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 6 February 20224** at **9.00am** in the Solt's Suite, Taunton Rugby Football Club, Veritas Park, Hyde Lane, Bathpool, Taunton, Somerset, TA2 8BU

If you are unable to attend, would you please notify Ben Edgar-Attwell, Deputy Director of Corporate Services at Somerset NHS Foundation Trust by email on ben.edgar-attwell@somersetft.nhs.uk

Yours sincerely

COLIN DRUMMOND
CHAIRMAN

AGENDA

		Action	Presenter	Time	Enclosure
1.	**Welcome and Apologies for Absence**		Chairman	09:00	Verbal
2.	**Questions from Members of the Public and Governors**		Chairman		Verbal
3.	**Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 7 November 2023**	Approve	Chairman		Enclosure A
4.	**Minutes of the Somerset NHS Foundation Trust's Extra Ordinary Public Board meeting held on 20 November 2023**	Approve	Chairman		Enclosure B
5.	**Minutes of the Somerset NHS Foundation Trust's Extra Ordinary Public Board meeting held on 6 December 2023**	Approve	Chairman		Enclosure C
6.	**Minutes of the Somerset NHS Foundation Trust's Extra Ordinary Public Board meeting held on 16 January 2024**	Approve	Chairman		Enclosure D
7.	**Action Logs and Matters Arising**	Review	Chairman		Enclosure E
8.	**Registers of Directors' Interests and Receive any Declarations of Interests relating to items on the Agenda**	Note and Receive	Chairman		Enclosure F

9.	**Chairman's Remarks**	Note	Chairman		Verbal
10.	**Chief Executive and Executive Directors' Report**	Receive	Peter Lewis	09:10	Enclosure G
ALL OBJECTIVES					
11.	**Board Assurance Framework and Q3 2023/24 Corporate Risk Register Report** • Board Assurance Framework • Corporate Risk Register	Receive	Phil Brice	09:20	Enclosure H Enclosure I
12.	**Fit and Proper Person Framework Update**	Receive	Phil Brice	09.35	Enclosure J
OBJECTIVE 2 – Provide the best care and support to people					
13.	**Patient Story – Matters of the Heart**	Receive	Rebecca Lambert	09:45	Verbal
14.	**Assurance Report of the Quality and Governance Assurance Committee meeting held on 22 November 2023**	Receive	Jan Hull	10:15	Enclosure K
OBJECTIVE 8 – To develop a high performing organisation delivering the vision of the Trust					
15.	**Quality and Performance Exception Report**	Receive	Pippa Moger	10:25	Enclosure L
OBJECTIVE 6 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture					
16.	**Assurance Report of the People Committee meeting held on 8 November 2023**	Receive	Kate Fallon	10:40	Enclosure M
17.	**Guardian of Safe Working for Postgraduate Doctors Reports**	Receive	Tom Rees	10:45	Enclosure N
10:55 – 11:10 - Coffee Break					
OBJECTIVE 7: To live within our means and use our resources wisely					
18.	**Verbal report from the Finance Committee meeting held on 29 January 2024**	Receive	Martyn Scrivens	11:10	Verbal
19.	**Finance Report**	Receive	Pippa Moger	11:15	Enclosure O

20.	**Assurance Report from the Charity Committee meeting held on 14 November 2023**	Receive	Barbara Gregory	11:30	Enclosure P
OBJECTIVE 4 – Reduce Inequalities					
21.	**Assurance Report from the Mental Health Act Committee meeting held on 12 December 2023**	Receive	|Alexander Priest	11.35	Enclosure Q
ALL OBJECTIVES/FOR INFORMATION					
22.	**Follow up questions from the Public and Governors**		Chairman	11:40	Verbal
23.	**Any other Business**		All		Verbal
24.	**Risks Identified**		All		Verbal
25.	**Evaluation of the Effectiveness of the Meeting**		Chairman		Verbal
26.	**Items to be discussed at the Confidential Board Meetings** The items presented to the Confidential Board include: Chief Executive verbal report; colleague suspensions and exclusions report; minutes of the October, November and January Finance Committee meetings; Simply Serve Q3 2023/24 highlight report; Symphony Healthcare Services Q3 2023/24 report.				
27.	**Withdrawal of Press and Public** To move that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.				
28.	**Date of Next Meeting** Tuesday 5 March 2024			11:45	

PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 7 NOVEMBER 2023 AT TAUNTON AND BRIDGWATER COLLEGE, TAUNTON

PRESENT

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

IN ATTENDANCE

Fiona Reid	Director of Communications
Jannine Hayman	Matron within the medical directorate at Musgrove Park Hospital (for item 9 only)
Claire White	Improvement Support and Data Analyst (for item 9 only)
Paul Foster	Consultant Urologist and Medical Director of YDH (for item 12 only)
Harriet Jones	Head of Inclusion (for item 15 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 Graham Hughes (Non-Executive Director) and Sube Banerjee (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 Inga Kennedy, James Phipps and Tina Oakley to their first public Board meeting.

1.3. The Chairman reminded Board members that the majority of the reports presented to today's Board meeting had already been scrutinised and discussed by the relevant Board Committee.

2. QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS

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

3. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 5 SEPTEMBER 2023

3.1. Jan Hull proposed, Alexander Priest seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 5 September 2023 as a correct record.

4. ACTION LOG AND MATTERS ARISING

4.1. The Board received the action log and noted that no actions had been identified at the September 2023 Public Board meeting. There were no matters arising.

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

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

- Colin Drummond – to change "Worshipful Company of Water Conservators - Master" to Worshipful Company of Water Conservators – Deputy Master".
- Barbara Gregory – to add "Non-Executive Director at Torbay and South Devon Healthcare NHS Trust"
- Isobel Clements – to add "Sister in law works in the pharmacy department at MPH" and "Nephew works as a physio assistant within MPH".
- Tina Oakley – to add "Son, Dr Tom Oakley, is Chief Executive Officer of a digital medical imaging company, Feedback Plc"

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

6. CHAIRMAN'S REMARKS

6.1. The Chairman provided feedback from the recent Leadership Quality Walkround at the "Ready to Go" unit in Musgrove Park Hospital and advised that the visit had been very interesting and had been relevant in view of the patient story at today's Board meeting. He highlighted the enthusiasm of colleagues at the unit and throughout the trust.

6.2. Colin Drummond further highlighted his conversation with Emma Davey, Director of Patient Experience and Engagement, and complimented Emma on the work taking place to improve the PALS and complaints service.

7. CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT

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

7.2. The Chief Executive particularly highlighted the report into sexual misconduct in surgery and the Trust's response. He advised that the report indicated that, nationally, 25% of the surgical workforce had experienced sexual misconduct during their career in the NHS. Work was taking place with the senior leadership team to identify ways for colleagues to speak up about their experiences. Since the publication of the report, some colleagues have come forward with their concerns and the fact that they have felt able to speak up was encouraging. Consideration is being given how to create the right environment and culture and how to respond to any concerns raised and an overview of the work taking place, including the routes for raising concerns, has been communicated with the surgical workforce.

7.3. The Chief Executive further highlighted: the signing up to the sexual safety charter; and the media coverage of the new post menopausal bleeding pathway. He further provided feedback from the visit by the national Getting It Right First Time (GIRFT) team and highlighted their positive feedback about the new post menopausal bleeding pathway and other ground-breaking work taking place in relation to shifting surgical work from inpatient to day case services, and the focus on outpatient care and the Hospital@Home service. The team was impressed with the work taking place and want to discuss this further. Feedback about theatre productivity was less positive and the national team was informed about the impact of the complex case mix on theatre productivity. The team expressed concerns about the reliance on the independent sector for elective surgery and noted the way these services had previously been commissioned. The team further noted the resulting impact on the trust's ability to deliver activity due to a more complex case mix; and the discussions taking place with the Integrated Care Board.

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

- That there were no dedicated gynaecological theatres and that gynaecology surgery was carried out in general theatres.

- That the contract with the independent sector had been extended by a further year and that, in view of the geographical and workforce challenges, a decision on the future use of the Shepton Mallet capacity will need to be made on a system basis.

- The development of the sexual safeguarding policy and the production of a video about sexual safety and boundaries between professionals.

8. BOARD ASSURANCE FRAMEWORK AND Q2 2023/24 CORPORATE RISK REGISTER REPORT

8.1. The Director of Corporate Services presented the report which was received by the Board.

Board Assurance Framework (BAF)

8.2. The Director of Corporate Services highlighted the key risks on the BAF and advised that the common areas of risks had remained unchanged. The aim of the format of the Board Assurance Framework was to ensure that the right conversations were taking place in the right places and that robust levels of assurance were received. Where appropriate, oversight of objectives had been assigned to committees to review the controls and assurances in place and to consider whether additional actions to strengthen controls will need to be implemented.

Corporate Risk Register

8.3. 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: pressures in social care, intermediate care and primary care; insufficient capacity to meet demand; workforce recruitment and retention; ageing estates – acute and community; and the financial position.

8.4. The Board discussed both reports and commented/noted that:

- The BAF and corporate risks had been discussed at the relevant Board Committee meetings.

- Three new risks had been added to the corporate risk register, relating to: failures in referral pathways to specialties from primary and the impact on emergency department attendances; the inability to recruit applicants within a timely manner on the applicant tracking system; and poor data quality in the Electronic Staff Record.

- It was queried where discussions about high level risks mitigating actions took place. The Director of Corporate Services advised that there was an opportunity for discussions at the Board meeting but discussions and review of the risks and mitigating actions took place at operational leadership team and directorate level meetings. In terms of the strategic risks, the high level red and amber rated risks were managed through the devolved governance assurance arrangements into Board committees and overall

oversight rested with the Audit Committee. The Director of Corporate Services offered to discuss the risk management process with the newly appointed Associate Non-Executive Directors.

- The number of red rated risks was a concern and concerns had also been raised at the Board Committee meetings. The Chief Executive acknowledged the number of high risks and advised that the risks reflected the increasing pressures on services, workforce and the financial position. The strategic risks were overseen by the Board as part of the Board Assurance Framework and the risks were also overseen by the relevant Board Committees. The reasons for the high risks were well understood and, where possible, mitigating actions had been put in place. He suggested reviewing some of the strategic risks to determine whether, for those risks which were difficult to mitigate, a different approach was required and this can be followed up as part of the Board development programme.

- The Audit Committee reviewed the BAF to ensure that it was a vibrant document and received assurance from the Board Committees that their relevant risks had been reviewed.

- The scoring of some risks had remained unchanged whilst mitigation in the form of strategies and plans had been put in place and clear target dates for the implementation of the mitigating actions had been agreed. It was suggested that either the controls were not working or that further mitigations will need to be considered. The Director of Corporate Services advised that these questions were being asked at the relevant Board Committees. He highlighted the example of the public health risk, the rating of which was not likely to change due to the longer term focus on public health on a system wide basis.

- The high rated red risks met the risk tolerance criteria as set out in the risk management strategy.

- Workforce demand was a key driver for some of risks and this was in line with national workforce challenges. The Audit Committee did not feel that they received sufficient assurance how this risk, as well as the risk in relation to the productivity agenda, was being managed.

  The Chairman of the People Committee commented that the Committee had tasked the executive team to provide an update on skill mix, productivity and effectiveness to a future People Committee meeting to enable the Committee to look into these risks in more detail. In addition, the Board also reviewed the risk appetite for all risks, as well as the strategic risks, on an annual basis. All high rated risks were challenged at those meetings and it was recognised that some of the risks were externally controlled or were impacted by other, including political, factors.

- The discussions at the Quality and Governance Assurance Committee also focussed on the linkage between service group risks and any upcoming operational risks and feedback from these discussions was

reported to the Board as part of the regular Committee assurance reports and was also reported on a six monthly basis to the Audit Committee.

8.5. The Chairman advised that the discussion had been helpful and encouraged the Associate Non Executive Directors to discuss the risk management process, and their views on the process, with the Director of Corporate Services.

9. PATIENT STORY AND CLINICAL TOPIC ON THE "READY TO GO ACUTE WARDS"

9.1. Jannine Hayman, Matron within the medical directorate at Musgrove Park Hospital, and Claire White, Improvement Support and Data Analyst, joined the meeting for this agenda item.

9.2. Jannine Hayman advised that the Ready to Go unit had been set up as part of the establishment of the Fit for Discharge wards. The aim of the unit was to improve patient experience whilst patients waited for onward care placements or discharge to their home. Admissions to the unit took the form of a maximum two week placement to improve mobility. The staffing model was different from inpatient wards and the model was aimed at aiding patients to achieve agreed therapy goals prior to their discharge. Jannine Hayman highlighted the positive impact the ready to go unit has had on patients.

9.3. Jannine Hayman advised that a video on the establishment of the ready to go unit had been shared with the Board. The video highlighted the use of quality improvement methodology and included details of the each of the seven steps of this methodology, including the formation of the team; understanding and identifying the problem; the aim of the project; the measures; the change ideas; the Plan, Do, Study Act (PDSA) rapid learning cycles; and the sharing of learning. The video further provided information in relation to the project benefits; patient feedback; and the roll out of the unit.

9.4. Claire White highlighted the video of a patient called "Beryl" and set out the background to her hospital admission following a fall at home. She further set out the positive impact the ready to go unit has had on Beryl's mobility and her ability to return home with a care package rather than having to be admitted to an intermediate care placement.

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

- The team was complimented on their excellent work and positive impact on patients.

- A recent Leadership Quality Walkround by some of the Non-Executive Directors to the unit had highlighted the focus on the reconditioning of patients and the benefits to patients. The relevant Non-Executive Directors expressed how impressed they had been with the care provided, outcomes and the significant majority of colleagues indicating that they had a great day at work.

- It was queried how data, including feedback from patients, was being collected. Claire White advised that a QR code and an electronic form was being used to collect data. The Chief of People and Organisational Development will discuss this further with Claire White outside of the meeting.

- The Chief Nurse highlighted the need to focus on preparing patients for their return home or to a care placement in all inpatient wards and provided an example where this focus had not been present. Jannine Hayman agreed that, where patients were not required to be in bed, they should be dressed in the same way as if they would be at home. She advised that it was important to continue to raise awareness of the benefits to patients and highlighted the work taking place. In addition, it was also important to explain the reasons of this approach to patients.

- The video clearly showed the positive impact of changing mindsets and it was suggested using the video as part of a ward induction programme and look at ways to make an impact in a shorter period of time. It was queried whether a performance measure had been developed to look at the benefits to patients in certain time periods, including whether patients were readmitted within a certain time frame. Claire White advised that re-admission rates were being reviewed but, at this stage, it was difficult to separate readmission data by patient groups. This data will be available in the next few weeks. It was noted that a total of 1,133 patients had, to date, used the unit. In terms of the video, it was noted that a shorter version of the video was available that could be used for awareness and training.

- It was queried whether a change in discharge patterns on wards was being measured. Claire White advised that this data was being collected. She advised that consideration will need to be given as to what level of support is appropriate in a hospital setting, however this approach was the best approach to prepare patients for their return home. It will be essential to collect data to be able to show the benefits to patients. Although data fluctuated, it was evident that the level of support provided was in line with the outcome for patients.

- The ready to go unit had been set up as there was a shortage of long term placement beds and the potential de-conditioning of patients waiting for these negatively impacted on patients. It was therefore difficult to measure against the counterfactual. It was queried how much the Trust should be doing to compensate for an ineffective care system. The Chief Executive acknowledged that the system will need to work as intended and this will need to be followed up as part of a wider strategic discussion.

- The philosophy was supported and, in view of the lower level of risk, it was suggested asking the Care Quality Commission to redesignate the unit as a reablement unit rather than as an NHS unit.

- It was easier to recruit new colleagues to the unit than to e.g. the medically fit for discharge ward and colleagues were now asking to work on the ward.

- Because of the pressures on services and capacity, there was a risk of becoming too task orientated rather than taking a holistic approach and this balance will need to be addressed as part of a wider programme of cultural work. The Chief Nurse commented that task orientation was often seen as the safest way of providing care whilst services were under pressure. An internal audit had highlighted the reduction in focus on personalised care and actions to address this balance will be identified and implemented.

- It was suggested adding an item on quality improvement to the agenda of a future Board Development Day.

9.6. The Chairman, on behalf of the Board, thanked Jannine and Claire for their excellent work.

10. ASSURANCE REPORT OF THE GOVERNANCE AND QUALITY ASSURANCE COMMITTEE MEETING HELD ON 27 SEPTEMBER 2023

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

- The assurance in relation to the fire safety actions.

- The devolved governance arrangements versus centralised governance.

- The recent stillbirth incidents 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.

10.2. Jan Hull advised that the Committee discussed the verdict of the Lucy Letby trial and actions to be taken and the Committee agreed that the strong speaking up and whistleblowing as well as the positive internal audit findings and the cultural work taking place provided significant assurance. Work on raising awareness of the Freedom to Speak Up process will continue to take place. The Committee agreed to review the findings of the external enquiry when available.

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

11. ASSURANCE REPORT OF THE GOVERNANCE AND QUALITY ASSURANCE COMMITTEE MEETING HELD ON 6 OCTOBER 2023

11.1. Jan Hull, Chairman of the Quality and Governance Assurance Committee, presented the report which was received by the Board. Jan Hull advised that all annual reports demonstrated high levels of assurance for the Trust across key statutory and regulatory areas. The annual reports will be published on the Trust's public website for people to access.

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

- The Committee had reviewed seven annual reports and all reports felt joined up and provided an excellent overview of activities and challenges.
- The opportunity to share experiences and areas of work with the Committee was welcomed by colleagues.
- Richard Painter, Director of Safeguarding Services, will be leaving the Trust at the end of December 2023 and the Chief Nurse highlighted how he had transformed safeguarding services over the last few years.

11.3. The Board thanked the Committee for its excellent work and areas of focus and further thanked all those who produced and presented the annual reports.

11.4. The Board agreed that the report provided significant assurance about of the levels of compliance and delivery as demonstrated by the annual reports. The Board particularly thanked Richard Painter for his outstanding contribution to the development of safeguarding services in the county.

12. LEARNING FROM DEATHS FRAMEWORK: MORTALITY REVIEW PROGRESS REPORT

12.1. Paul Foster, Consultant Urologist and Medical Director of YDH, 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. It was noted that the report had been reviewed by the Quality and Governance Assurance Committee.

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

- The extension of the Medical Examiner work into the community will provide an opportunity to better understand the work taking place by different providers in the community and will enable qualitative data, not previously collected, to be analysed and lessons learned to be identified.

- Post discharge mortality data was being collected as part of the SHMI dataset.

- In contrast to the governance arrangements for learning from deaths in secondary care services, arrangements in primary care services were less consistently developed. It will be important to consider how the information collected can make a difference on a whole system basis.

- As the number of deaths in community hospital was low it was queried whether the standardised mortality data provided real value in those settings. The Chief Medical Officer advised that the Board had been on a long journey in terms of the datasets. He advised that the SHMI data was part of a benchmark exercise and showed expected and actual performance data. In view of the small numbers in community hospitals, the data was subject to increased levels of fluctuation. It was not possible to benchmark community hospital data because the benchmarked data related to acute inpatient services. Discussions had taken place with NHS Digital about the small cohorts and a number of these have subsequently been removed from the SHMI dataset. The Chief Medical Officer assured the Board that patient level deep dives were undertaken in those settings when the SHMI triggered concerns.

12.4. The Board agreed that the report provided significant assurance about the rigour of the review process and the learning derived from it.

12.5. Paul Foster left the meeting.

13. ASSURANCE REPORT OF THE PEOPLE COMMITTEE MEETING HELD ON 13 SEPTEMBER 2023

13.1. Kate Fallon presented the report which was received by the Board. She highlighted the areas of assurance received and the areas for follow up. It was noted that no areas to be reported to the Board had been identified.

13.2. Kate Fallon highlighted the colleague story and advised that the issues raised had highlighted the need to consider how to support colleagues through difficult interactions and the management of patients who present with challenging behaviour.

13.3. The People Committee was changing the information presented to the Committee and was moving away from historical information to focus more on human rather than transactional workforce reports. This change in reporting had been challenging for the workforce team and other colleagues but the focus on culture and wellbeing enabled a review of qualitative as well as quantitative information and was in line with the objectives of the people strategy.

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

14. GUARDIAN OF SAFE WORKING FOR POSTGRADUATE DOCTORS REPORTS

14.1. 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.

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

- The total number of exception reports was subject to cyclical variations and there had been an increase in the last quarter. The majority of exception reports originated from acute and general medicine.

- The mitigations put in place to manage the industrial actions had been effective as the number of exception reports did not seem to have been impacted by the industrial actions.

- The report indicated that the year on year increase in the number of exception reports suggested greater engagement, understanding and acceptance of the reporting process, particularly at lower grade levels. It was queried whether it was correct to make this assumption. The Chief Medical Officer advised that considerable pro-active work had taken place to increase visibility and understanding of exception reporting. He was confident that Postgraduate Doctors in Training were aware of the process and felt comfortable to report exceptions. The Chief Medical Officer provided assurance that every exception report was reviewed and, where any themes were identified, these were further investigated and any mitigating actions identified and implemented.

15. SIX MONTHLY INCLUSION REPORT

15.1. Harriet Jones, Head of Inclusion, joined the meeting and presented the report which was received by the Board. It was noted that the report was scheduled to be presented to the People Committee meeting on 8 November 2023.

15.2. Harriet Jones advised that this report focused on data, and assurance that the Trust is meeting requirements under national frameworks including the Workforce Race Equality Standard (WRES), the Workforce Disability Equality Standard (WDES) and the Gender Pay Gap report. Bringing together reporting frameworks (including the WDES, WRES and gender pay gap) that focus on individual protected characteristics into one holistic inclusion data report will enable the identification of common challenges and focus on the behaviours, processes and systems that need improving.

15.3. The report identifies where data is missing and where plans are in place to collect and present data in future. The Board was asked for feedback on other data sets or information to be included in further reports. The Board was further asked to consider how the data can be used effectively to inform discussion and decision making at Board and Board committee level?

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

- The report was excellent and provided helpful information.

- It will be helpful to set out the ambition, the action plan timeframe and the roadmap towards achieving the ambition. The report only covered inclusion data for the workforce and consideration should also be given to inclusion data relating to patients and how the data can drive transformation of services.

- There was a significant demographic shift in students signing up to universities. This included more females signing up to medical qualifications and the conclusions set out in the report may in future shift. The reference to the need to progress female medical colleagues and BAME colleagues into consultant roles was queried. The representation of data was important and the Trust will be able to take some actions but it was not in control of students signing up to medical qualifications. A shift in gender and diversity balance will be achieved through developments in inclusive interview processes and natural shifts. The Chief of People and Organisational Development advised that the data will be driving the narrative and focus but traditionally these groups have been struggling with progression into consultant roles.

  The Chief Medical Officer advised that there had been a shift in more trainees opting to work part time and all medical colleagues, including consultants, will need to be supported to work flexibly. There was a tendency for females of child-bearing age not to follow formal training routes and the trust's consultant training scheme was being strengthened to support female colleagues. The Certificate of Eligibility for Specialist Registration (CESR) process was the route to specialist registration for doctors who have not completed a GMC-approved training programme, and a simplified process will come into effect from 30 November 2023. The Trust wanted to help doctors to achieve consultant status and retain this valued group of colleagues. It was commented that it will be helpful to include this narrative in future reports.

- Benchmarking information will be beneficial but, in addition to quantitative data, it was also important to have measurable qualitative data. Some data for 2022/23 was missing and the reason for this omission was queried. Harriet Jones advised that year on year trend data will be included in future reports. The data from both legacy trusts had been integrated but not all data was transferrable or measured in the same way and the 2022/23 data had therefore not been included.

- There was a need to really understand the data and identify the actions which can be taken. Some actions had already been taken and this was reflected in the data.

- Harriet Jones and Sun Sanders-Jackson had identified a number of recommendations and it will be helpful to have oversight of this work as well as the data as solutions will need to be more systemic in nature. In relation to the high level recruitment data, Harriet Jones advised that the

impact of the focus on recruitment will need to be assessed in individual work areas and further actions may need to be identified.

- Harriet Jones had queried whether there had been sufficient focus on inclusion at Board and People Committee level and consideration should also be given as to where responsibility for inclusion rests. The team only consisted of three colleagues and the team received a large number of requests for advice from colleagues. Other team members were being upskilled to be able to raise the profile of inclusion but inclusion should be part of everyone's role.

- It was commented that inclusion should be managed at organisational level as it was linked to culture. A clear strategy will need to be developed with clear aims and it was suggested following this up as part of a Board development session. The Chief Executive agreed that it will be helpful to discuss this further at a Board development day. He advised that it was not the intention to answer the questions at today's public Board meeting but the report will inform these discussions.

- One of the Non-Executive Directors attended the LGBTQ+ network meetings and this was another way to link with Board members.

- The Chief Nurse welcomed a further discussion to be able to set out the work taking place to raise the profile of inclusion across the organisation. The key challenge will be how to translate that work through all layers of the organisation.

- Inclusion should not be seen in isolation, should be embedded in everything the Trust does, and should apply to colleagues as well as patients.

15.5. The Board asked the Executive Team to discuss the next steps and to arrange a further discussion at a future Board development day. The Board thanked Harriet Jones for the excellent report. **Action: Executive Team.**

15.6. Harriet Jones left the meeting.

16. SIX MONTHLY CHAMPION WELLBEING REPORT

16.1. In the absence of Graham Hughes, Non-Executive Director wellbeing champion, the Chief of People and Organisational Development presented the report which was received by the Board. The report set out the health and wellbeing work undertaken over the last six months and highlighted areas of current work, future work streams, key challenges and support needed. It was noted that the report will be presented to the People Committee meeting to be held on 8 November 2023.

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

17. ANNUAL MEDICAL APPRAISAL AND REVALIDATION REPORT

17.1. The Chief Medical Officer presented the report which was received by the Board. It was noted that the report, following formal sign off by the Board, will need to be submitted to NHS England. It was further noted that the report had been reviewed by the People Committee.

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

- The Trust had a well-established appraisal and revalidation process but the increasing numbers of doctors required to manage the 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.

- Overall performance compared well with other trusts in the South West and the Trust received assurance from the visit by the regional Higher Level Responsible Officer (HLRO) team during the summer about the appraisal and revalidation process, and the integration of services and culture.

- There was a difference in how new starters were accounted for in the legacy SFT and YDH trusts which impacted on the number of missed appraisals. Whilst the legacy SFT process included new starters in the denominator and exempted the new starters in the first year, the YDH process included new starters in the following year. There was therefore an appearance of higher number of missed appraisals in the legacy SFT and a lower number in the legacy YDH. However, the percentage of appraisals was good and the number of missed appraisals was not an area of concern.

- It was queried whether learning from both processes will be being used to develop a new single system.

- The regional HLRO visit action in relation to administrative support had been implemented.

- The report provide assurance that there was good oversight of every appraisee. The Chief Medical Officer advised that the governance system relating to the appraisal and revalidation process was well-developed.

- Medical colleagues joining as part of a fellowship programme did not often have a track record of previous appraisals and may need help setting up their appraisal record in the run-up to revalidation.

17.3. Jan Hull proposed, Kate Fallon seconded and the Board supported the content of the report and agreed that it was assured that due diligence was paid to the medical appraisal and revalidation processes.

18. QUALITY AND PERFORMANCE REPORT

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:

- The lasting impact of Covid-19 continued to be a significant risk, especially relating to clinical capacity and the ability to recover elective activity. As well as the legacy impact, there was currently a spike in Covid-19 related absences and this further impacted on services and colleagues. Although the way Covid-19 positive patients were managed in inpatient services had evolved, there remained a legacy impact.

- The majority of the KPIs had been developed in response to national requirements and standards, and it was queried whether, over the next few months, the report could be more tailored to evolving KPIs on culture and productivity. The current KPIs were very much looking retrospectively and did not tell the Board anything they were not already aware of. It was suggested reviewing the KPIs to ensure that forward looking information and trends were also captured.

  The Chief Executive agreed that the KPIs did not provide a clear view as to what the trust wanted to achieve as an organisation and the KPIs did not necessarily demonstrate the success of the organisation. Much of the information presented was used by NHS England to measure the performance of trusts generally and it will be helpful to give this further thought outside of the Board meeting.

- The report covered quality and performance and it was queried by the new Associate Non-Executive Directors why the report was presented by the Chief Finance Officer. The Chief Executive advised that performance was within the remit of the Chief Finance Officer and had been since the establishment of a single executive team – in which there had originally been two Chief Operating Officers (one for acute and one for community and mental health services). The report covered integrated performance and the Chief Executive did not feel that it was appropriate for the Chief Operating Officer to report on performance due to a potential conflict of interest. The director level oversight for performance management and performance management of the service groups was deliberately separated from the delivery aspect of performance.

- Although the report was titled “quality and performance” report, the report was thorough in terms of performance information but it was queried whether it provided sufficient assurance in relation to the quality of services. The report however provided sufficient information to enable the Board and Board Committees to identify areas for further follow up. In terms of the quality aspects, quality runs through every Board report and it will be difficult to pull all quality aspects together into a single report. It was

recommended that the new Board members attended the service groups' Quality, Outcomes, Finance and Performance (QOFP) meetings to get a feel of discussions and oversight at those meetings.

- The report was presented to the Quality and Governance Assurance Committee alongside other quality information and the different processes enabled the triangulation of information. It was noted that patient experience metrics were being further developed.

- Stroke performance continued to be an area of concern at Yeovil District Hospital and the narrative provided assurance that patients received good quality care. It will not be possible to improve performance until the flow of patients out of hospital improved. The Chief Executive advised that the performance issue was one of the reasons for the strategic change in the stroke pathway in Somerset.

19. VERBAL REPORT FROM THE FINANCE COMMITTEE MEETING HELD ON 30 OCTOBER 2023

19.1. Martyn Scrivens, Chairman of the Committee, provided feedback from the meeting held on 30 October 2023 and advised that the Committee reviewed the finance report for September 2023.

19.2. There had been a focus on productivity and workforce and an interest at national level in understanding the bridge between workforce numbers over the last few years and the investment made to account for the increase in workforce numbers. Information was being produced and will be reviewed by the Committee at a future meeting.

19.3. The Committee further reviewed and challenged the electronic health record business case.

20. FINANCE REPORTS

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

- An in-month deficit of £2.091 million against an in-month deficit of £0.576 million.

- A year to date deficit of £9.197 million against a planned deficit position of £6.167 million.

- An in-month agency spend of £2.630 million which was £0.121 million above the agency cap. This was a significant improvement compared to previous months.

- An agreed cost improvement plan of £33.8 million and the delivery of £3.450 million cost improvements in September 2023 against a forecast delivery of £2.366 million.

- A year to date capital expenditure of £25.2 million against a plan of £27.7 million.

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

- There had been a change to the reporting of the costs for covering industrial actions and the inclusion of these costs - £1.5 million - had impacted on the in-month financial position.

- The loss of income as a result of the industrial actions - £0.6 million - had been brought into position.

- The financial position had further been impacted by under performance in relation to income from other commissioners - £0.6 million.

- Discussions were still ongoing whether trusts will receive additional income to compensate for the costs relating to industrial actions.

- Section 256 funding was expected to be received by the ICB by the end of December 2023. This funding was not a risk in itself but there was uncertainty about the timing and allocation of this funding.

- Scrutiny of performance against the cost improvement programme was carried out by the Finance Committee. The Committee reviewed the data on a monthly basis but also carried out deep dives into particular areas on a quarterly basis. Performance was also monitored at the monthly quality and finance directorate meetings.

- It was expected that the £5 million cost improvement programme gap will be closed, but there was a concern that the majority of cost improvements still to be identified will be non recurrent cost improvements and this will impact on the cost improvement requirement for future years. It was noted that planning for 2024/25 cost improvements was already taking place.

- Quality impact assessments of the cost improvements programmes were reviewed as part of an annual planning exercise. Assessments were required for cost improvements over £21,000 and the assessments were reviewed, and where required, signed off by the Chief Medical Officer, Chief Nurse, the Chief Finance Officer and the Chief Operating Officer. The Integrated Care Board was involved in this process but the process was not overseen at Board Committee level.

21. ASSURANCE REPORT FROM THE AUDIT COMMITTEE MEETING HELD ON 11 OCTOBER 2023

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

21.4. The following areas to be reported to the Board had been identified:

- The declarations of interests compliance rate (Executive Team).
- The findings of the Symphony internal audit reports (Board).
- The number of high scoring risks on the Board Assurance Framework.

21.5. In addition to the above issues, the Committee agreed that, in view of the significant workforce risks, the six monthly report from the People Committee did not sufficiently cover discussions on workforce risks. The Audit Committee therefore did not feel that the report provided sufficient assurance about the work of the People Committee in terms of managing workforce demand and supply. The Board noted that, in view of the impact of the workforce challenges on the financial position, the link between the People and Finance Committees had been strengthened and there will be a stronger focus on workforce risks at both Committees.

22. ASSURANCE REPORT FROM THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON 12 SEPTEMBER 2023

22.1. 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.

22.2. The following areas had been identified as areas to be reported to the Board:

- The improvements in relation to out of area placements.
- The increase in the number of Allied Mental Health Professionals (AMHPs) but the continuing concerns about delivery of the Mental Health Act assessments.
- The lack of assurance on compliance with the Section 117 statutory requirements by the Local Authority.
- The work in relation to Right Care, Right Person proposal.
- The findings of the Mental Health Act annual report.

22.3. The Board discussed the report and noted that discussions with the Local Authority about their statutory responsibilities both in terms of Section 117 and Mental Health Act assessments were taking place. The Local Authority acknowledged that relationships between practitioners and AMHPs and the timeliness of

interventions could be improved. Contractual standards for response times and an escalation process for managing clinical risks were currently not in place and will need to be developed. The Trust will need to ensure that these actions will be followed up.

23. FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS

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

24. ANY OTHER BUSINESS

24.1. The Chairman advised that this was expected to be Daniel Meron's last public Board meeting as he will be retiring from his role as Chief Medical Officer with the Trust in 2024. The Chairman thanked Daniel Meron for everything he has done for the Trust over many years and for signing up to the vision of doing everything in the interest of the patient.

25. RISKS IDENTIFIED

25.1. The Board reiterated the large number of high rated risks and noted the following risks: productivity; workforce; equality, diversity and inclusion; risk assessments; and the risks raised as part of the Mental Health Act Committee assurance report.

25.2. The sheer volume of papers was raised as a possible risk but it was felt that the papers reflected the challenging environment the Trust was operating in.

25.3. The Board discussed whether the Trust was at risk to the issues described in the Lucy Letby enquiry. The Chief Executive advised that the findings of the inquiry will be reviewed when the inquiry has been conducted. The issues raised at the trial had been considered, including at the Quality and Governance Assurance Committee, but in view of the findings of internal audit reports and presentations at Committee meetings, it was felt that this was currently not an area of significant risk.

26. EVALUATION OF THE EFFECTIVENESS OF THE MEETING

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

26.2. Concerns were raised that it had not been possible to dedicate sufficient time to the quality and performance report and timings may need to be reconsidered.

27. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

27.1. 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.

28. WITHDRAWAL OF PRESS AND PUBLIC

28.1. 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.

29. DATE FOR NEXT MEETING

6 February 2024

EXTRA ORDINARY PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST EXTRA ORDINARY PUBLIC BOARD MEETING HELD ON 20 NOVEMBER 2023 VIA TEAMS

PRESENT

Colin Drummond	Chairman
Martyn Scrivens	Non-Executive Director
Paul Mapson	Non-Executive Director
Kate Fallon	Non-Executive Director
Graham Hughes	Non-Executive Director
Alexander Priest	Non-Executive Director
Tina Oakley	Associate Non-Executive Director (non voting)
James Phipps	Associate Non-Executive Director (non voting)
Peter Lewis	Chief Executive
Andy Heron	Chief Operating Officer
David Shannon	Director of Strategy and Digital Development (non voting)
Hayley Peters	Chief Nurse

IN ATTENDANCE

Mark Hocking	Deputy
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: Jan Hull (Non-Executive Director), Barbara Gregory (Non-Executive Director), Sube Banerjee (Non-Executive Director), Inga Kennedy (Associate Non-Executive Director), Phil Brice (Director of Corporate Services), Pippa Moger (Chief Finance Officer), Isobel Clements (Chief of People and Organisational Development), and Daniel Meron (Chief Medical Officer).

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

2. DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA

2.1. 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.

3. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

3.1. The Chairman advised that the focus of the Confidential Board meeting will be on the discussion and approval of the system-wide plan to manage the financial and performance pressures created by industrial actions. This report was included in the Confidential Board as the report has not as yet been approved by all system partners.

4. WITHDRAWAL OF PRESS AND PUBLIC

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

5. ANY OTHER BUSINESS

5.1. There was no other business.

6. DATE OF NEXT MEETING

6 February 2024

EXTRA ORDINARY PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST EXTRA ORDINARY PUBLIC BOARD MEETING HELD ON 6 DECEMBER 2023 VIA TEAMS

PRESENT

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

IN ATTENDANCE

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 Sube Banerjee (Non-Executive Director).

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

2. DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA

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

3. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

3.1. The Chairman advised that the focus of the Confidential Board meeting will be on the approval of a commercial contract in support of the electronic health record programme.

4. WITHDRAWAL OF PRESS AND PUBLIC

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

5. ANY OTHER BUSINESS

5.1. There was no other business.

6. DATE OF NEXT MEETING

6 February 2024

EXTRA ORDINARY PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST EXTRA ORDINARY PUBLIC BOARD MEETING HELD ON 16 JANUARY 2024 AT THE MONKS YARD, HORTON CROSS, ILMINSTER

PRESENT

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

IN ATTENDANCE

Ben Edgar-Attwell	Deputy Director of Corporate Services (minute taker)

1. WELCOME AND APOLOGIES FOR ABSENCE

1.1. It was noted that apologies had been received from Sube Banerjee (Non-Executive Director) and Barbara Gregory (Non-Executive Director)

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

2. DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA

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

3. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

3.1. The Chairman advised that the focus of the Confidential Board meeting will be on the approval of the contractual and project documents in support of the Yeovil Clinical Decisions Centre.

4. WITHDRAWAL OF PRESS AND PUBLIC

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

5. ANY OTHER BUSINESS

5.1. There was no other business.

6. DATE OF NEXT MEETING

6 February 2024

SOMERSET NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETINGS HELD ON 7 NOVEMBER 2023, 20 NOVEMBER 2023 AND 6 DECEMBER 2023

AGENDA ITEM	ACTION	BY WHOM	DUE DATE	PROGRESS
7 NOVEMBER 2023 BOARD MEETING				
15. Six monthly inclusion report	To schedule a further discussion at a future Board Development Day	Executive Team	To be confirmed	This item has been included in the work programme.
20 NOVEMBER 2023 BOARD MEETING				
No actions had been identified at the Board meeting held on 20 November 2023				
6 DECEMBER 2023 BOARD MEETING				
No actions had been identified at the Board meeting held on 6 December 2023				

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:	6 February 2024

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

Executive Summary and Reason for presentation to Committee/Board	The Registers of Interests are presented to the Board at every meeting and reflect the interests of Board members as at 15 January 2024.
Recommendation	The Board is asked to: • note the Register of Interests; • declare any changes to the Register of Interests; • declare any conflict of interests in relation to the agenda items.

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

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

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

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

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

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

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

REGISTERS OF DIRECTORS' INTERESTS

NON EXECUTIVE DIRECTORS	
Colin Drummond Chairman	• Honorary Vice President of Calvert Trust Exmoor (outdoor holidays for people with disabilities) – current • President of Wadham College Oxford 1610 Society • Deputy Lieutenant for Somerset • Worshipful Company of Water Conservators – Deputy Master
Jan Hull Non-Executive Director	• Trustee of the Dulverton Abbeyfield Society. • Formerly Managing Director of South, Central and West Commissioning Support Unit
Dr Kate Fallon Non-Executive Director (Senior Independent Director)	• Daughter is a Consultant at the Trust • Symphony Health Services Board member • 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 • Non-Executive Director at Torbay and South Devon Healthcare NHS Trust
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 Ltd Company is registered as not trading at this time. • Portsmouth Hospitals University Trust - Position - Non-Executive Director (end of term is Mar 24) • Isle of Wight NHS Trust - Position - Non-Executive Director (end of term is Mar 24)

Tina Oakley	• Son, Dr Tom Oakley, is Chief Executive Officer of a digital medical imaging company, Feedback plc.
EXECUTIVE DIRECTORS	
Peter Lewis Chief Executive (CEO)	• Member of the NHS Confederation Community Network Board • Management Board Member, Somerset Estates Partnership (SEP) Board • Director, Somerset Estates Partnership Project Co Limited
Phil Brice Director of Corporate Services	• Sister works for the Trust • Non-Executive Director of the Shepton Mallet Health Partnership • Shareholder Director of SSL
Isobel Clements Chief of People and Organisational Development	• Sister in law works in the pharmacy department at MPH • Nephew works as a physio assistant within MPH.
Andy Heron Chief Operating Officer/Deputy Chief Executive	• Wife works for Avon and Wiltshire Mental Health Partnership NHS Trust (and is involved in a sub contract for liaison and diversion services) • Director of the Shepton Mallet Health Partnership • Executive Director for SHS
Pippa Moger Chief Finance Officer	• Stepdaughter works at Yeovil District Hospital • Son works for the Trust • Director of the Shepton Mallet Health Partnership • Director of Somerset Estates Partnership Project Co Limited • Member of the Southwest Pathology Services (SPS) Board • Shareholder Director for SSL
Hayley Peters Chief Nurse	None to declare
David Shannon Director of Strategy and Digital Development	• Member of the Southwest Pathology Services (SPS) Board • Daughter is employed as a healthcare assistant at Musgrove Park Hospital • Member of the Symphony Health Care Services (SHS) Board • Director of Symphony Health Services (SHS)

	• Wife works within the Neighbourhood's Directorate. • Management Board Member, Somerset Estates Partnership (SEP) Board • Director Predictive Health Intelligence Ltd
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:	6 February 2024

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

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

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

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

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

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

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

Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
The report includes a number of references to work involving colleagues, 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. OVERVIEW OF ACHIEVEMENTS IN 2023

1.1. We have just begun 2024 and, while we are all looking ahead to what is coming up this year, it is important to remember all the achievements and hurdles overcome last year.

1.2. Perhaps the biggest accomplishment of last year was completion of the merger of our former trusts in April, creating the new Somerset NHS Foundation Trust. Together, we care for people across Somerset and into Dorset, through hundreds of services spanning community, mental health, learning disabilities, and out of our acute hospitals, MPH and YDH.

1.3. Several substantial projects and innovations took place last year, with one goal in mind: to improve patient care and experience across the county. Teams launched new services, including tobacco reduction, and post-menopausal bleeding, as well as extending the offer of day surgeries to many more patients. The Somerset TogethEHR programme also launched last year, which works toward the procurement of a unified electronic health record.

1.4. Last year was a big year for the opening of new centres or buildings, with a new radiotherapy superficial x-ray unit at Musgrove Park, operating day theatre at Yeovil Hospital, a new macular treatment centre in Taunton, and a mental health hub on Fore Street in Bridgwater.

1.5. A new community diagnostic centre for Yeovil was announced earlier last year, with planning confirmed in December, while construction continued on the new surgical centre at Musgrove Park, and work started on the Breast Cancer Unit at Yeovil Hospital – we can not wait to see these buildings continue to take shape this year.

1.6. Our teams gained access to cutting-edge innovations, such as the use of repetitive Transcranial Magnetic Stimulation (rTMS) treatment, a groundbreaking treatment for severe depression, as well as welcoming two new robots to our theatres at both MPH and YDH.

1.7. 2023 was also a great year for colleague recognition, and we were proud to see many colleagues and teams get nominated and awarded for various titles throughout the year. The cleaning team at Yeovil Hospital received top marks for cleanliness, while the national organisation responsible for guidance and best practices in the peri-operative field praised our services, and the team at Highbridge Medical Centre achieved a 'Good' rating in its Care Quality Commission (CQC).

1.8. This is a huge testament to our colleagues' enthusiasm and passion, highlighted by just how many colleagues were nominated for Our Somerset

Star of the Months awards! Since the merger in April 2023, over 200 teams and colleagues were nominated for the trust's monthly awards, with our executive team choosing the winners each month.

1.9. Colleagues and members of the public came together to help celebrate another big date in the diary for 2023 – the 75th birthday of the NHS! Other celebrations were had across the trust for dates such as International Day of the Midwife, Nurses' Day, the King's Coronation, Black History Month & Freedom to Speak Up Month, and many more. In fact, the trust highlighted over 80 awareness days and campaigns last year!

2. ICB REACHES DECISION ON FUTURE OF STROKE SERVICES IN SOMERSET

2.1. The ICB met on Thursday 25 January 2024 to consider the future of stroke services in Somerset and agreed that the following acute hospital-based stroke services will be developed in the future:

- A single Hyper Acute Stroke Unit at Musgrove Park in Taunton, providing 24/7 emergency treatment. Research shows that more people survive stroke and are able to live independently when specialised stroke services are located in one place.
- Acute stroke units at both Musgrove Park Hospital, Taunton and Yeovil District Hospital, Yeovil. Maintaining two acute stroke units would mean that following their emergency stroke treatment, patients could move to Yeovil District Hospital if this was closer to where they live.
- Patients would be taken to their nearest hyper acute stroke unit. This could be out of Somerset if it was closer such as Dorset County Hospital, Dorchester.

2.2. These changes will be phased in over the coming 18 months and updates will be provided as we plan and implement these changes.

2.3. The ICB requested that its finance committee review the financial case in terms of maximising value for money for the investment and seeking assurance around the affordability of the capital case. The finance committee paper will come back to the next ICB board meeting.

2.4. You can read about this review on the ICB's stroke pages.

3. INSPECTION OF OUR MATERNITY SERVICE

3.1. The Care Quality Commission (CQC) aims to provide an up-to-date view of the quality of hospital maternity care across the country, and a better understanding of what is working well to support learning and improvement at a local and national level. You can read more about this work on the CQC website Maternity inspection programme - Care Quality Commission

(cqc.org.uk).

3.2. The Care Quality Commission (CQC) visited our Trust's maternity services at the end of November 2023 as part of its national review of maternity services. The team of inspectors visited maternity services at Musgrove Park and maternity services at Yeovil and Bridgwater. They also held interviews and focus groups with colleagues from maternity and relevant non-executive directors.

3.3. Informal feedback was received after the inspection visit and the final report is still awaited. The final report will be available on the Care Quality Commission and the trust's website following its publication.

4. UPDATE ON BMA CONSULTANT BALLOT

4.1. A British Medical Association (BMA) ballot of consultants has rejected the government's pay offer for consultants in England by a narrow margin. 51.1% voted against accepting the offer with 64.8%. taking part in the ballot.

4.2. The BMA discussed the results at its consultants committee this week and has decided not to call strike action at the current time but instead enter discussions with Government to see whether we can secure improvement to address our members' concerns. It says that if that is unsuccessful, consultants in England remain in dispute.

4.3. We are of course closely following this, and any updates on the dispute between postgraduate doctors in training and the government, to understand what this means for our services and our patients.

5. WINTER PRESSURES

5.1. For a number of years, the NHS has been facing increased demands on its services. But as the winter months approach, those numbers can start to creep ever higher. From seasonal viruses and illnesses like flu and norovirus, to the impact of the colder weather, and darker days on our mental health, there are many reasons why more people need support from the NHS over winter.

