFECTION PREVENTION AND CONTROL – YDH - PRESENTED BY VAL YICK, LEAD NURSE FOR INFECTION PREVENTION AND CONTROL

9.1 The Committee received the report for Yeovil District Hospital NHS Foundation Trust which provided an overview of the infection prevention and control activity during the year and assurance on investigation and learning from outbreaks.

9.2 The Committee noted in particular:

- There were no Trust attributed Methicillin Resistant Staphylococcus aureus (MRSA) bloodstream infections in 2022/23, compared to one

the previous year. The Trust has one of the lowest rates in the region.

- There were 23 Trust attributed Methicillin Sensitive Staphylococcus aureus (MSSA) bloodstream infections compared with 12 cases the previous year.
- There were 15 Trust apportioned cases of Clostridioides difficile infection. The Trust has the lowest rate in the region.
- There were 43 Trust attributed E.coli bloodstream infections, compared to 25 in the previous year.
- There were nine Trust attributed Klebsiella species bloodstream infections, compared to six in the previous year.
- There were nine Trust attributed Pseudomonas aeruginosa bloodstream infections, compared to three in the previous year.
- There was an outbreak of Carbapenemase Producing Organisms (CPO) during the period of this report.
- There was one norovirus outbreak in 2022/23, a lower number than would normally be seen.
- There were six outbreaks of influenza, affecting 43 patients.
- There were 20 inpatient ward outbreaks of Covid-19 affecting 109 patients.
- The Post Infection Review.
- The good levels of infection control.
- The key challenge dealing with the Carbapenemase Producing Organisms (CPO) outbreak and the actions taken.

9.3 The Committee recognised the continued pressure on the team; the excellent levels of assurance received by the reports; and the ongoing need to adapt to changes in guidance and working closely with clinical and operational colleagues to explain the changes and provide a level of assurance.

9.4 The Committee agreed that the report provided significant assurance and approved the report.

10. INFORMATION GOVERNANCE – SFT AND YDH - PRESENTED BY LOUISE COPPIN, HEAD OF INFORMATION GOVERNANCE AND DATA PROTECTION OFFICER

10.1 The report provided the Committee with assurance that post merger Somerset NHS Foundation Trust is fulfilling its statutory responsibilities with regard to the Data Protection Act 2018 and the Freedom of Information Act 2000.

10.2 The Committee noted in particular:

- That the final assessment of the Data Security and Protection toolkit for the post merger organisation was submitted in June 2023 with a level of Standards Exceeded, the highest level of attainment.

- That an internal audit on the Toolkit was undertaken in February 2023 and that the two recommendations relating to available evidence were corrected prior to the Toolkit submission. The internal audit had rated the quality of the Trust's Toolkit return as high. The recommendation relating to the development of an Information Asset Register was expected to be implemented by January 2024.

- That annual information governance audits were undertaken internally across the trust to monitor compliance and confirm knowledge of our colleagues and, in addition, the Trust was also audited for the Cyber Plus accreditation.

- The increase in data access requests; the backlog of subject access requests and the non compliance with timescales allowed by the Data protection Act. Response rates were now improving.

- The compliance rates for Data Security and Protection Training remained high and SFT achieved the 90% rate required for the DSP Toolkit submission in June 2023.

- The number of Freedom of Information requests – 70 per month – and the need to use Section 12 exemptions due to the time required to search significant amounts of data covering the legacy organisations. Where needed the requester will be asked to refine their request.

10.3 The Committee agreed that the report provided significant assurance and approved the report.

11. HEALTH AND SAFETY – SFT AND YDH - PRESENTED BY SAMANTHA HANN, HEAD OF HEALTH, SAFETY AND RISK

11.1 The report provided the Committee with continued assurance that the processes and systems that are in place for managing health and safety within Somerset NHS Foundation Trust remain effective and are compliant with the Health and Safety at Work etc. Act 1974 and other legislation protecting colleagues, patients and visitors at our sites.

11.2 The Committee noted in particular:

- The integration work – the establishment of a joint Health and Safety Committee since March 2023; the trust wide representation on the Safety Environmental Advisors Group (SEAG); the work to align processes; the alignment of the recording of health and safety incidents to ensure alignment of data and content recorded.

- The excellent mandatory training compliance – consistently around 95%.

- The work to update policies.

- The training and resources available to support colleagues and the refresh of the Health and Safety and Risk Monitors training programme.

- The increase in capital project work due to a growing property portfolio and the inconsistent involvement of the health and safety team at early stages of project work, leading to issues having to be addressed at a late stage in the project. Further project safety assurance improvement will be required.

- The work in relation to sharps safety at YDH following an Improvement Notice issued by the Health Safety Executive. Further work will be required to roll out the learning from the issues raised as part of the inspection. The Committee noted that the issues highlighted in the Improvement Notice had been addressed and that the Improvement Notice had been removed.

- The challenges in the team due to a change in the model of service provision previously provided at YDH and the need to manage expectations. Work continues to manage such expectations and to educate and upskills managers to address the concerns raised. The Committee noted that the model aligned with the devolved governance structure of the organisation and was in line with the legislation around responsibility and accountability under the Health and Safety Act.

- The reduced resource and capacity during the reporting period and the impact on progress made; the appointment of a Band 7

manager and a Band 3 assistant to address the capacity issues; the ongoing challenges in meeting the demand of the service given the size and breadth of the organisation.

- The concerns in relation to the reduction in the number of Health and Safety Trade Union representatives attending the Health and Safety Committee meetings and the impact on the quoracy of the meeting.

- The development of the Health and Safety Strategy.

- The improved position in relation to the number of moving and handling incidents and the reduction in the number of incidents involving equipment and resources within YDH.

- The increase in the number of incidents of violence and aggressive behaviour and assaults.

11.3 The Committee agreed that the report provided significant assurance and approved the report.

12. CONCLUSIONS

12.1 The Committee acknowledged the excellent work over the last 12 months highlighted in the reports. The reports reflect a year of hard work as we came towards merger with incredible demands on all services while still coming out of Covid-19 pandemic. Everyone had a lot to contend with and these topics are key building blocks that enable us to provide clinical services effectively which makes them extremely important.

12.2 The annual reports demonstrated high levels of assurance for the Trust across these key statutory and regulatory areas which we can provide to the Trust Board in the form of a summary report. The annual reports will be published on the Trust's public website for people to access.

12.3 The Board is asked to note the Committee's report and receive assurance of the levels of compliance and delivery demonstrated by the annual reports.

CHAIR OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Learning from Deaths Report
SPONSORING EXEC:	Daniel Meron, Chief Medical Officer
REPORT BY:	Claire Bailey, Learning from Deaths Lead Laura Walker, Head of Patient Safety and Learning Gary Filer, Quality and Safety Lead Analyst
PRESENTED BY:	Paul Foster, Medical Director, Learning from Deaths Medical Lead
DATE:	7 November 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 National Guidance on Learning from Deaths (National Quality Board, March 2017) and the Implementing Learning from Deaths framework, key requirements for Trust Boards (NHS Improvement, July 2017), places a number of requirements on NHS Trusts. This includes the need to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public Board meetings. This report also demonstrates the processes in place for how Somerset FT learn from deaths and how this learning is shared and improvements are made.
Recommendation	The board is asked to discuss this report.

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

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

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

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

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

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

Equality and Inclusion

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

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

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

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

Public/Staff Involvement History

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

Public or staff involvement or engagement has not been required for the attached report. Staff are involved in the learning from deaths process.

Previous Consideration

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

The report is presented to the Board on a quarterly basis.

The report has been reviewed at the October 2023 Quality Governance and Assurance Committee and Operational Leadership meetings.

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

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

SOMERSET NHS FOUNDATION TRUST

LEARNING FROM DEATHS REPORT – QUARTER 2 2023-2024

1. BACKGROUND AND PURPOSE

1.1. In December 2016 the CQC report Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England, identified that learning from deaths was not given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed.

1.2. In March 2017 the National Quality Board published national guidance on learning from deaths to initiate a standardised approach to learning which includes several recommendations to be included into Trust's governance frameworks. These recommendations included having a Director responsible for the learning from deaths agenda, a Non-Executive Director to take oversight of progress and implementing a systematic approach to identifying the deaths requiring review, with a robust methodology for case record reviews.

1.3. Ongoing developments included specific guidance for NHS Trusts in working with families, published in July 2018 and the introduction of Medical Examiners who commenced their role in the Trust on 1st July 2020. The intention is to make sure that all deaths not investigated through the coronial process are subject to a degree of independent scrutiny, with increased transparency for the bereaved and an opportunity for them to raise concerns.

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

1.5. On 1 April 2023, a new Trust called Somerset NHS Foundation Trust was created from the merger of Yeovil District Hospital NHS Foundation Trust (YDH) and Somerset NHS Foundation Trust (SFT). Whilst the Learning from Deaths arrangements at the two legacy Trusts have been overseen by the team at SFT since September 2022, all mortality data continued to be reported separately to the board. This report reflects the Learning from Deaths agenda for the new merged organisation and as such brings this data together using a redesigned template.

1.6. The Quarterly Learning from Deaths report confirms our progress with the evolving systems used to identify and learn from a patient's death. The way we review a patient's death can take many forms with learning identified

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

2. UPDATE ON THE MORTALITY REVIEW PROCESS

2.1. We continue to work closely with our colleagues in the Bereavement and Medical Examiner's teams to support each other with our alignment and development of processes:

- In the last report, we described the progress that has been made towards a single referral process, utilising the digital platform that was developed to record the Medical Examiner's scrutiny of deaths. During Quarter 1 Claire Bailey met with Helen Gilliland, the Lead Bereavement and Medical Examiner Officer, and a colleague from IT to discuss further developing the Medical Examiner platform to improve its functionality. Claire and Helen were then intending to review these changes on the test site prior to them being added to the live system. Helen has recently returned following an unforeseen period of absence, and this work will now resume.

- Dr Richard Innes has stepped down from his role as Lead Medical Examiner for services based at the MPH site to take up a new role as the Clinical Director for Research and Development. Richard has been integral to developing the service since it first rolled out across inpatient services at MPH in September 2020, and has strongly advocated for the organisation to drive out any learning from concerns that the service raises. Dr Phil Raines stepped into the Lead Medical Examiner role on an interim basis earlier this year pending the recruitment of a Lead Medical Examiner for the whole of the system in line with the merger of the two formerly separate services in Somerset. Both Richard and Phil will continue to contribute to the service as Medical Examiners, and we thank them for their support. Dr Peter Campbell has been appointed to the role of Lead Medical Examiner. As part of their process alignment work, Peter is writing a new SOP for the Medical Examiner service. We look forward to working with Peter and are due to meet with him and Helen to support this process.

- The next phase of the roll out of the Medical Examiner service is due to be statutory on 01/04/24 and will see this service expanded to include all deaths in the community. To date, 15 out of 61 GP practices in the catchment area are referring deaths to the Medical Examiner service. In this reporting period, the team completed reviews on 99 community deaths. We have begun to see an impact of this roll-out, with the Medical Examiner team sharing feedback about SFT care for patients who have died in the community, giving us further opportunities to learn and improve our services. We have in recent weeks met with the ICB CMO and with NHSE Regional CMO to progress the plans for a system-wide approach to Learning from Deaths, including the

processes necessary to underpin the expansion of Medical Examiner service.

2.2. We are still working on developing a clear pathway for the escalation of concerns raised by families or carers and establishing closer working with our colleagues in PALS and Complaints:

- Following our meeting with Caroline Taylor, Head of Patient Experience, we agreed that we could establish a pathway from Learning from Deaths to PALS and Complaints when a Structured Judgement Review is not thought to be the optimal method for addressing any concerns raised by the family of the deceased. Claire Bailey will meet with Helen Gilliland to firm up this pathway with our Bereavement Team so that families are aware of the potential avenues that their concerns can take.

- Laura Walker has approached Emma Davey, the Director of Patient Experience and Engagement, about the possibility of there being a quarterly meeting between representatives from PALS and Complaints and colleagues from the Patient Safety and Learning arm of the Governance Support Team. The aim of this would be to share information and discuss any themes that are arising from the various workstreams.

2.3. Structured Judgement Reviews:

- We are moving closer to introducing a digital version of the SJR tool, hosted on the Radar risk management platform. As previously described, this depended on getting the agreement to develop a solution to enable the forms to be used by staff at the YDH site. This solution has been successfully implemented for our Bereavement team, who now use the radar system to capture all their data. We will now plan how we will roll out the digital SJR tool across the organisation and support colleagues with using this new tool.

- We have continued to develop consistent processes for the completion of SJR's. The previously described processes put in place by our medical colleagues at YDH are going well and we are seeing an improvement in the timeliness of return of reviews. We are now turning our attention to completion of reviews of deaths in our community hospitals and are working closely with colleagues in our Neighbourhood Service Group to ensure that robust processes are in place for completion of SJR's and sharing of learning.

2.4. The core function of the Mortality Surveillance Group (MSG) is to ensure that we have strategic level oversight and can provide assurances that our processes maximise learning from the deaths of people in our care. Due to industrial action, the difficult decision was made for MSG to be stood down in both July and September. Whilst unavoidable, we were concerned about the impact of this and prepared a briefing pack covering the agenda items for the

September meeting. This was circulated to all members of the group, with a request for feedback to be shared.

2.5. We currently have a mixture of standardised mortality data from the legacy trusts pre-existing contracts, Telstra Health for YDH and Healthcare Evaluation Data (HED) for the rest of SFT. These contracts are reaching the end of their terms. We met with the Director of Governance, Stephen Thomson, the Deputy Head of Data Insights and Intelligence, Bernadette Ford, and our Quality and Safety Lead Analyst, Gary Filer, to discuss how our benchmarking data will be harnessed in the future. In this meeting, new proposals for the merged organisation from each provider were reviewed and it was agreed that we will proceed with a single provider. This change will be reflected in future board reports.

2.6. We have recently had sight of a report published by Demos in September 2023 making the case for Martha's Rule. This came about following a campaign from the parents of a 13-year-old girl who sadly died from sepsis whilst an inpatient at King's College Hospital NHS Foundation Trust. The inquest concluded that her death could have been avoided had her parents concerns about her deterioration been listened to. If brought into law, Martha's Rule would mean that in the event of a suspected deterioration or serious concern, patients and their families will have the power to formally request a clinical review or second opinion. The report makes the following recommendations:

- NHS England should develop best practice guidance to allow hospitals to adopt this system as soon as possible.
- Hospitals should adopt Martha's Rule as a matter of urgency and communicate it clearly to patients.
- The Care Quality Commission should consider Martha's Rule standard practice in inspections and include their implementation in inspections.

2.7. MPH has had a similar initiative in place since 2014, with the "ring for reassurance" line. This is staffed by our Critical Care Outreach team, Monday-Friday 8am-5pm. When best practice guidelines are available, this service will be reviewed and extended across the organisation to ensure we are meeting the requirements of Martha's Rule. In the meantime, teams will look at readvertising the existing service to raise its profile.

2.8. In September the Senior Coroner for Somerset Mrs Samantha Marsh came to the trust to meet with Dan Meron and Hayley Peters. Also in the meeting was Helen Gilliland, Lead Medical Examiner's Officer, Clare Allen, CSM, Laura Walker, head of patient safety and learning, and Jeremy Smith Head of Medical Services. During the meeting we discussed Mrs Marsh's time in the role since her appointment in April 2022, how the trust can continue to assist her with her enquiries, both the standard of reports and attendance in court by colleagues from SFT, and the impact of the new patient safety incident response framework (PSIRF). It was a very positive meeting and she followed this with meetings with the bereavement team, the paediatric and neonatal team, and the Director of Midwifery for Somerset.

2.9. The Patient Safety Incident Response Framework (PSIRF), which will replace the Serious Incident Framework (SIF), represents a significant shift in the way NHS Trusts respond to patient safety incidents, moving towards developing and maintaining effective systems and processes for the purpose of learning and improving patient safety. There are four key aims to PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents.
- Supportive oversight focused on strengthening response system functioning and improvement.

2.10. At SFT, Hannah Roe has been in post as the PSIRF Implementation Lead since March 2023. The expected timescales for the implementation of PSIRF have been agreed. A transition period will commence on 01/01/24. Full implementation is expected on 01/04/24. Hannah has prepared the first draft of the PSIRF policy and plan, which has gone out to key stakeholders for review. A programme of offering training to colleagues who will commissioned to complete Patient Safety Incident Investigations has begun. Work is ongoing to identify the priority areas which will form the focus of investigations, Quality Improvement and Service Development for the initial 12-18 months.

2.11. The PSIRF model focuses on a considered and proportionate response to patient safety incidents, and this will impact how we learn from deaths, especially unexpected deaths. We will move away from the root cause analysis (RCA) model to focus more on thematic learning in line with trust and national priorities and as a consequence coroners will not be able to rely on RCA's as part of evidence in an inquest. This may result in an increased request for statements from the coroner. Engagement with families from the beginning of the process is fundamental to ensuring they continue to feel that they and their loved one are valued.

3. LEARNING, IMPROVEMENT AND CHANGE FROM THE MORTALITY REVIEW PROCESS

3.1. **Examples of learning:**

- A patient was admitted to one of our respiratory wards with symptoms of heart and respiratory failure. Sadly, despite treatment they continued to deteriorate, and the clinical team anticipated that they were approaching the end of their life. The patient's family raised a complaint about the impact of poor communication regarding end-of-life processes. The care that the patient received was reviewed as part of the complaint response and was thought to be of a high standard, however it was acknowledged that the team could have done more to prepare the family for the reality of end of life and what the care provided at this time may entail. The palliative care team have

delivered bespoke training to the nursing and medical teams to enhance their skills in recognising signs and symptoms of end of life, use of medication, and how to supportively communicate with patients and their families about end-of-life care. This training will be extended across all medical wards. The palliative care team are also developing a leaflet that ward staff can share with families.

- An SJR completed by our colorectal surgical team highlighted excellence in the pre-operative care given to a patient with bowel cancer, who sadly died following elective surgery after developing a pneumonia. It was noted that the patient was supported to make an informed decision. There had been full and frank discussions with the patient about the options available to them, including not proceeding with surgery and focusing on managing symptoms to sustain quality of life. When the patient expressed a preference for pursuing a surgical option, the team again took the time to reiterate the significant risks and potential impact of the proposed surgery.

- A patient with dementia in one of our intermediate care beds sadly died unexpectedly following an incident in which they fell and hit their head. Whilst this incident did not directly cause their death, a Serious Incident Investigation was commissioned to look at the governance processes for commissioned beds in nursing homes. Whilst it was found that the existing arrangements were robust, some additional safeguards were identified to strengthen the process. To ensure that staff in commissioned placements know what actions to take in the event of an unexpected death, the Discharge Pathway Managers have developed a flowchart for care home staff to follow. A daily MDT meeting to facilitate communication between SFT teams and staff at care homes with commissioned beds has been introduced. This enables staff to discuss how patients are presenting, agree any actions to manage additional care needs, as well as any new referrals for admission.

- A patient was admitted under the care of our gastroenterology team with acute liver failure due to known liver metastases. The team completed a Structured Judgement Review, which identified delays in recognising signs of deterioration associated with a high INR. Whilst this was not thought to have had an impact on the outcome as these signs were thought to be indicative of a terminal event, it was thought that conversations about end of life could have been had with the patient and their family at an earlier stage. Training will be provided for staff concerning the effects of blood clotting in patients with liver disease and the risk of potential bleeds in patients with a history of a high INR.

- Our haematology team completed a Structured Judgement Review following the death of a patient known to them with a recent diagnosis of leukaemia. The patient attended one of our Emergency Department's after hitting their head following a fall. The patient subsequently collapsed in the department several hours later. A CT

scan was performed which showed a large intracranial haemorrhage. Sadly, it was identified that the prognosis was poor, and the patient was supported palliatively. Our haematology team shared their review with the Emergency Department, highlighting learning around the need for patients with haematological conditions, such as leukaemia, to have an urgent CT scan in the context of a head injury. This has been fed back to the wider team. The haematology team have also shared reminders within their own team to educate patients about the importance of carrying the thrombocytopenia alert card as this supports patients to notify any medical staff that they are at increased risk of bleeding. This alert card was introduced as a result of learning that was referenced in legacy SFT's Quarter 1 report from 2022-2023.

- Somerset LeDeR, who undertake reviews following the deaths of people with Learning Disability and/or Autistic people, published their 2022-2023 annual report in July. This report outlines learning from reviews that have been completed, as well as summarises some of the service improvement initiatives that these have resulted in.

    - There were 44 deaths of people with Learning Disability and/or Autistic people within the reporting period, of which 24 occurred within a hospital setting. This is in line with what is reported nationally.
    - In Somerset the most common cause of death related to conditions of the respiratory system. Nationally, this is the third most common cause of death. Going forwards, our local LeDeR team will undertake focused reviews, which is their most in-depth review, for all deaths where the cause of death relates to the respiratory system. They will also carry out a "deep dive" of the 20 deaths identified from 2022-2023 to ensure that any thematic learning is captured and shared.
    - LeDeR have also developed a series of learning briefs that have been shared with organisations on key topics such as dysphagia, epilepsy, and oral health care.
    - Whilst there have been examples of excellent collaborative working, reasonable adjustments and good practice in clinical care, there were still instances where services did not effectively meet the needs of people with Learning Disability and/or Autism. From July 2022 the Health and Care Act 2022 included a duty for ICB and Local Authority regulated service providers to ensure that all staff receive role appropriate training on Learning Disability and Autism. Launched in May 2023, the Oliver McGowan Mandatory Training package has been implemented across the health and social care workforce in Somerset.

3.2. The following section of the report describes the differing processes used to identify learning such as that noted above. Where there has been activity within the reporting period this is included along with details of any more general themes identified.

Scrutiny through the Medical Examiner service

3.3. There is an expectation that all patients who die in our bedded care settings have an initial review of the notes completed by the Medical Examiner. Whilst the Medical Examiner service is independent of SFT, this scrutiny enables early identification of any case where a potential problem exists, for example where a potential omission in care or poor management is identified, or where the bereaved raise a significant concern. These are then referred to Learning from Deaths for consideration for further review. The Medical Examiner also ensures the appropriate direction of deaths to the coroner. Medical practitioners have a duty to report deaths to a coroner for which they are unable to ascertain the cause of death, the cause of death is unnatural, or the death occurred in custody or state detention, e.g., whilst under a section of the Mental Health Act.

3.4. The Medical Examiner's office had 562 deaths of patients under the care of SFT reported to them between April and June 2023. Of these, 500 were within the acute hospital, 62 were within our community hospitals, and 0 deaths were in our mental health inpatient settings. 100% of the 562 deaths were scrutinized by the Medical Examiner team. In total, 59 deaths were highlighted to Learning from Deaths.

Structured Judgement Reviews

3.5. Structured Judgement Reviews (SJR's) are carried out by clinicians using adapted versions of the tools developed by the Royal College of Physicians and the Royal College of Psychiatrists. There is a mandatory requirement for SJR's to be completed on cases where concerns exist, in accordance with the automatic inclusion criteria as described in the Trust's Learning from Deaths Policy. These cases are identified via the Medical Examiner service or the incident reporting system, and completion of these reviews is overseen by the Learning from Deaths Lead. In addition to these reviews, specialities may also routinely undertake SJR's on a sample of cases in the absence of any particular concern about care. The output from all completed reviews is collated so that common themes and trends can be seen from looking at good practice as well as problems with quality of care. This can then inform the Trust's quality improvement work.

3.6. During Quarter 4 of 2022/2023 and Quarter 1 of 2023/2024, the Medical Examiner service have highlighted a potential theme around deaths on the Ready to Go wards and referred 9 deaths in line with this theme. There have been a further 2 deaths highlighted during Quarter 2. We have requested SJR's for all of these deaths. We are in the process of collating the data and will report on any outcomes in due course.

3.7. We are additionally seeing a potential theme from the Medical Examiner referrals and completed SJR's concerning Treatment Escalation Plans (TEPs). Workstreams around how TEPs are utilised at SFT are ongoing, and we will share the outcome of any relevant reviews with our colleagues who are undertaking this work. We are also aware that this is a system wide issue. The Learning from Deaths Network, which was chaired and administratively supported by colleagues from Somerset ICB, was established to develop and

monitor the effectiveness and potential outcomes of mortality review processes across health providers in Somerset. This has not taken place for some time but will be relaunched as a system wide Mortality Group and will support this work being shared at this forum.

LeDeR review

3.8. All deaths of patients with Learning Disabilities are reported in line with national requirements and reviewed using the LeDeR methodology. Unless the death meets the threshold for investigation as a Serious Incident, all acute hospital inpatient deaths will be subject to an SJR. Once completed, the output of these reviews are shared with the local LeDeR team.

3.9. During this reporting period 7 inpatient deaths met the criteria for SJR, 6 of which related to deaths in our acute hospital settings. No concerns were raised by the Medical Examiner service about the care that these patients received. An additional SJR was requested concerning the death of a patient with Learning Disability in one of our community hospitals due to concerns raised by the Medical Examiner about confusion seen in the records about the patient's EOL status. To date, 3 SJR's have been completed and shared with LeDeR. There were no deaths that met the Serious Incident threshold. We were made aware of 2 community deaths that will be subject to a LeDeR review, one concerning a patient with Learning Disability and the other concerning a patient with autism. Local teams will complete After Action Reviews. Any learning identified will be shared.

Serious Incident process

3.10. The twice weekly rapid review meetings enable pan-organisational discussion of deaths where significant concerns about a death have been raised the Medical Examiner and/or an incident report. The meeting is usually chaired by a member of the Medical Leadership Team and is typically attended by clinicians or managers from the area involved, members of the senior nursing team, and governance team. These meetings focus on three core questions: 1. Is there anything that needs to be changed now to prevent this happening again? 2. What support is in place for patients/family/colleagues? 3. What is the most appropriate way to investigate this, to ensure we get the best learning from this incident?

3.11. Within this reporting period, 7 deaths have been discussed at rapid review meetings. 1 of these deaths will require further investigation under the serious incident process as it related to a patient who was subject to the Mental Health Act at the time of their death. None will be subject to a Structured Judgement Review and 5 will be reviewed locally by the specialty teams. In the remaining case, no further review was required, and it was identified that all learning had already been actioned. There are 3 deaths from this period that are still pending a rapid review meeting.

PALS and complaints

3.12. During this quarter, 16 PALS queries and 2 formal complaints have been raised concerning the deaths of patients in our care. Common themes are

around poor communication, inadequate discharge planning and concerns about care and treatment at the end of life.

Maternal and Perinatal Deaths

3.13. There have been no maternal deaths during this reporting period.
All perinatal deaths are reviewed using the Perinatal Mortality Review Tool (PMRT). This tool facilitates a standardised and robust review of all eligible perinatal deaths. A monthly PMRT meeting is held to enable regular review of cases with the multidisciplinary team (MDT) and an external representative, allowing for a 'fresh eyes' perspective. A joint action plan for each month's review of cases (unless being managed as a serious incident) enables the maternity governance team to highlight any common actions and identify themes from reviews. All finalised reports and subsequent action plans are shared with the parents according to their wishes.

3.14. In this reporting period, there were 4 perinatal deaths eligible to be notified to MBRRACE-UK, all of which met the criteria for PMRT review and concerned intrauterine deaths. The review process has concluded for one case and learning has been identified around the timing of serial Ultrasound Scans. The remaining 3 are scheduled for PMRT within expected timescales.
The Maternity and Newborn Safety Investigations (MNSI) programme investigates certain cases of early neonatal deaths, intrapartum stillbirths, and maternal deaths. Where the criteria for these investigations are met, this will replace an NHS trust's internal investigation. None of the above-mentioned deaths have met these criteria.

3.15. Further details of any reviews undertaken, as well as any findings and subsequent action plans, are held within the quarterly report provided to the Trust Board by maternity services.

Paediatric Deaths

3.16. Reviews of these deaths are mandatory and undertaken by the Child Death Overview Panel (CDOP). Notification of a child death to the local Safeguarding Children Board is made at the time of any agency becoming aware of the death of a child. Where the death occurs within the hospital, responsibility for completing this notification is usually undertaken by the paediatrician managing the case.

3.17. During this reporting period, there have been no paediatric deaths.

Coronial activity

3.18. During this reporting period, there were 29 new enquiries from the coroner concerning the deaths of patients known to SFT. Formal statements have been requested for all cases.

3.19. Several inquests pending from previous reporting periods have been concluded during this quarter. This includes 29 read-only inquests, 3 inquests heard with witnesses called. There have been no inquests heard with a jury present. There have been 4 pre inquest review hearings heard for inquests that are due to be heard at a later date. There have been no prevention of

future deaths reports since July 2022 at legacy SFT and November 2021 at legacy YDH.

3.20. **Standardised mortality**

- **Summary Hospital-level Mortality Indicator (SHMI), April 2022 - March 2023**

Source: NHS England (August 2023)
Note: All sub-national counts have been rounded to the nearest five, with SHMI values calculated from the unrounded values.

Trust level

Trust	Provider spells	Observed deaths	Expected deaths	SHMI value
Somerset NHS FT	75,485	2,890	2,925	0.9880 As expected

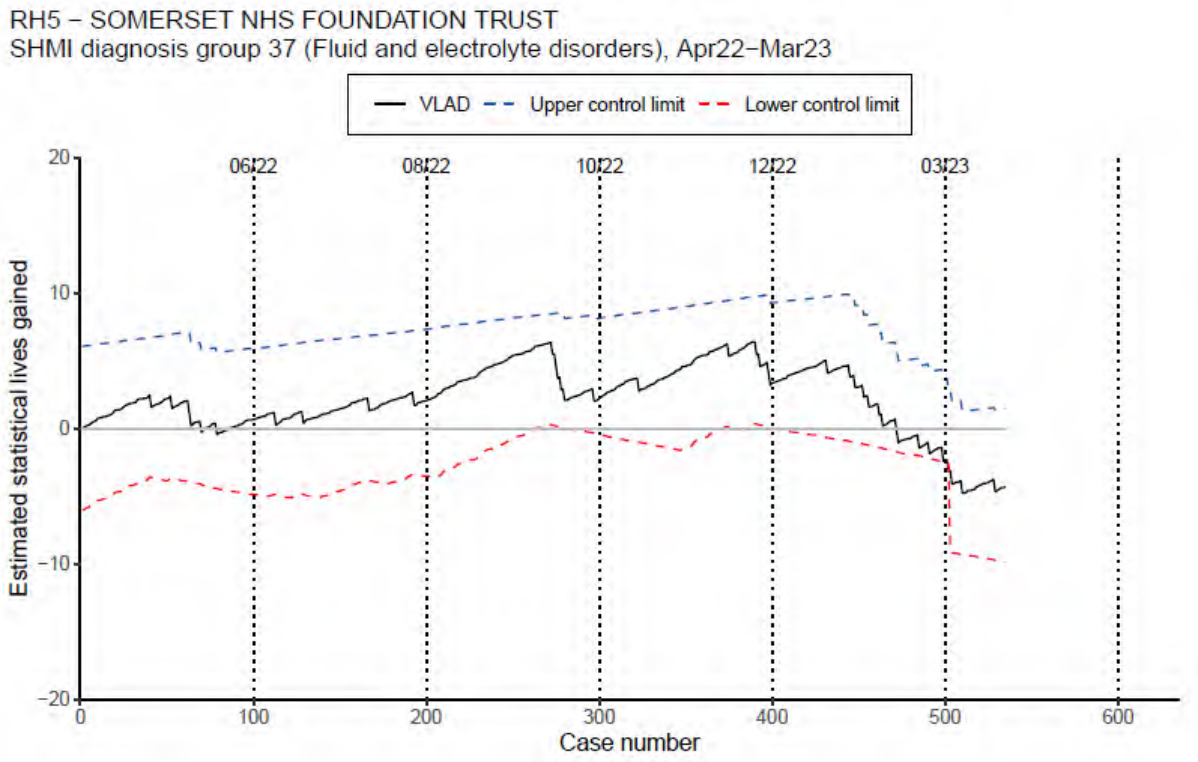
Site level *Acute hospitals and exceptions*

Site	Provider spells	Observed deaths	Expected deaths	SHMI value
Musgrove Park Hospital	47,620	1,790	1,740	1.0279 As expected
Yeovil District Hospital	25,900	955	1,065	0.8975 As expected
South Petherton Hospital	235	10	25	0.5202 **Lower than expected**
Crewkerne Hospital	75	20	10	2.1789 **Higher than expected**

Diagnosis group *Reported groups by exception*

Diagnosis group	Provider spells	Observed deaths	Expected deaths	SHMI value
Septicaemia (except in labour), Shock	1,355	280	335	0.8288 **Lower than expected**

Visual life adjusted display (VLAD) – recent alerts



- **Standard mortality ratios from HED, April 2022 to March 2023**
  Source: HED.nhs.uk - SHMI HES and HSMR HES modules (20th July 2023)

  This report refers to two measure of standardised mortality: summaryhospital-level mortality index (SHMI) and hospital standardised mortality ratio (HSMR).

  Trust level

Trust	SHMI (Jun 22 – May 23)	HSMR (Jul 22 – Jun 23)
Somerset NHS FT	97 (As expected) 95% CI: 93.4 - 100.7 Observed: 2,753 Expected: 2,838 Spells: 71,503	108 **(Above expected)** 95% CI: 103.3 - 112.8 Observed: 2,007 Expected: 1,859 Spells: 52,660

Site level *Acute hospitals and exceptions*

Trust	SHMI (Jun 22 – May 23)	HSMR (Jul 22 – Jun 23)
Musgrove Park Hospital	99.0 (As expected) 95% CI: 94.3 - 103.8 Observed: 1,662 Expected: 1,679 Spells: 46,025	114.6 **(Above expected)** 95% CI: 108.0 - 121.4 Observed: 1,135 Expected: 991 Spells: 32,594

Trust	SHMI (Jun 22 – May 23)	HSMR (Jul 22 – Jun 23)
Yeovil District Hospital	90.6 **(Below expected)** 95% CI: 84.9 - 96.6 Observed: 940 Expected: 1,037 Spells: 23,617	94.5 (As expected) 95% CI: 87.9 - 101.5 Observed: 751 Expected: 795 Spells: 17,980
Crewkerne Hospital	194.4 **(Above expected)** 95% CI: 111.0 - 315.7 Observed: 16 Expected: 8 Spells: 80	174.8 (As expected) 95% CI: 95.5 - 293.3 Observed: 14 Expected: 8 Spells: 49
Frome Community Hospital	158.7 **(Above expected)** 95% CI: 106.3 - 228.0 Observed: 29 Expected: 18 Spells: 158	202.8 **(Above expected)** 95% CI: 131.2 - 299.3 Observed: 25 Expected: 12 Spells: 85
Wincanton Community Hospital	158.2 **(Above expected)** 95% CI: 101.3 - 235.4 Observed: 24 Expected: 15 Spells: 143	155.6 **(Above expected)** 95% CI: 101.6 - 228.0 Observed: 26 Expected: 17 Spells: 82

Plans for reviews in response to Standardised Mortality Data:
As shown above, we continue to see above expected numbers of deaths at some of our community hospitals. This has been a consistent trend. We have previously co-ordinated reviews into these deaths which provided assurance that there were no clinical concerns with the care that the patients received. As part of our ongoing monitoring, we are conducting a further review and will report the outcome when complete.

Whilst not listed as an exception in this report, Katy Darvall, our Trust Mortality Lead has identified that there is a need to review deaths within the diagnosis group of influenza. We are in the process of extracting the relevant data and will report on the findings of this review in due course.

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

Appendix 1

NHS Somerset NHS Foundation Trust

		2022/2023															2023/2024				
		July	Aug	Sept	Q2 total	Oct	Nov	Dec	Q3 total	Jan	Feb	Mar	Q4 total	April	May	June	Q1 total	July	Aug	Sept	Q2 total
ACUTE INPATIENTS*	Total deaths (including ED)	188	198	170	556	187	183	275	645	275	227	223	725	182	203	202	587	157	182	155	500
	Total Scrutinised by ME	179	171	156	506	180	164	215	559	264	221	213	699	182	199	190	571	157	182	155	500
	SJR's requested by LfD	18	6	11	35	14	12	13	39	24	12	16	52	12	9	8	29	13	10	8	31
	SJR's completed	32	11	19	62	35	23	23	81	44	19	21	84	15	8	13	36	12	5	0	17
	Problems in care**	0	0	0	0	0	0	1	1	0	0	0	0	1	1	1	3	1	0	0	1
	Serious Incident process initiated	2	2	3	7	2	0	0	2	0	1	0	1	1	0	0	1	0	0	0	0
	Learning Disabilities: internally all deaths in acute inpatient settings are subject to review or investigation																				
	Total deaths	4	1	3	8	2	1	5	8	3	1	3	7	3	0	2	5	4	0	2	6
	Review/investigation completed	4	1	3	8	2	1	2	5	3	1	3	7	2	0	1	3	3	0	1	4
COMMUNITY HOSPITAL	Total deaths	13	28	21	62	14	22	28	64	16	16	21	53	22	22	16	60	19	17	26	62
	Total scrutinised by ME	8	23	15	46	11	17	15	43	8	11	18	37	22	19	15	56	19	17	26	62
	SJR's requested by LfD	1	0	0	1	0	0	1	1	0	0	1	1	0	1	1	2	1	0	2	3
	SJR's completed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Problems in care**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incident process initiated	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
MENTAL HEALTH	Total deaths (reported as incident)	8	1	8	17	3	7	4	14	6	9	9	24	5	10	6	21	7	10	3	20
	Total scrutinised by ME	0	0	1	1	0	0	1	1	0	0	1	1	0	0	0	0	0	0	0	0
	SJR's requested by LfD	6	1	6	13	1	3	3	7	4	6	7	18	1	5	3	9	1	0	2	3
	SJR's completed	6	1	4	11	1	3	1	5	2	4	6	12	0	2	2	4	0	0	0	0
	Problems in care**	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incident process initiated	2	0	0	2	0	1	1	2	0	1	0	1	0	1	0	1	1	0	0	1
COMMUNITY SERVICES	SJR's requested by LfD	0	0	0	0	0	0	1	1	0	0	0	0	0	1	1	2	0	0	0	0
	SJR's completed	2	4	5	11	3	1	3	7	2	2	1	5	0	0	1	1	0	0	0	0
	Problems in care**	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incident process initiated	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total deaths subject to Coroner's Inquests		24	16	18	58	15	17	11	43	18	18	27	63	16	29	14	59	10	11	8	29

* Note – figures for legacy SFT and YDH Trusts have been combined for this report
**Where SJR has identified that a death was thought more likely than not to be related to problems with care

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the People Committee meeting held on 13 September 2023
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Graham Hughes, Acting Chairman of the People Committee
DATE:	7 November 2023

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the People Committee meeting held on 13th September and the assurance received. The meeting was conducted as a video conference call. The Committee received assurance in relation to: • The colleague story and the actions taken to manage unacceptable and discriminatory behaviours • The Deep Dive into Compassionate and Inclusive Leadership • The Annual Medical Appraisal and Revalidation report and Statement of Compliance • The review of the Board Assurance Framework • The Director report • The findings of the Health and Wellbeing, Freedom to Speak up and Performance Appraisal internal audits The Committee identified the following areas for follow up: • The review of the updated KPIs • The Workforce Risk Register

	• The findings of the Sickness Absence and the implementation of the Disability Content audit recommendations • The review of the Committee's effectiveness The Committee did not identify any areas to be reported to the Board. The Committee is able to provide the Board with assurance that the items discussed at the meeting provide significant assurance in relation to addressing gaps in controls and assurances for objective six of the Board Assurance Framework.
Recommendation	The Board is asked to discuss the report and note the areas of assurance and follow up.

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

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

Equality and Inclusion The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
The colleague story is one way of identifying potential impacts on colleagues with protected characteristics and any lessons learned will be followed up.

The deep dive into compassionate and inclusive leadership enables performance data to be robustly reviewed and any areas for follow to be identified.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
The views from colleagues have been considered through the colleague story.

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

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

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

SOMERSET NHS FOUNDATION TRUST (SFT)

ASSURANCE REPORT FROM THE PEOPLE COMMITTEE

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 13 September 2023, the assurance received by the Committee and any areas of concern identified.

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

2. ASSURANCE RECEIVED

Colleague Story/Learning Item – Radiotherapy Services

2.1. The Committee received a story from a colleague about how managing unacceptable and discriminatory patient behaviours in the service fits in with the work on changing culture and supporting colleagues.

2.2. The Committee listened to the story relating to the inappropriate behaviours of an older patient, which included racial comments, and noted: the challenging of the patient's behaviours by a colleague; the escalation of the concerns about the patient's ongoing inappropriate behaviours; the formal action taken; the refusal of the patient to apologise; and the resulting refusal of the service to treat the patient. The Committee further noted that the patient had subsequently been admitted to the emergency department where his inappropriate behaviour had been accommodated.

2.3. The Committee noted the actions taken to provide colleagues within the radiotherapy team with the tools to challenge unacceptable behaviours, which included diversity and equality training and suggested phrases to be used in the case of incidents. The Committee was advised of the further work required to provide guidance to all colleagues on how to deal with unacceptable behaviours, including the need to update policies; and how to directly access the relevant HR support.

2.4. The Committee further noted: the inclusion of examples of responses in the violence and aggression policy; the need to involve the leadership team when dealing with unacceptable behaviours, the suggestion to have a follow up meeting to discuss learning and further actions to be taken, particularly in relation to policies and communications.

2.5. The Committee was further advised of an example of sexual harassment of a colleague and agreed that further consideration will be required on how to create a safe environment for colleagues. The Committee recognised that some patients displaying racial and sexist behaviour may not have capacity

and, where needed, the right support was put in place to support the relevant team.

Deep Dive – Compassionate and Inclusive Leadership

2.6. The Committee received an update on the work in relation to compassionate and inclusive leadership and noted: the ambitions of the People Strategy; the year 1 deliverables of the People Strategy; the challenges bringing teams together; the role of leaders in creating a positive, inclusive and safe environment; the skills and vision required; the benefits of compassion leadership in terms of the quality of care provided and the reduction in the rate of bullying and harassment.

2.7. The Committee further noted: the inconsistencies in approach; the lack of confidence of some colleagues; the overarching themes in relation to behaviours, including a culture of hierarchy, poor communication, lack of confidence raising concerns; inconsistent feedback on interpreting policies and different experiences for diverse groups. The Committee agreed that the deep dive had provided an opportunity to take stock and understand the work taking place to address. .

2.8. The Committee agreed that the clinical away days were beneficial in terms of bringing clinical leaders together to explore leadership and the development of leadership.

2.9. The Committee discussed: examples of colleague who had indicated that inclusion was not embedded within the trust; the further work required to capture the full diversity of colleagues; the need to review the support provided by the various groups including the sharing of intelligence and the collation of themes; and the need to ensure that colleagues were provided with the tools to treat colleagues as individuals.

Annual Medical Appraisal and Revalidation

2.10. The Committee received the annual report and statement of compliance and noted: the increase in the number of doctors requiring revalidation and the resulting pressure on appraisers and the administration team; the increase in the number of missed appraisals over the last few years; the need for further administrative resources to take account of the changes to the appraisal process; the increase in the number of international medical graduates and locum employed doctors and the need to effectively link recruitment systems.

2.11. The Committee further received feedback from the higher-level responsible officer's team to the trust and noted the positive feedback in relation to the support culture for colleagues and the quality of appraisals; the "must do" action to improve the administrative issues; and the need to increase the uptake of appraisals. The action plan from this visit will be presented to the next Committee meeting.

2.12. The Committee noted that the appraisal toolkit had been adjusted to be able to capture wellbeing and engagement but that further work could be carried

out to review themes and complaints data. In addition, an appraisal strategy was being developed to ensure consistency across the organisation.

Review of the Board Assurance Framework

2.13. The Committee reviewed strategic objective six of the Board Assurance Framework (BAF).

2.14. The Committee discussed: the key performance indicators (KPIs); the need to understand growth in the number of whole time equivalents (wtes); the establishment of the People Governance Group; the delay in relation to the development of a listening strategy; the inclusion of a future action to describe the link between patient and colleague experiences; and the ongoing work to link the people and workforce information to enable clear oversight by both the People and Finance Committees.

Director Report

2.15. The Committee received the report and noted: the update in relation to the development of the yearly People Strategy deliverables; the commencement of the annual staff survey on 28 September 2023; the publication of a national report on sexual misconduct within the surgical workforce and the review of the findings of the report by the leadership team.

2.16. The Committee discussed the issues raised at the Lucy Letby trial and noted that the findings of the public enquiry will need to be awaited to be able to understand the issues at trust level and identify areas of learning. The maternity teams were being supported and communications have taken place with parents to ensure that they are confident with the service provided. The Committee further noted that a discussion on the issues raised at the Lucy Letby trial had also been scheduled at the next Quality and Governance Assurance Committee meeting.

Internal Audit Report

2.17. The Committee received an overview of the findings of the Health and Wellbeing, Freedom to Speak Up and Performance Appraisals internal audit reports.

2.18. The Committee noted the positive findings in relation to the Freedom to Speak Up, Health and Wellbeing, and Performance Appraisals internal audit reports.

Assurances Received

2.19. The Committee agreed that assurances had been provided in following areas:

- Medical appraisal and revalidation report
- Health and Wellbeing, Freedom To Speak Up, and Performance Appraisals internal audit

Review of Effectiveness

2.20. The Committee discussed the findings of the self effectiveness review and agreed that overall the Committee was compliant with its Terms of Reference. The Committee asked for an overview of the Non-Executive Directors induction pack to be circulated.

2.21. The Committee further noted the need to consider the deep dive programme as it will take a further five meetings before the programme will be completed. The Committee agreed to consider whether an assurance report from the People Governance Group will be required.

3. AREAS OF CONCERNS/FOLLOW UP

Review of the Board Assurance Framework

3.1. The Committee noted that trajectories for each of the KPIs had not yet been set and that further work to develop a programme of actions to improve the KPIs was being developed. The Committee noted that the updated KPIs will be shared at the next Committee meeting.

Workforce (Corporate Risk Register)

3.2. The Committee discussed the workforce risks and noted that there were currently 24 risks on the Corporate Risk Register. The Committee noted the details of the risks and noted that the risk systems will be merged into a single system by April 2024.

3.3. The Committee particularly discussed the need to review the impact of the merger on colleagues and the impact of national changes and noted that any new risks as a result of this review will be reflected in the next report.

3.4. The Committee further noted that: the first non-medical staffing related risk surgery to review risks with service group representatives had taken place and that a similar process will also be put in place for medical risks.

Internal Audit Report

3.5. The Committee received an overview of the findings of the Sickness Absence, Disability Content, and Performance Appraisals internal audit reports.

3.6. The Committee particularly noted the concerns in relation to the sickness absence audit report and the outstanding actions. The Committee received an update on the actions taken and noted that: the sickness absence policy had been drafted but that a further review was required to ensure that the policy was in line with the “just and restorative” culture of the organisation; further work was required in relation to the consistency of policies; the long term sickness actions had been implemented, audits were in place and the findings were shared at business planning meetings; further work was required in relation to short term absences and the monitoring of themes.

3.7. The Committee noted that it was expected that the sickness absence policy will be signed off by the end of October 2023.

3.8. In relation to the Disability Confident internal audit, the Committee noted that the implementation of the actions will take more time as a shift in culture will be required to fully implement the recommendations. A trajectory for the implementation of the actions had been agreed.

3.9. The Committee discussed the concerns expressed by the Audit Committee in relation to the lack of controls on colleague absences and noted that: a fully established HR advisor team was now in place; absence triggers were being flagged; absence level KPIs were monitored at service group level; and that the management of absences was a key responsibility of line managers.

3.10. The Committee noted that a further progress sickness absence report will be presented to the next Committee meeting.

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

4.1. The Committee did not identify any issues to be reported to the Board.

5. ASSURANCE FRAMEWORK

5.1. The Committee received the assurance on strategic objective six in the following areas:

- The colleague story and the actions taken to manage unacceptable behaviours
- The Deep Dive into Compassionate and Inclusive Leadership
- The Annual Medical Appraisal and Revalidation report and Statement of Compliance
- The review of the Board Assurance Framework
- The Director report
- The findings of the Health and Wellbeing, Freedom to Speak up and Performance Appraisal internal audits

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Guardian of Safe Working for Postgraduate Doctors
SPONSORING EXEC:	Daniel Meron, Chief Medical Officer
REPORT BY:	Tom Rees (SFT) and John McFarlane (YDH), Guardian of Safe Working Lee-Ann Toogood, Medical Workforce Manager
PRESENTED BY:	Daniel Meron, Chief Medical Officer
DATE:	7 November 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	This report covers quantitative and qualitative summary of exception report data generated between 1 July 2023 and 30 September 2023 across Somerset NHS Foundation Trust.
Recommendation	The Board is asked to discuss and note the report.

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

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

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

Equality and Inclusion

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

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

This report has been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History
How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Not applicable for this report.

