Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee Business meeting held on 27 November 2024
SPONSORING EXEC:	Peter Lewis, Chief Executive
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Inga Kennedy, Chairman of the Quality and Governance Assurance Committee
DATE:	4 February 2025

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 Business meeting held on 27 November 2024. The Committee received assurance in relation to: • The progress made in relation to the MHRA bed rails alert • The Board Assurance Framework update • The Corporate Risk Register update • The Quality and Performance exception Report • The Patient Safety Board update • The Patient Experience and engagement assurance report • The Mental Health and Learning Disabilities Service Group assurance report • The Independent Investigation and Mental Health Homicide Decision letter • The feedback from the Maternity Safety Support programme visit

	• The oversight of the Maternity and Perinatal Incentive Scheme Year 6 The Committee identified the following areas of concern or for follow up: • The Governance Support Summary – the lack of assurances for some of the topics The Committee identified the following areas to be reported to the Board: • The overlap between the People Committee and the Quality and Governance Assurance Committee in relation to culture and workforce shortages. • The need for a Board level update on no criteria to reside. • To consider the need for a Board development day session on PSIRF and LfPSE in terms of event reporting as a stocktake; and on the process for agreeing the process for identifying the next set of priorities.
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Quality and Governance Assurance Committee. The Board is further asked to note the areas to be reported to the Board.

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

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

Equality and Inclusion **The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.** **How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?**
The needs and potential impacts on people with protected characteristics are considered by each individual service group as part of their update to the Committee. The Committee reviews data presented to the Committee and will raise any queries if required.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.
Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Staff involvement takes place through the regular service group and topic updates.

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

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

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

SOMERSET NHS FOUNDATION TRUST

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

1. PURPOSE

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

2. ASSURANCE RECEIVED

MHRA Bed Rails Alert

2.1. The Committee received an update on the progress made actioning the alert and noted that training had been rolled out but that it will take approximately six months to ensure that all colleagues will be trained. The outstanding action related to the risk assessment of equipment in community settings, particularly linked to adult social care. The Committee noted that discussions will continue to take place with the ICB about progressing this action with regional support.

2.2. The Committee observed that all actions, which were in control of the trust, had been completed but that the outstanding action was not in direct control of the trust.

Board Assurance Framework

2.3. The Committee received the Board Assurance Framework and noted that a review of the governance elements of the BAF will be undertaken in 2025 and that therefore the BAF had been updated based on the current arrangements.

2.4. The Committee received an update on the following objectives: objective 2 – the identification of an aspirational measure relating to improved colleague engagement and the delay in relation to the implementation of the urgent treatment centre business case for YDH; objective 3 – the identification of aspirational measures relating to increasing the number of admissions prevented by Acute Home Treatment and Rapid Response services; objective 4 – further work required to identify the aspirational measure for this objective; the need to capture deprivation and exclusion data; and the need to discuss objective 4 and its link to objective 1 at a future Board Development Day; and objective 5 – the identification of an aspirational measure relating to reducing the number of patient not meeting the “criteria to reside” in acute beds.

2.5. The Committee noted the following high level risks: access to primary care; increase in emergency department demand; fragility of primary care; possible impact of GP action; shortfalls in social care capacity; and length of stay.

2.6. The Committee further noted that actions plans were in place to address the low levels of referral activity into Hospital@Home.

Corporate Risk Register

2.7. The Committee received the up-to-date combined Corporate Risk Register report and noted that there were currently 30 corporate risks on the risk register of which six scored 20 or above. The Committee noted the details of these risks and noted the new risk in relation to data integrity in respect of mental health services. The Committee was advised that this new risk will be reviewed to take account of the shift to Learning from Patient Safety Events (LFPSE).

2.8. The Committee further noted the new risks regarding discrimination – the inability to become the equitable and inclusive organisation we aspire to be for our colleagues and patients due to systemic discrimination; and the inability to create a compassionate and inclusive culture where all colleagues can thrive due to discriminatory behaviour.

2.9. The Committee was advised of a new emerging risk regarding the impact of GPs taking collective action on the trust's services. This risk was currently being reviewed at service group level and will be reviewed from an organisational perspective.

Quality and Performance Exception Report

2.10. The Committee received the report and noted that the report had been presented to the November 2024 Board meeting.

2.11. The Committee discussed the following areas*:* the emerging concern regarding the long delays in terms of Ministry of Justice cases and the impact of the delays on individual patients which will be discussed by the Mental Health Legislation Committee; the strong and consistent performance from mental health services; the work to understand the increase in the use of prone restraints; the successful implementation of the ICE pathology system and the actions being taken to address concerns about historic results; and the no criteria to reside position.

2.12. The Committee particularly discussed the increase in the number of referrals for ADHD and autism spectrum disorders. The Committee noted that innovative ways in which the ADHD service can be provided, e.g. digital assessments prior to face-to-face appointments, are being considered. The Committee further noted: that a group of people have been referred from the private sector to the NHS to restart their treatment; the need to consider patients transitioning from children to adult services; and the establishment of a steering group to look at working practices to ensure that the service was as effective as possible.

2.13. The Committee was provided with feedback from the NHS England Workforce and Education virtual visit which took place mid November 2024. The national team had reviewed the whole training programme and feedback indicated that the visit had been very positive, with positive feedback about the trust itself but also about the trust's response to issues which were not going as well.

Patient Safety Board Report (PSB)

2.14. The Committee received a report on the work of the Patient Safety Board and noted that the PSB was working well across the trust to bring together the safety culture of the trust. The first learning responses from the Patient Serious Incident Response Framework (PSIRF) had been produced and the trust had been able to sign off four patient safety incident investigations.

2.15. The Committee discussed the work of the PSB and noted: the wider concerns regarding the structure and roles within patient safety due to the departure of key colleagues; the discussion about the future approach to safety in line with the quality strategy; the process of scoping current work and identify gaps and opportunities aligned to similar work across governance; the regular review of the membership and terms of reference of the PSB; and the good engagement with service groups and service group reporting to the PSB.

2.16. The Committee discussed the publication of signed off patient safety incident investigations as, at the request of family, not all reports were anonymised. The Committee agreed that it was important to get the balance right and that the aim should be to be open and transparent about the publication of the reports. In addition, the Committee noted that other processes such as sharing reports with the coroner will need to be considered.

2.17. The Committee noted: the work required regarding people who matter (including carers) which will need to include: a deep dive to explore areas of concern and actions to be taken to address these concerns; the system level support for carers including carers in the community; and the support for colleagues in managing these relationships. The Committee further noted the progress in relation to the implementation of Martha's rule, including the ongoing engagement and preparation work, the simulation testing of the phone line and electronic referral form; and the expectation that live testing will start on wards at MPH and YDH by December 2024 with roll out across the acute sites by April/May 2025.

Patient Experience and Engagement Assurance Report

2.18. The Committee received the first report and the purpose of the report was to provide a summary and analysis of patient experience and engagement activity across the trust, including PALS, complaints, feedback from Healthwatch and National Survey results.

2.19. The Committee noted: the number of second letters received and the action being taken to understand the drivers for second letters, including the analysis of themes; the commencement of an NHS complaints standards diagnostic

focussing on resolution meetings; the training provided with a focus on compassionate engagement and early and timely resolution; the decrease in the number of new complaints; performance in relation to resolving complaints within an agreed timeframe and the process for monitoring and reporting exceptions; and the completed risk assessment for formal complaints, including identified mitigations.

2.20. The Committee further noted: the work undertaken over the last six months to develop the Radar system to be able to manage complaints; the service areas with the highest proportion of complaints; the work in the emergency department to triangulate complaints information and to put the information into context with the number of concerns and the high levels of demand; the thematic analysis by AI technology as part of the Copilot trial to help to identify trends; details of the closed Parliamentary and Health Service Ombudsman (PHSO) case; the ongoing use of Care Opinion as a platform for obtaining patient feedback and the work taking place to increase the use of Care Opinion to obtain patient feedback; the interpretation and translation service trial and its positive impact to date within maternity services; the engagement work taking place with less heard communities; and the impact of vacancies within the complaints team on response times' performance.

Service Group Assurance Report – Mental Health and Learning Disabilities

2.21. 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 significant improvements in the service group's governance arrangements; the implementation of the learning from patient safety events (LfPSE) and patient safety incident response framework (PSIRF) systems within the service group and the data challenges faced by the service group; the need for designated spaces for colleagues to discuss HR issues and concerns; and the successful establishment of HR groups for colleagues to be able to resolve longstanding issues more efficiently.

2.22. Committee further noted: the me@SFT interviews held as part of the Joy at Work programme, the roll out of this process within community services, and the reporting arrangements; the establishment of an overarching group at executive level, including the ICB, to explore the concerns in relation to ADHD demand and capacity; the positive feedback from the Leadership Quality Walkround particularly in relation to visibility of the senior leadership team; the increase in the number of PALS enquiries for the South Somerset team, the development of an improvement plan to address any concerns and the senior support provided to the team; the national accreditation of Holford Ward by the Royal College of Psychiatrists; and the progress made in relation to the carers assessment service, including the establishment of a Carers Group to explore opportunities to bring carers into services.

2.23. The Committee received an update on the ongoing NHS England project across all mental health wards regarding inpatient transformation and noted:

the different workstreams, including on culture of care; and the positive feedback by colleagues on the programme.

2.24. The Committee discussed the definition of mental health homicides and noted that the traditional definition had been clear, but that in the light of the PSIRF process, the national definition has been reviewed and changed to “anyone who has had any contact with mental health services”. Discussion on the implications of this new definition were taking place with NHS England’s regional Independent Investigation Review Team and the ICB. The Committee noted that the new and more generalised definition may result in an increase in the number of homicide reviews.

2.25. The Committee agreed that the report provided good assurance about the service group’s approach to governance.

Independent Investigation and Mental Health Homicide Decision Letter

2.26. The Committee received an overview of the incident that led to the homicide investigation in March 2023 and noted that the report was positive, that the Homicide Group will continue to monitor the action plan, and that an assurance visit to the ward by the senior leadership team will be undertaken in 2025. In addition, the ICB and the regional Independent Investigation Review Team (IIRT) will also be visiting the ward in 2025.

Maternity Safety Support Programme (MSSP) Visit

2.27. The Committee received feedback from the visit and noted that the visit had been positive. Feedback had highlighted areas for improvement and, with the exception of the availability of blood products on the labour wards, these areas were as expected. The Committee noted that two blood fridges had been ordered and that the factual accuracy report was expected in December 2024.

2.28. The Committee further noted that: the team had found the visit really positive and that the MSSP team will continue to provide support to the team with useful tools and resources.

Maternity and Incentive Scheme (MIS) Year 6

2.29. The Committee received the quarterly maternity and perinatal safety and quality report and noted that an audit on the evidence against six of the ten safety actions was being undertaken by internal auditors.

2.30. The Committee received an update on the following areas of concern:

- Safety action 9 – demonstrating clear oversight to the Board on maternity and neonatal safety and quality issues – regular briefings reports have been presented to the Quality and Governance Assurance Committee alongside briefings on transitional care (safety action 3), the anaesthetic workforce (safety action 4) and Saving Babies Lives care bundle implementation (safety action 6). The Committee has provided the Board with regular assurance reports.

- Safety action 8 – training – compliance will be reported to the Committee in December 2024 but work was ongoing to ensure that all required colleagues attend fetal monitoring and maternity emergencies training.

- Safety action 5 – data relating to the percentage of specialist midwives employed and mitigation to cover any inconsistencies still have to be reported to the Board. The Committee noted that the percentage of specialist midwives, at 9.78%, was compliant with the 2021 Birthrate + workforce recommendations but that a new midwifery workforce assessment recommended a percentage of 15%. This uplift amounted to 10.62 wte and the service was looking at actions to be taken to address this shortfall.

- Safety action 6 – the requirement to demonstrate that best endeavours, and sufficient progress, had been made towards full implementation of version 3 of the Saving Babies Lives care bundle. A review by the LMNS Programme Board meeting concluded that best endeavours had been made, but that further progress was required. The Committee noted that progress against this safety action will be reported to the December Committee meeting.

  The Committee noted: the progress in relation to the implementation of the culture improvement plan; and that the Chief Nurse will continue to meet with the Perinatal Leadership team bi-monthly.

- Safety action 9 – evidence that a review of maternity and neonatal quality and safety was undertaken by the Board or an appropriate Committee – further work will be required as the service had only presented one thematic review to the Committee to date. The Committee noted that the team was still adjusting to the new PSIRF reporting framework and embedding the concept.

- Safety action 3 – the Committee reviewed and accepted the action plan.

2.31. The Committee acknowledged that this process had been difficult for the service and thanked the team for their dedication and commitment.

3. AREAS OF CONCERN OR FOLLOW UP

Governance Support Summary

3.1. The Committee received feedback from the Quality Assurance Group and the Data Review Group meetings. In relation to the Quality Assurance Group, the Committee noted the discussion in relation to the topic reports, including the red rating for the introduction of New Clinical Procedures topic due to the lack of assurance that appropriate processes were being followed, and the amber

rating for six topics due to limited levels of assurance available for elements of the topics and/or parts of the trust.

3.2. In relation to the Data Review Group, the Committee noted the discussion in relation to: a wide range of data, including Care Quality Commission patient surveys; a new potential outlier alert in respect of the National Bowel Cancer Audit adjusted 18-month unclosed ileostomy after anterior resection and the review by the team to ensure that this was an outlier and to identify any follow up actions.

3.3. The Committee further noted the receipt of 15 national audit reports with potential areas for improvement identified in seven of the reports.

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 overlap between the People Committee and the Quality and Governance Assurance Committee in relation to culture and workforce shortages.
- The need for a Board level update on no criteria to reside.
- To consider the need for a Board development day session on PSIRF and LfPSE in terms of event reporting as a stocktake; and on the process for agreeing the process for identifying the next set of priorities.

5. BOARD ASSURANCE FRAMEWORK (BAF)

5.1 The Committee agreed that it had received both positive and negative assurance for the various objectives that this Committee is responsible for.

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.

Inga Kennedy
CHAIRMAN OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee business meeting held on 18 December 2024
SPONSORING EXEC:	Peter Lewis, Chief Executive
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Inga Kennedy, Chairman of the Quality and Governance Assurance Committee
DATE:	4 February 2025

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 business meeting held on 18 December 2024. The Committee received assurance in relation to: • Strategic objective 5 – respond well to complex needs • The Leadership quality Walkround 20024 Report • The Premises Assurance Report • The Sustainability Update • The Maternity and Perinatal Incentive Scheme (MPIS) Year 6 • Care Quality Commission Action Plan • Management of Colleague Personal Files The Committee identified the following areas of concern or for follow up: • Personalised Care – update to be provided to a future meeting • Premise Assurance Report – update to be presented to a future meeting.

	• Inquest regarding a mental health inpatient death in 2020 The Committee did not identify any areas to be reported to the Board.
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Quality and Governance Assurance Committee. The Board is further asked to note the areas to be reported to the Board.