5.2. NHS organisations across the country have been preparing for what is referred to as 'winter pressures', and at Somerset NHS Foundation Trust, we are no different. This winter, our focus is on caring for people in the right way, in the right place, and at the right time – and we have created a specific page on our internet to act as a hub of information on how and where to access services. The information is available on the following link Preparing for winter in your local NHS – Somerset NHS Foundation Trust (somersetft.nhs.uk).

6. LAUNCH OF OUR TRUST COLLEAGUE AWARDS

6.1. In January, we launched our first Our Somerset Colleague Awards, or the OSCAs as we are calling them. This will be the first annual colleague recognition process and awards programme that we have held as a merged trust, and we hope that they give us an excellent platform on which to recognise the very best of our colleagues' work, wherever they work and whatever their role.

6.2. One of the Trust's strategic aims is to support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture – and a very important part of that is ecognizing and rewarding their contribution.

6.3. In April 2023, we launched our recognition framework for our merged trust which offers everyday recognition, informal recognition, and formal trust-wide recognition. Therefore, we have:

- Thank you cards – available for all colleagues to provide to another colleague at any time
- Everyday Champions – colleagues are able to nominate any colleague for this award, a certificate is then awarded at the end of each month.
- Our Star of the Month – our executive team have the pleasure of judging winners of the award from the nominations that are put forward by colleagues. Runners-up for this award are automatically awarded an everyday champion award. We share information about our winners and nominees through our trust communications every month.
- Finally, we have our Our Somerset Colleague Awards which celebrate our colleagues' best achievements across the trust from the past year.

7. PLANNING APPROVAL FOR OUR NEW YEOVIL DIAGNOSTIC CENTRE

7.1. We have been given planning permission for our Yeovil Diagnostic Centre adjacent to Yeovil District Hospital that will deliver over 70,000 diagnostic tests and outpatient appointments a year. Building work is expected to begin in February and the centre is planned to open in winter 2024.

7.2. The modern state-of-the-art, stand-alone centre on the hospital site will benefit patients in Somerset and north west Dorset who will receive quicker diagnostic tests thanks to the additional capacity the centre will provide. Open seven days a week, it will provide radiology, endoscopy, cardiology and audiology diagnostic tests and outpatient appointments.

7.3. The Yeovil Diagnostic Centre will be the second stand-alone diagnostic centre in Somerset, and is being developed with InHealth, a specialist provider of diagnostic solutions, and Prime, a specialist health and care property developer. InHealth will provide radiology and endoscopy services. Somerset NHS Foundation Trust will provide all other diagnostic and outpatient services. Prime, the trust's strategic estates partner, will design and build the centre in partnership with InHealth and the trust.

7.4. In addition to the upcoming Yeovil Diagnostic Centre and the Taunton Diagnostic Centre that opened in September 2021, the trust has also opened two ophthalmology diagnostic centres – one in Yeovil town centre and the other on the Blackbrook Business Park in Taunton. Community investigation hubs have also been set up in each of Somerset's Primary Care Networks.

7.5. All of these facilities expand our diagnostic capacity and mean that patients do not need to go into our busy hospitals for some diagnostic tests, and capacity within our busy hospitals is freed up for patients who require more complex care and those who are in hospital.

8. YEOVIL HOSPITAL CHARITY REACHES £2.5 MILLION FUNDRAISING TARGET FOR OUR BREAST CANCER UNIT APPEAL

8.1. Early November 2023 our Yeovil Hospital Charity reached its £2.5 million breast cancer unit target. From running marathons and wing-walking, to sponsored events and selling (and eating!) cakes, it has been an incredible journey of fundraising.

8.2. Work has already begun on the new Breast Cancer Unit with the first patients set to be welcomed in late 2024, though fundraising will continue into 2024 and our charity team will try to raise as much as they can over the next few months.

8.3. The purpose-built unit has been designed with lots of art and natural light, a dedicated area for difficult conversations, and a comfortable waiting area, away from other busy outpatient areas and treatment rooms.

8.4. James Kirton, our head of charity who led on the appeal, said: "*It is absolutely incredible that we have reached the £2.5 million appeal target, after four years of amazing fundraising from our volunteers and supporters. This moment has been a long time coming and I could not think of a better organisation than Yeovil Town Football Club to push us over the target, we are so grateful to them. We have run fundraising events with Yeovil Town many times in the past, but it was a big surprise that they've raised £40,000 for our appeal."*

9. BURNHAM AND BERROW MEDICAL CENTRE SHOWS SIGNIFICANT IMPROVEMENT WITH CARE QUALITY COMMISSION (CQC) GOOD RATING

9.1. Healthcare services at Burnham and Berrow Medical Centre have been rated 'Good' in all elements (safe, effective, caring, responsive to people's needs and well-led) following an announced comprehensive CQC inspection on 13 September 2023. This is a tribute to the management of our Symphony subsidiary which six months ago took over this practice.

9.2. The inspection report, published in November 2023 sets out significant improvements since the previous inspection in November 2022, and the inspection report of January 2023, when urgent conditions were applied to the practice after it was rated inadequate overall.

9.3. During the recent visit, inspectors found that:

- The practice provided care in a way that kept patients safe and protected them from avoidable harm.
- Patients received effective care and treatment that met their needs.
- Staff dealt with patients with kindness and respect and involved them in decisions about their care.
- Patients could access care and treatment in a timely way.
- The way the practice was led and managed promoted the delivery of high-quality, person-centre care.

9.4. The improvement in quality-of-care ratings, follows the integration of Burnham and Berrow Medical Centre into Symphony Healthcare Services in April 2023.

10. APPOINTMENT OF OUR NEW CHIEF MEDICAL OFFICER

10.1. We are pleased to announce the appointment of Dr Melanie Iles as our new Chief Medical Officer from 1 April 2024.

10.2. Dr Iles is currently NHS England's national chief clinical information officer (CCIO) on an interim basis, on secondment from her substantive role as NHS England's medical director and CCIO for the East of England region.

10.3. Our chief executive, Peter Lewis, said: "*I am very excited to welcome Melanie to Somerset in spring next year. She is a paediatrician by background and has worked as a medical director both at local level within a trust and at a regional level in a number of different parts of the country.*

"Our trust is unique in England and provides acute, community, mental health and learning disability services, and primary care services via our subsidiary. We aim to support people to stay well, provide the best care and support, strengthen care and support in local communities, and reduce health inequalities. I am confident that Melanie will support us to achieve this while at the same time supporting our colleagues within the trust to develop and continue to innovate."

10.4. Dr Melanie Iles said: "*I am delighted to have been appointed as chief medical officer for Somerset NHS Foundation Trust. It will be a privilege to join the trust and work with the amazing staff to deliver the trusts vision to improve the health and care outcomes for the people of Somerset and the benefits of the trust merger. I have big shoes to fill taking on this role from Dr Dan Meron who has done a fantastic job. I am looking forward to starting in April and getting to know the people and the services they deliver. I have been fortunate to have a varied career and experience which I intend to put to good use for the benefit of the organisation".*

10.5. Melanie is currently the national chief clinical information officer for NHS England, a post which she has taken on an interim basis to support the formation of the new digital clinical informatic team through the merger of NHS England, NHS Digital and Health Education England. In her previous position as interim regional medical director in the East of England she was the chief clinical information officer.

10.6. She is an experienced leader, having worked as a medical director in different settings for over 8 years, in an acute trust, for NHS Improvement and for NHS England at regional level. Prior to this, she held a variety of regional and national roles as a senior clinical leader focussed on children and young people. She is a paediatrician with over 31 years' service in the NHS.

11. BOARD AND SUB-COMMITTEE EFFECTIVENESS REVIEWS

11.1. In line with our governance framework, the Board and its sub-committees undertake annual formal reviews of their effectiveness to ensure they are meeting their purpose and delivering effective governance of the Trust.

11.2. The Board reviews the effectiveness of Board meetings at the end of each meeting, but this is not a detailed review. The Board and each sub-committee have approved Terms of References which are used as the basis for an annual effectiveness reviews.

11.3. An effectiveness questionnaire was developed, based on the HFMA template developed for Audit Committees. All Board and sub-committee members were asked to complete the questionnaires. The questions in the framework have been amended to align with the Board's and individual committee's Terms of Reference.

11.4. The Board reviewed the findings of the reviews at its Board Development Days held on 6 December and 16 January where the following RAG ratings were noted.

11.5. The RAG rating is based on the percentage of respondents who agreed that the Board is compliant with the relevant sections of its Terms of Reference and the RAG rating thresholds for the items marked as "(1) must do" or "(2) should do" are as follows:

Board Effectiveness

Heading	**RAG Rating** Green – 75% and above Amber – 60 to 75% Red – below 60%
Composition, establishment and duties	
Meetings	
Leadership and Strategy	
Performance, patient care and workforce	
Governance – legislatory and regulatory	
Finance	
Other Issues	
OVERALL RAG RATING	

11.6. Although all headings were rated as "Green", the responses for a small number of questions had a slightly lower individual score or issues raised. These will be addressed in the coming months and include:

- *Are new Board members provided with appropriate induction?*
  In view of the mergers over the past few years and the number of very experienced Board members, there has not been a need for an induction programme over many years and the need to review the induction programme was raised by a number of Board members.

- *Does the Board promote training, teaching, research and innovation in healthcare in line with the Trust's values and strategic direction?*
  This question has been rated amber as comments indicated that there was a lack of, or only limited, focus on research and development at Board meetings.

- *Does the Board give appropriate consideration to which items are to be discussed at Public Board meetings v Confidential Board meetings?*
  This question scored 100% compliant but it was recognised that there was a need to keep monitoring which items are to be presented to the Part B Board meeting.

- *Does the Committee ensure public scrutiny at public Board meetings?*
  This question scored 93%. All attendees – and the wider public - are

given the opportunity to submit questions for the Board in advance of the meeting. Members of the public are given the opportunity to attend public Board meetings. Consideration can be given as to whether or not further actions are required.

- *Does the Board oversee the implementation of the Trust's strategic aims and objectives?*
  This question scored 100% but concerns were raised that the delegation to Board Committees has led to the Board not fully understanding its role in leading on some subject areas, e.g. inclusion.

- *Does the Board receive and consider high level reports on quality of care, patient experience, colleague/staffing, operational, financial and clinical performance*?
  This question scored 100% but comments were made that the Board did not receive regular high-level reports on patient experience.

- *Has the Board reviewed the robustness of the data behind reports and assurances received?*
  The overall view was that the Board itself did not review the robustness of data but that it was relying on internal and external audit reviews of data and scrutiny at Board Committees.

- *Has the Board reviewed whether the reports it receives are timely and have the right format and content to enable it to discharge responsibilities?*
  This question scored 93% and one comment was made that a review of the format and content of reports presented to the Board had not recently been carried out.

- *Has the Board considered the costs that it incurs: and are the costs appropriate to the perceived risks and the benefits?*
  This question is a "could do" question and is not a requirement. It is recommended that the Board considers whether its costs should be considered or whether this question can be removed from subsequent effectiveness reviews.

11.7. The findings from the effectiveness review indicate that the Board is compliant with its Terms of Reference and conducts its business effectively in line with its stated objectives and duties.

11.8. **Committee Effectiveness**

	RAG Rating
People Committee	
Charity Committee	
Mental Health Act Committee	
Quality and Governance Assurance Committee	

Audit Committee	
Finance Committee	

11.9. The findings from the effectiveness reviews indicate that the committees are compliant with their Terms of Reference and conduct their business effectively in line with its stated objectives and duties. Further work is being done to ensure that the Committees' terms of reference remain relevant to the changing demands of the trust for 2024/25.

12. CHRIS HOPSON VISITS SOMERSET

12.1. Chris Hopson, chief strategy officer for NHS England visited Somerset on 17 November 2023. While in the county, Peter Lewis took him to the rural health hub at Junction 24, where he spoke to a range of our colleagues who have set up and run the clinic at Junction 24 and the rural health hubs in Exmoor and Frome. He also met with Peter Lewis, Jane Yeandle, service group director for mental health and learning disabilities, an expert by experience, and Claudine Brown, head of CAMHS, to talk about our transformation of mental health services in Somerset in partnership with patients by experience and the third sector, how we consider mental health, learning disabilities and deprivation in our management of our waiting lists, and to hear about the transformation of our CAMHS service over the last two years.

12.2. While in Somerset, he has also found out about:

- how four GP practices in Somerset are trialling an AI system which can highlight registered patients with complex health needs, at risk of hospital admission or who rarely contact their GP and reach out to them for conversations about their health.

- The work the NHS in Somerset is doing with local education providers including the University Centre Somerset to enhance the variety of routes we can provide students locally.

13. BISHOP MICHAEL VISITS MUSGROVE PARK HOSPITAL

13.1. On Monday 22 January, we welcomed Bishop Michael of Bath and Wells to Musgrove Park Hospital.

13.2. During his visit, Bishop Michael spoke to patients and colleagues in the hospital's intensive care unit and emergency department, to its chaplaincy team and to representatives of the various colleague networks throughout the hospital. He was also given an overview of plans for the vitally needed new Somerset maternity and paediatric unit, to replace the current facility which dates back to the Second World War.

13.3. Bishop Michael said: “It was a privilege to visit Musgrove Park Hospital and to see our NHS in action. Among the staff who serve us at Musgrove, it was inspiring to see such professionalism and expertise combined with such warmth and humanity.

13.4. “A place like Musgrove Park is an astonishing collection of many different moving parts – from those on reception to those renewing the buildings, those offering critical care to those serving up meals and nourishment – nurses, doctors, porters, cleaners, trustees, maintenance staff and of course many more.

13.5. “I could only be struck at the way everyone was working as a team to enable so much to happen. People are going the extra mile at Musgrove.”

14. BURNHAM-ON-SEA MINOR INJURY UNIT TO OPEN SEVEN DAYS A WEEK

14.1. From 1 December 2023, the minor injuries unit (MIU) at Burnham Community Hospital returned to seven days a week opening, from 10am to 6pm (last patient at 5:30pm). It follows the successful recruitment of three additional emergency nurse practitioners, and the return of an additional colleague from maternity leave, which means a safe and consistent service can be provided from the MIU every day of the week.

15. NEW CHECKLIST INTRODUCED TO HELP PATIENTS RETURN HOME FROM HOSPITAL

15.1. It is well known that patients recover from illness and injury quicker when at home, with a prolonged hospital stay often leading to a loss of muscle power, strength and other every day activities.

15.2. Research shows that on average patients can lose around 15% of their muscle mass while in hospital, especially if they stay in bed most of the time. However sometimes there are barriers to a patient leaving hospital even when ready for discharge for many reasons. From packages of care not yet being available to them in the community, to simple things like their home not being set up ready for them to return to.

15.3. To combat this one of the ways we make things easier for patients to return home is by transferring patients to our discharge lounge on the day that they are ready to leave hospital. Using the discharge lounge provides a safe way of caring for patients who are ready and waiting to start their journey home or being transferred to another care facility, while also freeing up much-needed beds on wards across the hospital.

15.4. It is one part of a number of initiatives we have been developing across Somerset to help keep patients out of hospital and to help those in hospital

get home as quickly as possible – even more important as we are now in the midst of winter.

15.5. One of the recent improvements made on our wards has been the introduction of yellow discharge checklists – documents that are used across the trust for all patients due to leave hospital, especially those going out on a supported discharge, where a patient gets additional care while they transition back to living at home. The checklists help to ensure that we achieve the best possible experience for our patients in that there are no errors or complications. It also provides a list of all the common and essential actions that need to be completed prior to the patient leaving hospital.

16. USE OF THE CORPORATE SEAL

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

16.2. The seal register entries over the period 1 April 2023 to 15 January 2024 are set out in the attached appendix.

17. MEDIA COVERAGE

17.1. Over the period November to 26 January 2024, there has been the following media coverage:

- **Media coverage about data breach at Musgrove Park Hospital**
  In November 2023 there has been media coverage about a data breach at Musgrove Park Hospital as a result of the actions of a member of staff, who no longer works in the trust. We communicated with the media at the request of the police who are investigating. The information that we provided to the media is below for your information.

  Somerset NHS Foundation Trust is contacting up to 200 people after a proportion of their hospital records were inappropriately accessed by a member of staff.

  The member of staff accessed the hospital records of people within their circle over a period of six years. The trust is this week contacting every person whose hospital record has been inappropriately accessed to let them know what has happened, to apologise unreservedly, and to offer to meet them to discuss it if they would like.

  The trust has reported the breach to the Information Commissioner and Avon and Somerset Police is investigating.

  Phil Brice, Director of Corporate Services for Somerset NHS Foundation Trust, said: "We apologise unreservedly to every person

whose hospital record has been inappropriately accessed in this way. Many NHS professionals need access to confidential information in order to do their jobs effectively. Every colleague in our trust undertakes regular information governance training and we understand that we are in a position of trust. Very sadly, this was not respected in this case."

The member of staff had access to one hospital system as part of their role. This enabled them to see demographic details; A&E attendances including dates and basic admission information; inpatient admissions including dates, the wards where patients were cared for, consultant and specialty; and outpatient appointments including dates, consultant and specialty. They were not able to access clinical letters, discharge summaries, community, mental health or sexual health records or medical or nursing records.

- **Media coverage in the HSJ**
  In November 2032, a statement from the trust was included in an HSJ article titled Revealed: the worst trusts for discharge delays. The article identifies those trusts with the most patients waiting at least a week after they are ready to be discharged.

  Newly published NHS England data shows that around 3.7% of all patients in England waiting a week or longer in hospital following their "discharge ready" date — although about half trusts have so far failed to report accurate data. We have previously highlighted the difficulties we face in 'delayed transfers of care' due to pressures in the social care system. Our trust is listed eighth on the list of ten trusts. Our statement says:

  "Like in many other areas of the country, we are continuing to experience difficulties in discharging patients from hospital when they require ongoing support, either at home or in other care settings. This is particularly concerning given the context of local authority partners managing severe financial challenges and the need to ensure that we can provide the best possible care to patients in the most appropriate settings as we go through the winter period.

  "We are working closely with our health and social care partners to address this, including looking at how we best deploy our community services to support discharges and to help people stay at home rather than be admitted to an acute bed. One example of this is our Hospital@Home service that aims to care for patients at home safely, rather than being in hospital. We have also opened Ready to Go Units for patients where we can provide additional reablement input for those who are medically-fit to leave hospital but there is not sufficient capacity in other settings to support them."

18. NATIONAL DEVELOPMENTS

Latest NHS performance data published – 1 December

18.1. The latest NHS performance figures were published by NHS England this week and show:

- Average 12,654 patients a day ready to leave hospital but cannot be discharged.
- Fewer ambulance handover delays than same time last year despite higher demand.
- More than 121,000 NHS vacancies in England.
- Anxiety, stress and depression behind 28% of staff sickness absences.
- Almost 7.8m appointments and treatments (almost 6.5 million people) on waiting list.

18.2. The NHSE press release and link to the data is here. NHS Providers response is below.

Miriam Deakin, director of policy and strategy at NHS Providers, said:

"*Demand for and pressure on the NHS continue to bite. Last winter was the worst that many in the NHS can remember and this time could be even tougher.*

"As temperatures plummet, pressure on the NHS hots up with winter illnesses and bugs like flu adding to already high demand on services and staff.

"Every day thousands of people are stuck in hospital beds when they could be recovering at or closer to home, largely because of a lack of capacity and resources in social care and community health services – with serious knock-on effects on the rest of the already stretched system.

"With more than 121,000 vacancies across the NHS in England and staff off sick due to anxiety, stress or depression – the equivalent of more than 571,500 lost days – hardworking hospital, ambulance, mental health and community trusts are up against it as they strive to treat more patients as quickly as possible and to bring down waiting lists – with the longest waits for planned procedures having been successfully reduced.

"Trusts are doing all they can to ensure patients receive timely care in the right settings, including investing in urgent community response services and more support at home where appropriate, as well as working hard to reduce handover delays when patients arrive at hospital in ambulances.

"However, to be able to give patients the best possible care this winter and beyond the NHS needs the right numbers and mix of staff, better supported

social care, more beds and more investment to modernise buildings and equipment."

NHS Providers response to announcement about curbs on visas for care workers

18.3. The government announced plans to cut net migration to the UK. These include plans to tighten the Health and Care Worker visa. From next spring, the government will increase the earning threshold for overseas workers by nearly 50% from its current position of £26,200 to £38,700. It will also increase the minimum income required for British citizens and those settled in the UK who want their family members to join them.

18.4. In response, Miriam Deakin, director of policy and strategy at NHS Providers said:

"It is vital that overseas health and care staff continue to view the UK as a viable place to work and live.

"With over 120,000 staff shortages in the NHS and over 150,000 in social care, measures that deter people from joining these professions are deeply concerning.

"The NHS Long Term Workforce Plan is clear that international recruitment will continue to play a key role in the NHS' future, alongside domestic training.

"We therefore need the health and care sectors to remain attractive not only to domestic workers but also to those educated internationally.

"The contributions of overseas staff are vital, and recently helped the government reach its target to recruit 50,000 extra nurses earlier than expected.

"But we cannot rely on overseas workers alone to plug the staffing gaps. More must also be done to recruit, develop and retain a sustainable UK workforce.

"For this to happen, the NHS Long Term Workforce Plan must be fully funded by the government."

Start of NHS Providers NHS Winter Watch 2023/4 series

18.5. NHS Providers began its NHS Winter Watch 2023/4 series following the release of the winter situation report data from NHS England. Every Thursday until the end of February, NHS Providers will track key activity and demand figures across the NHS, with contributions from our members and stakeholders to connect those numbers with the real-life experiences of trusts.

Final report on detainment of people with a learning disability and autistic people – and NHS Providers response

18.6. The Government has published a final report by Baroness Hollins titled *My heart breaks – solitary confinement in hospital has no therapeutic benefit for people with a learning disability and autistic people*.

18.7. This report focuses on people with a learning disability and/or autistic people who are detained in mental health and specialist learning disability hospitals. The Independent Care (Education) and Treatment Review (IC(E)TR) programme reviewed the care and treatment of 191 people who were detained in long-term segregation between November 2019 and March 2023. The programme was established because of serious concerns about the use of long-term segregation, and in particular about lengthy stays and difficulties in discharging people from long-term segregation. The aim was to identify the blocks to discharge and to assess whether independently chaired Care (Education) and Treatment Reviews (C(E)TRs) would be more effective than commissioner chaired C(E)TRs in developing the right support for each person detained in long-term segregation.

18.8. The Oversight Panel found a lack of urgency in addressing the many systemic issues that were identified through the IC(E)TR reviews. International consensus across various sectors and disciplines on the harms caused by enforced isolation are scientifically evidenced and compelling, and the consensus is that enforced isolation has no therapeutic benefit.

18.9. Members are unanimous in recommending that all instances of enforced social isolation, including seclusion and long-term segregation, should be renamed 'solitary confinement'. The panel recommends that its use with children and young people under the age of 18 should be ended with immediate effect, and that the use of solitary confinement for people with a learning disability and/or autistic people should be severely curtailed and time limited. Minimum standards for the use of solitary confinement should be introduced urgently through amendments to the Mental Health Act 1983: Code of Practice.

18.10. In response, NHS Providers has said: *"The findings of this report are deeply concerning and underline the urgent need for trusts to tackle high levels of long-term segregation.*

"People with a learning disability and autistic people must be properly supported and receive high-quality care.

"It makes a big difference when reasonable adjustments are put in place and when patients, carers and families are fully involved in decisions about their care.

"It is important to ensure the full range of services that people with a learning disability and autistic people rely on are properly resourced and prioritised across the country.

"This means having enough staff with the right skills and experience.

"Greater capital investment is also crucial for patients to get the care they need in environments that properly meet their needs."

SOMERSET NHS FOUNDATION TRUST

SEAL REGISTER

1 APRIL 2023 to 15 JANUARY 2024

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
2 November 2023	63	Variation Agreement – South West Pathology Services LLP (analytics agreement)	Hayley Peters	Daniel Meron
27 November 2023	64	Canonsgrove Halls of Residence, Staplehay, Taunton	David Shannon	Phil Brice
19 December 2023	65	Prime Infrastructure Management Services Agreement Section 106 + 278 at YDH	David Shannon	Peter Lewis

NHS Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	2023/24 Q3 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:	6 February 2024

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

Executive Summary and Reason for presentation to Committee/Board	Somerset NHS Foundation Trust (SFT) has identified eight strategic objectives, which remain the long term aims for the newly merged organisation. The five clinical objectives are aligned with the system clinical aims which also form the basis for the clinical model. These sit alongside our financial, people and organisational objectives. **The Board Assurance Framework (BAF)** An Assurance Framework has been developed to clearly outline the highest risks to the Trust in achieving these objectives; the plans in place to manage and mitigate these and to provide the Committees and Board with a summary of key plans and strategies supporting their delivery. The highest risks to the strategic objectives are currently: • Workforce shortages (objective 3) – 25 • Failure to deliver HER (objective 5) – 20 • Core numbers of junior and consultant medical workforce (objective 6) – 25 • Insufficient capacity to meet demand (objective 8) – 20 Further information on the current risk position is outlined in the report.
Recommendation	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.

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 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

2023/24 Q3 BOARD ASSURANCE FRAMEWORK

1. PURPOSE OF THE REPORT

1.1 To present the 2023/24 Q3 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.

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

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

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

Audit Committee	12 July 2023 11 October 2023 10 January 2024
Quality and Governance Assurance Committee	28 June 2023 26 July 2023 25 October 2023 20 December 2023
People Committee	25 July 2023 13 September 2023 8 November 2023
Finance Committee	31 July 2023 30 October 2023
Board	4 July 2023 7 November 2023

3.4 Deep dives of the five clinical aims and objectives are underway with strategic objectives 1 and 2 reviewed at the meeting of the Quality and Governance Assurance Committee held on 20 December 2023. This included an overview and update on progress against the flagship/Quality Account programmes of work within the relevant areas. The remaining objectives will be reviewed by the Committee at its meeting in February 2024.

4. AMENDMENTS TO THE BAF TEMPLATE

4.1 At the meeting of the Audit Committee held in October 2023, members of the Committee discussed amending the summary page of the BAF to clearly illustrate the current risk profile of the objectives against the Trust's risk appetite. As such, the template has been amended to illustrate the risk appetite for the strategic risks and whether the current risk position is above, in line or below this position. These amendments were reviewed at the Audit Committee in January 2024.

5. CURRENT POSITION

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

Corporate Objective	Risk Appetite		Highest Risk
1. Improve the health and wellbeing of the population	G	Seek 15-16	12
2. Provide the best care and support to people	R	Open 12	16
3. Strengthen care and support in local communities	R	Seek 15-16	25
4. Reduce inequalities	A	Seek 15-16	16
5. Respond well to complex needs	R	Seek 15-16	20
6. Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture	R	Seek 15-16	25
7. Live within our means and use our resources wisely	R	Financial Manag – Open 12	15
	A	Commercial – Seek 15-16	
8. Develop a high performing organisation delivering the vision of the trust	R	Seek 15-16	20

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

- Access to primary care / increasing ED demand (objective 2) – **16**
- Age of acute and community estates (objective 2) – **15**
- Shortfalls in Social Care capacity (objectives 2 & 3) – **15**
- Workforce shortages (objective 3) – **25**
- Fragility of Primary Care (objective 3) – **16**
- Data quality issues leading to poor information (objective 4) – **16**
- Sub-optimal links between primary care & SFT services (objective 5) – **16**
- Personalised care doesn't get required focus (objective 5) – **16**
- Failure to deliver HER (objective 5) – **20**
- Not improving retention rate – nursing/estates/facilities/admin roles (objective 6) – **16**
- Reduced colleague resilience (objective 6) – **16**
- Core numbers of junior and consultant medical workforce (objective 6) – **25**
- Failure to identify & deliver sufficient recurrent CIP (objective 7) – **15**
- Lack of pace of system-wide changes to address deficit (objective 7) – **15**

- Insufficient capacity to meet demand (objective 8) – **20**
- Failure to secure the necessary infrastructure (objective 8) – **16**

6. CONCLUSION

6.1 It is clear that the Trust continues to carry a significant number of high strategic risks that are over and above the level of risk it has outlined it is willing accept within its Risk Appetite Statement. There is a mixed level of assurance across the strategic objectives, although it has been demonstrated that there has been progress made against the identified actions.

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

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

7. RECOMMENDATION

7.1 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 3 2023/24

Ref	Executive Owner	Corporate Objective	Overseeing Committee	Risk Appetite		Highest Risk		Plans & Strategies		Policies & Processes		Oversight Arrangements	
1	DS	Improve the health and wellbeing of the population	Board	G	Seek 15-16	12	⇔	G	⇧	A	⇔	A	⇔
2	HP	Provide the best care and support to people	Quality & Governance Assurance Committee	R	Open 12	16	⇔	G	⇔	A	⇔	G	⇔
3	AH	Strengthen care and support in local communities	Quality & Governance Assurance Committee	R	Seek 15-16	25	⇔	G	⇔	G	⇔	A	⇔
4	PB	Reduce inequalities	Quality & Governance Assurance Committee	A	Seek 15-16	16	⇔	A	⇔	A	⇔	A	⇔
5	DM	Respond well to complex needs	Quality & Governance Assurance Committee	R	Seek 15-16	20	⇔	G	⇔	A	⇩	A	⇔
6	IC	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture	People Committee	R	Seek 15-16	25	⇔	A	⇔	R	⇔	A	⇔
7	PM	Live within our means and use our resources wisely	Finance Committee	R A	Financial Manag - Open 12 Commercial - Seek 15-16	15	⇔	A	⇔	A	⇔	A	⇔
8	PL	Develop a high performing organisation delivering the vision of the trust	Board	R	Seek 15-16	20	⇔	A	⇔	G	⇧	A	⇔

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

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

Key Performance Indicators

Diabetes: HbA1C checks	Aug	100% ⇔	Addiction (smoking/Alcohol) YDH IP		56% ⇩	Suicide/Self harm prev: MH Staff		389 ⇧
Suicide/Self harm prev: non-MH		217 ⇧	28 day cancer faster diagnostic	Sep	76.0% ⇩	Number of pats enrolled to Periop		126 ⇧

	Key Risks (High Consequence risks that may stop us achieving the objective)	Risk Reference (From corporate risk register)	Current Risk Con		Lik		RS	Target Risk Con		Lik		RS
1	Population Health may not get the focus required	R1613	3	x	4	=	12	3	x	3	=	9
2	Approach to Population Health may be uncoordinated	R1615	4	x	2	=	8	4	x	2	=	8
3	Lack of understanding of shared accountability/resourcing	R1616	4	x	3	=	12	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	Positive	
ICS Population Health Strategy		Neutral	Green
Smoking Cessation and Perioperative care programme		Positive	
Processes for Delivering Plans			
ICS Action learning set to support PHM development completed	Priorities developed for ICS aligned with core20 plus 5	Positive	
Development of Pop Health integrated dataset data group	Compliance with regional and national programmes	Negative	Amber
Hypertension Flagship for ICS		Neutral	
Oversight Arrangements for Governance & Engagement			
ICS Health Transformation Board	Progress on KPIs presented to Board on regular basis	Positive	
ICS Data Development Group	Overview of Programme to Board Development Session	Neutral	Amber
Trust Data and Population Health Insights Group	Oversight off flagship priorities & clinical strategy - QGAC	Positive	

Actions to Improve Controls and Assurance (Required for any areas assessed Amber or Red)	Lead	Target Date	Progress Summary
Oversight of priority progammes - Smoking Cessation, Periop care & Suicide prevention	DS	Oct-23	Complete
Insights group to focus on neighbourhood / PCN service access	DS	Jul-23	Complete
Development & implementation of resource plan - Training and Development Sessions	DS	Apr-24	Behind Schedule
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	10688 ⇧	Cancelled operations		⇔	C.Diff year to date cases		47 ⇩
Patient Initiated follow up (PIFU)	7.8% ⇔	Falls resulting harm per 1000 days	Jun	0.37 ⇩	Pressure ulcers per 1000 bed days	Jun	0.87 ⇧
Acute Home Treatment caseload	82 ⇧	Pats waiting social wk assessment		32 ⇧	End of Life pat discharges <24hrs	Sep	100% ⇧

	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
Ward Accreditation programme - building Ward2Board measurement dashboard for input wards	HP	Jul-23	Significantly Behind Schedule
Delivery of Quality Strategy Work Plan - Year One, including measurement of delivery	HP	Jan-24	On Plan
Chief Nurse Core Standards - First release complete - preping second release of 3 core standards	HP	Jan-24	On Plan
The introduction of 'Martha's Rule' – phase 1, adult general beds and paediatrics	HP	Jul-24	On Plan
Publication of the research strategy and delivery plan	HP	Mar-24	On Plan
Production of a detail workplan following internal audit for Personalised Care	CB-J	Jan-24	On Plan

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

Key Performance Indicators

Pats ref to Acute Home Treatment	214 ⇧	Adm. Prevented by Rapid Resp/AHT	440 ⇧	Urgent Community response <2hrs	Sep	94.0% ⇧
PCNs with integrated models	2 ⇧	Increase Open MH attendances	23371 ⇧	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	R2044, R1624, R1815, U925	5 x 5 =	25		4 x 4 =	16	
2	Fragility of Primary Care	R673	4 x 4 =	16		4 x 4 =	16	
3	Shortfalls in Social Care capacity	R831/U331 & R1513	5 x 3 =	15		4 x 3 =	12	

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

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

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

Key Performance Indicators

Prot characteristics data complete	May	98.9% ⇔	Ethnicity equity of access:acute RTT		tbc	Ethnicity equity of access: cancer	Sep	Equal ⇔
Ethnicity equity of access: MH	Aug	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	5 x 2 =	10		4 x 2 =	8	
2	Data quality issues leading to poor information	R1616	4 x 4 =	16		4 x 3 =	12	
3	Historical funding/resource gaps including in MH & LD	R1622	3 x 4 =	12		3 x 3 =	9	

Controls (What we have in place to support delivery of the objective)	Assurance (Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.))	Outcome of assurance	Assessment (See assessment guidance)
Plans & Strategies			
Open Mental Health	Internal Audit - Mental Health (January 2023)	Positive	
Digital Strategy - population health data	Digital Board/Board review	Neutral	Amber
Stolen Years flagship	QGAC annual review	Neutral	
Processes for Delivering Plans			
Equality Impact Assessment	None	Negative	
Master Patient Index - data quality review	Data Quality reports	Neutral	Amber
Elective Recovery inequalities programme	Board reports	Positive	
Oversight Arrangements for Governance & Engagement			
System Quality Governance Committee	CQC Inspection/Insight	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	Significantly Behind Schedule
Development of strategy to incorporate of deprivation/exclusion markers into trust data	DS	Mar-24	On Plan
Review NHSE Statement of Information on Health Inequalities to meet provider actions	PB	Apr-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	97.4% ⇔	Reduce time in ED: intensity users	64,188 ⇧
Dementia diagnosis rate-Symphony	55.2% ⇩	Persistent physical symptoms prog.	Yes ⇔	Time to assessment in CYPNP	86w ⇩
Homeless service: annual referrals	714 ⇩	Personalised convs/health coaching	208 ⇧		

	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	R1840 & R1612	5 x 4 =	20		5 x 1 =	5	

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, audit	Positive	Amber
Connecting Dots developments	Internal monitoring, GP provider board	Neutral	
Oversight Arrangements for Governance & Engagement			
Accountabilty Framework process/meetings	Reports to QGAC	Positive	
Symphony board	Oversight reports for ICB, Primary Care Board etc.	Neutral	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	Complete
Personalised care audit for SFT commissioned. CBJ taking lead on response to audit	CBJ	Dec-23	Complete
PL and AT have set up quarterly meetings with PCN leads	AT	Dec-23	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	71.0% ⇩	Pulse Engagement	6.5% ⇔	Inclusion: % B8S reg.disabled	2.9% ⇔
Pulse Advocacy measure	6.5% ⇩	Inclusion: % B8s who are female	58.5% ⇧	Inclusion: % B8s ethnic minority	20.9% ⇧

	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	R2044	5 x 5 =	25		4 x 4 =	16	
2	Not improving retention rate - nursing/estates/facilities/admin role	R1880	4 x 4 =	16		3 x 3 =	9	
3	Reduced colleague resilience	R1944	4 x 4 =	16		3 x 3 =	9	

Controls (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 / year 1 deliverables / NQPS	Neutral	
People Promise Exemplar programme Retention Roadmap	NHS Staff Survey Results	Positive	Amber
Processes for Delivering Plans			
Year 1 deliverables work	Highlight reports	Negative	
Retention roadmap	Internal audit - Moderate findings	Neutral	Red
Inclusion Roadmap	Internal audit / NHS Staff Survey results/ NQPS/WDES/WRES/Gend	Negative	
Oversight Arrangements for Governance & Engagement			
People Committee	People Committee strategy commitments assurance deep dives	Neutral	
People Services Governance Committee	Year 1 deliverables highlight reports and project charters	Neutral	Amber
Cultural Strategy Group	Cultural Maturity Review - internal audit	Positive	

Actions to Improve Controls and Assurance (Required for any areas assessed Amber or Red)	Lead	Target Date	Progress Summary
Implement governance arrangements for people strategy year 1 deliverables	IC	Jul-23	Complete
Develop listening strategy to support an improvement in uptake rate of people pulse	IC	Mar-24	On Plan
Undertake retention internal audit	IC	Dec-23	Complete
Strengthen the link between colleague experience and patient experience through intrinsically linking expe	IC	Dec-23	Complete
Strengthen the link between colleague experience and learning	IC	Dec-23	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)	4.3m ad ⇩	% of CIP identified as recurrent	57% ⇧	Agency v plan (YTD)	3.9m 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
Productive Care Programme launched for 24/25 & 25/26 CIP planning	AH/ PM	Apr-24	On Plan
Work with Social Care to increase capacity in care market to reduce delays and increased costs	AH	Mar-24	Behind Schedule
Quarterly review of underlying position to be presented to Finance Committee	PM	Quarterly	On Plan
Strengthen arrangement between People and Finance Committees regarding workforce reporting	PM / IC	Mar-24	On Plan

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

Key Performance Indicators

A&E 4-hour standard		74.1% ⇩	78 week acute RTT waiters		49 ⇧	6 week diagnostics		77.6% ⇧
62 day cancer waiting time	Sep	68.8% ⇧	Mental health 6 week waiting time		90.0% ⇩	Community waiters >18 weeks		3,498 ⇧

	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 & R1624	4	x	4	=	16	4	x	2	=	8
3	Failure to realise benefits of merger & service integration	R1612/U985	3	x	3	=	9	3	x	2	=	6

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

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

GREEN	AMBER	RED
Well functioning controls in place to manage risks and deliver objective	Some key controls in place, but may not cover all risks or elements of objective	Clear gaps in controls for management of risks and delivery of objective
Assurance available for key controls	Some assurances available, but may not cover all controls	Limited or no assurance available
Assurance is overall **positive**	Assurance is overall **neutral**	Assurance is overall **negative**
	Clear actions to address gaps in controls and/or assurances	Plan not sufficient to address gaps in controls and/or assurances

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Corporate Risk Register Report
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Deputy Director of Integrated Governance
PRESENTED BY:	Director of Corporate Services
DATE:	6 February 2024

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

Executive Summary and Reason for presentation to Committee/Board	The Board of Directors are ultimately responsible and accountable for the comprehensive management of risks faced by the Trust. They will: … ***receive and review the Corporate Risk Register via the Board Assurance Committees*** *and the Assurance Framework quarterly, which identify the principal risks and any gaps in assurance regarding those risks* Each Board Assurance Committee will receive the Corporate Risk Register report with the specific risks assigned to them. The Committees will formally review and scrutinise the risks within their remit. These reports will be received at least once a quarter together with the Board Assurance Framework. The highest areas of risk for the organisation are: • pressures in social care; intermediate care; and primary care • insufficient capacity to meet demand • workforce recruitment and retention • aging estates - acute and community • financial position
Recommendation	The report covers those risks detailed on the Somerset Foundation Trust Corporate Risk Register on 27 December 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 27 DECEMBER 2023

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 27 December 2023 and the changes within the quarter.

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 At the end of Quarter 3, 2023/24 there are currently thirty risks on the Corporate Risk Register detailed within the circle heat map, five of which score 20 or 25:

- Risk R2044 Vacancies and absence rates within trainee and senior doctor workforce and current establishment not mapped to year on year increasing demand

- Risk 004 Demand

- Risk 0012 Waiting Times

- Risk 0497 Symphony Healthcare Services not becoming financially self-sustaining

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

New Risks

3.2 There have been seven new risks added to the Corporate Risk Register during Quarter 3 2023/24:

Risk Reference	Risk Description
Extract taken from Corporate Risk Register Report dated 30 October 2023	
R1968	Failures in referral pathways to specialities from Primary Care increasing Emergency Department attendances
R1984	Inability to recruit applicants within timely manner on the applicant tracking system (ATS)
R1985	Poor data quality in Electronic Staff Record (ESR)
Extract taken from Corporate Risk Register Report dated 5 December 2023	
R1999	Inability to undertake Mental Health Act Assessments in a timely manner by Approved Mental Health Professionals (AMHP)
R2013	Inability to track and access patient referral information if the upgrade to the digital surgical decision unit patient tracker is delayed
R2044	Vacancies and absence rates within Junior and Consultant Workforce
Extract taken from Corporate Risk Register Report dated 27 December 2023	
R2053	Increased risk of harm due to development of episode of care pressure ulcers

Increased Risks

3.3 There have been five risks which have increased during Quarter 3, 2023/24 which have been included on the Corporate Risk Register:

Risk Reference	Risk Description
Extract taken from Corporate Risk Register Report dated 5 December 2023	
R0363	Patient outcomes and treatments not recorded in a timely and accurate way whilst in Emergency Department
R1542	Insufficient Medical Physics Expertise leading to all radiation services ceasing
R1660	Children's respiratory management programmes not being optimised in the community due to being unable to provide treatments that are needed; colleagues working in isolation; lack of equipment and specialist training and lack of escalation pathway
Extract taken from Corporate Risk Register Report dated 27 December 2023	
R0862/U49	Use of escalation beds across SFT
R2044	Vacancies and absence rates within trainee and senior doctor workforce and current establishment not mapped to year on year increasing demand

Risks which have Reduced

3.4 There have been six risks which have reduced since the last report on 5 December 2023 from the Corporate Risk Register:

Risk Reference	Risk Description
Extract taken from Corporate Risk Register Report dated 5 December 2023	
R1329	Core numbers of Junior and Consultant medical workforce
R1513	Community & Adult Social Care provision for mental health and learning disability patients
R1620/U991	Failure to achieve our objective of reducing healthcare inequalities
R1984	Inability to recruit applicants within timely manner on the applicant tracking system (ATS)
R1985	Poor data quality in Electronic Staff Record (ESR)
Extract taken from Corporate Risk Register Report dated 27 December 2023	
R1958	Inability to meet organisational responsibilities under Multi Agency Public Protection Arrangements

Risks which have been Archived

3.5 There have been two risks which have been archived from the Corporate Risk Register during Quarter 3, 2023/24:

Risk Reference	Risk Description
Extract taken from Corporate Risk Register Report dated 30 October 2023	
U1042/R1799	Inability to fill vacancies – organisationally
Extract taken from Corporate Risk Register Report dated 5 December 2023	
U189/R1879	Failure to achieve mandatory training levels

Risk Appetite & Risk Tolerance

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

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

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

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

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

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

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

Figure 1

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

Figure 2

Simply Serve Limited Strategic Objectives	Risk Appetite

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

Service Group & Corporate Function Risks

3.13 A number of additional risks scoring 15 or more continued to be identified at Service Group and departmental levels during the quarter. These risks have been linked to risks on the Corporate Risk Register as shown in Appendix 1. The movement of these risks during Quarter 3, 2023/24 has also been included within Appendix 1.

3.14 During Quarter 3, 2023/24, there have been a number of risks at Service Group and departmental levels which have increase, reduced or been archived, the detail of which has been included in Appendix 2.

Emerging Risks

3.15 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.

3.16 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.

3.17 During Quarter 3, 2023/24, there has been twenty-seven emerging risks which have been added to the service group and departmental risk registers with a score of 12 which will be closely monitored and mitigating action plans developed. These have been included within Appendix 3.

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. Following a pre-market engagement process undertaken in November

2023, RADAR have been the successful provider who has been awarded the contract to provide the Risk Management System the Trust will use from April 2024.

4.3 The Governance Support Team has launched an Implementation Board who will oversee the intensive implementation programme across the organisation to train colleagues in the use of the system and the changes required. This covers all elements of the system including but not limited to; incident reporting; PALS and complaints; claims; etc.

4.4 Specifically in relation to the risk register element of the system, the Risk team have already begun work with Risk Owners to ensure all risks are reviewed and moved from Ulysses to RADAR. This work further cements the work that has been underway for some time to review the risks on the current risk registers ensuring the risks are live and have been reviewed recently. This work will continue and risks on both systems will be reviewed.

4.5 The risk management training packages (Level 1 & Level 2 training as defined by the Risk Management Strategy) will now be finalised following the award of the contract to RADAR. The Risk Team will present to the Learning Committee on 9 April 2024 for the training to be approved and uploaded to LEAP for use within the organisation.

4.6 A baseline assessment of the risks on the Trust's risk register will be undertaken late March 2024 against the KPIs set out in the Risk Management Strategy. This will be presented to the Audit Committee in April 2024 as part of the monitoring of the implementation of the Strategy.

4.7 The Risk Management Policy has been under development with key stakeholders across the Trust with input from the Service Groups and Corporate Teams. This will now be finalised following the award of the contract to RADAR. The draft Policy will be presented to the Audit Committee in April 2024 for approval.

4.8 During November and December 2023 BDO undertook a Risk Maturity Audit at the Trust. The audit focused on the risk management arrangements already in place as well as reviewing the maturity of the arrangements planned as described within the Risk Management Strategy. Initial feedback has been positive. At the time of writing this report, the draft report is awaited. It is expected this will be received early in the New Year and will be presented to the Audit Committee in April 2024 together with an update on the work undertaken within Quarter 4 2023/24 to meet the agreed recommendations.

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 and the progress against the Risk Management Strategy implementation plan.