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

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

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

SOMERSET NHS FOUNDATION TRUST

QUARTERLY REPORT ON SAFE WORKING HOURS:

DOCTORS AND DENTISTS IN TRAINING

1. INTRODUCTION

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

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

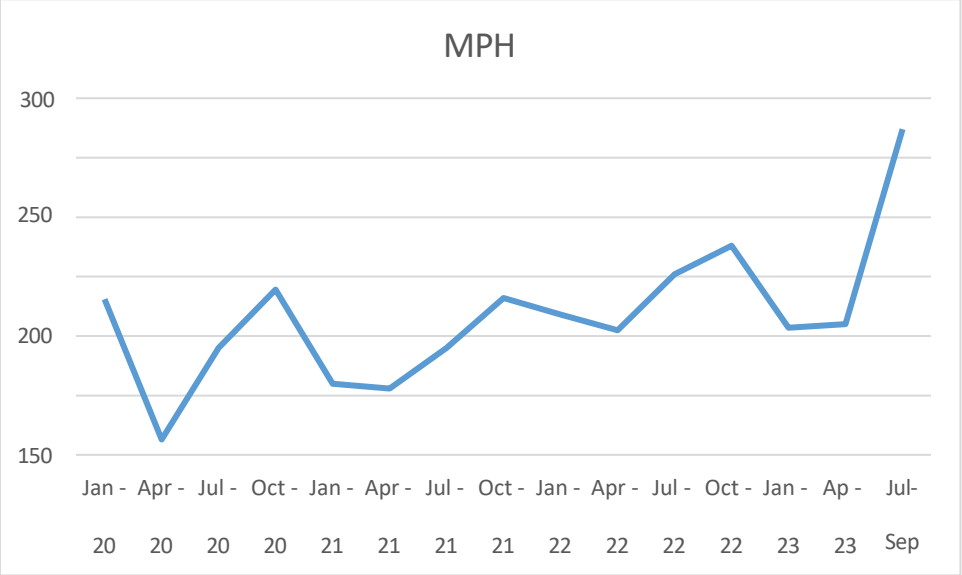
2. EXCEPTION REPORT DATA:

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

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

2.1. As of 14/07/2023 - Total of exception reports since implementation of 2016 TCS (December 2016). 3307 for Taunton and for Yeovil 1489. The overall cost of exception report overtime is £83,830.14

Figure 1 Quarterly total for exception reporting



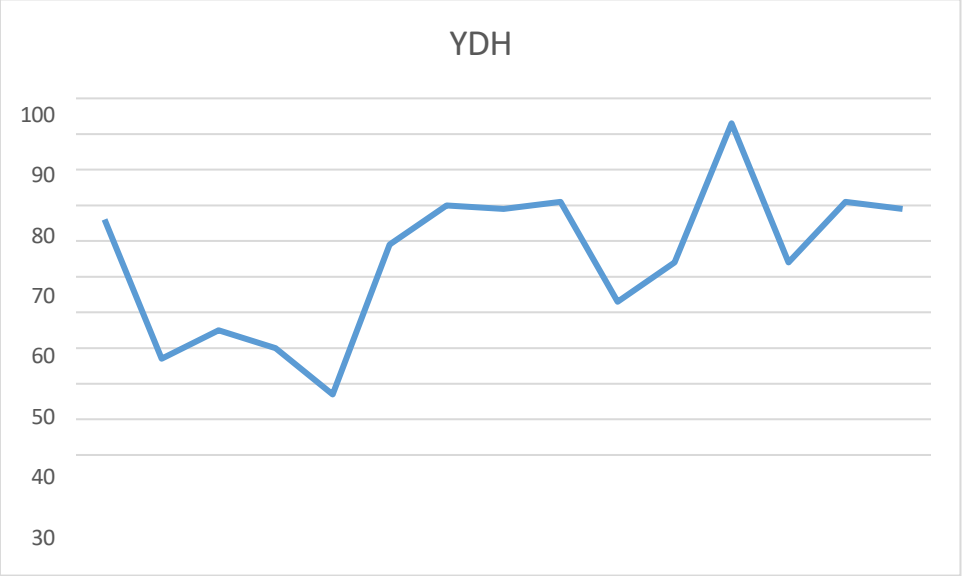
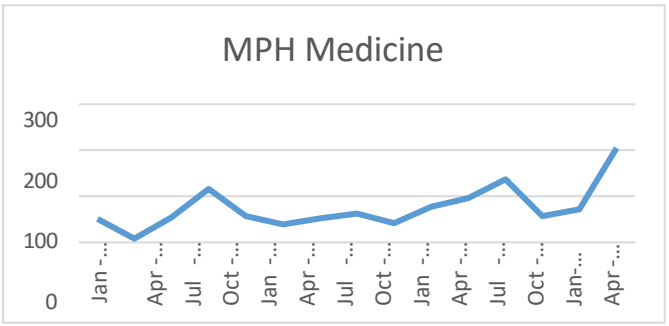
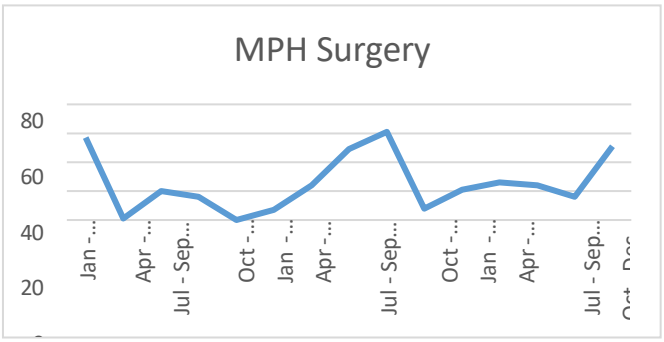
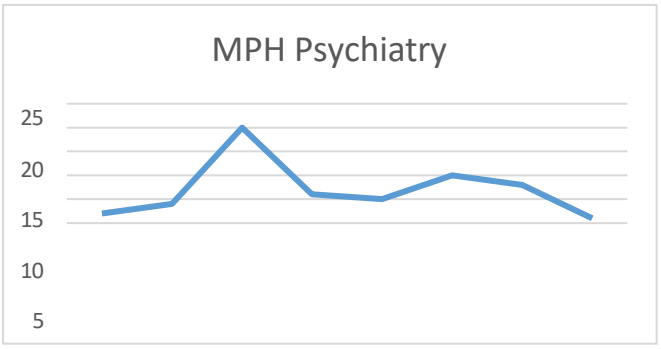
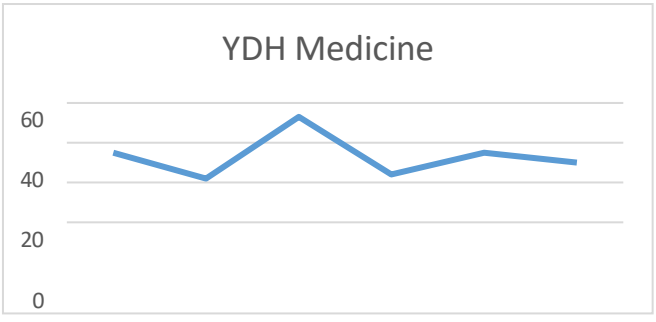


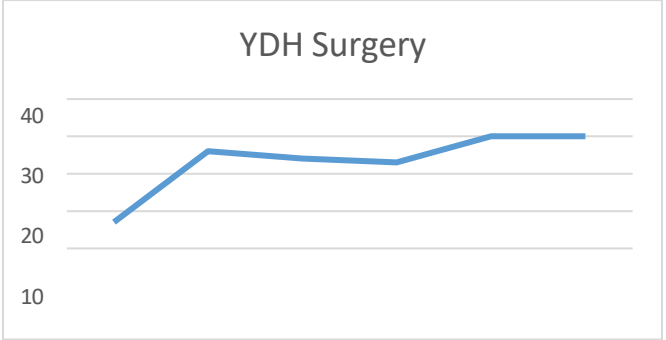
Figure 2 Exception Report Trends by Specialty











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

Table 1: Exception reports per specialty

Specialty	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**	**Type**
Acute & General Medicine	MPH 169 (71) YDH 30 (45)	137 30	32 0	Hours MPH 164 YDH 29 Educational MPH 5
Anaesthetics	1 *(0)*	0	1	Service Support MPH 1
DCT Trainees	0 *(0)*	0	0	
Emergency Medicine	MPH 26 (0) YDH 0 (2)	26	0	Educational 26
ENT	7 *(0)*	3	4	Educational 3 Hours 4
General Surgery	MPH 47 *(16)* YDH 20 (29)	21 20	26 0	Hours YDH 14 MPH 29 Pattern YDH 2 Service Support YDH 3 MPH 18
O&G	YDH 3 *(0)*	3	0	Hours YDH 3
Oncology/ Haematology	MPH 11 *(5)*	0	1	Educational MPH 1 Pattern MPH 1 Hours 9
Paediatrics	MPH 5 *(3)*	1	4	Hours MPH 4 Pattern MPH 1
Psychiatry	MPH 1 *(9)*	0	1	Service Support MPH 1
Trauma & Ortho	MPH 1 *(10)* YDH 9 (5)	0 9	1 0	Hours YDH 9 Service Support MPH 1
Urology	MPH 0 *(1)*	0	0	
Vascular	0 *(0)*	0	0	
Total	**329**	**250**	**79**	

Table 2: Exception reports per trainee grade

Grade of trainee	**No. exceptions raised Taunton**	**No. exceptions raised Yeovil**
F1	218	42
F2	18	20
CT1-2 / ST1-2	22	7
ST3+	13	0

Total	**271**	**69**

K

Locum Agency Spend to cover Post Graduate Doctors in Training

Division	Pay Gross (No VAT)	Booking Gross (No VAT)
Clin Supp & Cancer Servs	£22,200.00	£28,223.60
Clin Supp & Cancer Servs/Clinical Support & Specia	£22,080.00	£27,335.04
CYP & Families Services	£167,353.88	£196,345.34
Medical Services	£843,427.12	£980,769.16
Medicine	£2,640.00	£2,880.00
Mental Health and LD	£434,509.86	£484,027.90
Neighbourhood Services	£2,400.00	£2,600.00
Primary Care & Neighbourhoods	£100,293.28	£116,372.02
Surgical Services	£33,958.20	£40,523.33
Grand Total	£1,628,862.34	£1,879,076.39

Qualitative summary of exception reports

2.2. As per previous quarters at PGDiT changeover, we have noticed a cyclical increase in ERs submitted this quarter. The majority of these are generated from acute and general medicine and relate to difference in the hours of work.

2.3. There is a general trend towards an increase in ERs submitted year-on-year which would suggest greater engagement, understanding and acceptance of the process, particularly at lower grade levels.

2.4. There was a noticeable increase in the ERs submitted for missed educational opportunities in ED at MPH over the prior quarter. These were all generated from a single postgraduate doctor and represented missed SDL time. This appears to be due to a misunderstanding of the rota. We have not seen this replicated since changeover in August but will be monitored.

2.5. The general trend in ER numbers at YDH has reduced this quarter which reflects the increased staffing levels from August.

Immediate safety concerns (ISCs)

2.6. There were no ISCs generated over the last quarter from TST 2 ISC from YDH.

Fines

2.7. No fines were issued during this quarter.

Work schedule reviews

2.8. There were no work schedule reviews this quarter.

3. ISSUES ARISING

Workforce development

3.1. As per previous quarters, acute and general medicine generate the majority of ERs at MPH, and these are almost exclusively due to difference in hours worked. Attempts should be made to improve the workload for PGDiTs through the delegation of work to other MDT members, medical support workers (MSW)/Physician associates (PAs), and through the use of technology. Attempts should be made to bolster workforce numbers, particularly as we head into winter periods which have historically been busy for medicine.

Postgraduate Doctor Forum (PDF)

3.2. We conducted our most recent PDF at MPH on 29 September. The main issues raised were around the mess fund, mess cleanliness and support during industrial action. The ER data was presented to the PGDiTs and discussion of the issues raised from ERs was welcomed in an informal and confidential environment.

3.3. At YDH we have commenced monthly JDF forums with refreshments which has been welcomed. Main issues arising in September were relating to locum shifts and teaching agendas and date which have been formulated to maximise attendance.

Rota management

3.4. Electronic rota management software is soon to be implemented at MPH. This is likely to reduce rota errors and gaps and therefore have a positive impact on ERs.

Weekend working

3.5. At MPH we have recently changed the way that weekend jobs are created and delegated on EPRO. This should have a positive impact on weekend ERs submitted which will be evident next quarter.

4. SUMMARY

4.1. As per prior quarters we have seen a general trend in increasing ERs submitted, particularly at lower grade levels, suggesting greater engagement and acceptance. There remains difficulty in interpreting this – does this just represent greater engagement and acceptance of the ER process, or is there a

considerable increase in workload causing frequent deviation in the hours worked for PGDiT?

4.2. We have no ISCs generated from MPH this quarter.

4.3. In YDH there were 2 ISC relating to night time staffing in ED which was resolved by slight rota adjustments.

4.4. The general trend in ER numbers has reduced this quarter which reflects the increased staffing levels from August.

4.5. We will monitor the impact that electronic rostering and the change in weekend job creation has on ERs in the medical directorate over the coming quarters.

5. RECOMMENDATIONS

5.1. The workload in the acute and general medicine directorate remains challenging, with PGDiTs regularly ER for overtime suggesting insufficient capacity during the day to complete tasks. The use of the wider MDT to help with tasks (PAs etc) along with technology may help improve efficiency.

5.2. The implementation of an electronic rota is welcome and will improve workforce allocation. This should have the desired effect of reducing ERs.

5.3. It is important from a workforce planning perspective that LTFT trainees ideally avoid taking non-working days (NWDs) at the same time to prevent the additional burden that this will pose on those that are full time. ERs have been submitted because of the burden this creates, particularly on Fridays.

TOM REES AND JOHN MCFARLANE GUARDIAN OF SAFE WORKING

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Six Monthly Inclusion Progress Report
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Harriet Jones, Head of Inclusion
PRESENTED BY:	Harriet Jones, Head of Inclusion
DATE:	7 November 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 Inclusion Team present to Board every six months. The purpose of this paper is to bring together reporting frameworks (including the WDES, WRES and gender pay gap) that focus on individual protected characteristics, into one holistic inclusion data report. This will ensure we are able to identify common challenges and focus on the behaviours, processes and systems that need improving. This report is focused on workforce inclusion and our duties and responsibilities under the Equality Act 2012 as an employer. As this is the first report providing an overview of all diversity demographic data, we would like to ask the Board the following questions: • The report identifies where data are missing and plans in place to collect and present data in future. However, we would also invite feedback from the Board on other data sets or information we should include in future. • How can this data be used effectively to inform discussion and decision making at Board and Sub-committee level?
Recommendation	The Board is asked to note the report and consider the questions posed above for future reporting.

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 and Inclusion
The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
The attached report provides an overview of key metrics and available data relating to diversity and inclusion. This data will form the basis of a long-term inclusion workplan for SFT.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History
How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
This paper predominantly focuses on workforce inclusion. The paper is based on quantitative data sets, survey responses, insights from colleague networks, and feedback from pilot programmes.

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 receives six monthly reports in respect of equality, diversity and inclusion. The People Committee also receives regular updates on the issues covered by this report.

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

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

SOMERSET NHS FOUNDATION TRUST

ANNUAL INCLUSION DATA REPORT

1. BACKGROUND AND PURPOSE

1.1 The purpose of this paper is to provide an annual update to Board on the state of workforce diversity and inclusion across our Trust. The Inclusion Team report to Board every six months. Our last report provided an overview of achievements to date and key areas of focus. This report will predominately focus on our data, and assurance that we are meeting requirements under national frameworks including the Workforce Race Equality Standard (WRES), The Workforce Disability Equality Standard (WDES) and the Gender Pay Gap report.

1.2 This paper brings together reporting frameworks that focus on individual protected characteristics, into one holistic inclusion data report. This will ensure we are able to identify common challenges and focus on the processes and systems that need improving.

1.3 The data provided in this report will inform the development of a long-term workforce inclusion workplan. A working version of this plan has been provided in this paper.

2. KEY THEMES IDENTIFIED IN OUR DATA

2.1 Recruitment

- In non-medical and medical recruitment, there is a significant drop in the representation of Black, Asian and ethnic minority (BAME) candidates throughout the recruitment process. In non-medical recruitment this drop happens from application to shortlisting stage, while in medical recruitment, the drop occurs between shortlisting and interview stages. Representation of BAME candidates then continues to fall throughout the recruitment process. In non-medical recruitment, 63% of applicants were BAME, compared to only 13% of appointed candidates.

- The representation of male candidates falls throughout the recruitment process in both medical and non-medical recruitment.

- It is likely that there are several causes for this trend including the potential impacts of bias in decision making, and a recruitment process that doesn't enable all candidate to evidence their skills.

- The representation of disabled candidates in non-medical recruitment increases from 4% at application to 8% at shortlisting. This may be an impact of the Disability Confident guaranteed interview scheme. However, this improvement isn't evidenced in medical recruitment.

2.2 Workforce Profile

- Gender: SFT is female dominated, with 79% of our workforce identifying as female. This compares to the Somerset population, where 51.1% of residents identify as female. Gender representation varies across services – for

example, 94% of colleagues in Children, Young People & Families identify as female, compared to 60% in Corporate Support Services. Gender representation also varies by staff group – for example 89% of Nursing and Midwifery colleagues are female compared to 51% in Estates & Ancillary roles, and 50% in Medical and Dental roles.

- Female representation generally decreases with seniority.

- Race: 17% of the SFT workforce are from a Black, Asian, or ethnic minority background. In comparison, 8.4% of the Somerset population identify as Black, Asian, mixed, or another ethnic groups. BAME representation varies by staff group and service group – BAME colleagues are more highly represented in Medical & Dental, and Nursing & Midwifery roles, and within the Medical and Surgical Service Groups.

- The majority of BAME colleagues are employed at band 5 – 41% of colleagues at band 5 are BAME. Representation then falls significantly to 12% at band 6.

- In comparison to 2021, the representation of BAME colleagues has increased from 14%. There has also been an increase across most bands, including an increase from 31% to 41% at band 5, and from 9% to 12% at band 6.

- In medical and dental roles, BAME colleagues are more highly represented in SAS roles (51%), compared to 22% in consultancy roles. Representation has not changed at consultant level since 2021.

- Race & Nationality: Our report explores the intersection of race and nationality. The majority of BAME colleagues have a nationality that is not British. Just 3% of the SFT workforce are BAME and British. This compares to the 2021 Census where 18% of residents in England and Wales identified as Black, Asian, mixed ace or another ethnic group. The representation of BAME British colleagues remains relatively consistent across bands, while our data suggests there is a particular barrier for international BAME colleagues to progress.

- Disability: 4% of colleagues have disclosed that they have a disability in ESR. 20% of colleagues have not provided any information. In comparison, in the 2022 staff survey, 23% of colleagues disclosed that they had a disability or long-term health condition. This compares to the Somerset population, where 18.7% of residents have a disability. There is a higher representation of disabled colleagues within Apprentice and band 1, and Foundation 1&2 medical roles.

- Sexuality: 3% of SFT colleagues identify as Lesbian, Gay, Bisexual, are undecided, or identify with another sexual orientation. This reflects the Somerset population, where 2.5% of the population identified with a sexual orientation other than heterosexual. Due to small numbers, we have not disaggregated this data further. 24% of colleagues have not provided any information. Increasing ESR completion rates will improve our ability to understand the progression and representation of LGB colleagues.

- Summary: Our data identifies several areas for action and improvement:

    - The progression and representation of BAME colleagues, particularly international colleagues, at bands 6 and above, and progressing into consultant roles.

    - The progression of female medical colleagues into consultant roles.

    - The progression of female colleagues into senior roles, whilst also improving the representation of men in bands 2 to 8b.

    - Improve ESR declaration rates, particularly in relation to disability and sexuality

2.3 **Progression**

- Progression has been estimated based on colleagues who had a change in banding in the past 12 months. This could have been the result of applying for a higher-banded role, organisational change or restructures, or through a re-banding process.

- 12% of female colleagues progressed compared to 9% of men. However, this varied by staff group and service group, for example, 15% of male colleagues in Nursing & Midwifery roles progressed compared to 13% of women.

- 13% of BAME colleagues progressed, compared to 11% of white colleagues. The progression of BAME colleagues was most pronounced in Administrative & Clerical, and Nursing & Midwifery staff groups, and within the Mental Health & Learning Disabilities service group, where 23% of BAME colleagues progressed compared to 14% of white colleagues.

- 12% of disabled colleagues progressed compared to 13% of colleagues with no disability. Progression varied across service group and staff group – with disabled colleagues being less likely to progress in some areas such as Clinical Support & Cancer Services and Mental Health and Learning Disabilities.

- Progression can be informed by multiple factors, including the support and sponsorship from line managers, affective career conversations, impactful training and development, and the availability of stretch opportunities. All these mechanisms for progression need to be accessible, equitable and meet the needs of diverse groups.

2.4 **Leavers**

- The proportion of leavers reflected the SFT workforce

    - 77% of leavers were female. This reflects the SFT workforce which is 79% female.

    - 15% of leavers were BAME. This reflects the SFT workforce which is 17% BAME.

- 4% of leavers were disabled. This reflects the SFT workforce of which 4% are disabled.

- BAME and male colleagues were more highly represented in those leaving at the end of a fixed-term contract. This may suggest that BAME and male colleagues are more likely to be in fixed-term roles.

- The trust recently introduced a new exit survey, which we hope will enable a detailed analysis and understanding of people's reasons for leaving, and whether this differs by demographic group.

2.5 **Pay Gap**

- The gender pay gap is currently at 26.2%. The gender pay gap has increased since 2022 (21%). There are multiple causes of the gender pay gap, including:

  - A higher proportion of men are in senior roles compared to women.

  - A higher proportion of men are in medical and dental roles, which are generally more highly paid than staff groups where women are in the majority, such as nursing or administrative roles.

- In addition, when we analyse the pay gap within bands, this highlights some potential inequalities that need further investigation. The pay gap increases with seniority – women are paid slightly more on average in lower bands, while men are paid higher salaries at bands 8b and above. There are also some larger gaps within SAS and Dental roles, whereas women are paid higher salaries on average within GP positions.

- The race pay gap is currently at +18%. This means that on average, BAME colleagues are paid more. There are several factors contributing to this trend:

  - 15% of BAME colleagues are in Medical & Dental roles, compared to 7% of white colleagues. This will impact the pay gap as these roles are generally more highly paid.

  - When the pay gap is analysed by banding, there are some differences where BAME colleagues receive higher salaries.

- However, the pay gap within Medical & Dental roles highlights some pay gaps, where BAME colleagues are paid less on average within Specialty Registrar, Consultant and Dental roles.

- As part of the annual national report analysing the gender pay gap, we also look at the pay gap within bonuses. The Clinical Excellence Award scheme is the primary bonus scheme used at SFT.

- We have analysed the impact of the historical CEA scheme, compared to the current scheme. Since COVID, it was agreed that the CEA money would be split equally between all consultants. As a result, the current scheme has created small pay gaps.

- In comparison, the historical CEA schemes, have created a significant gender pay gap as these pay awards are still in place. The gender pay gap created by these historical awards is at 30.6%.

- This analysis suggests there is a need to investigate any within-band pay gaps, to understand what is contributing to these differences. There is also a need to work with national teams to ensure any future CEA scheme is designed to be equitable and inclusive and does not create further pay gaps.

2.6 **Staff Survey**

- **Violence and Aggression**: BAME colleagues, and Lesbian, Gay and Bisexual (LGB) colleagues at Yeovil, were significantly more likely to report experiencing physical violence from patients or service users. 36% of LGB colleagues at Yeovil reported experiencing violence from patients, and this group was also the least likely to report their experience (53% had reported). BAME colleagues were more likely to report compared to white colleagues, particularly at Yeovil. Disabled colleagues were less likely to report their experience compared to colleagues with no disability.

- Harassment, bullying or abuse: Female, BAME, disabled and LGB colleagues were more likely to report experiencing harassment, bullying or abuse from patients or service users. The proportion of colleagues experiencing harassment, bullying or abuse from their manager was relatively low – but roughly 10% of colleagues did report this experience. Disabled colleagues, and LGB colleagues were more likely to say they experienced this behaviour.

- The proportion of colleagues experiencing harassment, bullying or abuse from their peers was higher, with BAME, disabled and LGB colleagues being more likely to have experienced negative behaviour from their colleagues. A lower proportion of colleagues had made a report of their experience of harassment, compared to physical violence. In general, reporting was more likely at Yeovil, but varied across demographic groups.

- Discrimination: Male, BAME, disabled and LGB respondents were more likely to experience discrimination from their manager or colleagues. Roughly 60% of colleagues felt the Trust acts fairly regarding career progression, however this did vary by demographic group – male and BAME colleagues in particular were less positive.

- **Wellbeing**: Disabled colleagues, LGB and male respondents were less positive about the Trust's action on health and wellbeing. LGB and disabled colleagues were significantly more likely to report that they had felt unwell as a result of work-related stress.

- BAME colleagues were more likely to report that relationships at work are strained, and LGB colleagues at Yeovil were significantly more likely to report relationships felt strained.

- **Civility and respect**: male, disabled and LGB colleagues were less likely to feel that the Trust respects individual differences. Responses to the question

'I receive the respect I deserve from my colleagues' varied across demographic groups at SFT and YDH.

- **Adjustments**: As highlighted above, a far higher proportion of colleagues identify as having a disability or long-term health condition in our staff survey, compared to declaration rates in ESR. Of the 23% of colleagues who have a disability or long-term health condition, roughly three quarters of colleagues had a reasonable adjustment in place.

- The staff survey results highlight a number of areas where more work is needed to create an inclusive culture, address the experiences of violence, abuse and harassment at work, and ensure wellbeing provisions are inclusive and accessible. Underrepresented or minority groups were generally less positive in the questions presented, and we need to ensure that any actions that aim to improve the culture at SFT, address the different experiences of diverse groups, so that we see improvements in experience of all our colleagues.

2.7 **Decision Making:**

- The data presented shows the diversity of Trust Board. While the Board is gender balanced, only 6% of the Board identify as BAME, and 0% identify as disabled. However, data relating to disability is missing for almost half of Board members.

- We need to implement mechanisms so we can record and understand the diversity of key decision-making groups at SFT, including, for example, the Trust Board, Board sub-committees, and the Governors.

2.8 **Parental Leave**

- Whether men are accessing parental leave, and the return rate from parental leave, can be indicators of an inclusive culture and progressive policies.

- A very small number of colleagues are currently accessing parental or paternity leave. There were no records of colleagues taking shared parental leave.

- Interestingly, BAME colleagues are more likely to access all forms of parental leave, but particularly shared parental and paternity leave. For example, male BAME colleagues represent 5% of the SFT workforce, and 34% of those taking paternity leave.

2.9 **Formal Processes**

- The data presented shows the information submitted within the WRES and WDES submissions. The WDES requires data for formal capability processes, while the WRES requires data on formal disciplinary processes.

- The analysis of this data suggests that BAME colleagues are more likely to enter formal disciplinary processes – however the numbers reported are very low withs just 4 cases reported in the 2022-23 financial year.

- 4% of colleagues entering formal capability processes were Disabled, and this reflects the proportion of colleagues with a disability across the trust.

- However, this analysis, along with conversations with teams across the trust, has raised concerns around the reliability and accuracy of this data. More work is needed to ensure we're capturing accurate data relating to formal processes, including referrals to bodies such as the NMC and GMC.

2.10 **Training & Development**

- Appraisal completion rates didn't differ significantly by gender, but BAME colleagues were slightly less compliant compared to white colleagues, and 42% of disabled colleagues had completed an appraisal compared to 48% of colleagues with no disability.

- There is very little difference between demographic groups in mandatory training compliance.

- Our data for non-mandatory training suggests BAME colleagues are more likely to access this training – 26% of colleagues accessing non-mandatory training are BAME, this compared to 17% of the workforce identifying as BAME.

3. WORKFORCE INCLUSION WORKPLAN

3.1 The workplan attached has been developed based on the data analysis outlined above. In addition, the actions have been informed by a number of reports and audits, including:

- Disability Confident Audit - An audit by BDO reviewing our progress towards a Disability Confident Employer accreditation. This audit reviewed the policies and processes in place to support colleagues with a disability, with a particular focus on our process for providing reasonable adjustments. SFT currently holds a Level 1 accreditation – Disability Confident Committed.

- The R**ainbow Badge Phase 2 programme** – this is an assessment and accreditation programme evaluating our progress towards LGBTQ+ inclusion. The programme has been co-delivered and designed by NHS England and the LGBT Foundation. The assessment is based on several data sources including a policy review, a staff survey, patient survey, service survey and a workforce assessment. We received our final report in October 2023. This included our final assessment score and recommended actions. SFT received an 'Initial Stage' outcome, with a final assessment score of 35 out of a potential total of 165.

3.2 The workforce inclusion plan attached is a working document, and we expect this to develop and grow as we implement our Inclusion Roadmap. The Roadmap sets out the steps we are taking to embed a systemic approach for inclusion – this will lead to improved data analysis and insight, which in turn will inform the workforce inclusion plan.

3.3 The plan below includes work that is already in progress, as well as additional action needed in response to our data.

3.4 The timeframes for the workforce inclusion plan aligns with the SFT People Strategy. This is because many of the actions are reflected in the People Strategy.

3.5 The Inclusion Team will support teams and leaders across the organisation to implement and progress the actions outlined in the workplan.

4. RECOMMENDATIONS AND DISCUSSION

4.1 As this is the first report providing an overview of all workforce diversity demographic data, we would like to ask the Board the following questions:

- The report identifies where data is missing and plans in place to collect and present data in future. However, we would also invite feedback from the Board on other data sets or information we should include in future.

- How can this data be used effectively to inform discussion and decision making at Board and Sub-committee level?

NHS
Somerset
NHS Foundation Trust

Annual Workforce Inclusion Report

Kindness, Respect, Teamwork
Everyone, Every day

Notes on data provided

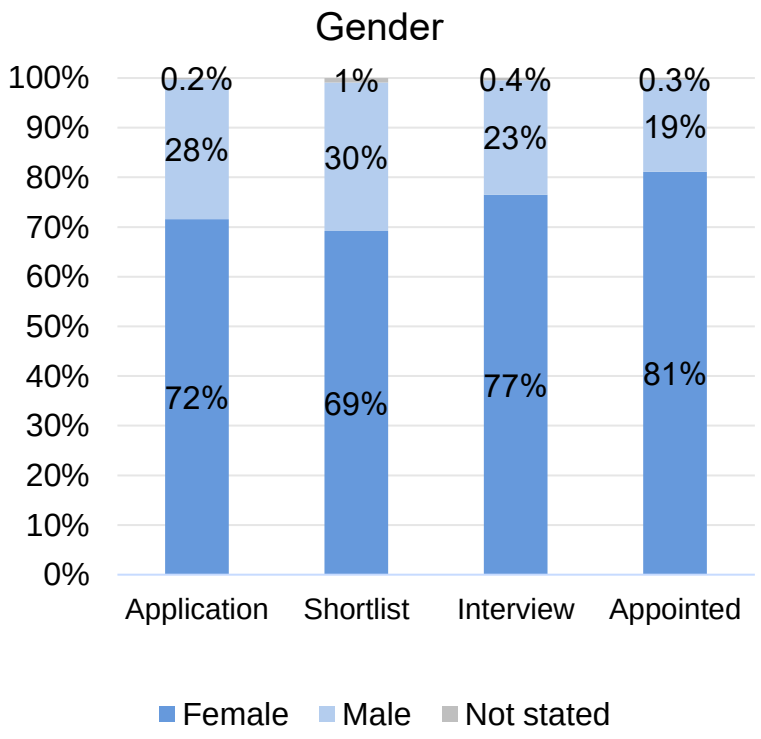
NHS Somerset NHS Foundation Trust

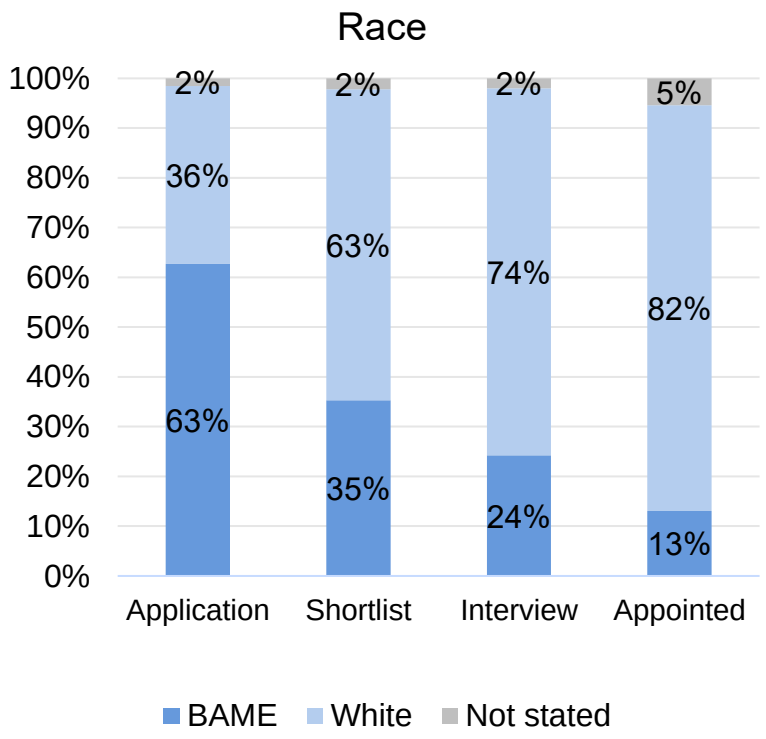
- Workforce profile data is as at 1st April 2023.
- Data sets such as leavers, recruitment, and pay gap reflects the 2022/23 financial year.
- Survey data presented is from the 2022 NHS staff survey. The 2022 survey was completed before the merger of SFT and YDH, so data has been presented separately.
- As our recruitment platforms have not yet been combined, the recruitment data below does not include recruitment data from YDH

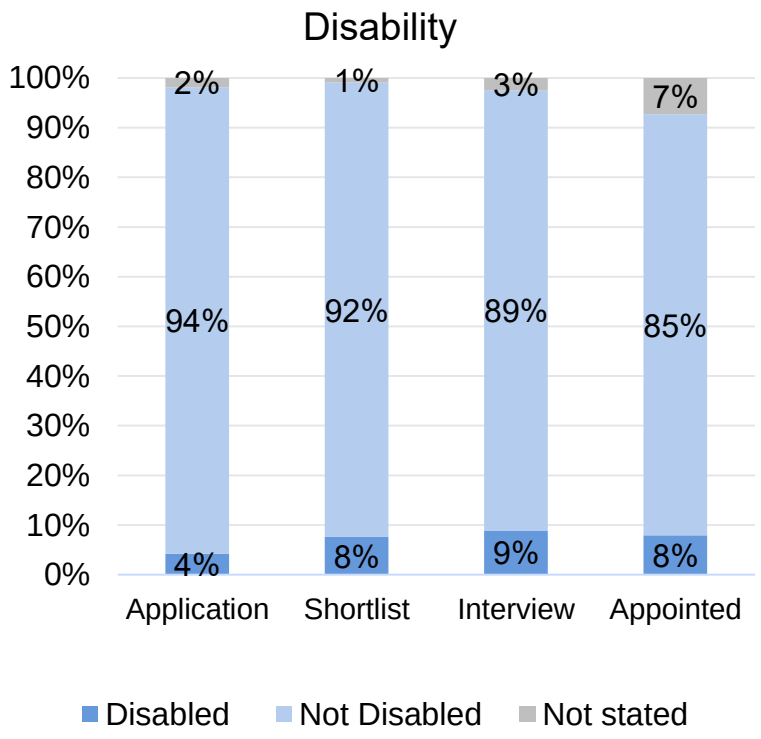
1. Recruitment

Non-Medical Recruitment

NHS Somerset NHS Foundation Trust







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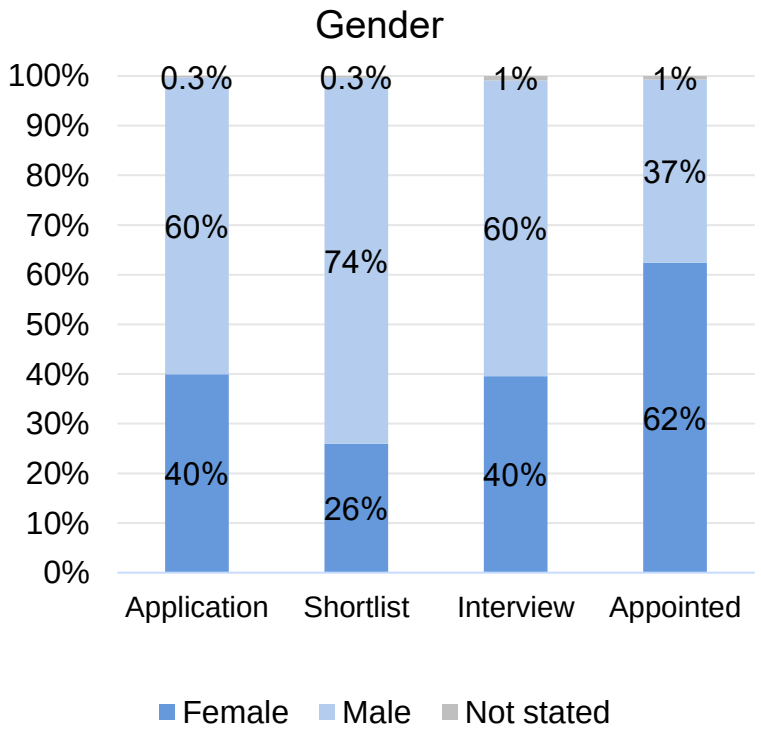
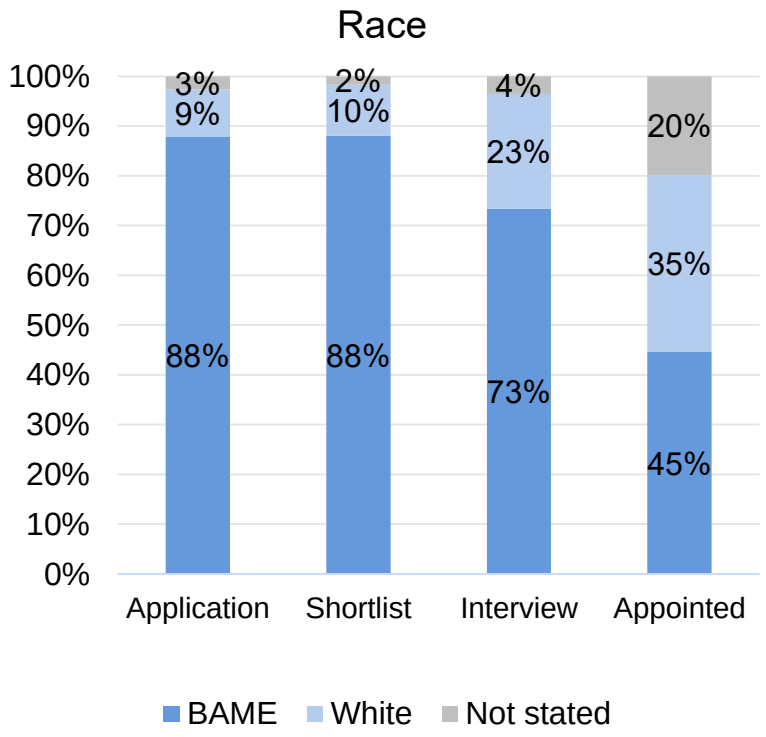
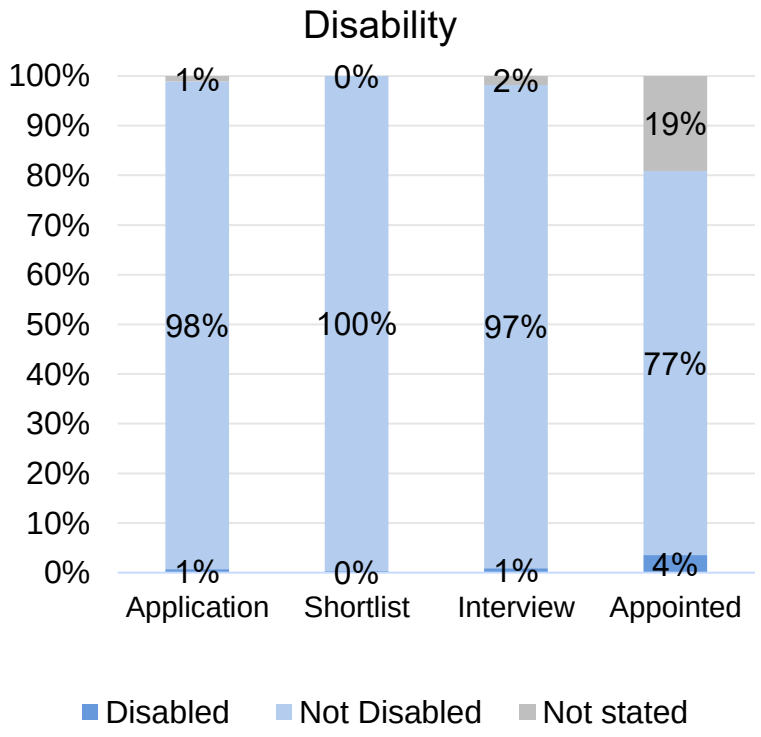
1. Recruitment

Medical Recruitment

NHS Somerset NHS Foundation Trust







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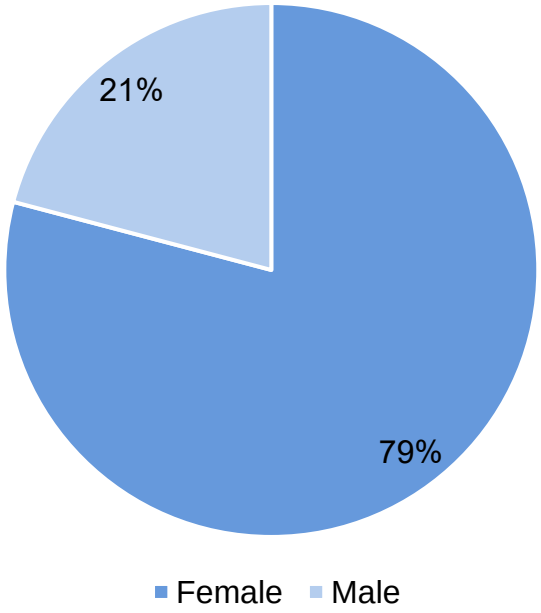
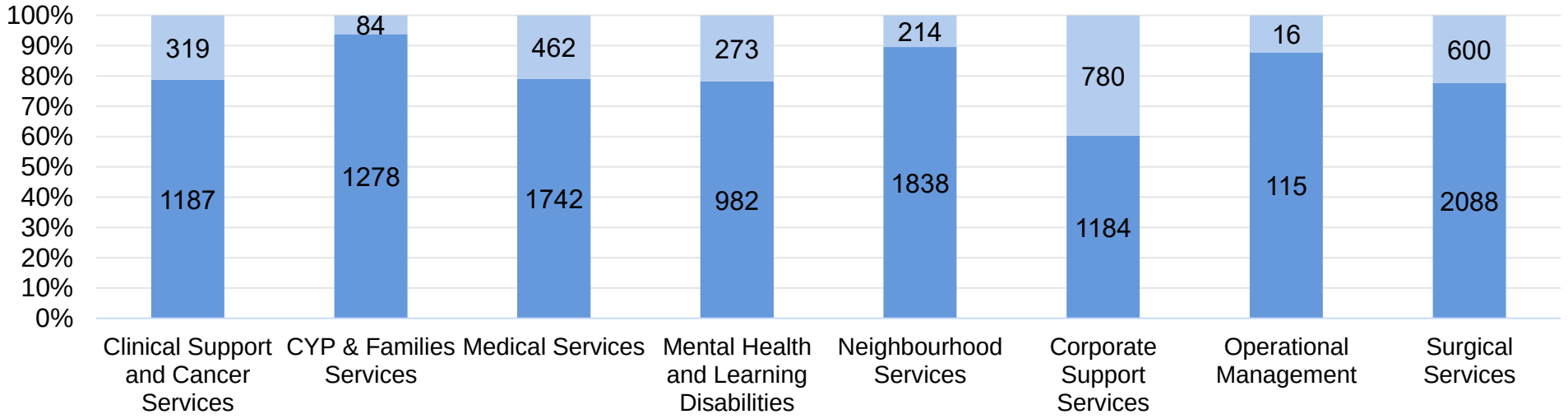
2. Workforce Profile

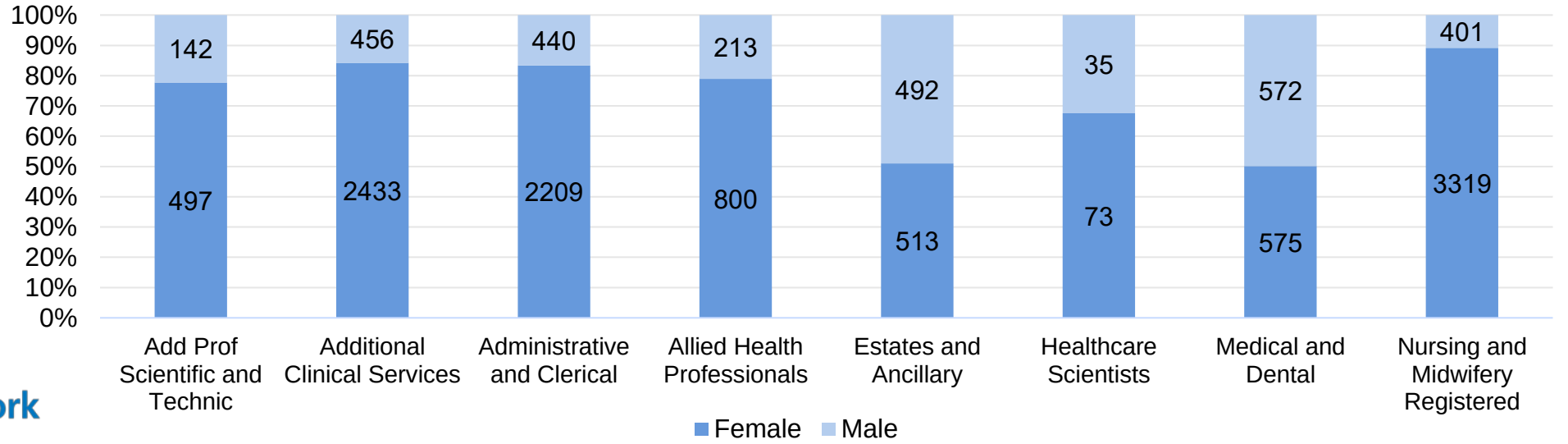
Gender



Service Group



Staff Group



Somerset NHS Foundation Trust

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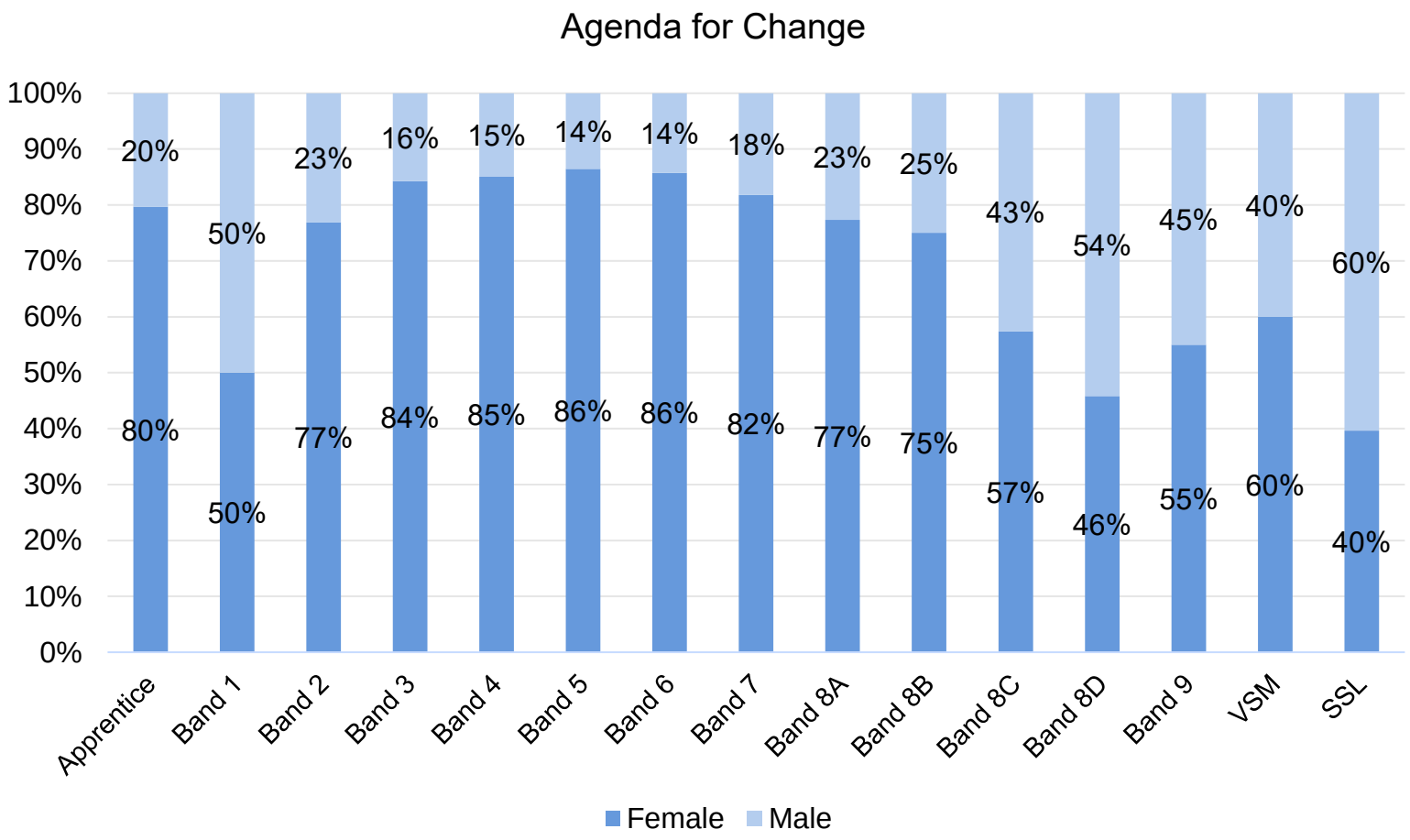
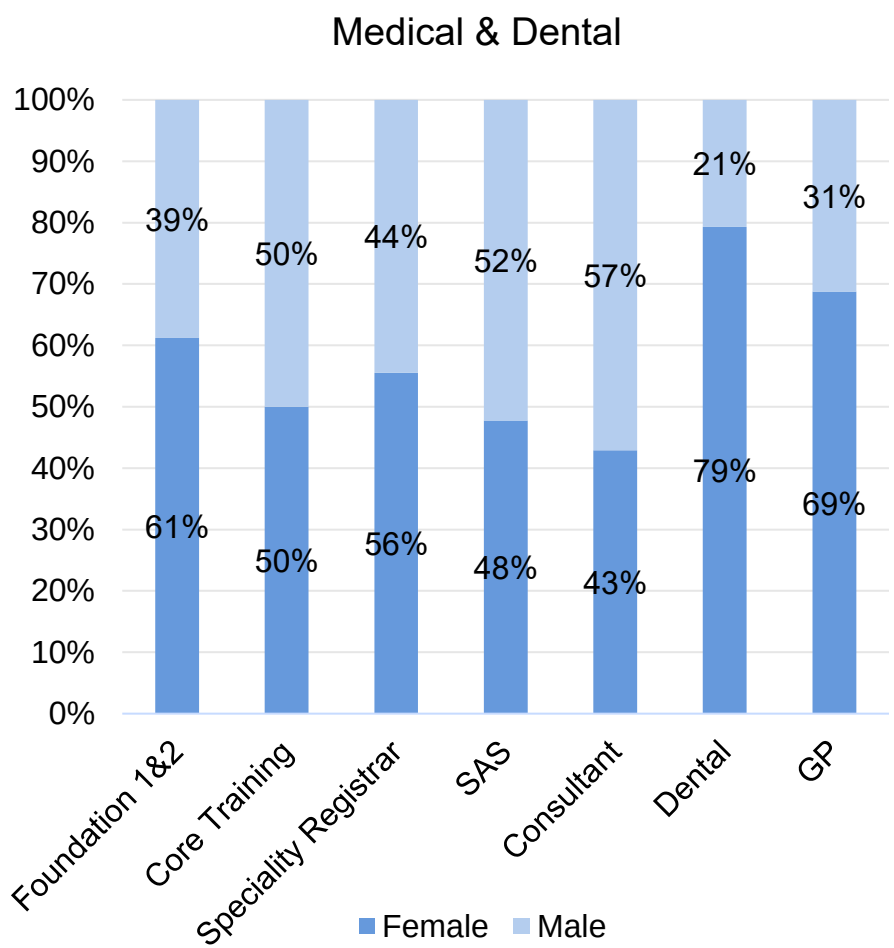
2. Workforce Profile