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

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

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

Equality and Inclusion

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

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

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

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE FOCUS MEETING HELD ON 18 DECEMBER 2024

1. PURPOSE

1.1. The report sets out the items discussed at the business meeting held on 18 December 2024, along with the assurance received by the Committee and any areas of concern identified. The meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

Strategic Objective 5 – respond well to complex needs

2.1. The Committee received a presentation on the work in relation to this objective and noted the aspirational measures relating to no criteria to reside and further noted the additional measures on "monitoring the length of wait to date for assessment for adults with ADHD/ASD" and "the number of young people with a transition plan".

2.2. The Committee received an update on the work in relation to the system wide work on patient flow, and particularly on the five key areas of focus: admission to being medically fit; transfer of care hub – decision making and enabling discharges; pathway 1 (discharge to asses) – capacity by geography and effective provision; pathway 2 delays with pathway 2 beds, effectiveness of reablement, future bed requirements and access criteria; and pathway 3 – new service model.

2.3. The Committee noted the challenges for each of these area of focus and the work taking place to improve processes and reduce delays in the pathways.

2.4. The Committee noted the establishment and the success of the multi-disciplinary and multi-professional services set up to manage high intensity adults (2 services) and young people (one service) users in the community. The Committee noted the positive impact of these services on ED attendances by these group of patients.

2.5. The Committee recognised that although assurances for this objective had been rated as positive, and actions had been rated as green, the majority of the KPIs continued to be rated red and it was therefore essential to consider whether the focus was on the right actions or whether additional actions will be required. The Committee noted that work on reviewing actions was taking place.

Leadership Quality Walkround 2024 Report

2.6. The Committee received a report on the Leadership Quality Walkrounds undertaken in 2024 and noted that 32 visits across mental health, community services and acute services had been undertaken during 2024.

2.7. The Committee noted: that the findings of the walkrounds provided assurance that the key themes from the visits were already areas of focus; that overall feedback from the visits had portrayed a positive, engaged leadership and compassionate and dedicated colleagues, experiencing challenging levels of demand and expectation through a period of change; the common theme around lack of appropriate or sufficient clinical and resting space and the longstanding issue in relation to the suitability of some of the estate. The committee observed that the key theme had not changed from the previous year and that consideration may need to be given as to whether the focus was on the right areas of improvement or whether the themes related to the risks held by the trust as it is difficult to mitigate these risks to drive the improvement that the trust would like to see.

2.8. The Committee noted: the main themes relating to workforce/recruitment, estates and facilities, and digital systems; and the need to consider how to capture feedback from other visits. The Committee noted the consensus about how much people value the process and the ability to be able to engage with colleagues and patients.

Premises Assurance Report

2.9. The Committee received an overview of the Premises Assurance Model (PAM) submitted for the trust.

2.10. The Committee noted: the background to the PAM; the “good” or “minimal improvement required” level of assurance for many aspects of estates and facilities related compliance; the areas where moderate levels of improvement are required; areas of inadequate compliance; the development of mitigation plans for each area of improvement or inadequate compliance; the implementation of the Quick Solutions software to support the collection of evidence for the PAM submission; the overview of the PAM submission for each domain and the work required to achieve full compliance; the introduction of a new domain relating to helipads and the work required to achieve compliance with this domain; the discussion in relation to the costed action plans for all domains to be able to make informed decisions as to the prioritisation of improvement work; and the work required regarding the triangulation of information from the PAM submission, the leadership quality walkrounds and patient and colleague feedback.

Sustainability Update

2.11. The Committee received an update on the progress made in relation to the implementation of the strategic aims set out in the Green Plan.

2.12. The Committee noted: the oversight by the Strategic Sustainability Group; the review of the Green Plan in 2025 following the receipt of guidance from Greener NHS; the updating of the objectives to include specific timeframes and milestones; the risks to implementing a number of the objectives, e.g. funding for decarbonising the existing estate, reducing omissions from travel by moving to EVs and implementing a number of digital programmes; the challenges in relation to reducing food waste and changing the content of meals provided; the limitations in the available data to determine the trust's carbon footprint and the work with the supply chain and other external organisations to understand how to use established method to overcome these challenges.

2.13. The Committee noted that adaptation to the impact of climate change and the risk related to digital resilience were areas where least progress had been made. In relation to the impact of climate change, the Committee asked Richard Harper to liaise with other rural organisations to check what discussions are taking place in other organisations.

2.14. The Committee agreed that the report provided assurance in terms of proper leadership and oversight for taking this work forward, and the implementation plan provided a set of milestones and evidenced the progress made. The Committee observed that a number of actions had a deadline of March 2025 and noted that the aim was to complete these actions by the deadline but, if not fully completed, some improvements will have been made. The Committee further noted that the majority of the actions from the internal audit had been addressed.

Maternity Incentive Scheme (MIS) Year 6

2.15. The Committee received an update of the current position regarding compliance with the MIS year 6 since the September 2024 meeting.

2.16. The Committee noted the internal audit on the evidence available to support the trust's position against six of the ten safety actions and the conclusion that the evidence indicated non-compliance with safety action 6 (implementing version 3 of the Savings Babies Lives care bundle) and safety action 9 (having clear oversight in place to provide the Board with assurance on maternity and neonatal safety and quality issues). The Committee noted the reasons for this non-compliance and the work taking place to support the implementation of the audit recommendations. The Committee noted that, although the remaining audited safety actions had been assessed as compliant, internal audit had identified opportunities to enhance the quality of the evidence provided to demonstrate compliance with the safety action.

2.17. The Committee received the report regarding safety action 1 quarterly perinatal mortality review and noted the two themes identified during the quarter: triage provision; and a number of cases where the baby had a known congenital anomaly. The Committee noted the work taking place to address these findings and further noted that the Board declaration will be presented to the January 2025 Committee meeting.

2.18. The Committee recognised the challenges and noted that discussions were taking place on how to improve governance, assurance and reporting to the Board; and that a virtual meeting had been set up with the national team to share learning and areas of best practice.

Care Quality Commission Action Plan

2.19. The Committee received the updated action plan and agreed: that the action plan provided assurance about the review process; and that appropriate support was in place to consider the evidence required to demonstrate delivery of the improvements made.

2.20. The Committee noted that four actions had been completed and closed and that a number of actions remained open pending the outcome of audits to test the actions.

Management of colleague personal files

2.21. The Committee received an update on the risk relating to colleague record keeping and noted that the risk was proactively managed and that a report on potential next steps in support of the overarching record keeping policy will be presented to the People Committee meeting and shared with the Quality and Governance Assurance Committee.

3. AREAS OF CONCERN OR FOLLOW UP

Personalised Care

3.1. The Committee received an update on the personalised care work programme and noted the findings of the personalised care internal audit undertaken in 2023 which related to: a lack of an organisational focus on personalised care; the lack of consistent personalised care plans; the low uptake of training; and the lack of sharing areas of good practice.

3.2. The Committee noted the actions taken to address the findings, including: a dedicated lead role to focus on personalised care; the establishment of a personalised care improvement group jointly with Healthwatch Somerset and other stakeholders, including two patient voice partners and colleagues; engagement with colleagues about their understanding of personalised care, to identify barriers to personalised care and to share ideas.

3.3. The Committee noted that the findings of the engagement exercise had highlighted a strong consensus of the definition of personalised care and its benefits but had also highlighted challenges such as time constraints, limited resources, cultural and attitudinal barriers and communication difficulties. Areas for improvement included: increased staffing and time allocation; enhanced communication and training; and the need to foster a patient-centred culture.

3.4. The Committee further noted: the key enablers for the delivery of personalised care – leadership behaviours and fostering trust, compassion, equality,

respect and innovation; the productive care project in Mendip; the work with the ICB to create a shared agenda to address the challenges and opportunities for embedding personalised care and providing support with developing plans through an improvement approach; collaboration with the patient experience and engagement team to utilise feedback from patients and carers; the development of a set of co-produced aims and measures; the next steps, including seeking leaders to develop workstreams of the test and learn cycles, the sharing of learning, and the development of a campaign for staff to think about personalised care in an active way. The Committee noted that the timeframe was to start work on 1 January 2025 and to have a personalised care plan in place for piloting by the end of March 2025 in Mendip.

3.5. The Committee asked for a further update to be provided to a future meeting.

Premises Assurance Report

3.6. The Committee recognised the value of the PAM self assessment and agreed that it will be important to triangulate and cross reference the PAM data with other sources of information such as the Care Quality Commission reports, patient feedback and other sources. The need for external assurance had been raised at the Audit Committee and it had been agreed to ask for a follow up report to be presented to a future Quality and Governance Assurance Committee meeting.

Inquest regarding a mental health inpatient death in 2020

3.7. The Committee received an update on the findings of the inquest and noted that a narrative verdict had been recorded. The issues identified related to supervision and the lack of securing the therapy room. The Coroner recognised the significant changes made to Rowan Ward since the incident in 2020.

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 or other Committee.

5. BOARD ASSURANCE FRAMEWORK (BAF)

5.1 The Committee agreed that the reports have enabled the triangulation of a number of topics relating to the Board Assurance Framework and provided both positive and negative assurance about objectives assigned to the Committee.

5.2 The Committee agreed that it had received positive assurance in terms of objective 5 – the development of the personalised care approach and the

current work in relation to no criteria to reside; and objective 2 – the condition of the estate and the maternity services update.

5.3 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.

Inga Kennedy
CHAIRMAN OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	New Hospital Programme (NHP) Review and Implications for Somerset Foundation Trust
SPONSORING EXEC:	David Shannon, Director of Strategy and Digital Development
REPORT BY:	David Shannon, Director of Strategy and Digital Development Ian Boswall, Director of Redevelopment
PRESENTED BY:	David Shannon, Director of Strategy and Digital Development
DATE:	4 February 2025

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 provides and update on the NHP Review and the implications for services provided on the Musgrove Park Hospital site. The announcement of the revised schedule for the New Hospital Programme has delayed the start date for any works on the Musgrove Park Hospital Site by at least 5 years, with a start date for construction set at 2033. This increases the risk of being able to deliver services for the medium to long term in buildings – specifically the maternity and Paediatric building.
Recommendation	To note the update and the revised timeline for the inclusion of Musgrove Park Hospital in the new hospital programme. To discuss the next steps in reviewing the continuity of service delivery with the new timeline and mitigations required during this period. To note the financial risk as a result of write off of previous investment in the programme.

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

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

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

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?

An EQIA and impact assessment has been completed for the Scheme, this has been updated as the plans developed. This will now need to be updated as a result of the change in programme timescales. The programme has completed an overarching EQIA https://www.gov.uk/government/publications/new-hospital-programme-review-outcome/new-hospital-programme-equality-impact-assessment

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.

Colleague and patient involvement and engagement has been undertaken over the five years of the programme. Following the recent announcement, meetings have been held with impacted services and communicated to all of the Trust.

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 –

The Board has previously received updates on the programme and associated business cases.

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

OUTCOME OF THE NATIONAL NEW HOSPITAL REVIEW AND THE IMPACT ON THE MUSGROVE PARK HOSPITAL SCHEME AND CLINICAL SERVICES

1. NATIONAL NHP REVIEW

1.1. In September 2024, the New Government stated that the current New Hospital Programme (NHP) is 'unaffordable and undeliverable' and announced that there would be a review of the Programme to ensure there was a realistic and deliverable timetable of schemes that are appropriately funded.

1.2. The outcome of the national review commits £15bn over next 5 years. This has reduced the number schemes proceeding to complete broadly by 2030 to 22. A number of those schemes are historic schemes that have either completed or are due for completion shortly. The schemes proceeding for completion by 2030 are now classified as 'Wave 1' schemes.

1.3. There were 22 schemes in scope of the review and 18 of those have been delayed. Of the 18 schemes that are delayed 9 are expected to be completed between 2030 and 2035, with the remaining 9 scheduled for construction between 2035 and 2040.

1.4. The evaluation process used in the review to profile schemes was based on key assessment criteria (multi criteria decision support analysis).

This included

- NHS England Estate Return Information Collection (ERIC) and Patient-Led Assessments of the Care Environment (PLACE) - this data is collated and submitted by trusts for their sites, then consolidated by NHS England

- Office for National Statistics (ONS) who maintain relevant statistics on a local authority basis

Some data was generated by NHP, including:

- Scheme deliverability which has been evaluated by scheme leads within the NHP team

- Data on the impact of estate condition. This had previously been completed by the NHP clinical team in conjunction with trusts, as part of site inspections

1.5. The outputs of the review model have not been shared with Trusts to date. The specific detail of the review the criteria and output can be found in the link below. New Hospital Programme: plan for implementation - GOV.UK

1.6. Through discussion between Department and Health and Social Care and Treasury Ministers the scheme phasing is based on a funding envelope of £3bn per year.

2. MUSGROVE PARK HOSPITAL SCHEME

2.1. The NHP Scheme at MPH consisted of 3 main parts:

- Replacement of the Maternity, Gynae and Pediatric department from the 1940s buildings
- Development of an elective care center replacing the theatres and wards in Queen Building and day surgery unit
- Redevelopment of Queens building to provide updated emergency services

2.2. The MPH is part of wave 2. Specifically, the expectation is that a restart of planning will happen in the financial year 2030/31, and to commence construction between 2033 and 2035 Based on the current 7-year construction programme, this would mean construction completion around 2040. The scheme has already been delayed for over 3 years so cumulatively this would be a 10-year delay assuming a restart to the programme in 2030/31.

2.3. Two business cases had been approved by the Trust Board and submitted to the Department of Health and Social care to support early enabling works for the scheme, this included a new multi-story car park and electrical infrastructure improvements. These projects will now be paused as funding is unlikely to be available until after 2030, although this will be reviewed in the context of the next round of capital allocations.

3. CRITICAL INFRASTRUCTURE INVESTMENT ASSESSMENT

3.1. In recognition of impact of delays on the 18 wave 2 and 3 schemes NHP have stated that they will working closely with NHSE to support Trusts to fund critical infrastructure investment to sustain services for the next 10 years. The recent 2025/26 capital allocations support this intention and NHP intend to initiate a data collection process to assess the extent of this requirement and that will inform capital allocations between 2026 and 2030.

3.2. Information is being gathered on the anticipated costs for bringing the accommodation in the scope of the scheme up to Condition B (sound and operationally safe estate) and maintain that status over 10 years. The assessment will also include the provision of a 2nd maternity theatre and replacement of the existing end of life modular maternity theatre, paediatrics

condition improvements, the replacement of the ventilation systems for day surgery unit and roof replacement to enable that upgrade. This cost over the next 10 years has been estimated at £98m which is in excess of the ability to fund from within normal system capital allocations. Support from the national team will be required to progress this level of development.

3.3. The ability to be able to undertake this maintenance and provide the upgrades is high risk. There is limited ability within the current site footprint to enable the decant of existing facilities. To provide a level of context the current maternity and neonates building is approximately 3000m sqm, more than a single floor of the Duchess building on the Site.

4. IMPACT OF PAUSING THE NHP SCHEME

4.1. NHP has requested that wave 2 schemes wind down their programme teams by end of March and will support with redeployment across the Programme where possible. An assessment of the implications of the redeployment of the current NHP is currently being made.