Corporate Risk Register 27 December 2023

NHS Somerset NHS Foundation Trust

People Committee

25 R2044 Vacancies and absence rates within trainee and senior doctor workforce and current establishment not mapped to year on year increasing demand

16 U0925/R1880 Retention and turnover of staff

16 R1624 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

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

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

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 R0862 / U49 Use of escalation beds across SFT

16 R1238 Fire Compartmentation

16 R1660 Children's respiratory management programmes not being optimised in the community due to being unable to provide treatments that are needed; colleagues working in isolation; lack of equipment and specialist training and lack of escalation pathway

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 R0363 Patient outcomes and treatments not recorded in a timely and accurate way whilst in Emergency Department

15 R0831/U331 Insufficient intermediate care capacity

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

15 R1789 Unsafe premises and environment

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

15 R1999 Inability to undertake Mental Health Act Assessments in a timely manner by Approved Mental Health Professionals (AMHP)

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

Appendix 1

QUALITY & GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust

Corporate Risks 15+

R0004	20	Demand
SO8	⇔	

Service Group / Corporate Function Risks 15+

U021/ R1811	25	⇔	Unsafe numbers of attendances in Emergency Department
R0372	20	⇔	Overcrowding in Emergency Department
R0560	16	⇔	Insufficient capacity to meet demand for Endocrine weight management service
U1120	16	NEW	Capacity and demand within Symphony Practices
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
U1023	15	⇔	Inability to meet demand for immunotherapy
R1362	15	↓	Insufficient theatre capacity for Urology cases to meet demand
R2035	15	NEW	Inability to meet demand for virtual macular reviews within the Ophthalmology service

R2013	20	Inability to track and access patient referral information if the upgrade to the digital surgical decision unit patient tracker is delayed
SO8	NEW	

Key: Risk Score = 15-25 R = Risk on RADAR U = Risk on Ulysses 01 = Unique Risk Reference
Service Group / Corporate Functions - Children, Young People & Families; Clinical Support and Cancer; Medical; Mental Health & Learning Disabilities; Neighbourhoods; Surgical; Corporate Functions; SFT Trustwide Corporate Risk: SSL Risk SHS Risk
Risk Appetite: Within Risk Appetite for the Strategic Objective (SO) risk is assigned to Outside of Risk Appetite for the Strategic Objective (SO) risk is assigned to

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

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

Appendix 1

QUALITY & GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust

Corporate Risks 15+

R0012	20		Waiting Times
SO2			
R0007 / U100	16		Referral to Treatment Times
SO8			
U83	16		Product shortages and/or significant delays of supply due to unpredictable market
SO2			
R0673	16		Impact of the current capacity and future resilience of Primary Care in Somerset on the Trust
SO3			

Service Group / Corporate Function Risks 15+

R0009	16		Diagnostic Waiting Times Performance
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
R2063	15	NEW	Increased wait time for category 2 (P2) Urology patients due to lack of theatre capacity
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
R1955	16		Insufficient freezer storage capacity for patient food at MPH to successfully prepare in the event of delays or cancellations of supply
R1951	16		Sub-optimal links between primary care and SFT services due to siloed working

Key: Risk Score = 15-25 R = Risk on RADAR U = Risk on Ulysses 01 = Unique Risk Reference
Service Group / Corporate Functions - Children, Young People & Families; Clinical Support and Cancer; Medical; Mental Health & Learning Disabilities; Neighbourhoods; Surgical; Corporate Functions; SFT Trustwide Corporate Risk: SSL Risk SHS Risk
Risk Appetite: Within Risk Appetite for the Strategic Objective (SO) risk is assigned to Outside of Risk Appetite for the Strategic Objective (SO) risk is assigned to

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

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

Appendix 1

QUALITY & GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust

Corporate Risks 15+

R862 / U49	16	Use of escalation beds across SFT
SO2	↑	

R1238	16	Fire Compartmentation
SO8	↔	

R1660	16	Children's respiratory management programmes not being optimised in the community due to being unable to provide treatments that are needed; colleagues working in isolation; lack of equipment and specialist training and lack of escalation pathway
SO3	↑	

Service Group / Corporate Function Risks 15+

R2050	16	NEW	Community hospital winter pressures bed escalation

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
U1105	15	NEW	Electrical and fire risk from damaged mattress electric cables
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

Key: Risk Score = 15-25 R = Risk on RADAR U = Risk on Ulysses 01 = Unique Risk Reference
Service Group / Corporate Functions - Children, Young People & Families; Clinical Support and Cancer; Medical; Mental Health & Learning Disabilities; Neighbourhoods; Surgical; Corporate Functions; SFT Trustwide Corporate Risk: SSL Risk SHS Risk
Risk Appetite: Within Risk Appetite for the Strategic Objective (SO) risk is assigned to Outside of Risk Appetite for the Strategic Objective (SO) risk is assigned to

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

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

Appendix 1

QUALITY & GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust

Corporate Risks 15+

R1852 SO2	16	Unsupported infection control electronic case management system
R1952 SO5	16	Lack of prioritisation for further development of personalised care
R0326 SO5	15	No coordinated approach to the transition of children and young people with complex care needs
R0363 SO8	15	Patient outcomes and treatments not recorded in a timely and accurate way whilst in Emergency Department
R0831 / U331 SO3	15	Insufficient intermediate care capacity

Service Group / Corporate Function Risks 15+

Key: Risk Score = 15-25 R = Risk on RADAR U = Risk on Ulysses 01 = Unique Risk Reference
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Appendix 1

QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R1789	15	Unsafe premises and environment
SO2	⇔	

Service Group / Corporate Function Risks 15+

R2054	25	NEW	Risk of injury from deterioration of Boiler House
R1849	20	⇔	Outbreak of Carbapenemase-producing organisms (CPO) due to an environmental reservoir of CPO
R1954	20	⇔	Loss of Switchboard, paging systems and emergency alarm systems due to SSD Flooring works
R1956	20	⇔	Resilience of radio network infrastructure due to works on the MPH site
R2029	20	NEW	Lift failures at Frome Community Hospital
U1088	16	NEW	Loss of waste compound at YDH due to planned site developments
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
R2016	16	NEW	Collapse of the Parkside floor leading to access to the Ward being lost
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
R1300	15	⇔	Air conditioning maintenance not undertaken to the correct legislative standards

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QUALITY & GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

R1542	15		Insufficient Medical Physics Expertise leading to all radiation services ceasing
SO8		↑	
R1968	15		Failures in referral pathways to specialities from Primary Care increasing Emergency Department attendances
SO2	NEW		

Service Group / Corporate Function Risks 15+

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
R2024	15	NEW	Failure of the boiler house electrical distribution board due to age and works required after recent boiler house flood
R2037	15	NEW	Road collisions due to the disrepair of the car park at Frome Community Hospital

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QUALITY & GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust

Corporate Risks 15+

R1999	15	Inability to undertake Mental Health Act Assessments in a timely manner by AMHPs
SO5	NEW	

R2053	15	Increased risk of harm due to development of episode of care pressure ulcers
SO2	NEW	

Service Group / Corporate Function Risks 15+

R1117	16		Responsiveness of Approved Mental Health Professionals (AMHPs) service out of hours for mental health patients within the Emergency Departments

R0131	16		Training and validation of pressure ulcers acquired in the Community

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PEOPLE COMMITTEE

Somerset NHS Foundation Trust

Corporate Risks 15+

R2044	25	Vacancies and absence rates within trainee and senior doctor workforce and current establishment not mapped to year on year increasing demand
SO6	↑	

U925 / R1880	16	Retention and turnover of staff
SO6	↔	

Service Group / Corporate Function Risks 15+

R1762	20	↔	Inability to recruit to medical vacancies – Holford & St Andrews
U0236	16	↑	Reduced GP cover within SHS Practices
R0530	16	↔	Somerset Lipid Service is not adequately developed and resourced
U1092	16	↓	Lack of Permanent GPs at Wincanton Health Centre
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)
R2051	16	NEW	Inability to recruit stroke consultants at YDH
U515 / R1900	15	↔	Inability to retain and recruit critical care consultant intensivists
R0999	15	↔	Inability to recruit substantive Orthodontic consultant
R1943	15	↔	Nuclear Medicine Service workforce
R2006	15	NEW	Inability to fill required number of Dental Core Trainee posts within the Maxillo-Facial department

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

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PEOPLE COMMITTEE

NHS Somerset NHS Foundation Trust

Corporate Risks 15+

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

Service Group / Corporate Function Risks 15+

R1396	20	⇔	Insufficient nursing establishment funding in cardiac cath lab
R1450	20	↑	Insufficient staffing to manage continuous growth in demand for ultrasound services (antenatal and general ultrasound services)
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
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
R1551	16	↑	Insufficient Psychologist staffing due to vacant posts
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
R1966	16	↑	Insufficient staffing within the vaccination team due to vacant posts as a result of the delay in the publication of the National Vaccination Strategy
R2064	16	NEW	Inability to staff theatre services on the YDH site due to registered and non-registered staffing vacancies

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PEOPLE COMMITTEE

Somerset NHS Foundation Trust

Corporate Risks 15+

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

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

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
R1856	15	⇔	Lack of radiology nursing cover

U1073	15	⇔	Inability to audit and review Sepsis and deteriorating patient records due to lack of resource

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FINANCE COMMITTEE

Somerset NHS Foundation Trust

Corporate Risks 15+

U497	20	SHS not becoming self-sustaining
SO7	⇔	

R1611 / U984	16	Failure to secure necessary infrastructure – physical & digital (funding)
SO7	⇔	

U1056	16	Non-delivery of service provision KPIs by Contractor
SO7 (SFT) SO3 (SSL)	⇔	

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
U1050	16	⇔	Insufficient investment from main contractor to reduce levels of backlog maintenance
R1419	16	⇔	Inability to financially support Yeovil Dental Access Centre

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FINANCE COMMITTEE

Somerset NHS Foundation Trust

Corporate Risks 15+			Service Group / Corporate Function Risks 15+
R0006 / U738	15	Delivery of CIP	
SO7	⇔		
U1047	15	Reduction of funding into SSL budget to meet service requirements	
SO7	⇔		
R1855	15	Failure to deliver financial plan	
SO7	⇔		

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Appendix 2

Service Group and Departmental Risks which have Increased, Reduced or been Archived Quarter 3 2023/24

During Quarter 3 2023/24, there have been a number of risks at Service Group and departmental levels which have increased, reduced or been archived as shown below:

Extract taken from Corporate Risk Register Report dated 30 October 2023		
Risk Reference	**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 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

Extract taken from Corporate Risk Register Report dated 5 December 2023		
Risk Reference	**Risk Description**	**Reduced / Archived**
Risk R236	Reduced GP cover within SHS Practices	Increased from 12 → 16
Risk R1551	Insufficient Psychologist staffing due to vacant posts	Increased from 12 → 16

Appendix 2

Service Group and Departmental Risks which have Increased, Reduced or been Archived Quarter 3 2023/24

Risk R1966	Insufficient staffing within the vaccination team due to vacant posts as a result of the delay in the publication of the National Vaccination Strategy	Increased from 6 → 16
Risk R1077	Cancellation of elective activity due to insufficient number of theatre slots for trauma lists to meet demand	Reduced from 20 → 16
Risk R1362	Insufficient theatre capacity for Urology cases to meet demand	Reduced from 16 → 15
Risk R1948	Inability to meet demand in Trauma and Orthopaedics to reduce admitted backlog	Reduced from 15 → 12
Risk R1927	Failure of Air Handling Units (AHUs) in Ophthamlic Theatre suite	Reduced from 20 → 12
Risk R1092	Lack of Permanent GPs at Wincanton Health Centre	Reduced from 20 → 16
Risk R1150	Orthogeriatric medical staffing	Reduced from 20 → 9
Risk R346	Inability to provide consistent consultant cover for Somerset Neuro Rehabilitation Unit	Reduced from 16 → 8
Risk R956	Rheumatology medical staffing	Reduced from 16 → 9
Risk R1812	Inability to recruit Sterile Services Technicians	Reduced from 16 → 9
Risk R306	Lower Paediatric Diabetic Senior Nurse to patient ratio in comparison to other SouthWest regional Units	Reduced from 16 → 12
Risk R1625	Paediatric high dependency unit staffing	Reduced from 16 → 9
Risk R336	Replacement Viewpoint (Colposcopy system) across Grace and Gynae Oncology Services	Reduced from 16 → 8
Risk U772 / R1759	Anaesthetic Practitioner on Call Service Provision	Risk Archived
Risk R1701	Increased risk of amputation for patients with Diabetic Foot due to delays in identification or management of ulceration	Risk Archived
Risk R1883	Insufficient CCTV security system in place	Risk Archived

Appendix 2

Service Group and Departmental Risks which have Increased, Reduced or been Archived Quarter 3 2023/24

Extract taken from Corporate Risk Register Report dated 27 December 2023		
Risk Reference	**Risk Description**	**Reduced / Archived**
Risk R1450	Insufficient staffing to manage continuous growth in demand for ultrasound services (antenatal and general ultrasound services)	Increased from 15 → 20
Risk R1117	Responsiveness of Approved Mental Health Professionals (AMHPs) service out of hours for mental health patients within the Emergency Departments	Increased from 12 → 16
Risk R0583	Insufficient resource to cover core clinical system support out of hours	Reduced from 16 → 12
Risk R0953	Increased demand impacting on patient flow within the Trust	Reduced from 16 → 12
Risk U1110	Lack of funding for specialist Paediatric Physiotherapy service	Reduced from 16 → 12
Risk R1616	Lack of analytic support and visibility of data to manage population health	Reduced from 16 → 12
Risk R1993	Insufficient resource within Asthma service	Reduced from 16 → 12
Risk R1077	Cancellation of elective activity due to insufficient number of theatre slots for trauma lists to meet demand	Reduced from 16 → 9
Risk R1258	Unmet organisational expectations of Digital Services and missed opportunities to innovate and improve services	Reduced from 16 → 9
Risk R1504	Referral rates into Children & Young People's Neurodevelopment Service	Reduced from 16 → 9
Risk R1875	Safeguarding Unborn Baby and Children Supervision compliance	Reduced from 15 → 12
Risk R1926	Increase in capital cost and delivery timeline for on premise datacentre for new EHR	Reduced from 15 → 10
Risk U1029 / R1810	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	Reduced from 15 → 8
Risk R1389	Backlog of clinical correspondence - Neurology admin team	Reduced from 15 → 8
Risk R0170	Insufficient clinic space availability for the Trauma & Orthopaedic service	Risk Archived
Risk U864	Inability to support the additional 10 escalation beds at La Fontana Care Home in Martock	Risk Archived
Risk R1004	Inability to meet demand for elective surgery to reduce admitted backlogs	Risk Archived
Risk R1819	Significant shortages in the sonographer work force impacting on the obstetric service	Risk Archived

Emerging Risks on the Service Group & Corporate Function Risk Registers Quarter 3 2023/24

During Quarter 3 2023/24, there has been twenty-seven emerging risks which have been added to the service group and departmental risk registers with a score of 12 which will be closely monitored and mitigating action plans developed.

Extract taken from Corporate Risk Register Report dated 30 October 2023	
Risk Reference	**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

Extract taken from Corporate Risk Register Report dated 5 December 2023	
Risk Reference	**Risk Description**
U1113	Inoperable Building Management system due to obsolete equipment and need for upgrade
R1993	South West Asthma Network have identified service and capacity gaps within Somerset which impacts on the timeliness and adequacy of patient assessments and subsequent treatment
R1997	Significant demand and capacity challenges within the Adult ADHD team
R1998	National ADHD medication shortages
R2004	Delayed patient treatment and inaccurate waiting lists due to outstanding follow up requests in Maxims – Children & Young People & Families Service Group
R2005	Lack of investment in community physiotherapy to support patients with neuro-muscular disorders causing a respiratory muscle weakness in the community
R2008	Inability to meet the growing demand on the adult speech and language team resources from care homes
R2009	Inability to meet service demand due to number of vacancies within the adult speech and language team
R2010	Non-compliance with national standards due to out of date maternity guidelines
R2018	Reduced clinical and administration capacity in the Somerset ADHD team due to absences within the team
R2019	Insufficient staffing establishment within the Community Urgent Care service to meet demand and manage the increasing acuity of patients
R2020	Inability to repair the obsolete medical gas terminal units across the Trust due to the lack of available replacement parts
R2021	Lack of non-medical prescribers in Bridgwater CMHS due to vacancies and inability for colleagues to receive training

Emerging Risks on the Service Group & Corporate Function Risk Registers Quarter 3 2023/24

R2032	Insufficient staffing resource for general medical wards across the two acute sites to meet the current demands
R2033	Inability to comply with National Stroke guidelines that patients should receive required dosage of therapy due to inadequate community stroke early supported discharge and community stroke intervention
R2039	Mental health section 17 patients staying on acute medical unit for longer than 72 hours

Extract taken from Corporate Risk Register Report dated 27 December 2023	
Risk Reference	**Risk Description**
U1115	Inability to provide patient care in a timely fashion at Hamdon Medical Centre due to the level of capacity and demand currently being experienced at the Practice and gaps in the clinical rota
U1116	Inability to provide timely access to GP services at Ryalls Park Medical Centre due to the lack of clinical and administration staff due to sickness and recruitment gaps
U1117	Inability to provide timely care and treatment to patients at Oaklands Surgery due to demand and capacity on the Practice
U1118	Inability to maintain safety to patients and colleagues at Yeovil Health Centre due to fire alarm not being heard in the Health Centre
U1119	Inability to maintain safety to patients and colleagues at Bruton Surgery due to the fire alarm sounding only at the outside and front of the building
R2060	Inability to store IV fluids and medication as per Trust policy due to lack of storage space on Ward 6a at YDH

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Fit and Proper Person Framework
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Phil Brice, Director of Corporate Services
DATE:	6 February 2024

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

Executive Summary and Reason for presentation to Committee/Board	The Fit and proper Person Test (FPPT) Framework was published by NHS England on 2 August 2023 in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT. The Framework takes account of the guidance produced by the Care Quality Commission "Regulation 5: Fit and Proper Persons: Directors Information for NHS Bodies" published in March 2015. The report sets out the changes to the existing fit and proper person process and the next steps.
Recommendation	The Trust Board is asked to discuss the report and approve the proposals that: • deputies (senior managers deputising for executive directors if required) should be included within the scope of the Fit and Proper Person Policy, from the point of appointment. • subsidiary companies are also required to comply with the Fit and Proper Person Framework and will be required to submit a letter of confirmation in line with Appendix B. • an annual report of FPPT compliance is presented to the Trust Board and Council of Governors. • following presentation at the Trust Board and Council of Governors, the high-level outcomes of the FPPT assessments will be included in the annual report and on the publications page of the Trust website. • the FPPT processes, controls and compliance supporting the FPPT assessments are subject to review by internal audit every three years.

	• the specification for any commissioned well-led or board effectiveness review should include the FPPT process and testing. • new DBS checks will be conducted for all board directors who have not had a DBS check in the previous three years. • the Fit and Proper Person Policy will be amended following presentation of this report 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?**
No impact on people with protected characteristics has been identified as part of the attached report.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

FIT AND PROPER PERSON FRAMEWORK

1. BACKGROUND

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

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

1.3. The Framework is effective from 30 September 2023 (this date refers to the new Board member reference template only) and should be implemented by all boards going forward from that date. The Framework will need to be fully implemented by 31 March 2024. The Framework does not require any retrospective action and specifies that it is for all new board appointments or promotions and for future annual assessments.

1.4. Participation in the extended Framework is not statutory but, in view of the benefits of an effective FPPT assessment process and framework, trusts are strongly encouraged to implement the Framework.

1.5. The Framework applies to the board members of NHS organisations, irrespective of voting rights or contractual terms. Deputies are included within the scope of the FPPT Framework if they act up to cover a board member's role for a period of six weeks or more. It would therefore be prudent to include deputies (who may in future be required to deputise for a Board Director) within the scope of the Fit and Proper Person Policy, from the point of appointment. When referring to Board members further in the report, this includes deputies.

1.6. The Framework is also applicable to subsidiary companies regulated by the Care Quality Commission but trusts may extend the scope to include subsidiary boards.

1.7. In support of the FPPT Framework, a new NHS Leadership Competency Framework is being developed to help inform the fitness assessment in FPPT. This framework will need to be incorporated into the annual appraisal process from the end of Q1 in 2024/25.

1.8. The framework will refer to six competency domains which should be incorporated into all senior leader job descriptions and recruitment processes and should form the core of the board member appraisal framework. The

Leadership Competency Framework should be taken into account when a board member reference is written. A directory of board level learning and development opportunities can be viewed on the following link: NHS England » Directory of board level learning and development opportunities.

1.9. A new board appraisal framework is being developed and it is expected that the framework will be published by the end of March 2024 with the expectation that the framework will be used for the 2023/24 appraisals.

1.10. This paper highlights the key changes to the Fit and Proper Person Test (FPPT) requirements and actions to be taken.

2. NEW BOARD APPOINTMENTS OR PROMOTIONS - THE INCLUSION OF ADDITIONAL REQUIREMENTS FOR RECRUITING OR PROMOTING AN INDIVIDUAL TO A BOARD DIRECTOR POSITION

2.1. The new guidance adds the following requirements for recruiting or promoting an individual to a Board Director position.

2.2. The requirement for references to cover a six-year continuous employment history (an increase from three years for current recruits) using a standard board member reference template (Appendix A). The reference is to be requested after a conditional offer of appointment has been made.

2.3. The Council of Governors to be informed of a satisfactory FPPT assessment for Chair and Non-Executive Director appointments and annual assessments.

2.4. In the case of a joint appointment, FPPT checks will need to be carried out by the designated host/employing organisation, and, in concluding the assessment, input from the chair of the other contracting organisation will be required. In the case of a joint appointment resulting in a new Board member, a letter of confirmation will need to be provided by the host/employing organisation. A sample letter is attached as Appendix B.

3. ANNUAL CHECKS AND SELF-ATTESTATIONS

3.1. The new guidance adds the following requirements for annual checks and self-attestations.

3.2. The completion of a new annual self-attestation pro-forma (Appendix C) with the recommendation to complete the pro-forma alongside the annual appraisal process.

3.3. The completion of additional annual training and development checks for executive directors with the expectation that the checks are completed as part of the appraisal process when core skills compliance and the personal development plan (PDP) are checked.

3.4. The requirement for DBS checks to be conducted at least every three years with the recommendation that the renewal dates of the DBS checks coincide with the annual self-attestation and appraisal process.

3.5. Following the completion of the FPPT checks, the Chair to be responsible for ensuring that processes to check that board members are, and remain, suitable for their role have been followed. The Chair's sign-off of FPPT checks will form part of the Chair's FPPT check.

3.6. The Senior Independent Director to review the Chair's FPPT check and ensure that the Chair is meeting the requirements of the FPPT.

3.7. The FPPT details to be added to ESR following the sign off of the FPPT checks by the Chair.

3.8. The annual NHS FPPT submission reporting template to be completed and sent to the NHS England Regional Director (Appendix D) by June each year.

4. LEAVING THE TRUST - REFERENCES

4.1. The new guidance adds the following requirements for references for those leaving the Trust:

4.2. The completion of a reference template as soon as a board member leaves the organisation, regardless of whether another organisation has asked for the reference. The FPPT Framework includes a standard board member reference template to ensure a consistent approach (Appendix A).

4.3. References to cover a six-year continuous employment history are to be retained on the individual's file for six years after departure.

4.4. In the case of a disagreement with the contents of the reference, directors are permitted a right of reply and a reference to this right of reply and process to be followed will be included in the Fit and Proper Persons Policy.

5. LEAVING THE TRUST – SETTLEMENT AGREEMENT

5.1. In the case of a Board member leaving with a settlement agreement, the new guidance includes a recommendation to include a term in the settlement agreement to state that information about that agreement will be included in ESR, and that doing so will not be a breach of confidence. The specific settlement agreement terms for inclusion in ESR have not as yet been provided.

6. PRIVACY AND DATA PROTECTION CONSIDERATIONS - BASIS FOR COLLECTING AND PROCESSING DATA

6.1. The new guidance adds the following requirements in respect of privacy and data protection.

6.2. The processing of data to undertake the Fit and Proper Person Test (FPPT) is necessary on the lawful bases set out in Articles 6(1)(c) and 6(1)(e) UK GDPR as it relates to the processing of personal data necessary for compliance with a legal obligation and is carried out in the public interest and/or in the exercise of official authority vested in the controller.

6.3. The processing of special category data to undertake the FPPT is necessary on the lawful bases set out in Articles 9(2)(b), 9(2)(g) and 9(2)(h) UK GDPR as processing is necessary for the purposes of carrying out the obligations in the field of employment; is necessary for reasons of substantial public interest; and is necessary for the management of health or social care systems and services.

7. PRIVACY NOTICE

7.1. A FPPT privacy notice which relates to the information collected and processed in relation to the FPPT is attached as Appendix E.

7.2. The guidance includes a requirement to make board members aware that they may object to their data being processed for the FPPT. However, this should be viewed against the trust's legal obligation to undertake the data processing.

8. ACCESS TO DATA

8.1. The new guidance adds the following requirements in respect of access to data.

8.2. Information held in ESR about board members to be accessible by a limited number of senior individuals within the trust only. It is recommended that information on the FPPT fields in ESR is provided to the chairman, chief executive, senior independent director, deputy chairman, secretary to the trust, and chief of people and organisational development through the workforce information team.

8.3. Access to the information about board members in one organisation will not be available to another NHS organisation or individual.

8.4. Personal data is exempt from the Freedom of Information Act, and any requests for information should be processed under section 7 of the Data Protection Act. Any requests for anonymised data will be shared with requestors in accordance with the Information Governance Policy.

8.5. The Trust's Data Protection and Information Governance Policy cover data processing (including special category data), and how data subjects can exercise their data protection rights, such as how to access information held about them.

8.6. The CQC will regulate data integrity and controls that the organisation has in relation to the records held in ESR.

9. RETENTION AND DISPOSAL OF DATA

9.1. It is recommended that FPPT documentation is held for six years in accordance with the NHS Records Management Code of Practice. ESR will hold a summary of the information until the 75th birthday of the board member.

9.2. Following the expiring of the retention period, data will be disposed of in accordance with the NHS Records Management Code of Practice.

10. REPORTING AND AUDIT

10.1. The new guidance adds the following requirements in respect of reporting and audit.

10.2. The recording of FPPT checks in ESR enables regular reports to be produced to show compliance with legislative and regulatory requirements.

10.3. The reference to the good practice for the Chair to present a report on completion of the annual FPPT to the board in a public meeting. It is further recommended to present a report on Non-Executive Director FPPT compliance to the Council of Governors for information.

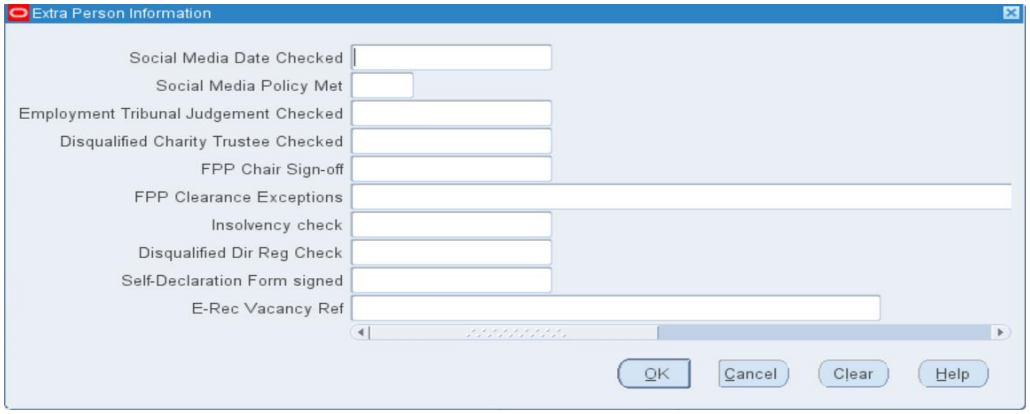
10.4. The reference to the good practice to report on the high-level outcomes of the FPPT assessments in the annual report or elsewhere on the trust's website.

10.5. The recommendation for internal audit to undertake an assessment of the processes, controls and compliance supporting the FPPT assessments, and sample testing of the FPPT assessments, every three years.

10.6. The recommendation to consider inclusion of the FPPT process and testing in the specification for any commissioned well-led or board effectiveness reviews.

11. ELECTRONIC STAFF RECORD – THE ADDITION OF ADDITIONAL FIELDS TO SUPPORT THE IMPLEMENTATION OF THE FPPT FRAMEWORK AND TO STANDARDISE RECORDING OF CHECKS ACROSS THE NHS

11.1. The new framework is supported by the addition of new data points to ESR to record the testing of relevant information about Board members' qualifications and career history.



11.2. A series of additional checks have been included, and which will need to be recorded on ESR, and these relate to:

- Disqualification from being a charity trustee check
- Employment Tribunal Judgement check
- Social media check

12. NEXT STEPS

12.1. A FPPT checklist has been produced and this checklist clearly sets out the actions to be taken to ensure compliance with the FPPT requirements. This checklist will be used for all new appointments and for the annual checks. A copy of the checklist is attached as Appendix F.

12.2. A review of the current ESR records will need to be undertaken to ensure that the ESR records for Board members (to include deputies) are populated in line with the FPPT requirements.

12.3. The Fit and Proper Person Test Policy will need to be amended to take account of the new FPPT Framework and FPPT process.

12.4. A review of DBS completion dates will need to be undertaken and, if needed, new enhanced DBS checks will need to be carried out to ensure that DBS checks have been undertaken within the last three years. It is recommended that all Board members sign up to the DBS Update Service.

12.5. Compliance with the Fit and Proper Person Framework will need to be included in the annual appraisal process from 31 March 2024. The

implementation of the NHS Leadership Competency Framework will need to be included in the Board members' appraisal process from Q1 2024/25.

13. RECOMMENDATIONS

13.1. The Trust Board is asked to:

- Agree that deputies (senior managers deputising for executive directors if required) should be included within the scope of the Fit and Proper Person Policy, from the point of appointment. The executive directors will be required to identify which senior managers will be covered under this framework.

- Agree that subsidiary companies are also required to comply with the Fit and Proper Person Framework and will be required to submit a letter of confirmation in line with Appendix B.

- Agree that an annual report of FPPT compliance is presented to the Trust Board and Council of Governors

- Agree that, following presentation at the Trust Board and Council of Governors, the high-level outcomes of the FPPT assessments will be included in the annual report and on the publications page of the Trust website.

- Agree that the FPPT processes, controls and compliance supporting the FPPT assessments are subject to review by internal audit every three years.

- Agree that the specification for any commissioned well-led or board effectiveness review should include the FPPT process and testing.

- Note that new DBS checks will be conducted for all board directors who have not had a DBS check in the previous three years.

- Note that the Fit and Proper Person Policy will be amended following presented of this report to the Board.

SECRETARY TO THE TRUST

Appendix A

Board Member Reference

STANDARD REQUEST: To be used only AFTER a conditional offer of appointment has been made.

[Date]

Human resources officer/name of referee

External/NHS organisation receiving request

Recruitment officer

HR department initiating request

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [Board Member position]

The above-named person has been offered the board member position of [post title] at the [name of the NHS organisation initiating request]. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

Board Member Reference request for NHS Applicants: To be used only AFTER a conditional offer of appointment has been made. Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.		
1. Name of the applicant (1)		
2. National Insurance number or date of birth		
3. Please confirm employment start and termination dates in each previous role *A:(if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)* *B: (As part of exit reference and all relevant information held in ESR under Employment History to be entered)*		
Job Title: From: To: Job Title From: To: Job Title: From: To: Job Title: From: To: Job Title: From: To:		
4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A): *(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)*		
5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	Starting:	Current:
6. Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*		

7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:
8. Confirmation of reason for leaving:		
9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)		
Date DBS check was last completed.	Date	
Please indicate the level of DBS check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level	
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults □ Children □ Both □	
10. Did the check return any information that required further investigation?	Yes □	No □
If yes, please provide a summary of any follow up actions that need to/are still being actioned:		

11. Please confirm if all annual appraisals have been undertaken and completed (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □
Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS** • **Dishonesty** • **Bullying** • **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □

If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:

14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive.
Alternatively state Not Applicable. (Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12)

Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Appendix B

Letter of confirmation

The following wording is given as an example. It may not be applicable in every case and may consequently need addition or amendment. For example, a confirmation at the time of initial appointment may be different to the annual core testing.

[**LEAD EMPLOYING ORGANISATION**[1] **LETTERHEAD**]

[**DATE**]

Dear [**CHAIR NAME**[2]],

Fit and Proper Person Test

This confirmation letter is provided in connection with [**name of board member, job title of board member, organisations that the joint board member post covers**] for [**year of test, eg 2023/24**] as at [**date of conclusion of annual**[3] **FPPT for the individual**] for the purpose of the Fit and Proper Person Test.

As Chair of [**lead employer**], I confirm that I have carried out the Fit and Proper Person Test for [**name of board member**].

The process and the evidence used by me in carrying out the Fit and Proper Person Test and in being able to reach a conclusion as to whether [**name of board member**] is fit and proper, is appropriate to reach that conclusion in the context of the Fit and Proper Person Framework.

In accordance with the Fit and Proper Person Test Framework requirements and in reaching my conclusion that [**name of board member**] is fit and proper as at [**date of conclusion of test**], I have assumed that you know no reason that this is not an appropriate conclusion to reach.

Please would you sign and return this letter as confirmation of receipt and that there are no further matters which should be taken into consideration.

Yours sincerely,

…….. (signature)

…….. (chair of lead employer organisation)

Date……..

I confirm that I have received the outcome for the FPPT for [**name of board member**] and that I have provided any necessary information for you to reach this conclusion.

[1] This is the organisation which holds the contract/employs the board member who works jointly across more than one organisation.
[2] This is the name of the chair of the other organisation that the joint board appointment is made with.
[3] It should be noted that while there will be an annual assessment of being fit and proper, it is a pervasive and ongoing process at all times. Any relevant matter related to the board member being fit and proper should be reported as soon as it arises.

…….. (signature)

…….. (chair of lead employer organisation)

Date……..

Appendix C

New starter/annual NHS FPPT self-attestation

Every board member should complete the template (over the page) annually and this attestation should be submitted to [complete as applicable, eg the company secretary] on behalf of the chair.

Fit and Proper Person Test annual/new starter* self-attestation

[NAME OF NHS ORGANISATION]

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (eg directors disqualification order)
- within the last five years:
  - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
  - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
  - nor is on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, any if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	

Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	
For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

*Delete as appropriate

Appendix D

Annual NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:

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

Role	Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Board member reference completed and retained? Yes/No
Chair/NED board members						
Executive board members						
Partner members (ICBs)						
Total						

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

Part 2: FPPT reviews / inspections

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

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC				
Other, e.g., internal audit, review board, etc.				

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR [name of organisation] [year]				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No

For the chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:

As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.	
Chair signature:	
Date signed:	
For the regional director to complete:	
Name:	
Signature:	
Date:	

Appendix E

Template Board Member FPPT Privacy Notice

[organisation name] is required to provide you with details on the type of personal information which we collect and process. In addition to any other privacy notice which we may have provided to you, this notice relates to the information collected and processed in relation to the FPPT.

The FPPT in ESR is commissioned by NHS England.

Contact:	[name in organisation who leads on this, eg SIRO]
Address:	[for the person or team above]
Phone Number	[for the person or team above]
Email:	[for the person or team above]

The type of personal information we collect is in relation to the FPPT for board members and is described below, much of which is already collected and processed for other purposes than the FPPT:

1. Name, position title (unless this changes).
2. Employment history – this includes details of all job titles, organisations, departments, dates, and role descriptions.
3. References.
4. Job description and person specification in their previous role.
5. Date of medical clearance.
6. Qualifications.
7. Record of training and development in application/CV.
8. Training and development in the last year.
9. Appraisal incorporating the leadership competency framework has been completed.
10. Record of any upheld, ongoing or discontinued disciplinary, complaint, grievance, adverse employee behaviour or whistle-blow findings.
11. DBS status.
12. Registration/revalidation status where required.
13. Insolvency check.

14. A search of the Companies House register to ensure that no board member is disqualified as a director.

15. A search of the Charity Commission's register of removed trustees.

16. A check with the CQC, NHS England and relevant professional bodies where appropriate.

17. Social media check.

18. Employment tribunal judgement check.

19. Exit reference completed (where applicable).

20. Annual self-attestation signed, including confirmation (as appropriate) that there have been no changes.

Processing of this data is necessary on the lawful basis set out in Article 6(1)(e) UK GDPR as the foundation for the database. This is because it relates to the processing of personal data which is necessary for the performance of the fit and proper person test which is carried out in the public interest and/or in the exercise of official authority vested in the controller.

For CQC-registered providers, ensuring directors are fit and proper is a legal requirement for the purposes of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and organisations are required to make information available connected with compliance to the CQC.

How we get the personal information and why we have it

Most of the personal information we process is provided to us directly by you as part of your application form and recruitment to satisfy recruitment checks and the FPPT requirements.

[If applicable] We may also receive personal information indirectly, from the following sources in the following scenarios:

- References when we have made a conditional offer to you.
- Publicly accessible registers and websites for our FPPT.
- Professional bodies for FPPT to test registration and or any other 'fitness' matters shared between organisations.

1. Regulatory bodies, eg CQC and NHS England.

We use the information that you have given us to:

- conclude whether or not you are fit and proper to carry out the role of board director

2. inform the regulators of our assessment outcome.

We may share this information with NHS England, CQC, future employers (particularly where they themselves are subject to the FPP requirements), and professional bodies.

Under the UK General Data Protection Regulation (UK GDPR), the lawful bases we rely on for processing this information are:

3. We need it to perform a public task.

How we store your personal information

Your information is securely stored. We keep the ESR FPPT information including the board member reference, for a career long period. We will then dispose of your information in accordance with our policies and procedures [insert].

Your data protection rights

Under data protection law, you have rights including:

- Your right of access – You have the right to ask us for copies of your personal information.
- Your right to rectification – You have the right to ask us to rectify personal information you think is inaccurate. You also have the right to ask us to complete information you think is incomplete.
- Your right to erasure – You have the right to ask us to erase your personal information in certain circumstances.
- Your right to restriction of processing – You have the right to ask us to restrict the processing of your personal information in certain circumstances.
- Your right to object to processing – You have the right to object to the processing of your personal information in certain circumstances.
- Your right to data portability – You have the right to ask that we transfer the personal information you gave us to another organisation, or to you, in certain circumstances.

4. You are not required to pay any charge for exercising your rights. If you make a request, we have one month to respond to you.

Please contact us at [insert email address, phone number and or postal address] if you wish to make a request.

How to complain

If you have any concerns about our use of your personal information, you can make a complaint to us at [Insert your organisation's contact details for data protection queries]. You can also complain to the ICO if you are unhappy with how we have used your data.

The ICO's address

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow

Cheshire
SK9 5AF

Helpline number: 0303 123 1113 ICO website: https://www.ico.org.uk

Appendix F

FPPT checklist

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
First name	✓	✓	✓	x – unless change	✓	✓	Application and recruitment process.	Recruitment team to populate ESR. For NHS-to-NHS moves via ESR / Inter-Authority Transfer/ NHS Jobs. For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency.
Second name/surname	✓	✓	✓	x – unless change	✓	✓		
Organisation (ie current employer)	✓	x	✓	N/A	✓	✓		
Staff group	✓	x	✓	x – unless change	✓	✓		
Job title Current Job Description	✓	✓	✓	x – unless change	✓	✓		
Occupation code	✓	x	✓	x – unless change	✓	✓		
Position title	✓	x	✓	x – unless change	✓	✓		
Employment history Including: • job titles • organisations/ departments • dates and role descriptions • gaps in employment	✓	x	✓	x	✓	✓	Application and recruitment process, CV, etc.	Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, do not need to be explained. The period for which information should be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that a career history of no less than six years and covering at least two roles would be the minimum. Where there have been gaps in employment, this period should be extended accordingly.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Training and development	✓	✓	✓	✓	✓	*	Relevant training and development from the application and recruitment process; that is, evidence of training (and development) to meet the requirements of the role as set out in the person specification. Annually updated records of training and development completed/ongoing progress.	* NED recruitment often refers to a particular skillset/experience preferred, eg clinical, financial, etc, but a general appointment letter for NEDs may not then reference the skills/experience requested. Some NEDs may be retired and do not have a current professional registration. At recruitment, organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role. For all board members: the period for which qualifications and training should look back and be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that key qualifications required for the role and noted in the person specification (eg professional qualifications) and dates are recorded however far back that may be. Otherwise, it is suggested that a history of no less than six years should be the minimum. Where there have been gaps in employment, this period should be extended accordingly.
References Available references from previous employers	✓	✓	✓	x	✓	✓	Recruitment process	Including references where the individual resigned or retired from a previous role

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Last appraisal and date	✓	✓	✓	✓	✓	*	Recruitment process and annual update following appraisal	* For NEDs, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.
Disciplinary findings That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement	✓	✓	✓	✓	✓	✓	Reference request (question on the new Board Member Reference). ESR record (high level)/ local case management system as appropriate.	The new BMR includes a request for information relating to investigations into disciplinary matters/ complaints/ grievances and speak-ups against the board member. This includes information in relation to open/ ongoing investigations, upheld findings and discontinued investigations that are relevant to FPPT. This question is applicable to board members recruited both from inside and outside the NHS.
Grievance against the board member	✓	✓	✓	✓	✓	✓		
Whistleblowing claim(s) against the board member	✓	✓	✓	✓	✓	✓		
Behaviour not in accordance with organisational values and behaviours or related local policies	✓	✓	✓	✓	✓	✓		
Type of DBS disclosed	✓	✓	✓	✓	✓	✓	ESR and DBS response.	Frequency and level of DBS in accordance with local policy for board members. Check annually whether the DBS needs to be reapplied for. Maintain a confidential local file note on any matters applicable to FPPT where a finding from the DBS needed further discussion with the board member and the resulting conclusion and any actions taken/required.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Date DBS received	✓	✓	✓	✓	✓	✓	ESR	
Date of medical clearance* (including confirmation of OHA)	✓	x	✓	x – unless change	✓	✓	Local arrangements	
Date of professional register check (eg membership of professional bodies)	✓	x	✓	✓	✓	x	Eg NMC, GMC, accountancy bodies.	
Insolvency check	✓	✓	✓	✓	✓	✓	Bankruptcy and Insolvency register	Keep a screenshot of check as local evidence of check completed.
Disqualified Directors Register check	✓	✓	✓	✓	✓	✓	Companies House	
Disqualification from being a charity trustee check	✓	✓	✓	✓	✓	✓	Charities Commission	
Employment Tribunal Judgement check	✓	✓	✓	✓	✓	✓	Employment Tribunal Decisions	
Social media check	✓	✓	✓	✓	✓	✓	Various – Google, Facebook, Instagram, etc.	
Self-attestation form signed	✓	✓	✓	✓	✓	✓	Template self-attestation form	Appendix 3 in Framework
Sign-off by Chair/CEO	✓	x	✓	✓	✓	✓	ESR	Includes free text to conclude in ESR fit and proper or not. Any mitigations should be evidence locally.
Other templates to be completed								

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Board Member Reference	✓	✓	x	x	✓	✓	Template BMR	To be completed when any board member leaves for whatever reason and retained career-long or 75th birthday, whichever latest. Appendix 2 in Framework.
Letter of Confirmation	x	✓	✓	✓	✓	✓	Template	For joint appointments only - Appendix 4 in Framework.
Annual Submission Form	x	✓	✓	✓	✓	✓	Template	Annual summary to Regional Director - Appendix 5 in Framework.
Privacy Notice	x	✓	x	x	✓	✓	Template	Board members should be made aware of the proposed use of their data for FPPT – Example in Appendix 6.
Settlement Agreements	x	✓	✓	✓	✓	✓	Board member reference at recruitment and any other information that comes to light on an ongoing basis.	Chair guidance describes this in more detail. It is acknowledged that details may not be known/disclosed where there are confidentiality clauses.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 22 November 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:	6 February 2024

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the Quality and Governance Assurance Committee meeting held on 22 November 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 • The assurance report from the Mental Health and Learning Disabilities Service Group – the progress made and the work and focus of the Service Group. • The Patient Safety Incident Response Framework (PSIRF) Action Plan – the significant progress made implementing the actions, and the approval of the PSIRF policy • Suicide prevention - the focus on suicide prevention • The update in relation to the Maternity Incentive Scheme Year Five safety actions; the maternity Insight report; and the CQC inspection of maternity services The Committee identified the following areas of concern or for follow up: • Suicide prevention – the national profile of Somerset in terms of the suicide rate

	• The assurance report from the Mental Health and Learning Disabilities Service Group – the demand for neurodiverse services in Somerset and the unmet needs in terms of assessments and ongoing support • The medication discharge process – the lack of sufficient assurance that the level of risk identified was being mitigated. The Committee asked for a progress report to be presented to a future meeting. • the significant data breach The Committee identified the following areas to be reported to the Board: • The neuro-diverse service needs. • The suicide rates in Somerset and actions to support better prevention. • Limited assurance of progress with the medication discharge process at MPH. • Formally report the PSIRF position to the Trust Board. • Positive assurance in relation to the governance arrangements within the mental health and learning disabilities service group.
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 22 NOVEMBER 2023

1. PURPOSE

1.1. The report sets out the items discussed at the formal meeting held on 22 November 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 29 corporate risks on the risk registers of which four scored 20 or above. The Committee noted the details of these risks, including the new risks relating to: failures in referral pathways to specialties from primary care increasing ED attendances; inability to recruit applicants within timely manner on applicant tracking system; and poor data quality in ESR.

2.2. The Committee noted details of the emerging risks scoring 12 or above which related to: Yeovil Dental Access Centre and computer room at MPH; escalation beds at Exmoor Ward; service provision – court practitioners; and transition pathway and processes for Learning Disabilities young people.

2.3. The Committee received an update on the risk management procurement process and timeline. The Committee noted that an implementation board was being set up to oversee the implementation of the new risk management system. The Committee further noted that it was expected that the supplier will be confirmed in December 2023.

2.4. The Committee received an update on the risk maturity internal audit which will be undertaken in December 2023. It was noted that the audit will focus on neighbourhoods and estates and facilities risk registers, walk through of the fire risks, and review the Corporate Risk Register, Board Assurance Framework, Board and sub Committee oversight.

2.5. The Committee received an update on the work with the Integrated Care Board and Local Authority in respect of risk management and noted that the scheduled meeting in October 2023 had been rescheduled to December 2023 due to Local Authority non attendance.

2.6. The Committee received an update on the risk management work with the Patient Engagement and Patient Experience Team and noted that the risks

identified by the team will be added to the risk register following the implementation of the new risk management system. The risks identified related to staffing; performance and Accessible Information Standards.

2.7. The Committee discussed the Multi-Agency Public Protection Arrangements (MAPPA) risk on the Corporate Risk Register and noted that additional funding had been agreed to be able to recruit a dedicated MAPPA lead who will sit within the resilience team.

2.8. The Committee agreed that the majority of the risks allocated to the Committee had been discussed in recent meetings and a discussion on the estates risks had been scheduled for the December 2023 meeting. The Committee noted that an internal audit report on personalised care will be included on the agenda following a review of the report at the January 2024 Audit Committee meeting. The Committee noted that a discussion on supply chain/procurement risk management will be included on the agenda of a future meeting.

2.9. The Committee noted that the information presented to the Committee will be discussed with the new Non-Executive Directors at an already scheduled meeting in December 2023.

Service Group Assurance Report – Mental Health and Learning Disabilities

2.10. The Committee received the assurance report from the Mental Health and Learning Disabilities Service Group and noted the key highlights from the report, including the findings of the local governance review of all teams within the service group that good local processes were in place with no significant concerns identified; the review of the service group's governance meeting agenda, the more detailed discussions around governance and the bi-weekly governance stocktakes; and the implementation within the MH&LD service group of the main elements of the trust's governance model.

2.11. The Committee further noted: the current challenges relating to the lack of joint oversight of complaints for monitoring purposes and the impact of the Patient Safety Incident Response Framework (PSIRF) on the team due to the large number of incidents meeting the current criteria for serious incidents; the engagement and work with experts by experience; the submission of a business case to increase the number of Learning Disabilities liaison nursing staff across both acute sites to help advocate for patients with learning disabilities when they come into hospital.

2.12. The Committee noted the service group's risks and particularly the risk relating to the timeliness of Mental Health Act assessments being convened in incidents where colleagues have requested an assessment and Approved Mental Health Practitioners have not agreed or been able to attend. The Committee noted that this concern had been escalated to the Mental Health Act Committee, executive directors, Quality Assurance Group and senior medical colleagues. The Committee further noted the high scoring risk in

relation to medical recruitment and the appointment to seven psychiatry posts from March/April 2024. It was noted that a further recruitment campaign had been scheduled for January 2024.