Gender

Somerset NHS Foundation Trust

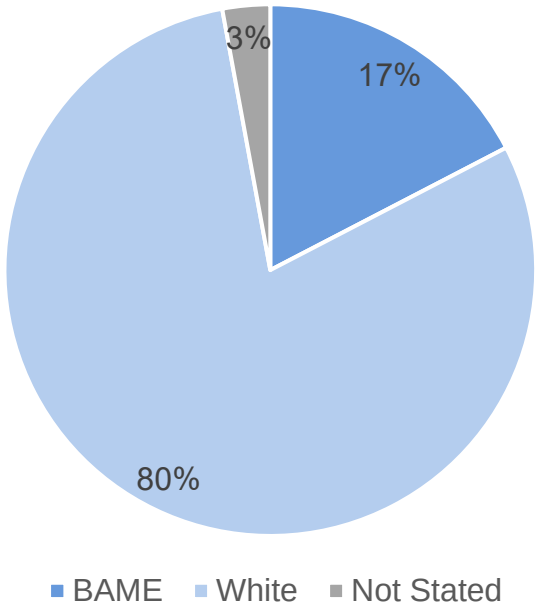




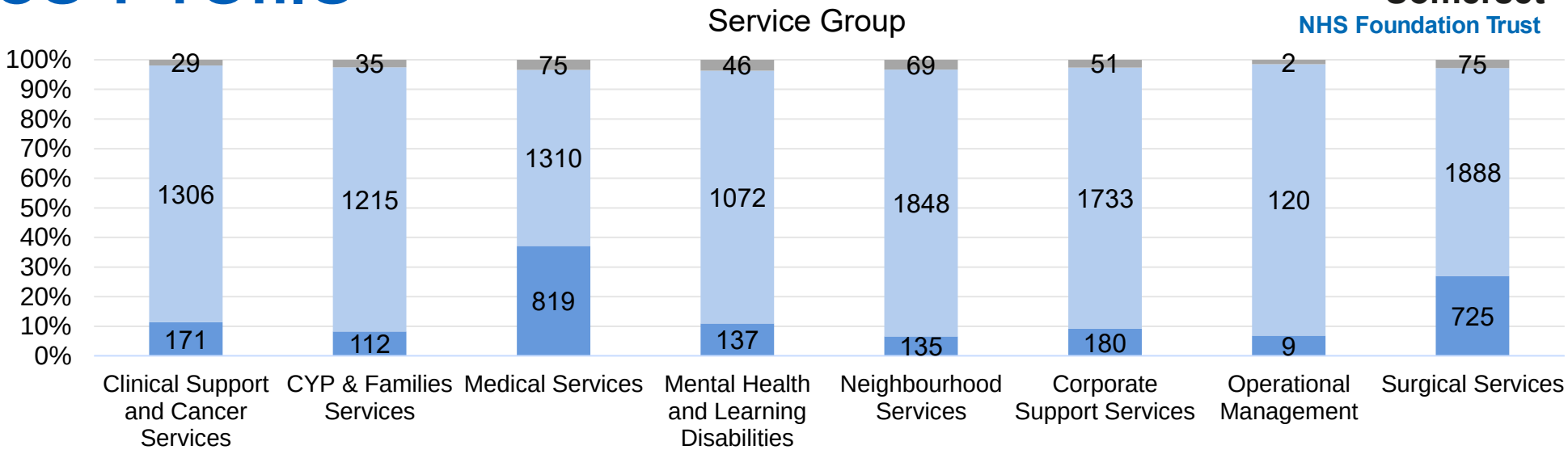
Kindness, Respect, Teamwork
Everyone, Every day

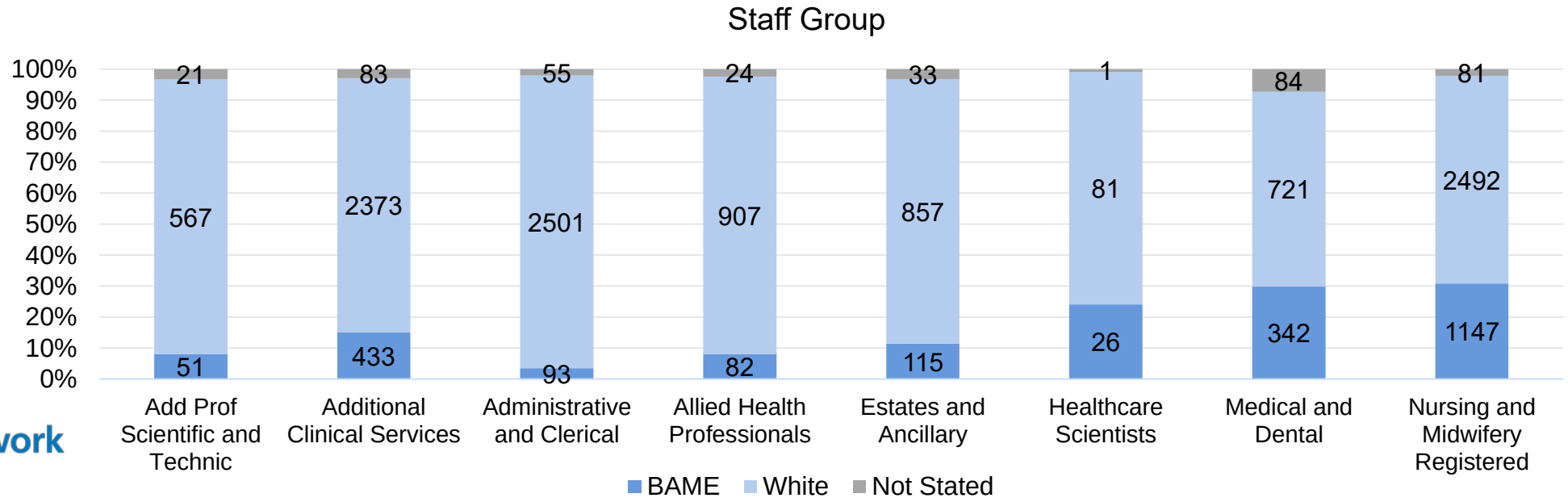
2. Workforce Profile

Race



Somerset NHS Foundation Trust



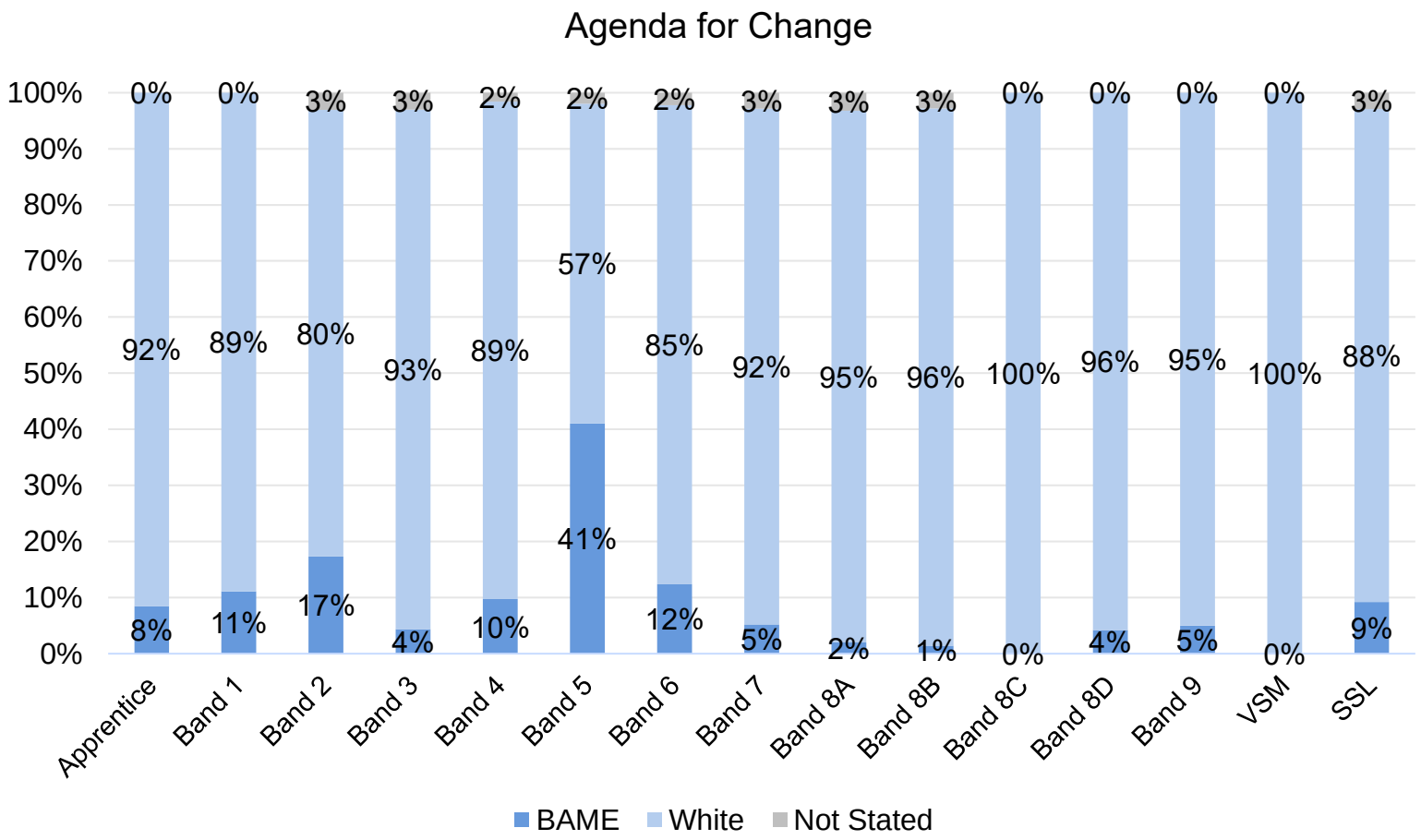


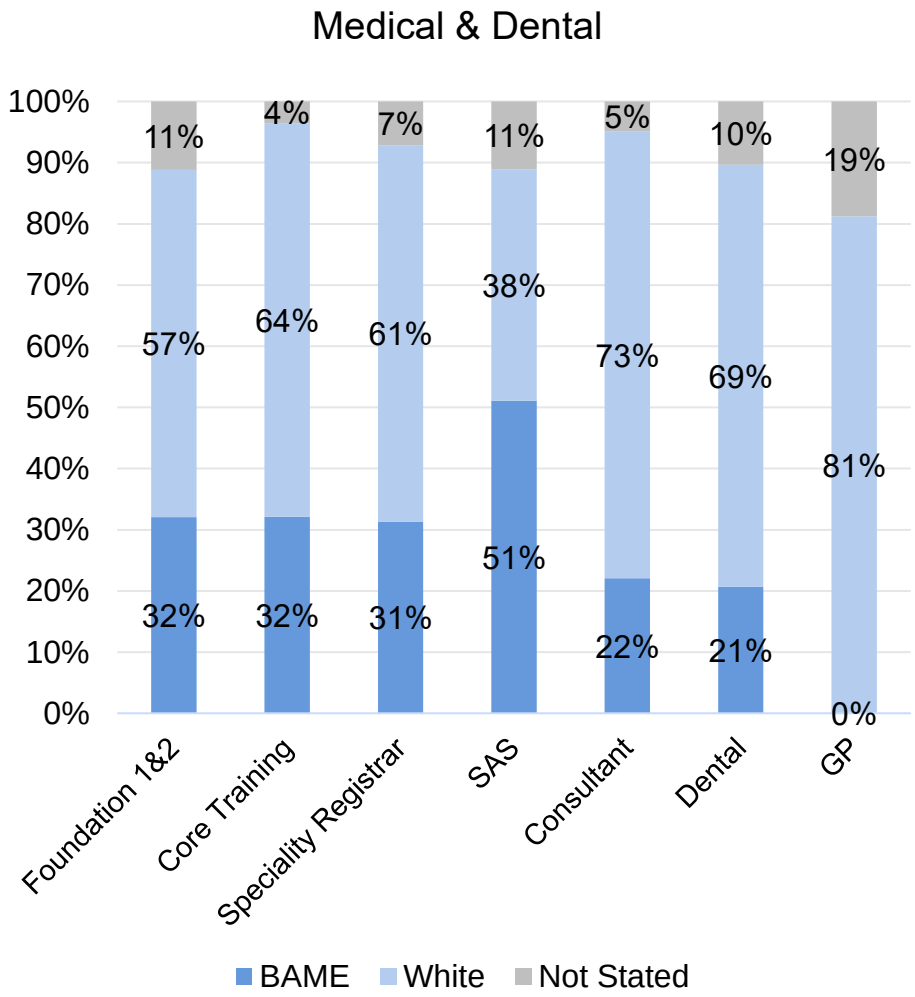
Kindness, Respect, Teamwork
Everyone, Every day

2. Workforce Profile

Race

Somerset NHS Foundation Trust

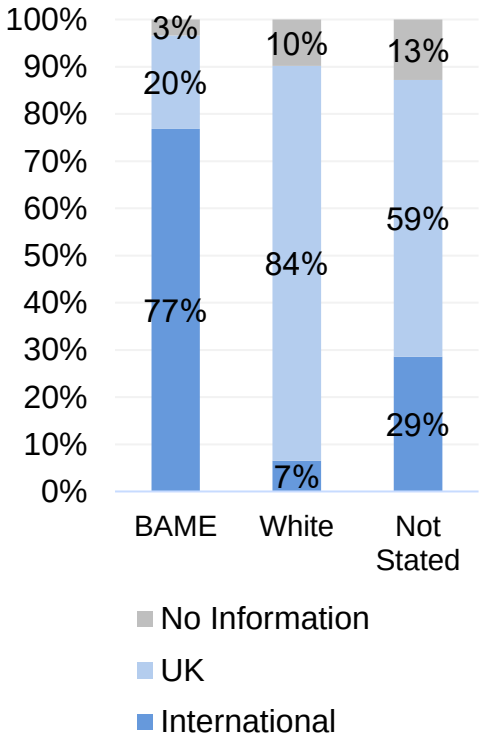




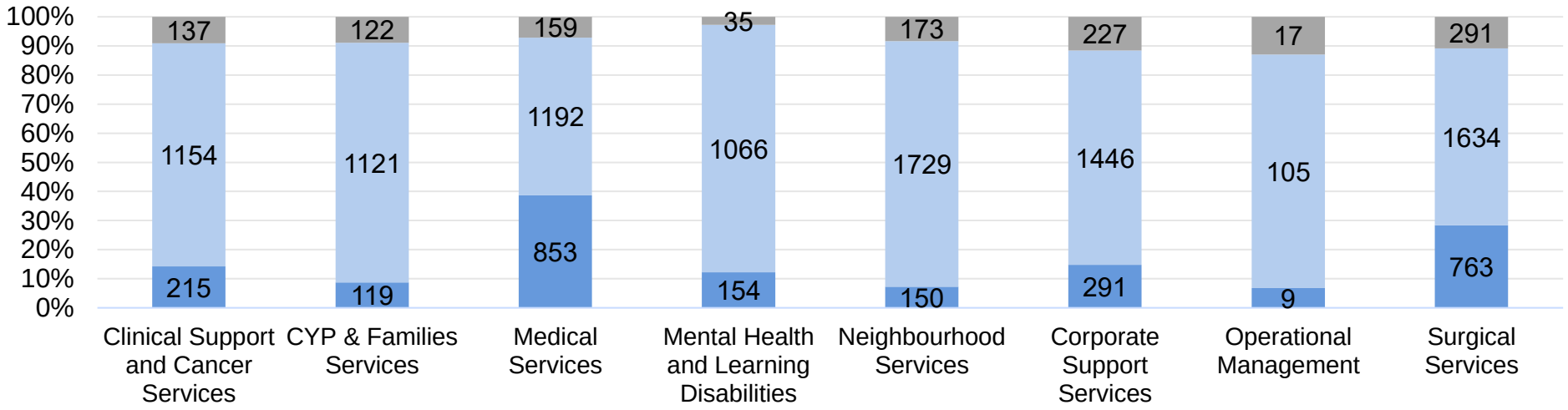
Kindness, Respect, Teamwork
Everyone, Every day

2. Workforce Profile

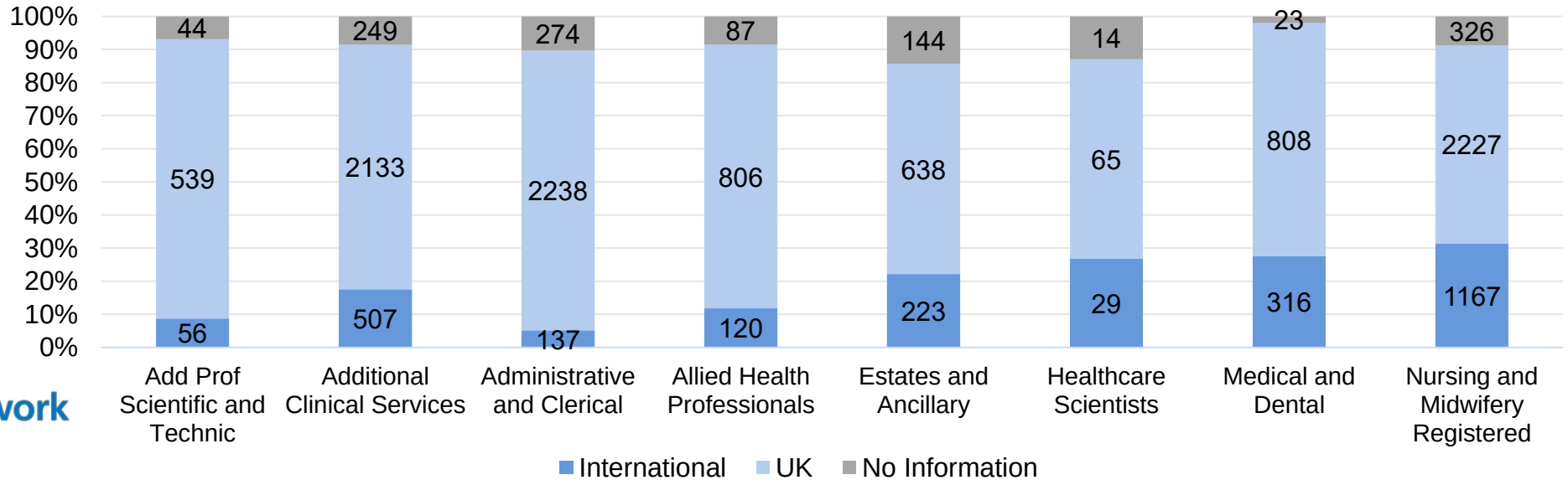
Race & Nationality



Service Group



Staff Group

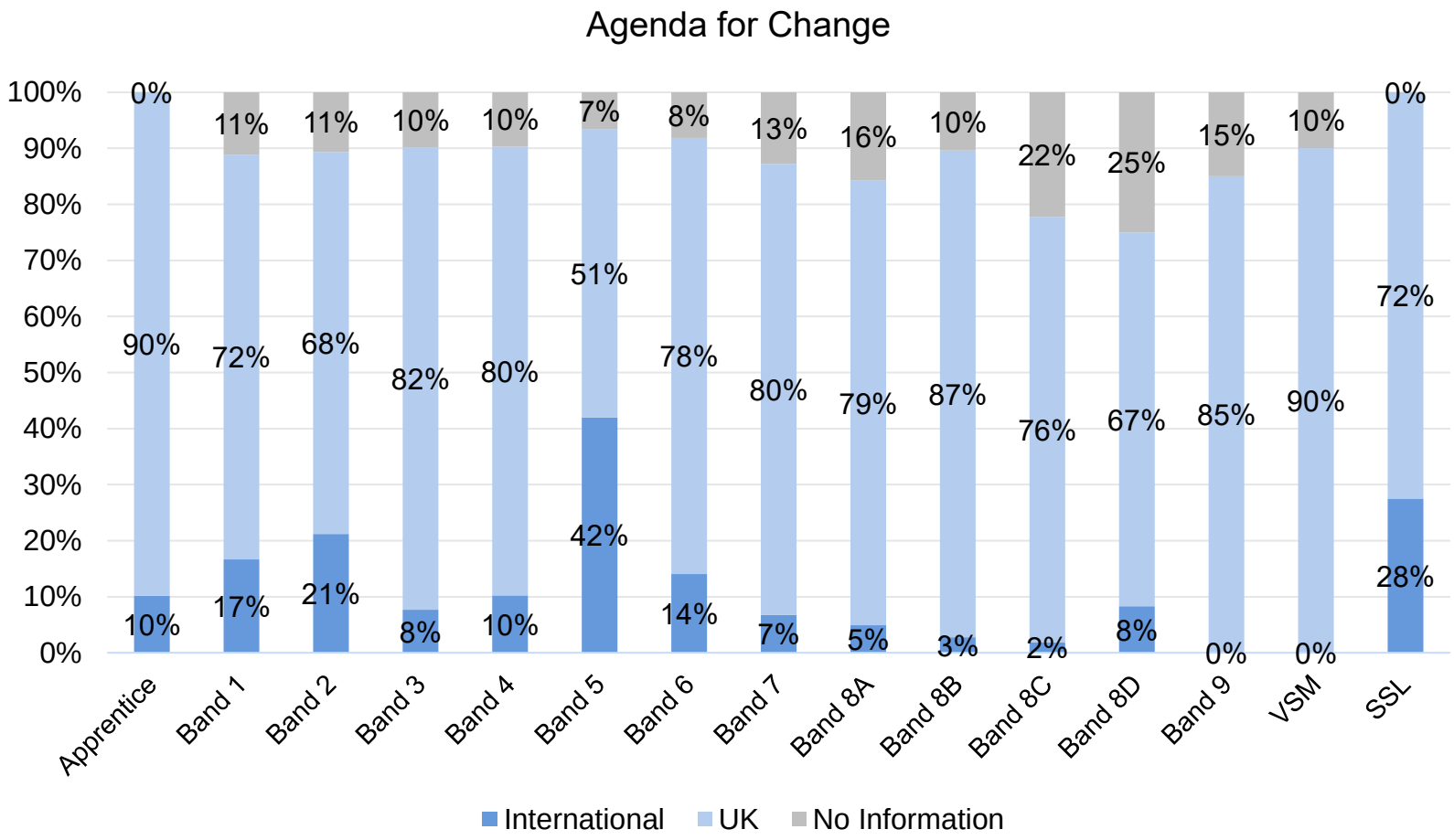


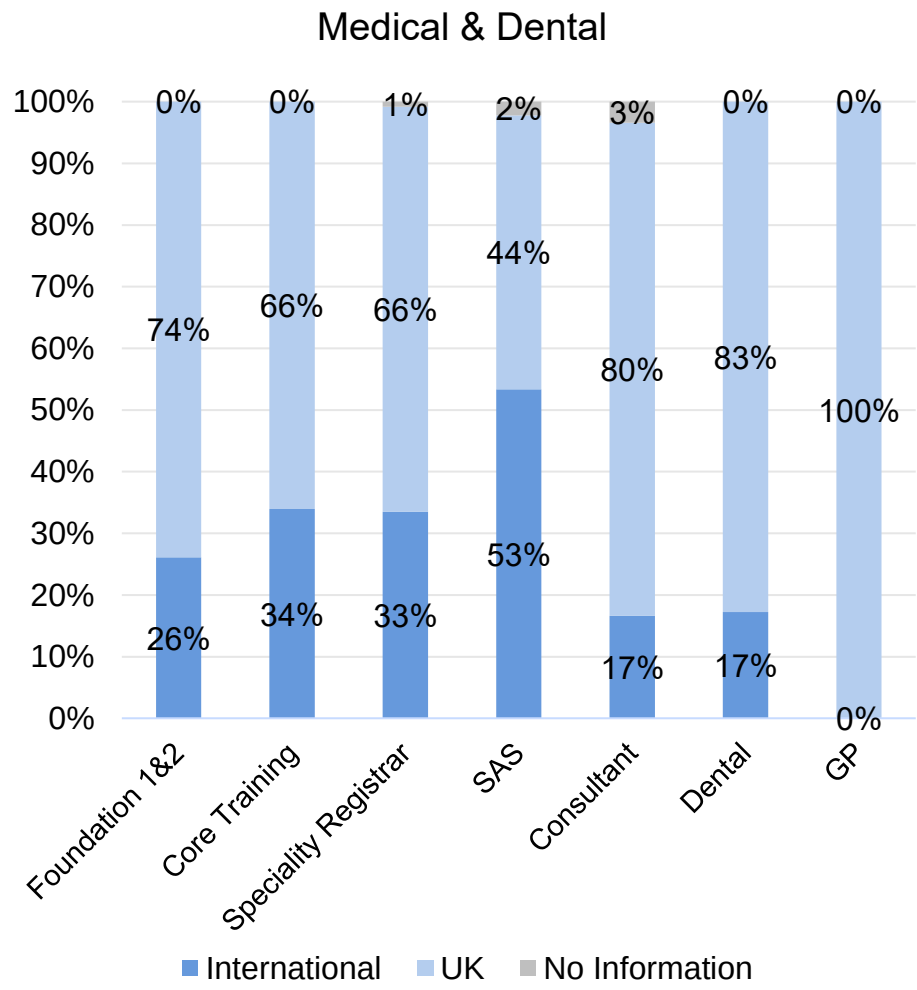
Kindness, Respect, Teamwork
Everyone, Every day

2. Workforce Profile

Race & Nationality

Somerset NHS Foundation Trust



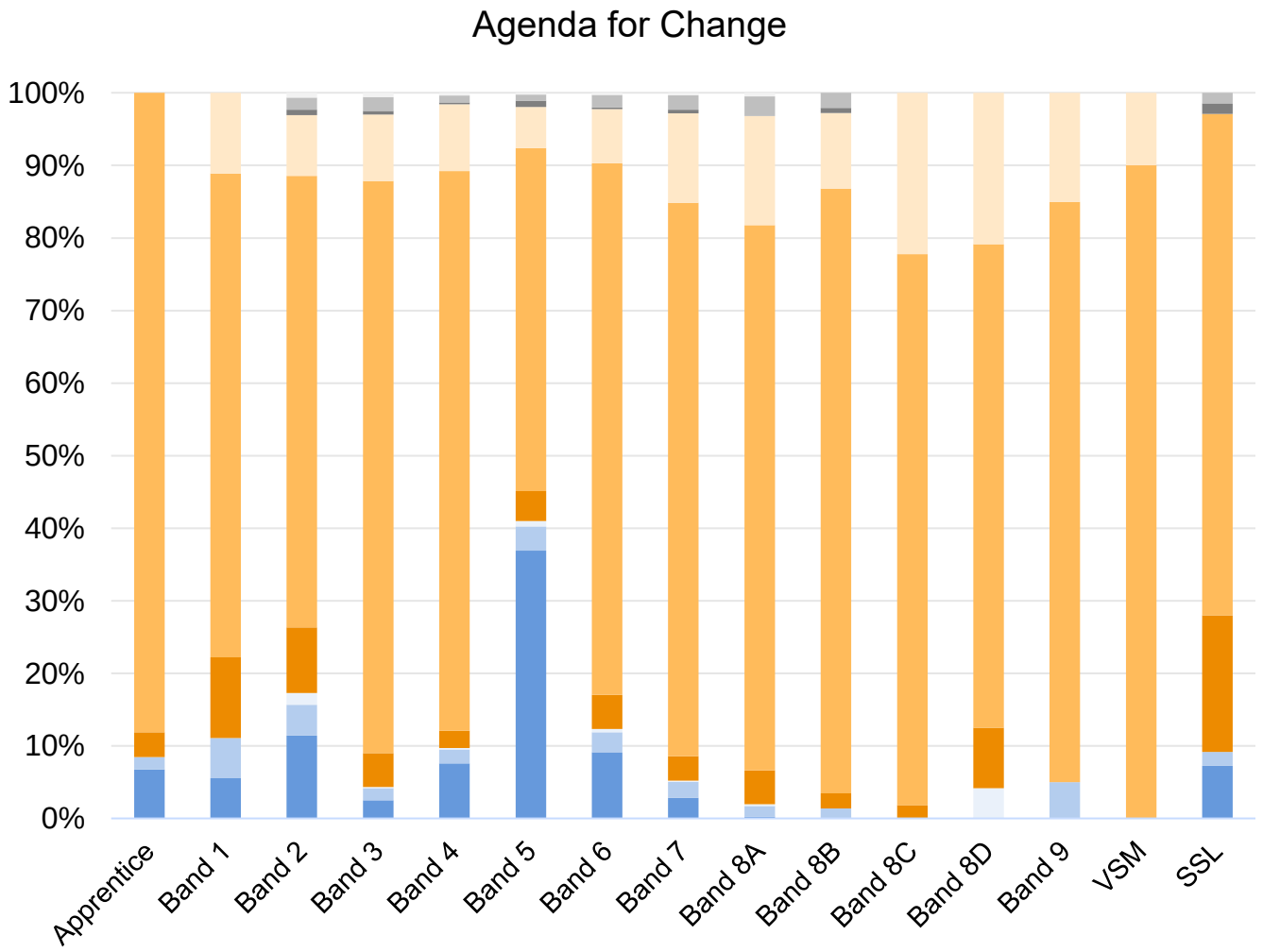


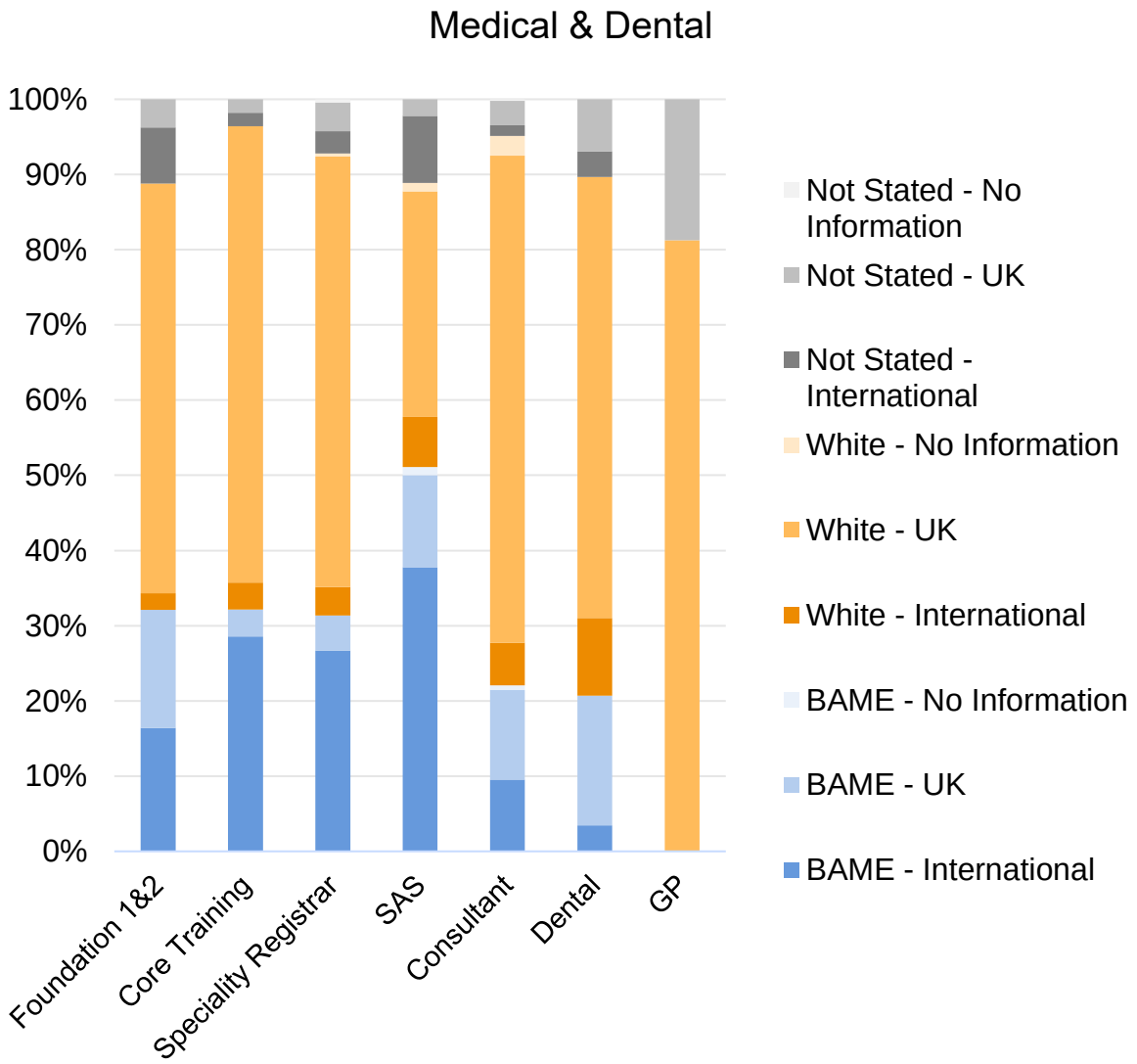
Kindness, Respect, Teamwork
Everyone, Every day

2. Workforce Profile

Race & Nationality

Somerset NHS Foundation Trust

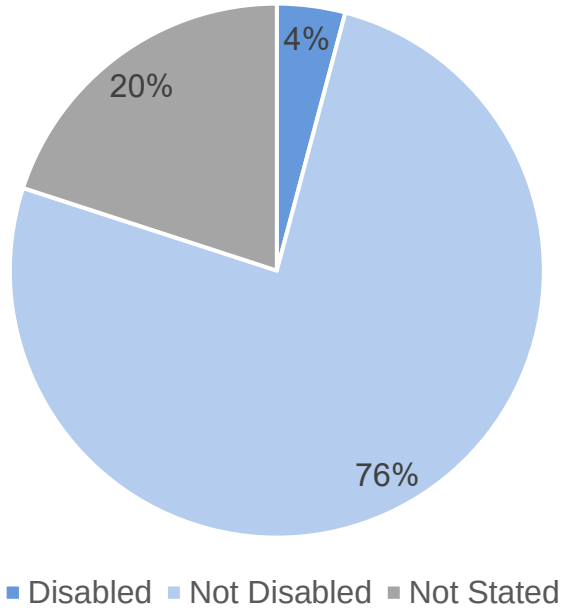


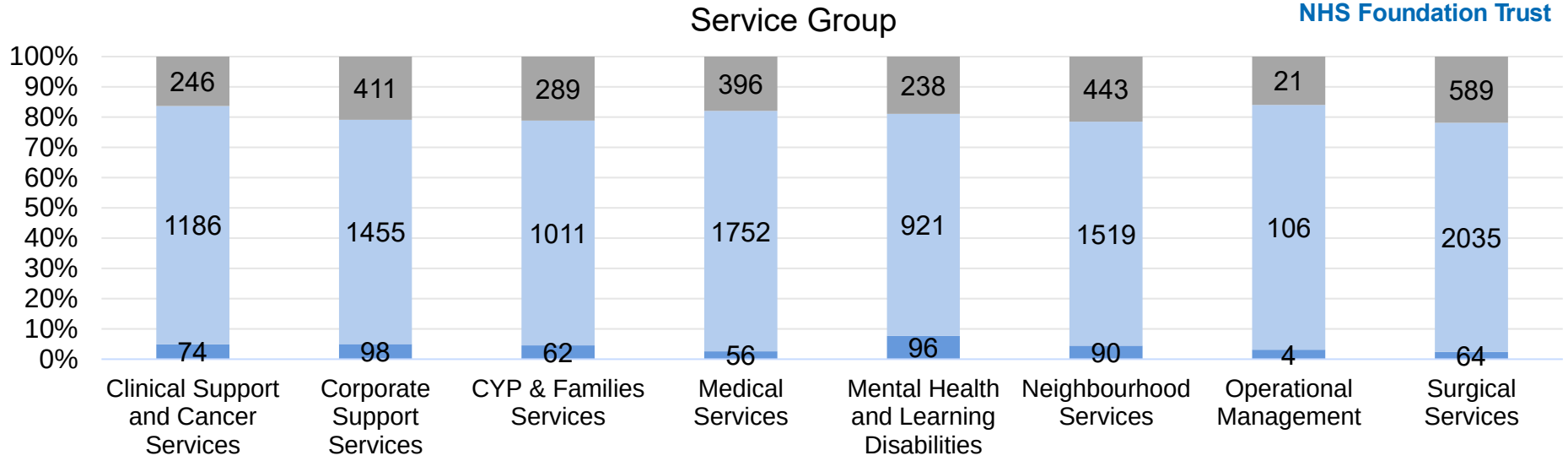


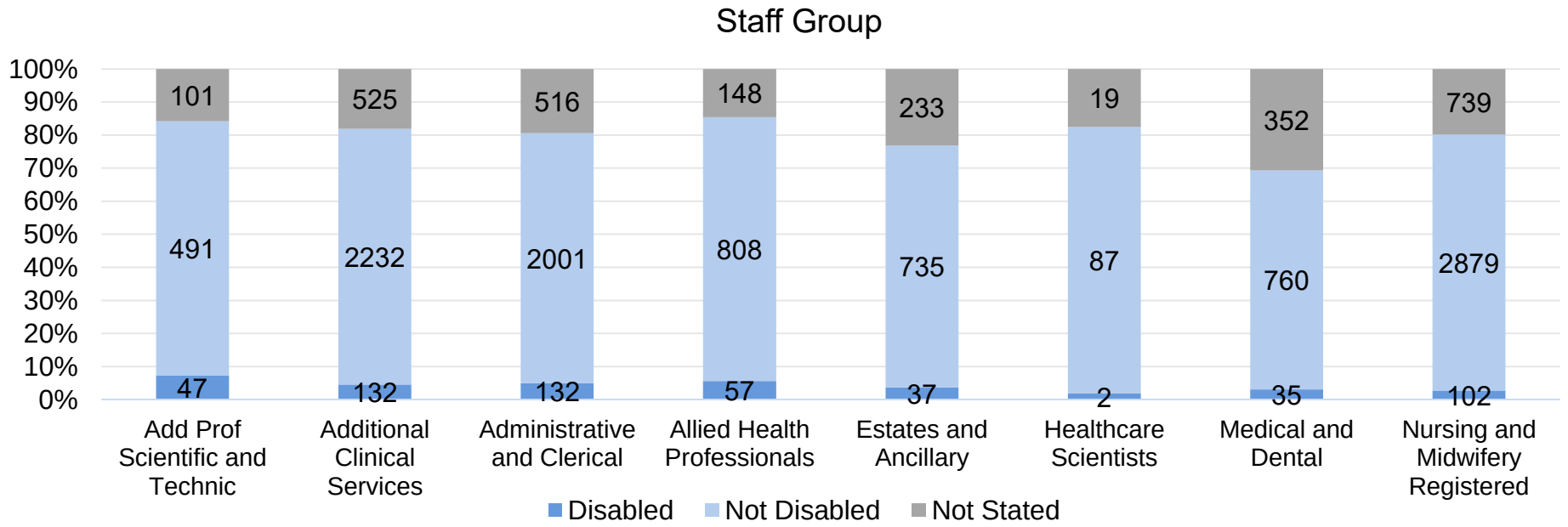
Kindness, Respect, Teamwork
Everyone, Every day

2. Workforce Profile

Disability





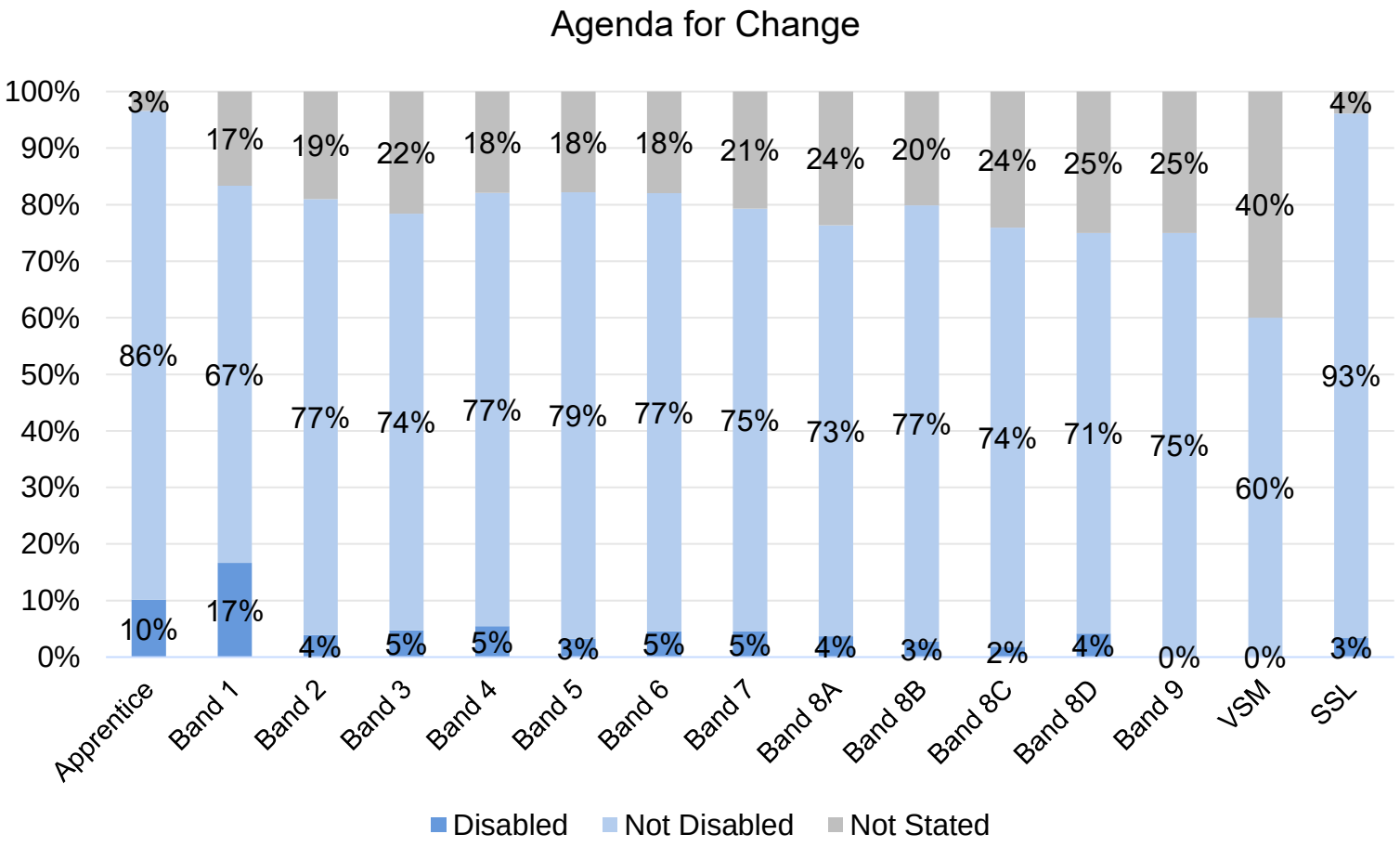


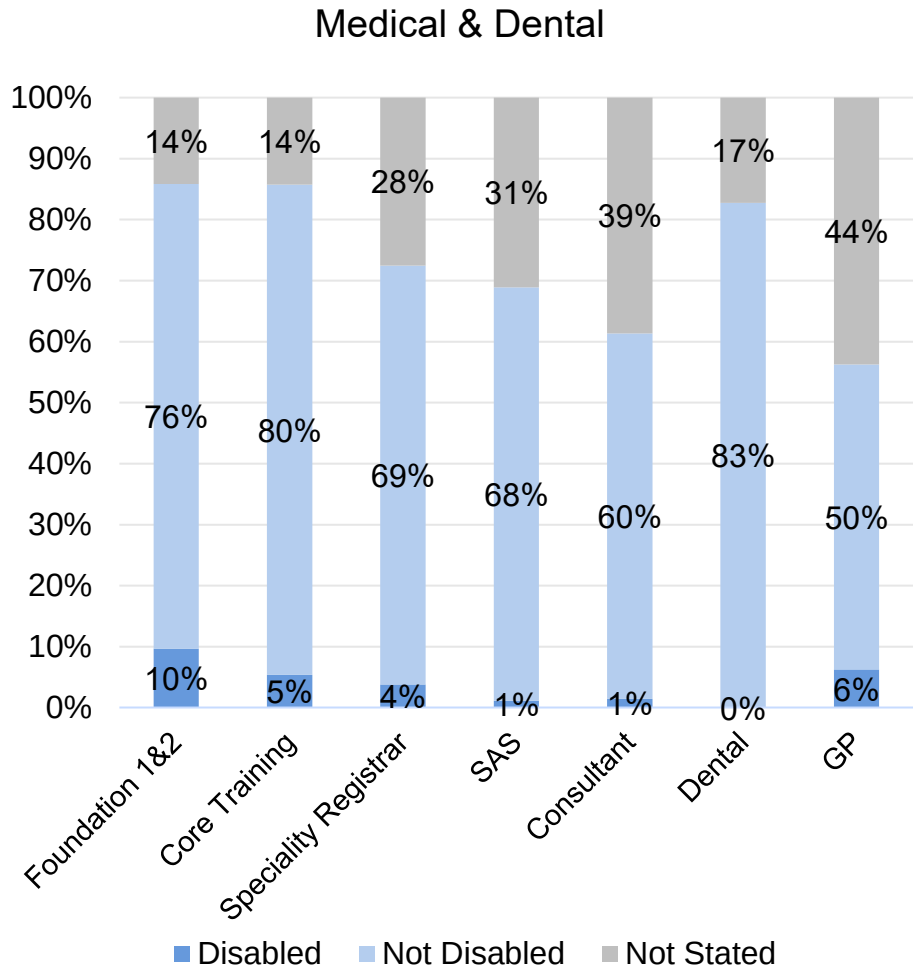
Kindness, Respect, Teamwork
Everyone, Every day