4.2. The expenditure on programme development to date since 2020 will need to be treated as a revenue cost in 2024/25 as the scheme delivery is several years away. NHP have advised they are working with Treasury to provide resource cover for these costs, this has yet to be confirmed, however will be impacting all schemes included in wave 2 and wave 3.

Impact on current and future service provision

4.3. The most significant risk from the scheme delay is the ability to sustain delivery of maternity services. However there are risks to sustain a suitable estate to maintain and improve the quality of other services including paediatrics, gynae services and the elective and emergency services provided from the Queens building.

4.4. The estate condition is currently recorded as a risk of 16 on the corporate risk register, this assumed that the new hospital programme would resolve a number of the issues in a timely way. This assessment will now need to be reviewed, and it is likely that without alternative mitigation, the risk will increase. There are a number of other risks on the risk register associated with fire safety and compartmentation and service impact of poor infrastructure that will need to be reviewed accordingly.

4.5. A detailed review of these continuity and estate risks will be undertaken over the next few weeks alongside next steps for mitigation

5. NEXT STEPS

5.1. There a several immediate and medium-term steps that will be undertaken as a result of the announcement.

- Manage the impact of the pause in the national programme and funding on the programme infrastructure. This will include ensuring financial support is received to manage the transition period and other revenue consequences in 2024/2025.

- Review and update the risk assessments relating to the estate and service continuity resulting from the new timeline.

- Assess the options for medium term investment into the estate to maintain services until the development of the new build. This will include a review of enabling works and short-term redevelopment options to inform a critical infrastructure bid.

- Continue to work with New Hospital Programme to understand the ongoing interaction and programme governance.

5.2. The specific timescale for the actions will need to be developed over the coming weeks, with priority to advise the Board on the first two actions at its next meeting.

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Guardian of Safe Working for Postgraduate Doctors Quarterly Report – Q3 2024/25
SPONSORING EXEC:	Melanie Iles, Chief Medical Officer
REPORT BY:	Tom Rees (TST) and John McFarlane (YDH), Guardian of Safe Working; Lee-Ann Toogood, Medical Workforce Manager
PRESENTED BY:	Melanie Iles, Chief Medical Officer
DATE:	4 February 2025

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

Executive Summary and Reason for presentation to Committee/Board	This report covers quantitative and qualitative summary of exception report data generated between 17 October 2024 and 24 January across Somerset NHS Foundation Trust. The key findings from the report are: • The downtrend in exception reporting (ERs) this quarter from YDH, but numbers are still higher than historical averages. ERs from MPH are comparable to previous quarters. We have seen a spike in ERs from Ophthalmology and DCT trainees at MPH which requires further investigation. • Both the GoSW and individual supervisors have found the current method of ER and actioning difficult to navigate and use. We anticipate further issues may arise from this in the future and would advocate for a better interim solution. The recommendations from the report are: • We continue to recommend that an interim solution is found to the current method of exception reporting across the trust. • We continue to be concerned that exception reporting may be under reported as a consequence and have found OOH exception reports to be minimal. We understand an interim solution is in the pipeline and would support expediting its implementation.

Recommendations	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)

Improve health and wellbeing of population

☐ Obj 2 Provide the best care and support to children and adults

☐ Obj 3 Strengthen care and support in local communities

☐ Obj 4 Reduce inequalities

☐ Obj 5 Respond well to complex needs

☒ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture

☐ Obj 7 Live within our means and use our resources wisely

☒ Obj 8 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

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

Details:

Equality and Inclusion

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

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

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.

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

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

CONTENTS	

QUARTERLY REPORT ON SAFE WORKING HOURS:

DOCTORS AND DENTISTS IN TRAINING

1. EXECUTIVE SUMMARY

1.1. We have seen a downtrend in ERs this quarter from YDH, but numbers are still higher than historical averages. ERs from MPH are comparable to previous quarters. We have seen a spike in ERs from Ophthalmology and DCT trainees at MPH which requires further investigation.

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:

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

3.1. **Exception reporting since the introduction of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016**
As of 24/01/2025 - Total of exception reports since implementation of 2016 TCS (December 2016). 3494 for Taunton and for Yeovil 1636. The overall cost of exception report overtime is £93,426.17

Figure 1 Quarterly total for exception reporting

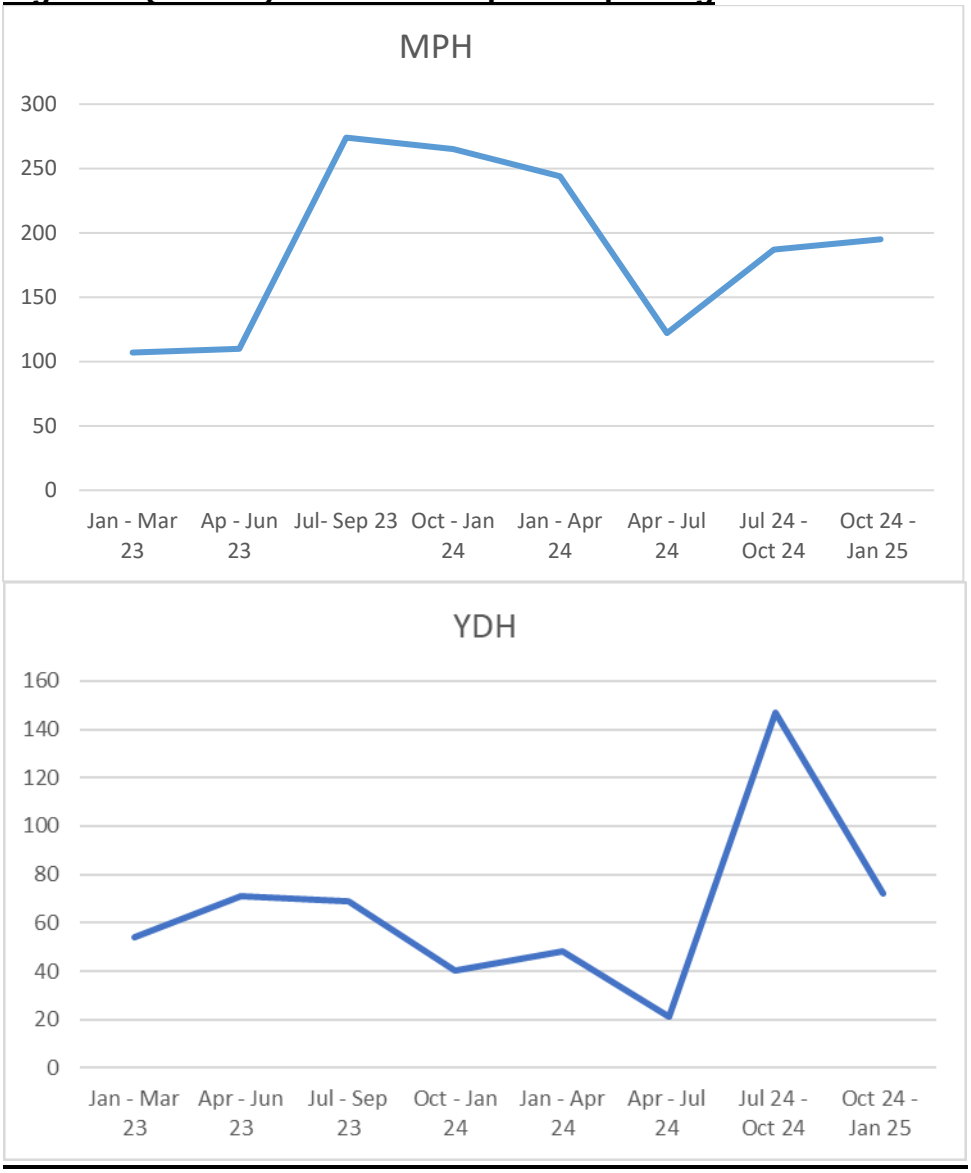
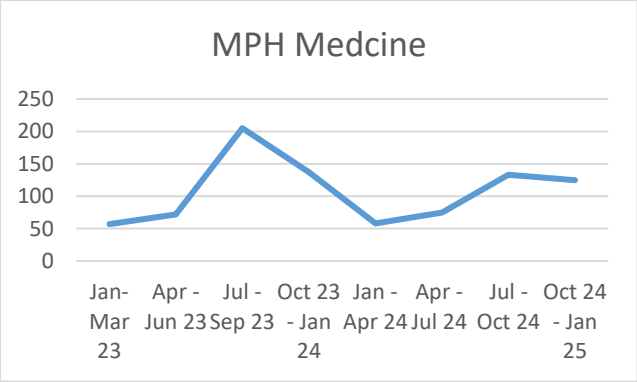
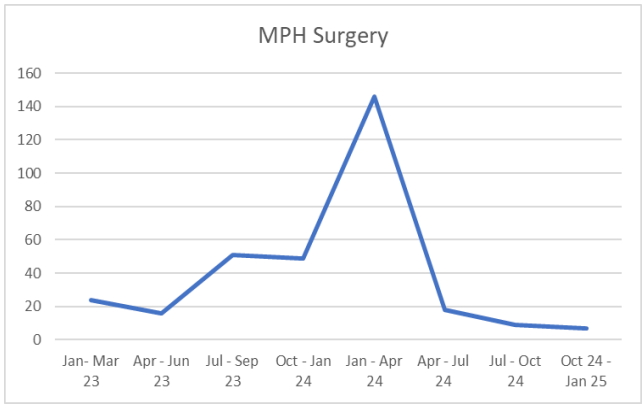
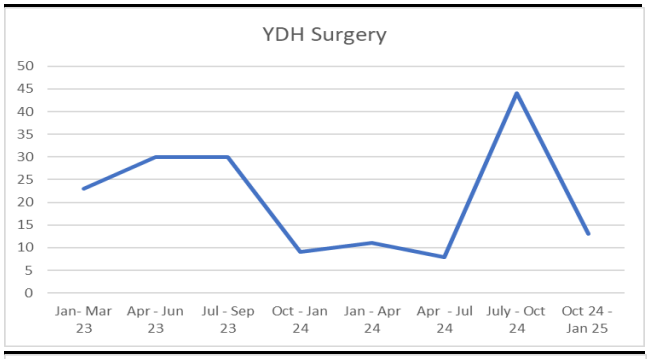
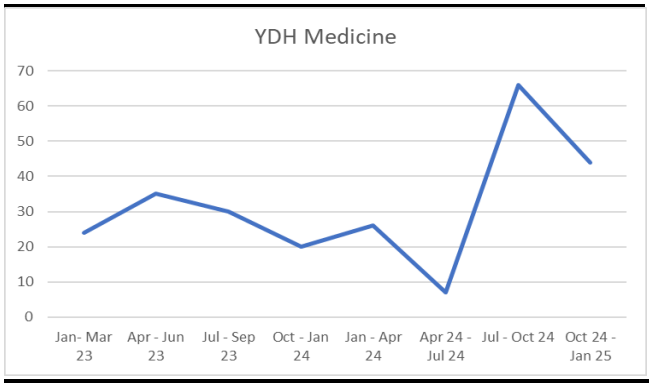


Figure 2 Exception Report Trends by Specialty









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

Table 1: Exception reports per specialty

Specialty	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**	**Type**
Acute & General Medicine	MPH 125 (133) YDH 44 (66)	48 44	77 0	Hours MPH 116 YDH 43 Educational MPH 7 Pattern YDH 1 Support MPH 1
Anaesthetics	0 *(0)*	0	0	
DCT Trainees	23 *(0)*	0	23	Hours 23
Emergency Medicine	MPH 3 (1) YDH 5 (1)	2 0	1 5	Hours MPH 3 YDH 5

Specialty	No. exceptions raised	No. exceptions closed	No. exceptions outstanding	Type
ENT	1 *(0)*	0	1	Hours MPH 1
General Surgery	MPH 6 *(9)* YDH 13 (44)	6 0	0 13	Hours MPH 6 YDH 10 Pattern 1 YDH Support 2 YDH
O&G	MPH 1 (13) YDH 1 *(1)*	1 0	0 1	Hours MPH 1 YDH 1
Oncology/ Haematology/Palliative Care	MPH 4 *(0)* *YDH 3 (0)*	3 1	1 2	Breaks YDH 3 Hours MPH 4
Ophthalmology	MPH 19 (0)	19	0	Hours 15 Education 2 Pattern 2
Paediatrics	MPH 0 *(0)*	0	0	
Psychiatry	MPH 10 *(12)*	1	9	Hours MPH 10
Trauma & Ortho	MPH 1 *(1)* YDH 5 (9)	0 0	1 5	Hours 5 YDH 1 MPH
Urology	MPH 0*(1)* *YDH 0 (2)*	0 0	0 0	Hours 1 MPH
Vascular	1 *(4)*	0	1	Hours 1 MPH
Total	**265**	**126**	**139**	

Table 2: Exception reports per trainee grade

Grade of trainee	No. exceptions raised Taunton	No. exceptions raised Yeovil
F1	65	40
F2	58	21
CT1-2 / ST1-2	66	9
ST3+	4	2
Total	**193**	**72**

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)
Clinical Support & Cancer Services	£401,204.37	£41,801.22	£24,176.00	£482,924.46
CYP & Families Services	£688,387.18	£40,564.85	£51,008.91	£800,863.13
Medical Services	£2,945,780.82	£164,139.65	£76,775.85	£3,479,745.16
Mental Health and LD	£1,031,155.76	£78,460.56	£83,347.72	£1,204,314.76
Neighbourhood Services	£115,119.02	£11,751.54	£1,450.98	£142,329.62
Operational Management	£63,437.50	£666.40	£183.20	£72,742.35
OPMH Sedgemoor	£12,920.00	£1,064.00	£0.00	£15,766.96
OPMH Taunton	£42,318.88	£3,268.00	£10,285.17	£51,426.71

Surgical Services	£450,601.04	£21,097.32	£8,977.20	£533,880.36
Grand Total	£5,750,924.57	£362,813.54	£256,205.03	£6,783,993.51

3.3. **Qualitative summary of exception reports**
At MPH we have seen a spike in the number of ERs generated from DCT trainees due to NROC work and Ophthalmology due to overrun clinics. TR due to meet DCT trainees and CSL, and meet Ophthalmology supervisors. Other ER numbers in line with previous Qs. However, we have seen an increase in missed educational opportunities at MPH, particularly from foundation trainees, mainly generated due to ward work load in medical specialities.

3.4. **Immediate safety concerns (ISCs)**
No ISCs have been reported this quarter at Yeovil. There was a single immediate safety concern raised at MPH generated on 20 January which was due to a deteriorating patient who was not transferred to an acute ward, despite escalation. I am awaiting further information from the Resident doctor and supervisor and will provide an update at the next Q report. Another ISC raised at MPH was misclassified.

3.5. **Fines**
No fines were issued during this quarter.

3.6. **Work schedule reviews**
There were no work schedule reviews this quarter.

4. ISSUES ARISING

4.1. **Postgraduate Doctor Forum (PDF)**
Yeovil continue to hold regular well attended PDFs, and hopefully these have helped to reduce the spike to exception reporting from last quarter.
PDF was held at MPH. Number of attendees was lower than previous forums. We will attempt to encourage attendance at next PDF.