2.13. The Committee recognised that significant progress had been made and agreed that the report provided the Committee with significant assurance about the work and focus of the Service Group, particularly in relation to the governance arrangements.

Patient Safety Incident Response Framework (PSIRF) Action Plan

2.14. The Committee received an update on the work to implement the PSIRF.

2.15. The Committee noted: the development of the PSIRF policy; the delivery of externally accredited training; the recruitment of Patient Safety Partners in line with the Patient Safety Strategy; the development of internal trust training for learning response leads; and the need to identify priority areas where the trust feels Patient Safety Incidents investigations are required to identify learning.

2.16. The Committee further noted that prioritiy areas of focus for the next 12 to 15 months have been identified and noted that the three final priority areas had been identified as follows: people who matter (engaging and involving families, friends and carers); recognition, escalation and management of deteriorating patients; and decision-making, documentation, and communication concerns in relation to Treatment Escalation Planning. Consideration will be given by the Patient Safety Board as to whether to include a fourth priority area at some point during that period. It was noted that the ICB has also identified PSIRF priorities which the Trust will support.

2.17. The Committee noted the next steps: sign off of the PSIRF policy; development of the final Patient Safety Incident Response Plan (PSIRP) which will be agreed by the Patient Safety Board and presented to the Committee in December; developing a trustwide communication strategy; stakeholder events; and the development of a business case for funding to recruit patient safety investigators. It was noted that the aim was to commence the transitioning to the PSIRF from January 2024.

2.18. The Committee discussed the process for providing the Committee with assurance that learning responses have been embedded and that the new Framework was working better than the previous incident systems. The Committee noted that feedback will be provided to the Committee as part of the service group assurance reports.

2.19. The Committee recognised the significant amount of work this programme of work has involved and thanked Hannah Roe and Ben Plumb for their contributions. The Committee approved the PSIRF policy and agreed that the report provided significant assurance in terms of the work taking place.

Maternity Incentive Scheme (MIS)

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

2.21. The Committee noted the safety action exception reports and approved safety actions 2, 3 and 4. It was noted that a further update on Safety Action 6 will be presented to the January 2024 meeting.

2.22. The Committee received an update from the Insight visit undertaken in October 2023 at which both areas of excellence and areas for improvements had been identified. An action plan will be developed to address the areas for improvement.

2.23. The Committee further received an update on the latest Care Quality Commission (CQC) Maternity Services inspection across YDH, MPH and Bridgwater Mary Stanley ward which was currently underway. The inspection report will be reviewed and an action plan developed in response to any issues raised.

3. AREAS OF CONCERN OR FOLLOW UP

Suicide Prevention

3.1. The Committee received an update on the work of the Suicide Prevention team. The Committee noted: the priorities of the Suicide Prevention Group; the publication and aims of the Suicide Prevention Strategy; the actions to be taken in response to the Suicide Prevention Strategy; the high risk groups identified in the strategy; and the work to align processes with the national strategy.

3.2. The Committee noted that the South West had been rated third highest on the national benchmarking for age-standardised suicide rates with Somerset being the second highest by local authority. The Committee noted the details of the suicide rates in Somerset and noted that the Somerset West and Taunton area had the highest average rate per 100,000 population. The Committee noted that the causes of the higher suicide rates in Somerset as a whole were difficult to identify and a review of the data with the National Confidentiality Inquiry into Suicide and Self Harm (NCISH) team had not identify a clear pattern. Generally, it was felt that rurality, early trauma, work/life pressures, drug and alcohol use may be factors.

3.3. The Committee noted: the mental health team's challenges in respect of the availability of local real time intelligence about suspected deaths by suicide; the work of the workstream with public health, police, ICB and the Trust to improve the early detection of suspected suicides; the identification of 10 key elements as quality and safety statements about clinical and organisational aspects of care; the suicide prevention work already being progressed in Somerset, e.g. no out of area placements, 24hr crisis team, working on personalised risk management, outreach teams, Dual Diagnosis strategy, and

follow up of patients within 48 hours post discharge; the findings from the review of the 2021/22 serious incidents reports; and the findings of the deep dive of incidents within Older People Services.

3.4. The Committee further noted he NICE guidance regarding self harm published in September 2022 and the resulting changes in cultural practice; the recommendations set out in the NICE guidance; the development of the NICE guidance project with the aim to review the guidance by developing staff focus groups and auditing risk processes; the establishment of a Steering Group and Task and Finish Groups and the work of the Groups; the drafting and testing of the RiO risk screen and risk formulation screens; the establishment of the workstream in relation to the development of a personalised safety plan; the next steps – development of training materials and a learning resource, the review of the Standard Operating Procedures and policies, and the review of clinical risk training; the work of the Dual Diagnosis Steering Group and the plans to develop a specific dual diagnosis carers support group and a programme of carers' education sessions; the large number of colleagues trained in suicide awareness and response; and the support available after suicide.

3.5. The Committee agreed that suicide prevention was an important area of work and the impact of the Local Authority's financial pressures and the possible decommissioning or changes to services will need to be closely kept under review. The Committee agreed that the report provided significant assurance about the focus on suicide prevention but provided negative assurance in terms of the national profile of Somerset which it was recognised will take some time to see progress on, given the time lapse in information.

Service Group Assurance Report – Mental Health and Learning Disabilities

3.6. The Committee discussed the concerns in relation to the demand for neuro-diverse services in Somerset and the unmet needs both in terms of assessments and ongoing support. The Committee agreed to add a discussion on this topic on the agenda for March/April 2024.

Medication Discharge Process – Update

3.7. The Committee received an update on the risks involved in the medication discharge process at Musgrove Park Hospital (MPH).

3.8. The Committee noted the complexities relating to the medical discharge process for patients; the lack of pharmacy involvement in the process at MPH; the small team at MPH and their focus on the admission of patients; the concerns about the process; the findings of the discharge audit and the actions taken to address the audit recommendations; the completion of the transformation programme with pharmacy services around the additional investment for a discharge team at MPH; the improvements to the electronic prescribing system and discharge letter.

3.9. The Committee further noted the approval of a business case to develop a pharmacy ward-based discharge service, similar to the model used at Yeovil District Hospital, and funding for nine ward-based discharge teams. Due to workforce challenges and shortages of pharmacists, the roll out of this service has been delayed but the service was now in place on the AMU. Subject to recruitment, this new service will be in place at the majority of wards/services between September and December 2024.

3.10. The Committee noted the progress made in relation to improving the prescribing system and discharge letters; the findings of the re-audit and the reduction in the number of prescribing errors and improvement in the risk profile of the errors; the need to further raise awareness of the electronic prescribing functionality as this will improve the quality of discharge prescriptions.

3.11. The Committee agreed that progress was being made but concluded that the report did not provide assurance that the level of risk identified was yet being effectively mitigated. The Committee asked for a further progress report to be provided to a future meeting.

Significant Data Breach

3.12. The Committee was informed of a significant data breach by a colleague and the details of the breach were noted. It was further noted that both the Police and Information Commissioner's Office were currently investigating the breach.

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 neuro-diverse service needs.
- The suicide rates in Somerset and actions to support better prevention.
- Limited assurance of progress with the medication discharge process at MPH.
- Formally report the PSIRF position to the Trust Board.
- Positive assurance in relation to the governance arrangements within the mental health and learning disabilities service group.

5. BOARD ASSURANCE FRAMEWORK (BAF)

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

- **Objective 2** – the level of significant risks relating to safe and high quality care which provided negative assurance against the impact of some key plans and priorities; initial findings from the CQC maternity service inspection; the lack of assurance in relation to the mitigation of the medication discharge risks.

- **Objective 4** – negative assurance in relation to the national profile of Somerset in respect of completed suicides and the time required to implement the actions and mitigate risks; positive assurance from the mental health and learning disabilities service group in terms of the effectiveness of their devolved governance approach; the new risk regarding unmet neurodiverse needs.

- **Objective 8** – the progress on the PSIRF and learning focus.

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

5.3 In December, the Committee is commencing its annual review of progress on the five strategic objectives of the clinical care and support strategy and the flagship quality account priorities which it will report to the Board in future updates.

Jan Hull
CHAIRMAN OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	The Trust Board
REPORT TITLE:	Quality and Performance Exception Report
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Associate Director – Planning and Performance Senior Performance Manager Chief of People and Organisational Development Deputy Chief Nurse Director of Elective Care
PRESENTED BY:	Pippa Moger. Chief Finance Officer
DATE:	6 February 2024

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

Executive Summary and Reason for presentation to Committee/Board	Our Quality and Performance Exception Report sets out the key exceptions across a range of quality and performance measures, and the reasons for any significant changes or trends. The growth in the size of waiting lists, as a result of the Covid-19 pandemic, continues to have a significant impact on a range of access standards, whilst restoration work is being undertaken to reduce the number of patients waiting and to shorten waiting times. As referrals recover to pre-Covid-19 levels this will also have an impact on services and numbers waiting. Urgent and emergency patients continue to be prioritised, to receive the treatments they need. Areas in which performance has been sustained or has notably improved include: • CAMHS Eating Disorders - Routine referrals to be seen within four weeks remains above the national standard and the national average. • Talking Therapies, percentage of people waiting under six weeks for their first therapy session. • Patients followed up within 72 hours of discharge from an adult mental ward. Areas in respect of which the contributory causes of, and actions to address, underperformance are set out in greater detail in this report include:

	• the percentage of patients seen within four hours and spending longer than 12 hours, in our accident and emergency department and minor injury units. • the percentage of people waiting under six weeks for a diagnostic test. • the percentage of ambulance handovers completed within 30 minutes of arrival at our Emergency Departments.
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:

The report provides an update on issues relating to patient safety and quality of service delivery, in Section 1 and also in Appendices 3, 4, 5, and 6. (patient safety and quality)

The report provides an update on issues relating to staffing, in Section 1 and also in Appendix 4. (workforce)

The report provides an update, by exception, on the position relating to statutory Fire training, in Section 1. (legislation)

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?
A range of key indicators, relating to waiting times for treatment including acute hospital services, cancer services, and mental health services, are routinely monitored to provide assurance that there is equity of provision and access in relation to people with protected characteristics. This includes standards delivered according to recorded ethnicity and learning disability. Our workforce measures also include indicators relating to ethnicity, gender and disability.
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]
A report is presented to every 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

QUALITY AND PERFORMANCE EXCEPTION REPORT: DECEMBER 2023

1. BACKGROUND AND PURPOSE

1.1 Our Quality and Performance exception report sets out the key exceptions across a range of quality and performance measures, and the reasons for any significant changes or trends.

1.2 The report presents information relating to the five key questions which the Care Quality Commission considers when reviewing and inspecting services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they well-led?
- Are they responsive to people's needs?

1.3 Underpinning each of these key questions are Quality Statements, which outline the commitments that providers, commissioners and system leaders should live up to. Expressed as 'we statements', these show what is needed to deliver high-quality, person-centred care. As a provider, we aim to ensure that we meet the requirements of these 'we statements', as well as the accompanying 'I statements', which reflect what people have said matters to them.

1.4 The exception reports include run charts, produced using Institute for Healthcare Improvement (IHI) methodology, and in consultation with the Academic Health Sciences Network. An explanation of how to interpret these charts is attached as Appendix 1.

1.5 A summary of our current Care Quality Commission ratings is included as Appendix 2.

1.6 A summary of the monthly data and run charts for our key quality measures is attached as Appendix 3.

1.7 Our Corporate Balanced Scorecard is attached as Appendix 4. The measures included in the Corporate Balanced Scorecard may change during the year as new priority areas are identified.

1.8 Supporting information relating to referral levels, activity levels, lengths of stay, tumour-site-specific activity and performance, and other key measures for our community and mental health services is included in Appendix 5. The

activity information in Appendix 5 shows the levels and trends for the current year and previous two years.

1.9 Appendix 6 provides additional details and commentary in relation to Infection Control and Prevention.

CHIEF FINANCE OFFICER

Overview

The table below provides a summary of key successes, priorities, opportunities, risks and threats in relation to our current levels of performance.

Successes	**Priorities**
• our eating disorders service for children and young people continued to exceed the national waiting times standard for routine appointments. • the national 28-day Faster Diagnosis Standard for cancer pathways was again met in the month. • compliance remains high in respect of mental health inpatients receiving a follow-up within 72 hours of discharge. • our Talking Therapies service maintained compliance in respect of patients waiting under six weeks for their first clinical appointment. • the compliance level in respect of mandatory training remains high despite the operational challenges faced by services.	• continue to maintain a safe service and making sure urgent patients are treated as quickly as possible within the context of the challenges the current coronavirus outbreak brings. • continue to support the health and wellbeing, both physically and psychologically, of colleagues across the Trust, as they continue to deliver high quality care to patients whilst managing significant and ongoing pressures associated backlogs arising from the time of the COVID-19 pandemic, and rising levels of demand. • continue to restore and expand capacity above pre-COVID-19 levels, to address backlogs in routine elective work. • work with the Somerset system to encourage continued referrals and presentations at hospital where needed and appropriate, especially in respect of urgent or emergency care.
Opportunities	**Risks and Threats**
• continue to progress the health and wellbeing plans for our colleagues at pace; this includes the psychological support offered alongside practical aspects of support such as accommodation provision and nutrition. • continue with new ways of working, particularly through the use of technology. • continue to adapt our recruitment practice, developing more innovative arrangements and reducing time to hire significantly. • develop reporting solutions to improve robustness of recording and reporting.	• the growth in the size of waiting lists caused by the reduction in capacity during the COVID-19 pandemic continues to present a significant challenge to the restoration of waiting times. • delays in discharge of medically fit patients needing domiciliary care will result in further cancellations of surgery which will reduce our capacity to treat long waiting patients. • significantly increasing levels of demand, particularly for urgent care and mental health services, leading potentially to increased pressures on teams and longer waiting times. • Sickness / absence presents a challenge for colleagues within some critical areas, and we need to ensure that we continue to support colleagues accordingly.

Safe

Infection Prevention and Control (IPC) performance is assessed by means of the numbers of key healthcare associated infections (HCAI) (Trust apportioned) against agreed thresholds. These are: MRSA bloodstream infections (BSI): zero tolerance, Clostridioides difficile (C. diff) infection (CDI): 54 cases, MSSA BSIs: 64, E. coli BSIs: 105 cases, Klebsiella BSIs: 31 Pseudomonas aeruginosa BSIs: 15.

Current performance (including factors affecting this)

- **MRSA:** No Trust-attributed MRSA bloodstream infection (BSI) were reported in December 2023, leaving the total since 1 April 2023 at two.
- **C. diff**: There were seven Trust-attributed cases reported in December 2023, bringing the total to 54 against a threshold for the year of 61.
- **MSSA:** There were five Trust-attributed MSSA BSIs reported in December 2023, bringing the total to 48 against an internal threshold for the year of 64.
- **E. coli**: There were nine Trust-attributed E. coli BSIs reported in December 2023, bringing the total to 110 against a threshold for the year of 105.
- **Klebsiella:** There were three Trust-attributed Klebsiella BSIs reported in December 2023, bringing the total to 42 against a threshold for the year of 31.
- **Pseudomonas:** There was one Trust-attributed Pseudomonas aeruginosa BSI reported in December 2023, bringing the total to 15 against a threshold for the year of 15.

Respiratory Viral Infections

- **COVID-19:** 245 inpatient cases of COVID-19 were identified during December 2023, of which 87 were healthcare-attributed.
- **Influenza:** 28 inpatient cases were identified during December 2023, almost all of which are Flu A.
- **Respiratory Syncytial Virus (RSV):** 152 inpatient cases of RSV were identified during December 2023.

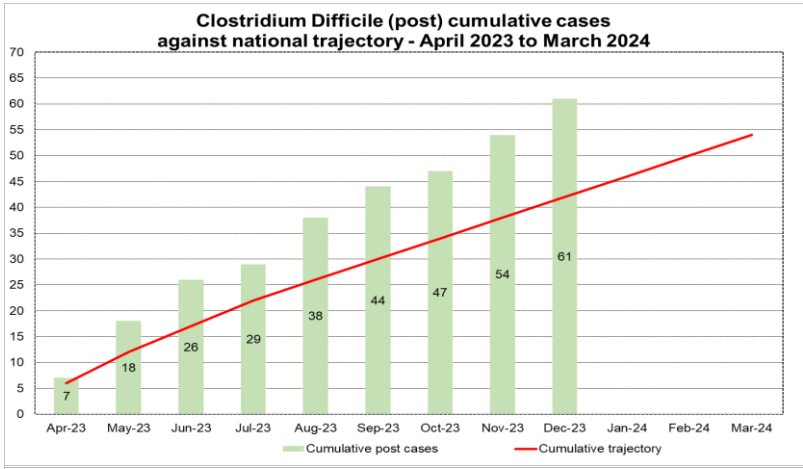
Outbreaks

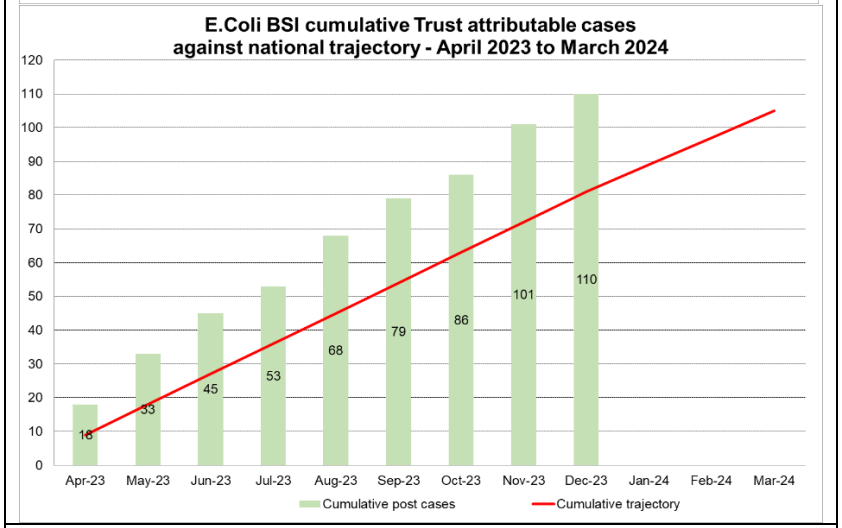
- During December 2023 a total of 16 outbreaks affected inpatient wards, 15 due to COVID-19 and one due to norovirus.

Surgical Site Infections

- A rise in infections following joint replacement surgery has been noted on the Yeovil District hospital site. Further details are in Appendix 6.

Line/Bar Charts





Recent performance

Area	Jul	Aug	Sept	Oct	Nov	Dec
MRSA	0	1	0	0	0	0
C.Diff	3	9	6	3	7	7
MSSA	6	6	6	4	5	5
E.coli	8	15	11	7	15	9

Safe

Ligatures and ligature point incidents – monthly numbers of incidents reported via our RADAR reporting system. Our aims are to maintain high rates of reporting, have a low proportion of incidents which result in harm, and minimise the use of ligatures.

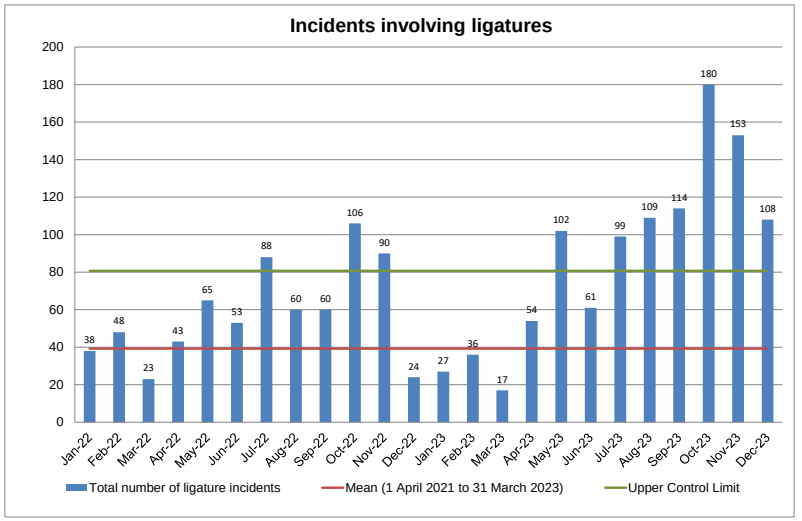
Current performance (including factors affecting this)

- During December 2023 a total of 108 ligature incidents were reported, involving 13 patients. There were also nine reported ligature point incidents, involving three patients.
- Of the 108 ligature incidents, 39 occurred at Rydon ward 1 involving four patients, with 34 relating to one patient.
- Of the 108 ligature incidents, 15 resulted in minor harm.
- One Rowan ward patient who was found with a non-fixed ligature and was unresponsive sadly passed away at Yeovil District Hospital Intensive Care Unit. A full investigation is currently in progress.
- Of the nine incidents involving ligature points four resulted minor harm to the patients. No other harm was reported.

Focus of improvement work

- All incidents involving ligatures are reviewed to ensure that assessments and care plans accurately reflect observation levels and the management of identified risk. A review of risks and observation levels is also undertaken at all handovers for each individual patient.
- The Rydon ward 1 patient is diagnosed with Recurrent Depressive Disorder and has been involved in a total of 274 incidents since May 2023.
- Risk management plans are in place and are carefully managed in order not to adopt an overly restrictive approaches, which would severely impact on patients' privacy and dignity.
- Potential technological solutions to reduce the risk of fixed ligature incidents are currently available including door-top alarms, and room monitors which will continue to be evaluated. Any use of technological solutions will continue to be supported with evidenced-based risk assessment and appropriate observation and engagement.
- Work is currently being undertaken to finalise the strategy for implementing a Complex Emotional Needs Clinical Pathway. This will place a greater emphasis on localities and MDT's determining whether inpatient admission is indicated for patients that might be at an increased risk of self-harm following admission to hospital.

SPC Chart



How do we compare

The latest NHS Benchmarking Network report, covering the year 2022/23, showed that Somerset NHS Foundation Trust had a higher level of reported adult acute mental health and PICU ligature incidents than peer providers nationally.

Recent Performance

The monthly numbers of incidents in recent months were as follows:

Area	Jul	Aug	Sep	Oct	Nov	Dec
Number of Ligature incidents	99	109	114	180	153	108
Number resulting in harm	12	19	7	7	11	17

Responsive

Emergency patients – All patients with a National Early Warning Score (NEWS2) of 5 or above should have Sepsis proforma completed.

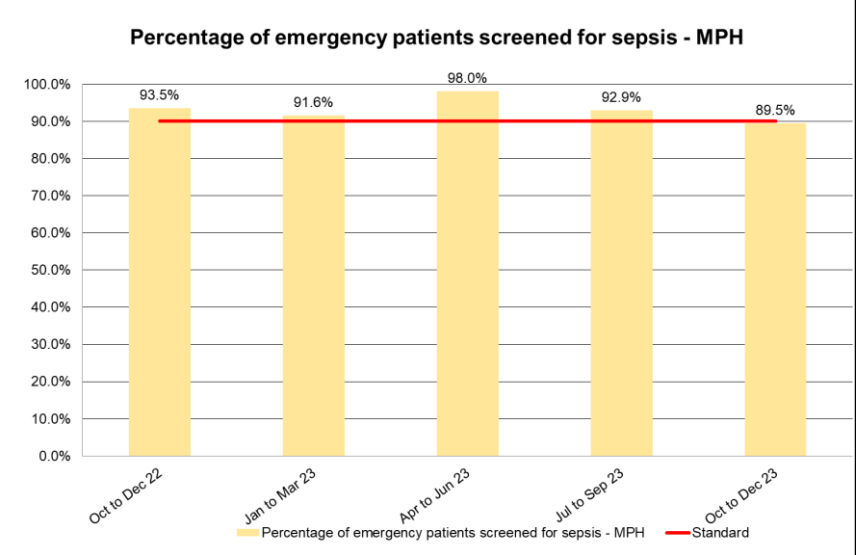
Current performance (including factors affecting this)

- During the reporting period from 1 October to 31 December 2023, compliance decreased compared to the period from 1 July to 30 September 2023.
- Of 38 patients relating to this specific reporting standard identified with a National Early Warning Score (NEWS2) score of 5 or above, a total of 34 patients within the reporting cohort (89.5%) had the required reporting proforma completed.

Focus of improvement work

- A joint NEWS2 audit tool is in use across both acute sites to provide consistency.
- The weekly ED simulation program has been difficult to run due to demands of staffing and beds. The Simulation team are continuing their efforts to provide this.
- The Sepsis Nurse will attend safety huddles within the department, to review notes and provide training as required.
- Registered Nurses and Nursing Associates are continuing to attend the Acute Illness Management course.
- Audit data is presented at the matrons and sisters meeting and results are discussed.
- A Silver Quality Improvement project is being undertaken within Acute Medical Unit (AMU), looking at escalation of patients with sepsis, and this learning will be shared across all admitting areas.
- An introductory audit meeting took place with ED to look at escalation of children in relation to their Paediatric Early Warning Signs (PEWS).

Line Chart



How do we compare

Compliance for the period 1 October to 31 December 2023 decreased when compared to the period 1 July to 30 September 2023.

Performance over the last six months

Area	Oct to Dec	Jan to Mar	Apr to Jun	Jul to Sep	Oct to Dec
% compliance	93.5%	91.6%	98.0%	92.9%	89.5%

Responsive

Patients with a National Early Warning Score (NEWS) of 5 or more acted upon appropriately - The registered nurse should immediately inform the medical team caring for the patient

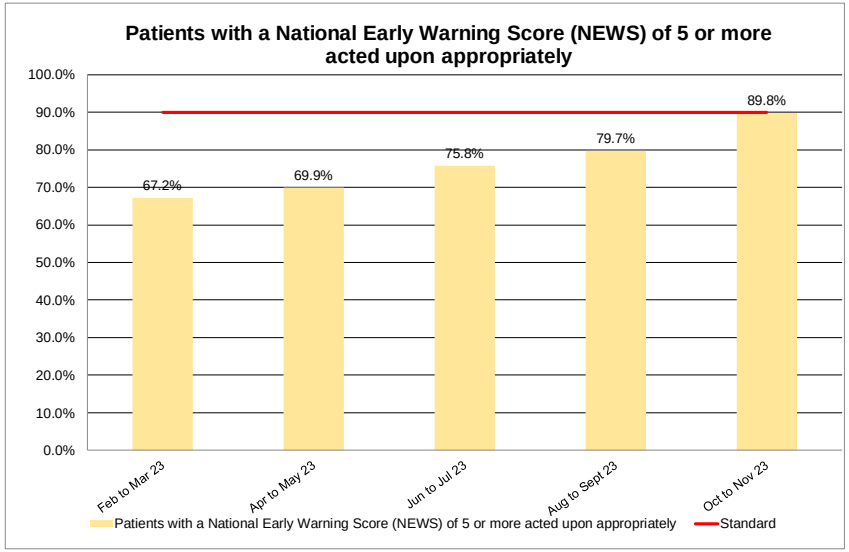
Current performance (including factors affecting this)

- During the reporting period from 1 October to 30 November 2023, compliance increased to 89.8%, from 79.7% for the period from 1 August to 30 September 2023.
- Of 49 patients relating to this specific reporting standard identified with a National Early Warning Score (NEWS2) of 5 or above, a total of 44 were appropriately acted upon by the registered nurses informing the medical team.
- Performance has improved in each of the last four reporting periods.

Focus of improvement work

- A joint NEWS2 audit tool is in use across both acute sites to provide consistency.
- All courses for Registered Nurses, Nursing Associates, Students and Health Care Assistants have dedicated teaching time on the recognition and escalation of NEWS2. The courses include Prepared 2 Care, New Nurse Induction and Acute Illness Management.
- The Deteriorating Patient and Sepsis Nurse undertakes a monthly clinical shift to ensure understanding of the ward pressures and difficulties that the ward staff face.
- All Deteriorating Patients and Sepsis teaching will be replicated across the Trust from February 2024.
- Face-to-face training takes place with our medical colleagues on joining the Trust.
- Audit data is presented at the matrons and sisters meeting and results are discussed.
- A Silver Quality Improvement project is being undertaken within the Acute Medical Unit, looking at escalation of patients with sepsis, and this learning will be shared across all admitting areas.

Bar Chart



How do we compare

Compliance for the period 1 October to 30 November 2023 increased when compared to the period 1 August to 30 September 2023.

Recent Performance

Area	Feb to Mar 2023	Apr to May 2023	Jun to Jul 2023	Aug to Sept 2023	Oct to Nov 2023
% compliance MPH	67.2%	69.9%	75.8%	79.7%	89.8%

Responsive

The Accident & Emergency (A&E) 4-hour standard is a measure of the length of wait from arrival in an Emergency Department (ED) to the time the patient is discharged, admitted or transferred to another provider. The target is that at least 76% of patients will wait less than four hours in the Emergency Department by March 2024.

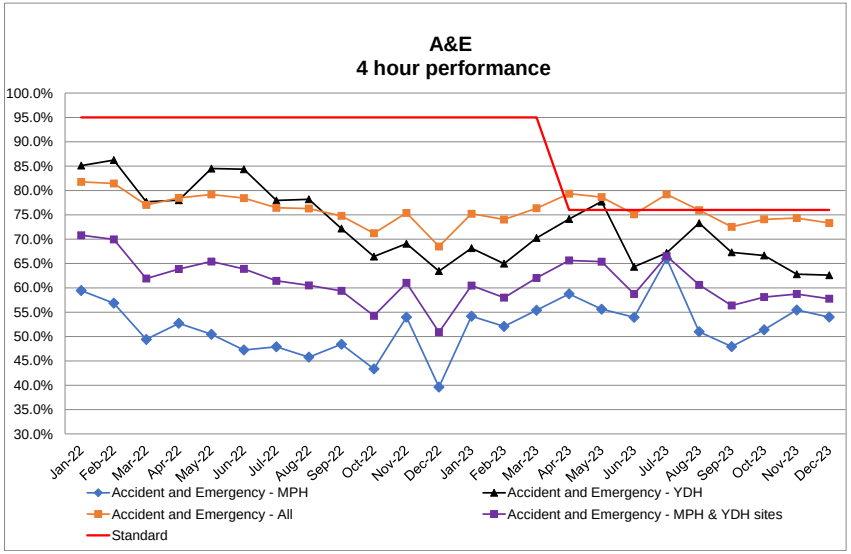
Current performance (including factors affecting this)

- Trust-wide A&E 4-hour performance for December 2023 was 57.8%, down from 58.7% in November 2023. With Minor Injury Units (MIUs) compliance included at 96.3%, our overall compliance was 73.3%, below the revised 76 % national standard.
- Compliance in respect of our two A&E departments was:
  - Musgrove Park Hospital (MPH): 54.0%.
  - Yeovil District Hospital (YDH): 62.6%.
- Although the combined year-to-date A&E attendances at MPH and YDH from 1 April to 31 December 2023 were similar to those for the same period in 2022, both sites have experienced several pronounced daily 'spikes' in activity levels, which have affected performance against the four-hour standard.
- The position has also been affected by high numbers of inpatients at both sites who do not meet the criteria to reside.
- The number of patients spending more than 12 hours in the departments was 4.8% at MPH and 5.9% at YDH.

Focus of improvement work

- Work is ongoing with the Site Director and the ED senior team to review escalation/flow processes.
- A new ambulance arrivals programme has been successfully implemented.
- On the MPH site, work is progressing in respect of the new urgent care CT scanner.
- Work is aimed to be completed by March 2024, to review ED medical rotas on both acute sites to enable shift patterns to match demand, within our current financial envelope.
- Work will be initiated in January 2024 to review triage processes at both acute sites.
- Focused work on Criteria Led Discharge is underway. This has the aim of facilitating earlier discharge and improving ED flow.
- A joint-site Same Day Urgent Care (SDEC) task and finish exercise is planned, to aim towards a seven-day service, 12 hours per day, aiming for implementation by 29 February 2024.

Line Chart



How do we compare

In December 2023, the national average performance for Trusts with a major Emergency Department was 54.7%. Our performance was 57.8%. We were ranked 40 out of 122 trusts. With Minor Injury Unit attendances included, we were ranked 21, with performance of 73.3%. National average performance was 66.4%.

Recent performance

Area	Jul	Aug	Sep	Oct	Nov	Dec
A&E only	66.5%	60.6%	56.4%	58.1%	58.7%	57.8%
Including MIU	79.2%	76.0%	72.5%	74.1%	74.3%	73.3%

Responsive

Ambulance handovers are to be completed within 30 minutes of arrival at an Emergency Department (ED). The target is that at least 95% of patient handovers are within the 30 minute standard.

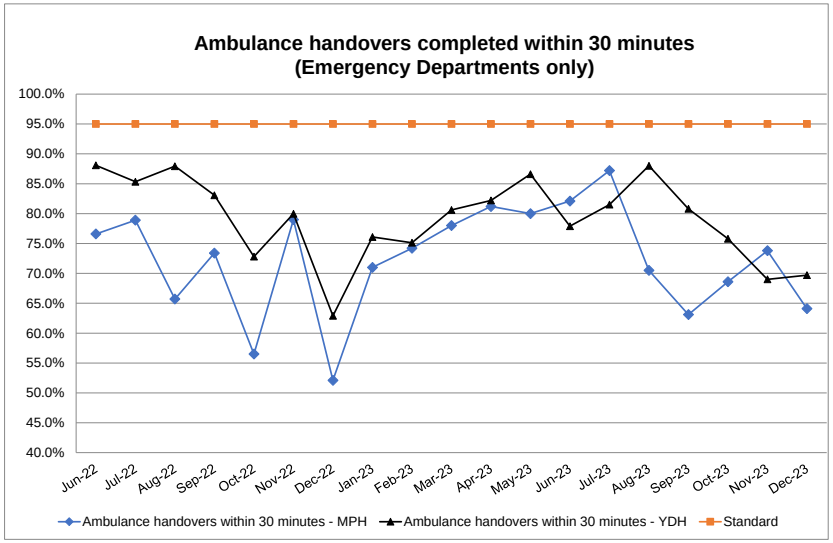
Current performance (including factors affecting this)

- During December 2023, performance for the handover within 30 minutes of patient arrivals by ambulance received into our Emergency Departments (EDs) decreased at Musgrove Park Hospital (MPH) but increased at Yeovil District Hospital (YDH) compared to November 2023. Compliance in December 2023 was as follows:
  - MPH: 64.1% (1,585 out of 2,473 handovers were within 30 minutes).
  - YDH: 69.7% (931 out of 1,336 handovers were within 30 minutes).
- The average performance across all hospitals served by SWAST in December 2023 was 52.9%.

Focus of improvement work

- The South Western Ambulance Service NHS Foundation Trust (SWAST) and acute sites have successfully implemented a new ambulance arrival screen and a new ambulance handover process to run alongside it. We will now monitor the effects on ambulance handover times and are working with system partners to review the implementation and continuation of the process.
- Acute sites are working with SWAST and community partners to look at alternative pathways for patients to follow. This has seen a reduction in conveyances, and work on this project will continue.
- We are working with SWAST to streamline and improve direct access pathways to Same Day Emergency Care (SDEC) at MPH.
- The Rapid Assessment and Triage (RAT) process is to be reviewed and streamlined across both acute sites.
- We are currently working through the implementation of a new escalation process, as released by NHSE, for long-waiting ambulance handovers.
- A review and redesign of ED escalation is ongoing, which will include internal response to ambulance handover delays.
- In January/early February 2024, a senior operational walk-through is planned, to review all elements of ambulance handover between acute sites and SWAST, to identify any further improvements.

Line Chart



How do we compare

In December 2023, 64.1% of all ambulance handovers at Musgrove Park Hospital and 69.7% of all ambulance handovers at Yeovil District Hospital were completed within 30 minutes. The average performance across all hospitals served by SWAST was 52.9%.

Recent performance

Performance in recent months against the 30-minute standard was as follows:

Area	Jul	Aug	Sep	Oct	Nov	Dec
MPH	86.2%	70.5%	63.1%	68.6%	73.8%	64.1%
YDH	80.8%	88.0%	80.8%	75.8%	69.0%	69.7%

Responsive

Referral to Treatment Time (RTT) is a measure of the length of time a patient waits from the point of referral through to receiving treatment. The target is for at least 92% of patients, who have not yet received treatment, to have been waiting less than 18 weeks at the month-end. Trusts should have no patients waiting over 65 weeks for treatment by 31 March 2024.

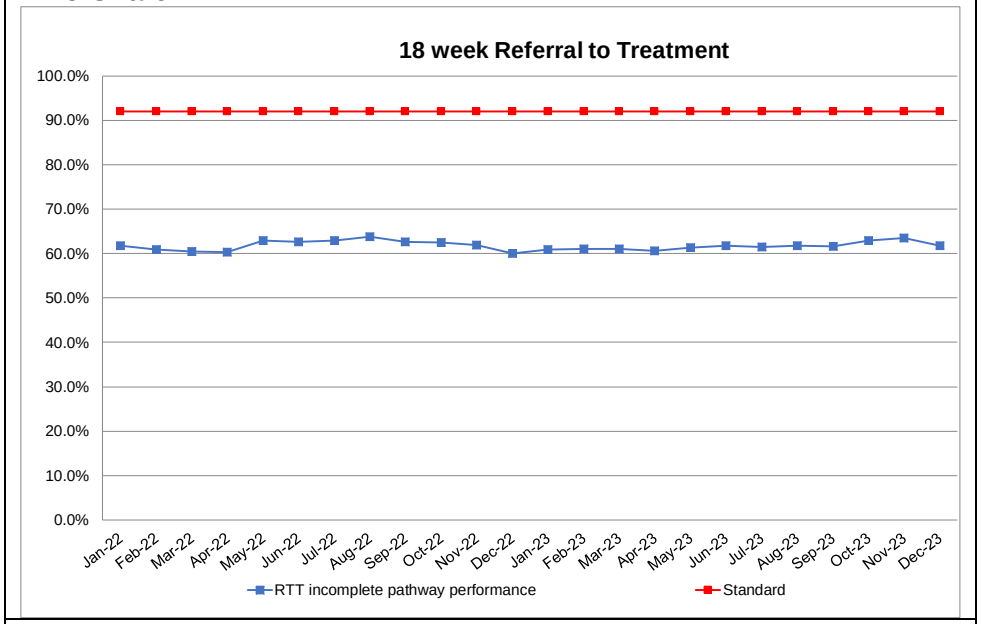
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT was 61.7% (combined acutes + community) in December 2023, down from 63.4% in November 2023.
- The total waiting list size increased by 261 pathways and was 4,131 lower (i.e. better) than the planning trajectory (53,667 actual vs. 57,798).
- The number of patients waiting over 52 weeks decreased by 58 pathways in December 2023 to 2,519 pathways, against a trajectory of 3,597 or fewer. The number of patients waiting over 65 weeks was 725 at month-end, nine better than the recently revised trajectory (734). The number of patients waiting 78 weeks or more increased by 12 to 61 and was worse than the revised trajectory for December 2023 of 55. We reported no patients waiting over 104 weeks.
- Until November 2021 Musgrove remained one inpatient theatre's worth of capacity down due to the conversion of a theatre into critical care capacity. This along with other factors has resulted in a backlog of more complex, longer routine cases on the waiting list.

Focus of improvement work

- The number of patients needing surgery this year to avoid becoming a 65-week RTT waiter by March 2024 has been quantified for each specialty, and detailed plans continue to be progressed to manage these volumes through improved productivity, increased capacity (including use of the Independent Sector) and reprioritisation of available theatre capacity across the System.
- A significant programme of work to support elective care recovery in the medium and long-term is in place.
- A programme of waiting list validation has been established, which includes contacting patients to check they still need to be seen.
- The Trust has implemented the national patient choice programme (PIDMAS).

Line Chart



How do we compare

The national average performance against the 18-week RTT standard was 58.3% in November 2023, the latest data available; our performance was 63.4%. National performance improved by 0.1% between October and November 2023; our performance improved by 0.5%. The number of patients waiting over 52 weeks across the country decreased by 22,206 to 355,412 (4.7% of the national waiting list compared with 4.7% for the Trust).

Performance trajectory: 78 week and 65 week wait performance

Area	Jul	Aug	Sep	Oct	Nov	Dec
78-week trajectory	55	31	17	12	62	55
78-week actual	49	66	70	55	49	61
65-week trajectory	836	933	1,040	1,218	682	734
65-week actual	659	724	741	687	661	725

Appendix 5a shows a breakdown of performance at specialty level.

Responsive

Acute bed days lost due to patients not meeting the criteria to reside: Working with strategic partners to facilitate the timely and appropriate discharge of patients from our hospitals, and reduce the number of patients occupying a bed who no longer require treatment or therapy.

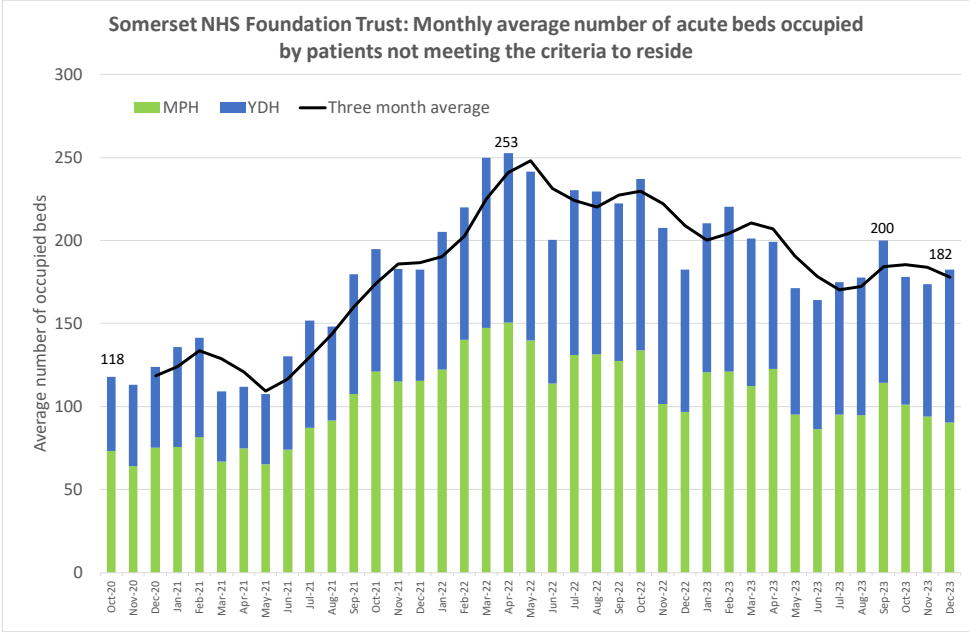
Current performance (including factors affecting this)

- During December 2023, the Trust-wide number of acute bed days occupied by patients not meeting the criteria to reside was 5,651 (2,807 at MPH and 2,844 at YDH), up from 5,213 in November 2023. This equates to 182 fully occupied beds during the month of December 2023, up from 174 in November 2023.
- In our community hospitals, the number of patients not meeting the criteria to reside reduced, from 58 as at 30 November 2023 to 53 as at 31 December 2023.
- Of the 993 acute inpatients discharged during December 2023 who had a Discharge Ready Date recorded, the average duration between the Discharge Ready Date and the actual date of discharge was 4.9 days compared to 4.3 days during November 2023. 80% of patients discharged in December 2023 were discharged within seven days of their Discharge Ready Date, and 93% were discharged within 14 days,

Focus of improvement work

- A range of actions are being taken to improve patient flow, care for people at home where appropriate, facilitate timely and appropriate discharge from hospital, and address the difficulties in the domiciliary care market.
- These actions include the expansion of Criteria-Led Discharge, to discharge a patient when they meet pre-agreed clinical criteria for discharge, as identified by the lead clinician. This reduces delays in the discharge process and ensures that patients can be discharged in an appropriate and timely way.

Trend Chart



How do we compare

The number of bed days lost due to patients not meeting the criteria to reside was almost unchanged at MPH and increased at YDH during December 2023 compared to November 2023.

Recent performance

Bed days lost where patients did not meet criteria to reside over recent months were as follows:

Area	Jul	Aug	Sep	Oct	Nov	Dec
MPH	2,947	2,942	3,432	3,134	2,819	2,807
YDH	2,476	2,565	2,569	2,386	2,394	2,844
Total	5,423	5,507	6,001	5,520	5,213	5,651

Responsive

Percentage of stroke patients directly admitted to an acute stroke ward within four hours – Patients who have had a stroke should be admitted directly to a specialist acute stroke unit. Our aim at least 95% of patients are so admitted.

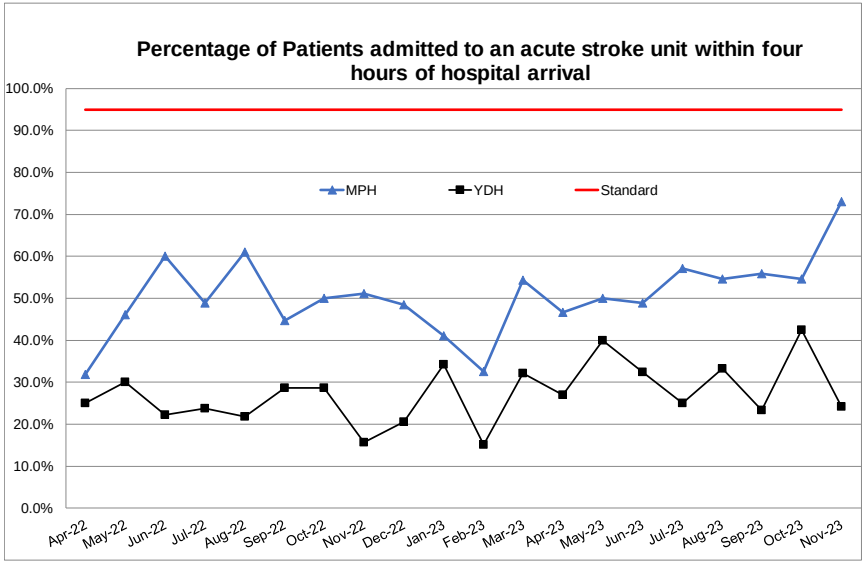
Current performance (including factors affecting this)

- During November 2023, compliance increased at Musgrove Park Hospital but decreased at Yeovil District Hospital when compared to October 2023. Both sites remained below the reporting standard of 95% with performance as follows:
  - Musgrove Park Hospital (MPH): 73.1%
  - Yeovil District Hospital (YDH): 24.2%
- Performance continues to be heavily influenced by bed availability, clinical presentation that may not immediately suggest stroke on admission, and medical decisions as when appropriate to move/transfer patients from the emergency departments (EDs) to the wards.

Focus of improvement work

- The Stroke team are proactive in aiming to identify promptly patients who present to ED with stroke symptoms, to ensure that any delays to transferring to a stroke unit are minimised.
- Current performance levels are reflective of wider pressures on the hospital rather than a disjointed pathway of treatment for patients, and when bed availability and flow are favourable, the four-hour target is achieved in the majority of cases. On review, the majority of those who are not admitted to a stroke bed within the four-hour standard transpire to be patients with stroke-like symptoms who have not actually had a stroke.
- Two Allied Clinical Professionals (ACPs) have recently been appointed. These ACPs will aid patient flow.
- Hyper acute stroke beds available at MPH are due to increase from four to eight in January 2024.

Line Chart



How do we compare

During November 2023 compliance increased at Musgrove Park Hospital but decreased at Yeovil District Hospital when compared to October 2023.