2. Workforce Profile

Disability

Somerset NHS Foundation Trust



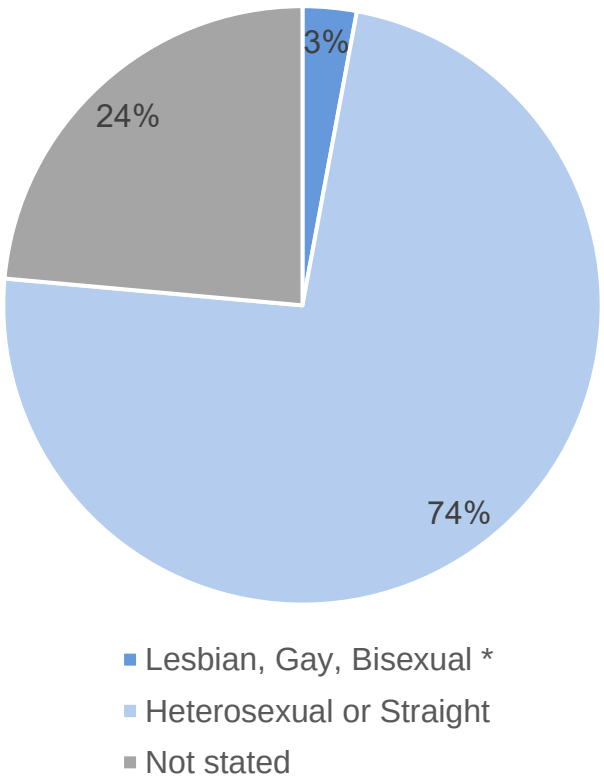


Kindness, Respect, Teamwork
Everyone, Every day

2. Workforce Profile

Sexuality

Somerset NHS Foundation Trust

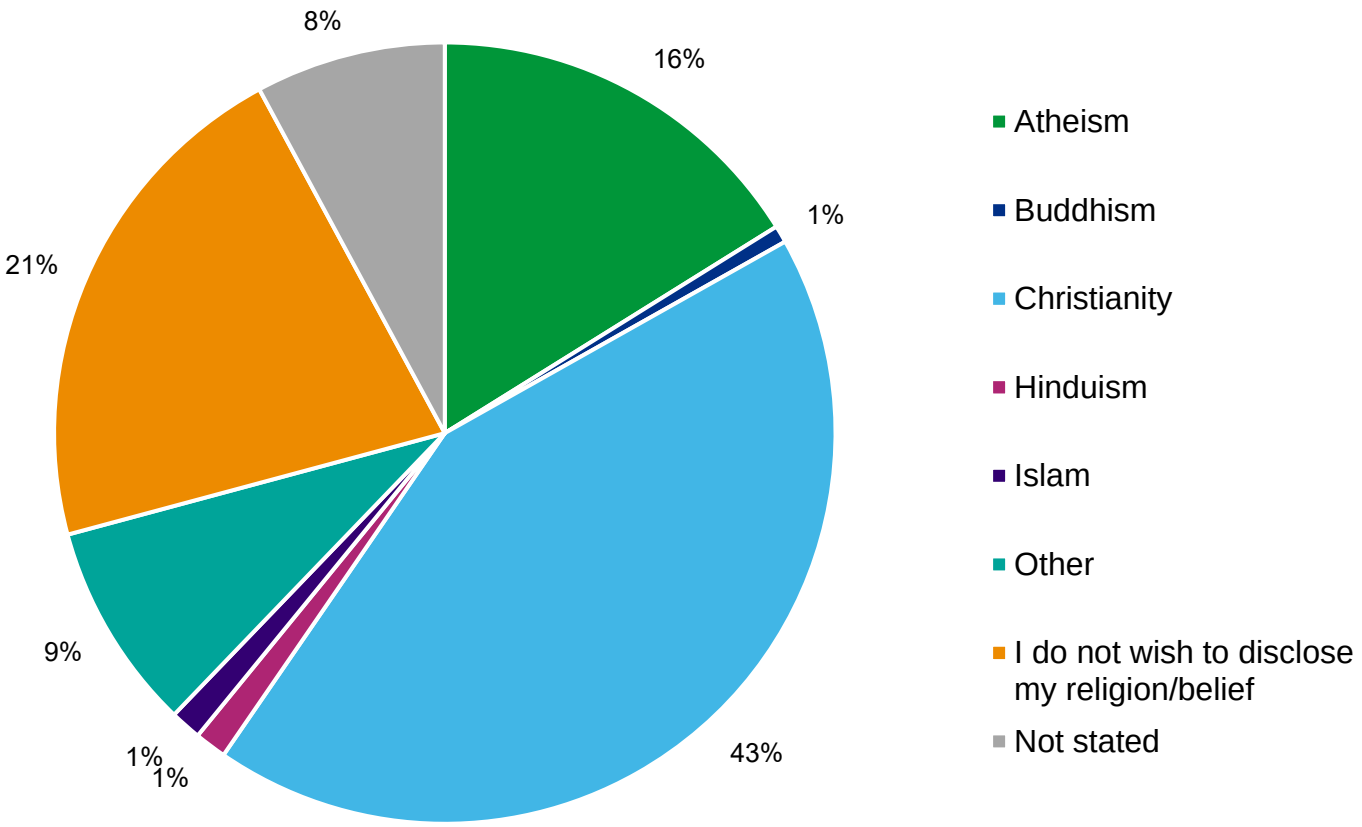


Kindness, Respect, Teamwork
Everyone, Every day

* Also includes a small number of people who selected ‘undecided’ and ‘other sexuality’

2. Workforce Profile

Religion & Belief

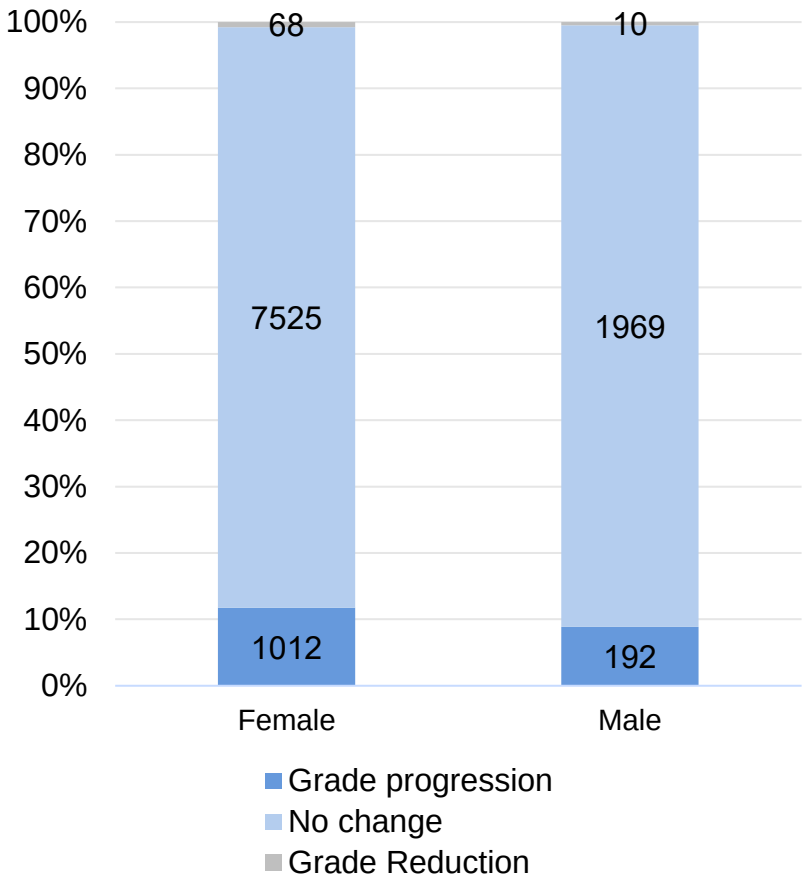


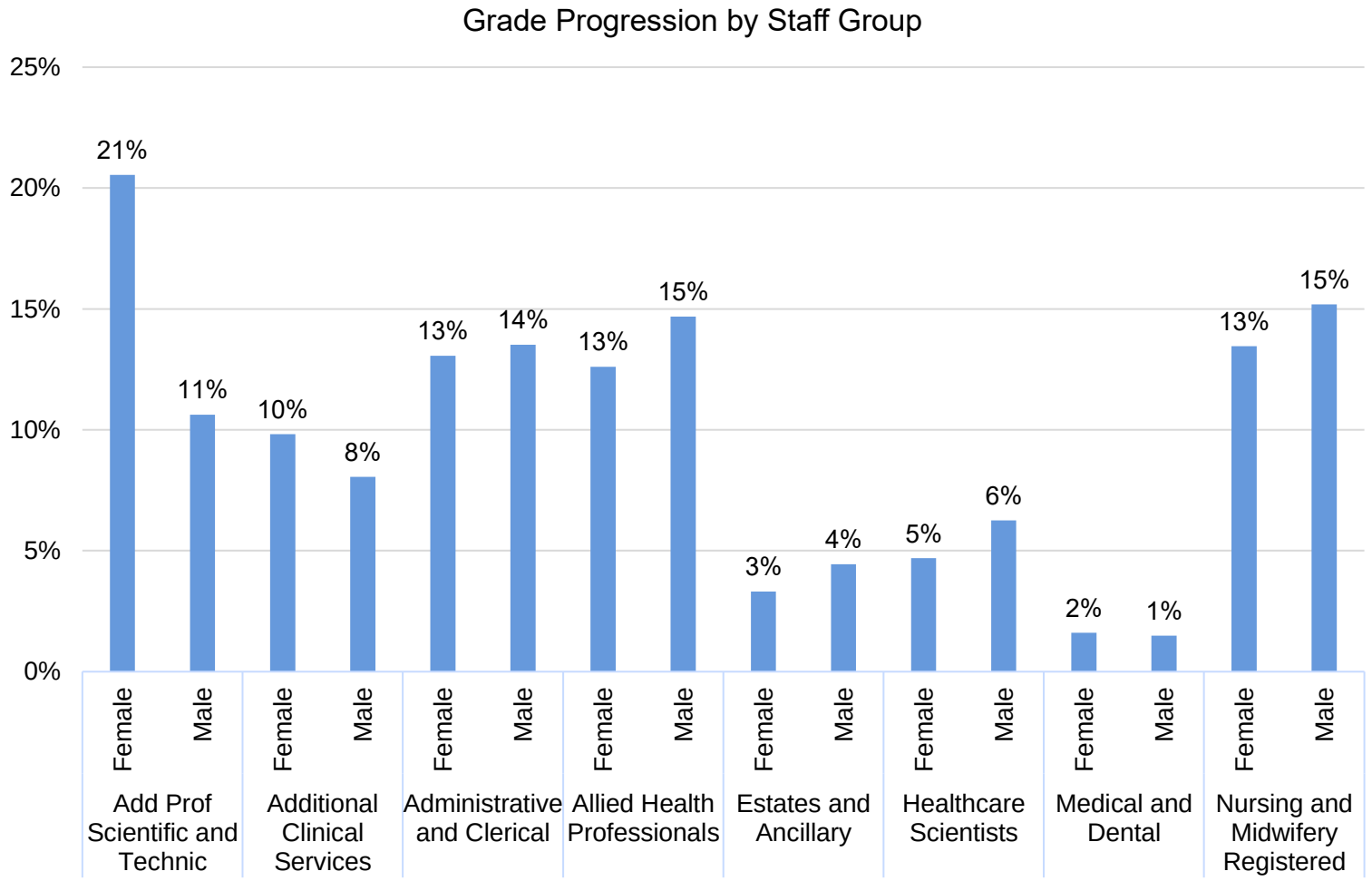
Somerset NHS Foundation Trust

Kindness, Respect, Teamwork
Everyone, Every day

3. Progression

Gender





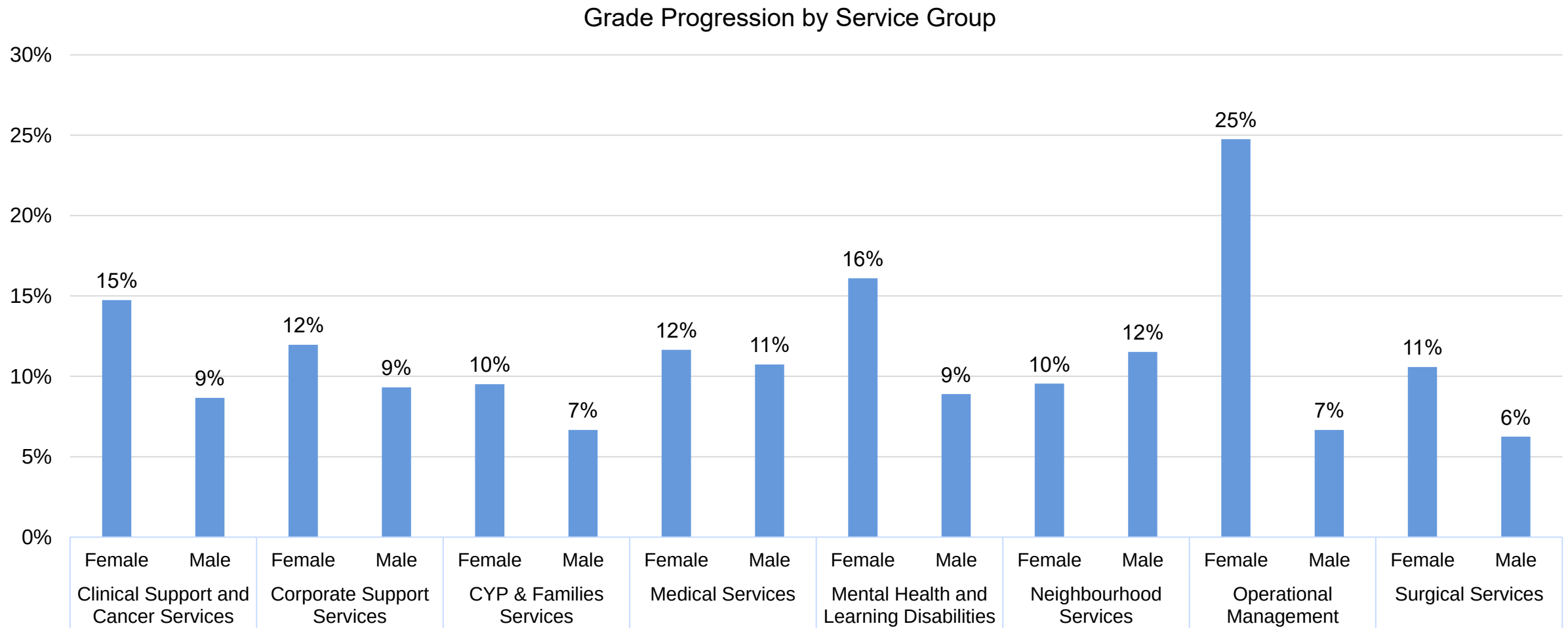
Somerset NHS Foundation Trust

Kindness, Respect, Teamwork
Everyone, Every day

3. Progression

Gender

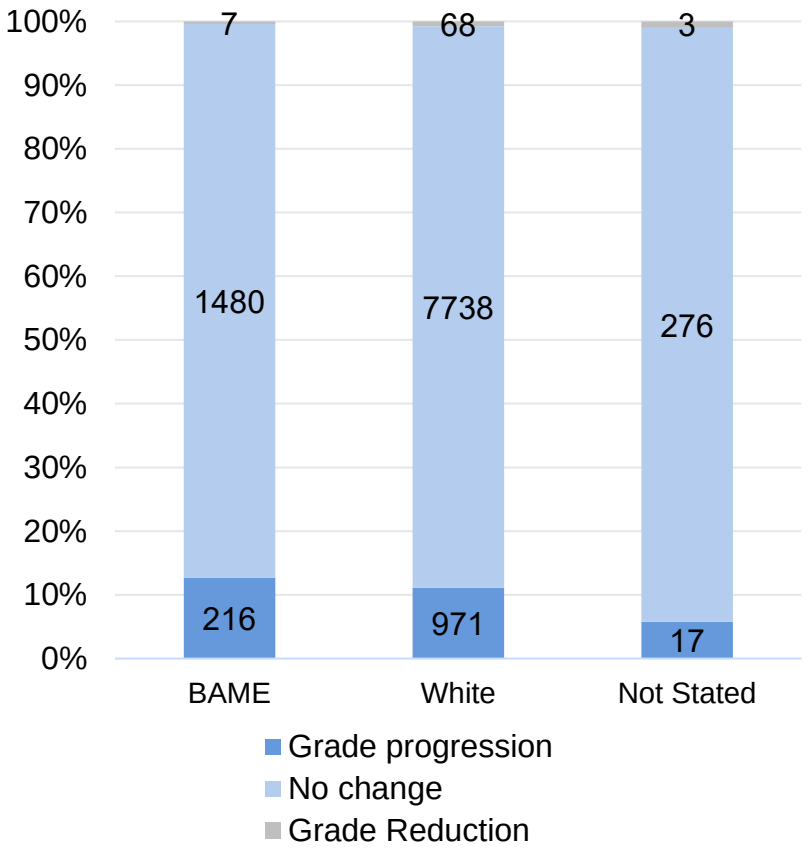
NHS Somerset NHS Foundation Trust

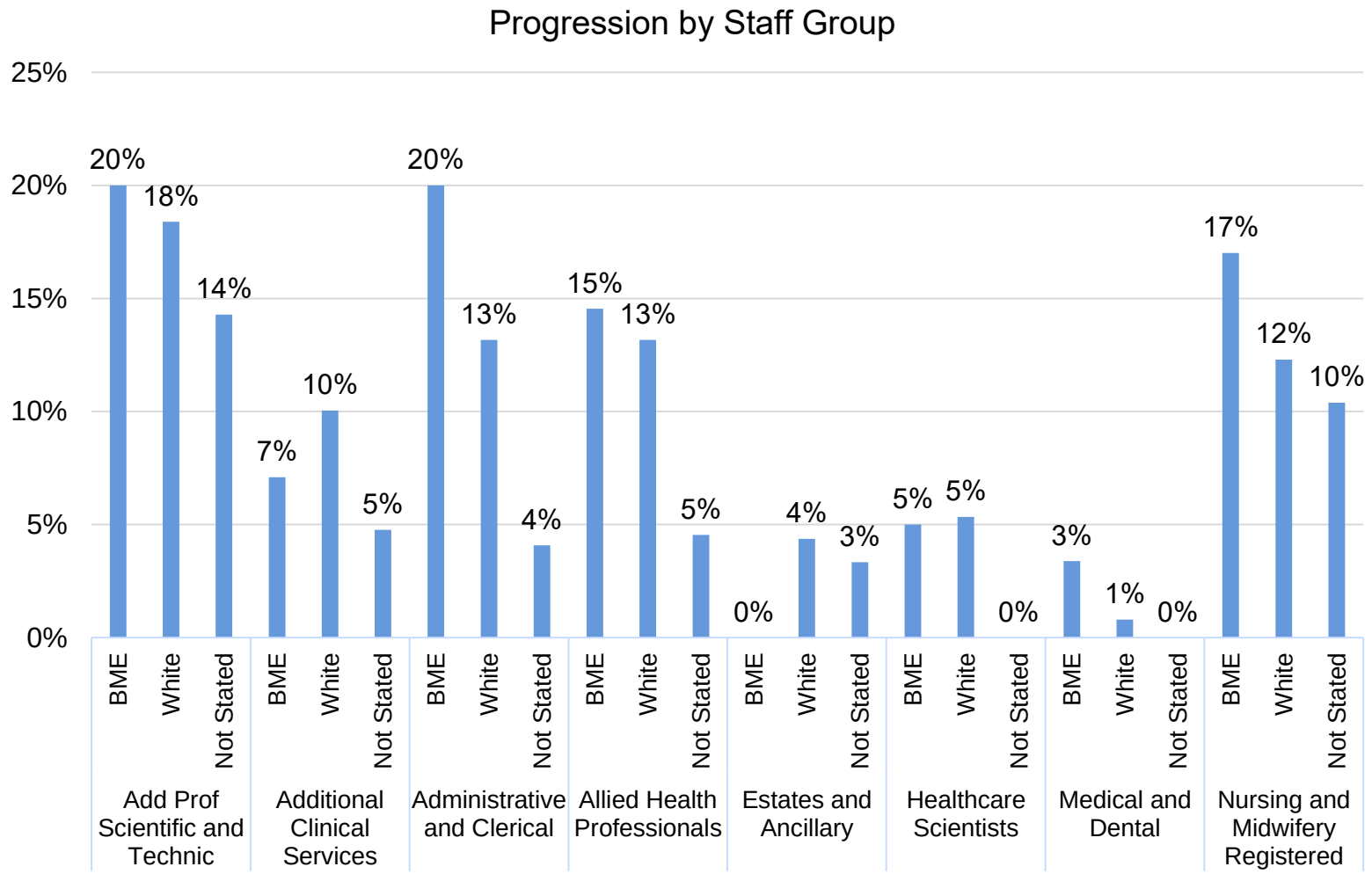


Kindness, Respect, Teamwork
Everyone, Every day

3. Progression

Race



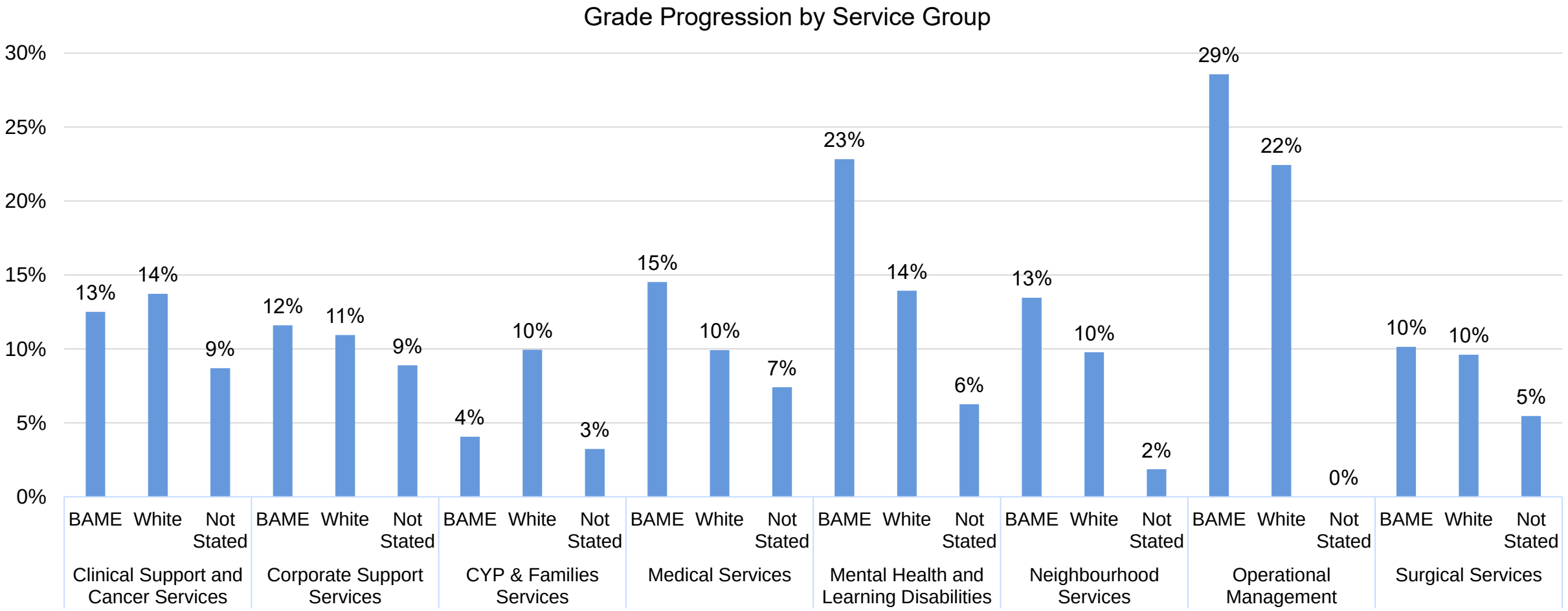


Kindness, Respect, Teamwork
Everyone, Every day

3. Progression

Race

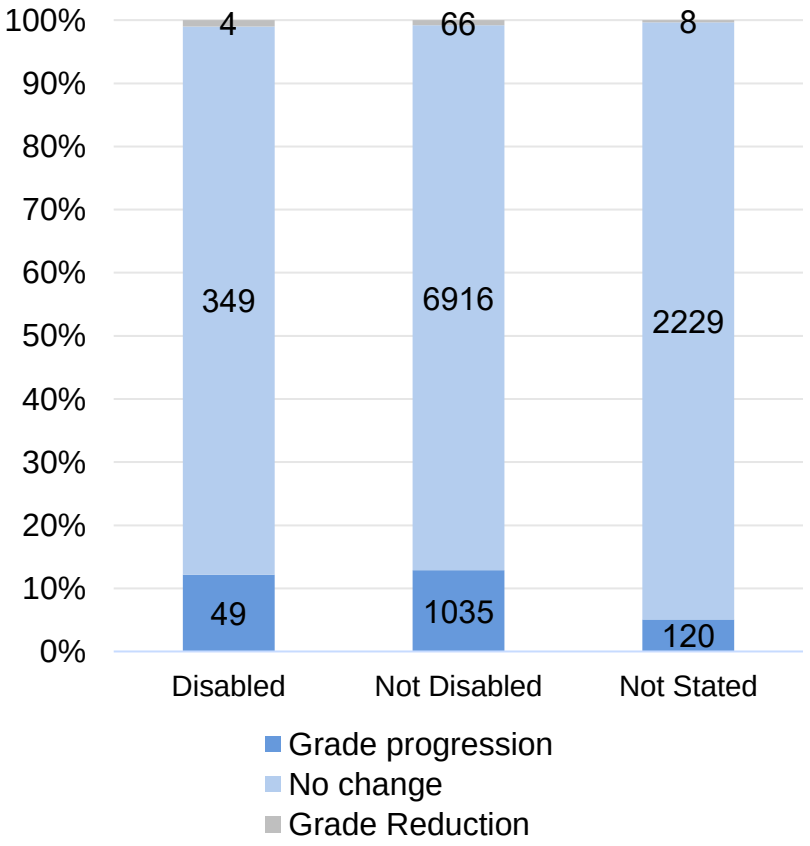
Somerset NHS Foundation Trust

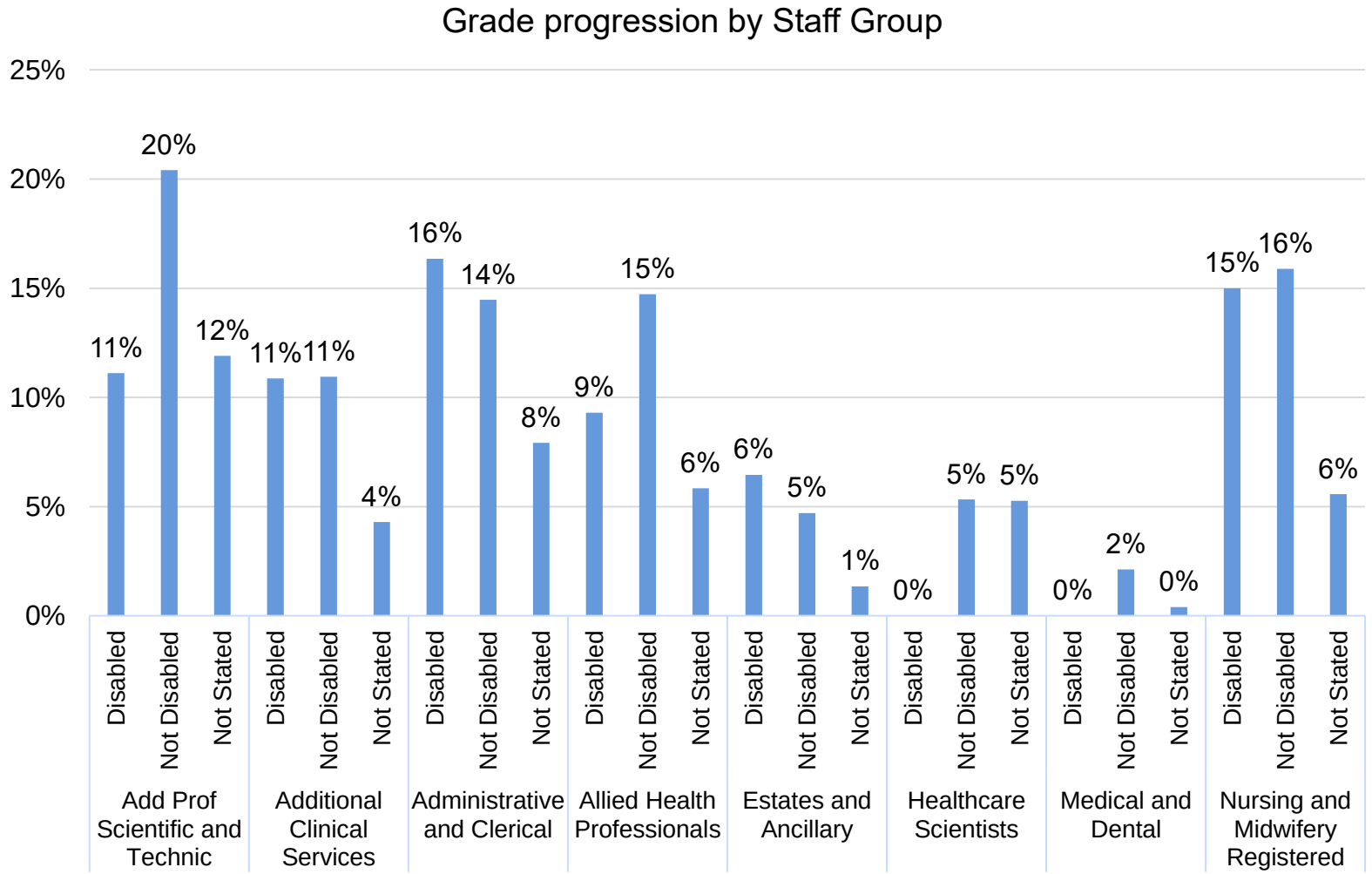


Kindness, Respect, Teamwork
Everyone, Every day

3. Progression

Disability



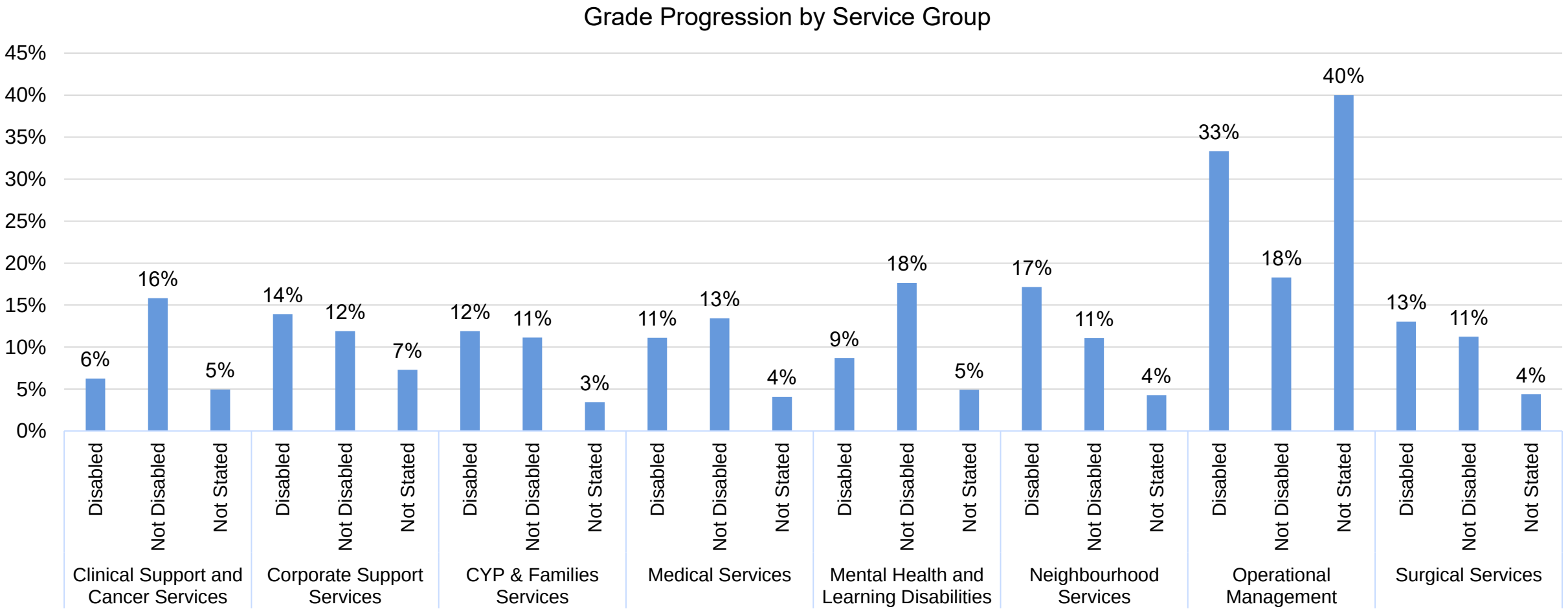


Kindness, Respect, Teamwork
Everyone, Every day

3. Progression

Disability

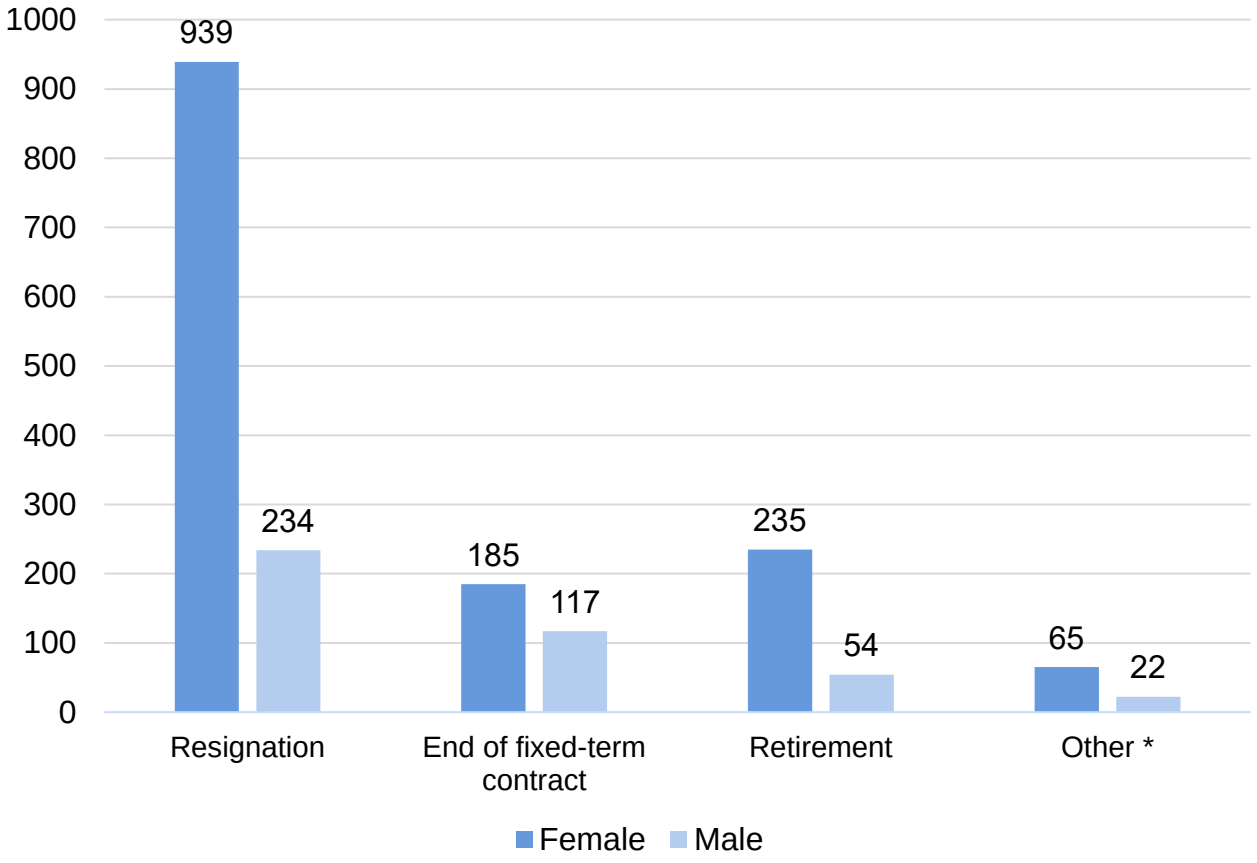
Somerset NHS Foundation Trust

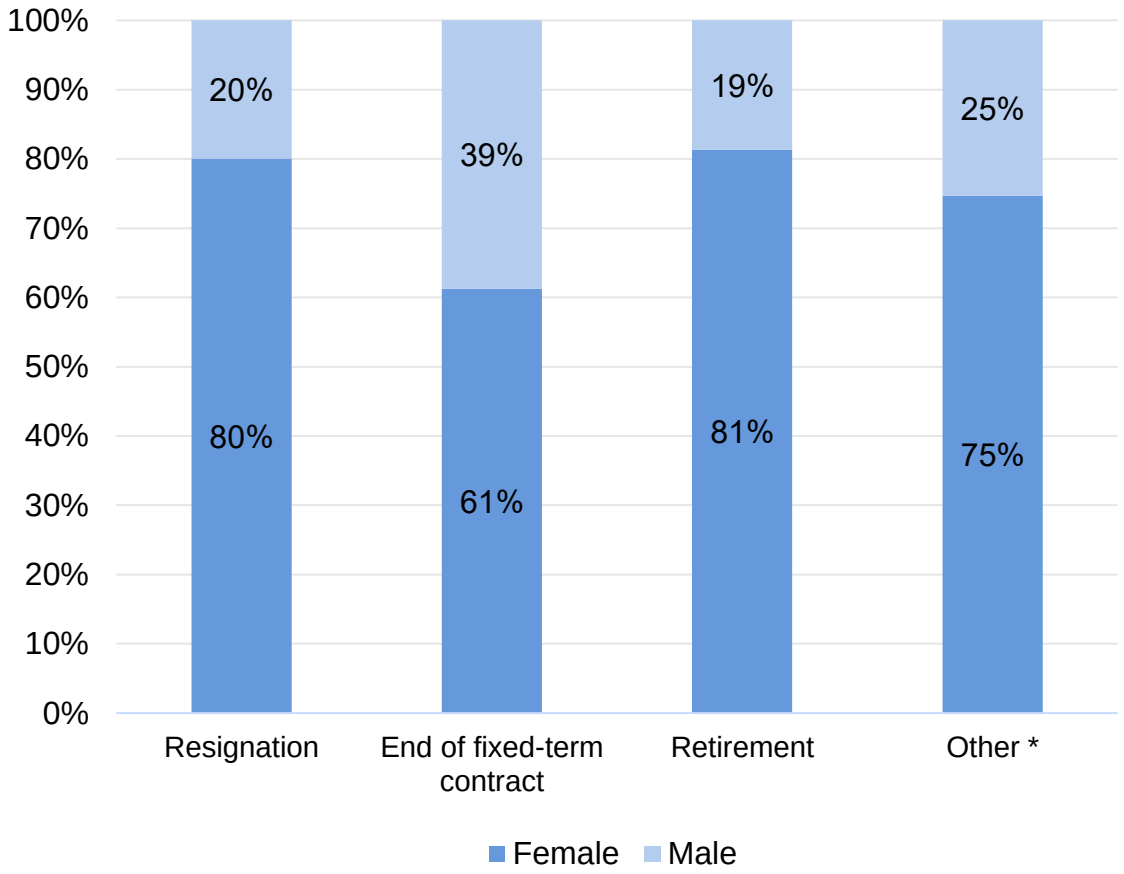


Kindness, Respect, Teamwork
Everyone, Every day

4. Leavers

Gender



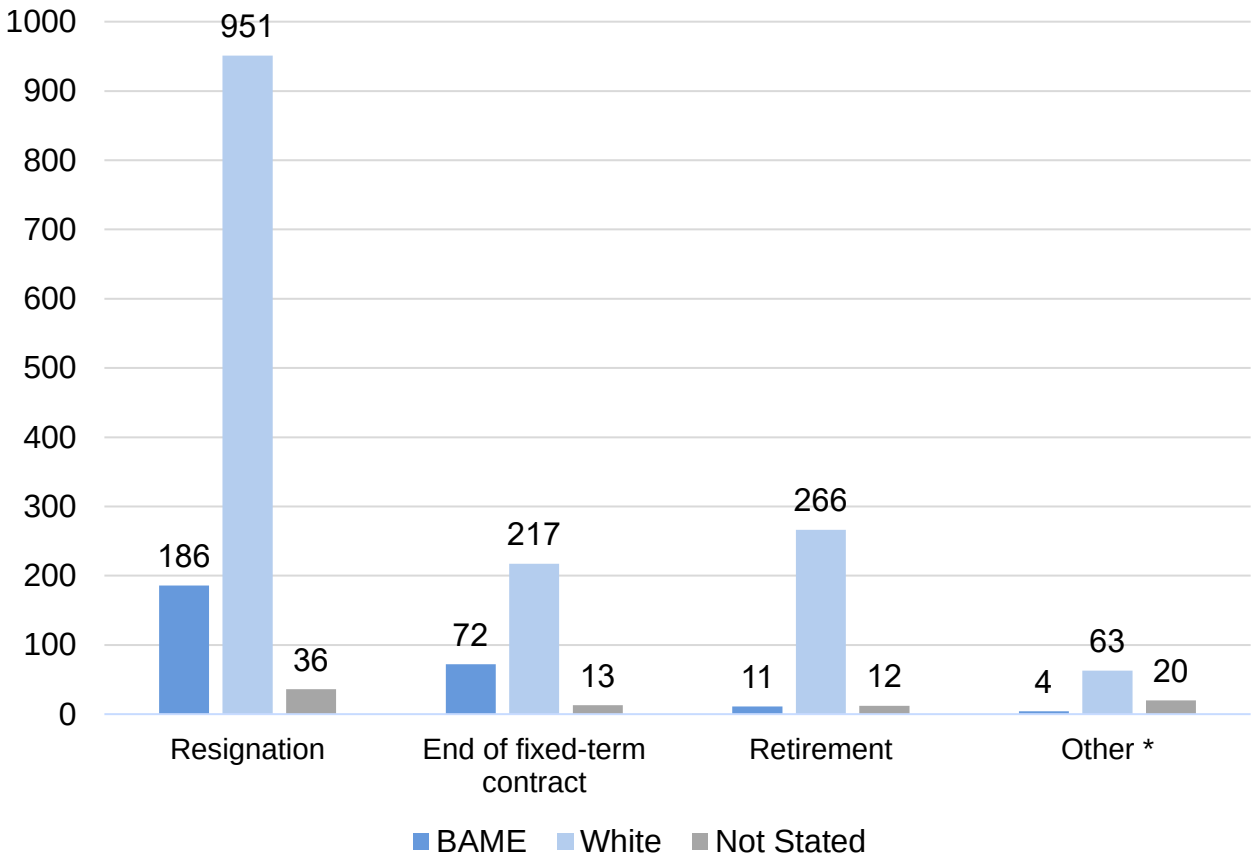


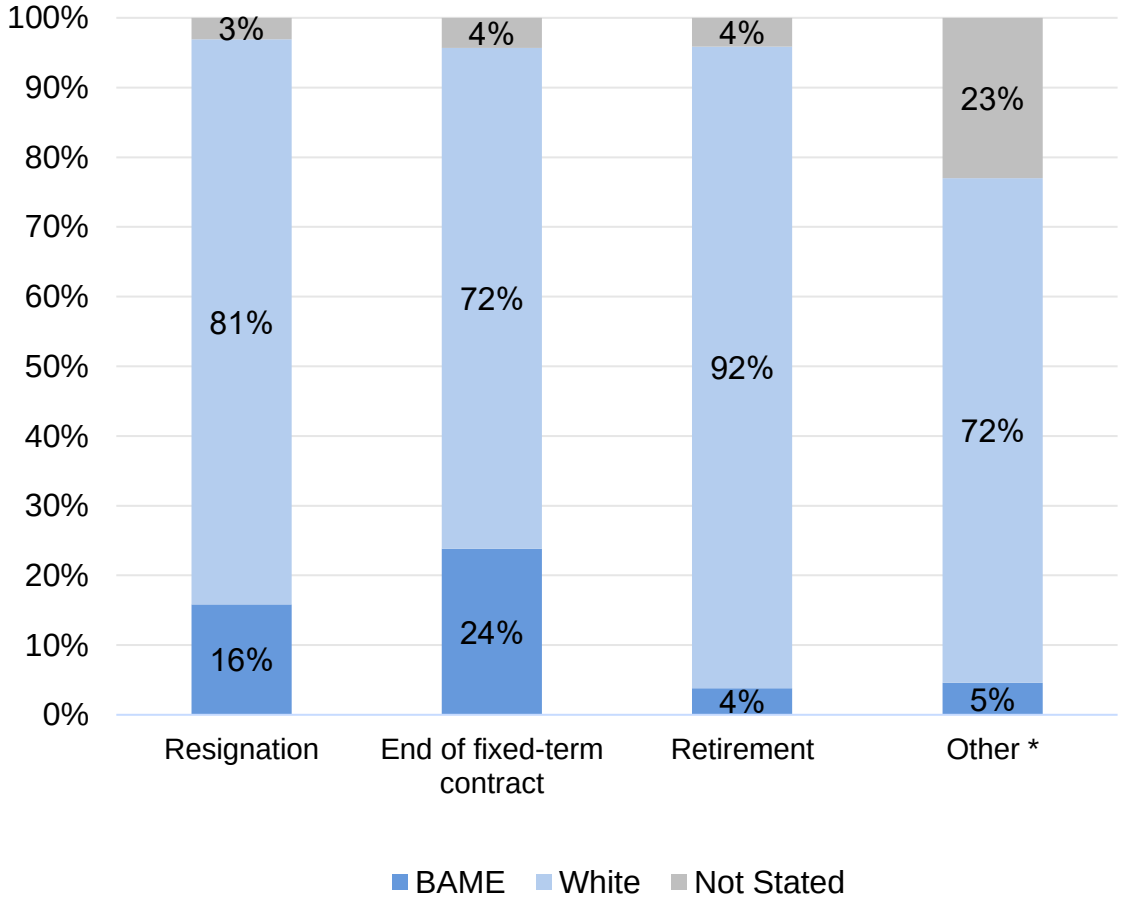
Kindness, Respect, Teamwork
Everyone, Every day