4.2. **Rota management**
At MPH there have been concerns raised regarding the issuance of the O&G rota, which was not allocated within the 6 week time window, but has now been resolved. There were also concerns regarding the Psychiatry rota which was not reflective of the work schedule (more OOH work) and has required change to the resident doctors pay.

4.3. **Weekend working/ Out of Hours Issues**
We continue to see few numbers of ERs raised from weekend working. No themes were raised this Q regarding OOH issues.

5. SUMMARY

5.1. At Yeovil the trend is downwards following the big spike in exception reports in both general surgery and medicine last quarter. The number of reports has

now fallen to 75 still above the average quarterly figure of 50. All supervisors at Yeovil struggle to use the current reporting system which makes monitoring and feedback to exception reports difficult. At MPH we have seen ER numbers comparable to previous quarters. However, we have seen a spike in ERs from Ophthalmology and DCT trainees, which require further investigation.

6. RECOMMENDATIONS

6.1. We continue to recommend that an interim solution is found to the current method of exception reporting across the trust. As one resident doctor wrote:

'The removal of the Allocate exception reporting system has severely hampered my ability to submit exception reports on time - previously they could be completed from home and the system would track them automatically, which was straightforward enough to do on a NWD or weekend. The new system cannot be accessed outside of the trust to my knowledge, and I have to track submissions manually, via a spreadsheet, and send the updated version to myself. Extrapolated, I suspect this results in significant underreporting at a trust level, although data, if available, may show otherwise.'

6.2. We continue to be concerned that exception reporting may be under reported as a consequence and have found OOH exception reports to be minimal. We understand an interim solution is in the pipeline and would support expediting its implementation.

Tom Rees and John McFarlane Guardian of Safe Working

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the People Committee meeting held on 4 December 2024
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Graham Hughes, Chairman of the People Committee meeting held on 4 December 2024
DATE:	4 February 2025

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 4 December 2024 and the assurance received and areas of concern or for follow up identified. The meeting was conducted as a video call. The Committee received assurance in relation to: • Colleague story – the programmes offered to individuals within services. • The review of the Board Assurance Framework – strategic objective six - and Corporate Risk Register. • Colleague Experience Group progress report - the ongoing work of the Employee Experience Group and the ambition to bring colleague experience alongside patient experience and performance elements. • Both negative and positive assurance from the flexible working learning item. • Director report - the positive progress with the workforce plan and controls in place and the positive assurance form NHS England. The Committee identified the following areas for follow up:

	• The Corporate Risk Register – follow up report on the "collective action by GPs" risk. • Colleague Experience Group progress report - follow up report to be provided to a future meeting. • Director Report **-** update on the workforce plan will be presented to the January 2025 Committee meeting. • Director Report – deep dive into the new workforce at a future meeting. • Director Report - update on the demand on the workforce data team to be provided to a future meeting. The Committee did not identify any issues 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 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

Equality and Inclusion
The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can. How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
The colleague story and learning item are ways of identifying potential impacts on colleagues with protected characteristics and any lessons learned will be followed up.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

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

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 4 December 2024, the assurance received by the Committee and any areas of concern or for follow up identified.

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

2. ASSURANCE RECEIVED

Colleague story – Rising Star Programme

2.1. The Committee received the colleague story which focussed on a colleague's journey from a healthcare assistant (HCA) to a deputy ward manager.

2.2. The Committee noted that the colleague had worked in the Intensive Care Unit for 18 years, 16 years as a Band 5 Staff Nurse and the last two years as a Band 6. The colleague shared her lack of confidence and self-belief and her decision to take part in the Leadership Development programme. The Committee noted the benefits of the leadership development programme and in particular the colleague's development of her self-awareness, and the increase in her confidence and self-belief.

2.3. The Committee further noted: the supportive team environment during the course and the ongoing peer support and networking; the colleague's successful application for a Band 6 post; the successful application of the skills learned during the course, especially shift leading, role modelling, handling of difficult situations and supporting junior colleagues; the use of the team engagement and development tool to gain colleague opinions and understand their needs, resulting in improved communication and recognition within the ICU team; the survey to be undertaken in June 2025, involving the team, allied health professionals and medical professionals, to improve teamwork across the wider team.

2.4. The Committee agreed that the story was an excellent example of the return on investment in people development and noted the need to encourage all colleagues to access the available development programmes to progress in their careers.

Review of Board Assurance Framework (BAF)

2.5. The Committee received the updated Board Assurance Framework in relation to strategic objective six.

2.6. The Committee noted: the improvement in the retention rates across the trust and the concerns in relation to nursing and midwifery colleague retention; the reconvened Retention Action Group with the aim to develop a retention dashboard to strengthen oversight; the improvement in the National Pulse Survey response rates and the ongoing efforts to further increase the response rate to be able to better understand colleague experiences; the challenges in relation to the inclusion measures, the negative rating for these measures and the long period of time required for the inclusion workforce plan to deliver the necessary cultural change; the two risks related to discrimination; the review of the listening roadmap; and the delays in strengthening controls relating to links between colleague experience and learning; and the implementation of the retention action plan.

2.7. The Committee noted that the workforce planning audit report will be presented to the January 2025 Audit Committee meeting.

2.8. The Committee discussed revised target dates whilst stressing the importance of retaining the original target dates to acknowledge implementation delays.

Corporate Risk Register

2.9. The Committee received the updated corporate risk register relating to the People Committee and noted that there had not been any significant changes since the last report. The Committee noted the following key points: the correction of the incorrectly rated discriminatory behaviour risk from 16 to 12; the ongoing risk around substandard multi-disciplinary teams (MDT) working and the mitigating actions being taken; the analysis of the workforce demographics to understand the risk of losing colleagues due to retirement; the work to assess the short and long-term impact of potential collective action by GPs on services, including exploring alternative service delivery models; the review of nurse staffing risks; and the review of the survey results for risk training .

2.10. The Committee received an update on the senior operational team meeting discussions on cultural indicators and noted: the need to identify red flags that could indicate service or cultural issues within teams; the need to make information more widely available; the need to consider concerns about managers not addressing workforce related issues as part of the process of developing the year 3 people strategy deliverables.

2.11. The Committee noted the review of the reward and recognition process and the need to ensure that unregistered colleagues have the ability to feel recognised as part of the wider organisation.

Colleague Experience Group progress report

2.12. The Committee received an update on the work of the Colleague Experience Group and noted that the group was still evolving and focussing on integrating data sources to measure colleague experience effectively. The Committee noted that assurance will be obtained from colleague experience, patient

feedback and activity and performance data to understand what is contributing to a positive workplace culture.

2.13. The Committee noted: the key objective to triangulate the intelligence relating to culture from colleague experience to be able to understand and assess how actions are aligning with the ambition; the works of the key action groups to break data down by services and review HR data against formal and informal complaints, Freedom to Speak Up concerns and the national quarterly Pulse survey results; the increase in the Pulse survey response rates; the opportunity for the Colleague Experience Group to influence additional questions in the survey to measure the impact; the Gold quality improvement process to be undertaken over the next 12 months to ensure that the aims and objectives of the group were the right aims and objectives; and that the operational leadership group meetings will be used to triangulate patient and colleague experience and performance to be able to understand the culture of the organisation.

2.14. The Committee further noted: the objective to support colleagues through wellbeing support and coaching and mentoring provided by the leadership and organisational development team; and that measures are being considered for the newly developed multi-disciplinary working for leadership and leadership programme.

Learning Item – Flexible Working Programme

2.15. The Committee received an update on the flexible working programme and learning from the last 18 to 24 months and noted that flexible working was a key focus within the People Promise.

2.16. The Committee noted: the increase in the number of colleagues who felt that the trust championed flexible working; that 61% of colleagues felt that they had a good work/life balance; the decrease in the number of colleagues leaving due to work-life balance issues; the development of a dashboard providing insight into key areas including colleagues working less than full time hours; the breakdown of information relating to colleagues working less than full time hours and the need to focus on the reasons why colleagues at band 7 and above were less likely to work less than full time hours; and the introduction of a self-service flexible working application to be able to provide a better oversight of flexible working arrangements.

2.17. The Committee further noted: the participation in the Timewise Flexible Working Programme focussing on leadership and supporting and managing the flexible working process; the positive progress made and the challenges in relation to generational differences and reluctance from managers; the need for continued education on flexible working; the need to advertise flexible working options more consistently to attract a broader candidate pool and reduce post-hire flexible working requests; the ongoing work with the Electronic Staff Record (ESR) in relation to team-based rostering; and the launch of a national policy around flexible working which will be implemented within the trust.

2.18. The Committee discussed the flexibility of work locations, especially the balance between home-based and office-based working and noted that there had been a shift in expectations post covid and that there was now more flexibility in terms of work location than pre covid. There was variation within services and some colleagues have left due to more rigid office-based work. The Committee recognised the importance of balancing team dynamics with individual flexibility and further recognised the ongoing challenge of managing these expectations.

2.19. The Committee noted that medical and nursing colleagues already work flexibly by providing cover seven days a week and through extended hours; and that the adaptation of the self-rostering system in several organisations had made a significant difference in terms of colleague satisfaction.

Director Report

2.20. The Committee received the report and received an update on the Somerset Workforce Plan. The Committee noted: the trajectory to deliver a workforce cap by the end of March 2025 in line with a national mandate to reduce the growth in workforce; the over-achievement against trajectory by 17 wte; the increase in workforce where appropriate, e.g. dermatology services; the year to date agency spend and the significant reduction in agency spend compared to the previous year; the under-delivery against the national agency cap due to gaps in primary care and mental health services; the plan to review the workforce plan following the receipt of national guidance; the aim to have a draft workforce, finance and activity plan by mid February 2025.

2.21. The Committee received an update on the collaborative work taking place across the system; the success from the service groups owning the recruitment control process; the positive feedback received from NHS England about finance and workforce management as part of the quarterly review meeting.

2.22. The Committee further noted: the significant work carried out to ensure that ESR was fit for purpose and ready for the new workforce solution expected in the next two years; the use of workforce data and the demand on the workforce data team; the transformation programme for people services planned for 2025 and the aim of the programme to streamline processes, improve digital capabilities, and reduce costs; the need to consider the Equality Impact Assessment process for large transformational change; and the work in relation to the use of AI and process automation to improve efficiency.

3. AREAS OF CONCERNS/FOLLOW UP

Corporate Risk Register

3.1. The Committee noted that a further update on the “collective action by GPs” risk will be presented to the January 2025 Committee meeting.

Colleague Experience Group progress report

3.2. The Committee asked for a further update to be provided to a future meeting.

Director Report

3.3. The Committee noted that an update on the workforce plan will be presented to the January 2025 Committee meeting.

3.4. The Committee agreed to undertake a deep dive into the new workforce solution at a future meeting.

3.5. The Committee further discussed the demand on the workforce data team and whether there were opportunities to reduce the reliance on the workforce data team. The Committee agreed to ask for an update to be provided to a future meeting.

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

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

5. ASSURANCE FRAMEWORK

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

- Colleague story – the programmes offered to individuals within services.
- The review of the Board Assurance Framework – strategic objective six - and Corporate Risk Register.
- The ongoing work of the Employee Experience Group and the ambition to bring colleague experience alongside patient experience and performance elements.
- Both negative and positive assurance from the flexible working learning item.
- The positive progress with the workforce plan and controls in place and the positive assurance form NHS England.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the People Committee meeting held on 14 January 2025
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Graham Hughes
DATE:	4 February 2025

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the People Committee meeting held on 14 January 2025 and the assurance received and areas for concern or follow up identified. The meeting was conducted as a video call. The Committee received assurance in relation to: • The review of the board Assurance Framework – the action plans to mitigate the areas of negative assurance. • The Corporate Risk Register • The People Strategy update - the progress of deliverables for year one and year two of the People Strategy. The Committee agreed the proposed approach for year three, focusing on consolidation and measurement of current initiatives. • The Approach to Recruitment - the significant improvements in recruitment systems and processes, including the alignment of the ledger, ESR, and recruitment systems. This alignment provides valuable insights into workforce management and control. - The Committee acknowledged the tremendous contribution of volunteers to the organisation.

	- The positive developments in AI applications for recruitment and the implementation of the vacancy tracker, which provides accurate and real-time data on vacancies and recruitment progress. • Director report - the job planning platform The Committee identified the following areas for follow up: • The Corporate Risk Register – a follow up on the senior medical workforce risk. • People Strategy – a table with RAG ratings to be developed to show progress against each of the people strategy initiatives • Terms of Reference and Planner - the terms of reference to be checked against the new Care Quality Commission framework and a new deputy chair to be appointed. • Frequency of meetings – *follow up on* the suggestion to change the frequency from monthly to bi-monthly • Approach to recruitment – achievement of the time to hire target. The Committee did not identify any issues 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	Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

Equality and Inclusion

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

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

The needs and impacts on people with protected characteristics are considered as part of the wide recruitment process.

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 people strategy adnd apporach to recruitment agenda items.

Previous Consideration

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

The assurance report is presented to the Board after each meeting.

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

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

SOMERSET NHS FOUNDATION TRUST (SFT)

ASSURANCE REPORT FROM THE PEOPLE COMMITTEE

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 14 January 2025, and the assurance received by the Committee and areas of concern or for follow up identified..

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

2. ASSURANCE RECEIVED

Review of Board Assurance Framework

2.1. The Committee received the updated Board Assurance Framework in relation to strategic objective six. The Committee noted that: the target dates for colleague experience and learning had been extended to June 2025 but that the original target date was still noted; the review of the next steps for retention focus had been moved from December 2024 to March 2025; and that the Retention Action Group was up and running with progress being monitored.

2.2. The Committee further noted that actions plans were in place to mitigate the areas of negative assurance.

Corporate Risk Register

2.3. The Committee received the updated corporate risk register relating to the People Committee and noted the reduction in the number of risks on the corporate risk register. The Committee noted the key highlights: five of the 25 risks were scored 20; the vacancies within the senior clinical workforce were a significant risk which may benefit from a further deep dive session; the new risk in relation to the inability to isolate patients in accordance with infection prevention and control requirements due to a lack of capacity within trust inpatient areas; and the emerging risk in relation to increased levels of colleague sickness due to respiratory illnesses.

2.4. The Committee noted: that 40 risks were held at service group level with an increase in workforce related risks; the decrease in the risk relating to the lack of an unified policy and approach for the management of colleague personal files and the oversight of the impact of this risk by the Quality and Governance Assurance Committee; the further consideration of the risks in the context of the 2025/26 financial framework and the workforce cap at the Operational Leadership Team meeting.

People Strategy

2.5. The Committee received the people strategy update report and noted that the strategy included 24 ambitions to be delivered over a five year period and that

consideration will need to be given to the year three deliverables. It was noted that 13 of the deliverables had been completed.

2.6. The Committee further noted: the challenge to measure the impact of the deliverables as the results of the National Staff Survey and Quarterly Pulse surveys did not provide a clear indication of the tangible improvements for colleagues; the proposal to take a pause in year three to consolidate the work done so far, ensuring clear and measurable Key Performance Indicators (KPIs) for each deliverable; that the staff survey findings were still awaited; that the people services function was embarking on a significant transformation programme to support the organisation and its future needs, including a focus on supporting the Board and subcommittees in understanding and embedding inclusion into their leadership; that performance against the retention measure had reduced slightly but continued to be within the expected parameters and that, overall, the trust was performing well.