Performance over the last six months

Area	Jun	Jul	Aug	Sep	Oct	Nov
% compliance MPH	48.9%	57.1%	54.6%	55.9%	54.6%	73.1%
% compliance YDH	32.4%	25.0%	33.3%	23.3%	42.5%	24.2%

Responsive

Patients spending >90% of time in stroke unit – Stroke units are able to offer the best quality of stroke care both acutely and in the long-term. Management of eligible patients in a stroke unit will result in long-term reductions in death, dependency and the need for institutional care. Our aim at least 80% of patients spend more than 90% of their pathway in designated stroke wards.

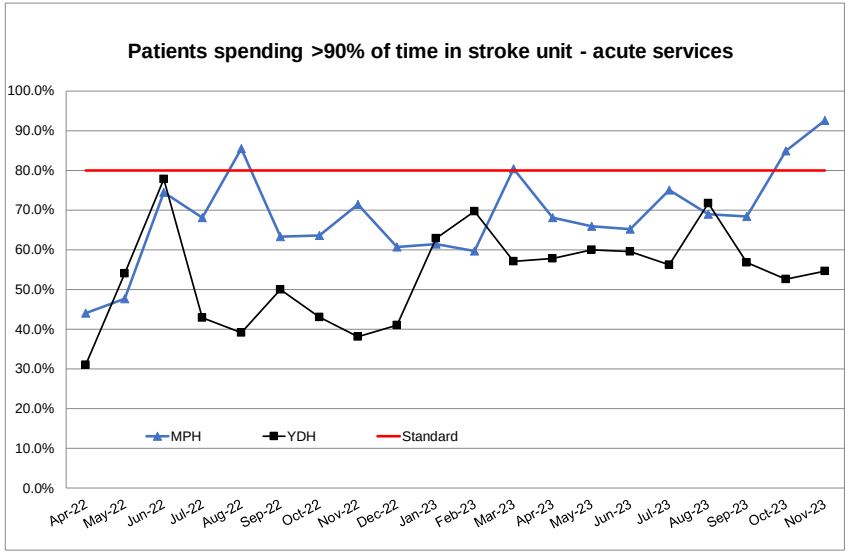
Current performance (including factors affecting this)

- During November 2023, compliance increased at Musgrove Park Hospital, and remained above the 80% reporting standard. Compliance also increased at Yeovil District Hospital, but remained below the reporting standard. Performance at the two sites was as follows:
  - Musgrove Park Hospital (MPH): 92.6%
  - Yeovil District Hospital (YDH): 54.5 %
- As is the case with the four-hour standard, performance in respect of this reporting standard is heavily influenced by patient flow and the availability of stroke beds.

Focus of improvement work

- For details of the improvement work being undertaken, please refer to the report on the four-hour direct admission standard.
- It should be noted that, regardless of whether or not they are on a Stroke ward, all patients remain on a stroke pathway throughout the whole time of their care and are seen by specialist stroke practitioners on non-Stroke wards and also throughout their time with our community Stroke rehabilitation services.

Line Chart



How do we compare

During November 2023, compliance increased at Musgrove Park Hospital and Yeovil District Hospital when compared to October 2023.

Performance over the last six months

Area	Jun	Jul	Aug	Sep	Oct	Nov
% compliance MPH	65.2%	75.0%	68.9%	68.4%	84.8%	92.6%
% compliance YDH	59.5%	56.2%	71.7%	56.7%	52.5%	54.5%

Safe

Out of Area Placements – The Five Year Forward View for Mental Health stated that placing people out of area for non-specialist acute mental health inpatient care due to local bed pressures was to be eliminated entirely by no later than 2020/21.

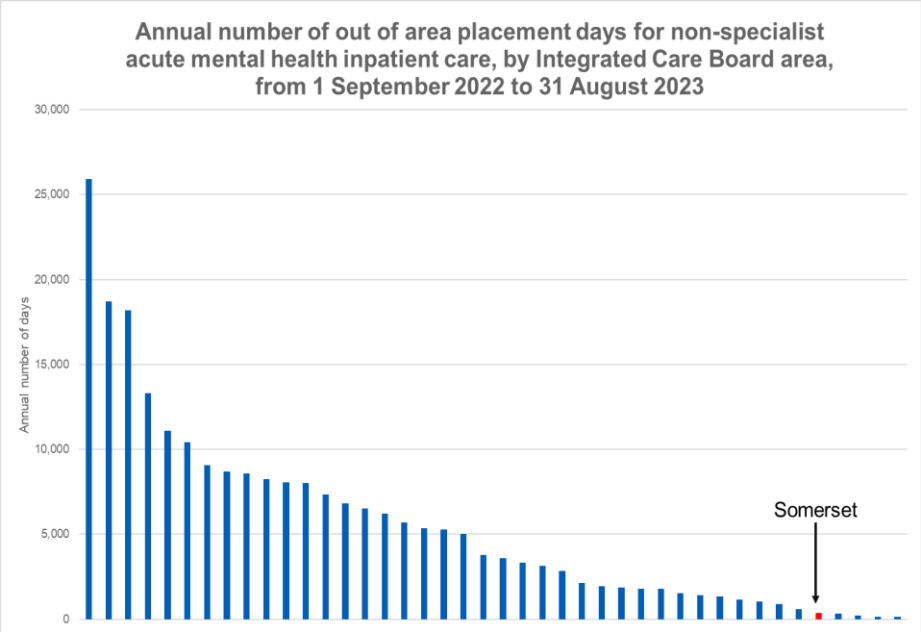
Current performance (including factors affecting this)

- During December 2023 two patients were placed out of area. One patient so placed on 21 November 2023 was repatriated to Holford ward our psychiatric intensive care unit (PICU), on 4 December 2023, as soon as an appropriate bed became available.
- The other patient who was placed out of county on 1 December 2023 remains so placed. This decision is clinically indicated due to the patient requiring a male-only ward because of risks towards females.

Focus of improvement work

- We continue have amongst the lowest levels of inappropriate out of area placements of all providers of mental health services nationally.
- The majority of out of area placements are due to patients requiring admission into our Psychiatric Intensive Care Unit (PICU). With only ten beds available there are occasions when, due to clinical acuity or gender, it would be unsafe to admit a patient.
- When a patient is so placed, a key worker is immediately assigned to maintain regular contact with the patient until the patient is either transferred back to our wards, discharged, or moved to secure services. The placements sought are always as close to Somerset as possible.
- At times, episodes relate to patients awaiting transfer to secure services. We work closely with other NHS providers, to facilitate such transfers and closely monitor processes to minimise risk.
- The service has reviewed processes to ensure barriers to repatriation and/or discharge of patients are minimised and escalated with system partners where appropriate.

Bar Chart



How do we compare

Data published by NHS Digital shows that we continue have amongst the lowest levels of out of area placements for non-specialist acute mental health inpatient care of all providers of mental health services nationally.

Recent Performance

The monthly numbers of patients who were placed out of area, and the numbers of patient days spent out of area over the last six months were as follows:

Area	Jul	Aug	Sep	Oct	Nov	Dec
Number of Days	14	0	0	10	10	34
Number of patients	2	0	0	1	1	2

Responsive

Waiting Times: One of our key priorities is to ensure that patients are able to access our services in as timely a manner as possible, and without unnecessary delays. Our aim is to ensure that at least 90% of people are seen by our adult mental health and learning disabilities services within six weeks of being referred.

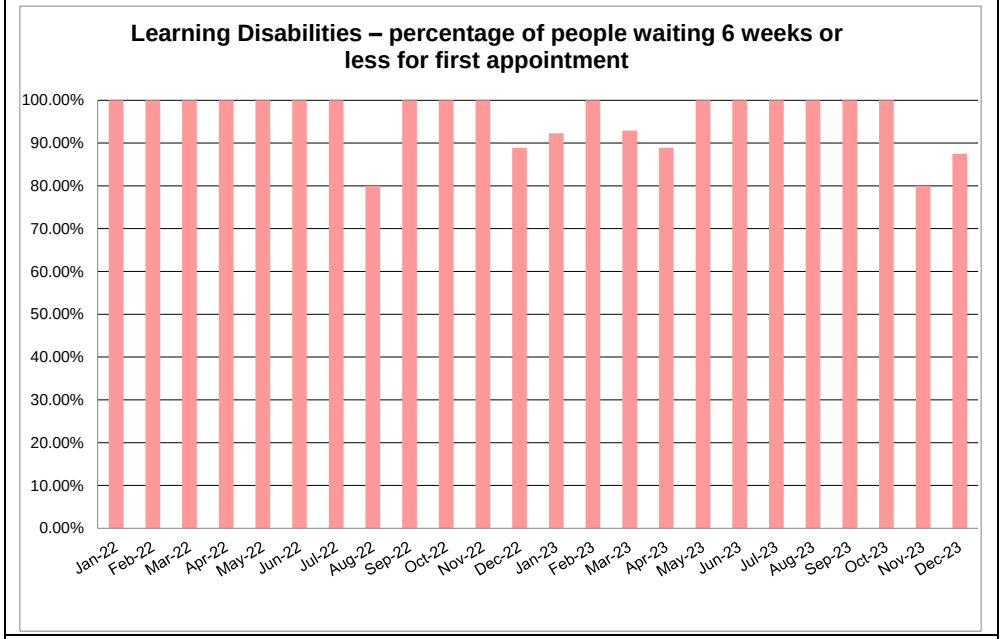
Current performance (including factors affecting this)

- As at 3 December 2023, seven out of eight people (87.5%) waiting to be seen by our learning disabilities service were reported as having waited under six weeks, against a required standard of 90%.
- Unfortunately, an appointment on 27 November 2023 for the patient who, as at 31 December 2023, had waited seven weeks, had to be cancelled due to unforeseen circumstances and the parent of the patient was subsequently unable to attend other offered appointments.
- The patient has since been seen, on 15 January 2024.

Focus of improvement work

- Regular waiting list reports are circulated to managers within all services to identify and respond to potential breaches of the six week waiting times.

Bar Chart



How do we compare

The latest NHS Benchmarking Network data shows our waiting times for people with Learning Disabilities to be in the best quartile nationally.

Recent performance

The numbers and percentages of people waiting six weeks or more at the month end in recent months were as follows:

Area	Jul	Aug	Sep	Oct	Nov	Dec
Number waiting	10	4	13	9	10	8
% < 6 weeks	100%	100%	100%	100%	80.0%	87.5%

Responsive

Waiting Times – One of our key priorities is to ensure that patients are able to access our services in as timely a manner as possible, and without unnecessary delays. Our aim is to reduce the number of people waiting over 18 weeks from being referred to having their first appointment. The data shown relates to our community physical health services, including dentistry.

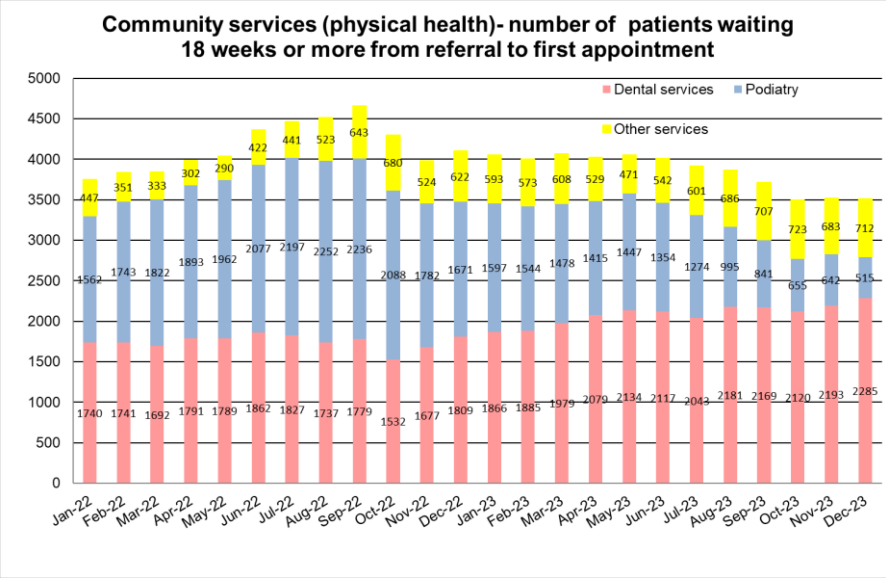
Current performance (including factors affecting this)

- As at 31 December 2023, the number of patients waiting 18 weeks or more totalled 3,491, a decrease of 27 compared to 30 November 2023.
- Our Somerset and Dorset dental service had 2,285 patients waiting 18 weeks or more to be seen, up from 2,193 as at 30 November 2023 (Somerset: 1,530 patients, up from 1,486 and Dorset: 755 patients, up from 707).
- The number of people waiting 18 weeks or more to be seen by our Podiatry service decreased to 494 patients, from 642 as at 30 November 2023, the seventh month in a row that the numbers had reduced. The Podiatry service continues to have significant levels of vacancies, which is a national issue.
- Of the numbers within 'Others', 50.1% related to our Musculoskeletal Physiotherapy Service, which increased from 262 as at 30 November 2023 to 357 as at 31 December 2023.
- As at 31 December 2023, a total of 759 patients had waited 52 weeks or more to be seen (up from 747 in November 2023), 402 had waited 65 weeks or more (up from 386 in November 2023), and 205 had waited 78 weeks or more (down from 209 in November 2023).

Focus of improvement work

- In Podiatry, priority continues to be given to high risk vascular / diabetic foot care and acute nail surgery cases. All routine patients are contacted by letter and telephone to provide advice and guidance. The waiting list initiative to reduce the number of patients waiting and the length of wait, which began in September 2022, remains ongoing.
- The Dental service continues to face considerable challenges due to vacancies, sickness absence and insufficient cover for colleagues on maternity leave, and continues with various recruitment initiatives.
- The Musculoskeletal Physiotherapy Service is undertaking a demand and capacity exercise and reviewing the impact of First Contact Practitioners who are embedded within GP practices.

Bar Chart



How do we compare

The number of patients waiting 18 weeks or more as at 31 December 2023 decreased by 27 when compared to 30 November 2023.

Recent performance

The numbers of people waiting 18 weeks or more at the month end, in recent months were as follows:

Area	Jul	Aug	Sep	Oct	Nov	Dec
Number waiting	3,918	3,862	3,717	3,498	3,518	3,491

Responsive

Waiting Times – One of our key priorities is to ensure that patients are able to access our services in as timely a manner as possible, and without unnecessary delays. Our aim is to reduce the number of people waiting over 18 weeks from being referred to having treatment. The data shown relates to our Somerset and Dorset Dental services, specifically children and young people waiting 18 weeks or more from assessment for an appointment to have a procedure requiring a general anaesthetic (GA).

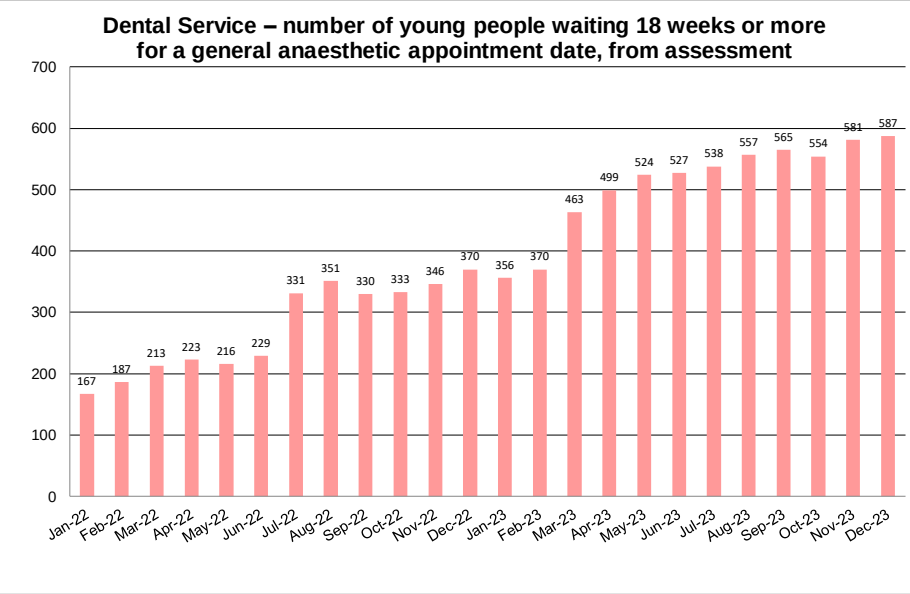
Current performance (including factors affecting this)

- As at 31 December 2023, 587 young people had waited 18 weeks or more, up from 581 as at 30 November 2023.
- Of the 587 patients waiting, 538 related to our Dorset service (up from 534 as at 30 November 2023), and 49 related to our Somerset service (up from 47 as at 30 November 2023).
- The service continues to have significant levels of vacancies, which is a national issue, exacerbated by sickness/absence affecting capacity within the service, as well as the loss of some theatre slots.

Focus of improvement work

- The service continually reviews its recruitment programme and clinical delivery structure and other initiatives in order to encourage applicants. When new colleagues commence in post, their contribution is gradual until they are fully up to speed. A recruitment campaign for senior specialist posts is underway.
- Following active engagement, and the development of an options appraisal to which the service contributed, the Dorset Integrated Care Board (ICB) has allocated funding for Paediatric GAs, as an active intervention. This will be at a lower level than originally planned, but in-sourcing is set up to provide up to 100 patients with a GA. This work commenced on 20 January 2024, with ongoing negotiations for more sustainable capacity in future.
- Across both Dorset and Somerset, a review to improve efficiencies of theatre utilisation continues to reduce loss of capacity due to the availability of anaesthetists and to ensure slots available are not lost to avoidable circumstances.

Bar Chart



How do we compare

The number of young people waiting 18 weeks or more as at 31 December 2023 increased by six compared to 30 November 2023.

Recent Performance

The numbers of young people waiting 18 weeks or more at the month end in recent months were as follows:

Area	Jul	Aug	Sept	Oct	Nov	Dec
Number waiting	538	557	565	554	581	587
% > 18 weeks	67.4%	66.8%	65.8%	63.0%	67.0%	68.3%

Responsive

31-day decision to treat to cancer treatment is a measure of the length of wait from the patient agreed decision to treat, through to treatment. The standard is for at least 96% of patients to be treated within 31 days of a decision to treat. This target includes first and subsequent treatments for cancer.

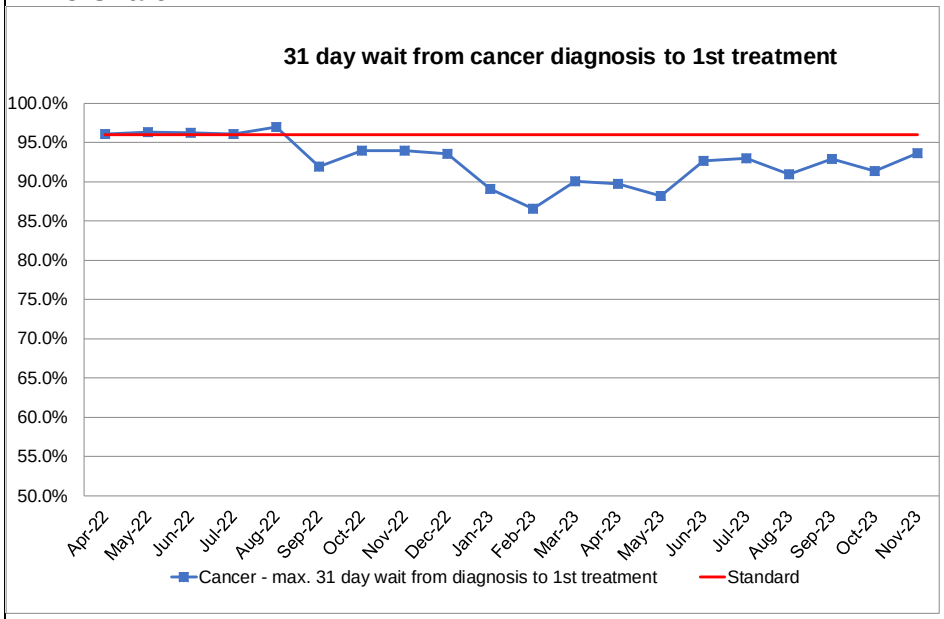
Current performance (including factors affecting this)

- Performance against the 31-day first combined treatment standard was 93.7% in November 2023, below the 96% national standard but above the national average performance.
- There were 44 breaches of the combined treatment standard, 17 for breast (39% of breaches), eight for gynaecology (18%), and seven for skin (16%). There were smaller volumes of breaches across a range of tumour sites.
- Over the past two months there has been an increase in breaches of the 31-day standard for skin patients, which has followed the repatriation of the skin cancer service for the west of the county from University Hospital Bristol & Weston NHS Foundation Trust (UHBW).
- 89% of the breaches were for surgical treatments. The ability to operate within 31 days of the decision to treat is affected by bulges in demand, which we have seen for breast, colorectal, gynaecology and skin.
- Industrial action and bed pressures have had a limited impact on planned cancer treatments. Any delays or cancellations of surgery are clinically risk assessed on a case-by-case basis by the operating surgeon.

Focus of improvement work

- Capacity and demand modelling has been undertaken for the repatriated dermatology two-week wait service. Additional capacity continues to be established, including further consultant appointments, GPs with Extended Roles being trained and insourcing. Allied service capacity is also being planned for, including pathology, plastics and melanoma oncology.
- The work outlined in the combined 62-day GP will also help to reduce delays in cancer pathways which will also help to smooth bulges in demand for cancer surgery.

Line Chart



How do we compare

National average performance for providers was 90.1% in November 2023, the latest data available. Our Trust-wide performance was 93.7%. We ranked 69 out of 138 providers.

Recent performance

31-day diagnosis to first treatment performance

Area	Jun	Jul	Aug	Sep	Oct	Nov
% Compliance	92.7%	93.0%	91.0%	92.9%	91.3%	93.7%

Responsive

62-day Cancer is a measure of the length of wait from referral from a GP, screening programme or consultant, through to the start of first definitive treatment. The target is for at least 85% of patients to be treated within 62 days of referral. The 28-day Faster Diagnosis is the first part of the 62-day pathway.

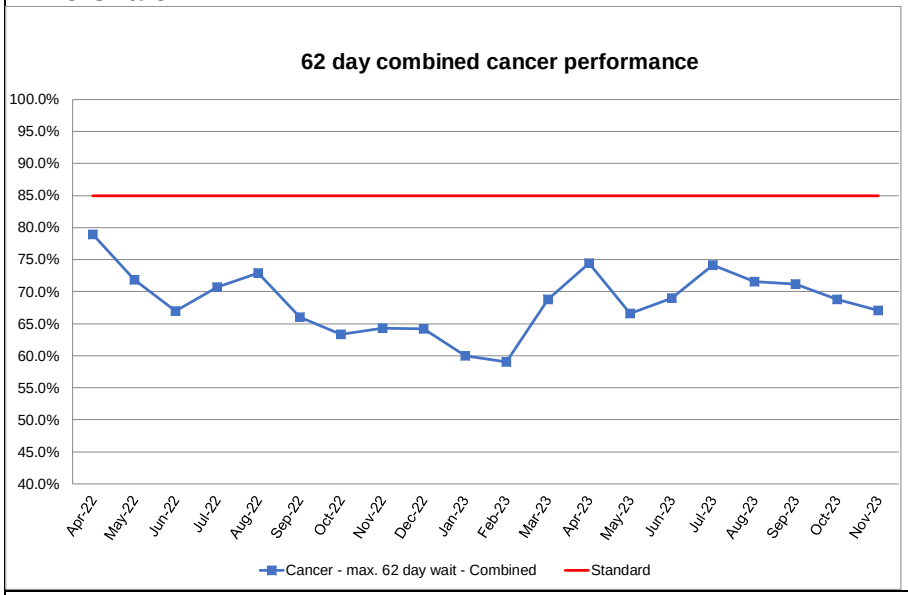
Current performance (including factors affecting this)

- The percentage of patients treated for a cancer within 62 days of referral was 67.1% in November 2023, below the national standard, but above the national average.
- The main breaches of the 62-day GP cancer standard were in urology (35% of breaches), colorectal (17%) and skin (13%).
- The main cause of the breaches continues to be high demand (urology 14% growth and colorectal 17% growth in referrals, relative to the same three-month pre-COVID period). This has resulted in an increase in diagnostic and treatment waiting times, both at the Trust and other treating providers. The increase in skin breaches relates to the sooner than planned repatriation of the service from University Hospitals Bristol & Weston NHS Foundation Trust (UHBW).
- Twenty-three GP-referred patients were treated in November on or after day 104 (the national 'backstop'); see Appendix 5a.
- The number of patients referred by their GP waiting over 62 days at the end of December 2023 was 44 patients above (i.e. worse than) the recovery trajectory (195 against a plan of 151). At the time the trajectory was set, plans were not in place to repatriate the skin service in-year, with skin currently making-up 29% of the backlog.

Focus of improvement work

- Pathway redesign work is continuing for prostate, across both MPH and YDH, to align both sites and reduce any delays.
- Additional prostate and colorectal diagnostic capacity continue to be established, to try to meet increasing demand.
- The community-based one-stop self-referral gynaecology pathway for post-menopausal bleed patients commenced in September 2023.
- Please also see the 31-day exception report for actions relating to the skin cancer pathway.
- The Trust reported 28-day Faster Diagnosis performance of 76.9% against the 75.0% standard in November 2023, linked with improvements in the colorectal and gynaecology pathways

Line Chart



How do we compare

National average performance for providers was 65.2% in November 2023, the latest data available. Our performance was 67.1%. We were ranked 74 out of 144 trusts.

Recent performance

62-day GP cancer performance

Area	Jun	Jul	Aug	Sep	Oct	Nov
% Compliance	68.8%	74.2%	71.7%	71.3%	68.8%	67.1%

Appendix 5a provides a detailed breakdown of tumour-site level performance.

Responsive

The Diagnostic six-week wait is a measure of the length of wait from referral through to diagnostic testing being carried out. This standard is applied to the top 15 national high-volume tests. The target is for at least 95% of patients to have been waiting less than six weeks for a test at the month-end, by March 2025.

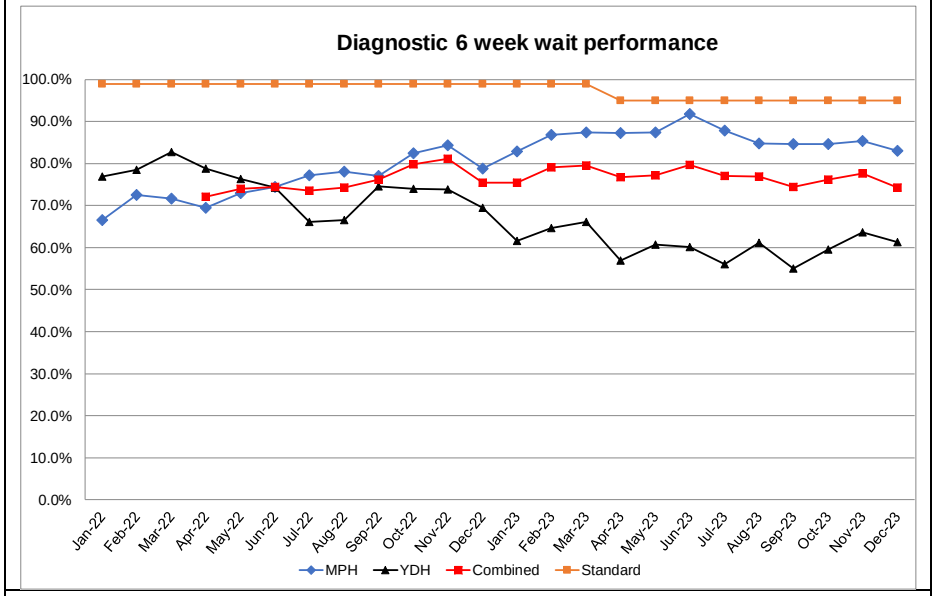
Current performance (including factors affecting this)

- The combined percentage of patients waiting under six weeks for their diagnostic test decreased to 74.3% in December 2023 below the regional March 2023 ambition of greater than 75%.
- The number of patients waiting over six weeks in December 2023 increased by 307 patients in the month; the highest numbers of patients were waiting for an MRI (up from 430 to 660; 21% of over six-week waiters), gastroscopy (up from 453 to 480; 15%), colonoscopy (up from 437 to 443; 14%), and non-obstetric ultrasound (down from 431 to 373; 12%), together making up 63% of the long waiters.
- A further decrease in the planned overdue surveillance colonoscopies will be seen in January 2024, with additional capacity put in place at weekends to scope these patients.
- The total waiting list size decreased by 3%, due to a reduction in new requests as a result of the bank holidays and industrial action.

Focus of improvement work

- Additional endoscopy sessions have been established at the weekend in Yeovil; appropriate patients are also being offered Shepton Mallet, Musgrove and Bridgwater Community Hospital as an alternative site for their surveillance procedure.
- Endoscopy capacity and demand modelling for the Yeovil site is being refreshed, to look at the proportion of capacity that needs to be dedicated to each procedure type.
- Weekend and in-week additional endoscopy sessions continue to be run at Musgrove.
- Additional ultrasound capacity has been established through waiting list initiatives and insourcing. The Musgrove and Yeovil sites are working together to share demand across available capacity.
- Additional MRI capacity is being established, through the rental of mobile scanning units. Plans are in place to increase the number of scans undertaken at the Taunton Diagnostic Centre.

Line Chart



How do we compare

National average performance for NHS providers (i.e. excluding Independent Sector providers) was 75.8% in November 2023, the latest data available. Our performance was 77.6%. We were ranked 94 out of 155 trusts for the 15 high-volume diagnostic tests.

Recent performance

Area	Jul	Aug	Sep	Oct	Nov	Dec
Musgrove Park Hospital (MPH)	87.9%	84.8%	84.6%	84.7%	85.4%	83.1%
Yeovil District Hospital (YDH)	56.0%	61.2%	55.0%	59.6%	63.6%	61.3%
Combined	77.1%	76.9%	74.4%	76.2%	77.6%	74.3%

Well Led

Mandatory training – Our aim is to maintain a compliance rate of 90% or more for all mandatory and statutory training courses.

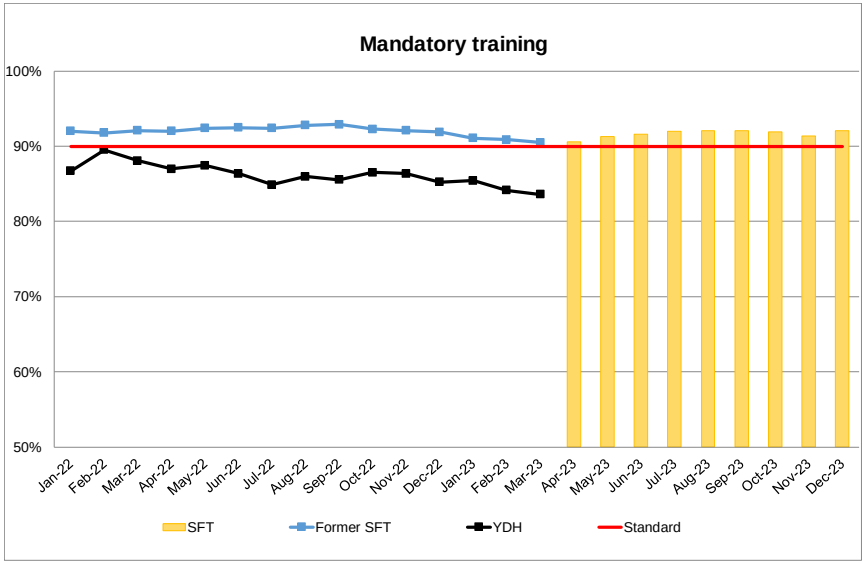
Current performance (including factors affecting this)

- As at 31 December 2023, our overall mandatory training rate was 92.1%, the highest rate recorded since 30 September 2023.
- Apart from Symphony Health Service (SHS), all colleagues moved to the newly commissioned Trust training system, LEAP, on 1 April 2023. As at 31 December 2023, compliance reported from the two separate systems was as follows:
  - LEAP: 92.2% (91.5% as at 30 November 2023)
  - SHS: 76.5% (80.9% as at 30 November 2023)
- Operational pressures, and limited capacity in areas with large backlogs such as life support and safeguarding continue to remain a challenge to full recovery.

Focus of improvement work

- Resuscitation compliance reversion to 12-months has now been completed, so figures are expected to become more stable. Work also continues in this area on reducing 'did not attends' and cancellations. Paediatric courses are now scheduled to run between adult sessions, so colleagues are able complete both sets of training on the same day.
- Service Groups and Corporate Directorates continue to receive tailored reports via their People Business Partners and have real-time access via the learning management system to data on their teams, and access to Sharepoint reports to help identify areas which require action.
- The Safeguarding Team continue to undertake a review to consider moving a risk-based solution to cover periods when operational pressures occur.
- The Deputy Chief People Officer and members of their senior management team are following up reported compliance of SHS to confirm actions being undertaken to improve performance.
- A group is reviewing mandatory training in respect of doctor and consultant colleagues.

Run Chart



How do we compare

Compliance as at 31 December 2023 increased by 0.7% compared to 30 November 2023.

Recent Performance

The overall month-end compliance rates for mandatory training in recent months are set out below:

Area	Jul	Aug	Sep	Oct	Nov	Dec
% Compliance	92.0%	92.1%	92.1%	91.9%	91.4%	92.1%

Well Led

Career Conversations: We are committed ensuring that colleagues have timely and appropriate career reviews, at least annually, to outline all aspects of their role, to highlight and promote excellence and identify core or developmental training needs to enable colleagues to progress in their chosen careers.

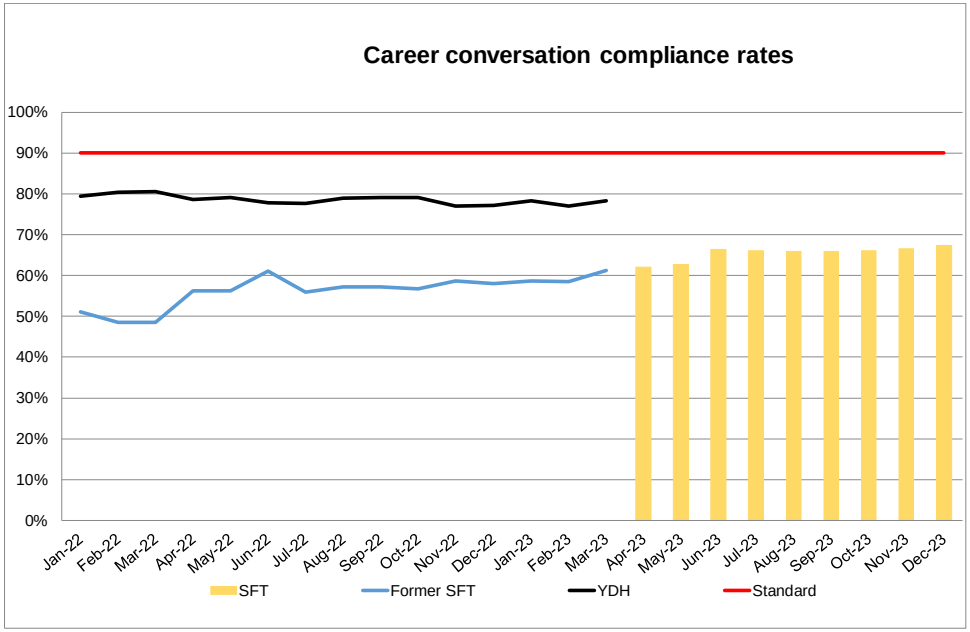
Current performance (including factors affecting this)

- Compliance as at 31 December 2023, in respect of career conversation reviews being undertaken at least annually, was 67.3%, up slightly from 66.6% as at 30 November 2023, but below the standard of 90%.
- Operational pressures continue to affect compliance along with legacy processes and systems which make it complex for managers to implement.

Focus of improvement work

- Plans for improvement are discussed with those service groups where performance is below expected levels, as part of the Quality, Outcomes, Finance and Performance (QOFP) meetings.
- The People Business Partner team undertook a review of issues affecting service group performance in this area and developed a Situation, Background, Assessment, Recommendation (SBAR) report. Further investigation into the system and approach is being undertaken.
- An improvement task and finish group was established to review and update policy. This was ratified in October 2023, and should enable improvements in reporting processes.

Run Chart



How do we compare

Compliance as at 31 December 2023 increased slightly compared to the position as at 30 November 2023.

Recent performance

The compliance rates in recent months were as follows:

Area	Jul	Aug	Sep	Oct	Nov	Dec
% compliance	66.1%	65.9%	65.9%	66.0%	66.6%	67.3%

Retention: We are committed to improving retention as a priority within our People Strategy, leading by example and being recognised for our success in retaining our talent. Our aim is to reduce the rate of colleagues leaving the Trust within 12 months of commencing employment.

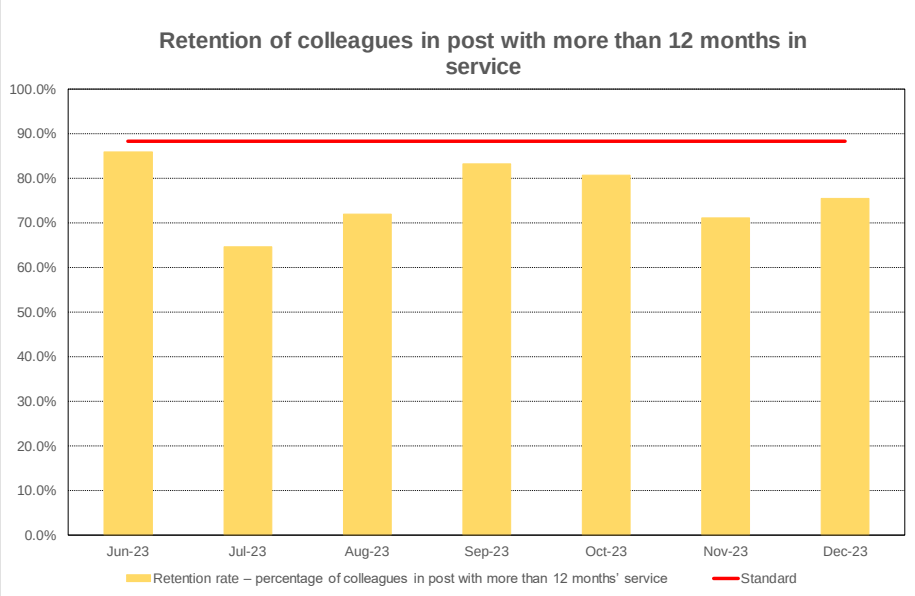
Current performance (including factors affecting this)

- Of 180 colleagues who had commenced employment on or after 1 January 2023, a total of 136 (75.5%) were still with the Trust as at 31 December 2023.
- Two areas were below the Trust average of 75.5% for December 2023. The Clinical Support and Cancer Services service group reported a rate of 68.4%, with 13 out of 19 colleagues being still in post after 12 months, although this is an improvement from a rate of 55.0% reported for November 2023. Corporate Services recorded a retention rate of 67.9% with 19 out of 28 colleagues remaining in post after 12 months.
- The highest rate reported was Mental Health and Learning Disabilities service group which had a retained rate of 85.7% of their new starters in the 12-month period.

Focus of improvement work

- Following the completion of a retention internal audit, the retention measure is being reviewed.
- The Allied Health Professional (AHP) and support to AHP leaver rates increased between April 2022 and July 2023 and these rates are higher than the national average. Work is underway to understand this trend and identify solutions across the Trust.
- Key areas of focus for the People Promise work include the local induction improvement project, stay conversation pilots, implementing legacy mentoring and developing a detailed flexible working improvement project.
- Retention is a key element of the People Strategy 2023 to 2028. A year-one deliverable focuses on implementing a talent management framework to support retention.

Trend Chart



How do we compare

The retention rate increased by 4.4% during December 2023 compared to November 2023.

Recent performance

The retention rates in recent months were as follows:

Area	Jul	Aug	Sep	Oct	Nov	Dec
Monthly rate	64.7%	72.0%	83.3%	80.8%	71.1%	75.5%

Well Led

Female colleagues in senior a role (band 8a and above and consultant roles): We are committed to providing a compassionate and inclusive environment where female colleagues in senior roles reflect the overall percentage of female colleagues employed within the Trust.

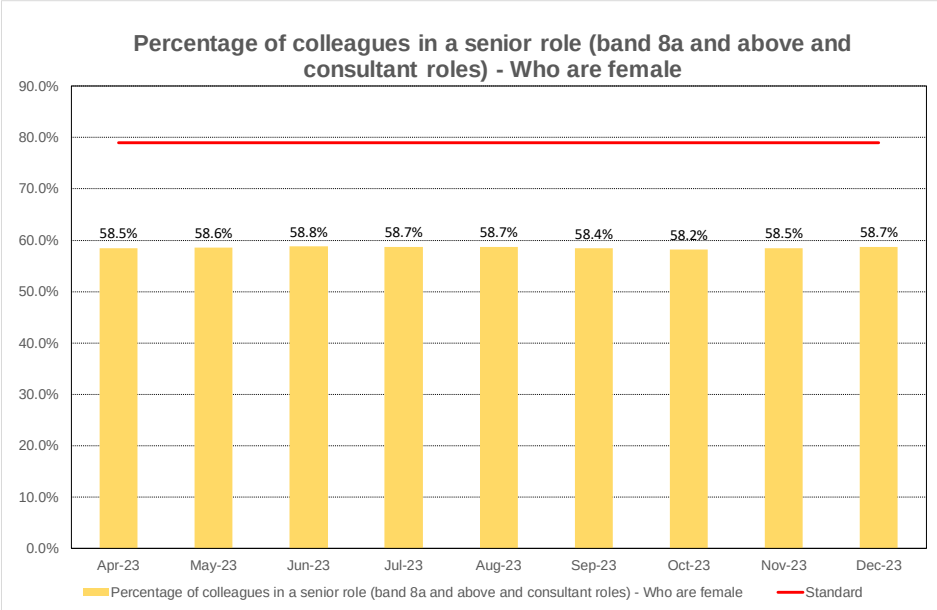
Current performance (including factors affecting this)

- Across Somerset NHS Foundation Trust as a whole, 79% of colleagues (excluding bank, locums and those on secondment) identify as female. Even though our organisation is female dominated, there is a lower representation of women in senior roles, which influences our organisational-wide pay gap.
- As at 31 December 2023, of 1,883 colleagues employed at Band 8a or above, a total of 1,106 identified as female, a rate of 58.7%. This is a slight increase from the rate reported as at 30 November 2023.
- Our mean gender pay gap is 20% (female colleagues on average paid less than male colleagues). When looking at role-type and pay bands, pay gaps within agenda for change bands are relatively low. However, there are much larger pay gaps within our medical and dental workforce.
- Analysis of the Clinical Excellence Awards identified inequalities in relation to race and gender, with women and BAME colleagues being less likely to apply and being awarded lower value awards.

Focus of improvement work

- Focus areas for action include improving the progression of female medical colleagues into consultant roles and female colleagues into senior roles.
- The inclusion workplan sets out a number of areas which will help improve our position in this area, for example there is specific focus on developing skills-based recruitment.
- Service groups with the greatest gap between their workforce and senior roles are:
    - Surgical Services
    - Medical Services
    - Clinical Support and Cancer Services

Run Chart



How do we compare

Nationally:

- 77% of the NHS workforce are women.
- 80% of Agenda for Change colleagues are women, 69% of bands 8a-9 are women.
- 45% of medical and dental colleagues are women, 37% of consultants are women, 53% of doctors in training are women.

Recent performance

Compliance over recent months were as follows:

Area	Jul	Aug	Sep	Oct	Nov	Dec
Monthly rate	58.7%	58.7%	58.4%	58.2%	58.5%	58.7%

Well Led

Colleagues recorded with a disability in senior a role (band 8a and above and consultant roles): We are committed to providing a compassionate and inclusive environment where colleagues in senior roles reflect the overall percentage of disabled colleagues employed within the Trust.

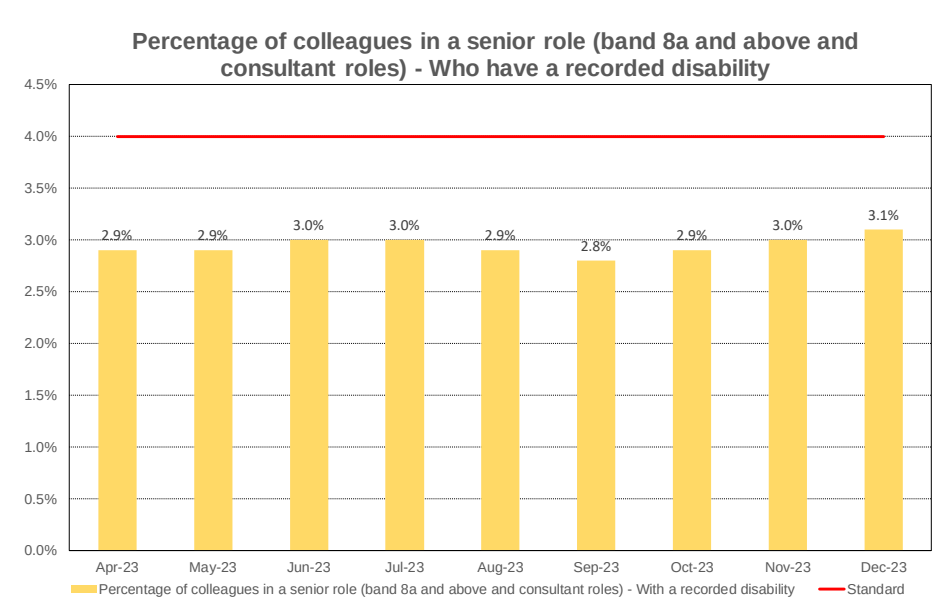
Current performance (including factors affecting this)

- Within Somerset NHS Foundation Trust, 4% of colleagues are recorded as having a disability.
- As at 31 December 2023, of 1,883 colleagues employed at Band 8a or above, a total of 58 (3.1%) were recorded as having a disability, up slightly from 30 November 2023. A total of 622 colleagues have no recorded disability status.
- Colleagues with a disability are under-represented when compared to the general population and under-represented at senior levels.
- Our data indicates that the proportion of colleagues who have not completed their data in ESR increases with seniority.

Focus of improvement work

- 20% of colleague records do not state whether or not they have a disability. Improving declaration rates will enable us to build a better picture of representation. Data relating to disability is missing for half of Board members. Board members are asked to update this information or seek support to update this.
- Included in the inclusion workplan and supported by a recent BDO audit are plans to progress as a Disability Confident Employer. This includes the development of a reasonable adjustment policy and supporting toolkits, which are ready to be launched.
- A review of the disability status by service group identifies the areas with the greatest difference in senior roles are:
  - Operational Management
  - Simply Serve Corporate
  - Mental Health & Learning Disabilities
- The People Business Partner will be working with the services to develop their improvement plan.

Run Chart



How do we compare

Nationally, 3.7% of the NHS workforce have declared a disability.
59% of trusts have five or fewer disabled staff in senior positions (bands 8c and above, including medical consultants and Board members).

Recent performance

Compliance over recent months were as follows:

Area	Jul	Aug	Sep	Oct	Nov	Dec
Monthly rate	3.0%	2.9%	2.8%	2.9%	3.0%	3.1%

Well Led

Vacancy: We are committed to recruiting and maintaining a strong workforce. Our aim is to reduce and maintain vacancy levels to 5% or less. The data outlined shows the difference between contracted full time equivalent (FTE) number of colleagues in post and our budgeted establishment.