* Other includes Redundancy, Dismissal, Transfer, and Death in Service

4. Leavers

Race



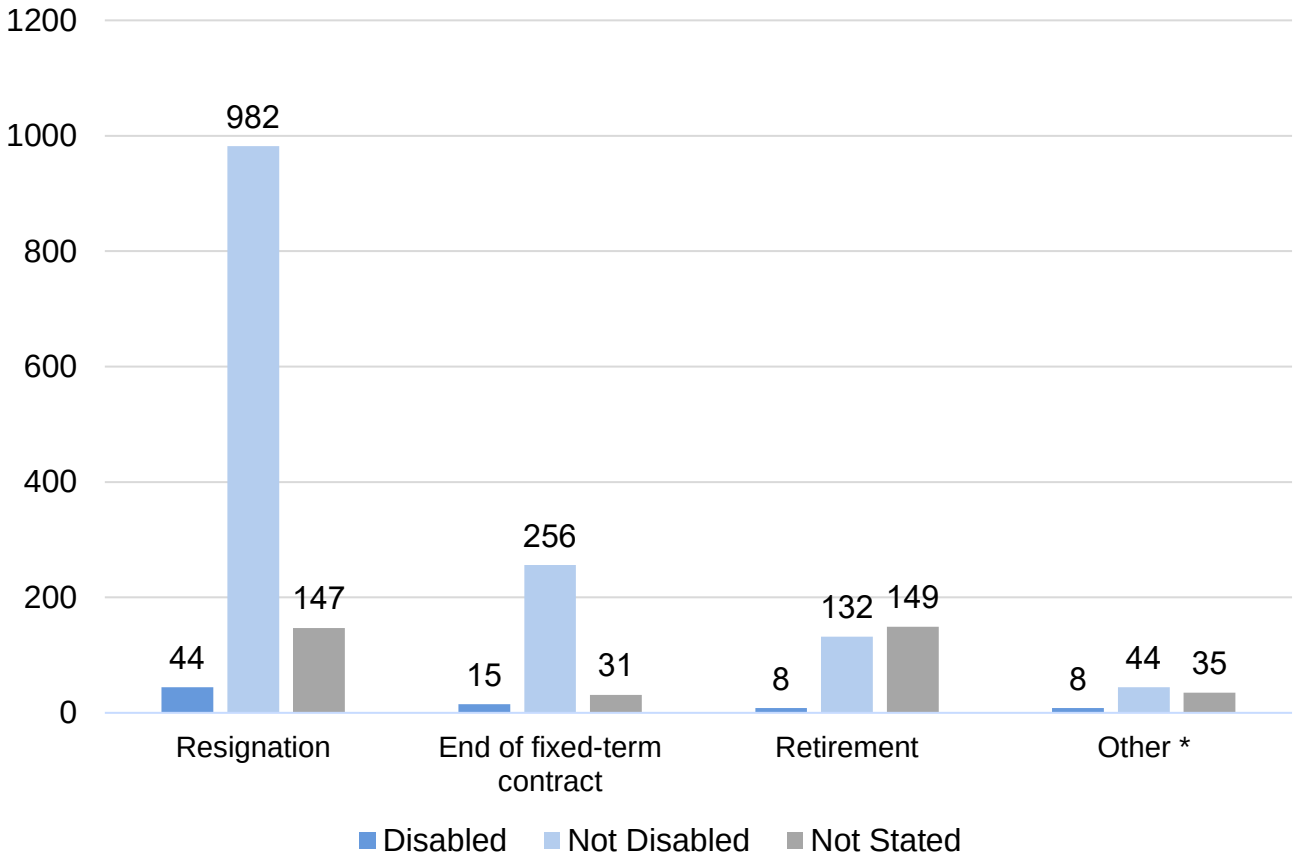


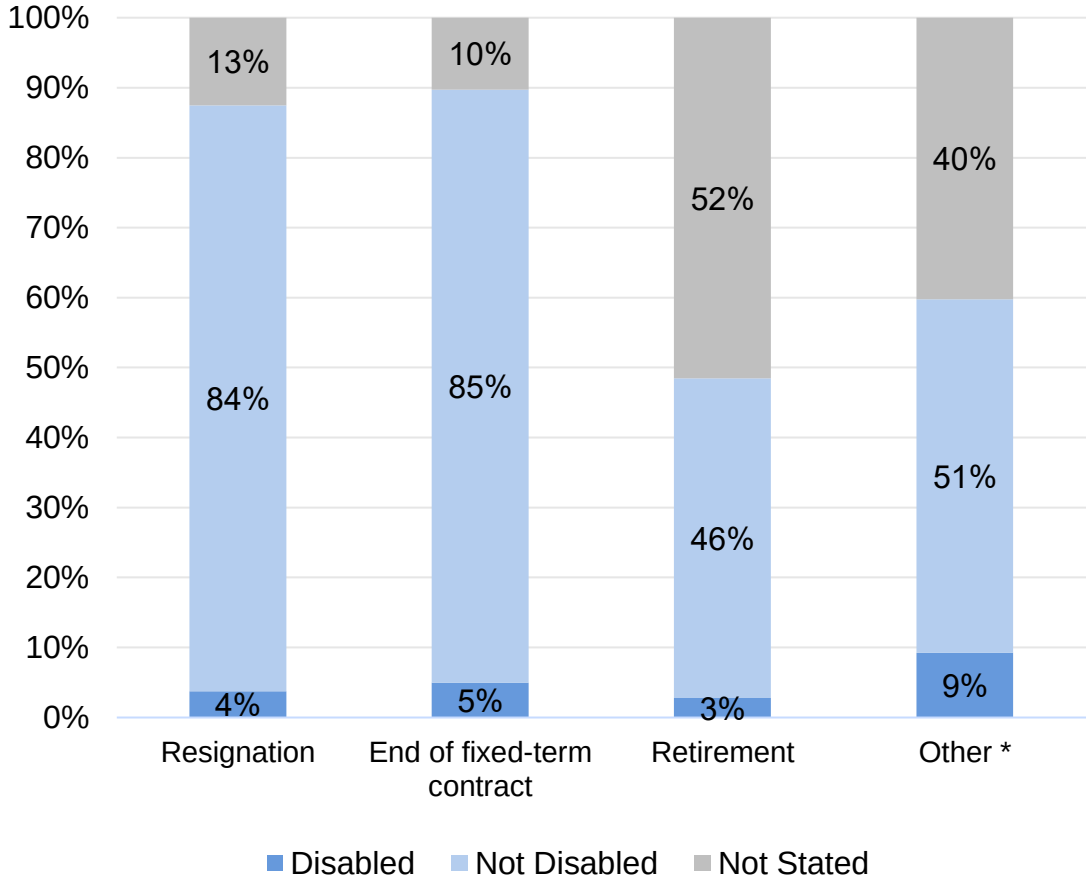
Kindness, Respect, Teamwork
Everyone, Every day

* Other includes Redundancy, Dismissal, Transfer, and Death in Service

4. Leavers

Disability





Kindness, Respect, Teamwork
Everyone, Every day

* Other includes Redundancy, Dismissal, Transfer, and Death in Service

5. Pay Gaps

GENDER & RACE

NHS Somerset NHS Foundation Trust

Gender

Mean: 26.2%

Median: 43.9%

Race

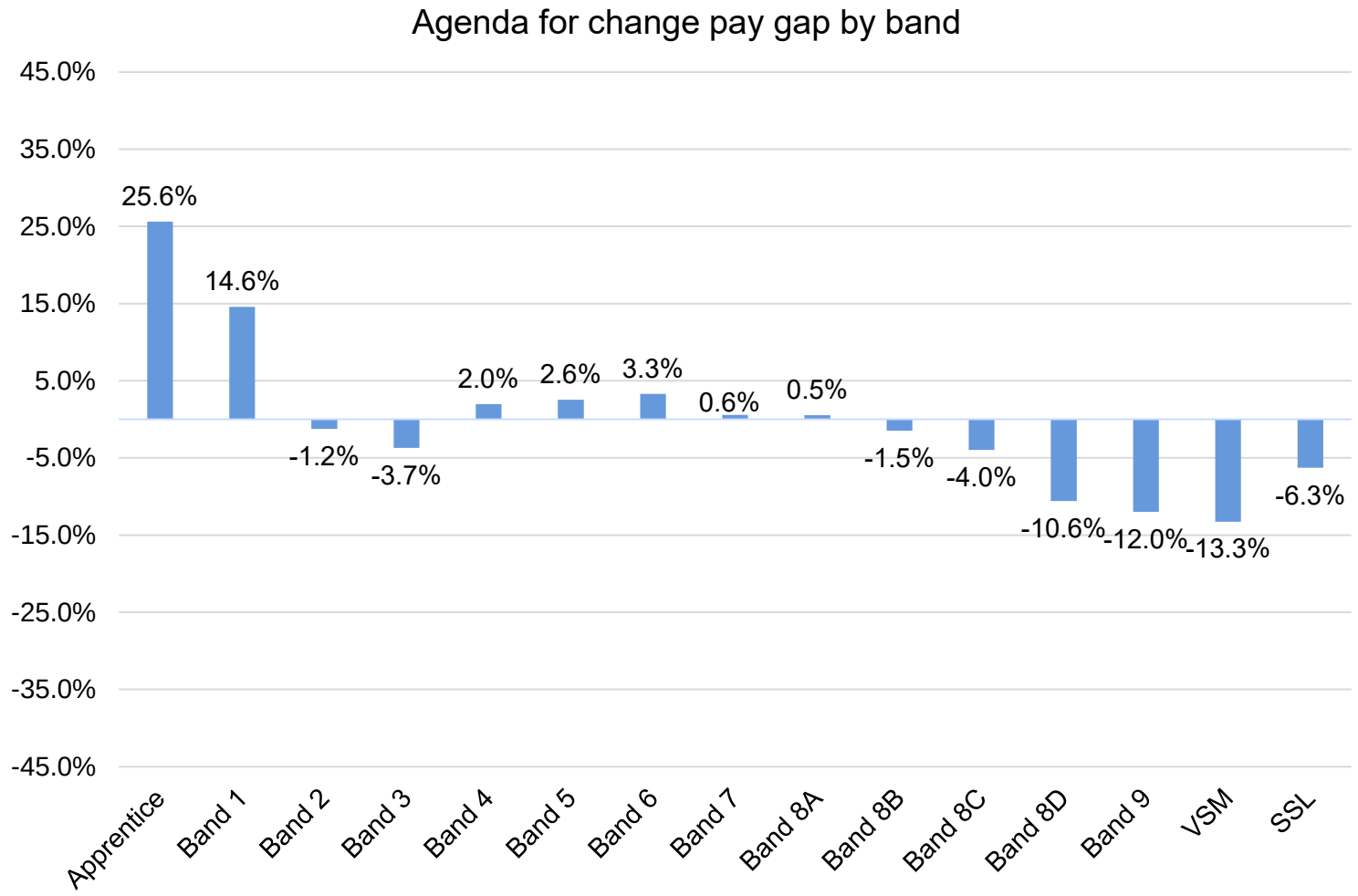
Mean: +18%

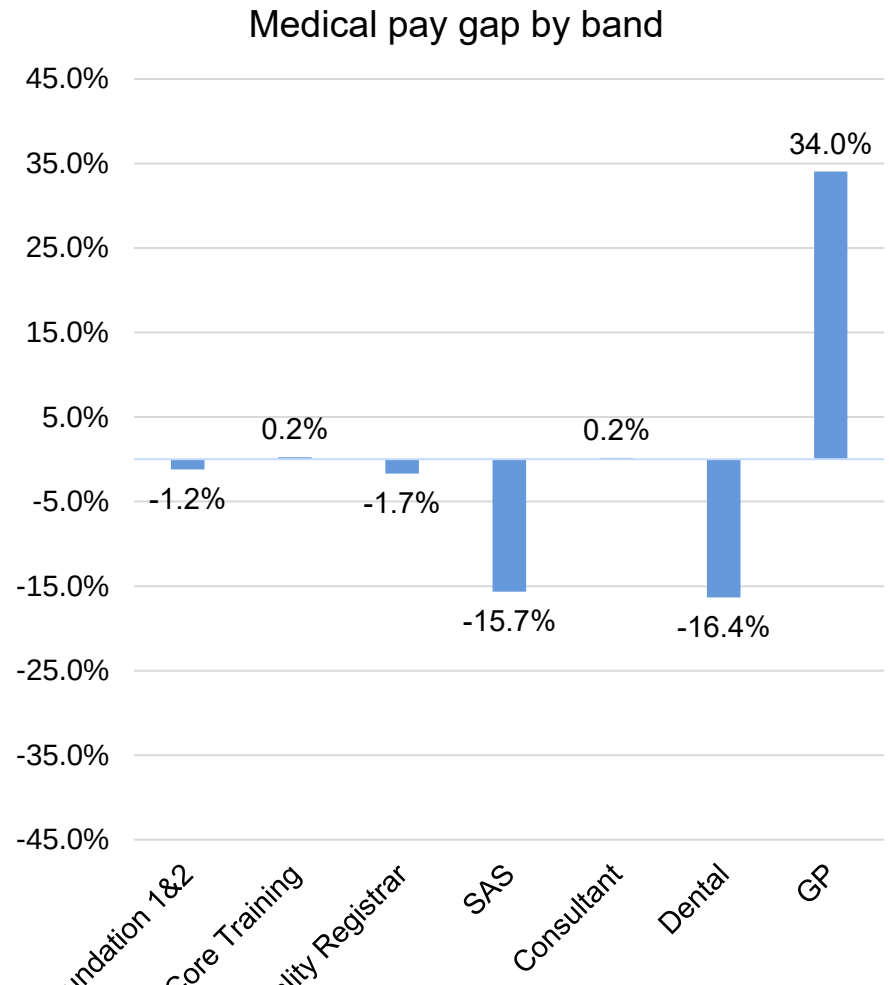
Median: 1%

Kindness, Respect, Teamwork
Everyone, Every day

5. Pay Gaps
GENDER

Somerset NHS Foundation Trust



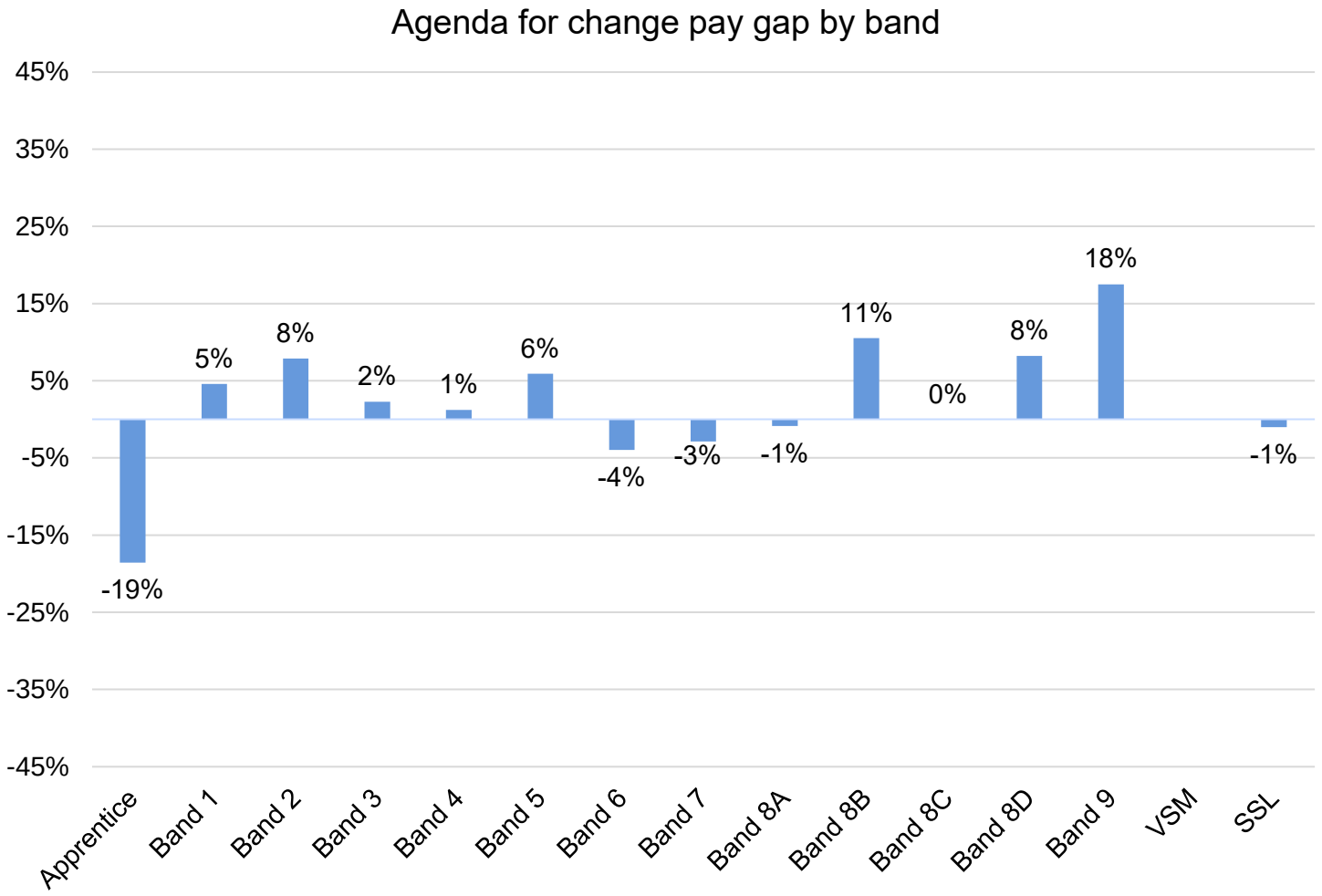


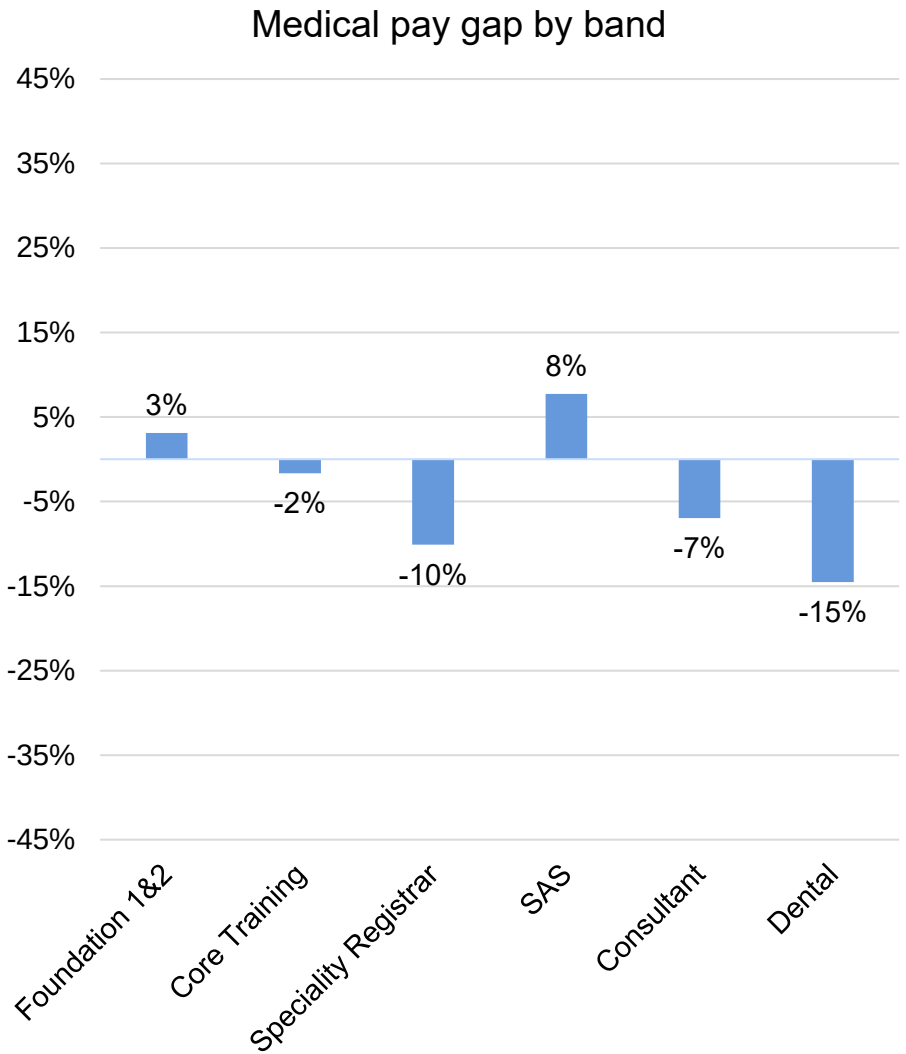
Kindness, Respect, Teamwork
Everyone, Every day

5. Pay Gaps

RACE

Somerset NHS Foundation Trust





Kindness, Respect, Teamwork
Everyone, Every day

5. Pay Gaps

BONUS PAY GAP – CLINICAL EXCELLENCE AWARDS

NHS Somerset NHS Foundation Trust

Gender

- Current CEA Scheme: 1.2%
- Historical CEA Scheme: 30.6%
- Total: 20.2%

Race

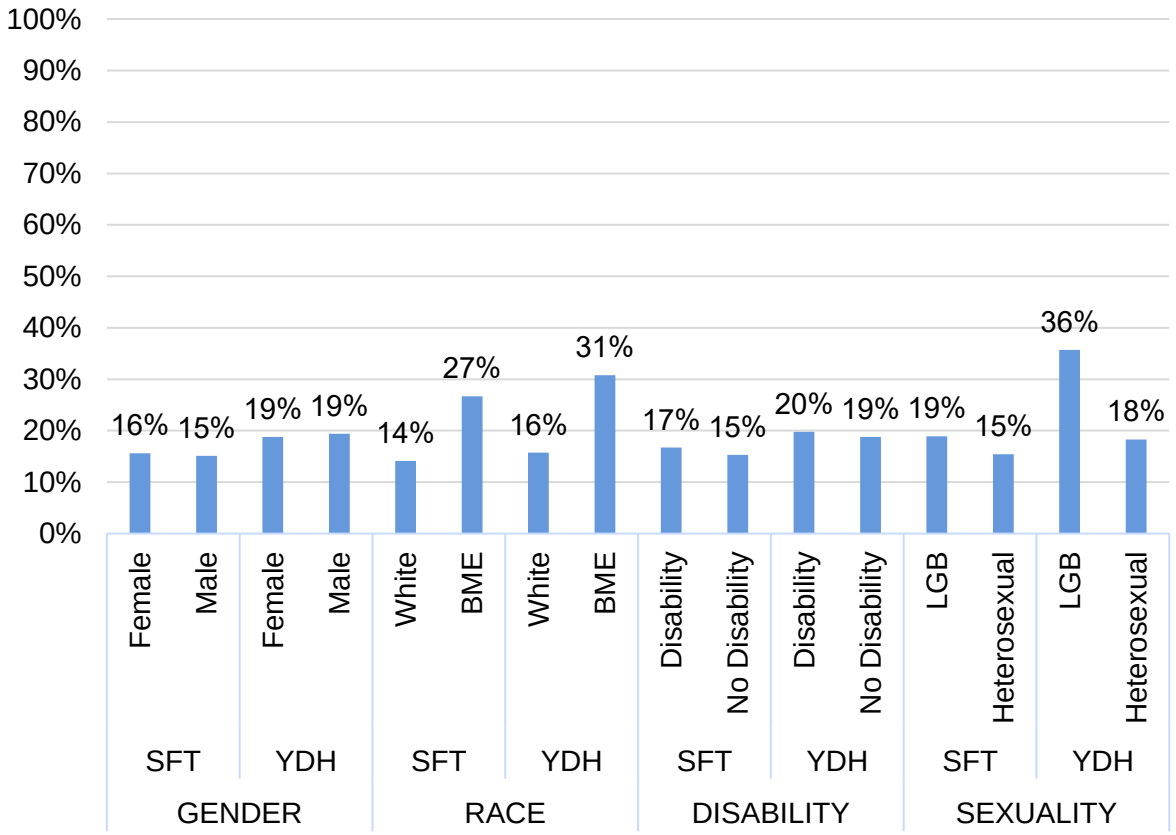
- Current CEA Scheme: +9.3%
- Historical CEA Scheme: +1.3%
- Total: 5.2%

6. Staff Survey

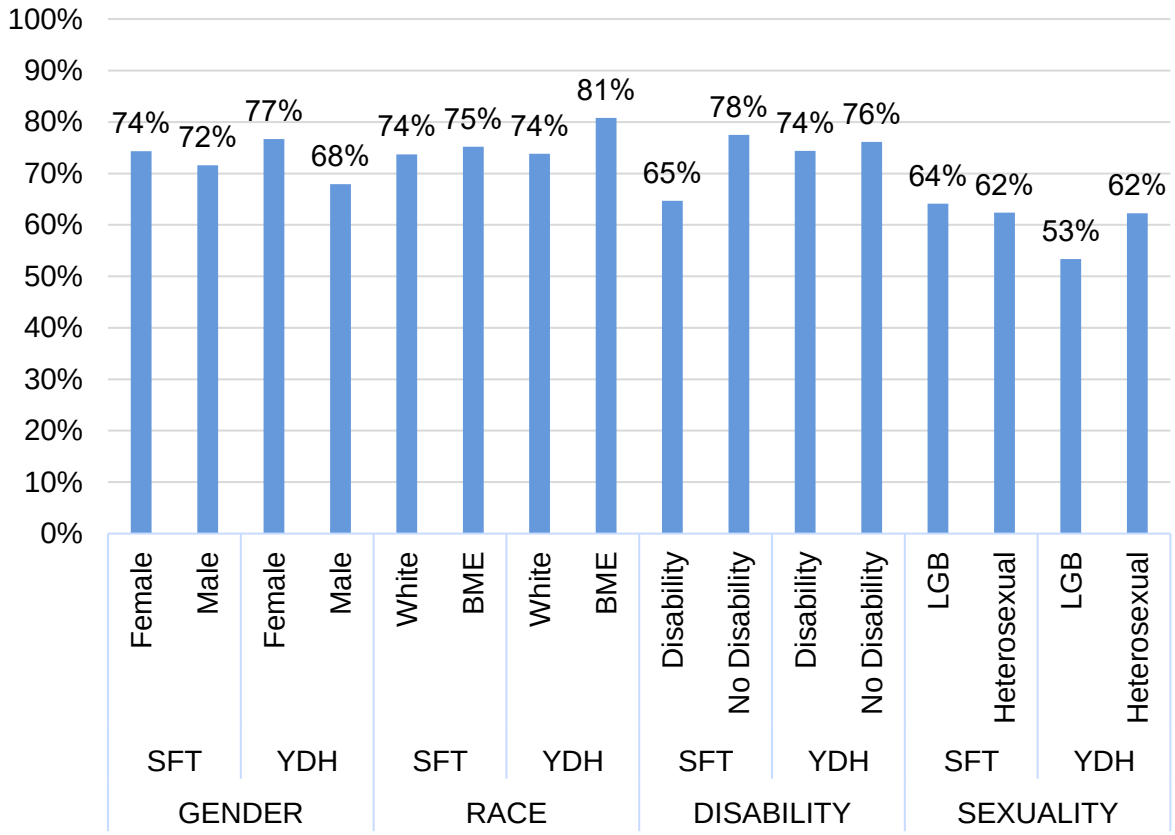
Violence & aggression

Somerset NHS Foundation Trust

In the last 12 months have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public



The last time you experienced physical violence at work, did you or a colleague report it



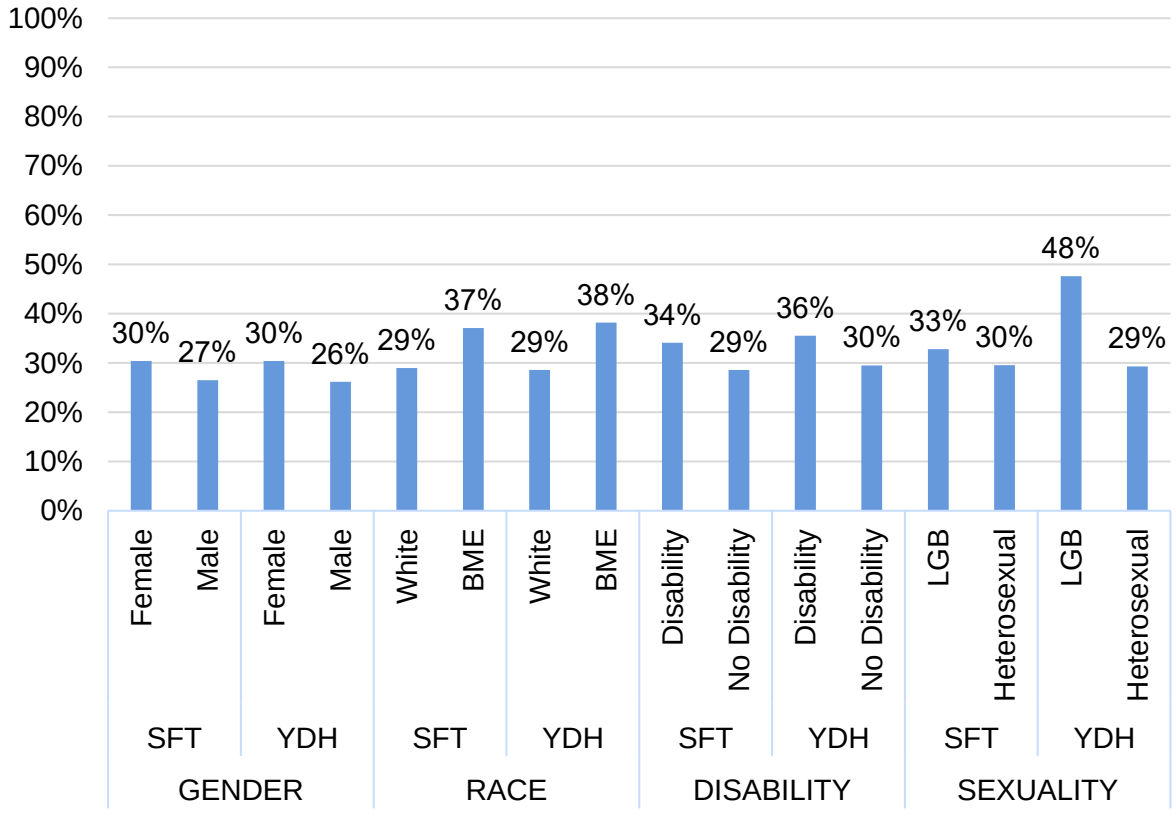
Kindness, Respect, Teamwork
Everyone, Every day

6. Staff Survey

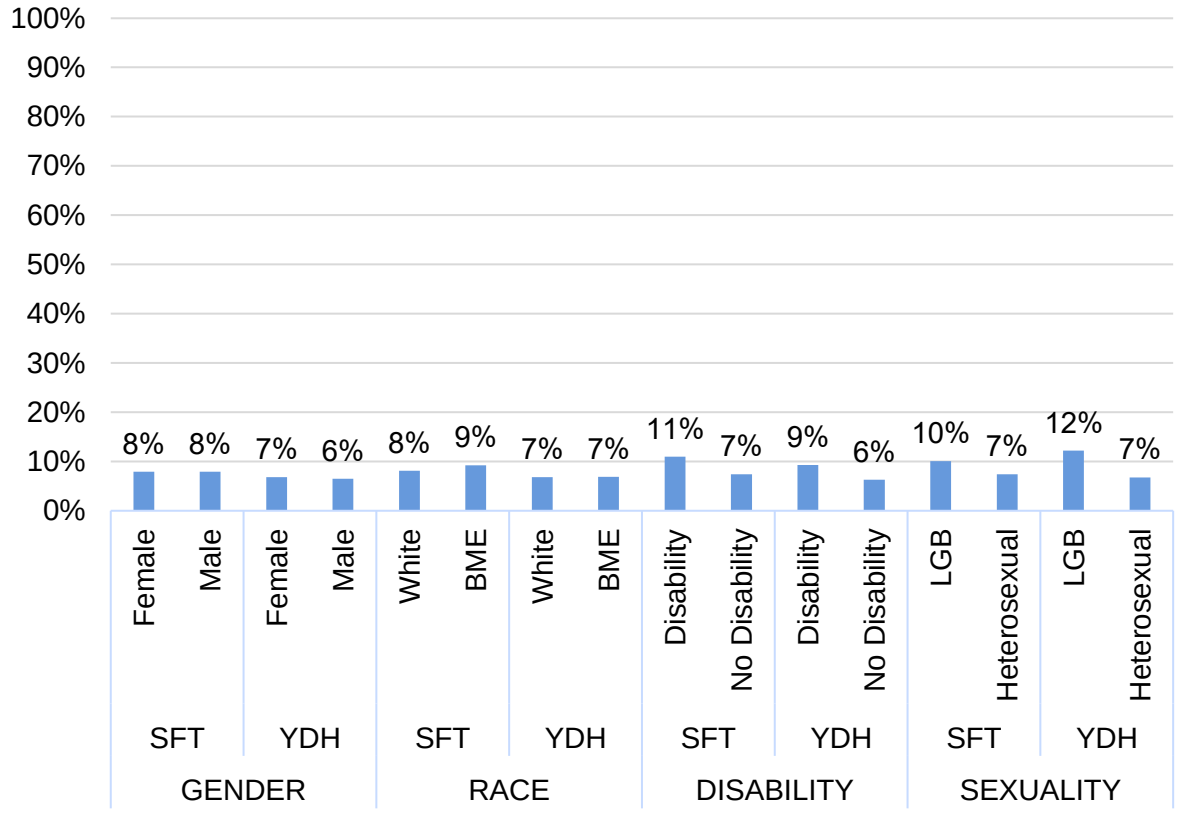
Harassment, bullying or abuse

Somerset NHS Foundation Trust

In the last 12 months have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public



In the last 12 months have you personally experienced harassment, bullying or abuse at work from managers



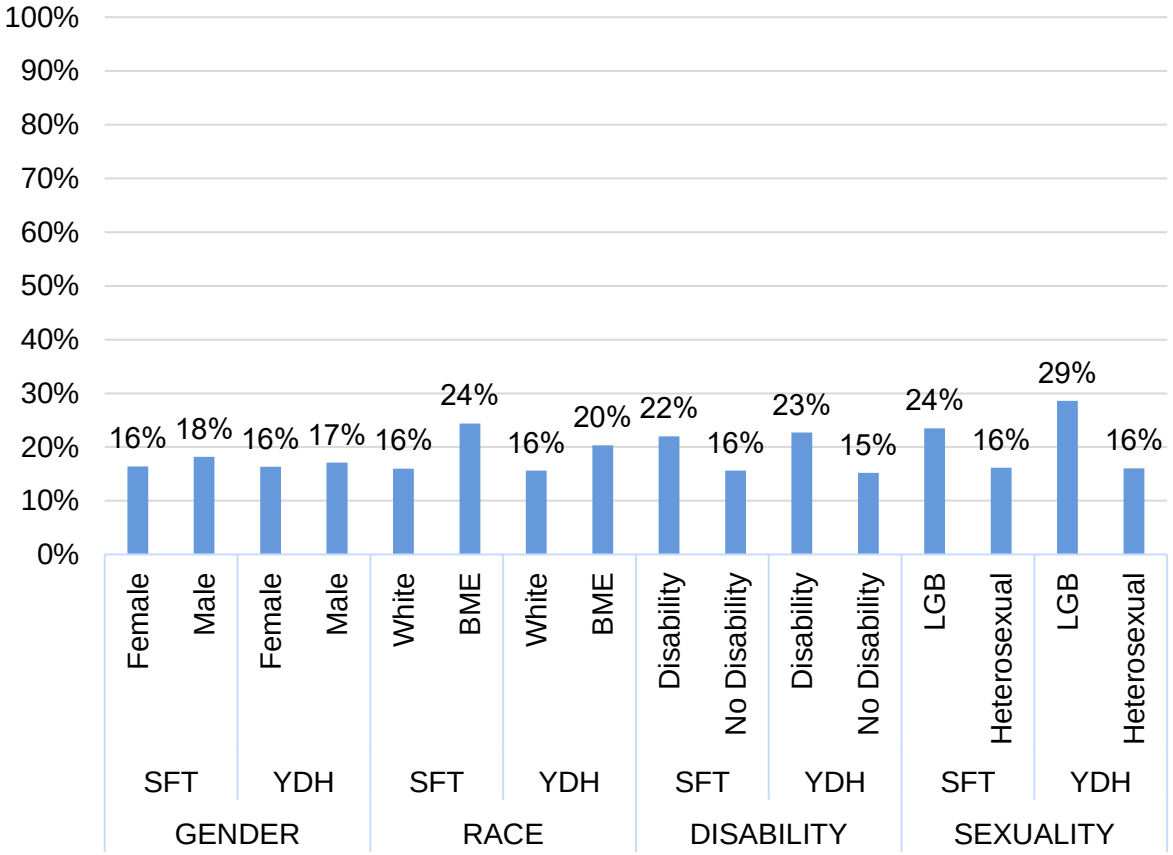
Kindness, Respect, Teamwork
Everyone, Every day

6. Staff Survey

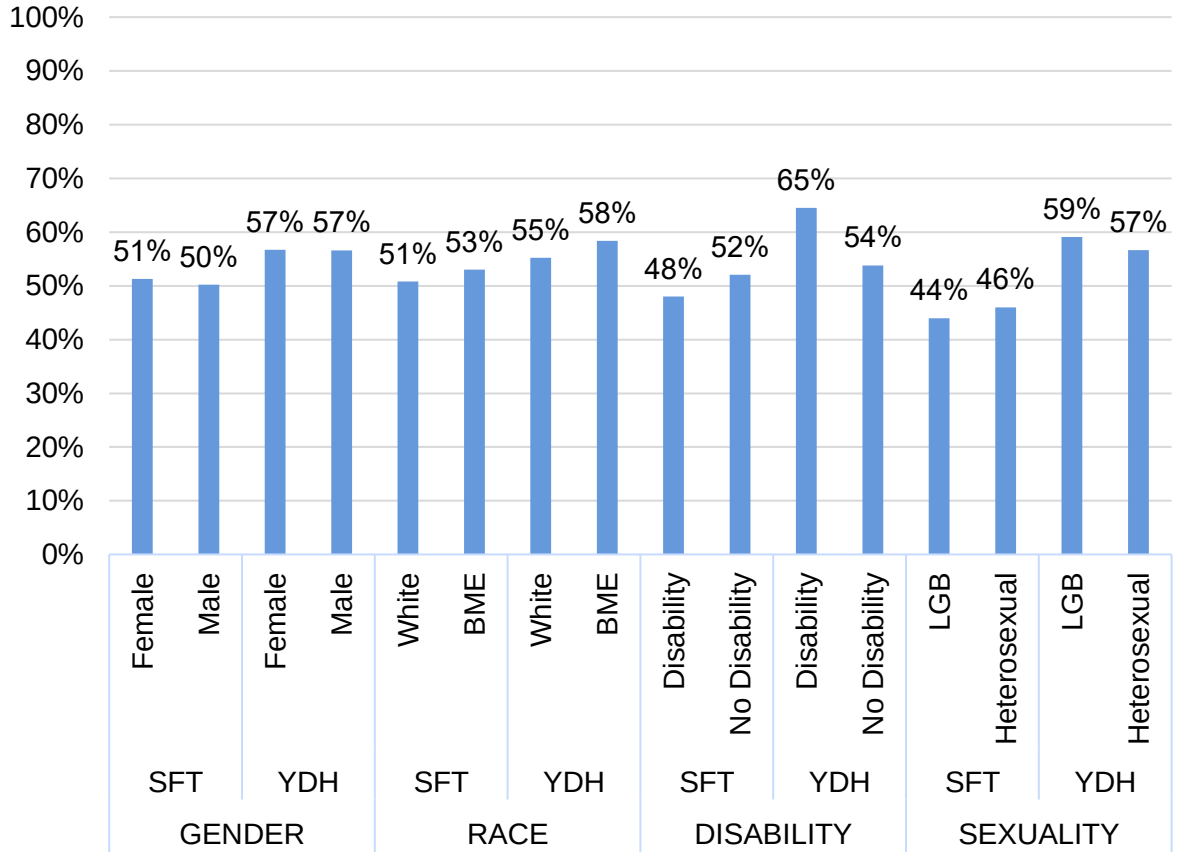
Harassment, bullying or abuse

Somerset NHS Foundation Trust

In the last 12 months have you personally experienced harassment, bullying or abuse at work from other colleagues



The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it



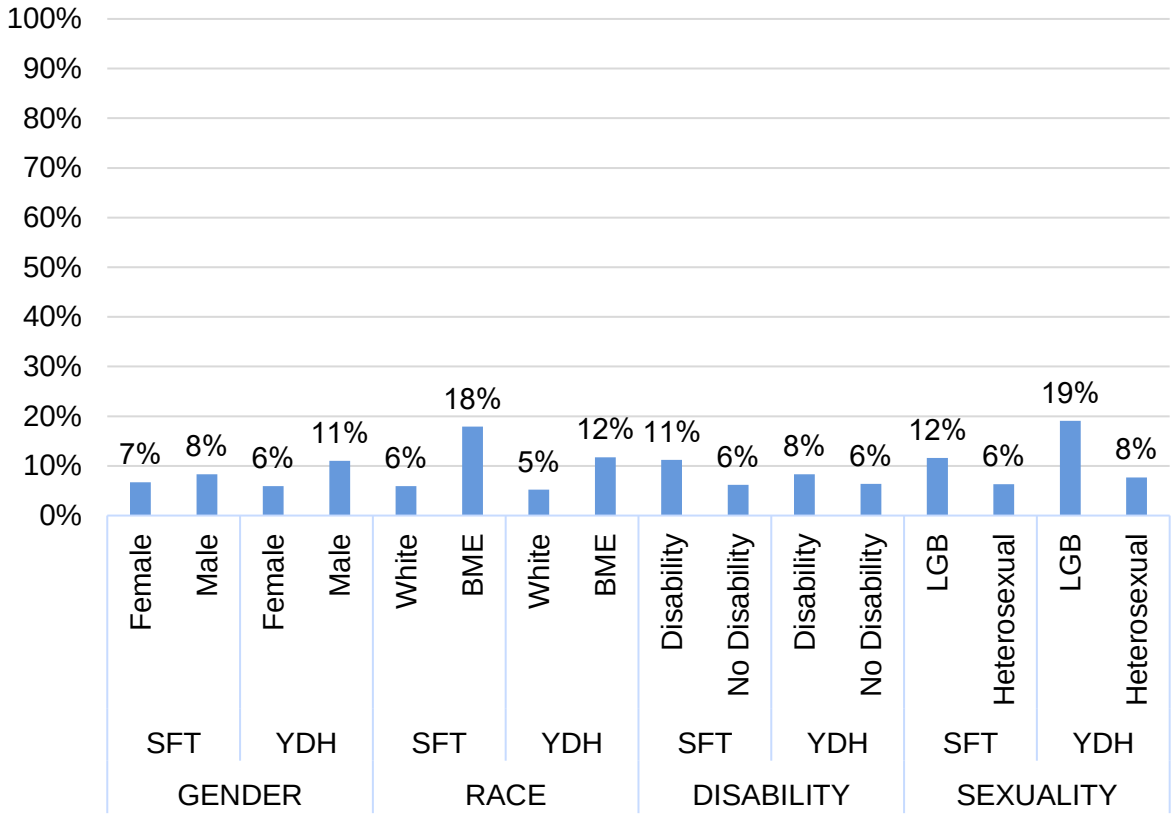
Kindness, Respect, Teamwork
Everyone, Every day

6. Staff Survey

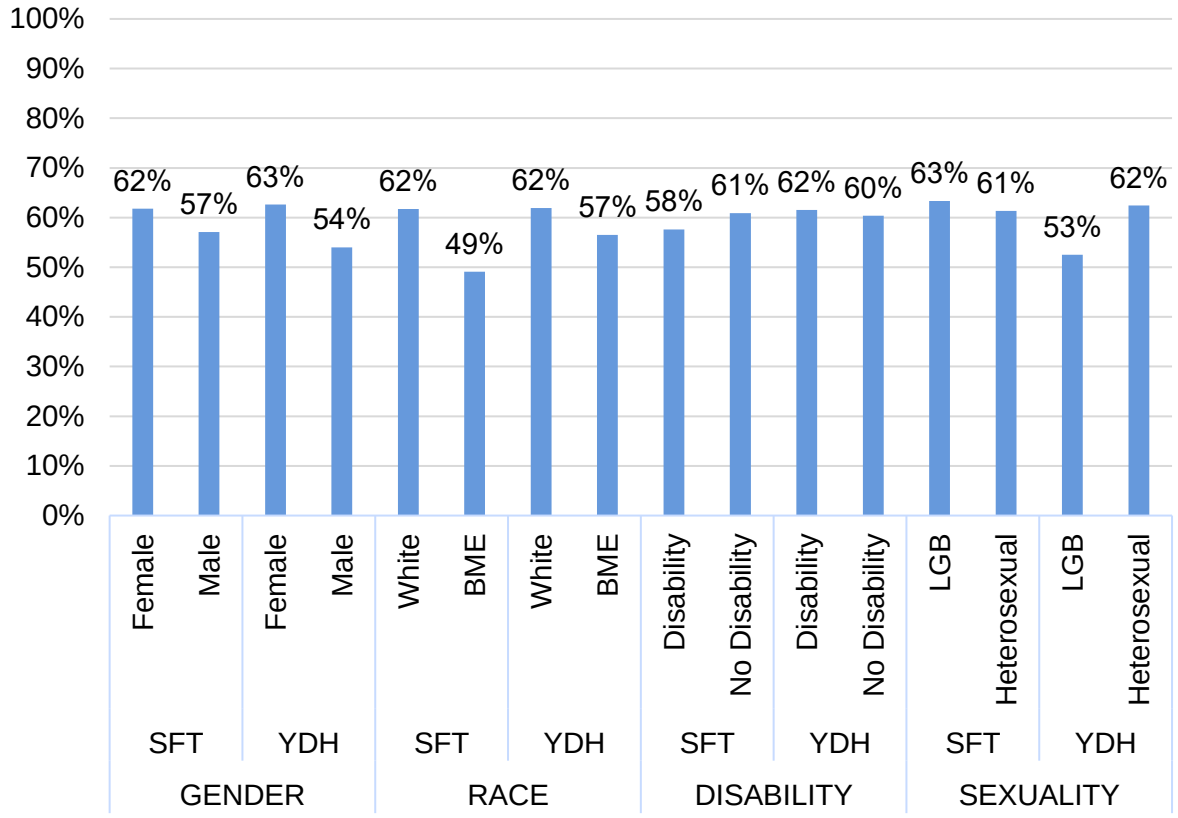
Discrimination

Somerset NHS Foundation Trust

In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues



Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age



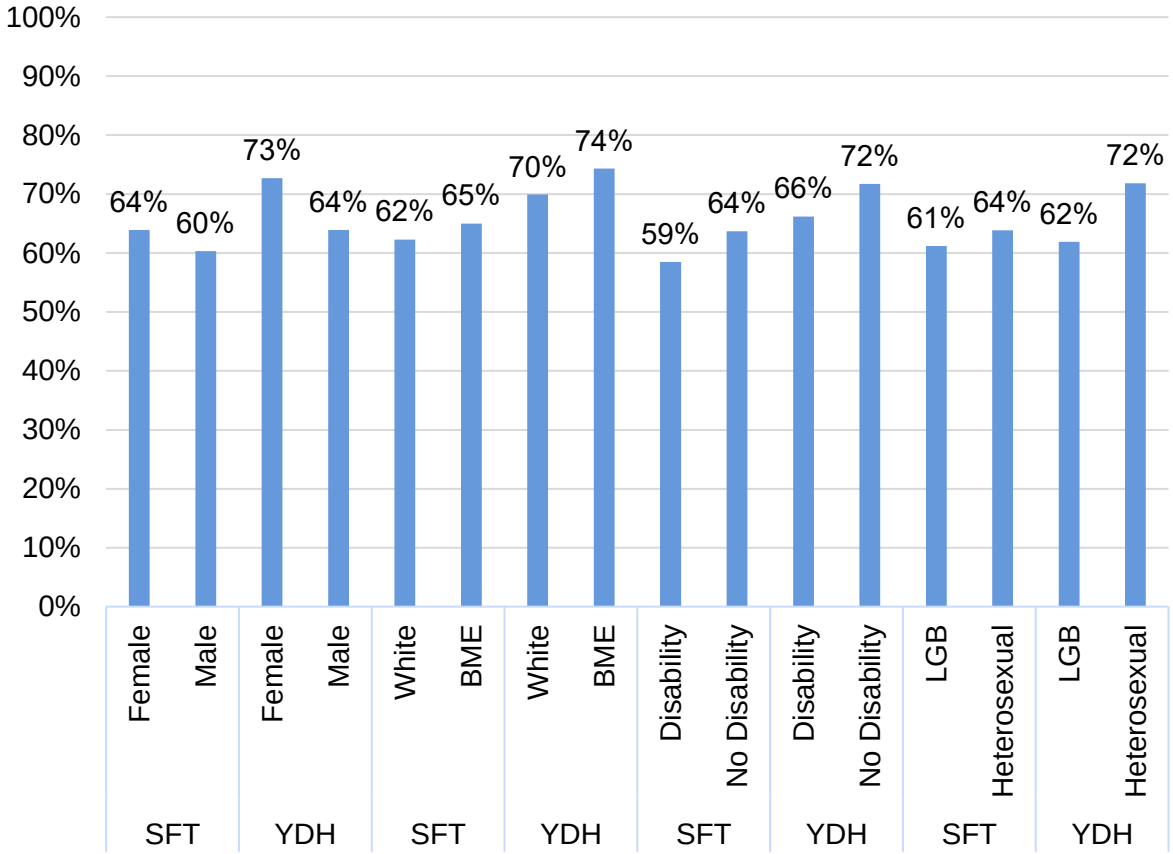
Kindness, Respect, Teamwork
Everyone, Every day

6. Staff Survey

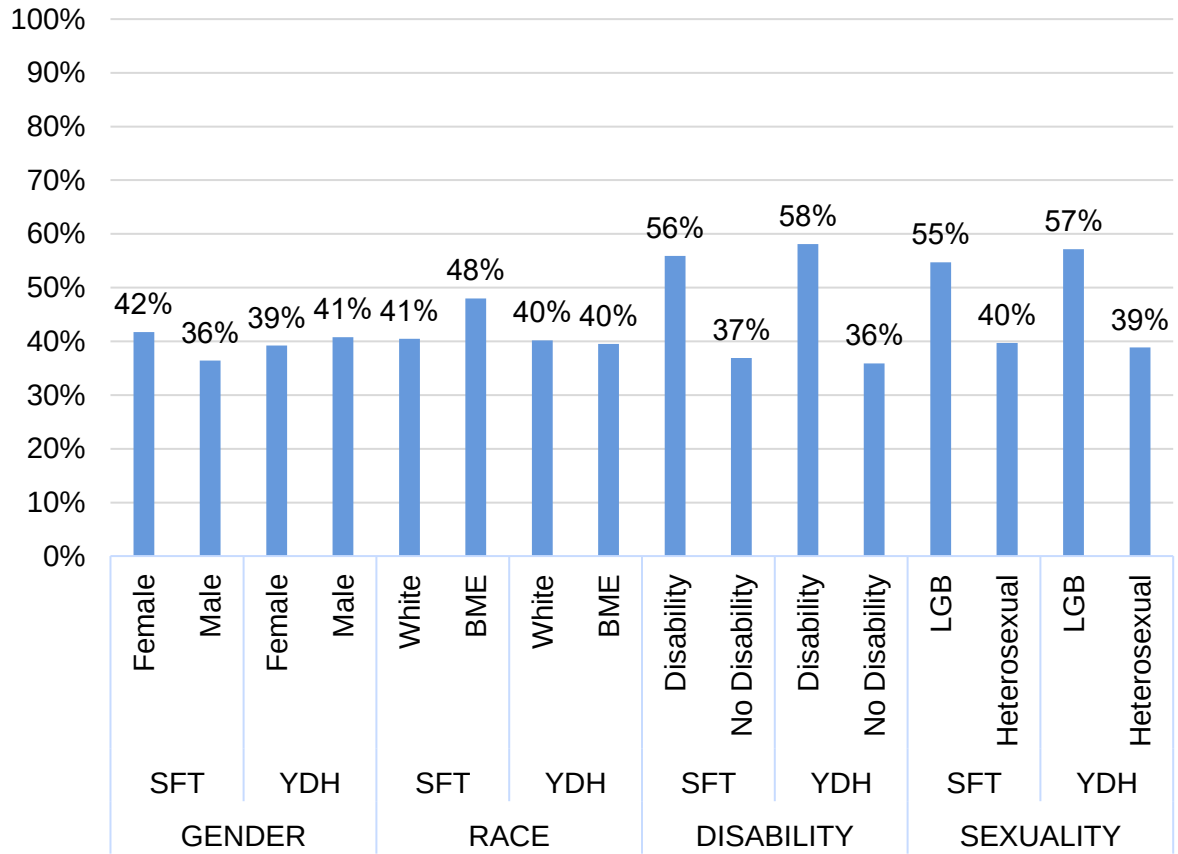
Wellbeing

Somerset NHS Foundation Trust

My organisation takes positive action on health and well-being



During the last 12 months have you felt unwell as a result of work related stress