2.7. The Committee accepted the proposal to consolidate work in year three, focussing on measuring the impact of deliverables and ensuring realistic targets. In response to a question, the Committee noted that work on tracking internal career development opportunities and movement from service to service was taking place.

Approach to Recruitment

2.8. The Committee received an update on the recruitment work and the Committee noted: the vacancy cap position – 55 whole time equivalent (wte) above the cap as at December 2024, but 11.99 wte above the planned target in terms of the workforce plan; the significant reduction in the use of temporary staffing.

2.9. The Committee noted the following key points:

- The significant demand on the recruitment team in 2024 with a peak of 259 vacancies in October 2024; and the increase in demand from 2023.
- The efficiency gains from the implementation of the Oleeo recruitment system and the challenges with system integration and communication issues.
- The improved quality and inclusion data with an increasing number of applicants declaring disabilities and other demographic information.
- The number of colleagues who have moved around the organisation via the recruitment pathway.
- The successful but challenging implementation of the Oleeo system in view of the management of a high demand whilst learning a new system; and the roll out of the system to cover medical and international recruitment towards the end of this financial year.

- The consideration of the use of AI for some of the recruitment tasks.

- The transition to a managed service model to improve efficiency and candidate experience by quarter four of this financial year.

- The successful implementation of the managed service by the medical recruitment team in December 2024.

- The development of central training for recruitment to support hiring managers with the process and ensure inclusivity.

- Details of the new vacancy tracker, the opportunity to view data by staff group and the role out of the tracker to hiring managers in February 2025.

2.10. The Committee discussed the use of AI in recruitment to improve inclusivity as part of the shortlisting process and noted: that previous experience had shown that the AI process had produced the same shortlist as the manual shortlisting process; the need to constantly monitor the basis on which AI models are trained; the importance of being clear to candidates if AI was being used; the need to monitor the use of AI by candidates; and the concerns in relation to the use of AI in agenda for change job descriptions matching and the request to involve staff side in the AI work.

2.11. The Committee further discussed: the further work to be carried out to ensure that the process for internal movements within the organisation is streamlined and consistent across the organisation; that additional resources may be required for the transformation to a managed service; the progress made in aligning the ledger, ESR and recruitment systems; the measurement of the effectiveness of recruitment decisions and the ongoing focus of the Retention Group on this area.

2.12. The Committee recognised: the excellent work to improve the recruitment process; the need to continue to focus on productivity and reducing agency and locum staffing costs; the resources required to deliver the transformation of the recruitment service.

Director Report

2.13. The Committee received the report and noted the following additional updates: the opportunity to obtain learning from a trust in the Midlands on the introduction of a virtual assistant to handle low-level queries and casework within the people services department and the opportunity to trial the virtual system; the need to review the state of employee relations across the organisation and the areas of focus - capability of managers and colleagues to handle casework, the efficiency of investigations, and the overall handling of grievances and sickness absence; the importance of reviewing the current learning and education offer within the organisation with the goal to ensure that the training and education provided are fit for purpose, effective, and aligned with the organisation's needs.

2.14. The Committee acknowledged the significant contributions of volunteers to the organisation, particularly highlighting their role in the smooth running of the trust and the opening of the Maple unit.

3. AREAS OF CONCERNS/FOLLOW UP

Corporate Risk Register

3.1. The Committee further discussed the concerns about the substantial number of medical vacancies and the effectiveness of recruitment strategies. The Committee noted that some vacancies are hard to fill and that there was a need to understand the short to medium-term impact on services. The Committee agreed to ask for an update on the senior medical workforce risk to be presented to a future meeting.

People Strategy

3.2. The Committee asked for a table with RAG ratings to be developed to show progress against each of the people strategy initiatives

Terms of Reference and Planner

3.3. The Committee discussed its terms of reference and asked for the terms of reference to be checked against the new Care Quality Commission framework. The Committee noted the need to appoint a deputy chair.

Frequency of meetings

3.4. The Committee discussed the frequency of the People Committee meetings and noted the suggestion to change the frequency from monthly to bi-monthly to be able to better manage the workload and focus on essential business. Feedback on this proposal was requested and this will be followed up at the February 2025 meeting.

Approach to Recruitment

3.5. The Committee noted:

- The time to hire of 73.2 days with a target to achieve a 45-day time to hire by April 2025 and the challenges to achieve this new target. In response to a question, the Committee noted that if this target was not achieved by April 2025, detailed plans to work towards achieving this target as soon as possible will be put in place.

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

4.1 The Committee did not identify any issue to be reported to the Board at this meeting.

5. ASSURANCE FRAMEWORK

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

- The Committee acknowledged the ongoing risk related to medical recruitment and workforce.

- Assurance was received on the progress of deliverables for year one and year two of the People Strategy. The Committee agreed the proposed approach for year three, focusing on consolidation and measurement of current initiatives.

- The significant improvements in recruitment systems and processes, including the alignment of the ledger, ESR, and recruitment systems. This alignment provides valuable insights into workforce management and control.

- The Committee noted that the current time to hire is still too long and emphasised the importance of keeping this KPI highly visible.

- The Committee acknowledged the tremendous contribution of volunteers to the organisation.

- The Committee was assured of the positive developments in AI applications for recruitment and the implementation of the vacancy tracker, which provides accurate and real-time data on vacancies and recruitment progress.

- The Committee received assurance on the job planning platform which was included in the Chief People Officer report.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Mental Health Legislation Committee meeting held on 10 December 2024
SPONSORING EXEC:	Jade Renville, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
DATE:	4 February 2025

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 Legislation Committee meeting held on 10 December 2024 and the assurance received by the Committee. The meeting was conducted as a video conference call. The Committees received assurance in relation to: • The Section 117 Update • The Patient and Carer Race Equality Framework update • The Mental Health Act Lead report • The MCA, DoLs and LPS update • The ICB commissioning update • The update from the children and adolescent mental health services (CAMHS) • The forensic progress report • The out of Area Treatment Somerset (OATS) progress report • The Care Quality Commission report for Holford Ward • The position in relation to complaints and other issues

	• The progress made in relation to the management of risks The following areas of concern or for follow up were identified: • Section 117 – business case • The Mental Health Lead Report – the lack of progress with the Mental Health Act assessment Standing Operating Procedure (SOP) • The Mental Health Lead Report – the relationship with the police • The MCA, DoLS and LPS update - training compliance for medical and dental colleagues • Approved Mental Health Professional Services – the lack of representation at the meeting • Complaints and issues – the review of the access to services The Committee identified the following areas to be reported to the Board: • The positive feedback from the CQC report for Holford Ward • The progress in relation to Section 117 • The ongoing demand on the mental health administration team • The lack of overall engagement from the police
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	Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

Equality and Inclusion

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

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

The needs and potential impacts on people with protected characteristics are considered 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 LEGISLATION COMMITTEE MEETING HELD ON 10 DECEMBER 2024

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 10 December 2024, the assurance received by the Committee and any areas of concern identified.

2. ASSURANCE AND UPDATES RECEIVED

Section 117

2.1. The Committee noted the longstanding Section 117 Aftercare challenges due to the shared responsibility arrangements between the Local Authority and the ICB and further noted: the changes in government policy in relation to funded nursing care for Section 117 patients and the necessary adjustments in funding allocations; the management of high-cost packages by an integrated panel and the streamlining of decision-making; the benefits of a single decision-making panel.

2.2. The Committee noted that a working group, involving the trust, local authority and the ICB will meet in 2025 to agree a unified Section 117 policy for Somerset.

2.3. The Committee noted that work on discharge planning for Section 117 patients and the recording of discharge planning was taking place and that guidance and training will be provided.

2.4. The Committee received the findings of a Parliamentary Health Service Ombudsman (PHSO) and Local Government Ombudsman (LGO) investigation into a complaint regarding Section 117 Aftercare. The Committee noted that some areas of improvement had been identified for both the local authority and the trust and that a response action plan will be prepared to implement the report's recommendations.

Patient and Carer Race Equality Framework

2.5. The Committee received an update on the Patient and Carer Race Equality Framework and noted: that the framework was a mandated framework; that the framework was designed to support mental health providers to improve access, experiences and outcomes for racialised and ethnically and culturally diverse communities; that providers will be required to produce actions to reduce racial inequalities and that progress will be monitored by the Care Quality Commission (CQC). The Committee noted the actions to be taken

and further noted that a report will be presented to the February 2025 Quality and Governance Assurance Committee.

Mental Health Act Lead Report

2.6. The Committee received the Mental Health Act Lead report and noted the following highlights from the report: the increase in the number of tribunals since the summer and the positive feedback from tribunal members; the staffing changes; the increase in training requests, including further requests from Musgrove Park Hospital clinicians and Rowan/Rydon clinicians for S52s (holding powers); the requests for CTO training and the intention to roll this training out to the wider community teams; the advocacy activities; the reduction in the percentage of lapsed detentions.

The Committee received an update from a CTO recall in January 2024 involving a patient from Wessex House and noted the circumstances and details of the recall and the placement of the patient at Sevenoaks. The Committee noted that lessons had been learned; that a clear process for managing such future situations was in place; that discussions about the next steps around duty of care were taking place; and that the patient was making progress in Sevenoaks.

The Committee received the statutory guidance on discharge from mental health inpatient settings.

The Committee further noted: that the implementation of Right Care Right Person was ongoing; the increase in the number of patients taken to the place of safety; the reduction in the number of patients taken to YDH; the increase in the number of patients discharged after admission to a place of safety to 76% with either ongoing or no further support; the good working relationship with the police to roll out Right Care Right Person.

MCA, DoLs and LPS updates

2.7. The Committee received a verbal update in relation to the MCA, DoLs and LPS work and noted the following key highlights: the refresh of the Mental Capacity Act Policy which included engagement with patients and families with experience to ensure a person-centred approach; the work taking place on Consent to Share and the launch of the Standard Operating Procedure in 2025; the differing approaches by local authorities regarding the intersection of DoLS and the Mental Health Act and the need to continue to monitor the difference in approaches; the increase in level 2 training and the excellent compliance levels at YDH.

ICB Commissioning

2.8. The Committee received an update and noted that: the ICB had received a court order to convene a multi-agency meeting to provide information to a patient tribunal; the right staff to take part in this meeting had been identified.

CAMHS

2.9. The Committee received an update on child and adolescent mental health services (CAMHS) out of area placements and noted*:* that currently three young people had been placed out of area; the work taking place to repatriate or discharge two of these patients; that Wessex House remained closed and was expected to re-open in March with a new staffing team.

Forensic Report

2.10. The Committee received a progress report and noted the report.

Out of Area Treatment Somerset (OATS) patients

2.11. The Committee received the report and noted that planned admissions remained at ten and the details of some of these patients were noted. The Committee noted that there was one inappropriate out of area placement and the reason for this placement was noted.

Care Quality Commission (CQC) Report – Holford Ward

2.12. The Committee received feedback from the CQC visit to Holford Ward on 11 September 2024 and noted the positive feedback with good feedback from patients, carers and the IMHA service. The Committee noted the two concerns raised and further noted that the concerns raised in the previous report had been resolved.

2.13. The Committee noted the reason for the late presentation of the report to the Committee and agreed that the report provided excellent assurance about the positive environment. The Committee complimented the Holford Ward team on the excellent report.

Complaints and Issues

2.14. The Committee received the report and noted that six new complaints had been received via the Care Quality Commission or through the Trust's complaints process. The Committee noted the details of the complaints and agreed that it was assuring that no common themes or areas of concern had been identified.

2.15. The Committee noted that the use of AI was being trialled within the patient experience team to help with thematic analysis of formal complaints.

Risk Register

2.16. 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 discussed the following risks*:* the introduction of Dialogue Plus had been an improvement but had created challenges for medical recording on RiO – a review of all patients with a diagnosis of schizophrenia was taken place to ensure that proper documentation was recorded; the risk relating to the safeguarding concerns about a residential supported living facility in Somerset – the learning disability team continued to actively monitor and review trust patients in residence at the facility; the ADHD risk – which was being managed by the Chief Medical Officer and the ICB.

Internal Audit Requests

2.17. The Committee asked for audits to be carried out on Section 17 Leave; and Section 136.

3. AREAS OF CONCERN OR FOR FOLOW UP

Section 117

3.1. The Committee received an update on the Section 117 proposal and noted that the business case for a small project team had not been successful due to resource implications. The Committee asked for this to be raised with the executive team.

Mental Health Act Lead Report

3.2. The Committee noted the lack of progress in relation to the Mental Health Act assessment Standing Operating Procedure (SOP) due to the concerns about additional paperwork for clinicians.

The Committee further noted the challenges in bridging the gap between health, mental health and the police in certain areas. The Committee agreed to explore the opportunities to improve the overall relationship with the police.

MCA, DoLs and LPS updates

3.3. The Committee noted the concerns in relation to medical and dental staff training levels. The Committee agreed to raise the training levels for medical and dental staff with the Chief Medical Officer and noted the offer from Emma Lawton to consider how best to deliver the training to suit the needs of the team.

AMHP (Approved Mental Health Professional) Services

3.4. The Committee noted that there was no representation from the local authority at the meeting and the local authority will be requested to nominate a deputy.

Complaints and Issues

3.5. The Committee noted that a further complaint may be received via the CQC regarding care provided by community mental health services, access to these services and care provided by the home treatment team. The Committee asked for access to services to be reviewed.

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

4.1. The Committee identified the following areas to be reported to the Board:

- The positive feedback from the CQC report for Holford Ward
- The progress in relation to Section 117

- The ongoing demand on the mental health administration team
- The lack of overall engagement from the police

Alexander Priest
CHAIRMAN OF THE MENTAL HEALTH LEGISLATION COMMITTEE

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Group Finance report
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Mark Hocking, Deputy Chief Finance Officer
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	4 February 2025

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 Group. It includes commentary on the key issues, risks, and variances, which are affecting the financial position.
Recommendation	The Board is requested 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 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

Equality and Inclusion

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

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

The report itself has not been assessed against the Trust's Equality Impact Assessment Tool but the impact on protected characteristics will be considered as part of the overall financial plan.
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

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

SOMERSET NHS FOUNDATION TRUST

FINANCE REPORT

1. SUMMARY

1.1 In December, the Trust recorded a surplus of £1.517m, this was in line with the planned position for the month. Cumulatively, the Trust is £8.177m in deficit, which is also breakeven to plan.

1.2 The main December headlines are:-

- Agency expenditure in month totalled £2.169m, this was £1.073m below the plan for the month. It was also £0.065m below the ceiling for the month and £0.259m below November expenditure. Cumulatively, the Trust has spent £4.7m less than in the equivalent 2023/24 period.
- CIP of £6.359m was delivered in December, in line with plan. Of this, recurrent savings were £2.433m (38% of total). Cumulatively, total efficiencies of £41.071m have been delivered which is on plan, of these, £14.449m (35%) are recurrent. The unidentified gap has reduced again this month and is now c£2m.
- Total whole time equivalents for all staff groups were 12,561 in December 30 below the expected trajectory for the month and we remain on course to deliver the cap.