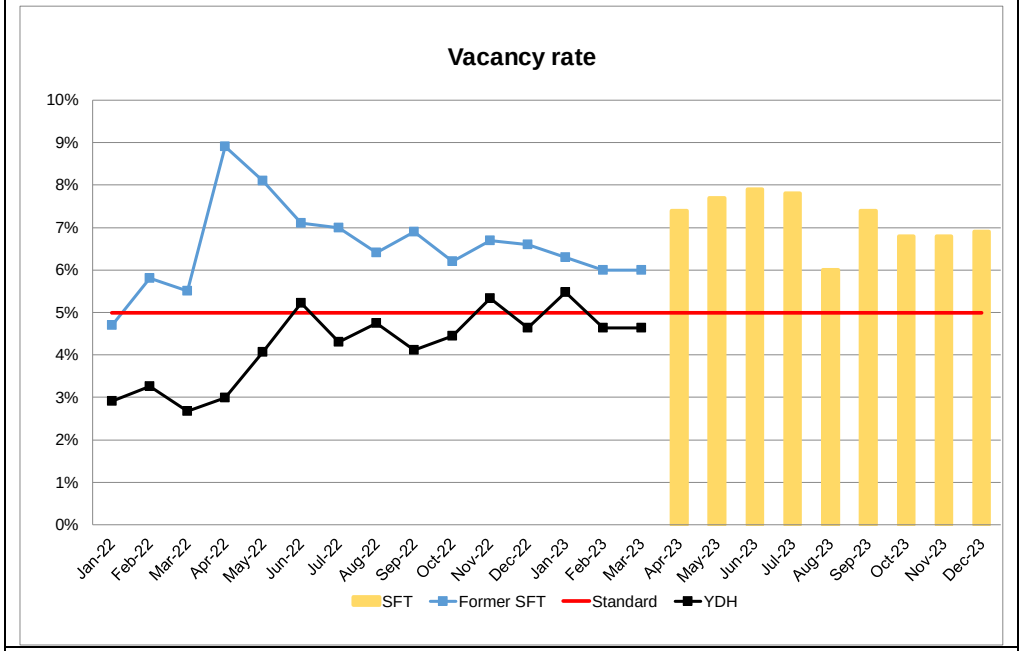
Current performance (including factors affecting this)

- The vacancy rate as at 31 December 2023 was 6.9%, up from 6.8% reported as at 30 November 2023.
- The areas with the greatest vacancy position are:
  - Simply Serve: 16.5%
  - Mental Health & Learning Disabilities: 12.5%
  - Estates and Facilities: 11.8%
- Across the Trust, medical and dental, Allied health professionals (AHPs), maintenance and a few specialist roles across Digital and People Services are particularly hard to recruit roles, affected by either national or local shortages.
- The surgical service group has a 1.1% vacancy rate. While positive, this equates to 27 roles, which are predominately hard to fill clinical roles.

Focus of improvement work

- Service groups continue to prioritise workforce plans for areas with hard to fill roles and identify solutions to reduce vacancy levels.
- Formation of talent pools (reservists, redeployment, SWAPs, and bank), adjustment of local recruitment processes to increase time to hire and reduce vacancies.
- The vacancy, retention and temporary staffing reduction meeting for nursing, support to nursing and AHP roles, meets monthly to drive improvements in these areas.
- The medical leadership team continues to focus on solutions to improve medical recruitment and workforce planning.

Run Chart



How do we compare

The vacancy rate within the Trust for December 2023 increased slightly when compared to November 2023.

Recent performance

The performance against the vacancy rate standard in recent months was as follows:

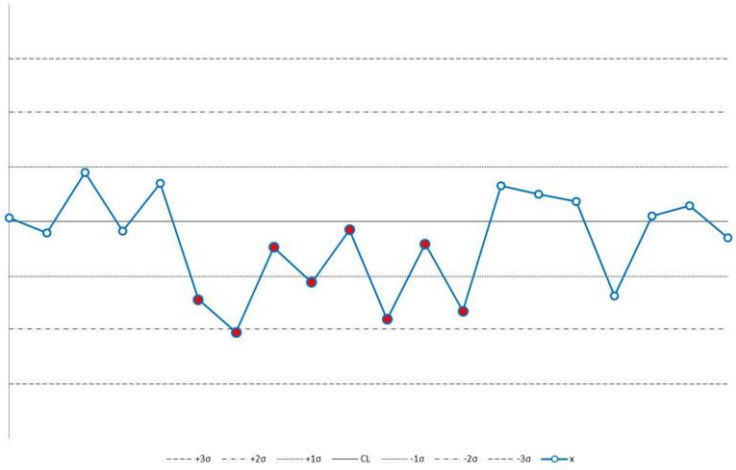
Dec	Jul	Aug	Sep	Oct	Nov	Dec
Vacancy rate	7.8%	6.0%	7.4%	6.8%	6.8%	6.9%

Appendix 1 - Procedure for Interpreting Run Charts

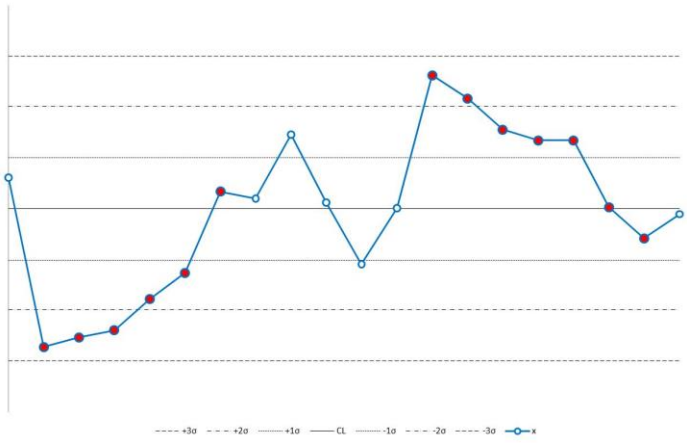
Special Cause Variation Rules

1. A single point outside the control limits

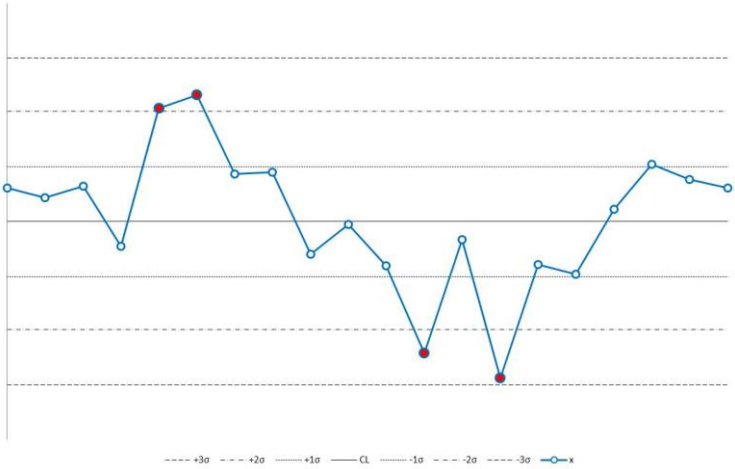
2. A run of eight or more points in a row above (or below) the centreline



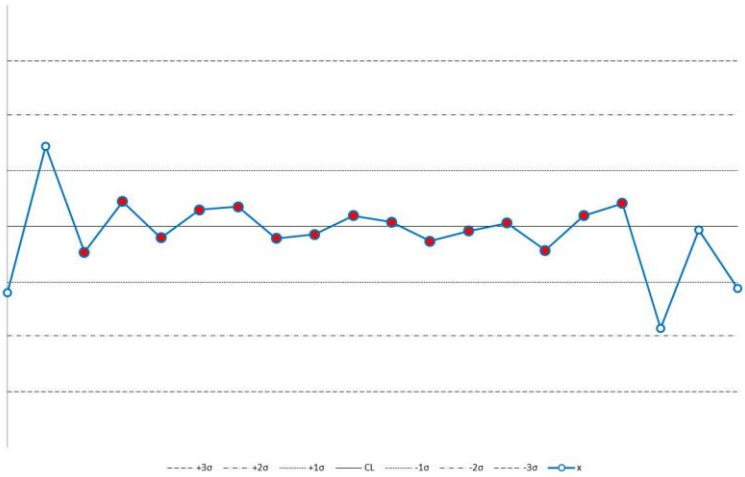
3. Six consecutive points increasing (trend up) or decreasing (trend down)



4. Two out of three consecutive points near (outer one-third) a control limit



5. Fifteen consecutive points close (inner one-third of the chart) to the centreline



APPENDIX 2

OUR CARE QUALITY COMMISSION RATINGS

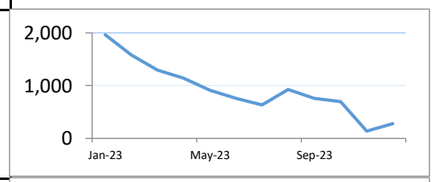
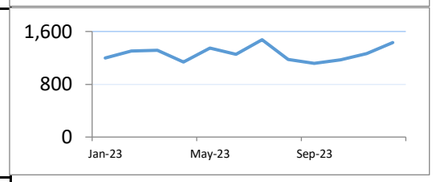
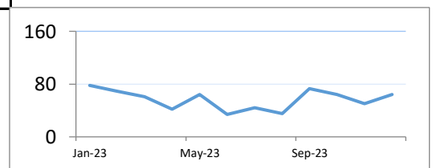
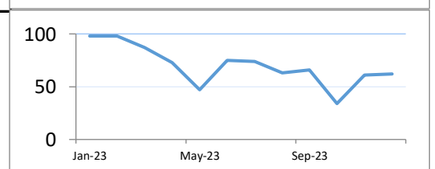
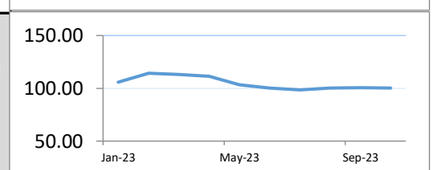
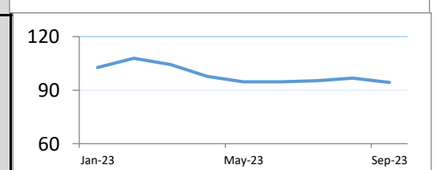
Our current Care Quality Commission ratings are as follows:

	Former Somerset NHS Foundation Trust	Yeovil District Hospital NHS Foundation Trust
Overall rating for the Trust	**Good**	**Good**

Are services safe?	**Requires improvement**	**Requires improvement**
Are services effective?	**Good**	**Good**
Are services caring?	**Outstanding**	**Good**
Are services responsive?	**Good**	**Good**
Are services well led?	**Good**	**Good**

SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	
Admissions	1	Number of medical and surgical outliers in acute wards	MPH	1,964	1,579	1,293	1,145	911	757	635	925	761	700	138	278	
	2		YDH	1,196	1,302	1,313	1,138	1,347	1,254	1,475	1,175	1,117	1,172	1,267	1,431	
	3	Admissions of under 16 year olds to adult mental health wards		0	0	0	0	0	0	0	0	0	0	0	0	
	4	Mixed sex accommodation breaches	Acute wards	0	0	0	0	0	0	0	0	0	0	0	0	
	5	Number of patients transferred between acute wards after 10pm	MPH	78	69	61	42	64	34	44	35	73	64	50	64	
	6		YDH	98	98	87	73	47	75	74	63	66	34	61	62	
Mortality (acute services)	7	Hospital Standardised Mortality Ratio (HSMR)		105.87	114.26	113.28	111.46	103.42	100.39	98.48	100.33	100.65	100.36	November 2023 to be reported after December 2023		
	8	Summary Hospital-level Mortality Indicator (SHMI)		102.66	107.88	104.43	97.81	94.61	94.65	95.32	96.64	94.34	October 2023 to be reported after December 2023			

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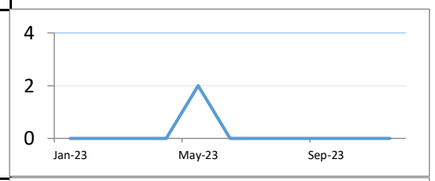
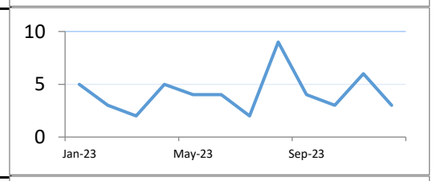
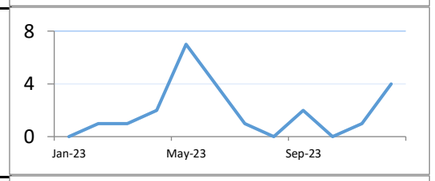
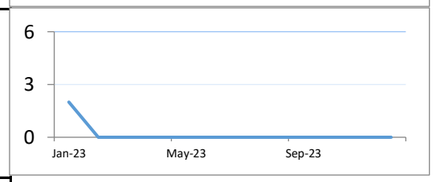
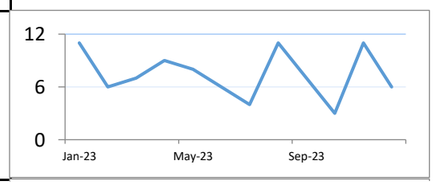
Area	Ref	Measure		Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	
Incident reporting	9	Number of Never Events		0	0	0	0	2	0	0	0	0	0	0	0	
Infection Control	10	Clostridium Difficile cases HOHA cases (Hospital Onset Hospital Acquired) and COHA cases (Community Onset Hospital Acquired)	MPH,	5	3	2	5	4	4	2	9	4	3	6	3	
	11		YDH	0	1	1	2	7	4	1	0	2	0	1	4	
	12		Community Hospitals and Mental Health wards	2	0	0	0	0	0	0	0	0	0	0	0	
	13		MPH,	0	0	0	0	1	0	0	1	0	0	0	0	
	14	MRSA bacteraemias (post)	YDH	0	0	0	0	0	0	0	0	0	0	0	0	
	15		Community Hospitals and Mental Health wards	0	0	1	0	0	0	0	0	0	0	0	0	
	16	E. coli bacteraemia	MPH,	11	6	7	9	8	6	4	11	7	3	11	6	

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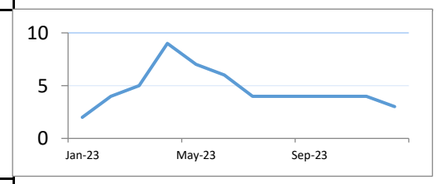
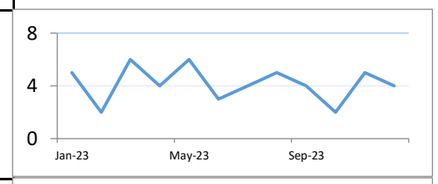
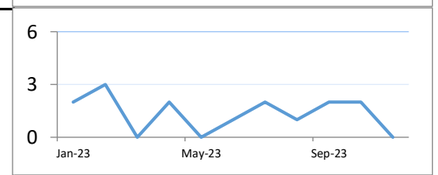
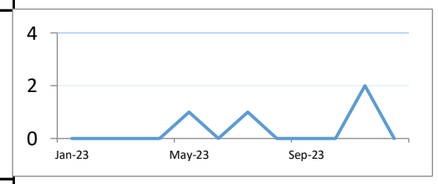
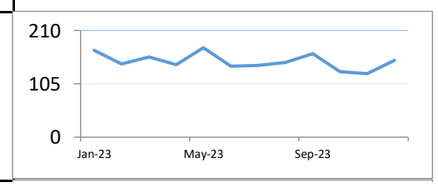
Area	Ref	Measure		Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	
Infection Control	17	E. coli bacteraemia	YDH	2	4	5	9	7	6	4	4	4	4	4	3	
	18		Community Hospitals and Mental Health wards	0	0	0	0	0	0	0	0	0	0	0	0	
	19	Methicillin-sensitive staphylococcus aureus	MPH,	5	2	6	4	6	3	4	5	4	2	5	4	
	20		YDH	2	3	0	2	0	1	2	1	2	2	0	1	
	21		Community Hospitals and Mental Health wards	0	0	0	0	0	0	0	0	0	0	0	0	
Maternity	22	No. of still births		0	0	0	0	1	0	1	0	0	0	2	0	
	23	No. of babies born in unexpectedly poor condition		0	0	0	0	0	0	0	0	0	0	0	0	
Falls	24	Total number of patient falls	MPH	171	144	158	143	176	140	141	147	164	129	125	151	

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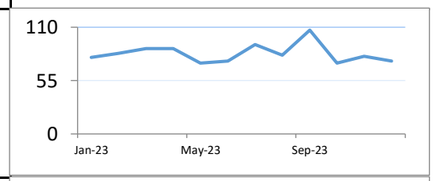
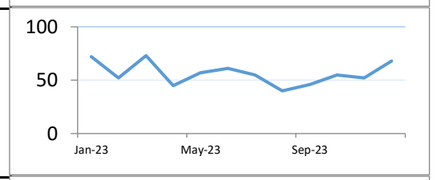
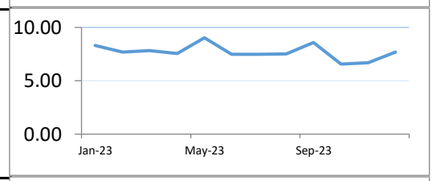
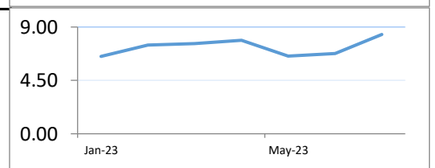
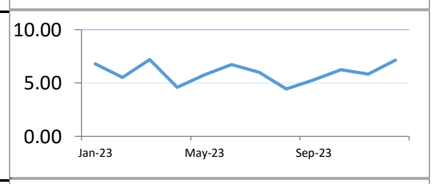
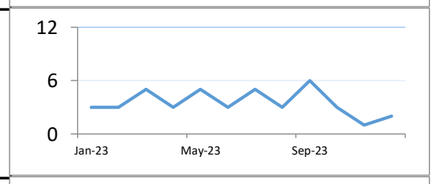
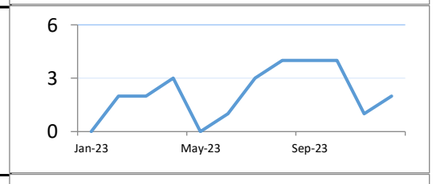
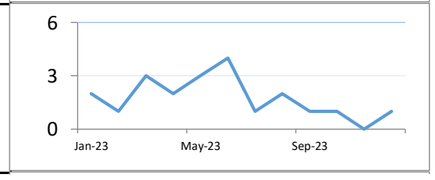
Area	Ref	Measure		Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	
Falls	25	Total number of patient falls	YDH	79	83	88	88	73	75	92	81	107	73	80	75	
	26		Community Hospitals and Mental Health wards	72	52	73	45	57	61	55	40	46	55	52	68	
	27	Rate of falls per 1,000 occupied bed days - all services	MPH	8.33	7.70	7.84	7.56	9.03	7.48	7.47	7.52	8.60	6.57	6.69	7.70	
	28	Rate of falls per 1,000 occupied bed days - all services	YDH	6.52	7.48	7.60	7.88	6.55	6.77	8.37	7.59	9.97	6.45	7.11	6.45	
	29		Community Hospitals and Mental Health wards	6.80	5.53	7.20	4.60	5.78	6.72	5.99	4.44	5.29	6.24	5.84	7.15	
	30	Moderate Harm - Number of falls resulting in moderate harm - all services	MPH	3	3	5	3	5	3	5	3	6	3	1	2	
	31	Moderate Harm - Number of falls resulting in moderate harm - all services	YDH	0	2	2	3	0	1	3	4	4	4	1	2	
	32	Moderate Harm - Number of falls resulting in moderate harm - all services	Community Hospitals and Mental Health wards	2	1	3	2	3	4	1	2	1	1	0	1	

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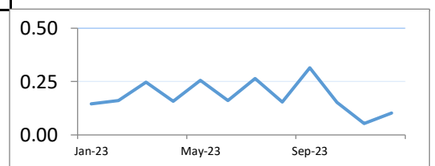
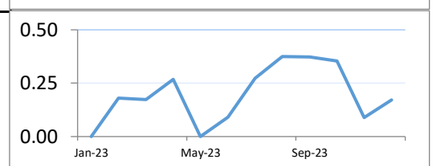
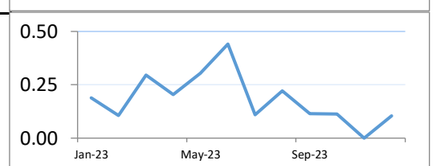
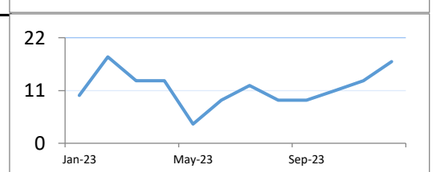
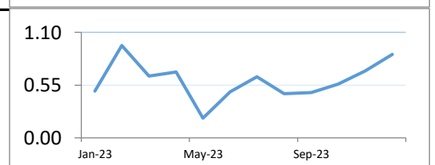
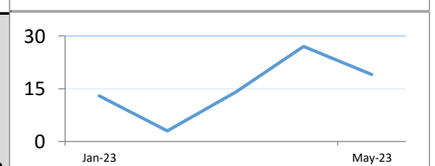
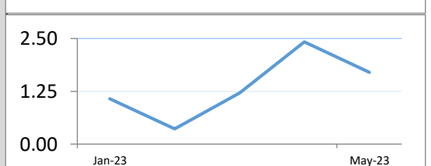
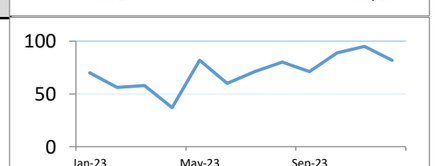
Area	Ref	Measure		Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	
Falls	33	Moderate Harm - Rate of falls resulting in moderate harm per 1,000 occupied bed days - all services	MPH	0.15	0.16	0.25	0.16	0.26	0.16	0.27	0.15	0.31	0.15	0.05	0.10	
	34		YDH	0.00	0.18	0.17	0.27	0.00	0.09	0.27	0.37	0.37	0.35	0.09	0.17	
	35	Moderate Harm - Rate of falls resulting in moderate harm per 1,000 occupied bed days - all services	Community Hospitals and Mental Health wards	0.19	0.11	0.30	0.20	0.30	0.44	0.11	0.22	0.11	0.11	0.00	0.11	
Pressure ulcer damage	36	Acute wards - number of incidents	MPH	10	18	13	13	4	9	12	9	9	11	13	17	
	37	Rate of pressure ulcer damage per 1,000 acute ward occupied bed days	MPH	0.49	0.96	0.64	0.69	0.21	0.48	0.64	0.46	0.47	0.56	0.70	0.87	
	38	Acute wards - number of incidents	YDH	13	3	14	27	19	Reported incidents are being reviewed by the Tissue Viability lead to ensure reported numbers are robust.							
	39	Rate of pressure ulcer damage per 1,000 acute ward occupied bed days	YDH	1.07	0.36	1.21	2.42	1.70								
	40	Community hospitals - number of incidents		70	56	58	37	82	60	71	80	71	89	95	82	

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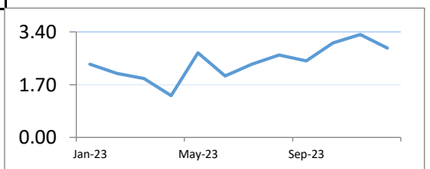
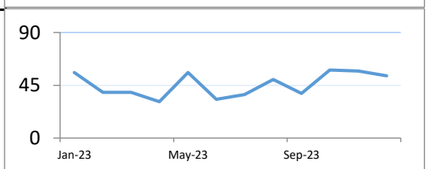
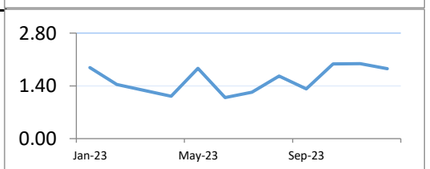
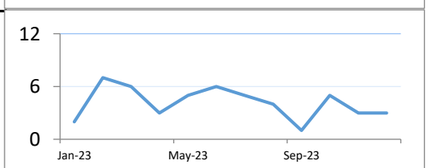
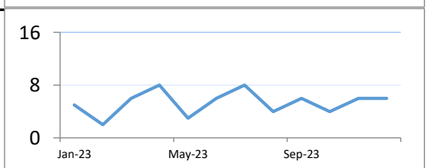
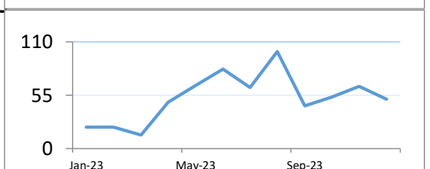
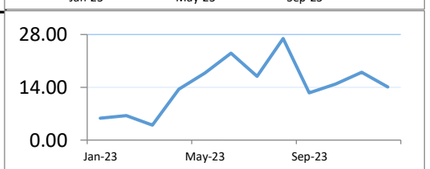
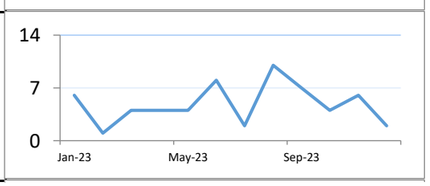
Area	Ref	Measure		Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	
Pre	41	Rate of pressure ulcer damage per 1,000 community hospital occupied bed days		2.36	2.06	1.90	1.35	2.73	1.98	2.36	2.65	2.47	3.04	3.31	2.88	
	42	District nursing - number of incidents		56	39	39	31	56	33	37	50	38	58	57	53	
	43	Rate of pressure ulcer damage per 1,000 district nursing contacts		1.89	1.44	1.28	1.13	1.87	1.09	1.23	1.66	1.32	1.98	1.99	1.86	
Cardiac Arrests	44	No. ward-based cardiac arrests - acute wards	MPH	2	7	6	3	5	6	5	4	1	5	3	3	
	45		YDH	5	2	6	8	3	6	8	4	6	4	6	6	
Restraints (mental health wards)	46	Total number of incidents	Mental Health Wards	22	22	14	48	65	82	63	100	44	53	64	51	
	47	Restraints per 1,000 occupied bed days	Mental Health Wards	5.77	6.49	3.97	13.51	17.77	23.05	16.94	26.94	12.57	14.84	18.03	14.11	
	48	Number of prone restraints	Mental Health Wards	6	1	4	4	4	8	2	10	7	4	6	2	

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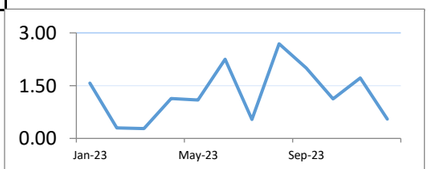
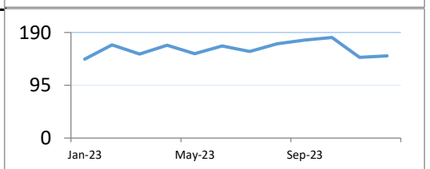
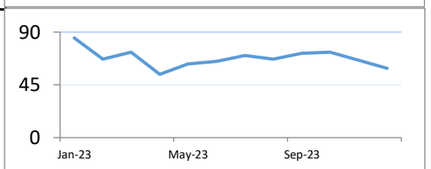
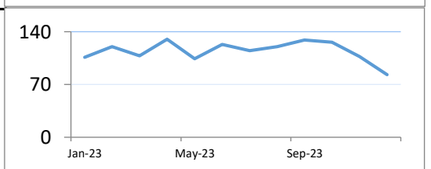
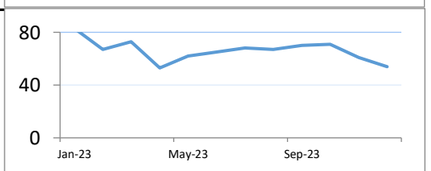
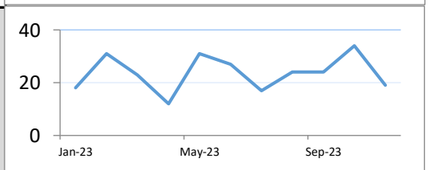
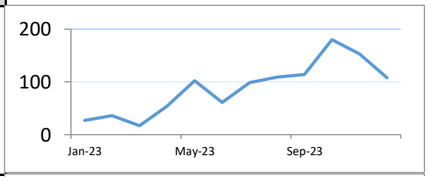
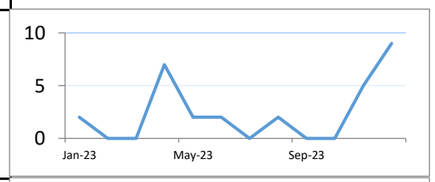
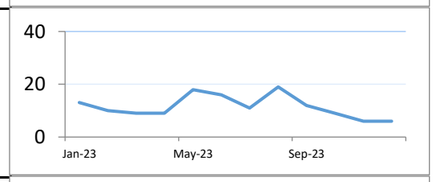
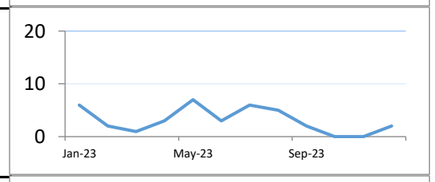
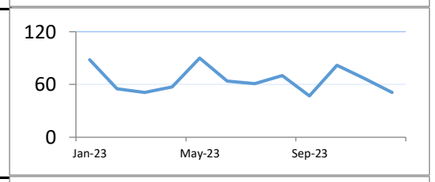
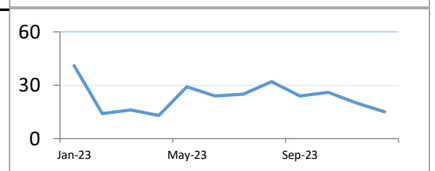
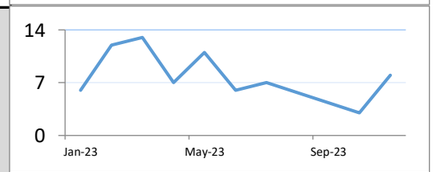
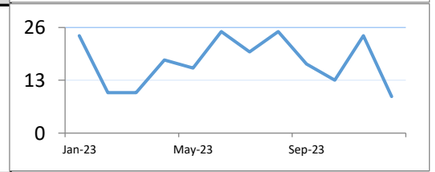
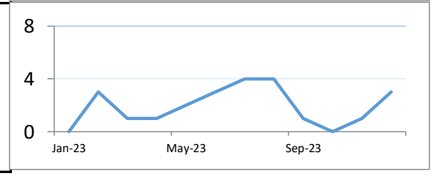
QUALITY MEASURES - 2023/24

Area	Ref	Measure		Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	
	49	Prone restraints per 1,000 occupied bed days	Mental Health Wards	1.57	0.30	0.28	1.13	1.09	2.25	0.54	2.69	2.00	1.12	1.72	0.55	
Medication incidents	50	Total number of medication incidents	MPH, Community Hospitals and Mental Health wards	142	168	151	167	152	166	156	170	176	181	145	148	
	51		YDH	85	67	73	54	63	65	70	67	72	73	66	59	
	52	Medication incidents - drug errors	MPH, Community Hospitals and Mental Health wards	106	120	108	130	104	123	115	120	129	126	107	83	
	53	Medication incidents - drug errors	YDH	83	67	73	53	62	65	68	67	70	71	61	54	
	54	Medication incidents - incorrect storage	MPH, Community Hospitals and Mental Health wards	18	31	23	12	31	27	17	24	24	34	19	Data awaited	
Medication incidents	55	Medication incidents - incorrect storage	YDH	This data category is not captured within Ulysses, the current YDH incident reporting system.												
Ligatures and ligature points	56	Ligatures: Total number of incidents	Mental Health Wards	27	36	17	54	102	61	99	109	114	180	153	108	

SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2023/24

Area	Ref	Measure		Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	
Ligatures and ligature points	57	Number of ligature point incidents	Mental Health Wards	2	0	0	7	2	2	0	2	0	0	5	9	
Violence and Aggression	58	Violence and Aggression: Number of incidents patient on patient (inpatients only)	MPH, Community Hospitals and Mental Health wards	13	10	9	9	18	16	11	19	12	9	6	6	
	59	Violence and Aggression: Incidents resulting in harm - patient on patient (inpatient only)	MPH, Community Hospitals and Mental Health wards	6	2	1	3	7	3	6	5	2	0	0	2	
	60	Violence and Aggression: Number of incidents patient on staff	MPH, Community Hospitals and Mental Health wards	88	55	51	57	90	64	61	70	47	82	67	51	
	61	Violence and Aggression: Incidents resulting in harm - patient on staff	MPH, Community Hospitals and Mental Health wards	41	14	16	13	29	24	25	32	24	26	20	15	
Unexpected deaths	62	Unexpected Deaths: Total number of incidents to be investigated	Community and mental health services	6	12	13	7	11	6	7	8	3	3	8	Data awaited	
Seclusion	63	Number of Type 1 - Traditional Seclusion	Mental Health Wards	24	10	10	18	16	25	20	25	17	13	24	9	
Seclusion	64	Number of Type 2 -Short term Segregation	Mental Health Wards	0	3	1	1	2	3	4	4	1	0	1	3	

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Thresholds
1	Accident and Emergency / Minor Injury Unit 4-hour performance	Accident & Emergency department (ED) - MPH	4, 6, 9	54.2%	52.1%	55.4%	58.8%	55.6%	54.0%	66.0%	51.0%	48.0%	51.4%	55.5%	54.0%	From April 2023 >=76%= Green >=66% - <76% =Amber <66% =Red
2		Accident & Emergency department (ED) - YDH		68.2%	65.0%	70.3%	74.1%	77.7%	64.3%	67.2%	73.3%	67.3%	66.6%	62.8%	62.6%	
3		Accident & Emergency department (ED) - Combined		60.5%	58.0%	62.0%	65.6%	65.4%	58.7%	66.5%	60.6%	56.4%	58.1%	58.7%	57.8%	
4		Minor Injury Units		96.3%	96.8%	96.7%	98.1%	97.1%	96.9%	96.9%	97.5%	95.1%	96.9%	97.4%	96.3%	
5		Trust-wide		75.2%	74.0%	76.3%	79.3%	78.7%	75.1%	79.2%	76.0%	72.5%	74.1%	74.3%	73.3%	
6	Accident and Emergency / Minor Injury Units: percentage of patients spending more than 12-hours in the department	Accident and Emergency department (ED) - MPH	4, 6, 9	7.1%	5.3%	2.6%	2.3%	2.1%	1.8%	0.7%	2.9%	4.7%	2.4%	1.7%	4.8%	<=2%= Green >2% - <=5% =Amber >5% =Red
7		Accident and Emergency department (ED) - YDH		7.5%	6.2%	4.4%	3.3%	1.1%	3.4%	3.6%	1.6%	3.2%	3.3%	4.1%	5.9%	
8		Minor Injury Units		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
9	Ambulance handovers waiting less than 30 minutes - Emergency Department only (MPH)		4, 6, 9	71.6%	73.5%	76.9%	80.2%	79.0%	81.8%	86.2%	70.5%	63.1%	68.6%	73.8%	64.1%	>=95%= Green >=85% - <95% =Amber <85% =Red
	Ambulance handovers waiting less than 30 minutes - Emergency Department only (YDH)			76.7%	75.1%	80.6%	82.3%	86.6%	77.9%	80.8%	88.0%	80.8%	75.8%	69.0%	69.7%	
11	Cancer - 28 days Faster Diagnosis All Cancers			61.1%	67.1%	68.6%	73.6%	70.6%	72.0%	79.4%	78.8%	76.0%	77.0%	76.9%	Data awaited	>=75%= Green <75% =Red
12	31 day wait - from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment			New reporting			89.7%	88.0%	92.7%	93.0%	90.9%	92.9%	91.3%	93.7%	Data awaited	>=96%= Green <96% =Red
13	Cancer - 62 day wait - from an Urgent Suspected Cancer or Breast Symptomatic Referral, or Urgent Screening Referral, or Consultant Upgrade to a First Definitive Treatment						73.8%	67.0%	68.8%	74.2%	71.7%	71.3%	68.8%	67.1%	Data awaited	>=85%= Green <85% =Red
14	Cancer: 62-day wait from referral to treatment for urgent GP referrals – number of patients treated on or after day 104			20	29	20	14	23	22	26	22	28	22.5	23	Data awaited	0= Green >0 = Red
15	CAMHS Eating Disorders - Urgent referrals to be seen within 1 week - (rolling 3 months)		3, 4, 9	Reporting change from a rolling 12 months to a rolling 3 month period						100.0%	100.0%	-	-	-	-	>=95%= Green >=85% - <95% =Amber <85% =Red
16	CAMHS Eating Disorders - Routine referrals to be seen within 4 weeks - (rolling 3 months)		3, 4, 9							100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>=95%= Green >=85% - <95% =Amber <85% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Thresholds
17	Mental health referrals offered first appointments within 6 weeks	All mental health services	4, 6, 9	91.3%	94.6%	94.4%	88.2%	90.0%	93.6%	93.2%	92.8%	92.5%	90.0%	93.9%	93.6%	>=90%= Green >=80% - <90% =Amber <80% =Red
18	Mental health referrals offered first appointments within 6 weeks	Adult mental health services		90.2%	92.7%	94.0%	89.6%	92.4%	94.5%	95.2%	90.4%	93.7%	91.6%	92.2%	93.9%	>=90%= Green >=80% - <90% =Amber <80% =Red
19		Older Persons mental health services		91.1%	95.2%	94.4%	86.5%	87.2%	92.0%	91.2%	94.0%	89.0%	87.5%	95.3%	93.0%	
20		Learning disabilities service		92.3%	100.0%	92.9%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	87.5%	
21		Children and young people's mental health services		95.1%	96.5%	95.4%	93.6%	95.1%	95.4%	93.2%	96.9%	100.0%	92.0%	96.6%	94.7%	
22	Percentage of women accessing specialist community Perinatal MH service - 12 month rolling reporting		4, 6, 9	8.2%	8.4%	8.6%	9.0%	9.4%	9.5%	9.9%	10.5%	11.0%	11.1%	11.7%	11.6%	>=10%= Green >=7.5% - <10% =Amber <7.5% =Red
23	Diagnostic 6-week wait - acute services	MPH	4, 9	82.9%	86.9%	87.5%	87.3%	87.4%	91.8%	87.9%	84.8%	84.6%	84.7%	85.4%	83.1%	From April 2023 >=95%= Green >=90% - <95% =Amber <90% =Red
		YDH		61.6%	64.7%	66.1%	56.9%	60.7%	60.1%	56.0%	61.2%	55.0%	59.6%	63.6%	61.3%	
		Combined		75.4%	79.1%	79.5%	76.8%	77.2%	79.7%	77.1%	76.9%	74.4%	76.2%	77.6%	74.3%	
24	RTT incomplete pathway performance: percentage of people waiting under 18 weeks		4, 6, 9	60.9%	61.1%	61.1%	60.6%	61.3%	61.7%	61.5%	61.8%	61.6%	62.9%	63.4%	61.7%	>=92%= Green <92% =Red
25	40 week RTT breaches			5,036	5,015	4,975	5,359	5,524	5,409	5,430	5,748	5,701	5,542	5,688	6,301	TBC
26	52 week RTT breaches			2,298	2,216	2,187	2,247	2,340	2,396	2,375	2,419	2,504	2,547	2,577	2,519	From April 2023 At or below trajectory = Green Above trajectory = Red
27	65 week RTT breaches			New reporting			714	710	712	659	724	741	687	662	725	
28	78 week RTT breaches		4, 6, 9	252	179	68	84	87	61	49	66	70	55	49	61	From April 2023 At or below trajectory = Green Above trajectory = Red
29	Referral to Treatment (RTT) incomplete pathway waiting list size			51,244	51,542	52,869	53,351	53,856	54,319	55,037	54,986	55,532	54,777	53,406	53,667	

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Thresholds
30	Average length of stay of patients on wards (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).	MPH	4, 9	7.2	6.8	6.2	6.5	6.2	6.1	5.9	6.0	6.4	6.5	6.1	6.1	Monitored using Special Cause Variation Rules. Report by exception.
31		YDH		8.6	7.8	7.9	7.3	6.5	6.7	6.4	6.4	6.4	6.3	6.1	6.8	
32	Patients not meeting the criteria to reside: % of occupied bed days lost	MPH	4, 9	19.6%	19.8%	19.1%	21.9%	16.7%	15.1%	17.2%	16.5%	20.3%	18.1%	17.1%	15.9%	SPC (Upper Control Limit 25.1%)
33		YDH		23.0%	25.0%	23.2%	20.5%	21.1%	21.1%	22.1%	23.7%	23.3%	22.1%	21.0%	24.5%	SPC (Upper Control Limit 28.1%)
34	Acute bed days lost due to patients not meeting the criteria to reside	MPH	4, 6, 9	3,735	3,392	3,484	3,682	2,954	2,588	2,947	2,942	3,432	3,134	2,819	2,807	TBC
35		YDH		2,785	2,775	2,751	2,293	2,359	2,333	2,476	2,565	2,569	2,519	2,394	2,844	
36	Waiting times: number of people waiting over 18 weeks from referral to first appointment - community services including dental		4, 6, 9	4,056	4,002	4,065	4,023	4,052	4,013	3,918	3,862	3,717	3,498	3,518	3,491	From April 2023 <4,065 = Green >=4065 = Red
37	52 week RTT breaches			New reporting			1,455	1,442	1,319	1,146	863	785	712	747	758	From April 2023 At or below trajectory = Green Above trajectory = Red
38	65 week RTT breaches						887	930	840	642	440	392	371	386	402	
39	78 week RTT breaches						514	565	466	335	223	220	184	209	205	
40	Community dental services - Child GA waiters waiting 18 weeks or more		4, 6, 9	356	370	463	499	524	527	538	557	565	554	581	587	From April 2023 <463 = Green >=463 = Red
41	Early Intervention In Psychosis: people to begin treatment with a NICE-recommended care package within 2 weeks of referral (rolling three month rate)		4, 6, 9	60.9%	68.8%	83.3%	88.2%	82.4%	83.3%	81.3%	83.3%	82.4%	84.6%	85.7%	83.3%	>=60%= Green <60% =Red
42	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) RTT : percentage of people waiting under 6 weeks		4, 6, 9	61.1%	60.9%	67.2%	65.9%	68.2%	70.3%	73.7%	74.6%	72.4%	77.7%	77.8%	82.7%	>=75%= Green <75% =Red
43	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) RTT: percentage of people waiting under 18 weeks		4, 6, 9	98.5%	97.6%	98.9%	98.0%	98.5%	99.1%	99.0%	99.0%	99.5%	98.9%	99.6%	98.2%	>=95%= Green <95% =Red
44	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) Recovery Rates		4, 7, 9	62.1%	59.2%	64.3%	60.2%	59.8%	58.1%	59.9%	60.6%	55.5%	58.3%	59.1%	59.6%	>=50%= Green <50% =Red
45	Adult mental health inpatients receiving a follow up within 72 hrs of discharge		4, 9	93.9%	90.3%	100.0%	97.8%	100.0%	97.3%	100.0%	96.2%	96.9%	100.0%	97.0%	100.0%	>=80%= Green <80% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Thresholds
46	Inappropriate Out of Area Placements for non-specialist mental health inpatient care (monthly number of patient days)		4, 5, 9	27	0	34	78	67	57	14	0	0	10	10	34	0= Green >0 = Red
47	Intermediate Care - Patients aged 65+ discharged home from acute hospital beds on pathway 0 or 1		4, 5, 9	92.8%	92.0%	92.6%	93.3%	93.2%	94.9%	95.1%	95.7%	93.8%	93.3%	93.3%	Data awaited	>=95%= Green >=85% - <95% =Amber <85% =Red
48	Urgent Community Response: percentage of patients seen within two hours		4, 5, 9	84.5%	79.0%	92.0%	94.3%	93.6%	90.9%	94.6%	92.3%	94.4%	93.8%	95.9%	Data awaited	>=70%= Green >=60% - <70% =Amber <60% =Red
49	% Stroke Patients direct admission to stroke ward in 4 hours	MPH	4, 6, 9	41.1%	32.6%	54.4%	46.7%	50.0%	48.9%	57.1%	54.6%	55.9%	54.6%	73.1%	Data awaited	>=90%= Green >=75% - <90% =Amber <75% =Red
50		YDH		34.3%	15.2%	32.1%	26.9%	40.0%	32.4%	25.0%	33.3%	23.3%	42.5%	24.2%	Data awaited	
51	Patients spending >90% of time in stroke unit - acute services	MPH	4, 6, 9	61.4%	59.6%	80.3%	68.1%	65.9%	65.2%	75.0%	68.9%	68.4%	84.8%	92.6%	Data awaited	>=80%= Green >=70% - <80% =Amber <70% =Red
52		YDH		62.9%	69.7%	57.1%	57.7%	60.0%	59.5%	56.2%	71.7%	56.7%	52.5%	54.5%	Data awaited	
53	Percentage of patients with a National Early Warning Score (NEWS) of 5 or more acted upon appropriately - The registered nurse should immediately inform the medical team caring for the patient	MPH, community hospitals and mental health wards	4, 9	Reporting criteria reviewed and updated.	67.2%		69.9%		75.8%		79.7%		89.8%		Bi-monthly reporting.	>=90%= Green >=80% - <90% =Amber <80% =Red
54	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services	MPH	4, 9	Due to capacity within the Governance Team required audits have been delayed. Testing of a reporting solution using electronic forms has now been completed by the Trust's Digital Team. Identified users of systems started to received training in the second week of September 2023 and reporting via this system is to commence by January 2024.												>=90%= Green >=49% - <90% =Amber <49% =Red
55	Percentage of emergency patients screened for sepsis - acute services	MPH		92.0%			98.0%			93.0%			89.5%			
56	Percentage of complaints responded to within 40 working days - Trust-wide	Former SFT	9	39.4%	37.5%	56.7%	51.5%	48.4%	51.5%	The review of this area of reporting has been completed. The intention is to commence reporting compliance for responses to complainants within an agreed time period, to be introduced from 1 April 2024						>=90%= Green >=75% - <90% =Amber >75% =Red
57		YDH		67.0%	100.0%	100.0%	100.0%	100.0%	100.0%							
58		Combined		New reporting			56.8%	52.9%	56.0%							
59	Mandatory training: percentage completed	Former SFT	1, 8, 9	91.1%	90.9%	90.5%	Post merger									All courses >=90%= Green Overall rate <80% =Red Any other position = Amber
60		YDH		85.6%	84.6%	84.5%										

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2023/24

No.	Description		Links to corporate objectives	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Thresholds
61	Mandatory training: percentage completed	Combined	1,8,9	New reporting			90.6%	91.3%	91.6%	92.0%	92.1%	92.1%	91.9%	91.4%	92.1%	
62	Proportion of days lost due to sickness		1,8,9	5.4%	5.0%	4.8%	4.2%	4.2%	4.2%	4.8%	4.8%	5.0%	5.3%	5.1%	4.7%	SPC
63	Sickness absence levels - rolling 12 month average (Trust-wide)		8, 9	5.8%	5.8%	5.6%	5.2%	5.1%	5.1%	4.9%	4.9%	5.0%	5.0%	5.0%	4.9%	SPC
64	Career conversations (12 months) - formerly 'Performance review (12-month)'		1,8,9	New reporting			62.1%	62.7%	66.4%	66.1%	65.9%	65.9%	66.0%	66.6%	67.3%	>=90%= Green >=80% - <90% =Amber <80% =Red
65	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)		8, 9				7.4%	7.7%	7.9%	7.8%	6.0%	7.4%	6.8%	6.8%	6.9%	<=5%= Green >5% to <=7.5% =Amber >7.5% =Red
66	Retention rate – percentage of colleagues in post with more than 12 months' service		8, 9				76.0%	74.4%	85.9%	64.7%	72.0%	83.3%	80.8%	71.1%	75.5%	>=88.3%= Green >=80% to <88.3% =Amber <80% =Red
67	Percentage of colleagues in a senior role (band 8a and above and consultant roles):	Who are of an ethnic minority	1,8,9				19.8%	19.8%	19.8%	19.5%	20.5%	20.3%	20.8%	20.9%	20.9%	>=17%= Green >=14% to <17% =Amber <14% =Red
68		Who are female	1,8,9				58.5%	58.6%	58.8%	58.7%	58.7%	58.4%	58.2%	58.5%	58.7%	>=79%= Green >=70% to <79% =Amber <70% =Red
69		With a recorded disability	1,8,9				2.9%	2.9%	3.0%	3.0%	2.9%	2.8%	2.9%	3.0%	3.1%	>=4%= Green >=2% to <4% =Amber <2% =Red
70	Number of formal HR case works (disciplinary, grievance and capability).		1,8,9	Reporting in respect of this new indicator was being developed									31	23	Data awaited	TBC

Appendix 5a – Specialty and tumour-site level performance

Table 1 – Performance against the RTT performance standard in December 2023, including the number of patients waiting over 18 weeks, the number of patients waiting over 52 weeks, and the average (mean) number of weeks patients have waited on the Trust's waiting list.