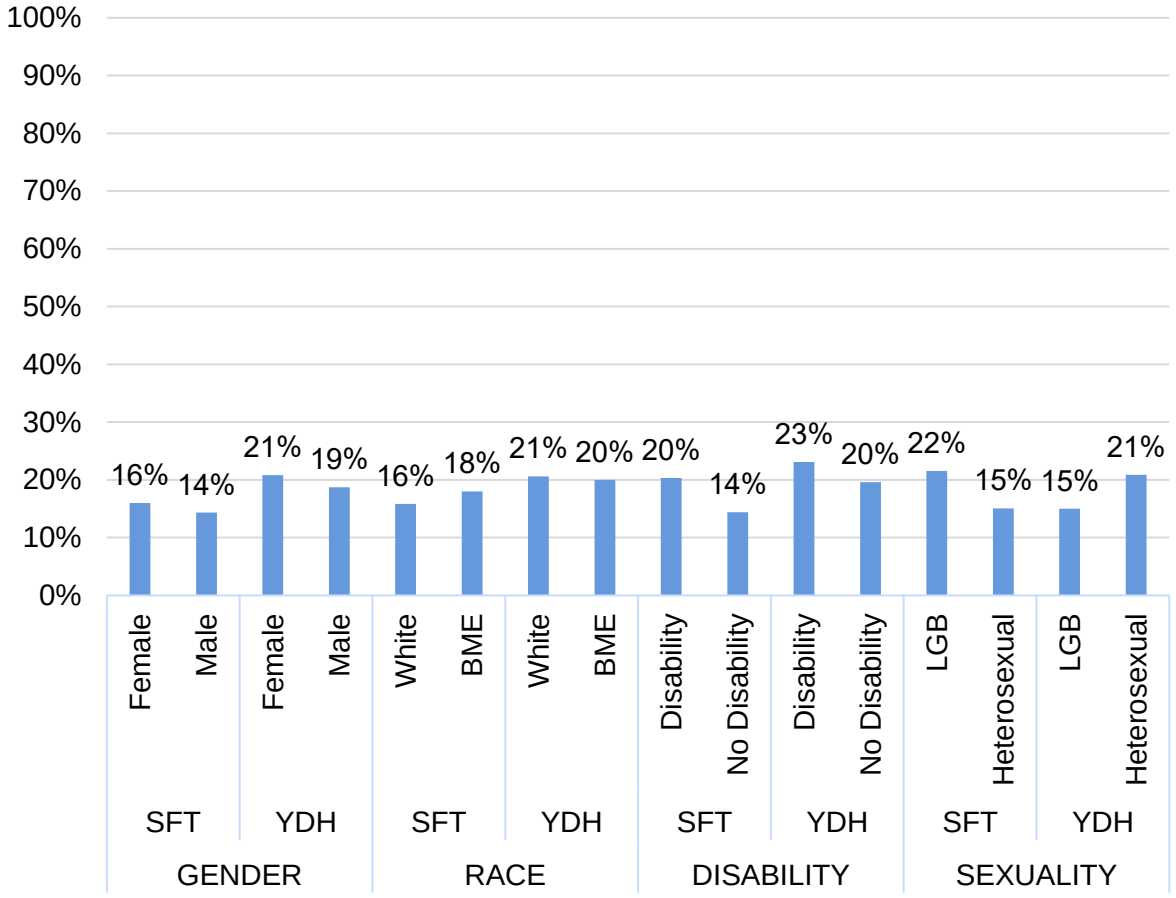
Kindness, Respect, Teamwork
Everyone, Every day

6. Staff Survey

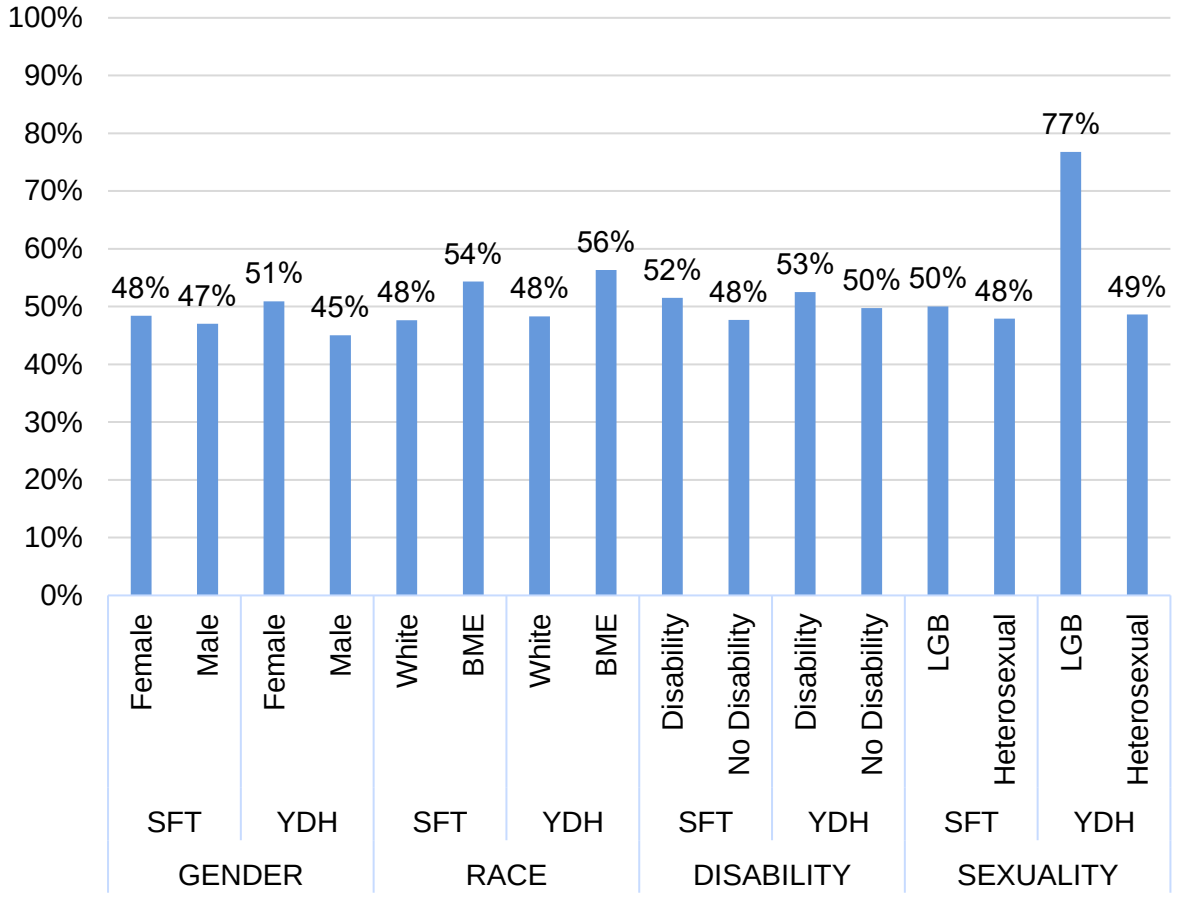
Wellbeing

Somerset NHS Foundation Trust

Have you felt pressure from your manager to come to work



Relationships at work are strained



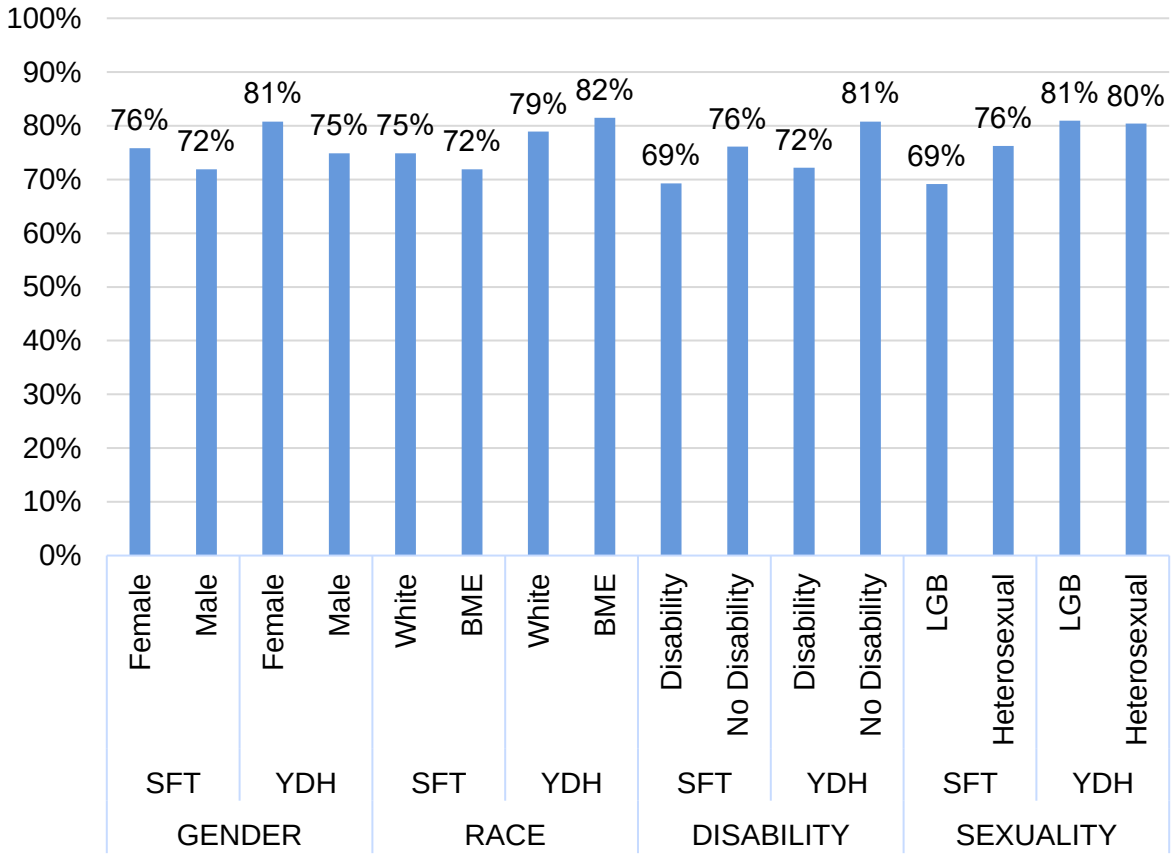
Kindness, Respect, Teamwork
Everyone, Every day

6. Staff Survey

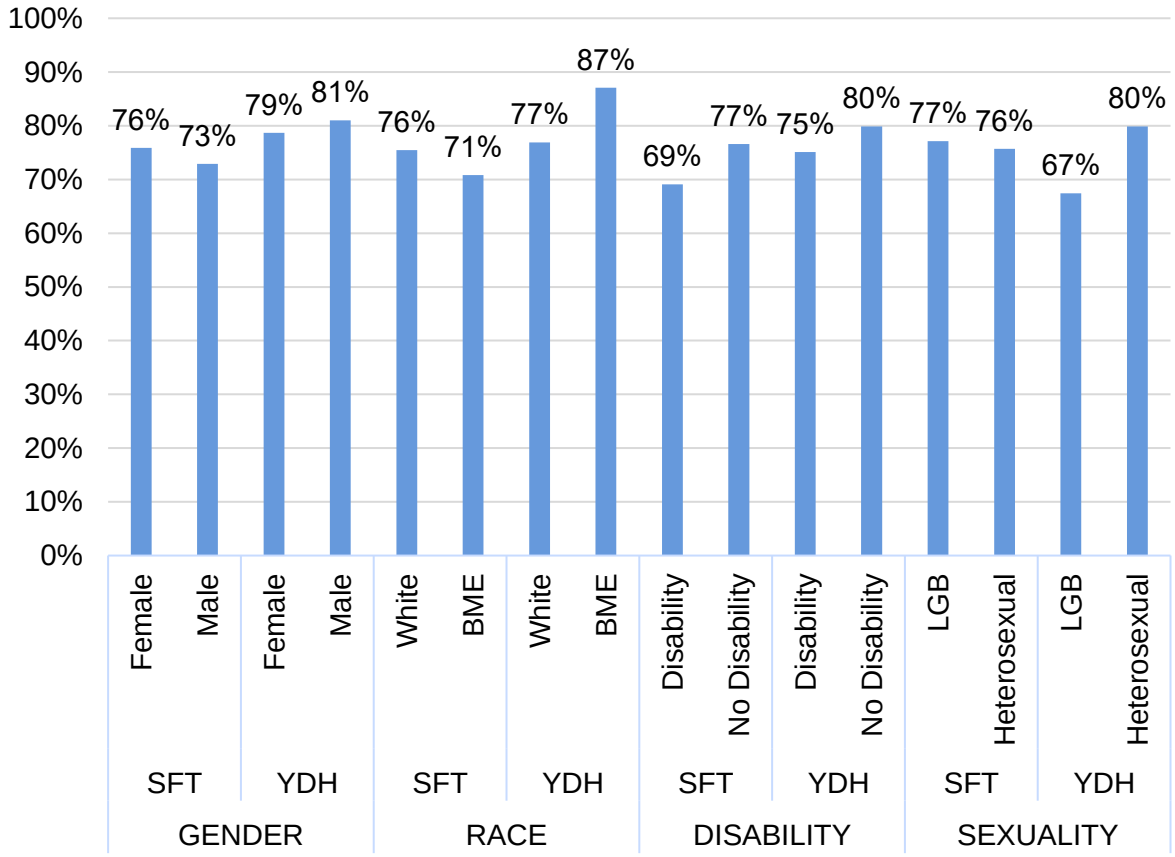
Civility & Respect

Somerset NHS Foundation Trust

I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc)



I receive the respect I deserve from my colleagues at work



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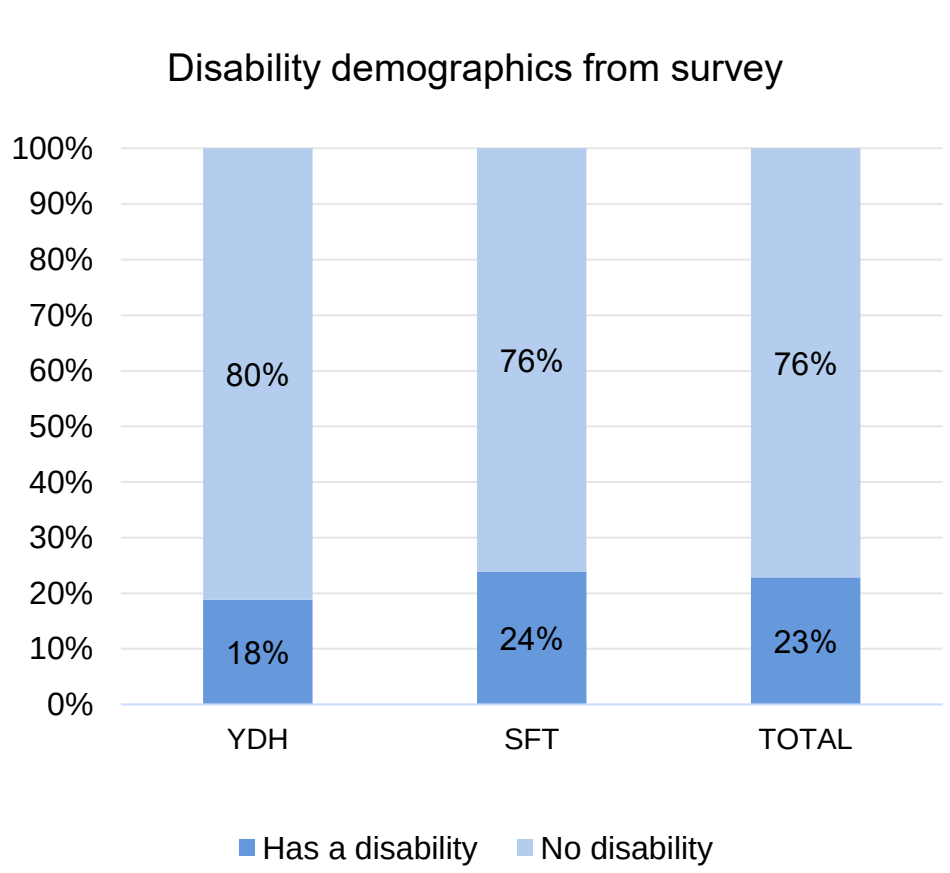
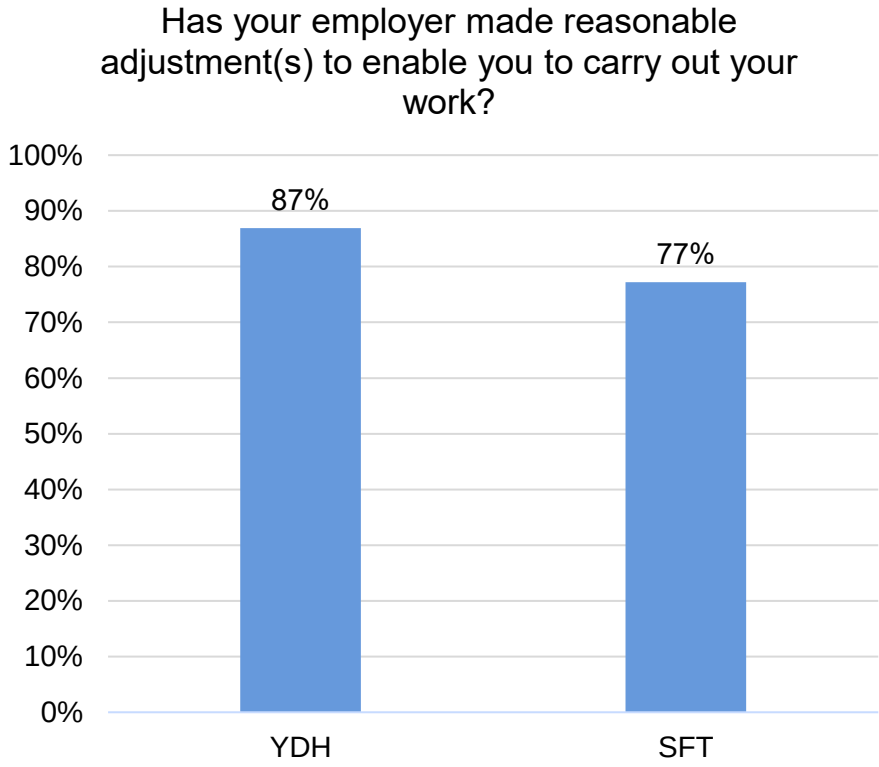
6. Staff Survey

Disability & Adjustments

Somerset NHS Foundation Trust





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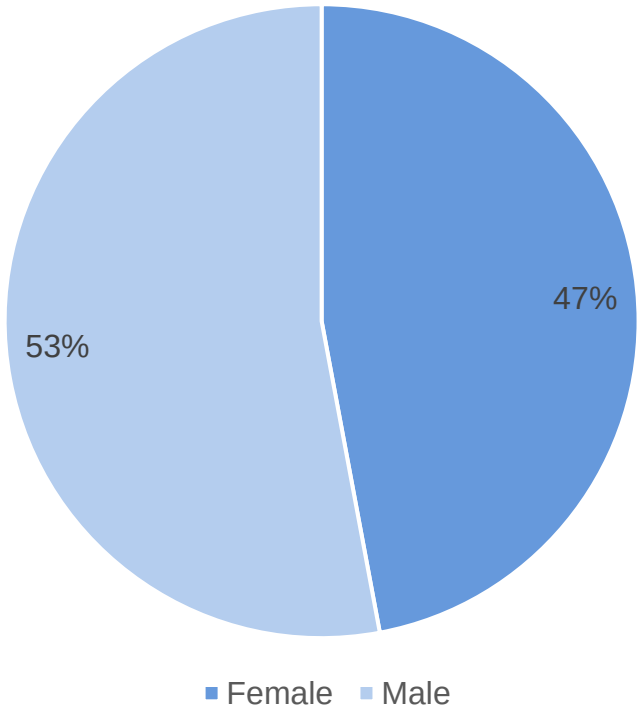
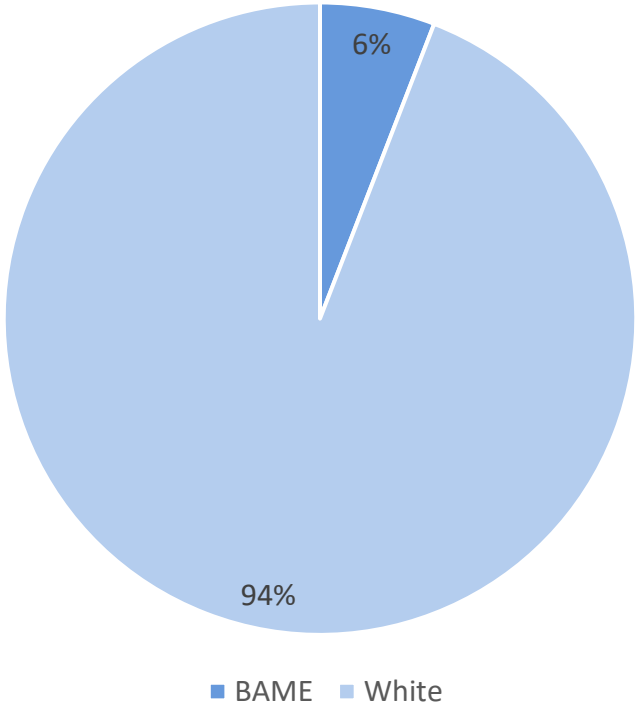
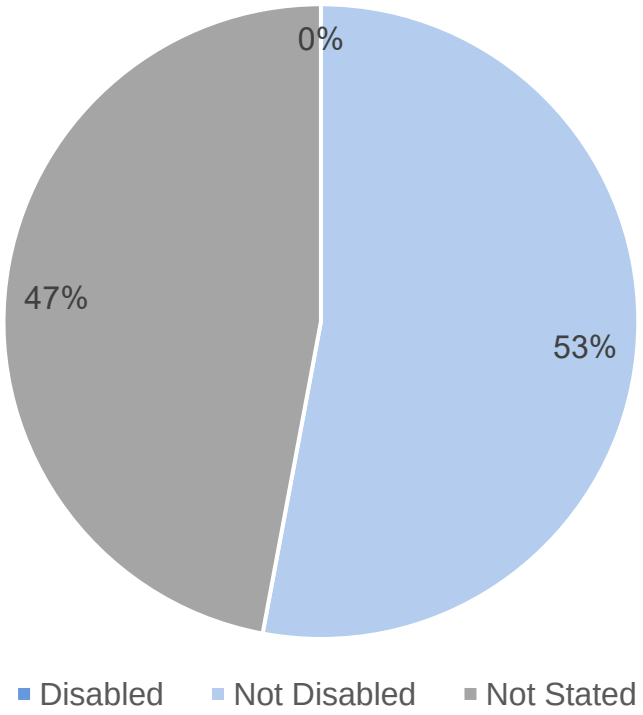
7. Decision Making

SFT BOARD

Somerset NHS Foundation Trust







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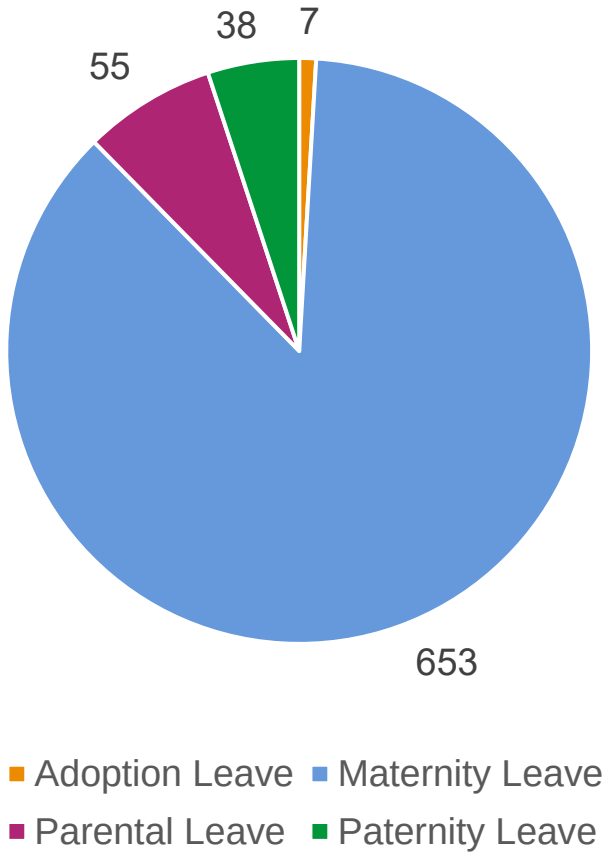
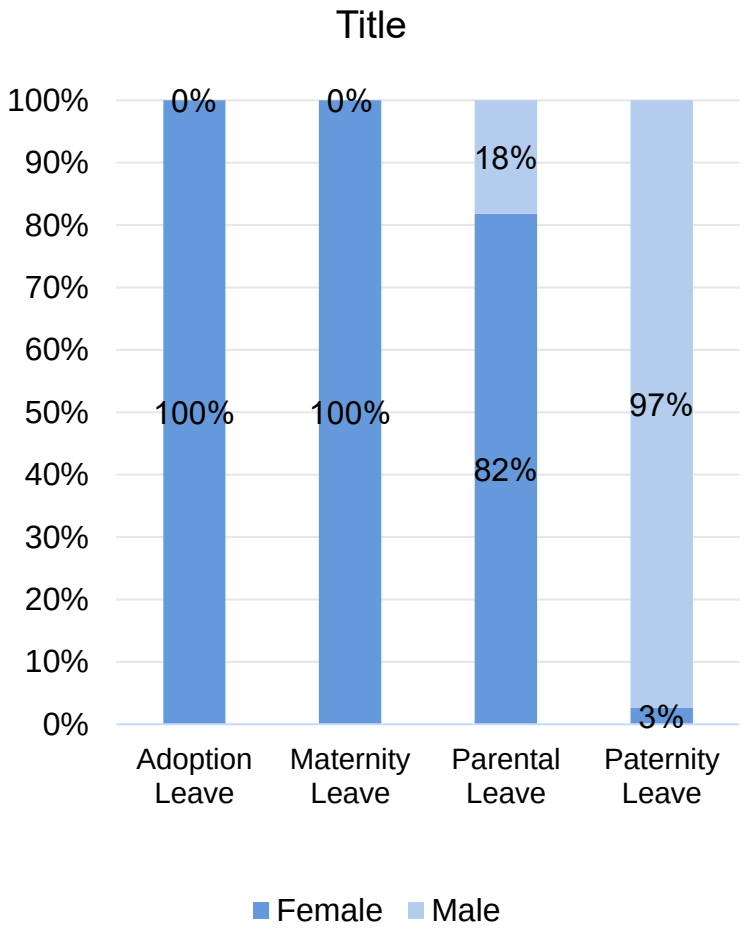
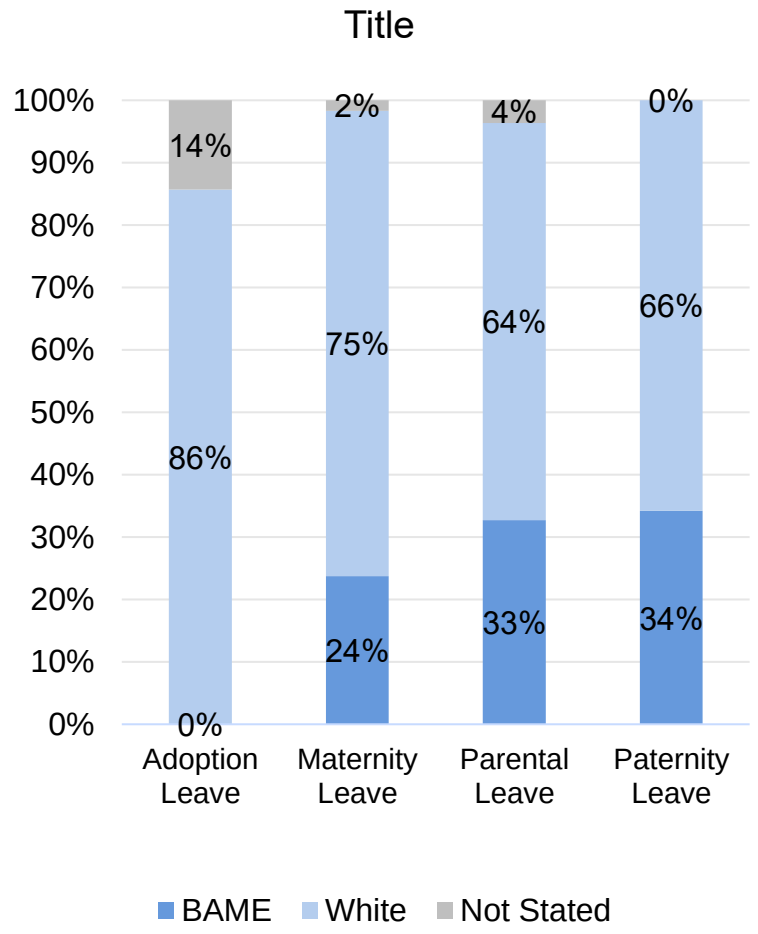
8. Parental Leave







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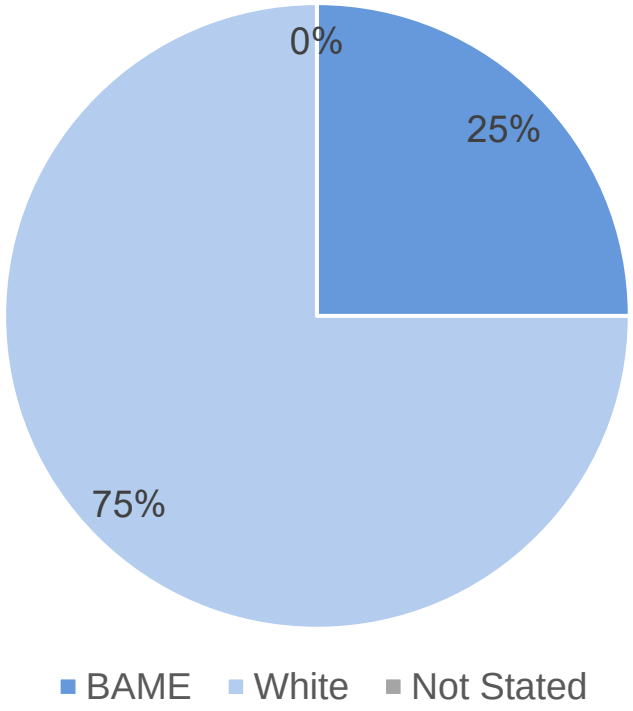
9. Formal Processes

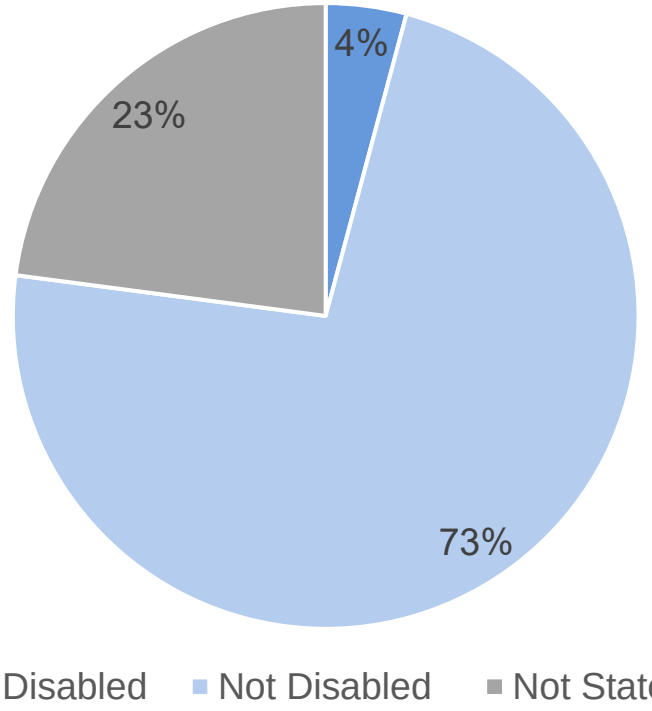
Somerset NHS Foundation Trust

WRES: formal capability



Relative likelihood of BAME colleagues entering formal process compared to white colleagues = 1.53

WDES: formal disciplinary



Relative likelihood of disabled colleagues entering formal process compared to colleague with no disability = 1.04

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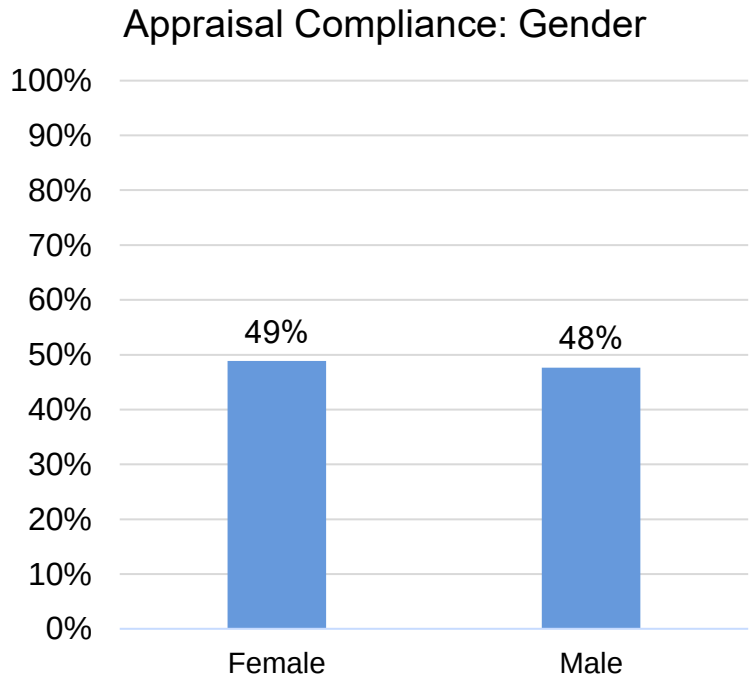
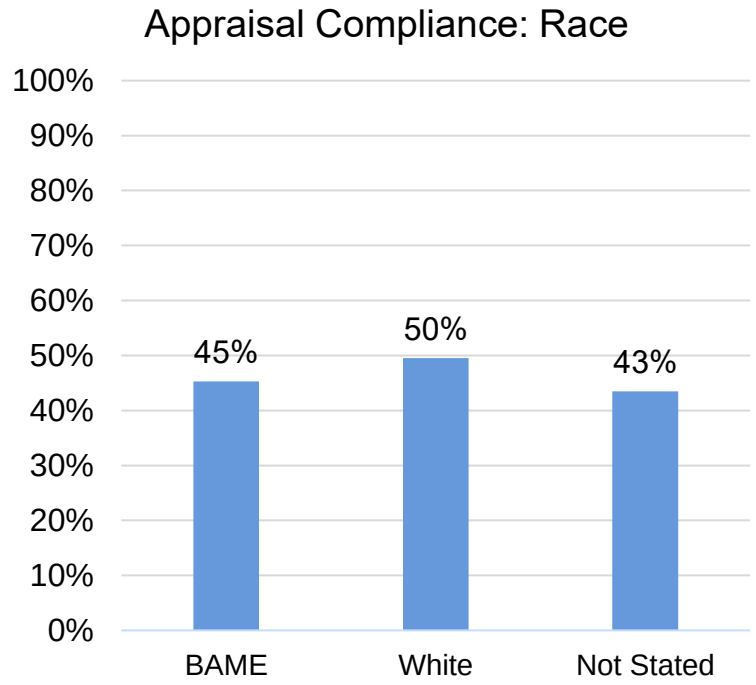
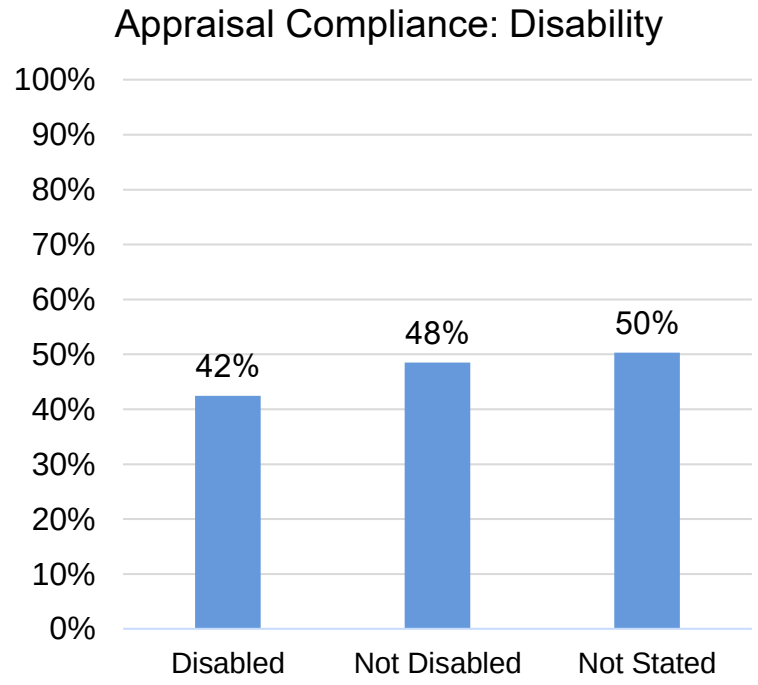
10. Training & Development

APPRAISALS

Somerset NHS Foundation Trust







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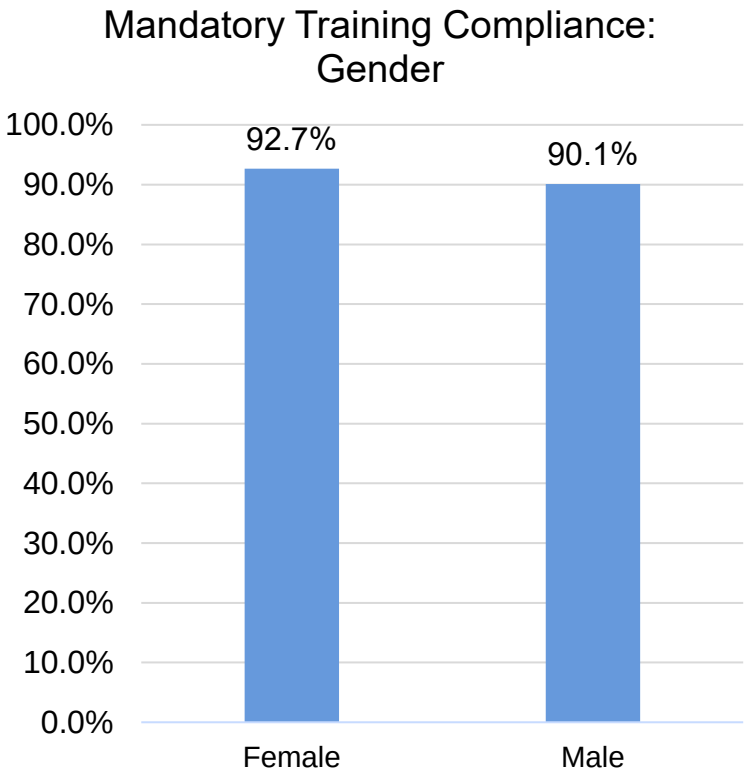
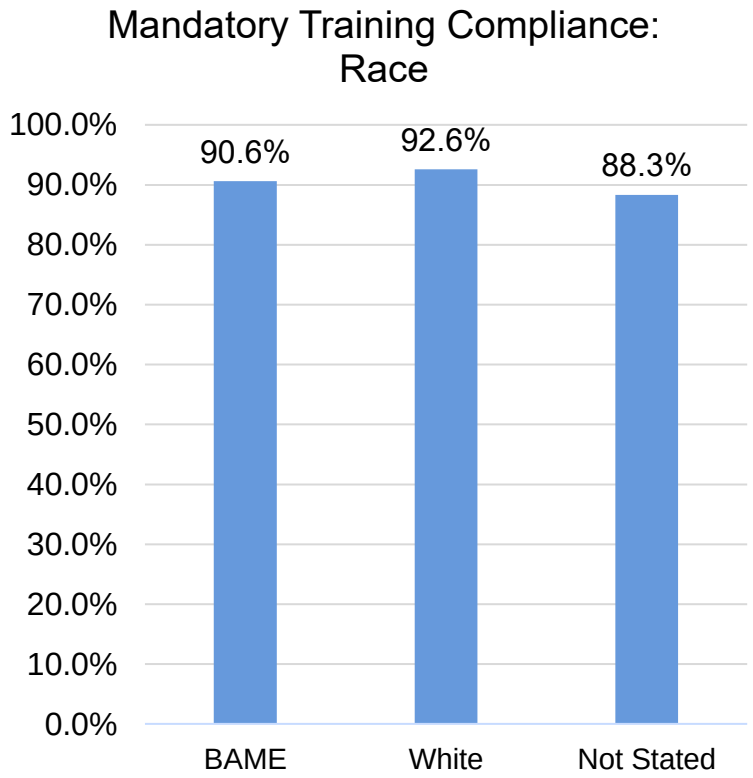
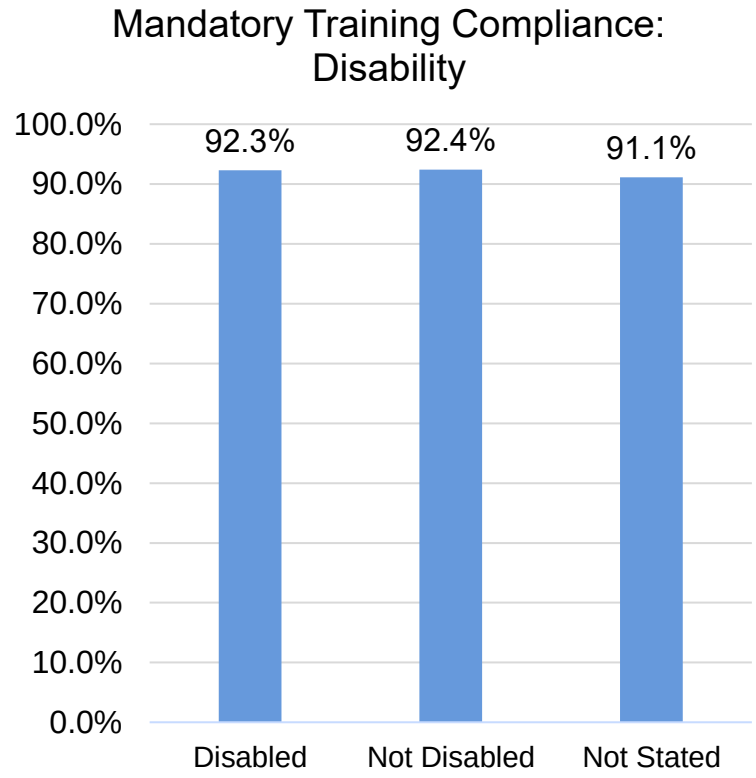
10. Training & Development

MANDATORY TRAINING

Somerset NHS Foundation Trust







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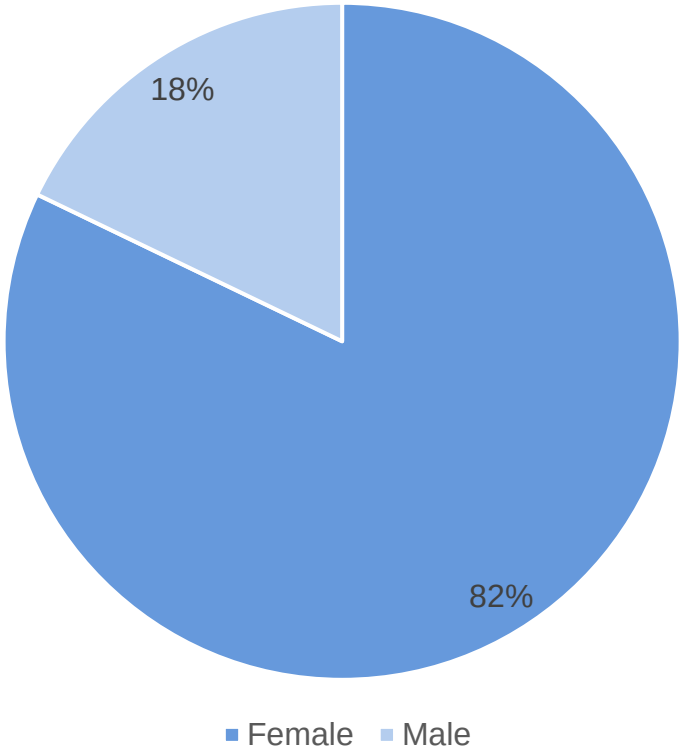
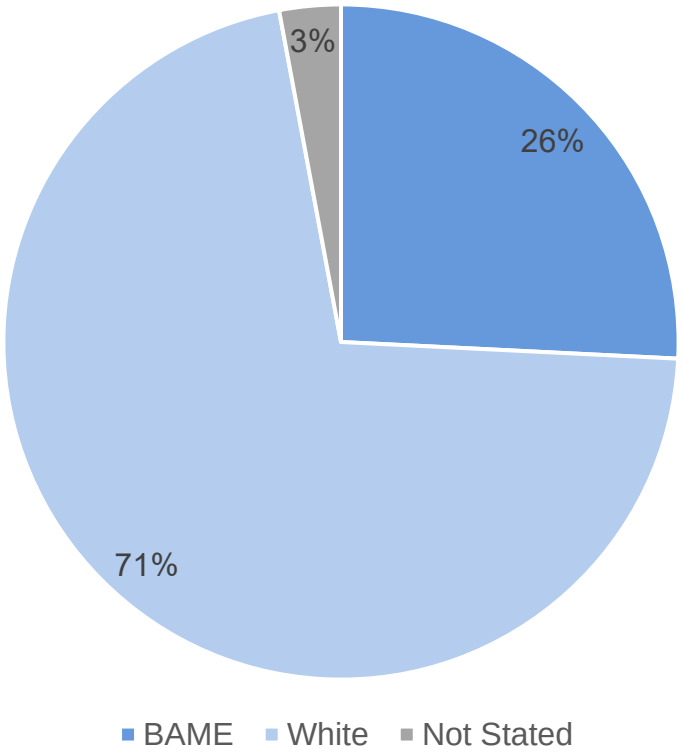
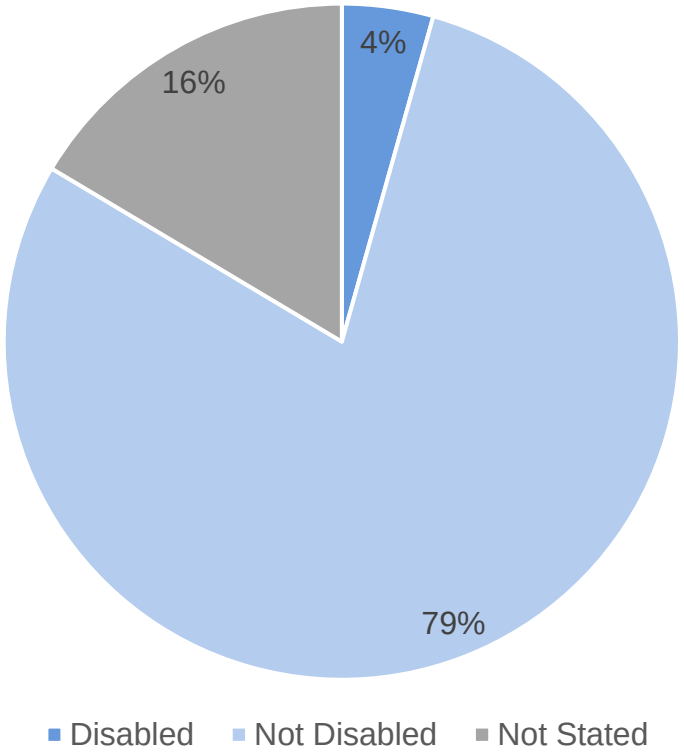
10. Training & Development

NON-MANDATORY TRAINING







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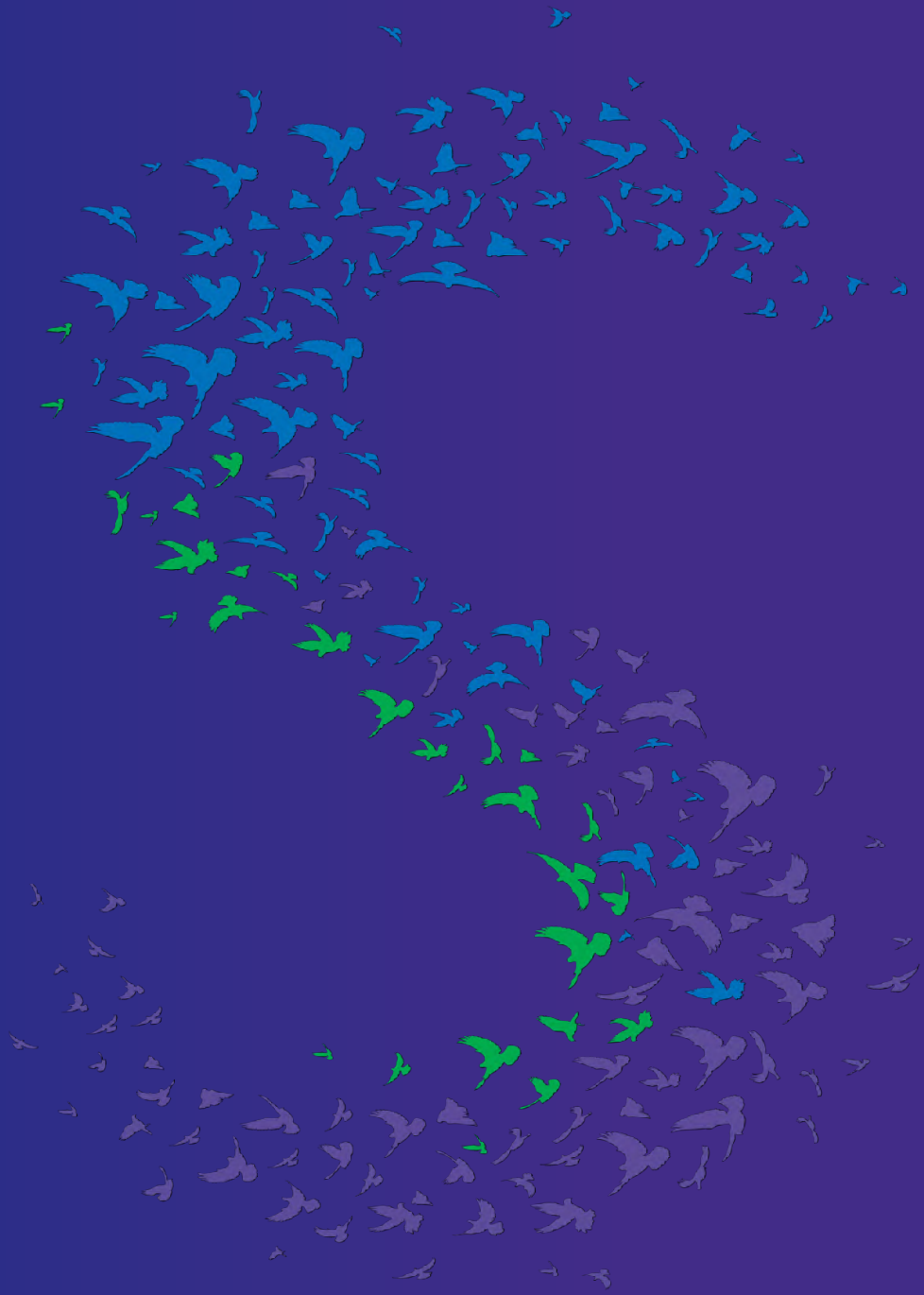

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WORKFORCE INCLUSION WORKPLAN 2023-2028

Action	What we know	Strategic and Reporting Links	2023 Progress update
Key Theme 1: Recruitment			
Procure and embed an Applicant Tracking System (ATS) that enables us to: 1. undertake a detailed analysis of diversity recruitment data at application, interview, and appointment stages. 2. ensure we provide an accessible and inclusive hiring process. 3. Ensure the Disability Confident guaranteed interview scheme works in practice.	There is a lack of reliable or accurate data on our recruitment process – impacting our ability to undertake an analysis of diversity trends. The data we do have, suggests a white candidate is more likely to be appointed in comparison to a BAME candidate. The Disability Confident Audit identified that the guaranteed interview scheme does not work in practice due to issues with our current ATS.	- People Strategy - Retain and attract talent - WRES Metric 1 & 2 - WDES Metric 1 & 2 - Disability Confident	New ATS procurement process undertaken in Q3 2023, with new provider identified. Requirements relating to inclusion were defined and embedded as a core part of the procurement process.
Move towards a skills-based model of hiring	Research suggests skills-based hiring is the most effective model for addressing bias in recruitment and ensuring equitable outcomes.	- People Strategy - Retain and attract talent - WRES Metric 1 & 2 - WDES Metric 1 & 2	Diagnostic review undertaken in partnership with RoleMapper. This identified opportunities for improvement across our recruitment process, and recommendations for revamping our process for creating job descriptions, adopting a structured job architecture, and moving to skills-based hiring.