2. INCOME AND EXPENDITURE

2.1 Table 1 below sets out the summary income and expenditure account to 31 December 2024:

Table 1: Income and Expenditure Summary December

Statement of Comprehensive Income	Annual Plan £000	Current Month 9			Year to date		
		Plan £000	Actual £000	Fav./ (Adv.) Variance £000	Plan £000	Actual £000	Fav./ (Adv.) Variance £000
Income							
Patient Care Income	998,488	83,087	85,277	2,190	750,225	766,562	16,338
Other Operating Income	72,568	6,732	6,644	(88)	51,970	58,141	6,171
Total operating income	**1,071,056**	**89,819**	**91,921**	**2,102**	**802,195**	**824,703**	**22,508**
Operating expenses							
Employee Operating Expenses	(739,748)	(60,801)	(63,057)	(2,257)	(557,036)	(567,904)	(10,869)
Drugs Cost: Consumed/Purchased	(93,421)	(8,035)	(7,965)	70	(71,546)	(71,642)	(95)
Clinical Supp & Serv Exc-Drugs	(32,992)	(2,379)	(5,573)	(3,195)	(27,998)	(48,602)	(20,604)
Supplies & Services - General	(35,549)	(2,962)	(2,669)	293	(26,662)	(25,945)	717
Other Operating Expenses	(158,268)	(13,203)	(11,036)	2,168	(118,819)	(114,307)	4,512
Total operating expenses	**(1,059,978)**	**(87,380)**	**(90,300)**	**(2,920)**	**(802,062)**	**(828,400)**	**(26,338)**
Operating Surplus/Deficit	11,078	2,439	1,621	(818)	133	(3,697)	(3,830)
Finance Expense	(13,070)	(1,089)	(331)	759	(9,805)	(7,983)	1,821
Finance Income	2,424	202	285	83	1,818	3,156	1,338
Other	0	0	0	(0)	(1)	0	1
Overall Surplus/(Deficit)	432	1,552	1,575	24	(7,855)	(8,524)	(669)
Depr On Donated Assets	1,397	116	81	(35)	1,047	740	(308)
Donated Assets Income	(2,591)	(216)	(102)	114	(1,943)	(1,682)	261
Amortisation	9	1	1	(0)	7	7	(0)
Impairments (Reversals)	0	0	0	0	0	1,039	1,039
Other	753	63	(36)	(99)	567	246	(321)
Adjustments to control total	(432)	(36)	(57)	(21)	(322)	349	671
Adjusted Financial Performance	0	1,517	1,517	0	(8,177)	(8,177)	0

2.2 The tables below set out pay expenditure and whole time equivalent (wte) information by month. Actual performance is compared with plan in each table.

2.3 In December, overall staffing levels were 30 wte below the workforce cap trajectory for the month: -

- Substantive staff were 36 wte over plan
- Bank staff were 39 wte under plan
- Agency staff were 37 wte under &
- Locums were 10 wte over the planned cap

2.4 The Trust continues to operate effective processes to manage and review our workforce. The annual Cap wte (12,505) is the workforce target the organisation has committed to try and achieve by the end of March 2025 in line with the NHSE planning expectation and is based on October 2023 staffing levels and we remain on track to deliver this.

2.5 Overall temporary staffing numbers were under plan in month and December's wte's decreased by 35.4 wte when compared with November. The agency decrease was 3.22 wte.

Table 2: Pay expenditure information

2024/25 Monthly Pay Expenditure analysis	Mar-24 £000	Apr-24 £000	May-24 £000	Jun-24 £000	Jul-24 £000	Aug-24 £000	Sep-24 £000	Oct-24 £000	Nov-24 £000	Dec-24 £000	2024/25 In Month Plan £000	F/(A) Variance £000	2024/25 Total £000	2024/25 YTD Plan £000	F/(A) Variance £000
Temporary staff															
Bank Staff	3,554	2,090	1,927	1,894	1,882	1,975	1,826	2,767	2,064	1,977	2,033	56	18,401	19,362	961
Medical Agency	1,819	1,830	1,685	1,275	1,411	1,779	1,424	1,865	1,722	1,418	2,087	669	14,409	16,861	2,452
Medical Locums	1,409	1,152	1,032	938	1,159	818	1,000	908	1,023	995	503	(492)	9,026	4,531	(4,496)
Nursing Agency	966	771	618	547	547	486	369	501	384	441	888	447	4,663	8,825	4,162
Other Agency	466	484	497	391	405	331	317	331	323	311	269	(42)	3,388	2,533	(855)
Total Temporary Staff	**8,214**	**6,326**	**5,759**	**5,044**	**5,404**	**5,388**	**4,936**	**6,372**	**5,516**	**5,142**	**5,779**	**637**	**49,887**	**52,111**	**2,224**
Nursing	21,933	15,075	14,998	15,079	14,949	14,854	14,993	18,511	15,649	15,664	16,631	967	139,772	149,634	9,861
Support to Nursing	8,300	6,307	6,229	6,256	6,106	5,999	6,061	7,302	6,082	5,967	5,528	(440)	56,310	49,478	(6,832)
Medical	15,301	12,773	10,722	11,723	12,261	12,263	12,138	15,250	16,541	13,071	12,041	(1,031)	116,743	111,847	(4,896)
AHP's	13,095	8,615	8,680	8,658	8,656	8,616	8,646	11,165	9,279	9,360	9,699	339	81,675	87,653	5,978
Infrastructure Support	10,612	9,657	9,326	9,461	9,302	9,599	9,355	11,518	9,686	9,662	7,903	(1,759)	87,567	77,143	(10,423)
Other	5,196	3,191	4,956	3,611	4,026	3,845	4,164	3,955	4,012	4,190	3,220	(970)	35,950	29,169	(6,781)
Substantive Staff	**74,437**	**55,618**	**54,912**	**54,789**	**55,300**	**55,176**	**55,357**	**67,701**	**61,250**	**57,915**	**55,021**	**(2,894)**	**518,017**	**504,925**	**(13,093)**
Total All Staff	**82,651**	**61,943**	**60,671**	**59,833**	**60,704**	**60,565**	**60,293**	**74,073**	**66,765**	**63,057**	**60,801**	**(2,257)**	**567,904**	**557,036**	**(10,869)**
% Temporary	9.94%	10.21%	9.49%	8.43%	8.90%	8.90%	8.19%	8.60%	8.26%	8.15%	9.51%		8.78%	9.36%	

Table 3: WTE information

2024/25 Monthly Workforce analysis	Planning Month WTE	Apr-24 WTE	May-24 WTE	Jun-24 WTE	Jul-24 WTE	Aug-24 WTE	Sep-24 WTE	Oct-24 WTE	Nov-24 WTE	Dec-24 WTE	In Month WTE	In Month Plan WTE	F/(A) Variance WTE	Plan	F/(A) Variance WTE
Temporary staff															
Bank Staff	611.40	588.90	493.89	493.02	516.60	518.54	487.53	554.72	519.78	498.22	498.22	537.31	39.09	539.24	41.02
Medical Agency	73.21	74.57	67.68	59.07	68.38	69.16	62.13	76.13	68.32	63.53	63.53	67.47	3.94	60.16	(3.37)
Medical Locums	22.40	31.19	25.72	26.61	33.27	32.54	29.98	28.65	29.85	29.25	29.25	19.69	(9.56)	19.76	(9.49)
Nursing Agency	93.45	94.58	69.57	64.96	70.88	67.02	46.30	47.29	48.55	59.27	59.27	86.12	26.85	76.79	17.52
Other Agency	53.61	67.26	77.61	59.76	58.10	58.65	55.32	52.70	45.45	42.74	42.74	49.41	6.67	44.05	1.31
Total Temporary Staff	**854.07**	**856.50**	**734.47**	**703.42**	**747.23**	**745.91**	**681.26**	**759.49**	**711.95**	**693.01**	**693.01**	**760.00**	**66.99**	**740.00**	**46.99**
Nursing	3,428.00	3,380.35	3,402.66	3,406.98	3,419.94	3,422.15	3,422.59	3,467.42	3,457.94	3,460.86	3,460.86	3,438.78	(22.08)	3,419.62	(41.24)
Support to Nursing	2,179.48	2,171.87	2,153.16	2,159.23	2,138.57	2,097.38	2,088.21	2,067.51	2,031.07	2,014.00	2,014.00	2,109.09	95.09	2,097.34	83.34
Medical	1,090.19	1,079.95	1,084.89	1,079.97	1,074.69	1,205.17	1,142.05	1,137.58	1,131.15	1,121.14	1,121.14	1,096.11	(25.02)	1,090.01	(31.13)
AHP's	1,663.11	1,590.04	1,589.92	1,586.06	1,600.67	1,607.25	1,626.72	1,653.37	1,649.77	1,658.43	1,658.43	1,602.99	(55.44)	1,594.06	(64.37)
Infrastructure Support	2,501.85	2,484.95	2,470.55	2,477.64	2,471.69	2,465.93	2,465.71	2,462.85	2,483.64	2,473.16	2,473.16	2,521.14	47.98	2,507.10	33.94
Other	1,080.51	1,136.01	1,161.37	1,145.51	1,126.36	1,127.82	1,134.55	1,113.43	1,130.66	1,140.14	1,140.14	1,062.79	(77.35)	1,056.87	(83.27)
Substantive Staff	**11,943.12**	**11,843.17**	**11,862.55**	**11,855.39**	**11,831.92**	**11,925.70**	**11,879.82**	**11,902.15**	**11,884.23**	**11,867.73**	**11,867.73**	**11,830.90**	**(36.83)**	**11,765.00**	**(102.73)**
Total All Staff	**12,797.19**	**12,699.67**	**12,597.02**	**12,558.81**	**12,579.15**	**12,671.61**	**12,561.08**	**12,661.64**	**12,596.18**	**12,560.74**	**12,560.74**	**12,590.90**	**30.16**	**12,505.00**	**(55.74)**
% Temporary	6.67%	6.74%	5.83%	5.60%	5.94%	5.89%	5.42%	6.00%	5.65%	5.52%	5.52%	6.04%		5.92%	

2.6 December agency expenditure was £2.169m. This was £0.259m lower than November and £0.831m lower than in the equivalent period in 2023/24. It should be noted that when compared to the same period last year, the Trust has spent £4.7m less on agency to date and remains on course to deliver £6.8m of recurrent cip.

2.7 Medical agency in December was £1.418m (£0.304m lower than November). Vacancies continue to be the largest driver of agency usage and accounted for £1.141m (66%) of the total SFT agency spend in month.

2.8 The Trust agency cap is £27.390m and is based on a 3.2% of planned pay spend. At the end of December, we are £2.209m above the cap. This variance has decreased by £0.065 in December. Clinical service groups continue to exercise rigorous controls on their agency use and usage is reviewed regularly by senior colleagues on a regular basis.

2.9 In addition to the effective controls in place to manage agency usage, the Trust continues to explore recruitment opportunities overseas. All service groups are working with their People Business Partners to explore additional supply avenues and review alternative staffing models to mitigate the difficulty of recruiting into hard to fill vacancies e.g. overseas consultants, clinical fellows and using a different skill mix.

3. COST IMPROVEMENT PROGRAMME

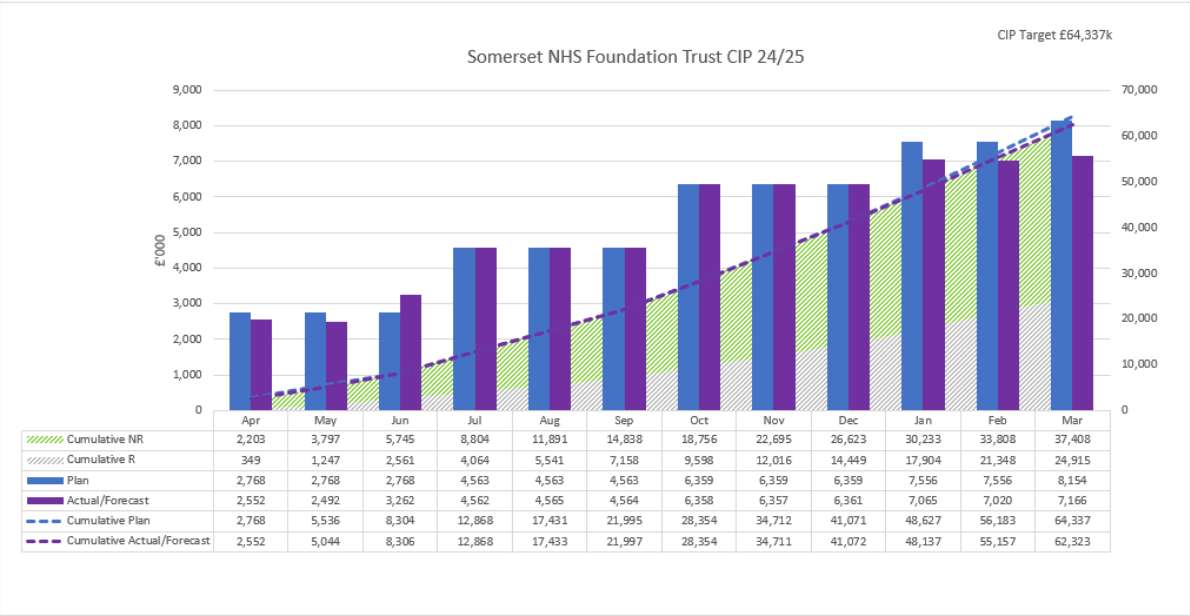
3.1 In December, savings of £6.359m were delivered. This was breakeven to plan. Recurrent savings formed £2.433m of the savings achieved (38%).

3.2 All schemes are continually risk assessed and categorised by their stage of maturity as part of the month end reporting process. The status of the schemes indicates 5% (November 6%) with a risk rating of red are largely all currently classified as non-recurring schemes. Low risk schemes are 87% (November 86%) and the remaining 8% medium (November 8%).

3.3 The level of savings achieved in month is reassuring, particularly as December was extremely challenging operationally. The profile of savings required in Quarter 4 presents the biggest challenge, however, the overall forecast achievement at service level remains consistent.