RTT specialty	Over 18-week waiters	Over 52-week waiters	Incomplete pathways	Incomplete pathways performance
General Surgery	645	87	1991	67.6%
Urology	1301	165	2930	55.6%
Trauma & Orthopaedics	3278	663	8289	60.5%
Ear, Nose & Throat (ENT)	2252	196	4868	53.7%
Ophthalmology	2293	290	5328	57.0%
Oral Surgery	1026	78	2344	56.2%
Plastic Surgery	91	17	213	57.3%
Cardiothoracic Surgery	16	1	31	48.4%
General Medicine	2		21	90.5%
Gastroenterology	763	32	2024	62.3%
Cardiology	513	2	3191	83.9%
Dermatology	261	4	1904	86.3%
Thoracic Medicine	771	3	1994	61.3%
Neurology	656	5	1687	61.1%
Rheumatology	449	21	1112	59.6%
Geriatric Medicine	99	3	548	81.9%
Gynaecology	1387	149	3672	62.2%
Other – Medical Services	1091	244	2706	59.7%
Other - Paediatric Services	617	18	1635	62.3%
Other - Surgical Services	2638	492	6112	56.8%
Other – Other Services	393	49	1067	63.2%
Total	**20542**	**2519**	**53667**	**61.7%**

Table 2 – Performance against the 62-day GP cancer standard in November 2023.

Tumour site	No of breaches	Trust performance
Breast	9.0	82.7%
Colorectal	19.0	56.8%
Gynaecology	7.0	58.8%
Haematology	5.0	73.7%
Head & Neck	2.5	70.6%
Lung	9.5	58.7%
Other	1.0	75.0%
Skin	15.0	79.7%
Upper GI	5.0	64.3%
Urology	38.5	53.9%
Total	**111.5**	**67.1%**

Twenty-three patients were treated in November on or after day 104 (the national 'backstop' for GP pathways). Eighteen patients were assessed as having unavoidable delays. A breakdown of the breaches is as follows:

- Nine patient pathways had internal delays, which in some cases resulted in a late transfer to the treating provider. But these pathways also had unavoidable delays, as a result of waiting times being longer than ideal for investigations and appointments at other providers. There were also periods of patient choice and medical deferral for some patients.
- Six patients had a complex pathway, including patients requiring additional or repeat diagnostics, transferring from a different cancer pathway and being treated at the same time for another cancer.
- Five patient pathways were mainly delayed due to our internal capacity.
- Two patients chose to delay their investigations and treatment planning for a significant period of time.
- One patient pathway was delayed for medical reasons (i.e., needing time to recover from surgery before having their cancer investigations).

Appendix 2 – RTT validation progress

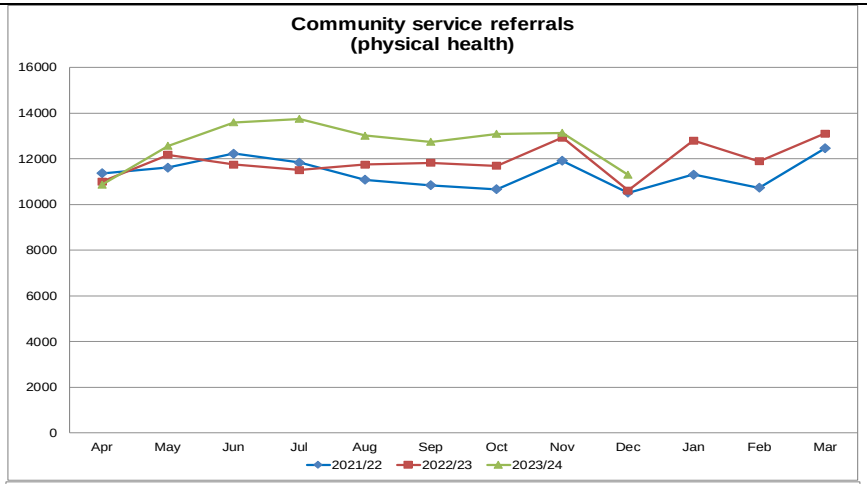
The national target is to reach a level of 90% validation of patients waiting 12 weeks and over from Referral to Treatment (RTT) by the 31st of October 2023. Validation includes both the administrative/technical validation and also contacting the patient to confirm they still wish to be seen.

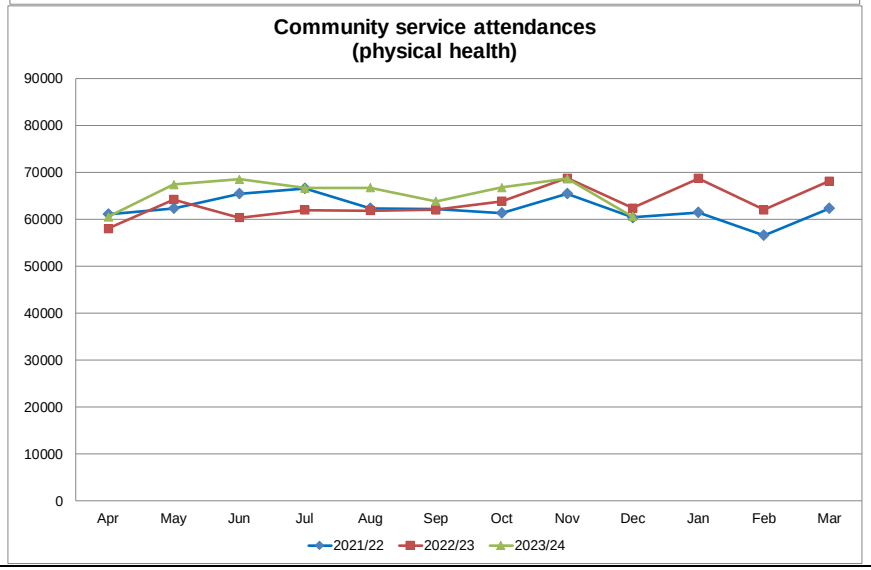
RTT waiting times bands	Week ending 10th September	Week ending 8th October	Week ending 12th November	Week ending 17th December	Week ending 14th January
12 weeks and over	34%	44%	63%	69%	70%
26 weeks and over	54%	57%	72%	76%	73%
52 weeks and over	85%	90%	92%	89%	89%

Please note, that across the remainder of quarter 4, a significant cohort of patients will be contacted, which were found to have been incorrectly excluded from our contacts list. The exact numbers are still being worked through, but we are expecting this to take performance for the 12 weeks and over cohort, to in excess of 80% by the end of March.

Operational context

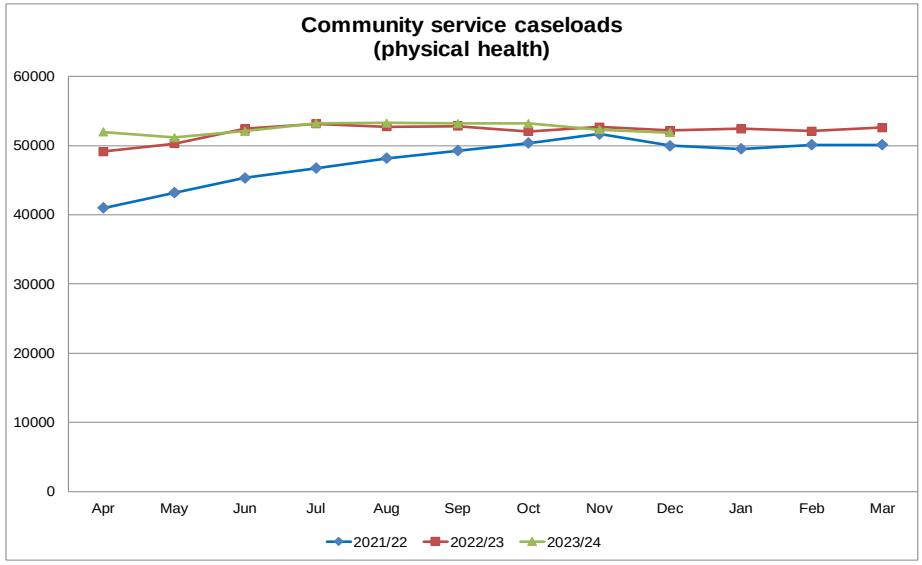
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





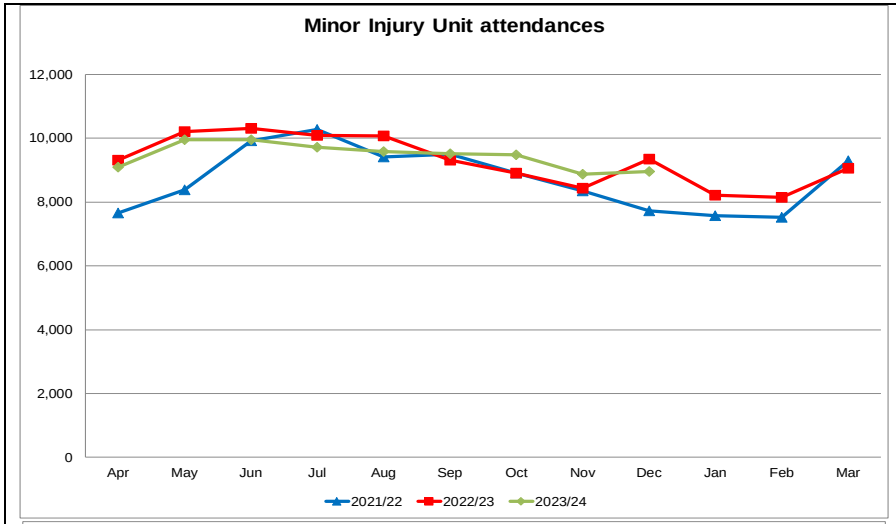
Summary:

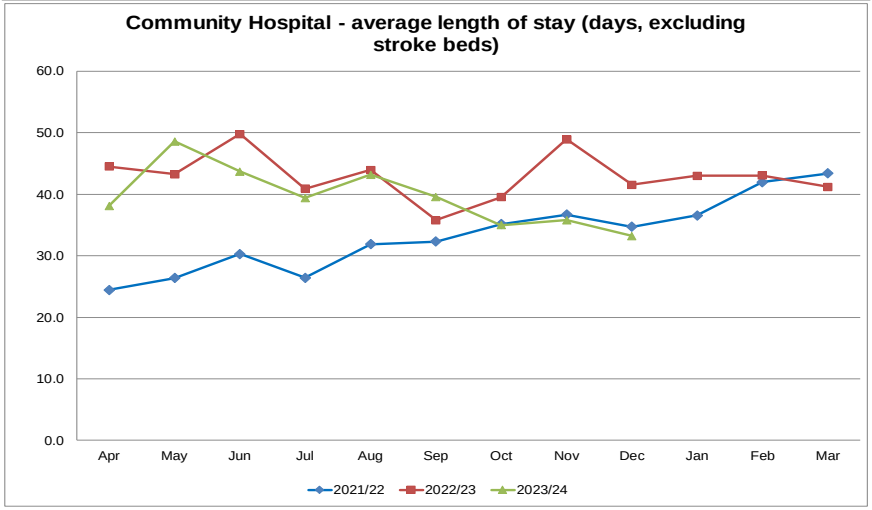
- Direct referrals to our community physical health services between 1 April and 31 December 2023 were 8.4% higher than the same months of 2022 and 11.8% higher than in the same months of 2021.
- Attendances for the same period were 4.7% higher than the same months of 2022 and 3.9% higher than the same months of 2021.
- Community service caseload levels as at 31 December 2023 were 0.6% lower than as at 31 December 2022, but 3.9% above 31 December 2021 levels.



Operational context

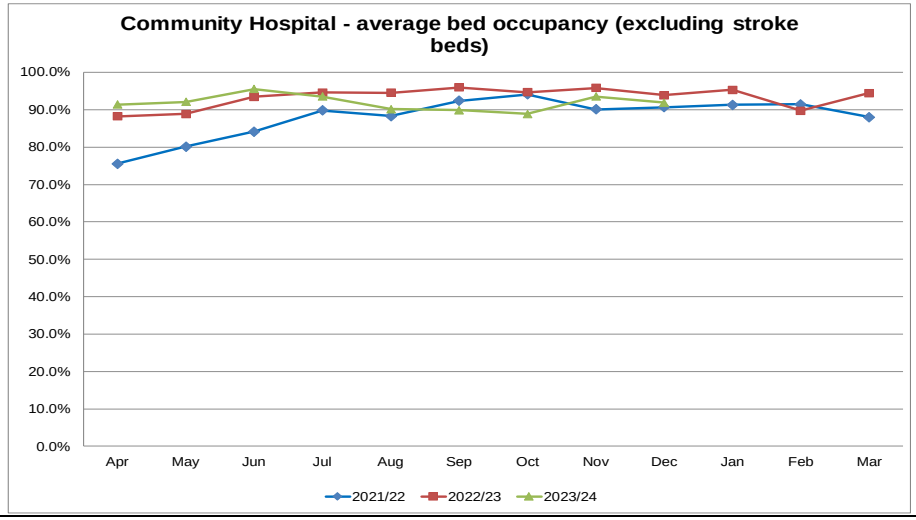
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





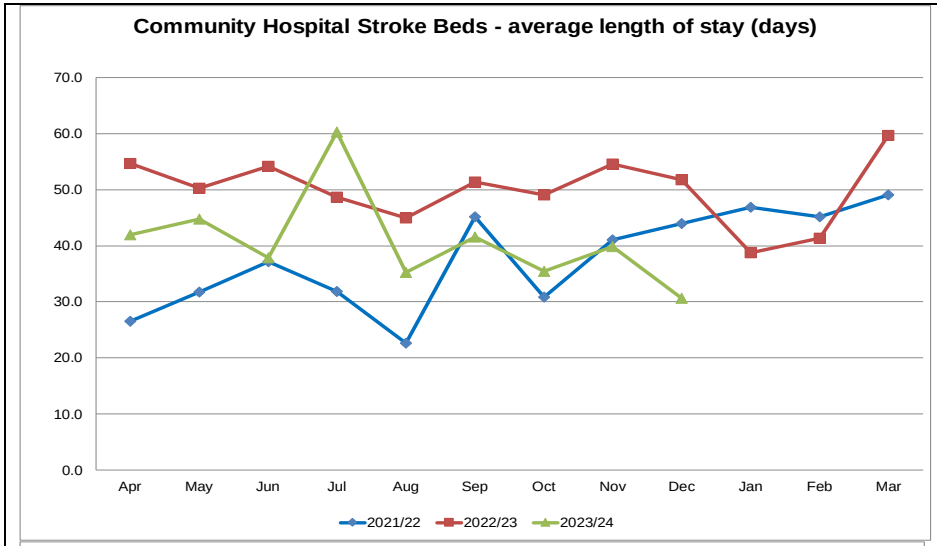
Summary:

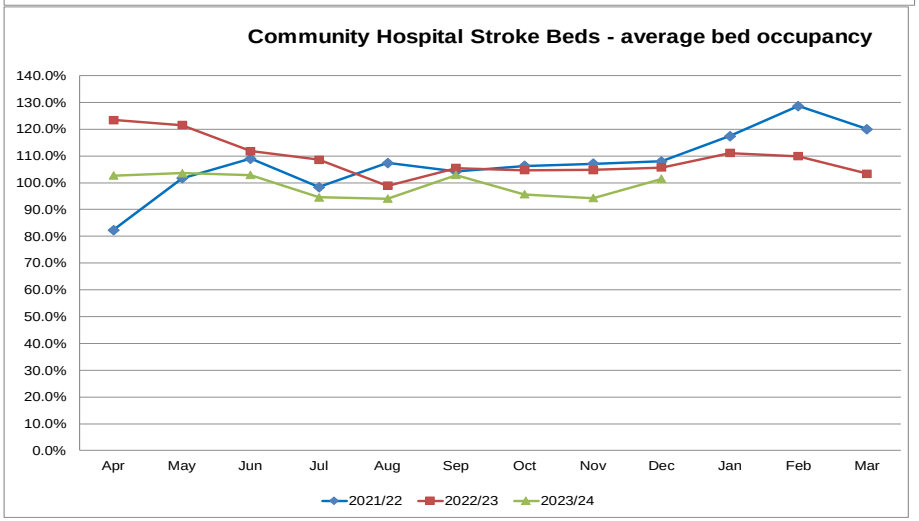
- Between 1 April and 31 December 2023, the number of Minor Injury Unit attendances was 1.0% lower than the same months of 2022/23, but 6.3% higher than same months of 2021/22. During December 2023, 96.3% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 76%, to be achieved by March 2024.
- The average length of stay for non-stroke patients in our community hospitals in December 2023 was 33.2 days, a decrease compared to November 2023. Four patients were discharged with lengths of stay longer than 100 days; the longest was 170 days for a patient at Bridgwater community hospital. The community hospital bed occupancy rate for non-stroke patients in December 2023 decreased to 91.9%, from 93.5% in November 2023.



Operational context

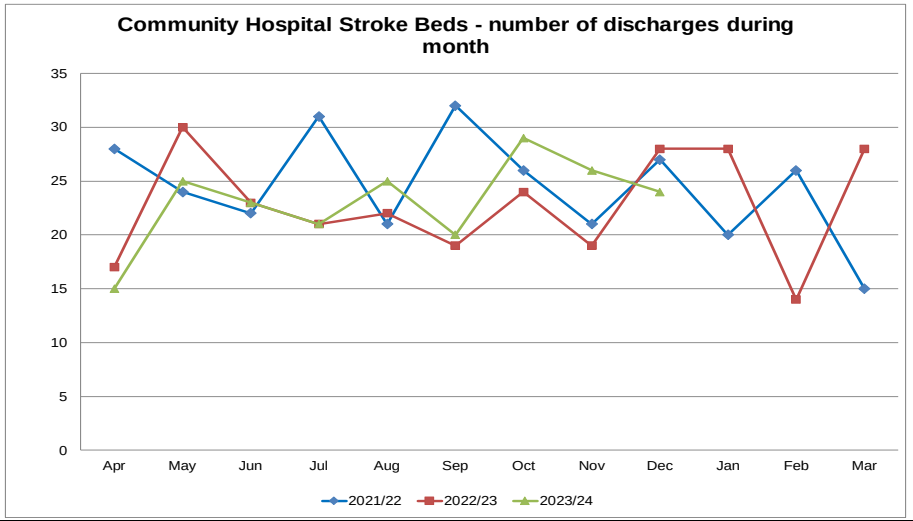
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





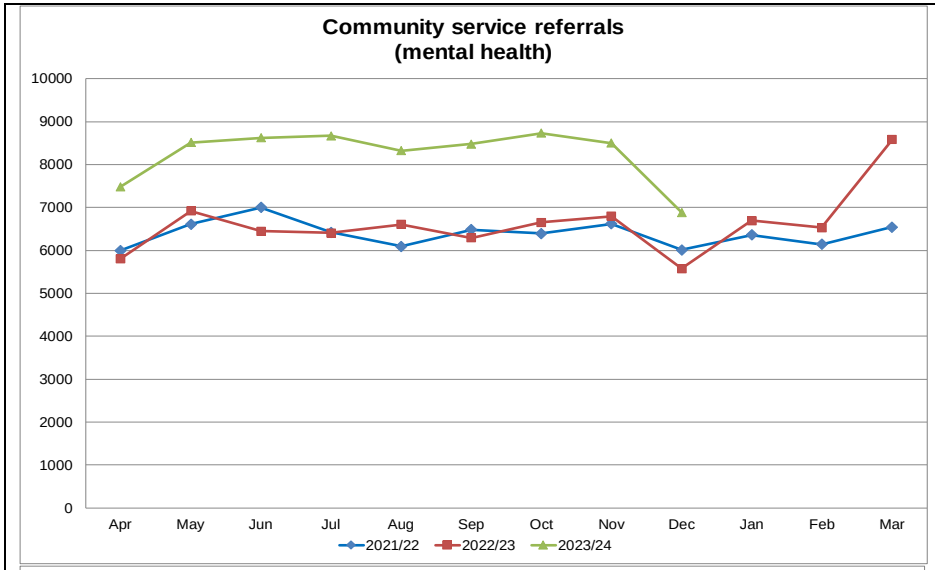
Summary:

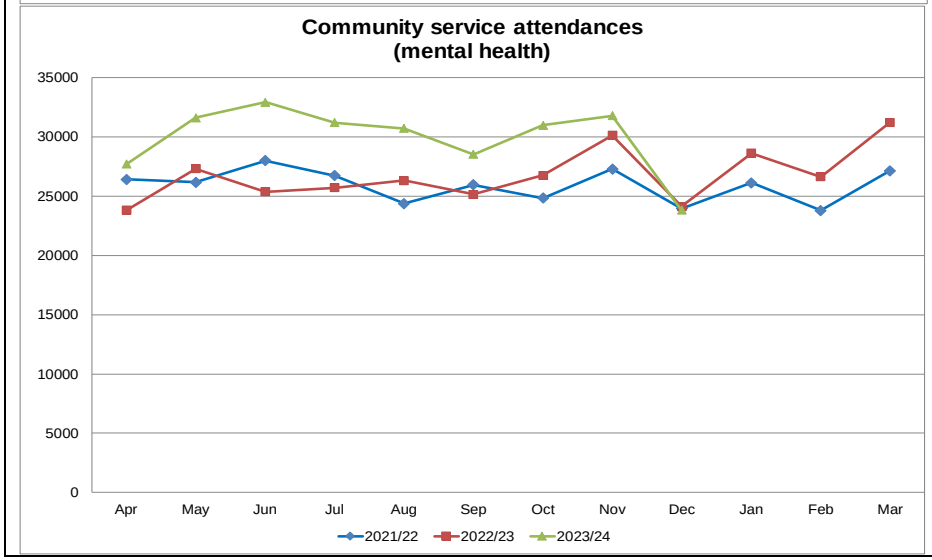
- The average length of stay for stroke patients in our community hospitals in December 2023 decreased to 30.6 days, from 40.0 days in November 2023. No patients had a stay longer than 100 days.
- Stroke bed occupancy in December 2023 increased compared to November 2023.
- During December 2023 there were 24 discharges of stroke patients, down from 26 discharged during November 2023.



Operational context

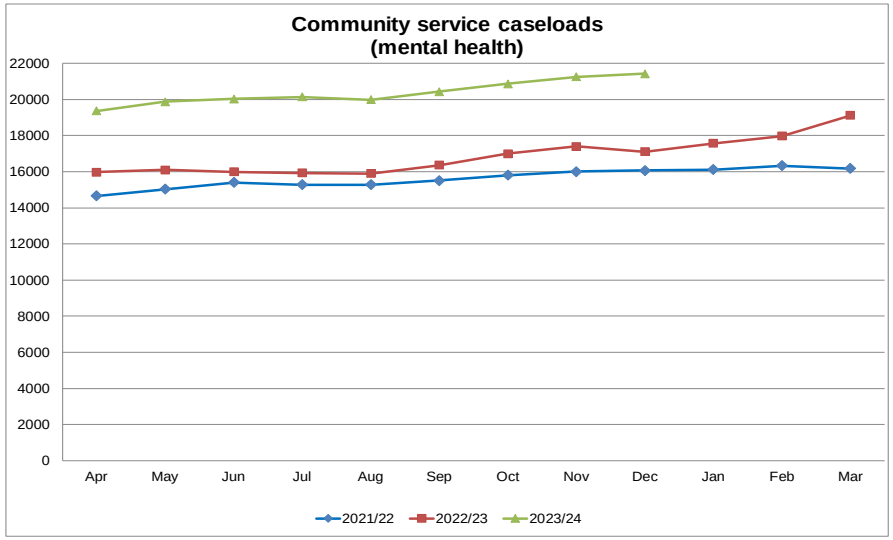
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





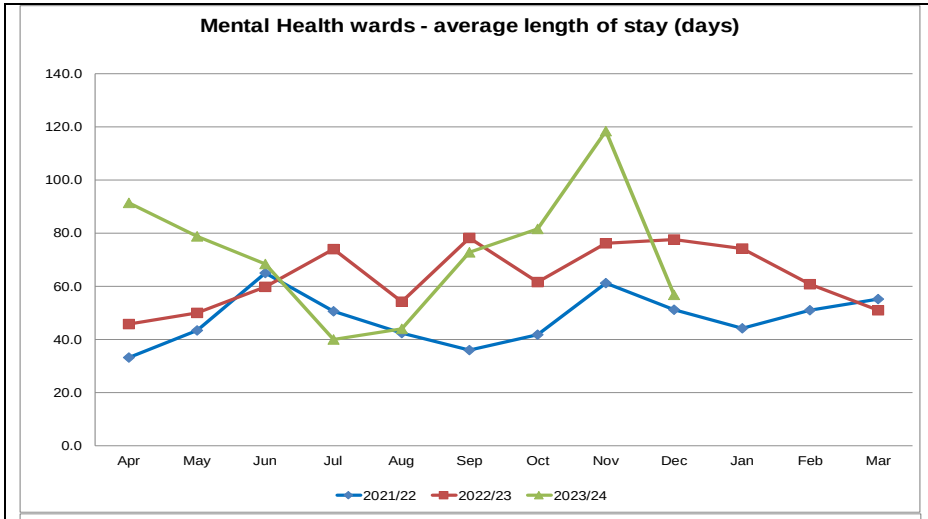
Summary:

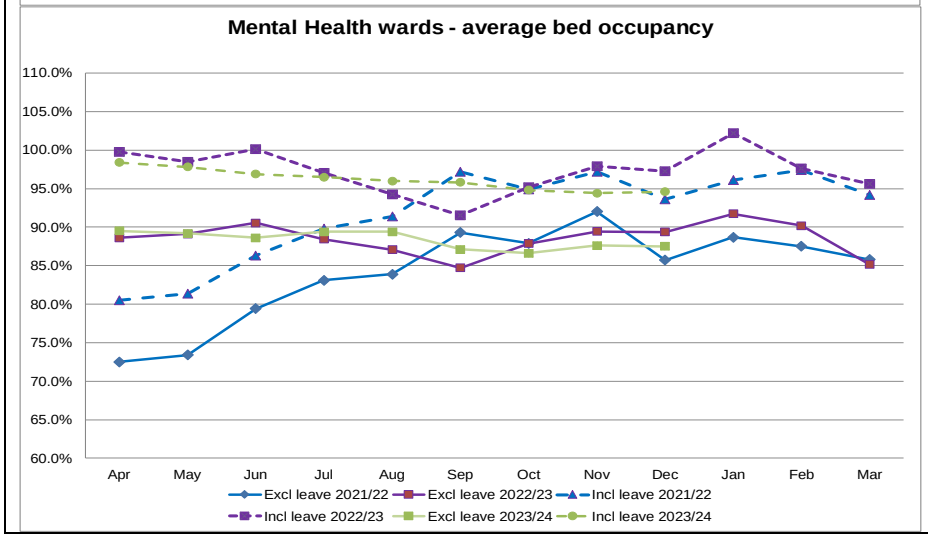
- Referrals to our community mental health services between 1 April and 31 December 2023 were 29.1% higher than the same months of 2022/23 and 28.8% higher than the same months of 2021/22.
- Attendances for the same reporting period were 16.3% higher than the same months of 2022/23 and 14.7% higher than the months of 2021/22. Services which have seen significant increases in recorded activity include Primary Care Mental Health Services (Open Mental Health), Home Treatment, and Older People's Community Mental Health services.
- Community mental health service caseloads as at 31 December 2023 increased by 25.2% when compared to 31 December 2022 and were 33.4% higher than as at 31 December 2021. It should be noted that investment facilitated the expansion of some community mental health services.



Assurance and Leading Indicators

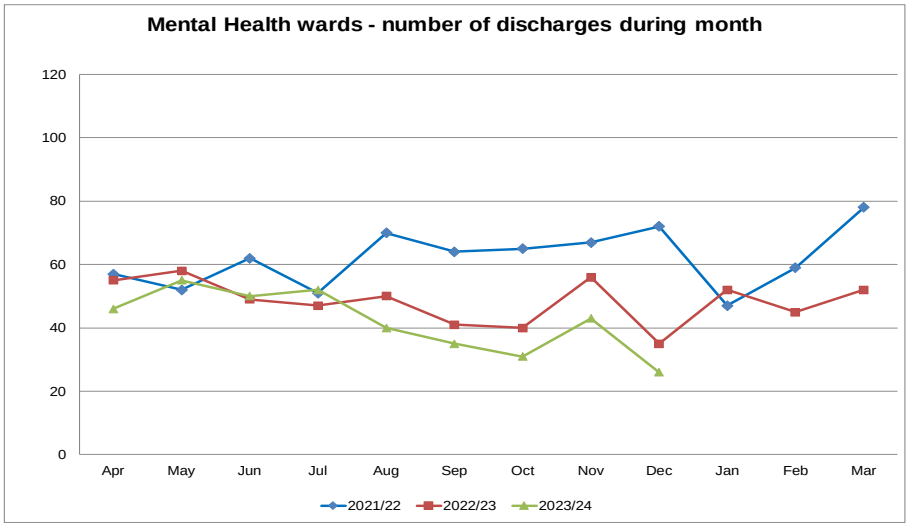
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





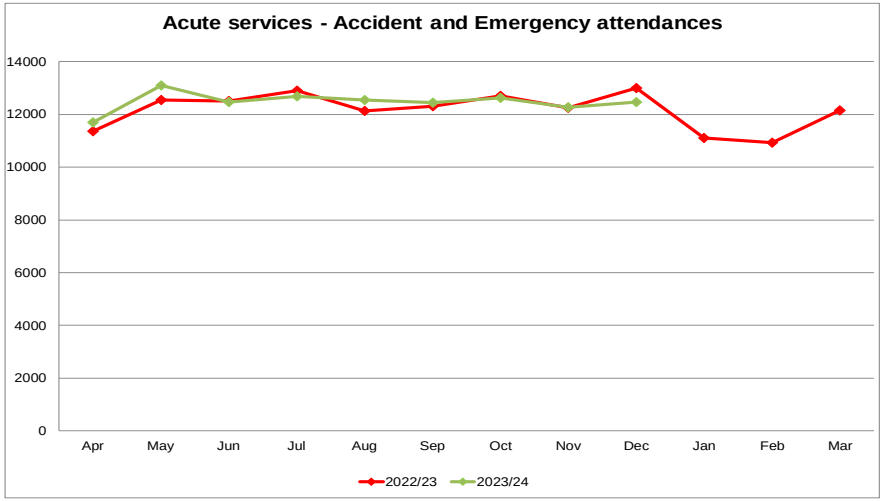
Summary:

- The average length of stay in our mental health wards in December 2023 significantly decreased compared to November 2023. During December 2023 five patients were discharged with lengths of stay of 100 days or more, including one patient discharged from St Andrews, who had a length of stay of 216 days.
- The mental health bed occupancy rate excluding leave in December 2023 decreased slightly when compared to November 2023, but increased slightly on the basis of including leave.
- A total of 26 patients were discharged in December 2023, down from 43 in November 2023.



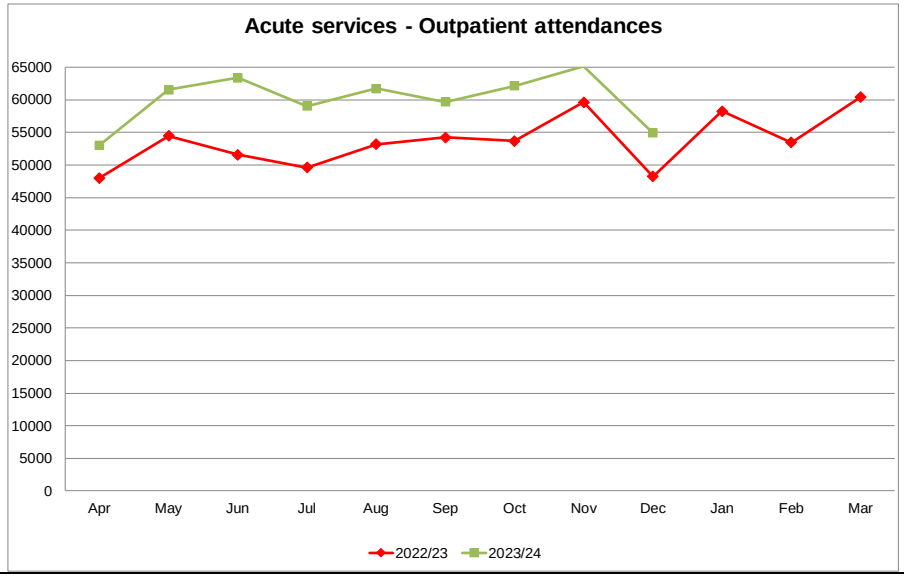
Operational context

Acute services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.



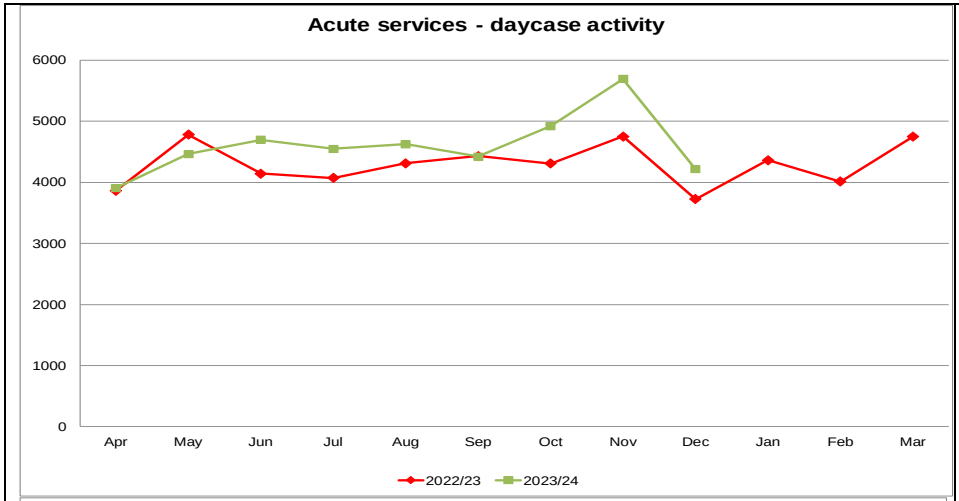
Summary:

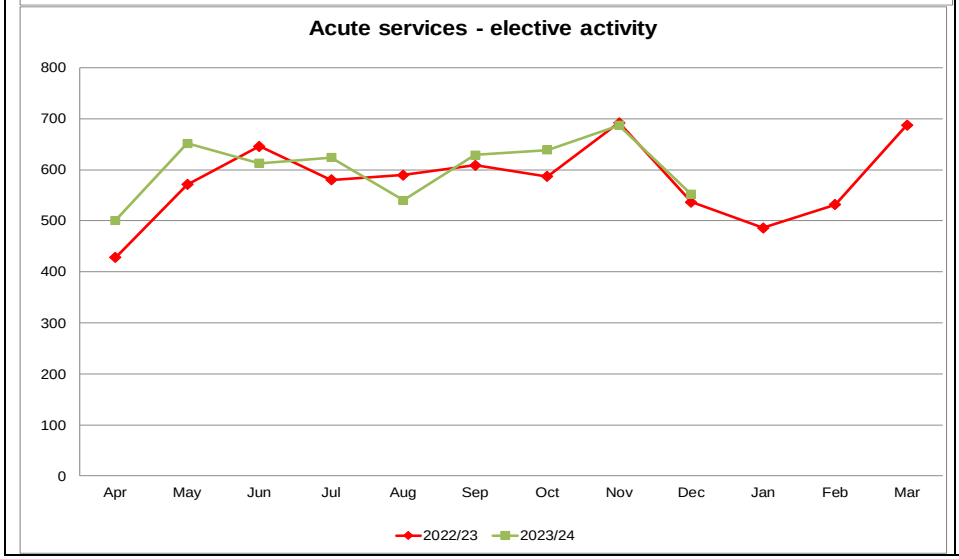
- Between 1 April and 31 December 2023 attendances to Accident and Emergency were 0.6% higher than the same months of 2022. In December 2023, 57.8% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 76%.
- GP and Dental referrals information is awaited and should be included within the next report.
- Outpatient attendances for the same period were 14.4% higher than the same months of 2022/23



Operational context

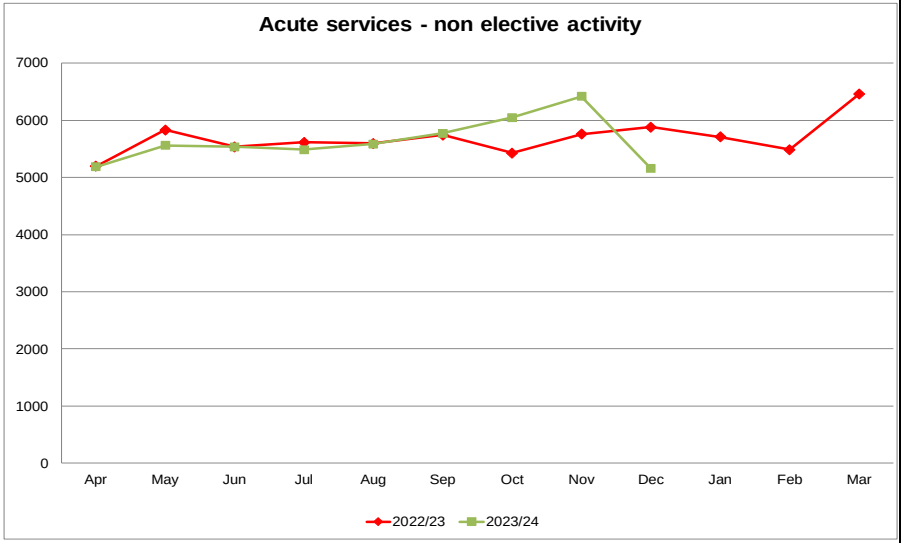
Acute services: This section of the report provides a summary of the levels of day case, elective, and non elective activity during the reporting period, compared to the previous months and prior year.





Summary:

- The number of day cases undertaken by our acute services between 1 April and December 2023 increased by 8.1% compared to the same months of 2022.
- Over the same period, elective admissions were 3.8% higher than the corresponding months of 2022 despite the significant operational pressures experienced at Musgrove Park Hospital over recent months.
- Non elective admissions between 1 April and 31 December 2023 were 0.3% higher than the same months of 2022.



Appendix 6 – Infection Control and Prevention – December 2023

MRSA bloodstream infections	Commentary on MRSA / MSSA BSIs
Musgrove Park Hospital = 0 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0	Improvement work to date has focused on reducing the proportion of cases linked to peripheral vascular cannulae. Progress is being made but time is needed to embed the strategies for sustained improvement. During December work began on preventing bloodstream infections within the homeless / rough sleeping community. This population have complex health needs and are not able to access basic hygiene facilities which means they are unable to follow some of the treatment paths for MRSA colonisation of the skin. The infection control team has started to work with the Homeless Nursing Services to create practical plans for this group of patients.
MSSA Bloodstream Infections	
Musgrove Park Hospital = 4 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0	
E. coli bloodstream infections	**Commentary on Gram-negative bloodstream infections**
Musgrove Park Hospital = 6 Yeovil District Hospital = 3 Community Hospitals / Mental Health = 0	**E. coli / Klebsiella** Overall, trust case numbers continue to rise and have now exceeded the annual thresholds set. Work continues to improve the cases linked to urinary catheters. This is a long-term system wide project therefore immediate reductions will not be achieved but once embedded will improve patient care. **Pseudomonas** There have been no more cases linked to the outbreak of cases following cystoscopy. The investigation has identified issues with the decontamination of these complex instruments. Training is in place for staff which is expected to be completed by the end of February. A new piece of equipment is being considered which could automate and replace the manual cleaning step. This is new to the market and needs to be reviewed before a trial is organised.
Klebsiella bloodstream infections	
Musgrove Park Hospital = 3 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0	
Pseudomonas bloodstream infections	
Musgrove Park Hospital = 1 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0	
C. difficile	**Commentary on C. difficile**
Musgrove Park Hospital = 3 Yeovil District Hospital = 4 Community Hospitals / Mental Health = 0	Trust case numbers continue to rise and the annual threshold of 54 cases has already been reached. However, the trust rate for C diff infections is 7.8 cases per 100,000 occupied bed days which is the lowest rate in the region. The rate range for the region is 7.8 to 76.94.

Respiratory Viral Infections - inpatients	Commentary on Respiratory Viral Infections
COVID (Trust Cases) = 87 Musgrove Park Hospital = 41 Yeovil District Hospital = 32 Community Hospitals / Mental Health = 14 **Influenza = 28** Musgrove Park Hospital = 16 Yeovil District Hospital = 12 **Respiratory syncytial virus (RSV) = 151** Musgrove Park Hospital = 84 Yeovil District Hospital = 67	**COVID** COVID cases increased during December as expected. The new variant JN.1, a subvariant of Omicron descended from the variant BA.2.86 is now circulating widely and has been identified in the trust. There is no evidence to suggest the variant is causing more severe disease but there are indications it could be more easily transmitted. No changes in guidance have been issued and the variant remains under review. **Influenza** Levels of influenza have increased during December as expected and will continue to rise through January. This is an expected seasonal pattern. Most cases are Flu A which is the strain that usually causes outbreaks. **RSV** Levels of RSV plateaued during December which is to be expected at this point in the RSV season.
Outbreaks	**Commentary on outbreaks**
COVID = 15 Musgrove Park Hospital = 6 Yeovil District Hospital = 6 Community Hospitals = 3 **Norovirus = 1** Yeovil District Hospital	**COVID** Outbreaks due to COVID have increased slightly in December as expected. **Norovirus** There has only been one norovirus outbreak in December but there are likely to be more through January
Surgical Site Infections	**Commentary on Surgical Site Infections**
Surgical Site Infection Surveillance enables early recognition of infections to inform remedial and improvement actions. **Musgrove Park Hospital Site** Continuous surveillance for THR, TKR and Spinal surgery has been in place on the MPH site since 2009	**Musgrove Park Hospital Site** Rates of infection for Spines and Total Hip Replacement remain in line with national data. Since December 2022 a total of 198 Total Knee Replacement procedures undertaken and 2 infections identified, giving an infection rate of 1.02%. This is slightly higher than the national benchmark which is around 0.4%. However, the national rate is calculated over the period April 2018 to March 2023 therefore it is not directly comparable. This situation is being monitored closely.

Yeovil District Hospital Site Continuous surveillance on total hip replacement surgery has been in place on the YDH site since April 2022. Prior to that several categories were monitored for short periods of time. Whilst this gave a “temperature test” of infection rates it can fail to identify a rise or fall in infection rates in a category. Total Hip Replacement • Total of 286 operations, 5 infections identified. • Rate of infection = 1.75%	**Yeovil District Hospital Site** Since February 2022 a total of 286 operations have been undertaken and five infections identified giving an infection rate of 1.75%. This is higher than the national benchmark which is around 0.5%. However, as previously described the national data is calculated over a different period and therefore not directly comparable but used as a guide . In addition, 2 infections following total knee replacement have also been identified by the surgical teams. Surveillance for TKR will commence in January 2024 to monitor this situation, using resource from the MPH site. All the infections across both acute sites are being reviewed in more depth. In addition, a joint piece of work is being undertaken with the Service Group using the national One Together framework. This framework is specific to surgical site surveillance and allows trusts to review each part of the patient journey following surgery. This will be used to identify any areas of improvement.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the People Committee meeting held on 8 November 2023
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Kate Fallon, Chairman of the People Committee
DATE:	6 February 2024

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the People Committee meeting held on 8 November 2023 and the assurance received. The meeting was conducted as a hybrid meeting – face-to-face and video call. The Committee received assurance in relation to: • The colleague story – the work of the Technology Enhanced Team • The Deep Dive into the Digital People Plan • The update in relation to the temporary and permanent medical workforce recruitment • The progress made implementing the High Level Responsible Officer (HLRO) action plan • The Director report The Committee identified the following areas for follow up: • The colleague story – links with Deep Dive – follow up actions • The update in relation to the temporary and permanent medical workforce recruitment – the higher vacancy rate in the South West and the lack of accommodation

	• The medical workforce emerging concerns escalated by the Quality and Governance Assurance Committee. The Committee asked for a progress report to be presented to a future meeting • The learning item – the further work to be undertaken in relation to strategic objective six • The workforce (Corporate Risk Register) – the new workforce related risks • The review of the frequency of meetings 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 8 November 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 – Links with Deep Dive

2.1. The Committee received an update on the work of the Technology Enhanced Learning (TEL) team in relation to supporting patient care through upskilling colleagues as well as in relation to the support provided to student projects at Taunton and Bridgwater College.

2.2. The Committee noted: details of the support available; the aim to ensure that all content created is engaging and interactive; the review of all training on The Learning Platform – LEAP - in terms of accessibility and ensuring that training is interactive; the work with local colleges to create content; the development of a virtual version of Conservators with information for patients; and the development of an interactive sepsis simulation tool.

2.3. The Committee further noted: the review of the use of Artificial Intelligence (AI) and the benefits to patients and colleagues; the development of an application to diagnose anaphylaxis; the development of digital courses to support colleagues to be able to fully access and engage with digital opportunities; and the development of guidance on the governance arrangements relating to the use of AI alongside NHS England.

2.4. The Committee discussed the use of TEL in relation to diversity and inclusion and noted that a micro-aggression package was being developed jointly with the diversity and inclusion lead, and that other projects were being considered. The Committee discussed the development of tools for patients and noted the development of a programme showing virtual tours of hospital areas.

2.5. The Committee agreed that the report provided significant assurance.

Deep Dive – Digital People Plan

2.6. The Committee received an update on the progress in relation to the development of the people digital strategy.

2.7. The Committee noted: the progress made in relation to the development of the digital strategy as part of the people strategy; the eight key themes set out in the Future of the NHS HR and Organisational Development report, including the theme relating to “embedding digital enabled solutions”; the focus on the end user experience by ensuring the right design and productivity; the national aim to deliver aligned initiatives which meet the individual needs and the link to the work on Electronic Staff Record optimisation and learning management systems; the aim for the ICS to have a people digital plan; and the work with Devon Partnership NHS Trust to ensure that the trust systems support the national work.

2.8. The Committee further noted that deliverables and success criteria for the strategy had been agreed and that an internal audit on the current system and processes will be undertaken during November 2023 to establish a baseline for the current position.