Action	What we know	Strategic and Reporting Links	2023 Progress update
Embed recruitment tools that our inclusive and accessible, for example, this would include, but not limited to: 1. Ensure we are equipped to provide reasonable adjustments at every stage of the recruitment process. 2. Exploring alternative methods of selection as well as or instead of a traditional interview. 3. Pilot providing interview questions in advance to all candidates.	Skills-based hiring, and the new ATS will make significant improvements to our recruitment process, and our ability to embed inclusive practice. However, there will be other mechanisms that we need to explore and embed within our process.	- People Strategy - Retain and attract talent - WRES Metric 2 - WDES Metric 2 - Disability Confident	Improvements have been made to the recruitment process to explicitly promote reasonable adjustments during recruitment. More work is needed to up-skill hiring managers on supporting these adjustments.
Review and update the SFT recruitment website to reflect diversity and inclusion, including a focus on: 1. The diversity of images used 2. Information on accessibility and reasonable adjustments 3. Information on the culture of inclusion at the trust, the progress being made, and colleague networks	Opportunities for improvement were identified through the Disability Confident Audit, this included promoting the trust as an inclusive employer, and providing information on arranging reasonable adjustments throughout the recruitment process.	- People Strategy - Retain and attract talent - WRES Metric 2 - WDES Metric 2 - Disability Confident	The recruitment website was reviewed and updated in Q2-3 2023. The pages are continuously reviewed, but significant improvements have been made, with positive feedback received from colleagues, and positive feedback in the Rainbow Badge results report. Pilots are being run where interview questions are being provided in advance. Initial feedback from internationally education colleagues, and those with disabilities, has indicated that this has been very helpful in preparing for interviews. We will continue to assess the impact and whether this could become standard practice.
Develop training for recruitment managers that guides them through inclusive practice and bias mitigation strategies at every stage.	While the new ATS will enable more inclusive approaches and techniques for hiring, there will still be a need for development for hiring managers.	- People Strategy - Retain and attract talent - WRES Metric 2 - WDES Metric 2 - Rainbow Badge	The recruitment team have built inclusive practice into current training provided for hiring managers. A review of training will be undertaken in line with the launch of the new ATS platform.

Action	What we know	Strategic and Reporting Links	2023 Progress update
Key Theme 2: Retention and Progression			
Take steps to improve the progression and retention for internationally educated colleagues. This will include, but is not limited to: 1. Understand the needs of internationally educated colleagues in different staff groups, including nurses, midwives, AHPs, and doctors. 2. Improvements to the induction and onboarding process. 3. Develop and implement Cultural Competency training for managers of culturally diverse teams. 4. Ensure colleagues are not charged as international students when completing qualifications. 5. Review opportunities to support colleagues applying for their right to remain visa (this comes at a significant financial cost to colleagues). 6. Review of the DAL programme, and opportunities to apply positive aspects to internal training. 7. Opportunities to support internationally education doctors become consultants. 8. Consider how we meaningful acknowledge and value experience gained oversees before joining the NHS.	The majority of BAME colleagues are employed at band 5 – 41% of colleagues at band 5 are BAME. Representation then falls significantly to 12% at band 6. In comparison to 2021, the representation of BAME colleagues has increased from 14%. There has also been an increase across most bands, including an increase from 31% to 41% at band 5, and from 9% to 12% at band 6. In medical and Dental roles, BAME colleagues are more highly represented in SAS roles (51%), compared to 22% in consultancy roles. Representation has not changed at consultant level since 2021.	- WRES Metric 1	Several Cultural Competency training offerings have been piloted, with a view to adopting a model to roll out across SFT. The training is intended to support managers, especially those who support internationally educated colleagues. 6 colleagues have taken part in the DAL programme – this is the Developing Aspirant Leaders (DAL) Programme for ethnic minority nurses and midwives, run by NHS England. Progress to date was shared at the 2023 Black History Month event, and a session provided opportunities for attendees to feedback on further improvements needed and priorities. Guidance on languages spoken at work is being developed. Our annual leave policy was amended following feedback from internationally educated colleagues that they were not being supported to take longer periods of leave to travel home.

Action	What we know	Strategic and Reporting Links	2023 Progress update
Review and improve our reasonable adjustments policy and process.	This was a key finding from the BDO Disability Confident Audit. In 2022, the staff survey showed that almost a third of colleagues with a disability do not have a reasonable adjustment in place to enable them to carry out their work. This could equate to roughly 1200 people without an adjustment in place. A large number of ongoing HR cases and tribunal cases related to disability, and often a lack of reasonable adjustments discussed and when offered they were not all fully considered or understood. We also recognised a significant increase in concerns being raised via the Lived Experience and Neurodiversity Networks.	- Disability Confident - WDES Metric 8	A working group has been in place and undertook a holistic review of the reasonable adjustment process. A new policy has been drafted, a central fund for reasonable adjustments has been crated, and training has been held for the HR Advisor Team. We hope to launch the new policy, process and guidance by the end of 2023. Further information and training will be developed early in 2024.
Ensure career conversations enable colleagues to effectively plan for their progression, with development opportunities provided by their manager and centrally via People Services. Ensure this is designed to meet the needs all colleague groups and demographics.		- People Strategy – Develop our people	A Retention Working Group has been established. In its first year, this group has been primarily focusing on the 'Scope for Growth' framework for career support and development. There will be three to four pilot groups, one of which will include internationally educated nurses. Pilot groups have been selected due to identified areas of attrition due to a lack of development or opportunities.

Action	What we know	Strategic and Reporting Links	2023 Progress update
Review our parental leave provisions, with a particular focus on: 1. Colleagues are encouraged and feel able to access shared parental and paternity leave. 2. Our policies are explicitly inclusive of LGBTQ+ families. 3. There are clear mechanisms and guidance for keeping in touch and up to date during parental leave. 4. There is a clear process and guidance to support a smooth and successful return from parental leave.	A relatively low number of colleagues are accessing parental and paternity leave. There were no records of colleagues accessing shared parental leave. However, our BAME colleagues are more likely to access these provisions. Within our Rainbow Badge assessment report, the trust scored 0 out of 5 for the review of policies relating to parental leave, as they were not seen to be explicitly inclusive of LGBTQ+ families. The Women's Network undertook a survey of colleagues who had recently taken parental leave in 2021. This was developed into a series of actions that need to be adopted and reviewed within people services.	- People Strategy - Care for our people - Rainbow badge	
Develop and implement guidance for colleagues who are transitioning. This guidance should include information for the individual and their manager.	As part of the rainbow badge scheme, there was a clear recommendation that the Trust finalises and publishes the draft guidance that has been developed. Feedback has been provided by the LGBT Foundation. Anecdotal feedback from colleagues who are transitioning is that there is very little information or advice available, and managers are unsure how best to support.	- Rainbow Badge	An initial outline of this guidance has been drafted. Further work is needed to ensure practical information relating to payroll, pensions and IT are developed alongside relevant teams, and in consultation with Trans and non-binary colleagues.

Action	What we know	Strategic and Reporting Links	2023 Progress update
Improve completion rates for demographic data in ESR.	Completion rates are particularly low for disability and sexuality. To improve our understanding of trends, we need to improve the completeness and accuracy of our data.	- All strategies and reports	A letter to colleagues with missing data in ESR has been drafted and will be sent out. Since 2021, completion rates have slightly improved, which we believe is a result of the move to ESR self-service. For example, 28% of colleagues had not answered demographic questions relating to disability in 2021, compared with 20% in 2023.
Ensure there is a consistent and accurate record of colleagues entering formal processes. Review diversity data of colleagues going through processes including: 1. Formal capability processes 2. Formal disciplinary processes 3. Referrals to bodies including the NMC and GMC	Research suggests that bias often increases the likelihood of underrepresented groups entering formal processes. Initial data from the WRES suggests BAME colleagues may be more likely to be involved in formal disciplinary processes. However, numbers are very small, there are concerns around data accuracy, and that data is not currently reflective of all formal processes in place.	- WDES Metric 3 - WRES Metric 3 - People Strategy - Care for our people	
Investigate within-band pay gaps, particularly gaps within senior roles. Analysis might include: 1. Analysis of starting salaries to explore whether the negotiation process establishes a pay gap. 2. Gender and race distribution across banding pay points.	There are some gender and race pay gaps within bands, particularly at band 8D and above, and within several Medical and Dental roles.	- Gender Pay Gap	
Ensure any future Clinical Excellence Award scheme is implemented and designed to be inclusive, so further pay gaps are not created.	The historic CEA scheme has created a legacy gender pay gap of 30.2%. This compares to the current scheme, where money is shared equally between all consultants.	- Gender Pay Gap	

Action	What we know	Strategic and Reporting Links	2023 Progress update
Implement mechanisms, including an exit survey, to understand: 1. People's reasons for leaving the trust and whether this differs across demographic groups. 2. The length of service when someone leaves, to understand whether the rate of retention and turnover differs across demographic groups.	Our leavers data doesn't indicate that any demographic group is more likely to leave than others. However, we aren't sure what contributes to people's decision to leave.	- People Strategy - Retain and attract talent	The trust recently introduced a new exit survey, which we hope will enable a detailed analysis and understanding of people's reasons for leaving, and whether this differs by demographic group.
Key Theme 3: Leadership			
Partner with Executive Team to develop specific inclusion actions and priorities for each member of the Executive Team.	Research and best practice shows the importance of senior leaders visibly taking accountability for, and implementing, actions relating to inclusion.	- People Strategy - Compassionate and inclusive leadership	Each member of the Executive has identified at least 1 inclusion objective. These objectives, and progress made, will be communicated to colleagues across the Trust. Some members of the Executive Group have also asked their senior teams to develop their own inclusion objective.
Ensure our leadership development programmes build compassionate and inclusive leadership skills across our organisation		- People Strategy - Compassionate and inclusive leadership - WDES Metric 6	An approach to inclusive leadership development was piloted at the senior nurse away days, reaching 300+ colleagues.
Implement mechanisms for collecting and analysing the diversity of key decision making committees, this may include: 1. Trust Board 2. Board sub-committees 3. Governors	WDES and WRES data indicates that some data is missing relating to the diversity of Board.	- WRES metric 9 - WDES metric 10	

Action	What we know	Strategic and Reporting Links	2023 Progress update
Key Theme 4: Workplace Culture			
Develop and progress a Trust-wide strategy on violence and aggression, which addresses the variation of experience for colleagues from diverse groups. This strategy will focus on: 1. Governance - including our reporting mechanisms, support options post-incident, and understanding our data on experiences of violence 2. Environment – including our approach to providing security, pilots of body cams, and ensuring Trust environments are designed with safety in mind 3. Behaviour – building de-escalation skills and a trauma informed approach across the trust, setting the tone of the behaviours that are expected, and clear processes and support if these expectations are not met.	Our 2022 staff survey indicated that: - BAME and LGB colleagues were more likely to report experiencing physical violence from patients or service users. - Female, BAME, disabled and LGB colleagues were more likely to report experiencing harassment, bullying or abuse from patients or service users. - Disabled colleagues were less likely to report their experience of violence compared to colleagues with no disability. - A lower proportion of colleagues had made a report of their experience of harassment, compared to physical violence.	- WRES Metric 5 - WDES Metric 4 - People Strategy - Care for our people	Dave Thomas has been appointed as the lead for this project, with senior leaders identified to lead the three workstreams. A working group has been established within people services to progress the 'behaviour' workstream. Radar reports are being monitored by ADPCs and are being discussed in regular governance meetings at Service Group level. The induction workshop for internationally educated nurses is being reviewed, with the aim to include an honest discussion about racism and other forms of discrimination, inside and outside the workplace. Content would cover reporting incidents, raising concerns, and seeking support.
Develop an Inclusion 101 training box set. Short videos will give people the information they need to feel confident with the basics of inclusion. Topics could include, but are not limited to: 1. What are pronouns and why are they important? 2. What is a reasonable adjustment and why are they important? 3. What is a People Impact Assessment and how do I use the PIA Tool?	Conversations with teams and managers has highlighted a need for basic information and training to improve people's confidence to have conversations around inclusion. This information would impact interactions with colleagues and with patients.	- People Strategy - Develop our people	

Action	What we know	Strategic and Reporting Links	2023 Progress update
Develop effective, just and restorative policies, processes and guidance relating to bullying, harassment and discrimination.	Within the rainbow badge assessment, SFT scored 1 out of a total 4 points on questions relating to discrimination, bullying or harassment policies.	- People Strategy - Care for our people - WDES Metric 4	
Develop informative and effective policies and processes in relation to sexual safety.		- People Strategy - Care for our people	The 2023 staff survey will include a specific question exploring college experience of sexual harassment at work. The Trust has signed up to the NHS sexual safety charter, which includes a commitment to 10 key actions. A working group has been established to plan the Trust's implementation of this charter.
Review our opportunities for speaking up to ensure they are inclusive and colleagues from all demographic groups feel safe to access these options.		- People Strategy - Care for our people	
Review our wellbeing offerings to ensure they are accessible and inclusive, and meet the needs of diverse demographic groups.	Staff survey data highlights that: - disabled colleagues, LGB and male respondents were less positive about the Trust's action on health and wellbeing. - LGB and disabled colleagues were significantly more likely to report that they had felt unwell as a result of work-related stress.	- People Strategy - Care for our people	
Roll out allyship training across SFT		- People Strategy - Care for our people	Allyship training was piloted with the Executive Group late in 2022. Each member of the Executive has committed to co-deliver these workshop, which are open to all SFT colleagues. These sessions are running every month from September 2023.

Action	What we know	Strategic and Reporting Links	2023 Progress update
			To upskill and promote allyship within the People Services team, all members of the People Services team have been offered tailored allyship training, delivered by the Chief of people and organisational development and inclusion team. Over 60 people have attended, and the training has received excellent feedback. Bespoke inclusive leadership and allyship sessions have also been held for 300+ senior nurse and AHP colleagues.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Wellbeing Guardian Update
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Graham Hughes, Wellbeing Champion Non-Executive Lead
PRESENTED BY:	Graham Hughes
DATE:	7 November 2023

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

Executive Summary and Reason for presentation to Committee/Board	This report provides information on the work taking place around Colleague Wellbeing and more specifically around the nine principles set out for Wellbeing Guardians. Please note that one of the principles refers to equality, diversity and inclusion.
Recommendation	The Board is asked to discuss the report.

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

- ☐ Obj 1 Improve health and wellbeing of population
- ☐ Obj 2 Provide the best care and support to children and adults
- ☐ Obj 3 Strengthen care and support in local communities
- ☐ Obj 4 Reduce inequalities
- ☐ Obj 5 Respond well to complex needs
- x 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	x Workforce	☐ Estates	☐ ICT	☐ Patient Safety/ Quality
Details: N/A					

Equality and Inclusion **The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.** **How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?**
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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

WELLBEING GUARDIAN UPDATE

1. INTRODUCTION

1.1. This report outlines the health & wellbeing work undertaken since the last submission. It highlights areas of current work, future work streams, key challenges and any support needed from the Board. It is set in the context of several key strategies that underpin our endeavours.

2. NATIONAL PERSPECTIVE

2.1. As described previously, the NHS People Plan, the People Promise NHS Staff and Learners' Mental Wellbeing Review and the NHSE Health & Wellbeing Framework provides the basis on which we build our work. See Appendix 1 for more details. Evidence from key reports that have studied which organisational interventions best support staff wellbeing work are also taken into consideration. [1]

All of this sets the context around why there is a need for our continued focus on Wellbeing and more importantly the need for us to embed this within our organisation.

3. LOCAL PERSPECTIVE

3.1. At a local level, these documents and recommendations have helped to shape our Trusts People Strategy (2023-2028).

3.2. The Year 1 ambition of the People Strategy will be achieved through the nine deliverables that have been agreed:

- Reducing Violence and Aggression
- Just and Restorative Culture
- Digital
- Leadership Capability
- Engagement
- Retention
- Recruitment
- Future Workforce Models
- Strategic Workforce Planning

3.3. In addition, each Trust is encouraged to complete the NHSE Health & Wellbeing Framework diagnostic tool to establish a baseline, covering seven key areas.

[1] Organisational Interventions to Support Staff Wellbeing K Teoh et al March 23 Birkbeck University of London

3.4. Appendix 1 details the results from the self-assessment, the tool and results are used to support the Wellbeing agenda for the Trust. Whilst all areas will need more work over the coming years, the focus in 2023 will be those areas highlighted as the least developed in the baseline survey.

3.5. The recent iteration of the Wellbeing Action Group (WAG) sets its purpose as implementing actions that are impactful, sustainable and infuse wellbeing across the trust. One of the key objectives to achieving this is triangulate all intelligence relating to wellbeing, enabling informed decisions to be made and appropriate actions taken to support our colleagues. The WAG holds the responsibility for identifying, reviewing, and progressing the wellbeing agenda to see organisational change that has a measurable impact on the wellbeing of our colleagues.

4. NHS SURVEY AND PEOPLE PULSE

4.1. The NHS staff survey results for our organisation shows positive results compared to the national comparator group average for:

- my organisation takes positive action on health and wellbeing.
- colleagues experiencing work-related Musculo-skeletal injuries.

4.2. The national People Pulse survey will provide evidence of progress throughout the year. See Appendix 1 for more detail on both survey results.

5. INTERNAL AUDIT FOR HEALTH & WELLBEING

5.1. Internal audits were carried out across both legacy organisations last year. Recommendations have been incorporated into an action plan which covers four key priority areas:

- **strengthening the governance structure for health & wellbeing including, reviewing reporting arrangements** – this objective has been achieved through broader representation in both the WAG and Culture Strategy Group. As a result, the responsibility for wellbeing is no longer confined to a single team, other stakeholders can now participate, enabling them to gain insights from colleagues in their service group and contribute to shaping work priorities.

- **gaining adequate feedback on wellbeing initiatives & services** – objective has been completed with the exception of the development of the wellbeing champion survey. Collecting this data allows us to assess whether we are making the right choices for our colleagues and the organisation. For example, see Appendix 1 for the data on 1:1 interventions with the Colleague Support Service that show clinically significant changes pre and post intervention on the mental wellbeing of colleagues who accessed the service.

- **better utilising the available data** – this objective is well underway, with an initial dashboard currently in development. Additionally, a

subset of the WAG is focussing on optimising data utilisation. For example, a recent impact of using the data has been in the feedback from the rollout of wellbeing conversation training. It has enabled us to see who in the participant group is routinely having wellbeing conversations and how confident they are in having them. Cumulative data is now coming in for the impact at three and six months.

- **enhancing the role of the wellbeing guardian** – this objective has been achieved and our wellbeing guardian has participated in walk-around visits alongside other executives to various teams. Any identified themes and observations will be brought back to the WAG for discussion.

6. KEY FINDINGS

6.1. The following section identifies key areas of interest for health and wellbeing and the actions taken or planned actions, plus any known impact.

- With Musculo Skeletal being one of the top reasons for absence within the Trust, there is a service enabling colleagues to self-refer into Physio4U as part of the wellbeing offer. The Service Level Agreement, (SLA) currently offers 60 slots per month, with a KPI that states from the first call to the first appointment it will be no longer than 2 days. Since April 2023 we have seen referrals into Physio4U regularly exceed the 60 slots per month and this is increasing as September 2023 data reported 97 referrals. (see Appendix 1) A review is underway for additional funding to support the access for colleagues following the merger of SFT and YDH, whilst this is ongoing an agreement has been made to reduce the KPI from 2 days to 5 days from first call to first appointment. Work needs to continue to understand the new data following the merger and the impact on delivery of service as well as understanding whether this service is also supporting the Trust avoid cost through keeping colleagues in work and not adding to absence. We acknowledge the impact of the current service is that colleagues may not get rapid access at all venues, due to demand. This will continue to be monitored through the monthly data and discussed at contract review meetings and amendments made accordingly.

- Stress and Anxiety is another top 3 reason for colleague absence and this is reflected in the Colleague Support Service data, with the top themes for colleagues using the service being anxiety, workplace stress and low mood. Data collected within the service, Appendix 1, informs us that colleagues are being supported to manage their specific needs around stress and anxiety - see Appendix 1 demonstrating clinically significant intervention score data. For managers supporting teams and colleagues with stress there is an offer of courses focussing on stress risk assessments as well as a bespoke offering for teams from the wellbeing team to help complete team stress risk assessments enabling actions to be identified. Further data and follow-up is required to assess impact of this support. A winter wellbeing programme has been developed to sit alongside the flu/covid campaign. This will

include webinars for colleagues on subjects that will support an individual to develop skills to support themselves. This type of input has been requested by colleagues via the CSS and wellbeing champion group.

- Using incident data, plus contact with wellbeing services, it is recognised that teams and individuals may need Staff Support Post Incident (SSPI) interventions which is a level 5 intervention. These are provided regularly each month for on average 5 teams up to a few weeks after an incident. This has the impact of group support and reflection post incident with positive coping strategies being identified which will hopefully enable an individual to avoid longer term mental health impacts. It was further identified that a more immediate, robust approach was needed and the TiM (Team immediate Meet) Tool was introduced. It has been piloted in ITU with 25 colleagues already trained and will extend to maternity services shortly. Improved access to immediate support following distressing events will increase the likelihood that staff will develop and maintain positive coping strategies. The data on impact is currently being analysed.

- It is known that colleagues in Critical Care encounter greater exposure to distressing events during their work and experience the impacts of this from relatives and patients too. A specific project for embedding a wellbeing practitioner within ITU has been in place since October 22. The aim of introducing a wellbeing practitioner onto ITU was to reduce sickness absences, reduce agency spend and to reduce time lost to incivility. Clinically significant outcomes can be seen for those working 1:1 with the wellbeing practitioner. Regular monthly group compassion circles are well known about and used. A range of communication channels are used to let the team know what is planned. Consistency of having a known colleague embedded within the team has also had a positive impact on uptake of services. See Appendix 1 for feedback from ITU colleagues.

- Lack of space for wellbeing conversations or adequate rest space for colleagues has been highlighted from several sources over a number of years. Most recently when delivering the wellbeing conversation training it has been emphasised by participants and was highlighted in the ITU project where finding a space for the wellbeing practitioner to see ITU staff is very difficult and an ongoing issue. Action on developing a wellbeing space at MPH has been put on hold until sometime next year. The impact is that colleagues still have fewer spaces to rest, away from visitors and patients and a private space for wellbeing conversations to take place.

- Analysis of the EAP (Employee Assistance Programme) data shows that usage has reduced, whilst CSS data shows an increase in usage. Reviewing these sources of data has resulted in a discussion with Optima our Occupational Health provider about costings for the EAP for next year. Different options are being explored. The impact of this is

unknown at present but could result in a redirection of funding to our own Trust services.

- Analysis of the other Occupational Health Services data show that our headcount is 62% higher as a merged Trust. 87% of pre-placement candidates are indicating over three underlying health conditions which require an additional review. We have an aging workforce and overseas colleagues from high risk TB areas need extra testing. This has an impact on the resource required to deliver the service. This will impact on the price for the final year of the contract.

- Cost of living group – main themes: mileage claim timescales, offering better options for colleagues e.g. new salary sacrifice schemes, new credit union Serve & Protect, signposting to relevant agencies and offering an individual check in on financial matters. Data shows colleagues are using the credit union – early figures show from the first two weeks of Sept after the launch, there were 34 colleagues signed up, 12 had applied for loans with the average amount £4,900. We are expecting it to enable colleagues who may not access other forms of credit/loans to have access to affordable loans, thus reducing the use of high interest loans. Also, the safeguards put in place, ensure that anyone refused a loan has access to further financial support. Debt consolidation is an identified reason for using the service. This is important to note, as referrals into wellbeing services for financial support are increasing and we know the cost of living pressures are a source of stress for colleagues. The knock on effect influencing other lifestyle factors such as quality of sleep and food intake. These factors can influence work performance.

- Colleague Housing group: pressure on accommodation across the Somerset system is immense, this also impacts on local school provision as families can't get their children into the schools they want. We have an issue with lack of reasonably priced family housing for colleagues. Also a reported underlying inequality in international colleagues being able to get the housing on offer. Feedback from courses such as customer care for international nurses demonstrate that for some, basic needs such as suitable housing, are not being met. The ICB is coordinating the development of a housing hub linked to other ICB systems, plus the promotion of other initiatives such as Home Share which we can be part of. The Colleague Housing meeting to date, has improved communication amongst teams, identified some custom and practice that could be reviewed and sourced new accommodation for colleagues at the Cannonsgrove site near Taunton.

7. CHALLENGES

- Changing ways of working and using a greater emphasis on using data takes time to embed. Collaborating with colleagues in the workforce information team to develop a data dashboard to bring sources of data, relating to wellbeing in one place is underway. Deciding on how best

to use this data is work in progress. It can be difficult to pinpoint and triangulate, how the data we do have, helps the wellbeing agenda. Some benefits will be seen at a later stage, not always immediately and not captured in a quantitative way. We need to explore further some assumptions about how, what we have done, prevents absence getting any worse and the cost avoidance of this.

- Future planning of provision for the Colleague Support service post March 24 is a risk due to the reduction in funding. This will result in team members looking for other jobs soon and a reduction in provision.

- Funding for capital projects is fiercely competitive – specific rest/wellbeing spaces for colleagues on acute sites particularly is not being prioritised highly enough. The messages it sends to colleagues is ambiguous when we are asking them to take breaks etc for patient safety reasons.

- Cost of living pressures on colleagues is great. As a Trust we need to identify what we can do to help and maintain the balance between what is the responsibility of the colleague and what as a compassionate, kind Trust, we can support.

- Enabling wellbeing conversations, respectful resolution and leadership development offers to be taken up in already stretched operational teams.

- Continued pressure on colleagues and the impact on colleague wellbeing, in turn the impact on patient safety and experience.

8. RISKS

- The reduction in funding for the CSS post March 24. This will be recorded on the People Services risk register.

- Physio4U service is not funded at the level that is needed to fully integrate YDH colleagues, this is resulting in a longer wait than the SLA. A risk assessment is to be developed.

- Increased cost of the general Occupational Health Service for the year 2024.

9. FUTURE WORK

- Development of a Health and Wellbeing roadmap to enable effective communication of the Health and Wellbeing approach and will outline a more proactive approach to infusing and embedding wellbeing systemically across the Trust.

- Continue to work with colleagues in workforce information to create a data dashboard for Health and Wellbeing, bring all data sources into one place for review and analysis.

- To further understand the impact of the work around Stress and MSK and the impact of this on absence for the Trust.

- Delivery of the Winter Wellbeing Conference 14th November focussing on retention and evaluate the impact of the webinars to use for future wellbeing initiatives.

- Continue to evaluate and review all data related to Wellbeing initiatives and continue to review and discuss at WAG.

- Review the HWB framework diagnostic tool to assess what progress has been made on the three areas for focus.

- Continue the review of Trust current Occupational Health services, Physio4U and EAP provision, to establish value for money and potential new providers ready for January 2025, to include the potential bringing back in-house of certain services.

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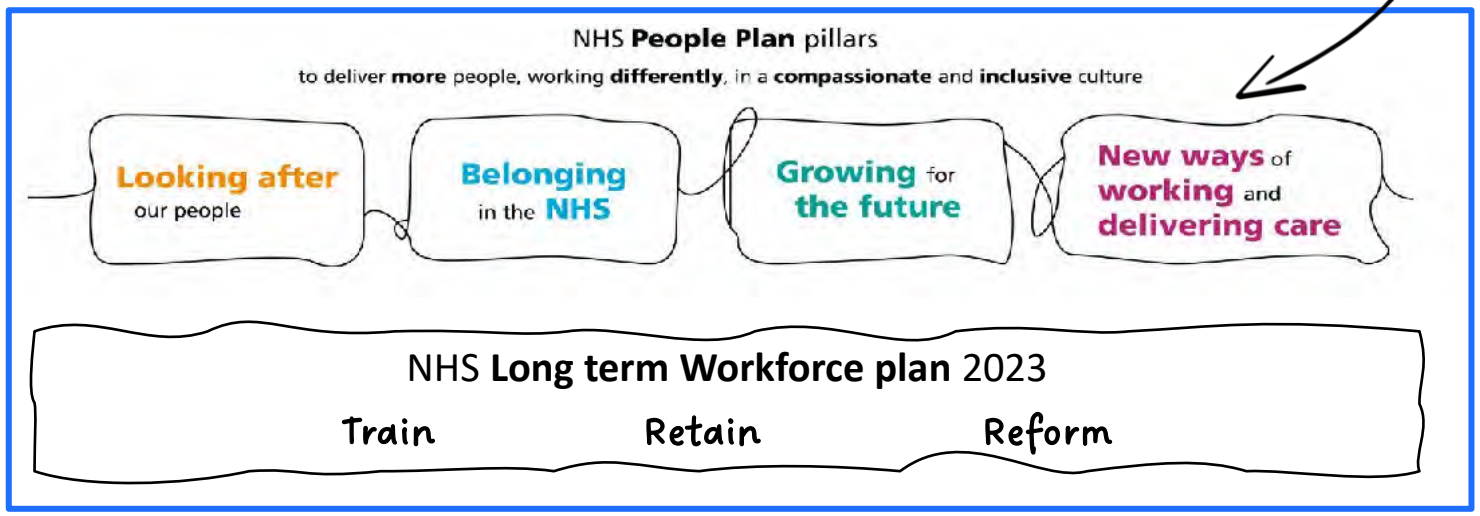
Wellbeing Guardian Report to the Trust Board Nov 23 Appendix 1

Kindness, Respect, Teamwork
Everyone, Every day

Context setting

The national plans



Kindness, Respect, Teamwork
Everyone, Every day

Somerset NHS Foundation Trust

Somerset Foundation Trust People Strategy
2023 – 2028

- **Care for our people**
- Develop our people
- Compassionate and Inclusive leadership
- Retain & attract talent
- Learning and Transformation

The commitments

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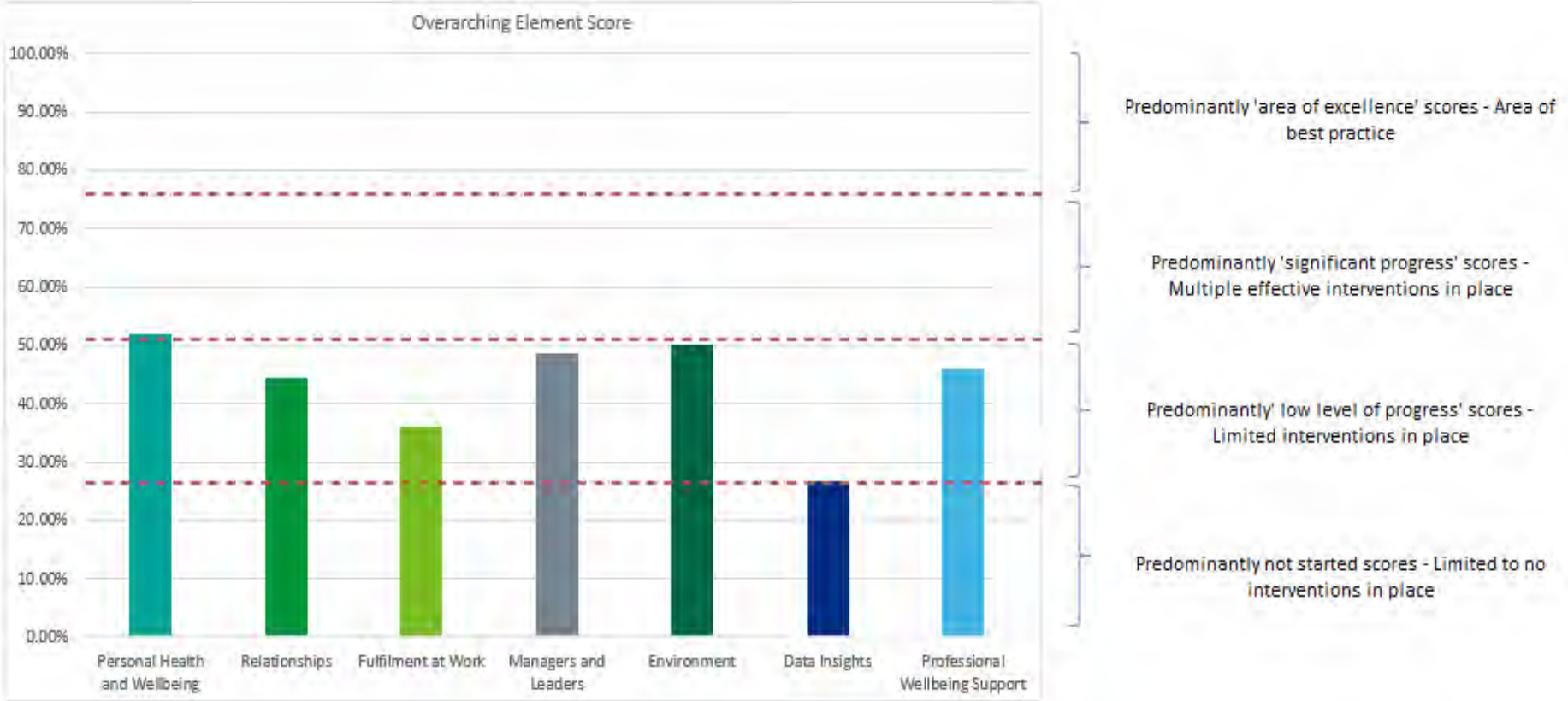
People Strategy Ambitions

Care for our people

We are safe and healthy ·We are recognised and rewarded · We have a voice that counts

Health & Wellbeing	Through healthy working lives colleagues will prioritise their physical and mental health equally. Wellbeing will be weaved through everything we do.
Violence and aggression	Develop and implement an approach to reduce violence and aggression, address systemic issues, and deliver long term improvements in our staff survey results
Speaking up	Foster a culture where colleagues have a strong voice and are empowered to speak up, share ideas and co-design solutions
Just and restorative culture	Underpinned by kindness and psychological safety focus on candid conversations and identifying solutions which address systemic issues
Belonging	Celebrating, recognising, respecting, and rewarding colleagues for their unique contribution
Environments	High performing teams who work, learn and rest in the best possible environments, where everyone is valued and recognised as a leader

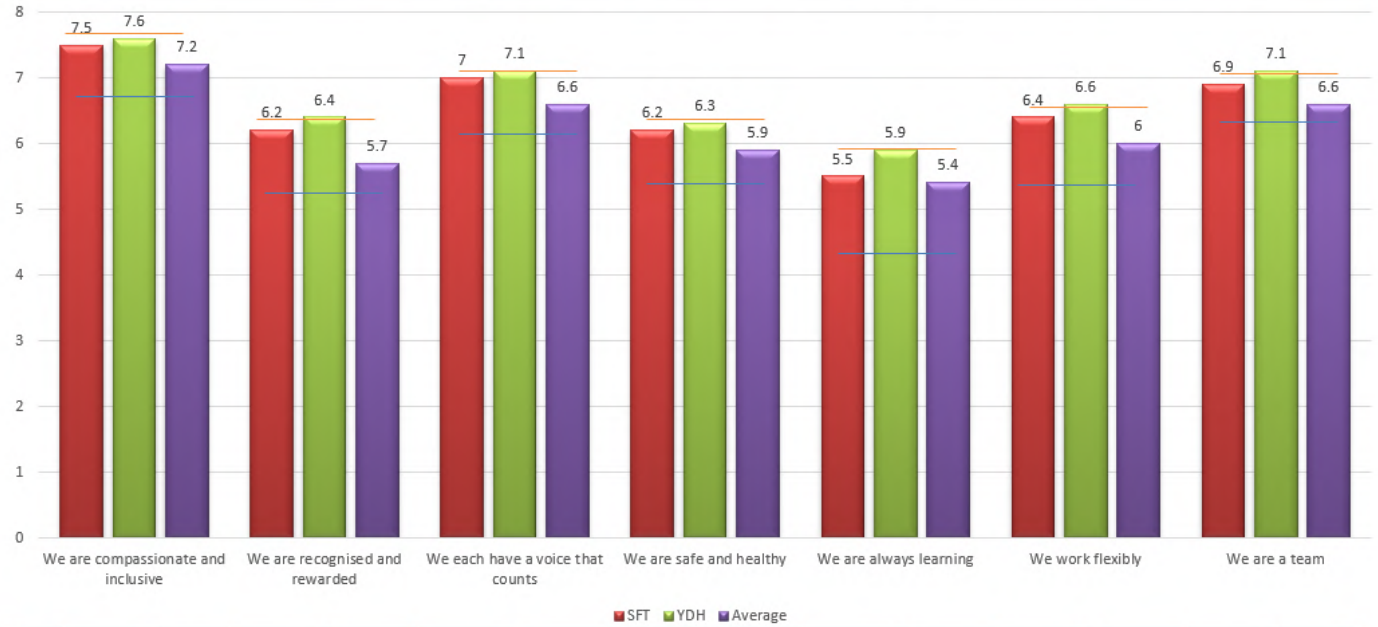
Health & Wellbeing Framework Diagnostic Tool
Seven areas - scores



NHS Staff Survey 2022

Yeovil District Hospital NHS Foundation Trust

People Promise Element Results



Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1
SFT	7.5	6.2	7.0	6.2	5.5	6.4	6.9
YDH	7.6	6.4	7.1	6.3	5.9	6.6	7.1
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3

Kindness, Respect, Teamwork
Everyone, Every day

NHS Staff Survey 2022

My organisation takes positive action on health & wellbeing

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Health & Safety climate	YDH 2021	YDH 2022	SFT 2021	SFT 2022	Peer Average 2022
My organisation takes positive action on health & wellbeing.	73.8%	71.4%	61.7%	62.1%	55.6%
	69% consultants 50% SAS	50% consultants 58% SAS	69% consultants 61% SAS	50% consultants 58% SAS	

NHS Staff Survey 2022

Experience of MSK problems as a result of work activities

NHS Somerset NHS Foundation Trust

Negative experiences	YDH 2021	YDH 2022	SFT 2021	SFT 2022	Peer Average 2022
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	27.1%	27.6%	27.5%	27.2%	30.6%

NHS Staff Survey 2022

During the past 12 months have you felt unwell as a result of work-related stress

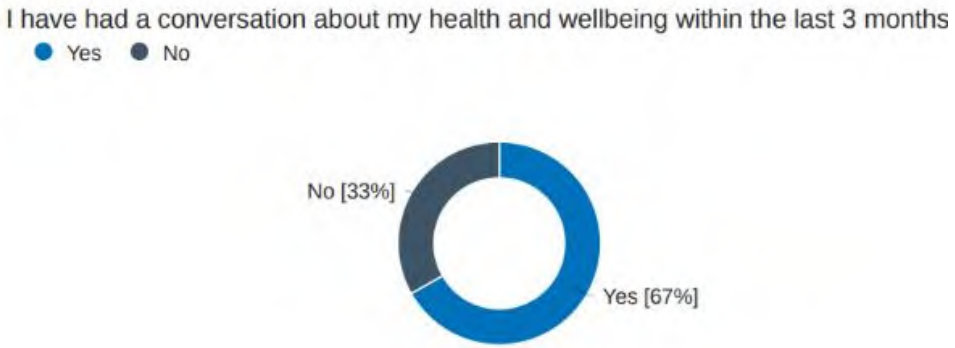
NHS Somerset NHS Foundation Trust

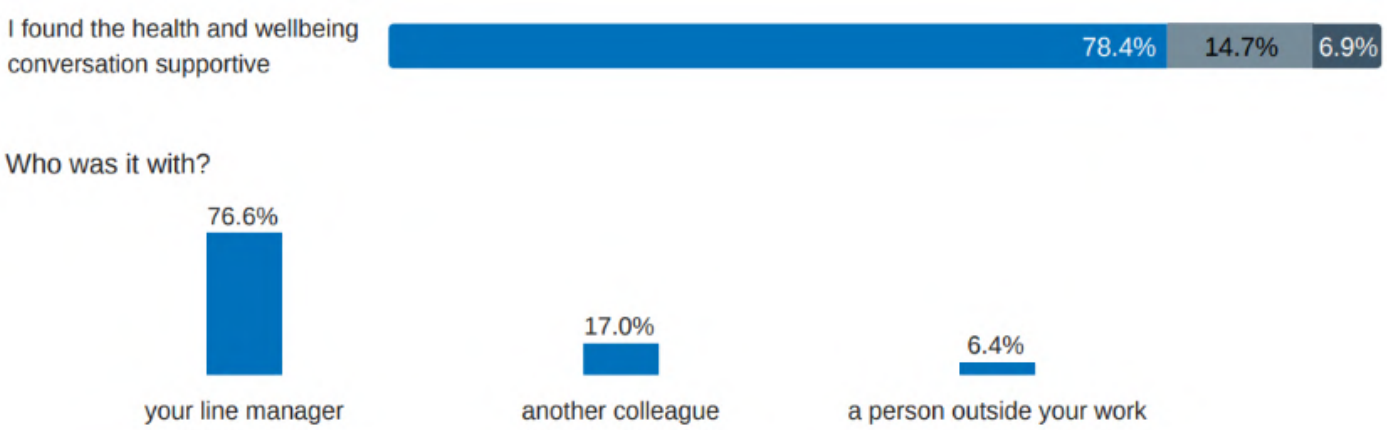
Negative experiences	YDH 2021	YDH 2022	SFT 2021	SFT 2022	Peer Average 2022
During the last 12 months have you felt unwell as a result of work-related stress?	38.5%	38.7%	44.5%	40.9%	45.1%
Senior Doctor results		62%		52%	58% average (not peer)

Pulse Survey April 23 n =373

NHS Somerset NHS Foundation Trust

Wellbeing Conversations





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Pulse Survey April 23 n =373

My organisation is proactively supporting my health & wellbeing

Colleague feedback	New SFT April 23	YDH Jan 2023	SFT Jan 2023	UK PLC benchmark April 23
My organisation is proactively supporting my health and wellbeing.	56.3%	69%	62.0%	56.8%

Pulse Survey April 23 n =373

In my team we support each other

Colleague Feedback	New SFT April 23	YDH Jan 2023	SFT Jan 2023	UK PLC benchmark April 23
In my team we support each other	75.9%	82%	81.8%	70.9%

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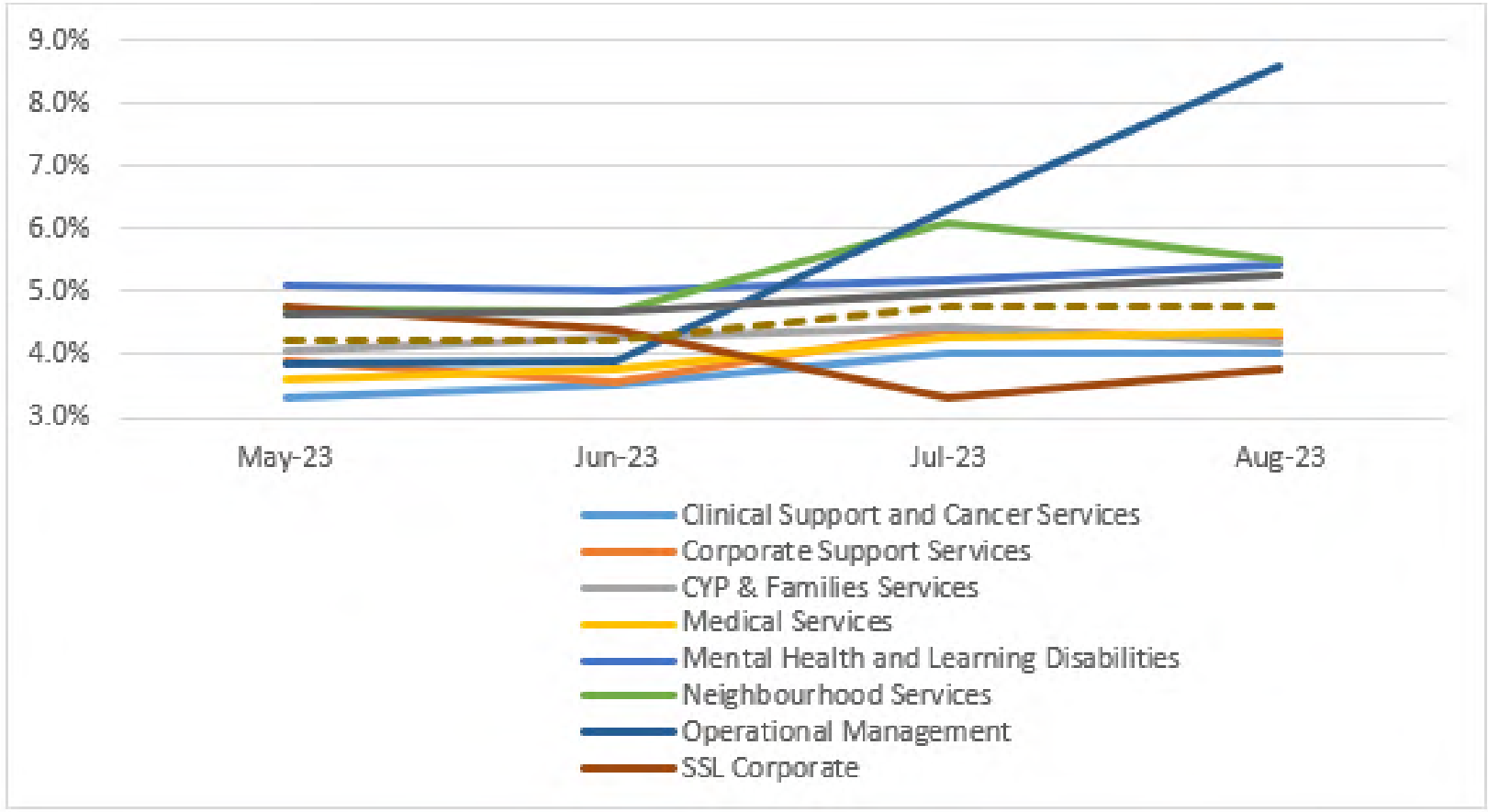
Speaking Up Data 2023