3.4 Further analysis is shown in the charts below: -

Chart 1: CIP Plan 2024/25

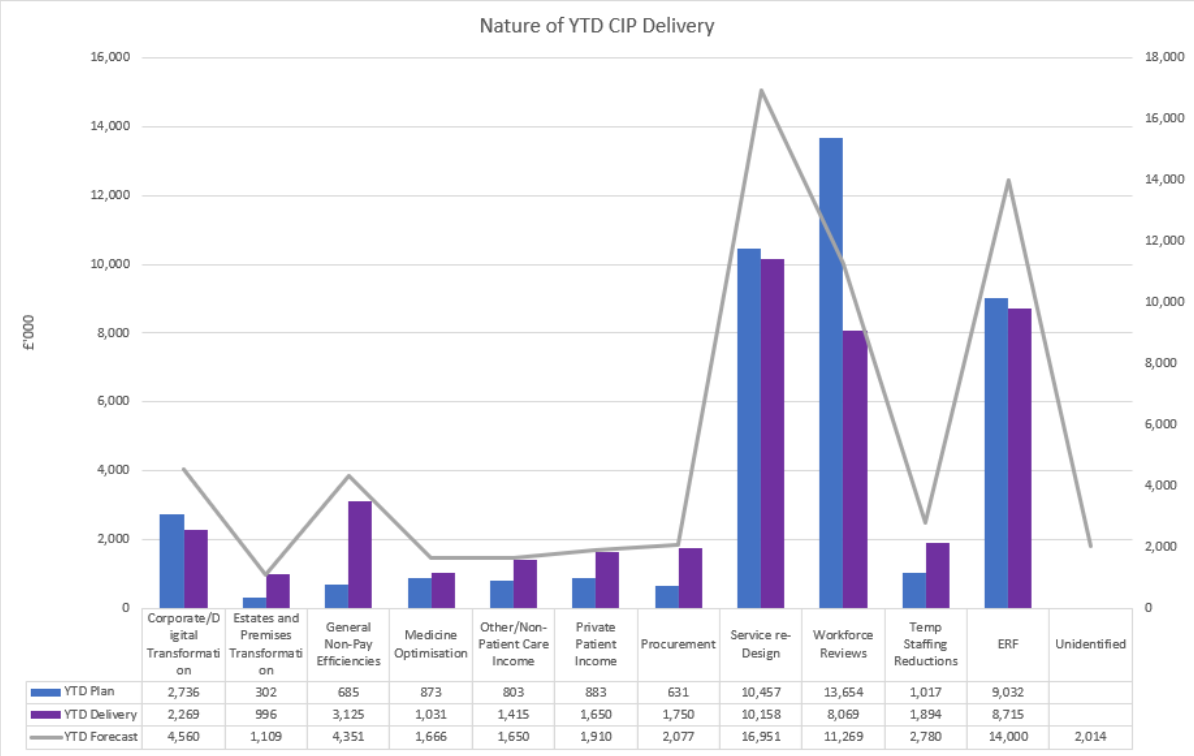


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative NR	2,203	3,797	5,745	8,804	11,891	14,838	18,756	22,695	26,623	30,233	33,808	37,408
Cumulative R	349	1,247	2,561	4,064	5,541	7,158	9,598	12,016	14,449	17,904	21,348	24,915
Plan	2,768	2,768	2,768	4,563	4,563	4,563	6,359	6,359	6,359	7,556	7,556	8,154
Actual/Forecast	2,552	2,492	3,262	4,562	4,565	4,564	6,358	6,357	6,361	7,065	7,020	7,166
Cumulative Plan	2,768	5,536	8,304	12,868	17,431	21,995	28,354	34,712	41,071	48,627	56,183	64,337
Cumulative Actual/Forecast	2,552	5,044	8,306	12,868	17,433	21,997	28,354	34,711	41,072	48,137	55,157	62,323

3.5 The nature of the efficiencies delivered through our cost improvement programme to date are summarised in the chart 2 below. A large element of the forecast savings are classified as service redesign; £16.951m.

Workforce reviews; £11.269m and general non-pay efficiencies; £4.351m are next largest contributors, respectively.

Chart 2: Nature of CIP delivery



	Corporate/Digital Transformation	Estates and Premises Transformation	General Non-Pay Efficiencies	Medicine Optimisation	Other/Non-Patient Care Income	Private Patient Income	Procurement	Service re-Design	Workforce Reviews	Temp Staffing Reductions	ERF	Unidentified
YTD Plan	2,736	302	685	873	803	883	631	10,457	13,654	1,017	9,032	
YTD Delivery	2,269	996	3,125	1,031	1,415	1,650	1,750	10,158	8,069	1,894	8,715	
YTD Forecast	4,560	1,109	4,351	1,666	1,650	1,910	2,077	16,951	11,269	2,780	14,000	2,014

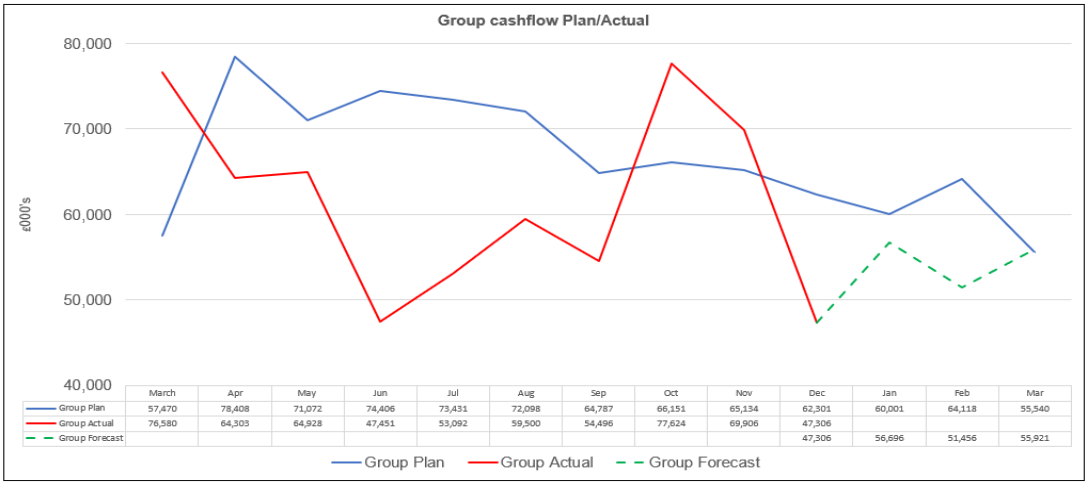
3.6 We continue to scope and identify further opportunities to close the gap, recognising also that the schemes already identified may not deliver in full. The level of unidentified savings has reduced again in December and is now c£2.0m an improvement of £0.3m since November.

4. CASH

4.1 Cash balances at 31 December were £47.306m; £14.995m lower than plan, this is primarily due to capital expenditure incurred in advance of PDC drawdown (£7.907m scheduled to be drawn down in January), £9.928m contract variations awaiting finalisation (including £8.82m for Elective recovery fund income) and timing differences in trade and other payables.

4.2 The planned, actual and forecast cash balances are set out in Chart 3 below:-

Chart 3: Cash flow Actual/Plan



	March	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Group Plan	57,470	78,408	71,072	74,406	73,431	72,098	64,787	66,151	65,134	62,301	60,001	64,118	55,540
Group Actual	76,580	64,303	64,928	47,451	53,092	59,500	54,496	77,624	69,906	47,306			
Group Forecast										47,306	56,696	51,456	55,921

5. STATEMENT OF FINANCIAL POSITION (BALANCE SHEET)

5.1 The movement in cash balances is due to capital expenditure incurred in advance of PDC drawdown (£7.907m scheduled to be drawn down in January), £9.928m contract variations awaiting finalisation (including £8.82m for Elective recovery fund) and timing differences in trade and other payables: non-capital.

5.2 Deferred income in-month movement is driven by £4.334m education income (including psychology students).

Nov-24	Dec-24	Movement		Mar-24	Dec-24	Movement in Year
£000	£000	£'000		£000	£000	£000
40,999	41,507	508	Intangible Assets	37,954	41,507	3,554
411,631	412,189	558	Property, plant and equipment, other	390,563	412,189	21,626
27,797	26,759	(1,038)	On SoFP PFI assets	28,360	26,759	(1,602)
81,903	81,232	(671)	Right of use assets	83,020	81,232	(1,788)
14	14	0	Investments	14	14	(0)
14	14	0	Other investments/financial assets	14	14	0
3,200	3,132	(68)	Trade & other receivables >1yr	2,957	3,132	175
565,559	564,847	(712)	Non-current assets	542,883	564,847	21,965
11,129	11,682	554	Inventories	11,005	11,682	677
24,994	24,586	(408)	Trade and other receivables: NHS receivables	7,081	24,586	17,505
25,980	29,080	3,100	Trade and other receivables: non-NHS receivables	24,932	29,080	4,148
466	466	0	Non current assets held for sale	466	466	0
69,906	47,306	(22,600)	Cash	76,580	47,306	(29,274)
132,475	113,120	(19,355)	Total current assets	120,064	113,120	(6,943)
(110,598)	(101,231)	9,366	Trade and other payables: non-capital	(96,052)	(101,231)	(5,179)
(13,868)	(11,213)	2,655	Trade and other payables: capital	(14,419)	(11,213)	3,207
(30,045)	(25,009)	5,037	Deferred income	(16,340)	(25,009)	(8,669)
(17,427)	(17,050)	376	Borrowings	(14,364)	(17,050)	(2,687)
(5,292)	(4,706)	587	Provisions <1yr	(7,805)	(4,706)	3,099
(177,230)	(159,208)	18,021	Current liabilities	(148,980)	(159,208)	(10,228)
(44,756)	(46,088)	(1,334)	Net current assets	(28,916)	(46,088)	(17,172)
(107,406)	(104,412)	2,994	Borrowings >1yr	(111,977)	(104,412)	7,565
(4,607)	(4,607)	0	Provisions >1yr	(3,073)	(4,607)	(1,534)
(1,509)	(1,488)	22	Deferred income >1yr	(1,682)	(1,488)	194
(113,523)	(110,507)	3,016	Total long-term liabilities	(116,732)	(110,507)	6,225
407,280	408,252	971	Net assets employed	397,234	408,252	11,018
			Financed by:			
383,329	383,329	0	Public dividend capital	363,752	383,329	19,577
77,897	77,897	0	Revaluation reserve	77,897	77,897	0
186	(4,434)	(4,620)	Other reserves	(4,441)	(4,434)	8
(2,471)	(2,471)	0	Financial assets at FV through OCI reserve	(2,471)	(2,471)	0
(52,058)	(46,575)	5,483	I&E reserve	(38,050)	(46,575)	(8,524)
			Other's equity			
397	505	109	Non-controlling Interest	548	505	(42)
407,280	408,252	971	Total financed	397,234	408,252	11,018

6. CAPITAL

6.1 Schemes are being progressed in accordance with the agreed programme for the year. There are several timing differences within the internal programme around backlog maintenance and IT (including digital and EHR) that continue to be reviewed ensuring spend is considered later in the programme.

6.2 Year to date, capital expenditure is £51.292m compared with the plan of £63.672m, resulting in an underspend of £12.381m, £8m relates to delays to the Yeovil Diagnostic Centre build programme causing delays to the commencement of the lease, but this is expected to complete in March 2025.

6.3 The continued pressure on access to clinical areas remains an ongoing risk as we are now in the winter period and may hinder the progress of a number of backlog schemes. This is being actively managed between the estates and site teams on a weekly basis. Reviews have been carried out with all capital project managers to assess the likely outturn capital expenditure for the financial year and several additional schemes have been identified to mitigate any potential shortfall in the originally agreed programme and we remain confident that our total capital funding will be fully utilised by year end.

6.4 A summary at overall programme level, together with the outturn position is shown in Table 4 below:

Table 4: Capital Programme monitoring

Capital Programme 2024-2025	Plan £000	Revised Budget £000	YTD Plan £000	YTD Actual £000	Variance Act v plan YTD £000	Forecast Outturn £000	Variance Forecast v Revised Budget £000
Backlog Maintenance	**9,108**	**8,613**	**6,168**	**2,707**	**(3,460)**	**7,607**	**(1,006)**
Essential Facilities Improvement Works	**1,450**	**1,662**	**948**	**1,211**	**263**	**1,993**	**331**
Service Redesign Enabling Works	**3,920**	**3,983**	**2,673**	**3,023**	**351**	**5,184**	**1,201**
Service Redesign Enabling Works - Major	**8,660**	**7,660**	**3,028**	**554**	**(2,474)**	**7,426**	**(234)**
Infrastructure	**906**	**906**	**168**	**67**	**(101)**	**1,012**	**106**
Rolling IT & Digital Development	**13,519**	**13,202**	**9,566**	**5,494**	**(4,072)**	**12,148**	**(1,054)**
Replacement Medical Equipment	**5,550**	**5,550**	**3,898**	**1,632**	**(2,266)**	**6,195**	**645**
Other	**410**	**530**	**375**	**290**	**(85)**	**542**	**12**
Total Internal Capital Envelope	**43,523**	**42,106**	**26,823**	**14,978**	**(11,844)**	**42,106**	**0**
Externally Funded Capital Schemes	**Plan £000**	**Revised Budget £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**	**Forecast Outturn £000**	**Variance Forecast v Revised Budget £000**
PDC STP 3 - MPH Surgical Centre	24,631	24,631	17,261	22,774	5,513	24,631	0
PDC NHP - MPH	900	1,040	665	721	56	1,040	0
PDC NHP Enabling	1,137	1,137	1,137	848	(289)	1,137	0
PDC Pathology Network	222	100	82	77	(5)	200	100
PDC Diagnostic Network	733	855	478	74	(404)	0	(855)
PDC Endoscopy - MPH	549	549	139	352	213	549	0
PDC Cyber Security	0	55	0	0	0	55	0
PFI Funded IFRIC 12 - SFT MES	424	424	212	220	8	424	0
Donated Acute MPH	50	56	41	56	15	56	0
PDC Tif - Elective Recovery/Theatre expansion	4,076	4,076	2,275	3,455	1,180	4,076	0
PFI Funded IFRIC 12 - YDH MES	333	641	166	641	475	641	0
Donated Salix (Slippage)	0	1,777	0	328	328	2,000	223
Donated Acute YDH Breast Unit	1,000	1,256	887	1,266	379	1,265	9
Donated YDH	0	32	0	32	32	32	0
PDC Yeovil CDC	1,292	1,292	1,292	408	(884)	1,292	0
PDC Somerset CYP Safe Spaces	275	275	110	36	(74)	275	0
Donated Community	110	110	137	0	(137)	110	0
PDC Diagnostic Screening-Colposcopy	0	176	0	0	0	176	0
PDC Critical Infrastructure	0	1,456	0	0	0	945	(511)
Total Additional Schemes	**35,732**	**38,306**	**24,882**	**31,288**	**6,406**	**38,904**	**(523)**
IFRS Leases	14,523	14,523	11,968	5,026	(6,942)	14,523	0
TOTAL TRUST PROGRAMME	**93,778**	**94,935**	**63,672**	**51,292**	**(12,381)**	**95,533**	**(523)**

6.5 The Board will be aware of the recent announcement following the review of the New Hospital Programme (NHP) to place the Musgrove Park Hospital scheme into Wave 2. This means that we would now expect to commence on-site construction between 2033 and 2035 and that we will need to pause further development of our scheme until 2030/31. At this point we will receive the necessary programme funding and support to enable us to develop a compliant scheme and the Strategic Outline Case. We are currently waiting for further clarity on how the costs incurred to date and any wind down costs will be managed.

7. CONCLUSION & RECOMMENDATION

7.1 We remain on track to deliver a balanced plan. There are a number of key actions we need to continue making progress on:-

- Clarification on how the impact of the recent announcement to the delay to the Musgrove Park Hospital redevelopment to wave 2 of the NHP programme will be managed and the potential impact this may have on the financial performance of the Trust.