2.9. The Committee received an update on the work of the workstream and particularly noted: the work to understand what information is currently used; the need to ensure that the workforce data is accurate; the work with the payroll and recruitment teams to implement new ways of working; and the implementation of lessons learned. The Committee noted that a national workforce solution was being sought to replace the Electronic Staff Record.

2.10. The Committee recognised the importance of a people digital strategy and the need to release time to care and noted that a communication strategy to support the digital people strategy was being developed. The Committee agreed that the report provided significant assurance but stressed the need for clear communications with all colleagues on progress with the implementation of the strategy.

Medical Workforce –Temporary and Permanent Recruitment Updates

2.11. The Committee received an update on the measures and year one deliverables for the Attract and Retain Talent workstream.

2.12. The Committee noted: the three priorities – workforce planning, GMC overseas sponsorship; and director engagement with TempRE; the lack of national focus on medical workforce planning resulting in hard to fill vacancies in an increasing number of specialties; the establishment and work of the workforce planning groups and links with the service groups; and the use of overseas recruitment to fill vacancies.

2.13. The Committee received an update on the developments in overseas medical recruitment particularly in relation to consultant level vacancies and noted that the trust’s has signed up to the General Medical Council Sponsorship Scheme which enabled the recruitment process to be accelerated.

2.14. The Committee received an overview of the TempRE system which had been implemented from April 2023 to monitor agency spend and noted the savings achieved as a result of the use of this new system and the nature of the

monitoring arrangements. The Committee further noted that a job planning and e-rostering system, which provides oversight of vacancies and rota compliance, was being tested. The aim was to have this system in place from May 2024.

2.15. The Committee discussed the findings of a recent audit report relating to job planning and noted the implementation of a new system which will make job planning mandatory for medical colleagues applying for a Clinical Excellence Award.

High Level Responsible Officer (HLRO) Action Plan

2.16. The Committee received an update on the implementation of the action plan from the HRLO visit in May 2023 and noted the background for the visit and the findings in relation to the need for additional administrators to manage the medical appraisal process and the need to allocate appraisers to doctors.

2.17. The Committee noted the increase in the number of medical colleagues requiring an appraisal following the merger; the reorganisation of the leadership team; the integration of the teams managing the medical appraisal process; the increase in the number of appraisal administrators; and the oversight of the team on job planning. The Committee noted the positive impact of the actions taken on the quality of the appraisal process.

2.18. The Committee acknowledged the significant progress made and agreed that the report provided significant assurance.

Director Report

2.19. The Committee received the report and noted the inclusion report presented to the November 2032 Public Board meeting. The Committee noted that the information included in the report will be reviewed to take account of the comments made at the Board meeting held on 7 November 2023.

Assurances Received

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

- Positive assurance on the digital people agenda but this was not currently part of the objectives within the BAF.

- Positive aspects in relation to medical workforce recruitment but further work will be required.

3. AREAS OF CONCERNS/FOLLOW UP

Colleague story – Links with Deep Dive

3.1. The Committee agreed the following actions: to arrange for a TEL representative to be invited to attend the Integrated Care System's (ICS) AI Monitoring Group meetings; and the review of the impact of digital technology on the organisation at a future Board Development Day.

Medical Workforce –Temporary and Permanent Recruitment Updates

3.2. The Committee discussed the vacancy rate and noted that the vacancy rate in the South West was 2% higher than in other regions and that this was mainly due to the inability to attract candidates in view of a lack of accommodation. The Committee noted the actions being taken to explore accommodation options, both on a local and system wide basis

Medical Workforce Merging Concerns – follow up from the Quality and Governance Assurance Committee

3.3. The Committee received an update on the emerging medical workforce concerns expressed at the recent Quality and Governance Assurance Committee and noted the key areas of concern or actions: (legacy SFT) the need to change focus from emergency medicine and psychiatry to medicine, obstetrics and gynaecology; (legacy YDH) the need to strengthen supervision, workforce, teaching and culture; the request to the Deanery not to create training gaps in small specialties; the vacancy risks particularly in emergency medicine, obstetrics and gynaecology services; the impact of the bed reconfiguration on clinical staffing levels; and the work required in relation to training standards; the inability to recruit to primary care vacancies.

3.4. The Committee acknowledged the areas of concern and asked for a further update to be presented to a future meeting.

Learning Item

3.5. The Committee received the learning item on medical recruitment and noted the challenges recruiting to vacant posts: delays in time to hire; favourable careers overseas; the time taken to gain GMC registration leading to increased agency costs. The Committee further noted the work taking place to attract candidates to Somerset and noted that four vacancies had recently been filled.

3.6. The Committee noted the successful recruitment of two consultants in the rheumatology department and the approach taken including listening to and understanding the need of candidates. The Committee noted that mentoring was available to all colleagues.

3.7. The Committee further noted the work in relation to understanding processes of good practice and expectations for overseas colleagues.

Review of the Board Assurance Framework

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

3.9. The Committee noted that: the trajectory for inclusion and retention was being reviewed and that a more detailed update will be presented to the January 2024 meeting; the risks are being reviewed and that risks in relation to junior medical workforce, nursing and allied health professionals vacancies and

absence rates will be added to the BAF and corporate risk register; the generic risks in relation to vacancies has been removed and this risk will be replaced with a more articulated risks.

Workforce (Corporate Risk Register)

3.10. The Committee discussed the workforce risks and noted the three new risks which fall under the remit of the Committee: colleague resilience, inability to recruit applicants in TRAC; and poor data quality in ESR. The risk in relation to vacancies has been archived and will be further monitored through the service group risk registers.

3.11. The Committee noted: that three new workforce related risks had been added to the service level risk registers; the focus of the internal audit which will be undertaken by BDO – internal auditors - in December 2023; and the progress in relation to the procurement of a single risk management system.

3.12. The Committee further noted that an emerging risk had been identified in relation to being an inclusive organisation and the process for capturing data but noted that further consideration will be required to articulate the risk.

Any Other Business – frequency of meetings

3.13. The Committee agreed that the frequency of meetings will need to be reviewed in view of the growing number of items to be reviewed by the Committee. The Committee agreed to consider the frequency of meetings from January 2024 onwards.

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 – the work of the Technology Enhanced Team
- The Deep Dive into the Digital People Plan
- The update in relation to the temporary and permanent medical workforce recruitment
- The progress made implementing the High Level Responsible Officer (HLRO) action plan
- The content of the Director report

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Guardian of Safe Working for Postgraduate Doctors
SPONSORING EXEC:	Dan Meron, Chief Medical Officer
REPORT BY:	Tom Rees (MPH) and John McFarlane (YDH), Guardian of Safe Working; Lee-Ann Toogood, Medical Workforce Manager
PRESENTED BY:	Dan Meron, Chief Medical Officer
DATE:	6 February 2024

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

Executive Summary and Reason for presentation to Committee/Board	This report covers quantitative and qualitative summary of exception report data generated between 1st October 2023 and 12th January 2023 across Somerset NHS Foundation Trust.
Recommendation	There remains a cyclical nature to the Exception Reports (ER). The challenge will be in finding a solution to the peak at August changeover, which is likely due to reduced productivity as a result of unfamiliarity with the hospital and software systems. The implementation of rota management software at TST is welcome. The integration of ER to the app could have the effect of increasing ER numbers if the process of reporting is more accessible.

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?
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. EXECUTIVE SUMMARY

1.1 In Yeovil District Hospital (YDH) there were no Immediate safety concerns (ISCs). The general trend in Exception Report (ER) numbers has reduced this quarter which reflects the increased staffing levels from August.

1.2 The trend in ER numbers is also down for Musgrove Park Hospital (MPH), although remain high on an historical level. Almost all of these are generated at an F1 level, and nearly all relate to deviated hours.

2. INTRODUCTION

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

2.2 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.

3. EXCEPTION REPORT DATA:

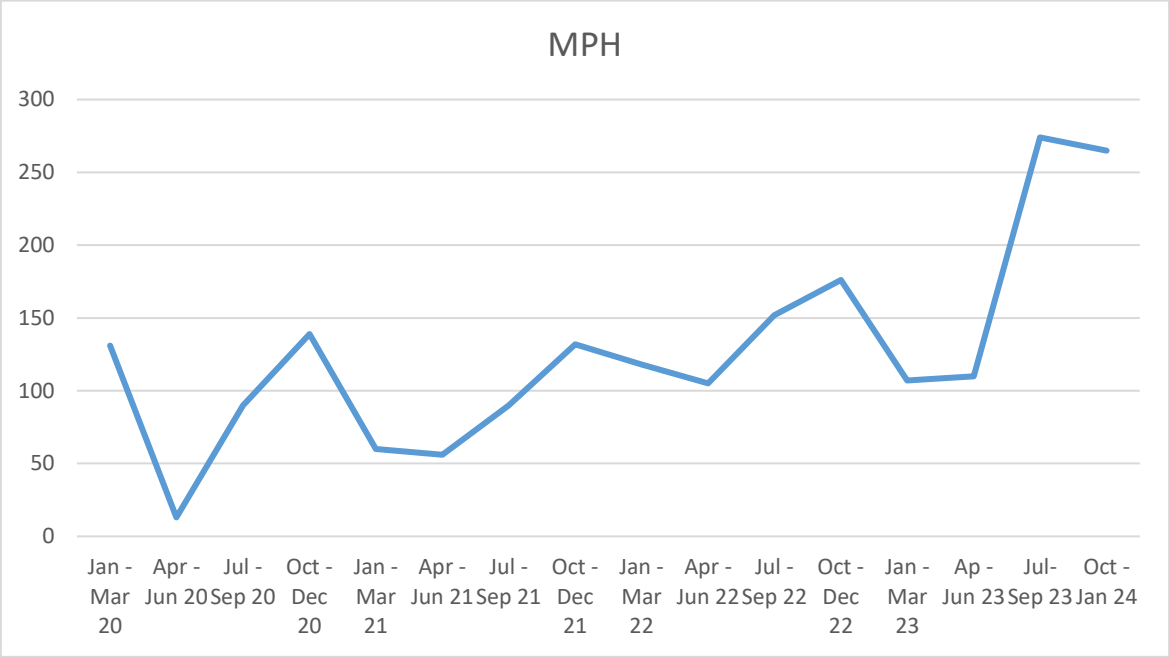
3.1

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

3.2 As of 12/01/2024 - Total of exception reports since implementation of 2016 TCS (December 2016). 3307 for Taunton and for Yeovil 1489. The overall cost of exception report overtime is £83,830.14

Figure 1 Quarterly total for exception reporting



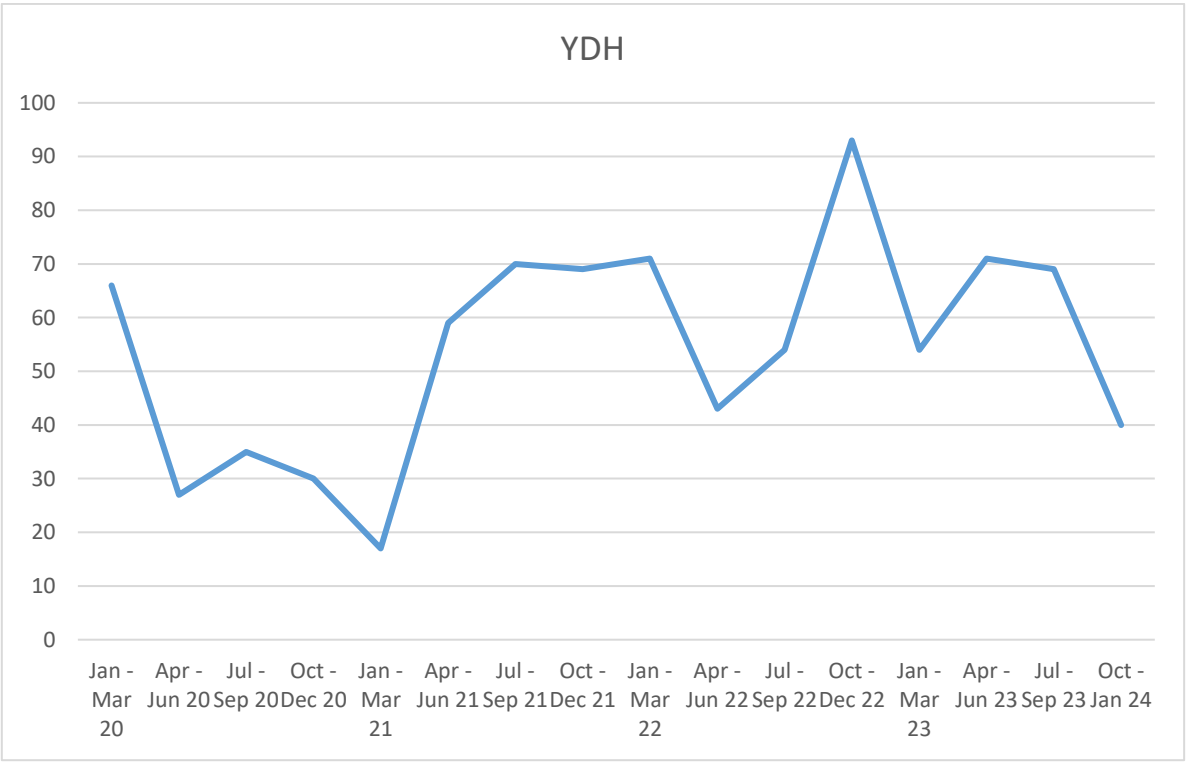
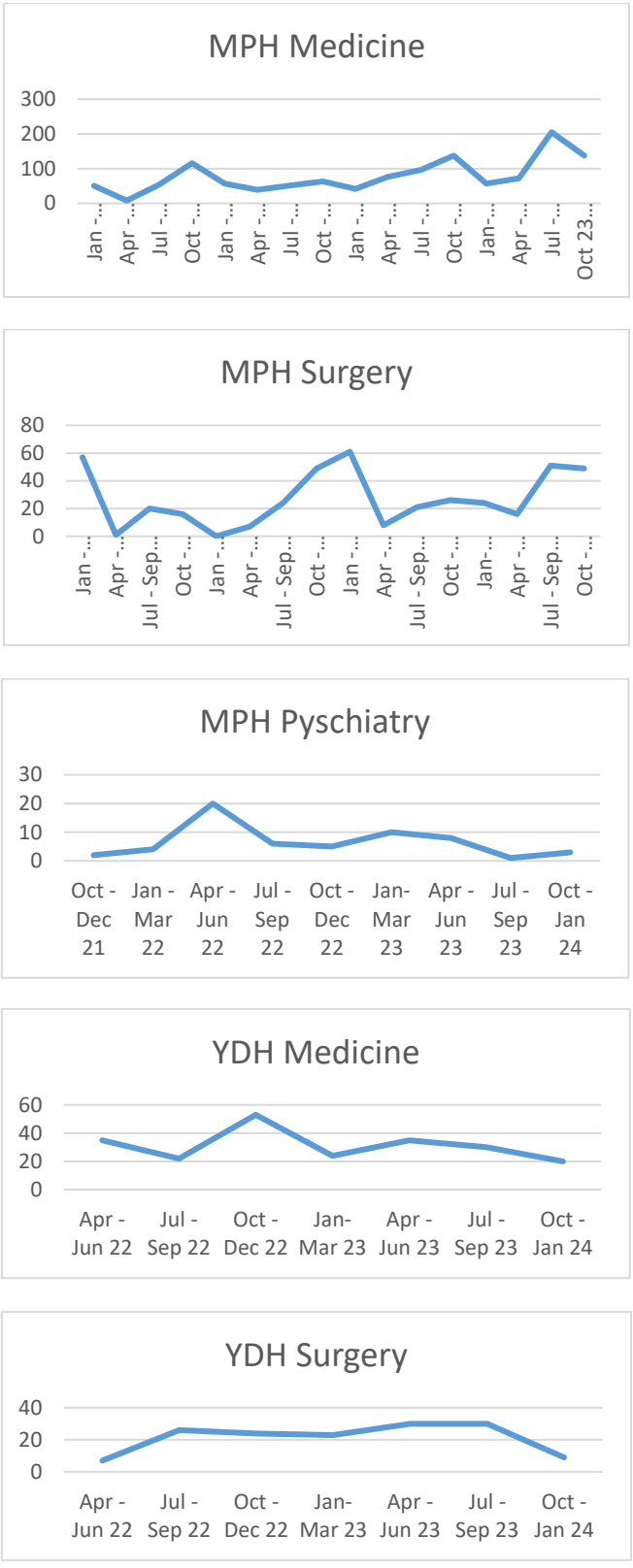


Figure 2 Exception Report Trends by Specialty



3.3 **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 137 (169) YDH 20 (30)	96 18	41 2	Hours MPH 131 YDH 16 Educational MPH 6 Service Support YDH 4
Anaesthetics	0 *(1)*	0	0	
DCT Trainees	0 *(0)*	0	0	
Emergency Medicine	MPH 3 (26) YDH 0 (2)	2	1	Hours 3 MPH
ENT	10 *(7)*	0	10	Educational 1 MPH Hours 9
General Surgery	MPH 49 *(47)* YDH 9 (20)	17 9	32 0	Hours YDH 9 MPH 45 Pattern MPH 1 Educational MPH 1
O&G	MPH 1 (0) YDH 1 *(3)*	0 1	1 0	Hours MPH 1 YDH 1
Oncology/ Haematology	MPH 1 *(11)*	1	0	Educational MPH 1 Pattern MPH 1 Hours MPH 1
Paediatrics	MPH 10 *(5)*	5	5	Hours MPH 10 Pattern MPH 1
Psychiatry	MPH 3 *(1)*	0	3	Hours MPH 2 Pattern MPH 1
Trauma & Ortho	MPH 5 *(1)* YDH 10 (9)	4 10	1 0	Hours MPH 5 YDH 10 Service Support MPH 1
Urology	MPH 6 *(1)*	0	6	Hours MPH 6
Vascular	0 *(0)*	0	0	
Total	**265**	**163**	**102**	

Table 2: Exception reports per trainee grade

Grade of trainee	No. exceptions raised Taunton	No. exceptions raised Yeovil
F1	175	23
F2	36	7
CT1-2 / ST1-2	6	10
ST3+	8	0
Total	**225**	**40**

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

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

Qualitative summary of exception reports

3.4 The general trend in ER numbers at YDH has reduced again this quarter which reflects the increased staffing levels from August. (41 relative to a mean of 50 per quarter). Although a slight increase in ERs in orthopaedics, 10 (9) will be monitored to see if a trend develops.

3.5 Slight downward trend in ERs generated at MPH, particularly in medicine (following last quarters record number). As previously documented, there is cyclical variation in ERs generated, with usually more generated around summer changeover, and subsequent decline during the year. Almost all ERs generated were due to hours deviation.

Immediate safety concerns (ISCs)

3.6 There are no immediate safety concerns at YDH.

3.7 A single ISC was generated at MPH in General Surgery as a consequence of a shortened working day related to an Occupational Health recommendation. Consequently, there was a short period of the shift (~ 3 hrs) where only one F1 doctor was on shift to cover. TR will discuss will HR/ER/CS to come to a solution have buddy shift cover for the individual in question.

Fines

3.8 No fines were issued during this quarter.

Work schedule reviews

3.9 There were no work schedule reviews this quarter.

4 ISSUES ARISING

Postgraduate Doctor Forum (PDF)

4.1 The October forum we had a presentation and discussion about discharge summaries. Concerns were raised about patients in medically fit for discharge wards having to have their discharge summaries altered due to length of stay.

4.2 November forum was a discussion about exception reporting and working bank shifts.

4.3 December forum was postponed due to industrial action.

Rota management

4.4 Electronic rota management software is soon to be implemented at MPH. This will also encompass ER generation. The impact of this will be monitored.

5. SUMMARY

5.1 In YDH there were no ISC. The general trend in ER numbers has reduced this quarter which reflects the increased staffing levels from August.

5.2 The trend in ER numbers is also down for MPH, although remain high on an historical level. Almost all of these are generated at an F1 level, and nearly all relate to deviated hours.

6. RECOMMENDATIONS

6.1 There remains a cyclical nature to the ERs. The challenge will be in finding a solution to the peak at August changeover, which is likely due to reduced productivity as a result of unfamiliarity with the hospital and software systems.

6.2 The implementation of rota management software at MPH is welcome. The integration of ER to the app could have the effect of increasing ER numbers if the process of reporting is more accessible.

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Somerset NHS Foundation Trust Finance Report – Month 9
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Deputy Chief Finance Officer
PRESENTED BY:	Chief Finance Officer
DATE:	6 February 2024

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

Executive Summary and Reason for presentation to Committee/Board	The Finance report sets out the overall income and expenditure position for the Trust. It includes commentary on the key issues, risks, and variances, which are affecting the financial position.
Recommendation	The Board is requested to discuss the report**.**

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

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

Implications/Requirements (Please select any which are relevant to this paper)					
☒ Financial	☐ 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.

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.
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]
Monthly 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

1. SUMMARY

1.1 In December the Trust recorded a surplus of £0.210m, this was £0.535m adverse compared with the plan for the month. Cumulatively, the Trust is £5.062m in deficit, this is £0.535m adverse when compared with the planned position for the period.

1.2 The in-month adverse variance has been driven by the impact of December's industrial action which was not funded. The financial impact is twofold: -

i) The costs of backfilling medical staff on strike days was £0.391m.

ii) The impact of elective activity stood down on strike days meant a reduction in income of £0.194m.

1.3 Excluding industrial action, performance in December and a forward look based on run rate indicates we are consistent with the H2 plan trajectory. Winter escalation increased markedly in December but remained within the cost estimates included within our planning assumptions.

2. INCOME AND EXPENDITURE

2.1 Table 1 below sets out the summary income and expenditure account to 31 December 2023: -

Table 1: Income and Expenditure Summary December

Statement of Comprehensive Income	Annual Plan	Current Month 9			Year to date		
	£000	Plan £000	Actual £000	Fav./ (Adv.) Variance £000	Plan £000	Actual £000	Fav./ (Adv.) Variance £000
Income							
Patient Care Income	928,490	77,815	81,633	3,818	696,146	715,771	19,625
Other Operating Income	54,102	4,512	4,214	(298)	40,049	51,757	11,708
Total operating income	**982,592**	**82,327**	**85,847**	**3,520**	**736,195**	**767,528**	**31,333**
Operating expenses							
Employee Operating Expenses	(674,225)	(56,027)	(58,342)	(2,316)	(506,845)	(521,472)	(14,627)
Drugs Cost: Consumed/Purchased	(71,060)	(5,990)	(6,086)	(96)	(53,654)	(56,010)	(2,356)
Clinical Supp & Serv Exc-Drugs	(45,272)	(3,552)	(7,589)	(4,037)	(36,071)	(61,647)	(25,577)
Supplies & Services - General	(27,780)	(2,315)	(3,073)	(758)	(20,835)	(26,074)	(5,239)
Other Operating Expenses	(151,017)	(12,599)	(11,105)	1,494	(113,377)	(99,814)	13,563
Total operating expenses	**(969,354)**	**(80,483)**	**(86,196)**	**(5,712)**	**(730,781)**	**(765,018)**	**(34,237)**
Operating Surplus/Deficit	13,238	1,843	(348)	(2,192)	5,414	2,510	(2,905)
Finance Expense	(12,651)	(1,054)	(171)	883	(9,488)	(8,619)	869
Finance Income	613	51	482	431	459	3,378	2,919
Other	0	5	0	(5)	(13)	0	13
Overall Surplus/(Deficit)	1,200	845	(38)	(883)	(3,628)	(2,731)	897
Depr On Donated Assets	1,386	115	92	(23)	1,039	862	(177)
Donated Assets Income	(2,591)	(216)	155	371	(1,943)	(3,200)	(1,257)
Amortisation	9	1	1	(0)	7	7	(0)
Impairments (Reversals)	0	0	0	0	0	0	0
Other	(4)	(0)	0	0	(3)	0	3
Adjustments to control total	(1,200)	(100)	248	348	(900)	(2,331)	(1,431)
Adjusted Financial Performance	(0)	745	210	(535)	(4,527)	(5,062)	(535)

2.2 Agency expenditure was £0.533m higher than November at £3.001m in December. In month, this was £0.979m over the plan and £0.053m above the ceiling. At the end of December, the Trust is c£5.5m above the cap.

2.3 January's industrial action (6 days) is expected to cost c£1.2m (total costs of backfill and lost elective income). There is uncertainty about the funding position in respect of these costs, but it is assumed if they are not funded, they will be discounted for the purposes of assessing performance against the H2 plan.

2.4 There are some encouraging signs that some longstanding medical vacancies are being filled which should reduce the current run rate further provided no other issues arise.

2.5 The Trust continues to explore recruitment opportunities overseas and all service groups are working with their People Business Partners to explore additional supply avenues to recruit into hard to fill specialities e.g.: physician's associates, clinical fellows etc. Further recruitment opportunities in relation to medical staffing are currently being explored in India.

3. COST IMPROVEMENT PROGRAMME

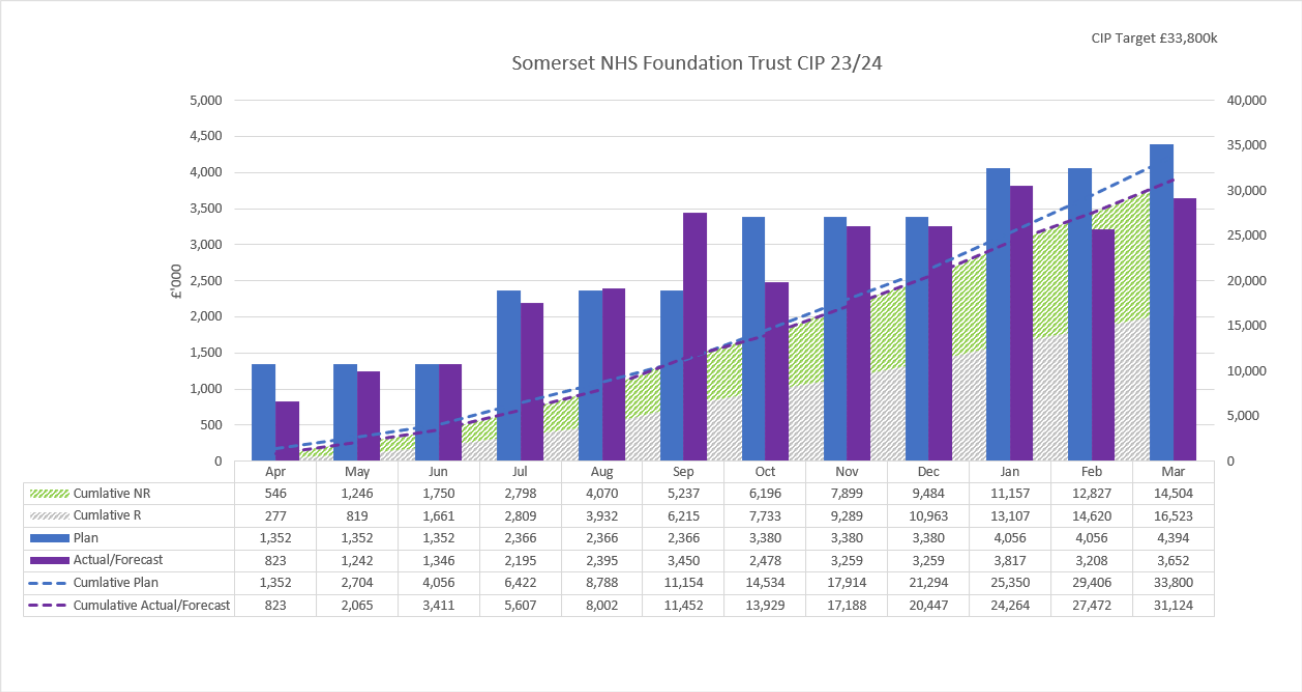
3.1 In December, savings of £3.259m were delivered which was an under-performance of £0.121m against the plan. Recurrent savings were £1.674m (51%).

3.2 Cumulatively, savings of £20.447m have been delivered compared with the planned delivery of £21.294m at the end of December, an under delivery of £0.121m. Of the savings delivered so far, 54% (£10.963m) are recurrent.

3.3 The level of savings already achieved represents a significant amount of work and services continue to explore further opportunities to close gaps in their plans, but it is acknowledged the significant additional pressure of winter will interrupt these efforts. The primary focus is on developing plans for 2024/25 through the Productive Care Programme.

3.4 Further analysis is shown in the chart below: -

Chart 1: CIP Plan 23/24

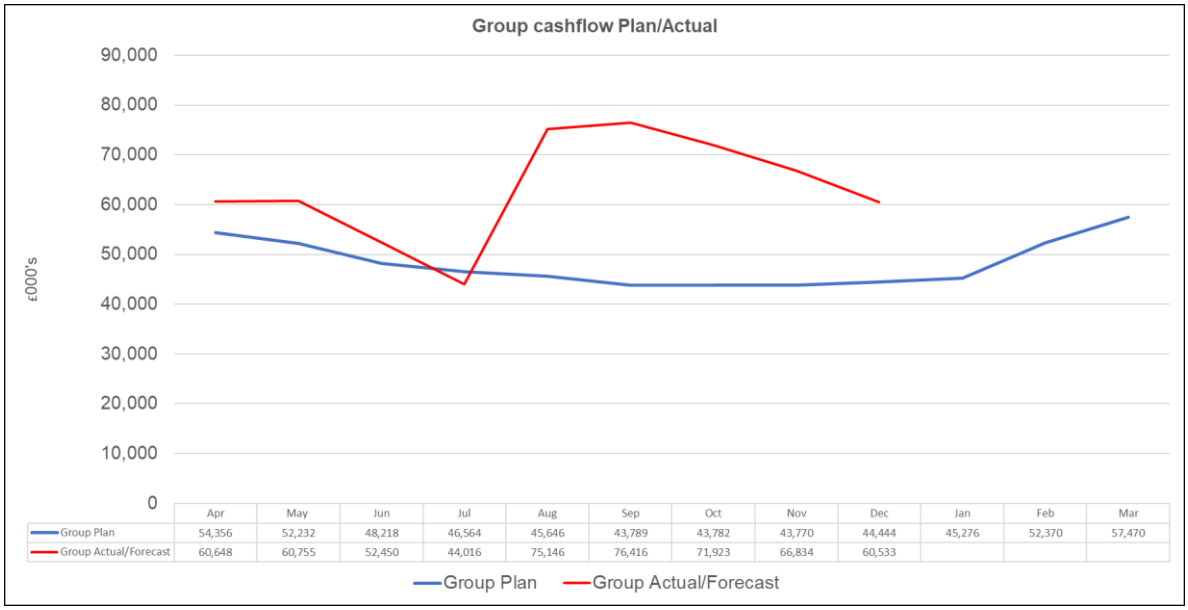


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumlative NR	546	1,246	1,750	2,798	4,070	5,237	6,196	7,899	9,484	11,157	12,827	14,504
Cumlative R	277	819	1,661	2,809	3,932	6,215	7,733	9,289	10,963	13,107	14,620	16,523
Plan	1,352	1,352	1,352	2,366	2,366	2,366	3,380	3,380	3,380	4,056	4,056	4,394
Actual/Forecast	823	1,242	1,346	2,195	2,395	3,450	2,478	3,259	3,259	3,817	3,208	3,652
Cumlative Plan	1,352	2,704	4,056	6,422	8,788	11,154	14,534	17,914	21,294	25,350	29,406	33,800
Cumulative Actual/Forecast	823	2,065	3,411	5,607	8,002	11,452	13,929	17,188	20,447	24,264	27,472	31,124

4. CASH

4.1 Cash balances as at 31 December were £60.5m, £16.1m higher than plan; primarily driven by Somerset Council paying their annual invoice in advance and receivable balances lower than plan. The actual/plan forecast cash flow for the year is shown in Chart 2 below: -

Chart 2: Cash flow Actual/Plan



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Group Plan	54,356	52,232	48,218	46,564	45,646	43,789	43,782	43,770	44,444	45,276	52,370	57,470
Group Actual/Forecast	60,648	60,755	52,450	44,016	75,146	76,416	71,923	66,834	60,533			

5. CAPITAL

5.1 Year to date, capital expenditure is £50.8m compared with the plan of £52.1m, resulting in an underspend of £1.3m. Further details at programme level are shown in Table 2 below:

Table 2: Capital Programme monitoring

Acute Programme MPH	Plan £000	Revised Budget £000	YTD Plan £000	YTD Actual £000	Variance Act v plan YTD £000	Forecast Outturn £000
Total MPH Site Risks / Plant & Equipment	3,980	4,034	2,256	1,461	(795)	4,357
Total MPH Site and Service Development	2,048	2,208	1,636	271	- 1,364	1,881
Acute Programme YDH	**Plan £000**	**Revised Budget £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**	**Forecast Outturn £000**
Total YDH Main Site Budgets	3,800	4,544	2,287	2,626	339	6,019
Total - YDH Site and Service Development	6,091	4,601	1,094	651	(443)	3,713
Total - YDH Site Risks / Plant and equipment Replacement	370	406	265	427	162	653
Total Acute	**16,289**	**15,793**	**7,538**	**5,436**	**(2,102)**	**16,623**
Community/Mental Health Programme	**Plan £000**	**Revised Budget £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**	**Forecast Outturn £000**
Total Community / Mental Health Site and Service Development	6,620	5,619	4,860	3,240	- 1,620	4,390
Total Community / Mental Health - Site Risks / Plant & Equipment	835	1,118	425	793	368	981
Total Community/Mental Health	**7,455**	**6,737**	**5,285**	**4,034**	**(1,252)**	**5,371**
Trustwide	**Plan £000**	**Revised Budget £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**	**Forecast Outturn £000**
Trustwide	**9,315**	**8,955**	**6,442**	**4,997**	**(1,445)**	**9,491**
Total Internal Capital Envelope	**33,059**	**31,485**	**19,265**	**14,466**	**(4,798)**	**31,485**
Additional Capital Schemes	**Plan £000**	**Revised Budget £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**	**Forecast Outturn £000**
Total Additional Schemes	**47,821**	**47,113**	**32,307**	**23,923**	**(8,384)**	**47,595**
IFRS Leases	3,535	3,781	524	12,441	11,917	12,745
TOTAL TRUST PROGRAMME	**84,415**	**82,379**	**52,096**	**50,830**	**(1,265)**	**91,825**

5.2 Monthly monitoring is undertaken by the Capital Delivery Group to ensure schemes remain on track and where there is slippage this is identified quickly to enable corrective action to be taken or alternative schemes accelerated. The Finance Committee receive a regular capital monitoring update at their meetings.

5.3 STATEMENT OF FINANCIAL POSITION (BALANCE SHEET)

Nov-23	Dec-23	Movement		Mar-23	Dec-23	Movement in Year
£000	£000	£'000		£000	£000	£000
22,069	21,806	(263)	Intangible Assets	25,142	21,806	(3,336)
372,813	376,676	3,863	Property, plant and equipment, other	356,521	376,676	20,155
27,799	27,632	(167)	On SoFP PFI assets	24,654	27,632	2,978
81,318	87,358	6,039	Right of use assets	82,143	87,358	5,215
1,652	918	(735)	Investments	296	918	622
14	14	0	Other investments/financial assets	14	14	0
3,329	3,415	86	Trade & other receivables >1yr	3,113	3,415	302
508,994	**517,818**	**8,824**	**Non-current assets**	**491,883**	**517,818**	**25,935**
11,879	12,324	445	Inventories	10,833	12,324	1,491
32,503	31,918	(585)	Trade and other receivables: NHS receivables	39,244	31,918	(7,326)
22,339	24,451	2,112	Trade and other receivables: non-NHS receivables	22,158	24,451	2,293
466	466	0	Non current assets held for sale	0	466	466
66,834	60,533	(6,301)	Cash	64,388	60,533	(3,855)
134,021	**129,692**	**(4,330)**	**Total current assets**	**136,623**	**129,692**	**(6,931)**
(115,802)	(99,824)	15,978	Trade and other payables: non-capital	(124,670)	(99,824)	24,846
(9,486)	(8,006)	1,480	Trade and other payables: capital	(10,942)	(8,006)	2,936
(33,222)	(38,193)	(4,971)	Deferred income	(8,524)	(38,193)	(29,669)
(6,655)	(5,563)	1,092	Borrowings	(6,210)	(5,563)	647
(4,573)	(4,169)	404	Provisions <1yr	(4,893)	(4,169)	724
(169,738)	**(155,755)**	**13,983**	**Current liabilities**	**(155,239)**	**(155,755)**	**(516)**
(35,717)	**(26,064)**	**9,653**	**Net current assets**	**(18,616)**	**(26,064)**	**(7,448)**
(95,579)	(102,463)	(6,884)	Borrowings >1yr	(103,041)	(102,463)	578
(4,015)	(4,354)	(339)	Provisions >1yr	(4,034)	(4,354)	(320)
(1,768)	(1,747)	22	Deferred income >1yr	(1,941)	(1,747)	194
(101,362)	**(108,565)**	**(7,202)**	**Total long-term liabilities**	**(109,016)**	**(108,565)**	**451**
371,916	**383,190**	**11,274**	**Net assets employed**	**364,251**	**383,190**	**18,939**
			Financed by:			
330,998	342,311	11,313	Public dividend capital	322,064	342,311	20,247
70,036	70,036	0	Revaluation reserve	76,094	70,036	(6,058)
(2,471)	(2,471)	0	Other reserves	(2,472)	(2,471)	1
(26,646)	(26,685)	(39)	I&E reserve	(31,435)	(26,685)	4,750
371,916	**383,190**	**11,274**	**Total financed**	**364,251**	**383,190**	**18,939**

5.4 The in-month movement in long-term borrowings relates to IFRS16 lease addition.

6. CONCLUSION & RECOMMENDATION

6.1 The recent H2 planning process enabled the system to agree a robust financial plan for the remainder of 2023/24 that will achieve a balanced position for all organisations if the assumptions prove to be sound. The industrial action in December and January will create an unplanned pressure of £1.7m and it remains to be confirmed how this will be managed by NHSE. The outcome of this is especially important as the Trust is reliant on additional capital of £1.5m in 2024/25 as a benefit of delivering the agreed plan.

6.2 Agency expenditure remains under constant review and scrutiny as we work with services to seek ongoing assurance that their controls and review mechanisms are well embedded and work effectively. There are continuing signs that the run rate is reducing in some areas (if we exclude the increased usage as a result of winter) but there is more to do, and we are expecting a

further reduction in our cap for 2024/25 so we will need to do more to continue to reduce our temporary staffing expenditure.

6.3 Through our governance and performance management processes we will continue to exercise robust oversight of our financial performance including the delivery of our activity plans. Monthly meetings remain in place for all service groups and corporate functions to ensure we maintain strong levels of grip and control and identify emerging risks at the earliest opportunity.

6.4 The Board are asked to note the financial performance for December.

CHIEF FINANCE OFFICER

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Charity Committee meeting held on 14 November 2023
SPONSORING EXEC:	Director of Strategy and Digital Development
REPORT BY:	Executive PA
PRESENTED BY:	Graham Hughes, Chairman of the Charity Committee
DATE:	26 January 2024

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the Charity Committee meeting held on 14 November 2023. The Committee received assurance/updates in relation to: • The committee effectiveness review • The fundraising report • Charity Charter • The financial position for the legacy charitable funds • The proposed collaboration between the Trust, Musgrove League of Friends and SURE The Committee identified the following areas for follow up: • Committee effectiveness review – induction process for new committee members and integration with other committees The Committee did not identify any issues to be reported to the Board.
Recommendation	The Board is asked to note the assurance and areas for follow up identified by the Charity 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?
This report has not been assessed against the Trust's Equality Impact Assessment Tool.

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE CHARITY COMMITTEE MEETING HELD ON 14 NOVEMBER 2023

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 14 November 2023, along with the assurance received by the Committee and any areas for follow up identified. The meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

COMMITTEE EFFECTIVENESS REVIEW

2.1. The Committee received the effectiveness review which indicates that the Committee is compliant with its terms of reference and conducts its business effectively.

2.2. The Committee noted that James Phipps has been confirmed as a committee member going forward.

FUNDRAISING REPORT

2.3. The Committee received the fundraising report and noted that the key points.

2.4. A significant amount of work continues bringing together the two charities and the committee noted that three sister charity websites are due to be launched on 21st November 2023.

2.5. The Committee noted a range of fundraising events are being arranged across the county including an overseas trek (Camino Trail), an abseil at Shepton Mallet Prison and a Fire Walk at Bridgwater Community Hospital.

2.6. The committee noted a number of garden initiatives are now underway and a working group has been established by Andy Heron to engage with the voluntary sector.

2.7. The Charity branding is now displayed across the Trust's digital advertising screens across MPH, YDH, some Symphony GP surgeries and some community hospitals.

FINANCE REPORTS AND APPROVALS

2.8. The Committee noted the report and accepted Nick Boatwright's correction that the total income for the charity is £826,152 year to date. The total expenditure for the period is £660k, which includes £187k in fundraising costs (£157k of this relates to salaries). Fundraising costs for the same period last

year were £29k, this did not contain salaries as these were previously provided by Compton Fundraising Consultants.

2.9. The Committee noted there are £2.5m of uncommitted funds at present.

2.10. The Committee noted that KPMG's audit of the charity will be discontinued and Nick Boatwright is in the process of exploring alternative auditor's to be in place by the end of February 2024.

2.11. The Committee agreed to work alongside Musgrove League of Friends and SURE to support the purchase of additional equipment for the surgical robot .

2.12. The Committee noted and ratified business cases BC146 to BC151 and BC153.

CHARITY CHARTER

2.13. The committee approved the charity charter document for Somerset NHS Charity.

ANY OTHER BUSINESS

2.14. The Committee agreed that one person is not enough of a beneficiary to receive charitable funds, with the exception of colleague training and development.

3. AREAS OF CONCERN OR FOLLOW UP

COMMITTEE EFFECTIVENESS REVIEW

3.1. The overall workload of the Committee and a review process, an induction process for new Committee members and how the Committee integrates with other sub-Board committees were agreed as areas that require follow up.

3.2. Graham Hughes noted the requirement of training for the Committee.

4. BE REPORTED TO THE BOARD OR OTHER COMMITTEES

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

Graham Hughes
CHAIRMAN OF THE CHARITY COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Mental Health Act Committee meeting held on 12 December 2023
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
PRESENTED BY:	Alexander Priest, Chairman of the Mental Health Act Committee
DATE:	6 February 2024

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the Mental Health Act Committee meeting held on 12 December 2023 and the assurance received by the Committee. The meeting was conducted as a video conference call. The Committees received assurance in relation to: • The Mental Health Act Co-ordination Report • AMHP (Approved Mental Health Professional) Services) • CAMHs out of area placements • The report from the forensic service • The Out of Area Treatment Somerset patients • Interface between AMHPs, ED and places of safety • The update on MCA, DoLs and LPS • The policies and procedures update • The complaints and PALs and serous investigation processes • The Mental Health and Learning Disabilities risk register

	No new items were identified as needing to be added to the risk register or reported to the Board.
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Mental Health Act Committee. The Board is further asked to note the areas to be reported to the Board.

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

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

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

Financial	☒ 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 with the mental health teams. 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.
N/A

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON 12 DECEMBER 2023

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 12 December 2023, the assurance received by the Committee and any areas of concern identified.

2. ASSURANCE AND UPDATES RECEIVED

Mental Health Act Lead Report

2.1. The Committee received the report of the Mental Health Act Lead and noted that it had been an extremely busy period, with higher than usual sickness absence. Despite this, the workload had been managed effectively.

2.2. A significant theme of the reporting period has been the Mental Health Act and Mental Capacity Act interface. The teams are working more closely on a number of cases and will continue to do so going forwards.

2.3. Training continues to be a challenge due to the availability of ward staff. Colleagues have been involved in scrutiny of patient records for audit purposes.

2.4. Audits - Recordings of the outcome of MHA assessments. Scrutiny has taken place on two specific time periods in June and September 2023. 41 patient records were examined, and the results are being collated into a formal audit of compliance.

2.5. A new patient information leaflet for informal patients is being developed. This will provide relevant information to support patients in making the decision whether to accept formal admission. This will go out to consultation with the AMHP and Trust interface group.

2.6. The Committee further noted the current issues relating to: Second Opinion Appointed Doctors (SOADs) not being requested in a timely manner which was raised as a potential rick of non-compliance. Another risk was regarding lapsed detentions. The lapsed detention rate is high compared to other trusts and information has been requested from neighbouring authorities to provide regional comparisons. A small working group will take this forward.

2.7. The Committee noted that 15% of S136 assessment outcomes resulted in no requirement for mental health follow up. Work is taking place with the police to reduce inappropriate S136s and this fits with Right Care Right

Person programme. One workstream is focussing on avoiding S136s where appropriate. Discharging with no mental health follow up can also be a successful outcome.

AMHP Services (Approved Mental Health Professional)

2.8. The Committee received an update and noted: that there remains an issue with the recording of MCA assessments. A review is underway to meet the balance between legislation and clinical practice but also ensuring that decisions are recorded in full and proper detail. The audit recommendations were regarding the documentation of the MCA rather than the practice.

CAMHS

2.9. The Committee received an update on child and adolescent mental health services (CAMHS) out of area placements and noted that there were currently no out of area patients. A piece of work was underway regarding transitions from CAMHS to adult services.

Forensic Report

2.10. The Committee received a progress report and noted: the current caseload levels which was at similar levels to the previous report.

Out of Area Treatment Somerset (OATS) patients

2.11. The Committee noted that 11 patients detained under the Mental Health Act had been placed out of area via a planned admission. Since the last report, the overall number of OATS patients had reduced.

2.12. The Committee received assurance that there were no inappropriate out of area admissions.

Interface between AMHPs, ED and places of safety

2.13. The Committee was advised that the availability of AMHPs was lower than hoped, and this has led to some extended stays in emergency departments for people awaiting assessments. However, work is taking place to improve communication and regular interface meetings with the AMHPs taking place. Workshops are also being set up with the EDs around Right Care Right Person and these will include AMHPs.

2.14. The Committee received an update on the s136 protocol where it was noted that it could not be agreed as a joint agency protocol until further information regarding Right Care Right Person is received. It has therefore been agreed to have a clear SOP regarding what should be done when a patient is brought in on s136 to ED or a s136 suite.

2.15. Assurance was provided that there was no evidence of cost savings affecting the service in light of the Council's financial difficulties.

2.16. The Committee is able to provide assurance to the Board that the cultural challenge is being addressed but there remains a medium-term capacity issue.

Q

Care Quality Commission Reports

2.17. The Committee received an update on the latest CQC MHA compliance report regarding the visit to Pyrland Ward 2. This was very positive, especially regarding patient and care feedback and involvement by carers. Issues which had been identified in a previous visit had been addressed. There were two areas to follow up which are being addressed. It was noted that the CQC had visited Rydon ward 1, but the report from this visit had not yet been received.

Policies and Procedures

2.18. The Committee approved the revised Deprivation of Liberty Safeguards Policy which had been reviewed and updated as there was still no implementation date for Liberty Protection Safeguards. The review had unified the two legacy organisation policies.

Complaints and Issues

2.19. The Committee received the report and noted that, over the period 1 September to November 2023, two new complaints had been received via the Care Quality Commission or through the Trust's complaints process. One complaint had been addressed and the other was still under investigation.

Risk Register

2.20. The Committee received the Mental Health and Learning Disability service group risk register and noted the high rated risks and actions taken to mitigate risks. The Committee particularly noted the risks in relation to: availability of psychology assessments and ADHD - waiting times.

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

3.1. The Committee agreed there were no significant items identified as needing to be added to the risk register or reported to the Board.

Alexander Priest
CHAIRMAN OF THE MENTAL HEALTH ACT COMMITTEE