Speaking Up data	Number of concerns with an element of worker safety or wellbeing
Q1 2023-24	22
Q2 2023-24	35

Sickness Absence data

Sickness Absence rolling total for Trust and Service Care groups May 23 – Aug 23



Top 3 reasons for absence May – Aug 23

- S10 Anxiety/stress/depression/other psychiatric illnesses
- S12 Other musculoskeletal problems
- S99 Unknown causes / Not specified

Physio4U Service

April 23 – Sept 23 referral data SFT

	April 23	May 23	June 23	July 23	Aug 23	Sept 23	Year Total	Total since Sept 21 Launch
Number of P4U Self Referrals	64	77	71	67	86	97	462	1467
% Receiving appointment within 2 working days	97%	83%	97%	94%	85%	52%		
Number of F2F follow ups	34	46	42	42	54	53	271	881
% Requiring F2F follow-up following initial consultation	53%	60%	59%	63%	63%	55%		

Breakdown of users of the EAP September 22 – August 23

NHS Somerset NHS Foundation Trust

Clients	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Total
New User	1	1	1	0	5	0	5	2	4	3	2	2	26
Repeat Caller	0	0	0	0	0	0	0	0	0	0	0	0	0
Re-User New Problem	2	0	0	0	0	1	0	1	0	0	0	0	4
Re-User Same Problem	0	0	0	0	0	0	2	0	0	0	0	0	2
Prefer not to say	0	0	0	0	0	0	0	0	0	0	0	0	0

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Breakdown of the services used in the EAP September 22 – August 23

Further interventions	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Total
Passed to Legal Helpline	0	1	0	0	0	0	0	1	0	1	0	0	3
Passed to Debt	0	0	0	0	0	0	0	0	0	0	0	0	0
Referred /Signposted to GP/NHS	1	0	0	0	1	0	0	0	0	0	0	0	2
Recommended Voluntary /Private Services	0	0	0	0	0	0	0	0	0	0	0	0	0
999/Emergency Services	0	0	0	0	0	0	0	0	0	0	0	0	0

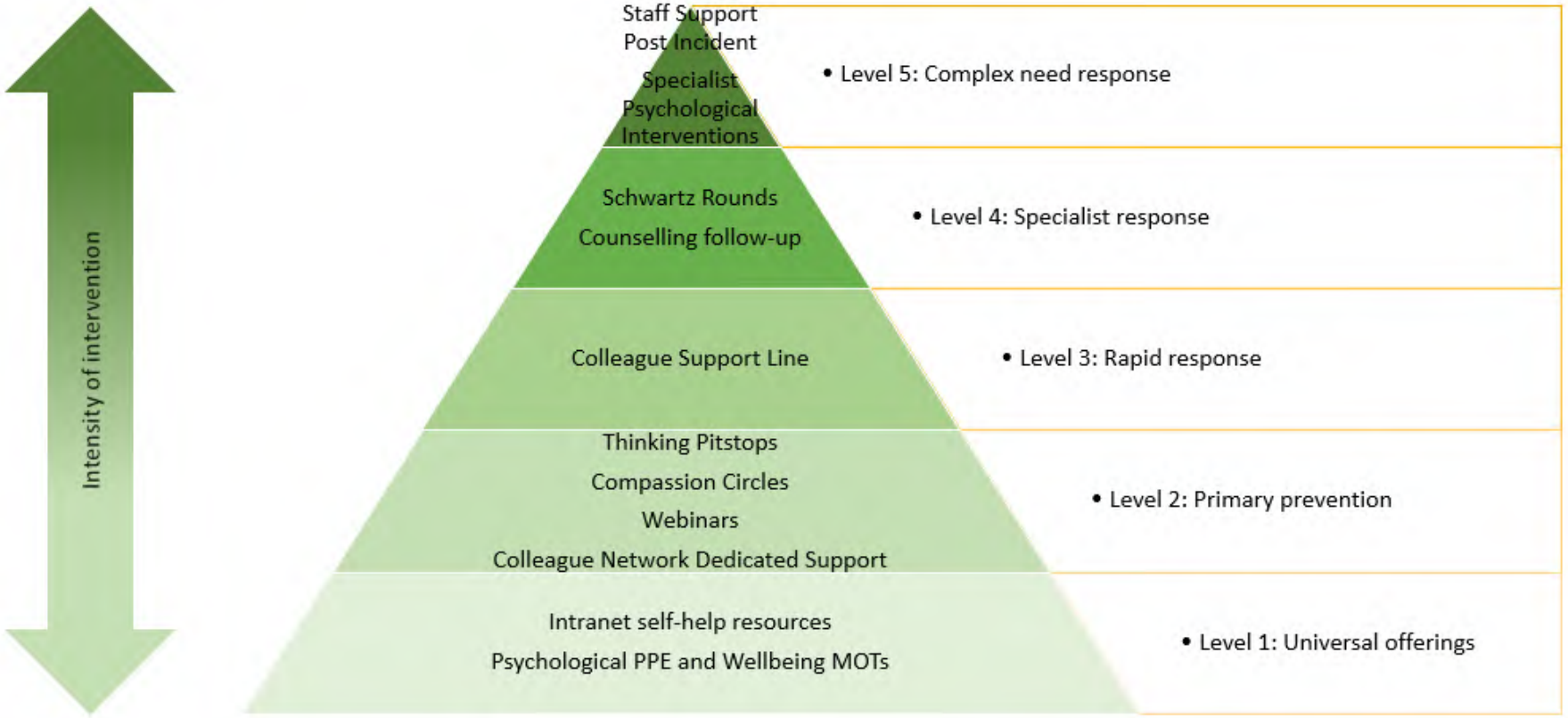
Breakdown of counselling services used in the EAP September 22 - August 23

NHS Somerset NHS Foundation Trust

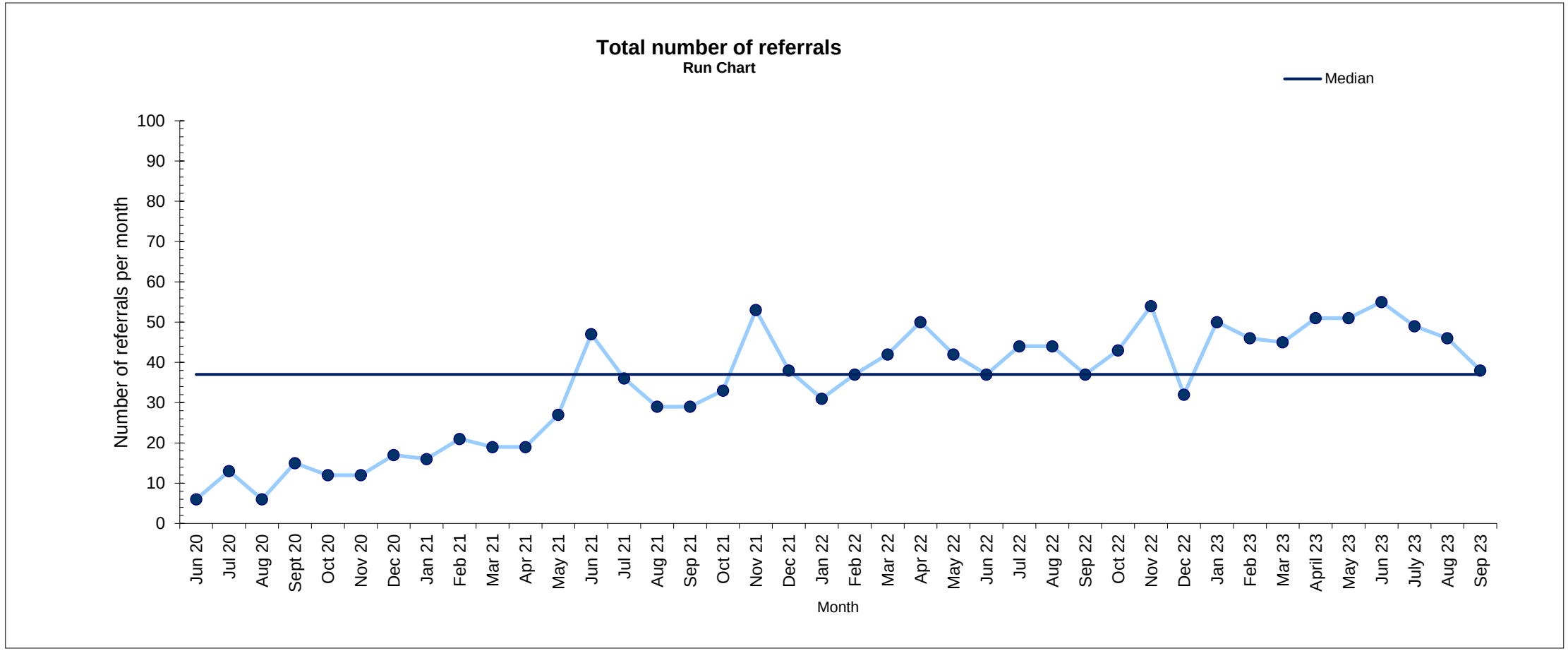
Counselling referrals	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Total
Referred to face to face counselling	0	0	0	0	0	0	0	0	0	0	0	0	0
Referred for telephone counselling	0	0	0	0	0	0	3	1	0	2	1	0	7
Passed for computerised CBT	0	0	1	0	0	0	0	0	1	0	0	0	2
Referred for video counselling	0	0	0	0	2	0	1	1	0	0	0	0	4

Colleague Support Service interventions

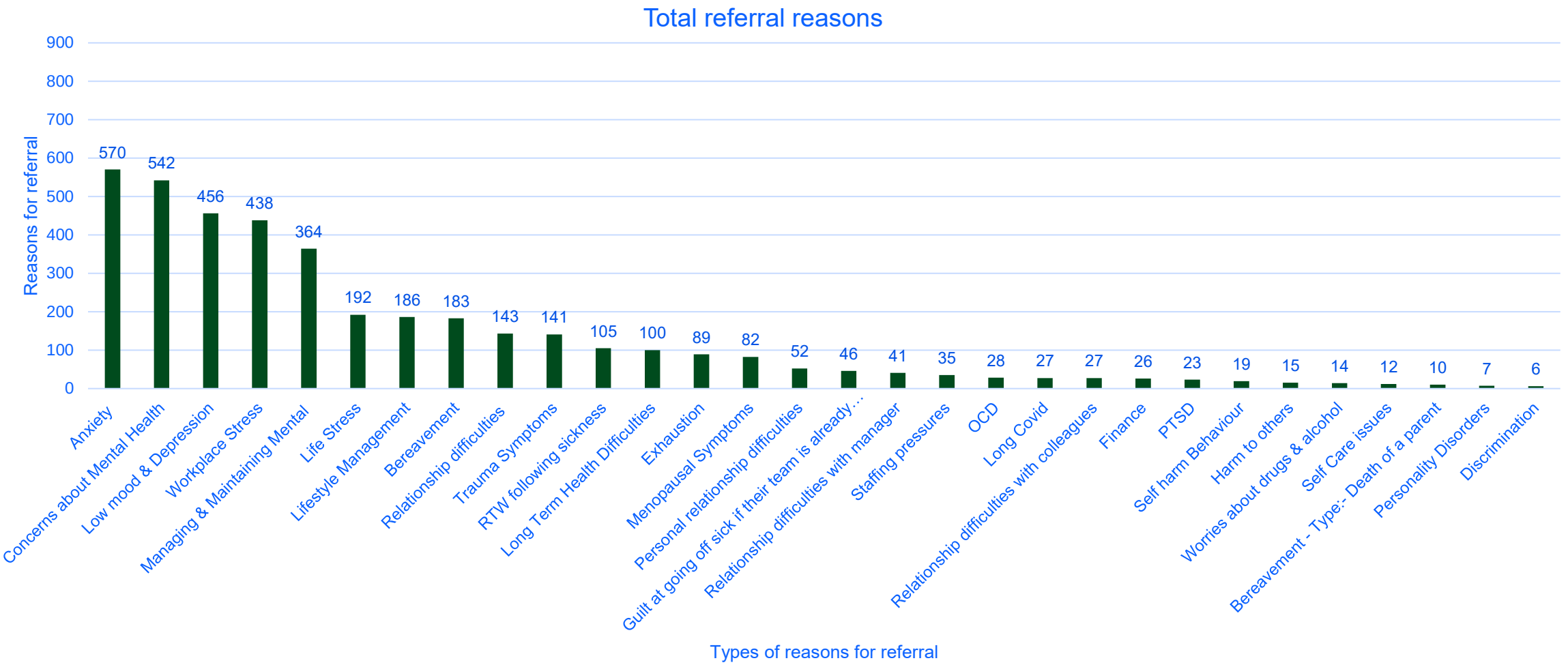
Tiers of intervention for individuals, teams and the organisation



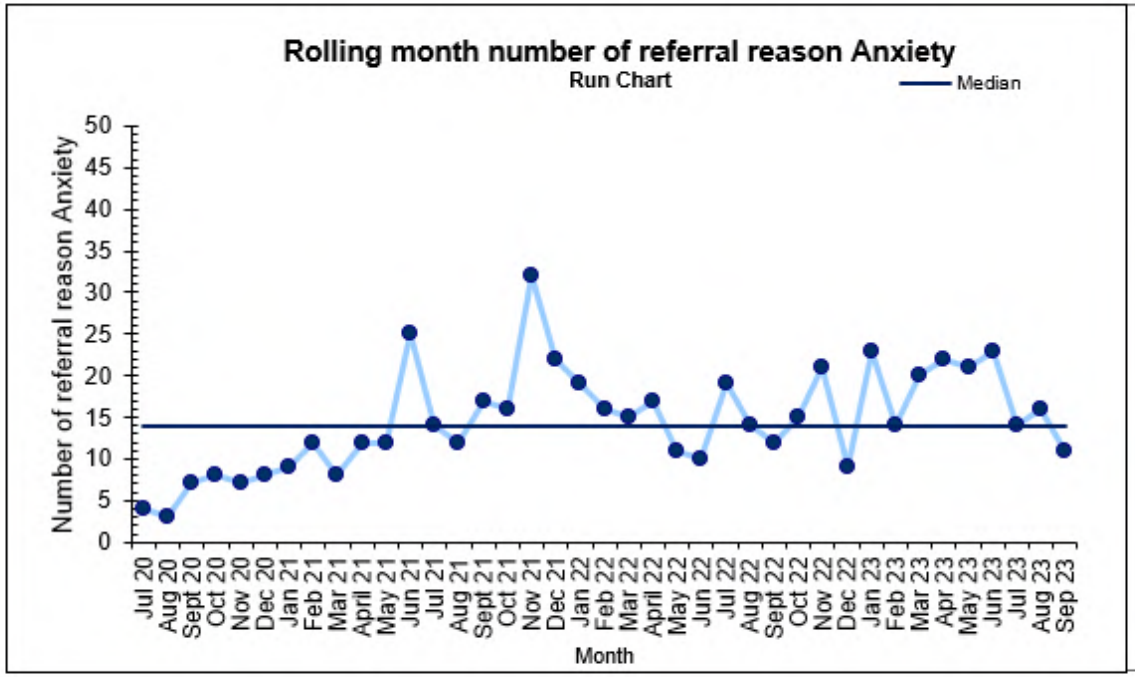
Total referrals for telephone line

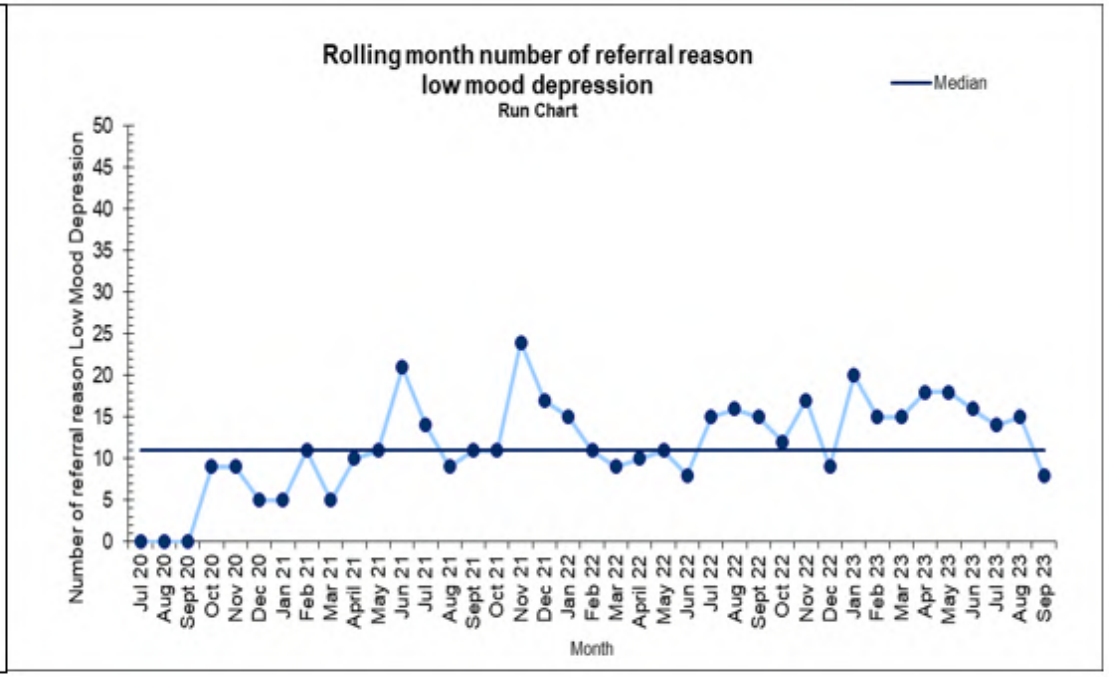


Reasons for referral



Reason for referral: Anxiety and Depression Run charts





Individual referrals for specialist care

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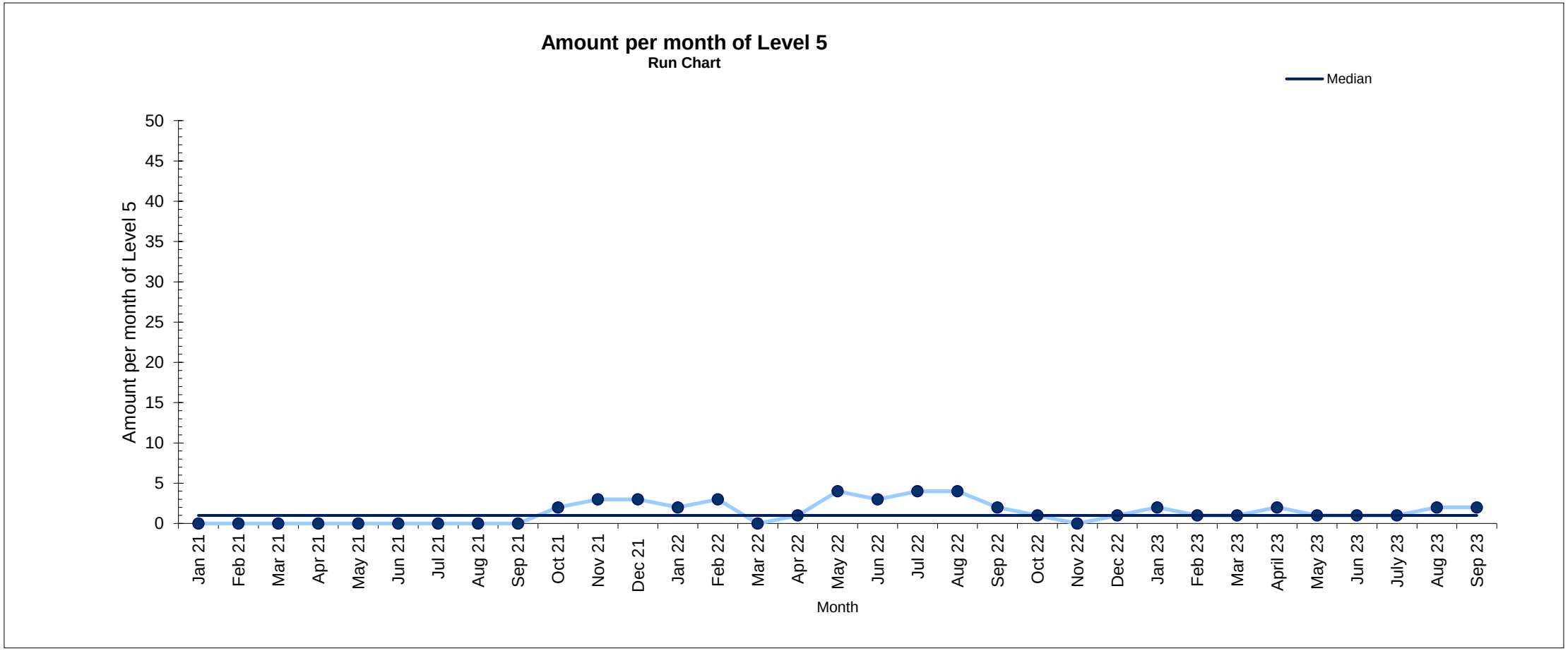
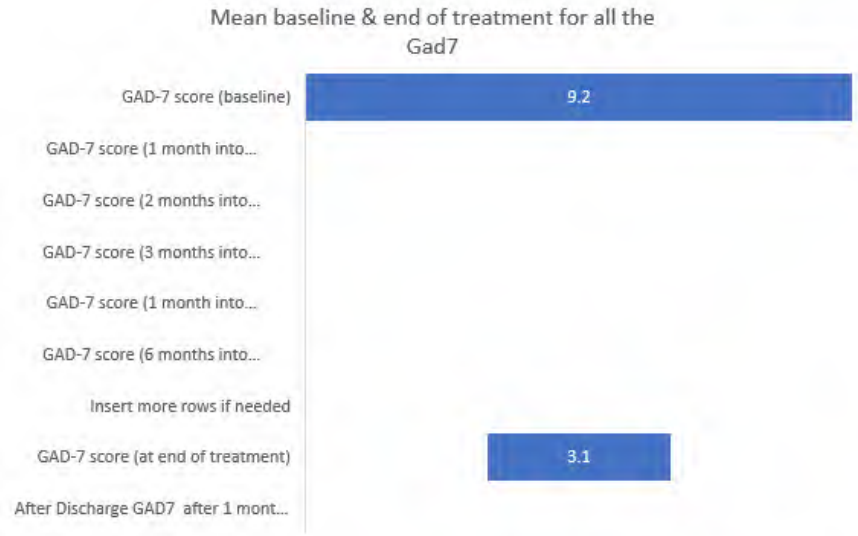
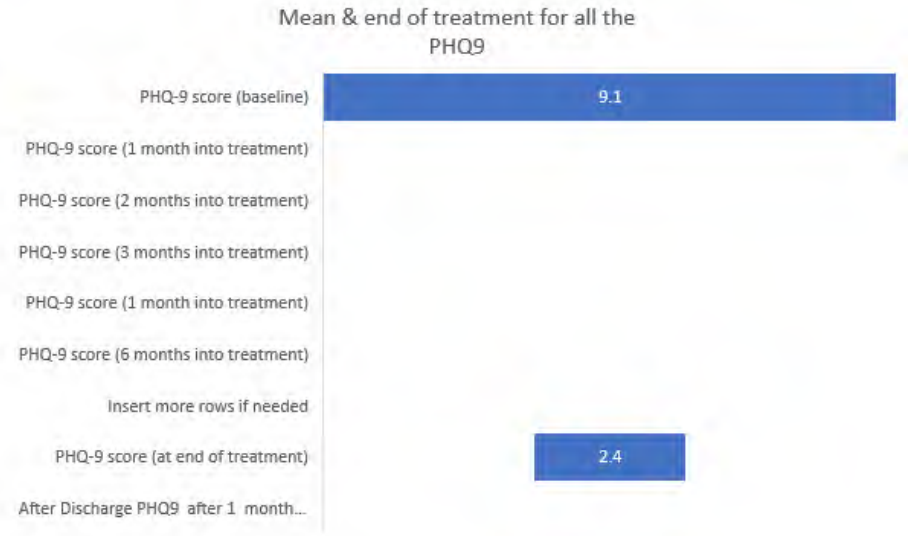


Clinical Impact: Individual GAD-7 and PHQ-9 scores

Clinical Impact: Individual GAD-7 and PHQ-9 scores





Clinical thresholds:

- 0-4 low symptom level
- 5-9 moderate symptom level
- 5 point change is considered clinically significant

Onward referrals to other services (balance measure for impact and non duplication of service)

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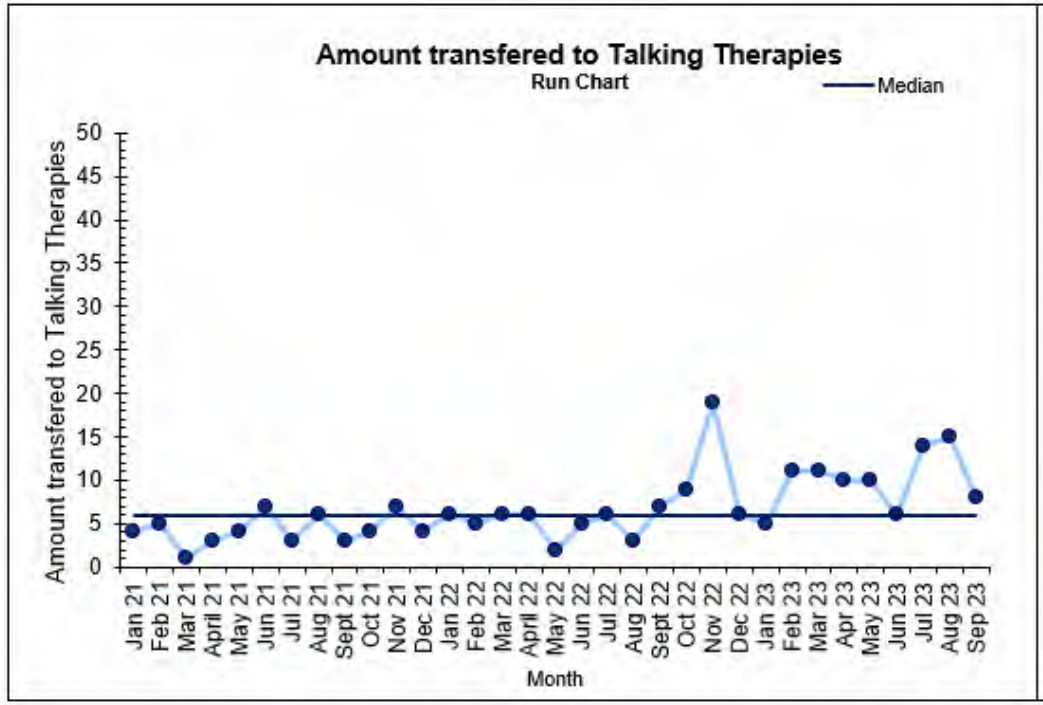
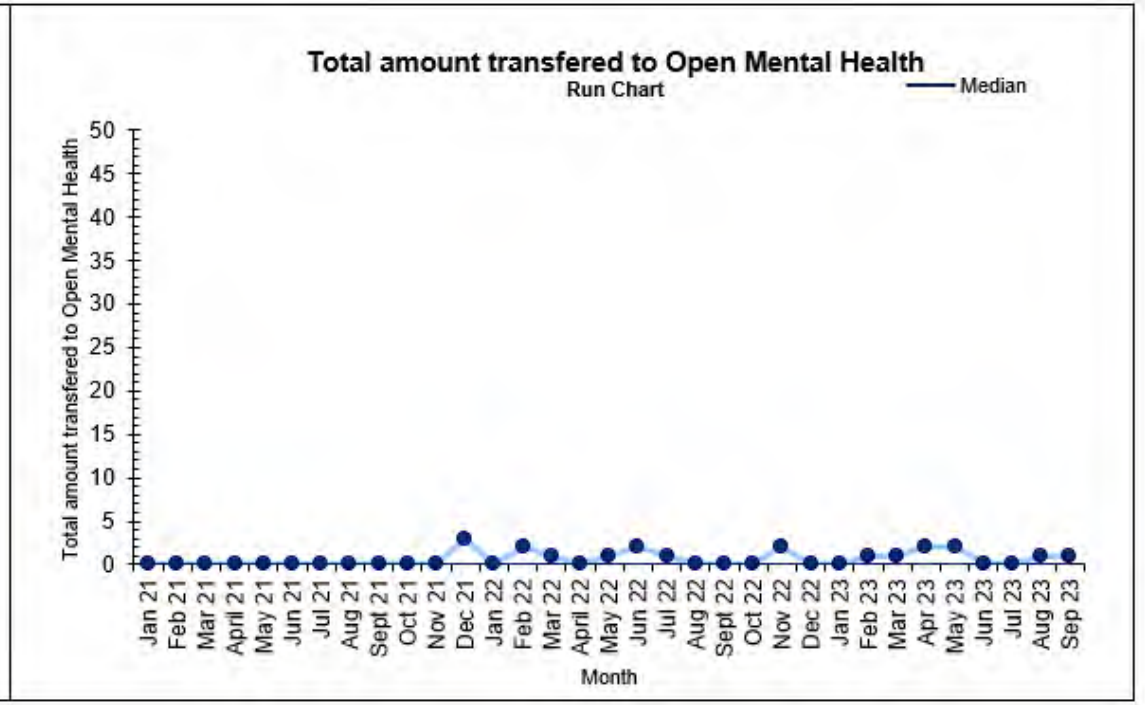




Feedback Quotes:

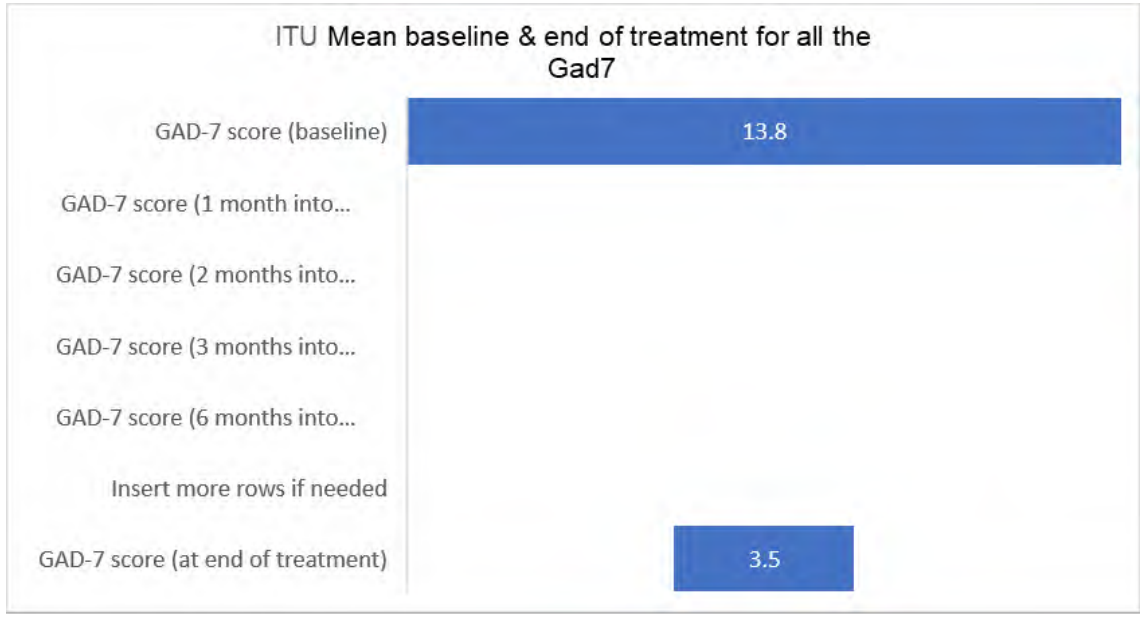
The call handler was wonderful. They got me through a very tough time

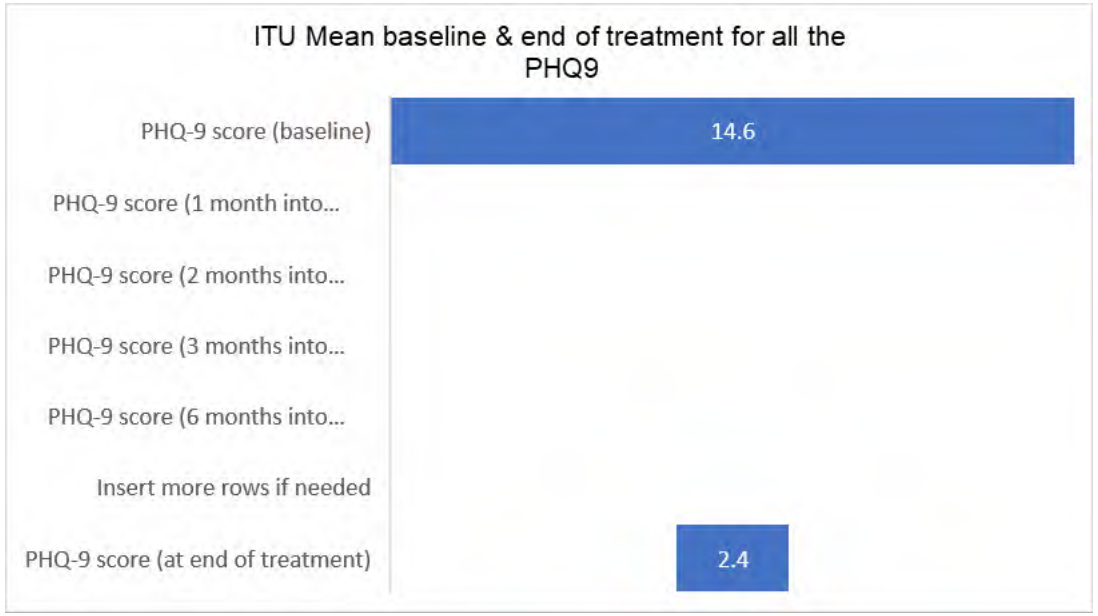
Hello this has been a helpful service; I was so stressed with work that I was at the point of leaving. The counselling supported me to discuss my issues, helped me highlight my concerns to management. It helped me unpick the areas of stress and helped me to feel listened too. I feel much calmer and more relaxed now, and because of the support I feel able to continue in my role. I'm very grateful for this service and support.

Having reached a point where I felt taking some time off work was my only option, I accessed the colleague support service. It was easy to access, the response was quick and the colleagues I spoke with were professional and compassionate and immediately made me feel I didn't have to manage on my own. In my appointment the call handler was kind and really helped me to understand why I was experiencing what I was, this made me feel like I wasn't going crazy and was a normal response to what had happened. The call handler gave me some helpful techniques to manage some distressing symptoms. Ultimately, this service has helped me to stay in work in a way that supported my mental health and wellbeing. I cannot say how grateful I am to the service, I would highly recommend it to other colleagues and feel it is an asset to SFT, particularly given how affected so many people have been by events of the last few years.

ITU wellbeing practitioner project

Somerset NHS Foundation Trust





ITU Feedback

“Having an ICU to see my GP and being referred into mental health services. It means I can be seen quickly, without problems getting worse.”

“Being in a difficult place and struggling to find the energy to do anything, it was really easy and required minimal energy to email X about support.

It also helped having already met and chatted to x, so it made it feel a bit more comfortable to reach out.

It was quick and easy to start, and benefits have already been noticeable.

It has helped me stay at work rather than continue to downward spiral and need time off. The service has been invaluable to myself and others, and I know people who have said they have reached out when they wouldn't otherwise and how helpful it’s been".

“It is so important that the psychologist is embedded- I feel they really understand the context of my work.”

Actions taken so far

Introduction of financial wellbeing resources such as WageStream for bank colleagues and the Serve & Protect Credit Union for all

Inclusion of YDH colleagues into the Physio4U service Sept 23

Revamp of the WAG and wider participation from stakeholders

Team immediate Meet (TiM) Tool pilot in ITU

Wellbeing Guardian Walkabouts on wards

Initiatives to support specific team wellbeing, including Compassion Circles, focus on specific topics such as menopause

Principal Psychologist CSS supporting the capital projects team to use a trauma-informed approach to building design

Flu & Covid Vaccination Project

Roll out of training on having effective Wellbeing Conversations

Identification of what data sources we could use to support wellbeing themes

Winter wellbeing conference

Inclusive Leadership Development within the senior doctor wellbeing plan

Roll out of wellbeing champion training across the Trust with a follow-up training programme in place to include FTSU training and topics requested by champions

Health Protection – health surveillance- reviewing documentation

Review of Occ Health Services to include EAP for year 2024.

Non- Executive Wellbeing Guardian principles reviewed regularly

Piloting emergency period products at MPH

Coordinating a Trustwide Housing group to review accommodation issues for colleagues

Somerset NHS Foundation Trust

Kindness, Respect, Teamwork
Everyone, Every day

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Annual Medical Appraisal Report
SPONSORING EXEC:	Daniel Meron, Chief Medical Officer
REPORT BY:	Reenee Barton, Medical Appraisal Lead
PRESENTED BY:	David Beacock
DATE:	7 November 2023

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

Executive Summary and Reason for presentation to Committee/Board	Each year the trust is required to provide a detailed report to NHS England on the number of medical appraisals that have taken place and the number of connected doctors who revalidated. The report follows a standard format as set by NHS England and requires sign off by the trust board prior to national submission.
Recommendation	The appraisal and revalidation team request that the board supports the content of the report and are assured that due diligence is being paid to the medical appraisal and revalidation processes.

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: Medical Appraisal is a mandatory annual activity required of all doctors in order to maintain their GMC registration. Appraisal is an essential part of revalidation which takes place every five years.					

Equality and Inclusion
The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
In recent years it has become apparent that overseas medical graduates require greater support than UK graduates with appraisal and revalidation. The medical leadership team are currently exploring ways we can continue to support this particular group of doctors, both with their clinical practice and integration into the NHS.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History
How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
N/A. This is an annual mandated report with a standard template provided by NHS England.

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

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

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

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – of Somerset NHS Foundation Trust can confirm that[1]:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Legacy SFT Responsible Officer (RO): Dr Matthew Hayman Deputy Responsible Officer (DRO): Dr David Beacock Legacy YDH Responsible Officer (RO): Meridith Kane

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

No Comments: The Higher Level responsible Officer Visit 15th May 2023 identified a single point of failure for administration on review of 2022-2023 appraisal year and recommended to identify adequate resources to fund the number of appraisals required annually, the number of revalidations and to resolve the issue of having a single point of failure for the administration of supporting both systems. 0.6 WTE Administrator Band 5 time was moved elsewhere during the previous merger. Action for next year: Business case for SPA allocations and for Administrator time.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes: all records are held within the Trust's IT systems which are appropriately protected and managed. The revalidation administrative team check the accuracy of GMC connect regularly.

[1] Please note that this report is submitted on behalf of the newly merged Somerset Foundation Trust. Any information that is specific to the legacy trusts will be detailed within this report. If no split in information is provided, this information is applicable to both legacy teams.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes: all such polices exist and are reviewed through quarterly meetings of the Appraisal and revalidation steering group: Action for next year: Merged SFT April 2023, need to develop a new merged policy.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Yes. In-depth Higher Level Responsible Officer Quality Review (HLROQR) took place May 15th 2023 of processes and set of recommendations shared. An action plan has been developed following the recommendations and will completed or under way within this financial year as requested by NHSE.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Bank Locums who have a prescribed connection will have full access to Trust CPD and annual appraisal which will be job planned in, if logging sufficient clinical hours. Agency locums will have an independent appraisal with their agency and will access departmental CPD and governance to keep them up to date. All doctors have a corporate and local induction and are signposted to mandatory training.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[2]

Action from last year:

Comments:

Legacy SFT: As of 31 March 2023, there were 531 doctors with a prescribed connection to Somerset NHS FT on GMC Connect. The appraisal status for the 2022-23 appraisal year for these doctors is as follows:

[2] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

Completed appraisals: 399 (75%) (6 of these doctors had a completed ARCP prior to joining the Trust and 1 who had recently exited training had an ePortfolio/HORUS educational review in lieu of an appraisal).

Educational Reviews in lieu of Appraisal

2 further doctors who had recently come out of a training programme informed us they were using HORUS for an educational review in lieu of an appraisal.

Under Review appraisals: 12 (2%) – of these 8 are awaiting the appraiser outputs (these are mainly from one appraiser who has been contacted and they are actioning this); 4 are awaiting the appraisee's sign-off (these doctors have been contacted).

Missed appraisals:

118 – (22%) of which:

17 were new starters in the last half of 2022-23 (10 of whom were from overseas and 4 of these were not due to start until April 2023 but needed to be connected to us beforehand); 2 had left the Trust before year-end; 1 was a Medical Support Worker who has since left the Trust; 1 was leaving clinical practice and didn't want an appraisal; 1 was on a career break; 1 was on extended leave; 2 were due to appraiser shortage/appraiser stepping down; 1 was due to strike action; 1 was under GMC investigation; 1 was on special leave; 2 were on long-term sick leave; 4 were on maternity leave. 17 of the missed appraisals were doctors who were in training the previous year and who may have had an ARCP/HORUS review (at the time of writing we are still awaiting confirmation of this); 6 were bank doctors (2 of whom new to the bank); 14 were part of the large August cohort of starters who needed to be set up on PReP (this was when the appraisal admin support was dramatically reduced and a number of doctors did not receive a PReP account in time); it was decided to grant the remaining 47 doctors who missed their appraisal an approved missed for the 2022-23 year, due to insufficient appraiser capacity to accommodate everyone (a number of doctors had been in touch with the appraisal admin team relaying difficulties in finding an appraiser with any remaining free slots). These doctors were targeted to have an early 2023-24 appraisal and 13 of those with a missed appraisal subsequently had their appraisal in the first quarter and 1 in the second quarter of 2023-24.

It should be noted that the disparity in the number of missed appraisals at SFT in comparison to YDH is in part because SFT includes new starters in its figures, whereas YDH does not. YDH also operates to a stricter appraisal due time frame, whereas SFT was operating to an appraisal year, with the result that many doctors postponed their appraisals (some more than once), thus filling up the vacant slots at year end, meaning many doctors were unable to be appraised before 31 March 2023.

Future actions – these points were noted during the HLROQR visit in May 2023 and an action plan is being put in place to address the issues.

Legacy YDH: As of 31 March 2023, there were 240 doctors with a prescribed connection to Yeovil District Hospital on GMC Connect. 180 of these doctors were due an appraisal in 22/23. The appraisal status for the 2022-23 appraisal year for these doctors is as follows:

Completed appraisals: 153 (85%)

Missed appraisals:

27 (15%) – of which 2 were approved due to maternity leave.

Action for next year:

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Yes. For all of the missed appraisals mentioned above we have a full understanding and breakdown of why.

Comments: Some of reasons for missed appraisals are due to the appraisal system itself (around allocation system, insufficient numbers of appraisers, limited administrative time)

Action for next year: those with a missed 2022-2023 are prioritised for 2023-2024 appraisals. Rehaul of appraisal system, system of allocations and change to an appraisal due month and investment in appraiser recruitment, training and administrative support.

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes, there are currently 2 policies in place for the legacies of SFT and YDH.

Action for next year: New policy now required for merged SFT on April 1 2023.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Legacy SFT

No.

There are 47 appraisers of which 4 are bank. The total number of possible appraisals that were required was 529. This would equate to 11 appraisals per appraiser if all appraisals took place, spread throughout the year. Currently appraisers are required to undertake up to 9 per 0.25 SPA. The additional appraisals conducted beyond the SPA time allocated is through the goodwill of the appraisers.

Legacy YDH

Yes, there is enough capacity to provide up to 192 appraisals per year. 32 appraisers complete up to 6 each for 0.25PAs.

Action: Business case for SPA allocations for appraisers in order to align PA allocation to YDH and employ more, recruitment drive per department regarding contribution to appraiser pool, change to appraisal due month, Merged appraiser pool with legacy YDH will increase overall appraiser numbers.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[3] or equivalent).

Yes, appraisers attend peer group training and refresher training.

Anonymised ASPAT audit is shared with peers for learning around good quality appraisal output documentation and governance. Half day face to face CPD event was organised for Feb 2023 to also enable merger relationship building. This included GMC update and ASPAT training tool and Medical Appraisal form July 2022 new format.

[3] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Yes. A representative sample of appraisals are quality assured using an audit tool by the Deputy Responsible Officer and Lead Medical Appraiser (who are also both appraisers). The last two years 2020-2021 and 2021-2022 the average has remained constant at 43/50 which is an excellent score. The 2022-2023 appraisals have not been audited due to time constraints but a sample were peer reviewed by the Higher Level Responsible Officer Quality Review team in May 2023 and all were deemed excellent.

The Appraisers also receive aggregated anonymised feedback from their appraisees and this remains consistently positive.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: Somerset NHS Foundation Trust	Legacy SFT	Legacy YDH
Total number of doctors with a prescribed connection as at 31 March 2023	531	240
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	399 completed + 2 HORUS reviews + 12 incomplete appraisals	153 (180 due an appraisal)
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	118	25
Total number of agreed exceptions	118	2 (maternity leave)

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Yes.

Legacy SFT

68 doctors were due to be revalidated between 01/4/2022 and 31/3/2023. Of these, 41 were positive recommendations and all made on time, except 1, which was delayed by 1 day.

27 deferrals were made, all on time except 2 that were delayed by 2 days and 1 that was delayed by 8 days.

The deferrals were mainly due to insufficient evidence (colleague and patient 360 multi-source feedback not being available) or gaps in appraisal due to the C-19 pandemic or the doctor being new to the UK or the NHS.

Legacy YDH

32 doctors were due to be revalidated between 01/4/2022 and 31/3/2023. Of these, 24 were positive recommendations and all made on time.

8 deferrals were made, all on time. These were due to a combination of insufficient evidence and new to the UK and NHS. The latter reason is a recurring theme and has been raised with the GMC via our Employee Liaison Adviser (ELA).

NFA

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

The RO or DRO routinely reviews revalidation cycle appraisal output forms and 360 MSF for those under notice. All positive recommendations, following approval are made on GMC connect; the GMC notifies the Doctor directly. Recommendations for deferral or non-engagement are discussed prior to these recommendations, through e-mail contact with the relevant doctor as necessary with recommendations for corrective action plans.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

The Responsible Officer (RO) is responsible for the delivery of the arrangements needed to support revalidation. The DRO at legacy SFT supports the RO in making revalidation recommendations and following up any concerns related to Doctors. The Responsible Officer Advisory Group (ROAG) meets monthly to report problems and develop action plans as necessary. ROAG membership: RO, DRO, Director of Medical Education, Associated Director of Medical Services, Chief Medical Officer, MPH site Medical Director, Associated Director of People Services, Medical Workforce manager. Action: non-executive director membership from board co-opted

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Yes. An annual summary of complaints / PALS / incidents registered to the Doctor's name is uploaded to the individual appraisal portfolios, and specifically discussed at every appraisal. The appraiser assurance through the output form is also audited through the ASPAT process.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes. There remain clear medical leadership structures through all clinical directorates within the Trust. Any problems can be escalated through service leads or clinical directors to the RO. Such problems can be discussed in the quarterly GMC employment liaison adviser meetings, but also at any stage should the need arise (as well as through the monthly RO advisory meetings). Should a significant, appropriately evidenced case be verified the Doctor can be contacted and appropriate action taken.

Action for next year: with the merged service, there will be cross-cover RO arrangements between the site ROs.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[4]

Yes. The Responsible Officer Advisory Group meets monthly with reference to formal reporting procedures, as necessary.

Concerns about medical staff are dealt with through the disciplinary policies for medical staff, as well as any remediation, re-skilling and rehabilitation through the relevant HR policies.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[5]

Yes. Information is available to relevant Responsible Officers (on an RO to RO basis), using NHSE medical practice transfer of information (MPIT) forms. There has sometimes been a delay in providing these due to the limited administrative capacity mentioned above.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's

[4] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[5] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Yes. All such actions are compliant with principle 3 of the GMC clinical governance recommendations. The RO and other appointed officers have received appropriate training and attend regional peer group meetings to help benchmark and seek advice.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Yes. These are undertaken by medical recruitment and temporary staffing and must be completed before a doctor can commence employment.

Section 6 – Summary of comments, and overall conclusion

SFT has a well-established appraisal and revalidation process. There is a dedicated team to manage the appraisal process and provide support where necessary. The increasing numbers of doctors being prescribed in the context of an increase in acuity and clinical demand will require recruitment of new appraisers, a change in SPA allocation, a new appraisal allocation system, and investment into additional appraisal administrative time. SFT merged with YDH in April 2023 and this is an opportunity to adopt the best of both systems.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

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