- Continue to close the CIP gap and support delivery of service group schemes in line with their forecasts.
- Identify further opportunities to mitigate ongoing cost pressures and mitigate any further unplanned risks. This now includes ensuring we can remain within the fixed ERF income envelope recently announced by NHSE.
- Review elective recovery performance forecast to determine any financial risk in terms of expected costs committed to deliver the expected level of performance.
- Manage the impact of winter pressures within the agreed funding envelope.
- Continue to focus on medical agency reduction and ensure our forecasts accurately and honestly reflect the expected run rate in the remaining months.

7.2 The Board are asked to discuss the financial performance for December.

CHIEF FINANCE OFFICER

Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance report from the Audit Committee meeting held on 15 January 2025
SPONSORING EXEC:	Jade Renville, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Paul Mapson, Chairman of the Audit Committee
DATE:	4 February 2025

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 Audit Committee meeting held on 15 January 2025 and the assurance received by the Committee. The meeting was conducted as a video conference call. The Committee received assurance in relation to: • Matters Arising – Terms of Reference discussion • Internal Audit Escalation Assurance Report • The Board Assurance Framework discussion • The Corporate Risk Register, Risk Management Update and Risk Management Policy • The Counter Fraud Progress Report and Recommendation Tracker • The Internal Audit Progress Report • The findings of the Capital Projects (Estates) Planning Audit • The findings of the KFS – Charitable Funds Audit • The findings of the People Strategy – Future Workforce Audit • Positive and negative assurance in relation to the MIS Year 6 Review

	• The findings of the Procurement Audit follow up report • The Internal Audit Follow Up report • The discussion on the draft Internal Audit Plan 2025/26 • The External Audit Progress Report – planning for the 2024/26 accounts audit • Losses and Special Payments • Single Quotation/Tender Waiver Action Report • The Terms of Reference Report The Committee identified the following areas for follow up: • The Corporate Risk Register – presentation of the 2025/26 risk appetite statement to the April 2025 Committee meeting and the outstanding decision in relation to mandating risk management training • The Corporate Risk Register – the need for a strategic risk relating to the Somerset demographics • The Counter Fraud Progress Report – the investigation into the validity of CVS by two colleagues • People Strategy – Future Workforce Audit Report – the need for a Board level workforce discussion • The findings of the Deterioration Patients (PEWS) Audit report The Committee identified the following area to be reported to the Board or other committees: • The Corporate Risk Register – the need for a strategic risk relating to the Somerset demographics • People Strategy – Future Workforce Audit Report – the need for a Board level workforce discussion

Recommendation	The Board is asked to note the assurance and areas of concern identified by the Audit Committee. The Board is further asked to note the areas to be reported to the Board or to Committees.

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

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

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

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

Details: N/A

Equality and Inclusion

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

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

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

AUDIT COMMITTEE MEETING HELD ON 15 JANUARY 2025

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 15 January 2025.

2. ASSURANCE RECEIVED

Matter Arising - Terms of Reference

2.1. The Committee discussed the reference to inviting senior officers to attend meetings as directed by the Audit Committee in view of the implementation of the escalation process. The Committee agreed to retain the authority of the Audit Committee to invite senior officers to the meetings and further agreed that duplication should be avoided as much as possible and that this reference was more relevant to inviting senior officers to meetings in the case of significant delays in implementing audit recommendations.

Internal Audit Escalation Assurance Report

2.2. The Committee received the report and noted that the escalation process had been initiated for the following audits: Frailty in Older People; Capital Projects (Estates) Planning; Deteriorating Patients – Paediatrics (PEWS); and Procurement Follow Up.

2.3. The Committee particularly discussed the frailty in older people report and noted the considerable pressure on the service, which had been further impacted by the bed and winter pressures. The Committee agreed that the underlying issues will need to be better understood and noted that the frailty service challenges will be raised at the Quality and Governance Assurance Committee.

Board Assurance Framework

2.4. The Committee discussed the Board Assurance Frameworks (BAF) and noted that the BAF will be presented to the November 2024 Board meeting.

2.5. The Committee recognised that the BAF was a high level document, that the strategic risks were unlikely to move significantly during the year and that it will be helpful to consider how to provide more information on actions being taken at lower levels.

2.6. The Committee noted that: recent deep dive into objectives had been undertaken at Committee level; some of the strategic objectives were wider system risks and mitigations actions were therefore limited to actions which could be taken by the trust; there was a need to differentiate between

risks to strategy and risk to current operations; the majority of controls and assurance levels had been rated green or amber whilst risk levels had remained red and that it was important to understand whether the actions had an impact on the risks, whether the actions were the right actions and whether further actions could be taken to mitigate the risk; system work was taking place but this work was not reflected in the BAF.

2.7. The Committee noted that risks were raised at service group level and that, in view of the scoring of the risk, the risk was not escalated to the corporate risk register. The concern was that if similar risks were raised in other service groups, there was no corporate oversight of these risks and the need for a compound higher scoring risk for escalation to the corporate risk register could be missed. The Committee further noted the work taking place with teams on risk profiling their service to be able to identify gaps in risks compared to central and corporate risks.

Corporate Risk Register (CRR)

2.8. The Committee received and discussed the report. The Committee noted the key themes; the high scoring corporate risk; and the mitigating actions taken.

2.9. The Committee further noted: the ongoing work with the subsidiaries; the work with GP practices to identify practice risks and uploading their risks onto Radar; the system work in relation to the development of a system risk management framework; the work with stakeholders on the development of the 2026/29 risk management strategy; and the need to ensure that the risk description reflected the actual risk.

Risk Management Update

2.10. The Committee noted that all risks had been transferred onto Radar and that a review of risks will be undertaken to ensure consistency and to avoid duplication.

2.11. The Committee received and noted the annual update and progress made.

Risk Management Policy

2.12. The Committee received the draft risk management policy which had previously been circulated for virtual approval. The Committee noted the changes to the policy.

Counter Fraud Progress Report

2.13. The Committee received the counter fraud progress report and noted the proactive work, investigations and performance against the functional standards.

2.14. The Committee noted the national recognition of the work of the Counter Fraud Manager on mandate invoicing fraud and the presentation of this work to a national fraud webinar.

2.15. The Committee noted the investigation into the attempt to divert a supplier payment of £3.2 million to a different bank account and complimented the finance team on the actions taken to avoid this fraud.

2.16. The Committee agreed that the report provided significant assurance about the work of the counter fraud service.

Counter Fraud Recommendations Tracker

2.17. The Committee received the counter fraud recommendations follow up report and the Committee agreed that the report provided significant assurance about the implementation of the recommendations. The Committee noted that there were no overdue recommendations.

Internal Audit progress report

2.18. The Committee received the internal audit progress report and agreed that good progress was being made implementing the internal audit plan with the field work underway for a further four reports and field work for three final audits commencing in January 2025.

Capital Projects (Estates) Planning Audit Report

2.19. The Committee received the audit report and noted the moderate opinion for design and a limited opinion for design effectiveness. The Committee noted that the report had been presented to the January 2025 Operational Leadership Team meeting. The Committee will monitor the implementation of the recommendations as part of the internal audit follow up report and progress will also be monitored by the Finance Committee.

KFS – Charitable Funds Audit Report

2.20. The Committee received the audit report and noted the moderate opinion for both design and design effectiveness. The Committee agreed that the report provided a good level of assurance.

People Strategy – Future Workforce Audit Report

2.21. The Committee received the audit report and noted the substantial opinion for design and a moderate opinion for design effectiveness. The Committee noted that workforce planning had been discussed in detail at the January 2025 People Committee meeting.

MIS Year 6 Review

2.22. The Committee received the audit report and noted that the audit did not provide an audit opinion. The Committee noted that the audit focussed on reviewing evidence for six out of the ten safety actions, in preparation for the annual submission, with t findings showing that the evidence for two of the safety actions did not meet the requirements. The Committee noted the findings and further noted that the report will be shared with the Quality and Governance Assurance Committee for further review and follow up.

Procurement Audit Follow up Report

2.23. The Committee received the audit report and noted that the audit was a follow up from a previous audit. The Committee noted that the findings showed significant progress made in relation to the implementation of the two high priority recommendations and the Audit Committee agreed to close the recommendations as having been completed.

Follow up Report

2.24. The Committee received the follow up report and noted the position in relation to the implementation of the 2023/24 and 2024/25 audit recommendations. The Committee noted that the implementation of two recommendations from 2023/24 were overdue and the details of these recommendations were noted.

2.25. The Committee agreed that there were no areas of significant concern.

Draft Internal Audit Plan 2025/26 and Charter

2.26. The Committee received the draft internal audit plan for 2025/26 and the internal audit charter.

2.27. The Committee discussed the report and recommended including an audit on the management of annual leave and sickness for medical staff in the audit plan. The Committee noted that the final version of the internal audit plan will be presented to the April 2025 Committee meeting.

External Audit Progress Report – Initial Audit Consideration and Approach

2.28. The Committee received the report and noted the work to date and the work scheduled over the next quarter, including the areas of focus for the 2024/25 accounts audit. The Committee noted that the land and building evaluation was due and that details of the valuation model and assumptions made will be shared with the Operational Leadership Team and the Finance Committee.

2.29. The Committee noted that the final external audit plan will be presented to the April 2025 Committee meeting.

Losses and Special Payments

2.30. The Committee received the losses and special payments report and noted the reasons for the losses and special payments.

2.31. The Committee agreed that the report did not highlight any areas of concern.

Single Quotation/Tender Waiver Action report

2.32. The Committee received the single quotation/tender waiver action report for the trust and for Simply Serve Limited and noted the single quotation and tender waiver actions and the reasons for these actions.

Policy Changes/Updates/Statutory requirements

2.33. The Committee noted that no policy changes or updates were to be brought to

the attention of the Committee. The Committee noted that the planning guidance for 2025/26 was still awaited.

Terms of Reference Progress Report

2.34. The Committee received the report which monitored progress against the Committee's Terms of Reference.

2.35. The Committee agreed that the report provided significant assurance about the work of the Committee but noted the need to consider including cyber security in the term of reference.

3. AREAS FOR FOLLOW UP

Corporate Risk Register (CRR)

3.1. The Committee received and discussed the report. The Committee noted the review of the 2025/26 risk appetite statement for discussion at the April 2025 Committee meeting.

3.2. The Committee received an update on risk management training and noted that approval from the Learning Committee about risk management training being assigned as mandated training was still awaited; that the delay in this approval had impacted on the delivery of the risk management strategy; and that it was expected that a decision will be made by the Learning Committee in February 2025.

3.3. The Committee discussed the frequent risk references over the last few years to an increase in demand and the need for additional staffing. The Committee highlighted the need to consider these risks in the context of demand and transformation and increasing productivity and noted that staffing establishment reviews were carried out for nursing and midwifery staff; that workforce planning took account of changing landscapes, including productivity requirements; that workforce numbers had flattened compared to the last few years; and that services were working on aligning workforce and adjusting roles in hard to recruit areas. The Committee further noted the need to reflect a strategic risk relating to the unique demographics of the population in Somerset and the impact on services and workforce.

Counter Fraud Progress Report

3.4. The Committee particularly discussed details of the investigation into the validity of CVs presented by two colleagues; the investigation findings; the management response; and noted the development of a Standard Operating Procedure setting out how individuals will be managed in these kinds of circumstances. The Committee asked for an update on the process and actions to be presented to the April 2025 Committee meeting.

People Strategy – Future Workforce Audit Report

3.5. The Committee highlighted the need for a strategic Board level discussion on the link between workforce and productivity but also on the wider

workforce planning in view of integration and transformation and agreed to escalate this to the Board as part of the assurance report.

Deterioration Patients (PEWS) Audit Report

3.6. The Committee received the audit report and noted the moderate opinion for design and a limited opinion for design effectiveness. The Committee expressed concern about the high priority risk, including the management response, and the Committee agreed to share the audit report with the Quality and Governance Assurance Committee for follow up.

3.7. The Committee further agreed to ask the Digital Committee to review the system issues.

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 Executive Team or other committees:

- The Corporate Risk Register – the need for a strategic risk relating to the Somerset demographics
- People Strategy – Future Workforce Audit Report – the need for a Board level workforce discussion

CHAIRMAN OF THE AUDIT COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Charity Committee meeting held on 21 October 2024
SPONSORING EXEC:	David Shannon, Director of Strategy and Digital Development
REPORT BY:	Katie Fry, Executive PA
PRESENTED BY:	Graham Hughes, Chairman of the Charity Committee
DATE:	4 February 2025

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 21 October 2024. The Committee received assurance in relation to: • Annual accounts • CCLA Investment Update • Major donation and proposed projects • Business cases 164, 171, 172, 173 and 175. The Committee did not identify any areas of follow up. 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.

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 21 OCTOBER 2024

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 21 October 2024, 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

Annual Accounts

2.1. Fiona Westwood provided feedback on Monahans audit of the charities accounts.

2.2. Adjustments were identified and made to the initial draft of the accounts including correcting an error where income and expenditure were grossed up due to a billing mistake by SFT.

2.3. Adjustments were made to correctly identify and treat certain funds as restricted.

2.4. Full benefits of key management personnel must be disclosed. Graham Hughes asked to group additional personnel in this disclosure to avoid transparency issues.

2.5. The accounts were adopted as drawn, subject to the discussed adjustment regarding key management personnel.

CCLA Investment Update

2.6. Daisy Mannifield attended for this item and provided an update.

2.7. Global equity markets have increased by 20% driven by factors such as artificial intelligence and technology.

2.8. The investment fund returned 12.55% for the year end to September with income around 2.7%.

2.9. There was a discussion regarding moving from the Investment Fund to the Ethical Investment Fund. This has more restricts but performance is slightly higher. There are 12 stocks difference, mainly relating to alcohol restriction.

Major Donation

2.10. Potential projects to be funded by the major donation are still being proposed.

Fundraising Report

2.11. The Breast Cancer (Maple) Unit opening was a well-attended success.

2.12. There have been several successful fundraising events such as the first fire walk at Bridgwater Community Hospital and Cycle 42.

Major Donation and Proposed Projects

2.13. The charity has worked with the donors to determine how to use the funds. The donation will be allocated to four main parts:

- Wells Site Renovation
- Urology Project
- Gardens and Mental Health
- Flexible Allocation

2.14. The Committee supported the proposed allocation.

2.15. James Kirton introduced the idea of using part of the donation for small grants to support mental health initiatives.

2.16. The plans for the major donation will be discussed with ICB colleagues in the future.

Finance Report and Approvals

2.17. Income for quarter two was reported at £833,000. Expenditure for the quarter was £353,000.

2.18. The total funds in the charity now stand at £9.6m. £3.5m of this is committed, with another £2.4m allocated to the breast unit. This leaves £6.1m available, including the major donation of £2m previously mentioned.

2.19. Five business cases were reviewed and ratified (BC164, BC171, BC172, BC173, BC175).

3. AREAS OF CONCERN OR FOLLOW UP

3.1. There were no areas of concern or follow up.

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